POLICY AND PROCEDURE MANUAL

FOR REPORTING FACILITIES

May 2015

Effective For Cases Diagnosed January 1, 2015 and Later

Indiana State Cancer Registry
Indiana State Department of Health
2 North Meridian Street, Section 6-B
Indianapolis, IN 46204-3010
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The Indiana State Cancer Registry Policy and Procedure Manual for Reporting Facilities was written by Jacqueline S. Harber, RHIA, CTR with assistance by Shelley Boltinghouse, RHIA, CTR and Stephen Nygaard of the Indiana State Department of Health and is in the public domain. It is based on the 1995 manual created by Martha Graves, RHIA, CTR (a former program director). The manual itself may be copied all, or in part.

Revised 2015, Indiana State Department of Health.
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INTRODUCTION

A. BACKGROUND

In 1985, the General Assembly of the State of Indiana passed Public Law 174-1985 establishing a cancer registry “for the purpose of recording all cases of malignant disease that occur in Indiana residents and compiling necessary and appropriate information concerning those cases...in order to conduct epidemiologic surveys of cancer and to apply appropriate preventive and control measures.”

An advisory committee was established to assist the State Department of Health in creating such a registry. The committee developed the standards for establishing and maintaining the State Cancer Registry. They also helped develop a Policy and Procedure Manual and implemented training throughout the state. Hospitals, physicians, dentists, and medical laboratories began reporting January 1, 1987.

A 1988 amendment to the law allows the State Cancer Registry to release confidential information to another state’s cancer registry if that state has entered into a reciprocal agreement with the State Department of Health. The reciprocal agreement must state that information that identifies a patient will not be released to any other entity without the written consent of the patient.

In 1991, IC 16-4-9-3 was amended to allow the state to enter into reciprocal agreements with other states in order to exchange data between cancer registries.

In a 1993 amendment, several laws were recodified. No substantial changes were made other than some minor wording changes, such as changing “State Board of Health” to “State Department of Health.” The current law is IC 16-38-2.

This manual has been revised from the edition released in 1995 to reflect current laws and standards.

B. PURPOSE

The intent of this manual is to serve as a reference for hospitals reporting cases of malignant disease to the State Cancer Registry. The procedures set out in the manual have been developed in accordance with IC-38-2 and 410 IAC 21-1 (Appendix A).

C. DEFINITIONS

The terms must, shall, and is required are used throughout the manual to indicate what is mandatory and the only acceptable method under the law and rule. Should is used to reflect commonly accepted practices, yet allows effective alternatives to be used. May is used to indicate an alternative that is acceptable, but not necessarily preferred.

D. REFERENCE MATERIALS

This Policy and Procedure Manual serves as a reference which is offered free of change to reporting entities. For a complete list of required references and other resources, see Chapter 1.

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1 IC 16-4-9 (IC 16-38-2 since 1993)
2 IC 16-4-9-6 (IC-38-2-6 since 1993)
E. CONSULTATION

Personnel of the State Cancer Registry are available by telephone and, in special circumstances, on site to provide consultation on all aspects of reporting. These include abstracting, organization and management, cancer registry software education, and updates on cancer data management at the both the state and national level. The Indiana Cancer Registrars Association has graciously offered to serve as a source for consultation, utilizing the expertise of experienced cancer registrars across the state.

F. OUTPUT

The rule for implementing statewide reporting mandates that the State provide each reporting facility a comprehensive annual report which outlines the trends of malignant disease in Indiana. Hospitals, physicians, dentists, medical laboratories, and other persons may request and be provided with individualized special reports as state resources permit.

G. QUALITY CONTROL

The State Cancer Registry monitors data quality through a variety of activities that are described in Chapter 7. The activities include careful monitoring of the number of cases submitted, visual review of abstracts for completeness and accuracy, and extensive electronic edits. Chapter 7 provides policies for clarification and modification of data. Continuing education and policy and procedure updates will focus on issues identified through quality control activities.

In summary, the State Cancer Registry serves as the state’s repository of cancer data and an important resource offering a wide spectrum of services to the hospitals, physicians, dentists, and medical laboratories reporting to the State. As a tax supported service to health care professionals and the public, feedback regarding improvements in State Cancer Registry policies and services is welcomed.
CHAPTER 1: REFERENCES

A. REQUIRED REFERENCES

1. Indiana State Cancer Registry Policy and Procedure Manual.  
   http://www.in.gov/isdh/24035.htm

   http://www.who.int/classifications/icd/adaptations/oncology/en/

3. Multiple Primary and Histology Coding Rules. National Cancer Institute, SEER Program  

4. Collaborative Stage Data Collection System Coding Instructions.  
   http://https://cancerstaging.org/cstage/Pages/default.aspx

5. Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.  

   http://seer.cancer.gov/tools/ssm/

B. ADDITIONAL RESOURCES

The following list identifies resources that may provide helpful information for use in the collection and abstraction of cancer data.

   http://www.facs.org/cancer/coc/fordsmanual.html

2. SEER*Rx – Interactive Antineoplastic Drugs Database.  
   http://seer.cancer.gov/tools/seerrx/

   http://www.cancerstaging.org


5. The Brain Book – Abstracting and Coding Guide for Primary Central Nervous System Tumors, SEER Program, National Cancer Institute  
   http://www.ccrcai.org/PDF/BrainTumor2.pdf


   http://seer.cancer.gov/tools/codingmanuals/

    http://www.naaccr.org/

   Volume I, Data Exchange Standards and Record Description. Intended for programmers, this provides the record layout and specifications for the standard for data exchange.

   Volume II – Data Standards and Data Dictionary. Intended for hospital and central cancer registries, programmers, and analysts, this provides detailed specifications and codes for each data item in the data exchange record layout.

   Volume III, Standards for Completeness, Quality, Analysis, and Management of Data. Intended for central registries, this provides detailed standards for many aspects of the operation of a population-based cancer registry.

   Volume IV, NAACCR Standard Edits. This standard document currently is only made available electronically as a program code and a database. It documents standard computerized edits for data corresponding to the data standards Volume II.
   http://www.naaccr.org/StandardsandRegistryOperations/VolumelIV.aspx

11. Cancer Program Standards 2012: Ensuring Patient-Centered Care, American College of Surgeons Cancer Programs Commission on Cancer
    http://www.facs.org/quality-programs/cancer/coc/standards

    http://www.ncra-usa.org/i4a/pages/index.cfm?pageid=3753

13. Anatomy, physiology, pathology, and other similar textbooks are invaluable for coding and abstracting of cancer data. Medical dictionaries, such as Dorland’s, Stedman’s Blakinston’s, Melloni’s, or Taber’s will also be needed.

For information regarding the National Cancer Registrars Association, Inc., write to:

National Cancer Registrars Association, Inc.
1330 Braddock Place, Suite 520
Alexandria, VA 22314
(703) 299-6640
Fax: (703) 299-6620
C. HISTORIC REFERENCES


SEER Program: Self-Instructional Manuals for Tumor Registrars; Surveillance, Epidemiology, and End Results (SEER) Program Informational Guidebook Training Aids. This series of books was published in the 1990’s as a mechanism for tumor registrars to learn the procedures for abstracting from medical records of cancer patients and for carrying out functions in the institution-based tumor registry. They are available on-line in both PDF and ZIP formats. If you experience problems downloading any of the files, you may order the manuals on CD-ROM.
http://seer.cancer.gov/training/manuals/

The set consists of:
- Book One - Objectives and Functions of a Tumor Registry, 1999.
- Book Four - Human Anatomy as Related to Tumor Formation, 1995.
- Book Five - Abstracting a Medical Record: Patient Identification, History, and Examinations, 1993.
- Book Six - Classification for Extent of Disease, 1977.(Out of print)
- Book Seven - Statistics and Epidemiology for Tumor Registrars, 1994.

To obtain the additional resources, call or write the publisher directly or call the State Cancer Registry for more information.
CHAPTER 2: CASEFINDING & SETTING UP A REGISTRY

A. OVERVIEW

The accuracy of a statewide database is dependent on the timeliness and completeness of casefinding (the identification of reportable cancer cases) at the hospital level. A variety of casefinding methods must be used since no single method can encompass all the possible medical resources used by cancer patients.

B. REPORTABLE LIST

A reportable list identifies diagnoses that will be included in the registry and those that are to be excluded. The hospital’s administration, cancer committee, and physicians; American college of Surgeons’ Cancer Program Manual; and the State Policy and Procedure Manual should be consulted when developing the reportable list. Appendix B contains the State reportable list. All diagnoses on the list must be reported to the State Registry. The hospital cancer committee may decide to collect additional diagnoses not on the list, called “Reportable-by-Agreement” cases (e.g., squamous cell carcinomas of the skin). These cases do not need to be reported to the State Registry.

C. METHODS OF CASEFINDING

Definition
Casefinding is a systematic method of identifying all reportable cancer cases. For a hospital, the cases include all patients diagnosed or treated in a hospital, both inpatient and outpatient, during the first course of therapy. Cases identified at autopsy must also be reported.

Responsibility
To assure consistency and completeness, casefinding should be the responsibility of one hospital department that has access to patients’ medical records and the appropriate hospital reports and listings. For this reason, the function is most commonly performed in the medical record department. However, it may be performed elsewhere, such as pathology, radiation therapy, oncology, or nursing department, provided there is ready access to the necessary records and a central place for record keeping. The person responsible for casefinding should have a knowledge of medical terminology, especially in the field of cancer diagnosis and treatment. Interdepartmental communication and cooperation are essential for complete casefinding.

Sources of Casefinding
The following are potential sources of cancer patient identification. Other sources, not listed here, may be appropriate, depending on the administrative structure of the hospital. To ensure that all potential sources of case identification are addressed, facilities should use the health information data systems and/or billing systems to print lists of cancer-related diagnostic codes. Casefinding should not be limited to a review of pathology reports. As potential cases are identified, the patient’s name and medical record number should be recorded for retrieval of the entire medical record.

1. Pathology and Cytology Departments
   - Pathology reports, including reports with negative findings
   - Bone marrow biopsies
   - Histology reports
   - Cytology reports
   - Hematology reports
   - Autopsy reports
   - Pathology logs
   - Pathology appointment registers
Most newly diagnosed cancer patients have a biopsy or surgical procedure for which a pathology report is written identifying and classifying the excised specimen. All pathology reports, along with the clinical summary, should be read to identify cases. Cases in which only specimens were reviewed by the reporting hospital may never have a medical record. The coded final histologic diagnoses (in SNOMED) should be reviewed. Sometimes a programmer can prepare a list containing only malignancies.

A negative pathology or cytology report may be a hidden source for finding certain cases. If an excisional biopsy was performed in a physician’s office and the patient was later referred to the hospital for additional treatment, the pathology report may be negative if no further cancer was detected. The case should still be reported to the State Registry by the hospital because the patient was referred to the hospital for further diagnosis or treatment.

**Example #1:** A physician diagnoses a melanoma and performs the excisional biopsy in the office. The patient is then admitted to the hospital for a wide excision. The pathology report does not show any malignancy. Although the pathology report is negative, the case should be reported to the State Registry by the hospital because the patient was referred to the hospital for additional treatment.

**Example #2:** A physician performs a lumpectomy for breast cancer in the office. The patient is later admitted to the hospital for a modified radical mastectomy. No residual tumor was noted on the pathology report. The hospital must report this case to the State Registry, even though the pathology report is negative.

2. **Health Information Management Department** (Medical Record Department)
   - Inpatient records
   - Outpatient records
   - Disease or diagnostic index
   - Computerized listings of specific cancer-related ICD-9-CM codes
   - Operation index
   - Admitting lists
   - Discharge lists

Health information management department personnel may assist in case identification in a number of ways. A regular listing of all cancer cases may be helpful in casefinding. Working with personnel responsible for assembly and analysis of records upon discharge may identify patients overlooked through other reviews. Coders could flag all medical records with malignant diagnoses for review by the Cancer Registrar. If feasible, direct review of all medical records by the cancer registrar assures more complete casefinding. Appendix C lists the ICD-9-CM codes that should be reviewed for eligible cases.

3. **Bill and Insurance Department** (Patient Accounts)
   - Print-outs listing cancer-related diagnostic codes

Hospital and/or departmental billing systems use diagnostic codes for billing purposes. Computerized billing systems may be used to generate lists of cancer-related diagnostic codes. See Appendix C of this manual for a list of cancer–related codes. Cancer registrars should work with billing department personnel to assess the capabilities of the system and develop the parameters of the report. The process may involve the computer vendor.

4. **Radiology Department**
   - Radiation therapy treatment summaries
   - Radiation therapy new patient listings
   - Radiation therapy log
   - Radiation therapy schedule
   - Radiation oncology records
Nuclear medicine reports
Nuclear medicine log
Nuclear medicine schedule
Diagnostic radiology reports
Scans

The radiation therapy department can be an important source of casefinding since many patients are treated solely as outpatients and may be missed by other casefinding methods. Radiology records should be made available to the person responsible for casefinding, by either providing copies of the reports or permitting access to the radiation therapy department’s patient records. A periodic review of the department’s therapy log or schedule will serve as a quality control check and help ensure completeness of casefinding.

5. Outpatients/Clinics/ER
   - Ambulatory/outpatient surgery records
   - Day surgery logs
   - Outpatient scheduling logs
   - CPT codes on outpatient records
   - Emergency room records/logs
   - ENT (ear, nose, throat) clinic records
   - Eye clinic records
   - Skin (melanoma, others) clinic records
   - Mycosis fungoides clinic records
   - OB/GYN clinic records
   - AIDS/Kaposi’s sarcoma clinic records

If outpatient records are not filed in the medical record department, arrangements should be made with the applicable departments and clinics for access to the patient records at a mutually convenient time.

6. Cancer Conference/Tumor Board
   The cancer committee of a hospital is responsible for conducting cancer conferences (tumor boards) to provide consultative services to patients and to educate the medical staff. Attendance at these conferences or review of minutes may identify additional cancer patients.

7. Other Sources of Casefinding
   - Operation/surgery log
   - Operation/surgery schedule
   - Oncology/Hematology records
   - Chemotherapy logs
   - Staff physician’s office

Preventing Duplicates
All cancer patients who have been identified by any of the methods described above should be checked against cases in the suspense system (Chapter 2, section D) and the patient index (Chapter 2, section F). If a patient’s name is found in either of these places with the same primary cancer, the case has been identified previously and should not be added to the database. These patients may be readmissions for additional treatment, recurrence, progression of or persistent disease, or follow-up.

The information obtained through casefinding should be preserved and used to help complete the abstract (if the case was found in the suspense system) or to complete follow-up (if the case was found in the patient index), if applicable.
D. SUSPENSE SYSTEM

Definition
A suspense system is a file or a list of cancer cases that have been identified but have not yet been completely entered, abstracted, or accessioned into the registry. The file or list serves as a method for keeping track of identified cancer patients until the abstracts are complete.

Purpose
The suspense system has two functions:
- To avoid duplicate case identification, and;
- To serve as a quality control check to assure that over a period of time, all identified cases have been abstracted.

Organization
For convenience in duplicate checking, the suspense system should be arranged alphabetically by month of case identification.

Patient data should include:
- Patient name
- Date of diagnosis
- Medical record number
- Cancer primary site

A paper abstract with the above information could be used as the suspense system, or an index card could be completed. The abstracts or cards should be filed alphabetically.

If the patient index described in Section F. is maintained on cards, these cards could be partially completed and used in a suspense file. Once the case is fully abstracted, the card in the suspense file could be moved to the alphabetic patient index and the rest of the information completed.

A suspense system can also be set up in the Rocky Mountain Cancer Data System (RMCDS) program. As much information as is initially known about the patient is entered (e.g., name, medical record number, admission date, etc.). In the “Suspense” field, code 1 is entered to indicate the case is in suspense. Records with suspense code 1 are excluded when extensive edits are applied. When the full case is later abstracted, the suspense code 1 should be changed to zero (0) and the edits should be applied. A list can be printed at any time of all patients with suspense code 1 to ensure abstracting has been completed for all cases in the suspense file.

E. ACCESSION REGISTER

Definition
The accession register is an annual, sequential listing of all reportable cases included in a hospital’s cancer registry. It serves to identify, count, and evaluate the annual caseload. The register can be used to audit other registry files, monitor casefinding, assess the workload, and verify patient identification.

Description
The following items should be included in the accession register:

1. Accession number
   The first four digits of the accession number should specify the year that the patient was first seen at the reporting hospital for the diagnosis and/or treatment of cancer following the registry’s reference date. The last five digits are a number each case is assigned in sequential order, beginning with 00001 at the start of each new calendar year. Detailed instructions on accession numbers can be found in Chapter 5.
2. Sequence number
   Sequence numbers indicate the chronological order of the diagnoses of independent, primary
   malignancies or reportable benign tumors that occur over the patient's lifetime. Detailed
   instructions on sequence numbers can be found in chapter 5.
3. Patient name
4. Primary site
5. Date initial diagnosis (or date first seen at the reporting institution)
6. Class of case (optional; see item description in Chapter 5 for further information)

A sample page follows, but the hospital should design their accession register according to their own
needs.

<table>
<thead>
<tr>
<th>Accn. Year &amp; Number</th>
<th>Seq.</th>
<th>Name</th>
<th>Primary Site</th>
<th>Date of Diagnosis</th>
<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>201200001</td>
<td>00</td>
<td>Brown, John Q.</td>
<td>prostate</td>
<td>01/02/2012</td>
<td>1</td>
</tr>
<tr>
<td>201200002</td>
<td>00</td>
<td>Smith, Susan</td>
<td>lung</td>
<td>01/15/2012</td>
<td>0</td>
</tr>
<tr>
<td>199700150</td>
<td>02</td>
<td>Jones, Mary</td>
<td>breast</td>
<td>02/07/2012</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(patient's first primary was in 1997)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>201200003</td>
<td>00</td>
<td>Green, George</td>
<td>pancreas</td>
<td>03/24/2012</td>
<td>2</td>
</tr>
<tr>
<td>201200001</td>
<td>02</td>
<td>Brown, John Q.</td>
<td>kidney</td>
<td>04/08/2012</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(patient's first primary was 200100001)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>201200004</td>
<td>00</td>
<td>Washington, Martha</td>
<td>colon</td>
<td>04/21/2012</td>
<td>0</td>
</tr>
</tbody>
</table>

An explanation of how the registry would assign the accession numbers in the 2012 table above
follows:

1. 201200001-00 (for the patient's first primary malignancy)
2. 201200002-00
3. 199700150-02 (A patient whose first primary was entered in the registry in 1997 retains the
   original accession number and only the sequence number changes.)
4. 201200003-00
5. 201200001-02 (For the patient's second of two primaries in 2012, the patient's original accession
   number remains the same, but the sequence number for his first primary must be changed from
   00 to 01.)
6. 201200004-00

The final (highest) accession number for a year will not necessarily be the total number of new cases
that year. Patients admitted with new primaries and who had accession numbers assigned in a
previous year will be listed but using the original number and therefore will not be counted in the
current year's sequence of accession numbers.

F. PATIENT INDEX

Definition
The patient index is a complete alphabetical file or list of all patients, living or dead, identified and
reported by the hospital since the reference date (starting date for reporting). Before a patient is
added to the registry, the patient index should be checked to see if the patient has already been
accessioned.
**Description**
The following data items must be included in the patient index:

- Name
- Date of birth
- Sex
- Medical record number
- Accession number
- Date of death
- Sequence number (for each primary site)
- Date of diagnosis (for each primary site)
- Laterality (for each primary site)
- Site (for each primary site)
- Histology (for each primary site)

Below is a sample patient index entry, but the hospital should design their file according to their own needs.

<table>
<thead>
<tr>
<th>Name:_________________________</th>
<th>DOB:___________</th>
<th>Sex:______</th>
</tr>
</thead>
<tbody>
<tr>
<td>MR#:_____________</td>
<td>Accn No:________</td>
<td>Date of Death:____________</td>
</tr>
<tr>
<td>Seq:____</td>
<td>Dx Date:_____________</td>
<td>Laterality:______</td>
</tr>
<tr>
<td>ICD-O-3 Site:______</td>
<td>Histology:____________</td>
<td></td>
</tr>
<tr>
<td>Seq:____</td>
<td>Dx Date:_____________</td>
<td>Laterality:______</td>
</tr>
<tr>
<td>ICD-O-3 Site:______</td>
<td>Histology:____________</td>
<td></td>
</tr>
<tr>
<td>Seq:____</td>
<td>Dx Date:_____________</td>
<td>Laterality:______</td>
</tr>
<tr>
<td>ICD-O-3 Site:______</td>
<td>Histology:____________</td>
<td></td>
</tr>
</tbody>
</table>

There should be only ONE entry or card per patient in the patient index. All independent primaries in the same patient are included on the same entry or card. The index should be maintained in alphabetic order and be retained indefinitely.

**G. FILING**

Hospitals reporting by paper abstracts should keep the original abstract form and submit a copy of the abstract form to the State Cancer Registry (see Chapter 3). The most efficient filing system for hospitals reporting on paper abstracts is filing all cases in ascending numerical order by the first two digits of the primary site code.

*Example:* All patients with cancer of the small intestine (C17._) are filed before all patients with cancer of the colon (C18._).

Within each site, cases are separated by accession year. Within each accession year, cases are filed alphabetically.
Example: All patients with colon cancer in 1994 will be filed alphabetically behind all patients with colon cancer in 1993.

The file of abstracts in site order could serve as a primary site index, making records more easily retrievable for studies.

The original abstract, any copies of it, and associated documentation must be regarded as confidential medical records and their storage should comply with applicable hospital and state regulations for confidentiality and security of records. Abstracts should be retained indefinitely.
CHAPTER 3: REPORTING

A. OVERVIEW

This chapter explains the cases and types of diagnoses to be reported, who should submit abstracts, when abstracts should be submitted, and how they should be submitted.

B. CASES TO REPORT TO THE STATE REGISTRY

1. General Requirements
   - All confirmed cases of reportable tumors diagnosed and/or initially treated in Indiana must be reported to the State Cancer Registry, as specified in this section. Reportable diagnoses are listed in Appendix B.
   - Confirmed cases include clinically diagnosed patients (not microscopically confirmed) as well as microscopically confirmed diagnoses. If a recognized medical practitioner documents that a patient has cancer, the diagnosis is reportable. Terms that constitute a clinical diagnosis can be found in Chapter 4.
   - Reportable cases include inpatients and outpatients (including hospital-affiliated ambulatory care settings).

2. Required Cases
      Exceptions (Not Reportable):
      - Preinvasive cervical neoplasia (CIS and CIN III) diagnosed 01/01/2003 or later;
      - Prostatic intraepithelial neoplasia, grade III (PIN III) diagnosed 01/01/2003 or later;
      - Basal cell and squamous cell carcinoma of skin (ICD-O-3 primary site codes C44.0-C44.9 with histology codes 8000-8110) diagnosed 01/01/2003 or later.
   b. If diagnosed before 01/01/2003, basal cell and squamous cell carcinoma of skin (ICD-O-3 primary site codes C44.0-C44.9 with histology codes 8000-8110) that meets at least one of the following conditions at the time of diagnosis:
      (1) Primary tumor more than 5 centimeters in greatest dimension;
      (2) Primary tumor that has invaded deep extradermal structures such as cartilage, skeletal muscle, or bone;
      (3) Primary tumor with regional node metastases;
      (4) Primary tumor with metastasis to distant sites.
   c. Basal cell and squamous cell carcinoma (ICD-O-3 histology codes 8000-8110) that originates in a mucous membrane site:
      - Lip C00.0 – C00.9
      - Anus C21.0
      - Labia C51.0 – C51.1
      - Clitoris C51.2
      - Vulva C51.8 – C51.9
      - Vagina C52.9
      - Prepuce C60.0
      - Penis C60.1 – C60.9
      - Scrotum C63.2
   d. Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, is required and should be reported as 9421/3.
e. The *ICD-O-3* code for Carcinoid tumor, NOS, of appendix (8240/1) is obsolete in 2015. Carcinoid tumors of the appendix must be coded to 8240/3 and are required to be reported.

f. All benign and borderline (behavior codes /0 and /1) intracranial and central nervous system tumors diagnosed January 1, 2004 or later. (*ICD-O-3* primary site codes C70.0-C72.9, C75.1-C75.3.)

g. Analytic cases (see Item 28 in Chapter 5 for further information on analytic and nonanalytic cases). Analytic cases include the following:

(1) All new malignancies diagnosed at the reporting facility on or after January 1, 1987 (class of case 00).

(2) All malignancies initially diagnosed and treated at the reporting facility for all or part of the first course of treatment on or after January 1, 1987 (class of case 10, 13, or 14).

(3) All malignancies initially diagnosed in a staff physician’s office on or after January 1, 1987 and treated at the reporting facility for all or part of the first course of treatment (class of case 11 or 12).

(4) All malignancies initially treated at reporting facility for all or part of the first course of treatment on or after January 1, 1987 (class of case 20, 21, or 22).

This includes patients who previously have been diagnosed with a cancer prior to January 1, 1987 and have a new primary malignancy diagnosed at the reporting facility on or after January 1, 1987. (**Only the new malignancy diagnosed on or after January 1, 1987 must be reported to the State Cancer Registry.**) Do not report the malignancy diagnosed before January 1, 1987.

h. Nonanalytic class of case 32 diagnosed on or after January 1, 1987. Class 32 includes cases first diagnosed elsewhere and all of the first course therapy elsewhere. The reporting facility diagnosed and/or treated the recurrence or progression of a malignancy diagnosed January 1, 1987 or later.

i. Cases with diagnoses (for example, VIN III), required by the State, but not by CoC that are diagnosed and/or treated at the reporting facility on or after January 1, 1987 (Nonanalytic class of case 34 or 36).

j. Nonanalytic class of case 35 or 37 diagnosed on or after January 1, 1987. Class 35 or 37 includes cases first diagnosed and/or first course of therapy at the reporting facility before the registry’s reference date. Class of case 35 or 37 would be applicable only for a registry with a reference date later than 1987.

*Example 1*: Hospital A changed their reference date from 1987 to 1992. In 1993, a patient is admitted who was diagnosed and treated for a melanoma at Hospital A in 1990 and has returned for a recurrence. The case is class 35 for the hospital and should be reported to the State Registry in 1993 if not previously reported when diagnosed.

*Example 2*: Hospital A changed their reference date from 1987 to 1992. In 1993, a patient is admitted with a second primary. The first primary, treated at Hospital A in 1990, is class of case 37 for the hospital and should be reported to the State Registry in 1993 if not previously reported when diagnosed.

k. Patients first diagnosed at autopsy (Nonanalytic class of case 38).

l. Patients diagnosed and treated only in a staff physician’s office (Nonanalytic class of case 40 or 41). Reportable by the hospital only if the hospital collects class 40 and 41 cases. Otherwise, reportable by the physician’s office.
m. The types of cases list below are reportable to the State Registry, though not reportable by CoC. Since documentation for these cases may be limited, report all information available either in your usual format, by paper abstract, or by sending copies of pertinent medical record documentation.

(1) Pathology-only cases (Nonanalytic class of case 43).

(2) Patients seen in consultation to confirm a diagnosis or first course treatment plan (Nonanalytic class of case 30). This includes cases where a patient is seen only once at the reporting hospital with an abnormal or positive appearing x-ray or scan, but the patient never returns for any work-up, confirmation of diagnosis, or treatment.

Example: A patient comes to the institution for a second opinion. Staff physicians order diagnostic tests and support the original treatment plan. The patient returns to the other institution for treatment.

C. CASES NOT REQUIRED

1. Cases with an *International Classification of Diseases of Oncology, Third Edition, 2000* (ICD-O-3) fifth digit behavior code of /0 (benign) or /1 (uncertain or borderline), which are the codes for precancerous conditions or benign tumors.

   Exceptions (Reportable):
   - Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, is required and should be reported as 9421/3.
   - All benign and borderline intracranial and central nervous system tumors diagnosed January 1, 2004 or later are reportable. (ICD-O-3 primary site codes C70.0-C72.9, C75.1-C75.3.)
   - Carcinoid tumor, NOS, of appendix, listed as 8240/1 in ICD-O-3, is required effective 2015 and should be coded to 8240/3.

2. If diagnosed 01/01/2003 or later, all basal cell and squamous cell carcinoma of skin (ICD-O-3 primary site codes C44.0-C44.9 with histology codes 8000-8110).

   If diagnosed before 01/01/2003, basal cell and squamous cell carcinoma of skin that are in situ or that are invasive and 5 centimeters or less in greatest dimension with no lymph node or distant metastasis.

3. Analytic cases (class of case codes 00-22) who were first diagnosed or first treated at the reporting facility on or after January 1, 1987 and return to the facility for:
   - A recurrence of that same primary;
   - Subsequent treatment;
   - Progression of recurrent disease (disease free period); or
   - Continued or persistent disease (never disease free).

   Note: An abstract would have been submitted when the patient was first diagnosed or first treated. Once a case has been accessioned into a registry, it is not re-accessioned or reported if the patient returns to the hospital for that same primary.

4. Nonanalytic class of case 30-33 diagnosed before January 1, 1987. Class 30-33 includes cases first diagnosed elsewhere and all of the first course therapy elsewhere. If the reporting facility is treating the recurrence or progression of a malignancy diagnosed before January 1, 1987, the case should not be reported to the state.

5. Nonanalytic class of case 35 and 37 diagnosed before January 1, 1987. Class 35 and 37 includes cases diagnosed and/or first course of therapy at the reporting facility before the registry’s reference date. Patients with the following situations would be non-reportable class of case 35 and 37:
Patients first diagnosed before January 1, 1987 who:

a. Received no treatment after being diagnosed;
b. Received first course of treatment before January 1, 1987;
c. Received first course of treatment before January 1, 1987 and subsequent treatment on or after January 1, 1987;
d. Received first course of treatment before January 1, 1987 and had a recurrence of that same primary on or after January 1, 1987.

6. Patients who receive transient care to avoid interrupting a course of therapy started elsewhere (class of case 31). Please verify with the State Cancer Registry that such patients who are Indiana residents have been reported by the other facility.

*Example 1:* A patient is visiting relatives in the area. The oncology department at the reporting facility dispenses the scheduled chemotherapy.

*Example 2:* Another institution sends a patient to the reporting facility because of equipment failure. The reporting facility administers the radiation therapy until the equipment is repaired. The patient returns to the original institution to complete therapy.

7. Patients with active cancer who are admitted for an unrelated medical condition. Please verify with the State Cancer Registry that such cases have been reported.

*Example:* A patient with active prostate cancer enters the reporting facility’s cardiac care unit for cardiac care only.

8. Patients with a history of cancer who currently have no evidence of the disease. Please verify with the State Cancer Registry that such cases have been reported.

9. Patients admitted to a designated hospice unit or home care service. Please verify with the State Cancer Registry that such cases have been reported.

10. Patients admitted for terminal supportive care only. Please verify with the State Cancer Registry that such cases have been reported.

11. Class of case 49 (diagnosed by death certificate only). The State Cancer Registry will collect cancer data on these patients after all reasonable efforts to obtain information from a health care provider have failed.

12. Residents of a foreign country.

13. Annual follow-up on all cases (optional reporting).

14. Hospitals may abstract cases that are not required by the State Registry, but are important for their own clinical, administrative, management, or marketing purposes. These patients often receive services and use the resources of the hospital (e.g., chemotherapy, radiation, lab tests, etc.). These cases should not be reported to the State Registry. Examples include non-reportable localized basal cell carcinoma of the skin and class 35 or 37 cases diagnosed before 1987.

D. DATA ITEMS TO REPORT

1. **Analytic Cases**
   Required and optional data items to report to the State Registry for analytic cases are identified in Chapter 5 of this manual. The items are listed in a table of the State data set in Chapter 5 and are presented in the pages following the table with descriptions, codes, formats, definitions, rules, and instructions.
2. **Reportable Nonanalytic Cases**

Since hospitals may have limited information about nonanalytic cases (reportable if diagnosed after January 1, 1987), a minimal data set for these cases is presented in the table below. Apply the codes, definitions, and rules in chapter 5 for these items and record them in either the paper or a computerized abstract. If the information for an item is not available, leave the item blank or code it according to the vendor's instructions for "unknown."

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Reporting hospital ID number</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Abstracted by Abstractor's initials</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Type of reporting source</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Patient last name</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>First name</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Middle name</td>
<td>If known</td>
</tr>
<tr>
<td>7.</td>
<td>Maiden name</td>
<td>If known</td>
</tr>
<tr>
<td>8.</td>
<td>Alias</td>
<td>If known</td>
</tr>
<tr>
<td>9.</td>
<td>Street address at diagnosis</td>
<td>Not current address; if unknown, record “unknown”</td>
</tr>
<tr>
<td>10.</td>
<td>City/town at diagnosis</td>
<td>Not current city/town; if unknown, record “unknown”</td>
</tr>
<tr>
<td>11.</td>
<td>State at diagnosis</td>
<td>Not current state; “ZZ” if unknown</td>
</tr>
<tr>
<td>12.</td>
<td>ZIP code at diagnosis</td>
<td>Not current ZIP; if unknown, record 9’s</td>
</tr>
<tr>
<td>13.</td>
<td>County at diagnosis</td>
<td>Not current county; if unknown, record 9’s</td>
</tr>
<tr>
<td>14.</td>
<td>Social Security Number</td>
<td>If known; if unknown, record 9’s</td>
</tr>
<tr>
<td>15.</td>
<td>Date of birth</td>
<td>If known; if unknown, record 9’s</td>
</tr>
<tr>
<td>16.</td>
<td>Medical record number</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Race/Spanish origin</td>
<td>At least race, if known</td>
</tr>
<tr>
<td>19.</td>
<td>Other primary tumor(s)</td>
<td>If known</td>
</tr>
<tr>
<td>20.</td>
<td>Date of first contact</td>
<td>At your hospital for this tumor</td>
</tr>
<tr>
<td>21.</td>
<td>Accession year this primary</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Hospital accession number</td>
<td>If assigned</td>
</tr>
<tr>
<td>23.</td>
<td>Sequence number</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>Class of case</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Referred from</td>
<td>If known</td>
</tr>
<tr>
<td>26.</td>
<td>If diagnosed elsewhere, record where</td>
<td>Name, phone number, and address of diagnosing physician, lab, clinic, etc., if known</td>
</tr>
<tr>
<td>27.</td>
<td>Date of initial diagnosis</td>
<td>If unknown, estimate year</td>
</tr>
<tr>
<td>28.</td>
<td>Primary site</td>
<td>Not metastatic site</td>
</tr>
<tr>
<td>29.</td>
<td>Laterality</td>
<td>For original, primary site, if known</td>
</tr>
<tr>
<td>30.</td>
<td>Diagnostic confirmation</td>
<td>If known</td>
</tr>
<tr>
<td>31.</td>
<td>Histology/behavior/grade</td>
<td>For original, primary site, if known</td>
</tr>
<tr>
<td>32.</td>
<td>Description of diagnosis</td>
<td>Narrative text of site and histology, if known</td>
</tr>
<tr>
<td>33.</td>
<td>Description of treatment</td>
<td>Narrative text, if known</td>
</tr>
<tr>
<td>34.</td>
<td>Date of last contact/death</td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>Vital status</td>
<td></td>
</tr>
</tbody>
</table>
E. WHO SHOULD SUBMIT REPORTS

The hospital that first diagnoses a case in 1987 or later is responsible for submitting an abstract to the State Cancer Registry.

A hospital that performs part or all of the first course treatment for cases diagnosed in 1987 or later is responsible for submitting an abstract to the State Cancer Registry.

A hospital that treats recurrence or progression of a malignancy first diagnosed elsewhere in 1987 or later and all of first course of treatment performed elsewhere is responsible for submitting an abstract to the State Cancer Registry.

The staff physician’s office is considered an extension of the hospital. Cases of patients who are diagnosed or treated in a staff physician’s office and referred to the hospital for definitive therapy must be reported as though they were diagnosed at the hospital. If these patients were referred to another institution for their first course of treatment, then their cases need not be included. Patients diagnosed and treated only in a staff physician’s office (class of case 40 or 41) are to be reported if such cases are collected by the hospital. If not reported by the hospital, these cases must be reported by the physicians’ offices.

When the distinction between a hospital-based department and a free-standing facility cannot readily be made (e.g., a radiation therapy group practice versus a hospital unit) the ownership of the medical record should be used to determine whether a case must be reported by the hospital. The owner of the medical record is responsible for reporting the case to the State Cancer Registry.

F. WHEN TO SUBMIT REPORTS

Facilities must complete and submit reports of confirmed cases of reportable tumors to the State Cancer Registry no later than six (6) months following the date the patient comes under the care of the reporting facility. Facilities should report on a schedule based on the size of their annual caseload. The minimum reporting requirements for each caseload range is provided in the table below. More frequent reporting is encouraged so that the State database remains as current as possible for analytic purposes.

<table>
<thead>
<tr>
<th>Average Number of Cases Diagnosed per Year</th>
<th>Minimum Frequency for Reporting to the State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-59</td>
<td>Once per year</td>
</tr>
<tr>
<td>60-149</td>
<td>Quarterly</td>
</tr>
<tr>
<td>150-299</td>
<td>Every other month</td>
</tr>
<tr>
<td>(\geq 300)</td>
<td>Every month</td>
</tr>
</tbody>
</table>

G. HOW TO SUBMIT REPORTS

1. Hospitals With Computerized Systems
   a. Hospitals with computerized registries should submit reports to the State Cancer Registry in an acceptable, machine-readable format (RMCDS format for hospitals using RMCDS)
b. Make sure all cases abstracted since the previous submission are selected for each new submission. Selecting cases by a range of accession numbers will omit patients with an earlier accession number who have a new primary. Contact your software vendor for procedures to ensure all cases are reported to the State Cancer Registry.

c. Submitting by FTP Program
The preferred method for submitting data is to use the ISCR FTP Program that encrypts your data file and sends it to the ISCR through the Internet using the File Transfer Protocol (FTP). If your facility prohibits or limits the use of FTP, the program can also send the encrypted file as an e-mail attachment. The method meets government security requirements. Contact the State Cancer Registry to obtain procedures for submitting data by using the FTP Program.

d. Submitting by Web Plus
An alternate method is to use the Web Plus program that securely uploads your file through a browser. The method also meets government security requirements. Contact the State Cancer Registry to obtain procedures for submitting data by using Web Plus.

e. Submitting on Diskettes
Effective July 2009 the State Cancer Registry can no longer process data submitted on diskettes.

f. Ensure that the contents of computerized abstracts are treated with the same level of security and confidentiality as the medical record. The abstracts are abbreviated medical records and should be treated as such. A full discussion of confidentiality is found in Chapter 8 of this manual.

g. The hospital should keep a record of cases submitted to the State. The State Cancer Registry personnel will keep track of the date, number of disks, and number of cases received from each hospital.

2. **Hospital Using Paper Forms**

a. Hospitals should submit reports to the State within the time frame described in this chapter, using the “Hospital Abstract” form designed and approved by the State Cancer Registry. Computerized registries may use the form to submit reportable nonanalytic cases that are not abstracted into their registry systems.

Forms may be obtained, free of charge, by calling or writing the State Cancer Registry.

Marsha Lundy  
Office: (317) 233-7158  
Indiana State Cancer Registry  
Fax: (317) 233-7722  
Indiana State Department of Health  
E-mail: mlundy@isdh.in.gov  
2 North Meridian Street, Section 6-B  
Indianapolis, IN  46204-3010

b. Attach a copy of the pathology report to the abstract form. State Cancer Registry staff need the reports to substantiate the codes.

c. When sending in more than one abstract for multiple tumors on a patient, do not staple abstracts on different tumors together, as they may be overlooked. Do staple copies of medical record documentation about the reported tumor to the applicable abstract.
d. The hospital should make a legible copy of the original abstract and mail the copy to the State Cancer Registry, keeping the original at the hospital. Illegible abstracts will be returned to the hospital.

e. Ensure that abstracts are treated with the same level of security and confidentiality as the medical record. The abstracts are abbreviated medical records and should be treated as such. A full discussion of confidentiality is found in Chapter 8 of this manual.

f. The hospital should keep a record of abstracts mailed to the State Cancer Registry, noting the date and number submitted. The State Cancer Registry personnel will keep track of the number of abstracts and date received from each hospital.

g. Envelopes containing copies of the abstracts should be carefully sealed and labeled “CONFIDENTIAL MEDICAL INFORMATION.” The envelope should be clearly addressed:

   Indiana State Cancer Registry
   Indiana State Department of Health
   2 North Meridian Street, Section 6-B
   Indianapolis, IN 46204-3010

3. Other Forms
   a. Correction and Follow-Up Form
      Chapter 6 of this manual describes a “Correction and Follow-Up Form” and instructions for completing it. Corrections or annual follow-up data on previously submitted Hospital Abstracts may be reported on this form.

   b. Correction Form for Multiple Patients
      Chapter 6 also describes a “Correction Form for Multiple Patients” and instructions for completing it.

These forms may be obtained by calling or writing the State Cancer Registry.
CHAPTER 4: GENERAL DEFINITIONS FOR CODING

A. INTRODUCTION
The State Cancer Registry uses definitions published by national standard-setting organizations in order to ensure that its instructions and the data collected are consistent with those from other registries. The standard-setting organizations include the American College of Surgeons, Commission on Cancer (ACoS/CoC); the North American Association of Central Cancer Registries (NAACCR); and the National Cancer Institute’s SEER (Surveillance, Epidemiology, and End Results) program.

B. GUIDELINES FOR INTERPRETATION OF TERMINOLOGY
The overall priority for using information to determine tumor involvement is pathological, operative, then clinical findings. The medical practitioner may use ambiguous terms when describing a clinical diagnosis or extent of disease in relation to tumor invasion of an organ or structure, especially when there is no cytologic or histologic proof of disease extension. When there are questions concerning terminology, consult with a physician or pathologist. The following lists should be used when the terminology is vague or ambiguous.

Terms That Indicate Clinical Diagnosis or Tumor Involvement/Extension

- adherent to
- apparent
- apparently
- appears to
- comparable with
- compatible with
- consistent with
- contiguous/continuous with
- encroaching upon
- extension - to, into, onto, or out onto
- favor(s)
- features of
- fixation (to another structure)
- fixed (involvement of other organ/tissue)
- impending perforation of
- impinging upon
- impose, imposing on
- incipient invasion
- induration (for breast cases)
- infringe, infringing
- into
- intrude
- invasion - to, into, onto, or out onto
- malignant appearing
- matted (for lymph nodes only)
- most likely
- neoplasm (only for C70.0-C72.9, C75.1-C75.3 diagnosed 01/01/04 and later)
- obliterate
- onto
- out onto
- overstep
- presumed
- probable
- probably
- protruding into (unless encapsulated)
- suspect
- suspected
- suspicious (for)
- to
- tumor (only for C70.0-C72.9, C75.1-C75.3 diagnosed 01/01/04 and later)
- violate
- typical of
- up to

Example: A chest x-ray is consistent with a carcinoma of the right upper lobe. Final diagnosis is probable carcinoma of the right lung. The case should be abstracted and reported.

Exception: If a cytology specimen is reported as “suspicious,” do not interpret this as a diagnosis of cancer unless it is confirmed by a positive biopsy or a physician’s clinical assessment.

2 These terms are considered involvement by the SEER Program and non-involvement by the Statistical Analysis and Quality Control Center at Fred Hutchinson Cancer Research Center in Seattle, WA. Consult the attending physician regarding these terms.
Terms That Do Not Indicate Clinical Diagnosis or Tumor Involvement

- abuts
- along side
- approaching
- approximates
- attached
- borders on
- cannot be excluded/ruled out
- efface, effacing, effacement
- encased, encasing
- encompass(ed)
- entrapped
- equivocal
- extending up along
- extension over
- extension to without invasion/involvement of
- kiss, kissing
- matted (except for lymph nodes)
- next to
- possible
- potentially malignant
- questionable
- reaching
- rule out
- suggests
- up along
- up over
- very close to
- without perforation of
- worrisome

Example: The final diagnosis is possible carcinoma of the breast. This case should not be abstracted and reported.
CHAPTER 5: CODING INSTRUCTIONS

OVERVIEW

An abstract is a summary of pertinent information about the patient, the cancer, the treatment, and outcome. A paper abstract for reporting such information is available for facilities with non-computerized registries. An abstract is used to collect the following three categories of information:

**Patient and Hospital Identification**
This includes data items related primarily to demographic information about the patient and hospital-specific information.

**Cancer Identification**
This includes data items related primarily to information about the patient’s tumor or cancer.

**Treatment Data**
This includes treatment data and follow-up information.

Chapter 5 explains how to complete each item within the three categories. Rules and codes for recording the information are consistent with the *Facility Oncology Registry Data Standards (FORDS)* to the extent possible and apply to both paper and computer abstracting unless they conflict with an alternative software vendor’s instructions. As with the FORDS, abstracters should use the rules and codes in this manual only for cases diagnosed January 1, 2015 and later unless instructed otherwise. Chapter 3, Section C. lists the types of cases to be reported on an abstract.

WHEN TO ABSTRACT A CANCER CASE

1. Cancer case information should be abstracted after complete work-up, cancer staging, and planned first course of treatment have been initiated. The first course of treatment is generally initiated within four months after the cancer is initially diagnosed. With the exception of early deaths, cases should not be abstracted less than four months after diagnosis.

2. Cases are due at the State Cancer Registry no later than six months following the date the patient comes under the care of the reporting facility.

3. Follow-up items are required and should be completed at the time the rest of the case is abstracted. Subsequent, annual follow-up information is optional, but may be reported if desired. See Chapter 6 for details on how to submit annual follow-up information at a later date.

4. There is no time limit for making revisions that give better information about the original diagnosis or stage. Data should be coded using the most accurate information available for an up-to-date and factual database. Over time, information that was missing when the case was first abstracted may be added to the patient’s medical record. Such additions may contain new information. The latest or most complete information available should be used. Thus, it is acceptable to change the primary site, histology, and extent of disease (staging data) as information becomes more complete.

**Note:** This does not mean that if the patient’s disease progresses, you should change the original stage to a higher stage. Staging should reflect only information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer. However, if the original stage is later found to be incorrect, it would be appropriate to change the stage to the correct code.
GENERAL ABSTRACTING INSTRUCTIONS AND DEFINITIONS

1. Each primary cancer should be abstracted only once by a facility. However, if a patient is diagnosed with more than one primary cancer, whether simultaneously or at different times, a separate abstract must be completed for each primary cancer.

2. Enter all information accurately. Entries on the paper abstract should be printed legibly.

3. The following terms are used throughout this chapter to indicate type, justification, and length of data fields:

   Numeric: The field will accept numbers only.
   Alphabetic: The field will accept letters only.
   Alphanumeric: The field will accept either letters or numbers, but no special characters.
   Text: The field will accept any letter, number, symbol, or space.
   Left-Justified: Data are to be entered starting at the first space toward the left. Leave unused spaces blank unless otherwise instructed.
   Right-Justified: Data are to be entered so that the last character falls in the last space on the right in the field. Leave unused spaces blank or zero fill, as directed.
   Length: Length refers to the number of characters in each data field.

4. The following abbreviations are used throughout Chapter 5:

   ACoS  American College of Surgeons
   AJCC  American Joint Committee on Cancer
   CDC  Centers for Disease Control and Prevention
   CoC  Commission on Cancer
   CS  Collaborative Stage
   FORDS  Facility Oncology Registry Data Standards (from Vol. II, Standards of the Commission on Cancer, ACoS)
   JCAHO  Joint Commission on Accreditation of Healthcare Organizations
   NAACCR  North American Association of Central Cancer Registries
   NPCR  National Program of Cancer Registries
   NPI  National Provider Identifier
   RMCDS  Rocky Mountain Cancer Data Systems
   SEER  Surveillance, Epidemiology, and End Results (National Cancer Institute program)
# STATE DATA SET

**Indiana State Cancer Registry Required Status Table for Cases Diagnosed in 2015**

**Required Status Key**
- **R** Data elements required by National Program of Cancer Registries (NPCR) and/or the Indiana State Cancer Registry (ISCR).
- **R** Data elements required if available.
- **RS** Data elements required for specific sites only.
- **RS** Data elements required, if available, for specific sites only.
- **R^** Text requirements that may be met with one or several text block fields.
- **RH** Required historically.
- **D** Required data elements derived from other elements by computer algorithm.
- **O** Optional data elements.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>(Date Implemented)</th>
<th>NAACCR ITEM #</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspense case</td>
<td></td>
<td></td>
<td>O</td>
</tr>
<tr>
<td>Where, if diagnosed elsewhere (text)</td>
<td></td>
<td>R^</td>
<td></td>
</tr>
<tr>
<td>Description of size (text)</td>
<td></td>
<td>R^</td>
<td></td>
</tr>
<tr>
<td>Other primary tumors (text)</td>
<td></td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Record type (computer-generated)</td>
<td>10</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Central tumor registry number - for State use only</td>
<td>20</td>
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<td></td>
</tr>
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<td>Registry ID</td>
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</tr>
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<td>NAACCR record version</td>
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<td></td>
</tr>
<tr>
<td>City/town at diagnosis</td>
<td>70</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>State at diagnosis</td>
<td>80</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>County at diagnosis</td>
<td>90</td>
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<td></td>
</tr>
<tr>
<td>Postal code at diagnosis</td>
<td>100</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Census tract 2000 - for State use only</td>
<td>130</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Census tract 2010 - for State use only</td>
<td>135</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Census Tr Poverty Indictr - for State use only (01/01/2014)</td>
<td>145</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Race 1-5</td>
<td>160-164</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Spanish/Hispanic origin</td>
<td>190</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>NIHIA derived Hispanic origin - for State use only</td>
<td>191</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>IHS Link - for State use only</td>
<td>192</td>
<td>R^</td>
<td></td>
</tr>
<tr>
<td>Race—NAPPIIA (derived API) - for State use only</td>
<td>193</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Computed Ethnicity - for State use only</td>
<td>200</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Computed Ethnicity Source - for State use only</td>
<td>210</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>220</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Age at diagnosis</td>
<td>230</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td>240</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Date of birth flag (01/01/2010)</td>
<td>241</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Birthplace</td>
<td>250</td>
<td>RH^</td>
<td></td>
</tr>
<tr>
<td>Birthplace – State (01/01/2013)</td>
<td>252</td>
<td>R^</td>
<td></td>
</tr>
<tr>
<td>Birthplace – Country (01/01/2013)</td>
<td>254</td>
<td>R^</td>
<td></td>
</tr>
<tr>
<td>Census occupation code 1970-2000 - for State use only</td>
<td>270</td>
<td>R^</td>
<td></td>
</tr>
<tr>
<td>Census industry code 2010 - for State use only (01/01/2013)</td>
<td>272</td>
<td>R^</td>
<td></td>
</tr>
<tr>
<td>ITEM</td>
<td>(Date Implemented)</td>
<td>NAACCR ITEM #</td>
<td>STATUS</td>
</tr>
<tr>
<td>------</td>
<td>---------------------</td>
<td>---------------</td>
<td>--------</td>
</tr>
<tr>
<td>Census industry code 1970-2000 - for State use only</td>
<td></td>
<td>280</td>
<td>R*</td>
</tr>
<tr>
<td>Census occupation code 2010 - for State use only</td>
<td>(01/01/2013)</td>
<td>282</td>
<td>R*</td>
</tr>
<tr>
<td>Occupation source - for State use only</td>
<td></td>
<td>290</td>
<td>R*</td>
</tr>
<tr>
<td>Industry source - for State use only</td>
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<td>300</td>
<td>R*</td>
</tr>
<tr>
<td>Usual occupation (text)</td>
<td></td>
<td>310</td>
<td>R*</td>
</tr>
<tr>
<td>Usual industry (text)</td>
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<td>320</td>
<td>R*</td>
</tr>
<tr>
<td>Occupation/industry coding system</td>
<td></td>
<td>330</td>
<td>R*</td>
</tr>
<tr>
<td>Census tract certainty 2000 - for State use only</td>
<td></td>
<td>365</td>
<td>R</td>
</tr>
<tr>
<td>GIS coordinate quality - for State use only</td>
<td></td>
<td>366</td>
<td>R*</td>
</tr>
<tr>
<td>Census tract certainty 2010 - for State use only</td>
<td></td>
<td>367</td>
<td>R*</td>
</tr>
<tr>
<td>Sequence number--central - for State use only</td>
<td></td>
<td>380</td>
<td>R</td>
</tr>
<tr>
<td>Date of initial diagnosis</td>
<td></td>
<td>390</td>
<td>R</td>
</tr>
<tr>
<td>Date of diagnosis flag</td>
<td>(01/01/2010)</td>
<td>391</td>
<td>R</td>
</tr>
<tr>
<td>Primary site</td>
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<td>400</td>
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<td>Laterality</td>
<td></td>
<td>410</td>
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</tr>
<tr>
<td>Grade</td>
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</tr>
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<tr>
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<td>(01/01/2011)</td>
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</tr>
<tr>
<td>Site coding system – current</td>
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<td>R</td>
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<td>Morphology coding system – current</td>
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</tr>
<tr>
<td>Diagnostic confirmation</td>
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<td>490</td>
<td>R</td>
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<tr>
<td>Type of reporting source</td>
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<td>Casefinding source</td>
<td>(01/01/2012)</td>
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<tr>
<td>Histologic type ICD-O-3</td>
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<td>522</td>
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<tr>
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<tr>
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<td>R</td>
</tr>
<tr>
<td>Primary payer at diagnosis</td>
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<td>630</td>
<td>R*</td>
</tr>
<tr>
<td>SEER Summary Stage 2000 (Cases diagnosed 2001-2003, 01/01/2015 and later)</td>
<td></td>
<td>759</td>
<td>R</td>
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<tr>
<td>SEER Summary Stage 1977 (Cases diagnosed through 12/31/2000)</td>
<td></td>
<td>760</td>
<td>RH</td>
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<tr>
<td>Tumor size (Cases diagnosed through 12/31/2003)</td>
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<tr>
<td>Regional nodes positive</td>
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<td>Regional nodes examined</td>
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<td>NAACCR ITEM #</td>
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</tr>
<tr>
<td>------</td>
<td>-------------------</td>
<td>--------------</td>
<td>--------</td>
</tr>
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<td>Pathologic T</td>
<td>(01/01/2014)</td>
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</tr>
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<td>(01/01/2014)</td>
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<td>R*</td>
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<td>(01/01/2014)</td>
<td>900</td>
<td>R*</td>
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<td>3010</td>
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</tr>
<tr>
<td>Derived SS2000 (autocoded)</td>
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<td>3020</td>
<td>D</td>
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<td>(01/01/2015)</td>
<td>3170</td>
<td>R</td>
</tr>
<tr>
<td>Date of most definitive surgery flag</td>
<td>(01/01/2015)</td>
<td>3171</td>
<td>R</td>
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<tr>
<td>Date systemic therapy started</td>
<td></td>
<td>3230</td>
<td>O</td>
</tr>
<tr>
<td>Date systemic therapy flag</td>
<td>(01/01/2010)</td>
<td>3231</td>
<td>O</td>
</tr>
<tr>
<td>Hematologic transplant and endocrine procedures</td>
<td></td>
<td>3250</td>
<td>R</td>
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<td>(01/01/2010)</td>
<td>3400</td>
<td>D</td>
</tr>
<tr>
<td>Derived AJCC-7 T descriptor (autocoded)</td>
<td>(01/01/2010)</td>
<td>3402</td>
<td>D</td>
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<tr>
<td>Derived AJCC-7 N (autocoded)</td>
<td>(01/01/2010)</td>
<td>3410</td>
<td>D</td>
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<tr>
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<td>3412</td>
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<tr>
<td>Derived AJCC-7 M (autocoded) (autocoded)</td>
<td>(01/01/2010)</td>
<td>3420</td>
<td>D</td>
</tr>
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<td>Derived AJCC-7 M descriptor (autocoded)</td>
<td>(01/01/2010)</td>
<td>3422</td>
<td>D</td>
</tr>
<tr>
<td>Derived AJCC-7 stage group (autocoded)</td>
<td>(01/01/2010)</td>
<td>3430</td>
<td>D</td>
</tr>
<tr>
<td>NPCR Specific Field - for State use only</td>
<td>(01/01/2014)</td>
<td>3720</td>
<td>R</td>
</tr>
<tr>
<td>ITEM</td>
<td>(Date Implemented)</td>
<td>NAACCR ITEM #</td>
<td>STATUS</td>
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**Coding Instructions**  
**Patient and Hospital Identification**  

**Chapter 5**

<table>
<thead>
<tr>
<th>REPORTING FACILITY ID NUMBER</th>
<th>Item Length: 3</th>
</tr>
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<tbody>
<tr>
<td>Data Type: Numeric</td>
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<tr>
<td>ACoS: Required</td>
<td></td>
</tr>
<tr>
<td>State Registry: Required</td>
<td></td>
</tr>
</tbody>
</table>

**Description**

This is a required 3-character field for recording a unique 3-digit identification number assigned to each reporting facility in Indiana.

The Facility ID number identifies the facility reporting the case. It also allows the State Registry to collect information from multiple facilities that have seen the same patient for the same tumor. In the State Cancer Registry database, up to ten different facility ID numbers can be recorded for each tumor. Each of the ten facilities can be listed with its admission date, accession year and number, medical record number, and class of case for that tumor.

**Instruction**

Referring to Appendix D, enter your 3-digit facility ID number in this field.
NPI-REPORTING FACILITY

Data item added for cases diagnosed 01/01/2007 or later, when available.

**Description**
This is a required 10-character field that identifies the facility submitting the data in the record. NPI (National Provider Identifier) is a unique identification number for health care providers implemented by the Centers for Medicare & Medicaid Services as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Rationale**
Each facility's NPI is unique. The number is essential to National Cancer Database (NCDB) for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

**Codes**
NPI numbers for Indiana facilities are provided in Appendix D of this manual.

**Instructions**

a. *NPI-Reporting Facility* is automatically coded by the software provider.

b. NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008.

c. NPI may be blank for cases diagnosed on or before December 31, 2006.
Coding Instructions  Patient and Hospital Identification  Chapter 5

ABSTRACTED BY

Item Length:  3  
Data Type:  Alphanumeric  
Left Justified, Blank Fill  
ACoS:  Required  
State Registry:  Required

Description
This is a required 3-character field to record the initials or assigned code of the individual who abstracted the case.

Rationale
This item is most useful for multi-staffed registries and can be used for quality control and management.

Instructions
a. Record the initials or assigned code of the individual who abstracted this case. If the initials are less than three characters, left justify and blank fill.

b. Do not code the data entry person unless that person is also the abstractor.

Instructions for RMCDS Facilities
a. The initials will automatically be entered in each abstract based on the identification used to log in.

b. The initials automatically entered may be manually changed if a second abstracter completes a case in a session logged in by someone else.
**Chapter 5**  
**Patient and Hospital Identification**  
**Coding Instructions**

<table>
<thead>
<tr>
<th>TYPE OF REPORTING SOURCE</th>
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<tbody>
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<td></td>
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<tr>
<td></td>
<td>ACoS: N/A</td>
</tr>
<tr>
<td></td>
<td>State Registry: Required</td>
</tr>
</tbody>
</table>

Data item revised for cases diagnosed 01/01/2006 and later.

**Description**
This is a required 1-character field for coding the source documents used to abstract the majority of information for the tumor being reported. The item is intended to indicate the completeness of information available to the abstractor.

**Rationale**
The code in this field can be used to explain why information for a tumor may be incomplete. For example, death certificate only cases have unknown values for many data items, so one may want to exclude them from some analyses. The field also is used to monitor the success of non-hospital case reporting and follow-back mechanisms. All population-based registries should have some death certificate-only cases where no hospital admission was involved, but too high a percentage can imply both shortcomings in casefinding and that follow-back to uncover missed hospital reports was not complete.

**Codes (effective for cases diagnosed 01/01/2006 and later)**
1. Hospital inpatient; managed health plans with comprehensive, unified medical records
2. Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
3. Laboratory only (hospital-affiliated or independent)
4. Physician’s office/private medical practitioner (LMD)
5. Nursing/convalescent home/hospice
6. Autopsy only (diagnosed at autopsy)
7. Death certificate only
8. Other hospital outpatient units/surgery centers

**Notes:**
- Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. This is a change to reflect the addition of codes 2 and 8 (for cases diagnosed 01/01/2006 and later) and to prioritize laboratory reports over nursing home reports. Facilities previously defined under code 1 have been split between codes 1, 2, and 8.

- Use the code that reflects the source documents used to abstract the majority of information for the tumor being reported. This may not be the source of original case finding. For example, if a case is identified through a pathology laboratory report review and all source documents used to abstract the case are from the physician’s office, record code 4.

**Definitions**
- **Code 1** includes hospitals as well as specified managed health plans. Reports from health plans (e.g., Kaiser, Veterans Administration, military facilities), in which all diagnostic and treatment information is maintained centrally and available to the abstractor, are expected to be at least as complete as reports for hospital inpatients. Therefore, these sources are grouped with inpatients and given the code with the highest priority.

- **Code 2** includes (radiation or medical) cancer treatment facilities, whether they are affiliated with a hospital or not. These sources usually have complete information on the cancer diagnosis, staging, and treatment.

- **Code 3** is generally for use by independent pathology laboratories. If a hospital’s pathology department has a report on a non-hospital case (with no inpatient or outpatient record) and no other information is available, code 3 should be used. For example, a hospital that finds a reportable case by reviewing pathology reports should report the case as Reporting Source 3 if no other records or
information were available. This might happen if an outside physician contracted to use the hospital’s pathology laboratory facilities.

d. **Code 4** includes physician offices as well as independent, free-standing clinics with no hospital affiliation and that are not defined under Code 2. Examples of these may include surgery centers with no hospital affiliation and HMOs.

e. **Codes 6 and 7** are used only when investigation can find no clinical diagnosis of any kind while the patient was alive.

f. **Code 8** sources would include, but would not be limited to, hospital outpatient surgery and nuclear medicine services. A physician’s office that calls itself a surgery center should be coded as a physician’s office. Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. If a physician’s office calls itself a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.
### SUSPENSE CASE

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>ACoS: N/A</td>
<td>State Registry: Optional</td>
</tr>
</tbody>
</table>

**Description**
This is an optional 1-character field in the RMCDS abstract screen to record a code that identifies an incomplete record (suspense, premalignant). Records identified as incomplete will be bypassed when normal edits are applied. A suspense system can be created using this field by printing a suspense list of the incomplete cases.

The paper Hospital Abstract does not include this field, since the suspense system for paper abstractors is created by a separate filing of the abstracts or by using index cards.

Facilities using other vendors’ registry programs should follow the applicable vendor’s instructions for suspense cases.

**Codes**
- 1 Partial record (suspense, premalignant, incomplete)
- 0 Complete record

**Instructions**
- a. Record a 1 in the suspense field for cases that have not been completely abstracted.
- b. When the record is completely abstracted, change the code and apply edits to the record.
- c. Refer to Chapter 2, Section D for requirements related to suspense systems.
**PATIENT LAST NAME**

**Description**
This is a required 40-character field for the patient’s last name. Left justify and leave unused space(s) at the right blank.

**Instructions**
a. In a hyphenated last name, record the hyphen (-) between the two surnames (last names). This might happen when a female marries and keeps her maiden name as part of her legal married name.

*Example:* SMITH-WALBRIDGE

b. Do not enter periods, apostrophes, blank spaces, punctuation, or other special characters (e.g., Jr, III) within the name.

*Example 1:* OHARA (NOT O’HARA)
*Example 2:* MCDONALD (NOT MC DONALD)
*Example 3:* STPIERRE (NOT ST. PIERRE OR SAINT PIERRE)

**Note:** The FORDS allows blanks, spaces, and apostrophes in the last name field. However, changing the name format at this point would compromise the linking or matching of new cases with cases previously entered in the registry. Therefore, it is advisable to continue following the old formatting rules.

c. Update the field if a patient marries and takes the spouse’s last name. If a patient changes his/her legal name, enter the patient’s most current legal name and put previous last name in the field for maiden name. If a patient has more than one tumor, previous records with different last names (AKA’s) should be updated to show the most recent name change. The old name should be recorded in **Maiden Name**.

*Example:* Jane White, who had a primary in 2009, marries in 2010 and becomes Jane Black. In 2015 she has a second primary. Change the last name in the 2009 abstract from White to Black and record White in **Maiden Name**. Record the same names for the 2015 primary: Black (White in **Maiden Name**).

d. Do not leave the field blank. If the patient’s last name is unknown, record UNKNOWN.
# PATIENT FIRST NAME

**Description**

This is a required 40-character field for the patient's first name. Left justify and leave unused space(s) at the right blank.

**Instructions**

a. Record the patient’s full first name.

b. If the first name is not known, leave the field blank.
### Description
This is a required 40-character field for the patient’s middle name or middle initial. Left justify and leave unused space(s) at the right blank.

### Instructions
- Record the patient’s middle name or middle initial. If recording only a middle initial, do not enter a period after the letter.
- If the middle name is not known, leave the field blank.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Item Length</th>
<th>Data Type</th>
<th>Justification</th>
<th>ACoS</th>
<th>State Registry</th>
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<tbody>
<tr>
<td>PATIENT MIDDLE NAME</td>
<td>40</td>
<td>Alphabetic</td>
<td>Left Justified, Blank Fill</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>(MIDDLE INITIAL)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**PATIENT MAIDEN NAME**

*Required if available for cases diagnosed 01/01/2006 and later.

**Description**

This is an optional 40-character field for the maiden name of female patients who are married or who have been married. Left justify and leave unused space(s) at the right blank.

**Instructions**

a. If a female is, or has been, married, record her maiden name.

b. If the maiden name is not known or the patient does not have a maiden name, leave the field blank.

c. Do not enter periods, apostrophes, blank spaces, punctuation, or other special characters (e.g., Jr, III) within the name.

*Example 1:* OHARA (NOT O’HARA)
*Example 2:* MCDONALD (NOT MC DONALD)
*Example 3:* STPIERRE (NOT ST. PIERRE OR SAINT PIERRE)
**PATIENT ALIAS**

<table>
<thead>
<tr>
<th>Item Length: 40</th>
<th>Data Type: Alphabetic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left Justified, Blank Fill</td>
<td>ACoS: N/A</td>
</tr>
</tbody>
</table>

**State Registry:** *Required

*Required if available for cases diagnosed 01/01/2006 and later.

**Description**

This is an optional 40-character field to record the alias, if the patient uses a different name or nickname. Left justify and leave unused space(s) at the right blank.

**Instructions**

a. **First name only alias**

If the patient uses an alias for a first name only, record the actual last name and the first name alias. In the RMCDS abstract screen, leave a blank space, without punctuation, between the last and first names.

*Example:* Ralph Williams uses the name Bud Williams. Record Williams Bud.

b. **Last name only alias**

If the patient uses only a last name alias, record the last name alias and the actual first name. In the RMCDS abstract screen, leave a blank space, without punctuation, between the last and first names.

*Example:* Janice Smith uses the name Janice Brown. Record Brown Jani.

c. **Alias first and last name**

If the patient uses an alias for the first and last name, record the last name alias and the first name alias. In the RMCDS abstract screen, leave a blank space, without punctuation, between the last and first names.

*Example:* Samuel Clemens uses the name Mark Twain. Record Twain Mark.

d. **If the patient does not use an alias, leave the field blank.**
GENERAL GUIDELINES FOR RECORDING PATIENT ADDRESS AT DIAGNOSIS

Rationale
The address is a part of the patient’s demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies. Address at diagnosis may be corrected, but never changed or updated. Changing this field would destroy its usefulness.

Rules and Definitions: Use the following guidelines for all patient address data items.

a. Record the patient’s usual residence when the cancer was diagnosed. Normally a residence is the home named by the patient. Do not use a temporary address, such as a winter or vacation home. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with rules used by the Census Bureau whenever possible. The registry can resolve residency questions by using the Census Bureau’s definition: “The place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home.” Vital statistics rules may differ from census rules. Do not record residence from the death certificate. Review each case carefully and apply the rules.

b. Do not use current address. Record the address for the patient’s home when he/she was diagnosed with cancer for both analytic and nonanalytic cases. If all or any part of the address is unknown, follow the instructions for unknowns under the applicable item heading in the following pages.

c. Rules for persons without apparent residences:

   (1) Persons with More than One Residence (summer and winter homes): Use the address the patient specifies if a usual residence is not apparent.

   (2) Persons with No Usual Residence (transients, homeless): Use the address of the place they were staying when the cancer was diagnosed. This could be a shelter or the diagnosing facility.

   (3) Persons Away at School: College students are residents of the school area. Boarding school children below college level are residents of their parents’ home.

   (4) Persons in Institutions: The Census Bureau states, “Persons under formally authorized, supervised care or custody” are residents of the institution. This includes:

   - Incarcerated persons
   - Persons in nursing, convalescent, and rest homes
   - Persons in homes, schools, hospitals, or wards for the physically disabled, mentally retarded, or mentally ill
   - Long-term residents of other hospitals, such as Veterans Administration (VA) or military hospitals

   (5) Persons in the Armed Forces and on Maritime Ships: Members of the armed forces are residents of the installation area. Use the stated address for military personnel and their family. Military personnel may use the installation address or the surrounding community’s address.

   The Census Bureau has detailed residency rules for Naval personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for the detailed rules.

Patient Address – Current
The State Registry does not collect the patient’s current address, although there are separate fields in the RMCDS program for recording it. For further coding instructions on current address, refer to the FORDS.
**Coding Instructions**

**Patient and Hospital Identification**

**Chapter 5**

**PATIENT ADDRESS (NUMBER AND STREET) AT DIAGNOSIS**

- **Item Length:** 60
- **Data Type:** Alphanumeric
- **Left Justified, Blank Fill**
- **ACoS:** Required
- **State Registry:** Required

**Description**

This is a required 60-character field for the patient’s house number and street address at the time of diagnosis. Enter the house number and street name or the rural mailing address. This may or may not be the patient’s current address. If the patient has multiple tumors, the address may be different for each primary. See “General Guidelines for Recording Patient Address at Diagnosis” for detailed residency rules.

**Rationale**

The address is a part of the patient’s demographic data and has multiple uses. It indicates referral patterns and allows for analysis of cancer clusters or environmental studies.

**Instructions**

a. Record the number and street address of the patient’s usual residence when the cancer was diagnosed. **Do not record a post office box number** unless it is the only address available.

b. Avoid using punctuation, except when necessary to convey the meaning. Limit punctuation to periods when the period carries meaning (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 1/2 MAIN ST), and hyphens when the hyphen carries meaning (e.g., 289-01 MONTGOMERY AVE). Avoid using the pound sign (#) to designate address units whenever possible. If a pound sign is used, there must be a space between the pound sign and the secondary number.

c. Do not update this data item if the patient’s address changes.

d. Use standard abbreviations recognized by the U.S. Postal Service (USPS). The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at [http://pe.usps.com/text/pub28/welcome.htm](http://pe.usps.com/text/pub28/welcome.htm). Standard abbreviations include, but are not limited to:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apartment APT</td>
<td>123 MAIN ST APT 5</td>
</tr>
<tr>
<td>Avenue AVE</td>
<td>RR 2 BOX 421</td>
</tr>
<tr>
<td>Boulevard BLVD</td>
<td>103 FIRST AVE SW APT 102</td>
</tr>
<tr>
<td>Building BLDG</td>
<td></td>
</tr>
<tr>
<td>Circle CIR</td>
<td></td>
</tr>
<tr>
<td>Court CT</td>
<td></td>
</tr>
<tr>
<td>Department DEPT</td>
<td></td>
</tr>
<tr>
<td>Drive DR</td>
<td></td>
</tr>
<tr>
<td>Floor FL</td>
<td></td>
</tr>
<tr>
<td>Lane LN</td>
<td></td>
</tr>
<tr>
<td>Parkway PKY</td>
<td></td>
</tr>
<tr>
<td>Place PL</td>
<td></td>
</tr>
<tr>
<td>Post Office PO</td>
<td></td>
</tr>
<tr>
<td>Road RD</td>
<td></td>
</tr>
<tr>
<td>Room RM</td>
<td></td>
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<tr>
<td>Rural Route RR</td>
<td></td>
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<tr>
<td>State Road SR</td>
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<td>Street ST</td>
<td></td>
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<tr>
<td>Suite STE</td>
<td></td>
</tr>
<tr>
<td>Terrace TER</td>
<td></td>
</tr>
<tr>
<td>Unit UNIT</td>
<td></td>
</tr>
<tr>
<td>North N</td>
<td></td>
</tr>
<tr>
<td>Northeast NE</td>
<td></td>
</tr>
<tr>
<td>Northwest NW</td>
<td></td>
</tr>
<tr>
<td>South S</td>
<td></td>
</tr>
<tr>
<td>Southeast SE</td>
<td></td>
</tr>
<tr>
<td>Southwest SW</td>
<td></td>
</tr>
<tr>
<td>East E</td>
<td></td>
</tr>
<tr>
<td>West W</td>
<td></td>
</tr>
</tbody>
</table>

e. If the number and street address at diagnosis is not known, enter “UNKNOWN” in this field.
### PATIENT ADDRESS (NUMBER AND STREET)

**AT DIAGNOSIS – SUPPLEMENTAL**

*Required if available for cases diagnosed 01/01/2006 and later.

**Description**

This item provides the ability to store additional address information, such as the name of a place or facility (e.g., a nursing home or name of an apartment complex), at the time of diagnosis.

**Rationale**

A registry may receive the name of a facility instead of a proper street address containing the street number, name, direction, and other elements necessary to locate an address on a street file for the purpose of geocoding.

**Instructions for Coding**

a. Record the place or facility (e.g., a nursing home or name of an apartment complex) of the patient’s usual residence when the tumor was diagnosed.

b. **Do not** record apartment number, lot number, or other such information in this item. Record this information in the street address line.

c. If the patient has multiple tumors, the address may be different for subsequent primaries.

d. Do not update this data item if the patient’s address changes.

e. If this address space is not needed, leave the item blank.
**Coding Instructions**  
**Patient and Hospital Identification**  
**Chapter 5**

**CITY/TOWN AT DIAGNOSIS**

<table>
<thead>
<tr>
<th>Item Length:</th>
<th>50</th>
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</thead>
<tbody>
<tr>
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<td>ACoS:</td>
<td>Required</td>
</tr>
<tr>
<td>State Registry:</td>
<td>Required</td>
</tr>
</tbody>
</table>

**Description**

This is a required 50-character field for the patient’s usual city or town at the time of diagnosis. If the patient has multiple tumors, the address may be different for each primary. See "General Guidelines for Recording Patient Address at Diagnosis" for detailed residency rules.

**Rationale**

The address is a part of the patient’s demographic data and has multiple uses. It indicates referral patterns and allows for analysis of cancer clusters or environmental studies.

**Instructions**

a. Record the city or town of the patient’s usual residence when the cancer was diagnosed.

b. Do not use punctuation or special characters and abbreviate when necessary.

c. Do not update this data item if the patient’s city/town of residence changes.

d. If the city is not known, enter “UNKNOWN.”
Description
This is a required 2-character field for the patient’s usual state of residence at the time of diagnosis. See "General Guidelines for Recording Patient Address at Diagnosis" for detailed residency rules.

Rationale
The address is a part of the patient’s demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Instructions
a. Record the standard U.S. Postal Service 2-letter abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory in which the patient resides at the time of diagnosis. The 2-letter codes appear on the following page.

b. If the patient has multiple tumors, the state of residence may be different for each primary.

c. Do not update this data item if the patient’s state of residence changes.

Special Codes
CD  Resident of Canada, NOS (province/territory unknown)
US  Resident of United States, NOS (state/commonwealth/territory/possession unknown)
XX  Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is known. Code the country of residence in County at Diagnosis.
YY  Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is unknown.
ZZ  Residence unknown
## State Abbreviation Codes

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<th>STATE</th>
</tr>
</thead>
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</tr>
<tr>
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<td>New Mexico</td>
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<td>New York</td>
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<tr>
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<td>North Carolina</td>
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<tr>
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<td>North Dakota</td>
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<td>Pennsylvania</td>
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<td>Rhode Island</td>
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<tr>
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<td>Missouri</td>
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<td>Tennessee</td>
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<td>Washington</td>
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<tr>
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<td>OH</td>
<td>Wyoming</td>
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<tr>
<td>Other</td>
<td></td>
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</tr>
<tr>
<td>American Samoa</td>
<td>AS</td>
<td></td>
</tr>
<tr>
<td>Guam</td>
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<td></td>
</tr>
<tr>
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<td>Virgin Islands</td>
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<td>FM</td>
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<td>Marshall Islands</td>
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<td></td>
</tr>
<tr>
<td>Outlying Islands</td>
<td>UM</td>
<td></td>
</tr>
<tr>
<td>APO/FPO Armed Services America</td>
<td>AA</td>
<td></td>
</tr>
<tr>
<td>APO/FPO Armed Services Europe</td>
<td>AE</td>
<td></td>
</tr>
<tr>
<td>APO/FPO Armed Services Pacific</td>
<td>AP</td>
<td></td>
</tr>
</tbody>
</table>

## Abbreviation Codes for Canadian Provinces and Territories

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>PROVINCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta</td>
<td>AB</td>
</tr>
<tr>
<td>British Columbia</td>
<td>BC</td>
</tr>
<tr>
<td>Manitoba</td>
<td>MB</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>NB</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>NL</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>NT</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>NS</td>
</tr>
<tr>
<td>Nunavut</td>
<td>NU</td>
</tr>
<tr>
<td>Ontario</td>
<td>ON</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>PE</td>
</tr>
<tr>
<td>Quebec</td>
<td>QC</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>SK</td>
</tr>
<tr>
<td>Yukon</td>
<td>YT</td>
</tr>
</tbody>
</table>
## Chapter 5  
### Patient and Hospital Identification  
#### Coding Instructions

<table>
<thead>
<tr>
<th>POSTAL CODE (ZIP CODE) AT DIAGNOSIS</th>
<th>Item Length: 9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data Type: Numeric</td>
</tr>
<tr>
<td></td>
<td>Left Justified, Blank Fill</td>
</tr>
<tr>
<td></td>
<td>ACoS: Required</td>
</tr>
<tr>
<td></td>
<td>State Registry: Required</td>
</tr>
</tbody>
</table>

### Description

This is a required 9-character field for the patient’s postal (ZIP) code at the time of diagnosis. The 4-digit extension is optional. See “General Guidelines for Recording Patient Address at Diagnosis” for detailed residency rules.

### Rationale

The address is a part of the patient’s demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

### Instructions

a. For U.S. residents record the U.S. Postal Service ZIP code for the patient’s residence at the time of diagnosis.

b. The ZIP code field in the RMCDS program will accept the “ZIP plus 4” extended ZIP code. Do not enter a dash before the 4-digit extension.

   Recording the 4-digit extension is optional. If the 4-digit extension is not recorded, left justify the 5-digit code and leave the remaining spaces blank.

c. For residents of Canada and Puerto Rico record the postal code, left justify, and leave the remaining spaces blank.

d. If the patient has multiple malignancies, the postal code may be different for each primary.

e. Do not update this data item if the patient’s postal code changes.

### Special Codes

- **88888**  Permanent address in a country other than Canada, United States, or US possession and postal code is unknown.
- **99999**  Permanent address in Canada, United States, or US possession and postal code is unknown.
Description
This is a required 3-character field to record the county of the patient’s usual residence at the time of diagnosis. See “General Guidelines for Recording Patient Address at Diagnosis” for detailed residency rules.

Rationale
This data item may be used for epidemiological purposes. It may be used, for example, to measure the cancer incidence in a particular geographic area.

Codes
Use the codes issued by the Bureau of Standards in the Federal Information Processing Standards (FIPS). FIPS codes for Indiana counties are listed on the following page.

Instructions
a. Residents of Indiana
   For Indiana Residents, enter the 3-digit FIPS code for the patient’s county of residence at the time of diagnosis from the list on the following page.

b. Residents of States Other than Indiana
   (1) If the patient is a resident of a state other than Indiana, and your facility does not collect identification codes for counties of that state, record the 998 code defined under “special codes.”

   (2) If the patient is a resident of a state other than Indiana, and your facility collects identification codes for counties of that state, use the FIPS codes for that state. Appendix H lists the FIPS codes for counties in the states adjoining Indiana. If you need codes for states other than those provided, contact the State Registry.

c. Residents of Countries other than the United States
   If the patient is a resident of a country other than the United States, record the code for the country in this field. An XX code would have been recorded in State at Diagnosis.

   For country codes, see one of the following:
   - The SEER Program Coding and Staging Manual, Appendix B (http://seer.cancer.gov);
   - NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Appendix B (http://www.naaccr.org); or

d. Do not update this data item if the patient’s county of residence changes.

