DATA COLLECTION MANUAL

MASSACHUSETTS CANCER REGISTRY

Abstracting and Coding Manual For Hospitals

Fifth Edition

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corresponding to NAACCR Data Exchange Record Layout Versions 10 and 10.1 for diagnoses made in 2003 and 2004

Version 10.1 edits for diagnoses made in 2004 will be added later.

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The manual will be posted electronically at www.state.ma.us/dph/bhsre/mcr/canreg.htm

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The information in the manual is largely compiled from previously published materials. It is not possible to provide specific citations within this manual each time a piece of information is derived from another source, so the MCR cites its main sources here.

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Extensive material is also used from the *Facility Oncology Registry Data Standards*, published in 2002 by the American College of Surgeons, Commission on Cancer ("*FORDS* Manual"), now updated as the *FORDS: Revised for 2004* Manual. The MCR has permission from the COC/AJCC Education and Training program to use *FORDS* Manual material with this citation. Jerri Linn Phillips, Andrew K. Stewart and Pat Tary were the original *FORDS* editors, and Mr. Stewart and Ms. Phillips were the editors of the 2004 version.

The National Institutes of Health, National Cancer Institute, Survival, Epidemiology and End Results program's *SEER Program Code Manual, Third Edition*, published in 1998 and updated several times since, is also a source of extensive material appearing in this manual. Its editors were April Fritz and Lynn Ries. Several other SEER publications and documents are also the source of important material -- see the **References** section on pages 4-7.

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Abbreviations Repeated in this Manual

ACoS	American College of Surgeons
AJCC	American Joint Committee on Cancer
aka	also known as
CDC	Centers for Disease Control and Prevention
CNS	Central Nervous System
COC	Commission on Cancer
CS	Collaborative Staging
DAM	COC's *Data Acquisition Manual*
DPH	Massachusetts Department of Public Health
Ed.	Edition
EOD	Extent of Disease (SEER coding system for stage)
FIN	Facility Identification Number
FORDS	COC's *Facility Oncology Registry Data Standards*
ICD-O-2	World Health Organization's *International Classification of Diseases for Oncology, Second Edition*
ICD-O-3	World Health Organization's *International Classification of Diseases for Oncology, Third Edition*
MCR	Massachusetts Cancer Registry
NAACCR	North American Association of Central Cancer Registries
NOS	not otherwise specified
NPCR	National Program of Cancer Registries
p., pp.	page, pages
ROADS	COC's *Registry Operations and Data Standards*
SEER	National Cancer Institute's Surveillance, Epidemiology and End Results program
TNM	staging system of the American Joint Committee on Cancer's *Cancer Staging Manual, Sixth Edition*
WHO	World Health Organization

PREFACE TO THE FIFTH EDITION

This edition of the Massachusetts Cancer Registry *Abstracting and Coding Manual for Hospitals* has had the title *Data Collection Manual* added to it. This is a revision of the Fourth Edition (published in 2001). It applies to cases diagnosed beginning in 2003 and corresponds, whenever possible, to the data standards for the North American Association of Central Cancer Registries' Data Exchange Record Layout Versions 10 and 10.1. Layout Versions 10 and 10.1 are physically identical with the exception of two Collaborative Staging fields added to 10.1. Material applicable to diagnoses made in 2004 have been incorporated to the extent possible, but Appendix E edits will need to be updated at a later date for 2004 diagnoses.

The Massachusetts Cancer Registry (MCR) strives for compatibility with coding and abstracting practices of the National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) program, the Centers for Disease Control and Prevention's National Program of Cancer Registries (CDC/NPCR), the North American Association of Central Cancer Registries (NAACCR) and the American College of Surgeons (ACoS), including the Commission on Cancer (COC) and American Joint Committee on Cancer (AJCC). Compatibility with these groups assures consistent coding and allows Massachusetts hospitals and the MCR to compare data with other states and the nation.

The Massachusetts Cancer Registry Cancer Information Management System (MCR-CIMS) has been revised to accommodate the 2003 changes in this manual. Vendors of reporting software have also been informed of these changes.

The codes in this edition are to be used for cases diagnosed beginning January 1, 2003. When abstracting and coding a case **diagnosed before 2003**, certain data fields will need to be coded **as they would have been at the time of diagnosis** (for example, some surgery codes). This manual cannot contain all the codes necessary from previous manuals, so please retain abstracting, coding and staging manuals from earlier diagnosis years for such cases.

If the Date of Diagnosis of a particular case is completely unknown, the year of diagnosis should be estimated and the case coded accordingly with the data standards of the estimated diagnosis year; if even the approximate year of diagnosis cannot be estimated, the case should be coded in accordance with the coding standards in place for the Date of First Contact. (For example, if your facility's first contact with a cancer patient is in September 2003 *and you cannot estimate the year of diagnosis* for the case, code the case as if the diagnosis occurred during 2003, i.e., with ICD-O-3 codes, Summary Stage 2000 and *FORDS* Manual treatment codes.)

The manual is formatted for use in a three-ring binder. As changes are made, updated replacement pages will be sent to all hospitals so that each copy of the manual will remain consistent with current abstracting and coding procedures. The manual posted on the MCR's website (www.state.ma.us/dph/bhsre/mcr/canreg.htm) will be kept updated.

The following is a summary of the **data fields that have been deleted, changed or added** since the previous edition of this manual:

Table I

Fields Deleted Since the Fourth Edition

These data fields are no longer collected by the MCR:

- Managing Physician Name
- Number of Regional Lymph Nodes Removed--At This Facility
- Number of Regional Lymph Nodes Removed--Summary
- Pediatric Stage
- Pediatric Staging System
- Radiation--At This Facility
- Radiation--Summary
- Reconstruction--First Course
- Type of Reporting Source
- Year First Seen for This Primary

Appendices B (paired sites, moved elsewhere) and H (pediatric stage, eliminated) are also deleted.

Fields Changed Since the Fourth Edition

Data Field	Comments
Facility Name (p. 37)	a few **name changes**
Facility Code (p. 37, Appendix G)	ACoS/COC **shortened codes**; some code changes.
Sequence Number -- Hospital (p. 39)	**new coding scheme**
Primary Payer at Diagnosis (p. 45)	some **code and category changes**
Date of First Contact (p. 46)	**rule** for Class 7 cases added
Birthplace, Place of Death (Appendix A)	a **new code** for a Canadian territory
Patient Name -- Suffix and Alias (p. 48, 50)	now **optional**
Address at Diagnosis (pp. 54-59)	street address **field lengthened** to conform with US Postal Service standards; new abbreviation for Newfoundland
Grade/Differentiation/ Immunophenotype (p. 100)	**new codes** for nuclear grades; new data **priority rules**; **COC rule** for coding Gleason 7 adopted
Class of Case (p. 111)	designation for **Class 7** cases added
Institution Referred From, Institution Referred To (pp. 114, 115)	ACoS/COC **codes shortened**; some new codes

Table I (cont.)

Data Field	Comments
EOD -- Tumor Size (p. 116)	**new rules** conforming to COC standards for 2003 diagnoses and Collaborative Staging for 2004 diagnoses
TNM fields (pp. 123-143)	**new timing rule and codes** from AJCC Sixth Edition staging
Regional Nodes Examined, Regional Nodes Positive (pp. 152-154)	**new rules** conforming to COC rules for 2003, and to Collaborative Staging rules for 2004; RN Positive **code changes**
Surgical Diagnostic and Staging Procedures (pp. 153-155)	**new name** for the fields that were called "diagnostic/ staging/palliative"; palliative bypasses moved into new field
Surgery of Primary Site, Scope of Regional Lymph Node Surgery, Surgery of Other Sites (Appendix D, pp. 177-186)	changes to some site-specific primary site surgery schemes and some **new codes**; RLN and Other Sites surgery **no longer site-specific**
Reason For No Primary Site Surgery (p. 181)	**name and rule changes**; a **new code**; now refers to only primary site surgery
Surgery of Primary Site, Scope of Regional Lymph Node Surgery, Surgery of Other Sites, 1998-2002 (pp. 187-188)	**new names** for *ROADS* surgery code fields, for diagnoses made before 2003
Chemotherapy, Hormone Therapy, Immunotherapy (pp. 195-204)	modality **fields lengthened**; **code changes**; **new date code** when treatment has not yet begun; dates **no longer edited;** transplants and endocrine surgery/radiation in new field
Appendix C (abbreviations)	more entries from NAACCR, AJCC, medical dictionaries
Fields Added Since the Fourth Edition	
Following Physician Name (p. 47)	**replaces** Managing Physician Name
Name -- Spouse/Parent (p. 76)	new **optional** item for the MCR to help us research addresses for patients who are difficult to find under their own names
Address at Diagnosis--Supplemental (p. 56)	new NAACCR item from US Postal Service standards
Current Address (p. 59)	**optional** and **not edited**
ICD-O-2 Conversion Flag (p. 99)	new administrative item for the MCR to help identify when ICD-O-2 codes were converted from ICD-O-3 codes
TNM Clinical/Pathologic Descriptors (pp. 127, 134)	new items for MCR for better interpretation of AJCC codes
CollaborativeStaging fields (pp. 162-167)	for 2004 diagnoses

Table I (cont.)

Data Field	Comments
Surgery of Primary Site, Scope of Regional Lymph Node Surgery, Surgery of Other Sites (pp. 177-181, Appendix D)	items for the *FORDS* surgery codes, for diagnoses made beginning in 2003
Date of Most Definitive Resection (p. 181)	date of most important primary site surgery
Radiation -- Regional Modality (p. 190)	partially replaces Radiation -- Summary and -- At This Facility
Systemic Treatment -- Date Started (p. 194)	new *FORDS* item covering overall start of systemic treatments
Hematologic Transplants & Endocrine Procedures (p. 205)	for procedures formerly recorded as Hormone Therapy and Immunotherapy
Palliative Care (pp. 210, 211)	new items; include some bypasses formerly coded as surgical diagnostic/staging/palliative procedures
First Recurrence -- Type and Date (p. 213)	new **optional** items to help identify those recurrences that must be counted as new primaries by central registries; **not edited**
Record Type, NAACCR Record Version (p. 218)	metadata fields to ensure that the MCR can verify the type of record received and its layout
Current Treatment Coding System, Original and Current COC Coding System, Original and Current Morphology Coding System (pp. 218-219)	administrative fields to ensure that the MCR can interpret codes received

The purpose of this manual is to establish common data standards governing the collection of cancer data by the MCR so as to ensure uniform reporting of statewide cancer information.

This manual is designed to be a working document that will change to reflect changes in coding and data standards. The MCR welcomes your questions, comments and suggestions for this manual. Please direct these to:

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SECTION I - INTRODUCTION

Introductory Note

The Massachusetts Cancer Registry (MCR) was established by legislation -- Massachusetts General Law Chapter 111, Section 111b -- in July 1980. This bill authorized the Commissioner of Public Health to establish a statewide cancer incidence registry and mandatory reporting system. After a planning and approval period of approximately two years, the MCR began operations on January 1, 1982.

The purpose of the MCR is twofold: first, the Registry is designed to provide public information and statistical analyses of cancer incidence in Massachusetts; second, it is designed to serve as a resource for epidemiologic investigations of cancer in Massachusetts. The design and structure of the registry were developed based upon the experience of several other population-based registries in North America and Europe.

In the fall of 1994, the MCR was awarded a grant from the CDC under the National Cancer Registries Amendment Act to expand both the data set collected and the existing reporting requirements to include not only hospitals, but all health care facilities and practitioners. As a result, the regulations governing cancer reporting in Massachusetts (105 CMR 301.000) were amended on March 24, 1995 to expand the collected data set. These regulations were then further revised to expand the definition of those required to report cancer cases to include non-hospital reporting sources on October 6, 1995.

The MCR *Data Collection Manual* (*Abstracting and Coding Manual for Hospitals*) is designed to provide hospitals with abstracting and coding procedures pertaining to those data items collected by the MCR. In no way does this manual imply any restriction on the type or scope of information collected at the hospital level. Many hospitals, particularly those with ACoS-approved cancer programs, will collect a much larger data set. Facilities may choose to accession cases that are not reportable to the MCR.

Confidentiality

As stated previously, Chapter 111, Section 111B of the Massachusetts General Laws established the Cancer Registry within the Massachusetts Department of Public Health to record cases of malignant disease in Massachusetts residents. The Cancer Registry Regulations (at 105 CMR 301.040) stipulate that the identity of individual patients whose cases are reported to the MCR are to be held in the strictest confidence. Information concerning a particular individual, and any other information maintained by the MCR which, because of name, identifying number, mark, or description, can be readily associated with a particular individual shall not be released to or discussed with anyone other than authorized personnel at the reporting facility, unless prior informed consent is received from the patient or his/her guardian or legal representative.

Massachusetts General Law does provide [at 105 CMR 301.040(E)] for the release of MCR data by the Commissioner of Public Health, for research and statistical purposes, to the authorized representative of a study or research project sanctioned by the Commissioner under strict conditions guaranteed to maintain confidentiality. The Cancer Registry Regulations specifically prohibit the release of Social Security Number. The MCR also maintains confidentiality policies and procedures to protect information that could be used to identify data concerning a specific facility or physician.

Casefinding

Casefinding is the process of identifying reportable cases. It involves careful monitoring of records maintained by the departments that usually deal with cancer patients at your facility. Primary sources for case identification include these records:

- pathology reports (histology, cytology, hematology, bone marrow, autopsy findings)
- disease indexes
- daily discharges
- outpatient records
- radiation therapy records
- oncology clinic records

At a minimum, the following should also be considered as additional sources for casefinding:

- surgery reports
- nuclear medicine logs and radiology logs (including logs of scans)

General Reporting Requirements

Hospitals must report all cancer cases diagnosed on or after January 1, 1982, whether first seen at your facility <u>with evidence of cancer</u> or for <u>treatment/palliative care</u>. Cases diagnosed first at autopsy should also be reported. A report is required regardless of whether or not the patient was diagnosed elsewhere previously. A report is <u>not</u> required if the patient was first seen at the reporting hospital for a cancer case prior to 1982 and is later admitted again for that cancer. Do not report recurrences except as specified by the MCR. Massachusetts residents and non-residents (including residents of foreign countries) are to be reported.

Analytic cases (Class 0, 1 and 2) are reportable for all diagnosis years beginning in 1982. Nonanalytic cases of Class 3, 4 and 9 *diagnosed during 1995 and thereafter* should be reported. Cases of Class 3, 4 and 9 *diagnosed before 1995* should <u>not</u> be reported so that MCR tumor counts can remain consistent with changes in reporting requirements necessitated by our becoming a CDC/NPCR registry. (Nonanalytic cases of Class 5 -- autopsy-only cases -- are reportable for any diagnosis year 1982 and later.) Reporting cases of Class 6 and 7 to the MCR is <u>optional</u>; if a Class 6 case was *diagnosed before 1996*, it should <u>not</u> be reported; Class 7 cases *diagnosed before 2003* need not be reported. Classes 6 and 7 were not clearly defined before 1996 and 2003, respectively.

Cases must be reported to the MCR within 180 days (six months) of the Date of Diagnosis for cases of Class 0, 1, 5 and 7. Cases of Class 2, 3, 4, 6 and 9 must be reported to the MCR within 180 days of your facility's Date of First Contact with the patient. [For example, if a patient was diagnosed October 1, 2002 but *your* facility had no contact with the patient until January 1, 2004 and the case is of Class 3 to you, then you are required to report the case to the MCR by July 1, 2004. See Question 5435 (November 2001) on the AJCC's I&R website for the COC's expectation of Class 2 cases being abstracted within six months of Date of First Contact.] MCR timely reporting requirements may be relaxed during national periods of conversion to record layouts and standard codes. The MCR communicates any deviations from the 180-day requirements to data reporters and software vendors at such times. The 180-day requirement is in effect unless otherwise specified by the MCR.

Please see the **REPORTABILITY** section for extensive details of reporting requirements.

Reporting Methods: Media and Formats

Cases should be reported to the MCR on floppy diskette (3.5-inch, IBM-formatted) or compact diskette in NAACCR Data Exchange Record Layout Version 10 or 10.1. If this is impossible, cases may be reported at this time on paper MCR Cancer Patient Abstracts, available from the MCR (telephone 617-988-3373). Paper submissions to the MCR must be printed legibly or typed. The MCR cannot at this time support the electronic transmission (for example, via the internet or electronic mail) of confidential public health data. The MCR provides a free Microsoft Access diskette reporting system (CIMS Satellite) upon request.

For facilities employing the services of a software vendor for reporting cases, it is the *hospital's* responsibility to work with that vendor to ensure that the proper data fields are received at the MCR in the proper format. The MCR does not have contracts with software vendors and therefore cannot be involved in arrangements with them. This is the hospital's responsibility.

Changes to Previously Submitted Cases

With the passage of time, a patient's medical record becomes more complete with regard to information initially missing or uncertain. It is therefore established practice to accept the thinking and information about the case at the time of the latest submission, or the most complete or detailed information. Thus, there may be changes in the coding of primary site, histology, stage (at diagnosis), etc., as the information becomes more certain. The patient's birthdate, Social Security Number, or the spelling of his/her name might also be changed on your data system. The MCR must be made aware of such changes.

There may also be cases reported which later information indicates never were reportable diagnoses. The MCR must be notified so that these cases can be deleted from our system.

You should call the MCR at 617-988-3382 or 617-988-3381 and report a change/delete over the telephone. Have the patient's identifiers ready. Be sure to speak directly to a registrar or leave a message that you'd like to be called back. Do not leave patient information on the MCR voice-mail system. The MCR cannot yet process electronic change forms ("M"-type records) except for identifying reportable recurrences, but we plan to develop a procedure for handling routine electronic change forms in the future.

References

In addition to this manual, a hospital registry should have the following references for coding [asterisks (*) mark materials used for 2003 and 2004 diagnoses]. Most of these materials are sources of the information contained in this MCR manual:

* *International Classification of Diseases for Oncology, Third Ed.* (World Health Organization, 2000; errata published May 2001 and May 2003, http://seer.cancer.gov/icd-o-3/errata.d05222001.pdf, http://seer.cancer.gov/icd-o-3/errata.d05062003.pdf) -- The "ICD-O-3" (purple) manual contains internationally recognized codes for different types of cancer and sites in the body where they occur. This edition is used for cases diagnosed beginning in 2001. The softcover version (subtitled *US Interim Version 2000*) differs slightly from the hardcover. Be sure that your copy (hard or soft) is kept updated.

- *International Classification of Diseases for Oncology, Second Ed.* (World Health Organization, 1990) -- The "ICD-O-2" (green) manual is used for cases diagnosed between 1992 and 2000. After its publication, a few histology codes (see *SEER Program Code Manual, 3rd Ed.*, pp. 98-99) and a grade/cell origin code (8) were added to the ICD-O-2 codes, and a topography code (C14.1) was deleted. Be sure that your copy was kept updated. (The MCR began accepting ICD-O-2 codes early -- for 1991 diagnoses -- because hospitals had already switched to ICD-O-2 by the time 1991 cases were being reported to us.)

- *International Classification of Diseases for Oncology, First Ed.* (World Health Organization, 1976) -- "ICD-O" or "ICD-O-1" is used to code cases diagnosed before 1992. (Field trial editions of ICD-O-2 published 1986 - 1988 may be used for coding diagnoses between these years and 1991.)

* *Clarifications for Abstracting and Coding Hematopoietic Diseases* (SEER Program, National Cancer Institute, 2001) - These brief notes provide guidance for handling ICD-O-3 hematopoietic diseases and some other ICD-O-3 rules and issues. They are at http://seer.cancer.gov/icd-o-3/hematopoietic_clarifications.d05222001.pdf .

* *Abstracting and Coding Guide for the Hematopoietic Diseases* (SEER Program, *National* Cancer Institute, 2002) - This orange booklet is valuable for identifying and abstracting the "new" ICD-O-3 blood and bone marrow diseases. It's available from the MCR or SEER (Publication # 02-5146).

* *Coding Complex Morphologic Diagnoses* (SEER Program, National Cancer Institute, last revised August 2002) - This document provides detailed rules and guidance for assigning the most proper ICD-O-3 morphology codes when there are multiple histologies and/or terms reported for a single tumor. There is also limited guidance for using combination codes for multiple tumors being counted as one primary. It's at http://seer.cancer.gov/icd-o-3/complex.histologies.2002.rev10-02.pdf.

* *SEER Summary Staging Manual 2000: Codes and Coding Instructions* (National Cancer Institute, 2001) -- This (red) book defines SEER Summary Stages and codes for diagnoses made beginning in 2001. The manual appears on the SEER website at http://seer.cancer.gov/tools/ssm/ . Electronic versions of this book posted on the SEER website *before June 18, 2001* differ slightly from the final (hard-copy) version. Errata were published June 2001, May 2002 and August 2002 (August includes the May revisions), and these are posted in the same area on the SEER website.

- *Summary Staging Guide for the Cancer Surveillance, Epidemiology and End Results Reporting (SEER) Program* (National Institutes of Health, 1977, last Revision 7/86) -- This staging guide defines SEER Summary Stages for diagnoses made between 1977 and 2000. The same material can be found in the SEER *Self Instructional Manual for Tumor Registrars: Book 6*. This may now be referred to as "SEER Summary Staging Guide 1977". Note that changes in SEER Extent of Disease coding caused changes in Summary Stage results over the years, but this book was not updated after 1986.

* *AJCC Cancer Staging Manual, Sixth Ed.* (American Joint Committee on Cancer/Springer-Verlag, 2002) - This manual (portions also published in smaller format as *AJCC Cancer Staging Handbook*) contains definitions and explanations for assigning TNM stages to cases diagnosed beginning in 2003. Clarifications originally issued in April 2003 are available (dated July 16, 2003) at http://www.cancerstaging.net/ under "Coding Updates and Clarifications". Springer-Verlag provided a few replacement pages for the Manual and Handbook at the end of June 2003. [The Fifth Edition should be used to stage cases diagnosed between 1998 and 2002. The Fourth Ed. (called *Manual for Staging of Cancer*) should be used to stage cases diagnosed between 1993 and 1997; the Third Ed. is for staging cases diagnosed 1989-1992; the Second Ed. is for cases diagnosed 1984-1988; the First Ed. is for cases diagnosed before 1988.] The publisher and AJCC wish this publication to be cited as "Greene F.L., Page D.L., Fleming I.D., et al. *AJCC Cancer Staging Manual, Sixth Edition*. New York: Springer-Verlag, 2002".

* *Collaborative Staging Manual and Coding Instructions, version 1.0*, Collaborative Staging Task Force of the American Joint Committee on Cancer [published by the AJCC (Chicago) and the US Dept. of Health and Human Services (Bethesda), 2003] - This manual for understanding and coding in the Collaborative Staging system is available in two parts at http://www.cancerstaging.org/collab.html. It applies to diagnoses made beginning in 2004. Updates (denoted by different version numbers) are expected.

* *Self Instructional Manual for Tumor Registrars, Book 8, Antineoplastic Drugs, Third Ed.* (SEER Program, National Institutes of Health, 1993) - *Book 8* is THE standard source for coding drugs used in cancer treatment. All standard-setters refer to this manual. Changes were made in May 2000, and additions made in May 2002 were slightly updated in June 2003: http://seer.cancer.gov/tools/SEER.Book8.Addenda.pdf.

The following references can be very helpful when abstracting and coding cases.

- *Self Instructional Manuals for Tumor Registrars* (SEER Program, National Institutes of Health)
  Book 1. *Objectives and Functions of a Tumor Registry* (1999)
  Book 2. *Cancer Characteristics and Selection of Cases* (1991)
  Book 3. *Tumor Registrar Vocabulary - The Composition of Medical Terms* (1992)
  Book 4. *Human Anatomy as Related to Tumor Function* (1995)
  Book 5. *Abstracting a Medical Record: Patient Identification, History and Examinations* (1993)
  Book 6. *Classification for Extent of Disease (Summary Staging Guide)* (1977)
  Book 7. *Statistics and Epidemiology for Cancer Registries* (1994)
  Book 8. *Antineoplastic Drugs* (1993) -- noted above

* *Facility Oncology Registry Data Standards* and *Facility Oncology Registry Data Standards: Revised for 2004 (FORDS)*. (American College of Surgeons, 2002) Numerous revisions were issued between August 2002 and March 2003, and then again in December 2003. The manual posted at http://www.facs.org/cancer/coc/fordsmanual.html is, in general, kept up to date and it contains (in its Appendix C) all revisions made between publication and December 2003. This manual contains field definitions and codes recommended for use in hospitals with ACoS approved cancer programs. It applies to diagnoses made in 2003 and 2004. Try to keep your copy updated.

- *Standards of the Commission on Cancer Volume II: Registry Operations and Data Standards (ROADS).* (American College of Surgeons, 1996, *Supplement* issued 1997; revisions dated January 1998, March 2000, August 2000, January 2002) -- The precursor to *FORDS* and the successor to the *Data Acquisition Manual* (DAM), ROADS applies to cases diagnosed between 1997 and 2002.

* *Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Seventh Ed.* (North American Association of Central Cancer Registries, 2002; important changes to this book dated January 2003 can be found at http://www.naaccr.org/index.asp?Col_SectionKey=7&Col_ContentID=133 -- This book describes the data fields and codes accepted in the NAACCR data exchange record layout Version 10 (2003). It is useful for understanding why certain codes fail edits, which data fields are required (or only recommended) by different groups, how the coding of some fields has changed, and on which data items the standard-setting organizations still disagree. The *Eighth Ed*. covers Version 10.1 for 2004 and was published in 2003; updates are dated November 2003 at the site listed above.

* *The SEER Program Code Manual, Third Ed*. (SEER Program, National Institutes of Health, 1998). This book provides the data standards for recording cancer cases for SEER registries. It applies to diagnoses made beginning in 1988. It has been updated several times, notably in January 2003 ("Revision 1"). The book is at http://seer.cancer.gov/tools/codingmanuals/ and Revision 1 updates for 2003 diagnoses are at http://seer.cancer.gov/tools/ . 2004 revisions have not yet been posted.
* *SEER Extent of Disease -- 1988, Codes and Coding Instructions, Third Ed*. (SEER Program, National Institutes of Health, 1998; updates issued several times). This book provides the codes and instructions for recording staging data in the SEER EOD system. The book and updates are at http://seer.cancer.gov/tools/codingmanuals/.
* *NAACCR 2003 Implementation Work Group: Guidelines and Recommendations* (January 2003) and *NAACCR 2004 Implementation Guidelines: Collaborative Staging and Benign/Borderline Intracranial and CNS Tumors* (North American Association of Central Cancer Registries, November 2003) - These detailed documents describe code conversions, data collection practices and software changes needed by hospital registries, central registries and software vendors when transitioning to reporting in NAACCR Versions 10 and 10.1, including the handling of "legacy" data. They are available at http://www.naaccr.org/index.asp?Col_SectionKey=7&Col_ContentID=122.

If you are missing and unable to locate important reference manuals or their errata, clarifications and updates, the MCR will try to assist you. SEER hard-copy publications are free or available from the SEER Program with a small shipping fee.

Abstracting Requirements for Nonanalytic Cases & Reportable Recurrences

Nonanalytic Cases

Although the ACoS does not require hospitals to abstract nonanalytic cases, population-based cancer registries like the MCR must record all cases regardless of place of diagnosis or Class of Case. The MCR therefore requires that nonanalytic cases (of Classes 3, 4, 5 and 9) be abstracted and submitted to the MCR. Reporting cases of Class 7 (also nonanalytic) and Class 6 (*now* nonanalytic) is optional; *if* your facility collects Class 6 or Class 7 cases, you should report them to us.

Reporting requirements for cases included in Classes 3, 4, 6, 7 and 9 are less stringent than those for other cases. The reporting hospital's medical record often does not contain all the required data, or contains only second-hand data. Report any information included in the medical record. It is not necessary to obtain *missing* information, although you may choose to do so. It is not necessary to obtain any information on staging or First Course of Treatment.

Although a complete abstract with narratives is not required, certain data items must be specified in order for the case to be processed:

- Reporting Facility Code
- Medical Record Number or Accession Number
- Patient Name (Last, First, Middle)
- Address (preferably at the time of diagnosis; otherwise, for the current admission)
- Birth Date
- Age at Diagnosis
- Social Security Number
- Sex
- Race Codes
- Primary Site Code
- Laterality
- Histology/Behavior/Grade Codes (not Grade for MCR-reportable recurrences)
- Date of Diagnosis
- Sequence Number--Hospital
- Date of Last Contact

Please try to provide good information for the data fields listed above. Even though information for many collected fields might not be available, all of the coded fields must be filled in (i.e., not left empty except as noted in this manual). When necessary, use the (default) entries and codes for UNKNOWN, NONE, NOT DONE or NOT APPLICABLE or let your data system generate these default codes.

Reportable Recurrences

Central population-based registries like the MCR are required to count certain recurrences as new primaries -- whenever an *in-situ* tumor diagnosed since 1995 recurs invasively after more than two months. Previously the MCR has required separate case reports for the original diagnosis and the recurrence. The COC, NPCR and other groups have worked together to try to make it easier for hospitals to report these recurrences to their central registries (for example, the COC changed its sequencing specifications and recurrence codes). No other kinds of recurrence are reportable to the MCR. We know of NO exceptions to the *in situ*-followed-by-invasive rule; for example, if diagnosed after two months, an invasive recurrence of a non-invasive transitional cell carcinoma of the bladder is MCR-reportable, as is invasive prostate carcinoma after PIN or invasive cervical carcinoma after cervical carcinoma *in situ*.

Users of the CIMS-Satellite data system must submit abstracts for both the original *in-situ* case AND the MCR-reportable invasive recurrence. They cannot at this time retrieve an already completed case and simply fill in the First Recurrence fields. Satellite users must report both cases separately, regardless of how quickly (after the two-month time period) the invasive recurrence occurs.

All other reporting facilities (those not using CIMS-Satellite) now have two options for reporting these recurrences to us. Choose only one of these reporting methods:

Option 1:

Continue to report both the original case and recurrence as separate primaries just as you have done before. (If your facility had no contact with the patient until the recurrence, you need only report the recurrence to us. If we have received no report from anyone about the original case, we may contact you for further information.)

Use the date on which the recurrence was diagnosed as the Date of Diagnosis. This then determines the time for all other at-diagnosis information (like age, address, etc.).

Use the original Primary Site where the *in-situ* case occurred with the recurrence's invasive (/3) morphology. The recurrence's Grade/Differentiation is not applicable.

Sequence the recurrence in the 60-88 range so that it is distinguishable from your COC-reportable cases (see Sequence Number--Hospital, pages 39-44).

Please report what you know about the recurrent case. You are not required to try and find information that is missing from your data system and medical records. Rely on the appropriate default entries for unknown/not applicable/none in the staging fields, treatment fields and other fields that you cannot specify. As a guide, refer to the list of specified fields needed for nonanalytic cases (page 8). The MCR will contact you if we need further clarification about the patient, the original case, or the recurrence.

Option 2:

Use the First Type of Recurrence fields (Type of First Recurrence and Date of First Recurrence, page 213).

Abstract the original *in-situ* case, and fill in the two First Type of Recurrence fields.

If the original *in-situ* case has been sent to the MCR when you fill in the Recurrence fields, be sure that your system recognizes that it needs to re-send us that record. (It may send it flagged as a "M"-type NAACCR record.) We will relate that record to the *in-situ* tumor on our system and change it into a new primary. We may need further information. The GenEDITS Lite system has trouble with "M" records at this time.

If the disease recurred quickly enough after the two-month period, you may not yet have reported the original *in-situ* case to us. Probably, when the *in-situ* case is exported for us, we'll find the Recurrence fields filled in. We will then create an abstract for a new primary at the MCR. Again, we may need more information.

If the *in-situ* case was diagnosed and treated at Facility A (in Massachusetts) and your hospital had no patient contact until the recurrence, please abstract the original case as best you can so that the Recurrence fields can be filled under Option 2. In fact the case may appear Class 3 to your facility and you may not know that the original case was *in situ*. If the *in-situ* case has been reported to us by Facility A, we will need just enough information to link your record to the original. If the original case has not been sent to us, we will need to determine if it was reportable to us at diagnosis; if it was not, then only the recurrence needs to be counted by the MCR. The MCR will have to determine when certain Class 3 reports are actually MCR-reportable recurrences.

Examples:

A patient has an *in-situ* breast cancer diagnosed and excised in April at your facility. She is then clinically free of disease. In October she is diagnosed at your facility with an invasive cancer in the same breast that has the same histology as the *in-situ* case. The physician calls this a recurrence rather than new disease. You may send the MCR two case abstracts (if you've chosen Option 1) or fill in the correct codes in the Recurrence fields in the *in-situ* case record (if you're using Option 2) and re-transmit it if it's already been sent to us.

A patient is diagnosed at your facility with an invasive cervical cancer in 2003. The medical record indicates that this is a recurrence (not just progression) of CIN III or an *in-situ* cervical cancer from two years earlier. CIN III and CIS of the cervix are not reportable to the MCR for diagnoses made in 2001, but the 2003 recurrence is reportable to us. Send an abstract record for just the recurrence (Option 1) or abstract the non-invasive 2001 case and fill in the two Recurrence fields (Option 2). (If your facility collects CIN III or CIS of the cervix on its own, you should just need to fill in the Recurrence codes for Option 2; but your software will need to recognize that a normally non-reportable case needs to be exported for the MCR because of the Recurrence codes.)

A patient is diagnosed with non-invasive transitional cell carcinoma of the bladder and this is reported to the MCR. A year later he is diagnosed with recurrent TCC of the bladder that is now invasive. There is no "bladder exception" for central registries following the NPCR recurrence rules, so <u>both</u> of these cases are MCR-reportable. Send a second record as if the recurrence were a new primary (Option 1), or fill in the Recurrence fields on the non-invasive record so that it can be re-sent to us (Option 2).

As has been repeated many times, the MCR may need further information from you whenever you report a recurrence to us. The more information you can send us in narratives, the less we will have to bother you later. The MCR is surveying facilities to see what your plans are for recurrence reporting so that we'll know what to expect. We need to be kept informed (617-988-3373) if you want to switch recurrence reporting Options.

Determining Reportability

The following supercedes any previous MCR reportability rules appearing in our manuals. These rules attempt to cover ALL years of case reportability to the MCR, but most specifically refer to diagnoses made in 2003 and 2004. If there are changes needed in these rules in the future, notification will be sent to reporting facilities and software vendors and replacement pages will be issued for this manual.

The MCR requires reporting facilities to submit all cases seen at that facility with neoplasms classified as invasive or *in situ* in the "Morphology of Neoplasms" section of ICD-O-3* (for cases diagnosed in 2001 and thereafter), ICD-O-2 (for diagnoses made between 1992 and 2000), or ICD-O[-1] (for 1982-1991 diagnoses). (This MCR Manual applies to diagnoses made beginning in 2003, so only ICD-O-3 codes appear here.) If you've changed a listed behavior in an ICD-O book to /**2** or /**3**, that case is also reportable (the "matrix" rule, ICD-O-3 Rule F). The only exceptions to these /**2** and /**3** reportability rules are the site/morphology combinations that follow:

morphology	
8000-8005	malignant neoplasms, NOS, of the skin (C44.0-C44.9)
8010-8046	epithelial carcinomas of the skin (C44.0-C44.9)
8050-8084	papillary and squamous cell carcinomas of the skin (C44.0-C44.9)
8090-8110	basal cell carcinomas of the skin (C44.0-C44.9)

Note: The above morphologies of *any* non-C44 primary site will be reportable to the MCR as of January 1, 2004. For diagnoses made before 2004 SEER phrasing pointed out that these cancers were reportable for skin of the genital sites, and some interpreted this as meaning that they were *only* reportable for these sites.

The MCR requires reporting of all cases with ICD-O behavior codes /**0**, /**1**, /**2** or /**3** of the meninges, brain and central nervous system (C70.0-C72.9) for all diagnosis years beginning in 1982. (There are new data standards for these cases beginning with diagnoses made in 2004.) Remember that non-malignant (/0, /1) diseases must have an ICD-O code to be reportable.

For primary sites C75.1-C75.3 (pituitary and pineal glands and craniopharyngeal duct), only report cases with invasive or *in situ* behavior (/**3**, /**2**) to the MCR when diagnosed before 2004. All ICD-O-3 behaviors (/**0**, /**1**, /**2** or /**3**) for these sites will be required when diagnosed beginning in 2004.

* Pilocytic astrocytomas, although appearing in ICD-O-3 as borderline malignancies, are to be coded with /**3** behavior in North America and are therefore reportable.

Beginning with cases diagnosed in 1998, the MCR no longer requires reporting facilities to submit cases of carcinoma *in situ* (CIS) of the uterine cervix (primary site C53._ with histologic type codes 8000-8110 and behavior /**2**). This includes cervical intraepithelial neoplasia, Grade III (CIN III, histology 8077/2), pre-invasive cervical neoplasia, and squamous intraepithelial neoplasia. Invasive carcinomas of the cervix (behavior /**3**) are reportable and must not be overlooked in casefinding. Prostatic intraepithelial neoplasia, Grade III (PIN, histology 8148/2) also became non-reportable to the MCR for diagnoses made beginning in 1998. Please note that SEER has recently clarified the concept of non-reportable CIS of the cervix, now excluding *all* histologies of the cervix with behavior /**2** from reportability (rather than just the simple carcinoma histology range, 8000-8110). This was apparently always SEER's intent so you may begin observing this rule at any time from the present. That is, only invasive cancers of the uterine cervix (behavior /**3** with primary site C53._) are now reportable to the MCR for diagnoses made beginning in 1998.

For diagnoses made between 1998 and 2003 the MCR does not require cases of anal, vaginal or vulvar intraepithelial neoplasia, Grade III (AIN, VAIN, VIN, histology 8077/2) because of uncertainty in the narrative descriptions of these diagnoses. (This "Grade III" does not refer to the histopathologic grade/differentiation; it refers to the highest category of dysplasia in the Bethesda system for non-invasive lesions.) These /**2** terms appear in ICD-O-3 and are reportable to the CDC/NPCR. Therefore the MCR is requiring AIN III, VAIN III and VIN III diagnosed beginning in 2004.

Summary of 2003 Reporting Differences Between the MCR and the COC

For diagnoses made in 2003 and 2004 the following differences in reportability exist between the COC and the MCR. (These are the COC reportability rules as the MCR understands them as of December 2003. Always consult COC materials directly if you have questions about what is COC-reportable.) All facilities in Massachusetts are required to report MCR-reportable cases to the central registry regardless of their reportability status from the COC's point of view. The COC does not determine what is reportable to the MCR. If you have any questions about MCR reportability consult David Rousseau, MCR Quality Assurance Supervisor, at 617-988-3382.