Special Codes
998 The patient resides outside of the state of the reporting facility.
999 Unknown county/country. The patient is a resident of Indiana but the address is unknown.
## INDIANA COUNTY CODES

<table>
<thead>
<tr>
<th>FIPS</th>
<th>County</th>
<th>FIPS</th>
<th>County</th>
<th>FIPS</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Adams</td>
<td>071</td>
<td>Jackson</td>
<td>141</td>
<td>St. Joseph</td>
</tr>
<tr>
<td>003</td>
<td>Allen</td>
<td>073</td>
<td>Jasper</td>
<td>143</td>
<td>Scott</td>
</tr>
<tr>
<td>005</td>
<td>Bartholomew</td>
<td>075</td>
<td>Jay</td>
<td>145</td>
<td>Shelby</td>
</tr>
<tr>
<td>007</td>
<td>Benton</td>
<td>077</td>
<td>Jefferson</td>
<td>147</td>
<td>Spencer</td>
</tr>
<tr>
<td>009</td>
<td>Blackford</td>
<td>079</td>
<td>Jennings</td>
<td>149</td>
<td>Starke</td>
</tr>
<tr>
<td>011</td>
<td>Boone</td>
<td>081</td>
<td>Johnson</td>
<td>151</td>
<td>Steuben</td>
</tr>
<tr>
<td>013</td>
<td>Brown</td>
<td>083</td>
<td>Knox</td>
<td>153</td>
<td>Sullivan</td>
</tr>
<tr>
<td>015</td>
<td>Carroll</td>
<td>085</td>
<td>Kosciusko</td>
<td>155</td>
<td>Switzerland</td>
</tr>
<tr>
<td>017</td>
<td>Cass</td>
<td>087</td>
<td>LaGrange</td>
<td>157</td>
<td>Tippecano</td>
</tr>
<tr>
<td>019</td>
<td>Clark</td>
<td>089</td>
<td>Lake</td>
<td>159</td>
<td>Tipton</td>
</tr>
<tr>
<td>021</td>
<td>Clay</td>
<td>091</td>
<td>LaPorte</td>
<td>161</td>
<td>Union</td>
</tr>
<tr>
<td>023</td>
<td>Clinton</td>
<td>093</td>
<td>Lawrence</td>
<td>163</td>
<td>Vanderburgh</td>
</tr>
<tr>
<td>025</td>
<td>Crawford</td>
<td>095</td>
<td>Madison</td>
<td>165</td>
<td>Vermillion</td>
</tr>
<tr>
<td>027</td>
<td>Daviess</td>
<td>097</td>
<td>Marion</td>
<td>167</td>
<td>Vigo</td>
</tr>
<tr>
<td>029</td>
<td>Dearborn</td>
<td>099</td>
<td>Marshall</td>
<td>169</td>
<td>Wabash</td>
</tr>
<tr>
<td>031</td>
<td>Decatur</td>
<td>101</td>
<td>Martin</td>
<td>171</td>
<td>Warren</td>
</tr>
<tr>
<td>033</td>
<td>DeKalb</td>
<td>103</td>
<td>Miami</td>
<td>173</td>
<td>Warrick</td>
</tr>
<tr>
<td>035</td>
<td>Delaware</td>
<td>105</td>
<td>Monroe</td>
<td>175</td>
<td>Washington</td>
</tr>
<tr>
<td>037</td>
<td>Dubois</td>
<td>107</td>
<td>Montgomery</td>
<td>177</td>
<td>Wayne</td>
</tr>
<tr>
<td>039</td>
<td>Elkhart</td>
<td>109</td>
<td>Morgan</td>
<td>179</td>
<td>Wells</td>
</tr>
<tr>
<td>041</td>
<td>Fayette</td>
<td>111</td>
<td>Newton</td>
<td>181</td>
<td>White</td>
</tr>
<tr>
<td>043</td>
<td>Floyd</td>
<td>113</td>
<td>Noble</td>
<td>183</td>
<td>Whitley</td>
</tr>
<tr>
<td>045</td>
<td>Fountain</td>
<td>115</td>
<td>Ohio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>047</td>
<td>Franklin</td>
<td>117</td>
<td>Orange</td>
<td></td>
<td></td>
</tr>
<tr>
<td>049</td>
<td>Fulton</td>
<td>119</td>
<td>Owen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>051</td>
<td>Gibson</td>
<td>121</td>
<td>Parke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>053</td>
<td>Grant</td>
<td>123</td>
<td>Perry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>055</td>
<td>Greene</td>
<td>125</td>
<td>Pike</td>
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<td>Hamilton</td>
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<td>059</td>
<td>Hancock</td>
<td>129</td>
<td>Posey</td>
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<td>061</td>
<td>Harrison</td>
<td>131</td>
<td>Pulaski</td>
<td></td>
<td></td>
</tr>
<tr>
<td>063</td>
<td>Hendricks</td>
<td>133</td>
<td>Putnam</td>
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<td></td>
</tr>
<tr>
<td>065</td>
<td>Henry</td>
<td>135</td>
<td>Randolph</td>
<td></td>
<td></td>
</tr>
<tr>
<td>067</td>
<td>Howard</td>
<td>137</td>
<td>Ripley</td>
<td></td>
<td></td>
</tr>
<tr>
<td>069</td>
<td>Huntington</td>
<td>139</td>
<td>Rush</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Coding Instructions**

**Patient and Hospital Identification**

**Chapter 5**

---

**CENSUS TRACT 2000**

- **Item Length:** 6
- **Data Type:** Numeric
- **Zero Fill:**
- **ACoS:** N/A
- **State Registry:** Required*  

---

**Description**

This is a required 6-character field in the RMCDS abstract screen for recording a census tract code that identifies the patient’s residence at time of diagnosis. The code pinpoints residence at diagnosis within a geographic area smaller than the county of residence. Census tract is collected to meet the requirements of the Federal cancer registries grant.

**Rationale**

Census tract codes allow central registries to calculate incidence rates for geographical areas having population estimates. This field allows a central registry to add Year 2000 Census tract to cases diagnosed in previous years.

**Definition**

Census tract codes originate from the Bureau of the Census and are constructed using the patient’s address. The boundaries of census tracts are established cooperatively by local committees and the Census Bureau. The corresponding population of the census tract area can be obtained from the Census Bureau. Codes are available from state health departments or the Bureau of the Census.

**Instructions**

a. **The State Cancer Registry will code this item** using computerized methods based on the patient’s address at diagnosis. If your facility already collects census tract, please contact the State Registry to avoid unnecessary duplication of effort. The field is described here for general informational purposes.

b. **When coding census tract, the decimal point is assumed to be between the fourth and fifth positions of the field.** Zeros are added to fill all six positions.

   *Example 1:* Census tract 409.6 (0409.60) would be coded 040960.
   *Example 2:* Census tract 516.21 (0516.21) would be coded 051621.

**Special Codes**

- **000000** Area is not census tracted
- **999999** Area is census tracted, but census tract is not available
- **blank** Census Tract 2000 not coded

---

*Completed by the State Registry*
CENSUS TRACT CERTAINTY 2000

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Census tract based on complete and valid street address of residence</td>
</tr>
<tr>
<td>2</td>
<td>Census tract based on residence ZIP + 4</td>
</tr>
<tr>
<td>3</td>
<td>Census tract based on residence ZIP + 2</td>
</tr>
<tr>
<td>4</td>
<td>Census tract based on residence ZIP code only</td>
</tr>
<tr>
<td>5</td>
<td>Census tract based on ZIP code of P.O. Box</td>
</tr>
<tr>
<td>9</td>
<td>Unable to assign census tract or bloc numbering based on available information</td>
</tr>
<tr>
<td>Blank</td>
<td>Not applicable (e.g., census tracting not attempted); Census Tract Certainty information for 2000 not coded</td>
</tr>
</tbody>
</table>

**Description**

This is a required 1-character field in the RMCDS abstract screen for recording the basis of assignment of census tract for an individual record. This item is not coded by the hospital. The information is usually provided by a geocoding vendor service, but may be manually assigned by central registry staff. The codes are hierarchical, with lower numbers having priority.

**Rationale**

This item is helpful in identifying cases tracted from incomplete information or P.O. Box.

**Instructions**

The State Cancer Registry will code this item using computerized methods based on the patient's address at diagnosis. The field is described here for general informational purposes.
SOCIAL SECURITY NUMBER

Description
This is a required 9-character field to record the patient's Social Security Number (SSN).

Rationale
This item is extremely important in identifying, linking, and matching multiple records on the same patient and in differentiating patients with similar names at the State Cancer Registry. Every effort should be made to obtain the correct number for each patient.

Instructions
a. Do not enter any dashes, other punctuation, or any alphabetical letters.
b. Do not record Social Security numbers that end with B or D. These letters signify that the number is the spouse's and indicate that the patient is receiving benefits under the spouse's number. Code as 999999999.
c. You can assume the Medicare number is the Social Security number if it is prefixed with “A” or “C.” Do not enter the prefix “A” or “C” on the abstract as part of the Social Security number.

Special Codes
999999999 The patient does not have a Social Security number or it is not available or unknown. Do not leave the field blank.
Chapter 5  Patient and Hospital Identification  Coding Instructions

DATE OF BIRTH

Item Length: 8
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 8-character field for recording the patient’s birth date.

Rationale
This data item is useful for patient identification. It is also useful when analyzing tumors according to age cohort.

Codes

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>January</td>
<td>01</td>
</tr>
<tr>
<td>02</td>
<td>February</td>
<td>02</td>
</tr>
<tr>
<td>03</td>
<td>March</td>
<td>03</td>
</tr>
<tr>
<td>04</td>
<td>April</td>
<td>...</td>
</tr>
<tr>
<td>05</td>
<td>May</td>
<td>...</td>
</tr>
<tr>
<td>06</td>
<td>June</td>
<td>25</td>
</tr>
<tr>
<td>07</td>
<td>July</td>
<td>26</td>
</tr>
<tr>
<td>08</td>
<td>August</td>
<td>...</td>
</tr>
<tr>
<td>09</td>
<td>September</td>
<td>30</td>
</tr>
<tr>
<td>10</td>
<td>October</td>
<td>31</td>
</tr>
<tr>
<td>11</td>
<td>November</td>
<td>blank = Day unknown</td>
</tr>
<tr>
<td>12</td>
<td>December</td>
<td>blank = Month unknown</td>
</tr>
<tr>
<td>blank</td>
<td>Month unknown</td>
<td>blank = Day unknown</td>
</tr>
</tbody>
</table>

Instructions
a. Record the patient’s date of birth as documented in the patient record. Use the full four-digit year for year. Determine whether your software vendor uses the traditional format for date entry (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format.

b. For in utero diagnosis and treatment, record the actual date of birth. The date of birth will follow one or both dates for those events.

c. If only the patient age is available, calculate the year of birth from age and the year of diagnosis and leave day and month of birth spaces blank.

Example:
The patient is 60 years old when admitted to the hospital on June 15, 2001 and no birth date is given. Record _ _/_ _/1941 or 1941/_ _/_ _, depending on the date format your software uses. Leave the month and day spaces blank.

d. If month is unknown, the day is coded unknown. If the year cannot be determined, code day and month as unknown.

e. If the date of birth cannot be determined at all, leave the date of birth field blank and record the reason in Date of Birth Flag. See the Date of Birth Flag section for examples illustrating the relationships among these items.
**Coding Instructions**  
*Patient and Hospital Identification*  
*Chapter 5*

**DATE OF BIRTH FLAG**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of Birth Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td><em>12/07/1953 or 1953/12/07</em></td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td><em>12/ _ _ /1953 or 1953/12/ _ _</em></td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>* _ _/ _ /1953 or 1953/ _ / _ _*</td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown date</td>
<td>* _ _/ _ _ _ _ _ _ or _ _ _ / _ _ _ _*</td>
<td>12</td>
</tr>
</tbody>
</table>

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format. The computer will store either in the interoperable format.

---

**Description**
This flag explains why there is no appropriate value in the corresponding date field, *Date of Birth* (NAACCR Item #240).

**Rationale**
As part of an initiative to standardize date fields, the date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

**Codes**
12. A valid date is applicable but not known (for example, birth date is unknown)  
Blank. A valid date is coded in the *Date of Birth* item (NAACCR Item #240).

**Instructions**
a. Leave this item blank if *Date of Birth* has a full or partial date recorded.  
b. Use code 12 if the *Date of Birth* cannot be determined at all.  
c. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

**Examples:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of Birth Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td><em>12/07/1953 or 1953/12/07</em></td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td><em>12/ _ _ /1953 or 1953/12/ _ _</em></td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>* _ _/ _ /1953 or 1953/ _ / _ _*</td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown date</td>
<td>* _ _/ _ _ _ _ _ _ or _ _ _ / _ _ _ _*</td>
<td>12</td>
</tr>
</tbody>
</table>
Chapter 5  Patient and Hospital Identification  Coding Instructions

AGE AT DIAGNOSIS

Description
This is a required 3-character field in the RMCDS abstract screen for recording patient age at the time of diagnosis. The patient's age at diagnosis is automatically calculated by the RMCDS program after the date of birth and date of diagnosis are recorded.

Definition
“Age at Diagnosis” is the patient's age at his or her last birthday before diagnosis.

Examples:

000  Less than one year old; diagnosed in utero
001  One year old, but less than two years old
002  Two years old
...  Actual age in years
999  Unknown age

Instructions for Facilities Using RMCDS

a. If the date of birth and date of diagnosis are recorded, leave the item blank. The RMCDS software program will automatically calculate age.

b. If either the date of birth or the date of diagnosis is unknown, you may manually enter the age at diagnosis in the RMCDS program if you know or can estimate the patient's age, even without a birth date or diagnosis date.
PLACE OF BIRTH

*This item was coded for cases diagnosed through 2012 and should be converted automatically by the registry's software to the 2013 items, Birthplace – State and Birthplace – Country.

Description
This is a 3-character field in the RMCDS abstract screen for recording a numeric code that identifies the state or country (if outside the United States) of the patient’s birth. The State Registry requires the item if the information is available.

Codes

Special Codes
000 United States, NOS
998 Place of birth outside of the United States, no other detail known
999 Place of birth unknown

Instructions
For further coding instructions, refer to the FORDS.
**Chapter 5  Patient and Hospital Identification  Coding Instructions**

**BIRTHPLACE - STATE**

<table>
<thead>
<tr>
<th>Item Length: 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACoS: Required</td>
</tr>
<tr>
<td>State Registry: Required if available</td>
</tr>
</tbody>
</table>

**Description**
This is a 2-character field for recording the patient’s state of birth. The State Registry requires the item if the information is available.

**Codes**
See the table provided for *State at Diagnosis* for the list of state codes.

**Special Codes**
XX  Born in a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is known (code the country in Birthplace-Country)
YY  Born in a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is unknown
US  Born in the U.S. (including its territories, commonwealths, or possessions) and the state is unknown
CD  Born in Canada and the province is unknown.
ZZ  Place of birth is unknown, not mentioned in the patient record

**Note**
This item was first defined for use in 2013. Cases diagnosed before 2013 should be converted automatically by the registry’s software from the former *Place of Birth*. 
**Coding Instructions**  
**Patient and Hospital Identification**  
**Chapter 5**

**BIRTHPLACE - COUNTRY**

<table>
<thead>
<tr>
<th>Item Length: 3</th>
<th>ACoS: Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Registry: Required if available</td>
<td></td>
</tr>
</tbody>
</table>

---

**Description**

This is a 3-character field for recording the country where the patient was born. The State Registry requires the item if the information is available.

**Codes**

For country codes, see one of the following:

- *The SEER Program Coding and Staging Manual, Appendix B* (http://seer.cancer.gov);
- *NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Appendix B* (http://www.naaccr.org); or

**Examples**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>United States</td>
</tr>
<tr>
<td>CAN</td>
<td>Canada</td>
</tr>
<tr>
<td>ZZX</td>
<td>Non-US NOS</td>
</tr>
<tr>
<td>ZZU</td>
<td>Place of birth is unknown, not mentioned in patient record</td>
</tr>
</tbody>
</table>

**Note**

This item was first defined for use in 2013. Cases diagnosed before 2013 should be converted automatically by the registry’s software from the former *Place of Birth*. 
MEDICAL RECORD NUMBER

Description
This is a required 11-character field to record the patient’s medical record number. The medical record number is a patient identification number usually assigned by a hospital’s medical record or health information management (HIM) department.

Instructions
a. If the number is less than 11 digits, right justify and leave the leading spaces blank.

Example: Medical record number 24937 should be entered as _ _ _ _ _ _ 24937.

Note (for facilities using RMCDS): The medical record number may be entered from the left (left justified). After the record is exited, the RMCDS program will automatically right justify the number.

b. Do not include any hyphens, dashes, slashes, or other punctuation.

c. If the hospital uses the patient’s Social Security Number for the medical record number, record it in this field without dashes or spaces. Right justify and leave the leading spaces blank.

Special Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNK</td>
<td>The patient’s medical record number is unknown.</td>
</tr>
<tr>
<td>RT</td>
<td>Radiation therapy department patient without HIM medical record number</td>
</tr>
<tr>
<td>SU</td>
<td>One-day surgery clinic patient without HIM medical record number</td>
</tr>
<tr>
<td>blank</td>
<td>The patient does not have a medical record number at your hospital.</td>
</tr>
</tbody>
</table>

Note: Other standard abbreviations may be used to indicate departments within the facility for patients without HIM numbers.
**Coding Instructions**  Patient and Hospital Identification  Chapter 5

**SEX**

<table>
<thead>
<tr>
<th>Item Length: 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Type: Numeric</td>
</tr>
<tr>
<td>ACoS: Required</td>
</tr>
<tr>
<td>State Registry: Required</td>
</tr>
</tbody>
</table>

**Description**

This is a required 1-character field to record a code that identifies the patient’s sex.

**Rationale**

This data item is used to compare cancer rates and outcomes by site. The same sex code should appear in each medical record for a patient with multiple tumors.

**Codes**

1  Male
2  Female
3  Other (hermaphrodite)
4  Transsexual, NOS
5  Transsexual, natal male
6  Transsexual, natal female
9  Not stated

**Note:** Codes 5 and 6 were added for 2015, but may be used for earlier diagnoses.
**Primary Payer at Diagnosis**

*Item Length: 2*
*Data Type: Numeric*
*ACoS: Required*
*State Registry: *Required if available*

*Required if available for cases diagnosed 01/01/2006 and later.

**Description**
This is a required 2-character field to identify the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

**Rationale**
This item is used in financial analysis and as an indicator for quality and outcome analyses. Joint Commission of Accreditation of Healthcare Organizations (JCAHO) requires the patient admission page to document the type of insurance or payment structure that will cover the patient while being cared for at the hospital.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Not insured</td>
<td>Patient has no insurance and is declared a charity write-off.</td>
</tr>
<tr>
<td>02</td>
<td>Not insured, self-pay</td>
<td>Patient has no insurance and is declared responsible for charges.</td>
</tr>
<tr>
<td>10</td>
<td>Insurance, NOS</td>
<td>Type of insurance unknown or other than the types described in the definitions for codes 20, 21, 31, 35, 60-68.</td>
</tr>
<tr>
<td>20</td>
<td>Private Insurance: Managed care, HMO, PPO</td>
<td>An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network, or a staff model. &quot;Gate-keeper model&quot; is another term for describing this type of insurance.</td>
</tr>
<tr>
<td>21</td>
<td>Private Insurance: Fee-for-Service</td>
<td>An insurance plan that does not have negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.</td>
</tr>
<tr>
<td>31</td>
<td>Medicaid</td>
<td>State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs. Medicaid other than those described in the definition for code 35.</td>
</tr>
<tr>
<td>35</td>
<td>Medicaid - Administered through a Managed Care plan</td>
<td>Patient is enrolled in Medicaid through a Managed Care program (e.g., HMO or PPO). The managed care plan pays for all incurred costs.</td>
</tr>
<tr>
<td>60</td>
<td>Medicare without supplement, Medicare, NOS</td>
<td>Federal government funded insurance for persons who are 65 years of age or older, or are chronically disabled (Social Security insurance eligible). Not described in the definitions for codes 61, 62, or 63.</td>
</tr>
<tr>
<td>61</td>
<td>Medicare with supplement, NOS</td>
<td>Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare.</td>
</tr>
<tr>
<td>62</td>
<td>Medicare - Administered through a Managed Care plan</td>
<td>Patient is enrolled in Medicare through a Managed Care plan (e.g., HMO or PPO). The Managed Care plan pays for all incurred costs.</td>
</tr>
<tr>
<td>63</td>
<td>Medicare with private supplement</td>
<td>Patient has Medicare and private insurance to pay costs not covered by Medicare.</td>
</tr>
<tr>
<td>64</td>
<td>Medicare with Medicaid eligibility</td>
<td>Federal government Medicare insurance with State Medicaid administered supplement.</td>
</tr>
<tr>
<td>Code</td>
<td>Label</td>
<td>Definition</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>65</td>
<td>TRICARE</td>
<td>Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>military dependents, retirees, and their dependents.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Formerly CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).</td>
</tr>
<tr>
<td>66</td>
<td>Military</td>
<td>Military personnel or their dependents who are treated at a military facility.</td>
</tr>
<tr>
<td>67</td>
<td>Veterans Affairs</td>
<td>Veterans who are treated in Veterans Affairs facilities.</td>
</tr>
<tr>
<td>68</td>
<td>Indian/Public Health Service</td>
<td>Patient who receives care at an Indian Health Service facility or at another facility and the medical costs are reimbursed by the Indian</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Service.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient receives care at a Public Health Service facility or at another facility and medical costs are reimbursed by the Public Health Service.</td>
</tr>
<tr>
<td>99</td>
<td>Insurance status unknown</td>
<td>It is unknown from the patient’s medical record whether or not the patient is insured.</td>
</tr>
</tbody>
</table>

**Instructions**

a. Record the applicable code from the above list for the type of insurance reported on the patient’s admission page.

b. Codes 21 and 65-68 are to be used for patients diagnosed on or after January 1, 2006.

c. If more than one payer or insurance carrier is listed on the patient’s admission page, record the first.

d. If the patient’s payer or insurance carrier changes, do not change the initially recorded code.

**Codes with Examples:**

- **01** An indigent patient is admitted with no insurance coverage.
- **20** A patient is admitted for treatment and the patient admission page states the primary insurance carrier is an HMO.
- **62** A 65-year old male patient is admitted for treatment and the patient admission page states the patient is covered by Medicare with additional insurance coverage from a PPO.
Description
This is a required 2-character field to record a code that identifies the patient’s race and a required 1-character field to record a code for the patient’s origin, if of Spanish/Hispanic descent.

Codes for Race
01 White
02 Black
03 American Indian, Aleutian, or Eskimo
04 Chinese
05 Japanese
06 Filipino
07 Hawaiian
08 Korean
09 Asian Indian, Pakistani
10 Vietnamese
11 Laotian
12 Hmong
13 Kampuchean (including Khmer and Cambodian)
14 Thai
20 Micronesian, NOS
21 Chamorro/Chamoru
22 Guamanian, NOS
25 Polynesian, NOS
26 Tahitian
27 Samoan
28 Tongan
30 Melanesian, NOS
31 Fiji Islander
32 New Guinean
88 No further race documented (for Race 2-5 in cases diagnosed 01/01/2000 and later)
96 Other Asian, including Asian, NOS and Oriental, NOS
97 Pacific Islander, NOS
98 Other
99 Unknown

Codes 20-97 were adopted for use effective with 1991 diagnoses. Code 14 was adopted for use effective with 1994 and later cases.

Definitions
a. **Code 01** (white) includes Mexican, Puerto Rican, Cuban, and all other Caucasians.

b. **Code 02** (black) includes persons reported as African American, Afro-American, Negro, brown, or colored.

c. **Code 13** (Kampuchean) includes patients whose race is listed as Cambodian.

Instructions
a. Additional races reported by the person should be coded in Race 2, Race 3, Race 4, and Race 5. If the patient is multiracial, code all races using Race 2 through Race 5, and code all remaining Race items 88.

b. All tumors for the same patient should have the same race code.
c. If Race 1 is coded 99, then Race 2 through Race 5 must all be coded 99. If Race 2, 3, or 4 is coded 88 or 99, then all the subsequent Race items must be coded with the same value.

d. For cases diagnosed prior to January 1, 2000 (Race Coding System—Current is less than six), Race 2 through Race 5 must be blank unless the patient has more than one primary with at least one primary diagnosed after January 1, 2000. In this case, the race codes for all primaries must be the same as the one for the primary diagnosed after January 1, 2000. Race Coding System—Current must be six and data items Race 2 through Race 5 that do not have specific race recorded must be coded 88.

e. Race 1 is the field used to compare with race data on cases diagnosed prior to January 1, 2000.

f. Race is based on birth place information when place of birth is reported as China, Japan, or the Philippines and race is reported only as Asian, Oriental, Mongolian, or Yellow.

   If place of birth is China, Japan, or the Philippines, and race is not reported, code the race as 99 (Unknown). Place of birth alone cannot be used to determine race or ethnicity.

   Codes with Examples:
   01 A patient was born in Mexico of Mexican parentage. Code also Spanish/Hispanic Origin.

   02 A black female patient. A specific race code (other than blank or 99) must not occur more than once. For example, do not code “Black” in Race 1 for one parent and “Black” in Race 2 for the other parent.

   05 A patient has a Japanese father and a Caucasian mother. (Caucasian will be coded in Race 2). If a person’s race is recorded as a combination of white and any other race, code to the other race in the Race 1 field and then code Caucasian as “White” in the next race field.

   05 A patient’s race is listed as Asian and the birthplace is Japan. Code to birthplace. When the race is recorded as “Oriental,” “Mongolian,” or “Asian,” and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on birthplace information.

   07 A patient has a Hawaiian father, black mother, Japanese grandfather, and Korean grandmother. If a person’s race is recorded as a combination of Hawaiian and any other race(s), code the person’s primary race as Hawaiian and code the other races in Race 2, Race 3, Race 4, and Race 5 as appropriate. In this case, black to Race 2; Japanese to Race 3; and Korean to Race 4.

   08 A patient is of Korean and Asian ancestry. Do not code “Asian” in a subsequent race field if a specific Asian race(s) has already been coded.

   25 A patient with a Polynesian mother, Tahitian father, and Samoan grandparents.

   99 A patient’s race is unknown. Race 2 through Race 5 must also be 99.

Description for Spanish Origin
This item identifies persons of Spanish/Hispanic surname or ethnicity. Persons of Spanish/Hispanic origin may be of any race, but these categories are generally not used for native Americans, Filipinos, or others who may have Spanish surnames.

   Codes for Spanish Origin
   0 Non-Spanish; non-Hispanic; not Spanish surname
   1 Mexican (includes Chicano)
   2 Puerto Rican
   3 Cuban
   4 South or Central American (except Brazilian)
   5 Other specified Spanish/Hispanic origin (includes European and third or fourth generation patients coded 1, 2, 3, or 4)
6 Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any of the categories 1 to 5; Spanish/Hispanic surname but country of origin unknown.)

7 Spanish surname only (The only evidence of the person’s Hispanic origin is surname or maiden name and there is no contrary evidence that the person is not Hispanic.)

9 Unknown whether Spanish or not

Code 7 was adopted for use effective with 1994 diagnoses. It does not include computer assignment of ethnicity.

Definitions and Rules for Spanish Origin

a. Use code 0 (Non-Spanish; non-Hispanic) for Portuguese and Brazilian persons.

b. Code European Spanish and Basque as other specified Spanish/Hispanic origin (Code 5).

c. Follow the rules for race in coding patients with mixed parentage.

d. If the patient has multiple tumors, all records should have the same code.
USUAL OCCUPATION

Description
This is a required text field to record the patient’s occupation, if available.

Rationale
Occupation is collected to meet the requirements of the Federal cancer registries grant. The item may be used to identify new work-related health hazards and to identify occupational groups in which cancer screening or prevention activities may be beneficial. It may also serve as an additional measure of socioeconomic status.

Instructions
a. Record the patient’s usual occupation (that is, the kind of work performed during most of the patient’s working life before diagnosis of this tumor). This may be different from the occupation at the time of diagnosis.

b. Do not record “retired.” Do not add, “retired,” to the usual occupation. (e.g., record “registered nurse” not “retired registered nurse.”)

c. Do not record “disabled,” “unemployed,” or “institutionalized” if the patient was ever employed. Record the longest-held occupation.

d. If self-employed, specify the kind of work performed. (e.g., “self-employed auto mechanic”)

e. If usual occupation is not available or is unknown, record the patient’s current or most recent occupation or any known occupation.

f. If the patient was a homemaker (housewife/househusband) and also worked outside the home during most of his/her adult life, record usual occupation outside the home.

   If the patient was a homemaker (housewife/househusband) and did not work outside the home for most of his/her adult life, record “homemaker.”

g. If the patient is less than 14 years of age at the time of diagnosis, record “child.”

h. If the patient was student at the time of diagnosis and had never held a job, record “student.”

i. If the patient was not a student or homemaker and had never worked, record “never worked” as the usual occupation.

j. If no information related to the patient’s occupation is available, record “unknown.”

k. Update this field if better information is obtained as to the usual occupation of the patient.
Description
This is a required text field to record the company or industry, if available, for the occupation recorded in the preceding field.

Rationale
Both occupation and business/industry are required to accurately describe an individual’s occupation. The item may be used to identify new work-related health hazards and to identify worksite-related groups in which cancer screening or prevention activities may be beneficial. It may also serve as an additional measure of socioeconomic status.

Instructions
a. Record the primary type of activity carried on by the business/industry where the patient was employed for the most number of years before diagnosis of this tumor. This may be different from the company or industry of the patient’s occupation at the time of diagnosis.

b. Be sure to distinguish among “manufacturing,” “wholesale,” “retail,” and “service” components of an industry that performs more than one of these components.

c. If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient to record the name of the company (with city or town) for which the patient performed his/her usual occupation.

d. If only current or most recent occupation (rather than usual occupation) is documented, record the patient’s current or most recent business/industry.

e. There should be an entry for Usual Industry if any occupation is reported.
   ▪ If Usual Occupation is “homemaker,” record “own home” in Usual Industry.
   ▪ If Usual Occupation is “child,” record “child” in Usual Industry.
   ▪ If Usual Occupation is “military,” record “military” in Usual Industry.
   ▪ If Usual Occupation is “student,” record the type of school (“high school,” “college”) in Usual Industry.
   ▪ If Usual Occupation is “never worked,” record “none” in Usual Industry.
   ▪ If no information is available regarding the industry in which the reported occupation was carried out, record “unknown” in Usual Industry.

f. Update this field if better information is obtained as to the usual industry of the patient.
Description
This is a required text field in the paper and RMCDS abstracts for recording any other primary, malignant tumors from the patient’s history, or other primary tumors diagnosed simultaneously with or after the tumor being reported. Facilities using other types of registry software should follow their vendor’s instructions for recording text about other primary tumors.

Rationale
Text is needed to justify the codes selected for the data items and to record information that is not coded at all. The text is used for quality control and special studies.

Instructions
a. Record site, histology, date of diagnosis, and sequence number for all other primary, malignant tumors from the patient’s history, or other primary tumors diagnosed simultaneously with or after the tumor being reported.

   Example: Right breast, infiltrating duct carcinoma, July 1980, 01

b. Follow the SEER Multiple Primary and Histology Coding Rules.

c. If the person does not have, or has not had, another primary, malignant tumor, record “None.”
**DATE OF FIRST CONTACT**

*(INPATIENT OR OUTPATIENT ADMISSION DATE)*

**Item Length:** 8  
**Data Type:** Numeric  
**ACoS:** Required  
**State Registry:** Required

**Description**

This is a required 8-character field for the date the patient was first seen at or first admitted to your hospital for this tumor after your reference date. Use whichever date is earlier. Determine whether your software vendor uses the traditional format for date entry (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format.

**Codes**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>January 01</td>
<td>Use four-digit year (e.g., 2015)</td>
</tr>
<tr>
<td>02</td>
<td>February 02</td>
<td>blank = Year unknown</td>
</tr>
<tr>
<td>03</td>
<td>March 03</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>April ...</td>
<td></td>
</tr>
<tr>
<td>05</td>
<td>May ...</td>
<td></td>
</tr>
<tr>
<td>06</td>
<td>June 25</td>
<td></td>
</tr>
<tr>
<td>07</td>
<td>July 26</td>
<td></td>
</tr>
<tr>
<td>08</td>
<td>August ...</td>
<td></td>
</tr>
<tr>
<td>09</td>
<td>September 30</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>October 31</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>November blank = Day unknown</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>December</td>
<td></td>
</tr>
</tbody>
</table>

**Instructions**

a. Record the first (earliest) date the patient was seen at your facility as either an inpatient or outpatient for diagnosis and/or first course treatment of a reportable tumor. The date may be the date of an outpatient visit for a biopsy, x-ray, or laboratory text, or the date a pathology specimen was collected at the facility.

b. For analytic cases (*Class of Case* 00-22), the *Date of First Contact* is the date the patient became analytic. For non-analytic cases, it is the date the patient first qualified for the *Class of Case* that causes the case to be abstracted.

c. If the patient was first seen as an outpatient, enter the date the patient was first seen in the outpatient department for this primary tumor. For cases diagnosed by scans or x-rays on an outpatient basis at your hospital and then admitted to your hospital, record the date of the scan or x-ray. If patient returned for subsequent outpatient visits, use only the initial date.

*Example:* A patient has an MRI of the brain on December 7, 2014 for symptoms of severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery is performed on December 19, 2014, removing all gross tumor. *Date of First Contact* is December 7, 2014.

d. For cases diagnosed in the staff physician’s office and then referred to your hospital for first course of therapy, record the date the patient was physically first seen at your hospital as an inpatient or outpatient.

*Example:* A biopsy is performed in a staff physician’s office on September 8, 2014. The biopsy specimen is read at the reporting facility’s pathology department as malignant melanoma. The patient presents to the reporting facility for wide re-excision on September 14, 2014. *Date of First Contact* is September 14, 2014.
e. For cases diagnosed at another hospital, the date of first contact would be the date first seen at your hospital for treatment of this tumor, even if the patient was previously seen at your hospital as a consultation or for other reasons and no treatment was given for cancer.

f. If the primary was diagnosed during a long-term hospitalization (those in nursing homes, psychiatric facilities, or VA hospitals), use the date of diagnosis as the date of first contact.

   Example: A patient has been an inpatient for several months at a Veterans Administration Hospital for an unrelated illness. After having been hospitalized for several months a new primary is discovered during a routine exam. Enter the date the diagnosis was made, rather than the date the patient was first admitted to the VA Hospital.

g. If the cancer was not suspected while the patient was alive and hospitalized, but was an incidental finding on post mortem exam (autopsy), use the date of death as the date of first contact. There must be no suspicion of cancer prior to autopsy.

h. For cases diagnosed at your hospital prior to your reference (starting) date, record the first date seen for that malignancy after your reference date.

i. For pathology-only cases, record the date on which the specimen was collected.

j. If the date of first contact cannot be determined at all, leave the date of first contact field blank and record the reason in Date of First Contact Flag. See the Date of First Contact Flag section for examples illustrating the relationships among these items.

**Coding Tip:** The year in the Date of First Contact item should match the first four digits of your hospital accession number for most patients’ first primary (unless patient was admitted at the end of one year and not diagnosed until the next year).
Chapter 5 Patient and Hospital Identification Coding Instructions

DATE OF 1ST CONTACT FLAG

Description
This flag explains why there is no appropriate value in the corresponding date field, Date of 1st Contact (NAACCR Item #580). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
12 A valid date is applicable but not known. (The date of 1st contact is unknown.)
Blank A valid date is coded in the Date of 1st Contact item (NAACCR Item #580).

Instructions
a. Leave this item blank if Date of 1st Contact has a full or partial date recorded.
b. Use code 12 if the 1st Contact cannot be determined at all.
c. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

Examples:

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of First Contact Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td>*01/08/2015 or 2015/01/08</td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td>*01/_ <em>/2015 or 2015/01/</em> _</td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>* <em>/</em> <em>/2015 or 2015/</em> <em>/</em> _</td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown date</td>
<td>* <em>/</em> <em>/</em> _ or _ <em>/</em> <em>/</em> _</td>
<td>12</td>
</tr>
</tbody>
</table>

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format. The computer will store either in the interoperable format.


**HOSPITAL ACCESSION NUMBER**

**Description**
This is a required 9-character field for the unique number assigned to each cancer patient seen at your hospital. The first 4 digits indicate a year (YYYY) and the next 5 digits indicate a sequential number (#####) in which the cancer was first entered into the registry, so that the accession number is recorded as YYYY#####. Each new calendar year starts over again on January 1 with accession number 00001.

*Examples:* 201200007; 201200014; 201200123; 201200537; 201500001.

**Instructions**

a. Assign accession numbers on a sequential basis, with the first four digits indicating the year the patient was first seen at your facility for the diagnosis and/or treatment of cancer. The last five digits indicate the numerical order in which the registry entered the case for that calendar year.

b. The first four digits of the accession number are based on the date the patient was first seen for the diagnosis and/or treatment of cancer at your hospital following your registry's reference date. The "reference date," which always begins on January 1 of a given year, is the date the hospital first started their registry. Therefore, the first four digits of the accession number is never less than the registry's reference date unless the reference date is changed (see *Exception* below).

*Example:* If you began reporting cancer cases to the State Cancer Registry when the requirement began on January 1, 1987 and continue to report only for state requirements, your reference date would be January 1, 1987. All cases in your registry should have an accession number of 1987_ _ _ _ _ or higher.

*Exception:* If a patient is first accessioned into the registry, then the registry later changes its reference date and the patient is subsequently accessioned into the registry with a new primary, use the original accession number associated with the patient and code the sequence appropriately.

*Example:* A patient is diagnosed by the hospital with prostate cancer in 1991 and assigned accession number 199100067. The registry later sets a new reference date of January 1, 1997. The same patient is admitted and diagnosed with lymphoma in 2015. Use accession number 199100067 and sequence 02 for the lymphoma case.

c. Enter leading zeros for numbers less than five digits.

*Example:* A patient is first admitted to your facility for treatment of cancer in 2015. The first four digits of the accession number are 2015. If the patient is the 25th patient to be accessioned (entered) in your registry in 2015, the last five digits of the accession number would be 00025. The full accession number for this patient would be 201500025.

d. Assign a unique accession number to each patient. A patient cannot have more than one accession number at your facility. Patients who contract a second or third primary cancer retain the same 9-digit accession number for primaries. (The sequence number will distinguish between the various primaries.)

Before assigning an accession number to a patient, check your alphabetic index to see if the patient has ever been entered in your registry before. Do *not* assign a new accession number to a patient who already has another accession number.
John Smith was first seen and diagnosed at your hospital in 1999 with a primary cancer of the prostate. He was assigned accession number 199900010-00 (1999 is the year first accessioned, 00010 is the accession number, and 00 is the sequence number). In 2015, he was diagnosed with a second primary cancer of the pancreas. The accession number for the pancreatic primary would be 199900010-02. The patient will always keep his originally assigned accession number. Only the sequence number changes. The sequence number will distinguish the two primaries.

e. Each new patient added to the registry should be given the next highest number in sequential order (201500001, 201500002, 201500003, etc.). The order patients are assigned an accession number within a particular year does not matter. Accession numbers do not need to be kept in date order of diagnosis, admission, discharge, or abstracting. For example, a case first seen in September 2015 (201500175) can have a lower accession number than a case first seen in July 2015 (201500176).

f. Do not skip over numbers to allow for earlier cases to be inserted later. Numeric gaps in accession numbers should occur only if a case is deleted from your database. Do not reuse the accession number for a different patient to avoid any chance of two cases having the same accession number.

g. The first four digits of the accession number are the year in which the patient was first seen at your hospital. If the patient’s first primary was seen at another hospital and therefore was not recorded in your registry, enter the year the patient’s earliest sequenced primary was diagnosed and/or treated at your facility.

Example 1: Mary Jones was diagnosed with her first primary malignancy at Hospital A in 2011. Hospital A gave her accession number 201100021-00, since she was the 21st patient to be accessioned at Hospital A in 2011. In 2015, Mary Jones went to Hospital B with a second primary. Hospital B assigned her accession number 201500152-02 since she was seen at hospital B for the first time in 2015 and was the 152nd patient entered in their registry. Hospital A should change their sequence number from 201100021-00 to 201100021-01.

Example 2: A new primary for a patient initially diagnosed and admitted in 2013 was not identified by the tumor registrar until 2015. The first four digits of the accession number would be 2013, based on the date of admission (date of first contact for this primary). It would not be 2015, the year the primary was identified by the registrar.

h. The first four digits of the accession number match the year recorded in Date of First Contact for the first accessioned primary (explained earlier in this chapter).

Example 1: A patient who was first seen as an outpatient in 2015 is the first patient to be entered into your registry in 2015. His accession number would be 201500001.

Exception: If the patient was first seen at your facility at the end of one year but was not diagnosed until the beginning of the next year, his accession number should be the year he was diagnosed.

Example 2: A patient first entered your hospital as an inpatient in December 2014, but was not diagnosed until January 2015. The first four digits of the accession number should be 2015, since the majority of the reports and service for this cancer would be provided in 2015.
Coding Instructions

Patient and Hospital Identification

Chapter 5

HOSPITAL SEQUENCE NUMBER

- Item Length: 2
- Data Type: Numeric
- ACoS: Required
- State Registry: Required

Description
This is a required 2-character field for the number that indicates the chronological order of this primary tumor in relation to other reportable, independent, malignant and non-malignant neoplasms diagnosed in the patient's lifetime. The sequence number reflects all of a patient's reportable tumors, not just those seen at your hospital.

Rationale
This data item is used to distinguish among cases having the same accession numbers, to select patients with only one malignant primary tumor for certain follow-up studies, and to analyze factors involved in the development of multiple tumors.

Codes for Reportable Malignant or In Situ Primary Tumors:

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>One malignant or in situ primary only in the patient's lifetime</td>
</tr>
<tr>
<td>01</td>
<td>First of two or more independent malignant or in situ primaries</td>
</tr>
<tr>
<td>02</td>
<td>Second of two or more independent malignant or in situ primaries</td>
</tr>
<tr>
<td>03</td>
<td>Third of three or more independent malignant or in situ primaries</td>
</tr>
<tr>
<td>...</td>
<td>(actual sequence of this malignant or in situ primary)</td>
</tr>
<tr>
<td>35</td>
<td>Thirty-fifth of thirty-five independent malignant or in situ primaries</td>
</tr>
<tr>
<td>99</td>
<td>Unspecified malignant or in situ sequence number or unknown</td>
</tr>
</tbody>
</table>

Note: When this field is left blank in the RMCDS program, the system defaults to code "00."

Codes for Non-Malignant Tumors and Nonreportable Malignant or In Situ Tumors:

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>Only one non-malignant primary</td>
</tr>
<tr>
<td>61</td>
<td>First of two or more independent non-malignant primaries</td>
</tr>
<tr>
<td>62</td>
<td>Second of two or more independent non-malignant primaries</td>
</tr>
<tr>
<td>...</td>
<td>(Consecutive number of non-malignant primaries)</td>
</tr>
<tr>
<td>...</td>
<td></td>
</tr>
<tr>
<td>87</td>
<td>Twenty-seventh of twenty-seven independent non-malignant primaries</td>
</tr>
<tr>
<td>88</td>
<td>Unspecified number of neoplasms in this category</td>
</tr>
</tbody>
</table>

Definitions
a. **Hospital sequence number**: The code indicating the sequencing of reportable neoplasms in the patient’s lifetime, according to the information and rules of the hospital registry.

b. **Central sequence number**: The code indicating the sequencing of reportable neoplasms in the patient’s lifetime, according to the information and rules of the central registry.

c. **Reportable-by-agreement tumors**: Diagnoses not required by CoC but defined as reportable by the facility’s cancer committee or the state registry. Such diagnoses may be benign, borderline, or malignant. Diagnoses required by the NPCR the Indiana State Cancer Registry, but not by CoC, include VIN III, VAIN III, and AIN.
Example: The State Registry requires the hospital to report vaginal intraepithelial neoplasia, grade III (VAIN III, 8077/2). The cancer committee adds VAIN III to their reportable-by-agreement list and decides to accession and abstract these cases to comply with State requirements.

d. The following table* illustrates the Indiana State Cancer Registry (ISCR) sequence number series by type of neoplasm.

<table>
<thead>
<tr>
<th>Neoplasm</th>
<th>ISCR Sequence (Numeric Series)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant (Behavior Code = 3)</td>
<td>00-35</td>
</tr>
<tr>
<td>Includes AJCC T3, T4, or M1 Skin Squamous Cell and Basal Carcinomas diagnosed before 2003.</td>
<td></td>
</tr>
<tr>
<td>Juvenile Astrocytoma diagnosed 2001 and later (Report as 9421/3.)</td>
<td>00-35</td>
</tr>
<tr>
<td>In Situ (Behavior Code = 2). Includes VIN III, VAIN III, AIN III.</td>
<td>00-35</td>
</tr>
<tr>
<td>Includes Cervix CIS/CIN III diagnosed before 1996.</td>
<td></td>
</tr>
<tr>
<td>Cervix CIS/CIN III diagnosed 1996-2002</td>
<td>98</td>
</tr>
<tr>
<td>Cervix CIS/CIN III diagnosed 2003 and later</td>
<td>60-87</td>
</tr>
<tr>
<td>PIN III</td>
<td>60-87</td>
</tr>
<tr>
<td>Borderline/Benign Intracranial and Central Nervous System</td>
<td>60-87</td>
</tr>
<tr>
<td>Other Borderline/Benign</td>
<td>60-87</td>
</tr>
<tr>
<td>Skin Squamous Cell and Basal Carcinomas diagnosed 2003 and later</td>
<td>60-87</td>
</tr>
</tbody>
</table>

*Adapted from “NAACCR 2003 Implementation Workgroup Guidelines, January 2003.”

Instructions

a. Use codes 00-35 and 99 for reportable invasive or in situ neoplasms.

b. Use codes 60-88 for non-malignant neoplasms and nonreportable invasive or in situ neoplasms.

c. Use Code 00 only if the patient has a single invasive or in situ primary. If the patient develops a subsequent invasive or in situ primary tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially.

Example 1: Use code 00 for a patient with no history of previous cancer is diagnosed within situ breast carcinoma January 13, 2015.

Example 2: Change the sequence to 01 for the January 13, 2015 breast carcinoma when the patient is diagnosed with a subsequent skin melanoma on July 30, 2015.

Example 3: Assign sequence 02 to the skin melanoma diagnosed on July 30, 2015 following a breast carcinoma diagnosed on January 13, 2015.

Use sequence 00 if there is no information available to indicate the patient has been diagnosed with an earlier primary malignancy. Assume the tumor being reported is the first. A history of surgery such as hysterectomy or colectomy should not be interpreted as evidence of an earlier malignancy without confirmation, since surgery is also performed to treat benign conditions.

d. Use sequence 99 only when there is information that suggests the possibility of an earlier malignancy, but the medical record does not document a definite diagnosis.

Example: A patient is diagnosed in the reporting hospital with cancer of the colon. The medical record contains the statement, “The patient recently had a salivary gland tumor removed. The patient does not know if the lesion was malignant.” The registry assigns sequence number 99 to the colon primary. The patient returns to the reporting facility a
year later for prostate cancer treatment. The medical record states, “The patient has a history of a malignant salivary gland tumor.” Change the sequence number of the colon cancer from 99 to 02. Assign the sequence number 03 to the prostate cancer.

e. If a patient has had a reportable tumor that the facility did not accession, it is accounted for in sequencing subsequent tumors.

Example 1: Your hospital diagnoses a patient with colon cancer. The patient has a history of kidney cancer diagnosed and treated elsewhere. Assign sequence number 02 to the colon cancer.

Example 2: A patient is diagnosed with breast cancer in 1985. Hospital A’s reference date is 1987. In 2015, this patient has a primary of the lung. Assign sequence number 02 to the lung cancer.

f. Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that would affect the sequence.

g. If two or more CoC required neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.

Example 1: A patient enters your facility with simultaneous invasive carcinoma of the cervix and invasive adenocarcinoma of the colon. Assign sequence number 01 to the colon primary and sequence number 02 to the cervix primary.

Example 2: A patient has simultaneous adenocarcinoma in situ in a colon polyp and squamous cell carcinoma in situ in a vocal cord polyp. Assign sequence numbers as you choose. Both primaries have similar prognoses.

h. Use code 60 only if the patient has single non-malignant primary. If the patient develops a subsequent non-malignant primary tumor, change the code for the first tumor from 60 to 61, and assign codes to subsequent non-malignant tumors sequentially.

i. The sequence codes for malignant/in situ and non-malignant cases are assigned independently. Assign sequence 60 to the first non-malignant tumor in a patient with a prior malignant or in situ primary with sequence number 00.
Chapter 5  Patient and Hospital Identification  Coding Instructions

CLASS OF CASE

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>For a hospital registry, Class of Case divides cases into two groups. Analytic cases (codes 00-22) are those that are required by CoC to be abstracted because of the program’s primary responsibility in managing the cancer. Analytic cases are grouped according to the location of diagnosis and treatment. Treatment and outcome reports may be limited to analytic cases. Nonanalytic cases (codes 30-49 and 99) may be abstracted by the facility to meet central registry requirements or because of a request by the facility’s cancer program. Nonanalytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.</td>
</tr>
</tbody>
</table>

Class of Case can be used in conjunction with Type of Reporting Source [500]. Type of Reporting Source is designed to document the source of documents used to abstract the cancer being reported.

<table>
<thead>
<tr>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class of Case reflects the facility’s role in managing the cancer, whether the cancer is required to be reported by CoC, and whether the case was diagnosed after the program’s Reference Date.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analytic Classes of Case (Required by CoC to be abstracted by approved programs)</td>
</tr>
<tr>
<td>00</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>11</td>
</tr>
<tr>
<td>12</td>
</tr>
<tr>
<td>13</td>
</tr>
<tr>
<td>14</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>21</td>
</tr>
<tr>
<td>22</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Classes of Case not required by CoC to be abstracted; required by Cancer Committee, state or regional registry, or other entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient appears in person at reporting facility</td>
</tr>
<tr>
<td>30</td>
</tr>
<tr>
<td>31</td>
</tr>
<tr>
<td>32</td>
</tr>
<tr>
<td>33</td>
</tr>
<tr>
<td>34</td>
</tr>
<tr>
<td>35</td>
</tr>
<tr>
<td>36</td>
</tr>
</tbody>
</table>

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required
initial diagnosis elsewhere AND all or part of first course treatment by reporting facility

37 Case diagnosed before program’s Reference Date, having initial diagnosis elsewhere AND all or part of first course treatment by facility

38 Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death

Patient does not appear in person at reporting facility

40 Diagnosis AND all first course treatment given at the same staff physician’s office

41 Diagnosis and all first course treatment given in two or more different offices of physicians with admitting privileges

42 Non-staff physician or non-CoC approved clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility

43 Pathology or other lab specimens only

49 Death certificate only

99 Case not required by CoC to be abstracted of unknown relationship to facility (not for use by CoC approved cancer programs for analytic cases.)

Definitions

a. Initial diagnosis: This refers to the first time a physician indicates that the patient has cancer. The initial diagnosis may be clinical or microscopic and it may be based on ambiguous terminology.

b. Treatment: Treatment includes any first course activity coded as Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, Surgical Procedure/Other Site, Radiation Treatment, Chemotherapy, Hormone Therapy, Immunotherapy, Hematologic Transplant and Endocrine Procedures, or Other Treatment.

Palliative care (undertaken to reduce the patient’s symptoms) involving surgery, systemic treatment, or radiation is also coded as treatment and qualifies the patient as analytic if given as part of planned first course treatment.

Decisions not to treat, whether initiated by the physician (contraindicating conditions) or by the patient (refusal), or decisions for active surveillance (“watchful waiting”) are also considered treatment for assigning Class of Case.

c. Physicians with admitting privileges: Physicians who are not employed by the reporting facility but are under contract with it or have routine admitting privileges there.

Instructions

a. Assign the Class of Case code that most precisely describes the patient’s relationship to the facility.

b. It is possible that information for coding Class of Case will change during the patient’s first course of care. Change the Class of Case code accordingly if that occurs.

If a patient has been accessioned into your registry as an analytic case (codes 00-22), do not reaccession or change the class of case code if the patient returns for a recurrence, subsequent treatment, or progression of disease involving the same primary.

c. Assign code 00 only when it is known that the patient went elsewhere for treatment. If it is not known that the patient actually went somewhere else, assign Class of Case code 10.

d. Report all analytic cases (codes 00-22), to the State Cancer Registry.

e. Report specified nonanalytic cases (codes 30, 32, 34-38, 40-41) that meet criteria described in Chapter 3 of this manual.
**NPI-INSTITUTION REFERRED FROM**

**Description**
This is a required 10-character field for recording an identification number for the facility from which the patient was referred. This field is used to identify referral patterns and is important for tracking patients within the statewide database.

**Codes**
Record the 10-digit NPI for the referring facility. NPI numbers for Indiana facilities are provided in Appendix D of this manual.

**Instructions**

a. Identify the referring facility **only** if the cancer being reported was definitively diagnosed and/or treated at the referring facility.

b. Leave the item blank for the following:
   - The NPI for the referring facility is unknown or not available; or
   - The patient was not referred to the reporting facility from another facility.
NPI-INSTITUTION REFERRED TO

Description
This is a required 10-character field for recording an identification number for the facility to which the patient is referred for definitive treatment after discharge from your facility. This field is used to identify referral patterns and is important for tracking patients within the statewide database.

Codes
Record the 10-digit NPI for the referring facility. NPI numbers for Indiana facilities are provided in Appendix D of this manual.

Instructions
a. If the patient was referred to more than one hospital for definitive treatment, record the code for the first hospital to which the patient was referred.

b. Leave the item blank for the following:
   ▪ The NPI for the facility referred to is unknown or not available; or
   ▪ The patient was not referred to another facility.
Chapter 5  Patient and Hospital Identification  Coding Instructions

IF DIAGNOSED ELSEWHERE, RECORD WHERE

<table>
<thead>
<tr>
<th>Description</th>
<th>Data Type: Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a required text field for recording where the patient was diagnosed, if not at your facility. The item is required if applicable and available.</td>
<td>ACoS: N/A</td>
</tr>
<tr>
<td>Rationale</td>
<td>State Registry: Required</td>
</tr>
<tr>
<td>Text is needed to justify the codes selected for the data items and to record information that is not coded at all. The text is used for quality control and special studies.</td>
<td></td>
</tr>
</tbody>
</table>

Instructions
a. Record the name of the facility or physician’s office where the patient was diagnosed.

   Examples: Name of another hospital, physician (by name) office, name of freestanding clinic, etc.

b. If the patient was diagnosed in your facility, leave the field blank.

c. Record "unknown" if the patient was diagnosed elsewhere, but it is unknown where.
CASEFINDING SOURCE

*Required if available for cases diagnosed 01/01/2012 and later.

**Description**
This is a required 2-character field for coding the source that first identified the tumor. For cases identified by a source other than reporting facilities (such as through death clearance or as a result of an audit), the codes reflect the type of source through which the tumor was first identified.

**Rationale**
This data item will help reporting facilities as well as regional and central registries in prioritizing their casefinding activities. It will identify reportable tumors that were first found through death clearance or sources other than traditional reporting facilities. It provides more detail than “Type of Reporting Source.” This data item cannot be used by itself as a data quality indicator. The timing of the casefinding processes (e.g., death linkage) varies from registry to registry, and the coded value of this variable is a function of that timing.

**Codes**

**Case first identified at a reporting facility**
- 10 Reporting hospital, NOS
- 20 Pathology department review (surgical pathology reports, autopsies, or cytology reports)
- 21 Daily discharge review (daily screening of discharged patients’ records in the medical record/health information department)
- 22 Disease index review (review of the medical record/health information department’s disease index)
- 23 Radiation therapy department/center
- 24 Laboratory reports (other than pathology reports defined for code 20)
- 25 Outpatient chemotherapy
- 26 Diagnostic imaging/radiology, including nuclear medicine (other than radiation therapy, code 23)
- 27 Tumor board
- 28 Hospital rehabilitation service or clinic
- 29 Other hospital source (including clinic, NOS or outpatient department, NOS)

**Case first identified by source other than a reporting facility covered in the above codes (10-29)**
- 30 Physician-initiated case
- 40 Consultation-only or pathology-only report (not abstracted by reporting hospital)
- 50 Independent (non-hospital) pathology-laboratory report
- 60 Nursing home-initiated case
- 70 Coroner’s office records review
- 75 Managed Care Organization (MCO) or insurance records
- 80 Death certificate (case identified through death clearance)
- 85 Out-of-state case sharing
- 90 Other non-reporting hospital source
- 95 Quality control review (case initially identified through quality control activities such as casefinding audit of a regional or central registry)
- 99 Unknown

**Instructions**

1. For State reporting, this item may be left blank for cases diagnosed before 2012.

2. Determine where the case was first identified and assign the appropriate code.

   If the case was first identified at a reporting facility (codes 10-29), assign the code for the earliest source of identifying information (based on patient or specimen contact at the facility).
At the regional or central level, if a hospital and a non-hospital source identified the case independently of each other, the code for the non-hospital source should be assigned. Codes 30-95 have priority over codes 10-29.

3. If a death certificate, independent pathology laboratory report, consultation-only report from a hospital, or other report was used to identify a case that was then abstracted from a different source, assign the code for the source that first identified the case, not the source from which it was subsequently abstracted.

4. If a regional or central registry identifies a case and asks a reporting facility to abstract it, assign the code that corresponds to the initial source, not the code that corresponds to the eventual reporting facility.
DATE OF INITIAL DIAGNOSIS

Description
This is a required 8-character field for the date this primary cancer was diagnosed by a recognized medical practitioner. Determine whether your software vendor uses the traditional format for date entry (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format.

Rationale
The timing for staging and treatment of cancer begins with the date of initial diagnosis for cancer.

Codes

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>January</td>
<td>01</td>
</tr>
<tr>
<td>02</td>
<td>February</td>
<td>02</td>
</tr>
<tr>
<td>03</td>
<td>March</td>
<td>03</td>
</tr>
<tr>
<td>04</td>
<td>April</td>
<td>...</td>
</tr>
<tr>
<td>05</td>
<td>May</td>
<td>...</td>
</tr>
<tr>
<td>06</td>
<td>June</td>
<td>25</td>
</tr>
<tr>
<td>07</td>
<td>July</td>
<td>26</td>
</tr>
<tr>
<td>08</td>
<td>August</td>
<td>...</td>
</tr>
<tr>
<td>09</td>
<td>September</td>
<td>30</td>
</tr>
<tr>
<td>10</td>
<td>October</td>
<td>31</td>
</tr>
<tr>
<td>11</td>
<td>November</td>
<td>blank = Day unknown</td>
</tr>
<tr>
<td>12</td>
<td>December</td>
<td></td>
</tr>
<tr>
<td>blank</td>
<td>Month unknown</td>
<td></td>
</tr>
</tbody>
</table>

Definition
This date refers to the date this cancer was diagnosed by any recognized medical practitioner. The first diagnosis is often clinical and may never be histologically confirmed. Refer to the list of terms that represent a clinical diagnosis in Chapter 4. Do not change the date of diagnosis when a later biopsy or cytology provides confirmation of a clinical diagnosis. Even if confirmed later, the diagnosis date refers to the date of the first clinical diagnosis and not to the date of confirmation. The date of the first clinical diagnosis provides a more accurate picture of the true survival time from date of diagnosis to death when determining survival statistics.

Example 1: A March 12, 2015 mammogram reveals a mass in the upperouter quadrant of a patient’s right breast compatible with carcinoma. On March 20, 2015, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma. Date of diagnosis is March 12, 2015.

Example 2: A physician notes a prostate nodule that is suspicious for cancer during a May 11, 2015 physical examination. On June 15, 2015, an ultrasound guided needle biopsy of the prostate provides histologic confirmation of adenocarcinoma. Date of diagnosis is May 11, 2015.

Instructions
a. If the physician says that in retrospect, the patient had cancer at an earlier date, use that earlier date as the date of diagnosis. When a tumor has been diagnosed as benign and a later medical or pathologic review of previous slides or x-ray films changes this to a diagnosis of a malignancy, the original date of diagnosis is considered to be the date of the initial slide or film review. In other words, the date of diagnosis is backdated.
**Example:** A patient has a total abdominal hysterectomy for endometriosis in January 2014. The patient is admitted with abdominal pain and distention in November 2015. A laparoscopy with omental biopsy shows metastatic cystadenocarcinoma. Pathologists review the 2014 hysterectomy specimen. They identify an area of cystadenocarcinoma in the left ovary. Date of diagnosis is January 2014 (01/ _ _/2014).

b. The date of the histology, cytology, or tissue exam should be used only if that is the first date the cancer was diagnosed or if the date of initial, clinical diagnosis is unknown and it is the earliest alternative confirmation.

c. If the date of initial clinical diagnosis is unknown but the diagnosis has been confirmed microscopically or through radiologic or other exam, use the date of the histology, cytology, tissue, or radiologic exam, whichever is earlier. In some cases, this may be a date prior to admission.

d. Use the date of first cancer-directed therapy as the date of diagnosis if the cancer-directed therapy was started prior to the definitive diagnosis of cancer.

e. The date of death is the date of diagnosis for class of case code 38 (first diagnosed at autopsy) or 49 (death certificate only).

f. Use the actual date of diagnosis for an in utero diagnosis, for cases diagnosed January 1, 2009 or later.

g. For patients diagnosed prior to admission to your facility, record the date of diagnosis from the referring hospital, practitioner, or clinic, if known. If the date is unknown, record the best estimate as described in paragraph h. below.

h. If you do not know the exact date of diagnosis, estimate the date based on available information. Recording an approximate date is preferable to recording an unknown date.

Every attempt should be made to enter the month and day, even if an estimate is necessary. If there is no basis for approximation, leave the month and day spaces blank.

If the year diagnosis cannot be identified, it must be approximated. In that instance, the month and day are unknown. Leave the month and day spaces blank.

i. If information is limited to a description, use the following:

<table>
<thead>
<tr>
<th>Descriptive Term Used</th>
<th>Date Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring</td>
<td>April</td>
</tr>
<tr>
<td>The middle of the year</td>
<td>July</td>
</tr>
<tr>
<td>Fall</td>
<td>October</td>
</tr>
<tr>
<td>Winter</td>
<td>Try to determine if this means the beginning of the year (January) or the end of the year (December). Code as indicated.</td>
</tr>
</tbody>
</table>

j. If the date of diagnosis cannot be determined at all, leave the date of diagnosis blank and record the reason in Date of Diagnosis Flag. See the Date of Diagnosis Flag section for examples illustrating the relationships among these items.
**Coding Instructions**

**Cancer Identification**

**Chapter 5**

**DATE OF DIAGNOSIS FLAG**

<table>
<thead>
<tr>
<th>Item Length: 2</th>
<th>Data Type: Numeric</th>
<th>ACoS: Required</th>
<th>State Registry: Required</th>
</tr>
</thead>
</table>

**Description**

This flag explains why there is no appropriate value in the corresponding date field, *Date of Diagnosis* (NAACCR Item #390).

**Rationale**

Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>A valid date is applicable but not known. (The date of diagnosis is unknown.)</td>
</tr>
<tr>
<td>Blank</td>
<td>A valid date is coded in the <em>Date of Diagnosis</em> item (NAACCR Item #390).</td>
</tr>
</tbody>
</table>

**Instructions**

a. Leave this item blank if *Date of Diagnosis* has a full or partial date recorded.
b. Use code 12 if the *Date of Diagnosis* cannot be determined at all.
c. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

**Examples:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of Diagnosis Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td>*01/08/2015 or 2015/01/08</td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td>*01/__/2015 or 2015/01/_</td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>*/<em>/</em>/2015 or 2015/<em>/</em></td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown date</td>
<td>*<em>/</em>/<em>/ or <em>/</em>/</em>/</td>
<td>12</td>
</tr>
</tbody>
</table>

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format. The computer will store either in the interoperable format.
Chapter 5  Cancer Identification  Coding Instructions

**PRIMARY SITE**

**Description**
This is a required 4-character field for recording the topography (anatomic site) code that best describes the primary site of malignancy. Metastatic lesions are NEVER coded in this field. Review the entire medical record before assigning this code.

**Instructions**

a. Enter the topography (anatomic site) code from the Topography section of the *International Classification of Diseases for Oncology*, Third Edition, 2000 (*ICD-O-3*)* that best describes the primary site of the tumor. The topography code should first be located in the Alphabetic Index (pages 105-218). Then the specific topography should be located in the Topography – Numerical List section (pages 45-65). The Alphabetic Index includes both topography and morphology terms.

*Note: *ICD-O-3 is effective for cases diagnosed January 1, 2001 forward. Continue to use ICD-O-2 for cases diagnosed prior to 2001.

b. Record the primary site as specifically as possible. For example, if the final diagnosis is “cancer of the colon,” review other reports in the medical record (e.g., operative note, pathology report, radiology reports, and physician progress notes) to ascertain whether a more specific site within the colon can be identified.

c. It is important that the primary site be coded, rather than a metastatic site. The primary site is the location where the cancer first developed, or the site of origin of a tumor. A metastatic site is the location to which the cancer has spread, or metastasized, from the primary site. Ask your physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.

d. Use the subcategory 8 (C_ _ .8) for single tumors that overlap the boundaries of two or more sub-sites and the point of origin is unknown.

*Example 1:* Code overlapping lesion (C10.8) when a large tumor involves both the lateral wall of the oropharynx (C10.2) and the posterior wall of the oropharynx (C10.3) and the point of origin is not stated.

*Example 2:* Code overlapping lesion of the bladder (C67.8) when one lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated.

e. Use the subcategory 9 (C_ _ .9) for multiple tumors that originate in one organ.

*Example 1:* Code bladder, NOS (C67.9) when multiple lesions arise in both the trigone (C67.0) and lateral wall (C67.2).

*Example 2:* Code lung, NOS (C34.9) when there are lesions in both the right middle lobe (C34.2) and the right lower lobe (C34.3) of lung.

*Example 3:* Code breast, NOS (C50.9) when there are lesions in both the left lower-inner quadrant (C50.3) and the left lower-outer quadrant (C50.5) of a breast.

f. If the specific site within an organ cannot be determined, code the primary site to the "NOS" (Not Otherwise Specified) category of the organ, organ system, or region. Refer to codes C76.0 to C76.8 (Other and Ill-Defined Sites) before coding C80.9 (Unknown primary site). If an unknown site is later specifically identified, the primary site code should be changed to the correct one.
Example: Your hospital clinically diagnoses a patient with carcinomatosis. The registry enters the case as an unknown primary (C80.9), carcinoma, NOS (8010/3), stage of disease unknown. Nine months later a paracentesis shows serous cystadenocarcinoma. The physician states that the patient has an ovarian primary. Change the primary site to ovary (C56.9), histology to serous cystadenocarcinoma (8441/3), and diagnostic confirmation to positive exfoliative cytology, no positive histology (2).

Code leukemia, multiple myeloma, chronic myeloproliferative disorders, and myelodysplastic syndromes to bone marrow (C42.1), because blood cells originate in the bone marrow.

**Exception:** Code myeloid sarcoma (9930/3) to the site of origin. (See ICD-O-3 page 26 for coding rules.)

Lymphomas

*For lymphoma diagnosed 2010 and later use the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.* Use the rules cited below only for lymphoma diagnosed before 2010.

1. Code lymphomas arising in lymphatic tissue or nodes to the site of origin. The lymphatic sites are lymph nodes(s) C77._, tonsil C09._, spleen C42.2, Waldeyer ring C14.2, and thymus C37.9.

2. Code extralymphatic lymphomas (lymphatic cells in non-lymphatic organs such as intestine or stomach) to the organ of origin (intestine C26.0, stomach C16.0-C16.9).

3. Code to lymph nodes, NOS (C77.9) when:
   - The site of origin is not identified for a lymphoma.
   - A patient has diffuse lymphoma and a primary site is unknown or not specified.
   - A lymphoma mass is identified as “retroperitoneal,” “inguinal,” “mediastinal,” or “mesentery,” and no specific information is available to indicate what tissue is involved.
   - Bone marrow metastases are present and the primary site of a lymphoma is unknown or not specified.

4. Code to lymph nodes, multiple regions (C77.8) when multiple lymph node chains are involved with disease. Do not code a specific lymph node chain from multiple lymph node chains, even if the specific chain was biopsied.

5. Code mycosis fungoides and cutaneous lymphomas to skin (C44._).

6. Carefully identify the origin of the tumor. Do not code the biopsy site or a metastatic site as the primary site. Lymphoma may be present in both an extralymphatic (extranodal) organ and one or more lymph node chain. Code the primary site as the extranodal organ or the lymph nodes, as directed by the managing physician or physician advisor.

**Note:** For purposes of analysis:
- Analyze the lymphatic sites C77._, C09._, C42.2, C14.2, and C37.9 together.
- Analyze extralymphatic lymphomas separately.

Code Kaposi sarcoma to the site in which it arises. Code to skin (C44.9) if Kaposi sarcoma arises simultaneously in the skin and another site, and the primary site is not identified. Kaposi sarcoma is reported only once.

Code to skin, NOS (C44.9) if a patient is diagnosed with metastatic melanoma and the primary site is not identified. Each occurrence of melanoma of the skin is a new/separate primary unless a physician says otherwise.
k. If any of the following histologies appears with only an ill-defined site description (e.g., “abdominal” or “arm”), code it to the tissue in which such tumors arise rather than the ill-defined region (C76._) of the body, which contains multiple tissues.

<table>
<thead>
<tr>
<th>Histology</th>
<th>ICD-O-3 Codes</th>
<th>Code to This Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanoma</td>
<td>8720-8790</td>
<td>C44._ Skin</td>
</tr>
<tr>
<td>Sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma</td>
<td>8800-8811, 8813-8830, 8840-8921, 9040-9044</td>
<td>C49._ Connective, Subcutaneous, and Other Soft Tissues</td>
</tr>
<tr>
<td>Mesenchymoma</td>
<td>8990-8991</td>
<td>C49._ Connective, Subcutaneous, and Other Soft Tissues</td>
</tr>
<tr>
<td>Blood vessel tumors, lymphatic vessel tumors</td>
<td>9120-9170</td>
<td>C49._ Connective, Subcutaneous, and Other Soft Tissues</td>
</tr>
<tr>
<td>Granular cell tumor and alveolar soft part sarcoma</td>
<td>9580-9582</td>
<td>C49._ Connective, Subcutaneous, and Other Soft Tissues</td>
</tr>
<tr>
<td>Mesenchymal chondrosarcoma and giant cell tumors</td>
<td>9240-9252</td>
<td>C40.<em>, C41.</em> for Bone and Cartilage, C49._ Connective, Subcutaneous, and Other Soft Tissues</td>
</tr>
<tr>
<td>Mixed tumor, salivary gland type</td>
<td>8940-8941</td>
<td>C07._ for Parotid Gland, C08._ for Other and Unspecified Major Salivary Glands</td>
</tr>
</tbody>
</table>

l. Rule H on page 21 of ICD-O-3 discusses the topic of “Site-Specific Morphology Terms.”

(1) If the patient record identifies a morphology term for which ICD-O-3 lists a specific topography code in parentheses, use this code if no definite site is identified or if only a metastatic site is identified.

Example: If the diagnosis hepatoma (8170/3) with no other statement about topography, code primary site as C22.0 (liver), since this morphology is always indicative of a primary malignancy in the liver.

(2) Some morphology codes list a specific topography code (C_ _ . _) to designate the usual primary site of origin for a particular neoplasm. If the actual primary site is different from the topography code listed, use the appropriate topography code of the actual site of origin and ignore the topography code listed next to the morphology code.

Example: If a patient has an infiltrating duct carcinoma of the pancreas (8500/3), code the primary as C25.9 (pancreas), even though “infiltrating duct carcinoma” has C50._ (breast) after it in the Alphabetic Index and the Morphology Numerical section of ICD-O-3, since breast is the usual site in which this histology arises.

m. For further guidelines on coding primary site, refer to the Introduction in ICD-O-3 on pages 20-21.

When the record is not clear, the physician should be contacted to determine the most definitive code to be used.

Rules for Determining Single vs. Multiple Sites
For all solid malignant tumors diagnosed January 1, 2007 or later, use the SEER Multiple Primary and Histology Coding Rules. Use the rules cited below only for cases diagnosed before 2007.

a. A difference in the third character of the ICD-O-3 topography code designates a separate site, with the exceptions listed under paragraph b. below.

Example: Separate sites and separate primaries:
   - Lower gum (C03.1)
   - Anterior floor of the mouth (C04.0)
The following table shows ICD-O-3 site groupings that are to be regarded as one primary site when determining multiple primaries. These sites used to be in the same 3-digit site code group in ICD-O-1, but have been put into different 3-digit site groups in ICD-O-2 and ICD-O-3. The groups are considered to be the same primary site in order to make valid historical comparisons between data collected under ICD-O-1 and data collected under ICD-O-2 and ICD-O-3.

<table>
<thead>
<tr>
<th>ICD-O-3 CODES</th>
<th>SITE GROUPINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>C01</td>
<td>Base of tongue</td>
</tr>
<tr>
<td>C02</td>
<td>Other and unspecified parts of tongue</td>
</tr>
<tr>
<td>C05</td>
<td>Palate</td>
</tr>
<tr>
<td>C06</td>
<td>Other and unspecified parts of mouth</td>
</tr>
<tr>
<td>C07</td>
<td>Parotid gland</td>
</tr>
<tr>
<td>C08</td>
<td>Other and unspecified major salivary glands</td>
</tr>
<tr>
<td>C09</td>
<td>Tonsil</td>
</tr>
<tr>
<td>C10</td>
<td>Oropharynx</td>
</tr>
<tr>
<td>C12</td>
<td>Pyriform sinus</td>
</tr>
<tr>
<td>C13</td>
<td>Hypopharynx</td>
</tr>
<tr>
<td>C23</td>
<td>Gallbladder</td>
</tr>
<tr>
<td>C24</td>
<td>Other and unspecified parts of biliary tract</td>
</tr>
<tr>
<td>C30</td>
<td>Nasal cavity and middle ear</td>
</tr>
<tr>
<td>C31</td>
<td>Accessory sinuses</td>
</tr>
<tr>
<td>C33</td>
<td>Trachea</td>
</tr>
<tr>
<td>C34</td>
<td>Bronchus and lung</td>
</tr>
<tr>
<td>C37</td>
<td>Thymus</td>
</tr>
<tr>
<td>C38.0</td>
<td>Heart</td>
</tr>
<tr>
<td>C38.1-C38.3</td>
<td>Mediastinum</td>
</tr>
<tr>
<td>C38.8</td>
<td>Overlapping lesion of heart, mediastinum, and pleura</td>
</tr>
<tr>
<td>C51</td>
<td>Vulva</td>
</tr>
<tr>
<td>C52</td>
<td>Vagina</td>
</tr>
<tr>
<td>C57.7</td>
<td>Other specified female genital organs</td>
</tr>
<tr>
<td>C57.8-C57.9</td>
<td>Unspecified female genital organs</td>
</tr>
<tr>
<td>C56</td>
<td>Ovary</td>
</tr>
<tr>
<td>C57.0</td>
<td>Fallopian tube</td>
</tr>
<tr>
<td>C57.1</td>
<td>Broad ligament</td>
</tr>
<tr>
<td>C57.2</td>
<td>Round ligament</td>
</tr>
<tr>
<td>C57.3</td>
<td>Parametrium</td>
</tr>
<tr>
<td>C57.4</td>
<td>Uterine adnexa</td>
</tr>
<tr>
<td>C60</td>
<td>Penis</td>
</tr>
<tr>
<td>C63</td>
<td>Other and unspecified male genital organs</td>
</tr>
<tr>
<td>C64</td>
<td>Kidney</td>
</tr>
<tr>
<td>C65</td>
<td>Renal pelvis</td>
</tr>
<tr>
<td>C66</td>
<td>Ureter</td>
</tr>
<tr>
<td>C68</td>
<td>Other and unspecified urinary organs</td>
</tr>
<tr>
<td>C74</td>
<td>Adrenal gland</td>
</tr>
<tr>
<td>C75</td>
<td>Other endocrine glands and related structures</td>
</tr>
</tbody>
</table>
**Example 1:** A patient is diagnosed at Hospital A with a malignant tumor of the lateral wall of the oropharynx (C10.2). The patient is then referred to Hospital B, where further assessment reveals the tumor site of origin to be the tonsillar pillar (C09.1). When both of these cases are received at the State Registry, they will be consolidated into one cancer case, with tonsil (C09.1) being listed as the primary site.

**Example 2:** A patient is diagnosed at Hospital A with a malignant tumor of the labia majora (C51.0). The patient is then referred to Hospital B, which reports the primary site as vagina (C52.9). To determine the primary site, review the pathology reports and consult with the attending physicians, surgeon, or registry advisor to identify the origin of the tumor. If there is a single lesion involving both sites and a site of origin cannot be determined, code to overlapping lesion of female genital organs (C57.8). If the tumor involves separate lesions and the site of origin cannot be determined, code to female genital tract, NOS (C57.9). These codes are for neoplasms of female genital organs whose point of origin cannot be assigned to any one of the categories C51 through C57.7, C58.

c. A single lesion (tumor) is one primary even if the lesion crosses site boundaries.

**Example:** A patient has a large maxillary sinus tumor that extends into the sphenoid sinus. This is one primary: Maxillary sinus (C31.0).

d. Sites may be anatomically separate and independent but are assigned to the same ICD-O-3 topography code. These should be considered sub-sites of the same organ and recorded as a single site.

**Example:** Ulna (C40.0) and radius (C40.0) are treated as one site and one primary.

e. A difference in the fourth character of the ICD-O-3 topography code designates a sub-site of the same organ and is considered one site, with the exceptions listed below.

**Example 1:** Soft palate (C05.1) and uvula (C05.2) are treated as one site and one primary, either overlapping lesion of sub-sites of palate (C05.8) or palate, NOS (C05.9).

**Example 2:** Trigone of the bladder (C67.0) and lateral wall of the bladder (C67.2) are treated as one site and one primary, either overlapping lesion of sub-sites of the bladder (C67.8) or bladder, NOS (C67.9).

**Exception:** A difference in the fourth character of the ICD-O-3 topography code designates a separate site only for the following site groups:

- Colon (see exception for polyps below) C18.0 – C18.9
- Anus/anal canal C21.0 – C21.8
- Pleura (visceral, parietal, NOS) C38.4
- Bone C40.0 – C41.9
- Melanoma of the skin C44.0 – C44.9
- Peripheral nerves/autonomic nervous system C47.0 – C47.9
- Connective Tissue C49.0 – C49.9
- Non-malignant meninges C70.0 – C70.9, Behavior Code /0 or /1
- Non-malignant brain C71.0 – C71.8, Behavior Code /0 or /1
- Non-malignant spinal cord, cranial nerves, and other parts of central nervous system C72.0 – C72.8, Behavior Code /0 or /1

**Example:** Separate sites and separate primaries:
- Sigmoid colon (C18.7)
- Transverse colon (C18.4)

**Note:** A non-specific site code, such as C18.9 (colon, NOS), and a specific site code, such as C18.2 (ascending colon), generally would not be recorded as separate sites for a single patient.
Exception: Colon Polyps

(1) Simultaneous lesions of adenocarcinoma or carcinoma and polyps (adenoma or adenomatous polyp) in one segment of the colon are a single primary.

Example 1: A physician detects two lesions in the same segment of the colon. The pathology identifies the lesions as an adenocarcinoma (8140/3) and an adenocarcinoma in a(n) (adenomatous) polyp (8210/3). Code the histology to adenocarcinoma (8140/3). Adenocarcinoma in an adenomatous polyp (8210/3) is an earlier stage of disease than a frank adenocarcinoma.

Example 2: Both an adenocarcinoma (8140/3) and an adenocarcinoma (in situ or invasive) in a(n) adenomatous polyp (8210) or an adenocarcinoma (in situ or invasive) in a (tubulo)villous adenoma (8261, 8263) arise simultaneously in the same segment of the colon or the rectum. Code as adenocarcinoma (8140/3).

Example 3: Both a carcinoma (8010/3) and a carcinoma (in situ or invasive) in a(n) (adenomatous) polyp (8210) arise in the same segment of the colon within two months of diagnosis. Code as carcinoma (8010/3).

(2) Polyps may be present in more than one segment of the colon. If the diagnosis reads “adenocarcinoma in multiple polyps,” it is one primary, colon, NOS (C18.9).

Familial polyposis is a genetic disease characterized by polyps that increase in numbers and may cover the mucosal surface of the colon. The benign disease usually develops into adenocarcinoma in adenomatous polyposis coli or adenocarcinoma in multiple adenomatous polyps.

Patients with the histologies “adenocarcinoma in adenomatous polyposis coli” (8220/3) and “adenocarcinoma in multiple adenomatous polyps” (8221/3) have a different disease process than those patients with frank adenocarcinomas of the colon or typical colon polyps. If multiple segments of the colon, or the colon and rectosigmoid, or the colon, rectosigmoid and rectum are involved with adenocarcinoma in adenomatous polyposis coli or adenocarcinoma in multiple adenomatous polyps, it is a single primary. Code the primary site to colon, NOS (C18.9).

f. Paired Organ Sites
Each side of a paired organ is considered a separate site unless a physician determines one side is metastatic from the other.

**Exception 1:** The following are always single primaries:
- Simultaneous bilateral involvement of the ovaries with a single histology
- Simultaneous bilateral retinoblastomas
- Simultaneous bilateral Wilms tumors

(Diagnoses that occur at the same time or within two months of each other are considered simultaneous or synchronous.)

**Exception 2:** Disregard laterality for determination of single or multiple primaries for malignant (behavior or /2 or /3) tumors of the meninges (C70._); brain (C71._); and spinal cord, cranial nerves, and other parts of central nervous system (C72._).

**Coding Tip:** The Primary Site code must be between 000 and 809.
Description
This is a required 1-character field for recording a code that identifies the side of a paired organ or the side of the body on which the tumor originated. Laterality refers to the primary site only and should be coded independently for each primary. Metastatic involvement is not coded.

Codes
0  Not a paired organ or site; not applicable; unknown primary site
1  Right side is origin of primary
2  Left side is origin of primary
3  Only one side is involved; right or left origin unspecified
4  Bilateral involvement, side of origin unknown; stated to be a single primary.
   Includes: Both ovaries involved simultaneously with a single histology
   Bilateral retinoblastomas
   Bilateral Wilms tumors
5  Paired site: midline tumor
9  Paired site, but no information on laterality

Instructions
a. If only one histologic type is reported and if both sides of a paired site are involved within two months of diagnosis, determine whether the patient had one or two independent primaries. Refer to the SEER Multiple Primary and Histology Coding Rules.
   (1) If there are two primaries, prepare two abstracts, recording the appropriate laterality and extent of disease for each.
   (2) If there is only one primary (originated on one side and metastasized to the other), prepare a single abstract and code laterality according to the side where the primary originated. If it is not possible to determine the side where the primary originated, record laterality code 4 (bilateral involvement, lateral origin unknown).

b. Record laterality for unknown primary site (C80.9) as 0 (not a paired organ or site).

c. The following list identifies the paired organs or paired sites. For all sites that are not on the list, record laterality code 0 (not a paired organ; not applicable). The FORDS laterality rules permit coding non-paired sites as right or left but the State Registry does not support this.

   Use laterality code 1 – 9 only for the following sites, except as noted. The listing includes only major categories. Code laterality for all subheadings included in ICD-O-3 under these headings, unless specifically excluded. Exclusions should be coded as “0.”
ICD-O-3 Primary

<table>
<thead>
<tr>
<th>Site Code</th>
<th>Paired Organ or Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>C07.9</td>
<td>Parotid gland</td>
</tr>
<tr>
<td>C08.0</td>
<td>Submandibular gland</td>
</tr>
<tr>
<td>C08.1</td>
<td>Sublingual gland</td>
</tr>
<tr>
<td>C09.0</td>
<td>Tonsillar fossa</td>
</tr>
<tr>
<td>C09.1</td>
<td>Tonsillar pillar</td>
</tr>
<tr>
<td>C09.8</td>
<td>Overlapping lesion of tonsil</td>
</tr>
<tr>
<td>C09.9</td>
<td>Tonsil, NOS</td>
</tr>
<tr>
<td>C30.0</td>
<td>Nasal cavity (excluding nasal cartilage and nasal septum – use code 0)</td>
</tr>
<tr>
<td>C30.1</td>
<td>Middle ear (Eustachian tube)</td>
</tr>
<tr>
<td>C31.0</td>
<td>Maxillary sinus</td>
</tr>
<tr>
<td>C31.2</td>
<td>Frontal sinus</td>
</tr>
<tr>
<td>C34.0</td>
<td>Main bronchus (excluding carina – use code 0)</td>
</tr>
<tr>
<td>C34.1-C34.9</td>
<td>Lung</td>
</tr>
</tbody>
</table>

Note: C34.2 Middle lobe is on right side only – laterality code 1

C38.4     | Pleura, NOS |
C40.0     | Long bones of upper limb, scapula, and associated joints (bones of arm) |
C40.1     | Short bones of upper limb and associated joints (bones of hand) |
C40.2     | Long bones of lower limb and associated joints (bones of leg) |
C40.3     | Short bones of lower limb and associated joints (bones of foot) |
C41.3     | Rib and clavicle (excluding sternum – use code 0) |
C41.4     | Pelvic bones and associated joints (excluding sacrum, coccyx, and symphysis pubis – use code 0) |
C44.1     | Skin of eyelid |
C44.2     | Skin of external ear |
C44.3     | Skin of other and unspecified parts of face (if site is non-paired or on midline, such as chin, record laterality code 9) |
C44.5     | Skin of trunk (if site is non-paired or on midline, record laterality code 9) |
C44.6     | Skin of upper limb and shoulder |
C44.7     | Skin of lower limb and hip |
C47.1     | Peripheral nerves and autonomic nervous system of upper limb and shoulder |
C47.2     | Peripheral nerves and autonomic nervous system of lower limb and hip |
C49.1     | Connective, subcutaneous, and other soft tissues of upper limb and shoulder |
C49.2     | Connective, subcutaneous, and other soft tissues of lower limb and hip |
C50.0-C50.9 | Breast |
C56.9     | Ovary |
C57.0     | Fallopian tube |
C62.0-C62.9 | Testis |
C63.0     | Epididymis |
C63.1     | Spermatic cord (vas deferens) |
C64.9     | Kidney, NOS |
C65.9     | Renal pelvis |
C66.9     | Ureter |
C69.0-C69.9 | Eye and adnexa (including lacrimal gland) |
C74.0-C74.9 | Adrenal gland (suprarenal gland) |
C75.4     | Carotid body |

For malignant and benign/borderline tumors diagnosed January 1, 2004 or later, the following central nervous system sites require a laterality code of 1-4 or 9:

C70.0     | Cerebral meninges, NOS |
C71.0     | Cerebrum |
C71.1     | Frontal lobe |
C71.2     | Temporal lobe |
C71.3     | Parietal lobe |
C71.4     | Occipital lobe |
C72.2     | Olfactory nerve |
The primary site codes listed below include both paired and a non-paired sub-sites.

<table>
<thead>
<tr>
<th>Code</th>
<th>Paired Sub-Sites</th>
<th>Non-Paired Sub-Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>C30.0</td>
<td>nasal cavity</td>
<td>nasal cartilage, nasal septum (0)</td>
</tr>
<tr>
<td>C34.0</td>
<td>main bronchus</td>
<td>carina (0)</td>
</tr>
<tr>
<td>C41.3</td>
<td>rib, clavicle</td>
<td>sternum (0)</td>
</tr>
<tr>
<td>C41.4</td>
<td>pelvic bones</td>
<td>sacrum, coccyx, symphysis pubis (0)</td>
</tr>
<tr>
<td>C44.3</td>
<td>skin of cheek, temple, eyebrow</td>
<td>skin of chin, face, nose, forehead (9)</td>
</tr>
<tr>
<td>C44.5</td>
<td>skin of abdomen, axilla, back, breast, buttock, chest</td>
<td>skin of anus (9)</td>
</tr>
</tbody>
</table>

**Example:** When coding for the main bronchus (C34.0), if bronchus (a paired organ) is the primary site, enter code 1, 2, 3, 4, or 9. Use code 0 if the carina (a non-paired organ) is the primary site.

**Text Documentation**

Include laterality for applicable sites when recording the description of the primary site in the text area of the abstract. Staff at the State Cancer Registry will then know whether to override (bypass) an edit that identifies an inconsistency between site and laterality codes.
**DIAGNOSTIC CONFIRMATION**

**Description**
This is a required 1-character field for recording the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history. It indicates whether at any time during the patient's disease course there was microscopic confirmation of the morphology of this cancer.

**Rationale**
This item is an indicator of the precision of diagnosis. The percentage of solid tumors that are clinically diagnosed only is an indication of whether casefinding procedures include sources outside of pathology reports. Complete casefinding must include both clinically and pathologically confirmed cases.

**Codes and Definitions for Solid Tumors (all tumors except M9590-9992)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Positive histology</td>
</tr>
<tr>
<td>2</td>
<td>Positive cytology</td>
</tr>
<tr>
<td>4</td>
<td>Positive microscopic confirmation, method not specified</td>
</tr>
<tr>
<td>5</td>
<td>Positive laboratory test/marker study</td>
</tr>
<tr>
<td>6</td>
<td>Direct visualization without microscopic confirmation</td>
</tr>
<tr>
<td>7</td>
<td>Radiography and other imaging techniques without microscopic confirmation</td>
</tr>
<tr>
<td>8</td>
<td>Clinical diagnosis only (other than 5, 6, or 7)</td>
</tr>
<tr>
<td>9</td>
<td>Unknown whether or not microscopically confirmed</td>
</tr>
</tbody>
</table>

**Instructions for Coding Solid Tumors (all tumors except M9590-9992)**

a. The codes are in priority order, with code 1 having the highest priority. Always code the diagnostic method with the lower numeric value when the diagnosis of cancer is confirmed with multiple methods. Change this data item to the lower (higher priority) code if a more definitive method confirms the diagnosis at any time during the course of the disease.

*Example:* A chest x-ray dated 02/01/2015 diagnoses a probable lung cancer. The patient refuses a diagnostic work-up. The registry codes the diagnostic confirmation to radiography (code 7). The patient allows a lymph node biopsy on 04/12/2015. The biopsy confirms small cell carcinoma. Change the diagnostic confirmation code to positive histology (code 1).
b. Assign code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy, dilatation and curettage (D & C), bone marrow biopsy or bone marrow aspiration (bone marrow FNA).

c. Assign code 2 when the microscopic diagnosis is based on cytologic examination of cells. The cells may be recovered from exudate, scrapings, secretions, or washings from tissue: sputum smears, bronchial brushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical and vaginal smears, or from paraffin-block specimens from concentrated spinal, pleural, or peritoneal fluid.

d. Assign code 4 when the case is reported as microscopically confirmed, but no information is provided about the method (histology, cytology). This may include cases where the medical record or physician states the histology type, but there is no path report in the record.

e. Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient’s clinical presentation.

f. If diagnosis was confirmed at another hospital, enter the code for how the other hospital confirmed the diagnosis, if known, unless further confirmation with a lower code occurred at your facility. (e.g., If the other hospital performed a mammogram and your hospital performed a biopsy, code the biopsy.) If unknown, enter code 9.

g. Some cytology specimens contain tissue. Some pathology/tissue specimens contain only cells or fluid aspiration. Read the report carefully to determine if the pathologist examined cells or tissue and code accordingly.

**Codes and Definitions for Hematopoietic and Lymphoid Neoplasms (M9590-9992)**

1. Positive histology
   - Histologic confirmation (tissue microscopically examined).

2. Positive cytology
   - Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).

3. Positive histology plus
   - Positive immunophenotyping
   - Positive genetic studies
   - Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results. For example, bone marrow examination is positive for acute myeloid leukemia (9861/3). Genetic testing shows AML with inv(16)(p13.1q22) (9871/3).

4. Positive microscopic confirmation, method not specified
   - Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.

5. Positive laboratory test/marker study
   - A clinical diagnosis of cancer is based on laboratory tests/marker studies that are clinically diagnostic for cancer.

6. Direct visualization without microscopic confirmation
   - The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.

7. Radiography and other imaging techniques without microscopic confirmation
   - The malignancy was reported by the physician from an imaging technique report only.

8. Clinical diagnosis only (other than 5, 6, or 7)
   - The malignancy was reported by the physician in the medical record. Refer to ambiguous terminology in Chapter 4.

9. Unknown whether or not microscopically confirmed
   - A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).
Instructions for Coding Hematopoietic and Lymphoid Tumors (M9590-9992)

a. There is no priority hierarchy for coding Diagnostic Confirmation for hematopoietic and lymphoid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing. See the Hematopoietic Database (DB) for information on the definitive diagnostic confirmation for specific types of tumors.

b. Assign code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy or bone marrow specimens from aspiration or biopsy.

c. For leukemia only, assign code 1 when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear. Do not use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow, or blood.

d. Assign code 2 when the microscopic diagnosis is based on cytologic examination of cells (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical or vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.

e. Assign code 3 when there are a histology positive for cancer and positive immunophenotyping and/or positive genetic testing results. Do not use code 3 for neoplasms diagnosed prior to January 1, 2010

f. Assign code 5 when the diagnosis of cancer is based on laboratory tests or marker studies that are clinically diagnostic for that specific cancer, but no positive histologic confirmation.

g. Assign code 6 when the diagnosis is based only on the surgeon’s report from a surgical exploration or endoscopy or from gross autopsy findings without tissue or cytological findings.

h. Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient’s clinical presentation.
HISTOLOGY

Description
This is a required 4-character field for recording histologic (cell) type.

Instructions
- For all solid malignant tumors diagnosed January 1, 2007 or later, use the SEER Multiple Primary and Histology Coding Rules.
- For lymphoma diagnosed 2010 and later use the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.


*Note: ICD-O-3 is effective for cases diagnosed January 1, 2001 forward. Continue to use ICD-O-2 for cases diagnosed prior to 2001.

b. In the Alphabetic Index, all morphology codes are identified by an M- preceding the code number. Do not record the M on the abstract. Do not record the virgule (/ - slash) on the abstract. All morphology codes begin with an 8 or 9.

Example: Infiltrating duct carcinoma is code M-8500/3. Record code 85003 on the abstract (paper or computer).

Note: Subsequent references to morphology codes will be stated without the preceding M- in the code.

c. Review all pathology reports that describe the primary site before coding histology and behavior. Read each pathology report in its entirety. Although reports from the definitive cancer-directed surgery is usually the best, sometimes all of the positive tissue is removed at biopsy.

Example: The pathology report from a skin biopsy states malignant melanoma, NOS. At wide excision, no residual tumor was found. Code the histology from the biopsy report as malignant melanoma, NOS (8720/3).

d. If no tissue or cytology specimen was obtained for a diagnosis of malignancy, but a recognized medical practitioner makes a clinical diagnosis of cancer, malignancy, malignant tumor, or malignant neoplasm, code to 8000/3 (Neoplasm, malignant). If the physician is more specific, use the more specific morphology code.

The codes for cancer, NOS (8000/3) and carcinoma, NOS (8010/3) are not interchangeable. If the physician says that the patient has carcinoma, code carcinoma, NOS (8010/3).

e. Code the final pathologic diagnosis.

Exception: At times, the final diagnosis is “Not Otherwise Specified” (NOS), e.g., carcinoma, NOS; melanoma, NOS; sarcoma, NOS; lymphoma, NOS; or malignant tumor, NOS. Code the histology from the microscopic description or comment if it describes a more specific histology (higher ICD-O-3 code) such as adenocarcinoma, amelanotic melanoma, spindle cell sarcoma, etc. Record the best information found.
Example: The final pathologic diagnosis is carcinoma (8010/3) of the prostate. The microscopic diagnosis states adenocarcinoma (8140/3) of the prostate, grade III. The more specific diagnosis, adenocarcinoma of the prostate, grade III (8140/33), should be coded.

f. Lymphomas may be classified by the Rappaport classification or the Working Formulation. If both systems are used to classify the disease, the term used to describe the lymphoma may differ, and the Working Formulation term should take precedence (ICD-O-3, pp. 13-18).

Example: In the Pathology report, the Working Formulation describes malignant lymphoma, large cell, immunoblastic (9684/3). The Rappaport classification describes malignant lymphoma, diffuse, histiocytic (9680/3). Use code 9684/3.

Histology Coding Rules

- For all solid malignant tumors diagnosed January 1, 2007 or later, use the SEER Multiple Primary and Histology Coding Rules.
- For lymphoma diagnosed 2010 and later use the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.

a. When multiple terms describe a single histology, record the numerically highest code.

Example: In the diagnosis “transitional cell epidermoid carcinoma,” transitional cell (8120/3) and epidermoid (8070/3) are both adjectives describing carcinoma. Record transitional cell (8120/3).

Note: If the diagnosis states “transitional cell and epidermoid carcinoma,” “transitional cell with areas of epidermoid carcinoma,” or “transitional cell with a focus of epidermoid carcinoma,” the diagnosis would be interpreted as one of mixed or multiple histologies.

b. The ICD-O-3 morphology code has five digits (e.g., 8500/3).

(1) When the first three digits of the ICD-O-3 morphology codes are identical, the lesions are the same histology. Record the numerically higher code, as it is usually a more specific histology.

Example: A stomach biopsy is interpreted as adenocarcinoma, NOS (8140/3). The pathology from the resection identifies the tumor as linitis plastica (8142/3). Record the morphology code for linitis plastica (8142/3). (Refer to Rule K in the Introduction of ICD-O-3 on page 21 for more information.)

(2) When the first three digits of the ICD-O-3 morphology code are different, the histologies are not the same. These lesion(s) have a mixed or multiple histology. Code using the rules under paragraph d. below, “Coding Mixed or Multiple Histologies.”

Exception 1: Lymphatic and hematopoietic disease. Use the guidelines in Appendix E-2 (Prepared by: SEER Program, NCI, 02/28/2001) to determine which histologies represent single or multiple primaries.

Exception 2: If one malignancy is stated to be carcinoma, NOS; adenocarcinoma, NOS; sarcoma, NOS; or melanoma, NOS and the second lesion is a more specific term, such as large cell carcinoma, mucinous adenocarcinoma, spindle cell sarcoma, or superficial spreading melanoma, consider this to be a single histology.

Note: This rule applies when a nonspecific morphology and a specific morphology exist in a single lesion. Code as a single primary with the more specific morphology.

Exception 3: Code the following as single primaries with a single histology, even though the first three digits of the ICD-O-3 morphology codes differ:
• Bladder lesions with morphology codes 8120-8130 (transitional cell and papillary transitional cell carcinomas) should be coded 8130/3, the combination code;
• Thyroid lesions with morphology codes 8260/3 (papillary carcinoma) and 8330/3 (follicular carcinoma) should be coded 8340/3, the combination code;
• Within each breast, lesions with morphology codes 8500/3 (ductal carcinoma) and 8520/3 (lobular carcinoma). Code such breast lesions to the combination code 8522/3. Use the combination code even if one of the lesions is in situ and the other invasive.

**Exception 4:** Use the following for the determination of single or multiple primaries of non-malignant (behavior /0 or /1) primary intracranial and central nervous system tumors (C70.0-C72.9, C75.1-C75.3).

• Two histologies appearing in the same grouping in the following table are the same. Code the more specific histology.
• A histology in the table and a histology not in the table that have the same first three digits are the same. Code its histology according to the rules for mixed histologies.
• Two histologies not appearing in the table but having the same first three digits are the same. Code its histology according to the rules for mixed histologies.

<table>
<thead>
<tr>
<th>Choroid plexus neoplasms</th>
<th>9390/0, 9390/1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ependymomas</td>
<td>9383, 9394, 9444</td>
</tr>
<tr>
<td>Neuronal and neuronal-glial neoplasms</td>
<td>9384, 9412, 9413, 9442, 9505/1, 9506</td>
</tr>
<tr>
<td>Neurofibromas</td>
<td>9540/0, 9540/1, 9541, 9550, 9560/0</td>
</tr>
<tr>
<td>Neurinomatosis</td>
<td>9560/1</td>
</tr>
<tr>
<td>Neurothekeoma</td>
<td>9562</td>
</tr>
<tr>
<td>Neuma</td>
<td>9570</td>
</tr>
<tr>
<td>Perineurioma, NOS</td>
<td>9571/0</td>
</tr>
</tbody>
</table>

(3) The fifth digit of the ICD-O-3 morphology code is the behavior code. The behavior code is not used to determine multiple histologies. Lesion(s) may have a single histology with invasive and in situ components. This is a single histology. Code the behavior of the invasive component. If a single lesion has multiple histologies, one invasive and one in situ, code the invasive histology, even if the histology code for the in situ component is higher.

**Note:** This rule is also used for multiple lesions with the same histology. One lesion may be invasive and another lesion in situ, or each of the lesions may have invasive and in situ components.

**Example 1:** Pathology of a breast mass shows infiltrating ductal carcinoma (8500/3) with a large intraductal component (8500/2). This is a single histology. Code the histology as infiltrating ductal (8500) and the malignant behavior (/3).

**Example 2:** A patient has a colectomy and the pathology identifies two lesions in the sigmoid colon. The first lesion is an invasive adenocarcinoma (8140/3) and the second lesion is an adenocarcinoma in situ (8140/2). This is a single histology. Code the histology and behavior as adenocarcinoma, NOS (8140/3).

**Exception:** Two primary intracranial and central nervous system tumors (C70.0-C72.9, C75.1-C75.3) in which one is malignant (behavior of /2 or /3) and one is non-malignant (behavior of /0 or /1) are always separate primaries, regardless of timing.

c. Cancers are considered simultaneous if diagnosed within two months of each other.
Coding Mixed or Multiple Histologies

A single lesion with mixed or multiple histologic types is one primary. To code mixed or multiple histologies with the same behavior existing in one primary, use the following guidelines in this priority order:

(1) Select a combination code

Example 1: The pathology report of a breast cancer describes mixed ductal (8500/3) and lobular carcinoma (8520/3). Record the combination code “ductal carcinoma and lobular carcinoma” (8522/3).

Example 2: The pathology report of a carcinoma of the cervix describes mixed adenocarcinoma and squamous cell carcinoma. Record the combination code “adenosquamous carcinoma” (8560/3).

(2) Code the histology that comprises the majority of the tumor. Phrases such as “predominantly” and “with features of” are often used to identify the principal histology.

Example: A lung lesion is predominantly squamous cell carcinoma (8070/3) with focal areas of bronchiolo-alveolar adenocarcinoma (8250/3). A combination code does not exist. Record the predominant histology, squamous cell carcinoma (8070/3).

Note: The terms “with foci of,” “areas of,” or “elements of” describe minor areas of involvement. Do not code the histologies described by these terms unless there is a combination code.

(3) Code the histology with the highest ICD-O-3 morphology code.

Example: A patient with bladder cancer is diagnosed with mixed transitional cell carcinoma (8120/3) and epidermoid carcinoma (8070/3). There is no combination code for these histologies, and the pathology report does not identify a predominant histology. Record the highest morphology code, transitional cell carcinoma (8120/3).

e. Determining Multiple Primaries

- For all solid malignant tumors diagnosed January 1, 2007 or later, use the SEER Multiple Primary and Histology Coding Rules.
- For lymphoma diagnosed 2010 and later use the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.

Enter the case into the database as a single or multiple primary as documented by the physician. If physician determination is absent or unavailable, use the following guidelines, which are based on the International Classification of Diseases for Oncology (ICD-O-3).

(1) Determine whether there is a single lesion or multiple lesions.

(2) Decide whether the tumor(s) involve a single site or multiple sites. Use the rules documented in the section for Primary Site in this chapter.

(3) Decide whether the tumor(s) are a single histology or mixed/multiple histologies. Follow the “Histology Coding Rules” described above in this section.
(4) Use the following table to decide whether the case should be abstracted as a single primary or multiple primaries. (Use only for cases diagnosed prior to 01/01/2007.)

<table>
<thead>
<tr>
<th>LESIONS</th>
<th>SITE(S)</th>
<th>HISTOLOGY</th>
<th>VARIABLES</th>
<th>PRIMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>Single</td>
<td>Single</td>
<td></td>
<td>Single</td>
</tr>
<tr>
<td></td>
<td>Single</td>
<td>Mixed/multiple</td>
<td>Different behavior codes, in situ (2)</td>
<td>Single</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>and invasive (3)</td>
<td></td>
</tr>
<tr>
<td>Single or multiple</td>
<td>Single</td>
<td>Single</td>
<td>Same as previous site</td>
<td>Recurrence of the original primary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mixed/multiple</td>
<td>Same as previous histology</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Within two months of diagnosis</td>
<td></td>
</tr>
<tr>
<td>Single or multiple</td>
<td>Single</td>
<td>Single</td>
<td>More than two months after diagnosis</td>
<td>New primary unless physician states it is recurrent or metastatic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mixed/multiple</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple</td>
<td>Single</td>
<td>Single</td>
<td>Simultaneous</td>
<td>Single</td>
</tr>
<tr>
<td></td>
<td>Multiple</td>
<td>Single</td>
<td>Simultaneous</td>
<td>Multiple unless physician states it is metastatic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Single</td>
<td>Mixed/multiple</td>
<td>Simultaneous</td>
<td>Multiple</td>
</tr>
<tr>
<td></td>
<td>Multiple</td>
<td>Multiple</td>
<td>Simultaneous</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Example 1:** Single lesion, single site, single histology, different behavior

The pathology report from the biopsy of a cervical lesion identified invasive carcinoma (8010/3) and squamous cell carcinoma in situ (8070/2). This is a single histology, because carcinoma, NOS is a nonspecific morphology and squamous cell carcinoma is a specific morphology. Code the more specific histology and the invasive behavior (8070/3).

**Example 2:** Multiple lesions, single site, single histology, diagnosed within two months

A patient has a colectomy in August 2002 for an adenocarcinoma (8140/3). The physician biopsies the anastomotic site in September 2002. The pathologic examination confirms adenocarcinoma. This is a recurrence of the original tumor and should not be reported again.

**Example 3:** Multiple lesions, single site, single histology, diagnosed more than two months apart

A patient has surgery for a squamous cell carcinoma (8070/3) of the hard palate (C05.0) in January 2003. The physician biopsies another hard palate lesion in April 2003. Pathology confirms squamous cell carcinoma. There is no physician statement identifying the disease as recurrent or metastatic. This is a new primary and should be reported.
Example 4: Multiple lesions, single site, multiple histologies, diagnosed more than two months apart, 

*Exception*

A transitional cell carcinoma (8120/3) of the trigone of the bladder (C67.0) was diagnosed in January of 2002. In May of 2003, a papillary transitional cell carcinoma (8130/3) of the bladder neck (C67.5) was diagnosed. Only the first bladder tumor would be reported, using a primary site code of C67.0 and a morphology code of 8120/3.

Example 5: Multiple lesions, multiple sites, single histology, simultaneous

The patient has masses in the esophagus and lung. Pathology identifies both lesions as squamous cell carcinoma, NOS (8070/3). Pathology does not identify either lesion as metastatic. There are two primaries: Esophagus (C15.9) and lung (C34.9).

Example 6: Multiple lesions, single site, multiple histologies, simultaneous

A patient has an adenocarcinoma (8140/3) at the gastroesophageal junction and a non-Hodgkin lymphoma (9591/3) in the body of stomach. The patient has two primaries.

Example 7: Multiple lesions, multiple sites, multiple histologies, simultaneous

A patient has a squamous cell carcinoma (8070/3) of the soft palate (C05.1) and an adenocarcinoma (8140/3) in Barrett esophagus (C15.9). The patient has two primaries.
BEHAVIOR

Description
The fifth digit, which follows the slash after the histology code, is the behavior code. Behavior codes are listed in ICD-O-3 page 66 and below. The State Cancer Registry requires only tumors ending in a fifth digit behavior code of /2 or /3 to be reported.

Note: ICD-O-3 is effective for cases diagnosed January 1, 2001 forward. Continue to use ICD-O-2 for cases diagnosed prior to 2001.

Codes
/0 Benign (do not report to State Registry)

Exception:
Benign neoplasms of the brain and central nervous system diagnosed January 1, 2004 or later should be reported.

/1 Uncertain whether benign or malignant (do not report to State Registry)
Borderline malignancy
Low malignant potential

Exceptions:
Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, is required and should be reported as 9421/3; Borderline neoplasms of the brain and central nervous system diagnosed January 1, 2004 or later should be reported.

/2 Carcinoma in situ (report to State Registry)
Intraepithelial
Noninfiltrating
Noninvasive

Exceptions: Preinvasive cervical neoplasia (in situ lesions and CIN III); prostatic intraepithelial neoplasia, grade III; and basal cell and squamous cell carcinoma of nongenital skin are not reportable if diagnosed 01/01/2003 or later.

/3 Malignant, primary site (report to State Registry)

/6 Malignant, metastatic site (do not use)
Malignant, secondary site

/9 Malignant, uncertain whether primary or metastatic site (do not use)

Instructions for Behavior Code
a. Since tumor registries include only primary, and not metastatic sites, behavior codes 6 and 9 should never be used. They are listed here for informational purposes only.

b. Behavior codes /0 (benign) and /1 (uncertain or borderline) are not reportable to the State Cancer Registry unless listed under exceptions above. However, at the discretion of the cancer committee, a hospital may choose to collect some of these cases, which are called “reportable-by-agreement.” The behavior codes are listed here for informational purposes only.

c. The behavior code /6 indicates a metastatic site. If the only specimen available for diagnosis was from a metastatic site, code the histologic type of the metastatic site and code a /3 for the behavior code.
If the primary site is known, record the applicable topography code. If the primary site is unknown, the
topography code should be C80.9.

Example: If the patient had a biopsy of the lung showing metastatic adenocarcinoma (8140/6), the
primary site is unknown (C80.9). Code the histology to adenocarcinoma (8140/3).

d. "In situ" is a concept based upon histologic evidence. Therefore, clinical evidence alone cannot justify
the usage of this term. If the fifth digit in Histology/Behavior is coded /2 (in situ), diagnostic
confirmation should be 1, 2, or 4.

The following terms are synonymous with in situ (fifth digit behavior code /2):

(Adeno)carcinoma in an adenomatous polyp with no invasion of stalk
AIN III – Anal intraepithelial neoplasia, grade III (C21.1, 8077/2)
Bowen disease (8081/2)
CIN III – Cervical intraepithelial neoplasia, grade III (C53.9, 8077/2)
Clark’s Level 1 for melanoma (limited to epithelium)
Comedocarcinoma, noninfiltrating (C50.9, 8501/2)
Confined to epithelium
High grade dysplasia in the gastrointestinal (GI) tract
(Confirm that the pathologist uses “high grade dysplasia” for in situ in the GI tract.)
Hutchinson melanotic freckle, NOS (C44.9, 8742/2)
Intracystic, noninfiltrating (carcinoma)
Intraductal (carcinoma)
Intraepidermal, NOS (carcinoma)
Intraepithelial, NOS (carcinoma)
Involvement up to but not including the basement membrane
Lentigo maligna (C44.9, 8742/2)
Lobular neoplasia (C50.9)
Lobular, noninfiltrating (C50.9, 8520/2) (carcinoma)
Noninfiltrating (carcinoma)
Noninvasive (carcinoma only)
No stromal involvement or invasion (If there is stromal invasion, it is not in situ.)
Papillary, noninfiltrating or intraductal (carcinoma)
Precancerous melanosis (C44.9, 8741/2)
PIN III – Prostatic intraepithelial neoplasia, grade III (C61.9, 8148/2)
Queyrat erythroplasia (C60.9, 8080/2)
AJCC Stage 0
VAIN III – Vaginal intraepithelial neoplasia, grade III (C52.9, 8077/2)
VIN III – Vulvar intraepithelial neoplasia, grade III (C51.9, 8077/2)

e. Code behavior as malignant (/3) if any malignant invasion is present, no matter how limited. Any
pathologic diagnosis qualified as “microinvasive” is not considered “carcinoma in situ” and behavior
should be coded as malignant (/3).

Example: The pathology report from a hysterectomy reads “carcinoma in situ (8010/2) of the cervix
with microinvasion.” Code to invasive carcinoma (8010/3).

f. Code behavior as malignant (/3) if any malignant metastasis to nodes or tissue beyond the primary is
present.

g. Gastro-intestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, they
must be assigned a behavior code of 3 and abstracted if they have multiple foci, metastasis or positive
lymph nodes.
GRADE/DIFFERENTIATION

Description
This is a required 1-character field to record the ICD-O-3 code for the histologic grading or differentiation of solid tumors. Differentiation describes the tumor’s resemblance to the normal tissue from which it arose. Well differentiated (Grade 1) is the most like normal tissue. Grade/differentiation is the sixth digit of the histology code. For lymphomas and leukemias, this sixth digit describes the lineage or phenotype of the cell.

Codes for Solid Tumors

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Well differentiated; differentiated, NOS</td>
</tr>
<tr>
<td>2</td>
<td>Moderately differentiated, moderately well differentiated, intermediate differentiation</td>
</tr>
<tr>
<td>3</td>
<td>Poorly differentiated, dedifferentiated</td>
</tr>
<tr>
<td>4</td>
<td>Undifferentiated, anaplastic</td>
</tr>
<tr>
<td>9</td>
<td>Grade not determined, not stated, or not applicable; unknown primaries; high-grade dysplasia.</td>
</tr>
</tbody>
</table>

Codes for Hematopoietic and Lymphoid Neoplasms

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>T-cell, T-precursor</td>
</tr>
<tr>
<td>6</td>
<td>B-cell, pre-B, B-precursor</td>
</tr>
<tr>
<td>7</td>
<td>Null cell, non T-non B</td>
</tr>
<tr>
<td>8</td>
<td>N K (natural killer cell) (effective for cases diagnosed 01/01/1995 and after)</td>
</tr>
<tr>
<td>9</td>
<td>Cell indicator not determined, not stated, or not applicable.</td>
</tr>
</tbody>
</table>

Instructions for Hematopoietic and Lymphoid Neoplasms

For hematopoietic and lymphoid neoplasms, refer to the “Grade of Tumor Rules” in the current Hematopoietic and Lymphoid Neoplasm Manual and Database at http://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules/.

General Instructions for Solid Tumor Grade

The instructions in this manual for coding solid tumor grade are based on the “Instructions for Coding Grade for 2014+” at http://seer.cancer.gov/tools/grade/.

a. Code the grade or differentiation from the pathology report prior to any neoadjuvant treatment. If there is no pathology report prior to neoadjuvant treatment, assign code 9.

b. Code the grade or differentiation from the pathologic examination of the primary tumor, not from metastatic sites.

Example: The pathology diagnosis for a biopsy of supraclavicular lymph nodes is “anaplastic adenocarcinoma compatible with lung primary.” The histology/behavior/grade would be coded 8140/39 because the biopsy was not from the primary site.

c. If the primary site is unknown, code the grade/differentiation as unknown (9).

d. Code the grade (6th digit) shown below for specific histologic terms that imply a grade.
   - Carcinoma, undifferentiated (8020/34)
   - Carcinoma, anaplastic (8021/34)
   - Follicular adenocarcinoma, well differentiated (8331/31)
   - Thymic carcinoma, well differentiated (8585/31)
   - Sertoli-Leydig cell tumor, poorly differentiated (8631/33)
• Sertoli-Leydig cell tumor, poorly differentiated with heterologous elements (8634/33)
• Undifferentiated sarcoma (8805/34)
• Liposarcoma, well differentiated (8851/31)
• Seminoma, anaplastic (9062/34)
• Malignant teratoma, undifferentiated (9082/34)
• Malignant teratoma, intermediate type (9083/32)
• Intraosseous osteosarcoma, well differentiated (9187/31)
• Astrocytoma, anaplastic (9401/34)
• Oligodendroglioma, anaplastic (9451/34)
• Retinoblastoma, differentiated (9511/31)
• Retinoblastoma, undifferentiated (9512/34)

e. Code the grade for in situ lesions if the information is available. Do not code grade for dysplasia, such as high-grade dysplasia. If the lesion is both invasive and in situ, code only the invasive portion. If the invasive component grade is unknown, assign code 9.

f. If more than one grade of tumor is specified, code to the highest grade, even if the highest grade is only a focus.

   Example: Code moderately to poorly differentiated carcinoma to poorly differentiated (3). Moderately differentiated is coded 2, and poorly differentiated is coded 3. Use the higher code.

g. Do not use the WHO grade to code this data item. For primary tumors of the brain and spinal cord diagnosed 01/01/2004 and later, record the WHO grade in the data item CS Site-Specific Factor 1.

h. When there is no pathology or cytology confirmation, code the grade of a tumor documented in CT scan, Magnetic Resonance Imaging (MRI), or Positron Emission Tomography (PET) report. Brain tumors can be graded using these methods.

Prioritization Rules for Solid Tumor Grade

Code grade using the first system that applies in the following priority order:

1) Special grade systems (See the instructions and conversion tables in section a below for breast, prostate, sarcomas, and kidney parenchyma.). Do not use the special grade system tables for any other groups.

2) Differentiation (See conversion tables in section b below for 2-, 3-, or 4- grade systems.)

3) Nuclear grade (See conversion tables in section b below for 2-, 3-, or 4- grade systems.)

   Note: If a 2-, 3-, or 4- grade system was used, code from the conversion tables below, even if it is not clear whether it is a differentiation or nuclear grade.

4) Terminology (See the conversion table in section c below for coding from terminology only.)

a. Special Grade Systems

   Breast (excluding lymphomas)
   Use the conversion table below to code grade for breast using the Bloom-Richardson (BR) or Nottingham score or grade. A BR score takes precedence over a BR grade.

   BR may also be called: modified Bloom-Richardson, Scarff-Bloom-Richardson, SBR grading, BR grading, Elston-Ellis modification of Bloom-Richardson score, the Nottingham modification of Bloom-Richardson score, Nottingham modification of Scarff-Bloom-Richardson, Nottingham-Tanovus grade, or Nottingham grade.

   Code using the highest score if multiple scores are reported, either in multiple pathology reports for the same primary or different scores for multiple tumors abstracted as a single primary. Exclude scores for specimens taken after neoadjuvant treatment was started.
BR Conversion Table for Invasive Breast Carcinoma

<table>
<thead>
<tr>
<th>Grade Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>BR score of 3, 4 or 5</td>
</tr>
<tr>
<td>2</td>
<td>BR score of 6 or 7</td>
</tr>
<tr>
<td>3</td>
<td>BR score of 8 or 9</td>
</tr>
<tr>
<td>1</td>
<td>Low grade, Bloom-Richardson (BR) grade 1, score not stated</td>
</tr>
<tr>
<td>2</td>
<td>Medium (intermediate) grade, BR grade 2, score not stated</td>
</tr>
<tr>
<td>3</td>
<td>High grade, BR grade 3, score not given</td>
</tr>
</tbody>
</table>

If there is no BR or Nottingham score stated and it is not clear that a stated grade is a BR or Nottingham grade, do not use the conversion table above. Use the next system that applies from the solid tumor prioritization rules listed above.

Prostate (excluding lymphomas)
For prostate cancers, code the tumor grade using the highest Gleason score reported, regardless of whether it is from a biopsy, TURP, prostatectomy or autopsy. Exclude scores for specimens taken after neoadjuvant treatment was started.

Gleason Pattern
Gleason grading is based on a 5-component system, based on 5 histologic patterns. The most predominant pattern and second most predominant pattern are identified and stated in the pathology report. If the primary pattern is 3 and and the secondary pattern is 4, Gleason pattern is 3 + 4.

Gleason Score
The primary and secondary Gleason patterns are added together to create Gleason score. If Gleason patterns are 3 + 4, the Gleason score is 7.

Rules for when only a single number for Gleason is stated:
- If the number is less than or equal to 5, and not specified as the score, do not use the information.
- If the number is greater than 5, assume that is is a score and use it.
- If the report states a specific number out of a total of 10, the specific number is the score. (e.g., for Gleason 3/10, the score would be 3.)

Gleason Conversion Table for Prostate Cancer (revised for cases diagnosed 2014 and forward)

<table>
<thead>
<tr>
<th>Grade Code</th>
<th>Gleason Score (sum of primary &amp; secondary patterns)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2, 3, 3, 4, 5, or 6</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>8, 9, or 10</td>
</tr>
</tbody>
</table>

Note: Gleason score 7 was moved from Grade code 2 to 3, effective for cases diagnosed from 01/01/2003 through 12/31/2013. Gleason scores 5 and 6 were moved from Grade code 2 to 1, effective for cases diagnosed on or after 01/01/2014.

Kidney Parenchyma (excluding lymphomas)
For kidney cancers, code the tumor grade using the Fuhrman Nuclear Grade. It is a direct conversion from Fuhrman Nuclear Grade to tumor grade as shown below. Do not use for kidney renal pelvis.

<table>
<thead>
<tr>
<th>Grade Code</th>
<th>Fuhrman Nuclear grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Grade 1</td>
</tr>
<tr>
<td>2</td>
<td>Grade 2</td>
</tr>
<tr>
<td>3</td>
<td>Grade 3</td>
</tr>
<tr>
<td>4</td>
<td>Grade 4</td>
</tr>
</tbody>
</table>
Sarcoma (Sites: soft tissue, heart, mediastinium, peritoneum, and retroperitoneum)
For sarcomas, code the tumor grade from any three-grade sarcoma grading system the pathologist uses. A numeric grade takes precedence over “low grade” or “high grade.”

<table>
<thead>
<tr>
<th>Grade Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Grade 1 (of 3)</td>
</tr>
<tr>
<td>3</td>
<td>Grade 2 (of 3)</td>
</tr>
<tr>
<td>4</td>
<td>Grade 3 (of 3)</td>
</tr>
<tr>
<td>2</td>
<td>Low grade, NOS</td>
</tr>
<tr>
<td>4</td>
<td>High grade, NOS</td>
</tr>
</tbody>
</table>

If only the terms “well differentiated” or “poorly differentiated” are used, use the table in section c below for coding grade from terminology.

b. Two-, Three-, and Four-grade Systems
Two-grade Systems
Use the two-grade conversion table to assign a grade code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Term</th>
<th>Exception for Breast and Prostate Grade Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Low grade</td>
<td>1/2, I/II</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>High grade</td>
<td>2/2, II/II</td>
<td>3</td>
</tr>
</tbody>
</table>

For transitional cell carcinoma (TCC) of bladder, code the terminology high grade TCC and low grade TCC using the two-grade system.

Three-grade Systems
Use the three-grade conversion table to assign a grade code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Term</th>
<th>Exception for Breast and Prostate Grade Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Low grade</td>
<td>I/III or 1/3</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Intermediate grade</td>
<td>II/III or 2/3</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>High grade</td>
<td>III/III or 3/3</td>
<td>3</td>
</tr>
</tbody>
</table>

Four-Grade Systems
Use the four-grade conversion table to assign a grade code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Grade I; well differentiated</td>
<td>1/4</td>
</tr>
<tr>
<td>2</td>
<td>Grade II; moderately differentiated</td>
<td>2/4</td>
</tr>
<tr>
<td>3</td>
<td>Grade III; poorly differentiated</td>
<td>3/4</td>
</tr>
<tr>
<td>4</td>
<td>Grade IV; undifferentiated</td>
<td>4/4</td>
</tr>
</tbody>
</table>
c. **Terminology**

When none of the above systems apply, and grade is coded from terminology only, use the table below. Breast and prostate use the same grade code, except as noted in the exception column.

<table>
<thead>
<tr>
<th>Grade Code</th>
<th>Exception for Breast and Prostate Grade Code</th>
<th>Description</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Differentiated, NOS</td>
<td>I</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Well differentiated</td>
<td>I</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Only stated as “Grade I”</td>
<td>I</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Fairly well differentiated</td>
<td>II</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Intermediate differentiation</td>
<td>II</td>
</tr>
<tr>
<td>2 1</td>
<td></td>
<td>Low grade</td>
<td>I-II</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Mid differentiated</td>
<td>II</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Moderately differentiated</td>
<td>II</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Moderately well differentiated</td>
<td>II</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Partially differentiated</td>
<td>II</td>
</tr>
<tr>
<td>2 1</td>
<td></td>
<td>Partially well differentiated</td>
<td>I-II</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Relatively or generally well differentiated</td>
<td>II</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Only stated as “Grade II”</td>
<td>II</td>
</tr>
<tr>
<td>3 2</td>
<td></td>
<td>Medium grade, intermediate grade</td>
<td>II-III</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Moderately poorly differentiated</td>
<td>III</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Moderately undifferentiated</td>
<td>III</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Poorly differentiated</td>
<td>III</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Relatively poorly differentiated</td>
<td>III</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Relatively undifferentiated</td>
<td>III</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Slightly differentiated</td>
<td>III</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Dedifferentiated</td>
<td>III</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Only stated as “Grade III”</td>
<td>III</td>
</tr>
<tr>
<td>4 3</td>
<td></td>
<td>High grade</td>
<td>III-IV</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Undifferentiated, anaplastic, not differentiated</td>
<td>IV</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Only stated as “Grade IV”</td>
<td>IV</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Non-high grade</td>
<td></td>
</tr>
</tbody>
</table>
**GRADE PATH VALUE**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>This is a required 1-character field to record the numerator or first number of a tumor grade reported in a 2, 3, or 4 grade system. It supplements but does not replace the field Grade/Differentiation, which is part of the ICD-O-3 morphology code structure and may be converted from another grading system or coded by a different set of rules. Grade Path Value is paired with Grade Path System to describe the original grade of the tumor.</td>
</tr>
</tbody>
</table>
| **Codes** | 1  Recorded as Grade I or 1  
2  Recorded as Grade II or 2  
3  Recorded as Grade III or 3  
4  Recorded as Grade IV or 4  
Blank  No 2, 3, or 4 grade system available. Unknown |
| **Instructions** | Refer to Part 1, Section 1 of the current *CS Manual* for coding instructions.  
This item may be left blank if unknown or there is no 2, 3, or 4 grade system available.  
This item should be blank for all lymphomas and hematopoietic malignancies. |
**GRADE PATH SYSTEM**

*Required if available for cases diagnosed 01/01/2011 through 12/31/2013.*

**Description**
This is a required 1-character field to record the denominator or second number of tumor grade reported in a 2, 3, or 4 grade system. It supplements but does not replace the field Grade/Differentiation, which is part of the ICD-O-3 morphology code structure and may be converted from another grading system or coded by a different set of rules. Grade Path System is paired with Grade Path Value to describe the original grade of the tumor.

**Codes**
- 2: Recorded as Grade x of or / II or 2
- 3: Recorded as Grade x of or / III or 3
- 4: Recorded as Grade x of or /IV or 4
- Blank: No 2, 3, or 4 grade system available. Unknown

**Instructions**
Refer to Part 1, Section 1 of the current CS Manual for coding instructions.

This item may be left blank if unknown or there is no 2, 3, or 4 grade system available.

This item should be blank for all lymphomas and hematopoietic malignancies.
LYMPH-VASCULAR INVASION

Description
This is a required 1-character field to record a code that indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as documented from the microscopic examination by the pathologist.

Other names for lymph-vascular invasion are LVI, lymphovascular invasion, vascular invasion, blood vessel invasion, angiolymphatic invasion, and lymphatic invasion. It does not include perineural invasion and is not the same as direct tumor extension from the primary tumor into adjacent blood vessels or involvement of regional lymph nodes.

Codes
0  Lymph-vascular invasion is not present (is absent) or is not identified.
1  Lymph-vascular invasion is present or identified.
8  Not applicable.
9  Unknown or indeterminate.

Instructions
1. For State reporting, this item may be left blank for cases diagnosed before 2012.

2. Code from documentation in the following priority order:
   - College of American Pathologist (CAP) synoptic report or checklist
   - Pathology report
   - Physician’s statement

   Use information documented for any specimen from the primary tumor.

3. Assign code 1 if lymph-vascular is identified anywhere in a primary tumor specimen.

4. Assign code 0:
   - If the pathology report indicates no lymph-vascular invasion was identified;
   - For in situ carcinoma.

5. Assign code 8 for the following diagnoses:
   - Hodgkin and non-Hodgkin lymphoma
   - Leukemias
   - Hematopoietic and reticuloendothelial disorders
   - Myelodysplastic syndromes, including refractory anemias and refractory cytopenias
   - Myeloproliferative disorders

6. Assign code 9 when:
   - No pathologic examination of primary site tissue was performed;
   - Lymph-vascular invasion is not mentioned in the pathology report;
   - The only primary site specimen is a cytology or a fine needle aspiration;
   - The biopsy is only a very small tissue sample;
   - The pathologist indicates the specimen is insufficient to determine lymph-vascular invasion;
   - It is not possible to determine whether lymph-vascular invasion is present.

*Required if available for cases diagnosed 01/01/2012 and later.

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: *Required
DESCRIPTION OF DIAGNOSIS

RMCDS Items: Primary Site Title, Histology Title, Dx Procedure Pathology

Data Type: Text
ACoS: N/A
State Registry: Required

Description
This is a required text field in the paper abstract and the corresponding required RMCDS fields for recording a narrative description of the primary site, histologic type, behavior, and grade. Facilities using other types of registry software should follow their vendor’s instructions for recording text about the site and histology.

Rationale
Text is needed to justify the codes selected for the data items and to record information that is not coded at all. The text is used for quality control and special studies.

Instructions
a. Record a brief, but specific, description of the site of origin for the tumor being reported. Include laterality if applicable. Use standard abbreviations to conserve space if necessary and if each abbreviation has a clear meaning and only one interpretation.

   Example 1: Upper outer quadrant (UOQ) of right (RT) breast.
   Example 2: Splenic flexure of colon.

b. Record a brief, but specific, description of the histologic type, behavior, and grade of the tumor being reported. Use standard abbreviations to conserve space if necessary and if each abbreviation has a clear meaning and only one interpretation.

   Example 1: Infiltrating duct and lobular carcinoma (ca).
   Example 2: Moderately well differentiated (MWD) adenocarcinoma (adenoca) in adenomatous polyp.
   Example 3: Malignant lymphoma, lymphocytic, poorly differentiated (PD), nodular.
   Example 4: Superficial spreading melanoma.
   Example 5: Astrocytoma, stage III.
   Example 6: Adult T-cell leukemia.

c. In the Description of Diagnosis or the RMCDS Dx Procedure Pathology field, record any additional pertinent information from cytology and histopathology reports. In RMCDS it is not necessary to repeat information recorded in the primary site and histology text fields. Include, as applicable:

   Date(s) of procedure(s)
   Type(s) of tissue specimen(s)
   Gross tumor size
   Extent of tumor spread
   Involvement of resection margins
   Information regarding lymph-vascular invasion (LVI)
   Number of lymph nodes involved and examined
   Differential diagnoses considered and any ruled out or favored.

d. Facilities using paper abstracts to report should also attach copies of medical record documentation (such as pathology reports and operative reports) that identifies the site and histology information for the primary being reported. However, text describing the site and histology must be completed by all reporting facilities.
Coding Instructions

Cancer Identification

Chapter 5

TUMOR SIZE

Item Length: 3
Data Type: Numeric
Right Justified, Zero Fill
ACoS: Required*
State Registry: Required*

*For cases diagnosed on or before 12/31/2003

Description
This is a required 3-character field to record the largest dimension, or the diameter, of the primary tumor in millimeters. Right justify and enter leading zeros.

Note: Code this data item for cases diagnosed on or before December 31, 2003. For cases diagnosed on or after January 1, 2004 code tumor size using CS Tumor Size.

Codes
000 No mass or tumor found; e.g., a tumor of a stated primary site is not found, but the tumor has metastasized.
001-988 Exact size in millimeters; for melanoma, depth in hundredths of millimeters.
989 989 millimeters or larger; melanomas greater than or equal to 9.89 mm in depth.
990 Microscopic focus or foci only, no size is given.
998 Tumor involvement of specified esophageal, stomach, colorectal, lung and main stem bronchus, and breast primaries. See coding instructions.
999 Unknown; size not stated; not stated in the patient record; not applicable.

Instructions
a. Code the exact size of the primary tumor in millimeters (mm).

Conversion/Rounding
• To convert centimeters to millimeters, move the decimal point one digit to the right (or multiply the centimeters by 10).

0.1 cm = 1 mm
1 cm = 10 mm
3.2 cm = 32 mm

• Use code 001 for tumors less than 1 mm in size
• Formulas for converting inches to millimeters are listed below.

394 inch = 10 mm
1 inch = 25 mm

Exception:
• For melanomas, code the depth of invasion in HUNDREDTHS of millimeters for the following sites: skin (C44.0-C44.9), vulva (C51.0-C51.9), penis (C60.0-C60.9), scrotum (C63.3), and conjunctiva (C69.0). A 1-mm depth would be recorded as 100.
• Use code 989 for melanomas of the above sites that are 9.89 mm or greater in depth.

b. Recording pathologic size versus clinical size:

(1) Use the size documented on the pathology report when:
• The pathologist identifies the size of a completely excised primary tumor.
• The surgical margins were grossly free of disease (there may be microscopic involvement).

(2) Use the clinical size when:
• The primary tumor was not surgically excised.
• The primary tumor was excised but the margins were grossly involved.
• The primary tumor was excised but the pathology report does not specify tumor size.
• The patient was treated with radiation therapy, chemotherapy, hormone therapy, or immunotherapy before the primary was surgically excised. Code the size of the tumor prior to the therapy.
Use the clinical tumor size documented in the following reports/examinations (listed in priority order): operative report, scans, x-ray, or physical examination.

c. Code the size of the primary tumor, rather than the size of the specimen, polyp, ulcer, cyst, or metastasis.

Example: The patient had an excisional breast biopsy. Pathology report states that the specimen measures 2 cm x 3 cm, but does not state the actual size of the tumor. Do not use the specimen size of 2 cm x 3 cm. Code the size from the operative report, mammography, or the physical exam.

d. Code the largest dimension or diameter of a tumor when multiple measurements are recorded.

e. Record the size of the largest tumor when a patient has more than one tumor in the same primary site.

f. When a tumor has both in situ and invasive components, record the size of the invasive component only. For purely in situ tumors, code the size as stated.

g. Do not report the tumor size based on a biopsy unless the biopsy removed all of the primary tumor. Code the size of the residual tumor if an excisional biopsy is performed, and residual tumor at the time of resection of the primary site is found to be larger than the excisional biopsy.

h. Do not add pieces or chips together to create a whole. They may not be from the same location, or they may represent only a very small portion of a large tumor. A clinical size may be documented in a physical exam, an ultrasound of the prostate, or a cystoscopy of the bladder.

i. Record 998 when the following terms describe tumor involvement in these specific sites:

- Esophagus (C15.0 – C15.9) Entire circumference
- Stomach (C16.0 – C16.9) Diffuse; widespread; 3/4 or more; linitis plastica
- Colorectal (C18.0 – C20.9) Familial/multiple polyposis (histology 8220 or 8221 with a behavior code of /2 or /3)
- Lung and main stem bronchus (C34.0 – C34.9) Diffuse, entire lobe or lung
- Breast (C50.0 – C50.9) Diffuse; widespread; 3/4 or more of breast; inflammatory carcinoma

j. Record 999 for the following:

- Tumor size is unknown or not documented in the patient record.
- Prostatic chips or bladder chips are the only measurement documented in the patient record.
- If only one size is given for a mixed in situ and invasive tumor.
- For a needle biopsy specimen.
- The patient was treated with radiation therapy, chemotherapy, hormone therapy, or immunotherapy before the primary was surgically excised and no clinical size prior to therapy is documented.
- For the following sites and diseases:
  - Hematopoietic, reticuloendothelial, immunoproliferative, myeloproliferative, and myelodysplastic diseases. (C42.0, C42.1, C42.3, C42.4 and/or M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)
  - Hodgkin and non-Hodgkin lymphomas, including mycosis fungoides of skin (9700) and Sezary disease (9701)
  - Kaposi sarcoma (9140)
  - Letterer-Siwe disease (9754)
  - Multiple myeloma (9732)
  - Unknown or ill-defined primary site or sites (C76.0-C76.8, C80.9)

Codes with Examples:
A patient with lung cancer is described as having a 1-cm nodule in the right upper lobe and a 1.3-cm nodule in the right middle lobe of the lung. Code the size of the largest nodule as 13 mm.

A pathology report describes the tumor size as 3 x 4.4 x 2.5 cm. Code the largest diameter of the tumor as 44 mm.

A pathology report describes a specimen that measures 2 x 3 cm with a focus (microscopic) of infiltrating carcinoma. Code microscopic focus as 1 mm.

A pathology report describes a breast mass as 2 x 1.5-cm intraductal carcinoma and a 1-cm nodule of infiltrating ductal carcinoma. Code the invasive component as 10 mm.

A patient with melanoma of the skin has the primary tumor excised, and the thickness of the tumor was measured as 0.45 mm. Code the depth of invasion in HUNDREDTHS of mm or 45.

The patient had a colonoscopy with polypectomy. The pathology report describes “a 1 x .5 cm polyp with a microscopic focus of adenocarcinoma in situ.” Do not record 10 mm as tumor size. Use the size given in the conversion table below for microscopic (001 mm).

**Conversion Table**

If a descriptive term rather than the actual size is documented, use the following list for size conversion.

*Example:* For microscopic foci of tumor, record tumor size as 001.

<table>
<thead>
<tr>
<th>OBJECT</th>
<th>CM</th>
<th>MM</th>
<th>OBJECT</th>
<th>CM</th>
<th>MM</th>
<th>OBJECT</th>
<th>CM</th>
<th>MM</th>
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<tr>
<td><strong>Fruits</strong></td>
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<td>Apple</td>
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<td>070</td>
<td>Almond</td>
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<td>030</td>
<td>Dollar, half</td>
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<td>030</td>
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<td>Chestnut</td>
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<td>020</td>
<td>Chestnut, horse</td>
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<td>040</td>
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<td>020</td>
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<tr>
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<td>020</td>
<td>Penny</td>
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<tr>
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<td>080</td>
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<td>050</td>
<td>Fist</td>
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<td>090</td>
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<td>060</td>
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<td>Marble</td>
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<td>010</td>
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<tr>
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<td>090</td>
<td>Egg, goose</td>
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<td>070</td>
<td>Match head</td>
<td>00.9</td>
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<td>009</td>
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<td>060</td>
<td>Egg, pigeon</td>
<td>03.0</td>
<td>030</td>
<td>Microscopic</td>
<td>00.1</td>
<td>001</td>
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<tr>
<td>Bean</td>
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<td>Egg, robin</td>
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<td>010</td>
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<tr>
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<tr>
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**Money**

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<td>Dime</td>
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**Other**

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<tr>
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**Miscellaneous Food**

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<td>Baseball</td>
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<tr>
<td>Fist</td>
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<td>090</td>
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<tr>
<td>Marble</td>
<td>01.0</td>
<td>010</td>
</tr>
<tr>
<td>Match head</td>
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<td>009</td>
</tr>
<tr>
<td>Pencil eraser</td>
<td>00.9</td>
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**Vegetables**

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<tbody>
<tr>
<td>Egg, pigeon</td>
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<td>030</td>
</tr>
<tr>
<td>Microscopic</td>
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<td>001</td>
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<td>Egg, robin</td>
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<td>1 centimeter</td>
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<tr>
<td>Lentil</td>
<td>00.9</td>
<td>009</td>
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<td>1 inch</td>
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<td>Egg</td>
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<td>009</td>
</tr>
<tr>
<td>.394 inches</td>
<td>01.0</td>
<td>010</td>
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</table>
Note: Text Documentation
In the RMCDS abstract screen, an optional text field labeled Description of Size follows the Tumor Size field. Facilities that choose to complete this field should briefly record the text from the medical record documentation used to code Tumor Size. If the Description of Size field is not completed, tumor size information should be recorded in any text field describing the site and histology. Facilities using other types of registry software should follow their vendor’s instructions for recording text.
REGIONAL NODES POSITIVE

Description
This is a required 2-character field to record the number of regional lymph nodes the pathologist examined and described as metastatic, or positive for malignancy. For numbers less than 10, enter a leading zero. Beginning with cases diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage Data Collection System (CS).

Codes
00  All regional nodes examined are negative.
01-89 1-89 regional nodes are positive. Code exact number of nodes positive.
90  90 or more regional nodes are positive.
95  Positive aspiration or core biopsy of regional lymph node(s) was performed.
97  Positive regional lymph nodes are documented, but the number is unspecified.
98  No regional nodes were examined.
99  It is unknown whether nodes are positive; not applicable; not stated in the patient record.

Example: The pathology report reads 11 out of 17 nodes examined were found to contain metastatic squamous cell carcinoma. Record 11 in the Regional Nodes Positive field.

Instructions
a. For complete information refer to the general instructions, definitions, and examples in Part 1, Section 1 of the current CS Manual and the site and histology-specific instructions in Part 2 of the current CS Manual.

b. Record the total number of regional lymph nodes removed as part of the first course of treatment, examined by the pathologist, and reported to contain cancer. The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
   - Do not record positive distant lymph nodes removed as part of the first course of treatment.
   - Do not code positive regional lymph nodes removed to establish recurrence or progression of disease.
   - Do not code nodes assessed by clinical examination only and stated to be positive.

c. Record the number positive regardless of whether the patient received preoperative treatment.

d. Since true in situ cases cannot have positive lymph nodes, the only allowable codes are 00 (negative) or 98 (not examined). Codes 01-97 and 99 are not allowed for in situ cases.

e. Use code 99 for the following primary sites and histologies:
   - Placenta
   - Brain and cerebral meninges
   - Other parts of central nervous system
   - Hodgkin and non-Hodgkin lymphoma
   - Hematopoietic, reticuloendothelial, immunoproliferative, myelodysplastic or myeloproliferative neoplasms
   - Myeloma and plasma cell disorders
   - Other and ill-defined primary sites
   - Unknown primary site.
Chapter 5  Cancer Identification  Coding Instructions

f. “Lymphatic invasion” means that tumor was found in lymph channels, but does not necessarily mean that the lymph node was invaded. It is a prognostic indicator, however, since it indicates that the tumor is present in the pathway by which it spreads.
REGIONAL NODES EXAMINED

**Description**
This is a required 2-character field to record the total number of regional lymph nodes that were examined by a pathologist. For numbers less than 10, enter a leading zero. Beginning with cases diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage System (CS).

**Codes**
- **00**  No regional lymph nodes were examined.
- **01-89** 1-89 regional lymph node(s) were examined. Code the exact number of regional lymph nodes examined.
- **90**  Ninety or more regional lymph nodes were examined.
- **95**  No regional lymph node(s) were removed but aspiration or core biopsy of regional lymph node(s) was performed.
- **96**  Regional lymph node removal was documented as a sampling and the number of lymph nodes is unknown/not stated.
- **97**  Regional lymph node removal was documented as a dissection and the number of lymph nodes is unknown/not stated.
- **98**  Regional lymph nodes were surgically removed but the number of lymph nodes unknown/not stated and not documented as sampling or dissection; nodes were examined but the number is unknown.
- **99**  It is unknown whether nodes were examined; not applicable or negative; not stated in the patient record.

**Instructions**
a. For complete information refer to the general instructions, definitions, and examples in Part 1, Section 1 of the current CS Manual and the site and histology-specific instructions in Part 2 of the current CS Manual.
b. Record the total number of **regional lymph nodes** removed as part of the **first course of treatment** and **examined by the pathologist**. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
   - Do not record **distant lymph nodes** removed as part of the first course of treatment.
   - Do not code regional lymph nodes removed to establish recurrence or progression of disease.
   - Do not code nodes assessed by clinical examination. The statement, “the neck was negative for nodes,” should be interpreted (coded) as “no nodes examined.”
c. Record the number examined regardless of whether the patient received preoperative treatment.
d. Use code 99 for the following primary sites and histologies:
   - Placenta
   - Brain and cerebral meninges
   - Other parts of central nervous system
   - Hodgkin and non-Hodgkin lymphoma
   - Hematopoietic, reticuloendothelial, immunoproliferative, myelodysplastic or myeloproliferative neoplasms
   - Myeloma and plasma cell disorders
   - Other and ill-defined primary sites
   - Unknown primary site
SUMMARY STAGE 2000
(GENERAL SUMMARY STAGE)

* Required by ACoS only for cancers diagnosed through 12/31/2003 with no AJCC staging schema.
Required by the State Registry for all cases diagnosed through 12/31/2003 and beginning with cases diagnosed 01/01/2015 and later.

Description
This is a required 1-character field for recording a code that indicates the extent of cancer spread. The only way to determine the correct Summary Stage is by referring to the SEER Summary Staging Manual, 2000. You cannot determine the correct code without using this manual. The Summary Stage must be completed on all cases diagnosed through 2003. Refer to the SEER Summary Staging Manual for complete guidelines on assigning Summary Stage to be used in this section.


Codes
0  In situ
1  Localized
2  Regional by direct extension
3  Regional to lymph nodes only
4  Regional by direct extension and to lymph nodes (combination of codes 2 and 3)
5  Regional, NOS
7  Distant metastases/systemic disease
9  Unstaged, unknown, or unspecified

Definitions and Rules
a. Summary Stage of disease is a clinical judgment of the extent of cancer spread and should include all information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer. Stage does not change as the disease progresses. Metastasis that is known to have developed after the original diagnosis was made should be excluded.

b. For all sites, the extent of disease is based on pathologic, operative, and clinical assessment. If there is a discrepancy between the pathology report and the operative report, the priority for assessing extent of disease is based on pathologic, operative, then clinical findings, respectively. Gross observations at surgery are particularly important when not all malignant tissue is removed. If no surgery is performed, use all diagnostic or radiological evidence and therapeutic procedures available in the medical record to determine the Summary Stage, if enough information is provided.

c. Autopsy reports are used in coding extent of disease by applying the same rules for inclusion and exclusion.

d. The terms used to describe tumor involvement are sometimes ambiguous. Chapter 4 lists terms that may be interpreted as tumor involvement or non-involvement.

e. There is only one correct Summary Stage for each tumor. If the State Cancer Registry receives reports from multiple hospitals for the same case and the Summary Staging doesn’t match, State Registry staff will select and save only the most appropriate Summary Stage based on the best information available.
### CODING INSTRUCTIONS

#### Cancer Identification

**Chapter 5**

<table>
<thead>
<tr>
<th>CODES</th>
<th>TERM</th>
<th>DEFINITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>In Situ</td>
<td>Not progressed through the basement membrane of the organ involved (non-invasive tumor). Only organs with an epithelium can be “in situ;” this excludes muscles, connective tissues, fat (adipose tissue), bones, cartilage, ligaments, tendons, blood cells and vessels, and lymph nodes and vessels. Used only when the pathology report demonstrates that involvement is confined to the basement membrane and the tumor is described as noninvasive, pre-invasive, noninfiltrating, intraductal, intraepithelial, or in situ. See the behavior section in this chapter for additional terms that are synonymous with “in situ.” If there is evidence of lymph node involvement of a tumor described as in situ, it would indicate that an area of invasion was missed, and it is not an in situ lesion. Be cautious regarding needle biopsy of the lung. The specimen may be from the edge of the lesion and be reported as “in situ,” when actually an invasive lesion of advanced stage is present. <strong>Coding Tips:</strong> If the fifth digit of Histology/Behavior code is /2 (in situ), Summary Stage must be coded 0 (in situ). If Summary Stage is coded 0, the behavior code must be /2.</td>
</tr>
<tr>
<td>1</td>
<td>Localized</td>
<td>Limited to the site of origin; progression through the basement membrane, but not beyond the walls of the organ involved. Includes tumors confined to the primary organ site or described as microinvasive or “early” invasion. Stage I (localized) lymphomas are included here.</td>
</tr>
<tr>
<td>2</td>
<td>Regional by direct extension</td>
<td>Tumors not confined to the organ of origin (primary site), but which extend into adjacent organs or tissues by passing through the wall of the primary organ. If the tumor spreads to a NON-contiguous organ from the primary site, it is no longer regional.</td>
</tr>
<tr>
<td>3</td>
<td>Regional to lymph nodes only</td>
<td>Tumor involvement with regional lymph nodes only. Includes lymph nodes in the area (region) of the primary tumor that contain tumor and the cancer has not spread to other organs by direct extension. Do not use evidence of palpable nodes as described in the physical examination of the patient to increase the stage of disease unless the record clearly states that in the physician’s judgment, the node is involved. Nodes described as “fixed” or “matted” are considered involved. “Mass in the mediastinum, retroperitoneum, and/or mesentery” (with no specific information as to tissue involved) is considered involvement of lymph nodes. Any unidentified lymph nodes included with the resected primary site specimen are to be considered regional, rather than distant, lymph nodes. Regional lymph nodes are not palpable for inaccessible sites such as bladder, kidney, lung, liver, and ovary. The best description concerning regional lymph nodes will be the surgeon’s evaluation at the time of exploratory surgery or definitive surgery, or x-ray and CT scans if no surgery is performed.</td>
</tr>
<tr>
<td>4</td>
<td>Regional by direct extension and to lymph nodes</td>
<td>Tumor invades adjacent organ(s) and regional lymph nodes (codes 2 and 3).</td>
</tr>
<tr>
<td>5</td>
<td>Regional, NOS</td>
<td>Regional, not other wise specified. (The stage is known to be regional, but the medical record is unclear as to whether it is through direct extension or lymph node involvement.) Stage II (regional) lymphomas are included here.</td>
</tr>
</tbody>
</table>
Chapter 5  Cancer Identification  Coding Instructions

<table>
<thead>
<tr>
<th>CODES</th>
<th>TERM</th>
<th>DEFINITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Distant</td>
<td>Cases that have (1) Direct extension beyond adjacent organs or tissues, (2) Metastases to distant lymph nodes, and/or (3) Metastases to distant site(s) via the circulatory or lymphatic system or by &quot;seeding&quot; or implantation to parts remote from the primary tumor. This category usually includes brain, liver, bone, and lung metastases. Code the following primary sites as having distant metastases/systemic disease (7): Leukemia, multiple myeloma, plasma cell myeloma, reticulendotheliosis, immunoproliferative neoplasms, myeloproliferative and myelodysplastic neoplasms, and Letterer-Siwe disease. Stage III and IV (distant) lymphomas are included here.</td>
</tr>
<tr>
<td>9</td>
<td>Unstaged</td>
<td>No information or death certificate only. Includes the following: 1) Unknown primaries (C80.9) 2) Unstaged or unspecified primaries 3) Patients with recurrent disease seen for the first time at your hospital after your reference date, unless the stage at initial diagnosis is known.</td>
</tr>
</tbody>
</table>

See additional definitions in the Glossary at the end of the Policy and Procedure Manual.

Instructions

a. To determine the Summary Stage code, using the SEER Summary Staging Manual, look up the section for the original site where the cancer started. Each such section is divided into general staging categories (localized, regional, and distant).

(1) The "Localized" category lists the layers or parts of the primary organ. If the cancer is contained within these layers, it is considered localized (code 1).

(2) The "Regional" category is divided into "Direct Extension" and "Lymph Nodes" subcategories. If the cancer has spread to any of the adjacent organs or sites listed in the Direct Extension subcategory, it is considered regional by direct extension (code 2). If the cancer has spread to the regional lymph nodes specified, it is considered regional to lymph nodes (code 3). If the cancer has spread to adjacent organs and to regional lymph nodes, use code 4, a combination of codes 2 and 3.

(3) The "Distant" category lists the most common, but not all, sites of distant spread for each primary site. If the cancer has spread to an organ that is not directly touching the original primary organ, it is considered distant by direct extension or metastasis (code 7). Positive lymph nodes that are not in the region of the original primary site are considered distant lymph nodes (Summary Stage code 7). Use the SEER Summary Staging Guide to determine if a lymph node is regional or distant. The AJCC Cancer Staging Manual (the TNM coding book) is also a good reference to use when determining Summary Stage, even if you do not actually assign TNM codes. The AJCC manual often lists lymph nodes that are considered regional (vs. distant lymph nodes) and includes illustrations that may clarify the various layers of an organ (e.g., colon).
b. In the *SEER Summary Staging Guide* 1977, the categories localized, regional by direct extension, and distant are subdivided into further categories, although these subdivisions are not used at the State Registry. The categories are not subdivided in the *SEER Summary Staging Manual* 2000. For cases diagnosed prior to January 1, 2001, the subdivisions should be coded as follows:

<table>
<thead>
<tr>
<th>CODES</th>
<th>SUMMARY STAGE</th>
<th>DESCRIPTION OF SUBDIVISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Localized</td>
<td>L1, L2, L3, LX</td>
</tr>
<tr>
<td>2</td>
<td>Regional by direct extension</td>
<td>R1, R2</td>
</tr>
<tr>
<td>7</td>
<td>Distant metastases/systemic disease</td>
<td>D1, D2</td>
</tr>
</tbody>
</table>

c. Unknown primaries (C80.9) should be coded 9 (unstaged), even if the unknown primary has been diagnosed from a metastatic site.

*Example:* A patient with an unknown primary site (C80.9) has metastases in the brain and liver. Although at least one of these sites has to be a metastatic site distant from the original primary (since brain and liver are not adjacent to each other), Summary Stage should be coded 9 (unknown) to be consistent with ACoS rules in the *FORDS*. If you want to document these metastatic sites, record them in the text item, *Substantiate Stage*.

d. Kaposi Sarcoma

(1) For cases diagnosed January 1, 2001 through December 31, 2003, use the Kaposi sarcoma staging scheme found in the *SEER Summary Staging Manual*, 2000.

(2) For cases diagnosed prior to 2001 (according to advice from NAACCR), since there is no disease-specific staging scheme for Kaposi sarcoma in the *SEER Summary Staging Guide*, 1977, registries may use the scheme appropriate for the primary site. If the primary site is skin, use the "skin other than melanoma" scheme. Although this is not ideal, it does allow grouping of cases based on how extensive the Kaposi sarcoma was at diagnosis.

*Example:* A single lesion of the skin with no lymph node or other involvement would be Summary Stage 1 (local). A patient with either a lesion on both the right and left legs, or widespread skin lesions, would be Summary Stage 7 (distant).

e. Malignant Melanoma

Clark’s Level and Breslow’s Depth of Invasion are other staging systems for malignant melanoma. Use the following conversion when the medical record reports only Clark’s Level or Breslow’s Depth of Invasion. (Use only for melanoma of skin, vulva, penis, and scrotum.)

<table>
<thead>
<tr>
<th>Summary Stage Code</th>
<th>Summary Stage</th>
<th>Clark’s Level</th>
<th>Breslow’s Depth of Invasion</th>
<th>Extent of Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>In situ</td>
<td>I</td>
<td>No invasion</td>
<td>Intraepidermal</td>
</tr>
<tr>
<td>1</td>
<td>Localized</td>
<td>II</td>
<td>≤ 0.75 mm</td>
<td>Invasion of papillary dermis</td>
</tr>
<tr>
<td>1</td>
<td>Localized</td>
<td>III</td>
<td>&gt; 0.75 - ≤ 1.50 mm</td>
<td>Invasion of papillary-reticular dermal interface</td>
</tr>
<tr>
<td>1</td>
<td>Localized</td>
<td>IV</td>
<td>&gt; 1.50 - ≤ 4.0 mm</td>
<td>Invasion of reticular dermis</td>
</tr>
<tr>
<td>2*</td>
<td>Regional extension*</td>
<td>V</td>
<td>&gt; 4.0 mm</td>
<td>Invasion subcutaneous tissue (through entire dermis)</td>
</tr>
</tbody>
</table>

*Summary stage 1, Localized, in *Summary Stage* 1977 for cases diagnosed prior to 2001.
f. Lymphomas

The staging system for lymphomas is provided below. It is based on the 1971 Ann Arbor classification and should be used for anatomic staging of Hodgkin and Non-Hodgkin lymphomas. Appendix E-1 has some tips for coding lymphomas and leukemias.

Note: The only valid Summary Stage codes for lymphomas are codes 1, 5, 7, or 9.

Example: A Stage II lymphoma is coded as Summary Stage 5, not 2.

<table>
<thead>
<tr>
<th>Summary Stage Code</th>
<th>Summary Stage</th>
<th>AJCC Staging</th>
<th>Extent of Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Localized</td>
<td>I</td>
<td>Involvement of a single lymph node region.</td>
</tr>
<tr>
<td>1</td>
<td>Localized</td>
<td>I_E</td>
<td>Localized involvement of a single extralymphatic organ or site.</td>
</tr>
<tr>
<td>5</td>
<td>Regional</td>
<td>II</td>
<td>Involvement of two or more lymph node regions on the same side of the diaphragm.</td>
</tr>
<tr>
<td>5</td>
<td>Regional</td>
<td>II_E</td>
<td>Localized involvement of a single associated extralymphatic organ or site and its regional nodes with or without other lymph node regions on the same side of the diaphragm. Note: The number of lymph node regions involved may be indicated by a subscript (e.g., II3).</td>
</tr>
<tr>
<td>7</td>
<td>Distant</td>
<td>III</td>
<td>Involvement of lymph node regions on both sides of the diaphragm.</td>
</tr>
<tr>
<td>7</td>
<td>Distant</td>
<td>III_E</td>
<td>Involvement of lymph node regions on both sides of the diaphragm that may also be accompanied by localized involvement of an extralymphatic organ or site.</td>
</tr>
<tr>
<td>7</td>
<td>Distant</td>
<td>III_S</td>
<td>Involvement of lymph node regions on both sides of the diaphragm that may also be accompanied by involvement of the spleen.</td>
</tr>
<tr>
<td>7</td>
<td>Distant</td>
<td>III_E+S</td>
<td>Involvement of lymph node regions on both sides of the diaphragm that may also be accompanied by localized involvement of an extralymphatic organ or site and involvement of the spleen.</td>
</tr>
<tr>
<td>7</td>
<td>Distant</td>
<td>IV</td>
<td>Disseminated (multifocal) involvement of one or more extralymphatic organs with or without associated lymph node involvement, or isolated extralymphatic organ involvement with distant (non-regional) nodal involvement.</td>
</tr>
<tr>
<td>9</td>
<td>Unspecified</td>
<td>99</td>
<td>Unstaged, unknown, unspecified.</td>
</tr>
</tbody>
</table>
OVERVIEW OF COLLABORATIVE STAGE (CS) DATA COLLECTION SYSTEM

The complete instructions and site-histology defined codes are available in the current version of the Collaborative Stage Data Collection System Coding Instructions (CS Manual). Part I provides general instructions and the instructions and codes for generic (non site-specific) items. Part II contains the site-specific instructions and codes. The CS Manual can be downloaded at: http://cancerstaging.org/cstage/manuals/index.html

Collaborative Stage was designed for registrar use.

- It relieves registrars from the necessity of staging a single case according to more than one staging system.
- It avoids the problems that can occur when it is necessary to consider multiple pieces of information simultaneously to assign a single code.
- The derived stage codes are ideally suited for data analysis because of the consistency that can be obtained with objectively recorded, identically processed data items.

Effective Date
Collaborative Stage (CS) is to be used for cases diagnosed on or after January 1, 2004. It is not to be used for cases diagnosed prior to that date.

How Collaborative Stage Works
For Collaborative Stage, registrars code discrete pieces of information once and the CS computer algorithm derives the values for AJCC T, N, M, and Stage Group (for cases that meet TNM criteria); Summary Stage 1977; and Summary Stage 2000.

The CS data items listed below are coded by the registrar.

- CS Tumor Size
- CS Extension
- CS Tumor Size/Ext Eval
- CS Lymph Nodes
- CS Reg Lymph Nodes Eval
- Regional Lymph Nodes Examined
- Regional Lymph Nodes Positive
- CS Mets at DX
- CS Mets Eval
- CS Mets at DX – Bone
- CS Mets at DX – Brain
- CS Mets at DX – Liver
- CS Mets at DX – Lung
- CS Site-Specific Factors 1-25, for some sites

The CS Algorithm produces the output items listed below. The derived AJCC items are separate from the physician-coded items, and the derived Summary Stage items are separate from the manually coded items collected by the CoC in the past. The derived items must never be manually altered.

- Derived AJCC-6 T
- Derived AJCC-6 T Descriptor
- Derived AJCC-6 N
- Derived AJCC-6 N Descriptor
- Derived AJCC-6 M
- Derived AJCC-6 M Descriptor
- Derived AJCC-6 Stage Group
- Derived AJCC-7 T
- Derived AJCC-7 T Descriptor
- Derived AJCC-7 N
Timing of Data Collection

The data collected in the Collaborative Stage System are limited to information gathered through completion of surgery(ies) in the first course of treatment, OR all information available within four months of the date of diagnosis in the absence of disease progression, whichever is longer.

Disease progression is defined as further direct extension or distant metastasis known to have developed after the diagnosis was established. Information about tumor extension, lymph node involvement, or distant metastasis obtained after disease progression is documented should be excluded from the CS coding.

Coding CS Items

a. Code the CS items for every analytic case. Read the medical record carefully to identify the primary site and histology and determine their ICD-O-3 codes. While you are reviewing the record, make mental notes about the tissues and lymph nodes that are involved by tumor.

b. The abstractor enters the primary site and histology codes into the cancer abstracting software. A schema selection algorithm determines which schema is appropriate to each combination of primary site and histology, and if applicable, an additional schema discriminator variable.

c. Begin assigning codes for the Collaborative Stage data items. Be sure to read the notes and follow the site/histology-specific instructions at the beginning of each item. Some schemas may have site-specific factors associated with extension, lymph nodes, or metastasis. Keep these in mind as you assign the codes.

- Code the tumor size in the CS Tumor Size item.
- Code the extent of direct tumor spread in the CS Extension item.
- Code how the greatest tumor size and spread was determined in the CS Tumor Size/Ext Eval item.
- Code whether regional lymph nodes are involved in the CS Lymph Nodes items.
- Code how the farthest regional lymph node spread was determined in the CS Reg Node Eval item.
- Code the number of positive regional lymph nodes from the pathology report in the Regional Nodes Positive item.
- Code the number of regional lymph nodes examined by the pathologist in the Regional Nodes Examined item.
- Code the farthest distant metastasis (including distant lymph nodes) in the CS Mets at Dx item.
- Code how the distant metastasis was determined in the CS Mets Eval item.
- Code whether there are metastases in the bone, brain, lung and/or liver in the appropriate CS Mets at DX – Bone, Brain, Liver, and Lung fields.
- Code the CS Site-Specific Factors as required or applicable.

d. When all the CS codes are completed, the computer can convert them into the T, N, M, Stage Group, Summary Stage 1977, and Summary Stage 2000. Depending on your software system, the final stage information may be derived now, when the case is saved, or prior to exiting the case. When the computer derives the final stage information, the program will check the histology code and other coded information to determine whether T, N, M and Stage Group will be generated for the case. If the histology code is on the computer’s exceptions list for that site, the T, N, M, and Stage Group will be reported as “Not applicable.” Summary Stage is generated for every case.
Site-Specific Factors
Some schemas require additional information to derive stage or that is considered to be of clinical or prognostic importance. *CS Site-Specific Factors 1-25* are designed to collect that information and are included in every schema where they are needed.
**CS TUMOR SIZE**

**Item Length:** 3  
**Data Type:** Numeric  
**ACoS:** Required*  
**State Registry:** Required*  

*For cases diagnosed 01/01/2004 and later.

**Description**  
This item records the largest dimension or diameter of the **primary tumor**, and is always recorded in millimeters.

**Rationale**  
Tumor size at diagnosis is an independent prognostic indicator for many tumors and it is used by Collaborative Stage to derive some AJCC “T” codes.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>Indicates no mass or no tumor found; e.g., when a tumor of a stated primary site is not found, but the tumor has metastasized.</td>
</tr>
<tr>
<td>001-988</td>
<td>Exact size in millimeters</td>
</tr>
<tr>
<td>989</td>
<td>989 millimeters or larger</td>
</tr>
<tr>
<td>990</td>
<td>Microscopic focus or foci only and no size of focus is given</td>
</tr>
<tr>
<td>991</td>
<td>Described as less than 1 cm</td>
</tr>
<tr>
<td>992</td>
<td>Described as less than 2 cm, or greater that 1 cm, or between 1 cm and 2 cm</td>
</tr>
<tr>
<td>993</td>
<td>Described as less than 3 cm, or greater that 2 cm, or between 2 cm and 3 cm</td>
</tr>
<tr>
<td>994</td>
<td>Described as less than 4 cm, or greater that 3 cm, or between 3 cm and 4 cm</td>
</tr>
<tr>
<td>995</td>
<td>Described as less than 5 cm, or greater that 4 cm, or between 4 cm and 5 cm</td>
</tr>
<tr>
<td>996-998</td>
<td>Site-Specific Codes Where Needed</td>
</tr>
<tr>
<td>999</td>
<td>Unknown; size not stated; not stated in patient record</td>
</tr>
</tbody>
</table>

**Instructions**  
Refer to the general instructions in Part 1, Section 1 of the current *CS Manual* and the site and histology-specific instructions in Part 2 of the current *CS Manual.*
CS EXTENSION

Item Length: 3
Data Type: Numeric
ACoS: Required*
State Registry: Required*

*For cases diagnosed 01/01/2004 and later.

Description
This item identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in CS Extension.

Rationale
Tumor extension at diagnosis is a prognostic indicator used by Collaborative Stage to derive some AJCC “T” codes and some SEER Summary Stage codes.

Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>TNM7 Map</th>
<th>TNM6 Map</th>
<th>SS77 Map</th>
<th>SS2000 Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>In situ; non-invasive</td>
<td>Tis</td>
<td>Tis</td>
<td>IS</td>
<td>IS</td>
</tr>
<tr>
<td></td>
<td><strong>Site/Histology-Specific Codes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>800</td>
<td>Further contiguous extension</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>950</td>
<td>No evidence of primary tumor</td>
<td>T0</td>
<td>T0</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>999</td>
<td>Unknown extension; primary tumor cannot be assessed; not documented in patient record</td>
<td>TX</td>
<td>TX</td>
<td>U</td>
<td>U</td>
</tr>
</tbody>
</table>

Instructions
Refer to the general instructions in Part 1, Section 1 of the current CS Manual and the site and histology-specific instructions in Part 2 of the current CS Manual.
**CS TUMOR SIZE/EXT EVAL**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Staging Basis</th>
</tr>
</thead>
</table>
| 0    | Does not meet criteria for AJCC pathologic staging:  
        No surgical resection done. Evaluation based on physical examination, imaging 
        examination, or other non-invasive clinical evidence. No autopsy evidence used. | c             |
| 1    | Does not meet criteria for AJCC pathologic staging:  
        No surgical resection done. Evaluation based on endoscopic examination, diagnostic 
        biopsy (including fine needle aspiration biopsy), or other invasive techniques, including 
        surgical observation without biopsy. No autopsy evidence used. | c             |
| 2    | Meets criteria for AJCC pathologic staging:  
        No surgical resection done, but evidence derived from autopsy (tumor was suspected or 
        diagnosed prior to autopsy). | p             |
| 3    | Either meets criteria for AJCC pathologic staging:  
        Surgical resection performed without pre-surgical systemic treatment or radiation; OR 
        surgical resection performed, unknown if pre-surgical systemic treatment or radiation 
        performed  
        And Evaluation based on evidence acquired before treatment, supplemented or modified 
        by the additional evidence acquired during and from surgery, particularly from pathologic 
        examination of the resected specimen. 
        No surgical resection done. Evaluation based on positive biopsy of highest T 
        classification. | p             |
| 5    | Does not meet criteria for AJCC yp-pathologic (yp) staging:  
        Surgical resection performed after neoadjuvant therapy and tumor size/extension based 
        on clinical evidence, unless the pathologic evidence at surgery (after neoadjuvant) is 
        more extensive (see code 6). | c             |
| 6    | Meets criteria for AJCC yp-pathologic (yp) staging:  
        Surgical resection performed after neoadjuvant therapy and tumor size/extension based 
        on pathologic evidence because pathologic evidence at surgery is more extensive than 
        clinical evidence before treatment. | yp            |
| 8    | Meets criteria for autopsy (a) staging:  
        Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy). | a             |
| 9    | Unknown if surgical resection done.  
        Not assessed; cannot be assessed. 
        Unknown if assessed. 
        Not documented in patient record. 
        For sites with no AJCC schema: not applicable. | c             |

*Note:* The codes in this common table do not apply to prostate. Refer to the current *CS Manual.*

**Instructions**

Refer to the general instructions in Part 1, Section 1 of the current *CS Manual* and the site and histology-specific instructions in Part 2 of the current *CS Manual.*
**CS LYMPH NODES**

Item Length: 3  
Data Type: Numeric  
ACoS: Required*  
State Registry: Required*  

*For cases diagnosed 01/01/2004 and later.

**Description**  
This item identifies the regional lymph nodes involved with cancer at the time of diagnosis.

**Rationale**  
The involvement of specific regional lymph nodes is a prognostic indicator used by Collaborative Stage to derive some AJCC “N” codes and SEER Summary Stage codes.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>TNM7 Map</th>
<th>TNM6 Map</th>
<th>SS77 Map</th>
<th>SS2000 Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>None; no regional lymph node involvement</td>
<td>N0</td>
<td>N0</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>999</td>
<td>Unknown; regional lymph nodes not stated; regional lymph nodes cannot be assessed; not documented in patient record</td>
<td>NX</td>
<td>NX</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>988</td>
<td>Not applicable; Information not collected for this schema</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Instructions**  
Refer to the general instructions in Part 1, Section 1 of the current *CS Manual* and the site and histology-specific instructions in Part 2 of the current *CS Manual*. 
**CS REG NODES EVAL**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Staging Basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Does not meet criteria for AJCC pathologic staging: No regional lymph nodes removed for examination. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.</td>
<td>c</td>
</tr>
<tr>
<td>1</td>
<td>Does not meet criteria for AJCC pathologic staging based on at least one of the following criteria: No regional lymph nodes removed for examination. Evaluation based on endoscopic examination, or other invasive techniques, including surgical observation without biopsy. No autopsy evidence used. OR Fine needle aspiration, incisional or core needle biopsy, or excisional biopsy of regional lymph nodes or sentinel nodes as part of the diagnostic workup without removal of the primary site adequate for pathologic T classification (treatment).</td>
<td>c</td>
</tr>
<tr>
<td>2</td>
<td>Meets criteria for AJCC pathologic staging: No regional lymph nodes removed for examination, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).</td>
<td>p</td>
</tr>
<tr>
<td>3</td>
<td>Meets at least one of the following criteria for AJCC pathologic staging. Any microscopic assessment of regional nodes (including FNA, incisional or core needle biopsy, excisional biopsy, sentinel node biopsy or node resection) with removal of the primary site adequate for pathologic T classification (treatment) or biopsy assessment of the highest T category. OR Any microscopic assessment of a regional node in the highest N category, regardless of the T category information.</td>
<td>p</td>
</tr>
<tr>
<td>5</td>
<td>Does not meet criteria for AJCC yp-pathologic (yp) staging. Regional lymph nodes removed for examination after neoadjuvant therapy and lymph node evaluation based on clinical evidence, unless the pathologic evidence at surgery (after neoadjuvant treatment) is more extensive (see code 6).</td>
<td>c</td>
</tr>
<tr>
<td>6</td>
<td>Meets criteria for AJCC yp-pathologic (yp) staging. Regional lymph nodes removed for examination after neoadjuvant therapy and lymph node evaluation based on pathologic evidence, because the pathologic evidence at surgery is more extensive than clinical evidence before treatment.</td>
<td>y</td>
</tr>
<tr>
<td>8</td>
<td>Meets criteria for AJCC autopsy (a) staging. Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy).</td>
<td>a</td>
</tr>
<tr>
<td>9</td>
<td>Unknown if lymph nodes removed for examination. Not assessed; cannot be assessed. Unknown if assessed. Not documented in patient record. For sites that have no AJCC staging: not applicable.</td>
<td>c</td>
</tr>
</tbody>
</table>

*For cases diagnosed 01/01/2011 and later.*

**Description**

This item records how the code for **CS Lymph Nodes** was determined, based on the diagnostic methods employed.

**Rationale**

This data item is used primarily to derive the staging basis for the N category in the TNM system.

**Codes**

- **Code**: Numeric
- **Data Type**: Numeric
- **ACoS**: Required
- **State Registry**: Required*

*For cases diagnosed 01/01/2011 and later.*
Instructions
Refer to the general instructions in Part 1, Section 1 of the current *CS Manual* and the site and histology-specific instructions in Part 2 of the current *CS Manual*. 
Chapter 5  
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CS METS AT DX

Item Length: 2  
Data Type: Numeric  
ACoS: Required*  
State Registry: Required*  

*For cases diagnosed 01/01/2004 and later.

Description
This item identifies the distant site(s) of metastatic involvement at time of diagnosis. This data item represents distant metastases (The AJCC “M” component or distant stage in Summary Staging) at the time of diagnosis. In other words, when the patient was diagnosed, tumor had already spread indirectly (through vascular or lymph channels) to a site remote from the primary tumor.

The structure of this data item is based on the “M” category of AJCC. In some schemas, there may be additional items in CS Extension or CS Lymph Nodes that map to distant stage in Summary Staging (1977 and/or 2000) and there may be some items in CS Mets at Dx that map to regional stage in Summary Staging. Regardless of where such items are recorded, the staging algorithms will properly account for the information.

Rationale
The presence of metastatic disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Stage to derive AJCC “M” codes and SEER Summary Stage codes.

Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>TNM7 Map</th>
<th>TNM6 Map</th>
<th>SS77 Map</th>
<th>SS2000 Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No distant metastasis</td>
<td>M0</td>
<td>M0</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>10</td>
<td>Distant lymph nodes(s)</td>
<td>M1</td>
<td>M1</td>
<td>D</td>
<td>D</td>
</tr>
</tbody>
</table>

Site/Histology-Specific Codes Where Needed

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>TNM7 Map</th>
<th>TNM6 Map</th>
<th>SS77 Map</th>
<th>SS2000 Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>Distant metastasis except code 10 Carcinomatosis</td>
<td>M1</td>
<td>M1</td>
<td>D</td>
<td>D</td>
</tr>
</tbody>
</table>

Site/Histology-Specific Codes Where Needed

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>TNM7 Map</th>
<th>TNM6 Map</th>
<th>SS77 Map</th>
<th>SS2000 Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>(40) + (10)</td>
<td>M1</td>
<td>M1</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>60</td>
<td>Distant metastasis, NOS</td>
<td>M1</td>
<td>M1</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>Stated as M1 with no other information on distant metastasis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>TNM7 Map</th>
<th>TNM6 Map</th>
<th>SS77 Map</th>
<th>SS2000 Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>99</td>
<td>Unknown; distant metastasis not stated; distant metastasis cannot be assessed; not documented in patient record</td>
<td>M0</td>
<td>MX</td>
<td>U</td>
<td>U</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>TNM7 Map</th>
<th>TNM6 Map</th>
<th>SS77 Map</th>
<th>SS2000 Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>98</td>
<td>Not applicable for this schema</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Instructions
Refer to the general instructions in Part 1, Section 1 of the current CS Manual and the site and histology-specific instructions in Part 2 of the current CS Manual.
**CS METS EVAL**

**Description**
This item records how the code for *CS Mets at Dx* was determined, based on the diagnostic methods employed.

**Rationale**
This data item is used primarily to derive the staging basis for the M category in the TNM system.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Staging Basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Does not meet criteria for AJCC pathologic staging of distant metastasis: Evaluation of distant metastasis based on physical examination, imaging examination, and/or other non-invasive clinical evidence. No pathologic examination of metastatic tissue performed or pathologic examination was negative.</td>
<td>c</td>
</tr>
<tr>
<td>1</td>
<td>Does not meet criteria for AJCC pathologic staging of distant metastasis: Evaluation of distant metastasis based on endoscopic examination or other invasive technique, including surgical observation without biopsy. No pathologic examination of metastatic tissue performed or pathologic examination was negative.</td>
<td>c</td>
</tr>
<tr>
<td>2</td>
<td>Meets criteria for AJCC pathologic staging of distant metastasis: No pathologic examination of metastatic tissue done prior to death, but positive metastatic evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).</td>
<td>p</td>
</tr>
<tr>
<td>3</td>
<td>Meets criteria for AJCC pathologic staging of distant metastasis: Specimen from metastatic site microscopically positive without pre-surgical systemic treatment or radiation; OR specimen from metastatic site microscopically positive, unknown if pre-surgical systemic treatment or radiation performed; OR specimen from metastatic site microscopically positive prior to neoadjuvant treatment.</td>
<td>p</td>
</tr>
<tr>
<td>5</td>
<td>Does not meet criteria for AJCC yp-pathologic (yp) staging of distant metastasis: Specimen from metastatic site microscopically positive with pre-surgical systemic treatment or radiation, but metastasis based on clinical evidence.</td>
<td>c</td>
</tr>
<tr>
<td>6</td>
<td>Meets criteria for AJCC yp-pathologic (yp) staging of distant metastasis: Specimen from metastatic site microscopically positive with pre-surgical systemic treatment or radiation, but metastasis based on pathologic evidence.</td>
<td>y</td>
</tr>
<tr>
<td>8</td>
<td>Meets criteria for AJCC autopsy (a) staging of distant metastasis: Evidence from autopsy based on examination of positive metastatic tissue and tumor was unsuspected or undiagnosed prior to autopsy.</td>
<td>a</td>
</tr>
<tr>
<td>9</td>
<td>Not assessed; cannot be assessed. Unknown if assessed. Not documented in patient record. For sites that have no AJCC staging: not applicable.</td>
<td>c</td>
</tr>
</tbody>
</table>

**Instructions**
Refer to the general instructions in Part 1, Section 1 of the current *CS Manual* and the site and histology-specific instructions in Part 2 of the current *CS Manual.*

*For cases diagnosed 01/01/2011 and later.
**CS METS AT DX-BONE**

*For cases diagnosed 01/01/2010 and later.*

**Description**
This item identifies the presence of distant metastatic involvement of bone at the time of diagnosis.

**Rationale**
The presence of metastatic bone disease at diagnosis is an independent prognostic indicator.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None; no bone metastases</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Not applicable (for all schemas where CS Mets at Dx is coded as 98)</td>
</tr>
<tr>
<td>9</td>
<td>Unknown whether bone is involved metastatic site</td>
</tr>
<tr>
<td></td>
<td>Not documented in patient record</td>
</tr>
</tbody>
</table>

**Instructions**
Refer to the general instructions in Part 1, Section 1 of the current *CS Manual* and the site and histology-specific instructions in Part 2 of the current *CS Manual.*
**CS METS AT DX-BRAIN**

**Description**
This item identifies the presence of distant metastatic involvement of brain at the time of diagnosis.

**Rationale**
The presence of metastatic brain disease at diagnosis is an independent prognostic indicator.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None; no brain metastases</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Not applicable (for all schemas where CS Mets at Dx is coded as 98)</td>
</tr>
<tr>
<td>9</td>
<td>Unknown whether brain is involved metastatic site</td>
</tr>
<tr>
<td></td>
<td>Not documented in patient record</td>
</tr>
</tbody>
</table>

**Instructions**
Refer to the general instructions in Part 1, Section 1 of the current *CS Manual* and the site and histology-specific instructions in Part 2 of the current *CS Manual.*
**Chapter 5  Cancer Identification  Coding Instructions**

**CS METS AT DX-LIVER**

*For cases diagnosed 01/01/2010 and later.*

**Description**

This item identifies the presence of distant metastatic involvement of liver at the time of diagnosis.

**Rationale**

The presence of metastatic liver disease at diagnosis is an independent prognostic indicator.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None; no liver metastases</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Not applicable (for all schemas where CS Mets at Dx is coded as 98)</td>
</tr>
<tr>
<td>9</td>
<td>Unknown whether liver is involved metastatic site</td>
</tr>
<tr>
<td></td>
<td>Not documented in patient record</td>
</tr>
</tbody>
</table>

**Instructions**

Refer to the general instructions in Part 1, Section 1 of the current *CS Manual* and the site and histology-specific instructions in Part 2 of the current *CS Manual.*
**Coding Instructions**  
**Cancer Identification**  
**Chapter 5**

**CS METS AT DX-LUNG**

*For cases diagnosed 01/01/2010 and later.*

**Description**
This item identifies the presence of distant metastatic involvement of lung at the time of diagnosis.

**Rationale**
The presence of metastatic lung disease at diagnosis is an independent prognostic indicator.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None; no lung metastases</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Not applicable (for all schemas where CS Mets at Dx is coded as 98)</td>
</tr>
</tbody>
</table>
| 9    | Unknown whether lung is involved metastatic site  
Not documented in patient record |

**Instructions**
Refer to the general instructions in Part 1, Section 1 of the current CS Manual and the site and histology-specific instructions in Part 2 of the current CS Manual.
### Description
This item identifies information required to derive stage or considered to be of clinical or prognostic importance.

### Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive AJCC TNM and/or SEER Summary Stage codes for specified site-histology schemas.

### Instructions
a. Refer to site/histology-specific instructions and codes in the current version of the *CS Manual*.

b. The State Registry requires *Site-Specific Factor 1* to be coded for the following primary sites/histologies diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>LipUpper</td>
<td>C00.0, C00.3</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>LipLower</td>
<td>C00.1, C00.4, C00.6</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>LipOther</td>
<td>C00.2, C00.5, C00.8, C00.9</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>TongueBase</td>
<td>C01.9, C02.4</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>TongueAnterior</td>
<td>C02.0-C02.3, C02.8, C02.9</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>GumUpper</td>
<td>C03.0</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>GumLower</td>
<td>C03.1, C06.2</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>GumOther</td>
<td>C03.9</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>FloorMouth</td>
<td>C04.0-C04.1, C04.8, C04.9</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>PalateHard</td>
<td>C05.0</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>PalateSoft</td>
<td>C05.1, C05.2</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>MouthOther</td>
<td>C05.8, C05.9, C06.8, C06.9</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>BuccalMucosa</td>
<td>C06.0, C06.1</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>ParotidGland</td>
<td>C07.9</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>Submandibular Gland</td>
<td>C08.0</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>SalivaryGlandOther</td>
<td>C08.1, C08.8, C08.9</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>Oropharynx</td>
<td>C09.0, C09.1, C09.8, C09.9, C10.0, C10.2-C10.4, C10.8, C10.9</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>EpiglottisAnterior</td>
<td>C10.1</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>Nasopharynx (includes pharyngeal tonsil)</td>
<td>C11.0-C11.3, C11.8, C11.9</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>Hypopharynx</td>
<td>C12.9, C13.0-C13.2, C13.8, C13.9</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>NasalCavity</td>
<td>C30.0</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>SinusMaxillary</td>
<td>C31.0</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>SinusEthmoid</td>
<td>C31.1</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>LarynxGlottic</td>
<td>C32.0</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>LarynxSupraglottic</td>
<td>C32.1</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>LarynxSubglottic</td>
<td>C32.2</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>LarynxOther</td>
<td>C32.3, C32.8, C32.9</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>Esophagus</td>
<td>C15.0-5,8,9</td>
<td>Clinical Assessment of Regional Lymph Nodes</td>
</tr>
<tr>
<td>EsophagusGE Junction</td>
<td>C16.0-2</td>
<td>Clinical Assessment of Regional Lymph Nodes</td>
</tr>
<tr>
<td>CS Schema</td>
<td>Sites</td>
<td>Site-Specific Factor 1</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Stomach</td>
<td>C16.1-6,8,9</td>
<td>Clinical Assessment of Regional Lymph Nodes</td>
</tr>
<tr>
<td>NETStomach</td>
<td>C16.0-6,8,9</td>
<td>Clinical Assessment of Regional Lymph Nodes</td>
</tr>
<tr>
<td>Lung</td>
<td>C34.0-3,8,9</td>
<td>Separate Tumor Nodules/Ipsilateral Lung</td>
</tr>
<tr>
<td>Pleura</td>
<td>C38.4</td>
<td>Pleural Effusion</td>
</tr>
<tr>
<td>MelanomaSkin</td>
<td>C44.0-9; C51.0-2,8,9; C60.0-2,8,9; C63.2</td>
<td>Measured Thickness (Depth), Breslow Measurement</td>
</tr>
<tr>
<td>SoftTissue</td>
<td>C47.0-6,8,9; C49.0-6,8,9</td>
<td>Grade for Sarcomas</td>
</tr>
<tr>
<td>Retroperitoneum</td>
<td>C48.0</td>
<td>Grade for Sarcomas</td>
</tr>
<tr>
<td>Peritoneum</td>
<td>C48.1-2, 8</td>
<td>Grade for Sarcomas</td>
</tr>
<tr>
<td>Breast</td>
<td>C50.0-6,8,9</td>
<td>Estrogen Receptor (ER) Assay</td>
</tr>
<tr>
<td>Placenta</td>
<td>C58.9</td>
<td>Prognostic Scoring Index</td>
</tr>
<tr>
<td>Prostate</td>
<td>C61.9</td>
<td>Prostate Specific Antigen (PSA) Lab Value</td>
</tr>
<tr>
<td>Retinoblastoma</td>
<td>C69.0-5,8,9</td>
<td>Extension Evaluated at Enucleation</td>
</tr>
<tr>
<td>Conjunctiva</td>
<td>C69.0</td>
<td>Tumor Size</td>
</tr>
<tr>
<td>Melanoma Conjunctiva</td>
<td>C69.0</td>
<td>Measured Thickness (Depth)</td>
</tr>
<tr>
<td>Brain</td>
<td>C70.0; C71.0-9</td>
<td>WHO Grade Classification</td>
</tr>
<tr>
<td>CNSOther</td>
<td>C70.1; C72.0-5,8,9</td>
<td>WHO Grade Classification</td>
</tr>
<tr>
<td>IntracranialGland</td>
<td>C75.1-3</td>
<td>WHO Grade Classification</td>
</tr>
<tr>
<td>Mycosis Fungoides</td>
<td>C44.0-9; C51.0-2,8,9; C60.0-2,8,9; C63.2</td>
<td>Peripheral Blood Involvement</td>
</tr>
</tbody>
</table>
CS SITE-SPECIFIC FACTOR 2

**Item Length:** 3  
**Data Type:** Numeric  
**ACoS:** Required  
**State Registry:** Required*

*For cases diagnosed 01/01/2004 and later.

**Description**  
This item identifies information required to derive stage or considered to be of clinical or prognostic importance.

**Rationale**  
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive AJCC TNM and/or SEER Summary Stage codes for specified site-histology schemas.

**Instructions**  

a. Refer to site/histology-specific instructions and codes in the current version of the CS Manual.

b. The State Registry requires Site-Specific Factor 2 to be coded for the following primary sites/histologies diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon</td>
<td>C18.0,2-9</td>
<td>Clinical Assessment of Regional Lymph Nodes</td>
</tr>
<tr>
<td>NETColon</td>
<td>C18.0,2-9</td>
<td>Clinical Assessment of Regional Lymph Nodes</td>
</tr>
<tr>
<td>Appendix</td>
<td>C18.1</td>
<td>Clinical Assessment of Regional Lymph Nodes</td>
</tr>
<tr>
<td>CarcinoidAppendix</td>
<td>C18.1</td>
<td>Clinical Assessment of Regional Lymph Nodes</td>
</tr>
<tr>
<td>Rectum</td>
<td>C19.9, C20.9</td>
<td>Clinical Assessment of Regional Lymph Nodes</td>
</tr>
<tr>
<td>NETRectum</td>
<td>C19.9, C20.9</td>
<td>Clinical Assessment of Regional Lymph Nodes</td>
</tr>
<tr>
<td>Small Intestine</td>
<td>C17.0-3,8,9</td>
<td>Clinical Assessment of Regional Lymph Nodes</td>
</tr>
<tr>
<td>MelanomaSkin</td>
<td>C44.0-9; C51.0-2,8,9; C60.0-2,8,9; C63.2</td>
<td>Ulceration</td>
</tr>
<tr>
<td>Breast</td>
<td>C50.0-6,8,9</td>
<td>Progesterone Receptor (PR) Assay</td>
</tr>
<tr>
<td>Corpus Adenosarcoma</td>
<td>C54.0-3,8,9; C55.9</td>
<td>Peritoneal Cytology</td>
</tr>
<tr>
<td>CorpusCarcinoma</td>
<td>C54.0-3,8,9; C55.9</td>
<td>Peritoneal Cytology</td>
</tr>
<tr>
<td>CorpusSarcoma</td>
<td>C54.0-3,8,9; C55.9</td>
<td>Peritoneal Cytology</td>
</tr>
<tr>
<td>Bladder</td>
<td>C67.0-9</td>
<td>Size of Metastasis in Lymph Nodes</td>
</tr>
<tr>
<td>Lymphoma OcularAdnexa</td>
<td>C44.1; C69.0,5,6</td>
<td>Systemic Symptoms at Diagnosis</td>
</tr>
<tr>
<td>Melanoma Conjunctiva</td>
<td>C69.0</td>
<td>Quadrants</td>
</tr>
<tr>
<td>MelanomaChoroid</td>
<td>C69.3</td>
<td>Measured Basal Diameter</td>
</tr>
<tr>
<td>MelanomaCiliary Body</td>
<td>C69.4</td>
<td>Measured Basal Diameter</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>C00.00-C68.9; C70.0-C80.9</td>
<td>Systemic Symptoms at Diagnosis</td>
</tr>
</tbody>
</table>
**Coding Instructions**

**Cancer Identification**

**Chapter 5**

**CS SITE-SPECIFIC FACTOR 3**

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>MelanomaSkin</td>
<td>C44.0-9; C51.0-2,8,9; C60.0-2,8,9; C63.2</td>
<td>Clinical Status of Lymph Node Mets</td>
</tr>
<tr>
<td>MerkelCellSkin</td>
<td>C44.0,2-9</td>
<td>Clinical Status of Lymph Node Mets</td>
</tr>
<tr>
<td>MerkelCellVulva</td>
<td>C51.0-2,8,9</td>
<td>Clinical Status of Lymph Node Mets</td>
</tr>
<tr>
<td>MerkelCellPenis</td>
<td>C60.0-2,8,9</td>
<td>Clinical Status of Lymph Node Mets</td>
</tr>
<tr>
<td>MerkelCellScrotum</td>
<td>C63.2</td>
<td>Clinical Status of Lymph Node Mets</td>
</tr>
<tr>
<td>Breast</td>
<td>C50.0-6,8,9</td>
<td>Number of Positive Ipsilateral Level I-II Axillary Lymph Nodes</td>
</tr>
<tr>
<td>Prostate</td>
<td>C61.9</td>
<td>CS Extension - Pathologic Extension</td>
</tr>
<tr>
<td>MelanomaChoroid</td>
<td>C69.3</td>
<td>Measured Thickness (Depth)</td>
</tr>
<tr>
<td>MelanomaCiliary Body</td>
<td>C69.4</td>
<td>Measured Thickness (Depth)</td>
</tr>
</tbody>
</table>

*Description*

This item identifies information required to derive stage or considered to be of clinical or prognostic importance.

*Rationale*

Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive AJCC TNM and/or SEER Summary Stage codes for specified site-histology schemas.

*Instructions*

a. Refer to site/histology-specific instructions and codes in the current version of the *CS Manual*.

b. The State Registry requires *Site-Specific Factor 3* to be coded for the following primary sites/histologies diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.

*For cases diagnosed 01/01/2004 and later.*
CS SITE-SPECIFIC FACTOR 4

Description
This item identifies information required to derive stage or considered to be of clinical or prognostic importance.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive AJCC TNM and/or SEER Summary Stage codes for specified site-histology schemas.

Instructions
a. Refer to site/histology-specific instructions and codes in the current version of the CS Manual.

b. The State Registry requires Site-Specific Factor 4 to be coded for the following primary sites/histologies diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>MelanomaSkin</td>
<td>C44.0-9; C51.0-2,8,9; C60.0-2,8,9; C63.2</td>
<td>LDH</td>
</tr>
<tr>
<td>Breast</td>
<td>C50.0-6,8,9</td>
<td>Immunohistochemistry (IHC) of Regional Lymph Nodes</td>
</tr>
<tr>
<td>Testis</td>
<td>C62.0-1,9</td>
<td>Radical Orchiectomy Performed</td>
</tr>
<tr>
<td>MelanomaChoroid</td>
<td>C69.3</td>
<td>Size of Largest Metastasis</td>
</tr>
<tr>
<td>MelanomaIris</td>
<td>C69.4 (Iris)</td>
<td>Size of Largest Metastasis</td>
</tr>
<tr>
<td>MelanomaCiliary Body</td>
<td>C69.4</td>
<td>Size of Largest Metastasis</td>
</tr>
</tbody>
</table>

*For sites listed below diagnosed 01/01/2011 and later.
CS SITE-SPECIFIC FACTOR 5

Item Length: 3
Data Type: Numeric
ACoS: Required
State Registry: Required*

*For sites listed below diagnosed 01/01/2011 and later.

Description
This item identifies information required to derive stage or considered to be of clinical or prognostic importance.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive AJCC TNM and/or SEER Summary Stage codes for specified site-histology schemas.

Instructions
a. Refer to site/histology-specific instructions and codes in the current version of the CS Manual.

b. The State Registry requires Site-Specific Factor 5 to be coded for the following primary sites/histologies diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>GISTPeritoneum</td>
<td>C48.0-2, 8</td>
<td>Mitotic Count</td>
</tr>
<tr>
<td>Breast</td>
<td>C50.0-6,8,9</td>
<td>Molecular Studies of Regional Lymph Nodes</td>
</tr>
<tr>
<td>Testis</td>
<td>C62.0-1,9</td>
<td>Size of Metastasis in Lymph Nodes</td>
</tr>
</tbody>
</table>
**CS SITE-SPECIFIC FACTOR 6**

*For sites listed below diagnosed 01/01/2011 and later.*

**Description**
This item identifies information required to derive stage or considered to be of clinical or prognostic importance.

**Rationale**
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive AJCC TNM and/or SEER Summary Stage codes for specified site-histology schemas.

**Instructions**

a. Refer to site/histology-specific instructions and codes in the current version of the *CS Manual*.

b. The State Registry requires *Site-Specific Factor 6* to be coded for the following primary sites/histologies diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>GISTEosophagus</td>
<td>C15.0-5,8,9</td>
<td>Mitotic Count</td>
</tr>
<tr>
<td>GISTStomach</td>
<td>C16.0-6,8,9</td>
<td>Mitotic Count</td>
</tr>
<tr>
<td>GISTSsmall Intestine</td>
<td>C17.0-3,8,9</td>
<td>Mitotic Count</td>
</tr>
<tr>
<td>SkinEyelid</td>
<td>C44.1</td>
<td>Perineural Invasion</td>
</tr>
</tbody>
</table>
CS SITE-SPECIFIC FACTOR 7

*For sites listed below diagnosed 01/01/2011 and later.*

**Description**
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

**Rationale**
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive AJCC TNM and/or SEER Summary Stage codes for specified site-histology schemas.

**Instructions**

a. Refer to site/histology-specific instructions and codes in the current version of the *CS Manual.*

b. The State Registry requires *Site-Specific Factor 7* to be coded for the following primary sites/histologies diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>MelanomaSkin</td>
<td>C44.0-9; C51.0-2,8,9; C60.0-2,8,9; C63.2</td>
<td>Primary Tumor Mitotic Count/Rate</td>
</tr>
</tbody>
</table>
CS SITE-SPECIFIC FACTOR 8

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>C50.0-6,8,9</td>
<td>HER2: IHC Test Lab Value</td>
</tr>
<tr>
<td>Prostate</td>
<td>C61.9</td>
<td>Gleason Score on Needle Core Biopsy/TURP</td>
</tr>
</tbody>
</table>

**Description**
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

**Instructions**

a. Refer to site/histology-specific instructions and codes in the current version of the *CS Manual*.

b. The State Registry requires *Site-Specific Factor 8* to be coded for the following primary sites/histologies diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.
**Coding Instructions**

**Cancer Identification**

**Chapter 5**

**CS SITE-SPECIFIC FACTOR 9**

*For breast cases diagnosed 01/01/2010 and later.

*For testis cases diagnosed 01/01/2011 and later.

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>C50.0-6,8,9</td>
<td>HER2: IHC Test Interpretation</td>
</tr>
</tbody>
</table>

**Description**

This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

**Instructions**

a. Refer to site/histology-specific instructions and codes in the current version of the *CS Manual*.

b. The State Registry requires Site-Specific Factor 9 to be coded for the following primary sites/histologies diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.
CS SITE-SPECIFIC FACTOR 10

Item Length: 3
Data Type: Numeric
ACoS: Required
State Registry: Required*

*For breast cases diagnosed 01/01/2010 and later.
*For other sites listed below diagnosed 01/01/2011 and later.

Description
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

Instructions
a. Refer to site/histology-specific instructions and codes in the current version of the CS Manual.

b. The State Registry requires Site-Specific Factor 10 to be coded for the following primary sites/histologies or diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>BileDucts Intrahepat</td>
<td>C22.0-1</td>
<td>Tumor Growth Pattern</td>
</tr>
<tr>
<td>GIST Peritoneum</td>
<td>C48.0-2,8</td>
<td>Location of Primary Tumor</td>
</tr>
<tr>
<td>Prostate</td>
<td>C61.9</td>
<td>Gleason Score on Prostatectomy/Autopsy</td>
</tr>
</tbody>
</table>
Coding Instructions  Cancer Identification  Chapter 5

CS SITE-SPECIFIC FACTOR 11

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>GISTColon</td>
<td>C18.0,2-9</td>
<td>Mitotic Count</td>
</tr>
<tr>
<td>Appendix</td>
<td>C18.1</td>
<td>Histopathologic Grading</td>
</tr>
<tr>
<td>GISTAppendix</td>
<td>C18.1</td>
<td>Mitotic Count</td>
</tr>
<tr>
<td>GISTRectum</td>
<td>C19.9; C20.9</td>
<td>Mitotic Count</td>
</tr>
<tr>
<td>Breast</td>
<td>C50.0-6,8,9</td>
<td>HER2: FISH Test Interpretation</td>
</tr>
<tr>
<td>Vulva</td>
<td>C51.0-2,8,9</td>
<td>Regional Lymph Node - Laterality</td>
</tr>
<tr>
<td>MerkelCellVulva</td>
<td>C51.0-2,8,9</td>
<td>Regional Lymph Node - Laterality</td>
</tr>
</tbody>
</table>

Item Length: 3  
Data Type: Numeric  
ACoS: Required  
State Registry: Required*

*For breast cases diagnosed 01/01/2010 and later.  
*For other sites listed below diagnosed 01/01/2011 and later.

Description
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

Instructions
a. Refer to site/histology-specific instructions and codes in the current version of the CS Manual.

b. The State Registry requires Site-Specific Factor 11 to be coded for the following primary sites/histologies diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.
CS SITE-SPECIFIC FACTOR 12

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td>C44.0,2-9</td>
<td>High Risk Features</td>
</tr>
<tr>
<td>Scrotum</td>
<td>C63.2</td>
<td>High Risk Features</td>
</tr>
</tbody>
</table>

*For breast cases diagnosed 01/01/2010 and later.
*For skin cases defined below diagnosed 01/01/2011 and later.

**Description**
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

**Instructions**
a. Refer to site/histology-specific instructions and codes in the current version of the CS Manual.

b. The State Registry requires Site-Specific Factor 12 to be coded for the following primary sites/histologies diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.
CS SITE-SPECIFIC FACTOR 13

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>C50.0-6,8,9</td>
<td>HER2: CISH Test Interpretation</td>
</tr>
<tr>
<td>Testis</td>
<td>C62.0-1,9</td>
<td>Post-orchiectomy Alpha Fetoprotein (AFP) Range</td>
</tr>
</tbody>
</table>

Description
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

Instructions
a. Refer to site/histology-specific instructions and codes in the current version of the *CS Manual*.

b. The State Registry requires *Site-Specific Factor 13* to be coded for the following primary sites/histologies diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.

*For breast cases diagnosed 01/01/2010 and later.
*For testis diagnosed 01/01/2011 and later.
CS SITE-SPECIFIC FACTOR 14

Description
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

Instructions
a. Refer to site/histology-specific instructions and codes in the current version of the CS Manual.

b. The State Registry requires Site-Specific Factor 14 to be coded for the following primary sites/histologies diagnosed in 2010 or later. See the site-specific schemas for acceptable codes and their definitions.

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>C50.0-6,8,9</td>
<td>HER2: Result of Other or Unknown Test</td>
</tr>
</tbody>
</table>

*For breast cases diagnosed 01/01/2010 and later.
### CS SITE-SPECIFIC FACTOR 15

- **Item Length:** 3
- **Data Type:** Numeric
- **ACoS:** Required*
- **State Registry:** Required*

*For sites listed below diagnosed 01/01/2011 and later.

**Description**

This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

**Instructions**

a. Refer to site/histology-specific instructions and codes in the current version of the *CS Manual*.

b. The State Registry requires *Site-Specific Factor 15* to be coded for the following primary sites/histologies or diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>C50.0-6,8,9</td>
<td>HER2: Summary Result of Testing</td>
</tr>
<tr>
<td>Testis</td>
<td>C62.0-1,9</td>
<td>Post-orchietomy Human Chorionic Gonadotropin (hCG) Range</td>
</tr>
</tbody>
</table>
CS SITE-SPECIFIC FACTOR 16

Item Length: 3
Data Type: Numeric
ACoS: Required*
State Registry: Required*

*For sites listed below diagnosed 01/01/2011 and later.

Description
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

Instructions
a. Refer to site/histology-specific instructions and codes in the current version of the CS Manual.

b. The State Registry requires Site-Specific Factor 16 to be coded for the following primary sites/histologies diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td>C44.0-2-9</td>
<td>Size of Lymph Nodes</td>
</tr>
<tr>
<td>Breast</td>
<td>C50.0-6,8,9</td>
<td>Combinations of ER, PR, and HER2 Results</td>
</tr>
<tr>
<td>Testis</td>
<td>C62.0-1,9</td>
<td>Post-orchiectomy Lactate Dehydrogenase (LDH) Range</td>
</tr>
<tr>
<td>Scrotum</td>
<td>C63.2</td>
<td>Size of Lymph Nodes</td>
</tr>
</tbody>
</table>
CS SITE-SPECIFIC FACTOR 17

Item Length: 3
Data Type: Numeric
ACoS: Required
State Registry: Required*

*For sites listed below diagnosed 01/01/2011 and later.

Description
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

Instructions
a. Refer to site/histology-specific instructions and codes in the current version of the CS Manual.

b. The State Registry requires Site-Specific Factor 17 to be coded for the following primary sites/histologies diagnosed in 2011 or later. See the site-specific schemas for acceptable codes and their definitions.

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penis</td>
<td>C60.0-2,8,9</td>
<td>Extranodal Extension of Regional Lymph Nodes</td>
</tr>
</tbody>
</table>
CS SITE-SPECIFIC FACTOR 18

Description
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

Instructions
a. Refer to site/histology-specific instructions and codes in the current version of the CS Manual.

b. Site-Specific Factor 18 is optional for reporting to the State Registry.
CS SITE-SPECIFIC FACTOR 19

Description
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

Instructions
a. Refer to site/histology-specific instructions and codes in the current version of the CS Manual.

b. Site-Specific Factor 19 is optional for reporting to the State Registry.
Description
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

Instructions
a. Refer to site/histology-specific instructions and codes in the current version of the CS Manual.

b. Site-Specific Factor 20 is optional for reporting to the State Registry.
### CS SITE-SPECIFIC FACTOR 21

<table>
<thead>
<tr>
<th>Item Length:</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Type:</td>
<td>Numeric</td>
</tr>
<tr>
<td>ACoS:</td>
<td>Required*</td>
</tr>
<tr>
<td>State Registry:</td>
<td>Optional</td>
</tr>
</tbody>
</table>

**Description**
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

**Instructions**

a. Refer to site/histology-specific instructions and codes in the current version of the *CS Manual*.

b. *Site-Specific Factor 21* is optional for reporting to the State Registry.
CS SITE-SPECIFIC FACTOR 22

<table>
<thead>
<tr>
<th>Item Length: 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Type: Numeric</td>
</tr>
<tr>
<td>ACoS: Required*</td>
</tr>
<tr>
<td>State Registry: Optional</td>
</tr>
</tbody>
</table>

Description
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

Instructions
a. Refer to site/histology-specific instructions and codes in the current version of the CS Manual.

b. Site-Specific Factor 22 is optional for reporting to the State Registry.
### CS SITE-SPECIFIC FACTOR 23

<table>
<thead>
<tr>
<th>Item Length:</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Type:</td>
<td>Numeric</td>
</tr>
<tr>
<td>ACoS:</td>
<td>Required*</td>
</tr>
<tr>
<td>State Registry:</td>
<td>Optional</td>
</tr>
</tbody>
</table>

**Description**

This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

**Instructions**

a. Refer to site/histology-specific instructions and codes in the current version of the *CS Manual*.

b. *Site-Specific Factor 23* is optional for reporting to the State Registry.
**CS SITE-SPECIFIC FACTOR 24**

<table>
<thead>
<tr>
<th>Item Length:</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Type:</td>
<td>Numeric</td>
</tr>
<tr>
<td>ACoS:</td>
<td>Required*</td>
</tr>
<tr>
<td>State Registry:</td>
<td>Optional</td>
</tr>
</tbody>
</table>

**Description**
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

**Instructions**

a. Refer to site/histology-specific instructions and codes in the current version of the *CS Manual*.

b. *Site-Specific Factor 24* is optional for reporting to the State Registry.
CS SITE-SPECIFIC FACTOR 25

Item Length: 3  
Data Type: Numeric  
ACoS: Required  
State Registry: Required*

*For sites listed below diagnosed 01/01/2010 and later.

Description
This item identifies additional information that is necessary to derive stage or is considered to be of clinical or prognostic importance.

Rational
CS Site-Specific Factor 25 is used to discriminate between CS staging schema or between AJCC chapters where site and histology alone are insufficient to identify the tumor type or location to identify the applicable staging method. Use of this item is limited to specific subsites and histologies as shown below.

Instructions
a. Refer to the site and histology-specific instructions in the current CS Manual for coding instructions.

b. The State Registry requires Site-Specific Factor 25 to be coded for the following primary sites/histologies diagnosed in 2010 or later. See the site-specific schemas for acceptable codes and their definitions.

<table>
<thead>
<tr>
<th>CS Schema</th>
<th>Sites</th>
<th>Site-Specific Factor 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasopharynx</td>
<td>C11.1</td>
<td>Schema Discriminator: Nasopharynx/PharyngealTonsil</td>
</tr>
<tr>
<td>PharyngealTonsil</td>
<td>C11.1</td>
<td>Schema Discriminator: Nasopharynx/PharyngealTonsil</td>
</tr>
<tr>
<td>EsophagusGE Junction</td>
<td>C16.1-2</td>
<td>Schema Discriminator: EsophagusGE Junction (EGJ)/Stomach</td>
</tr>
<tr>
<td>Stomach</td>
<td>C16.1-2</td>
<td>Schema Discriminator: EsophagusGE Junction (EGJ)/Stomach</td>
</tr>
<tr>
<td>Cystic Duct</td>
<td>C24.0</td>
<td>Schema Discriminator: Subsite of Extrahepatic Bile Ducts</td>
</tr>
<tr>
<td>BileDuctsPerihilar</td>
<td>C24.0</td>
<td>Schema Discriminator: Subsite of Extrahepatic Bile Ducts</td>
</tr>
<tr>
<td>BileDuctsDistal</td>
<td>C24.0</td>
<td>Schema Discriminator: Subsite of Extrahepatic Bile Ducts</td>
</tr>
<tr>
<td>GISTPeritoneum</td>
<td>C48.1</td>
<td>Location of Primary Tumor</td>
</tr>
<tr>
<td>Peritoneum</td>
<td>C48.1-2,8</td>
<td>Schema Discriminator: Peritoneum/PeritoneumFemaleGen</td>
</tr>
<tr>
<td>PeritoneumFemaleGen</td>
<td>C48.1-2,8</td>
<td>Schema Discriminator: Peritoneum/PeritoneumFemaleGen</td>
</tr>
<tr>
<td>MelanomaCiliary Body</td>
<td>C69.4</td>
<td>Schema Discriminator: Melanoma Ciliary Body/Melanoma Iris</td>
</tr>
<tr>
<td>MelanomaIris</td>
<td>C69.4 (Iris)</td>
<td>Schema Discriminator: Melanoma Ciliary Body/Melanoma Iris</td>
</tr>
<tr>
<td>Lacrimal Gland</td>
<td>C69.5</td>
<td>Schema Discriminator: Lacrimal Gland/Lacrimal Sac</td>
</tr>
<tr>
<td>Lacrimal Sac</td>
<td>C69.5</td>
<td>Schema Discriminator: Lacrimal Gland/Lacrimal Sac</td>
</tr>
</tbody>
</table>
**DERIVED AJCC-6 ITEMS**

*ACoS: Autocoded*
*State Registry: Autocoded*

*For cases diagnosed 01/01/2004 and later.

**Description**
The AJCC-6 staging elements listed below are derived from coded fields using the CS algorithms.

*Derived AJCC-6 T*
*Derived AJCC-6 T Descriptor*
*Derived AJCC-6 N*
*Derived AJCC-6 N Descriptor*
*Derived AJCC-6 M*
*Derived AJCC-6 M Descriptor*
*Derived AJCC-6 Stage Group*

**Instructions**
a. These data items are autocoded and are not recorded by registry staff.

b. Refer to the applicable *AJCC Cancer Staging Manual* for item descriptions.
DERIVED AJCC-7 ITEMS

*For cases diagnosed 01/01/2004 and later.

Description
The AJCC-7 staging elements listed below are derived from coded fields using the CS algorithms.

- Derived AJCC-7 T
- Derived AJCC-7 T Descriptor
- Derived AJCC-7 N
- Derived AJCC-7 N Descriptor
- Derived AJCC-7 M
- Derived AJCC-7 M Descriptor
- Derived AJCC-7 Stage Group

Instructions
a. These data items are autocoded and are not recorded by registry staff.

b. Refer to the applicable AJCC Cancer Staging Manual for item descriptions.
**Chapter 5  
Cancer Identification  
Coding Instructions**

**DERIVED SS1977**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>In situ</td>
</tr>
<tr>
<td>1</td>
<td>Localized</td>
</tr>
<tr>
<td>2</td>
<td>Regional, direct extension only</td>
</tr>
<tr>
<td>3</td>
<td>Regional, regional lymph nodes only</td>
</tr>
<tr>
<td>4</td>
<td>Regional, direct extension and regional lymph nodes</td>
</tr>
<tr>
<td>5</td>
<td>Regional, NOS</td>
</tr>
<tr>
<td>7</td>
<td>Distant metastases/systemic disease</td>
</tr>
<tr>
<td>9</td>
<td>Unstaged, unknown, or unspecified</td>
</tr>
<tr>
<td></td>
<td>Not derived</td>
</tr>
</tbody>
</table>

*For cases diagnosed 01/01/2004 and later.

**Description**

This item is the “SEER Summary Stage 1977” derived using the CS algorithm.

**Rationale**

Collaborative Stage (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive “best stage” for the major staging systems in current use. Derived SS1977 can be used to evaluate patterns of disease spread at diagnosis, track treatment patterns, and analyze outcomes.

**Instructions**

Refer to the *SEER Summary Staging Manual, 1977* for site-specific categories.
**DERIVED SS2000**

*For cases diagnosed 01/01/2004 and later.*

**Description**
This item is the “SEER Summary Stage 2000” derived using the CS algorithm.

**Rationale**
Collaborative Stage (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive “best stage” for the major staging systems in current use. Derived SS2000 can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

**Instructions**
Refer to the *SEER Summary Staging Manual, 2000* for site-specific categories.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>In situ</td>
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</tr>
<tr>
<td>2</td>
<td>Regional, direct extension only</td>
</tr>
<tr>
<td>3</td>
<td>Regional, regional lymph nodes only</td>
</tr>
<tr>
<td>4</td>
<td>Regional, direct extension and regional lymph nodes</td>
</tr>
<tr>
<td>5</td>
<td>Regional, NOS</td>
</tr>
<tr>
<td>7</td>
<td>Distant metastases/systemic disease</td>
</tr>
<tr>
<td>9</td>
<td>Unstaged, unknown, or unspecified</td>
</tr>
<tr>
<td>(leave blank)</td>
<td>Not derived</td>
</tr>
</tbody>
</table>

Item Length: 1  
Data Type: Numeric  
ACoS: Autocoded*  
State Registry: Autocoded*
SUBSTANTIATE STAGING
RMCDS Item: Staging

Description
This is a required text field in the paper and RMCDS abstracts for recording a narrative description of information that substantiates the Summary Stage or the Collaborative Stage (CS) data items, as applicable. It is not sufficient to merely code the items. The information from the medical record supporting the codes must be recorded. Facilities using other types of registry software should follow their vendor’s instructions for recording text that substantiates staging.

Instructions
a. Identify the specific evidence in the medical record that justifies the staging and record the evidence briefly, in this field. Standard abbreviations can be used to save space. It is not necessary to repeat information documented in other text fields.

Examples:
<table>
<thead>
<tr>
<th>Staging</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary Stage 4</td>
<td>Small cell carcinoma of the rt. lung with extension to the pericardium and mets to 3 of 4 hilar lymph nodes.</td>
</tr>
<tr>
<td>Summary Stage 1</td>
<td>Poorly differentiated adenocarcinoma of the sigmoid colon with invasion through the muscularis propria. LN neg.</td>
</tr>
<tr>
<td>Summary Stage 7</td>
<td>Mucinous cystadenocarcinoma of the rt. ovary with extension to the small intestine.</td>
</tr>
<tr>
<td>Summary Stage 5</td>
<td>Diffuse, histiocytic malignant lymphoma of the cervical and mediastinal lymph node regions. Bone marrow free of disease.</td>
</tr>
</tbody>
</table>

5 mm melanoma, 1.2 mm thick, no ulceration, 20 neg. LN, remainder of physical exam negative

b. Use this field to clarify any coding that is vague (e.g., specific metastatic site coded as a “9”) or to justify any coding that requires the coder to override an edit error message (e.g., metastatic site coding that is consistent with AJCC staging but inconsistent with Summary Stage).

c. Document any unresolved discrepancies between physician and registry staging decisions.

d. Facilities using the paper abstract to report should also attach copies of medical record documentation (such as the pathology and operative reports) that substantiates the extent of disease. However, text that substantiates the staging must be completed by all reporting facilities.
GENERAL RULES FOR TNM STAGING

The TNM (Tumor, Nodes, Metastasis) staging items are required when available for State reporting, effective for cases diagnosed 01/01/2014 and later. Facilities should refer to the current AJCC Manual for Staging of Cancer for staging rules.

ACoS Requirements
Hospitals with cancer programs approved by the American College of Surgeons (ACoS) must record pathologic or clinical classifications of TNM and stage group in order to meet ACoS approval standards.

In October 1981, the Commission on Cancer resolved that the staging system of the American Joint Committee on Cancer (AJCC) would be used in all approved cancer programs. The AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcome, design follow-up strategies, and assess early detection results.

In 1982, breast cancer was the first site implemented. Effective January 1991, ACoS required AJCC TNM staging for all required (analytic) cases that had a staging scheme in the AJCC Manual for Staging of Cancer, Third Edition. The Commission has since published the fourth, fifth, sixth, and seventh editions of the manual. The effective dates for the various editions are listed below.

<table>
<thead>
<tr>
<th>AJCC Edition</th>
<th>Effective Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Edition</td>
<td>Effective for cases diagnosed in 1988 or earlier.</td>
</tr>
<tr>
<td>Third Edition</td>
<td>Effective for cases diagnosed from 1989 through 1992</td>
</tr>
<tr>
<td>Fourth Edition</td>
<td>Effective for cases diagnosed from 1993 through 1997</td>
</tr>
<tr>
<td>Fifth Edition</td>
<td>Effective for cases diagnosed from 1998 through 2002</td>
</tr>
<tr>
<td>Seventh Edition</td>
<td>Effective for cases diagnosed 2010 and later.</td>
</tr>
</tbody>
</table>

AJCC Staging System
The TNM system for describing the anatomic extent of disease is based on the assessment of three components:

\[
\begin{align*}
T &= \text{The extent of the primary tumor} \\
N &= \text{The absence or presence and extent of regional lymph node metastasis} \\
M &= \text{The absence or presence of distant metastasis}
\end{align*}
\]

The TNM elements are defined for specific anatomic sites and/or histologic types in the AJCC Cancer Staging Manual. These elements should be recorded on a staging form or in the medical record.

Refer to the AJCC Cancer Staging Manual and review Chapter 1, "Purposes and Principles of Staging" and the rules in each of the site-specific chapters. Each site-specific chapter outlines the site(s) and histologies that are included in the chapter.

Definitions
a. Clinical (pretreatment) stage is based on information and evidence obtained before treatment. Symptoms, physical examination, imaging, endoscopy, biopsy, surgical exploration (without resection), and other relevant findings are the basis of clinical staging. Clinical stage of disease is assigned using all information available before initiation of definitive treatment or within four months after the date of diagnosis, whichever is shorter, as long as the cancer has not progressed during that time frame. The clinical stage is essential to select and evaluate therapy.

b. Pathologic stage is based on information obtained before treatment and supplemented by additional evidence from surgery and pathologic examination of the resected specimen(s). Pathologic stage of disease is assigned using all information though completion of definitive (first course) surgery or identified within four months after the date of diagnosis, whichever is longer, as long as there is no
systemic or radiation therapy initiated or the cancer has not progressed during that time frame. It is a combination of all findings. The pathologic stage provides the most precise data to estimate prognosis. Pathologic assessment of the primary tumor requires a resection of the primary tumor or a biopsy adequate to evaluate the highest pT (pathologic Tumor) category. The pathologic assessment of the regional lymph nodes requires the removal of enough nodes to confirm the absence of regional lymph node metastasis and evaluate the highest pN (pathologic Nodes) category.

**General Instructions**

a. Locate the specific site in the AJCC manual for the assignment of TNM elements.

b. When AJCC staging does not apply to a particular site or histology because they have been excluded from the *AJCC Cancer Staging Manual*, record 88 in the T, N, M, and Stage Group fields.

c. When the primary site is unknown, staging may be based on clinical suspicion of the site of origin. If no suspected site of origin is identified, record 88 in the T, N, M, and Stage Group fields.
CLINICAL T

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>TX</td>
</tr>
<tr>
<td>0</td>
<td>T0</td>
</tr>
<tr>
<td>A</td>
<td>Ta</td>
</tr>
<tr>
<td>IS</td>
<td>Tis</td>
</tr>
<tr>
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<td>Tispu</td>
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<tr>
<td>ISPD</td>
<td>Tispd</td>
</tr>
<tr>
<td>1MI</td>
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<td>T1</td>
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<tr>
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<td>T1a</td>
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<td>T1a2</td>
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<td>T1b</td>
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<td>T1b1</td>
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<td>T1c</td>
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<tr>
<td>1D</td>
<td>T1d</td>
</tr>
<tr>
<td>2</td>
<td>T2</td>
</tr>
<tr>
<td>2A</td>
<td>T2a</td>
</tr>
</tbody>
</table>

*Data item added for cases diagnosed 01/01/2014 or later, when available.

Description
This is a required (when available) 4-character field to record a code for the clinical T classification. The clinical T evaluates only the primary tumor and reflects tumor size and/or extension prior to the start of any therapy.

Definitions
The following general definitions are used throughout the TNM classification:

- **T0**: No evidence of a primary tumor
- **Tis**: Carcinoma in situ
- **T1**, **T2**, **T3**, and **T4**: Describe increasing size and/or local extension of the primary tumor
- **TX**: Primary tumor cannot be assessed (use of TX should be minimized)

Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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</tr>
<tr>
<td>2A2</td>
<td>T2a2</td>
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<tr>
<td>2B</td>
<td>T2b</td>
</tr>
<tr>
<td>2C</td>
<td>T2c</td>
</tr>
<tr>
<td>2D</td>
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<td>T3</td>
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<td>3C</td>
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<tr>
<td>4C</td>
<td>T4c</td>
</tr>
<tr>
<td>4D</td>
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<td>T4e</td>
</tr>
<tr>
<td>88</td>
<td>Not applicable (no AJCC staging scheme)</td>
</tr>
<tr>
<td>Blank</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Instructions

a. Record the code for the clinical T documented by the first treating physician or the managing physician.

b. If the managing physician has not recorded clinical T, registrars may code this item based on the best available information.

c. If the value does not fill all 4 characters, record the value to the left and leave the remaining spaces blank.

d. For lung, occult carcinoma is coded TX.

e. Refer to the current AJCC Cancer Staging Manual for staging rules.
**CLINICAL N**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<td>N0i-</td>
</tr>
<tr>
<td>0I+</td>
<td>N0i+</td>
</tr>
<tr>
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<td>N0m-</td>
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</tr>
<tr>
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<td>N0a</td>
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<tr>
<td>0B</td>
<td>N0b</td>
</tr>
<tr>
<td>1</td>
<td>N1</td>
</tr>
<tr>
<td>1A</td>
<td>N1a</td>
</tr>
<tr>
<td>1B</td>
<td>N1b</td>
</tr>
</tbody>
</table>

*Data item added for cases diagnosed 01/01/2014 or later, when available.*

**Description**

This is a required (when available) 4-character field to record a code for the clinical N classification. The clinical N identifies the absence or presence of regional lymph node metastases and describes the extent of regional lymph node metastases prior to the start of any therapy.

**Definitions**

The following general definitions are used throughout the TNM classification:

- **N0**: No regional lymph node metastasis
- **N1, N2, N3, and N4**: Describe increasing number or extent of regional lymph node involvement
- **NX**: Regional lymph nodes cannot be assessed (use of NX should be minimized)

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>NX</td>
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<tr>
<td>0</td>
<td>N0</td>
</tr>
<tr>
<td>0I-</td>
<td>N0i-</td>
</tr>
<tr>
<td>0I+</td>
<td>N0i+</td>
</tr>
<tr>
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<td>N0a</td>
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<tr>
<td>0B</td>
<td>N0b</td>
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<tr>
<td>1</td>
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</tr>
<tr>
<td>1A</td>
<td>N1a</td>
</tr>
<tr>
<td>1B</td>
<td>N1b</td>
</tr>
</tbody>
</table>

**Instructions**

a. Record the code for the clinical N documented by the first treating physician or the managing physician.

b. If the managing physician has not recorded clinical N, registrars may code this item based on the best available information.

c. If the value does not fill all 4 characters, record the value to the left and leave the remaining spaces blank.

d. Refer to the current *AJCC Cancer Staging Manual* for staging rules.
CLINICAL M

Description
This is a required (when available) 4-character field to record a code for the clinical M classification. The clinical M records the presence or absence of distant metastases known prior to the start of any therapy.

Definitions
The following general definitions are used throughout the TNM classification:

- M0  No distant metastasis
- M1  Distant metastases are present

Codes
- X = MX (AJCC editions 1-6 only)
- 0 = M0
- 0I+ = M0(i+)
- 1 = M1
- 1A = M1a
- 1B = M1b
- 1C = M1c
- 1D = M1d
- 1E = M1e
- 88 = Not applicable (no AJCC staging scheme)
- blank = Not recorded

Instructions
a. Record the code for the clinical M documented by the first treating physician or the managing physician.
b. If the managing physician has not recorded clinical M, registrars may code this item based on the best available information.
c. If the value does not fill all 4 characters, record the value to the left and leave the remaining spaces blank.
d. Refer to the current AJCC Cancer Staging Manual for staging rules.
e. When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If the physician later identifies which primary has metastasized, update the stage(s) as appropriate.
**CLINICAL STAGE GROUP**

*Data item added for cases diagnosed 01/01/2014 or later, when available.*

**Description**
This is a required (when available) 4-character field for recording a code that condenses the clinical T, N, and M elements into categories for purposes of tabulation and analysis. It defines the anatomic extent of disease based on the previously coded T, N, and M elements.

The TNM (Tumor, Nodes, Metastasis) Stage Grouping codes are from the *AJCC Cancer Staging Manual*. Efforts should be made to capture this information on a staging form or in the medical record.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
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</tr>
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<td>Stage 0A</td>
</tr>
<tr>
<td>0IS</td>
<td>Stage 0is</td>
</tr>
<tr>
<td>1</td>
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<td>Stage T1B2</td>
</tr>
<tr>
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<td>Stage IC</td>
</tr>
<tr>
<td>1S</td>
<td>Stage IS</td>
</tr>
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<td>Stage II</td>
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</tr>
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</tr>
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</tr>
<tr>
<td>88</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**Instructions**

a. Record the code for the clinical stage group documented by the first treating physician or the managing physician.

b. If the managing physician has not recorded clinical stage group, registrars may code this item based on the best available information.

c. If the value does not fill all 4 characters, record the value to the left and leave the remaining spaces blank.

d. Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.

*Example 1:* Stage IV converts to stage 4.
*Example 2:* Stage IIA converts to stage 2A.

E. Refer to the current *AJCC Cancer Staging Manual* for staging rules.
**CLINICAL STAGE (PREFIX/SUFFIX) DESCRIPTOR**

*Data item added for cases diagnosed 01/01/2014 or later, when available.*

**Description**
This is a required (when available) 1-character field for coding the AJCC clinical stage (prefix/suffix) descriptor of the tumor prior to the start of any therapy. Stage descriptors identify special cases that need separate analysis. The descriptors do not change the stage group.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
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<td>None</td>
<td>There are no prefix or suffix descriptors that would be used for this case.</td>
</tr>
<tr>
<td>1</td>
<td>E: Extranodal, lymphomas only</td>
<td>A lymphoma case involving an extranodal site.</td>
</tr>
<tr>
<td>2</td>
<td>S: Spleen, lymphomas only</td>
<td>A lymphoma case involving the spleen.</td>
</tr>
<tr>
<td>3</td>
<td>M: Multiple primary tumors in a single site</td>
<td>This is one primary with multiple tumors in the primary site at the time diagnosis.</td>
</tr>
<tr>
<td>5</td>
<td>E&amp;S: Extranodal and spleen, lymphomas only</td>
<td>A lymphoma case with involvement of both an extranodal site and the spleen.</td>
</tr>
<tr>
<td>9</td>
<td>Unknown; not stated in patient record</td>
<td>A prefix or suffix would describe this stage, but it is not known which would be correct.</td>
</tr>
</tbody>
</table>

**Instructions**

a. Record the code for the clinical stage (prefix/suffix) descriptor as documented by the first treating physician or the managing physician in the medical record.

b. If the managing physician has not documented the descriptor, registrars may code this item based on the best available information.

c. Refer to the current *AJCC Cancer Staging Manual* for staging rules.
PATHOLOGIC T

*Data item added for cases diagnosed 01/01/2014 or later, when available.

Description
This is a required (when available) 4-character field for recording a code for the pathologic T classification. The pathologic T evaluates only the primary tumor and reflects tumor size and/or extension.

Definitions
The following general definitions are used throughout the TNM classification:

- **T0**: No evidence of a primary tumor
- **Tis**: Carcinoma in situ
- **T1, T2, T3, and T4**: Describe increasing size and/or local extension of the primary tumor
- **TX**: Primary tumor cannot be assessed (use of TX should be minimized)

Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<td>Tispu</td>
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</tr>
<tr>
<td>1A2 = T1a2</td>
<td>T1a2</td>
</tr>
<tr>
<td>1B = T1b</td>
<td>T1b</td>
</tr>
<tr>
<td>1B1 = T1b1</td>
<td>T1b1</td>
</tr>
<tr>
<td>1B2 = T1b2</td>
<td>T1b2</td>
</tr>
<tr>
<td>1C = T1c</td>
<td>T1c</td>
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<tr>
<td>1D = T1d</td>
<td>T1d</td>
</tr>
<tr>
<td>2 = T2</td>
<td>T2</td>
</tr>
<tr>
<td>2A = T2a</td>
<td>T2a</td>
</tr>
<tr>
<td>2A1 = T2a1</td>
<td>T2a1</td>
</tr>
<tr>
<td>2A2 = T2a2</td>
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<td>2B = T2b</td>
<td>T2b</td>
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<tr>
<td>2D = T2d</td>
<td>T2d</td>
</tr>
<tr>
<td>3 = T3</td>
<td>T3</td>
</tr>
<tr>
<td>3A = T3a</td>
<td>T3a</td>
</tr>
<tr>
<td>3B = T3b</td>
<td>T3b</td>
</tr>
<tr>
<td>3C = T3c</td>
<td>T3c</td>
</tr>
<tr>
<td>3D = T3d</td>
<td>T3d</td>
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<td>4 = T4</td>
<td>T4</td>
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<tr>
<td>4A = T4a</td>
<td>T4a</td>
</tr>
<tr>
<td>4B = T4b</td>
<td>T4b</td>
</tr>
<tr>
<td>4C = T4c</td>
<td>T4c</td>
</tr>
<tr>
<td>4D = T4d</td>
<td>T4d</td>
</tr>
<tr>
<td>4E = T4e</td>
<td>T4e</td>
</tr>
<tr>
<td>88 = Not applicable (no AJCC staging scheme)</td>
<td>Not applicable (no AJCC staging scheme)</td>
</tr>
</tbody>
</table>

Instructions

a. Record the code for the pathologic T documented by the first treating physician or the managing physician.

b. If the managing physician has not recorded pathologic T, registrars may code this item based on the best available information.

c. If the value does not fill all 4 characters, record the value to the left and leave the remaining spaces blank.

d. For lung, occult carcinoma is coded TX.

e. Refer to the current AJCC Cancer Staging Manual for staging rules.
PATHOLOGIC N

Description
This is a required (when available) 4-character field to record a code for the pathologic N classification. The pathologic N identifies the absence or presence of regional lymph node metastases and describes the extent of regional lymph node metastases.

Definitions
The following general definitions are used throughout the TNM classification:

N0 No regional lymph node metastasis
N1, N2, N3, and N4 describe increasing number or extent of regional lymph node involvement
NX Regional lymph nodes cannot be assessed (use of NX should be minimized)

Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>NX</td>
</tr>
<tr>
<td>0</td>
<td>N0</td>
</tr>
<tr>
<td>0I-</td>
<td>N0i-</td>
</tr>
<tr>
<td>0I+</td>
<td>N0i+</td>
</tr>
<tr>
<td>0M-</td>
<td>N0m-</td>
</tr>
<tr>
<td>0M+</td>
<td>N0m+</td>
</tr>
<tr>
<td>1MI</td>
<td>N1mi</td>
</tr>
<tr>
<td>0A</td>
<td>N0a</td>
</tr>
<tr>
<td>0B</td>
<td>N0b</td>
</tr>
<tr>
<td>1</td>
<td>N1</td>
</tr>
<tr>
<td>1A</td>
<td>N1a</td>
</tr>
<tr>
<td>1B</td>
<td>N1b</td>
</tr>
<tr>
<td>2</td>
<td>N2</td>
</tr>
<tr>
<td>2A</td>
<td>N2a</td>
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<td>2B</td>
<td>N2b</td>
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<tr>
<td>2C</td>
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<td>3</td>
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<td>3A</td>
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<td>N3c</td>
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<tr>
<td>4</td>
<td>N4</td>
</tr>
<tr>
<td>88</td>
<td>Not applicable (no AJCC staging scheme)</td>
</tr>
<tr>
<td>Blank</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Instructions
a. Record the code for the pathologic N documented by the first treating physician or the managing physician.

b. If the managing physician has not recorded pathologic N, registrars may code this item based on the best available information.

c. If the value does not fill all 4 characters, record the value to the left and leave the remaining spaces blank.

d. Refer to the current AJCC Cancer Staging Manual for staging rules.
PATHOLOGIC M

*Data item added for cases diagnosed 01/01/2014 or later, when available.

Description
This is a required (when available) 4-character field to record a code for the pathologic M classification. The pathologic M records the presence or absence of distant metastases.

Definitions
The following general definitions are used throughout the TNM classification:

- **M0**: No distant metastasis
- **M1**: Distant metastases are present

Codes

- **X**: MX (AJCC editions 1-6 only)
- **0**: M0 (AJCC editions 1-6 only)
- **0I+**: M0(i+)
- **1**: M1
- **1A**: M1a
- **1B**: M1b
- **1C**: M1c
- **1D**: M1d
- **1E**: M1e
- **88**: Not applicable (no AJCC staging scheme)
- **blank**: Not recorded

Instructions

a. Record the code for the pathologic M documented by the first treating physician or the managing physician.

b. If the managing physician has not recorded pathologic M, registrars may code this item based on the best available information.

c. If the value does not fill all 4 characters, record the value to the left and leave the remaining spaces blank.

d. Refer to the current AJCC Cancer Staging Manual for staging rules.

e. When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If the physician later identifies which primary has metastasized, update the stage(s) as appropriate.
PATHOLOGIC STAGE GROUP

Description
This is a required (when available) 4-character field for recording a code that condenses the pathologic T, N, and M elements into categories for purposes of tabulation and analysis. It defines the anatomic extent of disease based on the previously coded T, N, and M elements.

The TNM (Tumor, Nodes, Metastasis) Stage Grouping codes are from the AJCC Cancer Staging Manual. Efforts should be made to capture this information on a staging form or in the medical record.

Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Stage 0</td>
</tr>
<tr>
<td>0A</td>
<td>Stage 0A</td>
</tr>
<tr>
<td>0IS</td>
<td>Stage 0is</td>
</tr>
<tr>
<td>1A</td>
<td>Stage IA</td>
</tr>
<tr>
<td>1</td>
<td>Stage I</td>
</tr>
<tr>
<td>1A1</td>
<td>Stage T1A1</td>
</tr>
<tr>
<td>1B</td>
<td>Stage T1B</td>
</tr>
<tr>
<td>1B1</td>
<td>Stage T1B1</td>
</tr>
<tr>
<td>1B2</td>
<td>Stage T1B2</td>
</tr>
<tr>
<td>1C</td>
<td>Stage IC</td>
</tr>
<tr>
<td>1S</td>
<td>Stage IS</td>
</tr>
<tr>
<td>2</td>
<td>Stage II</td>
</tr>
<tr>
<td>2A</td>
<td>Stage IIA</td>
</tr>
<tr>
<td>2A1</td>
<td>Stage IIA1</td>
</tr>
<tr>
<td>2A2</td>
<td>Stage IIA2</td>
</tr>
<tr>
<td>2B</td>
<td>Stage IIB</td>
</tr>
<tr>
<td>2C</td>
<td>Stage IIC</td>
</tr>
<tr>
<td>3</td>
<td>Stage III</td>
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<tr>
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<td>Stage IIIA</td>
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<tr>
<td>3B</td>
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</tr>
<tr>
<td>4C</td>
<td>Stage IVC</td>
</tr>
<tr>
<td>88</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Unknown</td>
</tr>
<tr>
<td>OC</td>
<td>Occult</td>
</tr>
</tbody>
</table>

Instructions

a. Record the code for the pathologic stage group documented by the first treating physician or the managing physician.

b. If the managing physician has not recorded pathologic stage group, registrars may code this item based on the best available information.

c. If pathologic M is coded as either X or blank and clinical M is coded as 0, 1, 1a, 1b, or 1c, then a combination of staging elements pT, pN, and cM may be used to complete the pathologic stage group.

d. If the value does not fill all 4 characters, record the value to the left and leave the remaining spaces blank.

e. Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.

Example 1: Stage IV converts to stage 4.
Example 2: Stage IIA converts to stage 2A.

f. Refer to the current AJCC Cancer Staging Manual for staging rules.
PATHOLOGIC STAGE (PREFIX/SUFFIX) DESCRIPTOR

*Data item added for cases diagnosed 01/01/2014 or later, when available.

**Description**
This is a required (when available) 1-character field for coding the AJCC pathologic stage (prefix/suffix) descriptor known following the completion of surgical therapy. Stage descriptors identify special cases that need separate analysis. The descriptors do not change the stage group.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
<td>There are no prefix or suffix descriptors that would be used for this case.</td>
</tr>
<tr>
<td>1</td>
<td>E: Extranodal, lymphomas only</td>
<td>A lymphoma case involving an extranodal site.</td>
</tr>
<tr>
<td>2</td>
<td>S: Spleen, lymphomas only</td>
<td>A lymphoma case involving the spleen.</td>
</tr>
<tr>
<td>3</td>
<td>M: Multiple primary tumors in a single site</td>
<td>This is one primary with multiple tumors in the primary site at the time diagnosis.</td>
</tr>
<tr>
<td>4</td>
<td>Y: Classification during or after initial multimodality therapy-pathologic staging only</td>
<td>Not applicable for clinical stage.</td>
</tr>
<tr>
<td>5</td>
<td>E&amp;S: Extranodal and spleen, lymphomas only</td>
<td>A lymphoma case with involvement of both an extranodal site and the spleen.</td>
</tr>
<tr>
<td>6</td>
<td>M&amp;Y: Multiple primary tumors and initial multimodality therapy.</td>
<td>The case meets the criteria for both codes 3 (multiple primary tumors in a single site) and 4 (classification during or after initial multimodality therapy).</td>
</tr>
<tr>
<td>9</td>
<td>Unknown; not stated in patient record</td>
<td>A prefix or suffix would describe this stage, but it is not known which would be correct.</td>
</tr>
</tbody>
</table>

**Instructions**

a. Record the code for the pathologic stage (prefix/suffix) descriptor as documented by the treating physician(s) or the managing physician in the medical record.

b. If the managing physician has not documented the descriptor, registrars may code this item based on the best available information.

c. Refer to the current *AJCC Cancer Staging Manual* for staging rules.
## TEXT FIELDS FOR WORKUP

<table>
<thead>
<tr>
<th>Field Type</th>
<th>Data Type</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>DX PROCEDURES X-RAY/SCANS</td>
<td>Text</td>
<td></td>
</tr>
<tr>
<td>DX PROCEDURES LAB TEXTS</td>
<td>Text</td>
<td></td>
</tr>
<tr>
<td>HISTORY AND PHYSICAL</td>
<td>Text</td>
<td></td>
</tr>
<tr>
<td>SURGICAL STAGING PROCEDURES</td>
<td>Text</td>
<td></td>
</tr>
<tr>
<td>DIAGNOSTIC SCOPE PROCEDURES</td>
<td>Text</td>
<td>ACoS: N/A</td>
</tr>
<tr>
<td>State Registry: Optional</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Description

The fields listed above are optional text fields in the RMCDS abstract screen for recording information from the work-up for the tumor being reported. Facilities using the paper abstract may record this information in the field, *Remarks*. Facilities using other types of registry software should follow their vendor’s instructions for recording text about the work-up. Although the items are optional, abstractors are strongly encouraged to document work-up that provides information about the malignancy or extent of disease that has not been recorded in other text fields.

### Instructions

#### Dx Procedures X-rays/Scans

a. Record documentation from all X-ray, scans, and/or other imaging examinations that provide information about the malignancy or extent of disease.

b. Include, as applicable: Dates, primary site, histology, tumor location, tumor size, lymph nodes, positive and negative findings, and distant disease or metastasis.

#### Dx Procedures Lab Tests

a. Record documentation from laboratory examinations other than cytology or histopathology. Tests can include tumor markers, serum and urine electrophoresis, special studies, etc.

b. Include, as applicable: Type of laboratory test/specimen(s), date(s) of test(s), and positive and negative findings.

#### History and Physical

a. Record documentation from the history and physical examination about the history and clinical description of the current tumor.

b. Include, as applicable: Date of physical exam; age, sex, race/ethnicity; history that relates to cancer diagnosis; primary site; histology (if diagnosed prior to this admission); tumor location; tumor size; palpable lymph nodes; positive and negative clinical findings; impression pertaining to cancer diagnosis; and treatment plan.

#### Surgical Staging Procedures

a. Record documentation of all surgical diagnostic and staging procedures.

b. Include, as applicable: Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived; number of lymph nodes removed; size of tumor removed; documentation of residual tumor; evidence of invasion of surrounding areas.

#### Diagnostic Scope Procedures

a. Record documentation from endoscopic examinations that provide information for staging and treatment.
b. Include, as applicable: Date(s) of endoscopic exam(s); primary site; histology; tumor location; tumor size; lymph nodes; and positive and negative clinical findings.
GENERAL DEFINITIONS AND RULES FOR CODING TREATMENT

a. **Definitive (cancer-directed) treatment** is any therapy whose purpose is to modify, control, remove, or destroy proliferating cancer tissue. Treatment may be directed toward either the primary or metastatic sites, regardless of the patient’s response.

Record all cancer-directed treatment administered to the patient in the first course of treatment. Include treatment provided in other facilities and failed treatments (the patient did not respond).

For statistical analysis of treatment, only the following codes are considered definitive treatment codes:

- 10-90 Surgery (removal of tumor cells)
- 20-98 Regional radiation treatment modality (destruction of cancer cells through rays, radons)
- 01-03 Chemotherapy (destruction of cancer cells through chemicals, drugs)
- 01 Hormone/steroid (endocrine) therapy (changing hormonal balance through hormones, steroids, or endocrine surgery)
- 01 Immunotherapy or Biological Response Modifier therapy (agents that alter the immune system or change the host response)
- 10-40 Hematologic transplant and endocrine procedures
- 1-3 Other cancer-directed therapy (nonspecific or experimental)

Codes that indicate a specific definitive treatment is not recommended, recommended but not given, or unknown whether recommended or given may be recorded in the treatment fields listed below.

1. Chemotherapy codes 82-99
2. Hormone Therapy codes 82-99
3. Immunotherapy (Biological Response Modifier) codes 82-99
4. Other Therapy codes 7, 8, and 9
5. Hematologic Transplant and Endocrine Procedure codes 82-99

b. **Non-definitive (non cancer-directed) treatments** are performed to establish a diagnosis or stage, relieve symptoms, prolong the patient’s life, or prepare the patient for cancer-directed therapy. Such treatments are not considered cancer-directed treatment. There is no expectation of reducing the size of the tumor or of delaying the spread of the disease. In effect, it is treatment of the patient, not the cancer.

The following examples of non-definitive treatment are not considered cancer-directed therapy, but can be recorded in the designated fields, when applicable.

1. Surgical Diagnostic and Staging Procedure codes 01 – 09. These procedures include:
   - Incisional biopsies
   - Exploratory procedures with or without biopsies
   - -otomy, -ostomy, or bypass only
2. Palliative Care codes 1-9 (Not collected by the State Cancer Registry - refer to the FORDS.)

The following treatments are also considered non-definitive therapies and are not coded:

1. Pain medication
2. Oxygen
3. Antibiotics administered for an associated infection
4. Transfusions (e.g., to counteract blood dyscrasia resulting from chemotherapy)
5. Medication (e.g., Epogen, Neupogen, or Procrit) to counteract blood dyscrasia resulting from chemotherapy
6. Intravenous therapy to maintain fluid or nutritional balance
7. Laser therapy directed at relieving symptoms
8. Closure of colostomy in a patient with prior resection for cancer of the bowel
9. Megestrol acetate, hormone therapy designed to improve nutritional status
c. **First Course of Treatment**

All cancer-directed therapies specified in the physician(s) treatment plan during or after the initial diagnosis are part of the first course of treatment. Documentation of a treatment plan may be found in several different sources, for example: medical clinic record, consultation reports, and outpatient records. The discharge plan may document all or part of the treatment plan.

(1) For all malignancies except leukemias, first course of treatment includes all methods of therapy recorded in the treatment plan and administered to the patient during or after the first diagnosis of cancer. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more.

If the therapy is a part of an established protocol or administered within accepted management guidelines for the disease, it is first course of treatment. When a treatment plan is not available or is unclear, consult the physician advisor.

If there is no treatment plan, established protocol, or management guidelines, and consultation with a physician advisor is not possible, use the principle: “Initial treatment must begin within four months of the date of initial diagnosis.”

(2) For leukemias, first course of treatment includes all methods of therapy recorded in the treatment plan and administered to the patient during or after the first diagnosis of leukemia. Record all remission-inducing or remission-maintaining cancer-directed therapy as first course of treatment. Treatment regimens may include multiple modes of therapy and may encompass intervals of a year or more. Certain pediatric leukemia protocols span two years or more from induction to the end of maintenance. In these protocols, induction, consolidation, and maintenance are all first course of treatment.

If the therapy for leukemia is a part of an established protocol or administered within accepted management guidelines for the disease, it is first course of treatment. When a treatment plan is not available or is unclear, consult the physician advisor.

A patient may relapse after achieving a first remission. All therapy administered after the relapse is secondary or subsequent treatment.

d. **No Treatment**

No therapy is a treatment option (the patient refused therapy, the family/guardian refused therapy, the patient expired before therapy started, or the physician recommended no therapy). Therefore, first course of treatment may be no treatment. Record the date the decision was made not to treat in Date of First Course of Treatment.

e. **Treatment for Recurrence or Progression** (subsequent treatment) includes all treatments administered after the first course of therapy is complete or was stopped. A physician may stop treatment if the disease progresses despite therapy or if the patient fails to respond. The patient may also choose to stop treatment. If therapy is not part of the planned first course of treatment, it is considered subsequent therapy.

If there is a change in the original planned or administered treatment because the patient does not respond or the disease progresses, such therapy should be excluded from the first course of therapy and be considered as part of a second or subsequent course of therapy.

The State Cancer Registry does not require facilities to report subsequent therapy. The RMCDS program includes “Subsequent Treatment” screens for facilities that choose to report it.
f. **Treatment Dates**

(1) If your software allows collection of information for only one cancer-directed surgery, record the first date on which the patient has cancer-directed surgery. Record the surgery code with the highest priority according to the rules defined in the Appendix G for site-specific surgery codes.

(2) If the exact date that therapy was started is not known, the *best estimate* based on available information is acceptable. In the absence of an exact date of treatment, the date of hospital admission for the first cancer-directed therapy is acceptable. Recording an approximate date is preferable to leaving the date blank.

(3) If there is no basis for estimating, leave the month and day spaces blank. Every attempt should be made to enter the month and year, even if an estimate is necessary. In those rare instances when it is necessary to enter unknown month, day, or year, leave the appropriate spaces blank.

If information is limited to a description, use the following:

<table>
<thead>
<tr>
<th>DESCRIPTIVE TERM USED</th>
<th>DATE CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring</td>
<td>April</td>
</tr>
<tr>
<td>The middle of the year</td>
<td>July</td>
</tr>
<tr>
<td>Fall</td>
<td>October</td>
</tr>
<tr>
<td>Winter</td>
<td>Try to determine if this means the beginning of the year (January) or the end of the year (December). Code as indicated.</td>
</tr>
</tbody>
</table>

(4) If cancer-directed therapy was initiated at another facility and you cannot approximate the date it began, leave the date blank. If you do know the exact date, you should record it, even if the therapy did not take place at your facility.

(5) If the documented, planned first course of therapy occurred after four months, enter the date this planned first course of therapy was initiated, even if it was initiated after four months from the date of initial diagnosis.