- Non-analytic cases of Class 3, 4, 5 and 9 are MCR-reportable but not COC-reportable.
- Brain and other CNS primary sites with any behavior are MCR-reportable; only those with *in situ* or invasive behavior are COC-reportable (until diagnoses made in 2004).
- Invasive recurrence of a disease that was originally *in situ*, diagnosed at least two months after the original diagnosis, is MCR-reportable but not COC-reportable.
- Cases in which the patient receives only transient treatment while temporarily in Massachusetts are MCR-reportable but not COC-reportable.
- Non-analytic cases of Class 6 and 7 are MCR-optional and not COC-required. You may include these in your regular MCR data submissions.

All other types of diagnosis and case that are COC-reportable are also MCR-reportable for diagnoses made in 2003. For diagnoses made in 2004:

- AIN III, VAIN III and VIN III are MCR-reportable beginning with diagnoses made in 2004 but are not COC-reportable.
- Pituitary and pineal glands and craniopharyngeal duct are added to those brain and other CNS sites reportable to the MCR with any ICD-O-3 behavior when diagnosed beginning in 2004. These will also be NPCR- and COC-reportable for 2004 diagnoses.
- Basal and squamous cell carcinomas of any primary site except C44 skin sites are MCR-reportable for diagnoses made as of January 1, 2004. These are also reportable to the COC (beginning with 2003 diagnoses) and the NPCR.

Definition of a Cancer Diagnosis

A patient is considered to have a reportable diagnosis if the diagnosis is made by a recognized medical practitioner, even if it is never pathologically confirmed. Usually the patient's medical record clearly presents a cancer diagnosis through specific terms synonymous with cancer. The physician, however, may not always be certain, nor the recorded language definitive. Tumor descriptions may be vague or ambiguous.

The lists on p. 14 should be used as a guide in determining reportability. Not every possible form of these terms can be listed, so consider variants of these terms to also be included. (For example, "apparent malignancy" does not specifically appear in the "Diagnostic of Cancer" list, but it is considered to be included as a variant of "apparently malignant".) A *positive pathology report* takes precedence over any other information as evidence of malignancy.

Only MCR-reportable diagnoses are considered here, so a malignancy like basal cell carcinoma in leg skin diagnosed via one of the "diagnostic" terms does not make the case reportable to the MCR. There are not special lists of diagnostic terms for mammography reports, so apply the lists on page 14 to all situations (except as noted).

For diagnoses made beginning in 2004, these lists of "malignant" terms are being extended to indicate the diagnosis of intracranial/CNS non-malignancies (C70.0-C72.9, C75.1-C75.3 with behaviors /0, /1) and two terms have been added that ONLY apply to such cases. (For example, "apparently a benign brain tumor" constitutes a reportable 2004 diagnosis, as does "brain neoplasm").

Diagnostic of Cancer

A case of cancer has been diagnosed if any of the following terms is used:

- apparently malignant
- appears malignant
- comparable with malignancy
- compatible with malignancy
- consistent with malignancy
- favors malignancy
- malignant appearing
- most likely malignant
- neoplasm *
- presumed malignant
- probable malignancy
- suspect(ed) malignancy
- suspicious of/for malignancy **
- tumor *
- typical of/for malignancy

Not Diagnostic of Cancer

A case is not reportable and a cancer diagnosis has not been made if any of the following terms is used (in the absence of more definitive terminology or better information):

- equivocal (for) malignancy
- malignancy cannot be ruled out
- possible malignancy
- potentially malignant
- questionable malignancy
- rules out malignancy
- suggests malignancy
- worrisome

* This term is considered sufficient for a reportable cancer diagnosis **ONLY** for **non-malignant** tumors of the meninges, brain, other CNS, pituitary gland, craniopharyngeal duct and pineal gland **diagnosed beginning in 2004** (primary site codes **C70.0-C72.9** and **C75.1-C75.3** with behavior codes /**0** and /**1**). "Neoplasm, NOS" and "tumor, NOS" appear in ICD-O-3 as 8000/1. For non-malignant brain/CNS/intracranial tumors diagnosed before 2004, for malignancies (behavior codes /**2** and /**3**) of any of these primary sites, and for all other primary sites diagnosed in any year, the terms "neoplasm" and "tumor" by themselves are NOT sufficient to identify the diagnosis of a MCR-reportable case.

** If a **cytology** (only) is reported as "suspicious", do not interpret this as a cancer diagnosis. Report the case only if positive pathology or a physician's clinical impression of cancer supports the cytology findings.

Lobular Carcinoma *in Situ*, Severe Dysplasia and High-Grade Dysplasia

Some physicians do not consider cases of lobular carcinoma *in situ* (LCIS) to be malignancies. Because the histologic type is listed in ICD-O-3 with behavior code **2** (8520/2), the disease is reportable to the MCR. Abstract and submit these to us.

The line of transition between dysplasia and outright neoplasm continues to blur. SEER does not consider the terms "severe dysplasia" and "high-grade dysplasia" to be automatically synonymous with truly *in situ* behavior (as of a neoplasm) at this time. Some pathologists and classification systems, however, may be using these terms rather than "*in situ*" to describe non-invasive malignancies. To be consistent with COC and AJCC advice, if you find that a particular pathologist is using "severe dysplasia" or "high-grade dysplasia" to mean "*in situ*" behavior for a reportable case***, report these cases to the MCR as *in situ* malignancies; but do NOT assume that these terms are always synonymous with "*in situ*" behavior unless you are certain of this. The MCR will decide how to categorize these cases on our data system.

*** For example, a 2004 diagnosis of severe dysplasia of the cervix would not be MCR-reportable even if the pathologist meant *in situ* behavior.

Identification of the Primary Neoplasm

To ensure the accurate reporting of cancer incidence in Massachusetts, it is essential that the primary neoplasm be identified accurately. The primary neoplasm is the original lesion, as opposed to a tumor that has developed as a result of extension or metastasis.

It is particularly important that metastatic lesions be distinguished from the primary lesion. Metastatic lesions are the result of the dissemination of tumor cells from the primary site to a remote part of the body. These new lesions do not represent primary tumors. Information regarding the nature of primary-versus-metastatic lesions is often found in pathology reports. The term "secondary" is often used to describe metastatic lesions.

It is important that those recurrences which are reportable to the MCR (invasive recurrences following an *in-situ* tumor after two months) be clearly identified as recurrences (as opposed to progression of the original disease). The site at which the recurrence is found is not necessarily the disease's site of origin; the recurrence's primary site is the primary site of the original non-invasive disease.

Single-Versus-Multiple Primaries

To ensure consistency, the MCR uses SEER rules and definitions for determining whether lesions are single or multiple primaries. (Facilities with COC approved cancer programs will at times count cases differently than the central registry.) SEER has been reviewing its "counting" rules on a site-by-site basis, but little has been released in terms of rule revision. As stated by SEER:

> ...the determination of how many primary neoplasms a patient has is, of course, a medical decision; but operational rules are needed to ensure consistent reporting by all participants. Basic factors include the site of origin, date of diagnosis, histologic type, behavior of the neoplasm (i.e., benign versus uncertain versus malignant) and laterality....In some neoplasms...one must be careful since different histologic terms are used to describe progressive stages or phrases of the same disease process.

In general, if there is a difference in the site where the neoplasms originate, then it is fairly easy to determine if they are separate primaries, regardless of dates of detection and histologic differences. Likewise, if there is a clear difference in histology, other data such as site and time of detection are not essential to determine the number of primaries.

A separate case report (abstract) must be submitted for each independent primary neoplasm present at the time of abstracting, unless it was previously reported by you. Those recurrences which are required by the MCR may be reported via separate abstracts or by using the Type and Date of First Recurrence fields. Neoplasms identified only by history need not be abstracted for the MCR.

Definitions and rules governing the determination of single-versus-multiple primaries follow.

General Principle: Report a single primary or multiple primaries as documented by a physician, remembering that physicians need not adhere to the "counting" rules governing cancer registries. The MCR "counts" tumors on our data system as objectively as we can using SEER rules, and we understand that different physicians may wish to record different numbers of tumors for a given patient. If physician determination is absent or unavailable to you, use the following guidelines.

Definitions Related to Single-Versus-Multiple Primaries

"Site Difference"

For the following, except for combinations of a "_.9 NOS" code with a specific site code from the same group, each topographic subcategory (4 characters, "C###") as delineated in ICD-O-3 is considered to be a separate site:

colon (C18._)
anus and anal canal (C21._)
bones, joints and articular cartilage (C40._, C41._)
skin (C44._) melanomas (8720-8790)
peripheral nerves and autonomic nervous system (C47._)
connective, subcutaneous and other soft tissues (C49._)
non-malignancies of the meninges (except meninges, NOS*) (C70.0 and C70.1 with behaviors /0 and /1)
non-malignancies of the brain (except brain, NOS*) (C71.0-C71.8 with behaviors /0 and /1)
non-malignancies of other CNS sites (except nervous system, NOS*) (C72.0-C72.8 with behaviors /0 and /1)
non-malignancies of the pituitary, craniopharyngeal duct and pineal gland (C75.1-C75.3 with behaviors /0 and /1)

* A combination of a __.9 "NOS" code and a specific primary site with the same first three digits (for example, C71.9 and C71.6) are considered the same site.

Each site grouping shown in Table II.1 (page 17) is considered *one site* when determining single-versus-multiple primaries. These sites were single sites in ICD-O-1, and SEER consistency rules require them to continue to be viewed as single sites. This applies to both invasive and *in-situ* cancers. The MCR believes that laterality should be used in the usual manner for determining multiple primaries in paired sites in Table II.1 -- that is, left kidney and right renal pelvis are not the same site, but left kidney and left renal pelvis are the same site. Note that C38.4 (pleura) is often shown listed by itself in this table because it is considered a site separate from all others; we simply indicate this by not including it in the table of grouped sites. When circumstances require reporting multiple tumors in Table II.1 site groups as a single

tumor, assign the best ICD-O-3 Primary Site Code possible to encompass all the sites involved.

Table II.1
ICD-O-3 Codes to be Considered ONE Primary Site When Determining Single-Versus-Multiple Primaries

ICD-O-3 Codes	Site Groupings
C01 C02	base of tongue other and unspecified parts of tongue
C05 C06	palate other and unspecified parts of mouth
C07 C08	parotid gland other and unspecified major salivary glands
C09 C10	tonsil oropharynx
C12 C13	pyriform sinus hypopharynx
C23 C24	gallbladder other and unspecified parts of biliary tract
C30 C31	nasal cavity and middle ear accessory sinuses
C33 C34	trachea bronchus and lung
C37 C38.0 C38.1 - C38.3 C38.8	thymus heart mediastinum overlapping lesion of heart, mediastinum and pleura
C51 C52 C57.7 C57.8 - C57.9	vulva vagina other specified parts of female genital organs overlapping lesion, female genital tract, NOS
C56 C57.0 C57.1 C57.2 C57.3 C57.4	ovary fallopian tube broad ligament round ligament parametrium uterine adnexa
C60 C63	penis other and unspecified male genital organs
C64 C65 C66 C68	kidney renal pelvis ureter other and unspecified urinary organs
C74 C75*	adrenal gland other endocrine glands and related structures

* Note for non-malignancies (behavior /0, /1) of C75.1, C75.2 and C75.3: each of these three primary sites is considered a separate site for counting non-malignant primaries; do NOT group them with C74._ and the remainder of C75._ for non-malignancies. All codes within C74._ and C75._ are considered the same site for malignancies (behavior /2, /3).

For all other primary sites, each topographic category (3 characters, "C##") as delineated in ICD-O-3 is considered to be a separate site.

Examples:

- Transverse colon (C18.4) and descending colon (C18.6) are considered separate sites.*
- Base of tongue (C01.9) and border of tongue (C02.1) are considered subsites of the tongue and are to be treated as one site -- either overlapping lesion of parts of the tongue (C02.8), or tongue, NOS (C02.9).
- Trigone of bladder (C67.0) and lateral wall of bladder (C67.2) are considered subsites of the bladder and are to be treated as one site -- either overlapping lesion of subsites of the bladder (C67.8), or bladder, NOS (C67.9).
- Non-malignancies originating in the cerebral meninges (C70.0) and spinal meninges (C70.1) are considered to be of separate primary sites.
- Non-malignancies originating in meninges, NOS (C70.9) and cerebral meninges (C70.0) are considered to be of the same site.
- Malignancies originating in the cerebral and spinal meninges (C70.0, C70.1) are considered to be of the same site.

* Exceptions: colon polyps

1. *Simultaneous* (diagnoses made within 2 months of each other) lesions and polyps in the *same segment* of the colon are a single primary.
2. Polyps may present in more than one segment of the colon. If the diagnosis reads "adenocarcinoma in multiple polyps", it is one primary of the 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. This benign disease usually develops into adenocarcinoma in adenomatous polyposis coli (8220/3) or adenocarcinoma in multiple adenomatous polyps (8221/3).

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 adenocarcinoma of the colon or typical colon polyps. If multiple segments of the colon, or of the colon and rectosigmoid, or of 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).

"Histologic Type Difference"

Differences in histologic type refer to differences in the first 3 digits of the morphology code, EXCEPT FOR lymphatic and hematopoietic diseases and non-malignant intracranial tumors. (See multiple primaries in **Lymphatic and Hematopoietic Diseases** on pages 27-33.)

Non-malignancies (behaviors /0 and /1) of primary sites C70.0-C72.9 and C75.1-C75.3 have special rules using the following histologic type groupings:

Group	**Histologic Type Codes** (/0, /1)
gliomas, astrocytomas, astroblastomas & glioblastomas	9380, 9381, 9382, 9400, 9401, 9410, 9411, 9420, 9421, 9423, 9424, 9430, 9440, 9441, 9442
subependymomas	9383, 9384
choroid plexus neoplasms	9390
ependymomas & choroid gliomas	9391, 9392, 9393, 9394, 9444
neuronal & neuronal-glial neoplasms	9412, 9413, 9505, 9506
oligodendrogliomas & oligodendroblastomas	9450, 9451, 9460

Histologic type codes in the same group (row) above are considered the same histology; assign the more specific histology for a single primary (or simply the earlier diagnosis if neither histology is more specific than the other).

A histologic type code anywhere in the table above and one NOT anywhere in the table above are the same histology if their first 3 digits are the same (usual rule); assign the histology based on multiple/mixed histology rules.

Two histologic type codes NOT anywhere in the table are the same histology if their first 3 digits are the same (usual rule); assign the histology based on multiple/mixed morphology rules.

Note that the codes above are ICD-O-3 codes. If trying to compare a new diagnosis with one made before 2001, convert the original morphology term or code into ICD-O-3 before using the code groups above.

"Simultaneous / Synchronous"

These terms describe diagnoses made within two months of each other.

Note that for non-malignancies (behavior /0, /1) of primary sites C70.0-C72.9 and C75.1-C75.3, there are NO TIME LIMITS involved in their single-vs.-multiple primary rules. Subsequent non-malignancies originating in the "same site" with the "same histologic type" as an earlier one are always considered recurrences (and not reportable to the MCR) for these cases; count only the earliest such diagnosis, and assign the most specific histology.

Single Primaries

The following are to be considered single primaries:

- A single lesion of *one histologic type* is considered a single primary even if the lesion crosses multiple primary sites.
- A single lesion with *multiple histologic types* is to be considered a single primary.
- A new cancer with the *same histology* as an earlier one, if diagnosed in the **same site** within two months, is considered to be a single primary.
- Multiple lesions of the *same histologic type*, if diagnosed in the **same site** within two months, are to be considered a single primary; further, if one lesion has an *in situ* behavior (/2) and another an invasive behavior (/3), this is still to be considered a single primary whose behavior is invasive (/3). Multifocal tumors are included.

Multiple Primaries

The following are to be considered separate primaries:

- Multiple lesions of the *same histologic type* that occur in **different sites** are considered separate primaries, unless stated to be metastatic or a type of recurrence that is not reportable to the MCR.

  Exception: Kaposi sarcoma (9140/3) is reported only once, even if it occurs in different primary sites. Further details about reporting Kaposi sarcoma appear on pages 21 and 25.

- A new cancer of the *same histology* as an earlier one, if diagnosed in the **same site** after two months, should be considered a separate primary unless stated to be metastatic. *Exceptions*:

  Invasive bladder cancers (C67._) with histology codes 8120-8131/3 [transitional cell carcinomas, including (micro)papillary types]: For these, a *single abstract is required for the first lesion only*. Any reappearance of disease in the bladder with histology codes 8120-8131/3 is considered a recurrence, regardless of the time that has passed since the initial diagnosis. If a non-invasive bladder cancer in this histology range is followed by an invasive recurrence after two months, these are considered separate primaries for the MCR (as described in the Note below).

  Invasive prostate adenocarcinomas (C61.9, 8140/3): Record the first of these diagnoses only. Any subsequent diagnosis of this disease is considered a non-reportable recurrence. If PIN III (8148/2) is followed after two months by an invasive prostate cancer, even if stated to be a recurrence, then the second diagnosis is reportable to the MCR even though the PIN III diagnosis is not MCR-reportable. (See the Note below.)

  Kaposi sarcoma (9140/3): Report only the first occurrence as detailed on page 25.

  Non-malignancies (behaviors /0 or /1) of intracranial primary sites (C70.0-C72.9 and C75.1-C75.3): For multiple diagnoses made in the same site with the same histologic type, record only the first diagnosis (regardless of time interval between diagnoses).

  Note: An *in situ* followed by an invasive cancer in the same site* more than two months apart is recorded as two primaries at the MCR even if stated to be a recurrence. Facilities may choose to report the cases in separate abstract records or may use the Type and Date of First Recurrence fields.

* This is a SEER rule, adopted by the NAACCR Uniform Data Standards Committee, for diagnoses as of January 1, 1995. The ACoS/COC does not want the invasive case sent to them if a physician has called it a recurrence but, as a central registry, the MCR follows SEER rules on this.

For MCR-reportable recurrences, we interpret this rule to mean that the invasive recurrence is not necessarily in the *same* site as the original diagnosis. An invasive local, regional or distant recurrence of a non-invasive cancer is reportable to the MCR if diagnosed after two months. The recurrence need not literally occur "in the same site" for the reporting rule to apply.

- Multiple lesions of *different histologic types* within a **single site** are considered separate primaries whether occurring simultaneously or at different times. *Exceptions*:
  - For multiple lesions within a single site occurring within two months, if one lesion is an NOS term (such as carcinoma, NOS; adenocarcinoma, NOS; melanoma, NOS; or sarcoma, NOS) and the second lesion is a more specific related term (such as large cell carcinoma, mucinous adenocarcinoma, nodular melanoma or spindle cell sarcoma), consider this to be a single primary and code the more specific histology. *Exceptions to this Exception*:
    - When an *in situ* or invasive adenocarcinoma arises within the same segment of the colon or rectum as an *in situ* or invasive adenocarcinoma in a polyp (in an adenomatous polyp, villous adenoma or tubulovillous adenoma), then use the less specific code -- (8140/2 or /3). That is, (8140/2 or 8140/3) AND (8210/2 or 8210/3 or 8261/2 or 8261/3 or 8263/2 or 8263/3) in C20.9 or in the *same* colon segment C18.*x* -- assign 8140. Use 8140/2 if there was no invasion; use 8140/3 if any of the tumors was invasive.
    - When an *in situ* or invasive carcinoma (8010/2 or 8010/3) arises within the same segment of the colon or rectum as an *in situ* or invasive carcinoma in an adenomatous polyp (8210/2 or 8210/3), use the less specific code -- (8010/2 or 8010/3). Use /3 if any of the tumors was invasive; use /2 if all were noninvasive.
  - Within each breast, combinations of separate ductal and lobular carcinomas occurring within two months of each other are considered a single primary. Assign the combination histology code 8522/2 or 8522/3. Further details are given on page 24.
  - Certain neoplasms may have multiple tumor foci and multiple histologic types occurring together commonly. When a combination histology code covering the multiple histologies exists, a single primary should be abstracted with that combination code. These multifocal/multi-histologic tumors occur most often in the breast (C50._), bladder (C67._) and thyroid (C73.9). It is almost as if a single cancer were being expressed in multiple places within the primary site in the cell types found in those different places. For example, a papillary carcinoma and a separate follicular carcinoma in the thyroid should be assigned the combination code 8340/3 (papillary and follicular carcinoma).
- Multiple lesions of *different histologic types* in **different sites** are considered separate primaries whether occurring simultaneously or at different times.

Paired Organs (Laterality)

Except for malignancies of the "newly paired" CNS primary sites*, each "side" of a paired organ (pages 83-85) is a separate site, but if only *one malignant histologic type* is reported and if **both sides** of a paired site are involved within two months of diagnosis, a determination must be made as to whether the patient has one or two independent primaries. If it is determined that there are two independent primaries, then two case reports should be sent to the MCR, each with appropriate Laterality and staging.

If it is determined that there is only one primary, then Laterality should be coded according to the side in which the cancer originated and a single case report should be submitted. If it is impossible to tell in which of the pair a single primary originated, Laterality (see page 82) should be coded **4** ("bilateral involvement, side of origin unknown") and a single case report should be submitted.

Exceptions:

- Simultaneous bilateral involvement of the ovaries (C56.9) in which there is only a single histology is to be considered one primary, and Laterality is to be coded **4**.
- Bilateral retinoblastomas (9510-9513) are always considered a single primary whether occurring simultaneously** or at different times. Laterality is coded **4**.
- Bilateral nephroblastomas (8960, also known as Wilms tumors) are always considered a single primary whether occurring simultaneously** or at different times. Laterality is coded **4**.

** The *FORDS* Manual specifies that these must be simultaneous occurrences, but the MCR is following SEER rules which have been expanded to include non-simultaneous tumors.

If one side of a paired organ is involved by tumor of one histologic type and the other side is involved by a different histologic type, then these are two separate primaries.

* For malignancies (behaviors /2 and /3) of the "newly paired" CNS primary sites (C70.0, C71.0-C71.4, C72.2-C72.5), different lateralities do NOT create separate primary sites. For example, malignancies of the right and left cerebral meninges are of the same site.

Breast Duct, Lobular, and Other Carcinomas

A single case report should be prepared for certain combinations of multiple separate carcinomas occurring in the **same breast** within two months of each other, even though they may have different histologies (i.e., a difference in the first three characters of the morphology codes). ICD-O-3 lists the morphology code 8522 for these combinations. If all the tumors are *in situ*, the behavior code should be /2; but if any part of a tumor is invasive, the behavior code must be /3. Some examples follow:

Multiple simultaneous tumors in the same breast being counted as one primary

- Infiltrating duct carcinoma (8500/3) and lobular carcinoma (8520/3) -- Code as 8522/3.
- Infiltrating duct carcinoma (8500/3) and lobular carcinoma *in situ* (8520/2) -- Code as 8522/3.
- Intraductal carcinoma (8500/2) and lobular carcinoma (8520/3) -- Code as 8522/3.
- Intraductal carcinoma (8500/2) and lobular carcinoma *in situ* (8520/2) -- Code as 8522/2.

The MCR awaits further clarification of the SEER multiple primary rules to understand the correct use of the combination codes 8523 (duct mixed with other types of carcinoma) and 8524 (lobular mixed with other types of carcinoma). At first advised that they could be used in the same manner as 8522 to combine separate tumors into one primary, we later found SEER to state more definitively that the two new ICD-O-3 codes should only be used for single tumors of multiple histologic types.

Separate case reports should be sent for a lesion in one breast and an unrelated lesion in the **other breast** having *different histologic types*, whether or not they occur within two months of each other.

Separate case reports should be sent for two lesions in the **same breast** diagnosed more than two months apart. Invasive recurrences diagnosed more than two months after an *in-situ* diagnosis are also reportable as separate primaries (send two case reports to the MCR or use the Type of First Recurrence fields).

(Intra)ductal Carcinoma and Paget Disease

The single morphology code 8543/3 should be used for a combination of intraductal carcinoma (8500/2) and Paget disease of the breast (8540/3). Code 8541/3 should be used for a combination of Paget disease of the breast (8540/3) and duct carcinoma (8500/3).

Kaposi Sarcoma

Kaposi sarcoma (9140/3) is reported only once for a patient (the first diagnosis). Kaposi sarcoma is coded to the site in which it first arises. If Kaposi sarcoma arises in a skin site and another site simultaneously, code to the skin primary site (C44._). If no primary site is stated, code to skin, NOS (C44.9).

Melanomas

The COC counts each skin melanoma as a new primary unless stated to be metastatic. Reporting hospitals may follow this rule. At the MCR we follow SEER rules which have no special exceptions for melanomas. For example, a superficial spreading melanoma on the skin of the left arm and a melanoma, NOS diagnosed on the same arm within two months would be coded as two primaries for the COC, but would be one primary (using the more specific histology) at the MCR because they occur in the same primary site.

Behavior Rules for Intracranial / CNS Tumors

The single-vs.-multiple primary rules do not ordinarily refer to behavior because they were originally meant to apply only to malignancies. Continue to apply the standard rules (including determining "same site", "same histologic type" and "simultaneous") to all malignancies.

Intracranial/CNS non-malignancies (C70.0-C72.9, C75.1-C75.3 with behaviors /0, /1) and combinations of malignant and non-malignant tumors require special rules.

For multiple non-malignant lesions: If the primary sites are different (see page 16), count as separate primaries. If the histologies are different (see page 19), count as separate primaries. If same site and same histology, if the lateralities are on opposite sides (right and left) then count as separate primaries. If same site, same histology, and same laterality (or left side with unknown/midline laterality, or right side with unknown/midline laterality), count as a single primary. These rules apply to any time period between diagnoses.

For combinations of malignant and non-malignant lesions: A non-malignant tumor followed by a malignant one are separate primaries. A malignant tumor followed by a non-malignant one are separate primaries. These two rules apply even when the sites, histologies and lateralities are the same, and there may be any time period between diagnoses.

If a tumor's behavior transforms from benign to borderline (/0 to/1), do not consider this a new primary. Retain the histology/behavior of the original diagnosis.

If a malignant tumor transforms to a higher WHO grade, do not consider this a new primary. Retain the histology/behavior of the original diagnosis.

If a tumor's behavior transforms from benign to malignant, consider the malignancy to be a new primary.

Examples: Two benign neoplasms (8000/0) of the right frontal lobe -- count as one primary because the lateralities are the same.

Benign neoplasms of the right and left frontal lobes -- count as separate primaries because they are on opposite sides.

A benign neoplasm of the right frontal lobe, and a benign neoplasm of the frontal lobe (laterality not specified) -- count as a single primary because the lateralities are not opposites.

A malignant glioma (9380/3) before or after a subependymoma (9383/1) -- count as separate primaries because one is malignant and other isn't.

A patient is diagnosed with a choroid plexus papilloma (9390/0) of the ventricle in 2004 and is treated. Later this patient is found to have a choroid plexus carcinoma (9390/3) in the same area. -- Count as separate primaries because the same disease has transformed from benign to malignant.

Lymphatic and Hematopoietic Diseases

Table II.2 (pages 30-33) is used to help determine single-vs.-multiple primaries of lymphomas, leukemias and similar diseases. (SEER's fold-out table is identical to the typed Table II.2, except the typed version in this manual labels the rows and columns with histologic type codes only, and the code 9699 is listed numerically as a separate row and column in Table II.2.)

To compare two diagnoses:

1. assign the best ICD-O-3 histologic type code to each;
2. find the code of the first diagnosis in the row headings;
3. find the code of the second diagnosis in the column headings;
4. find the intersection of that row and column;
   - a **S** in the intersection indicates that the two diagnoses are considered parts of the **s**ame disease process, and are a single primary;
   - a **D** in the intersection indicates that they are considered **d**ifferent disease processes and are two separate primaries.

Examples (see page 30):

- first diagnosis -- lymphoma, NOS (9590)
  second diagnosis -- Hodgkin lymphoma, mixed cellularity (9652)
  The **S** at the intersection of row "9590" and column "9650-9667" indicates that this would be considered one primary.
- first diagnosis -- multiple myeloma (9732)
  second diagnosis -- lymphoma, NOS (9590)
  The **D** at the intersection of row "9731-9734" and column "9590" indicates that these would be considered separate primaries.

Rules and Guidelines:

1. Primary site (topography) is NOT to be considered in determining single/multiple primaries of these malignancies. Only the histologic types matter.

   Example: A patient has a lymphoma arising in lymph nodes and an extranodal lymphoma. You need to determine the two histologic types and use Table II.2 to determine if these are different diseases; the difference in primary sites is irrelevant.

2. The time interval between diagnoses is NOT to enter into the decision. Two leukemias diagnosed years apart could be considered a single primary.

3. The sequence (chronological order) of diagnoses may affect single-versus-multiple primary decisions. Always be careful to look for the earlier diagnosis code down the row labels of the table, and for the more recent diagnosis code across the top column labels.

   Examples: A patient is diagnosed with composite Hodgkin and non-Hodgkin lymphoma (9596) in January 2001, and with lymphoid leukemia (9820) in December 2003. This is a single primary (**S**) (9596), diagnosed in January 2001.

   A patient is diagnosed with lymphoid leukemia (9820) in January 2003, and with composite Hodgkin and NHL (9596) in December 2003. The December diagnosis is a new (**D**) primary.

4. Table II.2 contains only ICD-O-3 codes. It should be used to compare diagnoses made in 2001 and thereafter; it should also be used to compare a diagnosis made before 2001 with one made in 2001 or thereafter. When comparing a pre-2001 diagnosis with a diagnosis made in 2001+, remember to look in the row headings for the best ICD-O-3 code equivalent to the pre-2001 diagnostic term.

   Example: A patient was diagnosed in 1999 with "chronic myelomonocytic leukemia" (ICD-O-2 code 9868, ICD-O-3 code 9945). In 2003 the patient is diagnosed with "myeloid sarcoma" (ICD-O-3 code 9930). Using the ICD-O-3 codes and Table II.2, the intersection of row "9945" and column "9930" contains **S**, so this is a single primary (diagnosed in 1999, so be sure that the ICD-O-2 code 9868 gets assigned to this case).

   When comparing two pre-2001 diagnoses, you should use the old ICD-O-2 version of Table II.2 to decide if these would have been considered the same or different diseases. (See the *ROADS* or Third Edition MCR coding manual for the ICD-O-2 tables.)

5. When two diagnoses are considered to be the same disease process (**S**), and one is an "NOS" term while the other is more specific, assign the more specific diagnosis code to the single primary regardless of the chronological order of the diagnoses.

   Example: first diagnosis -- lymphoma, NOS (9590)
   second diagnosis --Hodgkin lymphoma, mixed cellularity (9652)

   This single primary will have the diagnosis date of the *first* diagnosis and the histologic type code of the *second* diagnosis because the first term is "NOS".

6. "Lymphoma" is a general term for solid malignancies of the lymphoid series of the hematologic diseases. "Leukemia" is a general term for liquid malignancies of the lymphoid or myeloid series. Because so many hematologic diseases can potentially arise as leukemias or lymphomas or both, all such malignancies are assumed to have the potential to appear in both forms.
7. Malignancies of the lymphoid series are to be considered different diseases from those of the myeloid series; and histiocytic malignancies are considered different diseases from those of both the lymphoid and myeloid series.
8. Hodgkin lymphoma is considered to be different from non-Hodgkin lymphoma. Among non-Hodgkin lymphomas, B-cell malignancies are to be considered different diseases from T-cell and NK cell malignancies.

Table II.2: Single ("S") vs. Subsequent ("D") Primaries for Lymphatic and Hematopoietic Diseases

Earlier Diagnosis ↓↓↓↓↓ / Later Dx →→→→	9590	9591	9596	9650 - 9667	9670 - 9671	9673	9675 - 9684	9687	9689	9690 - 9698	9699	9700, 9701
9590	S	S	S	S	S	S	S	S	S	S	S	S
9591	S	S	D	D	S	S	S	S	S	S	S	S
9596	S	S	S	S	S	S	S	S	S	S	S	S
9650 - 9667	S	D	D	S	D	D	D	D	D	D	D	D
9670 - 9671	S	S	D	D	S	D	S	D	D	D	D	D
9673	S	S	D	D	D	S	D	D	D	D	D	D
9675 - 9684	S	S	D	D	S	D	S	S	D	S	D	D
9687	S	S	D	D	D	D	D	S	D	D	D	D
9689	S	S	D	D	D	D	D	D	S	D	S	D
9690 - 9698	S	S	D	D	D	D	S	D	D	S	D	D
9699	S	S	D	D	D	D	D	D	S	D	S	D
9700, 9701	S	S	D	D	D	D	D	D	D	D	D	S
9702 - 9719	S	S	D	D	D	D	D	D	D	D	D	D
9727	S	S	D	D	D	D	D	D	D	D	D	D
9728	S	S	D	D	D	D	D	D	D	D	D	D
9729	S	S	D	D	D	D	D	D	D	D	D	D
9731 - 9734	D	D	D	D	D	D	D	D	D	D	D	D
9740 - 9742	D	D	D	D	D	D	D	D	D	D	D	D
9750 - 9756	D	D	D	D	D	D	D	D	D	D	D	D
9757, 9758	S	S	D	D	D	D	D	D	D	D	D	D
9760	S	S	D	D	S	D	S	D	D	D	D	D
9761	S	S	D	D	S	D	S	D	D	D	D	D
9762	S	S	D	D	D	D	D	D	D	D	D	D
9764	S	S	D	D	D	D	D	D	D	D	D	D
9800, 9801	S	S	D	D	D	D	D	S	D	D	D	D
9805	S	S	D	D	S	S	S	S	S	S	S	S
9820	S	S	D	D	D	D	D	S	D	S	D	S
9823	S	S	D	D	S	D	S	D	D	D	D	D
9826	S	S	D	D	D	D	D	S	D	D	D	D
9827	S	S	D	D	D	D	D	D	D	D	D	D
9832	D	D	D	D	S	D	D	D	D	D	D	D
9833	D	D	D	D	S	D	D	D	D	D	D	D
9834	D	D	D	D	D	D	D	D	D	D	D	D
9835	S	S	D	D	D	D	D	D	D	D	D	D
9836	S	S	D	D	D	D	D	D	D	D	D	D
9837	S	S	D	D	D	D	D	D	D	D	D	D
9840 - 9910	D	D	D	D	D	D	D	D	D	D	D	D
9920	D	D	D	D	D	D	D	D	D	D	D	D
9930	D	D	D	D	D	D	D	D	D	D	D	D
9931	D	D	D	D	D	D	D	D	D	D	D	D
9940	D	D	D	D	D	D	D	D	D	D	D	D
9945	D	D	D	D	D	D	D	D	D	D	D	D
9946	D	D	D	D	D	D	D	D	D	D	D	D
9948	S	S	D	D	D	D	D	D	D	D	D	D
9950	D	D	D	D	D	D	D	D	D	D	D	D
9960	D	D	D	D	D	D	D	D	D	D	D	D
9961	D	D	D	D	D	D	D	D	D	D	D	D
9962	D	D	D	D	D	D	D	D	D	D	D	D
9963	D	D	D	D	D	D	D	D	D	D	D	D
9964	D	D	D	D	D	D	D	D	D	D	D	D
9980 - 9986	D	D	D	D	D	D	D	D	D	D	D	D
9987	D	D	D	D	D	D	D	D	D	D	D	D
9989	D	D	D	D	D	D	D	D	D	D	D	D

Table II.2: Single ("S") vs. Subsequent ("D") Primaries for Lymphatic and Hematopoietic Diseases

Earlier Diagnosis ↓↓↓↓↓ / Later Dx →	9702-9719	9727	9728	9729	9731-9734	9740-9742	9750-9756	9757, 9758	9760	9761	9762	9764
9590	S	S	S	S	S	S	S	S	S	S	S	S
9591	S	S	S	S	D	D	D	S	S	S	S	S
9596	S	S	S	S	D	D	D	D	S	S	S	S
9650 - 9667	D	D	D	D	D	D	D	D	D	D	D	D
9670 - 9671	D	D	D	D	D	D	D	D	D	S	D	D
9673	D	D	D	D	D	D	D	D	D	D	D	D
9675 - 9684	D	D	D	D	D	D	D	D	S	S	S	S
9687	D	D	D	D	D	D	D	D	D	D	D	D
9689	D	D	D	D	D	D	D	D	D	D	D	D
9690 - 9698	D	D	D	D	D	D	D	D	D	D	D	D
9699	D	D	D	D	D	D	D	D	D	D	D	D
9700, 9701	D	D	D	D	D	D	D	D	D	D	D	D
9702 - 9719	S	D	D	D	D	D	D	D	S	D	D	D
9727	D	S	S	S	D	D	D	D	D	D	D	D
9728	D	S	S	D	D	D	D	D	D	D	D	D
9729	D	S	D	S	D	D	D	D	D	D	D	D
9731 - 9734	D	D	D	D	S	D	D	D	D	D	D	D
9740 - 9742	D	D	D	D	D	S	D	D	D	D	D	D
9750 - 9756	D	D	D	D	D	D	S	D	D	D	D	D
9757, 9758	D	D	D	D	D	D	D	S	D	D	D	D
9760	D	D	D	D	S	D	D	D	S	S	S	S
9761	D	D	D	D	D	D	D	D	S	S	D	D
9762	D	D	D	D	D	D	D	D	S	D	S	S
9764	D	D	D	D	S	D	D	D	S	D	S	S
9800, 9801	S	S	S	S	D	D	D	D	D	D	D	D
9805	S	S	S	S	D	D	D	D	D	D	D	D
9820	S	S	S	S	D	D	D	D	S	S	S	D
9823	D	D	D	D	D	D	D	D	S	D	D	D
9826	D	D	D	D	D	D	D	D	D	D	D	D
9827	D	D	D	D	D	D	D	D	D	D	D	D
9832	D	D	D	D	D	D	D	D	D	D	D	D
9833	D	D	D	D	D	D	D	D	D	D	D	D
9834	D	D	D	D	D	D	D	D	D	D	D	D
9835	D	S	S	S	D	D	D	D	D	D	D	D
9836	D	S	S	D	D	D	D	D	D	D	D	D
9837	D	S	D	S	D	D	D	D	D	D	D	D
9840 - 9910	D	D	D	D	D	D	D	D	D	D	D	D
9920	D	D	D	D	D	D	D	D	D	D	D	D
9930	D	D	D	D	D	D	D	D	D	D	D	D
9931	D	D	D	D	D	D	D	D	D	D	D	D
9940	D	D	D	D	D	D	D	D	D	D	D	D
9945	D	D	D	D	D	D	D	D	D	D	D	D
9946	D	D	D	D	D	D	D	D	D	D	D	D
9948	S	D	D	D	D	D	D	D	D	D	D	D
9950	D	D	D	D	D	D	D	D	D	D	D	D
9960	D	D	D	D	D	D	D	D	D	D	D	D
9961	D	D	D	D	D	D	D	D	D	D	D	D
9962	D	D	D	D	D	D	D	D	D	D	D	D
9963	D	D	D	D	D	D	D	D	D	D	D	D
9964	D	D	D	D	D	D	D	D	D	D	D	D
9980 - 9986	D	D	D	D	D	D	D	D	D	D	D	D
9987	D	D	D	D	D	D	D	D	D	D	D	D
9989	D	D	D	D	D	D	D	D	D	D	D	D