(6) If class of case is 38 (diagnosed at autopsy), do not record any treatment or treatment dates. *Date of First Course Treatment* would be left blank.
### SURGICAL DIAGNOSTIC AND STAGING PROCEDURE

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No surgical diagnostic or staging procedure was performed.</td>
</tr>
<tr>
<td>01</td>
<td>A biopsy (incisional, needle, or aspiration) was done to a site other than the primary. No exploratory procedure was done.</td>
</tr>
<tr>
<td>02</td>
<td>A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.</td>
</tr>
<tr>
<td>03</td>
<td>A surgical exploration only. The patient was not biopsied or treated.</td>
</tr>
<tr>
<td>04</td>
<td>A surgical procedure with a bypass was performed, but no biopsy was done.</td>
</tr>
<tr>
<td>05</td>
<td>An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.</td>
</tr>
<tr>
<td>06</td>
<td>A bypass procedure was performed, and a biopsy of either the primary site or another site was done.</td>
</tr>
<tr>
<td>07</td>
<td>A procedure was done, but the type of procedure is unknown.</td>
</tr>
<tr>
<td>09</td>
<td>No information of whether a diagnostic or staging procedure was performed.</td>
</tr>
</tbody>
</table>

#### Instructions

a. Record the type of procedure performed as part of the initial diagnosis and work-up, whether this is done at your facility or another facility.

b. Only record positive procedures. For benign and borderline reportable tumors, report the biopsies positive for those conditions. For malignant tumors, report procedures if they were positive for malignancy.

c. If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, record code 02 (Incisional biopsy of primary site).

d. Record code 02 for lymphoma primaries when a lymph node is biopsied or removed for diagnosis or staging and that node is not the only node involved with lymphoma. When the lymph node removed is the only node involved with lymphoma, record the applicable surgical procedure code in *Surgical Procedure of Primary Site*.

e. Do not code surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease in this data item. Use the data item Scope of Regional Lymph Node Surgery to code these procedures. Do not record the date of surgical procedures that aspirate, biopsy, or remove regional lymph nodes in the data item Date of Surgical Diagnostic and Staging Procedure. See instructions for Scope of Regional Lymph Node Surgery.

f. Do not code brushing, washings, cell aspiration, or hematologic findings (peripheral blood smears). These are not considered surgical procedures and should not be coded in this item.
Coding Instructions  Treatment Data  Chapter 5

Coding Instructions

Treatment Data

Chapter 5

Coding Instructions

Treatment Data

Chapter 5

g. Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item Surgical Procedure of Primary Site to code these procedures.

h. When a needle biopsy of the primary site is followed by an excisional biopsy or more extensive surgery, code both, even if no tumor remained at the time of the surgery. (Code Surgical Diagnostic and Staging Procedure and Surgical Procedure of Primary Site.)

i. Do not code palliative surgical procedures in this data item. Use the Palliative Care field to code these procedures. The State Registry does not collect the Palliative Care data item. Refer to the FORDS manual for codes.

Codes with Examples:

00 A lung cancer primary was diagnosed by CT scan. The patient expired. No surgical diagnostic or staging surgical procedure was performed.

00 A sputum sample is examined cytologically to confirm a diagnosis of suspected lung cancer. The procedure is not surgical.

01 A needle biopsy of a liver metastasis in a patient with suspected widespread colon cancer was done. Gross residual tumor is left at the biopsy site.

02 During a colonoscopy, a biopsy of a primary rectal mass was done. Gross residual tumor is left at the biopsy site.

03 During abdominal exploratory surgery, a gastric lesion and suspicious retroperitoneal lymph nodes were observed. No biopsy or treatment was done.

04 An abdominal exploration of a patient revealed pancreatic carcinoma with extension into surrounding organs and arteries. There was no attempt to treat. A bypass was performed to alleviate symptoms.

05 An open, exploratory procedure was performed for primary colon carcinoma with biopsy of suspicious liver lesions.

06 Esophagogastrostomy was performed for infiltrating gastric tumor following a biopsy of the primary site.

07 Stage III lung carcinoma was diagnosed and staged prior to admission.

09 A patient expires in the emergency room with recently diagnosed metastatic melanoma. It is unknown whether a diagnostic or staging procedure was done.
**DATE OF FIRST COURSE OF TREATMENT**

**Description**
This is a required 8-character field for recording the date on which treatment (surgery, radiation, systemic, or other therapy) of the patient began at any facility. Determine whether your software vendor uses the traditional format for date entry (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format.

**Codes**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>January</td>
<td>01</td>
</tr>
<tr>
<td>02</td>
<td>February</td>
<td>02</td>
</tr>
<tr>
<td>03</td>
<td>March</td>
<td>03</td>
</tr>
<tr>
<td>04</td>
<td>April</td>
<td>...</td>
</tr>
<tr>
<td>05</td>
<td>May</td>
<td>...</td>
</tr>
<tr>
<td>06</td>
<td>June</td>
<td>25</td>
</tr>
<tr>
<td>07</td>
<td>July</td>
<td>26</td>
</tr>
<tr>
<td>08</td>
<td>August</td>
<td>...</td>
</tr>
<tr>
<td>09</td>
<td>September</td>
<td>30</td>
</tr>
<tr>
<td>10</td>
<td>October</td>
<td>31</td>
</tr>
<tr>
<td>11</td>
<td>November</td>
<td>blank = Day unknown</td>
</tr>
<tr>
<td>12</td>
<td>December</td>
<td>blank = Month unknown</td>
</tr>
</tbody>
</table>

**Instructions**

a. Record the earliest of the following dates: Date of First Surgical Procedure, Date Radiation Started, Date Chemotherapy Started, Date Hormone Therapy Started, Date Immunotherapy Started, Date of Hematologic Transplant and Endocrine Procedure, or Date Other Treatment Started. Record the earliest treatment date, whether it occurs at your facility or elsewhere. For example, if the patient receives preoperative radiation elsewhere before admission to your facility for surgery, record the date of the preoperative radiation.

b. If active surveillance or watchful waiting is selected as the first course of treatment, record the date this decision is made.

c. In cases of non-treatment, in which a physician decides not to treat a patient or a patient’s family or guardian declines all treatment, record the date this decision was made.

d. If the cancer was diagnosed at autopsy and not suspected prior to that, leave this item blank.

e. Do not record the date of incisional, core, or fine needle biopsy in this field, even if it is the only procedure performed.

f. Record the date of an excisional biopsy as the Date of First Course of Treatment, whether followed by further definitive therapy or not. The excisional biopsy date will remain Date of First Course of Treatment even when followed by other surgery of the primary site. Enter the date of the excisional biopsy, whether or not residual tumor was found at the time of later resection. If the biopsy was not stated to be excisional, but no residual tumor was found at a later resection, assume that the biopsy was excisional. Use the date of admission if an exact treatment date is not obtainable for the excisional biopsy.

g. If the exact date of the beginning of treatment is not available, record an approximate date. If information is limited to a description, use the following:

<table>
<thead>
<tr>
<th>DESCRIPTIVE TERM USED</th>
<th>DATE CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring</td>
<td>April</td>
</tr>
<tr>
<td>The middle of the year</td>
<td>July</td>
</tr>
<tr>
<td>Fall</td>
<td>October</td>
</tr>
<tr>
<td>Winter</td>
<td></td>
</tr>
</tbody>
</table>

Try to determine if this means the beginning of the year (January) or the end of the year (December). Code as indicated.

j. If the date of first course of treatment cannot be determined at all or is not applicable, leave the date of first course of treatment blank and record the reason in Date of First Course of Treatment Flag. See the Date of First Course of Treatment Flag section for examples illustrating the relationships among these items.
**DATE OF FIRST COURSE TREATMENT FLAG**

**Description**
This flag explains why there is no appropriate value in the corresponding date field, *Date of First Course Treatment* (NAACCR Item #1270). This data item was added to Volume II Version 12 (effective January 2010).

**Rationale**
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

**Codes**
10. No information whatsoever can be inferred from this exceptional value (It is unknown whether treatment was administered.)
11. A valid date is not applicable in this context (for example, autopsy only case)
12. A valid date is applicable but not known (for example, treatment was administered but the date is unknown)
Blank. A valid date is coded in the *Date of First Course Treatment* item (NAACCR Item #1270).

**Instructions**

a. Leave this item blank if *Date of First Course Treatment* has a full or partial date recorded.

b. Use code 12:
   If the *Date of First Course Treatment* cannot be determined at all, but the patient did receive first course treatment, or;
   If a decision not to treat was made, but the date is totally unknown, or;
   If a decision to use active surveillance was made, but the date is totally unknown.

c. Use code 10 if it is unknown whether any treatment was administered.

d. Use code 11 if the initial diagnosis was made at autopsy.

e. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

**Examples:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of 1st Crs Rx Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td>*01/08/2015 or 2015/01/08</td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td>*01/_ <em>/2015 or 2015/01/</em> _</td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>* _ <em>/</em> <em>/2015 or 2015/</em> <em>/</em> _</td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown if Rx given</td>
<td>* / _ / _ _ _ _ or _ _ / _ _ / _</td>
<td>10</td>
</tr>
<tr>
<td>Diagnosed at autopsy</td>
<td>* / _ / _ _ _ _ or _ _ / _ _ / _</td>
<td>11</td>
</tr>
<tr>
<td>Rx given, unknown date</td>
<td>* / _ / _ _ _ _ or _ _ / _ _ / _</td>
<td>12</td>
</tr>
</tbody>
</table>

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format. The computer will store either in the interoperable format.
**DATE MOST DEFINITIVE SURGICAL RESECTION OF PRIMARY SITE**

*Required for cases diagnosed 01/01/2015 and later.*

**Description**

This is a required 8-character field for recording the date the most definitive surgical procedure of the primary site was performed. Determine whether your software vendor uses the traditional format for date entry (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format.

**Codes**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>January</td>
<td>01</td>
</tr>
<tr>
<td>02</td>
<td>February</td>
<td>02</td>
</tr>
<tr>
<td>03</td>
<td>March</td>
<td>03</td>
</tr>
<tr>
<td>04</td>
<td>April</td>
<td>...</td>
</tr>
<tr>
<td>05</td>
<td>May</td>
<td>...</td>
</tr>
<tr>
<td>06</td>
<td>June</td>
<td>25</td>
</tr>
<tr>
<td>07</td>
<td>July</td>
<td>26</td>
</tr>
<tr>
<td>08</td>
<td>August</td>
<td>...</td>
</tr>
<tr>
<td>09</td>
<td>September</td>
<td>30</td>
</tr>
<tr>
<td>10</td>
<td>October</td>
<td>31</td>
</tr>
<tr>
<td>11</td>
<td>November</td>
<td>blank = Day unknown</td>
</tr>
<tr>
<td>12</td>
<td>December</td>
<td></td>
</tr>
</tbody>
</table>

**Instructions**

a. Record the date on which the surgery described by *Surgical Procedure of Primary Site* (NAACCR Item #1290) was performed at your facility or elsewhere. For example, if the patient receives surgery elsewhere before admission to your facility for adjuvant treatment, record the date of the surgery.

b. If the exact date of surgery is not available, record an approximate date. If information is limited to a description, use the following:

<table>
<thead>
<tr>
<th>DESCRIPTIVE TERM USED</th>
<th>DATE CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring</td>
<td>April</td>
</tr>
<tr>
<td>The middle of the year</td>
<td>July</td>
</tr>
<tr>
<td>Fall</td>
<td>October</td>
</tr>
<tr>
<td>Winter</td>
<td>Try to determine if this means the beginning of the year (January) or the end of the year (December). Code as indicated.</td>
</tr>
</tbody>
</table>

c. If the date of surgery cannot be determined at all or is not applicable, leave the date of most definitive surgery blank and record the reason in *Date of Most Definitive Surgery Flag*. See the *Date of Most Definitive Surgery Flag* section for examples illustrating the relationships among these items.
Chapter 5  Treatment Data  Coding Instructions

DATE OF MOST DEFINITIVE SURGERY FLAG

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of 1&lt;sup&gt;st&lt;/sup&gt; Crs Rx Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td>*01/08/2015 or 2015/01/08</td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td>*01/<em><strong>/2015 or 2015/01/</strong></em></td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>*<strong>/</strong>/2015 or 2015__/<strong>/</strong></td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown if surgery performed</td>
<td>*<strong>/</strong>/___ or <strong>/</strong>/<em><strong>/</strong></em></td>
<td>10</td>
</tr>
<tr>
<td>No surgery performed</td>
<td>*<strong>/</strong>/___ or <strong>/</strong>/<em><strong>/</strong></em></td>
<td>11</td>
</tr>
<tr>
<td>Surgery performed, unknown date</td>
<td>*<strong>/</strong>/___ or <strong>/</strong>/<em><strong>/</strong></em></td>
<td>12</td>
</tr>
</tbody>
</table>

* Required for cases diagnosed 01/01/2015 and later.

**Description**
This flag explains why there is no appropriate value in the corresponding date field, Date of Most Definitive Surgical Resection of Primary Site (NAACCR Item #3170). This data item was added to Volume II Version 12 (effective January 2010).

**Rationale**
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

**Codes**
10 No information whatsoever can be inferred from this exceptional value (It is unknown whether treatment was administered.)
11 A valid date is not applicable in this context (for example, no surgery performed)
12 A valid date is applicable but not known (for example, surgery was performed but the date is unknown)
Blank A valid date is coded in the Date of Most Definitive Surgical Resection of Primary Site item (NAACCR Item #3170).

**Instructions**
a. Leave this item blank if Date of Most Definitive Surgical Resection of Primary Site has a full or partial date recorded.
b. Use code 12 if the Date of Most Definitive Surgical Resection of Primary Site cannot be determined, but the patient did receive first course surgery.
c. Use code 10 if it is unknown whether any surgery was performed.
d. Use code 11 if no surgical procedure was performed.
e. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

**Examples:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of 1&lt;sup&gt;st&lt;/sup&gt; Crs Rx Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td>*01/08/2015 or 2015/01/08</td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td>*01/<em><strong>/2015 or 2015/01/</strong></em></td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>*<strong>/</strong>/2015 or 2015__/<strong>/</strong></td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown if surgery</td>
<td>*<strong>/</strong>/___ or <strong>/</strong>/<em><strong>/</strong></em></td>
<td>10</td>
</tr>
<tr>
<td>No surgery performed</td>
<td>*<strong>/</strong>/___ or <strong>/</strong>/<em><strong>/</strong></em></td>
<td>11</td>
</tr>
<tr>
<td>Surgery performed,</td>
<td>*<strong>/</strong>/___ or <strong>/</strong>/<em><strong>/</strong></em></td>
<td>12</td>
</tr>
<tr>
<td>unknown date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format. The computer will store either in the interoperable format.
**TREATMENT STATUS**

*Required if available for cases diagnosed 01/01/2010 and later.

**Description**
This data item summarizes whether the patient received any first course treatment or the tumor was under active surveillance.

**Rationale**
This item documents active surveillance (watchful waiting) and eliminates searching each treatment modality to determine whether treatment was given. It is used in conjunction with *Date of First Course of Treatment* to document whether treatment was or was not given, it is unknown if treatment was given, or treatment was given on an unknown date.

**Codes**
- 0  No treatment given
- 1  Treatment given
- 2  Active surveillance (watchful waiting)
- 9  Unknown if treatment was given

**Instructions for Coding**

a. Leave this item blank for cases diagnosed prior to 2010,

b. Treatment given after a period of active surveillance is considered subsequent treatment and should **not** be coded as “Treatment given” (code 1) in this item.

**Examples:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>An elderly patient with pancreatic cancer requested no treatment.</td>
</tr>
<tr>
<td>0</td>
<td>The patient is expected to receive radiation, but it has not occurred yet (Code 8 is recorded in <em>Reason for No Radiation</em>.)</td>
</tr>
<tr>
<td>2</td>
<td>The treatment plan for a patient with lymphoma is active surveillance.</td>
</tr>
</tbody>
</table>
GENERAL INSTRUCTIONS FOR RMCDS TREATMENT FIELDS

Description
Ten hospital-specific first course treatment screens are available in the RMCDS FORDS version for recording first course treatment provided at the reporting facility and/or other facilities. Each of the screens is similar to the illustration provided below and includes fields for recording the facility where the treatment occurred, the codes for the various treatment modalities, and the respective dates of treatment. The first available screen is opened by double clicking on the First Course Treatment field or by using the “Alt” and “T” keys. The “Next” button will open an additional first course treatment screen only if data has been entered in the current screen. Use the “Exit” button or the “Esc” key to close the treatment screens.

First Course Treatment

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>When data is entered, the facility ID is recorded.</td>
</tr>
<tr>
<td>Dx/Stage Proc</td>
<td>Date/Stage Date</td>
</tr>
<tr>
<td>Surg Prim Site</td>
<td>Surgery Date</td>
</tr>
<tr>
<td>Radiation (SEER)</td>
<td>Discharge Date</td>
</tr>
<tr>
<td>Rad Rx Mod</td>
<td>Rad Date</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Horm Date</td>
</tr>
<tr>
<td>Hormonal</td>
<td>BRM Date</td>
</tr>
<tr>
<td>BRM</td>
<td>Tr/E Date</td>
</tr>
<tr>
<td>Transpl/Endo</td>
<td>Other Date</td>
</tr>
<tr>
<td>Other</td>
<td>Scope of LN Surgery</td>
</tr>
<tr>
<td>Surgery of Other Sites</td>
<td>Surgery of Other Sites</td>
</tr>
<tr>
<td>Palliative Procedure</td>
<td>Reg LN Examined</td>
</tr>
<tr>
<td>Location of Radiation</td>
<td>Screen/Bx</td>
</tr>
<tr>
<td>Surgical Approach</td>
<td>Treatment Status</td>
</tr>
<tr>
<td>Surgical Appr 2010</td>
<td>Readm 30 days</td>
</tr>
<tr>
<td>Surgical Margins</td>
<td>Reconstructive Surg</td>
</tr>
</tbody>
</table>

Instructions
a. Hospital (Refer to Appendix D of this manual for facility identification (ID) numbers.) If any of the treatment modalities were provided at your facility, record your facility number in the hospital field. If more than one surgery of the primary site are performed at your facility, use the other “First Course Treatment” screen(s) as needed.

If additional treatment is known to have been provided at other facility(ies), use the other “First Course Treatment” screen(s) as needed, recording the facility’s ID number or 999. Code facility ID as 700 for treatment provided in a physician’s office. If the only known treatment was provided at another facility, use the first available screen. If it is unknown where the treatment occurred, record code 999.
b. Surgical Diagnostic and Staging Procedure
   Record the appropriate Surgical Diagnostic and Staging Procedure code from the list defined in that section of this manual.

c. Treatment Modality Fields
   Record the appropriate treatment code(s) from the applicable list(s) in this manual for Surgery of Primary Site, Radiation, Radiation Modality, Chemotherapy, Hormone Therapy, Biological Response Modifier, Transplant/Endocrine Procedure, or Other Treatment.

d. Dates
   Record the eight-character date (MM/DD/YYYY) that the treatment was performed or started in the date field adjacent to the applicable treatment code. Fill with leading zeros where needed (e.g., record June 3, 2015 as 06/03/2015). If the patient received no treatment or if the date is unknown, leave the date field blank. If the month or day is unknown, leave the applicable section of the date item blank and enter the appropriate numbers for the known component(s) of the date (usually at least the year).

   In the Date Systemic item, record the first or earliest date on which systemic therapy was administered. Systemic therapy includes Chemotherapy, Hormone Therapy, Immunotherapy, and Hematologic Transplant and Endocrine Procedures.

e. Date Flags
   Spaces for the two-digit Date Flag codes are provided after the hyphen on the right side of each treatment date field. For each treatment date field that is blank, enter the appropriate Date Flag code. Leave the Date Flag spaces blank for any full or partial treatment date.

   The Date Flag codes may be entered either manually, by placing the cursor in the first space and entering the code, or by clicking the tab labeled “F” and selecting the appropriate code for auto-entry.

f. Scope of Lymph Node Surgery
   Record the appropriate Scope of Lymph Node Surgery code from the list defined in that section of this manual.

g. Surgery of Other Sites
   Record the appropriate Surgery of Other Sites code from the list defined in that section of this manual.

h. Treatment Status (State required for cases diagnosed 2010 and later)
   Record the appropriate Treatment Status code from the list defined in that section of this manual.

i. The items listed below must be coded for cases diagnosed before 2003. Record the appropriate codes from historical coding manuals, such as the 1998 State Manual or the ROADS 1998. The related data items (Surgery Primary Site, Scope of LN Surgery, and Surgery of Other Sites) must also be coded using codes and instructions from current manuals.

   Surg 98-02
   Scope 98-02
   SX (Surgery) Other 98-02

j. The items listed below are not required by the State Cancer Registry. Facilities that wish to collect them should use the codes defined in the FORDS manual.

   Palliative Procedure (Palliative Care)
   Location of Radiation
   Surgical Appr (Approach) 2010
   Surgical Margins
   Readm 30 days
k. The items listed below were created from coding manuals for cases diagnosed before 2003 and may be left blank if abstracting cases diagnosed before or after 2003. For cases abstracted prior to the 2003 conversion, these items will have retained any original coding.

Surgical Approach  
Regional Lymph Nodes Examined  
Screen/Bx (Screening/Biopsy) Procedure  
Reconstructive Surg  
Surgery Type

l. Radiation Detail  
Clicking on the tab labeled “Radiation Detail” opens a screen for coding the additional radiation treatment information that is not required by the State Registry. Facilities that wish to collect these items should use the codes defined in the FORDS manual.

Subsequent Treatment  
Ten “Subsequent Treatment” screens are available in the RMCDS program. The first available screen is opened by using the Alt and “Q” keys. Subsequent treatment is optional for reporting to the State Registry.
**SURGICAL PROCEDURE OF PRIMARY SITE**  
(CANCER-DIRECTED SURGERY)

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>None; no surgical procedure of primary site; diagnosed at autopsy only</td>
</tr>
<tr>
<td>10-19</td>
<td>Site-specific codes. Tumor destruction; no pathologic specimen or unknown whether there is pathologic specimen</td>
</tr>
<tr>
<td>20-80</td>
<td>Site-specific codes. Resection; pathologic specimen</td>
</tr>
<tr>
<td>90</td>
<td>Surgery, NOS. A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.</td>
</tr>
<tr>
<td>98</td>
<td>Special code for hematopoietic, reticuloendothelial, immunoproliferative, myeloproliferative diseases; unknown primaries; and ill-defined sites (See site-specific codes for the sites and histologies), except death certificate only</td>
</tr>
<tr>
<td>99</td>
<td>Unknown if surgery performed; death certificate only</td>
</tr>
</tbody>
</table>

**Definitions**

a. **Definitive (cancer-directed) surgery** is surgery that removes or destroys proliferating cancer tissue. This includes excisional biopsy with microscopic residual disease or no residual disease. Valid codes for cancer-directed surgery of the primary site are 10-90.

b. **Non cancer-directed procedures** are performed to diagnose or stage the disease (Surgical Diagnostic and Staging Procedure codes 01-07), or for relief of symptoms (Palliative Care code 1). Record Surgical Diagnostic and Staging Procedures in the designated field of the RMCDS “First Course of Treatment” screens. The State Registry does not collect the Palliative Care data item.

The following procedures are examples of exploratory (diagnostic or staging) surgery (code 03 without biopsy or code 05 with biopsy).

- Celiotomy
- Laparotomy
- Cystotomy
- Nephrotomy
- Gastrostomy
- Thoracotomy, including Chamberlain procedure

The following non cancer-directed procedures are examples of bypass surgery (code 04 without biopsy or code 06 with biopsy). Code only if performed as part of the initial diagnosis and work-up. If performed for palliation only, code in Palliative Care if collected. The State Registry does not collect the Palliative Care data item.

- Colostomy
- Nephrostomy
- Esophagostomy
- Tracheostomy
- Gastrostomy
• Urethrostomy

The following examples of diagnostic (non cancer-directed) procedures are not considered exploratory surgery. These procedures do not require an incision, since entry into a body cavity is made through a natural orifice. Code only if a biopsy was done as part of the procedure.

• Bronchoscopy
• Colonoscopy
• Cystoscopy
• Endoscopy
• ERCP (endoscopic retrograde cholangiopancreatography)
• Laryngoscopy
• Mediastinoscopy
• Dilatation & curettage (D & C) – Use non cancer-directed surgery code 02 when primary site is corpus uteri. Use the cancer-directed surgery code only when performed for in situ cancer of the cervix.

Brushings, washings, aspiration of cells, and hematologic findings (peripheral blood smears) are not surgical procedures.

Instructions
a. After determining that cancer-directed surgery of the primary site was performed, use the best information in the operative and pathology reports to determine the operative procedure. The operative report title may not have adequate information for the surgery code. Use the operative report text and the pathology report to correctly identify the procedure performed. Use the information from the pathology report when an operative report is unclear or is inconsistent.

Exception: If the pathology report states they cannot give an accurate accounting of organs removed (tumor encasement, crush artifact, etc).

b. In the “Surgery” field, record the site-specific 2-digit surgical code from Appendix G for the specific surgery performed as part of the first course of treatment. For RMCDS users, record the date the surgery was performed in the adjacent “Date” field.

c. Record Surgical Diagnostic and Staging Procedures in the designated field of the RMCDS “First Course of Treatment” screens. Do record all biopsies as well as cancer-directed surgical procedures.

d. More than one cancer-directed surgical procedure can be recorded in the RMCDS “First Course of Treatment” screens.

If a biopsy was followed by a re-excision or wide excision within the first course of cancer-directed therapy and the path report for the re-excision or wide excision is negative for residual tumor, code the biopsy as an excisional biopsy. In the RMCDS program or the paper abstract, record both procedures, each with its respective date. Record the excisional biopsy date as the date of first course of treatment.

Example 1: A patient has an excisional breast biopsy at your hospital January 12, 2015. The pathology report reveals an axillary node with micrometastasis. The patient opted to have a mastectomy on March 21, 2015. Code the procedures as follows:

<table>
<thead>
<tr>
<th>Surgery Code</th>
<th>Procedure</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>Simple mastectomy</td>
<td>03/21/2015</td>
</tr>
<tr>
<td>22</td>
<td>Excisional biopsy</td>
<td>01/12/2015</td>
</tr>
</tbody>
</table>

If you can record only one surgical procedure in your system, record the surgical code with the highest priority according to the rules on the following page and use the first date on which the patient has cancer-directed surgery (41-01/12/2015).
Example 2: A patient had a breast biopsy on March 15, 2015 in the physician’s office. A simple mastectomy was done at your hospital on March 27, 2015. Both procedures should be recorded, as follows:

<table>
<thead>
<tr>
<th>Surgery Code</th>
<th>Procedure</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>Mastectomy</td>
<td>03/27/2015</td>
</tr>
<tr>
<td>02</td>
<td>Incisional biopsy of primary site</td>
<td>03/15/2015</td>
</tr>
</tbody>
</table>

If you can record only one surgical procedure in your system, code surgery 41 with 03/27/2015 as the date of treatment.

e. If the patient had no surgery at your hospital, but had surgery at another facility, you may enter the surgery information from the other hospital, if known. In one of the RMCDS “First Course Treatment” screen(s), record the facility ID and the appropriate surgery code and date. In the paper abstract, identify the facility in the Description of Treatment text field.

f. If the patient did not have cancer-directed surgery, record the reason as instructed in the Reason for No Surgery of Primary Site section.

Special Rules

a. Coding Multiple Definitive Surgeries

1. If a single field is available for the data item Surgical Procedure of Primary Site or if a summary treatment field is provided and the patient has multiple cancer-directed surgeries of the primary site, code the most invasive, definitive surgery. For codes 00 through 79, the code positions are hierarchical. Last-listed codes take precedence over codes listed above. Use codes 80 and 90 only if more precise information about the surgery is unavailable.

   Example: A patient has a colonoscopy with removal of a polyp in the sigmoid colon (code 28). The pathology report identifies carcinoma extending into the stalk. A week later, the patient has a hemicolectomy (code 40). Code the hemicolectomy since it is the most invasive, definitive surgery.

2. If multiple fields are available to record consecutive surgical events, code each consecutive surgery of the primary site. For the example above, record both procedures, each with its respective date. Record the polypectomy date as the date of first course of treatment.

b. Coding Surgery for Multiple Primaries

Code the appropriate surgery for each site when multiple primaries are excised at the same time.

Example 1: A patient who has cancer of the cervix and of the endometrium enters your facility for a total abdominal hysterectomy. Code a total abdominal hysterectomy for each of the two primaries.

Example 2: A patient has colon and skin cancer. The patient had a hemicolectomy and a wide excision of the skin lesion. Code the colectomy for colon and the wide excision for skin.

c. If a surgical procedure removes the remaining portion of an organ that had been partially resected previously for any condition, code as total removal of the organ. If none of the primary organ remains, the code should indicate that this is the case.

Example 1: Resection of a stomach that had been partially excised previously is coded as total removal of stomach.

Example 2: Removal of a cervical stump is coded as total removal of uterus.

Example 3: Lobectomy of a lung with a previous wedge resection is coded as total removal of lobe.

d. Code 98 applies to specific tumors that cannot be clearly defined in terms of primary or non-primary site. Use code 98 for the following:

   - All hematopoietic, reticuloendothelial, immunoproliferative, myeloproliferative diseases;
   - All unknown primaries and ill-defined sites.
**Exception:** For death certificate only cases, use code 99.

e. For extra-lymphatic lymphoma, code surgery using the site-specific surgery coding scheme for the primary site (not the lymph node scheme).

f. For facilities that collect *Palliative Care:* If the procedure coded in this item was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the *Palliative Care* field. The State Registry does not collect the *Palliative Care* data item.
DATE OF SURGERY FLAG

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of First Surgical Procedure* (NAACCR Item #1200). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
10 No information whatsoever can be inferred from this exceptional value. (It is unknown if any surgical procedure was performed.)
11 No valid date is applicable in this context (for example, no surgical procedure was performed).
12 A valid date is applicable but not known. (Surgery was performed but the date is unknown.)
Blank A valid date is coded in item *Date of First Surgical Procedure* (NAACCR Item #1200).

Instructions
a. Leave this item blank if *Date of First Surgical Procedure* (NAACCR Item #1200) has a full or partial date recorded.
b. Use code 12 if the *Date of First Surgical Procedure* cannot be determined, but the patient did receive first course surgery.
c. Use code 10 if it is unknown whether any surgery was performed.
d. Use code 11 if the no surgical procedure was performed.
e. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

Examples:

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of Surgery Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td>*01/08/2015 or 2015/01/08</td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td>*01/<em>/</em>/2015 or 2015/01/_</td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>*<strong>/</strong>/2015 or 2015/<strong>/</strong></td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown if surgery performed</td>
<td>*<strong>/</strong>/__ or <strong>/</strong>/__/</td>
<td>10</td>
</tr>
<tr>
<td>No surgery performed</td>
<td>*<strong>/</strong>/__ or <strong>/</strong>/__/</td>
<td>11</td>
</tr>
<tr>
<td>Surgery performed, date unknown</td>
<td>*<strong>/</strong>/__ or <strong>/</strong>/__/</td>
<td>12</td>
</tr>
</tbody>
</table>

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format. The computer will store either in the interoperable format.
SCOPE OF REGIONAL LYMPH NODE SURGERY

Description
This item identifies the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event. The item can be used to compare and evaluate the extent of surgical treatment.

Codes
0 None
1 Biopsy or aspiration of regional lymph node(s)
2 Sentinel lymph node biopsy (only)
3 Number of regional nodes removed unknown or not stated; regional lymph nodes removed, NOS
4 1 to 3 regional lymph nodes removed
5 4 or more regional lymph nodes removed
6 Sentinel node biopsy and procedures that would be coded 3, 4, or 5 performed at the same time, or timing not stated
7 Sentinel node biopsy and procedures that would be coded 3, 4, or 5 performed at different times
9 Unknown or not applicable

Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. Review both the surgeon’s planned procedure as well as the description of the procedure that was actually performed. The operative report takes precedence over the pathology report for distinguishing between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.

Definitions

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.</td>
</tr>
<tr>
<td>1</td>
<td>Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease. Notes: If additional procedures were performed on the lymph nodes, use the appropriate code 2-7. For breast, biopsy or aspiration of regional lymph node(s) is uncommon. Confirm that the procedure was not actually a sentinel lymph biopsy.</td>
</tr>
<tr>
<td>2</td>
<td>Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye, radio-label, or a combination at the site of the primary tumor. Notes: Additional non-sentinel nodes can be taken during the same operative procedure. The additional nodes may be discovered by the pathologist or selectively removed (harvested) as part of the SLNBx procedure by the surgeon. If the operative report confirms that a regional lymph node dissection followed the SLNBx, use code 6.</td>
</tr>
<tr>
<td>3</td>
<td>Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel node biopsy.</td>
</tr>
<tr>
<td>Code</td>
<td>Definition</td>
</tr>
<tr>
<td>------</td>
<td>------------</td>
</tr>
</tbody>
</table>
| 4    | Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen.  
Note: Code 4 should be used infrequently. Ensure that the procedure is not specified as SLNBx in the operative report. |
| 5    | Sampling or dissection of four or more regional lymph nodes.  
Notes: If relatively few nodes were examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes was examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7). |
| 6    | SLNBx and procedures that would be coded 3, 4, or 5 performed at the same time, or timing not stated.  
Notes: Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. If relatively few nodes were examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a SLNBx is attempted and the patient fails to map (no sentinel lymph nodes are identified by the dye and/or radio-label injection) and the surgeon performs a more extensive dissection of regional lymph nodes, use code 6. |
| 7    | SLNBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events.  
Notes: Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. If relatively few nodes were examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). |
| 9    | It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease. |

**Instructions**

a. Record the scope of regional lymph node surgery for each surgical event even if no surgery of the primary site was performed.

b. Record surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item. Record the date of this surgical procedure in data item *Date of First Course Treatment* and/or *Date of First Surgical Procedure* as appropriate.

c. Codes 0-7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.

d. If two or more surgical procedures of regional lymph nodes are performed, the code for each subsequent procedure must include the cumulative effect of all preceding procedures. For example, a sentinel lymph node biopsy followed by a regional lymph node dissection at a later time is coded 7.

e. Code the removal of regional nodes for both primaries when the patient two primaries with common regional lymph nodes.

f. Use code 9 for the following:
   - Primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (C70.0-C70.9, C71.0-C71.9, C72.0-C72.9, C75.1-C75.3);
   - Lymphomas (histologies 9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948, and 9971) with a lymph node primary site (C77.0-C77.9);
   - Unknown or ill-defined primary (C76.0-C76.8, C80.9);
g. Do not code distant lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field Surgical Procedure/Other Site.

h. Refer to the current AJCC Cancer Staging Manual for site-specific identification of regional lymph nodes.

i. For facilities that collect Palliative Care: If the procedure coded in this item was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the Palliative Care field. The State Registry does not collect the Palliative Care data item.

Codes with Examples:
0 No effort was made to locate sentinel lymph nodes and no nodes were found in pathologic analysis.
2 Primary site is breast (C50.1). There was an attempt at sentinel lymph node dissection, but no lymph nodes were found in the pathological specimen.
1 Primary site is pharynx (C14.0). Aspiration of regional lymph node was performed to confirm histology of widely metastatic disease.
2 Primary site is skin of back (C44.5). Histology is melanoma. A sentinel lymph node dissection was done with the removal of one lymph node. This node was negative for disease.
3 Primary site is prostate (C61.9). Bilateral pelvic lymph node dissection was performed.
6 Primary site is breast (C50.3). Sentinel lymph node biopsy of right axilla, followed by right axillary lymph node dissection during the same surgical event.
7 Primary site is breast (C50.4). Sentinel lymph node biopsy of left axilla, followed by a left axillary lymph node dissection in a second procedure 5 days later.
9 Primary site is lung (C34.9). Patient was admitted for radiation therapy following surgery for lung cancer. There is no documentation on the extent of surgery in the patient record.
SURGICAL PROCEDURE/OTHER SITE

Description
This item records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

Codes
0  None
1  Nonprimary surgical procedure performed, unknown whether regional or distant
2  Nonprimary surgical procedure to other regional sites
3  Nonprimary surgical procedure to distant lymph node(s)
4  Nonprimary surgical procedure to distant site
5  Combination of codes
9  Unknown

Definitions

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No surgical procedure of nonprimary site was performed. Diagnosed at autopsy.</td>
</tr>
<tr>
<td>1</td>
<td>Nonprimary surgical resection other site(s), unknown if the site(s) is regional or distant.</td>
</tr>
<tr>
<td>2</td>
<td>Resection of regional site.</td>
</tr>
<tr>
<td>3</td>
<td>Resection of distant lymph node(s).</td>
</tr>
<tr>
<td>4</td>
<td>Resection of distant site.</td>
</tr>
<tr>
<td>5</td>
<td>Any combination of surgical procedures that would be coded 2, 3, or 4.</td>
</tr>
<tr>
<td>9</td>
<td>It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only.</td>
</tr>
</tbody>
</table>

Instructions

a. Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgery code.

b. Do not code incidental removal of tissue or organs as Surgical Procedure/Other Site.

c. Record the Surgical Procedure/Other Site for each surgical event even if no surgery of the primary site was performed.

d. Use code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0-C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, myeloproliferative, or myelodysplastic disease (C42.0, C42.1, C42.3, C42.4 or 9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992).

e. If multiple first course surgical procedures coded in this item are performed for a single primary, use the code that represents the cumulative effect of those surgeries.

f. For facilities that collect Palliative Care: If the procedure coded in this item was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the Palliative Care field. The State Registry does not collect the Palliative Care data item.

Codes with Examples:
0 Primary site is colon (C18.1). The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon.
1 Surgical removal of metastatic lesion from liver; unknown primary.
2 Primary site is colon (C18.3). Surgical ablation of solitary liver metastasis, hepatic flexure primary.
4 Primary site is rectosigmoid (C19.9). Excision of multiple liver metastasis.
4 Primary site is lung (C34.9). Removal of solitary brain metastasis.
5 Primary site is anus (C21.0). Excision of solitary liver metastasis and one large hilar lymph node.
**Reason for No Surgery of Primary Site**

*Required if available for cases diagnosed 01/01/2006 and later.*

**Description**

This is an optional 1-character field for recording the reason that no surgery was performed on the primary site. This item **is related only to first course of therapy.** This information is to be coded if it is available in the medical record.

**Codes**

0  Surgery of the primary site was performed.
1  Surgery of the primary site was not performed because it was not part of the planned first course treatment. Diagnosed at autopsy.
2  Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned surgery, etc.).
3  Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
4  Surgery of the primary site was not performed. It was recommended by the patient’s physician, but was not performed as part of the first course of therapy. No reason was noted in the patient record.
5  Surgery of the primary site was not performed. It was recommended by the patient’s physician, but this treatment was refused by the patient, the patient’s family member, or the patient’s guardian. The refusal was noted in the patient record.
6  Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
7  It is unknown whether surgery of the primary site was recommended or performed. Death certificate only cases.

**Instructions**

a. If *Surgical Procedure of Primary Site* is coded 00, then record the reason based on documentation in the patient record.

b. Use code zero (0) if the record specifies that surgery of the primary site was performed. (Surgery of Primary Site is coded in the range of 10-90.)

c. Use code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include surgery of the primary site, or if the option of, “no treatment,” was accepted by the patient.

d. Use code 1 if *Surgical Procedure of Primary Site* is coded 98.

e. Use code 7 if the patient refused recommended surgical treatment, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

f. Use code 8 if it is known that a physician recommended primary site surgery, but no further documentation is available yet to determine whether surgery was performed. Cases coded 8 should be followed and updated to a more definitive code as appropriate.

g. Use code 9 if the treatment plan offered multiple choices, but it is unknown which treatment, if any, was provided.

**Codes with Examples:**

2  A patient with a primary tumor of the liver is not recommended for surgery due to advanced cirrhosis.

8  A patient is referred to another facility for recommended surgical resection of a gastric carcinoma, but further information from the facility to which the patient was referred is not available.
REGIONAL RADIATION TREATMENT MODALITY

**Description**
This is a required 2-character field to record the dominant modality of radiation therapy used to deliver the most clinically significant regional dose to the primary volume of interest during the first course of treatment. Record radiation delivered at your facility, as well as radiation done in any other facilities, if known.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No radiation treatment</td>
<td>Radiation therapy was not administered to the patient. Diagnosed at autopsy.</td>
</tr>
<tr>
<td>20</td>
<td>External beam, NOS</td>
<td>The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.</td>
</tr>
<tr>
<td>21</td>
<td>Orthovoltage</td>
<td>External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).</td>
</tr>
<tr>
<td>22</td>
<td>Cobalt-60, Cesium-137</td>
<td>External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. (Intracavitary use of these sources is coded either 50 or 51.)</td>
</tr>
<tr>
<td>23</td>
<td>Photons (2-5 MV)</td>
<td>External beam therapy using a photon producing machine with a beam energy in the range of 2-5 MV.</td>
</tr>
<tr>
<td>24</td>
<td>Photons (6-10 MV)</td>
<td>External beam therapy using a photon producing machine with a beam energy in the range of 6-10 MV.</td>
</tr>
<tr>
<td>25</td>
<td>Photons (11-19 MV)</td>
<td>External beam therapy using a photon producing machine with a beam energy in the range 11-19 MV.</td>
</tr>
<tr>
<td>26</td>
<td>Photons (&gt; 19 MV)</td>
<td>External beam therapy using a photon producing machine with a beam energy of more than 19 MV.</td>
</tr>
<tr>
<td>27</td>
<td>Photons (mixed energies)</td>
<td>External beam therapy using more than one energy over the course of treatment.</td>
</tr>
<tr>
<td>28</td>
<td>Electrons</td>
<td>Treatment delivered by electron beam.</td>
</tr>
<tr>
<td>29</td>
<td>Photons and electrons mixed</td>
<td>Treatment delivered using a combination of photon and electron beams.</td>
</tr>
<tr>
<td>30</td>
<td>Neutrons, with or without photons/electrons</td>
<td>Treatment delivered using neutron beam.</td>
</tr>
<tr>
<td>31</td>
<td>IMRT</td>
<td>Intensity modulated radiation therapy, an external beam technique that should be clearly stated in the patient record.</td>
</tr>
<tr>
<td>32</td>
<td>Conformal or 3-D therapy</td>
<td>An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in the patient record.</td>
</tr>
<tr>
<td>40</td>
<td>Protons</td>
<td>Treatment delivered using proton therapy.</td>
</tr>
<tr>
<td>41</td>
<td>Stereotactic radiosurgery, NOS</td>
<td>Treatment delivered using stereotactic radiosurgery, type not specified in the patient record.</td>
</tr>
<tr>
<td>Codes</td>
<td>Label</td>
<td>Definition</td>
</tr>
<tr>
<td>-------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>42</td>
<td>Linac radiosurgery</td>
<td>Treatment categorized as using stereotactic technique delivered with a linear accelerator.</td>
</tr>
<tr>
<td>43</td>
<td>Gamma Knife</td>
<td>Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.</td>
</tr>
<tr>
<td>50</td>
<td>Brachytherapy, NOS</td>
<td>Brachytherapy, interstitial implants, molds, seeds, needles, radioembolization, or intracavitary applicators of radioactive materials not otherwise specified.</td>
</tr>
<tr>
<td>51</td>
<td>Brachytherapy, intracavitary, LDR</td>
<td>Intracavitary (no direct insertion into tissues) radioisotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).</td>
</tr>
<tr>
<td>52</td>
<td>Brachytherapy, intracavitary, HDR</td>
<td>Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.</td>
</tr>
<tr>
<td>53</td>
<td>Brachytherapy, interstitial, LDR</td>
<td>Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.</td>
</tr>
<tr>
<td>54</td>
<td>Brachytherapy, interstitial, HDR</td>
<td>Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.</td>
</tr>
<tr>
<td>55</td>
<td>Radium</td>
<td>Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.</td>
</tr>
<tr>
<td>60</td>
<td>Radioisotopes, NOS</td>
<td>Iodine-131, Phosphorus-32, etc.</td>
</tr>
<tr>
<td>61</td>
<td>Strontium-89</td>
<td>Treatment primarily by intravenous routes for bone metastases.</td>
</tr>
<tr>
<td>62</td>
<td>Strontium-90</td>
<td>(not defined in FORDS)</td>
</tr>
<tr>
<td>80 *</td>
<td>Combination modality, specified *</td>
<td>Combination of external beam radiation and either radioactive implants or radioisotopes. *</td>
</tr>
<tr>
<td>85 *</td>
<td>Combination modality, NOS *</td>
<td>Combination of radiation treatment modalities not specified by code 80. *</td>
</tr>
<tr>
<td>98</td>
<td>Other, NOS</td>
<td>Radiation therapy administered, but the treatment modality is not specified or is unknown.</td>
</tr>
<tr>
<td>99</td>
<td>Unknown</td>
<td>It is unknown whether radiation therapy was administered. Death certificate only.</td>
</tr>
</tbody>
</table>

*Note:* For cases diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation administered to the patient as part or all of the first course of therapy. Codes 80 and 85 describe specific conversion of radiation therapy coded according to earlier coding rules and should not be used to record regional radiation for cases diagnosed on or later than January 1, 2003.

**Instructions**

a. Select the code for the regional radiation treatment modality that the patient received as part of the first course of treatment. Record all radiation that is given as part of first course therapy, even if it is palliative.

1. Radiation treatment modality will typically be found in the radiation oncologist’s summary letter for the first course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.

2. In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality.

3. Note that in some circumstances the boost treatment may precede the regional treatment.

4. For purposes of this data item, photons and x-rays are equivalent.

5. Code radioembolization as brachytherapy.
(6) Do not confuse a radioiodine scan with treatment. Only treatment is coded in this item.

b. In the Regional Radiation Treatment Modality field, enter the code from the list above for the radiation treatment modality that the patient received.

For RMCDS users, record the date the radiation treatment started in a hospital-specific treatment screen in the date field adjacent to the Radiation item.

c. If only one radiation treatment modality is delivered to a patient and it is not specified as either regional or boost treatment, assume it’s regional treatment and code in Regional Radiation Treatment Modality.

Codes with Examples:

00 PUVA (psoralen and long-wave ultraviolet radiation) is used to treat melanoma. Record PUVA treatment as Code 1 in Other Treatment.

20 A patient with prostate carcinoma receives pelvic irradiation at the reporting facility, and is then referred to a major medical center for experimental proton therapy boost.

24 A patient treated with breast conserving surgery has an interstitial boost at the time of the excisional biopsy. The implant uses Ir-192 and is left in place for three days. This is followed by 6 MV photon treatment of the entire breast. In this case, the "boost" precedes the regional treatment.

25 In an experimental program, a patient with a Stage III carcinoma of the prostate receives 4,500 cGy to the pelvis using 15 MV photons, and then the prostate receives a 600 cGy boost with neutrons.

29 A patient with carcinoma of the parotid receives daily treatments of which 60% are delivered by 15 MV photons and 40% of the dose is delivered by 16 MV electrons.

50 Yttrium-90 microsphere radioembolization is used to treat an inoperable liver cancer.

53 A prostate cancer patient is treated with I-125 seeds. I-125 is low dose brachytherapy.

89 A patient with a head and neck cancer underwent regional radiation treatment elsewhere and was referred to the reporting facility for an HDR brachytherapy boost. Detailed treatment records from the other facility are not available.

Radiation Treatment Summary Codes

(For RMCDS users, record in the single digit field above the Regional Radiation Treatment Modality field.)

0 No radiation therapy, diagnosed at autopsy (Radiation treatment modality code 00.)

1 Beam radiation (Radiation treatment modality codes 20 through 43.)

Examples: X-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, intraoperative radiation, and stereotactic radiosurgery, such as gamma knife and proton beam, regardless of the source of the radiation.

2 Radioactive implants (Radiation treatment modality codes 50 through 55.)

Examples: Brachytherapy, interstitial implants, molds, seeds, needles, radioembolization, or intracavity applicators of radioactive materials, such as cesium, radium, radon, and radioactive gold.

3 Radioisotopes (Radiation treatment modality codes 60 through 62.)

Examples: Internal use of radioactive isotopes, such as iodine-131, phosphorus-32, strontium 89 and 90. Can be given orally, intracavitarily, or by intravenous injection.

4 Combinations of beam radiation (code 1) with radioactive implants (code 2) and/or radioisotopes (code 3) (Radiation treatment modality codes 80 or 85.)

The patient was treated with a combination of beam radiation and at least one of the two methods described by codes 2 and 3.

5 Radiation therapy, NOS - method or source not specified (Radiation treatment modality code 98.)

7 Patient or patient’s guardian refused radiation therapy.

8 Radiation recommended, unknown if administered.
9  Unknown if radiation therapy recommended or performed; death certificate only cases. (Radiation treatment modality code 99.)
**Chapter 5**

**Treatment Data**

**Coding Instructions**

**DATE OF RADIATION FLAG**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of Radiation Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td>*01/08/2015 or 2015/01/08</td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td>*01/<em>/</em>/2015 or 2015/01/_ _</td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>* <em>/</em> _/2015 or 2015/ <em>/</em> _</td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown if radiation given</td>
<td>* <em>/</em> _/ _ _ or _ _ / _ _ / _ _</td>
<td>10</td>
</tr>
<tr>
<td>No radiation given</td>
<td>* <em>/</em> _/ _ _ or _ _ / _ _ / _ _</td>
<td>11</td>
</tr>
<tr>
<td>Radiation given, date unknown</td>
<td>* <em>/</em> _/ _ _ or _ _ / _ _ / _ _</td>
<td>12</td>
</tr>
<tr>
<td>Radiation planned, not started yet</td>
<td>* <em>/</em> _/ _ _ or _ _ / _ _ / _ _</td>
<td>15</td>
</tr>
</tbody>
</table>

**Description**

This flag explains why there is no appropriate value in the corresponding date field, *Date Radiation Started* (NAACCR Item #1210). This data item was added to Volume II Version 12 (effective January 2010).

**Rationale**

Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>No information whatsoever can be inferred from this exceptional value. (It is unknown whether any radiation therapy administered.)</td>
</tr>
<tr>
<td>11</td>
<td>No valued date is applicable in this context (for example, no radiation therapy administered).</td>
</tr>
<tr>
<td>12</td>
<td>A valid date is applicable but not known. (Radiation therapy was administered but the date is unknown.)</td>
</tr>
<tr>
<td>15</td>
<td>Information is not available at this time, but it is expected that it will be available later. (Radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up.)</td>
</tr>
</tbody>
</table>

**Blank**

A valid date value is provided in item *Date Radiation Started* (NAACCR Item #1210). The case was diagnosed between 2003 and 2009 and the *Date Radiation Started* was not recorded by the facility.

**Instructions**

a. Leave this item blank if the *Date Radiation Started* (NAACCR Item #1210) has a full or partial date recorded.
b. Use code 12 if the *Date Radiation Started* cannot be determined, but the patient did receive first course radiation.
c. Use code 10 if it is unknown whether any radiation was given.
d. Use code 11 if no radiation is planned or given.
e. Use code 15 if radiation is planned, but not yet started and the start date is not yet available. Follow this patient for radiation treatment and update this item, *Date Radiation Started*, and the relevant radiation items.
f. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

**Examples:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of Radiation Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td>*01/08/2015 or 2015/01/08</td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td>*01/<em>/</em>/2015 or 2015/01/_ _</td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>* <em>/</em> _/2015 or 2015/ <em>/</em> _</td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown if radiation given</td>
<td>* <em>/</em> _/ _ _ or _ _ / _ _ / _ _</td>
<td>10</td>
</tr>
<tr>
<td>No radiation given</td>
<td>* <em>/</em> _/ _ _ or _ _ / _ _ / _ _</td>
<td>11</td>
</tr>
<tr>
<td>Radiation given, date unknown</td>
<td>* <em>/</em> _/ _ _ or _ _ / _ _ / _ _</td>
<td>12</td>
</tr>
<tr>
<td>Radiation planned, not started yet</td>
<td>* <em>/</em> _/ _ _ or _ _ / _ _ / _ _</td>
<td>15</td>
</tr>
</tbody>
</table>
* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format. The computer will store either in the interoperable format.
**RADIATION/SURGERY SEQUENCE**

*Required if available for cases diagnosed 01/01/2006 and later.*

### Description
This is a required 1-character field to record a code that indicates the sequencing of radiation and surgical procedures during the first course of treatment. Surgical procedures include *Surgical Procedure of Primary site, Scope of Regional Lymph Node Surgery*, and *Surgical Procedure/Other Site*.

### Codes
- **0**: No radiation therapy and/or surgical procedures
- **2**: Radiation therapy before surgery
- **3**: Radiation therapy after surgery
- **4**: Radiation therapy both before and after surgery
- **5**: Intraoperative radiation therapy
- **6**: Intraoperative radiation therapy with other therapy administered before or after surgery
- **7**: Surgery both before and after radiation
- **9**: Sequence unknown, but both surgery and radiation therapy were given

### Definitions

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No radiation therapy given or unknown if radiation given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s) or it is unknown whether any surgery performed.</td>
</tr>
<tr>
<td>2</td>
<td>Radiation therapy given before surgery to primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).</td>
</tr>
<tr>
<td>3</td>
<td>Radiation therapy given after surgery to primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).</td>
</tr>
<tr>
<td>4</td>
<td>At least two courses of radiation therapy are given before and at least two more after any surgery to primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).</td>
</tr>
<tr>
<td>5</td>
<td>Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).</td>
</tr>
<tr>
<td>6</td>
<td>Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).</td>
</tr>
<tr>
<td>7</td>
<td>Radiation was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).</td>
</tr>
<tr>
<td>9</td>
<td>Administration of radiation therapy and surgery to primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record.</td>
</tr>
</tbody>
</table>

### Instructions
a. If the patient did not receive both radiation therapy and surgery during the first course of therapy, record code 0. Code 0 (no radiation therapy and or surgical procedures) includes the following types of cases:

1. Patients who received neither radiation therapy nor surgery;
2. Patients who received radiation therapy but no surgery;
3. Patients who received surgery but were not treated with radiation therapy; or
(4) It is not known whether the patient received both surgery and radiation.

b. For patients who had both surgery and radiation, enter the code that describes the sequence in which the patient received radiation therapy and surgery during the first course of therapy. Code this item 2-9, as appropriate, if the patient received both radiation therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site, Regional Lymph Node Surgery, or Surgical Procedure/Other Site.*

Code in the range of 2-9 only if the patient had both surgery and radiation therapy as first course treatment. Surgical Diagnostic and Staging Procedures (codes 01-09) do not qualify.

c. If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

*Codes with Examples:*
0  Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.
2  A large lung lesion was treated with radiation therapy prior to resection.
3  A patient received a wedge resection of a right breast mass with axillary lymph node dissection followed by radiation to right breast.
4  Preoperative radiation therapy was given to a large, bulky vulvar lesion and was followed by a lymph node dissection. This was then followed by radiation therapy to treat positive lymph nodes.
5  A cone biopsy of the cervix was followed by intracavitary implant for IIIB cervical carcinoma.
6  Stage IV vaginal carcinoma was treated with 5,000 cGy to the pelvis followed by a lymph node dissection and 2,500 cGy of intracavitary brachytherapy.
9  An unknown primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. The patient enters for chemotherapy.
**REASON FOR NO RADIATION**

**Description**
This is a required 1-character field to record a code that indicates the reason no regional radiation therapy was administered to the patient.

**Codes**
0 Radiation therapy was administered.
1 Radiation therapy was not administered because it was not part of the planned first course treatment. Diagnosed at autopsy.
2 Radiation therapy was not recommended/administered because it was contraindicated based on other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation, etc.).
5 Radiation therapy was not administered because the patient died prior to planned or recommended therapy.
6 Radiation therapy was not administered; it was recommended by the patient’s physician, but was not administered as part of first course treatment. No reason was noted in patient record.
7 Radiation therapy was not administered; it was recommended by the patient’s physician, but was refused by the patient, the patient’s family member, or the patient’s guardian. The refusal was documented in the patient record.
8 Radiation therapy was not administered; it was recommended by the patient’s physician, but was refused by the patient, the patient’s family member, or the patient’s guardian. The refusal was documented in the patient record.
9 It is unknown if radiation therapy was recommended or administered. Death certificate only cases.

**Instructions**
1. If *Regional Treatment Modality* is coded 00 (not performed), record a code that indicates the reason based on patient record documentation.
2. Record code 1 if the treatment plan included multiple alternative treatment options and the patient selected treatment that did not include radiation therapy.

   *Example:* A patient is offered either surgery or brachytherapy to treat his stage 1 prostate and chooses surgical treatment. Record code 1 in *Reason for No Radiation.*
3. Record code 7 if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
4. Record code 8 if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.
5. Record code 8 to indicate referral to a radiation oncologist was made and the registry should follow to determine whether radiation was administered. If follow-up to the specialist or facility determines the patient was never there and no other documentation can be found, change the code to 1.
6. Cases coded to 8 should be followed and updated to a more definitive code as indicated.
7. Record code 9 if the treatment plan included multiple alternative treatment options, but it is unknown which treatment, if any, was provided.
CHEMOTHERAPY

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

**Description**
This is a required 2-character field to record chemotherapy administered as first course of therapy. If chemotherapy was not administered, this item records the reason it was not administered to the patient. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Record chemotherapy administered at your facility, as well as chemotherapy given at any other facilities, if known.

**Codes**
00 None, chemotherapy was not part of the planned first course of therapy; diagnosed at autopsy.
01 Chemotherapy administered as first course therapy, but the type and number of agents is not documented in the patient record.
02 Single-agent chemotherapy administered as first course therapy.
03 Multiagent chemotherapy administered as first course therapy.
82 Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (e.g., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
85 Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86 Chemotherapy was not administered. It was recommended by the patient’s physician, but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87 Chemotherapy was not administered. It was recommended by the patient’s physician, but this treatment was refused by the patient, a patient’s family member, or the patient’s guardian. The refusal was noted in the patient record.
88 Chemotherapy was recommended, but it is unknown if it was administered.
99 It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in the patient record. Death certificate only.

**Instructions**
a. Select the code for the type of chemotherapy that the patient received as part of the first course of treatment. Record chemotherapy as cancer-directed therapy when it is delivered concurrently or as adjuvant treatment.

(1) Use code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
(2) Use code 00 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include chemotherapy.
(3) Use code 00 if the option of, “no treatment,” was accepted by the patient.
(4) Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents used.
(5) If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason it was not administered.
(6) Use code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
(7) Use code 88 if it is known that a physician recommended the patient receive chemotherapy, but no further documentation is available yet to confirm its administration.
(8) Use code 88 to indicate referral was made medical oncologist and the registry must follow to determine whether it was given. If follow-up with the specific specialist or facility indicates the patient was never there, use code 00.
(9) Use code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.

(10) If a chemotherapy drug is given for a reason other than cancer-directed treatment, do not code the drug as chemotherapy. If in doubt whether the chemotherapy drug is given to alleviate a symptom and not for cancer-directed treatment, consult your oncologist or oncology nurse.

(11) For facilities that collect Palliative Care: If chemotherapy was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy provided in the Palliative Care field. The State Registry does not collect the Palliative Care data item.

b. In the Chemotherapy field, enter the code from the list above for the chemotherapy that the patient received. For RMCDS users, record the date the course of chemotherapy was started in the adjacent “Date” field.

Example: Single agent chemotherapy 5-FU was started on July 15, 2011 at a physician’s office as part of the first course of treatment. The treatment would be entered as follows:
Chemotherapy code 02, Date: 07/15/2011.

c. One planned course of chemotherapy may be given in several segments. These segments are recorded as one course. The date listed for that course of chemotherapy should be the date the first segment of that course began.

d. Two or more single agents given at separate times during the first course of cancer-directed therapy are considered a combination regimen and coded 03 (chemotherapy, multiple agents). If two or more single agents are given at different times after the first course, it is subsequent treatment and can be recorded in the “Subsequent Treatment” RMCDS screens. The State Registry does not collect subsequent treatment.

Chemotherapy Information and Definitions

a. Refer to the SEER*Rx Interactive Drug Database (http://seer.cancer.gov/) to determine whether the drugs used are classified as chemotherapeutic agents.

b. Chemotherapeutic agents may be administered by intravenous infusion or given orally. Other methods of administration include:

   - **Intrathecal.** Administered directly into the cerebrospinal fluid through a lumbar puncture needle into an implanted access device (Ommaya reservoir).
   - **Pleural/pericardial.** Injected directly into pleural or pericardial space to control malignant effusions.
   - **Intraperitoneal.** Injected into the peritoneal cavity.
   - **Hepatic artery.** Injected into a catheter inserted into the artery that supplies blood to the liver.

c. Chemotherapy agents may be administered singly or in a combination regimen of two or more chemotherapy drugs. They are administered in treatment cycles. The time span of a treatment cycle varies. It is dependent upon the histology, stage of disease, and treatment modalities. Chemotherapy may be administered for several weeks or several years.

d. Clarification of terms:

   (1) **Concurrent chemotherapy** (multimodality therapy, combined modality therapy) is given before, during, or after other treatment modalities (surgery, radiation, etc.) as part of the treatment plan.

   (2) **Adjuvant chemotherapy** is given after other methods have destroyed the clinically detectable cancer cells. Chemotherapy is given to destroy micrometastases (undetectable cancer cells). The intent is to prevent or delay a recurrence.

   Example: A patient has breast cancer with positive nodes. All detectable tumor is removed by a modified radical mastectomy. The patient receives adjuvant chemotherapy to destroy any micrometastasis that may be present. The chemotherapy is given to delay or prevent a recurrence.
(3) **Neoadjuvant therapy** is given prior to surgical resection or radiation therapy to reduce the bulk of a locally advanced primary cancer.

*Example:* A patient with locally advanced breast cancer receives chemotherapy to reduce tumor size. Chemotherapy is followed by a modified radical mastectomy.

(4) **Chemoembolization** is a procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. Code as Chemotherapy when the embolizing agent(s) is a chemotherapeutic drug(s). Use SEER*Rx Interactive Drug Database (http://seer.cancer.gov/) to determine whether the drugs used are classified as chemotherapeutic agents.

*Example:* A patient with primary liver cancer is treated using the following procedure: Under x-ray guidance, a small catheter is inserted into an artery in the groin and the catheter tip is threaded into the artery in the liver that supplies blood flow to the tumor. Chemotherapy is injected through the catheter into the tumor and mixed with particles that embolize or block the flow of blood to the tumor.

(5) **Ancillary drugs** are medications whose actions are not directed at the patient’s malignancy per se but that enhance the effects of the cancer-directed therapy. For example, ancillary drugs may modulate the actions of specific chemotherapeutic agents by increasing their effectiveness in destroying tumor cells or by decreasing the potential for specific side effects. Ancillary drugs are not to be coded as cancer-directed therapy.

*Example:* Folinic acid (leucovorin) stabilizes the drug-enzyme complex and thus increases the cytotoxic effects of 5-FU and is frequently administered with 5-FU for this purpose. Use chemotherapy code 02 (single agent) for 5-FU and leucovorin treatment.

e. Chemotherapy is divided into the following classifications:

<table>
<thead>
<tr>
<th>Group</th>
<th>Subgroup(s)</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alkylating agents</td>
<td>Mustard gas derivatives/nitrogen mustards</td>
<td>Mechlorethamine, Melphalan, Chlorambucil</td>
</tr>
<tr>
<td></td>
<td>Ethylenimines</td>
<td>Thiota and Hexamethylmelamine</td>
</tr>
<tr>
<td></td>
<td>Alkyl sulfonates</td>
<td>Busulfan</td>
</tr>
<tr>
<td></td>
<td>Nitrosoureas</td>
<td>Carmustine, Lomustine, and Streptozotocin</td>
</tr>
<tr>
<td></td>
<td>Hydrazines and triazenes</td>
<td>Altretamine, Procarbazine, Dacarbazine, and Temozolomide</td>
</tr>
<tr>
<td></td>
<td>Metal salts</td>
<td>Carboplatin, Cisplatin, Oxaliplatin</td>
</tr>
<tr>
<td>Antimetabolites</td>
<td>Folic acid antagonist</td>
<td>Methotrexate</td>
</tr>
<tr>
<td></td>
<td>Pyrimidine antagonist</td>
<td>5-Fluorouracil (5-FU), Floxuridine, Cytarabine, Capecitabine, and Gemcitabine</td>
</tr>
<tr>
<td></td>
<td>Purine antagonist</td>
<td>6-Mercaptopurine (6-MP) and 6-Thioguanine</td>
</tr>
<tr>
<td></td>
<td>Adenosine deaminase inhibitor</td>
<td>Cladribine, Fludarabine, Nelarabine, and Pentostatin</td>
</tr>
<tr>
<td>Natural products</td>
<td>Antitumor antibiotics</td>
<td>Anthracyclines: Doxorubicin, Daunorubicin, Epirubicin, Mitoxantrone, and Idarubicin</td>
</tr>
<tr>
<td></td>
<td>Plant alkaloids</td>
<td>Vinca alkaloids: Vinblastine, Vincristine, and Vinorelbine</td>
</tr>
<tr>
<td></td>
<td>Taxanes: Paclitaxel and Docetaxel</td>
<td>Podophyllotoxins: Etoposide and Teniposide</td>
</tr>
<tr>
<td></td>
<td>Miscellaneous: Mitomycin and Bleomycin</td>
<td></td>
</tr>
</tbody>
</table>

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### Group Subgroup(s) Examples

**Topoisomerase inhibitors**
- Camptothecin analogs: Irinotecan and Topotecan
- Topoisomerase I inhibitors: Irinotecan, Topotecan
- Topoisomerase II inhibitors: Amsacrine, Etoposide, Etoposide phosphate, and Teniposide

**Miscellaneous agents**
- Ribonucleotide reductase inhibitor: Hydroxyurea
- Adrenocortical steroid inhibitor: Mitotane
- Enzymes: Asparaginase and Pegaspargase
- Antimicrotubule agent: Estramustine
- Retinoids: Bexaratene, Isotretinoin, Tretinoin (ATRA)

**Targeted therapy**
- A group of newer cancer drugs that act directly against abnormal proteins in cancer cells.

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**f.** If the patient has an adverse reaction, the physician may change one of the drugs in a combination regimen. If the replacement drug belongs to the same **group** as the original drug, there is no change in the regimen.

*Example:* The physician documents a multimodality treatment plan that includes a combination regimen of chemotherapy. Vinblastine is one of the drugs in the chemotherapy regimen. After two cycles of chemotherapy, the physician says the Vinblastine will be replaced with Vincristine and the chemotherapy will continue as planned. This is a continuation of the planned first course of therapy.

If the replacement drug is in a different **group** than the original drug, it is subsequent therapy.

*Exception:* Unless there is disease progression, neoadjuvant chemotherapy and all subsequent planned first course of treatment would be recorded as first course, even if there is a change in chemotherapeutic agents and/or groups.

**g.** Code the six drugs listed below as BRM, beginning with January 1, 2013 diagnoses. Continue to code cases diagnosed prior to 01/01/2013 as chemotherapy.

- Alemtuzumab/Campath
- Bevacizumab/Avastin
- Rituximab/Rituxan
- Trastuzumab/Herceptin
- Pertuzumab/Perjeta
- Cetuximab/Erbitux
**DATE OF CHEMOTHERAPY FLAG**

**Description**
This flag explains why there is no appropriate value in the corresponding date field, *Date Chemotherapy Started* (NAACCR Item #1220). This data item was added to Volume II Version 12 (effective January 2010).

**Rationale**
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

**Codes**

10  No information whatsoever can be inferred from this exceptional value. (It is unknown if chemotherapy was administered.)

11  No proper value is applicable in this context (for example, no chemotherapy was administered).

12  A valid date is applicable but not known. (Chemotherapy was administered but the date is unknown.)

15  Information is not available at this time, but it is expected that it will be available later. (Chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up.)

Blank  A valid date value is provided in item *Date Chemotherapy Started* (NAACCR Item #1220), or the date was not expected to have been transmitted. The case was diagnosed between 2003 and 2009 and the *Date Chemotherapy Started* was not recorded by the facility.

**Instructions**

a. Leave this item blank if the *Date Chemotherapy Started* has a full or partial date recorded.

b. Use code 12 if the *Date Chemotherapy Started* cannot be determined, but the patient did receive first course chemotherapy.

c. Use code 10 if it is unknown whether any chemotherapy was administered.

d. Use code 11 if no chemotherapy is planned or given.

e. Use code 15 if chemotherapy is planned, but not yet started. Follow this patient for chemotherapy and update this item, *Date Chemotherapy Started*, and the relevant chemotherapy items.

f. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

g. Leave this item blank for diagnoses between 2003 and 2009 if your facility did not collect *Date Chemotherapy Started* at that time.

**Examples:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of Chemo Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td>*01/08/2015 or 2015/01/08</td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td>*01/<em>/</em>/2015 or 2015/01/_</td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>*<em>/</em>/2015 or 2015_/_/</td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown if chemo given</td>
<td>*<em>/</em>/ or <em>/</em>/_ or <em>/</em>/_/</td>
<td>10</td>
</tr>
<tr>
<td>No chemo given</td>
<td>*<em>/</em>/ or <em>/</em>/_ or <em>/</em>/_/</td>
<td>11</td>
</tr>
<tr>
<td>Chemo given, date unknown</td>
<td>*<em>/</em>/ or <em>/</em>/_ or <em>/</em>/_/</td>
<td>12</td>
</tr>
<tr>
<td>Chemo planned, not started yet</td>
<td>*<em>/</em>/ or <em>/</em>/_ or <em>/</em>/_/</td>
<td>15</td>
</tr>
</tbody>
</table>
* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format. The computer will store either in the interoperable format.
**SYSTEMIC/SURGERY SEQUENCE**

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No systemic therapy was given and/or no surgery defined above was performed. It is unknown whether both surgery and systemic treatment were provided.</td>
</tr>
<tr>
<td>2</td>
<td>Systemic therapy was given before any surgery defined above was performed. Note: Both treatments must be coded.</td>
</tr>
<tr>
<td>3</td>
<td>Systemic therapy was given after any surgery defined above was performed. Note: Both treatments must be coded.</td>
</tr>
<tr>
<td>4</td>
<td>At least two courses of systemic therapy were given before and at least two more after any surgery defined above was performed. Note: Both the surgery and the systemic treatments must be coded.</td>
</tr>
<tr>
<td>5</td>
<td>Intraoperative systemic therapy was given during any surgery defined above. Note: Both treatments must be coded.</td>
</tr>
<tr>
<td>6</td>
<td>Intraoperative systemic therapy was given during any surgery defined above with other systemic therapy administered before or after surgery. Note: Both treatments must be coded.</td>
</tr>
<tr>
<td>7</td>
<td>Systemic therapy was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).</td>
</tr>
<tr>
<td>9</td>
<td>The patient had systemic therapy and surgery and the sequence of the treatments is not stated in the patient record. Note: Both treatments must be coded.</td>
</tr>
</tbody>
</table>

*Required for cases diagnosed 01/01/2006 and later.*

**Description**

This is a required 1-character field in the RMCDS abstract screen to record a code that indicates the sequencing of systemic therapy and surgical procedures provided as part of the first course of treatment.

For the purpose of coding systemic treatment sequence with surgery, “surgery” is defined as any one or a combination of the following:

- Surgical Procedure of Primary Site (codes 10-90)
- Scope of Regional Lymph Node Surgery (codes 1-7)
- Surgery to other regional site(s), distant site(s), or distant lymph node(s) (codes 1-5).

Systemic therapy is defined as:

- Chemotherapy
- Hormone therapy
- Biological response therapy/immunotherapy
- Bone marrow transplant
- Stem cell harvests
- Surgical and/or radiation endocrine therapy

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No systemic therapy and/or surgical procedures; unknown if surgery and/or systemic therapy given</td>
</tr>
<tr>
<td>2</td>
<td>Systemic therapy before surgery</td>
</tr>
<tr>
<td>3</td>
<td>Systemic therapy after surgery</td>
</tr>
<tr>
<td>4</td>
<td>Systemic therapy both before and after surgery</td>
</tr>
<tr>
<td>5</td>
<td>Intraoperative systemic therapy</td>
</tr>
<tr>
<td>6</td>
<td>Intraoperative systemic therapy with other therapy administered before or after surgery</td>
</tr>
<tr>
<td>7</td>
<td>Surgery both before and after systemic therapy</td>
</tr>
<tr>
<td>9</td>
<td>Sequence unknown, but both surgery and systemic therapy were given</td>
</tr>
</tbody>
</table>

**Definitions**
**Instructions**


b. Code the administration of systemic therapy in sequence with the first surgery performed.

c. If the patient did not receive both systemic therapy and surgery during the first course of therapy, record code 0. Code 0 (no systemic therapy and or surgical procedures) includes the following types of cases:

   (1) Patients who received neither systemic therapy nor surgery;
   (2) Patients who received systemic therapy but no surgery;
   (3) Patients who received surgery but were not treated with systemic therapy; or
   (4) It is not known whether the patient received both surgery and systemic therapy.

d. If the patient received both systemic therapy and any on or a combination of the following surgical procedures: *Surgical Procedure of Primary Site*, *Scope of Regional Lymph Node Surgery*, and *Surgical Procedure/Other Site*, then code this item 2-9, as appropriate.

e. If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies. For example: Use code 4 for chemotherapy then surgery then hormone therapy then surgery.

**Codes with Examples:**

0  Due to other medical conditions surgery was not performed. The patient refused other treatment.

0  A patient with lobular carcinoma in situ of the breast underwent an excisional biopsy. No chemotherapy was recommended.

0  A patient with small cell carcinoma of the lung was treated with VP-16 and carboplatin.

2  A patient with prostate cancer received hormone therapy prior to a radical prostatectomy.

3  A patient underwent a colon resection followed by a 5-FU based chemotherapy regimen.

3  A patient has a lymph node dissection, followed by chemotherapy, followed by primary site surgery.

4  A patient with breast cancer receives pre-operative chemotherapy followed by post-operative Tamoxifen.

5  A patient with an intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity.

6  A patient with metastatic colon cancer receives intraoperative chemotherapy to the liver followed by postoperative chemotherapy.

9  An unknown primary of the head and neck was treated with surgery and chemotherapy prior to admission, but the sequence is unknown. The patient enters for radiation therapy.
### DATE SYSTEMIC THERAPY STARTED

**Description**
This is a required 8-character field for recording the date of initiation for systemic therapy that is part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormonal agents, biological response modifiers, bone marrow transplants, stem cell harvest, and surgical and/or radiation endocrine therapy.

**Codes**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>January</td>
<td>01</td>
</tr>
<tr>
<td>02</td>
<td>February</td>
<td>02</td>
</tr>
<tr>
<td>03</td>
<td>March</td>
<td>03</td>
</tr>
<tr>
<td>04</td>
<td>April</td>
<td>...</td>
</tr>
<tr>
<td>05</td>
<td>May</td>
<td>...</td>
</tr>
<tr>
<td>06</td>
<td>June</td>
<td>25</td>
</tr>
<tr>
<td>07</td>
<td>July</td>
<td>26</td>
</tr>
<tr>
<td>08</td>
<td>August</td>
<td>...</td>
</tr>
<tr>
<td>09</td>
<td>September</td>
<td>30</td>
</tr>
<tr>
<td>10</td>
<td>October</td>
<td>31</td>
</tr>
<tr>
<td>11</td>
<td>November</td>
<td>blank = Day unknown</td>
</tr>
<tr>
<td>12</td>
<td>December</td>
<td></td>
</tr>
<tr>
<td>blank</td>
<td>Month unknown</td>
<td></td>
</tr>
</tbody>
</table>

**Instructions**

a. Record the first or earliest date on which systemic therapy was administered. Systemic therapy includes *Chemotherapy, Hormone Therapy, Immunotherapy, and Hematologic Transplant and Endocrine Procedures*. Determine whether your software vendor uses the traditional format for date entry (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format.

b. Record the month, day, and year (MM/DD/CCYY) the systemic therapy was started. Fill in with leading zeros where needed. For example, record June 3, 2015 as 06/03/2015.

c. If the exact date of the beginning of systemic therapy is not available, record an approximate date. If information is limited to a description, use the following:

<table>
<thead>
<tr>
<th>DESCRIPTIVE TERM USED</th>
<th>DATE CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring</td>
<td>April</td>
</tr>
<tr>
<td>The middle of the year</td>
<td>July</td>
</tr>
<tr>
<td>Fall</td>
<td>October</td>
</tr>
<tr>
<td>Winter</td>
<td>Try to determine if this means the beginning of the year (January) or the end of the year (December). Code as indicated.</td>
</tr>
</tbody>
</table>

d. Do not record the date of initiation of *Other Treatment* in this field, even if it is the only treatment administered.

**Examples:**
12152014 A patient with breast cancer begins her regimen of chemotherapy on December 15, 2014, and is subsequently given tamoxifen on January 20, 2015.
A patient with Stage IV prostate cancer has an orchiectomy on June 2, 2015. The patient is then started on a regime of hormonal agents on June 9, 2015.

If the exact date of the beginning of treatment is not available, record an approximate date. For example, September 2015.

The information is limited to the description “Spring” of 2015.

The information is limited to the description “The middle of the year,” 2015.

The information is limited the description “Fall” of 2015.

The information is limited to the description “Winter.” Try to determine if this means the beginning or the end of the year. Code January or December as indicated.
Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Systemic Therapy Started* (NAACCR Item #3230). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
10  No information whatsoever can be inferred from this exceptional value. It is unknown whether systemic therapy was administered.
11  A valid date is not applicable in this context. No systemic therapy was administered.
12  A valid date is applicable but not known. Systemic therapy was administered but the date is unknown.
15  Information is not available at this time, but it is expected that it will be available later. Systemic therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up.
Blank  A valid date is coded in the *Date Systemic Therapy Started* (NAACCR Item #3230).

Instructions
a. Leave this item blank if *Date Systemic Therapy Started* has a full or partial date recorded.
b. Use code 12 if the *Date Systemic Therapy Started* cannot be determined, but the patient did receive first course systemic therapy.
c. Use code 10 if it is unknown whether any systemic therapy was administered.
d. Use code 11 if no systemic therapy is planned or administered.
e. Use code 15 if systemic therapy is planned, but not yet started.
f. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

Examples:

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of 1st Crs Rx Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td>*01/08/2015 or 2015/01/08</td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td>*01/_ <em>/2015 or 2015/01/</em> _</td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>* <em>/</em> <em>/2015 or 2015/</em>/_ _</td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown if Rx given</td>
<td>* <em>/</em> <em>/</em> or _ <em>/</em>/_ _</td>
<td>10</td>
</tr>
<tr>
<td>Diagnosed at autopsy</td>
<td>* <em>/</em> <em>/</em> or _ <em>/</em>/_ _</td>
<td>11</td>
</tr>
<tr>
<td>Rx given, unknown date</td>
<td>* <em>/</em> <em>/</em> or _ <em>/</em>/_ _</td>
<td>12</td>
</tr>
<tr>
<td>RX planned, not yet started</td>
<td>* <em>/</em> <em>/</em> or _ <em>/</em>/_ _</td>
<td>15</td>
</tr>
</tbody>
</table>

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format. The computer will store either in the interoperable format.
**Hormone Therapy**  
(Hormone/Steroid [Endocrine] Therapy)

**Description**
This is a required 2-character field to record hormone or steroid (endocrine) therapy administered as part of the first course of treatment. If hormone therapy was not administered, this item records the reason it was not administered. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth and includes hormones, antihormones, and steroids.

Record hormone therapy administered at your facility, as well as hormone therapy given in any other facilities, if known.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>None; hormone therapy was not part of the planned first course of therapy; diagnosed at autopsy.</td>
</tr>
<tr>
<td>01</td>
<td>Hormone therapy administered as first course therapy.</td>
</tr>
<tr>
<td>82</td>
<td>Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (e.g., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).</td>
</tr>
<tr>
<td>85</td>
<td>Hormone therapy was not administered because the patient died prior to planned or recommended therapy.</td>
</tr>
<tr>
<td>86</td>
<td>Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in the patient record.</td>
</tr>
<tr>
<td>87</td>
<td>Hormone therapy was not administered. It was recommended by the patient’s physician, but this treatment was refused by the patient, a patient’s family member, or the patient's guardian. The refusal was documented in the patient record.</td>
</tr>
<tr>
<td>88</td>
<td>Hormone therapy was recommended, but it is unknown if it was administered.</td>
</tr>
<tr>
<td>99</td>
<td>If is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in the patient record. Death certificate only.</td>
</tr>
</tbody>
</table>

**Definitions**

a. Hormones promote hormonal withdrawal or hormonal interface to alter the growth of cancer. Hormone therapy may effect a long-term control of the cancer growth. It is not usually used as a curative measure.

Hormone categories are:
- Androgens: fluoxymesterone (Halotestin, Androxy)
- Anti-androgens: bicalutamide (Casodex), flutamide (Eulexin), and nilutamide (Nilandron)
- Corticosteroids, Adrenocorticotropic agents: prednisone and dexamethasone (Decadron)
- Estrogen: diethylstilbestrol (DES)
- Progestins: Provera and Megace
- Estrogen antagonists, Anti-estrogens: tamoxifen (Nolvadex), fulvestrant (Faslodex), toremifene (Fareston)
- Aromatase inhibitors, Antiaromatase: anastrozole (Arimidex), exemestane (Aromasin), letrozole (Femara)
- Gonadotropin releasing hormones (GnRH) and Luteinizing-hormone-releasing hormones (LH-RH): leuprolide (Lupron) and goserelin (Zoladex)
- Thyroid hormones: levothyroxine (Synthroid) and liothyronine (Cytomel)

b. Refer to the [SEER*Rx Interactive Drug Database](http://seer.cancer.gov/) to determine whether the drugs used are classified as hormone therapy.

c. Adrenocorticotropic hormones (cancer-directed only) are coded for leukemias, lymphomas, multiple myelomas, breast, and prostate cancer.
**Instructions**

a. Record code 01 if the patient received hormone therapy as part of the first course of treatment. Administration of hormones or antihormones (cancer-directed only) should be recorded for all primary and metastatic sites.

(1) Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

(2) Code 01 for thyroid replacement therapy that inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.

(3) Do not code hormone drugs as hormone therapy when administered for reasons other than chemotherapeutic treatment. Examples:
   - Hormone drug used to alleviate symptoms (e.g., Solu-Medrol used to control vomiting; Decadron to reduce edema and relieve neurological symptoms from brain metastasis in a lung primary.) Do not code as hormone therapy.
   - Hormone replacement therapy used when tumor involvement or cancer-directed treatment has destroyed hormone-producing tissue. Do not code as hormone therapy.

(4) For facilities that collect Palliative Care: If hormone therapy was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy provided in the Palliative Care field. The State Registry does not collect the Palliative Care data item.

b. Record code 00:

(1) If hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer;

(2) If the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include hormone therapy; or

(3) If the option of, “no treatment,” was accepted by the patient.

c. If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason it was not administered.

d. Use code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

e. Use code 88:

(1) If it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration; or

(2) To indicate referral was made medical oncologist and the registry must follow to determine whether hormone therapy was given. If follow-up with the specific specialist or facility indicates the patient was never there, use code 00.

f. Use code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.

g. In the Hormone Therapy field, record 01 for hormone therapy. For RMCDS users, record the date the course of hormone therapy was started in the adjacent “Date” field.

Example: Tamoxifen was started on July 15, 2015. The treatment would be entered as follows:

Hormone Therapy code 01, Date: 07/15/2015.

**Codes with Examples:**

00 A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormonal therapy.
### Chapter 5

#### Treatment Data

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>A patient with breast cancer may be treated with aminogluthimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. This patient must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (Florinef) as a replacement therapy.</td>
</tr>
<tr>
<td>00</td>
<td>A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy.</td>
</tr>
<tr>
<td>01</td>
<td>A patient with metastatic prostate cancer is administered flutamide (an antiandrogen).</td>
</tr>
<tr>
<td>87</td>
<td>A patient with metastatic prostate cancer declines the administration of Megace (a progestin) and the refusal is noted in the patient record.</td>
</tr>
</tbody>
</table>
**Coding Instructions**

**DATE OF HORMONE THERAPY FLAG**

**Description**
This flag explains why there is no appropriate value in the corresponding date field. *Date Hormone Therapy Started* (NAACCR Item #1230). This data item was added to Volume II Version 12 (effective January 2010).

**Rationale**
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>No information whatsoever can be inferred from this exceptional value. (It is unknown if any hormone therapy was administered.)</td>
</tr>
<tr>
<td>11</td>
<td>No valid date is applicable in this context. (No hormone therapy was administered.)</td>
</tr>
<tr>
<td>12</td>
<td>A valid date is applicable but not known. (Hormone therapy was administered but the date is unknown.)</td>
</tr>
<tr>
<td>15</td>
<td>Information is not available at this time, but it is expected that it will be available later (Hormone therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up.)</td>
</tr>
<tr>
<td>Blank</td>
<td>A valid date value is provided in item <em>Date Hormone Therapy Started</em> (NAACCR Item #1230). The case was diagnosed between 2003 and 2009 and the <em>Date Hormone Therapy Started</em> was not recorded by the facility.</td>
</tr>
</tbody>
</table>

**Instructions**

a. Leave this item blank if the *Date Hormone Therapy Started* has a full or partial date recorded.
b. Use code 12 if the *Date Hormone Therapy Started* cannot be determined, but the patient did receive first course hormone therapy.
c. Use code 10 if it is unknown whether any hormone therapy was administered.
d. Use code 11 if no hormone therapy is planned or given.
e. Use code 15 if hormone therapy is planned, but not yet started. Follow this patient for chemotherapy and update this item, *Date Hormone Therapy Started*, and the relevant hormone therapy items.
f. Code this data item (when appropriate) even if your software uses the traditional format for date entry.
g. Leave this item blank for diagnoses between 2003 and 2009 if your facility did not collect *Date Hormone Therapy Started* at that time.

**Examples:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of Hormone Rx Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td>*01/08/2015 or 2015/01/08</td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td>*01/_ _/2015 or 2015/01/ _ _</td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>* _ _/ _ _/2015 or 2015/ _ _/ _ _</td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown if hormone Rx given</td>
<td>* _ _/ _ _/ _ _ or _ _ _/ _ _/ _ _</td>
<td>10</td>
</tr>
<tr>
<td>No hormone Rx given</td>
<td>* _ _/ _ _/ _ _ or _ _ _/ _ _/ _ _</td>
<td>11</td>
</tr>
<tr>
<td>Hormone Rx given, date unknown</td>
<td>* _ _/ _ _/ _ _ or _ _ _/ _ _/ _ _</td>
<td>12</td>
</tr>
<tr>
<td>Hormone Rx planned, not started yet</td>
<td>* _ _/ _ _/ _ _ or _ _ _/ _ _/ _ _</td>
<td>15</td>
</tr>
</tbody>
</table>
* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format. The computer will store either in the interoperable format.
Description
This is a required 2-character field to record immunotherapy or Biological Response Modifier (BRM) therapy administered as part of the first course of treatment. Record immunotherapy administered at your facility, as well as immunotherapy given in any other facilities, if known.

Codes
00  None; immunotherapy was not part of the planned first course of therapy; diagnosed at autopsy.
01  Immunotherapy administered as first course therapy.
82  Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (e.g., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
85  Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86  Immunotherapy was not administered. It was recommended by the patient’s physician, but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87  Immunotherapy was not administered. It was recommended by the patient’s physician, but this treatment was refused by the patient, a patient’s family member, or the patient’s guardian. The refusal was noted in the patient record.
88  Immunotherapy was recommended, but it is unknown if it was administered.
99  It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in the patient record. Death certificate only.

Definitions
a. Immunotherapy (BRM) consists of biological or chemical agents that alter the immune system or change the host’s response (defense mechanism) to the tumor cells.

b. Examples of immunotherapy (BRM) agents are:

- Aldara
- Allogenic cells
- BCG
- C-Parvum
- Interferon
- Ontak
- Interleukin (IL-2)
- Levamisole
- MVE-2
- Thymosin
- TNF (Tumor Necrosis Factor)
- Vaccine therapy

Note: Monoclonal antibodies (Mab) are used in various ways as systemic therapy and can be categorized as chemotherapy, immunotherapy, or ancillary drugs. Use the SEER reference cited below to identify the treatment category in which each monoclonal antibody should be coded.

c. Refer to the SEER*Rx Interactive Drug Database (http://seer.cancer.gov/) to determine whether the drugs used are classified as immunotherapy (BRM).

Instructions
a. Record code 01 if immunotherapy (BRM) was administered and determine the date it was started.

b. Use code 00:
   If immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer;
   If the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include immunotherapy; or
   If the option of, “no treatment,” was accepted by the patient.
c. If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason it was not administered.

d. Use code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

e. Use code 88:
   (1) If it is known that a physician recommended immunotherapy, but no further documentation is available yet to confirm its administration; or
   (2) To indicate referral was made medical oncologist and the registry must follow to determine whether immunotherapy was given. If follow-up with the specific specialist or facility indicates the patient was never there, use code 00.

f. Use code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.

g. In the Immunotherapy field, record code 01 for immunotherapy (BRM). For RMCDS users, record the date the course of immunotherapy was started in the adjacent “Date” field.

   Example: Interferon was started on July 15, 2015. The treatment would be entered as follows:
   Immunotherapy code 01, Date: 07/15/2015.

   For facilities that collect Palliative Care: If immunotherapy was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy provided in the Palliative Care field. The State Registry does not collect the Palliative Care data item.

h. Code the six drugs listed below as BRM, beginning with January 1, 2013 diagnoses. Continue to code cases diagnosed prior to 01/01/2013 as chemotherapy.

   Alemtuzumab/Campath
   Bevacizumab/Avastin
   Rituximab/Rituxan
   Trastuzumab/Herceptin
   Pertuzumab/Perjeta
   Cetuximab/Erbitux
**DATE OF IMMUNOTHERAPY (BRM) FLAG**

**Description**
This flag explains why there is no appropriate value in the corresponding date field, *Date Immunotherapy Started* (NAACCR Item #1240). This data item was added to Volume II Version 12 (effective January 2010).

**Rationale**
Prior to version 12 (through 2009 diagnosis), date fields included codes which provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>No information whatsoever can be inferred from this exceptional value. (It is unknown if immunotherapy was administered.)</td>
</tr>
<tr>
<td>11</td>
<td>No valid date is applicable in this context (for example, no immunotherapy was administered).</td>
</tr>
<tr>
<td>12</td>
<td>A valid date is applicable but not known. (Immunotherapy administered but the date is unknown.)</td>
</tr>
<tr>
<td>15</td>
<td>Information is not available at this time, but it is expected that it will be available later. (Immunotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up.)</td>
</tr>
</tbody>
</table>

**Blank**
A valid date is coded in the *Date Immunotherapy Started* item (NAACCR Item #1240. The case was diagnosed between 2003 and 2009 and the *Date Immunotherapy Started* was not recorded by the facility.

**Instructions**

a. Leave this item blank if the *Date Immunotherapy Started* has a full or partial date recorded.
b. Use code 12 if the *Date Immunotherapy Started* cannot be determined, but the patient did receive first course immunotherapy or a biologic response modifier.
c. Use code 10 if it is unknown whether any immunotherapy or biologic response modifier was administered.
d. Use code 11 if no immunotherapy or biologic response modifier is planned or given.
e. Use code 15 if immunotherapy or a biologic response modifier is planned, but not yet started. Follow this patient for immunotherapy and update this item, *Date Immunotherapy Started*, and the relevant immunotherapy items.
f. Code this data item (when appropriate) even if your software uses the traditional format for date entry.
g. Leave this item blank for diagnoses between 2003 and 2009 if your facility did not collect *Date Immunotherapy Started* at that time.

**Examples:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of BRM Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td>*01/08/2015 or 2015/01/08</td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td>*01/ /2015 or 2015/1/</td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>* /2015 or 2015/</td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown if BRM given</td>
<td>* /or /</td>
<td>10</td>
</tr>
<tr>
<td>No BRM given</td>
<td>* /or /</td>
<td>11</td>
</tr>
<tr>
<td>BRM given, date unknown</td>
<td>* /or /</td>
<td>12</td>
</tr>
<tr>
<td>BRM planned, not started</td>
<td>* /or /</td>
<td>15</td>
</tr>
</tbody>
</table>
* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format. The computer will store either in the interoperable format.
HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURE

Description
This is a required 2-character field to record any systemic therapeutic procedures administered as part of the first course of treatment at this and all other facilities. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy. If none of these procedures were administered, then use this field to record the reason they were not performed.

Rationale
This data item allows the evaluation of patterns of treatment that involve the alteration of the immune system or change the patient’s response to tumor cells but does not involve the administration of anti-neoplastic agents. In addition, when evaluating the quality of care, it is useful to know the reason if these procedures were not performed.

Codes
00  No transplant procedure or endocrine therapy was administered as part of first course therapy; diagnosed at autopsy.
10  A bone marrow transplant procedure was administered, but the type was not specified.
11  Bone marrow transplant - autologous.
12  Bone marrow transplant - allogeneic.
20  Stem cell harvest and infusion; umbilical cord stem cell transplant with blood from one or multiple umbilical cords.
30  Endocrine surgery and/or endocrine radiation therapy.
40  Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of procedures coded as 30 and 10, 11, 12, or 20.)
82  Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (e.g., comorbid conditions, advanced age, progression of disease prior to administration, etc.).
85  Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.
86  Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient’s physician, but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87  Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient’s physician, but this treatment was refused by the patient, a patient’s family member, or the patient’s guardian. The refusal was noted in the patient record.
88  Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99  It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in the patient record. Death certificate only.

Definitions
a. **Bone marrow transplant (BMT):** A procedure used to restore stem cells that were destroyed by chemotherapy and/or radiation.

   **Autologous BMT:** "Auto" means "self." Stem cells are removed from the patient before high-dose chemotherapy or radiation treatment is administered. After these treatments are done, the patient’s own stem cells are reinfused to restore the destroyed cells.

   **Allogeneic BMT:** "Allo" means "other." Stem cells are removed from another person, called a donor. Most times, the donor must have the same genetic makeup as the patient, so that their blood is a "match." A relative may be a good match or donors who are not related to the patient may be found through national bone marrow registries. Bone marrow transplanted from an identical twin (syngeneic BMT) is coded as an allogeneic BMT.
b. **Stem cell harvests** involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.

c. **Endocrine irradiation and/or endocrine surgery** are procedures that suppress the naturally occurring hormonal activity of the patient and thus alter or affect the long-term control of the cancer’s growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.

**Instructions**

a. Select the code for the type of procedure the patient received and determine the date it was performed.

(1) Use code 00:
- If a transplant or endocrine procedure was not administered to the patient and it is known that these procedures are not usually administered for this type and stage of cancer;
- If the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include a transplant or endocrine procedure; or
- If the option of, “no treatment,” was accepted by the patient.

(2) Use code 10 if the patient has “mixed chimera transplant” (mini-transplant or non-myeloablative transplant). These transplants are a mixture of the patient’s cells and donor cells.

(3) Use code 20 if the patient has a stem cell harvest followed by a rescue or reinfusion (stem cell transplant, including allogenic stem cell transplant) as first course therapy. If the patient does not have a rescue, code the stem cell harvest as 88, recommended, unknown if administered.

(4) If it is known that a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason it was not administered.

(5) Use code 87 if the patient refused a recommended transplant or endocrine procedure, or made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

(6) Use code 88:
- If it is known that a physician recommended transplant or endocrine procedure, but no further documentation is available yet to confirm its administration;
- If a bone marrow or stem cell harvest was undertaken, but was not followed by a rescue or reinfusion as part of first course treatment; or
- To indicate referral was made to a specialist for hematologic transplant or endocrine procedures and the registry must follow the case. If follow-up with the specific specialist or facility indicates the patient was never there, use code 00.

(7) Use code 99 if it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer and there is no mention in the patient record whether is was recommended or administered.

b. In the **Hematologic Transplant and Endocrine Procedure** field, enter the code from the list above for the procedure that the patient received. For RMCDS users, record the date the procedure was performed in the adjacent “Date” field.

For facilities that collect **Palliative Care**: If the hematologic transplant or endocrine procedure coded in this item was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the procedure provided in the **Palliative Care** field. The State Registry does not collect the **Palliative Care** data item.
### OTHER TREATMENT

**Description**

This is a required 1-character field to record cancer-directed treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. Record the therapy delivered at your facility, as well as other therapy given in any other facilities, if known.

**Codes and Definitions**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
<td>All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.</td>
</tr>
<tr>
<td>1</td>
<td>Other</td>
<td>Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy).</td>
</tr>
<tr>
<td>2</td>
<td>Other—Experimental</td>
<td>This code is not defined. It may be used to record participation in institution-based clinical trials.</td>
</tr>
<tr>
<td>3</td>
<td>Other—Double Blind</td>
<td>A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.</td>
</tr>
<tr>
<td>6</td>
<td>Other—Unproven</td>
<td>Cancer treatments administered by nonmedical personnel.</td>
</tr>
<tr>
<td>7</td>
<td>Refusal</td>
<td>Other treatment was not administered. It was recommended by the patient’s physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient’s family member, or the patient’s guardian. The refusal was noted in the patient record.</td>
</tr>
<tr>
<td>8</td>
<td>Recommended; unknown if administered</td>
<td>Other treatment was recommended, but it is unknown whether it was administered.</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
<td>It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.</td>
</tr>
</tbody>
</table>

**Instructions**

a. Select the code for other treatment received by the patient as part of the first course of treatment.

b. In the Other Treatment field, enter the code from the list above for the “other” therapy that the patient received. For RMCDS users, record the date the course of other therapy was started in the adjacent “Date” field.

1. Use code 0 for any of the following:
   - There is no information in the patient’s medical record about other therapy and it is known that other therapy is not usually performed for this type and/or stage of cancer or there is no reason to suspect that the patient would have had other therapy.
   - The treatment plan offered multiple options and the patient selected treatment that did not include other therapy.
   - The patient elects to pursue no treatment following the discussion of other therapy. (Discussion does not equal a recommendation.)
   - The patient is diagnosed at autopsy.
(2) Use code 1 for any of the following:
   - Embolization using alcohol as an embolizing agent.
   - Embolization to a site other than the liver where the embolizing agent is unknown.
   - PUVA (psoralen and long-wave ultraviolet radiation).

   **Note:** Do not code presurgical embolization performed to shrink the tumor and make resection of the primary tumor easier. Examples where presurgical embolizations may be used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

(3) Use code 1 for supportive care (e.g., phlebotomy, transfusion, or aspirin) used in the treatment of only certain hematopoietic diseases. Consult the most recent version of the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* for instructions for coding care of specific hematopoietic neoplasms in this item.

(4) Use code 6 for the following:
   - Unconventional methods whether they are the only therapy or are given in combination with conventional therapy (complementary medicine).
   - Alternative therapy only if the patient receives no other type of treatment.

   **c.** Do not code ancillary drugs (defined in the chemotherapy section of this manual) in this field. There is no coding scheme for ancillary drugs.

   **Examples of ancillary drugs:**
   - Allopurinol
   - G-CSF (growth stimulating factors)
   - Epogen
   - Leucovorin
   - Neupogen

   This a partial list. Refer to the [SEER*Rx Interactive Drug Database](http://seer.cancer.gov/) if in doubt as to which drugs are ancillary drugs and not coded.

   **d.** Do not code supportive care, observation, or any treatment that does not meet the usual definition in which treatment “modifies, controls, removes, or destroys proliferating cancer tissue.”

   **Exception:** For specific hematopoietic diseases as instructed in the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*.

**Definitions**

   **a.** Complementary and Alternative Medicine (CAM): any medical system, practice, or product that is not thought of as standard medicine (conventional medicine). CAM treatments may include dietary supplements, megadose vitamins, herbal preparations, acupuncture, massage therapy, magnet therapy, spiritual healing, and meditation. Complementary medicine is used along with standard medicine. Alternative medicine is used in place of standard treatment.

   **b.** Phlebotomy may be called blood removal, bloodletting, or venesction.

   **c.** Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.
Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Other Treatment Started* (NAACCR Item #1250). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
10  No information whatsoever can be inferred from this exceptional value. (It is unknown if other therapy was administered.)
11  No valid date is applicable in this context (for example, no other treatment was administered).
12  A valid date is applicable but not known. (Other therapy administered but the date is unknown.)
15  Information is not available at this time, but it is expected that it will be available later. (Other therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up.)
Blank  A valid date value is provided in item *Date Other Treatment Started* (NAACCR Item #1250). The case was diagnosed between 2003 and 2009 and the *Date Other Treatment Started* was not recorded by the facility.

Instructions
a. Leave this item blank if the *Date Other Treatment Started* (NAACCR Item #1250) has a full or partial date recorded.
b. Use code 12 if the *Date Other Treatment Started* cannot be determined, but the patient did receive first course other treatment.
c. Use code 10 if it is unknown whether any other treatment was administered. (The *Other Treatment* item is coded 9.)
d. Use code 11 if no other treatment is planned or given. (The *Other Treatment* item is coded 0, 7, or 8.)
e. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

Examples:

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of Other Rx Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td><em>01/08/2015</em> or 2015/01/08</td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td><em>01/ / /2015</em> or 2015/ / /</td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td>* / /2015* or 2015/ / /</td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown if other Rx given</td>
<td>_ _ / / _ _ _ _ _ _ or _ _ _ _ / _ _ _ _</td>
<td>10</td>
</tr>
<tr>
<td>No other Rx given</td>
<td>_ _ / / _ _ _ _ _ _ or _ _ _ _ / _ _ _ _</td>
<td>11</td>
</tr>
<tr>
<td>Other Rx given, date unknown</td>
<td>* _ _ / / _ _ _ _ _ _ or _ _ _ _ / _ _ _ _</td>
<td>12</td>
</tr>
</tbody>
</table>

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format. The computer will store either in the interoperable format.
Description
This is required text for recording narrative descriptions of all treatment given for the tumor being reported, whether treatment is to the primary or metastatic site. In the paper abstract, the Description of Treatment field is a single field for recording all types of treatment. The RMCDS abstract screen provides a separate text field for each treatment modality. Facilities using other types of registry software should follow their vendor's instructions for recording treatment text.

Rationale
Text is needed to justify the codes selected for the data items and to record information that is not coded at all. The text is used for quality control and special studies.

Instructions
Surgical Procedures
a. Record information describing all surgical procedures performed as part of treatment.
b. Include, as applicable: Date of each procedure; facility where each procedure was performed; type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites; lymph nodes removed; regional tissues removed; metastatic sites; and positive and negative findings.

Radiation Beam
a. Record information regarding treatment of the tumor with beam radiation.
b. Include, as applicable: Date radiation treatment began; facility where treatment was given; type(s) of beam radiation (e.g., orthovoltage, cobalt 60, MV x-rays, electrons, mixed modalities); and other treatment information (e.g., patient discontinued after five treatments).

Radiation Other
a. Record information regarding treatment of the tumor with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy.
b. Include, as applicable: Date treatment began; facility where treatment was given; type(s) of non-beam radiation (e.g., high dose rate brachytherapy, seed implant, radioisotopes [I-131]); and other treatment information.

Chemotherapy
a. Record information regarding chemotherapy treatment of the tumor.
b. Include, as applicable: Date chemotherapy began; facility where chemotherapy was given; type of chemotherapy (e.g., name of agent(s) or protocol); and other treatment information (e.g., treatment cycle incomplete).

Hormone
a. Record information about hormonal cancer-directed treatment.
b. Include, as applicable: Date treatment began; facility where treatment was given; type of hormone or antihormone agent(s) (e.g., Tamoxifen); type of endocrine surgery or radiation (e.g., orchiectomy); and other treatment information (e.g., treatment cycle incomplete).

Immunotherapy/BRM
a. Record information regarding the treatment of the tumor with biological response modifiers or immunotherapy.
b. Include, as applicable: Date treatment began; facility where treatment was given; type of BRM agent (e.g., Interferon, BCG); BRM procedures (e.g., bone marrow transplant, stem cell transplant); and other treatment information (e.g., treatment cycle incomplete).

Other Treatment
a. Record information treatment that cannot be defined as one of the other treatment modalities. This includes experimental and blinded clinical trials.
b. Include, as applicable: Date treatment began; facility where treatment was given; type of treatment (e.g., blinded clinical trial, hyperthermia); and other treatment information (e.g., treatment cycle incomplete).
DATE OF LAST CONTACT OR DEATH

**Description**
This is a required 8-character field to record the date of last contact (DLC). If the patient is dead, this field records the date of death. Determine whether your software vendor uses the traditional format for date entry (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format.

**Definition**
This date may be the discharge date, date of death, date of a patient’s visit to a doctor’s office or clinic, or the date the patient was last contacted, whichever is the most recent. This date must be the latest date in the record. For example, a treatment date cannot be later than the Date of Last Contact.

**Instructions**

a. If no information is known after the patient is discharged from your hospital, record the date of discharge or the date of the patient’s last outpatient visit. When abstracting a case with more than one admission or clinic visit, make sure the date of last contact is the last clinic visit date or the last discharge date, or whatever the latest date is.

b. If you are aware of a more recent date the patient was last alive after discharge (such as through correspondence or telephone contact), record the latest date of contact known. The date may be the date the patient was contacted by telephone or responded to a letter. Record the date of the actual patient contact. Do not use the date information was received in the mail, or the date information was requested from a patient, physician, or clinic. Do not record the date follow-up information was recorded on the abstract or follow-up card, or the date the case was entered into the computer. **Note:** Failure to find a patient on a list of deceased individuals does not constitute evidence that the patient is alive. Neither Vital Status nor Date of Last Contact or Death should be changed.

c. If a patient has multiple primaries, all records should have the same date of last contact. If the State Cancer Registry receives information from more than one facility for the same patient, this field will be updated in each of the patient’s records. The latest date of last contact or death will be recorded for all of the patient’s tumors.

d. Estimate the date of last contact when the exact date is not available. An approximate date is better than using unknowns.

If the specific day of the month is unknown, leave the the day section blank.

e. If information is limited to a description, use the following:

<table>
<thead>
<tr>
<th>DESCRIPTIVE TERM USED</th>
<th>DATE CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring</td>
<td>April</td>
</tr>
<tr>
<td>The middle of the year</td>
<td>July</td>
</tr>
<tr>
<td>Fall</td>
<td>October</td>
</tr>
<tr>
<td>Winter</td>
<td>Try to determine if this means the beginning of the year (January) or the end of the year (December). Code as indicated.</td>
</tr>
</tbody>
</table>

The Vital Status and Cancer Status fields below relate to this date.
DATE OF LAST CONTACT FLAG

**Description**
This flag explains why there is no appropriate value in the corresponding date field, *Date of Last Contact* (NAACCR Item #1750). This data item was added to Volume II Version 12 (effective January 2010).

**Rationale**
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

**Codes**
- **12**: A valid date is applicable but not known. (The date of last contact or death is unknown).
- **Blank**: A valid date is coded in the *Date of Last Contact or Death* item.

**Instructions**
- Leave this item blank if *Date of Last Contact or Death* has a full or partial date recorded.
- Use code 12 if the *Date of Last Contact or Death* cannot be determined.
- Code this data item (when appropriate) even if your software uses the traditional format for date entry.

**Examples:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date (Leave unknown portions blank.)</th>
<th>Date of Last Contact Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td><em>01/08/2015</em> or 2015/01/08</td>
<td>Blank</td>
</tr>
<tr>
<td>Month &amp; year known</td>
<td><em>01/_ _/2015</em> or 2015/01/_ _</td>
<td>Blank</td>
</tr>
<tr>
<td>Year only known</td>
<td><em>_/ _/2015</em> or 2015/_ <em>/</em> _</td>
<td>Blank</td>
</tr>
<tr>
<td>Unknown date</td>
<td>*_/ _/ <em>/</em> <em>/</em> _ or _ <em>/</em> <em>/</em> _</td>
<td>12</td>
</tr>
</tbody>
</table>

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The RMCDS program uses the traditional format. The computer will store either in the interoperable format.
**VITAL STATUS**  
*(STATUS OF PATIENT)*

**Description**  
This is a required 1-character field to record a code that indicates patient’s vital status (dead or alive) as of the *Date of Last Contact (or Death)*. Use the most accurate information available.

**Codes**

0  Dead  
1  Alive

**Instructions**

a. If no follow-up information is ever received, code the patient’s vital status on the date of his/her last discharge from the hospital.

b. If a patient has multiple primaries, all records should have the same patient vital status. Do not change a patient’s vital status at discharge unless new follow-up information is available.

c. There is no code for “unknown,” since you must know at least whether the patient was alive or dead at the time he or she last left your facility.

**Note:** Failure to find a patient on a list of deceased individuals does not constitute evidence that the patient is alive. Neither *Vital Status* nor *Date of Last Contact or Death* should be changed.
**CANCER STATUS**

*(STATUS OF TUMOR)*

**Description**

This is a required 1-character field to record a code that indicates the presence or absence of clinical evidence of the patient’s malignant or non-malignant tumor as of the *Date of Last Contact (or Death)*. Tumor status changes if the patient has a recurrence or relapse.

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No evidence of this tumor</td>
</tr>
<tr>
<td>2</td>
<td>Evidence of this tumor</td>
</tr>
<tr>
<td>9</td>
<td>Unknown, indeterminate whether this tumor is present, not stated in the patient record</td>
</tr>
</tbody>
</table>

**Instructions**

a. Code the best available information concerning the tumor status of the patient as of the date of last contact or death.

b. Code tumor status independently for each primary tumor. If a patient has multiple primaries, each record could have a different tumor status. If the patient has evidence of the other primary tumor, but does not have evidence of this tumor, code 1, no evidence of this tumor.

c. Code patients who have hematopoietic disease (e.g., leukemia) that is in remission as no evidence of this tumor (code 1).

d. Official death certificates do not always record the presence of tumors. If the registry abstract indicates that the patient had a malignant or non-malignant tumor immediately before death, code evidence of this tumor (code 2). Consult the registry physician advisor when questions arise. Decisions on tumor status coding can be based on information such as:

- How much time elapsed between the last follow-up and patient’s death?
- Was the last follow-up and tumor status information from a medical source (physician, hospital admission)?
- Are autopsy findings available to the registry?

*Example:* A prostate cancer patient has a two-year history of metastatic disease. The patient had a bone scan at your facility in April 2015. The urologist’s diagnosis was progressive bony metastases and the bone scan confirmed extensive bone destruction. The registrar finds an obituary documenting the patient’s death in a nursing home in June 2015. Record the tumor status as “evidence of this tumor” (code 2).
FOLLOW-UP SOURCE

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: Required if available*

*Required if available for cases diagnosed 01/01/2008 and later.

Description
This item records the source from which the latest follow-up information was obtained.

Rationale
This data item is used by registries to identify the most recent follow-up source.

Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Reported hospitalization</td>
<td>Hospital at another institution/hospital or first admission to the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>reporting facility.</td>
</tr>
<tr>
<td>1</td>
<td>Readmission</td>
<td>Hospitalization or outpatient visit at the reporting facility.</td>
</tr>
<tr>
<td>2</td>
<td>Physician</td>
<td>Information from a physician.</td>
</tr>
<tr>
<td>3</td>
<td>Patient</td>
<td>Direct contact with the patient.</td>
</tr>
<tr>
<td>4</td>
<td>Department of Motor Vehicles</td>
<td>The Department of Motor Vehicles confirmed the patient has a current license.</td>
</tr>
<tr>
<td>5</td>
<td>Medicare/Medicaid file</td>
<td>The Medicare or Medicaid office confirmed the patient is alive.</td>
</tr>
<tr>
<td>7</td>
<td>Death certificate</td>
<td>Information from the death certificate only.</td>
</tr>
<tr>
<td>8</td>
<td>Other</td>
<td>Friends, relatives, employers, other registries, or any sources not covered by other codes.</td>
</tr>
<tr>
<td>9</td>
<td>Unknown/ not stated in patient record</td>
<td>The follow-up source is unknown or not stated in the patient record.</td>
</tr>
</tbody>
</table>
CAUSE OF DEATH

Item Length: 4  
Data Type: Alphanumeric  
Left Justified  
ACoS: N/A  
State Registry: Required

Description
This is a required 4-character field in the RMCDS abstract screen to record the ICD-10 (International Statistical Classification of Diseases and Related Health Problems, Tenth Revision) code for the underlying cause of death. Record the cause of death listed on the death certificate. Central (state) registries are the primary users of this data item. Use the underlying cause of death (ICD-10 code), even if believed to be in error. All underlying causes of death should be left-justified. The decimal point is assumed to be between the third and fourth digit, but should not be entered.

Special Codes
0000  Patient alive at last follow-up
7777  State death certificate or listing not available
7797  State death certificate or listing available, but underlying cause of death not coded; or the coded underlying cause of death is not available

Instructions
a. For all cases not meeting one of the above code descriptions and where the patient has died and the cause of death is known, record the ICD-10 underlying cause of death code.

b. Use code 7777 when the patient has died, but the death certificate is not available. Hospitals would almost always record code 7777 for cause of death.

c. Use code 7797 when the patient has died, but the coded underlying cause of death is not available.

d. Some codes have an optional fifth digit. The fifth digit is not used in coding cause of death.

e. The ICD-9-CM code for cause of death obtained from the medical record should not be used for the underlying cause of death code if no death certificate is available. Use only the ICD-10 code from the death certificate. If hospitals record cause of death from the medical record for their own use, the State Registry will replace it with the death certificate code.

f. Examples:

<table>
<thead>
<tr>
<th>Underlying Cause of Death</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer of the thyroid</td>
<td>C73</td>
</tr>
<tr>
<td>Acute appendicitis with peritonitis</td>
<td>K35.0</td>
</tr>
<tr>
<td>Adenocarcinoma of stomach</td>
<td>C16.9</td>
</tr>
</tbody>
</table>
PLACE OF DEATH - STATE

Description
This is a 2-character field for recording the state or province where the patient died. The State Registry requires the item if the information is available.

Codes
See the table provided for State at Diagnosis for the list of state codes.

Special Codes
XX Died in a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is known (code the country in Birthplace-Country)
YY Died in a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is unknown
US Died in the U.S. (including its territories, commonwealths, or possessions) and the state is unknown
CD Died in Canada and the province is unknown
ZZ State where patient died is unknown

Note
This item was first defined for use in 2013. Cases diagnosed before 2013 should be converted automatically by the registry’s software from the former Place of Death.
PLACe OF DEATH - COUNTRY

Description
This is a 3-character field for recording the country where the patient died. The State Registry requires the item if the information is available.

Codes
For country codes, see one of the following:

- The SEER Program Coding and Staging Manual, Appendix B (http://seer.cancer.gov);
- NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Appendix B (http://www.naaccr.org); or

Examples
USA United States
CAN Canada
ZZX Non-US NOS
ZZU Place of death is unknown

Note
This item was first defined for use in 2013. Cases diagnosed before 2013 should be converted automatically by the registry’s software from the former Place of Death.
REMARKS

**Description**
This is an optional text field in the paper and RMCDS abstracts for recording information not elsewhere provided for or for overflow from other text fields. Facilities using other types of registry software should follow their vendor’s instructions for recording text.

**Rationale**
Text is needed to justify the codes selected for the data items and to record information that is not coded at all. The text is used for quality control and special studies.

**Instructions**
The following kinds of information may be recorded in this field:

a. History of symptoms

b. Clinical findings

  *Example 1:* Mass noted in right (rt.) breast 2 months ago; mammogram prior to admission (PTA) suspicious. Physical exam (PE) revealed 2 cm. mass in the upper outer quadrant (UOQ) of the right breast. No axillary lymphadenopathy noted.

  *Example 2:* Pleural effusion or ascites, weight loss, etc.

c. Diagnostic and metastatic work-up (type of procedures, dates, and results)

  1. Record only work-up related to the malignancy and the spread of the disease.

  2. When recording test results, include the interpretation (positive, negative, elevated, within normal limits) with the value because the definition or parameters for "normal" values may differ from one facility to another.

d. Overflow from other text fields if additional space is needed.
Description
This is an 8-character field (when combined with sequence number). The Central Tumor Registry (CTR) Number is an internal number that will be assigned and used by the State Cancer Registry only. In the RMCDS program, it appears in the abstract screen and on reports as CTR # (Central Tumor Registry Number). There is a unique CTR number for each person in the central registry. If a person has more than one primary tumor, the sequence number will distinguish one tumor from the next.

In hospitals using the RMCDS program, the CTR number that appears in the hospital’s abstract screen is the same as the hospital registry’s accession number for the patient. The first four digits are the accession year (YYYY). The next five digits are the accession number (#####). The last two digits are the sequence number (SQ), so that the number looks like this: YYYY#####SQ.

When the hospital submits cases on diskette to the State Registry, the CTR number is automatically changed to the unique CTR number used by the central registry. Hospital accession numbers are also maintained in the central registry.
Description
This is an 8-character field for the date the electronic or paper abstract (or source record) is received by the State Cancer Registry for the respective tumor. If multiple reports are received from two or more sources, the applicable date for each reporting source is maintained in the State record for the tumor. The item label is Stamp Date in the State RMCDS screens. RMCDS screens for hospitals do not include this item.

Rationale
This item is used to assess and monitor the timeliness of reporting. Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations and consequently, timeliness standards have been established. This item can be used with the Date of First Contact to measure timeliness of reporting by individual facilities to the State Registry.
CHAPTER 6: CORRECTIONS AND FOLLOW-UP

OVERVIEW

This chapter describes how corrections, deletions, and follow-up information on previously submitted cases are reported to the State Cancer Registry. Part I explains the purpose for corrections and follow-up; who submits reports; and when, how, and where reports are submitted. Part II describes various methods to accomplish follow-up. Part III details how to complete the Correction and Follow-up Form. Part IV explains how to complete the Correction form for Multiple Patients. Forms are available upon request from the State Cancer Registry.

PART I: GENERAL INSTRUCTIONS

A. Purpose

1. Corrections

The latest or most complete information and conclusions about a case should be reported. Over time, documentation may be added to a patient’s medical record that was not available when an abstract was originally completed. Such information may, in the interest of accuracy, require modification of the originally reported data. For example, early diagnostic information may support a diagnosis of metastatic lung cancer. Later it may be learned that the original site of disease was breast cancer. In another case, more extensive work-up may reveal that disease originally thought to be malignant is benign and the case should be deleted from the State Cancer Registry database. For such cases it is important to correct the primary site, histology, and/or extent of disease as information becomes more complete. There is no time limit for making revisions that give better information about the original diagnosis or stage.

Note: This does not mean that as the disease progresses, the stage should be changed according to the latest stage of disease. Staging should reflect only information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.

2. Follow-Up

Systematic, annual follow-up of cancer patients is an important function of the cancer registry. Annual follow-up achieves two important objectives:

- To encourage continued medical surveillance of patients for early detection and treatment of recurrences and subsequent cancer;
- To obtain information for patient care studies and survival.

Additional benefits of hospital-based follow-up efforts include provision of follow-up service to physicians and enhanced public relations resulting from the hospital’s continued concern for patient welfare.

From an epidemiologic perspective, a statewide follow-up effort permits tracking of patients in the event that case control studies are required or patient contact is necessary to assess public health risks.

The American College of Surgeons, Commission on Cancer requires a specified successful follow-up rate for all cancer programs seeking approval.

B. Who Submits Correction and Follow-Up Reports

Any hospital having correction or follow-up information about a patient who was previously reported to the State Cancer Registry may submit information on that patient to the State Cancer Registry.
C. When to Submit Corrections and Follow-Up Information

1. **Corrections**
   Corrections or modifications to previously submitted data should be completed and submitted to the State Cancer Registry as soon as possible after the need for correction is discovered.

2. **Follow-Up**
   Follow-up should be performed at least annually for each patient, usually on the anniversary of the date of last contact.

   Follow-up reports may be submitted to the State Registry at least quarterly, particularly for hospitals that treat a large number of cancer patients. Hospitals are encouraged to submit updated information more frequently in order to maintain a complete record of the patient’s treatment and a current database for analytic purposes. This permits an orderly workflow at both the State Cancer Registry and the reporting hospital.

D. How to Report Corrections and Follow-Up Information

Corrections, deletions, and follow-up can be submitted in a number of different ways that are outlined below.

1. **Copies of the Original Paper Abstract**
   If your hospital reports by paper abstract, changes or follow-up may be submitted on a copy of the original paper abstract.
   a. Make a copy of the original form.
   b. In red, write “Correction,” “Delete,” or “Follow-Up” at the top of the form.
   c. In red, cross out the original data in the field to be corrected and write the corrected or follow-up information beside the old.

2. **Corrector and Follow-Up Form**
   Changes and/or follow-up may be submitted on a “Correction and Follow-Up Form,” explained in Part III of this chapter.
   a. Complete all identifying information on the form to ensure the appropriate case is corrected, deleted, or updated.
   b. Complete section D. “Corrections” or section F. “Follow-Up Information,” as applicable.
   c. Make a legible copy of the original form and mail the copy to the State Cancer Registry, keeping the original at your hospital.

3. **Corrections for Multiple Patients**
   Corrections for multiple patients, such as those identified on a discrepancy report from the State Cancer Registry, may be submitted by one of the following two methods:
   a. Write the correct information next to the error message on the discrepancy report and return the corrected report to the State Registry; or
   b. Record the corrections on the “Correction Form for Multiple Patients” explained in Part IV of this chapter.

4. **Corrections by Telephone**
   Changes may be submitted by calling the State Cancer Registry at (317) 233-7158 with the correction or deletion. Changes of this type should be limited to five patients or less. Be prepared to identify the case by patient name, sequence number, and possibly date of birth or Social Security Number so that State Registry staff can change the correct record.

5. **Computerized Registries**
   Follow-Up and Recurrence
   When the State Registry processes disks received from hospitals with computerized registries, the most current follow-up information is automatically entered into the computer from the
diskettes. This includes date of last contact or death, patient’s vital status, and cause of death, if applicable.

Other Changes (Corrections or Deletions)
All other information the hospital may have changed, updated, or corrected in any previously reported case is NOT automatically updated in the computer when the disks are processed. **These changes must be reported manually, in writing, or verbally.**

The information will not be automatically updated in order to prevent writing over data which had been previously corrected or consolidated by State Registry staff. The system at the State Registry is designed so that when reports for a single case are received from multiple hospitals and there are significant differences in the information reported, they are not permitted to write over each other or merge until State Registry staff have analyzed and researched the differences and determined the best information and/or codes. The cases are then manually changed and consolidated. The work of the State Registry staff would be lost if new information from one of the hospitals could write over any changes made in the consolidation process. The consolidation process is described in more detail in Chapter 7 of this manual.

E. Where to Send Correction and Follow-Up Reports
Envelopes should be carefully sealed and labeled “CONFIDENTIAL MEDICAL INFORMATION.” The envelope should be clearly addressed:

Indiana State Cancer Registry
Indiana State Department of Health
2 North Meridian Street, Section 6-B
Indianapolis, IN 46204-3010

All reports submitted must be legible. Illegible forms will be returned to the hospital.

The hospital should keep a record of reports submitted to the State. Cancer Registry personnel will keep track of reports received from each hospital.

F. Confidentiality
As correction and follow-up reports are being completed, care should be taken to ensure that the content of each is treated with the same level of security and confidentiality as the medical record. These reports are abbreviated medical records and should be treated as such. A full discussion of confidentiality is found in Chapter 8 of this manual.

PART II. FOLLOW-UP

Reporting annual follow-up data to the State Cancer Registry is optional. The State encourages hospitals to report follow-up information whenever possible in order to obtain a more complete record. Accurate and complete information about the current health of each patient may be difficult to obtain, but the importance of collecting this information is undeniable.

A. Frequency of Follow-Up
Follow-up efforts should be initiated on those patients for whom no information has been received within the last 12 months. Cases are considered delinquent if no contact has been made within 15 months after the date of last contact. A follow-up (tickler) file must be maintained, either manually or by computer, by which to identify patients due for follow-up. For hospitals that submit follow-up information, it is recommended that follow-up data collection be a monthly task of the hospital that first treats a case.

B. Cases to Include in Follow-Up
The American College of Surgeons, Commission on Cancer, requires annual follow-up on all analytic cases.
A hospital may elect to report recurrence or follow-up information on any case that has been reported to the State Cancer Registry. See Chapter 3 on Reporting for further information on the reportable cases.

Patient of advanced age and stage of disease should not be assumed deceased and withdrawn from follow-up after a prescribed time period. These patients may have exceptional responses and occasionally be long-term survivors.

C. Cases Not to Include in Follow-Up

- Carcinoma in situ of the cervix
- Non-analytic cases (cases neither diagnosed nor receiving any part of the first course of therapy at the reporting hospital)
- Patients residing in foreign countries
- Cases which were not required to be reported to the State Cancer Registry (see Chapter 3, Section D of this manual.)

D. Data Fields to Include in Follow-Up

The State Cancer Registry needs minimal follow-up data on patients in its database in order to calculate survival time from date of cancer diagnosis to date of death. This data includes:

- Date of last contact or death
- Patient’s vital status (alive or dead)
- Cancer status (with or without disease)

A full explanation of these items is found in Chapter 5 of this manual.

There are additional data items relating to recurrences and follow-up that hospitals may want to collect for their registries: date and type of first recurrence, distant site(s) of first recurrence, and subsequent treatment for persistent or recurrent disease. Since the State Registry does not collect these items, they will not be explained here. Please refer to the Facility Oncology Registry Data Standards (FORDS) for coding rules and information.

E. Follow-Up Sources

1. Most follow-up information is obtained through review of hospital readmissions, outpatient visits, or letters to the patient’s physician. Hospitals are encouraged to share follow-up information with other facilities that are following the same patient. Remember to re-contact physicians even though the first contact may not have been productive. After a period of time, the patient may have returned for a subsequent visit to the physician. When these methods are not effective in providing follow-up information, a variety of other sources may be employed.

2. Hospital policy, consistent with legal requirements for confidentiality, should be developed governing potential contact with relatives, friends, etc. If hospital policy permits, patients may be contacted by letter or telephone. All patient contact should be accomplished in a responsible and compassionate manner. Many hospitals’ policies caution against mention of the patient’s diagnosis.

3. Voter Registration roles can be a source of addresses for patients who have moved. Date of the last election in which the patient voted or date of registration to vote may be used as the date of last contact if no further information can be obtained.

4. Miscellaneous methods of locating patients include the Social Security Administration office, medical and life insurance companies, local utility companies, and credit bureaus. Most of these sources will provide only last known address.
5. More information on follow-up techniques can be obtained through the American College of Surgeons.
PART III: INSTRUCTIONS FOR COMPLETING CORRECTION AND FOLLOW-UP FORM

The number in front of the title of each item described below corresponds to the number on the Correction and Follow-Up Form for that data field. Shaded fields indicate items which are optionally reportable: completion is desirable, but not required. It is important to enter all information accurately and legibly.

A. Purpose of form
Check the box which describes your purpose for completing the Correction and Follow-Up Form.

1. **Correction**
   Check the “Correction” box if you are modifying or correcting a record you have previously submitted to the State Cancer Registry.

2. **Follow-Up**
   Check the “Follow-Up” box if you are reporting follow-up information.

3. **Delete Case**
   Check the “Delete Case” box if you want the State Cancer Registry to delete a record previously submitted. This might be used if, after reporting a case to the State Cancer Registry, you obtained additional information and concluded the case was non-reportable. Record the reason the case should be deleted in the “Remarks” section of the form.

B. Patient Identification
The information in Items 4 through 6 should match the information previously submitted for the patient. It will be used to identify the record that requires the change or follow-up being reported.

4. **Patient Name**
Enter the patient’s last name, first name, and middle initial according to instructions in Chapter 5.

5. **Social Security Number**
Enter the patient’s Social Security Number according to instructions in Chapter 5.

6. **Date of Birth**
Enter the patient’s birth date according to instructions in Chapter 5.

7. **State CTR #, if known**
   This is a unique 10-digit number assigned to every patient in the State Registry. Additional information on the CTR number can be found in Chapter 5.

   If you have a report from the State Registry that lists the Central Tumor Registry (CTR) number, enter it in Item 7. The CTR number appears in the first column of Discrepancy Reports from the State Registry. After the 10-digit CTR number, a dash follows, and then the 2-digit sequence number, which should be recorded in Item 10 on the Correction and Follow-Up Form.

   Leave the item blank if the CTR number is unknown or unavailable.

C. Hospital and Tumor Identification

8. **Hospital Identification Number**
Enter the 3-digit hospital ID number according to instructions in Chapter 5.

9. **Hospital Accession Number**
Enter the 9-digit hospital Accession Number according to instructions in Chapter 5.

10. **Sequence Number**
Enter the 2-digit Sequence Number according to instructions in Chapter 5.
11. **Original Primary Site**
Enter the ICD-O-3 primary site code number as originally submitted to the State Registry according to instructions in Chapter 5. If primary site is the item you want to correct or change, the corrected code will be reflected in Item 14 where corrections are described.

D. **Corrections**

12. **Item Name**
Enter the name of the item (field) you want to correct or change. For example, if you are changing the primary site code, enter “Primary Site.”

13. **Change From**
Enter the information that was originally submitted for the field you are correcting. If you are changing the Summary Stage from “localized” to “in situ,” for example, enter the code you originally submitted (1). Enter the code first, and the description if space allows. For example, enter 1 – localized.

14. **Change To**
Enter the new information for the field you are correcting. If you are changing the Summary Stage from “localized” to “in situ,” for example, enter the code you want to change the Summary Stage to (0). Enter the code first, and the description if space allows. For example, enter 0 – in situ.

E. **Remarks**
The “Remarks” field is to be used to record any information that may be helpful to you or State Cancer Registry staff who will be entering the data. The type of information that might be recorded here includes an explanation of the correction if it is anything other than routine. If a case is being deleted, record the reason in this field.

F. **Follow-Up Information**
The “Follow-Up Information” fields allow for submission of up to three years of follow-up information. The hospital should keep the original abstract and send a copy to the State Registry. Additional years of follow-up can then be added to the original Correction and Follow-Up form, with a copy being sent to the State every year.

After each 12-month follow-up contact is made, complete the next follow-up information section.

15. **Date of Last Contact**
Enter the date of the most recent patient contact or the patient’s date of death. Complete this section according to instructions in Chapter 5.

16. **Vital Status (Patient Status)**
Enter the patient’s vital status (alive or dead) as of the last date of contact. Complete this section according to instructions in Chapter 5.

17. **Cancer Status**
Enter the patient’s cancer status (with or without evidence of cancer) for this primary as of the last date of contact or death using the best available information. Complete this section according to instructions in Chapter 5.

18. **Cause of Death**
Enter the ICD-10 underlying cause of death code listed on the death certificate. Complete this section according to instructions in Chapter 5.

Special Codes
0000  Patient alive at last follow-up
7777  State death certificate or listing is not available
7797  State death certificate or listing is available, but the underlying cause of death is not coded or the coded underlying cause of death is not available

19. Submitted By
Enter the name or initials of the person completing the Correction and Follow-Up Form. The name or initials may be legible printed, written, or typed. The signature of the preparer is not required. This information is collected in case the State needs to contact the preparer for questions.

20. Date Completed
Enter the date the form was completed. The date may be legibly printed, written, or typed.
PART IV: INSTRUCTIONS FOR COMPLETING CORRECTION FORM FOR MULTIPLE PATIENTS

The “Correction Form for Multiple Patients” can be used to report corrections for up to four different patients. The form can be used to address questions identified on the State Registry’s discrepancy lists or to report any corrections on multiple patients.

A. Hospital Identification

1. Enter the name of your hospital. If there is more than one hospital with the same name (e.g., there are six St. Joseph hospitals in Indiana), add the city name or an abbreviation of the city.

2. Enter the 3-digit hospital identification number according to instructions in Chapter 5.

B. Corrections

1. Enter the patient’s last and first names in the space under the item title Name according to instructions in Chapter 5.

2. Enter the Central Tumor Registry (CTR) number, if known, as it appears in the first column of the Discrepancy Report. The first 10 digits are the CTR number, followed by a dash, and then the 2-digit Sequence Number (e.g., 0000123456-00). Additional information on the CTR and Sequence Numbers can be found in Chapter 5.

3. Enter your hospital’s Accession Number, according to instructions in Chapter 5. The first 4 digits are the year the patient was first accessioned, followed by a dash, and then the five digit Accession Number.

4. On lines 1-5, record an explanation of the change(s) being reported. The change(s) should be recorded as described for the “Correction and Follow-Up Form.” If the correction involves a change of codes, record both the old and the new codes.

C. Submitted By and Date

Enter the name or initials of the person completing the form on this line. The name or initials may be legibly printed, written, or typed. The signature of the preparer is not required. This information is collected in case State Registry staff need to contact the preparer for questions.

Enter the date the form was completed. The date may be legibly printed, written, or typed.
CHAPTER 7: QUALITY CONTROL

A. OVERVIEW

Definition
Quality control is the cancer registry function concerned with the assessment and improvement of data quality. The characteristics of quality include case completeness, data accuracy, data completeness, and timeliness.

Goals
- To detect and correct errors or omissions in existing data;
- To identify and effectively address opportunities for improvement in training, documentation, and/or systems in order to assure the quality of subsequent data collection.

Responsibility
A designated CTR (Certified Tumor Registrar) is responsible for the quality assurance program. Qualified, experienced CTRs conduct quality assurance activities.

Components of Quality Control
The State Registry quality control activities include the following:

- Analysis of observed/expected completeness rates
- Casefinding audits
- Reabstracting and re-coding audits
- Visual editing of data quality
- Computer editing of data quality
- Evaluation and consolidation of case-sharing and duplicates
- Procedure manual (documentation) maintenance
- Staff training and development
- Feedback and consultation from quality control activities to data collectors
- Resolution of discrepancies

B. ASSESSMENT/IMPROVEMENT OF DATA ACCURACY AND COMPLETENESS

1. Observed/Expected Completeness Rates

Case Volume
Case volume is monitored to assess and improve the completeness of data. The actual number of cases reported by each facility is compared to an estimated expected volume. The expected case volume for a year is based on an assessment of the number of cases reported in each of the preceding five years. An annual caseload can be estimated by the number of acute care medical and surgical beds at the facility. A hospital with 250 acute medical and surgical beds may typically see 250 new cancer cases per year. For small hospitals without radiation therapy centers, this figure is probably within 20% of the actual caseload for the first years of the registry. For hospitals offering radiation therapy, 50% is added to the total number of beds to determine annual caseload (e.g., a hospital with 100 beds would see 150 cancer cases per year). This formula is not reliable for major referral centers.

When fewer reports are received than expected for a given year, the reporting source is contacted to assess the reason. If the decline in number of cases is not the result of an explainable cause, such as a change in facility services or an abstracting backlog, the facility will be asked to review casefinding procedures. The Indiana State Cancer Registry personnel will be available for consultation and assistance in the review. A review would include an examination of the hospital’s patient index; pathology reports; chemotherapy, radiation therapy, and outpatient logs; diagnostic or disease index; and print-outs of cancer-related diagnostic codes from the billing system.
Patterns
Indiana data is compared with national averages in order to assess and improve the completeness of data. Based on data from the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute, the proportion of cases from each of the common organ sites is compared to Indiana data and used to determine whether Indiana data are comparable to national data. Any discrepancies will be investigated.

2. Casefinding Audits
Casefinding audits are performed to assess and improve the completeness of reporting. The audit is a study to verify that a facility is reporting all applicable newly diagnosed cancer cases and to help the facility improve casefinding procedures if needed. The audit involves reviewing the facility's casefinding procedures and all sources for potential cases in the facility. The cases identified in this review are compared with cases reported and missed cases are documented. The reviewer calculates a completeness rate from these numbers and compares the rate with the completeness rate goal of 95%. Separate procedures are available describing in more detail how casefinding audits are conducted.

Each year the State Registry will select up to 20% of Indiana hospitals for casefinding audits. Sample specifications will be based on hospital annual caseload. Six months will be reviewed for hospitals with 0-100 annual cases. Three months will be reviewed for hospitals with 101-499 annual cases. One month will be reviewed for hospitals with 500 or more annual cases.

The State Registry will make consultative recommendations to the hospital registrar during the audit and will submit a written report of results and recommendations to the hospital and the State Registry within thirty days of the audit.

3. Reabstracting Audits
Reabstracting audits are performed to assess and improve data accuracy in terms of the data collectors’ adherence to established principles of coding, abstracting, and staging. The audit involves reviewing the facility’s source records for randomly selected cases and reabstracting selected data elements. The reabstracted items are compared with the facility's abstract and discrepancies are reviewed to identify needs for clarification, corrections, and education. Separate procedures are available describing in more detail how reabstracting audits are conducted.

Each year the State Registry will select up to twelve (10%) Indiana hospitals for reabstracting audits. The sample will be limited to a subset of cases diagnosed the previous year in the same half of the year as the time of the audit.

The State Registry staff will make consultative recommendations to the hospital registrar at the time of the audit and will submit a written report of results and recommendations to the hospital and the State Registry within thirty days of the audit.

4. Recoding Audits
Recoding audits may be performed to assess and improve the accuracy of data from new coders or from coders with educational needs identified by other quality control activities. The audits involve independently reassigning codes to abstracted text information or from copies of specific medical record documentation requested from the facility. The recoded items are compared with the original codes submitted and discrepancies are analyzed to identify needs for clarification, correction, and education.

The State Registry staff will submit a written report of results and recommendations to the hospital and the State Registry within thirty days of the audit.

5. Quality Control for Newly Submitted Cases
Each new submission of cases is loaded into a subsystem and subjected to both visual and computer edits before being transferred into the main database.
a. **Visual Edits**

Visual editing is performed to assess and improve data accuracy and completeness. Visual reviews are performed on cases received by State Cancer Registry staff to determine if data are complete, as well as, logical and internally consistent. Visual editing includes assessment of frequency reports of required items for blank items or invalid codes. It may involve analysis of listings with specified data items for all cases in a subsystem. It may involve one hundred per cent review of each abstract when the cases involve difficult diagnoses, are from new coders, or are from coders with educational needs identified by other quality control activities.

- Dates of birth, accession years, admission and discharge, initial diagnosis, and treatment are monitored for logical progression.
- Accession number, sequence number, and class of case are visually reviewed for logic.
- Agreement with laterality, site codes, histology, and sex are reviewed for logical consistency.
- Completeness is assessed by monitoring the number of “unknowns” or blanks in demographic and cancer data.

The reporting source is contacted as needed for correction, clarification, or completion of required data elements.

Transcription accuracy reflects the quality of procedures for transferring the data from the paper abstract to electronic medium. For cases entered from paper abstracts by State Cancer Registry personnel, each screen is carefully checked against the abstract for transcription errors prior to transfer to the main database.

b. **Computer Edits**

The State Cancer Registry develop and apply State-required computerized edit sets based on those from the NAACCR standard edits that are required by NPCR. These edits are provided to RMCDS hospitals; are available to facilities using other registry systems as part of the FTP submission procedure; and are made available to other vendors for incorporation into their registry systems.

The computerized edit sets assess the accuracy of all data received by applying standard computerized data edits. The computerized edits include the following: single field (to check for valid codes), multi-field (to check for consistency and logic between different fields), multi-record (to check for consistency between multiple sequences), and multi-database (to check for consistency between different hospitals seeing the same patient for the same tumor). Inconsistencies or discrepancies not detected during manual edit checks are identified by these edits.

The Rocky Mountain Cancer Data Systems’ (RMCDS) edit program, though no longer updated by the vendor, are applied by the State Cancer Registry to identify potential Indiana ZIP code/county code inconsistencies that are not addressed by the NAACCR edits.

State Registry staff members analyze the edit reports and the abstracts and make corrections as indicated. When the staff member determines that the original information is correct, the edit is overridden and the reason is recorded in the “Comments” section.

When the analysis of computerized edits identifies variations from coding rules or incomplete information, the issues are reported to the responsible facility for correction, clarification, or completion of required data elements. Responses from the reporting source with justification and/or documentation supporting the original information are reviewed and changes made as indicated.

Quality control reviews are performed on reports before the data are released. In addition to the routine computerized edit checks, the subset of cases used in the report is checked for duplicate
cases to ensure patients are not counted more than once for each tumor. Patterns in the data are studied for inconsistencies. For example, a listing of pediatric cases containing colon, breast, or prostate cancers would identify a need for further review and action.

6. Consolidation
The State Cancer Registry may receive duplicate reports for a single case from the same hospital, multiple hospitals, nonhospital facilities, death records, or another state registry. State Cancer Registry staff identify duplicate reports for a single case, resolve any discrepancies between reports, and consolidate the reports into a single record. Applicable multiple primary rules of the standard-setting organizations are applied. The purpose of consolidation procedures is to accurately determine cancer incidence in Indiana.

Identification of Duplicate Cases
The process of identifying duplicate reports (that have been submitted electronically) is initiated when recently received cases are transferred into the main database. See Attachment B, Procedure for Transferring Subsystems to the Main Database. The following mechanisms are used to identify potential duplicates: computer-automated merges, computer-generated identification of potential duplicates (error reports), manual search of the database by Social Security Number, and periodic execution of computerized multiple sequence consistency checking.

Computer-automated Merges
When critical identifying data elements are identical (e.g., patient name, Social Security Number, date of birth, sex, sequence number, primary site code), the oncoming case merges with the duplicate case in the main database. A list of all such merges is generated by the system and printed by staff for analysis described in the Analysis of Discrepancies section below.

Error and Possible Match Reports
When some, but not all, critical, identifying data elements are identical, the oncoming case is added as a new case into the main database. The system identifies most of these cases on either the Error Report or the Possible Match Report. The Error Report lists the cases that match all critical elements except the primary site and identifies each new case by the original case’s Central Tumor Registry (CTR) number and a sequence in the 90’s. The Possible Match Report lists the cases that match all critical elements except the sex, date of birth, or Social Security Number and identifies each new case by a newly assigned CTR number with the sequence as reported. The reports are printed by staff for analysis described in the Analysis of Discrepancies section below.

Note: The system does not identify possible matches that differ only in sequence, last name, or some variations in first name (e.g., Theodore versus Ted). Most of these are identified by Multiple Sequence Report analysis or the Social Security Number search procedure.

Social Security Number Search
After resolution of potential duplicates identified by the Error and Possible Match Reports, staff search the main database by the Social Security Numbers of all the oncoming cases, identifying additional potential duplicates for analysis described in the Analysis of Discrepancies section below.

Computerized Multiple Sequence Consistency Checking
The system’s Multiple Sequence Consistency Checking identifies discrepancies between legitimate multiple primary cases, as well as potential duplicate cases that may not have been resolved in the procedures described above. This program is executed periodically and all discrepancies and potential duplicates are analyzed and resolved.

The process of identifying duplicate reports (that have been submitted in other than electronic format) is initiated by manually searching the main database and subsystems. Matched records for the same patient are compared, using applicable multiple primary rules to determine whether
the same primary is involved. If the reports are determined to be for the same primary, the analysis of discrepancies process described below is applied.

**Analysis of Discrepancies**

The abstracts for each of the potentially duplicate cases are opened and reviewed side by side so that all data items are compared and any discrepancies identified. For cases that were automatically merged, the original abstract for oncoming case is available as the “pristine” record, which can be opened and compared with the existing abstract.

Discrepancies between patient identifying data items may be resolved by searching the Social Security Death Index, if applicable. The reporting facilities may also be contacted for review of their source records for the correct information. If the analysis results in a determination that the cases are duplicate cases, the abstract that will be the consolidated record (the case with the earlier date-on-file) is corrected as applicable.

Discrepancies between cancer identifying data items and treatment data are reviewed with analysis of supporting text; assessment of the more extensive diagnostic work-up; consideration of class of case and dates seen; and appropriate application of coding rules. The more accurate and complete information is identified. The reporting facilities may also be contacted for review of their source records for clarification. If the analysis results in a determination that the cases are duplicate cases, the abstract that will be the consolidated record (the case with the earlier date-on-file) is corrected as applicable.

If the analysis results in a determination that the reports are duplicate cases that have not been automatically merged, they are manually merged. The oncoming case is merged to the case with the earlier date-on-file (the consolidated case) by deleting the oncoming case and entering the consolidated case CTR number and sequence in the box provided by the system. The consolidated records for all merged cases retain the facility-specific information (accession number, sequence, admission and discharge dates, medical record number, and class of case) for up to ten facilities. In addition, the original abstract submitted by each facility is retained as a “pristine” record.

If the analysis results in a determination that the cases are separate primaries (same patient), both reports are saved. (If these were computer-automated merges, the cases are “unmerged.”) Sequencing is updated, and any discrepancies between CTR number, Social Security Number, race, date of birth, place of birth, date last seen, vital status, and cause of death are resolved and corrected.

If the analysis results in a determination that the cases are separate primaries (different patients), both reports are saved.

After cases have been consolidated and pass all computerized edit checks, inter-record edit checks are applied periodically to identify and resolve inconsistencies between multiple primary records for one patient.

**Facility Feedback**

When the analysis of discrepancies identifies variations from coding rules, the issues are reported to the responsible facility for educational purposes.

### 7. Procedure Manual Maintenance

Current, written documentation of the State Registry’s definitions and methods are maintained in a policy and procedure manual, which is provided to all State Registry employees, contract consultants, and employees of reporting facilities. The manual documents the Registry’s data set definitions, codes, coding rule interpretations, and procedures. The standards of ACoS, NAACCR, and SEER are incorporated in the manual to the extent possible. Appropriate portions of the documentation will be provided to investigators and users of the data, as needed, to explain definitions and methods.
A Policy and Procedure Manual maintenance system is used for updating the documentation and keeping it current. The system involves monitoring release of new standards, rules, and definitions by ACoS, NAACCR, and SEER. Information from quality control activities are also be used in assessing the need to revise the procedure manual. When revised, dated pages are provided to all Registry staff, contract consultants, and reporting facilities. A library of revisions to the manual is kept at the State Cancer Registry. When revised, dated pages are provided to all Registry staff, contract consultants, and reporting facilities. The State Cancer Registry also maintains an “unusual case” reference file to aid in consistent data collection for difficult cancers.

8. **Staff Training and Development**

The State Cancer Registry provide training opportunities for employees of the State Registry and employees of reporting facilities. Training programs are developed in cooperation with the Indiana Cancer Registrars Association, Indiana Health Information Management Association, and Rocky Mountain Cancer Data Systems. Training will provide feedback to State Cancer Registry staff on the quality and effectiveness of services provided to reporting sources and the public.

Training programs are based on standard reference manuals and may address the following areas:

- Anatomy and physiology
- Medical terminology
- Site specific or other topics in oncology
- Reporting requirements
- Confidentiality and information security
- Casefinding
- Abstracting/coding/staging
- Follow-up
- Quality control
- Data processing (computer software)
- American College of Surgeons updates
- Hospital based cancer/tumor registry management
- Topics identified through other quality control activities

9. **Feedback and Consultation**

The results of quality control activities are reported to the applicable data collector to maintain data quality and eliminate recurring errors. Feedback may be written or by telephone call or one-on-one meetings. Feedback to the reporting facilities include the following:

- Information about changes or corrections made to abstracts at the State Registry
- Discrepancy lists resulting from computer or visual edits
- Results of casefinding and reabstracting audits with analysis of discrepancies and recommendations for improvement
- Information from analysis of observed/expected completeness rates.

The abstractor’s identification and date completed are required items in the RMCDS and are useful in identifying contacts for feedback. A complete list of the abstractors and/or contact person for each hospital is maintained at the State Cancer Registry. When feedback is indicated, the questions are directed to the person on this list.

C. **ISSUES RELATED TO QUALITY**

1. **Timeliness of Data**

Data collection must be conducted according to schedule. With the exception of early deaths, no case should be abstracted less than four months after admission. Abstracting too soon may result in the omission of important information from the database if complete information is unavailable at the time of abstracting. Cases are due at the State Registry no later than six months following a confirmed
diagnosis. Abstracting too late reduces the usefulness of the cancer registry data and reports. Cases submitted by each reporting source are monitored for timely receipt.

2. **Personnel**

Data collection in reporting facilities must be performed by knowledgeable and qualified individuals. The individuals serve as the primary abstractors and may be responsible for staff supervision, cancer case auditing, and report writing.

The Commission on Cancer, American College of Surgeons encourages registry staff to maintain Certified Tumor Registrar (CTR) credentials. The State Cancer Registry can provide hospitals with information on how to become a CTR, certified by the National Cancer Registrars Association (NCRA). Information on NCRA is found in Chapter 1 on References.

3. **Use of References and Edits**

Hospital staff should use available reference materials, many of which are free, rather than trying to memorize codes. Hospitals with computerized registries should ensure all records pass computer edits at the hospital level before sending data to the State. Standard edits, such as the EDITS project system developed by NAACCR, are available from standard setting organizations.

4. **Maintenance of Logs and Records**

Hospitals must keep documentation by date sent of reports submitted to the State Cancer Registry. Hospitals submitting paper abstracts must submit a legible copy of the original to the State Cancer Registry and keep the original for their records. State Cancer Registry personnel will keep a copy of discrepancy reports returned to the reporting source for completion, clarification, and correction.

5. **Submitting Correction or Follow-Up**

Chapter 6 details how to submit corrections and follow-up information. Two correction forms, which permit changes or deletions to be made to the Hospital Abstract Form, are explained. The Correction and Follow-Up Form also allows reporting of annual follow-up information.

6. **Other Resources**

Further information on quality control procedures may be obtained by requesting Volume I: Cancer Program Standards published by the Commission on Cancer, American College of Surgeons. The State Cancer Registry complies with the NAACCR Standards for Cancer Registries, Volume III: Standards for Completeness, Quality, Analysis, and Management of Data.
CHAPTER 8: CONFIDENTIALITY

A. OVERVIEW

1. Purpose
   The State Cancer Registry is committed to preserving the confidentiality of information obtained for medical, educational, research, and statistical purposes. Confidentiality policies and procedures are maintained in all phases of the State Registry operations in order to:

   - Protect the privacy of individual patients;
   - Protect the privacy of the facilities reporting the cases;
   - Abide by applicable confidentiality-protecting legislation or administrative rules.

2. Definition
   Confidential data includes any information that identifies a specific patient, health care professional, or institution. The obligation to protect confidentiality extends indefinitely, even after the death of the patient.

   Legal requirements for confidentiality are described in IC 16-38-2-(4-7) and 410 IAC 21-1-5, found in Appendix A.

B. RESPONSIBILITY

1. Reporting Source (Hospital or Other Health Care Provider)
   The reporting source (hospital or other health care provider) is responsible for protecting the confidentiality of registry data collected and maintained on site and for submitting data to the State Registry in a way that protects confidentiality. The hospital should develop and implement confidentiality policies and procedures that address staff training, access control, record/abstract handling and storage, and release of registry data.

   Paper abstracts must be handled and stored in a way that prevents unauthorized individuals from viewing confidential data. Information maintained in computerized systems must be protected by physical and electronic measures to control access to confidential data. Hospitals should mail copies of completed abstracts and/or patient record copies promptly to the State Registry, following the instructions in Chapter 3 of this manual for sealing and labeling the container and for keeping records of the cases submitted.

2. State Registry
   The Program Director is ultimately responsible for information security at the State Registry. This responsibility includes ensuring that State Registry staff are accountable for compliance with the confidentiality policies and procedures of this chapter.

C. STATE REGISTRY POLICIES AND PROCEDURES

1. Staff Awareness
   a. All State Registry personnel and consultants receive specific training about the confidentiality of registry information and their responsibilities.

   b. All personnel handling or having access to cancer registry data are required to sign a Confidentiality Agreement. This includes staff from other departments, sections, or programs that are outside the State Cancer Registry but within the Indiana State Department of Health. The agreement documents that the employee has read and understands the State Cancer Registry policies for handling the data, agrees to abide by the policies, and is aware that failure to comply with any of these requirements constitutes a class A misdemeanor which
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will result in disciplinary action in accordance with State policies. The agreement remains in effect after cessation of employment. A copy of the Confidentiality Agreement is available from the State Cancer Registry upon request.

2. Access Control
   a. A current, written list of persons with legitimate access to confidential cancer data is kept in the State Cancer Registry office. The nature and extent of their access to registry data are defined and are restricted to the information needed to do his/her job.

   b. All file cabinets where confidential data are stored in open areas are locked except when in use by authorized State Cancer Registry staff. The file room designated for the Cancer Registry Program is locked except when authorized State Cancer Registry staff are present.

   c. Employees are provided with the equipment for ensuring the physical security of confidential information. Confidential patient abstracts are stored in locked file cabinets. Backup tapes of the statewide database are stored in a locked, fireproof safe.

   d. Field staff maintain abstracts and/or printed reports in locked briefcases which are kept in a secure place when unattended. Access to confidential information is limited to authorized hospital personnel. Discussions regarding patient records occur only in settings where privacy is assured.

   e. The computer system provides access only to authorized individuals. The system has a three tiered level of security.

      1) The first level is the user Login Name. Each central registry staff logging into the network file server must enter his/her unique user login name.

      2) The second level is the confidential password, established by the user. The password is altered on a regular basis and when there is concern that security may be in jeopardy.

      3) The third level is the password to gain entry to the Rocky Mountain Cancer Data Systems (RMCDS) software. Network users who need the data for epidemiologic studies may be allowed limited access to only the non-confidential portions of the database. The RMCDS program is set up to allow “Read Only” for such individuals.

         When a user is no longer employed at the State Registry, his/her password and access codes are deactivated immediately.

   f. Disclosure or sharing of codes, numbers, or names used to access the computer is strictly prohibited.

   g. When printed reports containing confidential information are no longer needed, they are disposed of by shredding.

3. Data Collection and Management
   a. Electronically Submitted Data

      The State supports the programs described below that ensure the secure transmission of electronic cancer data by reporting facilities.

      1) The FTP Program

         The preferred method for submitting data is the ISCR FTP Program that encrypts the facility’s data file and sends it to the ISCR through the Internet using the File Transfer Protocol (FTP). If the facility prohibits or limits the use of FTP, the program can also send the encrypted file as an e-mail attachment. The method meets government security requirements.
2) Web Plus
   An alternate method is the Web Plus program that securely uploads the facility’s data file through a browser. The method also meets government security requirements.

b. Submitting on Diskettes
   Effective July 2009 the State Cancer Registry no longer processes data submitted on diskettes. Diskettes received and processed prior to this date have been securely backed up to a server and have been destroyed by the Commission on Public Records.

c. Abstract Forms & Paper Copies of Medical Records
   Mail labeled “CONFIDENTIAL MEDICAL INFORMATION” is opened only by designated State Registry staff. Such mail is kept in a secure location before and after it is processed. State Cancer Registry personnel stamp each form with the date received and maintain a register by hospital documenting the date the batch was received, the date the batch was entered, the number of forms enclosed, and the accession year for the cases. The State Registry retains the abstract forms and registers indefinitely. After processing, abstract forms are filed by hospital, accession year, and accession number.

d. Quality Control Communications
   When State Registry quality control (QC) activities require returning abstracts, inquiry forms, or discrepancy lists to reporting facilities, the mailings are carefully sealed and labeled “CONFIDENTIAL MEDICAL INFORMATION.” When telephone calls are made to address QC issues, reasonable efforts are made to ensure the conversations are private and addressed to an authorized data collector at the reporting facility. When QC communications are transmitted by electronic mail (e-mail), patient-identifying information will be limited to accession numbers. Patient-identifying e-mail received at the State Registry is treated with the same level of security and confidentiality as other confidential medical information.

e. Facsimile Transmission
   Confidential information should be transmitted via facsimile only when urgently needed for patient care. When such transmission is necessary, the cover page will include a confidentiality notice that indicates the information is confidential and limits its use. After transmission, a follow-up call will be made to verify that the information was sent to the appropriate destination.

4. Disaster Recovery
   The Indiana State Department of Health Information Technology Services is responsible for the comprehensive disaster recovery plan that includes the State Cancer Registry data and systems. The plan includes frequent and regular backup, off-site storage, and procedures for retrieval. It is designed to protect operating systems, applications, and data.

5. Sabotage
   Anti-virus software is used to help detect and block computer viruses and other forms of sabotage.

6. Release of Registry Data
   a. Hospital Requests
      Confidential information may be released by authorized State Registry personnel to health care providers and institutions upon verbal or written request and without further review procedures under either of the following circumstances:
      1. The requestor is directly involved in the care or follow-up of the patient;
      2) The information requested is from the hospital’s own registry.

   b. Patient or Individual Requests
The State Cancer Registry staff do not respond to individuals requesting whether or not the State Registry contains information about them. Individuals making such requests are referred to their treating physician.

c. **Physician Requests**
Confidential information may be released to physicians and local health officers for diagnostic and treatment purposes if the patient signs a written consent and the patient’s attending physician gives verbal or written consent to the release.

d. **Other States**
Pursuant to IC 16-38-2-7, effective May 15, 1988, the Indiana Cancer Registry may release confidential information concerning individual cancer patients to the cancer registry of another state under the following condition: The other state has entered into a reciprocal agreement with the State Cancer Registry which provides that information that identifies a patient will not be released to any other person without the written consent of the patient.

e. **Other External Requests**
1) Requests for use of confidential data are handled in accordance with IC 16-38-2-(5-7).
2) Confidential cancer registry data will not be made available for the following purposes:
   a) Businesses that are trying to market a product to cancer patients;
   b) Health care institutions that are trying to recruit new patients;
   c) Insurance companies that are trying to determine the medical status of a patient.
3) Requests for State Cancer Registry data for other purposes, such as research projects, are processed as outlined below.
   a) The request must be submitted in writing and include the following information:
      ▪ The purpose for which data are needed or an outline of the proposed research with a justification of the need for the data;
      ▪ The information required;
      ▪ The names of the persons who will have access to the confidential information;
      ▪ The time period for which the data are needed.

   A record is kept of the date and type of all requests.

   b) The written request is submitted to the Indiana State Department of Health Data Request Committee for review. The committee must approve the request before release can be made. The State Cancer Registry reserves the right to limit the amount of data to be provided to an individual requestor.

   c) If the request is approved, researchers must sign an agreement acknowledging responsibility to maintain patient confidentiality, cite the source of the data in any publication or presentation, and provide the State Cancer Registry with copies of any publications or presentations that may use the data prior to their release. Violation of any part of this agreement shall prevent further access to the data, and shall result in a letter of reprimand to the chief executive officer of the researcher’s institution. In addition, other researchers at the institution may be denied access to the data until the Program Director is assured that no other violations will occur.

   All requestors must assure:
   ▪ That he/she is bound by the principles of confidentiality observed by the personnel of the State Cancer Registry;
   ▪ That the data will not be used for purposes other than those agreed upon at the time of release;
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That the data will not be released to unauthorized individuals or parties; and
That data that are no longer needed for the designated purpose will be returned or destroyed.

f. State Initiated Requests
The Program Director monitors all state initiated research activities to ensure that only relevant activities are undertaken. State affiliated researchers are expected to abide by the same restrictions as outside researchers.
APPENDIX A: LEGISLATION AND REGULATIONS
INDIANA CODE 16-38-2
Public Law 2-1993, Section 21

IC 16-38-2-1 Cancer registry; establishment

Sec. 1. (a) The state department shall establish a cancer registry for the purpose of:
(1) recording:
   (A) all cases of malignant disease; and
   (B) other tumors and precancerous diseases required to be reported by:
      (i) federal law or federal regulation; or
      (ii) the National Program of Cancer Registries;
   that are diagnosed or treated in Indiana; and
(2) compiling necessary and appropriate information concerning those cases, as
determined by the state department; in order to conduct epidemiologic surveys of
cancer and to apply appropriate preventive and control measures.

   (b) The department may contract for the collection and analysis of, and the research
related to, the epidemiologic data compiled under this chapter.


IC 16-38-2-2 Development of registry from existing data

Sec. 2. The state department shall, to the greatest extent possible, utilize information compiled by
public or private cancer registries in the development of a statewide cancer registry under
this chapter.


IC 16-38-2-3 Reports

Sec. 3. (a) The following persons shall report to the cancer registry each confirmed case of
cancer and other tumors and precancerous diseases required to be recorded under
section 1 of this chapter:
(1) Physicians.
(2) Dentists.
(3) Hospitals.
(4) Medical laboratories.
(5) Ambulatory outpatient surgical centers.
(6) Health facilities.

   (b) A person required to report information to the state cancer registry under this section
may utilize, when available:
(1) information submitted to any other public or private cancer registry; or
(2) information required to be filed with federal, state, or local agencies; when
completing reports required by this chapter. However, the state department may
require additional, definitive information.


IC 16-38-2-4 Confidentiality

Sec. 4. Except as provided in sections 5, 6, and 7 of this chapter, information obtained under this
chapter by the state department concerning individual cancer patients is for the confidential
use of the state department only.


IC 16-38-2-5 Access to confidential information for research purposes
Sec. 5. The state department shall grant any person involved in a legitimate research activity access to confidential information concerning individual cancer patients obtained by the state department under this chapter if all of the following conditions are met:

1. The person conducting the research provides written information about the following:
   (A) The purpose of the research project.
   (B) The nature of the data to be collected and how the researcher intends to analyze the data.
   (C) The records the researcher desires to review.
   (D) The safeguards the researcher will take to protect the identity of the patients whose records the researcher will be reviewing.

2. The proposed safeguards are adequate to protect the identity of each patient whose records will be reviewed.

3. An agreement is executed between the state department and the researcher that meets all of the following conditions:
   (A) Specifies the terms of the researcher's use of the records.
   (B) Prohibits the publication or release of the names of individual cancer patients or any facts tending to lead to the identification of individual cancer patients.


IC 16-38-2-6 Additional information requests; individual patients; consents

Sec. 6. Researchers may, with the approval of the state department, use the names of individual cancer patients when requesting additional information for research purposes or soliciting an individual patient's participation in a research project. However, if a researcher requests additional information for an individual cancer patient's participation in a research project, the researcher must first obtain the oral or written consent of the patient's attending physician. If the consent of the patient's attending physician is obtained, the researcher must then obtain the individual cancer patient's written consent by having the patient complete a release of confidential medical information form.


IC 16-38-2-7 Release of confidential information

Sec. 7 The state department may release confidential information concerning individual cancer patients to the following:

1. The cancer registry of another state if the following conditions are met:
   (A) The other state has entered into a reciprocal agreement with the state department.
   (B) The agreement provides that information that identifies a patient will not be released to any other person without the written consent of the patient.

2. Physicians and local health officers for diagnostic and treatment purposes if the following conditions are met:
   (A) The patient's attending physician gives oral or written consent to the release of the information.
   (B) The patient gives written consent by completing a release of confidential information form.


IC 16-38-2-8 Immunity from liability

Sec. 8. A person who reports information to the cancer registry system under this chapter is immune from any civil or criminal liability that might otherwise be imposed because of the release of what is otherwise confidential information.

IC 16-38-2-9 Epidemiological information; release

Sec. 9 This chapter does not prevent the release to any interested person of epidemiological information that does not identify individual cancer patients.


IC 16-38-2-10 Administrative rules

Sec. 10. The state department shall adopt rules under IC 4-22-2 necessary to carry out this chapter.


IC 16-38-2-11 Annual report

Sec. 11. Not later than December 31 of each year, the department shall publish and make available to the public an annual report summarizing the information collected under this chapter during the previous calendar year.

ARTICLE 21. REPORTING

Rule 1. State Cancer Registry

410 IAC 21-1-1 Definitions
Authority: IC 16-38-2-10
Affected: IC 16-38-2

Sec. 1. As used in 410 IAC 21-1:

“Cancer registry” means a mechanism by which data relating to all cases of malignant disease that occur in Indiana residents is recorded and, necessary and appropriate information is compiled concerning those cases as determined by the board, in order to conduct epidemiologic surveys of cancer and to apply appropriate preventive and control measures.

“Confirmed case” means the best evidence available for determining the nature of malignant disease using the following methods and codes: 1 = positive histology; 2 = positive exfoliative histology in the absence of positive histology; (3 is vacant) 4 = positive microscopic confirmation not otherwise specified (NOS); (5 is vacant) 6 = direct visualization without microscopic confirmation; 7 = radiography without microscopic confirmation; 8 = clinical diagnosis (other than 6 or 7) including gross examination at autopsy; and 9 = unspecified whether or not microscopically confirmed, unknown. This is a priority series with code 1 taking precedence. Each number takes priority over all higher numbers (i.e., 1 over 4, and 5 over 9 etc.).

“Data set” means all clinical, pathological [sic.] therapeutic and demographic information defined in 410 IAC 21-1-3 and 410 IAC 21-1-4.


“Indiana resident” means an individual domiciled in the state of Indiana.

“Malignant disease” means confirmed cases of cancer enumerated in the ICD-O excluding superficial, squamous and basal cell carcinomas of the skin.

“Patient” means any individual who is ill, or undergoing diagnosis or treatment for disease by a dentist, medical laboratory, physician or hospital.