Table II.2: Single ("S") vs. Subsequent ("D") Primaries for Lymphatic and Hematopoietic Diseases

Earlier Diagnosis ↓↓↓↓ / Later Dx →→→→	9800, 9801	9805	9820	9823	9826	9827	9832	9833	9834	9835	9836	9837	9840-9910	9920
9590	S	S	S	S	S	S	S	S	S	S	S	S	S	S
9591	S	S	S	S	S	S	D	D	D	S	S	S	D	D
9596	S	D	S	S	S	S	D	D	D	S	S	S	D	D
9650 - 9667	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9670 - 9671	D	S	S	S	D	D	S	S	D	D	D	D	D	D
9673	D	S	D	D	D	D	D	D	D	D	D	D	D	D
9675 - 9684	D	S	S	S	D	D	S	S	D	D	D	D	D	D
9687	S	S	S	D	S	D	D	D	D	D	D	D	D	D
9689	D	S	D	D	D	D	D	D	D	D	D	D	D	D
9690 - 9698	D	S	D	D	D	D	D	D	D	D	D	D	D	D
9699	D	S	D	D	D	D	D	D	D	D	D	D	D	D
9700, 9701	D	S	S	D	D	D	D	D	D	D	D	D	D	D
9702 - 9719	D	S	S	D	D	D	D	D	D	D	D	D	D	D
9727	S	S	S	D	D	D	D	D	D	S	S	S	D	D
9728	S	S	S	D	D	D	D	D	D	S	S	D	D	D
9729	S	S	S	D	D	D	D	D	D	S	D	S	D	D
9731 - 9734	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9740 - 9742	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9750 - 9756	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9757, 9758	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9760	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9761	D	D	S	S	D	D	D	D	D	D	D	D	D	D
9762	D	D	S	S	D	D	D	D	D	D	D	D	D	D
9764	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9800, 9801	S	S	S	D	S	S	D	D	D	S	S	S	S	S
9805	S	S	S	S	S	S	S	S	S	S	S	S	S	S
9820	S	S	S	S	S	S	S	S	S	S	S	S	D	D
9823	D	S	S	S	D	D	S	S	D	D	D	D	D	D
9826	S	S	S	D	S	D	D	D	D	D	D	D	D	D
9827	D	S	S	D	D	S	D	D	D	D	D	D	D	D
9832	D	S	S	S	D	D	S	S	S	D	D	D	D	D
9833	D	S	S	S	D	D	S	S	D	D	D	D	D	D
9834	D	S	S	D	D	S	S	D	S	D	D	D	D	D
9835	S	S	S	D	D	D	D	D	D	S	S	S	D	D
9836	S	S	S	D	D	D	D	D	D	S	S	D	D	D
9837	S	S	S	D	D	D	D	D	D	S	D	S	D	D
9840 - 9910	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9920	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9930	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9931	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9940	S	S	D	D	D	D	D	D	D	D	D	D	D	D
9945	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9946	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9948	S	S	S	D	D	D	D	D	D	D	D	D	D	D
9950	S	D	D	D	D	D	D	D	D	D	D	D	D	D
9960	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9961	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9962	S	D	D	D	D	D	D	D	D	D	D	D	S	S
9963	S	D	D	D	D	D	D	D	D	D	D	D	S	S
9964	S	D	D	D	D	D	D	D	D	D	D	D	S	S
9980 - 9986	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9987	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9989	S	S	D	D	D	D	D	D	D	D	D	D	S	S

Table II.2: Single ("S") vs. Subsequent ("D") Primaries for Lymphatic and Hematopoietic Diseases

Earlier Diagnosis ↓↓↓↓ / Later Dx →→→→	9930	9931	9940	9945	9946	9948	9950	9960	9961	9962	9963	9964	9980-9986	9987	9989
9590	S	S	S	S	S	S	D	D	D	D	D	D	D	D	D
9591	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9596	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9650 - 9667	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9670 - 9671	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9673	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9675 - 9684	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9687	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9689	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9690 - 9698	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9699	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9700, 9701	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9702 - 9719	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9727	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9728	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9729	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9731 - 9734	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9740 - 9742	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9750 - 9756	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9757, 9758	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9760	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9761	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9762	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9764	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9800, 9801	S	D	D	S	S	D	D	S	S	D	S	S	D	S	S
9805	S	S	S	S	S	S	D	S	S	D	D	D	S	S	S
9820	D	D	S	D	D	S	D	D	D	D	D	D	D	D	D
9823	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9826	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9827	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9832	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9833	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9834	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9835	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9836	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9837	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9840 - 9910	S	S	D	S	S	D	D	S	S	S	S	S	D	S	S
9920	S	S	D	S	S	D	D	D	S	D	D	D	D	S	S
9930	S	S	D	S	S	D	D	S	S	S	S	D	D	S	S
9931	S	S	D	S	S	D	D	D	S	D	D	D	D	S	S
9940	D	D	S	D	D	D	D	D	D	D	D	D	D	D	D
9945	S	S	D	S	S	D	D	S	S	D	S	D	D	S	S
9946	S	S	D	S	S	D	D	D	S	D	D	D	D	S	S
9948	D	D	D	D	D	S	D	D	D	D	D	D	D	D	D
9950	D	D	D	D	D	D	S	S	S	D	D	D	D	D	D
9960	S	S	D	S	D	D	D	S	S	S	S	D	D	D	D
9961	S	S	D	S	S	D	D	S	S	S	S	D	D	S	S
9962	S	S	D	S	D	D	D	S	S	S	S	D	D	D	D
9963	S	S	D	S	D	D	D	S	S	S	S	D	D	D	D
9964	S	S	D	S	S	D	D	S	S	D	D	S	D	D	D
9980 - 9986	S	S	D	S	S	D	D	S	S	D	D	D	S	S	S
9987	S	S	D	S	S	D	D	S	S	D	D	D	S	S	S
9989	S	S	D	S	S	D	D	S	S	D	D	D	S	S	S

Differences in Reportability Between ICD-O-2 and ICD-O-3

The year of diagnosis determines coding and other data standards for case reporting.* If a case was first diagnosed before 2001 and was reportable to the MCR under ICD-O-2 coding, then that case is reportable to the MCR regardless of when you abstract and report the case. If a case was first diagnosed before 2001 and was *not* reportable under ICD-O-2 coding, then it is *not* reportable. If a case was first diagnosed in 2001 or thereafter, then only its ICD-O-3 coding determines whether or not it is reportable.

Exception: If a hematopoietic disease diagnosed before 2001 transforms (progresses) to a different reportable disease in 2001 or later, abstract the later diagnosis even if *not* a new primary. This ensures registration of the now reportable disease.

Examples: Refractory anemia first diagnosed in 2000 and first seen at your facility in 2002 -- case is *not* reportable because the ICD-O-2 code is 9980/1. Had the case been first diagnosed in 2001, it *would* be reportable.

Serous cystadenoma, borderline malignancy, diagnosed in 2003 -- case is *not* reportable because the ICD-O-3 code is 8442/1. Had the case been diagnosed before 2001, it *would* be reportable.

Chronic myeloproliferative disease first diagnosed before 2001 is *not* reportable because its ICD-O-2 code is 9960/1. The same disease first diagnosed in 2001 *would* be reportable because its ICD-O-3 code is 9960/3.

Myeloproliferative disease, *NOS* (9960/1 in ICD-O-2 and 9975/1 in ICD-O-3) is *not* reportable under either pre-2001 or 2001+ rules.

Myelodysplastic syndrome diagnosed in 1999 transforms to refractory anemia in 2003. The original diagnosis was not reportable under ICD-O-2 rules (9989/1). The second diagnosis is reportable under ICD-O-3 rules (9980/3). Even though the anemia is part of the same disease process (not a new primary), abstract the 2003 diagnosis because the original disease has become something reportable (and note in a narrative that this anemia was originally myelodysplastic syndrome).

Remember that, in North America, ICD-O-3 coding rules state that 9421/1 pilocytic astrocytomas diagnosed in 2001 and thereafter should be reported with the ICD-O-3 morphology code changed to 9421/**3**. Such cases are reportable to the MCR even with the /1 code because of our brain/CNS tumor collection rules, but please remember to change the Behavior Code to /3 when reporting histologic type code 9421. SEER, the ACoS/COC, NAACCR and CDC/NPCR agree on this rule.

* If the year of diagnosis is unknown to you, try to estimate it. If you cannot estimate the diagnosis year, use the "Date of First Contact" year (the year of your facility's first contact with the patient for this case) to determine which coding rules pertain.

Negative Biopsies

Cases in which a positive cytology is followed by a negative biopsy must be carefully evaluated. The case should not be reported if the biopsy rules out the presence of cancer; if a negative biopsy does *not* rule out cancer, the case is considered cytologically confirmed and it should be reported. (Also see the "suspicious cytology" notes on page 14.)

Consultation-Only Cases and Pathology-Only Cases

Cases seen only for diagnostic or treatment consultation are not reportable to the COC for diagnoses made as of 2003. The MCR has made the reporting of such cases optional since diagnoses made in 1995, but we are now discontinuing this practice. Consultation-only cases (that is, the patient came to your facility for *discussion* only) should NOT be submitted to the MCR. We have determined that such cases contribute little to our overall casefinding completeness.

Pathology-only cases are now assigned to Class 7 for diagnoses made beginning in 2003 (see page 113 for Class 7 description). Cases of Class 7 are not required, but if your facility chooses to collect such cases they should be sent to the MCR along with your regular cases (analytic and nonanalytic). The MCR understands that it may be difficult to determine whether a case is truly Class 7 (for example, your pathology department produced a report but you can't tell if your facility had any actual patient contact; the pathology report may represent a second-opinion pathology consultation). The MCR will be pursuing direct reporting from hospital pathology laboratories (rather than through the hospital registry) for pathology-only cases in the coming year.

Whenever there is doubt about whether or not to submit a particular case, consult MCR Quality Assurance Supervisor David Rousseau at 617-988-3382.

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SECTION III - PATIENT INFORMATION

Facility Name (not a standard field in NAACCR Version 10)

This field is not *collected* from you in each case record. Our data system assigns a reporting facility name to each record when it is uploaded. When sending cases to us on diskette or CD, please include the facility name on each disk label. This also helps us organize data storage.

Reporting Facility Code NAACCR Version 10 field "Reporting Hospital", Item 540, columns 382-391

This field should contain the ACoS/COC Facility Identification Number (FIN) for your facility, but the special code assigned to your facility by the MCR (usually four digits) is also acceptable if your data system can produce it (see next page for MCR codes). Facilities reporting on diskette or CD should include their MCR Code on each disk or CD label. (Records received from other central registries have this field zero-filled.)

Example: Hospital A's registry may send its COC FIN ending with "148765" *or* its MCR Code "2102". The diskette label should include "2102".

Accession Number NAACCR Version 10 field "Accession Number--Hosp", Item 550, columns 402-410

This unique number identifies a patient at your facility based on when s/he was first accessioned onto your data system. The first four digits are the year in which the patient was first seen at your facility for the diagnosis and/or treatment of cancer, after your registry's reference date. The last five digits represent the numeric order in which you entered the case into your system. All of a patient's primaries should have the same Accession Number.

Example: A patient's first diagnosis at your facility is in 2003, and this is the 23rd patient accessioned in 2003. The Accession Number is **200300023**. The patient has another primary diagnosed in 2004 for which you provide chemotherapy. The second case's Accession Number is also **200300023**.

If a patient is deleted from your data system, do NOT re-use the Accession Number that had been assigned! (This may have quirky consequences for patient identification that will be confusing for us and your data system.) Numeric gaps may exist in each year's Accession Numbers, and the COC *FORDS* Manual also specifies that an Accession Number should not be reassigned even if your registry re-sets its reference date. If your facility uses non-standard formatting for this field, that is fine with the MCR because we only use it to help identify the patient when we communicate with you. If your facility does not use Accession Numbers or has not assigned one to a particular patient, you may leave this field empty.

PATIENT INFORMATION cont.

These are the MCR codes and ACoS FIN codes (source: ACoS/COC website and a vendor) for facilities regularly reporting cases to us as of the end of 2003. (The facility name below is not the official name of each institution -- just a simple identifier for use in this table.) Cambridge Health Alliance and Holyoke's Valley Cancer Center have the newer-style ACoS codes 0010000145 and 0010000019.

Facility (short name)	MCR Code	FIN
Anna Jaques	2006	0006141500
Athol	2226	0006140065
Baystate	2339	0006141955
Berkshire	2313	0006141705
Beth Israel Deaconess	2069	0006140170
Beverly	2007	0006140130
Boston Med. Ctr	2084	0006140440
Brigham & Women's	2341	0006140218
Brockton	2118	0006140630
Cambridge	2108	0006140730
Cape Cod	2135	0006141130
Carney	2003	0006140255
Charlton	2337	0006140905
Children's DFCI	2139	0006140270
Clinton	2126	0006140840
Cooley Dickinson	2155	0006141570
Dana Farber	2335	0006140583
Deaconess-Nashoba	2298	0006140090
Emerson	2018	0006140850
Fairview	2052	0006141010
Falmouth	2289	0006140923
Faulkner	2048	0006140310
Franklin	2120	0006141020
Glover BI Needham	2054	0006141450
Good Samaritan	2101	0006140631
Harrington	2143	0006141890
Health Alliance	2127	0006141190
Heywood	2036	0006140980
Holy Family	2225	0006141355
Holyoke	2145	0006141110
Hubbard	2157	0006142130
Jordan	2082	0006141720
Lahey	2342	0006140690
Lawrence General	2099	0006141170
Lawrence Memorial	2038	0006141330
Lemuel Shattuck	2821	not applicable
Lowell General	2040	0006141200
Malden	2041	0006141280
Marlborough	2103	0006141300
Martha's Vineyard	2042	0006141640
Mary Lane	2148	0006142100
Mass. General	2168	0006140430
Melrose-Wakefield	2058	0006141340
Mercy	2149	0006141940
Merrimac Valley	2131	0006141080
MetroWest	2020	0006140960
Milford-Whitinsville	2105	0006141395
Milton	2227	0006141410
Morton	2022	0006142000
Mt. Auburn	2071	0006140780
Nantucket	2044	0006141430
New England Baptist	2059	0006140460
New England Med. Ctr	2299	0006140465
Newton-Wellesley	2075	0006141530
Noble	2076	0006142200
North Adams	2061	0006141560
North Shore	2014	0006141820
Norwood	2114	0006141630
Quincy	2151	0006141740
St. Anne's	2011	0006140900
St. Elizabeth's	2085	0006140620
St. Luke's	2010	0006141460
St. Vincent's	2128	0006142350
Saints Memorial	2029	0006141220
Somerville	2001	0006141860
South Shore	2107	0006141900
Sturdy	2100	0006140080
Tobey	2106	0006142110
UMass. Med. Ctr	2841	0010000086
Union Atlanticare	2073	0006141260
VA System	2988	0010000090
Waltham	2067	0006142090
Whidden	2046	0006140880
Winchester	2094	0006142280
Wing	2181	0006141660

Registry Code

NAACCR Version 10 field "Registry ID", Item 40, columns 20-29

This field should contain the ACoS/COC Facility Identification Number (FIN) for your *registry* (usually identical to your facility although multiple registries may report data under one FIN). The special code assigned to your facility by the MCR (usually four digits) is also acceptable if your data system can produce it (see preceding page for MCR codes). Facilities reporting on diskette or CD should include their MCR Code on each disk or CD label. (Records received from other central registries contain that registry's NAACCR code here.)

Medical Record Number

NAACCR Version 10 Item 2300, columns 2086-2096

Enter the patient's identifying Medical Record Number. If the patient has not been assigned a Medical Record Number by your facility's health information department, letter codes may be attached to some other type of identifier (for example, add "OP" to the end of some identifying number assigned by an outpatient therapy unit):

Reason a Medical Record Number Can't Be Reported	**Add-on Codes** (when there's no actual Medical Record Number)
Medical Record Number is unknown.	**UNK**
Outpatient treatment only	**OP**
Pathology only	**PATH**
Radiation therapy only	**RT**
One-day surgical clinic only	**SU**

The MCR uses Medical Record Number to help identify patients when communicating with the reporting facility, and to help identify multiple case reports for the same patient from a facility. The field is not edited by the MCR, so it may include any punctuation or special characters used at your facility in Medical Record Numbers or other assigned identifiers.

Sequence Number--Hospital

NAACCR Version 10 Item 560, columns 411-412

Note: The *FORDS* Manual's 2004 revisions have abandoned the terminology of COC-reportable and non-COC-reportable cases in describing this field. The MCR is not certain about the extent of this revision. We believe that for diagnoses made beginning in 2003 these revisions are NOT causing any actual *changes* in the sequencing of cases from what was originally intended by the COC. We will, therefore, <u>not</u> abandon our original interpretation of this field until we have further information.

You should sequence tumors according to the rules of your facility's registry as YOU understand the COC's rules for this field. The MCR sequences tumors in a separate field on our system according to central registry rules.

Sequence Number represents the chronological order of a patient's neoplasms during his/her lifetime, whether they exist at the same or at different times, and whether or not they are entered in the reporting facility's registry.

There are now two ranges of Sequence Numbers (**00-35**, **99** and **60-88**) so that malignant neoplasms reportable to the COC at the time of their diagnosis may be sequenced separately from diagnoses that are not COC-reportable and from COC-reportable non-malignancies. Consult the *FORDS*, *ROADS* and *DAM* to determine which kinds of diagnoses were reportable to the COC during different diagnosis years. For example, a basal cell carcinoma of the skin that had spread to lymph nodes when diagnosed was reportable to the COC if diagnosed in 2002; but if diagnosed in 2003 the same neoplasm would not be COC-reportable. All neoplasms known in a patient's history must be taken into account when assigning Sequence Numbers, regardless of whether or not each diagnosis is accessioned into your registry, and regardless of whether or not any earlier diagnoses were COC-reportable.

Brain and central nervous system tumors of benign or borderline malignancy are also sequenced in the **60-88** range even after they become reportable to the COC (with 2004 diagnoses).

The *FORDS* Manual originally referred to whether or not a "case" was reportable to the COC; the MCR interprets this as meaning whether or not the *cancer diagnosed* was COC-reportable or not; non-malignant intracranial/CNS tumors diagnosed beginning in 2004 are an exception.

Example: A patient with invasive breast cancer is first seen at your facility as a Class of Case 3. The "case" is not COC-reportable because it is nonanalytic, but invasive breast cancer is a COC-reportable *diagnosis*, so this would be sequenced in the **00-35**, **99** range.

Note that codes **36-59** and **89-98** are not valid.

Malignancies Reportable to the COC

Until diagnoses made in 2004, only certain malignancies (Behavior Code **2** or **3**) are reportable to the COC. These cases are sequenced with codes **00-35**, and **99** is the "unknown" code.

Tumor Sequence	Code
1 COC-reportable malignant case only	**00**
first of multiple COC-reportable malignancies	**01**
second COC-reportable malignancy	**02**
third COC-reportable malignancy	**03**
…subsequent COC-reportable malignancies…	**...**
thirty-fifth COC-reportable malignancy	**35**
unknown sequence for this COC-reportable malignancy*	**99**

* **99** should be used when there is a substantial reason to believe that the patient had a previous COC-reportable malignancy, but it is not *definitely* known. If, however, the patient has undergone a procedure that *might have been* for cancer but there is no substantial reason for assuming that it *was* for cancer, do not enter code **99**. For example, in the absence of specific information indicating cancer, a previous hysterectomy or the removal of a rectosigmoid polyp would not be sufficient reason for entering code **99** when the patient presents with a COC-reportable case. If the current case is COC-reportable and you have only a vague cancer history for the patient (i.e., you cannot tell if the previous cancers were COC-reportable or not), use **99** for the current case.

Sequence code **00** indicates that the patient has only one primary malignancy that was reportable to the COC at its diagnosis. The sequence code for this case should be changed from **00** to **01** if the patient develops a second primary COC-reportable malignancy.

Examples: A patient had a basal cell skin carcinoma that was COC-reportable at the time of its diagnosis in January 2002 because it had spread to the lymph nodes. The patient is diagnosed in December 2003 with a second such case. The first primary is sequenced **00**. The facility does not have to register the second primary because neither the MCR nor COC require skin cancers diagnosed as of 2003. [If the facility chooses to collect skin cancers as reportable-by-agreement cases, the second primary would be sequenced **60** (see next page).] The patient has an invasive colon cancer in January 2004. This is sequenced **02** and the patient's 2002 cancer is re-coded **01**.

Tumors NOT Reportable to the COC; and Non-Malignant Intracranial/CNS Tumors

Codes **60-88** sequence cases which a facility registers (partially or wholly) that are not reportable to the COC; the range also records benign and borderline intracranial/CNS tumors (primary sites C70.0-C72.9, C75.1-C75.3, behaviors /0 and /1, called "BBT" cases here as a shorthand for benign brain tumor) *even after* they become reportable to the COC with diagnoses made beginning in 2004.

Diagnoses sequenced in this code range may be required by the central registry, optional for the central registry, or may be of special interest to the reporting facility (reportable-by-agreement or "RBA" cases). Examples of cases required by the MCR but not the COC include benign/borderline CNS tumors diagnosed before 2004; AIN III, VAIN III and VIN III diagnosed beginning in 2004; and MCR-reportable recurrences (see the **REPORTABILITY** section for complete information). Any types of case that are picked up by the reporting facility for its own purposes that are not MCR-reportable or COC-reportable are also sequenced in this range.

The code **60** corresponds to **00** in the COC-reportable code range, **61** corresponds to **01**, and **88** is equivalent to the unknown code **99**. When a patient has a second RBA or non-malignant intracranial/CNS case, change the **60** on the first case to **61** and sequence the second case as **62**. All codes between **60** and **88** are valid.

Example: A patient was diagnosed with ductal carcinoma *in situ* of the breast in 2000. It recurred in 2002 but was now invasive. In 2003 she is diagnosed with a benign brain tumor. The *in-situ* case is sequenced **00** because it is the only COC-reportable malignancy. The invasive recurrence is only MCR-required so that case is initially sequenced **60** and is later changed to **61** when the benign brain cancer is diagnosed. The benign case is sequenced **62**.

Codes for benign/borderline intracranial/CNS tumors ("BBT") and neoplasms that are not COC-reportable at the time of their diagnosis follow:

Tumor Sequence	Code
1 RBA or BBT case only	**60**
first of multiple RBA and/or BBT cases	**61**
second RBA/BBT case	**62**
…subsequent RBA/BBT cases…	**...**
27th RBA/BBT case	**87**
unknown sequence for this RBA/BBT case*	**88**

* Just as for code **99**, use **88** only when there is substantial reason to believe that the patient has had at least one previous RBA/BBT diagnosis and you can't tell how you should sequence the patient's new case. Also, as long as the current case is RBA or BBT, assign **88** (rather than **99**) when you have only a vague cancer history for the patient and you cannot tell if the previous cases were COC-reportable or not (or BBTs).

The **60-88** sequence codes do not affect the COC-reportable malignancy codes -- they are independent. The double-alpha codes (**AA**, **BB**, etc.) formerly used for sequencing benign/-borderline brain/CNS cases are *replaced* by the new codes.

Example: A patient developed a malignant colon cancer in 1995. The Sequence Number is **00**. The patient developed a benign meningioma in 2001. Meningiomas are reportable-by-agreement in the reporting facility (and required by the MCR, but not required by COC for 2001), so the registry assigns the Sequence Number **60** (one RBA/BBT case only). The Sequence Number for the first primary remains **00** (does *not* change to **01**). The patient has a second independent benign brain tumor diagnosed in 2004. Now the patient has three tumors sequenced **00**, **61** and **62**.

Both Sequence Ranges

Within both sets of Sequence Number code ranges, when two cases are diagnosed simultaneously, assign the *lower* (smaller) Sequence Number to the primary with the *worse* prognosis. When the prognoses are alike, the assignment of a Sequence Number is arbitrary.

Examples: A patient is diagnosed with simultaneous non-invasive adenocarcinoma in a colon polyp and metastatic lung cancer. Assign Sequence Number **01** to the advanced cancer and **02** to the non-invasive case.

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 because both cases have similar prognoses.

When multiple institutions deal with a patient, the Sequence Number of each case should be the same at each institution if both facilities follow the same reportability rules *and are aware of the patient's cancer history*.

Example: The reporting facility diagnoses a patient with lung cancer. The patient has a history of colon cancer that was diagnosed and treated elsewhere. The lung cancer is known to be this patient's second COC-reportable malignancy, so assign **02** to the lung cancer even though the patient's first primary is not registered in your data system.

For patients with both COC-reportable malignancies and RBA/BBT cases, note that it is impossible to tell the order of a patient's primaries without using the dates of diagnosis. (For example, if a patient has two cases sequenced **00** and **60**, the Sequence Numbers alone cannot reveal if the RBA/BBT diagnosis came before or after the COC-reportable malignancy.)

PLEASE -- If you know that a patient had or has a cancer(s) in addition to the particular case you're reporting to us, record in the Comments/Narrative Remarks field any important information you know about the diagnoses and diagnosis dates of these other cases. This information helps the MCR match and link patient and tumor data from multiple facilities, and its inclusion will mean fewer telephone calls to your registry when we are trying to understand the patient's cancer history and resolve case sequencing. For example, the Comments/Narrative Remarks field might say "breast cancer 1993 dx'd Maine; bladder TCC June 1999".

Primary Payer at Diagnosis | NAACCR Version 10 field "Primary Payer at DX", Item 630, columns 445-446

This field reflects the payer paying for *most* of the patient's care *at the time of diagnosis*. Do not update this if the primary payer changes later. If more than one category applies around the time of diagnosis, code whichever payer provided the *largest* amount. The diagnosing institution usually has the most reliable information to code this field correctly. If your facility is seeing the patient quite some time after diagnosis and you are not certain of the payer *at* diagnosis, use the **10** code if you believe the patient was insured at diagnosis, or **99** if you aren't even sure if s/he was insured then at all. (The *FORDS* Manual instructions for coding this field simply ask for the first payer listed on a patient's admission record regardless of the amount of time that has passed since diagnosis; but the COC does not have to be concerned with coding details for nonanalytic cases.) The Commonwealth's Department of Insurance website has a file listing payer names and types at www.state.ma.us/doi/Consumer/CSS_health.html.

Codes **01** and **02** are for uninsured patients. **10** is for an unknown type of insurance, whereas **99** indicates that you aren't sure if the patient was insured or not. Codes **31-36** are primarily state-funded, and **50-56** are primarily federally funded. The codes are as follows:

Primary Payer at Diagnosis	**Code**
not insured, charity case/free care provided	**01**
not insured, self-paid	**02**
insurance, NOS (type unknown or not covered by the codes that follow)	**10**
managed care provider, NOS; Health Maintenance Organization (HMO); Preferred Provider Organization (PPO)	**20**
Medicaid, NOS (for patients uninsured, below the poverty level, or covered by Transitional Assistance or other state programs)	**31**
Medicaid administered through a managed care plan (HMO, PPO)	**35**
Medicaid (state) with Medicare supplement (federal)	**36**
Medicare, NOS (for retired or disabled patients)	**50**
Medicare with supplement (costs not covered by Medicare are paid by another type of insurance)	**51**
Medicare (federal) with Medicaid (state) supplement	**52**
TRICARE (Dept. of Defense program for military dependents and retirees treated at a non-military facility)	**53**
military (personnel/dependents treated at a military facility)	**54**
Veterans Administration	**55**
Indian Health Service; Public Health Service	**56**
unknown if insured or not (*not* an unknown insurer)	**99**

Abstracted By

NAACCR Version 10 Item 570, columns 413-415

Enter the initials of the individual who abstracted the case. Do not record the data entry person unless that person was also the abstractor. If your facility uses code *numbers* in this field these will be meaningless to the MCR; so your data system should translate these codes into alphabetic initials when a case report is exported for us.

Date of First Contact

NAACCR Version 10 field "Date of 1st Contact", Item 580, columns 416-423

Enter the date the patient was first admitted to or seen at your facility (in MMDDCCYY format) for the diagnosis and/or treatment of this case. This includes reporting facility contact for a diagnostic procedure (such as a mammogram), review of a treatment plan, palliative care, or pathologic review (as for a Class of Case 7). Contact with a staff physician's office does not count for this field; enter the date of your facility's first contact. For cases of Class 2, use the date on which your facility actually began treating the patient rather than the date of an initial treatment consult (an MCR rule). Use the following rules:

inpatient: first admission date if the patient's cancer was known or suspected before admission, or the date when diagnosis of a reportable neoplasm was made during hospitalization for another condition

outpatient: date the patient was first diagnosed, treated or seen as an outpatient for the neoplasm being reported (for example, for an outpatient biopsy, X-ray, scan or laboratory test)

autopsy: date of death for a case diagnosed at autopsy (Class of Case 5) (not necessarily the autopsy date)

pathology-only: date of the specimen collection (not necessarily the date the specimen is reviewed) for Class of Case 7

If your first contact with a patient is only through a pathology specimen (that is, the case appears to be Class 7) but the patient later comes to your facility for care or treatment for this case (that is, the Class has changed from 7), the MCR requests that you UPDATE the original Date of First Contact when you report the patient's later substantive contact with your facility. Keeping the original pathology date could make your reporting of the case seem late to the MCR. Note that the *FORDS* Manual (on its pages 6, 7 and 88) has been revised to come into agreement with this rule.

Estimate the Date of First Contact when necessary. Use **9**'s to code unknown parts of the date when it cannot be estimated. If all you know is that first contact was in a certain part of the year, estimate the date as follows: April for the spring, July for summer or mid-year, October for fall/autumn, and December or January for winter.

Codes for Date of First Contact follow:

Month	Code
January	**01**
February	**02**
March	**03**
April	**04**
May	**05**
June	**06**
July	**07**
August	**08**
September	**09**
October	**10**
November	**11**
December	**12**
unknown*	**99**

Day	Code
first	**01**
second	**02**
third	**03**
...	**..**
...	**..**
...	**..**
thirty-first	**31**
unknown*	**99**

Year	Code
1990	**1990**
2003	**2003**
unknown*	**9999**

*Try to estimate rather than use unknown!

For death certificate-only cases produced at the MCR, this field is filled with the date of death.

Following Physician Name

stored in NAACCR Version 10 field "State/Requestor Items", Item 2220, columns 1447-1506

This is not a standard field in the NAACCR case record layout. When you choose a code for the standard field "Physician--Follow-Up" (Item 2470, columns 2563-2570), your data system should translate this code into an alphabetic name for us, and store that name in columns 1447-1506 of the record layout. The name need not be in any particular format, but we hope that your system produces as *complete* a name as possible (for example, "Smith John James" rather than just "J. Smith" in case there is more than one physician with this name at your facility). Titles derived from education or occupation such as "M.D.", "D.D.S.", etc. do not have to be included. There is space for sixty characters -- more than is allotted to the patient's name!

Determine the physician most responsible for the patient's current care (at the time of abstracting), if any. It is this physician who may be contacted regarding enrollment of the patient in a special study or about permission for a researcher to contact the patient or patient's family. If there is question as to which physician to record, choose the discharging physician. The field may be left empty when not applicable (for example, when the patient died at your facility or left the country). This field does not have to be updated for the MCR after the case has been reported.

Patient Name

A standardized format for recording patient name is essential for matching and linking all of a patient's case records. If three facilities send in the same patient name expressed in different ways (for example, Jane Doe Buck, Jane Doe-Buck and Jane D. Buck), it becomes more difficult to recognize that these three records are for the same person. When matching names from our data system to mortality records, differences in name format are also problematic.

If a patient's name changes (or you make a spelling correction) and this name has already been sent to the MCR, please let us know about the change (617-988-3381 or 617-988-3382). Name changes are very important to us.

Last Name

NAACCR Version 10 field "Name--Last", Item 2230, columns 1947-1971

Enter the patient's surname, preferably without punctuation or spaces. (The MCR understands that the COC allows embedded spaces and punctuation.) For people with more than one surname separated by a space or a hyphen, enter the compound name in this single field. For example, "Doe-Buck" or "Doe Buck" is entered as **Doebuck**; "O'Neill" is entered as **Oneill**. If a last name begins with the word "Saint", abbreviate "Saint" and connect it to the rest of the name (for example, "Saint John" is entered as **Stjohn**). Do not enter titles and designations such as Mr., Mrs., Dr., Rev., Br., Sr., Jr., III, etc. in this field. (See the field Name Suffix.) The Last Name field may not be empty. The field holds up to 25 characters. Truncate (from the end) any last name that is longer.

If punctuation marks (hyphen, apostrophe, period) or embedded spaces are included in this field, we prefer that your data system filter/remove them when an MCR data file is exported. If punctuation/spaces are sent our data system will remove them upon upload, but your original data may not pass our pre-upload ("scan") edits.

Name Suffix

NAACCR Version 10 field "Name--Suffix", Item 2270, columns 2003-2005

This is an identifier following a last name -- usually to distinguish generations (such as Junior) -- which helps tell patients with otherwise identical names apart. Do not use punctuation. Leave the field empty if the patient does not have a Name Suffix or if it's unknown. This field is optional for the MCR and holds up to three characters.

Identifier	Suffix
Junior	**JR**
Senior	**SR**
the Third	**III**
the Fourth	**IV**

First Name

NAACCR Version 10 field "Name--First", Item 2240, columns 1972-1985

Enter the patient's first name. For patients with a compound first name (e.g., Mary Jane), include the space separating the parts of the name (**Mary_Jane**). For a patient who usually uses only the first letter of his/her first name and is known by the middle name (e.g., C. Douglas Jones), enter the first initial and the middle name, separated by a space, into the "First Name" field (**C_Douglas**); then leave the Middle Name field empty.

The field holds up to fourteen characters. Truncate (from the end) any first name which is longer.

For patients with religious or other titles (e.g., Sister Mary White or Doctor Mary White), enter only the patient's first name (**Mary**) here -- not the title. (The MCR obtains information on religious and other occupational titles in the occupation/industry fields.)

For patient matching and other functions, this field cannot be empty for the MCR. We understand that COC allows the field to be empty. We may contact you for clarification if First Name comes in empty.

Middle Name

NAACCR Version 10 field "Name--Middle", Item 2250, columns 1986-1999

Enter the patient's entire middle name whenever possible. If only the middle initial is known, enter just this. Leave empty if there is no middle name/initial, or if it is unknown. This field may contain embedded spaces, but not punctuation. It holds up to fourteen characters.

Maiden Name

NAACCR Version 10 field "Name--Maiden", Item 2390, columns 2021-2035

Enter the maiden name of a female patient, preferably without punctuation or embedded spaces. Leave the field empty if maiden name is not applicable or not known (i.e., leave the field empty for males and for any female whose maiden name is identical to her surname). Do not enter an alias or "aka" name here (see next field description).

If you enter punctuation or spaces in this field, we prefer your data system to filter/remove them when an MCR data file is prepared. This field is not optional for the MCR -- it is of great importance for identifying female patients submitted under different last names.

Alias

NAACCR Version 10 field "Name--Alias", Item 2280, columns 2006-2020

Patients may sometimes use different names or nicknames, or may have had different names at different times in their lives. These "also known as" or "aka" names are categorized as aliases. This item helps identify multiple case reports for a patient having records under different names. This field is optional and we have relaxed its data entry standards.

If the field is too short (fifteen characters) to contain the entire "aka" name, fill in as much as you can of the alias portion(s) of the name. If a patient uses part of his or her real name with an alias portion, record both parts (when space permits) or just the alias portion of the name (if too long). Leave the field empty if the patient does not have an alias, or if the alias is unknown.

Examples: Ralph Williams also uses the name *Bud* Williams. Record **Williams_Bud** or **Bud_Williams** in the Alias field.

Ann Smith also goes by Ann *Brown*. Record **Brown_Ann** or **Ann_Brown**.

Elizabeth Smith also has records under Elizabeth *Longfellow* (twenty characters). The field only holds fifteen characters, so record just **Longfellow**.

Joe Jones also uses *Sam Smith*. Record **Smith_Sam** or **Sam_Smith**.

Birth Date

NAACCR Version 10 Item 240, columns 122-129

Enter the patient's date of birth in MMDDCCYY format. If the month or day has only one digit, enter a zero before the number. Enter all four digits of the birth year.

Estimate the birth year when exact information is unavailable, and indicate in the Comments/ Narrative Remarks field that the date entered is an estimate. (It is preferable to estimate than to code the year as unknown.) ONLY enter **9999** if there is no basis for estimating birth year.

Example: The patient is 70 years old when diagnosed on June 15, 2003. The medical record has no exact birth date. Record unknown month (**99**) and day (**99**), and estimate the year as 1933. The complete birth date entered would be **99991933**, and the Comments/Narrative Remarks field should include the important fact that the birth year was estimated.

Codes for Birth Date follow:

Month	Code
January	**01**
February	**02**
March	**03**
April	**04**
May	**05**
June	**06**
July	**07**
August	**08**
September	**09**
October	**10**
November	**11**
December	**12**
unknown	**99**

Day	Code
first	**01**
second	**02**
third	**03**
...	**..**
...	**..**
...	**..**
thirty-first	**31**
unknown	**99**

Year	Code
1890	**1890**
1990	**1990**
unknown*	**9999**

*Try to estimate year rather than use unknown!

Age at Diagnosis

NAACCR Version 10 Item 230, columns 119-121

Enter the patient's age at the time of initial diagnosis, measured in completed years of life (age at the most recent birthday before diagnosis). The maximum possible age is 120 years.

The patient's age at admission may not be the patient's age on the date of diagnosis. To calculate Age at Diagnosis, subtract the year of the patient's birth from the year of diagnosis; if the patient's birthday is <u>after</u> the day of diagnosis, <u>subtract one year</u> from that calculated age.

Example: A patient is diagnosed with cancer in March 2003. The date of birth is December 1933. Subtract 1933 from 2003 to get a calculated age of 70. Since the patient has not yet had a birthday in 2003, subtract one year from the calculated age. The patient was therefore 69 at diagnosis. Enter **069**.