“Person” means an individual, association, partnership, corporation, or governmental entity.

“State board” means the Indiana state board of health. (Indiana State Department of Health; 410 IAC 21-1-1; filed Nov 7, 1986, 3:30 pm: 10 IR 420; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234)

410 IAC 21-1-2 General requirements
Authority: IC 16-38-2-10
Affected: IC 5-15-5.1-5; IC 16-38-2

Sec. 2. (a) All physicians, dentists, hospitals and medical laboratories shall report all confirmed cases of cancer occurring in Indiana residents who have been diagnosed or treated in Indiana, to the state board cancer registry.

(b) Any health care provider reporting to a public or private cancer registry on September 1, 1985 shall make available to the state cancer registry, all data as required under 410 IAC 21-1-3 (hospitals) or
410 IAC 21-1-4 (physicians, dentists and medical laboratories) upon the effective date of 410 IAC 21-1.

(c) The state board shall assure state cancer registry computer compatibility for any health care provider who on or before the effective date of 410 IAC 21-1 elects to transmit the required data by way of a computerized mechanism.

(d) Any health care provider who, after the effective date of 410 IAC 21-1, establishes a computerized mechanism for the purpose of transmitting abstracted data sets via computer link up, tape transfer, or direct interface, shall be responsible for assuring system compatibility with the state board cancer registry.

(e) Any health care provider who elects to transfer abstracted data sets to the state cancer registry in paper form, shall utilize an abstract form designed or approved by the state board pursuant to IC 5-15-5.1-5.

(f) All manually prepared data sets shall be mailed or delivered by the health care provider to the state cancer registry.

(g) All health care providers not reporting to a public or private cancer registry on September 1, 1985, shall begin submitting data on cases diagnosed on or after January 1, 1987 to the state cancer registry as set out in 410 IAC 21-1-3 (hospitals) or 410 IAC 21-1-4 (physicians, dentists and medical laboratories), no later than six (6) months following the date of such diagnosis.

(h) Reports of confirmed cases of malignant disease shall be submitted to the state cancer registry within six (6) months following a confirmed diagnosis. (Indiana State Department of Health; 410 IAC 21-1-2; filed Nov 7, 1986, 3:30 pm: 10 IR 420; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234)

410 IAC 21-1-3 Hospitals
Authority: IC 16-38-2-10
Affected: IC 16-38-2

Sec. 3. (a) All hospitals shall submit abstracted data sets to the state board cancer registry which shall include but not be limited to the following data items:

(1) site code
(2) accession number
(3) sequence number
(4) accession year
(5) social security number
(6) medical record number
(7) full name (including maiden name)
(8) home address, city, county, state and zip code
(9) phone number
(10) date of birth
(11) sex
(12) race
(13) class of case
(14) admission date
(15) follow-up physician
(16) discharge date
(17) date of initial diagnosis
(18) topography code
(19) paired organ involvement
(20) histology code
(21) tumor grade
(22) diagnostic confirmation
(23) tumor size (largest dimension)
(24) number of positive nodes
(25) number of nodes examined
(26) sites of distant metastasis
(27) general summary stage
(28) TNM stage  
(29) AJCC stage group  
(30) TNM staging basis  
(31) date and method of first course of treatment  
(32) subsequent therapies/treatments (dates and methods)  

(b) Available updated information regarding all elements enumerated in 410 IAC 21-1-3(a) shall be  
reported to the state board cancer registry each twelve (12) month period following the initial reporting  
of the disease. (Indiana State Department of Health; 410 IAC 21-1-3; filed Nov 7, 1986, 3:30 pm: 10  
IR 421; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234)  

410 IAC 21-1-4 Physicians, dentists and medical laboratories  
Authority: IC 16-38-2-10  
Affected: IC 16-38-2  

Sec. 4. (a) Any physician, dentist or medical laboratory who diagnoses a case of malignant disease when  
such case is not referred to a hospital for further diagnosis or treatment, shall submit required data sets to  
the state cancer registry. Such data sets shall include but not be limited to the following available data  
items:  

(1) patient's full name (including maiden name)  
(2) patient's address (including city, county, state and zip code)  
(3) social security number  
(4) date of birth  
(5) sex  
(6) race  
(7) date of diagnosis  
(8) topography  
(9) morphology  
(10) diagnostic confirmation  
(11) hospital referred to  
(12) physician, dentist or laboratory license number  
(13) physician, dentist or laboratory name, address and phone number  

(b) Physicians, dentists and medical laboratories whose offices are located within the confines of a  
hospital or, who are employed or contracted by a hospital and who diagnose or treat patients for  
malignant disease, shall not be required to report cases of malignant disease under 410 IAC 21-1-4.  
Such cases shall be reported in accordance with 410 IAC 21-1-3. (Indiana State Department of  
Health; 410 IAC 21-1-4; filed Nov 7, 1986, 3:30 pm: 10 IR 421; readopted filed Jul 11, 2001, 2:23  
p.m.: 24 IR 4234)  

410 IAC 21-1-5 Security and confidentiality of data  
Authority: IC 16-38-2-10  
Affected: IC 5-14-3-10; IC 16-38-2  

Sec. 5. (a) The state board shall assure confidentiality of patient record data when entering, retrieving,  
reviewing and utilizing such data.  

(b) The state board shall take all precautions and security measures necessary in order to protect the  
cancer registry data from intrusion or misuse by unauthorized individuals, and to preserve the right to  
privacy of individual patients maintained on the registry.  

(c) Pursuant to IC 5-14-3-10, any public employee or official, or any employee or officer of a contractor or  
subcontractor of a public agency who knowingly or intentionally discloses the identity of a patient  
maintained on the state cancer registry system to a person not authorized to receive such  
information, commits a Class A misdemeanor. Any public employee shall be disciplined in  
accordance with the personnel policies of the agency by which he is employed if he intentionally,
knowingly, or recklessly discloses or fails to protect the identity of patients maintained on the state cancer registry system.

(d) A person who reports information to the cancer registry system in accordance with 410 IAC 21-1, is immune from any civil or criminal liability that might otherwise be imposed because of release of what is otherwise confidential information. (Indiana State Department of Health; 410 IAC 21-1-5; filed Nov 7, 1986, 3:30 pm: 10 IR 422; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234)

410 IAC 21-1-6 Cancer registry reports
Authority: IC 16-38-2-10
Affected: IC 16-38-2

Sec. 6. (a) The state board shall make available to all hospitals licensed under IC 16-10-1 [IC 16-10 was repealed by P.L.2-1993, SECTION 209, effective April 30, 1993.], a comprehensive annual report which outlines the trends of malignant disease in Indiana and focuses on specific elements of special study regarding the disease.

(b) Hospitals, physicians, dentists, laboratories and other persons may request and be provided with special reports from the state cancer registry, providing the data requested does not disclose the identity of a patient. (Indiana State Department of Health; 410 IAC 21-1-6; filed Nov 7, 1986, 3:30 pm: 10 IR 422; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234)
Appendix A  PUBLIC LAW 102-515—OCT. 24, 1992  106 STAT. 3372

Public Law 102-515
102d Congress

An Act

Oct. 24, 1992
[S. 3312]

Cancer
Registries
Amendment
Act.
Diseases.
Health and health
care.
42 USC 201 note.
42 USC 280e note.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Cancer Registries Amendment Act.”

SEC. 2. FINDINGS AND PURPOSE

(a) FINDINGS.-Congress finds that-
(1) cancer control efforts, including prevention and early detection, are best addressed locally by State health departments that can identify unique needs;
(2) cancer control programs and existing statewide population-based cancer registries have identified cancer incidence and cancer mortality rates that indicate the burden of cancer for Americans is substantial and varies widely by geographic location and by ethnicity;
(3) Statewide cancer incidence and cancer mortality data, can be used to identify cancer trends, patterns, and variation for directing cancer control intervention;
(4) the American Association of Central Cancer Registries (AACCR) cites that of the 50 States, approximately 38 have established cancer registries, many are not statewide and 10 have no cancer registry; and
(5) AACCR also cites that of the 50 States, 39 collect data on less than 100 percent of their population, and less than half have adequate resources for insuring minimum standards for quality and for completeness of case information.

(b) PURPOSE.-It is the purpose of this Act to establish a national program of cancer registries.

SEC. 3. NATIONAL PROGRAM OF CANCER REGISTRIES.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following new part:

“PART M—NATIONAL PROGRAM OF CANCER REGISTRIES”

“SEC. 399H. NATIONAL PROGRAM OF CANCER REGISTRIES.
“(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control, may make grants to States, or may make grants or enter into contracts with academic or nonprofit organizations designated by the State to operate the State’s cancer registry in lieu of making a grant directly to the State, to support the operation of population-based, statewide cancer registries in order to collect, for each form of in-situ and invasive cancer (with the exception of basal cell and squamous cell carcinoma of the skin), data concerning-
“(1) demographic information about each case of cancer;
“(2) information on the industrial or occupational history of the individuals with the cancers, to the extent such information is available from the same record;
“(3) administrative information, including date of diagnosis and source of information;
“(4) pathological data characterizing the cancer, including the cancer site, stage of disease (pursuant to Staging Guide), incidence, and type of treatment; and
“(5) other elements determined appropriate by the Secretary.
“(b) MATCHING FUNDS.-
“(1) IN GENERAL.-The Secretary may make a grant under subsection (a) only if the State, or the academic or nonprofit private organization designated by the State to operate the cancer registry of the State, involved agrees, with respect to the costs of the program, to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 25 percent of such costs or $1 for every $3 of Federal funds provided in the grant.
“(2) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION; MAINTENANCE OF EFFORT.-
“(A) Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.
“(B) With respect to a State in which the purpose described in subsection (a) is to be carried out, the Secretary, in making a determination of the amount of non-Federal contributions provided under paragraph (1), may include only such contributions as are in excess of the amount of such contributions made by the State toward the collection of data on cancer for the fiscal year preceding the first year for which a grant under subsection (a) is made with respect to the State. The Secretary may decrease the amount of non-Federal contributions that otherwise would have been required by this subsection in those cases in which the State can demonstrate that decreasing such amount is appropriate because of financial hardship.
“(c) ELIGIBILITY FOR GRANTS.-
“(1) IN GENERAL.-No grant shall be made by the Secretary under subsection (a) unless an application has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such a manner, and be accompanied by such information, as the Secretary may specify. No such application may be approved unless it contains assurances that the applicant will use the funds provided only for the
purposes specified in the approved application and in accordance with the requirements of this section, that the application will establish such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting of Federal funds paid to the applicant under subsection (a) of this section, and that the applicant will comply with the peer review requirements under sections 491 and 492.

“(2) ASSURANCES.—Each applicant, prior to receiving Federal funds under subsection (a), shall provide assurances satisfactory to the Secretary that the applicant will—

“(A) provide for the establishment of a registry in accordance with subsection (a);

“(B) comply with appropriate standards of completeness, timeliness, and quality of population-based cancer registry data;

“(C) provide for the annual publication of reports of cancer data under subsection (a); and

“(D) provide for the authorization under State law of the statewide cancer registry, including promulgation of regulations providing—

“(i) a means to assure complete reporting of cancer cases (as described in subsection (a)) to the statewide cancer registry by hospitals or other facilities providing screening, diagnostic or therapeutic services to patients with respect to cancer;

“(ii) a means to assure the complete reporting of cancer cases (as defined in subsection (a)) to the statewide cancer registry by physicians, surgeons, and all other health care practitioners diagnosing or providing treatment for cancer patients, except for cases directly referred to or previously admitted to a hospital or other facility providing screening, diagnostic or therapeutic services to patients in that State and reported by those facilities;

“(iii) a means for the statewide cancer registry to access all records of physicians and surgeons, hospitals, outpatient clinics, nursing homes, and all other facilities, individuals, or agencies providing such services to patients which would identify cases of cancer or would establish characteristics of the cancer, treatment of the cancer, or medical status of any identified patient;

“(iv) for the reporting of cancer case data to the statewide cancer registry in such a format, with such data elements, and in accordance with such standards of quality timeliness and completeness, as may be established by the Secretary;

“(v) for the protection of the confidentiality of all cancer case data reported to the statewide cancer registry, including a prohibition on disclosure to any person of information reported to the statewide cancer registry that identifies, or could lead to the identification of, an individual cancer patient, except for disclosure to other State cancer registries and local and State health officers;
“(vi) for a means by which confidential case data may in accordance with State law be disclosed to cancer researchers for the purposes of cancer prevention, control and research;
“(vii) for the authorization or the conduct, by the statewide cancer registry or other persons and organizations, of studies utilizing statewide cancer registry data, including studies of the sources and causes of cancer, evaluations of the cost, quality, efficacy, and appropriateness of diagnostic, therapeutic, rehabilitative, and preventative services and programs relating to cancer, and any other clinical, epidemiological, or other cancer research; and
“(viii) for protection for individuals complying with the law, including provisions specifying that no person shall be held liable in any civil action with respect to a cancer case report provided to the statewide cancer registry, or with respect to access to cancer case information provided to the statewide cancer registry.

“(d) RELATIONSHIP TO CERTAIN PROGRAMS.—
“(1) IN GENERAL.—This section may not be construed to act as a replacement for or diminishment of the program carried out by the Director of the National Cancer Institute and designated by such Director as the Surveillance, Epidemiology, and End Results Program (SEER).
“(2) SUPPLANTING OF ACTIVITIES.—In areas where both such programs exist, the Secretary shall ensure that SEER support is not supplanted and that any additional activities are consistent with the guidelines provided for in subsection (c)(2) (C) and (D) and are appropriately coordinated with the existing SEER program.
“(3) TRANSFER OF RESPONSIBILITY.—The Secretary may not transfer administration responsibility for such SEER program from such Director.
“(4) COORDINATION.—To encourage the greatest possible efficiency and effectiveness of Federally supported efforts with respect to the activities described in this subsection, the Secretary shall take steps to assure the appropriate coordination of programs supported under this part with existing Federally supported cancer registry programs.
“(e) REQUIREMENT REGARDING CERTAIN STUDY ON BREAST CANCER.—In the case of a grant under subsection (a) to any State specified in section 399K(b), the Secretary may establish such conditions regarding the receipt of the grant as the Secretary determines are necessary to facilitate the collection of data for the study carried out under section 399C.

“SEC. 399I. PLANNING GRANTS REGARDING REGISTRIES.
“(a) IN GENERAL.—
“(1) STATES.—The Secretary, acting through the Director of the Centers for Disease Control, may make grants to States for the purpose of developing plans that meet the assurances required by the Secretary under section 399B(c)(2).
“(2) OTHER ENTITIES.—For the purpose described in paragraph (1), the Secretary may make grants to public entities other than States and to nonprofit private entities. Such a grant may be made to an entity only if the State in which the purpose is to be carried out has certified that the State approves the entity as qualified to carry out the purpose.

“(b) APPLICATION.—The Secretary may make a grant under subsection (a) only if an application for the grant is submitted to the Secretary, the application contains the certification required in subsection (a)(2) (if the application is for a grant under such subsection), and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

42 USC 280e-2.

“SEC. 399J. TECHNICAL ASSISTANCE IN OPERATIONS OF STATEWIDE CANCER REGISTRIES.

“The Secretary, acting through the Director of the Centers for Disease Control, may, directly or through grants and contracts, or both, provide technical assistance to the States in the establishment and operation of statewide registries, including assistance in the development of model legislation for statewide cancer registries and assistance in establishing a computerized reporting and data processing system.

42 USC 280e-3.

“SEC. 399K. STUDY IN CERTAIN STATES TO DETERMINE THE FACTORS CONTRIBUTING TO THE ELEVATED BREAST CANCER MORTALITY RATES.

“(a) IN GENERAL.—Subject to subsections (c) and (d), the Secretary, acting through the Director of the National Cancer Institute, shall conduct a study for the purpose of determining the factors contributing to the fact that breast cancer mortality rates in the States specified in subsection (b) are elevated compared to rates in other States.

“(b) RELEVANT STATES.—The States referred to in subsection (a) are Connecticut, Delaware, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont, and the District of Columbia.

“(c) COOPERATION OF STATE.—The Secretary may conduct the study required in subsection (a) in a State only if the State agrees to cooperate with the Secretary in the conduct of the study, including providing information from any registry operated by the State pursuant to section 399H(a).

“(d) PLANNING, COMMENCEMENT, AND DURATION.—The Secretary shall, during each of the fiscal years 1993 and 1994, develop a plan for conducting the study required in subsection (a). The study shall be initiated by the Secretary not later than fiscal year 1994, and the collection of data under the study may continue through fiscal year 1998.

“(e) REPORT.—Not later than September 30, 1999, the Secretary shall complete the study required in subsection (a) and submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report describing the findings and recommendations made as a result of the study.
“SEC. 399L. AUTHORIZATION OF APPROPRIATIONS.

“(a) REGISTRIES.-For the purpose of carrying out this part, the Secretary may use $30,000,000 for each of the fiscal years 1993 through 1997. Out of any amounts used for any such fiscal year, the Secretary may obligate not more than 25 percent for carrying out section 399I, and not more than 10 percent may be expended for assessing the accuracy, completeness and quality of data collected, and not more than 10 percent of which is to be expended under subsection 399J.

“(b) BREAST CANCER STUDY.-Of the amounts appropriated for the National Cancer Institute under subpart 1 of part C of title IV for any fiscal year in which the study required in section 399K is being carried out, the Secretary shall expend not less than $1,000,000 for the study.”

Public Law 107-260

Benign Brain Tumor Cancer Registries Amendment Act

SECTION 1. SHORT TITLE.

This Act may be cited as the “Benign Brain Tumor Cancer Registries Amendment Act.”

SEC. 2. NATIONAL PROGRAM OF CANCER REGISTRIES; BENIGN BRAIN-RELATED TUMORS AS ADDITIONAL CATEGORY OF DATA COLLECTED.

(a) IN GENERAL- Section 399B of the Public Health Service Act (42 U.S.C. 280e), as redesignated by section 502(2)(A) of Public Law 106-310 (114 Stat. 1115), is amended in subsection (a)--

(1) by redesignating paragraphs (1) through (5) as subparagraphs (A) through (E), respectively, and indenting appropriately;

(2) by striking "(a) IN GENERAL- The Secretary" and inserting the following:

(a) IN GENERAL-

(1) STATEWIDE CANCER REGISTRIES- The Secretary;

(3) in the matter preceding subparagraph (A) (as so redesignated), by striking “population-based” and all that follows through “data” and inserting the following: population-based, statewide registries to collect, for each condition specified in paragraph (2)(A), data; and

(4) by adding at the end the following:

(2) CANCER; BENIGN BRAIN-RELATED TUMORS-

(A) IN GENERAL- For purposes of paragraph (1), the conditions referred to in this paragraph are the following:

(i) Each form of in-situ and invasive cancer (with the exception of basal cell and squamous cell carcinoma of the skin), including malignant brain-related tumors.

(ii) Benign brain-related tumors.

(B) BRAIN-RELATED TUMOR- For purposes of subparagraph (A):

(i) The term “brain-related tumor” means a listed primary tumor (whether malignant or benign) occurring in any of the following sites:

(I) The brain, meninges, spinal cord, cauda equina, a cranial nerve or nerves, or any other part of the central nervous system.

(II) The pituitary gland, pineal gland, or craniopharyngeal duct.

(ii) The term “listed,” with respect to a primary tumor, means a primary tumor that is listed in the International Classification of Diseases for Oncology (commonly referred to as the ICD-O).

(iii) The term “International Classification of Diseases for Oncology” means a classification system that includes topography (site) information and histology (cell type information) developed by the World Health Organization, in collaboration with international
centers, to promote international comparability in the collection, classification, processing, and presentation of cancer statistics. The ICD-O system is a supplement to the International Statistical Classification of Diseases and Related Health Problems (commonly known as the ICD) and is the standard coding system used by cancer registries worldwide. Such term includes any modification made to such system for purposes of the United States. Such term further includes any published classification system that is internationally recognized as a successor to the classification system referred to in the first sentence of this clause.

(C) STATEWIDE CANCER REGISTRY- References in this section to cancer registries shall be considered to be references to registries described in this subsection.

(b) APPLICABILITY- The amendments made by subsection (a) apply to grants under section 399B of the Public Health Service Act for fiscal year 2002 and subsequent fiscal years, except that, in the case of a State that received such a grant for fiscal year 2000, the Secretary of Health and Human Services may delay the applicability of such amendments to the State for not more than 12 months if the Secretary determines that compliance with such amendments requires the enactment of a statute by the State or the issuance of State regulations.
APPENDIX B: REPORTABLE LIST

The definitions in the State Cancer Registry Policy and Procedure Manual describe reportable cases in terms of their ICD-O-3 topography and morphology codes. These pages contain all reportable malignancies with an International Classification of Diseases of Oncology, Third Edition (ICD-O-3) behavior code of /2 or /3. Diagnoses with a behavior code of /0 (benign) or /1 (borderline) are not reportable to the State Cancer Registry except for intracranial and central nervous tumors diagnosed 01/01/2004 and later. See section B of this appendix for the reportable list of benign and borderline intracranial and central nervous tumors.

A. REPORTABLE MALIGNANCIES

Conditions are to be reported if the diagnosis includes the words:

- Cancer
- Carcinoma (except certain basal or squamous cell carcinomas of the skin, CIS, CIN III, and PIN III, as described in Chapter 3)
- Leukemia
- Lymphoma
- Malignant
- Melanoma
- Sarcoma

The following terms, used as adjectives, are also to be reported when used in the description of a malignancy:

- Anaplastic
- Histiocytic
- Intraepithelial
- Keratinizing
- Medullary
- Moderately differentiated
- Non-keratinizing
- Poorly differentiated
- Small cell
- Well differentiated

The morphologic terms listed below are malignancies and should be reported. Changes in ICD-O-3 are identified by special formatting that is explained below.

- **Underlined** terms represent newly reportable morphology terms for 2010 diagnoses. Most, but not all, of the underlined terms have new ICD-O-3 codes associated with them.
- **Highlighted items** are terms that changed from borderline in ICD-O-2 to malignant in ICD-O-3 and are reportable if diagnosed on or after January 1, 2001.
- **A strikethrough** indicates the term was changed from malignant in ICD-O-2 to borderline in ICD-O-3 and is not reportable if diagnosed on or after January 1, 2001.
- [obs] designates terminology that is identified as obsolete in ICD-O-3.

**A**

- Acidophil adenocarcinoma
- Acidophil carcinoma
- Acinar adenocarcinoma
- Acinar carcinoma
- Acinar cell carcinoma
- Acinar cell cystadenocarcinoma
- Acinic cell adenocarcinoma
- Acral lentiginous melanoma, malignant

= Acute basophilic leukemia
- Acute bilineal leukemia
- Acute biphenotypic leukemia
- Acute differentiated progressive histiocytosis (See acute progressive histiocytosis X)
- Acute erythremia [obs]
- Acute erythremic myelosis [obs]
- Acute erythroid leukemia
- Acute granulocytic leukemia, minimal differentiation
Appendix B

Reportable List

Acute granulocytic leukemia (FAB or WHO type not specified)
Acute granulocytic leukemia with maturation
Acute granulocytic leukemia without maturation
Acute leukemia, Burkitt type [obs]
Acute leukemia, NOS
Acute lymphatic leukemia
Acute lymphatic leukemia, L1 type
Acute lymphatic leukemia, L2 type
Acute lymphoblastic leukemia, Burkitt type
Acute lymphoblastic leukemia, L1 type, NOS
Acute lymphoblastic leukemia, L2 type, NOS
Acute lymphoblastic leukemia, mature B-cell type
Acute lymphoblastic leukemia, NOS
Acute lymphoblastic leukemia, precursor-cell type
Acute lymphoblastic leukemia-lymphoma, NOS
Acute lymphocytic leukemia
Acute lymphocytic leukemia, L1 type
Acute lymphocytic leukemia, L2 type
Acute lymphoid leukemia
Acute lymphoid leukemia, L1 type
Acute lymphoid leukemia, L2 type
Acute megakaryoblastic leukemia
Acute mixed lineage leukemia
Acute monocytic leukemia
Acute monocytic leukemia, minimal differentiation
Acute myeloblastic leukemia
Acute myeloblastic leukemia, minimal differentiation
Acute myeloblastic leukemia (FAB or WHO type not specified)
Acute myeloblastic leukemia with maturation
Acute myeloblastic leukemia without maturation
Acute myelocytic leukemia
Acute myelocytic leukemia, minimal differentiation
Acute myelocytic leukemia (FAB or WHO type not specified)
Acute myelocytic leukemia with maturation
Acute myelocytic leukemia without maturation
Acute myeloid leukemia (megakaryoblastic) with t(1;22)(p13;q13); BLM15-MKL1
Acute myeloid leukemia, minimal differentiation
Acute myeloid leukemia, NOS
Acute myeloid leukemia with abnormal marrow eosinophils (includes all variants)
Acute myeloid leukemia with inv(3)(q21;q26.2) or t(3;3)(q21;q26.2); RPN1-EVI1
Acute myeloid leukemia with maturation
Acute myeloid leukemia with multilineage dysplasia
Acute myeloid leukemia with prior myelodysplastic syndrome
Acute myeloid leukemia with t(6;9)(p23;q34) DEK-NUP214
Acute myeloid leukemia without maturation
Acute myeloid leukemia without prior myelodysplastic syndrome
Acute myeloid leukemia, 11q23 abnormalities
Acute myeloid leukemia, AML1(CBF-alpha)/ETO
Acute myeloid leukemia, CBF-beta/MYH11
Acute myeloid leukemia, inv(16)(p13;q22)

Acute myeloid leukemia, M6 type
Acute myeloid leukemia, MLL
Acute myeloid leukemia, PML/RAR-alpha
Acute myeloid leukemia, t(8;21)(q22;q22)
Acute myeloid leukemia, t(15;17)(q22;q11-12)
Acute myeloid leukemia, t(16;16)(p13;q11)
Acute myelomonocytic leukemia, NOS
Acute myelomonocytic leukemia with abnormal eosinophils
Acute myelosclerosis
Acute non-lymphocytic leukemia
Acute panmyelosis, NOS [obs]
Acute panmyelosis with myelofibrosis
Acute progressive histiocytosis X
Acute promyelocytic leukemia, NOS
Acute promyelocytic leukemia, PML/RAR-alpha
Acute promyelocytic leukemia, t(15;17)(q22;q11-12)
Adaman tinoma, malignant
Adaman tinoma of long bones
Adenocanthoma
Adenocarcinoid tumor
Adenocarcinoma combined with other types of carcinoma
Adenocarcinoma, cylindroid
Adenocarcinoma, diffuse type
Adenocarcinoma, endocervical type
Adenocarcinoma in a polyp, NOS
Adenocarcinoma in adenomatous polyp
Adenocarcinoma in multiple adenomatous polyps
Adenocarcinoma in polyoid adenoma
Adenocarcinoma in situ in a polyp, NOS
Adenocarcinoma in situ in adenomatous polyp
Adenocarcinoma in situ in polyoid adenoma
Adenocarcinoma in situ in tubular adenoma
Adenocarcinoma in situ in tubulovillous adenoma
Adenocarcinoma in situ in villous adenoma
Adenocarcinoma in situ, NOS
Adenocarcinoma in tubular adenoma
Adenocarcinoma in tubulovillous adenoma
Adenocarcinoma in villous adenoma
Adenocarcinoma, intestinal type
Adenocarcinoma, NOS
Adenocarcinoma of anal ducts
Adenocarcinoma of anal glands
Adenocarcinoma with apocrine metaplasia
Adenocarcinoma with cartilaginous and osseous metaplasia
Adenocarcinoma with cartilaginous and osseous metaplasia
Adenocarcinoma with cartilaginous metaplasia
Adenocarcinoma with mixed subtypes
Adenocarcinoma with neuroendocrine differentiation
Adenocarcinoma with osseous metaplasia
Adenocarcinoma with spindle cell metaplasia
Adenocarcinoma with squamous metaplasia
Adenocystic carcinoma
Adenoid basal carcinoma
Adenoid cystic carcinoma
Adenoid squamous cell carcinoma
Adenosarcoma
Adenosquamous carcinoma
Adnexal carcinoma
Adrenal cortical adenocarcinoma
Adrenal cortical carcinoma
Adrenal cortical tumor, malignant
Adrenal medullary paraganglioma, malignant
Adult T-cell leukemia
Adult T-cell leukemia/lymphoma
Adult T-cell leukemia/lymphoma (HTLV-1 positive)
(includes all variants)
Adult T-cell lymphoma
Adult T-cell lymphoma/leukemia
Aggressive NK-cell leukemia
Agnogenic myeloid metaplasia
AIN III
Aleukemic granulocytic leukemia [obs]
Aleukemic leukemia, NOS [obs]
Aleukemic lymphatic leukemia [obs]
Aleukemic lymphocytic leukemia [obs]
Aleukemic myelogenous leukemia [obs]
Aleukemic myeloid leukemia [obs]
ALK positive large B-cell lymphoma
Alpha cell tumor, malignant
Alpha heavy chain disease
Alveolar adenoscarcinoma
Alveolar carcinoma
Alveolar cell carcinoma
Alveolar rhabdomyosarcoma
Alveolar soft part sarcoma
Amelanotic melanoma
Ameloblastic carcinoma
Ameloblastic fibrodentinosarcoma
Ameloblastic fibrosarcoma
Ameloblastic odontosarcoma
Ameloblastic sarcoma
Ameloblastoma, malignant
AML M6
Anal intraepithelial neoplasia, grade III
Anaplastic large B-cell lymphoma
Anaplastic large cell lymphoma (ALCL), CD 30+
Anaplastic large cell lymphoma, NOS
Anaplastic large cell lymphoma, T cell and Null cell type
Anaplastic oligoastrocytoma
Androblastoma, malignant
Angiocentric T-cell lymphoma [obs]
Angioendotheliosis
Angioimmunoblastic lymphoma [obs]
Angioimmunoblastic T-cell lymphoma
Angiomyosarcoma
Angiosarcoma
Angiotropic lymphoma
Apocrine adenocarcinoma
Argentaffinoma, malignant [obs]
Arrhenoblastoma, malignant
Askin tumor
Astroblastoma
Astrocytic glioma
Astrocytoma, anaplastic
Astrocytoma, low grade
Astrocytoma, NOS
Astrogloma [obs]
Atypical carcinoid tumor
Atypical chronic myeloid leukemia, BCR/ABL negative
Atypical chronic myeloid leukemia, Philadelphia chromosome (Ph1) negative
Atypical medullary carcinoma
Atypical proliferative papillary serous tumor
Atypical teratoid/rhabdoid tumor

-B-

B lymphoblastic leukemia/lymphoma, NOS
B lymphoblastic leukemia/lymphoma with hyperdiploidy
B lymphoblastic leukemia/lymphoma with hypodiploidy
(hypodiploid ALL)
B lymphoblastic leukemia/lymphoma with
\( t(1;19)(q23;p13.3); \) E2A PBX1 (TCF3 PBX1)
B lymphoblastic leukemia/lymphoma with
\( t(5;14)(q31;q32); \) IL3-IGH
B lymphoblastic leukemia/lymphoma with
\( t(9;22)(q34;q11.2); \) BCR-ABL1
B lymphoblastic leukemia/lymphoma with
\( t(12;21)(p13;q22); \) TEL-AML1 (ETV6-RUNX1)
B lymphoblastic leukemia/lymphoma with \( t(11q23); \) MLL rearranged
B-ALL [obs]
Ballooon cell melanoma
BALT lymphoma
Basal cell adenocarcinoma
Basaloid carcinoma
Basaloid squamous cell carcinoma
Basophil adenocarcinoma
Basophilic leukemia
B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma
B-cell lymphoma, NOS
Bednar tumor
Bellini duct carcinoma
Beta cell tumor, malignant
Bile duct adenocarcinoma
Bile duct carcinoma
Bile duct cystadenocarcinoma
Blast cell leukemia
Blastoma, NOS
Blue nevus, malignant
Botryoid sarcoma
Brenner tumor, malignant
Bronchial adenoma, carcinoid
Bronchial adenoma, cylindroid [obs]
Bronchial-associated lymphoid tissue lymphoma
Bronchiolar adenocarcinoma
Bronchiolar carcinoma
Bronchiolo-alveolar adenocarcinoma, NOS
Bronchiolo-alveolar carcinoma, NOS
Bronchiolo-alveolar carcinoma, Clara cell
Bronchiolo-alveolar carcinoma, Clara cell and goblet cell type
Bronchiolo-alveolar carcinoma, goblet cell type
Bronchiolo-alveolar carcinoma, indeterminate type
Bronchiolo-alveolar carcinoma, mixed mucinous and non-mucinous
Bronchiolo-alveolar carcinoma, mucinous
Bronchiolo-alveolar carcinoma, non-mucinous
Bronchiolo-alveolar carcinoma, type II pneumocyte
Bronchiolo-alveolar carcinoma, type II pneumocyte and goblet cell type  
Burkitt cell leukemia  
Burkitt-like lymphoma  
Burkitt lymphoma, NOS  
Burkitt tumor [obs]  

-C-  
C cell carcinoma  
C-ALL  
Cancer  
Carcinofibroma  
Carcinoid, NOS (except appendix)  
Carcinoid tumor, argentaffin, malignant  
Carcinoid tumor, NOS (except appendix)  
Carcinoma, anaplastic, NOS  
Carcinoma, diffuse type  
Carcinoma in a polyp, NOS  
Carcinoma in adenomatous polyp  
Carcinoma in pleomorphic adenoma  
Carcinoma in situ in a polyp, NOS  
Carcinoma in situ in adenomatous polyp  
Carcinoma in situ, NOS  
Carcinoma, intestinal type  
Carcinoma, NOS  
Carcinoma showing thymus-like differentiation  
Carcinoma showing thymus-like element  
Carcinoma simplex  
Carcinoma, undifferentiated, NOS  
Carcinoma with apocrine metaplasia  
Carcinoma with neuroendocrine differentiation  
Carcinoma with osteoclast-like giant cells  
Carcinoma with productive fibrosis  
Carcinosarcoma, embryonal  
Carcinosarcoma, NOS  
CASTLE  
Cellular ependymoma  
Central neuroblastoma  
Central osteosarcoma  
Central primitive neuroectodermal tumor, NOS  
Cerebellar sarcoma, NOS [obs]  
Germinous adenocarcinoma  
Germinous carcinoma  
Chloroma  
Cholangiocarcinoma  
Chondroblastic osteosarcoma  
Chondroblastoma, malignant  
Chondroid chordoma  
Chondrosarcoma, NOS  
Chordoma, NOS  
Choriocarcinoma combined with embryonal carcinoma  
Choriocarcinoma combined with other germ cell elements  
Choriocarcinoma combined with teratoma  
Choriocarcinoma, NOS  
Chorioepithelioma  
Chorionepithelioma  
Choroid plexus carcinoma  
Choroid plexus papilloma, anaplastic  
Choroid plexus papilloma, malignant  
Chromophobe adenocarcinoma  
Chromophobe carcinoma  

Chromophobe cell renal carcinoma  
Chronic eosinophilic leukemia  
Chronic erythremia [obs]  
Chronic granulocytic leukemia  
Chronic granulocytic leukemia, BCR/ABL  
Chronic granulocytic leukemia, Philadelphia chromosome (Ph1) positive  
Chronic granulocytic leukemia, t(9;22)(q34;q11)  
Chronic idiopathic myelofibrosis  
Chronic leukemia, NOS [obs]  
Chronic lymphatic leukemia  
Chronic lymphocytic leukemia  
Chronic lymphocytic leukemia, B-cell type (includes all variants of BCLL)  
Chronic lymphoid leukemia  
Chronic lymphoproliferative disorder of NK-cells  
Chronic monocytic leukemia [obs]  
Chronic myelocytic leukemia  
Chronic myelogenous leukemia, BCR/ABL positive  
Chronic myelogenous leukemia, Philadelphia chromosome (Ph1) positive  
Chronic myelogenous leukemia, t(9;22)(q34;q11)  
Chronic myelogenous leukemia  
Chronic myeloid leukemia  
Chronic myelomonocytic leukemia in transformation [obs]  
Chronic myelomonocytic leukemia, NOS  
Chronic myelomonocytic leukemia, Type I  
Chronic myelomonocytic leukemia, Type 2  
Chronic myeloproliferative disease, NOS  
Chronic myeloproliferative disorder  
Chronic neutrophilic leukemia  
Circumscribed arachnoidal cerebellar sarcoma [obs]  
Classical Hodgkin lymphoma, lymphocyte depletion, diffuse fibrosis  
Classical Hodgkin lymphoma, lymphocyte depletion, NOS  
Classical Hodgkin lymphoma, lymphocyte depletion, reticular  
Classical Hodgkin lymphoma, lymphocyte-rich  
Classical Hodgkin lymphoma, mixed cellularity, NOS  
Classical Hodgkin lymphoma, nodular sclerosis, cellular phase  
Classical Hodgkin lymphoma, nodular sclerosis, grade 1  
Classical Hodgkin lymphoma, nodular sclerosis, grade 2  
Classical Hodgkin lymphoma, nodular sclerosis, NOS  
Clear cell adenocarcinofibroma  
Clear cell adenocarcinoma, mesonephroid  
Clear cell adenocarcinoma, NOS  
Clear cell carcinoma  
Clear cell chondrosarcoma  
Clear cell cystadenocarcinofibroma  
Clear cell ependymoma  
Clear cell sarcoma, NOS  
Clear cell sarcoma of kidney  
Clear cell sarcoma, of tendons and aponeuropses  
Cloacogenic carcinoma  
Collecting duct carcinoma  
Colloid adenocarcinoma  
Colloid carcinoma  
Combined carcinoid and adenocarcinoma
Reportable List

Appendix B

Combined hepatocellular carcinoma and cholangiocarcinoma
Combined small cell carcinoma
Combined small cell-adenocarcinoma
Combined small cell-large cell carcinoma
Combined small cell-squamous cell carcinoma
Comedocarcinoma, noninfiltrating
Comedocarcinoma, NOS
Common ALL
Common precursor B ALL
Composite carcinoma
Composite Hodgkin and non-Hodgkin lymphoma
Condylomatous carcinoma
Congenital fibrosarcoma
Conventional central osteosarcoma
Cortical T ALL
CPNET
Cribiform carcinoma, NOS
Cribiform carcinoma in situ
Cutaneous lymphoma, NOS [obs]
Cutaneous T-cell lymphoma, NOS
Cylindrical cell carcinoma
Cylindroma, NOS (except Cylindroma of skin M-8200/0)
Cystadenocarcinoma, NOS
Cyst-associated renal cell carcinoma
Cystic astrocytoma [obs]
Cystic hypersecretory carcinoma
Cystosarcoma phyllodes, malignant

-D-

DCIS, comedo type
DCIS, NOS
DCIS, papillary
Dedifferentiated chondrosarcoma
Dedifferentiated chordoma
Dedifferentiated liposarcoma
Dendritic cell sarcoma, NOS
Dermatofibrosarcoma, NOS
Dermatofibrosarcoma protuberans, NOS
Dermoid cyst with malignant transformation
Dermoid cyst with secondary tumor
Desmoplastic medulloblastoma
Desmoplastic melanoma, amelanotic
Desmoplastic melanoma, malignant
Desmoplastic mesothelioma
Desmoplastic nodular medulloblastoma
Desmoplastic small round cell tumor
Di Guglielmo disease [obs]
Diffuse astrocytoma
Diffuse astrocytoma, low grade
Digital papillary adenocarcinoma
Diktyoma, malignant
DIN 3
Duct adenocarcinoma, NOS
Duct carcinoma, desmoplastic type
Duct carcinoma, NOS
Duct cell carcinoma
Ductal carcinoma, NOS
Ductal carcinoma in situ, comedo type
Ductal carcinoma in situ, cribriform type
Ductal carcinoma in situ, micropapillary
Ductal carcinoma in situ, NOS

-D-

Ductal carcinoma in situ, papillary
Ductal carcinoma in situ, solid type
Ductal carcinoma, cribriform type
Ductal intraepithelial neoplasia 3
Dysgerminoma

-E-

EC cell carcinoma
Eccrine adenocarcinoma
Eccrine papillary adenocarcinoma
Eccrine poroma, malignant
ECL cell carcinoid, malignant
Ectomesenchymoma
Embryonal adenocarcinoma
Embryonal carcinoma, infantile
Embryonal carcinoma, NOS
Embryonal carcinoma, polyembryonal type
Embryonal hepatoma
Embryonal rhabdomyosarcoma, NOS
Embryonal rhabdomyosarcoma, pleomorphic
Embryonal sarcoma
Embryonal teratoma
Endodermal sinus tumor
Endolympathic stromal myosis
Endometrial sarcoma, NOS
Endometrial stromal sarcoma, NOS
Endometrial stromal sarcoma, high grade
Endometrial stromal sarcoma, low grade
Endometrial stromatosis
Endometrioid adenocarcinoma, NOS
Endometrioid adenocarcinoma, ciliated cell variant
Endometrioid adenocarcinoma, secretory variant
Endometrioid carcinoma, NOS
Endometrioid cystadenocarcinoma
Endometrioid cystadenofibroma, malignant
Enterochromaffin cell carcinoid
Enterochromaffin-like cell tumor, malignant
Enteroglucagonoma, malignant
Enteropathy associated T-cell lymphoma
Enteropathy type intestinal T-cell lymphoma
Eosinophil adenocarcinoma
Eosinophil carcinoma
Eosinophilic leukemia
Ependymoblastoma
Ependymoma, anaplastic
Ependymoma, NOS
Epidermoid carcinoma in situ, NOS
Epidermoid carcinoma in situ with questionable stromal invasion
Epidermoid carcinoma, keratinizing
Epidermoid carcinoma, large cell, nonkeratinizing
Epidermoid carcinoma, NOS
Epidermoid carcinoma, small cell, nonkeratinizing
Epidermoid carcinoma, spindle cell
Epithelial ependymoma
Epithelial tumor, malignant
Epithelial-myoepithelial carcinoma
Epithelioid cell melanoma
Epithelioid cell sarcoma
Epithelioid hemangioendothelioma, malignant
Appendix B

Reportable List

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Hemangioendothelial sarcoma
Hemangioendothelioma, malignant
Hemangiopericytoma, malignant
Hemangiosarcoma
Hepatoblastoma
Hepatocarcinoma
Hepatocellular carcinoma, clear cell type
Hepatocellular carcinoma, fibrolamellar
Hepatocellular carcinoma, NOS
Hepatocellular carcinoma, pleomorphic type
Hepatocellular carcinoma, sarcomatoid
Hepatocellular carcinoma, scirrhous
Hepatocellular carcinoma, spindle cell variant
Hepatocellular carcinoma, type unspecified
Hepatoid adenocarcinoma
Hepatoid carcinoma
Hepatoid yolk sac tumor
Hepatoma, malignant
Hepatoma, NOS
Hepatosplenic (gamma-delta) lymphoma
Hidradenocarcinoma
High grade surface osteosarcoma
Histiocyte-rich large B-cell lymphoma
Histiocytic medullary reticulosis [obs]
Histiocytic sarcoma
Hodgkin disease, lymphocyte depletion, diffuse fibrosis
Hodgkin disease, lymphocyte depletion, NOS
Hodgkin disease, lymphocyte depletion, reticular
Hodgkin disease, lymphocyte predominance, diffuse [obs]
Hodgkin disease, lymphocyte predominance, nodular
Hodgkin disease, lymphocyte predominance, NOS [obs]
Hodgkin disease, lymphocyte-histiocytic predominance [obs]
Hodgkin disease, mixed cellularity, NOS
Hodgkin disease, nodular sclerosis, cellular phase
Hodgkin disease, nodular sclerosis, lymphocyte depletion
Hodgkin disease, nodular sclerosis, lymphocyte predominance
Hodgkin disease, nodular sclerosis, mixed cellularity
Hodgkin disease, nodular sclerosis, NOS
Hodgkin disease, nodular sclerosis, syncytial variant
Hodgkin disease, NOS
Hodgkin granuloma [obs]
Hodgkin lymphoma, lymphocyte depletion, diffuse fibrosis
Hodgkin lymphoma, lymphocyte depletion, NOS
Hodgkin lymphoma, lymphocyte depletion, reticular
Hodgkin lymphoma, lymphocyte predominance, nodular
Hodgkin lymphoma, lymphocyte-rich
Hodgkin lymphoma, mixed cellularity, NOS
Hodgkin lymphoma, nodular lymphocyte predominance
Hodgkin lymphoma, nodular sclerosis, cellular phase
Hodgkin lymphoma, nodular sclerosis, grade 1
Hodgkin lymphoma, nodular sclerosis, grade 2
Hodgkin lymphoma, nodular sclerosis, NOS
Hodgkin lymphoma, NOS
Hodgkin paragranuloma, nodular [obs]
Hodgkin paragranuloma, NOS [obs]
Hodgkin sarcoma [obs]
Hurthle cell adenocarcinoma

Hurler cell carcinoma
Hutchinson melanotic freckle, NOS
Hydroa vacciniforme-like lymphoma
Hypereosinophilic syndrome
Hypernephroma [obs]

Idiopathic hemorrhagic thrombocytopenia
Idiopathic thrombocytopenia
Immature teratoma, malignant
Immature teratoma, NOS
Immunoblastic sarcoma [obs]
Immunocytoma [obs]
Immunoproliferative disease, NOS
Immunoproliferative small intestinal disease
Infantile fibrosarcoma
Infiltrating and papillary adenocarcinoma
Infiltrating duct adenocarcinoma
Infiltrating duct and colloid carcinoma
Infiltrating duct and cribriform carcinoma
Infiltrating duct and lobular carcinoma
Infiltrating duct and lobular carcinoma in situ
Infiltrating duct and mucinous carcinoma
Infiltrating duct and tubular carcinoma
Infiltrating duct carcinoma, NOS
Infiltrating duct mixed with other types of carcinoma
Infiltrating ductular carcinoma
Infiltrating lobular carcinoma
Infiltrating lobular carcinoma and ductal carcinoma in situ
Infiltrating lobular mixed with other types of carcinoma
Infiltrating papillary adenocarcinoma
Inflammatory adenocarcinoma
Inflammatory carcinoma
Inflammatory liposarcoma
Insulinoma, malignant
Insulinoma, benign
Intestinal T-cell lymphoma
Intracortical osteosarcoma
Intracystic carcinoma, NOS
Intracystic papillary adenocarcinoma
Intraductal adenocarcinoma, noninfiltrating, NOS
Intraductal and lobular carcinoma
Intraductal carcinoma and lobular carcinoma in situ
Intraductal carcinoma, clinging
Intraductal carcinoma, noninfiltrating, NOS
Intraductal carcinoma, NOS
Intraductal carcinoma, solid type
Intraductal micropapillary carcinoma
Intraductal papillary adenocarcinoma, NOS
Intraductal papillary adenocarcinoma with invasion
Intraductal papillary carcinoma, NOS
Intraductal papillary-mucinous carcinoma, invasive
Intraductal papillary-mucinous carcinoma, non-invasive
Intraepidermal carcinoma, NOS
Intraepithelial carcinoma, NOS
Intraepithelial neoplasia, grade III, of vulva or vagina
Intraepithelial squamous cell carcinoma
Intraosseous carcinoma
Intraosseous low grade osteosarcoma

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Intraosseous well differentiated osteosarcoma
Intratubular germ cell neoplasia
Intratubular malignant germ cells
Intravascular B-cell lymphoma
Intravascular bronchial alveolar tumor (obs)
Intravascular large B-cell lymphoma
Islet cell adenocarcinoma
Islet cell carcinoma
- J -
Juvenile astrocytoma (reportable as behavior 3 in North America)
Juvenile carcinoma of breast
Juvenile chronic myelomonocytic leukemia
Juvenile myelomonocytic leukemia
Juxtacortical chondrosarcoma
Juxtacortical osteogenic sarcoma (see Juxtacortical osteosarcoma)
Juxtacortical osteosarcoma
- K -
Kaposi sarcoma
Klatskin tumor
Krukenberg tumor (/6)
Kupffer cell sarcoma
- L -
Langerhans cell histiocytosis, disseminated
Langerhans cell histiocytosis, generalized
Langerhans cell histiocytosis, multifocal
Langerhans cell histiocytosis, NOS
Langerhans cell histiocytosis, unifocal
Langerhans cell sarcoma
Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease
Large cell (Ki-1+) lymphoma (obs)
Large cell carcinoma, NOS
Large cell carcinoma with rhabdoid phenotype
Large cell medulloblastoma
Large cell neuroendocrine carcinoma
LCIS, NOS
Leiomyosarcoma, NOS
Leiomyosarcoma, NOS
Lennert lymphoma
Lentigo maligna
Lentigo maligna melanoma
Leptomeningeal sarcoma
Letterer-Siwe disease
Leukemia, NOS
Leukemic reticuloendotheliosis
Leydig cell tumor, malignant
Linitis plastica
Lipid-rich carcinoma
Lipoma-like liposarcoma
Liposarcoma, differentiated
Liposarcoma, NOS
Liposarcoma, well differentiated
Liver cell carcinoma
Lobular adenocarcinoma
Lobular and ductal carcinoma
Lobular carcinoma in situ, NOS
Lobular carcinoma, noninfiltrating
Lobular carcinoma, NOS
Lymphangiendothelioma, malignant
Lymphangiendothelial sarcoma
Lymphangiosarcoma
Lymphatic leukemia, NOS [obs]
Lymphoblastic leukemia, L1 type
Lymphoblastic leukemia, L2 type
Lymphoblastic leukemia, NOS
Lymphoblastoma [obs]
Lymphocytic leukemia, NOS [obs]
Lymphoepithelial carcinoma
Lymphoepithelioid lymphoma
Lymphoepithelioma
Lymphoepithelioma-like carcinoma
Lymphoid leukemia, NOS
Lymphoma, NOS
Lymphomatoid papulosis
Lymphosarcoma cell leukemia [obs]
Lymphosarcoma, diffuse [obs]
Lymphosarcoma, NOS [obs]
-L-
Malignancy
Malignant chondroid syringoma
Malignant cystic nephroma
Malignant eccrine spiradenoma
Malignant fibrous histiocytoma
Malignant giant cell tumor of soft parts
Malignant histiocytosis
Malignant lymphoma, centroblastic, diffuse
Malignant lymphoma, centroblastic, follicular
Malignant lymphoma, centroblastic, NOS
Malignant lymphoma, centroblastic-centrocytic, diffuse [obs]
Malignant lymphoma, centroblastic-centrocytic, follicular [obs]
Malignant lymphoma, centroblastic-centrocytic NOS [obs]
Malignant lymphoma, centrocytic [obs]
Malignant lymphoma, cleaved cell, NOS [obs]
Malignant lymphoma, convoluted cell [obs]
Malignant lymphoma, diffuse, NOS
Malignant lymphoma, follicle center, follicular
Malignant lymphoma, follicle center, NOS
Malignant lymphoma, follicular, grade 1
Malignant lymphoma, follicular, grade 2
Malignant lymphoma, follicular, grade 3
Malignant lymphoma, follicular, NOS
Malignant lymphoma, histiocytic, diffuse
Malignant lymphoma, histiocytic, nodular [obs]
Malignant lymphoma, histiocytic, NOS [obs]
Malignant lymphoma, Hodgkin
Malignant lymphoma, immunoblastic, NOS
Malignant lymphoma, large B-cell, diffuse, centroblastic, NOS
Malignant lymphoma, large B-cell, diffuse, immunoblastic, NOS
Malignant lymphoma, large B-cell, diffuse, NOS
Malignant lymphoma, large B-cell, NOS
Malignant lymphoma, large cell, cleaved and noncleaved [obs]
Malignant lymphoma, large cell, cleaved, diffuse
Malignant lymphoma, large cell, cleaved, NOS [obs]
Malignant lymphoma, large cell, diffuse, NOS [obs]
Malignant lymphoma, large cell, follicular, NOS
Malignant lymphoma, large cell, immunoblastic
Malignant lymphoma, large cell, noncleaved, diffuse, NOS [obs]
Malignant lymphoma, large cell, noncleaved, NOS
Malignant lymphoma, large cell, noncleaved, follicular [obs]
Malignant lymphoma, large cell, noncleaved, Burkitt type [obs]
Malignant lymphoma, small lymphocytic, NOS
Malignant lymphoma, small lymphocytic, Burkitt type [obs]
Malignant lymphoma, small noncleaved, Burkitt type [obs]
Malignant lymphoma, undifferentiated, Burkitt type [obs]
Malignant lymphoma, undifferentiated cell, non-Burkitt [obs]
Malignant lymphoma, undifferentiated cell type, NOS [obs]
Malignant lymphomatous polyposis [obs]
Malignant mast cell tumor
Malignant mastocytoma
Malignant mastocytosis
Malignant melanoma in congenital melanocytic nevus
Malignant melanoma in giant pigmented nevus
Malignant melanoma in Hutchinson melanotic freckle
Malignant melanoma in junctional nevus
Malignant melanoma in precancerous melanosis
Malignant melanoma, NOS
Malignant melanoma, regressing
Malignant midline reticulosis [obs]
Malignant mucinous adenofibroma
Malignant mucinous cystadenofibroma
Malignant multilocular cystic nephroma
Malignant myelosclerosis [obs]
Malignant myoepithelioma
Malignant peripheral nerve sheath tumor
Malignant peripheral nerve sheath tumor with rhabdomyoblastic differentiation
Malignant reticulosis, NOS [obs]
Malignant rhabdoid tumor
Malignant Schwannoma, NOS [obs]
Malignant Schwannoma with rhabdomyoblastic differentiation
Malignant serous adenofibroma
Malignant serous cystadenofibroma
Malignant tenosynovial giant cell tumor
Malignant teratoma, anaplastic
Malignant teratoma, Burkitt type
Malignant teratoma, clear cell type
Malignant teratoma, NOS [obs]
Malignant teratoma, non-Burkitt type
Malignant teratoma, undifferentiated
Malignant tumor, unspecified cell type
Malignant tumor, anaplastic
Malignant tumor, clear cell type
Malignant tumor, giant cell type
Malignant tumor, spindle cell type
MALT lymphoma
Mature T cell lymphoma
Mature T-cell lymphoma, NOS
Medial cell lymphoma, NOS
Medial cell lymphoma, unspecified type
Mediastinal large B-cell lymphoma
Mediterranean lymphoma
Medullary adenocarcinoma
Medullary carcinoma, NOS
Medullary carcinoma with amyloid stroma
Medullary carcinoma with lymphoid stroma
Medullary osteosarcoma
Medulloblastoma, NOS
Appendix B

Reportable List

Indiana Cancer Registry 2015 Draft
Myeloproliferative neoplasm, unclassifiable
Myelosclerosis with myeloid metaplasia
Myoepithelial carcinoma
Myosarcoma
Myxoid chondrosarcoma
Myxoid leiomyosarcoma
Myxoid liposarcoma
Myxiliposarcoma
Myxosarcoma

-O-
OAT cell carcinoma
Odontogenic carcinoma
Odontogenic carcinosarcoma
Odontogenic fibrosarcoma
Odontogenic sarcoma
Odontogenic tumor, malignant
olfactory neuroblastoma
olfactory neuroepithelioma
olfactory neurogenic tumor
olfactory neurocytoma
oligoastrocytoma
oligodendroblastoma [obs]
Oligodendroglioma, anaplastic
Oligodendroglioma, NOS
Oncocytic adenocarcinoma
Oncocytic carcinoma
Orchioblastoma
Osteoblastic sarcoma
Osteochondrosarcoma
Osteoclastoma, malignant
Osteofibrosarcoma
Osteogenic sarcoma, NOS
Osteosarcoma in Paget disease of bone
Osteosarcoma, NOS
Oxyphilic adenocarcinoma

-P-
Paget disease and infiltrating duct carcinoma of breast
Paget disease and intraductal carcinoma of breast
Paget disease, extramammary
Paget disease, mammary
Paget disease of breast
Pagetoid reticulosis
Pancreatoblastoma
Papillary adenocarcinoma, follicular variant
Papillary adenocarcinoma, NOS
Papillary and follicular adenocarcinoma
Papillary and follicular carcinoma
Papillary carcinoma, columnar cell
Papillary carcinoma, diffuse sclerosing
Papillary carcinoma, encapsulated
Papillary carcinoma, follicular variant
Papillary carcinoma in situ
Papillary carcinoma, NOS
Papillary carcinoma of thyroid
Papillary carcinoma, oxyphilic cell
Papillary carcinoma, tall cell
Papillary cystadenocarcinoma, NOS
Papillary cystadenoma, borderline malignancy
Papillary ependymoma
Papillary epidermoid carcinoma
Papillary meningioma
Papillary microcarcinoma
Papillary mucinous cystadenocarcinoma
Papillary mucinous cystadenoma, borderline malignancy
Papillary mucinous tumor of low malignant potential
Papillary pseudomucinous cystadenocarcinoma
Papillary pseudomucinous cystadenoma, borderline malignancy
Papillary renal cell carcinoma
Papillary serous adenocarcinoma
Papillary serous cystadenocarcinoma
Papillary serous cystadenoma, borderline malignancy
Papillary serous tumor of low malignant potential
Papillary squamous cell carcinoma
Papillary squamous cell carcinoma in situ
Papillary squamous cell carcinoma, non-invasive
Papillary transitional cell carcinoma
Papillary transitional cell carcinoma, non-invasive
Papillary urothelial carcinoma
Papillary urothelial carcinoma, non-invasive
Papillocystic adenocarcinoma
Papillotubular adenocarcinoma
Parafollicular cell carcinoma
Paraganglioma, malignant
Parietal cell adenocarcinoma
Parietal cell carcinoma
Parosteal osteosarcoma
Perineural MPNST
Perineurioma, malignant
Periosteal chondrosarcoma
Periosteal fibrosarcoma
Periosteal osteogenic sarcoma (see Periosteal osteosarcoma)
Periosteal osteosarcoma
Periosteal sarcoma, NOS
Peripheral neuroectodermal tumor
Peripheral primitive neuroectodermal tumor, NOS
Peripheral T-cell lymphoma, AILD (Angiioimmunoblastic Lymphadenopathy with Dysproteinemia) [obs]
Peripheral T-cell lymphoma, large cell
Peripheral T-cell lymphoma, pleomorphic medium and large cell
Peripheral T-cell lymphoma, NOS
Peripheral T-cell lymphoma, pleomorphic small cell
Pheochromoblastoma
Pheochromocytoma, malignant
Phyllodes tumor, malignant
Pigmented dermatofibrosarcoma protuberans
Pilocytic astrocytoma (reportable as behavior 3 in North America)
Piloid astrocytoma (reportable as behavior 3 in North America)
Pineal parenchymal tumor of intermediate differentiation
Pineoblastoma
Pinkus tumor
Pituitary carcinoma, NOS
Plasma cell leukemia
Plasma cell myeloma
Plasmacytic leukemia
Plasmacytoma, extramedullary (not occurring in bone)
Plasmacytoma, NOS
Plasmacytoma of bone
Pleomorphic carcinosarcoma
Pleomorphic cell sarcoma
Pleomorphic liposarcoma
Pleomorphic rhabdomyosarcoma, NOS
Pleomorphic rhabdomyosarcoma, adult type
Pleomorphic xanthoastrocytoma
Pneumoblastoma
Pre-B ALL
Precancerous melanosis, NOS
Precursor B-cell lymphoblastic leukemia
Precursor B-cell lymphoblastic lymphoma
Precursor cell lymphoblastic leukemia, NOS
Precursor cell lymphoblastic leukemia, not phenotyped
Precursor cell lymphoblastic lymphoma, NOS
Precursor T-cell lymphoblastic leukemia
Precursor T-cell lymphoblastic lymphoma
Preleukemia [obs]
Preleukemic syndrome [obs]
Pre-pre-B ALL
Pre-T ALL
Primary cutaneous anaplastic large cell lymphoma
Primary cutaneous CD30+ large T-cell lymphoma
Primary cutaneous CD30+ T-cell lymphoproliferative disorder
Primary cutaneous follicle centre lymphoma
Primary cutaneous gamma-delta T-cell lymphoma
Primary cutaneous neuroendocrine carcinoma
Primary effusion lymphoma
Primary intraosseous carcinoma
Primary serous papillary carcinoma of peritoneum
Primitive neuroectodermal tumor, NOS
Primitive polar spongioblastoma [obs]
Pro-B ALL
Proliferative polycythemia
Prolymphocytic leukemia, B-cell type
Prolymphocytic leukemia, NOS
Prolymphocytic leukemia, T-cell type
Pro-T ALL
Protoplasmic astrocytoma
Pseudoglandular squamous cell carcinoma
Pseudomucinous adenocarcinoma
Pseudomucinous cystadenocarcinoma, NOS
Pseudomucinous cystadenoma, borderline malignancy
Pseudomyxoma peritonei with unknown primary site
Pseudosarcomatosus carcinoma
Pulmonary blastoma

-Q-
Queyrat erythroplasia

-R-
RAEB
RAEB I
RAEB II
RAEB-T
RARS
Refractory anemia, NOS
Refractory anemia with excess blasts
Refractory anemia with excess blasts in transformation [obs]
Refractory anemia with ringed sideroblasts
Refractory anemia with sideroblasts
Refractory anemia without sideroblasts
Refractory cytopenia with multilineage dysplasia
Refractory neutropenia
Refractory thrombocytopenia
Renal carcinoma, collecting duct type
Renal cell adenocarcinoma
Renal cell carcinoma, NOS
Renal cell carcinoma, chromophobe cell
Renal cell carcinoma, chromophobe type
Renal cell carcinoma, sarcomatoid
Renal cell carcinoma, spindle cell
Reserve cell carcinoma
Reticulosarcoma, diffuse [obs]
Reticulosarcoma, NOS [obs]
Reticulum cell sarcoma, diffuse [obs]
Reticulum cell sarcoma, NOS [obs]
Retinoblastoma, differentiated
Retinoblastoma, diffuse
Retinoblastoma, NOS
Retinoblastoma, undifferentiated
Rhabdoid meningioma
Rhabdoid sarcoma
Rhabdoid tumor, NOS
Rhabdomyosarcoma, NOS
Rhabdomyosarcoma with ganglionic differentiation
Rhabdosarcoma
Round cell carcinoma
Round cell liposarcoma
Round cell osteosarcoma
Round cell sarcoma

-S-
SALT lymphoma
Sarcoma botryoides
Sarcoma, NOS
Sarcomatoid carcinoma
Sarcomatoid mesothelioma
Schminke tumor
Schneiderian carcinoma
Scirrhouss adenocarcinoma
Scirrouss carcinoma
Scirrous liposarcoma
Sclerosing hepatic carcinoma
Sclerosing sweat duct carcinoma
Sebaceous adenocarcinoma
Sebaceous carcinoma
Secretory carcinoma of breast
Seminoma, anaplastic
Seminoma, NOS
Seminoma with high mitotic index
Serotonin producing carcinoid
Serosus adenocarcinofibroma
Serosus adenocarcinoma, NOS
Serosus carcinoma, NOS
Serosus cystadenocarcinofibroma
Serosus cystadenocarcinoma, NOS
Serosus cystadenocarcinoma, borderline malignancy
Serosus papillary cystic tumor of borderline malignancy
Serous surface papillary carcinoma
Serous tumor, NOS, of low malignant potential
Sertoli cell carcinoma
Sertoli-Leydig cell tumor, poorly differentiated
Sertoli-Leydig cell tumor, poorly differentiated, with heterologous elements
Sertoli-Leydig cell tumor, sarcomatoid
SETTLE
Sezary disease
Sezary syndrome
Signet ring cell adenocarcinoma
Signet ring cell carcinoma
Skin appendage carcinoma
Skin-associated lymphoid tissue lymphoma
Small cell carcinoma, fusiform cell
Small cell carcinoma, intermediate cell
Small cell carcinoma, NOS
Small cell osteosarcoma
Small cell sarcoma
Small cell-large cell carcinoma
Small cell neuroendocrine carcinoma
Soft tissue sarcoma
Soft tissue tumor, malignant
Solid adenocarcinoma with mucin formation
Solid carcinoma, NOS
Solid carcinoma with mucin formation
Solid pseudopapillary carcinoma
Solitary fibrous tumor, malignant
Solitary myeloma
Solitary plasmacytoma
Somatostatin cell tumor, malignant
Somatostatinoma, malignant
Spermatocytic seminoma
Spermatocytoma
Spindle cell carcinoma
Spindle cell melanoma, NOS
Spindle cell melanoma, type A
Spindle cell melanoma, type B
Spindle cell rhabdomyosarcoma
Spindle cell sarcoma
Spindle epithelial tumor with thymus-like differentiation
Spindle epithelial tumor with thymus-like element
Spindled mesothelioma
Splenic lymphoma with villous lymphocytes
Splenic marginal zone B-cell lymphoma
Splenic marginal zone lymphoma, NOS
Spongioblastoma multiforme
Spongioblastoma, NOS [obs]
Spongioblastoma polare
Spongioneuroblastoma
Squamous carcinoma
Squamous cell carcinoma, acantholytic
Squamous cell carcinoma, adenoid
Squamous cell carcinoma, clear cell type
Squamous cell carcinoma in situ, NOS
Squamous cell carcinoma in situ with questionable stromal invasion
Squamous cell carcinoma, keratinizing, NOS
Squamous cell carcinoma, large cell, keratinizing
Squamous cell carcinoma, large cell, nonkeratinizing, NOS
Squamous cell carcinoma, microinvasive
Squamous cell carcinoma, nonkeratinizing, NOS
Squamous cell carcinoma, NOS
Squamous cell carcinoma, pseudoglandular
Squamous cell carcinoma, sarcomatoid
Squamous cell carcinoma, small cell, nonkeratinizing
Squamous cell carcinoma, spindle cell
Squamous cell carcinoma with horn formation
Squamous cell epithelioma
Squamous intraepithelial neoplasia, grade III
Stem cell leukemia
Steroid cell tumor, malignant
Stromal endometriosis
Stromal myosis, NOS
Stromal sarcoma, NOS
Struma ovarii, malignant
Subacute granulocytic leukemia [obs]
Subacute leukemia, NOS [obs]
Subacute lymphatic leukemia [obs]
Appendix B

Reportable List

Indiana Cancer Registry
2015 Draft

Subacute lymphocytic leukemia [obs]
Subacute lymphoid leukemia [obs]
Subacute monocytic leukemia [obs]
Subacute myelogenous leukemia [obs]
Subacute myeloid leukemia [obs]
Subcutaneous panniculitic, T-cell lymphoma (See subcutaneous panniculitis-like T-cell lymphoma)
Subcutaneous panniculitis-like T-cell lymphoma
Superficial spreading adenocarcinoma
Superficial spreading melanoma
Supratentorial PNET
Sweat gland adenocarcinoma
Sweat gland carcinoma
Sweat gland tumor, malignant
Sympathicoblastoma
Synovial sarcoma, biphasic
Synovial sarcoma, epithelioid cell
Synovial sarcoma, monophasic fibrous
Synovial sarcoma, NOS
Synovial sarcoma, spindle cell
Synovioma, malignant
Synovioma, NOS
Syringomatous carcinoma
Systemic EBV positive T-cell lymphoproliferative disease of childhood
Systemic tissue mast cell disease

-T-

T lymphoblastic leukemia/lymphoma
T/NK-cell lymphoma
T-lymphocytic ependymoma
T-cell/histiocyte rich large B-cell lymphoma
T-cell large granular lymphocytic leukemia
T-cell lymphoma, NOS
T-cell rich B-cell lymphoma
T-cell rich large B-cell lymphoma
T-cell rich/histiocyte-rich large B-cell lymphoma
T-zone lymphoma
Telangiectatic osteosarcoma
Teratoblastoma, malignant
Teratocarcinoma
Teratoid medulloepithelioma
Teratoma, malignant, NOS
Teratoma with malignant transformation
Terminal duct adenocarcinoma
Thecoma, malignant
Therapy-related acute myeloid leukemia and myelodysplastic syndrome, NOS
Therapy-related acute myeloid leukemia, alkylating agent related
Therapy-related acute myeloid leukemia, epipodophyllotoxin-related
Therapy-related acute myeloid leukemia, NOS
Therapy-related myelodysplastic syndrome, alkylating agent related
Therapy-related myelodysplastic syndrome, epipodophyllotoxin-related
Therapy-related myelodysplastic syndrome, NOS
Thymic carcinoma, NOS
Thymic large B-cell lymphoma
Thymoma, atypical, malignant
Thymoma, cortical, malignant
Thymoma, epithelial, malignant
Thymoma, lymphocyte-rich, malignant
Thymoma, lymphocytic, malignant
Thymoma, malignant
Thymoma, medullary, malignant
Thymoma, mixed type, malignant
Thymoma, organoid, malignant
Thymoma, predominantly cortical, malignant
Thymoma, spindle cell, malignant
Thymoma, type A, malignant
Thymoma, type AB, malignant
Thymoma, type B1, malignant
Thymoma, type B2, malignant
Thymoma, type B3, malignant
Thymoma, type C
Tibial adamantinoma
Trabecular adenocarcinoma
Trabecular carcinoma
Transitional carcinoma
Transitional cell carcinoma in situ
Transitional cell carcinoma, micropapillary
Transitional cell carcinoma, NOS
Transitional cell carcinoma, sarcomatoid
Transitional cell carcinoma, spindle cell
Transitional pineal tumor
Triton tumor, malignant
Trophoblastic tumor, epithelioid
True histiocytic lymphoma [obs]
Tubular adenocarcinoma
Tubular carcinoma
Tubulopapillary adenocarcinoma
Tumors cells, malignant
Tumor, malignant, NOS
Typical carcinoid
T-zone lymphoma

-U-

Unclassified tumor, malignant
Undifferentiated leukemia
Undifferentiated sarcoma
Urothelial carcinoma
Urothelial carcinoma in situ

-V-

Vaginal intraepithelial neoplasia, grade III
VAIN, III
Verrucous carcinoma, NOS
Verrucous epidermoid carcinoma
Verrucous squamous cell carcinoma
Villous adenocarcinoma
VIN, III
Vipoma, malignant
Vulvar intraepithelial neoplasia, grade III

-W-

Waldenstrom macroglobulinemia
Warty carcinoma
Water-clear cell adenocarcinoma
Water-clear cell carcinoma
Well differentiated thymic carcinoma
Wilms tumor
Wolffian duct carcinoma
Wuchernde Struma Langhans [obs] (Deleted in ICD-O-3)

-XYZ-

Yolk sac tumor
B. REPORTABLE BENIGN AND BORDERLINE INTRACRANIAL AND CENTRAL NERVOUS SYSTEM TUMORS

-A-
- Acidophil adenoma
- Acoustic neurina
- Adamantinomatous craniopharyngioma
- Adenoma, NOS
- Adult cystic teratoma
- Adult teratoma, NOS
- Ancient schwannoma
- Angioblastoma
- Angioendothelioma
- Angiolipoma, NOS
- Angioma, NOS
- Angiomatous meningioma
- Atypical choroid plexus papilloma
- Atypical lipoma
- Atypical meningioma

-B-
- Basophil adenoma

-C-
- Capillary hemangioma
- Cavernous hemangioma
- Cellular schwannoma
- Central neurocytoma
- Cerebellar liponeurocytoma
- Chordoid glioma
- Chordoid glioma of third ventricle
- Chordoid meningioma
- Choroid plexus papilloma, NOS
- Chromophobe adenoma
- Clear cell adenoma
- Clear cell meningioma
- Clear cell tumor, NOS
- Craniohypophysis
- Cystic teratoma, NOS

-D-
- Degenerated schwannoma
- Dermoid cyst, NOS
- Dermoid, NOS
- Desmoplastic infantile astrocytoma
- Desmoplastic infantile ganglioglioma
- Diffuse melanocytosis
- Diffuse meningiomatosis
- Dysembryoplastic neuroepithelial tumor
- Dysplastic gangliocytoma of cerebellum
  (Lhermitte-Duclos)

-E-
- Endotheliomatous meningioma
- Eosinophil adenoma
- Epithelial tumor, benign

-F-
- Fibroblastic meningioma
- Fibrolipoma
- Fibroma, NOS
- Fibromyxoma
- Fibrous meningioma

-G-
- Gangliocytoma
- Ganglioglioma, NOS
- Ganglioneuroma
- Glandular papilloma
- Gliofibroma
- Giomeuroma [obs]
- Granular cell myoblastoma, NOS
- Granular cell tumor of the sellar region
- Granular cell tumor, NOS

-H-
- Hemangioblastoma
- Hemangioblastoma, benign
- Hemangioblastoma, NOS
- Hemangioma simplex
- Hemangioma, NOS
- Hemangiopericytic meningioma [obs]
- Hemangiopericytoma, benign
- Hemangiopericytoma, NOS

-I-
- Infantile hemangioma
- Intraneural perineurioma
- Intravascular leiomyomatosis

-J-
- Juvenile hemangioma

-K-
- Kaposiform hemangioendothelioma

-L-
- Leiomyofibroma
- Leiomyoma, NOS
- Leiomyomatosis, NOS
- Lipoleiomyoma
- Lipoma, NOS
- Lipomatous medulloblastoma
- Localized fibrous tumor
- Lymphplasmacytoid rich meningioma
| -M-         | Pregnant teratoma               | Plexiform neurofibroma |
|            | Medullocytoma                   | Plexiform schwannoma   |
|            | Melanotic neurofibroma          | Prolactinoma           |
|            | Melanotic schwannoma           | Psammomatous meningioma|
|            | Meningeal melanocytoma         | Psammomatous schwannoma|
|            | Meningioma, NOS                |                        |
|            | Meningiomaticis, NOS           |                        |
|            | Meningothelial meningioma      |                        |
|            | Metaplastic meningioma         |                        |
|            | Microcystic meningioma         |                        |
|            | Mixed acidophil-basophil adenoma|                        |
|            | Mixed cell adenoma             |                        |
|            | Mixed meningioma               |                        |
|            | Mixed subependymoma-ependymoma |                        |
|            | Monomorphic adenoma           |                        |
|            | Mucoid cell adenoma            |                        |
|            | Multiple meningiomas          |                        |
|            | Multiple neurofibromatosis     |                        |
|            | Myxopapillary ependymoma       |                        |
| -N-        | Neoplasm, benign               |                        |
|            | Neoplasm, uncertain whether benign or malignant |                        |
|            | Nerve sheath myxoma            |                        |
|            | Neurilemoma, NOS               |                        |
|            | Neurinoma                      |                        |
|            | Neurinomatosis                 |                        |
|            | Neuroastrocytoma [obs]         |                        |
|            | Neurocytoma                    |                        |
|            | Neurofibroma, NOS              |                        |
|            | Neurofibromatosis, NOS         |                        |
|            | Neurolipocytoma                |                        |
|            | Neuroma, NOS                   |                        |
|            | Neurothekeoma                  |                        |
| -O-        | Oncocytic adenoma              |                        |
|            | Oncocytoma                     |                        |
|            | Oxyphilic adenoma              |                        |
| -P-        | Papillary adenoma, NOS         |                        |
|            | Papillary craniopharyngioma    |                        |
|            | Paraganglioma, NOS             |                        |
|            | Perineurioma, NOS              |                        |
|            | Pigmented schwannoma          |                        |
|            | Pinealoma, NOS                 |                        |
|            | Pineocytoma                    |                        |
|            | Pituitary adenoma, NOS         |                        |
|            | Plexiform hemangioma           |                        |
|            | Plexiform leiomyoma            |                        |
|            | Plexiform neurofibroma         |                        |
APPENDIX C: ICD-9-CM CODE SCREENING LISTS FOR CASEFINDING
With Equivalent ICD-10-CM Codes
Revised for 2015 diagnoses.

The following list is intended to assist in casefinding activities that are performed in casefinding sources that use ICD-9-CM (or ICD-10-CM) codes to codify the diagnoses.

**Casefinding List for Reportable Tumors**

<table>
<thead>
<tr>
<th>ICD-9-CM Codes</th>
<th>ICD-10-CM Codes</th>
<th>Diagnoses (in preferred ICD-O-3 terminology)</th>
</tr>
</thead>
<tbody>
<tr>
<td>140.<em>-172.</em></td>
<td>C00.<em>-C43.</em></td>
<td>Malignant neoplasms (excluding category 173), stated or presumed to be primary (of specified sites) and certain specified histologies</td>
</tr>
<tr>
<td>174.<em>-209.36, 209.7</em></td>
<td>C45.<em>-C96.</em></td>
<td></td>
</tr>
<tr>
<td>173.00</td>
<td>C44.00</td>
<td>Unspecified and other specified malignant neoplasm of skin of lip</td>
</tr>
<tr>
<td>173.09</td>
<td>C44.09</td>
<td></td>
</tr>
<tr>
<td>173.10</td>
<td>C44.101</td>
<td>Unspecified and other specified malignant neoplasm of eyelid, including canthus</td>
</tr>
<tr>
<td>173.19</td>
<td>C44.191</td>
<td></td>
</tr>
<tr>
<td>173.20</td>
<td>C44.201</td>
<td>Unspecified and other specified malignant neoplasm of ear and external auricular canal</td>
</tr>
<tr>
<td>173.29</td>
<td>C44.291</td>
<td></td>
</tr>
<tr>
<td>173.30</td>
<td>C44.30</td>
<td>Unspecified and other specified malignant neoplasm of skin of other and unspecified parts of face</td>
</tr>
<tr>
<td>173.39</td>
<td>C44.39</td>
<td></td>
</tr>
<tr>
<td>173.40</td>
<td>C44.40</td>
<td>Unspecified and other specified malignant neoplasm of scalp and skin of neck</td>
</tr>
<tr>
<td>173.49</td>
<td>C44.49</td>
<td></td>
</tr>
<tr>
<td>173.50</td>
<td>C44.50</td>
<td>Unspecified and other specified malignant neoplasm of skin of trunk, except scrotum</td>
</tr>
<tr>
<td>173.59</td>
<td>C44.59</td>
<td></td>
</tr>
<tr>
<td>173.60</td>
<td>C44.601</td>
<td>Unspecified and other specified malignant neoplasm of skin of upper limb, including shoulder</td>
</tr>
<tr>
<td>173.69</td>
<td>C44.691</td>
<td></td>
</tr>
<tr>
<td>173.70</td>
<td>C44.701</td>
<td>Unspecified and other specified malignant neoplasm of skin of lower limb, including hip</td>
</tr>
<tr>
<td>173.79</td>
<td>C44.791</td>
<td></td>
</tr>
<tr>
<td>173.80</td>
<td>C44.80</td>
<td>Unspecified and other specified malignant neoplasm of other specified sites of skin</td>
</tr>
<tr>
<td>173.89</td>
<td>C44.89</td>
<td></td>
</tr>
<tr>
<td>173.90</td>
<td>C44.90</td>
<td>Unspecified and other specified malignant neoplasm of skin, site unspecified</td>
</tr>
<tr>
<td>173.99</td>
<td>C44.99</td>
<td></td>
</tr>
<tr>
<td>225.0-225.9</td>
<td>D32.<em>-D33.</em></td>
<td>Benign neoplasm of brain and spinal cord neoplasm</td>
</tr>
<tr>
<td>227.3</td>
<td>D35.2</td>
<td>Benign neoplasm of pituitary gland, craniopharyngeal duct (pouch) and pineal gland</td>
</tr>
<tr>
<td>227.4</td>
<td>D35.3</td>
<td></td>
</tr>
<tr>
<td>228.02</td>
<td>D18.02</td>
<td>Hemangioma; of intracranial structures</td>
</tr>
<tr>
<td>228.1</td>
<td>D18.1</td>
<td>Lymphangioma, any site (Note: Includes only lymphangioma of brain, other parts of nervous system and endocrine glands.)</td>
</tr>
<tr>
<td>230.0-234.9</td>
<td>D00.<em>-D09.</em></td>
<td>Carcinoma in situ</td>
</tr>
<tr>
<td>237.0-237.1</td>
<td>D44.3-D44.5</td>
<td>Neoplasm of uncertain behavior of endocrine glands and nervous system: pituitary gland, craniopharyngeal duct and pineal gland</td>
</tr>
<tr>
<td>237.5</td>
<td>D42._</td>
<td>Neoplasm of uncertain behavior of endocrine glands and nervous system: brain and spinal cord, meninges, endocrine glands and other and unspecified parts of nervous system</td>
</tr>
<tr>
<td>237.6</td>
<td>D43.0_</td>
<td></td>
</tr>
<tr>
<td>237.9</td>
<td>D43.0_</td>
<td></td>
</tr>
<tr>
<td>238.4</td>
<td>D45</td>
<td>Polycythemia vera (9950/3)</td>
</tr>
<tr>
<td>238.6</td>
<td>D47.79</td>
<td>Plasma cells</td>
</tr>
<tr>
<td>238.7_</td>
<td>C46._</td>
<td>Other lymphatic and hematopoietic tissues</td>
</tr>
</tbody>
</table>
### Alphabetical List of Facilities

<table>
<thead>
<tr>
<th>ICD-9-CM Codes</th>
<th>ICD-10-CM Codes</th>
<th>Diagnoses (in preferred ICD-O-3 terminology)</th>
</tr>
</thead>
<tbody>
<tr>
<td>239.6</td>
<td>D49.6</td>
<td>Neoplasms of unspecified nature: brain, endocrine glands and other parts of nervous system</td>
</tr>
<tr>
<td>239.7</td>
<td>C88.0</td>
<td>Macroglobulinemia (Waldenstrom macroglobulinemia)</td>
</tr>
<tr>
<td>277.89</td>
<td>C96.5</td>
<td>Other specified disorders of metabolism: Hand-Schuller-Christian disease, histiocytosis (acute) (chronic), histiocytosis X (chronic)</td>
</tr>
<tr>
<td>288.4</td>
<td>D76.1-D76.3</td>
<td>Hemophagocytic syndrome (histiocytic syndromes)</td>
</tr>
<tr>
<td>289.6</td>
<td>D45</td>
<td>Familial polycythemia (synonym for polycythemia vera)</td>
</tr>
</tbody>
</table>

**Notes:**
The State Cancer Registry will continue to collect pilocytic/juvenile astrocytoma, M-9421, as a behavior code /3, although the behavior was changed to code /1 in ICD-O-3. This is consistent with the SEER program guidelines.

For cases diagnosed 1/01/2001 and later, the State Cancer Registry will not collect borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries which changed from behavior code /3 in ICD-O-2 to /1 in ICD-O-3. This is also consistent with the SEER program guidelines.
### APPENDIX D-1: ALPHABETICAL LIST OF FACILITIES WITH IDENTIFICATION NUMBERS

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Indiana ID Number</th>
<th>ACoS ID Number</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams Memorial Hospital (Decatur)</td>
<td>001</td>
<td>6420240</td>
<td>1689696148</td>
</tr>
<tr>
<td>Bluffton Regional Medical Center (Bluffton)</td>
<td>009</td>
<td>6420140</td>
<td>1376594366</td>
</tr>
<tr>
<td>Cameron Memorial Community Hospital (Angola)</td>
<td>008</td>
<td>6420055</td>
<td>1386683316</td>
</tr>
<tr>
<td>Cancer Care Partners (South Bend)</td>
<td>814</td>
<td>10001167</td>
<td>1265735674</td>
</tr>
<tr>
<td>Clark Memorial Hospital (Jeffersonville)</td>
<td>010</td>
<td>6420750</td>
<td>1134186315</td>
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<tr>
<td>Columbus Regional Health (Columbus)</td>
<td>004</td>
<td>6420200</td>
<td>1104998624</td>
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<tr>
<td>Community Hospital (Munster)</td>
<td>018</td>
<td>6421050</td>
<td>1003912810</td>
</tr>
<tr>
<td>Community Hospital Anderson (Anderson)</td>
<td>017</td>
<td>6420008</td>
<td>1972500452</td>
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<tr>
<td>Community Hospital East (Indianapolis)</td>
<td>014</td>
<td>6420605</td>
<td>1336119478</td>
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<tr>
<td>Community Hospital North (Indianapolis)</td>
<td>015</td>
<td>6420605</td>
<td>1619163854</td>
</tr>
<tr>
<td>Community Hospital of Bremen (Bremen)</td>
<td>016</td>
<td>6420165</td>
<td>1568417004</td>
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<tr>
<td>Community Hospital South (Indianapolis)</td>
<td>128</td>
<td>6420605</td>
<td>1235109778</td>
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<tr>
<td>Community Howard Regional Health (Kokomo)</td>
<td>041</td>
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<td>1902878994</td>
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<tr>
<td>Community Westview Hospital (Indianapolis)</td>
<td>119</td>
<td>6420640</td>
<td>1609873124</td>
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<td>Daviess Community Hospital (Washington)</td>
<td>020</td>
<td>6421460</td>
<td>1861465999</td>
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<tr>
<td>Deaconess Hospital (Evansville)</td>
<td>022</td>
<td>6420230</td>
<td>1053361642</td>
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<tr>
<td>Dearborn County Hospital (Lawrenceburg)</td>
<td>023</td>
<td>6420855</td>
<td>1326142498</td>
</tr>
<tr>
<td>Decatur County Memorial Hospital (Greensburg)</td>
<td>024</td>
<td>6420530</td>
<td>1952300477</td>
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<tr>
<td>DeKalb Health (Auburn)</td>
<td>021</td>
<td>6420085</td>
<td>1902897937</td>
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<tr>
<td>Dukes Memorial Hospital (Peru)</td>
<td>025</td>
<td>6421120</td>
<td>1619920949</td>
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<tr>
<td>Dupont Hospital (Fort Wayne)</td>
<td>132</td>
<td>10000266</td>
<td>1538110556</td>
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<tr>
<td>Eskenazi Health (Indianapolis) (formerly Wishard Health Services)</td>
<td>125</td>
<td>6420620</td>
<td>1568407310</td>
</tr>
<tr>
<td>Elkhart General Hospital (Elkhart)</td>
<td>027</td>
<td>6420270</td>
<td>1477551489</td>
</tr>
<tr>
<td>Faith, Hope, and Love Cancer Center (Lafayette)</td>
<td>805</td>
<td></td>
<td>1508935552</td>
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Indiana Cancer Registry

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APPENDIX E: RULES FOR DETERMINING MULTIPLE PRIMARIES FOR LYMPHATIC AND HEMATOPOIETIC DISEASES

Definitions of single and subsequent primaries for hematologic malignancies based on *ICD-O-3* reportable malignancies, effective for cases diagnosed 01/01/2001 through 12/31/2009.

Cancer registrars are often faced with multiple pathology reports for patients with hematologic malignancies, and the diagnoses reported may require different morphology codes. This is due in part to the fact that more intensive diagnostic study may yield a more specific diagnosis, and in part to the natural histories of hematopoietic diseases, which may progress from one diagnosis into another.

The table on the following pages, provided to aid the registrar in determining single versus subsequent primaries, employs the following guidelines:

1. “Lymphoma” is a general term for hematopoietic solid malignancies of the lymphoid series. “Leukemia” is a general term for liquid malignancies of either the lymphoid or the myeloid series. While it is recognized that some malignancies occur predominantly (or even exclusively) in liquid or solid form, because so many malignancies can potentially arise as either leukemias or lymphomas (or both), all hematopoietic malignancies are assumed to have this potential.

2. Malignancies of the lymphoid series are considered to be different from those of the myeloid series. Therefore, a lymphoid malignancy arising after diagnosis of a myeloid malignancy (or myelodysplastic or myeloproliferative disorder) would be considered a subsequent primary; however, a myeloid malignancy diagnosed after a previous myeloid malignancy would not count as a subsequent primary. Histiocytic malignancies are considered different from both lymphoid and myeloid malignancies.

3. Hodgkin lymphoma is considered to be different from non-Hodgkin lymphoma (NHL). Among the NHLs, B-cell malignancies are considered different from T-cell/NK cell malignancies. Therefore, a B-cell malignancy arising later in the course of a patient previously diagnosed with a T-cell malignancy would be considered a subsequent primary. However, a T-cell malignancy diagnosed later in the same patient would not be considered a subsequent primary.

4. The sequence of diagnoses affects whether a diagnosis represents a subsequent primary. In some cases, the order of occurrence of the two diagnoses being compared is a factor in the decision as to whether the second diagnosis is a new primary.

How to Use the Table
Assign the *ICD-O-3* code to the first diagnosis and find the row containing that code. Assign the *ICD-O-3* code for the second diagnosis and find the column containing that code. In the cell at the intersection of the first diagnosis row and the second diagnosis column, an "S" symbol indicates that the two diagnoses are most likely the same disease process (prepare/update a single abstract), and a "D" indicates that they are most likely different disease processes (prepare more than one abstract).

Note 1: If one of the two diagnoses is an NOS (not otherwise specified) term and the other is more specific and determined to be the same disease process, code the more specific diagnosis regardless of the sequence. For example, if a diagnosis of non-Hodgkin lymphoma, NOS is followed by a diagnosis of follicular lymphoma, assign the morphology code for the follicular lymphoma.

Note 2: The table on the following pages and the "Complete Diagnostic Terms for Table (Based on ICD-O-3)" display only the *ICD-O-3* primary (boldfaced) term associated with the code. Refer to the *International Classification of Diseases, Third Edition (ICD-O-3)* for a complete list of related terms and synonyms.

Prepared by: SEER Program, NCI, 02/28/2001. E-mail: seerweb@ims.nci.nih.gov
We gratefully acknowledge the assistance of Drs. Charles Lynch, Charles Platz, and Fred Dick of the University of Iowa, Dr. Tim Cote of the SEER Program, Jennifer Seiffert, MLIS, CTR, and Annette Hurlbut, RHIT, CTR, for their assistance with this project.
### Determining Multiple Primaries for Lymphatic and Hematopoietic Diseases

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## Determining Multiple Primaries for Lymphatic and Hematopoietic Diseases

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Key: S = one primary only; D = presumably a subsequent primary

SEER Program, NCI. E-mail: seeerweb@ims.nci.nih.gov
### Appendix E

**Determining Multiple Primaries for Lymphatic and Hematopoietic Diseases**

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Key: S = one primary only; D = presumably a subsequent primary

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## Determining Multiple Primaries for Lymphatic and Hematopoietic Diseases

### Appendix E

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#### First Diagnosis Down

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Key: S = one primary only; D = presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov
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Key: S = one primary only; D = presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov
### Determining Multiple Primaries for Lymphatic and Hematopoietic Diseases

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SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov
### COMPLETE DIAGNOSTIC TERMS FOR TABLE (BASED ON ICD-O-3)

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<tr>
<td>9590</td>
<td>Malignant lymphoma, NOS</td>
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<tr>
<td>9591</td>
<td>Malignant lymphoma, non-Hodgkin, NOS</td>
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<td>9596</td>
<td>Composite Hodgkin and non-Hodgkin lymphoma</td>
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<tr>
<td>9650-9667</td>
<td>Hodgkin lymphoma (all subtypes)</td>
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<tr>
<td>9670-9671</td>
<td>Malignant lymphoma, small B lymphocytic</td>
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<td>9673</td>
<td>Mantle cell lymphoma</td>
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<tr>
<td>9675-9684</td>
<td>Malignant lymphoma, diffuse large B-cell</td>
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<tr>
<td>9687</td>
<td>Burkitt lymphoma</td>
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<tr>
<td>9689, 9699</td>
<td>Marginal zone B-cell lymphoma</td>
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<tr>
<td>9690-9698</td>
<td>Follicular lymphoma</td>
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<tr>
<td>9700-9701</td>
<td>Mycosis fungoides and Sezary syndrome</td>
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<tr>
<td>9702-9719</td>
<td>T/NK-cell non-Hodgkin lymphoma</td>
</tr>
<tr>
<td>9727</td>
<td>Precursor cell lymphoblastic lymphoma, NOS</td>
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<tr>
<td>9728</td>
<td>Precursor B-cell lymphoblastic lymphoma</td>
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<tr>
<td>9729</td>
<td>Precursor T-cell lymphoblastic lymphoma</td>
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<tr>
<td>9731-9734</td>
<td>Plasma cell tumors</td>
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<tr>
<td>9740-9742</td>
<td>Mast cell tumors</td>
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<td>9750-9756</td>
<td>Histiocytosis/Langerhans cell histiocytosis</td>
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<tr>
<td>9757-9758</td>
<td>Dendritic cell sarcoma</td>
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<tr>
<td>9760</td>
<td>Immunoproliferative disease, NOS</td>
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<tr>
<td>9761</td>
<td>Waldenstrom macroglobulinemia</td>
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<td>9762</td>
<td>Heavy chain disease, NOS</td>
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<td>9764</td>
<td>Immunoproliferative small intestinal disease</td>
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<td>9800-9801</td>
<td>Leukemia, NOS/Acute leukemia, NOS</td>
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<td>9805</td>
<td>Acute biphenotypic leukemia</td>
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<td>9820</td>
<td>Lymphoid leukemia, NOS</td>
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<td>9823</td>
<td>B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma</td>
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<td>9826</td>
<td>Burkitt cell leukemia</td>
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<td>9827</td>
<td>Adult T-cell leukemia/lymphoma (HTLV-1 positive)</td>
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<td>9832</td>
<td>Prolymphocytic leukemia, NOS</td>
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<td>9833</td>
<td>Prolymphocytic leukemia, B-cell type</td>
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<td>Prolymphocytic leukemia, T-cell type</td>
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<td>Precursor cell lymphoblastic leukemia, NOS</td>
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<td>Precursor B-cell lymphoblastic leukemia</td>
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<td>Precursor T-cell lymphoblastic leukemia</td>
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<td>Myeloid leukemias</td>
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<td>Therapy related acute mylogenous leukemia</td>
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<td>9930</td>
<td>Myeloid sarcoma</td>
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<td>Acute panmyelosis with myelofibrosis</td>
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<td>Hairy cell leukemia</td>
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<td>9945</td>
<td>Chronic myelomonocytic leukemia, NOS</td>
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<td>9946</td>
<td>Juvenile myelomonocytic leukemia</td>
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<td>9948</td>
<td>Aggressive NK-cell leukemia</td>
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<tr>
<td>9950</td>
<td>Polycythemia vera</td>
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<tr>
<td>9960</td>
<td>Chronic myeloproliferative disease, NOS</td>
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<tr>
<td>9961</td>
<td>Myelosclerosis with myeloid metaplasia</td>
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<tr>
<td>9962</td>
<td>Essential thrombocytopenia</td>
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<tr>
<td>9963</td>
<td>Chronic neutrophilic leukemia</td>
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<tr>
<td>9964</td>
<td>Hypereosinophilic syndrome</td>
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<tr>
<td>9980-9986</td>
<td>Refractory anemias</td>
</tr>
<tr>
<td>9987</td>
<td>Therapy related myelodysplastic syndrome, NOS</td>
</tr>
<tr>
<td>9989</td>
<td>Myelodysplastic syndrome, NOS</td>
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</tbody>
</table>

SEER Program, NCI, 02/28/2001. E-mail: seerweb@ims.nci.nih.gov
APPENDIX F: CODING TIPS

Appendix F is under revision and unavailable at this time.
APPENDIX G: SURGERY TREATMENT CODES

DEFINITIONS AND RULES
Additional site-specific definitions and rules may be found with the site-specific codes.

Surgical Procedure of Primary Site

a. If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site.

If registry software allows multiple procedures to be recorded, “Surgical Procedure of Primary Site” refers to the most invasive surgical procedure of the primary site.

b. For codes 00 through 79, the code positions are hierarchical. The codes’ numeric sequence may deviate from the order in which the codes are listed. Last-listed codes take precedence over codes listed above, because:
   1) Within groups of codes, procedures are listed with increasing degrees of descriptive precision; and
   2) Succeeding groups of codes define progressively more extensive forms of resection.

Example for RECTOSIGMOID (C19.9): A polypectomy with electrocautery is coded 22.

20 Local tumor excision, NOS
   26 Polypectomy
   27 Excisional biopsy
   Combination of 20 or 26-27 WITH
      21 Photodynamic therapy (PDT)
      22 Electrocautery
      23 Cryosurgery
      24 Laser ablation
      25 Laser excision

C. Use codes 80 and 90 only if more precise information about the surgery is unavailable.

d. Code 98 applies to specific tumors that cannot be clearly defined in terms of primary or non-primary site. Use code 98 for the following:

   ▪ All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment;
   ▪ All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

   If any surgical treatment was performed on these cancers, assign code 1 in the item, “Surgical Procedure/Other Site.”

e. Biopsies that remove all of the tumor and/or leave only microscopic margins are to be coded in “Surgical Procedure of Primary Site.”

f. Surgery to remove regional tissue or organs is coded in “Surgical Procedure of Primary Site” only if the tissue/organs are removed in continuity with the primary site, except where noted in Appendix G.

g. If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results. When multiple first course primary site surgical procedures are performed for a single tumor, the most extensive or definitive is the last performed, and the code should represent the cumulative effect of the separate procedures.
ORAL CAVITY (C00.0 – C06.9)

Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9, Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9, Other Parts of Mouth C06.0-C06.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
   26 Polypectomy
   27 Excisional biopsy
      Any combination of 20 or 26-27 WITH
         21 Photodynamic therapy (PDT)
         22 Electrocautery
         23 Cryosurgery
         24 Laser ablation
         25 Laser excision

30 Wide excision, NOS
   Code 30 includes:
      Hemiglossectomy
      Partial glossectomy

40 Radical excision of tumor, NOS
   41 Radical excision of tumor ONLY
   42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
   43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

Codes 40-43 include:
   Total glossectomy
   Radical glossectomy

Specimen sent to pathology from surgical events 20-43.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY
PAROTID AND OTHER UNSPECIFIED GLANDS (C07.9 – C08.9)
Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00 None; no surgery of primary site; autopsy ONLY
10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
   26 Polypectomy
   27 Excisional biopsy
      Any combination of 20 or 26-27 WITH
      21 Photodynamic therapy (PDT)
      22 Electrocautery
      23 Cryosurgery
      24 Laser ablation
      25 Laser excision

30 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS
   31 Facial nerve spared
   32 Facial nerve sacrificed
33 Superficial lobe ONLY
   34 Facial nerve spared
   35 Facial nerve sacrificed
36 Deep lobe (Total)
   37 Facial nerve spared
   38 Facial nerve sacrificed

40 Total parotidectomy, NOS; total removal of major salivary gland, NOS
   41 Facial nerve spared
   42 Facial nerve sacrificed

50 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
   51 WITHOUT removal of temporal bone
   52 WITH removal of temporal bone
   53 WITH removal of overlying skin (requires graft or flap coverage)

80 Parotidectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY
PHARYNX (C09.0 – C14.0)
Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9, Pyriform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00 None; no surgery of primary site; autopsy ONLY
10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser
   15 Stripping

No specimen sent to pathology from surgical events 10-15.

20 Local tumor excision, NOS
   26 Polypectomy
   27 Excisional biopsy
   Any combination of 20 or 26-27 WITH
      21 Photodynamic therapy (PDT)
      22 Electrocautery
      23 Cryosurgery
      24 Laser ablation
   25 Laser excision
   28 Stripping

30 Pharyngectomy, NOS
   31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
   32 Total pharyngectomy

40 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)
   41 WITH laryngectomy (laryngopharyngectomy)
   42 WITH bone
   43 WITH both 41 and 42

50 Radical pharyngectomy (includes total mandibular resection), NOS
   51 WITHOUT laryngectomy
   52 WITH laryngectomy

Specimen sent to pathology from surgical events 20-52.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY
ESOPHAGUS (C15.0 – C15.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
   26 Polypectomy
   27 Excisional biopsy
      Any combination of 20 or 26-27 WITH
         21 Photodynamic therapy (PDT)
         22 Electrocautery
         23 Cryosurgery
         24 Laser ablation
         25 Laser excision

30 Partial esophagectomy

40 Total esophagectomy, NOS

50 Esophagectomy, NOS WITH larynxectomy and/or gastrectomy, NOS
   51 WITH larynxectomy
   52 WITH gastrectomy, NOS
   53 Partial gastrectomy
   54 Total gastrectomy
   55 Combination of 51 WITH any of 52-54

80 Esophagectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY
STOMACH (C16.0 – C16.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00  None; no surgery of primary site; autopsy ONLY

10  Local tumor destruction, NOS
   11  Photodynamic therapy (PDT)
   12  Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13  Cryosurgery
   14  Laser

No specimen sent to pathology from surgical events 10-14.

20  Local tumor excision, NOS
   26  Polypectomy
   27  Excisional biopsy
   Any combination of 20 or 26-27 WITH
      21  Photodynamic therapy (PDT)
      22  Electrocautery
      23  Cryosurgery
      24  Laser ablation
   25  Laser excision

30  Gastrectomy, NOS (partial, subtotal, hemi-)
   31  Antrectomy, lower (distal - less than 40% of stomach)**
   32  Lower (distal) gastrectomy (partial, subtotal, hemi-)
   33  Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:
   Partial gastrectomy, including a sleeve resection of the stomach
   Billroth I: anastomosis to duodenum (duodenostomy)
   Billroth II: anastomosis to jejunum (jejunostomy)

40  Near-total or total gastrectomy, NOS
   41  Near-total gastrectomy
   42  Total gastrectomy

   A total gastrectomy may follow a previous partial resection of the stomach.

50  Gastrectomy, NOS WITH removal of a portion of esophagus
   51  Partial or subtotal gastrectomy
   52  Near-total or total gastrectomy

   Codes 50-52 are used for gastrectomy resection when only portions of esophagus are
   included in procedure.

60  Gastrectomy with a resection in continuity with the resection of other organs, NOS***
   61  Partial or subtotal gastrectomy, in continuity with the resection of other organs ***
   62  Near-total or total gastrectomy, in continuity with the resection of other organs ***
   63  Radical gastrectomy, in continuity with the resection of other organs ***

   Codes 60-63 are used for gastrectomy resections with organs other than esophagus. Portions
   of esophagus may or may not be included in the resection.

80  Gastrectomy, NOS

Specimen sent to pathology from surgical events 20-80.
90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included
COLON (C18.0 – C18.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Note
Code removal/surgical ablation of single or multiple liver metastases under the data item Surgical Procedure/Other Site.

Codes
00 None; no surgery of primary site; autopsy ONLY
10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
   27 Excisional biopsy
   26 Polypectomy, NOS
   28 Polypectomy – endoscopic
   29 Polypectomy – surgical excision
   Any combination of 20 or 26-29 WITH
   21 Photodynamic therapy (PDT)
   22 Electrocautery
   23 Cryosurgery
   24 Laser ablation
   25 Laser excision

30 Partial colectomy, segmental resection
   32 Plus resection of contiguous organ; example: small bowel, bladder

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)
   41 Plus resection of contiguous organ; example: small bowel, bladder

50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)
   51 Plus resection of contiguous organ; example: small bowel, bladder

60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
   61 Plus resection of contiguous organ; example: small bowel, bladder

70 Colectomy or coloproctectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)
   Code 70 includes: Any colectomy (partial, hemicolecotomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Resection of other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

80 Colectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS
99 Unknown if surgery performed; death certificate ONLY
RECTOSIGMOID (C19.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item Surgical Procedure/Other Site.

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser ablation

**No specimen sent to pathology from surgical events 10-14.**

20 Local tumor excision, NOS
   26 Polypectomy
   27 Excisional biopsy

Combination of 20 or 26-27 WITH
   21 Photodynamic therapy (PDT)
   22 Electrocautery
   23 Cryosurgery
   24 Laser ablation
   25 Laser excision

30 Wedge or segmental resection; partial proctosigmoidectomy, NOS
   31 Plus resection of contiguous organs; example: small bowel, bladder

**Procedures coded 30 include, but are not limited to:**
   Anterior resection
   Hartmann’s operation
   Low anterior resection (LAR)
   Partial colectomy, NOS
   Rectosigmoidectomy, NOS
   Sigmoidectomy

40 Pull through WITH sphincter preservation (colo-anal anastomosis)

50 Total proctectomy

51 Total colectomy

55 Total colectomy WITH ileostomy, NOS
   56 Ileorectal reconstruction
   57 Total colectomy WITH other pouch; example: Koch pouch

60 Total proctocolectomy, NOS
   65 Total proctocolectomy WITH ileostomy, NOS
   66 Total proctocolectomy WITH ileostomy and pouch

**Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.**

70 Colectomy or proctocolectomy in continuity with other organs; pelvic exenteration

80 Colectomy, NOS; proctectomy, NOS
Specimen sent to pathology from surgical events 20-80.

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY

Terminology

Duhamel operation: A modification of a pull-through procedure with a longitudinal anastomosis between the proximal ganglionated segment of the colon and the rectum, leaving the rectum functional.

Hartmann's operation: A one-stage resection of primary rectal cancer with colostomy. The lower part of the sigmoid or the upper part of the rectum is resected distal to the neoplasm. The bowel is divided in the region of the descending colon. After the intervening segment of bowel has been removed, the proximal end of the descending colon is brought to the surface, as in a single-barreled colostomy. The proximal end of the distal segment is oversewn and left in place, leaving a blind rectal pouch.

Miles' operation: An abdominoperineal resection for cancer of the lower sigmoid and rectum, which includes permanent colostomy; removal of the pelvic colon, mesocolon, and adjacent lymph nodes; and wide perineal excision of the rectum and anus.

Pull-through operation: Permits removal of the desired portion of bowel (may include rectum, sigmoid, and, when indicated, descending colon and part of transverse colon) in one stage with retained sphincters, and end-to-end anastomosis. This operation is performed largely through the abdomen and does not require resection or removal of any part of the bony pelvis.

Swenson's operation: A pull-through resection with sphincter preservation.

Swenson's procedure: An abdomino-anal pull-through resection with partial internal sphincterectomy.
RECTUM (C20.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site*.

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
   27 Excisional biopsy
   26 Polypectomy
   Any combination of 20 or 26-27 WITH
   21 Photodynamic therapy (PDT)
   22 Electrocautery
   23 Cryosurgery
   24 Laser ablation
   25 Laser excision
   28 Curette and fulguration

30 Wedge or segmental resection; partial proctectomy, NOS

*Procedures coded 30 include, but are not limited to:*
- Anterior resection
- Hartmann's operation
- Low anterior resection (LAR)
- Transsacral rectosigmoidectomy
- Total mesorectal excision (TME)

40 Pull through WITH sphincter preservation (coloanal anastomosis)

50 Total proctectomy

*Procedures coded 50 include but are not limited to:*
- Abdominoperineal resection (Miles’ procedure)

60 Total proctocolectomy, NOS

70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration

80 Proctectomy, NOS

**Specimen sent to pathology from surgical events 20-80.**

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY
Terminology

**Duhamel operation:** A modification of a pull-through procedure with a longitudinal anastomosis between the proximal ganglionated segment of the colon and the rectum, leaving the rectum functional.

**Hartmann's operation:** A one-stage resection of primary rectal cancer with colostomy. The lower part of the sigmoid or the upper part of the rectum is resected distal to the neoplasm. The bowel is divided in the region of the descending colon. After the intervening segment of bowel has been removed, the proximal end of the descending colon is brought to the surface, as in a single-barreled colostomy. The proximal end of the distal segment is oversewn and left in place, leaving a blind rectal pouch.

**Miles' operation:** An abdominoperineal resection for cancer of the lower sigmoid and rectum, which includes permanent colostomy; removal of the pelvic colon, mesocolon, and adjacent lymph nodes; and wide perineal excision of the rectum and anus.

**Pull-through operation:** Permits removal of the desired portion of bowel (may include rectum, sigmoid, and, when indicated, descending colon and part of transverse colon) in one stage with retained sphincters, and end-to-end anastomosis. This operation is performed largely through the abdomen and does not require resection or removal of any part of the bony pelvis.

**Swenson's operation:** A pull-through resection with sphincter preservation.

**Swenson's procedure:** An abdomino-anal pull-through resection with partial internal sphincterectomy.
ANUS (C21.0 – C21.8)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00 None; no surgery of primary site; autopsy ONLY
10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser
   15 Thermal ablation
No specimen sent to pathology from surgical events 10-15.

20 Local tumor excision, NOS
   26 Polypectomy
   27 Excisional biopsy
   Any combination of 20 or 26-27 WITH
      21 Photodynamic therapy (PDT)
      22 Electrocautery
      23 Cryosurgery
      24 Laser ablation
      25 Laser excision

60 Abdominal perineal resection, NOS (APR; Miles’ procedure)
   61 APR and sentinel node excision
   62 APR and unilateral inguinal lymph node dissection
   63 APR and bilateral inguinal lymph node dissection
The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery or Scope of Regional Lymph Node Surgery at This Facility.

Specimen sent to pathology from surgical events 20-63.

90 Surgery, NOS
99 Unknown if surgery performed; death certificate ONLY
LIVER AND INTRAHEPATIC BILE DUCTS (C22.0 – C22.1)

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00 None; no surgery of primary site; autopsy ONLY
10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser
   15 Alcohol (Percutaneous Ethanol Injection - PEI)
   16 Heat-Radio-frequency Ablation (RFA)
   17 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events 10-17.

20 Wedge resection or segmental resection, NOS
   21 Wedge resection
   22 Segmental resection, NOS
      23 One
      24 Two
      25 Three
      26 Segmental resection AND local tumor destruction

30 Lobectomy, NOS
   36 Right lobectomy
   37 Left lobectomy
   38 Lobectomy AND local tumor destruction

50 Extended lobectomy, NOS (extended: resection of single lobe plus a segment of another lobe)
   51 Right lobectomy
   52 Left lobectomy
   59 Extended lobectomy AND local tumor destruction

60 Hepatectomy, NOS
   61 Total hepatectomy and transplant

65 Excision of a bile duct (for an intrahepatic bile duct primary only)
   66 Excision of an intrahepatic bile duct PLUS partial hepatectomy

75 Extrahepatic bile duct and hepatectomy WITH transplant

Specimen sent to pathology from surgical events 20-75.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY
PANCREAS (C25.0 – C25.9)

**Codes**

00  None; no surgery of primary site; autopsy ONLY

25  Local excision of tumor, NOS

30  Partial pancreatectomy, NOS; example: distal

35 Local or partial pancreatectomy and duodenectomy

36  WITHOUT distal/partial gastrectomy

37  WITH partial gastrectomy (Whipple)

40  Total pancreatectomy

60  Total pancreatectomy and subtotal gastrectomy or duodenectomy

70  Extended pancreatectoduodenectomy

80  Pancreatectomy, NOS

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY
LARYNX (C32.0 – C32.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00 None; no surgery of primary site; autopsy ONLY
10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser
   15 Stripping

No specimen sent to pathology from surgical events 10-15

20 Local tumor excision, NOS
   26 Polypectomy
   27 Excisional biopsy
   Any combination of 20 or 26-27 WITH
      21 Photodynamic therapy (PDT)
      22 Electrocautery
      23 Cryosurgery
      24 Laser ablation
   25 Laser excision
   28 Stripping

30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy, NOS; hemilaryngectomy, NOS
   31 Vertical laryngectomy
   32 Anterior commissure laryngectomy
   33 Supraglottic laryngectomy

40 Total or radical laryngectomy, NOS
   41 Total laryngectomy ONLY
   42 Radical laryngectomy ONLY

50 Pharyngolaryngectomy

80 Laryngectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Terminology (Robbins et al. 1991):
A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection the same lymph nodes are removed as in a radical neck dissection; however, one or more non-lymphatic structures are preserved.

A selective neck dissection is neck dissection with preservation of one or more lymph nodes group routinely removed in radical neck dissection.
LUNG (C34.0 – C34.9)  
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00  None; no surgery of primary site; autopsy ONLY

19  Local tumor destruction or excision, NOS  
   Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

15  Local tumor destruction, NOS  
   12  Laser ablation or cryosurgery  
   13  Electrocautery; fulguration (includes use of hot forceps for tumor destruction)  
   No specimen sent to pathology from surgical events 12-13 and 15.

20  Excision or resection of less than one lobe, NOS  
   23  Excision, NOS  
   24  Laser excision  
   25  Bronchial sleeve resection ONLY  
   21  Wedge resection  
   22  Segmental resection, including lingulectomy

30  Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)  
   33  Lobectomy WITH mediastinal lymph node dissection  
   The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery or Scope of Regional Lymph Node Surgery at This Facility.

45  Lobe or bilobectomy extended, NOS  
   46  WITH chest wall  
   47  WITH pericardium  
   48  WITH diaphragm

55  Pneumonectomy, NOS  
   56  WITH mediastinal lymph node dissection (radical pneumonectomy)  
   The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery or Scope of Regional Lymph Node Surgery at This Facility.

65  Extended pneumonectomy  
   66  Extended pneumonectomy plus pleura or diaphragm

70  Extended radical pneumonectomy  
   The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery or Scope of Regional Lymph Node Surgery at This Facility.

80  Resection of lung, NOS

Specimen sent to pathology from surgical events 20-80.

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY
HEMATOPOIETIC/RETICULOENDOTHELIAL/IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE (C42.0, C42.1, C42.3, C42.4)

C42.0, C42.1, C42.3, C42.4 (with any histology) or

M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992 (with any site)

**Code**

98  All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment.

Surgical procedures for hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative primaries are to be recorded using the data item Surgical Procedure/Other Site or Surgical Procedure/Other Site at This Facility.
Appendix G

Site-Specific Surgery Codes

BONES, JOINTS, AND ARTICULAR CARTILAGE (40.0 – C41.9)
PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM (C47.0 – C47.9)
CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES (C49.0 – C49.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
   Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction
   No specimen sent to pathology from surgical event 15.

25 Local excision

26 Partial resection

30 Radical excision or resection of lesion WITH limb salvage

40 Amputation of limb
   41 Partial amputation of limb
   42 Total amputation of limb

50 Major amputation, NOS
   51 Forequarter, including scapula
   52 Hindquarter, including ilium/hip bone
   53 Hemipelvectomy
   54 Internal hemipelvectomy

Specimen sent to pathology from surgical events 25-54.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY
SPLEEN (C42.2)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00  None; no surgery of primary site; autopsy ONLY

19  Local tumor destruction or excision, NOS.
   Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

21  Partial splenectomy
22  Total splenectomy
80  Splenectomy, NOS

Specimen sent to pathology from surgical events 21-80.

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY
SKIN (C44.0 – C44.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00  None; no surgery of primary site; autopsy ONLY
10  Local tumor destruction, NOS
   11  Photodynamic therapy (PDT)
   12  Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13  Cryosurgery
   14  Laser ablation

No specimen sent to pathology from surgical events 10-14.

20  Local tumor excision, NOS
   26  Polypectomy
   27  Excisional biopsy
   Any combination of 20 or 26-27 WITH
   21  Photodynamic therapy (PDT)
   22  Electrocautery
   23  Cryosurgery
   24  Laser ablation
   25  Laser excision

30  Biopsy of primary tumor followed by a gross excision of the lesion (does not have to be done under the same anesthesia)
   31  Shave biopsy followed by a gross excision of the lesion
   32  Punch biopsy followed by a gross excision of the lesion
   33  Incisional biopsy followed by a gross excision of the lesion
   34  Mohs’ surgery, NOS
   35  Mohs’ with 1-cm margin or less
   36  Mohs’ with more than 1-cm margin

45  Wide excision or re-excision of lesion or minor (local) amputation with margins more than 1 cm, NOS.
   Margins MUST be microscopically negative.
   46  WITH margins more than 1 cm and less than or equal to 2 cm
   47  WITH margins greater than 2 cm

If the excision does not have clinically negative margins greater than 1 cm, use the appropriate code, 20-36.

60  Major amputation

Specimen sent to pathology from surgical events 20-60.

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY
BREAST (C50.0 – C50.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

**Codes**

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS
   No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

20 Partial mastectomy, NOS; less than total mastectomy, NOS
   21 Partial mastectomy WITH nipple resection
   22 Lumpectomy or excisional biopsy
   23 Re-excision of the biopsy site for gross or microscopic residual disease
   24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)
   Procedures coded as 20-24 remove gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

30 Subcutaneous mastectomy
   A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.

40 Total (simple) mastectomy
   41 WITHOUT removal of uninvolved contralateral breast
   43 With reconstruction, NOS
   44 Tissue
   45 Implant
   46 Combined (Tissue and Implant)
   42 WITH removal of uninvolved contralateral breast
   47 With reconstruction, NOS
   48 Tissue
   49 Implant
   75 Combined (Tissue and Implant)
   A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed.

   For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site* or *Surgical Procedure/Other Site at This Facility.*

   If contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

   Reconstruction that is planned as part of first course treatment is coded 43-46, 47-49, or 75; whether it is done at the time of mastectomy or later.

76 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma

50 Modified radical mastectomy
   51 WITHOUT removal of uninvolved contralateral breast
   53 With reconstruction, NOS
   54 Tissue
   55 Implant
56 Combined (Tissue and Implant)
52 WITH removal of uninvolved contralateral breast
57 With reconstruction, NOS
58 Tissue
59 Implant
63 Combined (Tissue and Implant)

**Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle.**

**If contralateral breast reveals a second primary, it is abstracted separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.**

**For single primaries only, code removal of involved contralateral breast under the data item Surgical Procedure/Other Site or Surgical Procedure/Other Site at This Facility.**

60 Radical mastectomy, NOS
61 WITHOUT removal of uninvolved contralateral breast
64 With reconstruction, NOS
65 Tissue
66 Implant
67 Combined (Tissue and Implant)
62 WITH removal of uninvolved contralateral breast
68 With reconstruction, NOS
69 Tissue
73 Implant
74 Combined (Tissue and Implant)

70 Extended radical mastectomy
71 WITHOUT removal of uninvolved contralateral breast
72 WITH removal of uninvolved contralateral breast

80 Mastectomy, NOS

**Specimen sent to pathology for surgical events coded 20-80.**

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**Terminology**

**Halsted radical mastectomy:** An en bloc resection of the entire breast and skin; pectoralis major and minor muscles; and contents of the axilla.

**Patey's and Dyson's operations:** Modified radical mastectomies with removal of the breast, pectoralis minor muscle, and axillary contents. The pectoralis major muscle remains intact.

**Urban's extended radical mastectomy:** Radical mastectomy and excision of internal mammary nodes.
CERVIX UTERI (C53.0 – C53.9)  
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

For invasive cancers, dilatation and curettage is coded as an incisional biopsy (02) under the data item Surgical Diagnostic and Staging Procedure.

Codes
00 None; no surgery of primary site, autopsy ONLY
10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser
   15 Loop Electrocautery Excision Procedure (LEEP)
   16 Laser ablation
   17 Thermal ablation

No specimen sent to pathology from surgical events 10-17.

20 Local tumor excision, NOS
   21 Electrocautery
   22 Cryosurgery
   23 Laser ablation or excision
   24 Cone biopsy
   25 Dilatation and curettage; endocervical curettage (for in situ only)
   26 Excisional biopsy, NOS
   27 Cone biopsy
   28 Loop Electrocautery Excision Procedure (LEEP)
   29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27, or 29 WITH
   21 Electrocautery
   22 Cryosurgery
   23 Laser ablation or excision

30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
   51 Modified radical hysterectomy
   52 Extended hysterectomy
   53 Radical hysterectomy; Wertheim’s procedure
   54 Extended radical hysterectomy

60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
   61 WITHOUT removal of tubes and ovaries
   62 WITH removal of tubes and ovaries
70 Pelvic exenteration
   71 Anterior exenteration
      Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

72 Posterior exenteration
   Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

73 Total exenteration
   Includes removal of all pelvic contents and pelvic lymph nodes.

74 Extended exenteration
   Includes pelvic blood vessels or bony pelvis

Specimen sent to pathology from surgical events 20-74.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Terminology
Wertheim’s operation: A radical abdominal hysterectomy for cancer of the cervix and uterus. The uterus and as much of the parametrial tissue as possible are removed, as well as a wide margin of the vagina.
CORPUS UTERI (C54.0 – C55.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

For invasive cancers, dilatation and curettage is coded as an incisional biopsy (02) under the data item Surgical Diagnostic and Staging Procedure.

Codes
00 None; no surgery of primary site; autopsy ONLY
19 Local tumor destruction or excision, NOS
   Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).
10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser
   15 Loop Electocautery Excision Procedure (LEEP)
   16 Thermal ablation
No specimen sent to pathology from surgical events 10-16.
20 Local tumor excision, NOS; simple excision, NOS
   24 Excisional biopsy
   25 Polypectomy
   26 Myomectomy
   Any combination of 20 or 24-26 WITH
   21 Electrocautery
   22 Cryosurgery
   23 Laser ablation or excision
30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies)
   31 WITHOUT tube(s) and ovary(ies)
   32 WITH tube(s) and ovary(ies)
40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)
   Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.
50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)
   Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.
60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
   61 Modified radical hysterectomy
   62 Extended hysterectomy
   63 Radical hysterectomy; Wertheim’s procedure
   64 Extended radical hysterectomy
65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)
   66 WITHOUT removal of tube(s) and ovary(ies)
   67 WITH removal of tube(s) and ovary(ies)
75 Pelvic exenteration  
76 Anterior exenteration  
   Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

77 Posterior exenteration  
   Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

78 Total exenteration  
   Includes removal of all pelvic contents and pelvic lymph nodes.

79 Extended exenteration  
   Includes pelvic blood vessels or bony pelvis

Specimen sent to pathology from surgical events 20-79.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**Terminology**

Wertheim’s operation: A radical abdominal hysterectomy for cancer of the cervix and uterus. The uterus and as much of the parametrial tissue as possible are removed, as well as a wide margin of the vagina.
OVARY (C56.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

**Codes**

00  None; no surgery of primary site; autopsy ONLY

17  Local tumor destruction, NOS
    *No specimen sent to pathology from surgical event 17.*

25  Total removal of tumor or (single) ovary, NOS
    26  Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
        27  WITHOUT hysterectomy
        28  WITH hysterectomy

35  Unilateral (salpingo-) oophorectomy; unknown if hysterectomy done
    36  WITHOUT hysterectomy
    37  WITH hysterectomy

50  Bilateral (salpingo-) oophorectomy; unknown if hysterectomy done
    51  WITHOUT hysterectomy
    52  WITH hysterectomy

55  Unilateral or bilateral (salpingo-) oophorectomy WITH OMENTECTOMY, NOS (partial or total); unknown if hysterectomy done
    56  WITHOUT hysterectomy
    57  WITH hysterectomy

60  Debulking; cytoreductive surgery, NOS
    61  WITH colon (including appendix) and/or small intestine resection (not incidental)
    62  WITH partial resection of urinary tract (not incidental)
    63  Combination of 61 and 62
    *Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.*

70  Pelvic exenteration, NOS
    71  Anterior exenteration
        *Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.*

72  Posterior exenteration
    *Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.*

73  Total exenteration
    *Includes removal of all pelvic contents and pelvic lymph nodes.*

74  Extended exenteration
    *Includes pelvic blood vessels or bony pelvis*
80  (Salpingo-) oophorectomy, NOS

**Specimen sent to pathology from surgical events 25-80.**

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY
PROSTATE (C61.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item Hematologic Transplant and Endocrine Procedures.

Codes
00 None; no surgery of primary site; autopsy ONLY
18 Local tumor destruction or excision, NOS
19 Transurethral resection (TURP), NOS, and no specimen sent to pathology or unknown if sent

Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19 (principally for cases diagnosed prior to January 1, 2003).

10 Local tumor destruction, NOS
14 Cryoprostatectomy
15 Laser ablation
16 Hyperthermia
17 Other method of local tumor destruction

No specimen sent to pathology from surgical events 10-17.

20 Local tumor excision, NOS
21 Transurethral resection (TURP), NOS, with specimen sent to pathology
22 TURP – cancer is incidental finding during surgery for benign disease
23 TURP – patient has suspected/known cancer
Any combination of 20-23 WITH
24 Cryosurgery
25 Laser
26 Hyperthermia

30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

50 Radical prostatectomy, NOS; total prostatectomy, NOS
Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.

80 Prostatectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY
TESTIS (C62.0 – C62.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00  None; no surgery of primary site; autopsy ONLY
12  Local tumor destruction, NOS
    No specimen sent to pathology from surgical event 12.
20  Local or partial excision of testicle
30  Excision of testicle WITHOUT cord
40  Excision of testicle WITH cord or cord not mentioned (radical orchiectomy)
80  Orchiectomy, NOS (unspecified whether partial or total testicle removed)

Specimen sent to pathology from surgical events 20-80.

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY
KIDNEY, RENAL PELVIS, AND URETER (C64.9 – C66.9)

Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9944-9946, 9950-9967, and 9975-9992)

Codes

00  None; no surgery of primary site; autopsy ONLY

10  Local tumor destruction, NOS
    11  Photodynamic therapy (PDT)
    12  Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
    13  Cryosurgery
    14  Laser
    15  Thermal ablation

No specimen sent to pathology from surgical events 10-15.

20  Local tumor excision, NOS
    26  Polypectomy
    27  Excisional biopsy

Any combination of 20 or 26-27 WITH
    21  Photodynamic therapy (PDT)
    22  Electrocautery
    23  Cryosurgery
    24  Laser ablation
    25  Laser excision

30  Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)

Procedures coded 30 include, but are not to limited to:
    Segmental resection
    Wedge resection

40  Complete/total/simple nephrectomy – for kidney parenchyma
    Nephroureterectomy

Includes bladder cuff for renal pelvis or ureter

50  Radical nephrectomy

May include removal of a portion of vena cava, adrenal gland(s), Gerota’s fascia, perinephric fat, or partial/total ureter.

70  Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with the resection of other organ(s) (colon, bladder)

The other organs, such as colon or bladder, may be partially or totally removed.

80  Nephrectomy, NOS
    Ureterectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY
Appendix G

Site-Specific Surgery Codes

BLADDER (C67.0 – C67.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00 None; no surgery of primary site; autopsy ONLY
10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser
   15 Intravesical therapy
   16 Bacillus Calmette-Guerin (BCG) or other immunotherapy
      Also code the introduction of immunotherapy in the immunotherapy items. If
      immunotherapy is followed by surgery of the type coded 20-80, code that surgery instead
      and code the immunotherapy only as immunotherapy.

   No specimen sent to pathology from surgical events 10-16.
20 Local tumor excision, NOS
   26 Polypectomy
   27 Excisional biopsy
      Combination of 20 or 26-27 WITH
         21 Photodynamic therapy (PDT)
         22 Electrocautery
         23 Cryosurgery
         24 Laser ablation
         25 Laser excision

   31 Partial cystectomy

50 Simple/total/complete cystectomy

60 Complete cystectomy with reconstruction
   61 Radical cystectomy PLUS ileal conduit
   62 Radical cystectomy PLUS continent reservoir or pouch, NOS
   63 Radical cystectomy PLUS abdominal pouch (cutaneous)
   64 Radical cystectomy PLUS in situ pouch (orthotopic)
      When the procedure is described as a pelvic exenteration for males, but the prostate is not
      removed, the surgery should be coded as a cystectomy (code 60-64).

70 Pelvic exenteration, NOS
   71 Radical cystectomy including anterior exenteration
      For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire
      urethra.
      For males, includes removal of the prostate. When the procedure is described as a pelvic
      exenteration for males, but the prostate is not removed, the surgery should be coded as a
      cystectomy (code 60-64).

72 Posterior exenteration
   For females, also includes removal of vagina, rectum and anus. For males, also includes
   prostate, rectum and anus.

73 Total exenteration
   Includes all tissue and organs removed for an anterior and posterior exenteration.
74  Extended exenteration
   *Includes pelvic blood vessels or bony pelvis.*

80  Cystectomy, NOS

**Specimen sent to pathology from surgical events 20-80.**

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY
BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM (C70.0 – C72.9)
Meninges C70.0-C70.9; Brain C71.0-C71.9; Spinal Cord, Cranial Nerves, and Other Parts of Central Nervous System C72.0-C72.9
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code laminectomies for spinal cord primaries.

Codes
00 None; no surgery of primary site; autopsy ONLY
10 Tumor destruction, NOS
   No specimen sent to pathology from surgical event 10.
   Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, Linac radiosurgery as surgical tumor destruction. All of these modalities are recorded in the radiation treatment fields.
20 Local excision of tumor, lesion or mass; excisional biopsy
   21 Subtotal resection of tumor, lesion or mass in brain
   22 Resection of tumor of spinal cord or nerve
30 Radical, total, gross resection of tumor, lesion or mass in brain
40 Partial resection of lobe of brain, when the surgery can not be coded as 20-30
55 Gross total resection of lobe of brain (lobectomy)

Codes 30 - 55 are not applicable for spinal cord or spinal nerve primary sites.

Specimen sent to pathology from surgical events 20 - 55.
90 Surgery, NOS
99 Unknown if surgery performed; death certificate ONLY
THYROID GLAND (C73.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00  None; no surgery of primary site; autopsy ONLY

13  Local tumor destruction, NOS
   No specimen sent to pathology from surgical event 13.

25  Removal of less than a lobe, NOS
26  Local surgical excision
27  Removal of a partial lobe ONLY

20  Lobectomy and/or isthmectomy
21  Lobectomy ONLY
22  Isthmectomy ONLY
23  Lobectomy WITH isthmus

30  Removal of a lobe and partial removal of the contralateral lobe

40  Subtotal or near total thyroidectomy

50  Total thyroidectomy

80  Thyroidectomy, NOS

Specimen sent to pathology from surgical events 25-80.

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY

Terminology (Robbins et al. 1991):
A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection the same lymph nodes are removed as in a radical neck dissection; however, one or more non-lymphatic structures are preserved.

A selective neck dissection is neck dissection with preservation of one or more lymph nodes group routinely removed in radical neck dissection.
LYMPH NODES (C77.0 – C77.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00 None; no surgery of primary site; autopsy ONLY
19 Local tumor destruction or excision, NOS
   Unknown whether a specimen was sent to pathology for surgical events coded to 19
   (principally for cases diagnosed prior to January 1, 2003).
15 Local tumor destruction, NOS
   No specimen sent to pathology from surgical event 15.
25 Local tumor excision, NOS
   Less than a full chain, includes an excisional biopsy of a single lymph node.
30 Lymph node dissection, NOS
   31 One chain
   32 Two or more chains
40 Lymph node dissection, NOS PLUS splenectomy
   41 One chain
   42 Two or more chains
50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
   51 One chain
   52 Two or more chains
60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy
   (Includes staging laparotomy for lymphoma.)
   61 One chain
   62 Two or more chains

Specimen sent to pathology from surgical events 25-62.
90 Surgery, NOS
99 Unknown if surgery performed; death certificate ONLY
### Site-Specific Surgery Codes

#### Appendix G

**ALL OTHER SITES**

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(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

#### Codes

00  None; no surgery of primary site; autopsy ONLY

10  Local tumor destruction, NOS

11  Photodynamic therapy (PDT)

12  Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13  Cryosurgery

14  Laser

**No specimen sent to pathology from surgical events 10-14.**

20  Local tumor excision, NOS

26  Polypectomy

27  Excisional biopsy

Any combination of 20 or 26-27 WITH

21  Photodynamic therapy (PDT)

22  Electrocautery

23  Cryosurgery

24  Laser ablation

25  Laser excision

30  Simple/partial surgical removal of primary site

40  Total surgical removal of primary site; enucleation

41  Total enucleation (for eye surgery only)

50  Surgery stated to be “debulking”

60  Radical surgery

**Partial or total removal of the primary site WITH resection in continuity (partial or total removal) with other organs.**

**Specimen sent to pathology from surgical events 20-60.**

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY
UNKNOWN AND ILL-DEFINED PRIMARY SITES (C76.0 – C76.8, C80.9)
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code
98  All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item Surgical Procedure/Other Site or Surgical Procedure/Other Site at This Facility.
# APPENDIX H: FIPS CODES FOR COUNTIES IN STATES ADJOINING INDIANA

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007  | Ballard  | 087  | Green  | 167  | Mercer  
009  | Barren  | 089  | Greenup  | 169  | Metcalfe  
011  | Bath  | 091  | Hancock  | 171  | Monroe  
013  | Bell  | 093  | Hardin  | 173  | Montgomery  
015  | Boone  | 095  | Harlan  | 175  | Morgan  
017  | Bourbon  | 097  | Harrison  | 177  | Muhlenberg  
019  | Boyd  | 099  | Hart  | 179  | Nelson  
021  | Boyle  | 101  | Henderson  | 181  | Nicholas  
023  | Bracken  | 103  | Henry  | 183  | Ohio  
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GLOSSARY OF REGISTRY TERMS

Terms in *italics* are defined within this glossary.

**Abbreviations**

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**A**

*abstract.* n. A summary, abridgement, or abbreviated record of pertinent information about a patient, the cancer, the cancer-directed treatment, and the outcome; the form or computer screen used to collect such information for each case. v: The act of collecting and recording cancer information from a health record.

*accession.* v. To enter a *case* into a *cancer registry* and assign it a number.

*accession number.* A unique 9-digit number assigned to the patient by the *registrar* indicating the year in which the patient was first seen for cancer at the reporting institution (first four digits) and the sequential order in which the patient was identified by the registry or *abstracted* into the database (last five digits). The number is used for all additional *primaries* the patient may develop, regardless of the year in which subsequent reportable *tumors* occur.

*accession register.* An annual, sequential listing of all reportable cases included in the *registry*. The accession register must include the *accession/sequence number*, patient name, *primary site*, and *date of initial diagnosis*. In a manual registry, it may be useful to include the *class of case* category. The accession register serves to identify, count, and evaluate the annual caseload.

*acinus (pl. acini).* A small saclike dilatation, particularly one found in various glands; synonymous with alveolus.

*ACoS.* American College of Surgeons.

*ACS.* American Cancer Society.

*adenocarcinoma.* A carcinoma derived from glandular tissue or in which the cells are arranged in the form of glands; a *malignant adenoma*.

*adenocarcinoma in an adenomatous polyp.* *Adenocarcinoma* in a glandular polyp of the colon.

*adenoma.* A *benign* epithelial *tumor* with a gland-like structure or in which the cells are clearly derived from glandular epithelium.

*adjunct.* An accessory or auxiliary agent or measure used in the *treatment* of disease or in other procedures.

*adjuvant therapy.* A treatment modality given in conjunction with another treatment modality, such as adjuvant chemotherapy given after surgery or radiation has destroyed the clinically detectable cancer cells, to prevent or delay recurrence.
adrenalectomy. Excision of adrenal glands.

adrenocorticotropic hormone (ACTH). A hormone that acts primarily on the adrenal cortex, stimulating its growth and its secretion of corticosteroids.

age specific rate. An incidence rate derived from analysis of data collected for a specific age group.

AJCC. American Joint Committee on Cancer.

allogenic cells. Cells belonging to or obtained from the same species but that are genetically different.

alphabetic. A term used to describe a data field that will accept letters only.

alphanumeric. A term used to describe a data field that will accept either letters or numbers but no special characters.

analytic case. A cancer case diagnosed and/or receiving all or part of the first course of treatment at the reporting facility. Analytic cases are eligible for inclusion in that registry’s statistical reports of treatment efficacy and survival.

anaplasia. Reversion of cells to a more primitive or less differentiated form, a characteristic of malignant tumors; also called dedifferentiation.

anastomosis. A union or connection between two normally separate spaces or organs; typically used in describing a surgical connection between segments in the colon.

anatomic site. The place, position or location within the anatomy or structure of the organism.

ancillary drugs. Medications that enhance the effects of the cancer-directed treatment but do not directly affect the cancer. Ancillary drugs are not to be coded as cancer-directed treatment.

annual report. A publication produced on a yearly basis that describes the activities of an organization. For a cancer program, the report also includes statistics on the types of cancer diagnosed and treated at the facility.

autopsy. Postmortem pathologic examination of a body. Autopsy reports are used in casefinding.

B

basal cell. The predominant cell of the deepest layer of the epidermis.

basement membrane. A sheet of extracellular material interposed between cellular elements and underlying connective tissue. The sheet functions as a filtration barrier and a boundary that helps to generate and maintain tissue structure. In skin, it is the layer called basal lamina that marks the junction of the dermis and epidermis.

beam radiation. Radiation administered from an external source that may be either x-ray or cobalt.

behavior. Description of how a tumor acts in terms of whether it is benign, noninvasive, malignant, or metastatic.

benign. Not malignant; not recurrent; favorable for recovery.

bilateral organs. Organs that occur as pairs, having a corresponding part on each side of the body.
biologic response modifier therapy. See immunotherapy.

biopsy. The removal of tissue for microscopic examination performed to establish a diagnosis and the characteristics of the cancer.

biostatistics. The application of statistics to the analysis of biological and medical data.

blastoma. A neoplasm composed of embryonic cells.

blood dyscrasia. A disease or pathologic condition of the blood.

bone marrow transplant. A type of treatment in which the patient’s bone marrow is destroyed or reduced with high-dose chemotherapy, with or without total body irradiation, after which bone marrow is returned to the body to restore marrow and immune system function.

borderline neoplasm. A tumor with a behavior type that cannot be determined to be completely benign, yet which does not meet all criteria for malignancy.

Bowen disease. A squamous cell carcinoma in situ occurring usually on sun-exposed areas of skin, but sometimes found on mucous membranes; also called Bowen precancerous dermatosis and precancerous dermatitis.

brachytherapy. A type of radiation therapy where the radiation source is placed in direct contact with the tumor; for example, cesium capsules inserted into the uterus for treatment of endometrial cancer.

BRM. Biological Response Modifier; see immunotherapy.

C

CA. Cancer.

cancer. A cellular tumor exhibiting the characteristics of anaplasia and invasion and the potential for metastasis.

cancer-directed treatment (or therapy). Treatment that is tumor directed. Its purpose is to modify, control, remove, or destroy primary or metastatic cancer tissue; excludes treatment solely for the relief of symptoms.

cancer (or tumor) registrar. An individual employed by a hospital or other institution for the purpose of recording, abstracting, and coding cancer cases. A cancer registrar collects and stores information on cancer patients, conducts periodic follow-up on these patients, and prepares reports on the data collected.

cancer (or tumor) registry. A data system designed for the collection, management, and analysis of data on persons with the diagnosis of a malignant disease (cancer).

carcinoma. A malignant tumor of epithelial origin.

carcinomatosis. Invasion of many organs of the body at the same time by metastases.

case. An occurrence of a primary site of a reportable cancer. One patient with two primary cancers represents two cases. See Chapter 3 and Appendix B for the State Cancer Registry’s reportable list.
**casefinding.** Systematic identification of all reportable cancer cases in a defined population, such as patients of a hospital or patients seen in a physician's office; also called case ascertainment.

**Caucasian.** Of or relating to the white race as defined by law.

**cauterization.** The application of an agent which destroys tissue by burning or searing.

**CDC.** Centers for Disease Control and Prevention.

**cesium.** A metallic element used in isotopic form as a radiation source for cancer-directed treatment.

**chemotherapy.** Treatment by administration of a chemical or drug that inhibits the reproduction of cancer cells and that does not achieve its effect through change of the hormone balance.

**class of case.** A registry term describing whether a case is analytic or nonanalytic based on where the initial diagnosis and treatment of the patient occurs.

**clinical case.** A cancer case for which the diagnosis is not microscopically confirmed.

**cluster.** An aggregation of cases of a disease or other health-related condition which are closely grouped in time and place.

**CoC.** Commission on Cancer of the American College of Surgeons.

**code.** Alphabetic and/or numeric characters representing information in a data set or report.

**colposcope.** A speculum for examining the vagina and cervix.

**comedocarcinoma.** A type of ductal breast carcinoma whose central cells are degenerated and easily expressed from the cut surface of the tumor.

**computerized axial tomography (CT or CAT).** A radiographic method of examining the body by creating an image from cross-sectional computerized "slices" of tissue. The computer calculates the degree of multiple x-ray beams that are not absorbed by all the tissue in its path and creates a computer image showing the geography and characteristics of tissue structures within solid organs.

**confidentiality.** The concept of maintaining the privacy of personal information obtained in the process of work.

**consultation.** Advice and counsel given about a patient by a physician who provides no treatment to that patient.

**contiguous.** Adjacent, touching, in contact with.

**contralateral.** Situated on or pertaining to the opposite side.

**core data set.** See required data set.

**cryosurgery.** Destruction of tissue by selective application of extreme cold.

**CTR.** Certified Tumor Registrar.

*-cyte, cyto-* Greek combining forms meaning pertaining to a cell.

**cytology.** The study of cells, their origin, structure, function, and pathology; the microscopic examination of cells obtained by aspirations, washings, scrapings, and smears.
Glossary of registry Terms

D


date of first recurrence. The point (month, day, and year) a cancer reappears after a disease-free interval.

date of initial diagnosis. The first time (month, day, year) that a recognized medical practitioner states that a patient has cancer, usually the date of first positive tissue specimen, although the first diagnosis can be clinical and may never be confirmed by histology.

date of last contact. The most recent point (month, day, and year) that a patient’s vital status is known.

death rate. The number of deaths occurring over a given period of time divided by the number of persons at risk of dying during the same time period; also called mortality rate.

debulking. The surgical removal of as much tumor as possible, with or without total removal of the primary tumor, so that adjuvant therapy will be more effective; also called cytoreductive surgery.

definitive treatment. See cancer-directed treatment.

demography. The study of populations, especially with reference to size and density, fertility, mortality, growth, age distribution, migration, and vital statistics, and the interaction of all these with social and economic conditions.

derm-. Greek combining form meaning pertaining to skin.

diagnosis (pl. diagnoses). The identification of the presence, nature, and extent of a disease.

diagnostic (or disease) index. A listing of diagnoses for patients diagnosed or treated during a given time period. The listing is arranged in diagnostic groupings according to a specific coding system. The index is a source for cancer casefinding.

differentiation. The degree to which a tumor resembles the normal tissue from which it arose; also called grade. Differentiation reflects the aggressiveness of the tumor.

direct extension. A term used in staging to indicate contiguous growth of tumor from the primary site into an adjacent organ or surrounding tissue.

direct visualization. Gross observation of a cancer mass usually made at the time of surgery or autopsy.

disease free. Absence of any detectable cancer (including recurrence over a specified period of time).

dissection. The act of cutting apart or separating tissue.

disseminated. Scattered; distributed over a considerable area; in registry terms, describes a tumor that has spread throughout the body. Some tumors, such as leukemias, are disseminated at diagnosis. Others become disseminated as the result of metastasis.

distant. A term describing stage of disease for a malignant neoplasm that has spread to parts of the body remote from the primary tumor either by direct extension (beyond immediately adjacent organs or tissues) or by discontinuous metastasis (e.g., implantation or seeding) to distant organs, tissues, or via the lymphatic system to distant lymph nodes. Stage of disease for all leukemias and multiple myelomas is distant.
**Glossary of Registry Terms**

**E**

-ectomy. Suffix meaning excision or cutting out of an organ or part.

*edit check.* Computerized comparison of data fields for logic and accuracy.

*en bloc resection.* The removal of organs in one piece at one time.

*endocrine surgery.* Removal of an endocrine gland to stop growth of a cancer in another organ, when the hormonal product of the endocrine gland is implicated in the growth of the tumor; e.g., orchiectomy performed for cancer of the prostate.

*endocrine therapy.* See hormone therapy.

*endoscopy.* The visual inspection of any body cavity with an endoscope, an instrument for the examination of the interior of a hollow organ.

*endothelium.* The layer of epithelial cells that lines the cavities of the heart, blood and lymph vessels, serous cavities, and wall linings of hollow organs.

*end results.* The evaluation of cancer treatment through the analysis of patient survival after treatment.

**EOD.** Extent of disease.

*excision.* The act of removing, as of an organ or tumor, by cutting.

*excisional biopsy.* Surgical removal of an entire small tumor, for whatever purpose; a biopsy, performed to identify the cell type of the tumor, that removes the entire tumor.

*exenteration.* Surgical removal of the inner organs; the term is commonly used to indicate radical excision of the contents of a body cavity, as of the pelvis.

*exfoliative cytology.* Microscopic examination of cells shed from a body surface as a means of detecting malignant change.

*extended data set.* See optional data set.

*extent of disease.* Detailed description of how far the disease has spread from the primary site of a cancer at the time of diagnosis.

**F**

*first course.* The initial planned course of treatment or therapy for a specific cancer. Such treatment is typically initiated within four months following diagnosis, but may be initiated later than four months post-diagnosis (e.g., consultation irradiation given after completion of chemotherapy).

*flag.* In registry and computer terms, a data field that indicates a special status; for example, an incomplete case or a data field requiring an override.

*flow cytometry.* A special diagnostic technique used for DNA analysis of a tumor. The information, called DNA ploidy value, has prognostic clinical significance for some tumors.

*focus (pl. foci).* The chief center of a morbid process.
**follow-up.** Continued surveillance of a patient at specified intervals (usually twelve months) for the remainder of the patient’s life following the initial diagnosis and treatment of a cancer. A documented contact with the patient, preferably through the attending physician, or through the spouse, a relative, or direct contact with the patient.

**FORDS.** *Facility Oncology Registry Data Standards* (from Vol. II, Standards of the Commission on Cancer, ACoS)

**frozen section.** A pathologic examination technique where part of a biopsy is quickly frozen, sliced thinly, and microscopically examined to determine the presence or absence of cancer cells. The technique is used for immediate diagnosis at the time of surgery so that, if indicated, more definitive surgical treatment can be completed at that time.

**fulguration.** Destruction of abnormal tissue by means of electric arc (indirect), or spark (direct), generated by high frequency current.

**G**

**glioma.** A tumor, usually associated with the brain, arising from the supporting structure of nervous tissue, including astrocytoma, oligodendroglioma, and ganglioglioma.

**grade.** The degree to which a tumor resembles the normal tissue from which it arose; also called differentiation. Grade reflects the aggressiveness of the tumor.

**gross anatomy.** That which deals with structures that can be distinguished with the unaided eye; also called macroscopic anatomy.

**gross observation.** Macroscopic examination; examination with the unaided eye; also called direct visualization.

**H**

**hematology.** The branch of medical science concerned with the study of the structure, functions, and disease of blood and blood-forming organs.

**hematopoietic.** Pertaining to the tissues that generate blood components, such as the bone marrow and stem cells.

**hepatic.** Pertaining to the liver.

**hermaphrodite.** An individual having the reproductive organs and many of the secondary sex characteristics of both sexes.

**histology.** The department of anatomy concerned with study of the minute structure, composition and function of the tissues; the microscopic structure of tissue.

**history of cancer.** The medical background for a patient who has been previously diagnosed with one or more cancers. The patient may or may not be disease free.

**homolateral.** Ipsilateral; same side.
**hormone therapy.** Cancer-directed treatment that interferes with the growth of cancer tissue by changing the hormonal balance of the patient. Hormone therapy may involve the use of hormones, antihormones, steroids, endocrine surgery, or endocrine radiation therapy.

**hyperbaric.** Characterized by greater than normal pressure or weight; for example, applied to oxygen under greater than normal atmospheric pressure.

**hypophysectomy.** Surgical removal of the hypophysis or pituitary gland.

**ICD-9.** International Classification of Diseases, Ninth Revision.

**ICD-9-CM.** International Classification of Diseases, Clinical Modification, 9th Revision, 4th Edition. This edition has been adapted for use in the United States. All codes are compatible with ICD-9.


**immunotherapy.** Cancer-directed treatment that boosts, directs, or restores the body's normal immune system and enhances the body's own ability to fight cancer. It is almost always used as an adjunct to surgery, radiation, and/or chemotherapy. Also called biologic response modifier therapy.

**incidence rates.** The number of new cases of a disease occurring in a period of time divided by the number of persons at risk of getting the disease during that time. The result is frequently multiplied by a base number such as 1,000 or 100,000.

**incision.** The act of cutting; a cut.

**incisional biopsy.** Surgical removal of a portion of a tumor performed to establish a diagnosis and the characteristics of the cancer.

**induration.** The quality of being hard; used to describe fibrous or connective tissue adjacent to the tumor and is to be interpreted as extension of the malignant growth.

**inpatient.** A hospital patient who is admitted for acute or critical care which is expected to require more than an overnight stay and whom the hospital classifies as an inpatient.

**in situ.** A term describing the behavior of a neoplasm which has all the characteristics of malignancy except invasion of neighboring tissues. It has not penetrated the basement membrane. A diagnosis of in situ behavior must be based on microscopic examination of tissue. Some synonyms are intraductal, intraepithelial, noninvasive, and noninfiltrating. Other terms meaning in situ are listed in Chapter 5 in the section for behavior.

**interferon.** Any of a family of agents with immuno-regulating effects and used to treat some types of cancer. Interferons are biological response modifiers.

**intracystic.** Within a cyst.

**intraductal.** Situated or occurring within the duct of a gland; in situ.
intraepithelial. Situated among the cells of the epithelium; in situ.

intrathecal injection. Injection of a substance into the cerebrospinal fluid surrounding the brain and spinal cord.

invasion. The infiltration and active destruction of tissue below the basement membrane, a characteristic of a malignant growth. (invasive adj.)

ipsilateral. Situated on or pertaining to the same side; homolateral.

J

JCAHO. Joint Commission on Accreditation of Healthcare Organizations.

K

L

laser surgery. Destruction of cancer tissue with a laser beam, most commonly used for vaginal or oral tumors.

laterality. Relationship to one side of the body or the other (left, right, both). Laterality is determined when the primary site is a paired site.

left-justified. A term describing characters in a data field when they are entered in the first space(s) to the left. Unused spaces at the right are left blank unless instructions specify otherwise.

lentigo maligna. A non-invasive melanotic freckle.

lentigo maligna melanoma. An invasive melanotic lesion.

lesion. Any pathological or traumatic discontinuity of tissue.

leukemia. A progressive, malignant disease of the blood-forming organs.

lobular neoplasm. A neoplasm resembling small lobes.

localized. A term describing stage of disease for an invasive malignant neoplasm that is confined entirely to the organ of origin.

lymphadenopathy. Disease of the lymph nodes, but not necessarily indicating tumor involvement.

lymph node. One of the accumulations of the lymphatic tissue organized as definite lymphatic organs, varying from 1 to 25 millimeters in diameter and situated along the course of lymphatic vessels.

lymphoma. Any neoplastic disorder of the lymphoid tissue. The term is often used alone to denote malignant lymphoma.
**Glossary of Registry Terms**

**macroscopic.** Visible to the unaided eye or without a microscope.

**macroscopic confirmation.** The process of supporting a diagnosis with evidence visible to the unaided eye.

**magnetic resonance imaging (MRI).** A diagnostic technique that uses an external magnetic field to visualize internal structures of the body by making it possible to distinguish between hydrogen atoms in different environments.

**malignant.** The tendency of a disease to become progressively worse and to result in death; having the properties of anaplasia, invasion, and metastasis; said of tumors.

**malignant melanoma.** A malignant neoplasm of melanocytes, usually developing from a nevus and consisting of black masses of cells with a marked tendency to metastasize.

**malignant tumor.** An uncontrolled, invasive growth capable of metastasizing (spreading to a distant part of the body). The opposite of benign tumor.

**master patient index.** The complete, alphabetized listing of every patient that has been accessioned into the registry since its reference date.

**medulloblastoma.** A radiosensitive tumor of undifferentiated neuroepithelial cells arising in the cerebellum.

**melanoma.** A tumor made up of melanin-pigmented cells (melanocytes). When used alone, the term refers to malignant melanoma.

**mesentery.** A membranous fold attaching organs to the body wall, most commonly used in reference to the fold attaching the small intestine to the dorsal body wall.

**mesocolon.** The section of peritoneum by which the colon is attached to the posterior abdominal wall. It is divided into ascending, transverse, descending, and sigmoid portions, according to the specific section of colon to which it gives attachment.

**metastasis (pl. metastases).** The transfer or spread of disease from the original site to another site not directly connected to it; the formation of a new foci of the disease. (v. metastasize. to spread.)

**metastatic.** Pertaining to the transfer (spread) of disease; spread to organs other than those listed in the regional areas; spread to other areas of the body; or spread to lymph nodes other than regional lymph nodes.

**micrometastasis.** Secondary tumors that are not visible to the unaided eye.

**microscopic confirmation.** The microscopic examination of tissue or cells removed from the site of a suspected cancer for the purpose of verifying a malignancy.

**morbidity rate.** An expression of the number of disease occurrences in a defined population during a specified interval of time.

**morphology.** The science concerned with the forms and structure of organisms; the form and structure of a particular organism, organ, or part.

**mortality rate.** An expression of the frequency of death occurring in a defined population during a specified interval of time.
**Glossary of registry Terms**

**multiple myeloma.** A primary **malignant neoplasm** of plasma cells usually arising in the bone marrow and associated with skeletal destruction resulting in **pathological fractures** and bone pain.

**myelodysplastic syndrome.** A unique preleukemic condition in which the bone marrow shows progressive deterioration in red blood cell production, platelet formation, and white blood cell maturation.

**myeloma.** A **tumor** composed of a type of cell normally found in bone marrow.

**N**

**NAACCR.** North American Association of Central Cancer Registries.

**National Center for Health Statistics.** The federal center for health statistics. It is one of the Centers for Disease Control and Prevention.

**NCI.** National Cancer Institute.

**necropsy.** The postmortem examination of a body; **autopsy**.

**neoadjuvant therapy.** Chemotherapy given prior to surgical **resection** or **radiation therapy** to reduce the bulk of a locally advanced primary cancer.

**neoplasm.** Any new and abnormal growth, such as a tumor. (**neoplastic** adj.)

**NIH.** National Institutes of Health.

**non-analytic case.** A **cancer case** that was diagnosed and received complete **first course** of treatment elsewhere prior to admission to the reporting facility, prior to the **cancer registry's reference date**, or diagnosed at **autopsy**. Such cases are generally not included in statistical reports of treatment and **survival**, but may be included in administrative reports.

**non cancer-directed treatment.** Treatment which prolongs the patient's life, alleviates pain, makes the patient comfortable, or prepares the patient for **cancer-directed treatment**. The treatment is not meant to destroy or control the tumor or delay the spread of disease.

**NOS.** Not otherwise specified.

**nuclear medicine.** The use of radioactive materials (isotopes) in **diagnosis** and **treatment** of disease; includes the application or internal use of radium, radioactive iodine, radioactive phosphorus, and radioactive gold, for example.

**numeric.** A term used to describe a data field that accepts numbers only.

**O**

-o-**ma.** Suffix meaning tumor or neoplasm; swelling.

**omentum.** A fold of the **peritoneum** extending from the stomach to adjacent organs in the abdominal cavity.

**oncology.** The study of tumors and cancers.

**oophorectomy.** The removal of an ovary or ovaries.
optional data set. Additional data items that may be collected as an extension of a required data set. These additional data items are optional and are not required for certification purposes by the ACoS; also called extended data set.

orchietomy. The removal of one or both testes.

organ of origin. Primary site of cancer.

-oscopy. Suffix meaning the act of examining or looking into an organ using an instrument called a scope.

osseous. Pertaining to bone.

-ostomy. Suffix meaning the surgical creation of an artificial opening into a hollow organ or a new opening between two such structures. The term “ostomy” is used alone when the opening is formed between two hollow organs or between one or more such organs and the abdominal wall for discharge of intestinal contents or of urine.

other cancer-directed treatment. Any cancer-directed treatment that is not appropriately assigned to the other specific treatment codes; includes any experimental or newly developed method of treatment differing greatly from accepted types of cancer therapy.

-otomy. Suffix meaning the operation of cutting, or incision.

outpatient. A hospital or clinic patient whose care and management is expected to require less than a one day stay and whom the hospital classifies as an “outpatient;” ambulatory (care) patient and short stay patient are terms for certain types of outpatients.

override. To indicate that an inconsistency (identified by edit check) between data elements has been reviewed and the information has been found to be correct.

P

paired site. Bilateral organs; two corresponding body parts on opposite sides of the midline.

palliative. An adjective used to describe medical care intended to relieve symptoms or make the patient more comfortable, but not cure. Some of the treatments termed palliative fall within the definition of cancer-directed treatment, but others are excluded because they treat the patient but not the cancer. If the distinction cannot be discerned in the medical record, a physician must interpret the purpose of the treatment.

papillary. Pertaining to or resembling a papilla or nipple.

Pap smear. A type of cytology examination used for the detection and diagnosis of malignant and premalignant conditions of the female genital tract; Papanicolaou smear or test.

parietal. Of or pertaining to the walls of a cavity.

parietal peritoneum. Peritoneum lining the abdominal and pelvic walls, including the undersurface of the diaphragm.

pathologic, pathological. Of or relating to pathology; relating to or caused by disease.
**pathology.** The branch of medicine concerned with the study of the nature of disease, its causes, processes, and development, as well as the structural and functional changes in tissues and organs of the body which cause or are caused by disease.

**peritoneal.** Pertaining to the serous membrane lining the abdominopelvic walls and enveloping the *viscera.*

**peritoneal fluid.** Fluid from the serous membrane lining the abdominopelvic walls and *viscera.*

**peritoneum.** The serous membrane lining the abdominopelvic walls and enveloping the *viscera*; see also *parietal peritoneum* and *visceral peritoneum.*

**pleura (pl. pleurae).** The serous membrane enveloping the lungs and lining the thoracic cavity, completely enclosing the *pleural cavity.*

**pleural cavity.** The potential space between the *parietal* and *visceral pleurae.*

**pleural fluid.** Fluid from the serous membrane enveloping the lungs and lining the thoracic cavity.

**precancerous.** Pertaining to a condition that tends to become *malignant.*

**prednisone.** An adrenocortical steroid which, when used as part of a chemotherapeutic regimen, is considered *hormone therapy* for certain types of *cancer.*

**primary site.** The organ or tissue where a *cancer* originates; where the cancer started in the body.

**primary site code.** A three digit code designated for the specific *anatomic site* of the primary *cancer.*

**Q**

**R**

**radiation.** Energy transmitted in the form of rays, waves, or particles; usually referring to electromagnetic radiation when used without a modifier.

**radiation therapy (radiotherapy).** The *treatment* of disease by roentgen rays or other radiant energy. Use of external beams or internal radioactive implants independently; or before, during, or after *surgery* to kill *tumor* cells. Examples include *beam,* seed, needle, and radioactive drugs.

**radiology.** The science of radiant energy (such as x-rays) and radioactive substances; the use of radiant energy in the *diagnosis* and *treatment* of disease.

**rate (incidence rate).** A measure of the frequency with which an event (e.g., death or disease) occurs in relation to a unit of population over a specified period of time.

**rectosigmoid.** The upper portion of the rectum and the lower portion of the sigmoid colon.

**recurrence.** The return of a *cancer* after a clinically disease free interval.

**reference date.** The starting date for a *cancer registry* after which all eligible *cases* must be entered into the registry. The date must be January 1 of a given year.
regional. A term describing stage of disease for a malignant neoplasm that 1) has extended beyond the limits of the organ of origin directly into surrounding organs or tissues, 2) involves regional lymph nodes by way of the lymphatic system, or 3) has both regional extension and involvement of regional lymph nodes, with no evidence of distant spread.

registrar. See cancer registrar.

registry. See cancer registry.

remission. Complete or partial disappearance of the signs and symptoms of disease; the period in which a disease is under control.

reportable list. A list developed by a cancer registry that identifies all diagnoses and types of cases that are to be included in the registry and those that are to be excluded. It must include malignancies with a behavior code (fifth digit) of 2 or higher.

required data set. Minimum required information established by a cancer registry to be collected for each cancer case; also called core data set.

resection. Excision of a portion or all of an organ or other structure.

retinoblastoma. A malignant tumor arising from retinal germ cells and appearing in one or both eyes, usually in children under 5 years of age; glioma of the retina.

rhabdomyosarcoma. A malignant soft-tissue tumor of muscle origin.

right-justified. A term describing characters in a data field when they are entered in the last space(s) to the right. Unused spaces preceding the string of characters are left blank unless instructions specify otherwise.

RMCDs. Rocky Mountain Cancer Data Systems.


S

salvage therapy. Treatment given after the failure of first course of therapy in order to prolong survival or to improve quality of life; a second attempt to cure the patient; see also subsequent treatment.

sarcoma. A malignant tumor of mesodermal origin. The mesoderm is the embryonic germ layer from which the supporting structures of the body (bone, muscle, connective tissue) are derived.

secondary site. The organ to which a malignant neoplasm has spread from a primary site; metastatic site.

SEER. Surveillance, Epidemiology, and End Results Program of the National Cancer Institute.

sentinel node. The first node to receive drainage from a primary tumor. It is identified by injection of dye or radio label at the site of the primary tumor.

sequence number. A number assigned to a case in a cancer registry that indicates the chronological order of all independent, primary malignancies diagnosed during the life of the patient, whether the tumors exist at the same or at different times.
sex-specific rate. An incidence or death rate calculated using data for one sex only.

simultaneous. Existing or occurring at the same time. Separate cancers are simultaneous if diagnosed within two months of each other.

site. The place, position or location; for cancer, the anatomic site where the malignancy occurs. See also primary site and secondary site.

site specific. Pertaining to a particular primary cancer; e.g., surgery codes are individualized to particular cancer sites (breast, colon, lung, etc.).

smear. A specimen for microscopic study prepared by spreading the material across a glass slide.

squamous cell. A flat, scalelike epithelial cell.

stage, stage of disease. A broad category which groups cases with similar prognoses based on how far the disease has spread from the site of origin at the time of diagnosis; e.g., in situ, localized, regional, or distant; or stage 0, I, II, III, or IV.

stem cell transplant. A type of bone marrow transplant in which stem cells (the immature cells from which all blood cells develop) are obtained from the bloodstream and then used to restore the bone marrow.

stereotactic technique (s. radiosurgery or surgery). Any of the techniques which use a system of three-dimensional coordinates to precisely locate the pathologic lesion or tumor to be removed or treated. The lesion is localized using precise images, usually made by computerized axial tomography or magnetic resonance imaging. The operative approach or irradiation is then directed by an apparatus called an arc guidance system.

subsequent treatment. Treatment administered after failure of the first course, due either to progression of the disease or lack of response to the initial treatment.

surgery. In cancer-directed treatment, an operative procedure to remove cancer tissue, even if the cancer tissue is known to be not entirely removed.

survival. The length of time a patient lives after some defined starting point; in cancer data management, the length of time after diagnosis of cancer.

T

teratoma. A true neoplasm made up of a number of different types of tissue, none of which is native to the area in which it occurs; most often found in the ovary or testis.

text. A term used to describe a data field that will accept any letter, number, symbol, or space; the narrative, descriptive information recorded in an abstract to justify the codes selected for the data items or to maintain information that is not coded at all.

therapy. The treatment of disease.

tissue specimen. Organs or tissue surgically removed for pathological examination and diagnosis.

TNM Staging. A cancer staging scheme developed by the American Joint Committee on Cancer that classifies primary tumor, regional lymph nodes, and distant metastasis.
topography. The name of an anatomic site or region.

transsexual. A person whose external anatomy has been changed to that of the opposite sex.

treatment. The management and care of a patient for the purpose of combating disease.

tumor. A swelling or mass; a new growth of tissue in which the multiplication of cells is uncontrolled and progressive; also called neoplasm. A tumor can be either benign or malignant.

tumor board (cancer conference). A meeting of medical professionals where the diagnosis and treatment of patients with cancer is discussed.

tumor marker. A substance in tissue or body fluids that can be measured quantitatively by biochemical or immunochemical means in order to detect a cancer and possibly the organ where it resides, to establish the extent of tumor burden before treatment, and to monitor the response to therapy.

tumor registrar. See cancer registrar.

tumor registry. See cancer registry.

U

V

validity. The degree to which a measurement actually measures or detects what it is supposed to measure; accuracy.

visceral peritoneum. The peritoneum reflected at various places over the viscera, forming a complete covering for the stomach, spleen, liver, ascending portion of the duodenum, jejunum, ileum, transverse colon, sigmoid flexure, upper end of rectum, uterus, and ovaries. It also partially covers the descending and transverse portions of the duodenum, the cecum, ascending and descending colon, the middle part of the rectum, the posterior wall of the bladder, and the upper portion of the vagina. The peritoneum serves to hold the viscera in position.

viscus (pl. viscera). Any large interior organ in any one of the three great cavities of the body, especially in the abdomen.

W

Wilms tumor. A rapidly developing malignant mixed tumor of the kidneys, made up of embryonal elements; also called nephroblastoma. It usually affects children before the fifth year, but may occur in the fetus and rarely in later life.

X

Y

Z