Number of years of age at last birthday	Code
less than 1 year old	**000**
1 year old (less than 2)	**001**
2 years old (less than 3)	**002**
...	**...**
98 years old (less than 99)	**098**
...	**...**

one hundred twenty years old or more	**120**
unknown	**999**

The patient's age helps to validate Birth Date and is the basis for grouping patients into age categories for statistical purposes. If your computer system automatically calculates age for you, please check that the Age at Diagnosis field makes sense for the case. It is easy to mis-enter a digit in the Birth Date (or enter diagnosis year instead of birth year) and produce a non-sensical Age at Diagnosis (e.g., a divorced infant who is retired, smokes and has lung cancer).

If a patient's age is unusual for his/her diagnosis (like a young man with prostate cancer), note that you've verified this unusual combination in the Comments/Narrative Remarks field.

Birthplace

NAACCR Version 10 Item 250, columns 130-132

Enter the code (Appendix A) for the patient's Birthplace. Continents, countries and U.S. regions and states are included. Massachusetts and nearby state codes are shown here for convenience:

State	Code	State	Code
Massachusetts	**005**	New York	**011**
Connecticut	**007**	Pennsylvania	**014**
Maine	**002**	Rhode Island	**006**
New Hampshire	**003**	Vermont	**004**
New Jersey	**008**		

Enter **000** for Birthplace in the U.S., exact state or region unknown.

Enter **998** for Birthplace outside the U.S. if the country or continent is unknown.

Enter **999** only for a completely unknown Birthplace.

We appreciate that it can be difficult to code this field, but Birthplace is important to some areas of public health research. Use your best judgment to code this field, and don't be afraid to make an "educated guess" if the medical record lacks specifics. Avoid using **999** -- see if there is anything to at least indicate probable foreign birth (**998**) or probable U.S. birth (**000**).

Be as specific as possible in coding Birthplace, but please note that you don't always need very exact information to avoid using an "unknown" code. Appendix A includes codes for many non-specific regions that would be preferable to a complete unknown.

A few examples of "NOS" codes that could be used when you have only partial information follow:

NOS Region examples	Code	NOS Region examples	Code
Southeastern U.S.	**030**	Scandinavia, NOS	**420**
Northern Midwest U.S.	**050**	Eastern Europe, NOS	**499**
Caribbean, NOS	**245**	Africa, NOS	**500**
Central America, NOS	**250**	Asia, NOS	**600**
Latin America, NOS	**265**	East Asia, NOS	**680**

Social Security Number

NAACCR Version 10 Item 2320, columns 2099-2107

If the patient has a Social Security Number, enter it without dashes. This field is vital for proper patient identification. It is used primarily to identify multiple reports for patients whose names have changed or been reported differently by different facilities (different spellings, for example). It is also used when attempting to match people in different databases -- for example, a match between MCR patients and mortality records -- and our data system uses it to suggest that a newly submitted patient may already be on our system.

Enter nine numerals. This number may be used as a Medicare claim number; however, a patient's Medicare claim number may not be that patient's Social Security Number (but rather, that of the spouse). Please try to ascertain the patient's own Social Security Number or clarify that the patient has no Social Security Number of his or her own.

Do not enter a Social Security Number that begins or ends with "B" or "D". These letters identify a spouse's Social Security Number (the letter indicates that the patient receives benefits under the spouse's number). Enter **999999999** for these patients. Social Security Numbers should not begin with "000", "8" or "9". Do *not* knowingly enter a spouse's, parent's or someone else's Social Security Number when you can find no Social Security Number for the patient -- use **999999999** instead.

If the patient has no Social Security Number or if it is unknown to you, enter **999999999**. The field should not be empty, and it should not be filled with zeroes. The MCR understands that a facility's cancer registry may not have final control over what is stored in this field on the facility's data system.

Address at Diagnosis

Address at diagnosis is used in determining cancer statistics within geographic areas (for example, the MCR publishes case counts by Massachusetts town of residence at diagnosis, and Massachusetts vs. out-of-state residency at diagnosis is key to determining which cases are reportable to other state registries). Environmental exposure investigations focus on the address at diagnosis -- even down to the level of individual units within a building. Therefore it is very important that the patient's own residence address at the time of diagnosis be reported. This may not be the patient's current or mailing address.

Becoming ill often changes a patient's living situation abruptly right around the time of diagnosis, especially for the elderly. Every effort should be made to determine the patient's usual address at diagnosis.

If a patient has multiple primaries over time, the address at diagnosis may be different for subsequent tumors. Do NOT update the "Address at Diagnosis" fields for a given primary if the patient moves later. (The Current Address on your data system is kept updated.)

The MCR has adapted the rules for determining residency of the U.S. Bureau of the Census. It is important to follow the rules exactly so that MCR data can be compared with data from other sources, and so that Census population data can be applied to our cancer data correctly. The following rules apply to entering the address.

- Enter the address of the patient's usual residence on the Date of Diagnosis. "**Usual residence**" is where the patient lives and sleeps most of the time or the place the patient considers to be his/her usual home. This is not necessarily the legal or voting residence. Do not record an address where the patient may be staying temporarily, such as a friend's or relative's local address. If both a street address and PO Box (or other mailing address) are given, enter the street address first, followed by the mailing address.
- If the patient has more than one home (e.g., lives on Cape Cod in summer and in Florida during winter), enter the residence where the patient lives most of the time. If that cannot be determined, or if they spend six months in each place, enter whichever address was given to your facility by the patient and please note in the Comments/Narrative Remarks field whatever you know about the patient's non-Massachusetts residence.
- For military personnel and their families living on a military base, enter the specific street address on the base. For military personnel living off-base, enter that off-base address.
- For patients institutionalized at the time of diagnosis, including those incarcerated or in long-term care facilities, their address is that of the institution. The institution's street address, if known to you, should be entered in the Street Address field, and the institution's name should be entered in the Supplemental field. If you have only the institution's name then you may record just that in Street Address.

- Use the at-diagnosis address for college students (where he/she lives most of the year -- probably at or near the college). For children in boarding schools below college level, enter the parents' address. Children in joint custody situations should be assigned the address where they live most of the time; if living time is divided equally between two parental addresses, record the first address reported to your facility.
- For Class 3 or 4 cases, the patient's usual residence may have changed since diagnosis. The address *at diagnosis* is preferred. If that is unknown and you cannot record it as unknown, enter the patient's address on admission to your facility or a current address; please note in the Comments/Narrative Remarks field if the "Address at Diagnosis" reported is actually a *current* address. A known current address should be recorded in the Current Address fields.
- If the patient is homeless or transient with no usual residence, use the address where he/she was staying when diagnosed (e.g., a shelter or the diagnosing institution). Please note in the Comments/Narrative Remarks field that the patient was homeless.
- For live-in professional caregivers (such as nannies, *au pair*s, home health aides, etc.), report the address where they live and sleep most of the time.

Street Address at Diagnosis

NAACCR Version 10 field "Addr at DX--No & Street", Item 2330, columns 2108-2147

Enter the building number and street of the patient's usual permanent residence at the time of diagnosis. Only use numbers, letters and the number symbol(#), slash(/), hyphen(-) or period(.) in this field. Include foreign street addresses. Be as specific as possible.

Building numbers should precede street names. Unit designations should be placed directly after the building number (e.g., **123E Main St**) or after the street name (e.g., **123 Main St Unit E**). Apartment numbers should follow the street name (**123 Main St Apt 123**). If the building number contains "½" (e.g., 38½ Main Street), enter this using the format **38_1/2_Main St**. Whenever possible, avoid entering just a building's name (e.g., Nice View Apartments or Smith Rest Home) without its street address. When both a building name and street address are available, record just the street address here and put the building name in the Supplemental field. If only a building name is available then that should be entered in Street Address.

Forty characters are allotted to this field. Use abbreviations (see the page 56 for common standard abbreviations used in addresses, and Appendix F for a complete list.). If you run out of space, use the Supplemental field to record the less important elements of a street address, such as an apartment number. Do not omit those elements needed to locate the address in a census tract, such as building number, full street name and street type. If there is not enough room for the *entire* apartment/unit number, put this in the Supplemental field rather than truncate it here.

If only a mailing address (such as a PO Box or delivery route number) is available, that should be entered here. If both a street address and mailing address are available, please enter the building number and street first and the mailing address second.

Do NOT update this field for a given primary if the patient's address changes after diagnosis.

Some standard postal abbreviations follow. The complete list is in Appendix F.

Avenue	**Ave**	Heights	**Hts**	Road	**Rd**
Boulevard	**BLVD**	Highway	**HWY**	Route	**RTE**
Building	**BLDG**	Lane	**LN**	Square	**SQ**
Circle	**CIR**	Manor	**MNR**	Street	**ST**
Court	**CT**	Mountain	**MTN**	Terrace	**TER**
Crescent	**CRES**	Parkway	**PKWY**	Trail	**TRL**
Drive	**DR**	Place	**PL**	Turnpike	**TPKE**
Extension	**EXT**	Plaza	**PLZ**	Village	**VLG**
Gardens	**GDNS**	Point	**PT**		

If the street address cannot be determined, enter "**Unknown**". Do not leave this field empty, or we will have to assume that it was left incomplete accidentally.

Street Address at Diagnosis -- Supplemental

NAACCR Version 10 field "Addr at DX--Supplementl", Item 2335, columns 2148-2187

This field contains address information that does not fit into or does not belong in the postal Street Address at Diagnosis field. Examples of information that may be recorded here include the name of the building in which the patient usually resides (such as Smith Nursing Home, Smith Mobile Home Park, Big Tower Apartments or MCI Townname), corresponding to the *street address* of the building that is recorded in the Street Address field. Any address that is too long to fit into the Street Address field (such as one that includes a residential address plus a mailing address) may be completed here. Address details (such as apartment/unit number, building number within a building complex, floor number, etc.) that don't fit fully into the Street Address field may also be entered.

Leave the field empty if there is nothing that needs to be recorded here. Do NOT update the at-diagnosis address information if it changes after diagnosis. The field holds up to forty characters.

City / Town at Diagnosis

NAACCR Version 10 field "Addr at DX--City", Item 70, columns 52-71

Enter the name of the city/town of residence. For patients using mailing addresses (such as P.O. boxes), try to determine the usual street address and town of residence. This may not be the mailing address' town or post office name. Use standard abbreviations. Include spaces for city/town names consisting of more than one word (**New_Bedford**).

If a patient's usual residence is in a foreign country, enter the name of the foreign city/town. Space permitting, you may also enter the country's name here (the MCR does not collect the country's name or code in a separate field), or give us the foreign country name in the Comments/Narrative Remarks field.

Do not update this field for a given primary if the patient's address changes after diagnosis. If the city/town where the patient lived at the time of diagnosis cannot be determined, enter "**Unknown**". Do not leave this field empty.

State at Diagnosis

NAACCR Version 10 field "Addr at DX--State", Item 80, columns 72-73

Enter the standard two-letter U.S. Postal Service abbreviation for the state/province of residence at diagnosis (see **Table III** on the next page). If the patient has multiple primaries, each address may be different for subsequent tumors. Do NOT update this field for a given primary if the patient's address changes after diagnosis.

If the patient lived outside the U.S. (including its territories, commonwealths/possessions in **Table III**) and outside Canada at diagnosis and the *country* of residence is *known*, enter **XX**.

If the patient lived outside the U.S. (including its territories, commonwealths/possessions in **Table III**) and outside Canada at diagnosis and the *country* is *un*known, enter **YY**.

If the patient lived inside the U.S. (including its territories, commonwealths/possessions listed in **Table III**) or Canada at diagnosis, but the specific *state/province* is *unknown*, enter **ZZ**.

If the country is *completely* unknown (i.e., you cannot even determine if the address is in the U.S./Canada or not), enter **ZZ**.

For foreign (non-U.S./Canadian) residents, the MCR does *not* collect country name/code in its own field. You may include the country name in the City / Town field if it will fit, or give it to us in the Comments/Narrative Remarks field.

Table III

Common Codes for the State Field

United States:

State	Code	State	Code	State	Code
Alabama	**AL**	Kentucky	**KY**	North Dakota	**ND**
Alaska	**AK**	Louisiana	**LA**	Ohio	**OH**
Arizona	**AZ**	Maine	**ME**	Oklahoma	**OK**
Arkansas	**AR**	Maryland	**MD**	Oregon	**OR**
California	**CA**	Massachusetts	**MA**	Pennsylvania	**PA**
Colorado	**CO**	Michigan	**MI**	Rhode Island	**RI**
Connecticut	**CT**	Minnesota	**MN**	South Carolina	**SC**
Delaware	**DE**	Mississippi	**MS**	South Dakota	**SD**
District of Columbia	**DC**	Missouri	**MO**	Tennessee	**TN**
Florida	**FL**	Montana	**MT**	Texas	**TX**
Georgia	**GA**	Nebraska	**NE**	Utah	**UT**
Hawaii	**HI**	Nevada	**NV**	Vermont	**VT**
Idaho	**ID**	New Hampshire	**NH**	Virginia	**VA**
Illinois	**IL**	New Jersey	**NJ**	Washington	**WA**
Indiana	**IN**	New Mexico	**NM**	West Virginia	**WV**
Iowa	**IA**	New York	**NY**	Wisconsin	**WI**
Kansas	**KS**	North Carolina	**NC**	Wyoming	**WY**

Canada:

Province	Code
Alberta	**AB**
British Columbia	**BC**
Manitoba	**MB**
Labrador	**NL**
New Brunswick	**NB**
Newfoundland	**NL**
Northwest Territories	**NT**
Nova Scotia	**NS**
Nunavut	**NU**
Ontario	**ON**
Prince Edward Island	**PE**
Quebec	**QC**
Saskatchewan	**SK**
Yukon Territory	**YT**

U.S. Territories/Commonwealths/Possessions:

Locality	Code
American Samoa	**AS**
Federated States of Micronesia	**FM**
Guam	**GU**
Marshall Islands	**MH**
Minor Outlying Islands	**UM**
Northern Mariana Islands	**MP**
Palau (Belau)	**PW**
Puerto Rico	**PR**
Trust Territories	**TT**
Virgin Islands	**VI**

Other codes:

U.S. Armed Services, Americas*	**AA**
U.S. Armed Services, Africa, Canada, Europe, Middle East*	**AE**
U.S. Armed Services, Pacific*	**AP**
Not U.S./Canada, country known	**XX**
Not U.S./Canada, country unknown	**YY**
U.S., NOS; Canada, NOS; Complete unknown	**ZZ**

* Army and Fleet Post Offices (APO, FPO)

ZIP / Postal Code at Diagnosis

NAACCR Version 10 field "Addr at DX--Postal Code", Item 100, columns 74-82

Enter the patient's 5-digit ZIP Code (or nine-digit ZIP+4 Code) corresponding to the Street Address at Diagnosis. If using a ZIP+4 Code, do not enter a hyphen before the last four digits. If using a 5-digit ZIP Code, the five digits are entered on the left and they are followed by four blanks. For Canadian residents, enter their 6-character alphanumeric Postal Code. Do NOT update this field for a given primary if the patient's address changes after diagnosis.

For foreign (non-U.S./Canadian) residents, enter their foreign Postal Code, if available. Enter **888888888** for foreign (non-U.S./Canadian) residents if their foreign Postal Code is unknown.

Enter **999999999** for U.S./Canadian residents if the patient's ZIP/Postal Code is unknown.

Enter **999999999** if the country of residence is completely unknown (i.e., you cannot even determine if the patient lives inside or outside the U.S./Canada).

Current Address

These fields record the patient's current address at the time you are abstracting the case. Once sent to the MCR, this information does not have to be updated for us. These fields are optional, but it is of great importance to us to recognize when the Address at Diagnosis that we receive from you is actually a current address. If you are NOT sending both the known Address At Diagnosis and the known Current Address, then please use the Comments/ Narrative Remarks field to make the address/timing situation clear to us, or appropriately use the "unknown" values for each field as specified in data standards. Because these items are optional they may be left empty and they are not edited, even when filled. Entries and codes for the Current Address fields are comparable to the Address at Diagnosis fields:

Street Address -- Current

NAACCR Version 10 field "Addr Current--No & Street", Item 2350, columns 2188-2227

Street Address -- Current -- Supplemental

NAACCR Version 10 field "Addr Current--Supplementl", Item 2355, columns 2228-2267

City / Town -- Current

NAACCR Version 10 field "Addr Current--City", Item 1810, columns 1307-1326

State -- Current

NAACCR Version 10 field "Addr Current--State", Item 1820, columns 1327-1328

ZIP / Postal Code -- Current

NAACCR Version 10 field "Addr Current--Postal Code", Item 1830, columns 1329-1337

Sex

NAACCR Version 10 Item 220, column 118

Enter the appropriate code for the patient's sex/gender:

Sex	Code
male	**1**
female	**2**
other (including hermaphrodite and persons with sex chromosome abnormalities)	**3**
transsexual (persons who have undergone sex-change surgery)	**4**
not stated	**9***

* Avoid this code! Rates cannot be calculated for unknown gender because population data cannot be assigned.

If the patient's gender is very unusual for his or her first name (a boy named "Sue", for example) but you have verified that both are correct, please put a note in the Comments/ Narrative Remarks field. The MCR does quality control checks on unusual first name/gender code combinations.

Marital Status at Diagnosis

NAACCR Version 10 field "Marital Status at DX", Item 150, column 102

Enter the patient's marital status at the time of initial diagnosis for each primary (case). This field is often important when a patient's residential (address) history is being researched because a change in marital status often results in a change of address.

If the patient is under 15 years of age, assume s/he has never married and enter **1**. Do not update this field for a given primary if the Marital Status changes after diagnosis. Marital Status may be coded differently for different primaries for a patient, but code **1** is *only* meant to be used when the patient has never been married. The field should not be left empty, and it is NOT optional.

Marital Status at Diagnosis	Code
single (has *never* been married)	**1**
married (including common law)	**2**
separated	**3**
divorced	**4**
widowed	**5**

unknown	**9**

Patient Race(s)

Race data are important in public health research. If information regarding a patient's race is not recorded on the face sheet of the medical record, every attempt should be made to find it in the history and physical examination or other parts of the medical record.

Up to five different races may be coded for each patient in accordance with U.S. Census Bureau procedures. [In the 2000 Decennial Census about 150,000 Massachusetts residents (~2.3 % of the population) described themselves as multiracial. These tended to be young people, however, so the percentage of *cancer patients* who are multiracial will be much smaller at this time.]

For patients diagnosed in 2000 and later all five race fields must contain a valid code and none may be empty; for cases diagnosed before 2000 if the patient has no case diagnosed in 2000 or later, you may leave fields Race 2-Race 5 empty. If a patient with a 2000 (or later) diagnosis also had a diagnosis from an earlier year, be sure that the complete race information is coded for both cases.

When coding race it is important to remember that race is defined by specific physical heredity -- NOT by birthplace, place of residence, language or cultural characteristics. The only exception to this rule involves the use of "Asian, NOS" and a race assumption based on an Asian birthplace -- see footnote #2 on each table of race codes that follows for details.

For patients described by a single race, code this in the Race 1 field, and fill Race 2, Race 3, Race 4 and Race 5 with code **88** (meaning "no further races are recorded"). For multiracial patients fill in the race fields with the appropriate codes (using the rules below and on page 62) to describe the patient's races, and fill remaining fields with **88** when no further races are documented.

Unfortunately, there are not clear guidelines at this time for determining *which* race should be considered "Race 1" for multiracial patients beyond the rules which follow. If the medical record has conflicting information (e.g., a patient described in one place as "Black and Korean" and in another as "Korean and Black"), use your best judgment to decide how to assign the codes. It is important to understand that Race 1 will *not always* reflect a multiracial patient's "main" race -- for example, someone with one Black grandparent and three White grandparents is assigned Race 1=Black and Race 2=White in accordance with the rules on the next page.

Race 1 should indicate the "primary" race of a multiracial patient, or the race that the patient identified first, with the following provisions:

- If a patient's race is recorded as a combination of White and any other race(s), code the *other* race(s) before White.

  Example: Patient is recorded "White and Native American". Code Race 1 as **03** for American Indian, Race 2 as **01** for White, and Races 3/4/5 as **88**.

- If a patient is a combination of Hawaiian and any other race(s), code Hawaiian first.

  Example: Patient is recorded "Japanese and Native Hawaiian". Code Race 1 as **07** for Native Hawaiian, Race 2 as **05** for Japanese, and Races 3/4/5 as **88**.

- Otherwise, code Race 1 as the first recorded non-White race.
- Code **96** is used for two different categories of Asians. **96** may denote "Asian, NOS" *or* it may indicate some *specific* Asian race not covered by the main Asian codes. Do *not* use **96** for "Asian, NOS" in a subsequent field if a specific Asian race has already been coded.

  Example: Patient is "Vietnamese and some other Asian race". Code Race 1 as **10** for Vietnamese and Races 2/3/4/5 **88**. Do *not* enter **96** for the additional Asian multiracial information; the patient is coded as if *completely* Vietnamese.

- **99** can only be used when all five race fields are filled with it. A multiracial person cannot be coded, for example, as "Chinese and some unknown race". If a multiracial heredity is only partially known, it is probably best to code just the known information.

If a patient's race is unknown s/he may be multiracial, so all five fields must be coded **99** to indicate unknown race*s*.

Code **88** for "no further race(s) documented" is not valid for the Race 1 field.

Among the five fields, *except for codes **88** and **99***, a race code may be used only once.

Example: If a patient (often a child) is described as "Black/White and Black/Asian" (i.e., the patient's parents are both multiracial), do not code Black twice. Race 1 is **02** for Black, Race 2 is **96** for Asian, Race 3 is **01** for White, and Races 4/5 are **88**.

Race 1

NAACCR Version 10 Item 160, columns 103-104

Use the following codes to enter the patient's single race, or the first of multiple races:

Race 1	Code	Race 1	Code
White; Caucasian[1]	**01**	Micronesian, NOS	**20**
Black; African American; Negro	**02**	Chamorran	**21**
American Indian; Aleutian; Eskimo; Native North, South or Central American	**03**	Guamanian, NOS	**22**
		Polynesian, NOS	**25**
Chinese	**04**	Tahitian	**26**
Japanese	**05**	Samoan	**27**
Filipino	**06**	Tongan	**28**
Hawaiian (Native)	**07**	Melanesian, NOS	**30**
Korean	**08**	Fiji Islander	**31**
Asian Indian; Bangladeshi; Bhutanese; Nepalese; Pakistani; Sikkimese; Sri Lankan	**09**	New Guinean	**32**
		other Asian race (including Indonesian, Burmese/Myanmaran); Asian, NOS[2]; Oriental, NOS[2]	**96**
Vietnamese	**10**		
Laotian	**11**		
Hmong	**12**	Pacific Islander, NOS	**97**
Kampuchean; Cambodian; Khmer	**13**	some other known race[3]	**98**
Thai	**14**	unknown[4]	**99**

[1] The Office of Management and Budget defines this category to include people with origins in Europe, the Middle East and North Africa. If the medical record does not specify race, and the patient is described as Mexican, Puerto Rican or Cuban, code the patient as White.

[2] When a patient's race is recorded only as "Asian" or "Oriental" and the Birthplace is a specific Asian nation synonymous with one of the specific Asian race codes above, use the specific race code. For example, if the patient is described just as "Asian" and was born in Japan, enter code **05** for Japanese rather than **96**.

[3] This race can't be assigned to one of the codes **01 - 97**.

[4] All five race fields must be **99** if the patient's race is unknown. Code partial race information if possible.

Race 2

NAACCR Version 10 Item 161, columns 105-106

Use the following codes to enter the patient's second race (enter **88** if the patient is not multiracial):

Race 2	Code	Race 2	Code
White; Caucasian[1]	**01**	Chamorran	**21**
Black; African American; Negro	**02**	Guamanian, NOS	**22**
American Indian; Aleutian; Eskimo; Native North, South or Central American	**03**	Polynesian, NOS	**25**
		Tahitian	**26**
Chinese	**04**	Samoan	**27**
Japanese	**05**	Tongan	**28**
Filipino	**06**	Melanesian, NOS	**30**
Hawaiian (Native)	**07**	Fiji Islander	**31**
Korean	**08**	New Guinean	**32**
Asian Indian; Bangladeshi; Bhutanese; Nepalese; Pakistani; Sikkimese; Sri Lankan	**09**	no further race(s) documented; patient not multiracial	**88**
Vietnamese	**10**	other Asian race (including Indonesian, Burmese/Myanmaran); Asian, NOS[2]; Oriental, NOS[2]	**96**
Laotian	**11**		
Hmong	**12**		
Kampuchean; Cambodian; Khmer	**13**	Pacific Islander, NOS	**97**
Thai	**14**	some other known race[3]	**98**
Micronesian, NOS	**20**	unknown[4]	**99**

[1] The Office of Management and Budget defines this category to include people with origins in Europe, the Middle East and North Africa. If the medical record does not specify race, and the patient is described as Mexican, Puerto Rican or Cuban, code the patient as White.

[2] When a patient's race is recorded only as "Asian" or "Oriental" and the Birthplace is a specific Asian nation synonymous with one of the specific Asian race codes above, use the specific race code. For example, if the patient is described just as "Black and Asian" and was born in Japan, enter code **05** (Japanese)for Race 2 rather than **96**.

[3] This race can't be assigned to one of the codes **01 - 97**.

[4] All five race fields must be **99** if the patient's race is unknown. Code partial race information if possible.

Race 3

NAACCR Version 10 Item 162, columns 107-108

Use the following codes to enter the patient's third race (enter **88** if the patient is not multiracial, or if the patient has only two races):

Race 3	Code	Race 3	Code
White; Caucasian[1]	**01**	Chamorran	**21**
Black; African American; Negro	**02**	Guamanian, NOS	**22**
American Indian; Aleutian; Eskimo; Native North, South or Central American	**03**	Polynesian, NOS	**25**
		Tahitian	**26**
Chinese	**04**	Samoan	**27**
Japanese	**05**	Tongan	**28**
Filipino	**06**	Melanesian, NOS	**30**
Hawaiian (Native)	**07**	Fiji Islander	**31**
Korean	**08**	New Guinean	**32**
Asian Indian; Bangladeshi; Bhutanese; Nepalese; Pakistani; Sikkimese; Sri Lankan	**09**	no further race(s) documented	**88**
		other Asian race (including Indonesian, Burmese/Myanmaran); Asian, NOS[2]; Oriental, NOS[2]	**96**
Vietnamese	**10**		
Laotian	**11**		
Hmong	**12**	Pacific Islander, NOS	**97**
Kampuchean; Cambodian; Khmer	**13**	some other known race[3]	**98**
Thai	**14**	unknown[4]	**99**
Micronesian, NOS	**20**		

[1] The Office of Management and Budget defines this category to include people with origins in Europe, the Middle East and North Africa. If the medical record does not specify race, and the patient is described as Mexican, Puerto Rican or Cuban, code the patient as White.

[2] When a patient's race is recorded only as "Asian" or "Oriental" and the Birthplace is a specific Asian nation synonymous with one of the specific Asian race codes above, use the specific race code. For example, if the patient's third race is described just as "Asian" and he/she was born in Japan, enter code **05** for Japanese rather than **96**.

[3] This race can't be assigned to one of the codes **01 - 97**.

[4] All five race fields must be **99** if the patient's race is unknown. Code partial race information if possible.

Race 4

NAACCR Version 10 Item 163, columns 109-110

Use the following codes to enter the patient's fourth race (enter **88** if the patient is not multiracial, or if the patient has only three races):

Race 4	Code	Race 4	Code
White; Caucasian[1]	**01**	Chamorran	**21**
Black; African American; Negro	**02**	Guamanian, NOS	**22**
American Indian; Aleutian; Eskimo; Native North, South or Central American	**03**	Polynesian, NOS	**25**
		Tahitian	**26**
Chinese	**04**	Samoan	**27**
Japanese	**05**	Tongan	**28**
Filipino	**06**	Melanesian, NOS	**30**
Hawaiian (Native)	**07**	Fiji Islander	**31**
Korean	**08**	New Guinean	**32**
Asian Indian; Bangladeshi; Bhutanese; Nepalese; Pakistani; Sikkimese; Sri Lankan	**09**	no further race(s) documented	**88**
		other Asian race (including Indonesian, Burmese/Myanmaran); Asian, NOS[2]; Oriental, NOS[2]	**96**
Vietnamese	**10**		
Laotian	**11**		
Hmong	**12**	Pacific Islander, NOS	**97**
Kampuchean; Cambodian; Khmer	**13**	some other known race[3]	**98**
Thai	**14**	unknown[4]	**99**
Micronesian, NOS	**20**		

[1] The Office of Management and Budget defines this category to include people with origins in Europe, the Middle East and North Africa. If the medical record does not specify race, and the patient is described as Mexican, Puerto Rican or Cuban, code the patient as White.

[2] When a patient's race is recorded only as "Asian" or "Oriental" and the Birthplace is a specific Asian nation synonymous with one of the specific Asian race codes above, use the specific race code. For example, if the patient's fourth race is described just as "Asian" and he/she was born in Japan, enter code **05** for Japanese rather than **96**.

[3] This race can't be assigned to one of the codes **01 - 97**.

[4] All five race fields must be **99** if the patient's race is unknown. Code partial race information if possible.

Race 5

NAACCR Version 10 Item 164, columns 111-112

Use the following codes to enter the patient's fifth race (enter **88** if the patient is not multiracial, or if the patient has only four races):

Race 5	Code	Race 5	Code
White; Caucasian[1]	**01**	Chamorran	**21**
Black; African American; Negro	**02**	Guamanian, NOS	**22**
American Indian; Aleutian; Eskimo; Native North, South or Central American	**03**	Polynesian, NOS	**25**
		Tahitian	**26**
Chinese	**04**	Samoan	**27**
Japanese	**05**	Tongan	**28**
Filipino	**06**	Melanesian, NOS	**30**
Hawaiian (Native)	**07**	Fiji Islander	**31**
Korean	**08**	New Guinean	**32**
Asian Indian; Bangladeshi; Bhutanese; Nepalese; Pakistani; Sikkimese; Sri Lankan	**09**	no further race(s) documented	**88**
Vietnamese	**10**	other Asian race (including Indonesian, Burmese/Myanmaran); Asian, NOS[2]; Oriental, NOS[2]	**96**
Laotian	**11**		
Hmong	**12**	Pacific Islander, NOS	**97**
Kampuchean; Cambodian; Khmer	**13**	some other known race[3]	**98**
Thai	**14**	unknown[4]	**99**
Micronesian, NOS	**20**		

[1] The Office of Management and Budget defines this category to include people with origins in Europe, the Middle East and North Africa. If the medical record does not specify race, and the patient is described as Mexican, Puerto Rican or Cuban, code the patient as White.

[2] When a patient's race is recorded only as "Asian" or "Oriental" and the Birthplace is a specific Asian nation synonymous with one of the specific Asian race codes above, use the specific race code. For example, if the patient's fifth race is described just as "Asian" and he/she was born in Japan, enter code **05** for Japanese rather than **96**.

[3] This race can't be assigned to one of the codes **01 - 97**.

[4] All five race fields must be **99** if the patient's race is unknown. Code partial race information if possible.

Spanish/Hispanic Origin

NAACCR Version 10 Item 190, column 115

In the absence of specific information in the medical record, this field is used to reflect the "best guess" as to whether or not the patient should be classified as Spanish/Hispanic for purposes of calculating cancer statistics. Information on Spanish/Hispanic Origin may be found in the medical record. *All information sources* should be used to determine the best code, including stated ethnicity, Birthplace, personal history and language spoken, and maiden name/surname. Persons with Spanish surname/origin may be of *any* race(s); therefore, coding should always be independent of race. Spanish/Hispanic origin is not necessarily synonymous with birth in a Spanish-language country; use Birthplace as a guide in determining the correct code, but do not rely on it exclusively. (The MCR may code some patients as Hispanic based solely on Birthplace if no other information becomes available to us.) Native Americans, Filipinos and Portuguese/Cape Verdeans often have Hispanic names without being Hispanic. The following codes are used for this field:

Origin	Code
non-Spanish; non-Hispanic (including Brazilians, Portuguese and Cape Verdeans)	**0**
Mexican; Chicano	**1**
Puerto Rican	**2**
Cuban	**3**
Central American or South American *except* Brazilian*	**4**
other specific Spanish/Hispanic origin (including Spanish Europeans)	**5**
Spanish/Hispanic/Latino, NOS/Latina, NOS (There is evidence other than surname/maiden name that the person is Hispanic, but he/she cannot be assigned to any of the categories **1**-**5**.)	**6**
Spanish surname only** (The *only* evidence of person's possible Hispanic origin is maiden name/surname, and there is no evidence that the patient is non-Hispanic.)	**7**
unknown whether Spanish/Hispanic or not***	**9**

* Code Brazilians as non-Hispanic (**0**). Central and South American countries include Argentina, Belize, Bolivia, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Nicaragua, Panama, Paraguay, Peru, Suriname, Uruguay and Venezuela.

** See next page for details.

*** Use this code sparingly! If the medical record indicates nothing about Hispanic origin, and the maiden name/surname is not typically Hispanic, do not be afraid to code the person as non-Hispanic if this is where your best judgment leads.

Using Spanish Surnames/Maiden Names (when all else fails) **and Code 7**

Although someone of Spanish origin may have *any* name, and someone *not* of Spanish origin may have a name that is "typically" Spanish, we would prefer a code based on name alone rather than a complete unknown. Entering **7** (for "Spanish surname *only*") does NOT mean that the patient is assumed Hispanic; it merely means that the person's *name* is typically Spanish.

Information recorded in the medical record about Hispanic ethnicity always takes precedence over assumptions based solely on name. If the medical record describes the patient as Mexican, Puerto Rican, Cuban or another specific origin in codes **1-5**, enter the appropriate code *regardless* of whether or not the patient's surname/maiden name is Hispanic.

If the patient has a Spanish surname/maiden name, but the medical record indicates that he/she is not of Spanish origin, enter **0** (for "non-Hispanic").

Lacking further information, the list on the following pages may be used to identify which names most commonly belong to those of Spanish origin. Researchers at the U.S. Census Bureau found that over 75% of individuals having each of these common surnames identified themselves as being of Spanish origin in the 1990 Census. Persons with these 639 surnames combined comprised over two-thirds of the U.S. Spanish-origin population.

If the medical record contains no useful information on Spanish origin, and if the patient's surname/maiden name matches one of the names listed, and nothing in the medical record indicates that the patient is *not* Spanish/Hispanic, enter code **7** (*not* code 6). If, however, the patient's name does *not* appear on this list, DO NOT AUTOMATICALLY ASSUME that the patient is non-Hispanic; use your best judgment to determine the best code.

Exceptions: If the surname/maiden name contains the letter "**k**" or "**w**" and the medical record does not indicate that the person is Hispanic, assume s/he is non-Hispanic and enter **0**. "K" and "w" are virtually *never* in Spanish surnames, although they may be in "Americanized" versions of originally Spanish surnames.

Examples:

Name is "John Howard". Medical record indicates that he *is Hispanic*. Enter **6** for Hispanic, NOS.

Name is "John Howard". Medical record has *no* information on Hispanic ethnicity. Enter code **0** for assumed non-Hispanic based on the "w" in the surname.

Name is "John Abeyta". Medical record indicates that he is *not* Hispanic. Enter code **0** because the medical record information takes precedence over the name.

Name is "John Abeyta". Medical record has *no* information on Hispanic ethnicity. Enter **7** because the surname appears in the Census list.

source: David L. Word & R. Colby Perkins, Jr., Technical Working Paper No. 13 -- "Building a Spanish Surname List for the 1990's", U.S. Bureau of the Census Population Division, March 1996.

Abeyta
Abrego
Abreu
Acevedo
Acosta
Acuna
Adame
Adorno
Agosto
Aguayo
Aguilar
Aguilera
Aguirre
Alanis
Alaniz
Alarcon
Alba
Alcala
Alcantar
Alcaraz
Alejandro
Aleman
Alfaro
Alicea
Almanza
Almaraz
Almonte
Alonso
Alonzo
Altamirano
Alva
Alvarado
Alvarez
Amador
Amaya
Anaya
Anguiano
Angulo
Aparicio
Apodaca
Aponte
Aragon
Arana
Aranda
Arce
Archuleta
Arellano
Arenas
Arevalo
Arguello
Arias
Armas
Armendariz
Armenta
Armijo
Arredondo
Arreola
Arriaga
Arroyo
Arteaga
Atencio
Avalos
Avila
Aviles
Ayala
Baca
Badillo
Baez
Baeza
Bahena
Balderas
Ballesteros
Banda
Banuelos
Barajas
Barela
Barragan
Barraza
Barrera
Barreto
Barrientos
Barrios
Batista
Becerra
Beltran
Benavides
Benavidez
Benitez
Bermudez
Bernal
Berrios
Betancourt
Blanco
Bonilla
Borrego
Botello
Bravo
Briones
Briseno
Brito
Bueno
Burgos
Bustamante
Bustos
Caballero
Caban
Cabrera
Cadena
Caldera
Calderon
Calvillo
Camacho
Camarillo
Campos
Canales
Candelaria
Cano
Cantu
Caraballo
Carbajal
Cardenas
Cardona
Carmona
Carranza
Carrasco
Carrasquillo
Carreon
Carrera
Carrero
Carrillo
Carrion
Carvajal
Casanova
Casares
Casarez
Casas
Casillas
Castaneda
Castellanos
Castillo
Castro
Cavazos
Cazares
Ceballos
Cedillo
Ceja
Centeno
Cepeda
Cerda
Cervantes
Cervantez
Chacon
Chapa
Chavarria
Chavez
Cintron
Cisneros
Collado
Collazo
Colon
Colunga
Concepcion
Contreras
Cordero
Cordova
Cornejo
Corona
Coronado
Corral
Corrales
Correa
Cortes
Cortez
Cotto
Covarrubias
Crespo
Cruz
Cuellar
Curiel
Davila
Deanda
Dejesus
Delacruz
Delafuente
Delagarza
Delao
Delapaz
Delarosa
Delatorre
Deleon
Delgadillo
Delgado
Delrio
Delvalle
Diaz
Dominguez
Dominquez
Duarte
Duenas
Duran
Echevarria
Elizondo
Enriquez
Escalante
Escamilla
Escobar
Escobedo
Esparza
Espinal
Espino
Espinosa
Espinoza
Esquibel
Esquivel
Estevez
Estrada
Fajardo
Farias
Feliciano
Fernandez
Ferrer
Fierro
Figueroa
Flores
Florez
Fonseca
Franco
Frias
Fuentes
Gaitan
Galarza
Galindo
Gallardo
Gallegos
Galvan
Galvez
Gamboa
Gamez
Gaona
Garay
Garcia
Garibay
Garica
Garrido
Garza
Gastelum
Gaytan
Gil
Giron
Godinez

PATIENT INFORMATION cont.

Godoy
Gomez
Gonzales
Gonzalez
Gracia
Granado
Granados
Griego
Grijalva
Guajardo
Guardado
Guerra
Guerrero
Guevara
Guillen
Gurule
Gutierrez
Guzman
Haro
Henriquez
Heredia
Hernadez
Hernandes
Hernandez
Herrera
Hidalgo
Hinojosa
Holguin
Huerta
Hurtado
Ibarra
Iglesias
Irizarry
Jaime
Jaimes
Jaquez
Jaramillo
Jasso
Jimenez
Jiminez
Juarez
Jurado
Laboy
Lara
Laureano
Leal
Lebron
Ledesma
Leiva
Lemus
Leon
Lerma
Leyva
Limon
Linares
Lira
Llamas
Loera
Lomeli
Longoria
Lopez
Lovato
Loya
Lozada
Lozano
Lucero
Lucio
Luevano
Lugo
Lujan
Luna
Macias
Madera
Madrid
Madrigal
Maestas
Magana
Malave
Maldonado
Manzanares
Mares
Marin
Marquez
Marrero
Marroquin
Martinez
Mascarenas
Mata
Mateo
Matias
Matos
Maya
Mayorga
Medina
Medrano
Mejia
Melendez
Melgar
Mena
Menchaca
Mendez
Mendoza
Menendez
Meraz
Mercado
Merino
Mesa
Meza
Miramontes
Miranda
Mireles
Mojica
Molina
Mondragon
Monroy
Montalvo
Montanez
Montano
Montemayor
Montenegro
Montero
Montes
Montez
Montoya
Mora
Morales
Morena
Mota
Moya
Munguia
Muniz
Munoz
Murillo
Muro
Najera
Naranjo
Narvaez
Nava
Navarrete
Navarro
Nazario
Negrete
Negron
Nevarez
Nieto
Nieves
Nino
Noriega
Nunez
Ocampo
Ocasio
Ochoa
Ojeda
Olivares
Olivarez
Olivas
Olivera
Olivo
Olmos
Olvera
Ontiveros
Oquendo
Ordonez
Orellana
Ornelas
Orosco
Orozco
Orta
Ortega
Ortiz
Osorio
Otero
Ozuna
Pabon
Pacheco
Padilla
Padron
Paez
Pagan
Palacios
Palomino
Palomo
Pantoja
Paredes
Parra
Partida
Patino
Paz
Pedraza
Pedroza
Pelayo
Pena
Perales
Peralta
Perea
Peres
Perez
Pichardo
Pino
Pineda
Pizarro
Polanco
Ponce
Porras
Portillo
Posada
Prado
Preciado
Prieto
Puente
Puga
Pulido
Quesada
Quezada
Quinones
Quinonez
Quintana
Quintanilla
Quintero
Quiroz
Rael
Ramirez
Ramon
Ramos
Rangel
Rascon
Raya
Razo
Regalado
Rendon
Renteria
Resendez
Reyes
Reyna
Reynoso
Rico
Rincon
Riojas
Rios
Rivas
Rivera
Rivero
Robledo
Robles
Rocha
Rodarte
Rodrigez
Rodriguez
Rodriquez
Rojas
Rojo
Roldan
Rolon
Romero
Romo
Roque
Rosado
Rosales
Rosario
Rosas
Roybal
Rubio
Ruelas
Ruiz
Ruvalcaba
Saavedra
Saenz
Saiz
Salas
Salazar

Salcedo	Serrato	Tijerina	Valenzuela	Vigil
Salcido	Sevilla	Tirado	Valladares	Villa
Saldana	Sierra	Toledo	Valle	Villagomez
Saldivar	Sisneros	Toro	Vallejo	Villalobos
Salgado	Solano	Torres	Valles	Villalpando
Salinas	Solis	Torrez	Valverde	Villanueva
Samaniego	Soliz	Tovar	Vanegas	Villareal
Sanabria	Solorio	Trejo	Varela	Villarreal
Sanches	Solorzano	Trevino	Vargas	Villasenor
Sanchez	Soria	Trujillo	Vasquez	Villegas
Sandoval	Sosa	Ulibarri	Vazquez	Yanez
Santacruz	Sotelo	Ulloa	Vega	Ybarra
Santana	Soto	Urbina	Vela	Zambrano
Santiago	Suarez	Urena	Velasco	Zamora
Santillan	Tafoya	Urias	Velasquez	Zamudio
Sarabia	Tamayo	Uribe	Velazquez	Zapata
Sauceda	Tamez	Urrutia	Velez	Zaragoza
Saucedo	Tapia	Vaca	Veliz	Zarate
Sedillo	Tejada	Valadez	Venegas	Zavala
Segovia	Tejeda	Valdes	Vera	Zayas
Segura	Tellez	Valdez	Verdugo	Zelaya
Sepulveda	Tello	Valdivia	Verduzco	Zepeda
Serna	Teran	Valencia	Vergara	Zuniga
Serrano	Terrazas	Valentin	Viera	

Tobacco History

NAACCR Version 10 Item 340, column 224

It is important to collect information on tobacco use for as many cancer patients as possible, regardless of diagnosis. This information can often be found in the medical record in the patient history and physical examination, anesthesia forms, nurses' notes, or social services notes. If necessary, the medical records of previous admissions should also be reviewed to see if there was past tobacco use for patients who are now non-users. Use the following codes for cases diagnosed beginning in 1996:

History	Code
never used tobacco	**0**
cigarette smoker, current	**1**
cigar or pipe smoker, current	**2**
snuff/chew/smokeless tobacco user, current	**3**
combination tobacco use, current	**4**
previous tobacco use	**5**
unknown	**9**

Occupation and Industry

Information on the occupation and industry of cancer patients can be used in research on possible links between workplace exposures and cancer. In addition, occupation and industry information can be useful in identifying groups of workers in particular need of preventive services (such as screening) regardless of whether or not their cancers were *caused* by their work. Because these studies rely on comparisons between different occupations and industries, it is important to collect accurate information for all cancer patients, regardless of age, sex, occupation or diagnosis. Occupation and industry information from the central registry is often used by researchers as a partial proxy indicator of socioeconomic status. Specific occupational information can also help identify a patient being reported by multiple hospitals in different ways (with different name spellings or birthdates, for example).

Information on occupation and industry may be found in a history and physical, nurses' notes, social services notes, admitting sheet, etc. It may be necessary to review earlier or later admission records. The MCR collects information regarding the patient's usual occupation and industry (meaning the type of job held during most of the person's working life). This is not necessarily the patient's current or most recent job, especially for the elderly. Please make every attempt to determine the patient's usual occupation and industry. If the medical record only includes the type of business or employer's name, enter this partial information.

The following rules and guidelines apply to the occupation and industry fields:

- No occupation/industry information: When there is no information available for either occupation or industry, enter **Unknown** in both the Usual Occupation and Usual Industry/Type of Business fields. Do not use the term "none" which could mean that the individual has never worked. Please don't leave the fields empty or we will have to assume that the medical record has not yet been reviewed for this information.
- Incomplete information: You need not have specific information in both fields if it is unavailable. Enter **Unknown** in the Usual Industry field if information on occupation, but not industry, is available. Similarly, if only information on industry is available, enter **Unknown** for Usual Occupation.
- More than one occupation/industry: Try to determine the occupation/industry held during most of the patient's life; otherwise, list all occupations as space allows.
- Only a current occupation/industry listed: If you know only the most recent or current occupation/industry, record this. Adding **Current** to the text would be helpful.
- Housewives/persons at home: For patients who worked outside the home but spent most of their lives homemaking, use **Housewife** or **Househusband**. Record the patient's Usual Occupation outside home if s/he spent most of their time working outside home. If no information is available for an occupation outside the home, enter **At Home** or **Own Home** in the Usual Industry field, and **Housewife/husband** in the Usual Occupation field. (These terms are preferable to "homemaker" or "housekeeper", which can be confused with occupations outside the home.)

- Retired persons: Review the patient's record for information on a past occupation, industry or employer. *Only* when there is no information available, enter **Retired** in both the Usual Occupation and Usual Industry fields.
- Unemployed/disabled persons: Attempt to find a former occupation or industry for persons currently unemployed or disabled. If it is known that the patient has *never* worked, enter **Never Worked** in both Usual Occupation and Usual Industry fields.
- Children: If the patient is a child, please enter **Child** in both fields. *Note*: It is no longer necessary to search for a parent's occupation/industry.
- Students: If the patient is an adult and is a student, review the patient's record for information about any job which the student may have held previously or concurrently with attending school. If no information is available, enter **Student** in both fields.
- Armed Forces: If known, enter the branch of service (Army, Navy, etc.) in the Usual Industry field; if the branch is not known, enter **Armed Forces** or **Military**. The Armed Forces include both civilian and military occupations: for civilian occupations, enter the appropriate description (e.g., nurse, payroll clerk, cook) in the Usual Occupation field; for military occupations, provide the rank (e.g., private, sergeant, captain), if available, as well as the type of job (e.g., pilot, tank driver).

Usual Occupation

NAACCR Version 10 field "Text--Usual Occupation", Item 310, columns 143-182

Enter the patient's "usual occupation", using up to forty characters. "Usual occupation" refers to the type of job the individual was engaged in for most of his/her working life (e.g., accountant, truck driver, teacher, auto mechanic, textile machine operator). If the patient is not employed at the time of diagnosis, make every attempt to determine the longest held occupation. Avoid general terms such as "student", "housewife", "retired", "unemployed" or "disabled" unless no other information regarding a previous occupation can be found.

Although any information is useful, please provide as detailed a description of occupation as possible, because this will allow for more accurate coding of the information.

Examples:

Common entry	Preferable detailed entry
Analyst	computer systems analyst, financial analyst, food analyst
Computers	software engineer, computer assembler, computer repair
Construction worker	construction laborer, carpenter, plumber, electrician
Engineer	electrical engineer, chemical engineer, power plant engineer
Factory worker	assembler, lathe operator, stitcher, spray painter, riveter
Mechanic	auto mechanic, elevator mechanic, refrigeration mechanic
Teacher	art teacher, gym teacher, welding teacher
Technician	computer technician, X-ray technician

Usual Industry / Type of Business

NAACCR Version 10 field "Text--Usual Industry", Item 320, columns 183-222

Enter the industry associated with the patient's Usual Occupation, using up to forty characters.

"Industry / Type of Business" refers to the kind of activity at a person's workplace. "Usual Industry" is the type of work or activity carried on by the business at the location where the individual worked in his/her Usual Occupation (e.g., accounting firm, trucking company, elementary school, auto repair shop, furniture manufacturer).

If the medical record contains the employer's name but does *not* specify what type of work went on there, then you may enter just the employer's name here. Do not abbreviate the name unless the employer is very commonly known. Also, if you cannot determine the type of work carried on by the employer, include the city/town where employed (e.g., **General Electric, Lynn, MA**) as this can help identify the employer's industry and distinguish different branches of a company having the potential for different occupational exposures.

Do not be concerned about trying to record the exact employer name and location for every patient! It is only *types* of industry/business that can be coded easily. When you can determine what type of work was carried out at the employer's location, you need only describe this *type* of work. You only have to try and specify the exact employer name/location if you *cannot* determine that employer's type of business/activity.

For self-employed persons, do not just enter "self" or "own company" here! Is the patient a self-employed artist, lawyer, writer, cook or dentist? Describe this person's type of business.

Avoid very general terms unless no other information can be found. Try to give sufficient detail so that someone can determine the actual business activity. For example, "automotive" could refer to manufacturing, car or parts sales, or repairs.

Examples:

Common entry	Preferable detailed entry
Electrical	electrical products manufacture, electric utility, electric contractor
Health care	hospital, doctor's office, home health service
Lumber	logging, sawmill, retail lumberyard
Sales	auto dealership, realtor, book seller, telemarketing
Transportation	bus company, taxi, trucking, airline, railroad, travel agency
Utility	electric utility, gas utility, water utility, communications utility

Name -- Spouse/Parent

NAACCR Version 10 Item 2290, columns 2036-2085

Record the name of the patient's most recent spouse (if applicable, living or dead) or a parent (if the patient is a child) when this information is known to you. Leave the field empty if it's not applicable for a given patient or if the information is unavailable. Use any format you wish. The field is optional and is not planned for automated matching purposes at this time, so we will not try to limit its entry with too many data standards. It holds up to fifty characters.

Example: The medical record notes that the patient's spouse is Charles Smith. Enter **Charles_Smith**, **Smith_Charles** or just **Charles**.

In addition to helping clarify a patient's identity, this field is useful when the MCR is trying to verify or track down a patient's usual residence address at the time of diagnosis. Children or elderly women, for example, may not be easily found *except* by proxy through the name of a parent or husband with whom they live -- so knowing that our patient Ann Smith with PO Box 5 is Mrs. Charles Smith of 10 Main Road can help a great deal. If a patient is a widow or widower, we may find the patient as the informant on the deceased spouse's death certificate and be able to track the patient's address forward from that point in time. We are NOT requesting this field for *contact* purposes and we have no plans to provide it to outside researchers; MCR staff will use it in our routine address research when a patient cannot easily be found under his or her own name.

Primary Site Code

NAACCR Version 10 field "Primary Site", Item 400, columns 291-294

Enter the code for the site of origin from the Topography section of ICD-O-3. [Note that ICD-O-2 code C14.1, laryngopharynx, should not be used for diagnoses made on or after January 1, 1995. "Laryngopharynx" became an equivalent term under C13.9 (hypopharynx, NOS) as of this diagnosis date. Code C14.1 is not an ICD-O-3 code.]

Enter the site code that matches the narrative primary site indicated in the medical record, or the site code most appropriate for the case. Site codes are found in ICD-O-3's Numerical Lists - Topography section (pages 45-65) and in its Alphabetic Index (pages 105-218).

In ICD-O-3 primary site codes consist of the letter "C" followed by two digits, a decimal point, and a third digit. "**C**" should be entered but the decimal point should *not* be entered.

Example: The primary site is "cardia of stomach". Look this up in the Alphabetic Index of ICD-O-3 under "stomach" (it's not under "cardia"), and the corresponding code "C16.0" is found. Enter **C160**.

Most sites include a third digit of "8" to be used for single tumors that overlap the boundaries of two or more anatomically contiguous subsites and whose exact point of origin cannot be determined, unless the combination of sites is specifically indexed elsewhere. For example, a tumor *originating* in the breast upper inner quadrant (C50.2) that has grown into the lower inner quadrant (C50.3) is assigned to the point of origin, **C502**; a tumor overlapping those two subsites whose exact origin is *not* determined would be assigned to **C508**. A carcinoma of the esophagus and stomach may be assigned to **C160** (esophagogastric junction) rather than a ".8" site. The exception is C77.8 -- **C778** is assigned for lymph node lymphomas involving multiple lymph node regions.

Some ".8" sites cover a single tumor overlapping multiple primary sites rather than just subsites; for example, **C218** is used for a lesion overlapping the rectum (C20.9), anus (C21.0) and anal canal (C21.1), and **C148** covers the lip, oral cavity and pharynx; see Table 17 on page 25 of ICD-O-3 for more of these codes.

Most sites also include a third digit of "9" to be used when a subsite is not specified, and for multiple tumors originating in different subsites of the organ. Sites C14, C21, C22, C30, C38, C42, C48 and C76 do not have ".9" codes. Not all "NOS" site terms have codes ending in ".9", however; for example, "bile duct, NOS" is assigned to C24.0 with the *extra*hepatic bile ducts and "pharynx, NOS" is C14.0. Some sites have *only* a ".9" code to define them (C01, C07, C12, C19, C20, C23, C33, C37, C52, C55, C56, C58, C61, C64, C65, C73, C80).

Site-Associated Morphologies

Some types of neoplasms are normally associated with certain primary sites by default. For example, hepatocellular carcinoma (8170/3) arises in the liver (C22.0); therefore, "hepatocellular carcinoma", with no other statement about topography, should be coded to primary site **C220**. If the patient's medical record contains a morphologic term which has an associated site code in ICD-O-3, use this site code if no definite site is given or if only a metastatic site is given. If the site specified by a physician differs from the associated site in ICD-O-3, report the site specified by the physician.

Example: A medical record describes infiltrating duct carcinoma (8500/3) of the pancreas. Assign site code **C259** (or a more specific portion of the pancreas, if possible) even though ICD-O-3 suggests that the site breast (C50._) is most ordinarily associated with this morphology.

For a more extensive discussion of site-associated morphologies, see "Rule H" in the "Summary of Principal Rules for Using ICD-O" and "Coding Guidelines for Morphology" sections (page 21 and pages 32-33) in ICD-O-3.

Pseudo-topographic Morphology Terms

Some *morphology* terms contain, or seem to contain, primary site terminology; but do not let these terms confuse your choice of primary site code when the medical record indicates otherwise. Examples are "adenocarcinoma, intestinal type" (8144/3) with an associated site of stomach (C16._) rather than an intestine site, and "adenoid basal carcinoma" (8098/3) with an associated site of cervix uteri (C53._) rather than adenoid. See specific examples on page 33 in ICD-O-3. Also, do not confuse histologic adjectives like "endometrioid" with similar sounding site terms like "endometrium".

Primary-Versus-Secondary (Metastatic) and Ill-Defined Sites

A primary site should always be reported to the MCR, rather than a metastatic or secondary site. If the place of origin cannot be identified exactly, use the following guidelines:

- NOS subcategory (usually ends with ".9"): Use these codes when an organ subsite is not specified. Do *not* use the NOS code if a more descriptive term is available.

- Other and Ill-Defined Sites (C76.0-C76.8): These may be used for diagnoses that refer to ill-defined sites or body regions, such as "pelvis", "arm" or "head". These sites contain many types of tissue (bone, skin, soft tissue). If the type of tissue in which the cancer originated can be identified or inferred, you may be able to use a more specific site than C76._. Watch for diagnoses like "basal cell carcinoma of the arm" because this may refer to skin of arm (therefore not a reportable case). Refer to Edits #76A and #76B on pages E-71-74 in Appendix E for specific examples of "assumed better primary sites" that may sometimes be assigned instead of a C76._ site.
- Unknown Primary Site (C80.9): If the primary site is unknown and the only available information is from a metastatic/secondary site, enter **C809** [but see also the sections **Site-Associated Morphologies** (above) and **Special Primary Site Conditions** below]. Please remember to notify the MCR (617-988-3382 or 617-988-3381) if a primary site is later identified for the case. If a primary site is not definitely identified but strongly suggested (as in "probably ovarian in origin" or "most likely from lung"), then assign the suggested site rather than a complete unknown.

Special Primary Site Conditions

Special rules apply to the following cases.

- Breast Duct and Lobular Carcinomas: See pages 24-25 for a discussion of certain mixed lesions of the breast. If such lesions occur separately but simultaneously in different quadrants (subsites) of the same breast, enter site code **C509**.
- Subareolar/Retroareolar Tumors: Code to central portion of breast (**C501**) to indicate that the tumor arose in tissue beneath the nipple and not in the nipple (C50.0) itself.
- Familial Polyposis: When multiple carcinomas arising from familial polyposis involve multiple segments of the colon (or colon and rectum), code the primary site as colon, NOS (**C189**).
- Kaposi Sarcoma (9140/3): Code the primary site in which the tumor arises. If Kaposi sarcoma arises in skin and another site simultaneously, or if no primary site is stated, code to skin, NOS (**C449**).
- Leukemias (*except* myeloid sarcomas) (9800-9920, 9931-9948): Code to bone marrow (**C421**). See "Rule E" on pages 20 and 26 in ICD-O-3. Myeloid sarcomas (9930) are coded to the site of the leukemic deposit (see also page 89 herein). The *FORDS* Manual originally stated that leukemic reticuloendotheliosis (9940) could be assigned to a site other than C42.1 but this instruction has now been removed; assign C42.1 for this diagnosis.
- Cross-Indexed Lymphomas/Leukemias: ICD-O-3/ICD-10 introduced some new wrinkles in assigning primary site for some closely related hematologic diseases. See details on pages 88-89 in this MCR Manual.

- Nodal Lymphomas: *If no primary site is given* but the lymphoma is described as nodal in origin (or is suspected of being nodal in origin), enter **C779** (lymph node, NOS) rather than C809. If a nodal lymphoma involves multiple lymph node regions at diagnosis, code to **C778** (lymph nodes of multiple regions). Nodal lymphomas include those arising in *lymphatic tissue* outside lymph nodes, such as in the tonsils, spleen, Waldeyer ring or thymus. (Assign nodal lymphomas to these primary sites when they are specified as such.) See "Rule D" on page 26 in ICD-O-3. A lymphoma with a *mass* described only as "retroperitoneal", "inguinal", "mediastinal" or "mesentery/mesenteric" should be coded as a nodal lymphoma (**C779**) when there is no more specific information for primary site.
- Extranodal Lymphomas: See "Rule D" on page 26 in ICD-O-3, and "ICD-O-3 Errata and Clarifications, 5/22/01, Rule D: coding extranodal lymphomas". Code to the appropriate extranodal site (e.g., stomach, lung, skin) when there is no nodal involvement of any kind, or if it is recorded that the origin was a specific extranodal site. If a lymphoma is described as extranodal in origin (or is suspected of being extranodal in origin) and lymph nodes are *not* involved but the exact primary site cannot be determined, assign an unknown primary site (**C809**) rather than C77.9; but if lymph nodes *are* involved, an extranodal lymphoma may be coded to a lymph node primary site (**C77_**) if the specific extranodal point of origin cannot be determined. If a lymphoma involves *both* nodal tissue and an extranodal site, try to determine the specific site of origin and code to that site (lymph node, lymphatic tissue, or extranodal site); but if the site of origin cannot be identified, use lymph node, NOS **C779**.
- Cutaneous Lymphomas: If no primary site is specified for mycosis fungoides or another cutaneous lymphoma, enter **C449** or a specific skin site (**C44_**) to which the disease is limited.
- Lymphoreticular Process: For malignancies of the lymphoreticular process classified as *myeloproliferative* (arising in bone marrow), code to bone marrow (**C421**). For lymphoreticular process malignancies classified as *lymphoproliferative* (arising in lymph tissue), code to lymph node, NOS (**C779**). Code *unspecified* malignancies of the lymphoreticular process to reticuloendothelial system, NOS (**C423**).
- Melanomas (8720-8790): If the primary site is unknown, code to skin, NOS (**C449**) unless a non-skin associated primary site is given in ICD-O-3 (for example, a spindle cell melanoma of type A (8773) would be assigned to **C69_** unless a different site is specified in the record). Assign **C449** if metastatic melanoma is found but no primary site is specified.
- Neuroblastomas (9500): Code neuroblastomas of ill-defined sites to the most likely site for each case. [Medulla of adrenal gland (**C741**) is a common site.] If the primary tumor's location is unknown, enter **C499** (connective, subcutaneous and other soft tissues, NOS).

- Prefixes: If a topographic term is modified by a prefix like "peri", "para", "pre", "supra", "infra" or similar modifiers, and the modified term is not specifically listed in ICD-O-3, assign the corresponding ill-defined site if the histology does not have an associated site. This rule also applies when tumors are described as originating "in the area of" or "in the region of" a specific site. (See Rule B on pages 20 and 25 in ICD-O-3.) For example, a tumor only described as arising "in the area of the rectum" should be assigned to **C763** (pelvis, NOS) because the type of tissue in which the tumor originated is not specified; "perirenal tissue" is assigned code **C480** in ICD-O-3, but a "perigastric" tumor should be assigned to **C762** (abdomen, NOS).

Inferred Primary Site and Experience

Lastly, text from the medical record cannot always be taken *literally* in assigning a primary site code. The need to assign a Primary Site Code to each cancer case is not always on the mind of individuals writing descriptions in the medical record. The general location of a tumor may be described rather than the specific type of tissue in which it arose, and sometimes a primary site must be *inferred* from information in the record. Consult a physician when possible if the site of origin is unclear. If your common sense and experience as a cancer registrar tell you that the medical record is indicating a very unusual primary site for a given diagnosis, be sure to verify this. For example, for simplicity a medical record may contain a phrase like "carcinoma of the mandible", "uterine sarcoma", "cholangiocarcinoma of the liver", "brain meningioma", "skull meningioma" or "lymphoma of the mediastinum" to describe the *general* current anatomic location of a tumor rather than its exact organ or tissue of origin.

If the combination of morphology and primary site for a particular case is unusual enough to trip an automated edit, and if you have verified the information, please note in the Comments/Narrative Remarks field (or other MCR-collected narrative) that this combination was verified, and indicate how it was verified.

If the primary site is unclear or doubtful in the medical record, document this in the Comments/Narrative Remarks field (or other MCR-collected narrative) and indicate why you chose the site code that you're reporting. For example, you might say, "probable lung primary", or "ovarian or lung primary? treatment as for ovary", or "MD favors lung primary".

Laterality

NAACCR Version 10 Item 410, column 295

Laterality must be coded for each case reported. Use the following codes to classify the Laterality *of the primary site* at diagnosis:

Laterality	**Code**
not a paired site, including unknown primary	**0**
Right side is origin of cancer.	**1**
Left side is origin of cancer.	**2**
only one side involved, right or left origin not specified	**3**
bilateral involvement, but origin unknown -- and stated to be a single primary (including bilateral ovarian primaries of the same histologic type diagnosed within 2 months of each other; bilateral retinoblastomas; and bilateral Wilms tumors)	**4**
paired site, but no information concerning Laterality; midline tumor in a singular "paired" site	**9**

For an unknown primary site (C80.9), always enter code **0**.

Code **4** should not be used for bilateral primaries for which separate abstracts are prepared, nor when the origin side is *known*, nor when both sides have metastatic disease except as noted.

Example: a left ovarian primary with metastasis to the right ovary -- enter code **2** (not **4**) because the origin of the disease was stated to be on the left

Codes **1-9** are used for the sites in **Table IV.1** (starting on next page) *except as noted*. Only "preferred" terms are listed in this table, but Laterality must be coded for all terms at these sites unless specifically excluded in the table's text; the exclusions are unpaired subsites to be coded **0**.

Examples: Primary Site is carina (unpaired), C34.0 - enter Laterality code **0**.
Primary Site is main bronchus (paired), C34.0 - enter a Laterality code **1-9**.

Note that beginning with diagnoses made in 2004, the number of primary sites to be coded **1-9** increases. Some CNS sites have been added to Table IV.1. Some are truly paired, while others are single organs for which tumor origin on the right/left side of the midline (right/left hemisphere) is being captured in Laterality. Although these "new" paired sites were coded unpaired (**0**) in the past, the standard-setters are allowing them to be coded unpaired *or* paired for pre-2004 diagnoses. That is, once your software has been updated for abstracting 2004 diagnoses, when coding a pre-2004 diagnosis you may code Laterality for the "newly paired" sites **0** or **1-9**; but for diagnoses beginning in 2004 you MUST code **1-9** for these sites.

SEER rules allow a non-zero Laterality to be coded for unpaired primary sites, but the MCR prefers the rule appearing in the *FORDS* Manual on its pages 10 and 92 -- all unpaired sites should be coded with **0** (with the CNS primary site exception noted above). The MCR wants *only* sites listed in Table IV.1 to be entered with Laterality codes **1 - 9**. Do NOT use codes **1 - 9** when *unpaired* sites are described with left/right terms (such as right colon, left lobe of thyroid or right celiac nodes). Note that lymph nodes (C77._) are NOT considered to be paired (use code **0**).

For paired primary sites, the narrative field for Primary Site MUST include text that will verify the Laterality (see page 86). It is very common for the MCR to receive Laterality codes which do not match their narrative descriptions.

Table IV.1 **Paired Organ Sites** -- sorted by Primary Site Code

ICD-O-3 Code	Site
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage, nasal septum)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1-C34.9	Lung
C38.4	Pleura, NOS
C40.0	Long bones of upper limb, scapula and associated joints
C40.1	Short bones of upper limb and associated joints
C40.2	Long bones of lower limb and associated joints
C40.3	Short bones of lower limb and associated joints
C41.4	Pelvic bones and associated joints (excluding sacrum, coccyx and symphysis pubis)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C41.3	Rib, clavicle and associated joints (excluding sternum)
C44.3	Skin of other and unspecified parts of face (midline code **9**)
C44.5	Skin of trunk (midline 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

Table continued on next page….

Table IV.1 **Paired Organ Sites** -- sorted by Primary Site Code

C50.0-C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0-C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and adnexa
C70.0*	Cerebral meninges (midline code **9**)
C71.0*	Cerebrum (midline code **9**)
C71.1*	Frontal lobe (midline code **9**)
C71.2*	Temporal lobe (midline code **9**)
C71.3*	Parietal lobe (midline code **9**)
C71.4*	Occipital lobe (midline code **9**)
C72.2*	Olfactory nerve
C72.3*	Optic nerve
C72.4*	Acoustic nerve
C72.5*	Cranial nerve, NOS
C74.0-C74.9	Adrenal gland
C75.4	Carotid body

* considered "paired" for diagnoses made beginning in 2004

Table IV.1 **Paired Organ Sites** -- sorted by preferred primary site term

ICD-O-3 Code	Site
C72.4*	Acoustic nerve
C74.0-C74.9	Adrenal gland
C50.0-C50.9	Breast
C75.4	Carotid body
C70.0*	Cerebral meninges (midline code **9**)
C71.0*	Cerebrum (midline code **9**)
C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C49.1	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C72.5*	Cranial nerve, NOS
C63.0	Epididymis
C69.0-C69.9	Eye and adnexa
C57.0	Fallopian tube
C71.1*	Frontal lobe (midline code **9**)
C31.2	Frontal sinus

* considered "paired" for diagnoses made beginning in 2004

Table continued on next page….

Table IV.1 **Paired Organ Sites** -- sorted by preferred primary site term

C64.9	Kidney, NOS
C40.2	Long bones of lower limb and associated joints
C40.0	Long bones of upper limb, scapula and associated joints
C34.1-C34.9	Lung
C34.0	Main bronchus (excluding carina)
C31.0	Maxillary sinus
C30.1	Middle ear
C30.0	Nasal cavity (excluding nasal cartilage, nasal septum)
C71.4*	Occipital lobe (midline code **9**)
C72.2*	Olfactory nerve
C72.3*	Optic nerve
C56.9	Ovary
C09.8	Overlapping lesion of tonsil
C71.3*	Parietal lobe (midline code **9**)
C07.9	Parotid gland
C41.4	Pelvic bones and associated joints (excluding sacrum, coccyx and symphysis pubis)
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C38.4	Pleura, NOS
C65.9	Renal pelvis
C41.3	Rib, clavicle and associated joints (excluding sternum)
C40.3	Short bones of lower limb and associated joints
C40.1	Short bones of upper limb and associated joints
C44.2	Skin of external ear
C44.1	Skin of eyelid
C44.7	Skin of lower limb and hip
C44.3	Skin of other and unspecified parts of face (midline code **9**)
C44.5	Skin of trunk (midline code **9**)
C44.6	Skin of upper limb and shoulder
C63.1	Spermatic cord
C08.1	Sublingual gland
C08.0	Submandibular gland
C71.2*	Temporal lobe (midline code **9**)
C62.0-C62.9	Testis
C09.9	Tonsil, NOS
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C66.9	Ureter

* considered "paired" for diagnoses made beginning in 2004

Narrative Primary Site

NAACCR Version 10 field "Text--Primary Site Title", Item 2580, columns 4095-4134

Describe the exact primary site in narrative, using up to forty characters. (If you need more space, continue in another text field.) A primary -- not metastatic -- site must be identified.

Information on primary site can be found in several sections of the medical record, and care should be taken to locate the most specific and accurate site. This is most often in the pathology report. If the record contains conflicting primary site information, a pathology report should take precedence over other information. If the primary site is still unclear, consult a physician.

Do not use an inappropriate automatic text label for the Primary Site Code (such as "skin of upper limb and shoulder" instead of "**skin right forearm**") to complete this field. This text is used to verify Primary Site Codes and help identify multiple reports received for the same case with different site codes. It often provides more specific site information than is conveyed by default/preferred terms and Primary Site Code alone (for example, "**carina**" is more specific than the default term "main bronchus" for Primary Site Code C340). NAACCR specifies that information from the medical record should be entered here manually and should NOT be generated from codes.

Remember that Laterality is tightly bound to Primary Site because different sides of paired organs are separate primary sites.* When a paired primary site is involved, *different* Laterality codes may be sent in by different facilities for the *same* case, making these appear to be reports of separate primaries. Important: We need text to verify the Laterality as well as the Primary Site Code for paired sites. Always add text like "**right**" or "**lt**" to verify the Laterality for paired sites. NAACCR also recommends verifying Laterality in this field.

For colorectal primaries, if the exact location of the cancer is described by a distance measurement from the anal verge, please include this measurement with your text. This is important because: *each* code C18.0-C20.9 (twelve codes) represents a separate primary site; because some facilities/pathologists never use the site C19.9 (rectosigmoid junction); and because it is very common for a single colorectal primary to be reported by different facilities under different Primary Site Codes, causing these reports to look like separate cases.

If the combination of primary site and morphology is unusual enough to trip an edit, include a note that this unusual combination has been verified and it was verified. The note could be in this field, the Narrative Histology/Behavior/Grade field, or Comments/Narrative Remarks.

If the primary site was unclear or doubtful in the record, indicate that here. If the primary site is truly unknown, enter "**unk primary site**" or some text that explains your choice of the code **C809**, such as "**liver mets found**", "**bx abdominal mass**" or "**possible lung or GI?**". (See page 81 in the "Primary Site Code" section.)

* except for malignancies of the "newly paired" CNS sites, C70.0, C71.0-C71.4, C72.2-C72.5

Histology / Behavior / Grade

ICD-O-2 Histologic Type Code

NAACCR Version 10 field "Histology (92-00) ICD-O-2", Item 420, columns 296-299

Refer to this Manual's Third Edition for coding diagnoses made before 2001. This field must be filled for pre-2001 diagnoses; it may remain empty for diagnoses made in 2001 and later.

ICD-O-3 Histologic Type Code

NAACCR Version 10 field "Histologic Type ICD-O-3", Item 522, columns 301-304

Enter the Histologic Type Code from the Morphology section of ICD-O-3. Histology codes appear in the Numerical Lists--Morphology (pages 69-104 in ICD-O-3) and in the Alphabetic Index (pages 105-218). Histologic Type need not be obtained from just the primary site.

Note: Both topography and morphology terms are included in the Alphabetic Index. Morphology codes are identified with "M" preceding the code but do not enter "M" in this field. Leukemias and lymphomas are *not* listed in the index under every possible wording of their associated terms; look first for these diseases in the index under "leukemia" (pages 158-162) and "lymphoma (malignant)" (pages 166-171). Compound morphology terms may be listed in the index with only one order of terms, but the reverse order of terms is also implied; for example, "fibromyxosarcoma" appears in the index and "myxofibrosarcoma" does not, but the same code would be applied to both.

The histology is represented by a five-digit code consisting of two parts: the Histologic Type (4 characters) and the Behavior Code (1 character). (Behavior is discussed on pages 95-98.) The MCR uses ICD-O rules for coding morphologies.

If a reportable histologic term is listed in ICD-O-3 followed by the notation "[obs]" (obsolete), that term may still be used and coded.

When coding Histologic Type from a pathology report, information in the final diagnosis is usually sufficient. The microscopic description or comments may have more specific information, however. If the final diagnosis only provides an "NOS" histologic description (such as just "carcinoma") but a more definitive statement (like "adenocarcinoma") can be found elsewhere in the report, the more definitive information should be used.

Specific cytogenetic data may take precedence over other terms for hematologic malignancies. For example, many codes are assigned to acute myeloid leukemias exhibiting different cytogenetic abnormalities. When a laboratory report specifies such cytogenetic data, this takes precedence over different descriptions of the morphology in the pathology report (see page 15 in ICD-O-3).

Lymphomas may be described under several classification schemes -- such as the Rappaport, Working Formulation, Revised European-American, French-American-British, WHO, Kiel and Lukes-Collins -- which may use different terms to describe the same disease. The WHO classification is most parallel to ICD-10 and ICD-O-3 coding. If a WHO term is absent, and if both Rappaport and Working Formation classifications are recorded, the *FORDS* Manual (on its page 93) specifies that the Working Formulation term should take precedence, although physicians may be decreasing their use of both schemes.

Cross-Indexed Lymphomas / Leukemias

Some lymphomas and leukemias are understood to be the same disease presenting differently (in different places, at different stages of development). In ICD-O-3 these diseases are listed with different codes and terms, but they have cross-referencing notes saying "(see also M-9###/3)" to denote that they are considered the same disease. The assignment of Histology (and primary site) for these cases is important for registries trying to group cases as lymphomas or leukemias.

If one of these diseases is diagnosed only in the blood or bone marrow, assign the leukemia morphology (and primary site C42.1, bone marrow).

If one of these diseases is diagnosed only in any other tissue, assign the lymphoma morphology (and primary site corresponding to the involved tissue -- usually lymph nodes, lymphatic structures or other lymph tissues).

If one of these diseases is diagnosed in both blood/bone marrow and some other tissue(s), use the lymphoma morphology and code primary site to the non-blood/bone marrow tissue involved.

Examples: "Burkitt lymphoma" diagnosed only in bone marrow -- Assign the Burkitt cell *leukemia* code **9826** and primary site bone marrow.

"Precursor B-cell lymphoblastic leukemia" found only in lymph nodes -- Assign the precursor B-cell lymphoblastic *lymphoma* code **9727**, with the primary site of the involved nodes.

"Precursor T-cell lymphoblastic leukemia" diagnosed in bone marrow cells and lymph nodes -- Assign the precursor T-cell lymphoblastic *lymphoma* code **9837** and the lymph node primary site.

The order of biopsies is *not* important in deciding the morphology and primary site. For example, if a positive lymph node biopsy is performed at one facility, and then a bone marrow biopsy at another facility also finds the disease there, the third category above applies. Obtaining diagnostic information from all facilities involved in the work-up of these cases may be especially important.

The cross-referenced ICD-O-3 lymphomas/leukemias (using just the "preferred" terms) are:

9670/3 malignant lymphoma, small B lymphocytic, NOS
and 9823/3 B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma (C42.1)

9687/3 Burkitt lymphoma, NOS
and 9826/3 Burkitt cell leukemia (C42.1)

9727/3 precursor cell lymphoblastic lymphoma, NOS
and 9835/3 precursor cell lymphoblastic leukemia, NOS (C42.1)

9728/3 precursor B-cell lymphoblastic lymphoma
and 9836/3 precursor B-cell lymphoblastic leukemia (C42.1)

9729/3 precursor T-cell lymphoblastic lymphoma
and 9837/3 precursor T-cell lymphoblastic leukemia (C42.1)

The following terms and codes are also cross-referenced in ICD-O-3:

9671/3 malignant lymphoma, lymphoplasmacytic
and 9761/3 Waldenstrom macroglobulinemia (C42.0)

Assign **9761** if diagnosed only in blood; assign **9671** if diagnosed only elsewhere; assign **9671** if both blood and other tissue(s) are involved.

9675/3 malignant lymphoma, mixed small and large cell, diffuse [obsolete term]
and 9690/3 follicular lymphoma, NOS

We don't understand this pair very well as they don't follow the pattern of the other "cross-indexed" diseases. Follicular lymphoma is a subcategory of mature B-cell neoplasms from the WHO classification of hematopoietic and lymphoid diseases. The obsolete mixed cellularity term is probably from an older classification system (perhaps Working Formulation), and its other associated terms seem to describe a more general type of disease that would include follicular lymphomas having transformations in both small and large cells.

Our best guidance from SEER has been that if these two diagnoses are made within two months of each other, assign **9690**. Differences in primary site and involved tissues do not seem determinant for choosing the appropriate histology as both are lymphomas and neither has a default ICD-O-3 primary site.

9861/3 acute myeloid leukemia, NOS (FAB or WHO type not specified) (C42.1)
and 9930/3 myeloid sarcoma

Assign **9861** if diagnosed only in bone marrow; assign **9930** if diagnosed only elsewhere; assign **9930** if both bone marrow and other tissue are involved.

Assigning the Best Histologic Type

General Rule: Before coding Histologic Type, a determination should be made as to whether the case involves a single primary or multiple primaries (because this determines whether or not you'll need to assign a single Histologic Type). (See pages 15-33 for a detailed discussion.) *All* pathology reports for the primary under consideration should be used. Although the report from the most representative tissue is usually the best, sometimes all of the cancerous tissue may be removed at biopsy; in such cases, the biopsy report must be used. If a definitive statement of a more specific histologic type is found in the microscopic description or in the comments, the more specific histologic diagnosis should be coded; in ICD-O-3, this is *not necessarily* the higher code number.

When coding histology, also use the following rules, adapted from SEER's 2002 document *Coding Complex Morphologic Diagnoses*. Follow these general rules in the order shown, and stop as soon as one applies to the particular situation in question.

Single Lesion, Multiple Morphologies: If a primary tumor contains multiple morphologies or a "mixed" morphology, proceed in the following order to assign the Histologic Type Code:

A. Use a combination code that includes all the morphologies, if one exists. ICD-O-3 contains *many* codes for describing single tumors containing multiple or mixed histologic types. Please see the SEER document *Coding Complex Morphologic Diagnoses*, pages 10-12, for a list of combination codes. There is also a special Appendix on this document clarifying the use of the combination code **8045**/3 (combined small cell carcinoma). Note that SEER cautions against using **8323**/3 (mixed cell carcinoma) as a combination code *except for* mixed cell carcinomas of gynecologic primary sites and mixed pancreatic islet cell carcinomas.

   Examples: mucinous adenocarcinoma and endometrioid adenocarcinoma of the ovary -- Use combination code **8323**/3.

   renal cell carcinoma, mixed clear cell and papillary -- Use combination code **8255**/3 (adenocarcinoma with mixed subtypes).

   adenocarcinoma of the lung, mixed acinar and papillary type -- Use combination code **8255**/3.

B. If there is no combination code for the histologies reported, compare the specificity of the terms. If one histologic term is more specific than the other, assign that one. If one of the histologies appears in ICD-O-3 as an "NOS term" (e.g., "adenocarcinoma, NOS") and the other term is more specific, use the more specific term.

   Example: invasive carcinoma, probably squamous cell type -- Code squamous cell carcinoma (**8070**/3) as it's more specific than "carcinoma, NOS" (8010/3).

C. Code the histology of the majority of the tumor if there is no combination code and if none of the terms is more specific than the others. Follow these choices in order:

C1. If the terms describe a "generic" cancer of a specific *type*, assume that the "type" represents the majority of the tumor and code that type.

Examples: duct carcinoma, cribriform type -- Code to cribriform carcinoma (**8201**/3).

adenocarcinoma, tubular type -- Code to tubular adenocarcinoma (**8211**/3).

C2. If there is not a subtype mentioned, look for other terms that may identify the majority of the tumor. "*Predominately...*", "*...type*", "*with features of...*" and "*with…differentiation*" are examples of phrases used to describe the majority of the tumor. (Examples of phrases which do not identify the majority of the tumor are "*with foci/focus of...*", "*with areas of...*", and "*with elements of...*".)

Example: predominately leiomyosarcoma (8890/3) associated with a focus of well-developed chondrosarcoma (9220/3) -- Code the histology of the majority of the tumor -- **8890**/3.

D. If the three situations (A-C) above do not apply, simply code the term that has the higher code number in ICD-O-3. Note that this is the easiest rule to remember, but it's the last choice you should make! These are usually cases of *very different* morphologies appearing in combination.

Examples: adenosquamous carcinoma (8560/3) and mixed small cell carcinoma (8045/3) -- There is not a combination code for these histologies, both are specific, and the majority histology is not identified. Assign the higher code number, **8560**/3.

malignant mesothelioma (9050/3) and neuroendocrine carcinoma (8246/3) -- Assign the higher code number, **9050**/3.

Single **Breast** Lesion, Complex Histologies: In addition to the above general rules, breast tumors have special detailed instructions for choosing the best histology. Again, follow the rules in the order listed and stop at the first situation that applies. Fall back on following the general rules (A-D) if the specific rules 1-5 do not apply to a particular case.

1. If the diagnosis involves duct/ductal AND lobular (infiltrating, *in situ*, or both), use the combination code for duct and lobular carcinoma (**8522**). (Assign invasive behavior if either term is invasive; assign *in situ* behavior if all terms are non-invasive.)

2. If the diagnosis involves invasive and *in situ* terms, code just the invasive histology. The noninvasive histology is considered to be of far less importance and is not captured in the histology assigned.

   Examples: infiltrating duct carcinoma with extensive cribriforming DCIS -- Code just the invasive histology, **8500**/3.

   invasive ductal carcinoma with DCIS of solid, cribriform and comedo types -- Code the only invasive histology, **8500**/3.

   foci of invasive lobular carcinoma with intraductal carcinoma and LCIS -- Code **8520**/3.

3. If the diagnosis involves duct/ductal OR lobular carcinoma mixed with another type of carcinoma, use the combination codes **8523** (duct mixed with other types of carcinoma)or **8524** (lobular mixed with other types of carcinoma). The words "mixed" or "and" should be used in the description between the histologies.

   Examples: duct carcinoma and tubular carcinoma -- Code **8523**/3.

   DCIS mixed with cribriform carcinoma *in situ* -- Code **8523**/2.

   lobular and adenoid cystic carcinoma -- Code **8524**/3.

   tubular carcinoma *in situ* and lobular carcinoma *in situ* -- Code **8524**/2.

4. Code a specific histologic type, subtype or variant, or look for terms denoting the majority of the tumor (such as "*predominantly*…." or "*with features of*…").

   Examples: duct carcinoma, tubular type -- Code as tubular carcinoma (**8211**/3).

   duct carcinoma with apocrine features -- Code as apocrine carcinoma (**8401**/3).

5. If there are multiple subtypes, assign a combination code.

   Examples: duct carcinoma, cribriform and comedo types -- Assign **8523**/3.

   DCIS showing both solid and cribriform features -- Assign **8523**/2.

Multiple Lesions in the Same **Breast**: If different histologies occur in separate tumors in one breast, use a combination code when possible and count the case as a single primary. When there is no combination code covering the histologies, count the tumors as multiple primaries and assign the histologies independently. SEER provides examples of using **8522** and **8543** (Paget disease and intraductal carcinoma) to combine multiple tumors, but they do not limit the rule to only these combination codes. The MCR believes that any combination code may be used in this way, including **8523** and **8524**. SEER does not refer to a time period, but the MCR believes that this rule must be referring to simultaneous diagnoses (made within two months of each other).

Mixed Germ Cell Tumor: SEER has detailed rules for assigning the best Histologic Type for a germ cell tumor of mixed/multiple morphologies, based on the relative rarity and severity of the limited different cell types. If one of the histologies is…

- choriocarcinoma (9100), then assign **9101** (choriocarcinoma combined with other germ cell elements);
- embryonal cell carcinoma (9070) or teratoma (9080), then assign **9081** (mixed embryonal carcinoma and teratoma);
- seminoma (9061-9064) with any non-seminoma (9070-9084, 9100), then assign **9085** (mixed germ cell tumor).

If none of the germ cell types is a seminoma (9061-9064), then assign **9065** (germ cell tumor, nonseminomatous).

Single Lesion, Multiple Histologies, Different Behaviors: If the ICD-O-3 Behavior Codes are different, select the morphology code with the higher Behavior Code number.

Example: squamous cell carcinoma *in situ* (8070/2) and papillary squamous cell carcinoma (8052/3) - Code as papillary squamous cell carcinoma (**8052**/3).

Exception: If the histology of the invasive component is a non-specific "NOS term" (e.g., carcinoma, adenocarcinoma, melanoma), and the noninvasive component has a more specific term, enter an invasive Behavior Code with the more specific Histologic Type.

Example: squamous cell carcinoma *in situ* (8070/2) with areas of invasive carcinoma (8010/3) - Code as squamous cell carcinoma (**8070**/3).

Multiple Lesions (with multiple histologies) Considered a Single Primary: When multiple tumors are considered a single primary, use the following rules in the order listed:

1. If one lesion is described with a non-specific "NOS term" (e.g., carcinoma, adenocarcinoma, sarcoma), and the other lesion is described with a more specific term (e.g., *large cell* carcinoma, *mucinous* adenocarcinoma, *spindle cell* sarcoma), code to the more specific term.

2. Some colon and rectum primaries are an exception to the above rule:

   When both an adenocarcinoma (8140/3) and an adenocarcinoma (*in situ* or invasive) in an adenomatous polyp (8210) or an adenocarcinoma (*in situ* or invasive) in (tubulo)villous adenoma (8261, 8263) arise in the same segment of the colon or rectum, code as adenocarcinoma, NOS (**8140**/3) rather than the more specific histology.

   When both a carcinoma (8010/3) and a carcinoma (*in situ* or invasive) in an (adenomatous) polyp (8210) arise in the same segment of the colon or of the rectum, code as carcinoma, NOS (**8010**/3) rather than the more specific histology.

3. If the histologies of multiple lesions can be represented by a combination code [e.g., a lobular carcinoma (8520/3) and a mucinous carcinoma (8480/3)], use that combination code (**8524**/3).

ICD-O-2 Behavior Code	NAACCR Version 10 field "Behavior (92-00) ICD-O-2", Item 430, column 300

Refer to the Third Edition of this manual for coding diagnoses made before 2001. This field must be filled for diagnoses made before 2001; it may be left empty for diagnoses made in 2001 and later.

ICD-O-3 Behavior Code

NAACCR Version 10 field "Behavior Code ICD-O-3", Item 523, column 305

The fifth digit of the ICD-O-3 morphology code (after the slash) is the Behavior Code. Use the best information from the entire pathology report to code behavior. *Any* amount of disease invasion makes the behavior invasive (/**3**).

Behavior is integral to case reportability requirements. The MCR requires that all cancers with a Behavior Code of **2** or **3** (malignancies) be reported, with certain exceptions noted below. If a histology appears in ICD-O-3 with *only* a Behavior Code of **0** or **1** but a pathologist has described the cancer as "malignant", you may change the Behavior Code to **3** and report the case (for example, a confirmed "malignant tumorlet" would be reportable as 8040/**3**; a carcinoid tumor of the appendix, if specified as invasive, would be reportable as 8240/**3** even though "NOS" carcinoid tumor of the appendix appears as 8240/1). (See "Rule F" on pages 20 and 29 of ICD-O-3.) Pilocytic astrocytomas, although appearing in ICD-O-3 with /**1**, are to be coded with /**3** Behavior in North America and are therefore reportable. As also noted on page 11 in this MCR Manual, the following are MCR malignancy reportability exceptions:

Morphology	
8000-8005	malignant neoplasms, NOS, of the skin (C44.0-C44.9)
8010-8046	epithelial carcinomas of the skin (C44.0-C44.9)
8050-8084	papillary and squamous cell carcinomas of the skin (C44.0-C44.9)
8090-8110	basal cell carcinomas of the skin (C44.0 - C44.9)

Note: The above morphologies of *any* non-C44 primary site will be reportable to the MCR as of January 1, 2004. For diagnoses made before 2004 SEER phrasing pointed out that these cancers were reportable for skin of the genital sites, and some interpreted this as meaning that they were *only* reportable for these sites.

In addition to malignancies, the MCR requires that cases with ICD-O Behavior Codes **0** or **1** of primary sites meninges, brain and central nervous system (C70._, C71._ and C72._) be reported for all diagnosis years beginning in 1982. Beginning with diagnoses made in 2004, cases with sites C75.1-C75.3 (pituitary gland, craniopharyngeal duct and pineal gland) also become reportable with any ICD-O-3 Behavior Code, including **0** and **1**. Remember that non-malignant (/0, /1) diseases must have an ICD-O code to be reportable.

For diagnoses made between 1998 and the end of 2003 the MCR does not require cases of anal, vaginal or vulvar intraepithelial neoplasia, Grade III (AIN, VAIN, VIN, histology 8077/**2**) because of uncertainty in the descriptions of these diagnoses. (This "Grade III" does not refer to the histopathologic grade/differentiation; it refers to the highest category of dysplasia in the Bethesda system for non-invasive lesions.) Per CDC/NPCR requirements, AIN, VAIN and VIN III become reportable to the MCR with diagnoses beginning in 2004.

Beginning with cases diagnosed on or after January 1, 1998, the MCR no longer requires reporting facilities to submit cases of carcinoma *in situ* (CIS) of the uterine cervix (Primary Site C53._ with Histologic Type Codes 8000-8110 and Behavior Code **2**). This includes cervical intraepithelial neoplasia, Grade III (CIN III, histology 8077/2), pre-invasive cervical neoplasia, and squamous intraepithelial neoplasia. Invasive carcinomas of the cervix (Behavior Code **3**) are reportable and must not be overlooked in casefinding. Prostatic intraepithelial neoplasia, Grade III (PIN, histology 8148/2) also became non-reportable to the MCR for diagnoses made as of January 1, 1998. Please note that SEER has recently clarified the concept of non-reportable CIS of the cervix, now excluding *all* histologies of the cervix with Behavior Code **2** from reportability (rather than just the simple carcinoma range). This was apparently always SEER's intent, so the MCR will begin observing this rule now and will in effect extend it back in time. Thus, for primary site C53._, *only* invasive cancers (Behavior Code **3**) are reportable to the MCR for diagnoses made as of 1998.

The codes for classifying Behavior are shown here:

Behavior	**Code**
benign	**0**
uncertain whether benign or malignant *borderline malignancy *low malignant potential *uncertain malignant potential	**1**
carcinoma *in situ* intraepithelial non-infiltrating non-invasive	**2**
malignant/invasive, primary site	**3**
malignant/invasive, metastatic site malignant/invasive, secondary site	** 6
malignant, uncertain whether a primary or metastatic site	** 9

* but pilocytic astrocytomas (9421/1) are coded as if malignant (**3**)

** This is a reportable behavior, but enter code **3** for the MCR. Code "6" indicates behavior at a metastatic site. If the only specimen is from a metastatic site, code the Histologic Type from this site but use **3** for Behavior Code.

Example: A patient had a liver biopsy showing metastatic adenocarcinoma (8140), and the primary site is unknown (C80.9). Code the histology as adenocarcinoma (8140/**3**).

Each of these Behavior Codes appears in ICD-O-3 next to varying number of histology codes:
about 290 histology codes appear with a /**0** benign behavior;
about 150 histology codes appear with a /**1** uncertain behavior;
only 30 histology codes appear with a /**2** *in situ* behavior;
about 550 histology codes appear with a /**3** malignant behavior;
only 6 codes appear with a /**6** metastatic behavior (8000, 8010, 8070, 8140, 8480, 8490);
only 3 codes appear with a /**9** primary/secondary uncertainty behavior (8000, 8010, 8800).

Remember that the Behavior Code appearing next to a histologic type in ICD-O-3 may be changed to reflect the cancer's true behavior; for example, not every histology which could be metastatic is shown with /**6**, and not all histologies which may be *in situ* are listed with /**2**.

In Situ -- The following terms indicate *in situ* /**2** behavior (ICD-O-3):

- adenocarcinoma in an adenomatous polyp with no invasion of stalk (8210/2)
- Bowen disease (8081/2) (C44._) (reportable for non-C44._ sites)
- Clark's Level 1 for melanoma, limited to epithelium (8720/2)
- comedocarcinoma, noninfiltrating (8501/2) (C50._)
- confined to epithelium
- Hutchinson melanotic freckle, NOS (8742/2) (C44._)
- intracystic, noninfiltrating (for example, a carcinoma 8504/2)
- intraductal*
- intraepidermal, NOS (except intraepidermal epithelioma of Jadassohn 8096/0; intraepidermal nevus 8740/0)
- intraepithelial, NOS
- intraepithelial neoplasia, grade III [Lower grades (I, II) do not warrant /**2** behavior.] (See **REPORTABILITY** to determine whether the case is reportable to the MCR.)
- intratubular malignant germ cells; intratubular germ cell neoplasia (9064/2) (C62._)
- involvement up to but not including the basement membrane
- lentigo maligna (8742/2) (C44._)
- lobular neoplasia (C50._) (There are differing opinions about the use of this term, especially whether only "grade III" lobular neoplasias should be recorded with /**2** behavior. The MCR follows SEER rules that the term "lobular neoplasia" is synonymous with /**2** behavior. We do not limit this to certain grades.)
- lobular, noninfiltrating (C50._)

* except in these terms:

8453/0 intraductal papillary-mucinous adenoma (C25._)
8453/1 intraductal papillary-mucinous tumor with moderate dysplasia (C25._)
8453/3 intraductal papillary-mucinous carcinoma, invasive (C25._)
8503/0 intraductal papilloma
8503/3 intraductal papillary adenocarcinoma with invasion (C50._)
8505/0 intraductal papillomatosis, NOS; diffuse intraductal papillomatosis
8543/3 Paget disease and intraductal carcinoma of breast (C50._)

- noninfiltrating
- noninvasive
- no stromal involvement (except squamous cell carcinoma *in situ* with questionable stromal invasion 8076/2)
- papillary, noninfiltrating or intraductal
- precancerous melanosis (8741/2) (C44._)
- Queyrat erythroplasia (8080/2) (C60._)
- squamous intraepithelial neoplasia, grade III (8077/2) [Grades < III) do not warrant /2.] (See **REPORTABILITY** to determine whether the case is reportable to the MCR.)
- Stage 0

Microinvasion

Code microinvasion (the earliest stage of invasion) as malignant (**3**), not *in situ*. For the diagnosis "microinvasive squamous cell carcinoma" (a common form of cervical cancer), use the morphology code provided by ICD-O-3 (8076/**3**). Even if the final diagnosis only describes "*in situ*" or "noninvasive" disease, code invasive behavior (**3**) if there is microinvasion documented anywhere in the pathology report.

Malignant Terms

Forms of the terms "invasive", "leukemia", "malignant" and "metastatic" are generally synonymous with Behavior Code **3** (or /6 reported as /**3**). The following ICD-O-3 terms are exceptions: metastasizing leiomyoma (8898/1); invasive hydatidiform mole or invasive mole, NOS (9100/1) (C58.9); and T-cell large granular lymphocytic leukemia (9831/1).

Behavior and Staging Differences

It may be difficult to distinguish descriptions of a tumor's behavior from descriptions of its stage. The term "*in situ*", for example, can describe behavior, extent of disease, or both. The Behavior Code collected by the MCR is the WHO (ICD-O-3) behavior. The behavior of a case reflected in its staging codes may differ. For example, mammary Paget disease with no underlying tumor found (8540/**3**) is AJCC-staged *in situ*; mammary Paget disease with an underlying intraductal carcinoma (8543/**3**) is also AJCC-staged *in situ*; the *in-situ* staging and Behavior Code **3** are compatible for these cases and the ICD-O Behavior Code /**3** is collected. If a pathologist specifically describes "Paget disease, *in situ*" and wants the *ICD-O Behavior* coded /**2**, this is permissible under ICD-O's "matrix" rule (Rule F on pp. 20 and 29-30 in ICD-O-3), but this is not the same as a physician describing AJCC *staging* of Paget disease as *in situ*. Another example is invasion of the lamina propria for colorectal cancers: AJCC pTis and Behavior Code **3**. If the behavior is unclear or not stated in the record, use the default ICD-O-3 Behavior Code.

ICD-O-2 Conversion Flag

NAACCR Version 10 Item 1980, column 1147

This field describes the origin of any ICD-O-2 codes in a case record. Now that ICD-O-3 coding is firmly established, it is possible that the ICD-O-2 codes required for pre-2001 diagnoses are produced from the conversion of ICD-O-3 codes. (For pre-1992 diagnoses, there may have even been conversion from ICD-O-1 codes.) The codes that refer to ICD-O-2 and ICD-O-3 morphologies follow; (the complete set of codes, including those describing ICD-O-1 conversions, are available in the *FORDS* Manual, p. 232):

Conversion Circumstances	**Code**
Case was originally (manually) coded in ICD-O-2.	**0**
ICD-O-2 codes produced by software conversion from ICD-O-3 morphologies without registrar review	**5**
As for code **5**, but a registrar has reviewed the ICD-O-2 codes.	**6**

ICD-O-3 Conversion Flag

NAACCR Version 10 Item 2116, column 1243

This coded field describes the origin of any ICD-O-3 codes (Histologic Type Code and Behavior Code) within a case record. Your data system may fill this field automatically, but you should also be able to change this field manually when appropriate (as when you have visually reviewed and corrected an automatic code conversion for a case diagnosed before 2001). It is impossible for us to describe exactly how each hospital data system may be handling the ICD-O-2 and ICD-O-3 fields. The codes for the ICD-O-3 Conversion Flag follow:

Conversion Circumstances	**Code**
No conversion took place. (ICD-O-3 fields are empty.)	leave empty
Case was originally coded in ICD-O-3.	**0**
Case was coded in ICD-O-2; ICD-O-3 fields were filled automatically by software and the ICD-O-3 codes have not been reviewed by a registrar.	**1**
As for code **1**, but a registrar has reviewed the ICD-O-3 codes.	**3**

Grade / Differentiation / Immunophenotype Code

NAACCR Version 10 field "Grade", Item 440, column 306

The Grade or Differentiation of a tumor describes the tumor's resemblance to normal tissue. A well differentiated (Grade I) tumor is the most like normal tissue, and *un*differentiated (Grade IV) cells are the most abnormal. The immunophenotype of a lymphoma or leukemia describes the type of cell (cell lineage) in which the disease developed. This field corresponds to the sixth digit of ICD-O morphology codes.

Grade / Differentiation

The MCR uses ICD-O/*FORDS* Manual rules for assigning Grade as the sixth digit of the ICD-O morphology code -- not AJCC rules. In the *AJCC Cancer Staging Manual, Sixth Edition* there are rules for assigning a "grade" code of "G1", "G2", "G3", "G4" or "G3-4"; but these are AJCC staging-related grade codes and are not the same type of Grade code collected by the MCR and described on page 67 of ICD-O-3 or pages 12-14 and 96-98 of *FORDS*.

Examples: The *AJCC Cancer Staging Manual, Sixth Ed*. staging grade for prostate cancer with Gleason score 7 is "G3-4"; the Grade code reported to the MCR is **3** (see page 108 herein, or pp. 14 or 97 in the *FORDS* Manual).

Page 7 of the *AJCC Cancer Staging Manual, Sixth Ed*. lists certain histologies that "…are by definition listed as G4 for staging purposes…" (small cell carcinoma, large cell carcinoma of lung, Ewing sarcoma of bone or soft tissue, and rhabdomyosarcoma of soft tissue); other such diagnoses include glioblastoma multiforme and astrocytoma. These morphologies should be reported to the MCR with the ICD-O-3 Grade that is indicated in the medical record (most likely in a pathology report). That is, a "poorly differentiated small cell carcinoma" would have Grade code **3**; the same diagnosis with *no* indication of grade or differentiation should have Grade code **9**. This coding rule also appears on page 7 of the *AJCC Cancer Staging Manual, Sixth Edition*.

The term "grade" in a medical record does *not* always describe cell Differentiation and thus should *not* always be coded here. It can be very confusing. For example, in describing some diseases, pathologists use "grade" as a synonym for "type" or "category" (as in different "grades" of nodular sclerosing Hodgkin lymphoma, follicular lymphoma, or intraepithelial neoplasia). "Grade" may also be used to refer to specific tissue or cellular characteristics that do not directly correlate with the ICD-O-3 Grade field. The word "differentiation" is a more reliable indicator of the morphology code's sixth digit Grade (as in "poorly differentiated lymphocytic lymphoma", code **3**). Terms like "high grade" or "low grade", when describing lymphomas or leukemias, are *not* coded in this field, but if a histologic term is listed in ICD-O-3 with the words "high grade" or "low grade" incorporated into the term (as in 8931/3, "endometrial stromal sarcoma, low grade"), then that *should* be coded here (code **2** for "low grade", code **4** for "high grade").

Code the Grade or Differentiation from the pathologic examination of the primary tumor site only -- NOT from metastatic sites (because cells at a metastatic site may have a different amount of Differentiation than those in the primary site). If the primary site is unknown, always code the Grade/Differentiation as unknown (**9**).

Example: A metastatic liver lesion is specified as "poorly differentiated carcinoma" and the primary site cannot be identified. Enter code **9** because the Differentiation *at the primary site* cannot be determined.

A Grade recorded in a histopathology report takes precedence over one in a cytology report. If the histopathology report lacks information on Grade/Differentiation, then information from cytology may be used. Grade/Differentiation information from a cytology or histopathology report's final diagnosis is usually used for coding Grade; but if Differentiation is NOT stated in the final diagnosis, check the entire report for any relevant information.

Examples: A cytology report finds moderately differentiated carcinoma cells, but the histopathology report identifies *poorly* differentiated carcinoma. Use code **3** because the histopathology information takes precedence.

A cytology report describes well differentiated carcinoma, and the histopathology report has *no* documentation of a Grade/Differentiation. The information from the cytology report must be used, so assign code **1**.

Microscopic Description: moderately differentiated squamous cell carcinoma with poorly differentiated areas
Final Diagnosis: *moderately* differentiated squamous cell carcinoma
Code Moderately Differentiated (**2**) from the final diagnosis.

Microscopic Description: moderately differentiated squamous cell carcinoma with *poorly* differentiated areas
Final Diagnosis: (no mention of Grade/Differentiation)
Lacking information from the Final Diagnosis, code Poorly Differentiated (**3**) -- the highest Grade documented in the Microscopic Description.

If a primary site surgical pathology report lacks information on Grade/Differentiation, then information from a primary site incisional biopsy may be used. If there is a difference between the Grade reported from the primary site biopsy and that reported for the resected primary site surgical specimen, use the higher Grade found, regardless of the tissue source.

Example: Histopathology report, incisional biopsy of neck mass, June 8th: well differentiated carcinoma
Histopathology report, tumor excision, June 11th: *moderately* differentiated carcinoma
Code moderately differentiated (**2**) because it represents the higher grade.

When a report specifies more than one Grade, code to the highest Grade given, even if it does not represent the majority of the lesion. If a tumor of mixed behavior (partly invasive, partly *in situ*) has Grades recorded for both the invasive and non-invasive components, record the Grade of the invasive component only.

Examples: moderately to poorly differentiated -- Code as poorly differentiated (**3**).

combination of Grades I and II carcinoma -- Code as Grade II (**2**).

predominantly Grade I, focus of Grade II -- Code as Grade II (**2**).

carcinoma, moderately differentiated, with well-differentiated carcinoma *in situ* -- Code the invasive component's Grade (moderately differentiated, **2**).

carcinoma with well-differentiated carcinoma *in situ* -- The invasive component's Grade is not stated, so code as unknown (**9**).

Code the Grade for purely *in-situ* lesions if available. Because it is not usually considered to be of importance in *in-situ* cases, Grade is seldom recorded; but do not automatically make the Grade **9** if a degree of Differentiation *is* specified for an *in-situ* case. The *FORDS* Manual, in its 2004 revisions, specifies that code **9** should be used for diagnoses of "high-grade dysplasia"; this diagnosis would be considered reportable only when this term is being used by a physician synonymously with (adeno)carcinoma *in situ*. Do not confuse *this* use of "high grade" with Grade code **4**.

A nuclear grade may be recorded (often for breast or renal cancers, as in Fuhrman or Van Nuys nuclear grades.) The *FORDS* Manual has now provided code conversions for nuclear grades that may be considered comparable with the sixth digit ICD-O Grade/ Differentiation code. The MCR *will* now accept nuclear grade information in accordance with the *FORDS* rules.

In addition to the prioritizing rules for pathology/cytology/other reports, for primary sites other than breast, prostate and kidney, use information to determine Grade in the following order: 1) terminology (word descriptions, such as "poorly differentiated" or "low grade"), 2) histologic grade, and 3) nuclear grade. Detailed rules for breast, prostate and kidney cancers are presented in separate sections below. For all other primary sites, when there is no grade terminology or histologic grade reported but a nuclear grade is available, use the following code conversions for two- and three-tiered nuclear grade classifications:

Nuclear Grade	Code
1/3, 1/2	**2**
2/3	**3**
3/3, 2/2	**4**

Grade / Immunophenotype

Codes **5-8** define cell origins for leukemias and lymphomas. For these cancer types cell classifications have precedence over grading and differentiation (i.e., "poorly differentiated T-cell lymphoma" should have code **5** for the immunophenotype rather than **3** for the differentiation). *Ignore* lymphoma descriptions of "high grade", "low grade" and "intermediate grade" for coding this field.

In ICD-O-3, "…the cell lineage is implicit in the four-digit morphology code" (see page 14 in ICD-O-3). Some *terms* in ICD-O-3 have an implied cell type origin; but note that not *all* terms listed with the same morphology code in ICD-O-3 necessarily should be coded with the same immunophenotype. For example, the preferred term for 9680/3 is "malignant lymphoma, large B-cell, diffuse, NOS" but not all of the other terms listed for that code should necessarily be coded with B-cell origin. If the medical record does *not* indicate an immunophenotype for lymphomas and leukemias, use code **9**.

The Grade/Differentiation/Immunophenotype codes are as follows:

Description	Grade/Cell Type	Code
well differentiated differentiated, NOS	Grade I	**1**
moderately differentiated; moderately well differentiated; intermediate differentiation	Grade II	**2**
poorly differentiated; dedifferentiated	Grade III	**3**
anaplastic; undifferentiated	Grade IV	**4**
for lymphomas and leukemias: T-cell; T-precursor; gamma-delta T-cell; γδ T-cell	T-cell origin	**5**
for lymphomas and leukemias: B-cell; Pre-B; B-precursor	B-cell origin	**6**
for lymphomas and leukemias: null cell; non T-non B; common cell	Null cell origin	**7**
for lymphomas and leukemias*: NK cell	Natural killer cell	**8**
Grade/Differentiation/Cell Type not determined, not stated, or not applicable; unknown primary site; high-grade dysplasia**; non-malignant disease (Behaviors /0, /1)	unknown	**9**

* Code **8** should only be used for diagnoses made beginning in 1995.

** when being reported because it is being used as a synonym for (adeno)carcinoma *in situ*

MRI / PET / Brain Tumor Grading

It may be possible to establish tumor Grade through magnetic resonance imaging (MRI) or positron emission tomography (PET) when there is no tissue diagnosis. (Brain/CNS tumors may be graded using these methods.) If there is *no* tissue diagnosis, but the Grade or Differentiation is indicated on an MRI or PET report, use that Grade; if there *is* a tissue diagnosis, however, do not use Grade information from any other source. Note that only malignancies (behaviors /2, /3) are Graded with codes **1-8** -- for benign disease and tumors of uncertain behavior (/0, /1), always assign code **9**.

WHO developed a malignancy scale for central nervous system tumors that includes a "WHO grade" (of I - IV). See the explanation on pages 39-40 of ICD-O-3. This "WHO grade" reflects the relative malignancy of a tumor. The "Who grade" is not recorded in the sixth digit ICD-O Grade field that we collect. For example, an anaplastic meningioma has a "WHO grade" III but would be coded **4** in the ICD-O Grade field because of the term "anaplastic". If a CNS tumor is described only by its "WHO grade" it should be assigned ICD-O Grade code **9**. Look for terminology in the medical record describing the tumor's ICD-O Grade, such as the terms shown in the table below. (The WHO grade for central nervous system tumors is captured in the field CS Site-Specific Factor 1 for diagnoses made beginning in 2004.)

Other Grade / Differentiation Terminology

When there is variation in the usual terms for Grade or Differentiation, use the following conversions:

Terminology	Grade	Code
low grade partially well differentiated	I-II	**2**
medium grade intermediate grade	II-III	**3**
moderately undifferentiated relatively undifferentiated	III	**3**
high grade	III-IV	**4**

A Grade may be recorded as "2/3" (Grade II in a three-tiered grade system) or "II/IV" (Grade II of a four-grade system). Some cancers may be categorized based on a simple two-grade system (low/high). Two-tier grading systems may be used for colorectal and heart tumors; three-grade classifications may be used for peritoneum, breast, endometrium, fallopian tube, prostate, kidney and CNS. For these types of classification, with the exception of the three-tiered Bloom-Richardson breast scheme (described on the next pages), use the following codes:

Two-Tier System		
Grade	**Grade**	**Code**
I / II	1 / 2	**2**
II / II	2 / 2	**4**

Three-Tier System		
Grade	**Grade**	**Code**
I / III	1 / 3	**2**
II / III	2 / 3	**3**
III / III	3 / 3	**4**

Four-Tier System		
Grade	**Grade**	**Code**
I / IV	1 / 4	**1**
II / IV	2 / 4	**2**
III / IV	3 / 4	**3**
IV / IV	4 / 4	**4**

Thus, simply specifying "Grade II" or "Grade 2" in narrative is not enough information for the MCR to determine if the correct Grade code has been assigned -- if this is Grade II in a three-tier system the correct code is **3**; but if from a four-tier system, the correct code would be **2**. Please specify whenever possible if a two-, three- or four-tiered classification has been used.

Coding Grade for Breast Cancers

The following exception (paraphrased) to usual Grade coding rules was approved by the NAACCR Uniform Data Standards Committee:

> Effective with breast cancer cases diagnosed 1/1/96 and later, when the terms "low", "intermediate" and "high" grade are used and the grading system is specified as (Scarff-) Bloom-Richardson, code [the ICD-O sixth digit] Grade as **1**, **2** and **3**, respectively. This is an exception to the usual rule for all other grading systems that "low", "intermediate" and "high" [grade] are coded **2**, **3** and **4**, respectively [except for lymphomas]. In the (Scarff-) Bloom-Richardson system, if Grades 1, 2 and 3 are specified, these should be coded **1**, **2** and **3**, respectively.

Prioritize Grade/Differentiation information from a breast cancer pathology report in this order:

1. Bloom-Richardson (BR) score (range 3-9, converted to Grade as shown on the next page)
2. Bloom-Richardson (BR) grade (low, intermediate or high, converted to ICD-O Grade as shown on the next page)
3. Nuclear grade only (conversion to Grade shown on the next page)
4. Differentiation or Grade Terminology (such as "well differentiated", "moderately undifferentiated", "anaplastic", "Grade i", "Grade ii", "Grade 3", etc.)
5. Histologic grade (such as Grade I, Grade II/III, Grade II-III, etc.)

Examples: well differentiated, nuclear grade 2/3 -- Record code **2** because the nuclear grade has priority over the terminology.

nuclear grade 2/3, BR low grade -- Use code **1** because the Bloom-Richardson grade has precedence.

The Bloom-Richardson grading scheme is a semi-quantitative grading method based on three morphologic features of "invasive no-special-type" breast cancers. These morphologic features are the percentage of tumor tubule formation, tumor mitotic activity (mitotic count in a defined area), and degree of tumor cell nuclear pleomorphism (nuclear grade). Each of these three features is assigned a score of 1-3 (1=favorable, 3=unfavorable). The three scores are added together to produce the combined Bloom-Richardson score.

If the combined Bloom-Richardson score or grade is not recorded in the medical record but scores for the three morphologic features listed above are included, sum up those three scores. The resulting combined BR scores (3-9) then correspond to the three BR grade categories (low, intermediate or high). Each of these three grades corresponds to a degree of differentiation (well, moderate or poor) and ICD-O sixth digit Grade codes of **1**, **2** or **3**.

Conversion Table for Bloom-Richardson Score and Grade, and Breast Nuclear Grade

Bloom-Richardson Score (combined)	**Bloom-Richardson Grade**	**Nottingham Grade**	**Differentiation**	**Nuclear Grade**	**Code**
3, 4, 5	low grade	favorable	well differentiated	1/3, 1/2	**1**
6, 7	intermediate grade	moderately favorable	moderately differentiated	2/3	**2**
8, 9	high grade	unfavorable	poorly differentiated	3/3, 2/2	**3**

NOTE: Bloom-Richardson score may also be called Nottingham combined histologic grade, modified Bloom-Richardson, Scarff-Bloom-Richardson, SBR Grading, BR grading, Elston-Ellis modification of Bloom-Richardson score, Nottingham modification of Bloom Richardson score, Nottingham-Tenovus or Nottingham grade.

Coding Grade for Kidney Cancers

(except nephroblastoma/Wilms tumor, 8960)

In addition to the prioritizing rules for pathology/cytology reports and other types of information, code Grade for primary site kidney (C64.9, except histology 8960/3) based on information in the following order: 1) Fuhrman Grade, 2) other nuclear grade, 3) terminology, and 4) histologic grade. The *FORDS* Manual does not present special Grade code conversions for kidney cancers, so the MCR is presuming at this time that the Fuhrman and nuclear grade codes convert to ICD-O Grade codes in the standard way (that is, do NOT use the special breast or prostate code conversions). Fuhrman grading is a four-tier system (Fuhrman Grades I - IV, corresponding to ICD-O Grade codes **1-4**) based on the size and appearance of tumor cell nuclei and nucleoli.

Prostate Tumors and Gleason's Score or Pattern

In addition to the prioritizing rules for pathology/cytology/other reports, code Grade for the primary site prostate based on information in the following order: 1) Gleason Score, 2) terminology, 3) histologic grade, and 4) nuclear grade.

Prostate cancers are usually graded using the Gleason Score or Pattern. The Gleason's classification is based on five basic histologic patterns found in prostate tumors. Prostate cancers generally exhibit two main histologic patterns -- a primary/predominant pattern (how more than half of the cells look) and a secondary pattern. Two numbers (1-5) representing these two patterns are added together to create the Gleason Score. Use the first table on page 108 to convert the Gleason Score to a sixth-digit ICD-O Grade/Differentiation code. Gleason Score information may be recorded in different ways in a record, so use the following guidelines to help identify it if you're uncertain:

If there is only one number or score recorded for a prostate cancer and that number is greater than 5, assume that this is the Gleason Score.

If there are two numbers -- each less than 5 (for example, "3+4", "3, 4" or "3-4") -- assume that these represent the primary and secondary patterns. Add the numbers together to produce the Gleason Score.

If there are two numbers recorded but the second one is 10, or if there is a number recorded as being "out of a possible 10" (for example, "3/10"), assume that the smaller number is the Gleason Score. (The maximum possible Gleason Score is 10.) If two numbers out of 10 are recorded ("1+3/10"), add the first two numbers to obtain the Gleason Score.

If there is only one number between 1 and 5, assume that this is the primary/predominate Gleason Pattern. If the secondary pattern cannot be found, use the second table below to convert the pattern to the proper Grade code.

If a Gleason Score and a primary/predominate Pattern are recorded, use just the Score to determine the correct Grade code.

Gleason Score	Grade and Differentiation	Code
2, 3, 4	I well differentiated; slight anaplasia	**1**
5, 6	II moderately differentiated; moderate anaplasia	**2**
7*, 8, 9, 10	III poorly differentiated; undifferentiated; marked anaplasia	**3**

* Gleason's Score 7 should be sent to the MCR coded **3** in accordance with COC (*FORDS* Manual) coding rules. These will be changed as necessary at the MCR so that our data adhere to SEER rules for the given diagnosis year. It is expected that SEER rules will coincide with the COC's for diagnoses made as of 2004.

If only the primary or predominate pattern (1-5) is recorded, use the following conversions:

Gleason's Pattern	Grade and Differentiation	Code
1, 2	I well differentiated	**1**
3	II moderately differentiated	**2**
4, 5	III poorly differentiated	**3**

Narrative Histology / Behavior / Grade

NAACCR Version 10 field "Text--Histology Title", Item 2590, columns 4135-4174

Enter the histology, behavior and grade/differentiation/immunophenotype in narrative form, using up to forty characters. If you run out of room, continue the text in another Narrative field.

Do not use an automatic text label to complete this field; instead, this field should contain histology, behavior and grade/differentiation information as derived from the medical record. The information in this field is used to verify the Histologic Type, Behavior and Grade Codes.

Information regarding histology, behavior and grade is primarily found in the pathology report. Use the most specific and accurate information. If the medical record contains conflicting information regarding histology, behavior or grade, information in the pathology report should take precedence. If histology, behavior or grade is still unclear, a physician should be consulted. If the diagnosis you are documenting here was uncertain or doubtful, indicate this here (space permitting) or in the Comments/Narrative Remarks field.

If the combination of primary site and morphology is unusual enough to trip an automatic edit, include a note that this unusual combination has been verified by you as correct, and note how you verified it. These remarks could be in this field, the Primary Site Narrative, or the Comments/Narrative Remarks field.

Date of Diagnosis

NAACCR Version 10 Item 390, columns 283-290

Enter the date, in MMDDCCYY format, on which a recognized medical practitioner first stated that the patient had the reported cancer, whether or not the diagnosis was ever histologically confirmed, and whether or not the diagnosis was made at the reporting hospital or before admission there. Remember to use the "ambiguous" terms for a cancer diagnosis on page 14 of the **REPORTABILITY** section ("suspicious", "probable", etc.) to help determine when the initial diagnosis was made. Date of Diagnosis is fundamental for determining the coding and reportability rules that apply to the case, the time period for all of the "at-diagnosis" fields, and the diagnosis year is key for the central registry in reporting statistics.

Use **9**'s to code unknown parts of the date (such as 06**99**2001 or **9999**2001).

For a diagnosis made *in utero*, use the eventual date of birth as the Date of Diagnosis.

For cases of Class 5 (first diagnosed at autopsy), enter the date of death as the Date of Diagnosis, even if the autopsy was actually performed on a later date.

For cases of Class 7 (pathology-only), enter the date on which the pathologist identified cancer -- not necessarily the date on which the specimen was taken -- unless you are aware that a clinical diagnosis had been made previously outside the reporting facility.

If a patient receives treatment before a definitive diagnosis, use the date on which treatment started as the Date of Diagnosis.

Do not change the Date of Diagnosis if a diagnosis was simply confirmed at a later date.

Example: A mammogram on September 14, 2003 reveals a mass in the lower inner quadrant "compatible with carcinoma". On September 20 the patient has an excisional biopsy that confirms infiltrating duct carcinoma. The Date of Diagnosis is **09142003** because of the clinical diagnosis made that day.

If, however, a physician reports that, in retrospect, a patient had cancer at an earlier date, use that earlier date as the Date of Diagnosis (i.e., backdate the diagnosis).

Example: In June 2003 a patient has a total abdominal hysterectomy for endometriosis. She is admitted October 2003 with abdominal pain and distension. A laparoscopy with omental biopsy reveals metastatic adenocarcinoma. Pathology reviews the hysterectomy slides, seeing adenocarcinoma in the left ovary. Backdate the diagnosis to June.

Vague Dates

Estimate the Date of Diagnosis if you do not know the exact date, and mention in the Comments/Narrative Remarks that this important date is an estimate. Approximation is preferable to entering an unknown date (see *FORDS* Manual, p. 89). The MCR cannot determine if a particular case is reportable to us without at least a year of diagnosis being estimated. Use the following procedures if information is limited to descriptive terms:

Descriptive Term	Date Coded
spring	April (**0499CCYY**)
middle of the year; summer	July (**0799CCYY**)
fall / autumn	October (**1099CCYY**)
winter	Try to determine if this refers to the beginning or end of the year, and then code January (**0199**) or December (**1299**).

Class of Case

NAACCR Version 10 Item 610, column 440

Class of Case divides registry data into analytic and nonanalytic categories. Analytic cases (**0**, **1**, **2**) are those included in treatment and survival analyses. Nonanalytic cases (**3**, **4**, **5**, **6**, **7**, **8**, **9**) are those that are not included in treatment and survival analyses. The code **6** became valid for the MCR for diagnoses made as of 1996; the ACoS requirements pertaining to Class 6 cases have undergone several revisions since that time; they are now considered nonanalytic (for diagnoses made in 2000 and thereafter). The code **7** has become valid for diagnoses made beginning in 2003. The MCR requires hospitals to report nonanalytic cases (Class 6 and Class 7 cases are optional), but only in an abbreviated fashion (see page 7).

Code **7** only applies to cases in which the patient is NEVER seen at the reporting facility for treatment of this cancer nor for further diagnostic work. If a case begins as a pathology-only Class 7 case to you but the patient later comes to your facility for this cancer, then the Class of Case code must be changed to reflect your facility's later contact with the patient. Also update the Date of First Contact field to reflect your first contact with the *patient* rather than the initial pathology contact (so that your reporting of the later case information does not appear to have been sent in late to the MCR). In the Class descriptions below, Palliative Care planned and given during the First Course of Therapy is considered in the same way that First-Course Treatment is.

Code	Class	Description
0	Class 0	First diagnosed at reporting institution since its reference date, and all of the first course of therapy given elsewhere. Cases include: • patients who choose to be treated elsewhere • patients who are referred elsewhere for treatment for any reason (e.g., lack of special equipment, proximity of a patient's residence to the treatment center, or financial, social or rehabilitative considerations) • patients who have a treatment plan developed at the reporting facility but have all treatment carried out elsewhere (if the facility chooses to collect these)

Code	Class	Description
1	Class 1	First diagnosed at reporting facility since its reference date, and either (a) received all or part of the first course of therapy at the reporting facility, or (b) was never treated. Includes: • patients who received all or part of their first course of therapy at the reporting institution • patients who refused any treatment • patients whose only first-course treatment is "watchful waiting" • patients who were untreatable or were only given palliative care because of age, advanced disease or other medical conditions • Specific treatment was recommended but not received at the reporting institution, and it is unknown if treatment was ever administered. • It is unknown if treatment was recommended or administered. • patients diagnosed at the reporting institution prior to the reporting institution's reference date, and all or part of the first course of therapy was received at the reporting institution after the reporting institution's reference date • patients who were first diagnosed and had staging workup at the reporting institution, and all or part of the first course of therapy was received in a staff physician's office • patients who were first diagnosed in a staff physician's office and then treated at the reporting institution • patients who were diagnosed and whose treatment was planned at the reporting institution, and treatment was delivered elsewhere in accordance with the reporting institution's treatment plan
2	Class 2	First diagnosed elsewhere, and either (a) received all or part of the first course of therapy or first-course palliative care at the reporting facility after its reference date, or (b) planning of the first course of therapy was done primarily at the reporting hospital. Cases include: • patients diagnosed at another hospital but not treated until admission to the reporting hospital, regardless of the interval between diagnosis and treatment • patients diagnosed and surgically treated at another hospital, then admitted to the reporting hospital for radiation therapy that completes planned first course of treatment • any cases the reporting hospital considered to be analytic (i.e., the planning/-management decisions were made at the hospital, even if treatment was administered elsewhere, when the planning facility chooses to collect such cases)
3	Class 3	First diagnosed at another institution, and either (a) entire first course of therapy was given elsewhere, (b) patient was never treated, or (c) unknown if treated. Cases include: • patients diagnosed and first course of therapy completed elsewhere, later admitted to the reporting hospital with disease persistence, progression or recurrence • no information available on patient's first course of therapy, and patient is now treated or managed at the reporting institution • The reporting institution is treating or managing the recurrence, progression, or subsequent treatment of a previously diagnosed malignancy. • patients whose treatment plan was developed at the reporting hospital, but the treatment was given elsewhere • patients who received a second opinion on treatment at the reporting hospital, but the treatment was given elsewhere

Note: Class 3 cases are not reportable to the MCR if originally diagnosed before 1995.

Code	Class	Description
4	Class 4	First diagnosed and first course of therapy at reporting institution before its reference date. Cases include: • cases where the reporting facility manages or treats a recurrence or progression of the disease after the facility's reference date • cases where it is unknown whether the reporting facility delivered the first course of treatment before its reference date *Note*: Class 4 cases are reportable to the MCR only if the reporting institution's reference date is later than the MCR's reference date of January 1, 1982.
5	Class 5	First diagnosed at autopsy. Cases include: • incidental finding of cancer at autopsy (no prior diagnosis/suspicion of cancer)
6	Class 6	Patients who were diagnosed and received all of first course of treatment in a staff physician's office. The patient may subsequently be seen at the reporting facility. Cases include: • cancer is diagnosed in the physician's office and that physician plans watchful waiting or "no treatment" as the first-course treatment *Note:* Class 6 cases refer only to active staff physicians with admitting privileges at the reporting facility. If a physician holds multiple staff appointments, s/he must assign reporting responsibility to one institution. *Note*: Class 6 cases are not required for the MCR, but if your facility collects them we do want them to be reported as for any nonanalytic case. Any Class 6 case originally diagnosed before 1996 is not reportable to the MCR. A physician office may report its cases directly to the MCR rather than having a facility registry report them.
7	Class 7	Pathology-only cases. The patient is NEVER seen at the reporting facility for diagnosis or treatment. Pathology-only *autopsy* cases are NOT Class 7. Cases include: • Reporting facility provides a pathology report only. • Reporting facility reviews pathology slides/specimens only. • Reporting facility provides some other type of pathology consult only.
8	Class 8	By death certificate only. This code is for MCR use only.
9	Class 9	Unknown. Cases include: • unknown if previously diagnosed or treated • previously diagnosed, but date unknown

Institution Referred From

NAACCR Version 10 Item 2410, columns 2485-2494

This coded field helps the MCR understand the interactions a patient has had with multiple facilities and where we could look for further information we might need about a case.

This field records where a patient was diagnosed or received any initial treatment for this case before being seen at your facility. If you know that a patient was seen at another facility for this case prior to your contact with the patient, please report that information even if the patient did not have a *formal referral* to your hospital. If a patient was seen at more than one facility before yours, record just the hospital where s/he was seen most recently before your facility.

If this case was diagnosed at your facility, was seen first at your facility, or has been seen only at your facility (cases of Class 0, 1, 4, 5), this field should be filled with zeroes.

This field should contain a ACoS/COC Facility Identification Number (FIN), but the special code assigned to a Massachusetts facility by the MCR (usually four digits) is also acceptable if your data system can produce it. See page 38 and Appendix G for FINs and MCR codes; the COC's website shows FINs at www.facs.org/cancer/coc/fin.html.

For patients previously seen at a U.S. facility outside Massachusetts, this field should contain a FIN. [The ACoS website (http://web.facs.org/cpm) has a "search feature" for FIN codes of facilities with approved cancer programs.] If you know that the patient came to you from another state but you can't identify or code the particular institution, please enter the other state's central registry code number (see Appendix G for these codes).

If you know that a patient was referred to your hospital but you cannot identify that facility (or its code number), fill this field with **0099999999**. This includes patients coming to you from a facility in a foreign country or a physician office/private practice.

If the facility a patient was referred from is now closed or no longer seeing cancer patients, there may still be a code for the facility in Appendix G that you may fill in here.

Institution Referred To

NAACCR Version 10 Item 2420, columns 2495-2504

This coded field helps the MCR understand the interactions a patient has had with multiple facilities and where we could look for further information we might need about a case.

This field records where a patient was referred by your facility for this case. This does not include just *formal referrals*; if you know that the patient was seen elsewhere after being seen at your hospital, code that facility. If the patient went to multiple facilities after yours, code just the one to which s/he went first after yours.

For patients not being seen later at any other facility (cases of Class 1, 3, 4, 5), this field should be filled with zeroes.

This field should contain a ACoS/COC Facility Identification Number (FIN), but the special code assigned to a Massachusetts facility by the MCR (usually four digits) is also acceptable if your data system can produce it. See page 38 and Appendix G for FINs and MCR codes; the COC's website shows FINs at www.facs.org/cancer/coc/fin.html.

For patients seen later at a U.S. facility outside Massachusetts, this field should contain a FIN. [The ACoS website (http://web.facs.org/cpm) has a "search feature" for FIN codes of facilities with approved cancer programs.] If you know that the patient is going to another state but you can't identify or code the particular institution, please enter the other state's central registry code number (see Appendix G for these codes).

If you know that a patient was referred elsewhere but you cannot identify that facility (or its code number), fill this field with **0099999999**. This includes patients going to a facility in a foreign country or a physician office/private practice.

If the facility a patient was referred to is now closed or no longer seeing cancer patients, there may still be a code for the facility in Appendix G that you may fill in here.

EOD -- Tumor Size

NAACCR Version 10 Item 780, columns 531-533

The MCR will collect Tumor Size using *FORDS* Manual rules for diagnoses made in 2003. We will change the codes as necessary at the MCR so that the field conforms to SEER data standards on our system. For diagnoses made beginning in 2004, this field is superseded by the corresponding Collaborative Staging field. ONLY code this field for **diagnoses made before 2004.**

This field records the pre-treatment diameter or maximum dimension of the primary tumor in millimeters (mm) for non-melanomas, using three digits. Do not record the size of a metastatic tumor, cyst, ulcer or polyp.

Example: A breast duct carcinoma is 2.5 cm (25 mm) in diameter. Enter code **025**.

For melanomas of the skin, vulva, penis, scrotum or conjunctiva (primary site C44._, C51._, C60._, C63.2 or C69.0 with Histologic Type Codes 8720-8790), this field records the primary tumor's depth of invasion or thickness in hundredths of millimeters to a maximum size of 9.89 mm. For a melanoma depth of invasion exceeding 9.89 mm, use code **989**.

Example: A melanoma of the skin of the back invades to a depth of 1.23 mm. Record **123**.

For completely *in situ* (noninvasive) melanomas of the sites above (including lentigo maligna 8742/2 and precancerous melanosis 8741/2), there is no "depth of invasion". *FORDS* does not specify what to do in such cases, so we believe the best code to use may be **999** (because "depth of invasion" is not applicable). Record the tumor "thickness" if available, in hundredths of a millimeter.

To convert centimeters to millimeters, move the decimal point one digit to the right (i.e., multiply the number of centimeters by 10).

Example: 2.1 centimeters is equivalent to 21 millimeters, so **021** would be entered.

The following are millimeter equivalents of centimeters and inches:

1.0 mm	=	0.1 cm	1.0 cm	≈	0.394 inch			
10.0 mm	=	1.0 cm	1.0 inch	≈	25.0 mm	1.0 inch	≈	2.5 cm

Round off to the nearest millimeter (for non-melanomas) or hundredth of a millimeter (for melanomas of the sites listed above) (MCR rule), unless this would round a measured size down to "zero"; see the paragraph on code **001** on page 118.

Examples: Tumor size 2.19 cm (= 21.9 mm) -- Round to the nearest mm and enter **022**.
Melanoma of the conjunctiva, depth of invasion 0.033 mm -- Record **003**.

Code the largest size when a tumor has multiple measurements.

Examples: 2 x 3.3 x 2.5 cm tumor -- Record **033**. 4.5 x 3.5 cm tumor -- Record **045**.

If the patient received *any* neoadjuvant therapy that changed or may have changed the Tumor Size (radiation, chemotherapy, hormone therapy or immunotherapy given before surgery), record the pre-treatment clinical Tumor Size; if that's unavailable, record code **999** only.

Examples: A breast cancer patient had a mammogram revealing a tumor of approximately 3.7 cm in diameter. Chemotherapy reduces the Tumor Size and when she later has the tumor excised, the pathology report states 0.8 cm. Record the pre-treatment size, **037**.

A breast cancer patient has chemotherapy before coming to the reporting facility for surgery. The pathology report documents a tumor size of 0.8 cm. No information on size before treatment began can be found. Use code **999**.

The most accurate Tumor Size information is usually in the pathology report from the primary tumor's excision. (An exception is the case of neoadjuvant therapy described above.) Do not calculate a tumor's size by adding the sizes of pieces or chips of tissue. Do not add measurements recorded in biopsy and resection reports. Use the report that documents the largest size. If an excisional biopsy is performed and residual tumor is found during a wider resection, base Tumor Size on the excisional biopsy report alone *unless* the residual tumor is found to be larger than the portion excised. Note that pathologists and other physicians *may* violate the rules above and use their judgment to estimate a Tumor Size -- and the registrar is supposed to appropriately code the Tumor Size recorded by the physician in such cases.

Example: A large tumor is surgically removed in three parts, and the pathologist adds their sizes to "reconstruct" the entire tumor's size. The Tumor Size recorded by the pathologist is 6.8 cm. Code **068**. If the pathologist had not reconstructed the tumor, the registrar could NOT add together the sizes of the three tumor pieces; code **999** would be used unless there were operative or clinical information on the whole tumor's size.

There are times when a pathologic Tumor Size is not available and clinical information must be used. The pathology report may not identify Tumor Size, or the tumor may not have been surgically excised. In these cases, use the Tumor Size documented in the following reports (listed in order of preference): 1. Operative reports; 2. Scans; 3. X-rays; 4. Physical exams.

Do not use the size of the entire surgical specimen for Tumor Size.

Example: A patient has an excisional breast biopsy. The pathology report records a specimen size of 2 cm x 3 cm, but does not state the actual size of the tumor. Do not use the specimen size; rather, code Tumor Size based on information from the operative report, mammography or physical exam, or **999** if no information can be found.

If only an inexact estimate involving a size range is available, code the larger size mentioned. For example, if "3 to 4 cm" is the best information you have, code **040**.

Code **000** is used when no primary tumor can be found but cancer is detected elsewhere (such as metastatic melanoma where the origin is never found). This rule applies only to solid tumors. Don't confuse **000** (no primary tumor found) with **999** (primary tumor's size not evaluated).

Code **001** is used for a microscopic focus where the tumor's size is stated, for non-melanoma tumors 1 mm in size, and for measured non-melanoma tumors smaller than 1 mm in size. It is also used for a melanoma (of the primary sites listed on page 116) that invades to a depth of 0.01 mm or less. When a microscopic focus is identified but no tumor measurement is given, use code **990** rather than **001**.

Examples: 1.3 cm *in-situ* tumor with a microscopic focus of invasion -- Record **001** because the invasive component is microscopic and the tumor's whole size is recorded.

In-situ tumor with a microscopic focus -- Record **990** because the tumor's size is unknown but the invasive component is known to be microscopic.

For multiple tumors being reported as one primary, record the size of the largest tumor.

Example: A patient has a 1 cm nodule in the upper lobe of the right lung and a 1.5 cm nodule with the same histology in the right middle lobe. Enter Tumor Size as **015**.

When a primary tumor has both *in situ* and invasive components, record the size of the invasive component only. When a primary tumor is completely *in situ* (has no invasive component), record the entire Tumor Size.

Examples: The pathology report describes a breast mass consisting of a 1.8 x 1.3 cm intraductal carcinoma, and a 0.7 cm nodule of infiltrating duct carcinoma. Enter **007**.

The only information available is that a 3-cm breast tumor had both non-invasive and invasive components. The size of the invasive component is unknown, so enter **999**.

The pathology report describes a breast mass consisting of a 1.8 x 1.3 cm intraductal carcinoma. Enter Tumor Size as **018**.

Code **998** is reserved for certain diagnoses, and when certain terms are used at certain sites:

"entire circumference" for esophageal cancers (C15._);

linitis plastica (8142/3), "diffuse", "widespread" or "3/4 or more" for gastric cancers (C16._);

familial/multiple polyposis (8220-8221) for colorectal cancers (C18.0-C20.9);

"diffuse", "entire lobe" or "entire lung" for lung cancers (C34._);

inflammatory carcinoma (8530/3), "diffuse", "widespread" or "3/4 or more" for breast cancers (C50._).

Record **999** for all of the following cases:

- ill-defined primary site (C76._)
- unknown primary site (C80.9)
- multiple myeloma (9732)
- Letterer-Siwe disease (9754)
- hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative diseases (Histologic Type Codes 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989 or primary sites C42.0, C42.1, C42.3, C42.4)
- no Tumor Size recorded
- size of primary tumor not evaluated

Note that lymphomas are NOT included in the types of case that should automatically be coded **999** in the *FORDS* Manual. Record the primary Tumor Size for extranodal lymphomas when it is available. Record a primary Tumor Size for nodal lymphomas when it is (rarely) available, and use **999** whenever it is not available.

Descriptive Terms

Physicians sometimes use various terms to describe the size of a tumor instead of giving an actual measurement, especially in clinical descriptions. The following table converts such terms into millimeters.

Table IV.2
Millimeter Equivalents of Descriptive Terms

Fruit:

Object	mm	Object	mm
Apple	**070**	Lemon	**080**
Apricot	**040**	Olive	**020**
Cherry	**020**	Orange	**090**
Date	**040**	Peach	**060**
Fig, dried	**040**	Pear	**090**
Grape	**020**	Plum	**030**
Grapefruit	**100**	Tangerine	**060**

Nuts:

Object	mm
Almond	**030**
Chestnut	**040**
Hazelnut	**020**
Hickory nut	**030**
Horse chestnut	**040**
Peanut	**010**
Pecan	**030**

Vegetables:

Object	mm
Bean	**010**
Lima bean	**020**
Pea	**009**
Pea, split	**009**

Kumquat	**050**		

Walnut	**030**

Table IV.2 continued
Millimeter Equivalents of Descriptive Terms

Eggs and Miscellaneous Foods:

Object	mm	Object	mm
Doughnut	**090**	Egg, Pigeon	**030**
Egg, NOS	**050**	Egg, Robin	**020**
Egg, bantam	**040**	Lentil	**009**
Egg, goose	**070**	Millet	**009**
Egg, hen	**030**		

Coins:

Object	mm
Dime	**010**
Half dollar	**030**
Nickel	**020**
Penny	**010**
Quarter	**020**
Silver Dollar	**040**

Other:

Object	mm
Baseball	**070**
Eraser, pencil	**009**
Fist	**090**
Golfball	**040**
Marble	**010**
Match head	**009**
Pencil eraser	**009**
Ping-pong ball	**030**
Tennis ball	**060**

Codes for non-melanomas follow:

Tumor Size	Code
no primary tumor found	**000**
rounds to 1 mm (0.1 cm) or less; microscopic focus/foci with tumor size recorded	**001**
rounds to 2 mm (0.2 cm)	**002**
. . .	. . .
rounds to 988 mm (98.8 cm)	**988**
rounds to 989 mm (98.9 cm) or more	**989**
microscopic focus/foci with tumor size not recorded	**990**
certain diagnoses/terms*	**998**
unknown; not stated; primary site C42.0, C42.1, C42.3, C42.4, C76._, C80.9; histology 9732, 9754, 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989	**999**

* C15._: tumor fills the entire circumference;
C16._: linitis plastica (8142/3), "diffuse", "widespread" or "3/4 or more" of stomach;
C18.0-C20.9: familial/multiple polyposis (8220-8221);
C34._: "diffuse", tumor fills entire lobe or entire lung;
C50._: inflammatory carcinoma (8530/3), "diffuse", "widespread" or "3/4 or more of breast".

Codes for melanomas follow. (Note: Code **990** is no longer used for melanomas of 9.9 mm or more in depth; it is *only* used for microscopic foci with no size specified.)

Tumor Thickness / Depth of Invasion	Code
no primary tumor found	**000**
up to 0.01 mm; 0.01 mm	**001**
. . .	. . .
0.10 mm (0.01 cm)	**010**
. . .	. . .
1.00 mm (0.1 cm)	**100**
. . .	. . .
2.00 mm (0.2 cm)	**200**
. . .	. . .
9.89 mm (0.989 cm) or more	**989**
unknown; not stated; primary tumor size not evaluated	**999**

Diagnostic Confirmation

NAACCR Version 10 Item 490, column 311

The Diagnostic Confirmation method indicates whether cancer was confirmed microscopically at any time during the course of the disease, and indicates the best type of confirmation that was ever obtained. It is a priority coding scheme with the lower code number taking priority over higher codes. The most conclusive method -- microscopic examination of tissue -- is therefore coded **1**. Consider the entire disease course for this field. Change the code to a lower number if a preferable method later confirms a diagnosis.

The codes for this field follow:

Microscopic Confirmation (codes **1**, **2**, **4**)

1 Positive histology

Microscopic confirmation based on tissue specimens from biopsy (such as punch biopsy and needle biopsy, including fine needle biopsy and fine needle aspiration *biopsy*), frozen section, surgery, autopsy with pathology specimens, or dilation and curettage. This applies to tumor tissue taken from the primary site or a metastatic site. It also applies to bone marrow biopsy and bone marrow aspiration results. Hematologic confirmation of leukemia (i.e., peripheral blood smear) should also be coded **1**.

2 Positive (exfoliative) cytology, with no positive histology

Diagnosis by cytology is based on the microscopic examination of cells rather than tissue. Code **2** should not be used if cancer is ruled out by histologic findings. Include fine-needle cell aspiration, sputum smear, bronchial brushing/washing, tracheal washing, prostatic or breast secretion, gastric or spinal fluid, peritoneal or pleural fluid, urinary sediment, cervical or vaginal smear, and diagnostic paraffin-block specimen from concentrated spinal, pleural or peritoneal fluid. Peripheral blood smear that diagnoses a cancer *other* than leukemia is coded **2**.

4 Positive microscopic confirmation, method not specified

These are cases that must have been microscopically confirmed, but you have no information about the method (histology vs. cytology).

No Microscopic Confirmation (codes **5-8**)

5 Positive laboratory test or marker study

This includes diagnoses of cancer based on certain laboratory tests or marker studies that are clinically diagnostic for cancer. Examples are the presence of alpha-fetoprotein for primary liver cancer and an abnormal electrophoretic spike for multiple myeloma or Waldenstrom macroglobulinemia. Note that an elevated PSA test alone is NOT clinically diagnostic for prostate cancer, but if a physician uses PSA results as a basis for diagnosing prostate cancer with no other work-up, the PSA test may be coded here as **5**.

6 Direct visualization without microscopic confirmation

This includes diagnoses of cancer by direct visualization and/or palpation during physical examination (for example, retinoblastoma), during surgical exploration, or by endoscopy or gross autopsy. Use this code only in the absence of positive histology or cytology.

7 Radiography or other imaging technique without microscopic confirmation

This includes all cases diagnosed only by radiology, including ultrasound, computerized (axial) tomography (CT or CAT scans), and magnetic resonance imaging (MRI). Use this code only in the absence of positive histology or cytology confirmation.

8 Clinical diagnosis only (other than **5**, **6** or **7**)

This includes cases diagnosed by clinical methods not covered above. Use this code only in the absence of positive histology or cytology. For example, if a physician records a clinical diagnosis of "suspicious for malignancy" (or other ambiguous diagnostic term, see page 14) without specifying the clinical basis for the diagnosis, use code **8**.

9 Unknown whether or not microscopically confirmed

Use this code when the method of confirmation (microscopic vs. clinical) is unknown. (includes death certificate-only cases)

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AJCC TNM Staging System

At this time, it is the COC's plan to continue collection of "manual" TNM staging even after Collaborative Staging goes into effect. The MCR now plans to NOT collect these fields for diagnoses made beginning in 2004. The AJCC staging fields are all required for pre-2004 diagnoses.

Cases diagnosed beginning in 2003 are TNM-staged using the *AJCC Cancer Staging Manual, Sixth Edition* (with updates). The codes used to record the staging information can be found in the *FORDS* Manual and this manual. Both the staging manual and a coding manual must be used to record AJCC staging fields.

Both clinical and pathologic staging fields are collected by the MCR. If you have enough information to specifically stage a case clinically and pathologically, then both stages should be specifically reported. The *FORDS* Manual, on its p. 23, and the *AJCC Cancer Staging Manual, Sixth Edition* note that both clinical and pathologic staging should be recorded. Use the codes for "unknown" and "not applicable" to complete the staging fields whenever appropriate. Some physicians seem to feel that a case with an unknown stage (for example, only an incisional biopsy of the primary tumor has been done) "cannot be staged"; everyone should be aware that a case with a correct "unknown" or "not applicable" stage assignment *has* been staged and can be recorded with appropriate codes (that do not appear in the *Cancer Staging Manual*).

The *FORDS* Manual specifies that some TNM fields should be left empty when a physician did not supply the staging information. None of the TNM fields may be left empty for the MCR -- the MCR MUST receive the staging information for pre-2004 diagnoses. The MCR is not concerned with whom staged the case, as long as the information is correct and is coded correctly. (This is why we don't collect the "Staged By" fields.) If the coded staging information we're receiving from you in the AJCC fields is known to be incorrect or questionable, please explain the situation in a Staging Narrative; the MCR will want to correct such stages on our data system. Those wishing to select cases in which staging was assigned only by physicians can use the "Staged By" fields to identify such records. According to the AJCC's website, the COC seeks to have *correct* staging information recorded, and also wants to know which staging has been done by physicians; cases in which a registrar has had to supply the staging will not meet the COC's physician staging requirements but will satisfy the MCR's reporting requirements.

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Not all types of cancer are AJCC-stageable. Use the primary site codes listed at the beginning of each chapter of the *Cancer Staging Manual*. The lists of histologic type codes in each chapter are only a *guide* to indicate the types of cancer which can be AJCC-staged using that staging scheme. Any cancer types listed as *exclusions* at the beginning of each chapter are to NOT be AJCC-staged with that staging scheme. Some chapters are specifically limited to certain cancer types only (such as melanomas of the skin). The lymphoma staging scheme applies to histologic types 9590-9729 and *does not limit* its applicable primary sites.

Examples: The beginning of the esophagus chapter (p. 91) indicates that all of primary site C15._ is included. The section titled Primary Site also discusses how to handle tumors arising in the esophagogastric junction (C16.0). Page 91 specifies that all sarcomas are excluded. Page 94 (under Histopathologic Type) says, "The classification applies to all carcinomas." Page 95 lists specific histologic type codes, including *adeno*sarcoma. The code for papillary carcinoma *in situ* (8050/2) is not listed here, but obviously it may be staged with this chapter.

Pediatric cancers do not have special TNM coding in the *AJCC Cancer Staging Manual, Sixth Ed*. They would ordinarily be considered *unstageable* in the AJCC system. If a physician has chosen to stage a pediatric case using the TNM system (clinically, pathologically or both), then this staging may be coded and *unknown* codes should be used for any unspecified fields.

Examples: A child has a soft tissue sarcoma and the TNM staging has been left unstaged. Both clinical and pathologic staging would be coded as *unstageable* -- T88N88M88, Stage Grouping 88.

A child has a soft tissue sarcoma and a physician clinically stages it using the sarcoma chapter in the *AJCC Cancer Staging Manual, Sixth Edition*. The requirements for pathologic staging are not reached. Code the clinical TNM and Stage Grouping to record the physician's staging, and use the *unknown* codes for the pathologic fields -- TX_NX_MX_, Stage Grouping 99.

If the primary site is not *definitely* known, AJCC staging of the cancer should be based on "reasonable clinical certainty" of a primary site identification. If there is *not* "reasonable clinical certainty" indicating one primary site, then the AJCC staging should be "not applicable" (as for an unknown primary site).

Examples: A scan finds brain metastases. The physician states that the primary site is *probably* lung. Use the AJCC scheme for lung primaries to stage this case.

A patient has liver metastases, and it is indicated that the primary site *may* be colon *or* lung. If the primary site is not clearly identified, this case should be AJCC-staged T88N88M88, Stage Grouping 88.

A patient has two primaries that are both carcinomas. Metastatic carcinoma is also found in the liver and its source cannot be determined. Stage *both* primaries as metastatic unless later information identifies which primary spread to the liver.

Lymph nodes are not often surgically removed for known *in-situ* tumors. The AJCC classification is therefore usually "pTis cN0 cM0, cStage Grouping 0" because there is usually only clinical evaluation of nodal and distant disease (see page 6 in the AJCC's *Cancer Staging Manual, Sixth Edition*).

Timing rule: For both Clinical and Pathologic staging information, use only information as described below obtained through the completion of the most definitive first-course surgery or within four months of diagnosis, whichever is longer. Patients who do not have first-course surgery are staged with the information available four months after diagnosis. If the cancer extent has progressed before surgery takes place, then the information obtained from the surgery does not reflect the "at-diagnosis" stage; if you have waited for surgery to take place and disease progression has been noted instead (for example, a PSA level rises), the staging should be based on the information available *before* the progression. If staging information has been affected by pre-surgical treatment, then again the information obtained from surgery will not reflect the "at-diagnosis" stage; use the appropriate Descriptor field to denote that the corresponding stage uses information obtained after neoadjuvant therapy (yTNM).

The Clinical AJCC classification (cTNM) is based on information and evidence obtained before treatment and is important for planning initial treatment. It is especially important for sites which are accessible for clinical examination, including the cervix, oral cavity and larynx. Physical examination, imaging, endoscopy, biopsy, surgical exploration and other relevant pre-treatment findings are the basis of clinical staging. Evaluate the clinical stage of disease using all information available before the first treatment. In compliance with AJCC rules, *do not change* the clinical staging based on information obtained later after treatment begins -- the clinical stage should always reflect the initial clinical impression of the disease extent before any treatment. The clinical stage and pathologic stage should not necessarily agree. If a decision is made to not treat a patient, the "time period" for gathering clinical staging information ends at that decision.

The Pathologic AJCC classification (pTNM) is based on clinical information obtained before treatment supplemented by additional evidence from surgery and pathologic examination of resected specimens. It is a combination of all findings through the most definitive surgery (for example, metastases only found after definitive surgery are not included in the AJCC staging). The pathologic stage provides the best data to estimate prognosis and evaluate results. Pathologic assessment of the primary tumor requires a resection or biopsy adequate to evaluate the highest pT category. Pathologic regional lymph node assessment requires the surgical removal of enough nodes to confirm the absence of regional lymph node metastasis and evaluate the highest pN category. There is no minimum number of nodes that must be examined -- even one sentinel lymph node may be sufficient for some cases.

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There are also retreatment (rTNM) classifications for recurrent disease. These employ the regular TNM categories but the staging evaluation is made at the time of the recurrence retreatment. Because the "r" prefix is not recorded in any data field, it is impossible to tell rTNM staging information from regular cTNM and pTNM information, so please do NOT record rTNM staging in the cTNM and pTNM fields collected by the MCR. We expect recurrences reportable to the MCR to have "unknown" or "not applicable" stages. If you must record the recurrent stage in these fields, be sure to tell us in a Staging Narrative field that the stage recorded is from the time of recurent diagnosis. Do not confuse the lower-case "r" prefix with the "R" categories for residual tumor.

There are also autopsy classifications (aTNM) for staging information derived for autopsy-only cases (Class 5). The "a" prefix is not recorded in any data field, but these stages are comparable to regular TNM information and the MCR will accept aTNM staging information recorded in the standard collected Clinical and Pathologic TNM fields.

If a medical record contains ambiguous terms describing disease extent, try to clarify this with a physician and use the following lists as *guidelines* within the context of AJCC staging information (not *all* forms of a word or phrase can be shown here):

Terms Indicating Tumor Involvement or Extension for AJCC	Terms NOT Indicating Tumor Involvement or Extension for AJCC
adherent	approaching
apparent	equivocal
compatible with	possible
consistent with	questionable
encroaching upon	suggests
fixation/fixed	very close to
induration	
into	
onto	
out onto	
probable	
suspect	
suspicious	
to	

Examples: "muscle probably involved" -- Muscle is involved.
"tumor approaches muscle" -- Muscle is *not* involved.

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The MCR collects 2 characters in each TNM field and one character in each Descriptor field. The MCR **does not collect** various other supplementary prefixes, suffixes and staging extensions used in the AJCC system that are not captured in the coded fields:

aTNM when the stage is determined from autopsy findings (the MCR collects only previously unsuspected cases found incidentally through autopsy);

F0, F1 for the fibrosis score for liver cancer;

LX, L0 and L1 for lymphatic invasion;

rTNM when recurrences are staged after a disease-free interval;

RX, R0, R1 and R2 for residual tumor following treatment;

"U" and "L" for upper and lower regional neck lymph nodes for head and neck sites;

VX, V0, V1 and V2 for venous invasion.

If these prefixes, suffixes or extensions are recorded at your facility, please include the information in one of the Staging Narratives. For example, for a MCR-reportable recurrence, if you code a rTNM stage, the MCR will not realize that the TNM stage we are seeing dates from the time of recurrence unless you tell us so in a narrative.

Clinical Descriptor

NAACCR Version 10 field "TNM Clin Descriptor", Item 980, column 581

This field records a code describing additional detail about the type of staging information recorded in the clinical TNM fields. Some of these codes reflect suffixes, prefixes or subscripts that may be added onto TNM elements or stage groupings. When none of the coded situations below applies to a particular case, a zero (**0**) is recorded. The field may not be left empty. The codes follow:

Descriptor category	**Code**
None; no special Descriptor (**1-5**) applies.	**0**
"E" Stage Grouping for extranodal lymphomas	**1**
"S" Stage Grouping for lymphomas involving the spleen	**2**
"m" T Element; multiple tumors in the primary site (at diagnosis) counted as one primary case	**3**
"E+S" Stage Grouping for extranodal lymphomas involving the spleen	**5**
A TNM prefix/suffix/subscript probably applies, but you don't know which; unknown Descriptor category.	**9**

Note: Codes **4** and **6** involve staging done after therapy. These do not apply to clinical staging.

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Clinical T

NAACCR Version 10 field "TNM Clin T", Item 940, columns 573-574

Under the TNM system, the T Element is used to describe the primary tumor's size and/or extension. Always refer to the AJCC *Cancer Staging Manual, Sixth Edition* for detailed site-specific/histology-specific coding rules.

The clinical T classification (cT) is based on information and evidence obtained before treatment. It is especially important for sites that are accessible for clinical examination, including cervix, oral cavity, and larynx. The physical examination, imaging, endoscopy, incisional biopsy, surgical exploration, and other relevant findings are the basis of clinical staging. Evaluate the clinical stage of disease using all information available before the first cancer-directed treatment.

When there are multiple simultaneous tumors being reported as one primary, the T Element for only the *largest* individual tumor or the individual tumor with the *highest* T category is coded. The tumor multiplicity is recorded in the Clinical Descriptor field. The EOD -- Tumor Size field will reflect the size of the largest tumor. You may include tumor multiplicity information in the Staging Narratives or Narrative Primary Site fields. The number of tumors is important in determining the T Element for some cancer types. Stage simultaneous bilateral *independent* tumors in paired organs (two primaries) separately.

Examples: There are two simultaneous duct carcinomas in the upper outer quadrant of the right breast -- one with diameter 0.4 cm, the other with diameter 0.8 cm. The case is reported with T**1B** because this corresponds to the size of the larger lesion. The Staging Narratives should include the fact that there were two tumors, along with their sizes.

Two primary tumors -- one sized 1.1 cm, the other 2.1 cm -- in the same lobe of the liver, without any vascular invasion. The coded T Element is T**2**_. Since this could also describe a single tumor with vascular invasion, use a Staging Narrative to specify the specific situation that was coded.

A patient is diagnosed in May with a 1-cm duct carcinoma of the right breast and a 0.5-cm lobular carcinoma of the left breast. Stage each primary separately (T**1B** for the right, T**1A** for the left).

The following general definitions are used throughout the T Element classification:

TX - primary tumor cannot be assessed or is unknown

T0 - no evidence of a primary tumor

Tis - carcinoma *in situ* (a pathologic T category)

T1, T2, T3, T4 - describe increasing size and/or local extent of the primary tumor

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Use **X_** when the site or histologic type has an AJCC staging scheme but there is not enough information to assign a T value.

Example: A patient has a fine needle biopsy of a breast mass. The cytology identifies infiltrating duct carcinoma. The patient is lost to follow-up. There is not enough information for clinical staging. Record cT**X_**NX_MX_.

T**X_** is also coded for certain lung cancers (occult) when a primary tumor mass cannot be evaluated.

Code T**88** is not included in AJCC staging. The addition of this code enables registries to distinguish unstaged cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. Use T**88** when the site or histologic type does not have an AJCC staging scheme (or does not have a scheme for classifying the T Element).

Examples: Leukemia, trachea, brain primary -- There are no staging schemes in the AJCC *Cancer Staging Manual, Sixth Edition* for these cancers. Record T**88**N88M88.

The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the AJCC *Cancer Staging Manual, Sixth Edition* does not apply to sarcomas. Record T**88**N88M88.

Lymphomas have AJCC Stage Grouping schemes, but not TNM Elements. Record T**88**N88M88 and the appropriate Stage Grouping code.

<u>Choose the lower</u> (less advanced) T category when there is uncertainty in which category to assign. For example, in the larynx supraglottis squamous cell carcinoma scheme, the T4a category specifies that the tumor invades *through* the thyroid cartilage, while the T3 category includes minor thyroid cartilage erosion; so if a supraglottis tumor invades *deeply into* but not *through* thyroid cartilage, it would be classified T3 because it does not meet the T4a requirements.

The MCR collects 2 characters in this field. If the value is only one character, enter it on the left and leave the second space blank. The following table shows how each T category should be coded (both cT and pT categories are included in this table).

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T Category	Code	T Category	Code	T Category	Code	T Category	Code
TX*	**X_**	T1mic	**1M**	T2	**2_**	T4	**4_**
T0	**0_**	T1	**1_**	T2a	**2A**	T4a	**4A**
Ta	**A_**	T1a	**1A**	T2b	**2B**	T4b	**4B**
Tis	**IS**	T1a1	**A1**	T2c	**2C**	T4c	**4C**
Tispu	**SU**	T1a2	**A2**	T3	**3_**	T4d	**4D**
Tispd	**SD**	T1b	**1B**	T3a	**3A**	T not applicable**	**88**
		T1b1	**B1**	T3b	**3B**		
		T1b2	**B2**	T3c	**3C**		
		T1c	**1C**				

* This cancer has a Sixth Edition AJCC T classification scheme, but there is not enough information to specify the T; occult lung cancers (primary tumor not evaluable).

** There is no Sixth Edition AJCC cT classification for this cancer.

Clinical N

NAACCR Version 10 field "TNM Clin N", Item 950, columns 575-576

The N Element identifies the absence or presence of regional lymph node metastases. Always refer to the AJCC *Cancer Staging Manual, Sixth Edition* for appropriate site-specific and histology-specific coding rules.

The following general definitions are used throughout the TNM classification:

NX - regional lymph nodes cannot be assessed or status unknown

N0 - nodes were assessed; no evidence of regional lymph node metastasis

N1, N2, N3 - indicate increasing involvement of regional lymph nodes

Classify a primary tumor that directly extends into lymph nodes in the N Element as lymph node metastasis (rather than in the T Element as continuous extension of the primary tumor). For colorectal cancers, smoothly contoured metastatic nodules resembling lymph nodes in surrounding fat tissue should be counted in the N Element even if no actual lymph node tissue is found in them; but *irregularly* contoured nodules in nearby fat should be counted in the extent of the T Element.

Metastasis in any lymph node not specified as regional in the appropriate AJCC staging scheme should be considered *distant* and classified in the M Element.

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Use code N**X_** when the site or histologic type has an AJCC staging scheme but there is not enough information to assign an N Element code.

Example: A testicular mass is biopsied. The biopsy identifies an embryonal carcinoma. The patient is lost to follow-up. The requirements for clinical N staging of testicular cancers have not been met. Code cNX_.

Code N**88** is not included in AJCC staging, but this code helps distinguish unstaged cases with no AJCC staging scheme from cases with a staging scheme that could not be staged. Use N**88** when the site/histologic type does not have an AJCC N staging scheme.

Examples: Leukemia, pituitary gland, ill-defined digestive primary site -- These do not have staging schemes in the AJCC *Cancer Staging Manual, Sixth Edition*. Record T88N**88**M88.

The pathology report identifies a gastric sarcoma. The stomach staging scheme in the AJCC *Cancer Staging Manual, Sixth Edition* does not apply to sarcomas. Record T88N**88**M88.

Gestational trophoblastic tumors do not have N categories. Record N**88**.

Choose the lower (less advanced) N category when there is any uncertainty. The MCR collects 2 characters in this field. If there is only one character, enter it on the left and leave the second space blank.

N Category	Code	N Category	Code
NX*	**X_**	N2	**2_**
N0	**0_**	N2a	**2A**
N1	**1_**	N2b	**2B**
N1a	**1A**	N2c	**2C**
N1b	**1B**	N3	**3_**
		N3a	**3A**
		N3b	**3B**
		N3c	**3C**
		N not applicable**	**88**

* This cancer has a Sixth Edition AJCC N classification scheme, but there is not enough information to specify the N.

** There is no Sixth Edition AJCC cN classification for this cancer.

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Clinical M

NAACCR Version 10 field "TNM Clin M", Item 960, columns 577-578

The M Element records the presence or absence of distant metastases (including spread to non-regional lymph nodes). Always refer to the AJCC *Cancer Staging Manual, Sixth Edition* for appropriate site-specific and histology-specific coding rules.

Metastasis in any lymph node not specified as regional in the appropriate AJCC staging scheme should be considered *distant* and classified in the M Element.

The following general definitions are used throughout the TNM classification:

MX - presence of distant metastasis cannot be assessed or is unknown

M0 - no known distant metastasis

M1 - distant metastasis present

Use M**X_** when the site or histologic type has an AJCC staging scheme but there is not enough information to code an M Element.

Example: A patient has a fine needle biopsy of a breast mass. Cytology identifies infiltrating duct carcinoma. The patient is lost to follow-up. There is not enough information for clinical staging. Record TX_NX_M**X_**.

Code M**88** is not included in AJCC staging, but its use helps registries distinguish unstaged cases in which the site/histology has no AJCC staging scheme from cases that could not be staged because of incomplete information. Use M**88** when the site or histologic type does not have an AJCC staging scheme.

Examples: Leukemia, parathyroid, cerebrum -- There are no staging schemes in the *AJCC Cancer Staging Manual, Sixth Edition* for these cancers. Record T88N88M**88**.

The medical record identifies a breast mass as sarcoma. The breast staging scheme in the AJCC *Cancer Staging Manual, Sixth Edition* does not apply to sarcomas. Record T88N88M**88**.

The MCR collects 2 characters in this field. The MCR **does not collect** the additional notations "PUL", "OSS", "HEP", etc. (see page 7 in the *Cancer Staging Manual, Sixth Edition*) to denote the site(s) of distant metastasis. Please include any known site(s) of distant metastasis in a Staging Narrative field.

Choose the lower (less advanced) M category when there is any uncertainty in which category to assign.

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Codes for Clinical M follow:

M Category	Code
MX*	**X_**
M0	**0_**
M1	**1_**
M1a	**1A**
M1b	**1B**
M1c	**1C**
M not applicable**	**88**

* This cancer has a Sixth Edition AJCC M classification scheme, but there is not enough information to specify the M Element.

** There is no Sixth Edition AJCC cM classification for this cancer.

Clinical Stage Grouping NAACCR Version 10 field "TNM Clin Stage Group", Item 970, columns 579-580

The Stage Grouping indicates the anatomic extent of disease and groups cases which are expected to have similar prognoses. The Clinical Stage Grouping is important for selecting and evaluating the primary therapy.

The TNM Stage Grouping is usually based on the previously coded TNM Elements. Lymphomas have only Stage Groupings in the TNM system (no TNM Elements). Many of the opthalmic cancers have TNM Elements but no Stage Groupings. Tumor Size, histopathologic Grade, Age at Diagnosis, risk factors, or serum tumor marker data are needed to determine the Stage Grouping for some cancer types. (When appropriate, relevant risk factor information can be included in a Staging Narrative.) Always refer to the AJCC *Cancer Staging Manual*, *Sixth Edition* for appropriate site-specific coding rules.

Code **88** does not appear in AJCC staging. Use code **88** when the site or histologic type does not have an AJCC Stage Grouping scheme.

Examples: Leukemia, central nervous system, adrenal gland, unknown primary -- There are no staging schemes in the AJCC *Cancer Staging Manual, Sixth Edition* for these cancers. Record Stage Grouping **88**.

Carcinoma of the eyelid -- The appropriate staging scheme in the AJCC *Cancer Staging Manual, Sixth Edition* has TNM Elements, but no Stage Groupings. Record Stage Grouping **88**.

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Code **99** also does not appear in AJCC staging. Use code **99** when the site or histologic type has an AJCC staging scheme but there is not enough information to assign a Stage Grouping.

Example: A patient has a fine needle biopsy of a breast mass. The cytology identifies infiltrating duct carcinoma. The patient is lost to follow-up. The AJCC TNM elements are TX_NX_MX_. Record Stage Grouping **99**.

The MCR collects 2 characters in this field. If the code is only one digit, enter it on the left and leave the second space blank. For lymphomas the MCR does *not* explicitly collect the number of lymph node regions involved (e.g., "II_3"), nor "A" and "B" to indicate systematic symptoms. Such details should be included in a Staging Narrative.

Choose the lower (less advanced) category when there is any uncertainty in which to assign.

Stage Grouping	Code	Stage Grouping	Code	Stage Grouping	Code
Stage Occult	**OC**	Stage IB1	**B1**	Stage IIIA	**3A**
Stage 0	**0_**	Stage IB2	**B2**	Stage IIIB	**3B**
Stage 0A	**0A**	Stage IC	**1C**	Stage IIIC	**3C**
Stage 0is	**0S**	Stage IS	**1S**	Stage IV	**4_**
Stage I	**1_**	Stage II	**2_**	Stage IVA	**4A**
Stage IA	**1A**	Stage IIA	**2A**	Stage IVB	**4B**
Stage IA1	**A1**	Stage IIB	**2B**	Stage IVC	**4C**
Stage IA2	**A2**	Stage IIC	**2C**	Stage Grouping not applicable*	**88**
Stage IB	**1B**	Stage III	**3_**	unknown, stage X**	**99**

* There is no Sixth Edition AJCC Stage Grouping classification for this cancer.
** This cancer has a Sixth Edition AJCC Stage Grouping classification, but there is not enough information to specify the Stage Grouping.

Pathologic Descriptor

NAACCR Version 10 field "TNM Path Descriptor", Item 920, column 571

This field records a code describing additional detail about the type of staging information recorded in the pTNM fields. Some of these codes reflect suffixes, prefixes or subscripts that may be added onto TNM elements or stage groupings. When none of the coded situations below applies to a particular case, a zero (**0**) is recorded. The field may not be left empty. The codes follow:

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Descriptor category	**Code**
None; no special Descriptor applies.	**0**
"E" Stage Grouping for extranodal lymphomas	**1**
"S" Stage Grouping for lymphomas involving the spleen	**2**
"m" T Element; multiple tumors in the primary site (at diagnosis) counted as one primary case	**3**
"y" prefix; staged after the start of pre-surgical (neoadjuvant) therapy*	**4**
"E+S" Stage Grouping for extranodal lymphomas involving the spleen	**5**
"m" and "y"; multiple tumors in the primary site and staging done after the start of neoadjuvant* therapy	**6**
A TNM prefix/suffix/subscript probably applies, but you don't know which; unknown Descriptor category.	**9**

* Radiation therapy, chemotherapy, hormone therapy, immunotherapy or endocrine procedures may have affected the extent of disease before the pathologic staging was done.

Pathologic T

NAACCR Version 10 field "TNM Path T", Item 880, columns 563-564

The Pathologic T Element (pT) describes the primary tumor's size and/or extension. Refer to the AJCC *Cancer Staging Manual, Sixth Ed.* for site-specific/histology-specific coding rules.

Pathologic classification is based on information obtained before treatment and supplemented by additional evidence from surgery and pathologic examination of resected specimens. It is a combination of all findings through the most definitive surgery done. The pathologic stage provides the most precise data to estimate prognosis and calculate end results. Pathologic assessment of the primary tumor generally requires a resection of the primary tumor or biopsy specimen adequate to evaluate the highest pT category.

When there are multiple simultaneous tumors being reported as one primary, the T Element for only the *largest* individual tumor or the individual tumor with the *highest* T category is coded. The tumor multiplicity is captured in the Pathologic Descriptor field. The EOD -- Tumor Size field will reflect the size of the largest tumor. You may include specific tumor multiplicity information in a Staging Narrative or Narrative Primary Site fields. The number of tumors is important in determining the T Element for some cancer types. Simultaneous *independent* bilateral tumors in paired organs are staged separately (multiple primaries).

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Examples: There are two simultaneous duct carcinomas in the upper outer quadrant of the right breast -- one with diameter 0.4 cm, the other with diameter 0.8 cm. The case is reported with T**1B** because this corresponds to the size of the larger lesion. The Staging Narratives should include the fact that there were two tumors, along with their sizes.

There are two primary tumors -- one sized at 1.1 cm, the other at 2.1 cm -- in the same lobe of the liver, without any vascular invasion. The coded T Element is T**2**_. As this could also describe a single tumor with vascular invasion, use a Staging Narrative to specify the specific situation that was coded.

A patient is diagnosed in May with a 1-cm duct carcinoma of the right breast and a 0.5-cm lobular carcinoma of the left breast. Stage each primary separately (T**1B** for the right, T**1A** for the left).

Many chapters in the AJCC staging system specifically include a classification for carcinomas *in situ* as "Tis". If there is an accepted histologic classification for carcinoma *in situ* as determined by a pathologist, you may use "pTis" even if the *Cancer Staging Manual, Sixth Edition* does not include this category for the given primary site.

The following general definitions are used throughout the TNM classification:

TX - primary tumor cannot be assessed or is unknown.

T0 - no evidence of a primary tumor

Tis - carcinoma *in situ**

T1, T2, T3, T4 - describe increasing size* and/or local extent of the primary tumor

* *Note*: For AJCC staging schemes in which a specific tumor size plays an important role in assigning the T Element category (such as breast carcinomas), there is sometimes confusion about how to stage an *in-situ* case that has a recorded tumor size. All lesions that are completely *in situ* (no invasive component) are assigned pTis regardless of the tumor size. A large *in-situ* tumor does not have the same prognosis as an invasive cancer with the same tumor size. pT1_, pT2_, etc. are assigned to *invasive* cancers of increasing size and/or extent. For a tumor with both *in situ* and invasive components, only the invasive component's size should be used for assigning the T Element.

Use code **X_** when the site or histologic type has an AJCC staging scheme but there is not enough information to assign a T value.

Example: A biopsy of a breast mass identifies infiltrating duct carcinoma. The patient is lost to follow-up. The AJCC staging scheme requires excision of the primary tumor with macroscopically clean margins for pathologic staging. Record pT**X**_.

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Code T**88** is not included in AJCC staging. This code enables the MCR to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. Use T**88** when the site or histologic type does not have an AJCC staging scheme.

Examples: Leukemia, brain primary -- These have no staging schemes in the AJCC *Cancer Staging Manual, Sixth Ed*. Record T**88**N88M88.

The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Cancer Staging Manual, Sixth Ed*. does not apply to sarcomas. Record T**88**N88M88.

Lymphomas have AJCC Stage Groupings, but no TNM Elements. Record T**88**N88M88.

Choose the lower (less advanced) T category when there is uncertainty in which category to assign. For example, in the larynx supraglottis squamous cell carcinoma scheme, the T4a category specifies that the tumor invades *through* the thyroid cartilage, while the T3 category includes minor thyroid cartilage erosion; so if a supraglottis tumor invades *deeply into* but not *through* thyroid cartilage, it would be classified T3 because it does not meet the T4a requirements.

The MCR collects 2 characters in this field. For only one character, enter it on the left and leave the second space blank. The following table shows the code for each T category.

T Category	Code	T Category	Code	T Category	Code	T Category	Code
TX*	**X_**	T1mic	**1M**	T2	**2_**	T4	**4_**
T0	**0_**	T1	**1_**	T2a	**2A**	T4a	**4A**
Ta	**A_**	T1a	**1A**	T2b	**2B**	T4b	**4B**
Tis	**IS**	T1a1	**A1**	T2c	**2C**	T4c	**4C**
Tispu	**SU**	T1a2	**A2**	T3	**3_**	T4d	**4D**
Tispd	**SD**	T1b	**1B**	T3a	**3A**	T not applicable**	**88**
		T1b1	**B1**	T3b	**3B**		
		T1b2	**B2**	T3c	**3C**		
		T1c	**1C**				

* This cancer has a Sixth Edition AJCC T classification scheme, but there is not enough information to specify the T; occult lung cancers (primary tumor mass not present or not evaluable).

** There is no Sixth Edition AJCC pT classification for this cancer.

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Pathologic N

NAACCR Version 10 field "TNM Path N", Item 890, columns 565-566

Pathologic N (pN) identifies the absence or presence of regional lymph node metastases. Always refer to the AJCC *Cancer Staging Manual, Sixth Edition* for appropriate site-specific and histology-specific coding rules.

The following general definitions are used throughout the TNM classification:

NX - regional lymph nodes cannot be assessed or status unknown

N0 - nodes were assessed and there was no pathologic evidence of regional lymph node metastasis

N1, N2, N3 - indicate increasing involvement of regional lymph nodes

A lymph node may be *pathologically* negative for cancer (when the specimen is examined under the microscope) and yet harbor a small number of cells which are cancerous. These may be *micrometastases* (> 0.2 mm and < 2.0 mm in largest dimension) or *isolated tumor cells* (a single cancerous cell or a tiny group of them ≤ 0.2 mm in largest dimension). The presence of these cells can be detected by immunohistochemical or molecular tests. Flow cytometry and DNA analysis may also be used to detect individual cells that are "suggestive" for being cancerous. As long as the node as a whole is *pathologically* negative, it is N**0_** even if micrometastatic cancer or isolated tumor cells are detected. Immunohistochemical and molecular test results are recorded in the pN, but they are *not* captured in the 2-character codes for the pN Element; the pN field collected by the MCR will simply be **N0_** whenever regional nodes are pathologically negative.

If the primary tumor extends directly into a lymph node, classify this in the N Element as a lymph node metastasis (rather than in the T Element). For colorectal cancers, smoothly contoured metastatic nodules resembling lymph nodes in surrounding fat tissue should be counted in the N Element even if no actual lymph node tissue is found in them; but *irregularly* contoured nodules in nearby fat should be counted in the extent of the T Element.

Metastasis in any lymph node not specified as regional in the appropriate AJCC staging scheme should be considered *distant* metastasis and classified in the M Element.

Use code N**X_** when the site or histologic type has an AJCC staging scheme but there is not enough information to assign an N Element code.

Example: A patient has a biopsy of a testicular mass. The biopsy identifies an embryonal carcinoma. The patient is lost to follow-up. This type of case has an AJCC staging scheme, but no assessment of regional lymph node involvement was made. Record N**X_**.

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Code **88** does not appear in AJCC staging. Its use enables registries to distinguish cases unstaged because of insufficient information from those unstaged because they have no AJCC staging scheme. Use code **88** when the site/histology does not have an AJCC staging scheme.

Examples: Adrenal gland, unknown primary site -- These have no staging schemes in the *AJCC Cancer Staging Manual, Sixth Edition*. Record T88N**88**M88.

The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Cancer Staging Manual, Sixth Edition* does not apply to sarcomas. Record T88N**88**M88.

Gestational trophoblastic tumors do not have N categories. Record N**88**.

Choose the lower (less advanced) N category when there is uncertainty. The MCR collects 2 characters. If there is only one character, enter it on the left and leave the second space blank.

N Category	Code	N Category	Code
NX*	**X_**	N2	**2_**
N0**	**0_**	N2a	**2A**
N1	**1_**	N2b	**2B**
N1a	**1A**	N2c	**2C**
N1b	**1B**	N3	**3_**
N1c	**1C**	N3a	**3A**
N1mi	**1M**	N3b	**3B**
		N3c	**3C**
		N not applicable***	**88**

* This cancer has a Sixth Edition AJCC N classification scheme, but there is not enough information to specify the N.

** includes N0, N0(i-), N0(i+), N0(mol-), N0(mol+)

*** There is no Sixth Edition AJCC pN classification for this cancer.

Pathologic M

NAACCR Version 10 field "TNM Path M", Item 900, columns 567-568

The M Element describes the presence or absence of distant metastases (including non-regional lymph nodes). Refer to the AJCC *Cancer Staging Manual, Sixth Edition* for site- and histology-specific coding rules.

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Metastasis in any lymph node not specified as regional in the appropriate AJCC staging scheme should be considered *distant* and classified in the M Element.

The following general definitions are used throughout the TNM classification:

MX - presence of distant metastasis cannot be assessed or is unknown

M0 - no known distant metastasis

M1 - distant metastasis present

For the evaluation of distant lymph nodes, as with the pN Element, a distant lymph node may be *pathologically* negative for cancer (when the specimen is examined under the microscope) and yet harbor isolated tumor cells detected by immunohistochemical or molecular tests. Flow cytometry and DNA analysis may also be used to detect individual cells that are "suggestive" for being cancerous. As long as the node as a whole is *pathologically* negative, it is coded M**0_** even if isolated tumor cells or micrometastases are detected.

In general, if a distant metastasis has been microscopically confirmed, this alone may satisfy the requirements for a pM category (such as pM**1_** or pM**1A**) and the Pathologic Stage Group may be assigned.

Use M**X_** when the site or histologic type has an AJCC staging scheme but there is not enough information to specify an M Element.

Example: A patient has a breast mass biopsy, finding infiltrating duct carcinoma. The patient is lost to follow-up. Breast carcinomas have an AJCC staging scheme, but the status of distant metastasis has not been evaluated. Record TX_NX_M**X_**.

Code **88** does not appear in AJCC staging. This code allows registries to distinguish unstaged cases in which the site/histology has no AJCC staging scheme from cases that could not be staged because of incomplete information. Use M**88** when the site or Histologic Type does not have an AJCC Staging scheme.

Examples: Leukemia, central nervous system, an ill-defined pelvic site -- These have no staging schemes in the AJCC *Cancer Staging Manual, Sixth Ed*. Record T88N88M**88**.

Pathology identifies gastric sarcoma. The stomach staging scheme in the AJCC *Cancer Staging Manual, Sixth Ed*. does not apply to sarcomas. Record T88N88M**88**.

The MCR collects 2 characters in this field. The MCR **does not collect** the additional notations "PUL", "OSS", "HEP", etc. (see page 7 in the *Cancer Staging Manual, Sixth Edition*) to denote the site(s) of distant metastasis. Please include any known site(s) of distant metastasis in a Staging Narrative.

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Choose the lower (less advanced) category when there is any uncertainty in which to assign.

M Category	Code
MX*	**X_**
M0	**0_**
M1	**1_**
M1a	**1A**
M1b	**1B**
M1c	**1C**
M not applicable**	**88**

* This cancer has a Sixth Edition AJCC M classification scheme, but there is not enough information to specify the M.

** There is no Sixth Edition AJCC pM classification for this cancer.

Pathologic Stage Grouping

NAACCR Version 10 field "TNM Path Stage Group", Item 910, columns 569-570

The Stage Grouping describes the anatomic extent of disease. Different cases which fall into the same Stage Grouping are expected to have similar prognoses. The Pathologic Stage Grouping can be used as a guide for the need of adjuvant therapy, for reporting end results, and for the estimation of prognosis. In order to assign a Pathologic Stage Grouping it is not always necessary to have three specific Pathologic TNM Elements. If sufficient tissue has been removed for pathologic examination to evaluate the highest T and N categories (that is, pT and pN are specified), you may use the specific pM *or cM* to assign a Pathologic Stage Grouping. In general, if a distant metastasis has been microscopically confirmed, this alone may satisfy the requirements for a pathologic M category (such as pM**1_** or pM**1A**) and the Pathologic Stage Grouping may be assigned.

The TNM Stage Grouping is *usually* based on the previously coded TNM Elements. Lymphomas have *only* Stage Groupings in the TNM system (no TNM Elements). Many of the opthalmic cancers have TNM Elements but no Stage Groupings. Tumor Size, histopathologic Grade, Age at Diagnosis, risk factors, or serum tumor marker data are needed to determine the Stage Grouping for some cancer types. (When relevant, risk factor information should be included in a Staging Narrative.) Always refer to the AJCC *Cancer Staging Manual*, *Sixth Edition* for appropriate site-specific and histology-specific coding rules.

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Code **88** does not appear in AJCC staging. Use code **88** when the site or histologic type does not have an AJCC Stage Grouping scheme.

Examples: Leukemia, trachea, unknown primary site -- There are no staging schemes in the AJCC *Cancer Staging Manual, Sixth Edition* for these cancers. Record Stage Grouping **88**.

The pathology report identifies a carcinoma of the eyelid. The appropriate staging scheme in the AJCC *Cancer Staging Manual, Sixth Edition* has TNM Elements, but no Stage Groupings. Record **88** here.

Code **99** also does not appear in AJCC staging. Use **99** when the cancer type has an AJCC staging scheme but there is not enough information to assign a pathologic Stage Grouping.

Example: A patient has a fine needle biopsy of a breast mass, identifying infiltrating duct carcinoma. The patient is lost to follow-up. The TNM Elements are TX_NX_MX_. Record Stage Grouping **99**.

The MCR collects 2 characters in this field. If the stage code is only one character, enter it on the left and leave the second space blank. For lymphomas the MCR does *not* explicitly collect the number of lymph node regions involved (e.g., "II_3"), nor "A" and "B" to indicate systematic symptoms. Such details should be included in a Staging Narrative.

Choose the lower (less advanced) grouping when there is any uncertainty in which to assign.

Stage Grouping	Code	Stage Grouping	Code	Stage Grouping	Code
Stage Occult	**OC**	Stage IB1	**B1**	Stage IIIA	**3A**
Stage 0	**0_**	Stage IB2	**B2**	Stage IIIB	**3B**
Stage 0A	**0A**	Stage IC	**1C**	Stage IIIC	**3C**
Stage 0is	**0S**	Stage IS	**1S**	Stage IV	**4_**
Stage I	**1_**	Stage II	**2_**	Stage IVA	**4A**
Stage IA	**1A**	Stage IIA	**2A**	Stage IVB	**4B**
Stage IA1	**A1**	Stage IIB	**2B**	Stage IVC	**4C**
Stage IA2	**A2**	Stage IIC	**2C**	Stage Grouping not applicable*	**88**
Stage IB	**1B**	Stage III	**3_**	unknown, stage X**	**99**

* There is no Sixth Edition AJCC Stage Grouping classification for this cancer.

** This cancer has a Sixth Edition AJCC Stage Grouping classification, but there is not enough information to specify the Stage Grouping.

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TNM Edition Number

NAACCR Version 10 Item 1060, column 593-594

This field identifies the edition of the AJCC *Manual for Staging of Cancer* that was used to stage the case. Staging criteria and timing inclusion rules differ between editions. This code allows analysis of cases grouped by edition number. The staging manual that is *appropriate* for the *year of diagnosis* of a case should be used; although this field may be automatically filled by your software system, please code the book *that was actually used to stage the case* when this is known, even if it is not the appropriate edition to have used for the given year of diagnosis (if you can manually enter this code on your system). The MCR uses this field to determine which book we must use to interpret the coded stage information.

AJCC Staging Edition	Code
not staged (case has an AJCC staging scheme, but staging was not done)	**00**
First Edition (for cases diagnosed before 1984)	**01**
Second Edition (for cases diagnosed 1984-1988)	**02**
Third Edition (for cases diagnosed 1989-1992)	**03**
Fourth Edition (for cases diagnosed 1993-1997)	**04**
Fifth Edition (for cases diagnosed 1998-2002)	**05**
Sixth Edition (for cases diagnosed 2003-?)	**06**
not applicable (case does *not* have an AJCC staging scheme in the edition used)	**88**
unknown edition (case was AJCC-staged, but the edition used is unknown)	**99**

If the year of diagnosis is unknown to you, stage the case as if it had been diagnosed in your facility's Date of First Contact year.

SEER Summary Stage 1977

NAACCR Version 10 Item 760, column 529

Refer to the Third Edition of this manual for coding diagnoses made before 2001. This field should be left empty for diagnoses made beginning in 2001; it must be filled for diagnoses made before 2001.

SEER Summary Stage 2000

NAACCR Version 10 Item 759, column 528

This field is required for all diagnoses made between January 1, 2001 and December 31, 2003. Beginning with diagnoses made in 2004, the MCR considers this field to be replaced by the Summary Stage 2000 fields "derived" from the Collaborative Staging fields. Thus, the field must be filled for diagnoses made between 2001 and 2003; it should be left empty for diagnoses made before 2001 and for those made after 2003. The MCR will notify reporting facilities of any changes in these plans.

SEER Summary Staging groups cases into broad categories (such as localized, regional and distant). Note: Before Collaborative Staging takes effect, the COC only requires Summary Staging for cases which are not TNM-staged. The MCR requires *both* Summary Staging and TNM staging for all reportable cases diagnosed between 2001 and 2003 (use "unknown" and "not applicable" codes as necessary).

All cases diagnosed between 2001 and 2003 must be staged using the red *SEER Summary Staging Manual 2000* (published 2001, with updates). All pre-2001 diagnoses must be staged using the green *Summary Staging Guide* (1977, with updates from SEER Extent of Disease coding changes). The two books have different staging schemes and rules -- be sure to use the correct book to stage each case based on its diagnosis year. If your data system shows both fields "SEER Summary Stage 1977" and "SEER Summary Stage 2000" on-screen, be sure that the correct field gets filled in based on each case's diagnosis year; if your system shows only one Summary Stage field, be sure to use the correct book to stage each case based on its diagnosis year; when the case is exported, your system will put that single field into the appropriate place in the NAACCR layout based on each case's diagnosis year.

If the year of diagnosis is unknown to you, stage the case as if it had been diagnosed in your facility's Date of First Contact year.

General Guidelines

Rules governing Summary Staging appear in the *SEER Summary Staging Manual 2000*'s first chapter (pages 2-15). The *entire* set of Guidelines on p. 10 is very important to keep in mind as you apply any specific staging scheme. Some of the Guidelines are paraphrased here:

- Instructions in a specific staging scheme take precedence over the General Guidelines on p. 10.
- Summary staging is based on a combination of clinical, operative and pathologic assessments. Clinical evaluations may include important staging information, such as skin involvement, missing from operative and path reports; but if some part of the clinical assessment is disproved by operative or pathologic findings, use the op/path findings. If information from an operative and path report conflict, priority goes to the pathologic assessment. An autopsy report should be given the same priority as a pathology report.

- When you have AJCC TNM staging recorded but no direct Summary Stage information, assign the Summary Stage 2000 code that is most equivalent to what the TNM staging reflects. If the medical record conflicts with a physician's TNM stage, the information in the record takes precedence; try to consult with the physician to see if s/he has information not available in the record, or if the record was incomplete at the time of the TNM staging.
- Include all information available within the following **timeframe**:

  through completion of first-course-of-treatment* surgeries **or**

  within four months of diagnosis *in the absence of disease progression*,

  whichever is longer.

  This applies to all cancers, including prostate. Do not stage too soon (before all the information you need is in the medical record). You must still report to the MCR in a timely manner, however; so when surgery is delayed for a case, you may need to send the case to us with an unknown Summary Stage; then be sure to call us (617-988-3382 or 617-988-3381) when the staging is complete so that we can update the report.

  * *Note*: This refers to the SEER definition of "first course of treatment" which may include a much longer timeframe than the COC definition *under certain circumstances only*. Applying the COC definition here should not make a difference in most cases (see pp. 32-33 in the NAACCR *Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Eighth Ed.*, 2003 for a concise comparison of the COC and SEER definitions of "first course of treatment").
- Exclude any metastasis known to have developed after the diagnosis was established.
- Information obtained after the start of treatment (radiation, chemotherapy, etc.) may be used unless it falls outside the timeframe described in the "surgery/four-months" Guideline. But if pre-surgical treatment affected the extent of disease found at surgery, then use the pre-treatment information for staging. (For example, a lung cancer case is clinically regionalized to lymph nodes and the patient receives chemotherapy before surgery; the surgery finds that no positive nodes now remain; the Summary Stage should reflect the clinically diagnosed node involvement that existed at diagnosis. So just as disease progression should not be included in Summary Staging, disease improvement resulting from treatment should also not be included. This is the MCR's interpretation of the Summary Stage rules.)
- Certain staging schemes are used for certain histologic types regardless of primary site:

  Kaposi Sarcoma of All Sites (page 274);

  Hodgkin and Non-Hodgkin Lymphomas of All Sites, excluding Mycosis Fungoides and Sezary Disease of Skin, Vulva, Penis, Scrotum (page 278);

  Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms (page 280).

  If a case has one of these histologies, ignore the primary site when choosing your staging scheme (e.g., a stomach lymphoma should be staged using the lymphoma scheme, even though the stomach scheme does not specify that it excludes lymphomas.)

Most schemes apply to all other histologies for the given primary sites, except as noted. See the lists on pages 285-287 of the staging manual.

Some schemes are limited to certain sites and histologies in combination:

Melanoma of Skin, Vulva, Penis, Scrotum (page 173) and Conjuctiva (page 252);

Mycosis Fungoides and Sezary Disease of Skin, Vulva, Penis, Scrotum (page 176);

Melanoma of Cornea, Retina, Choroid, Ciliary Body, Eyeball, and Overlapping and Other Eye (page 256);

Retinoblastoma (page 258).

Ambiguous terms may be used in the medical record to describe tumor involvement. The following lists should be used as a guide when assigning Summary Stage 2000. (Not all forms of the words can be shown here.)

Involved: Consider the following terms to be indicative of cancer involvement:

- adherent
- apparent(ly)
- appear(s) to
- comparable with
- compatible with
- consistent with
- contiguous with
- continuous with
- encroaching upon*
- extension to, into, onto or out onto
- features of
- fixation to another structure**
- fixed**
- impending perforation of
- impinging upon
- impose/imposing on
- incipient invasion
- induration***
- infringe(s)/infringing
- into*
- intrude(s)
- invasion to, into, onto or out onto
- matted (indicates involvement for lymph nodes only)
- most likely
- onto*
- overstep(s)
- presumed
- probable
- protruding into (unless encapsulated)
- suspect(ed)
- suspicious
- to*
- up to

* indicates cancer involvement whether found in a clinical, operative or pathologic description

** indicates that the *other* structure or tissue is involved

*** used to describe surrounding fibrous or connective tissue adjacent to the tumor; interpreted as extension of the malignant growth

Not Involved: Consider the following terms to be indicative of cancer non-involvement:

- abuts
- approaching
- approximates
- attached
- cannot be excluded
- cannot be ruled out
- effaces/effacing/effacement
- encases/encasing
- encompass(es)
- entrapped
- equivocal
- extension to without invasion
- extension to without involvement of
- kiss(es)/kissing
- matted (except for lymph nodes)
- possible
- questionable
- reaching out
- rule(s) out
- suggests
- very close to
- worrisome

The special use of some terms in the *Summary Staging Manual 2000* are discussed on page 14 therein. When used in other places, these terms may have different meanings.

"adjacent organ(s)": Anatomic structures with specific physiologic functions other than (or in addition to) support and storage that are located next to the primary site organ.

"adjacent structure(s)": connective tissues large enough to have been given a specific name (for example, brachial artery, broad ligament)

"adjacent tissue(s), NOS": This term may appear in the staging schemes for ill-defined and non-specific sites. The term is used to mean "the unnamed tissue(s) that immediately surround an organ or structure containing a primary cancer". The tumor has invaded past the outer border (capsule, serosa, other edge) of the primary organ into the organ's supportive structures but has *not* invaded larger structures and adjacent organs.

"connective tissue(s)": These do not generally have specific names. They include adipose tissue, aponeuroses, blood vessels, bursa, fascia, fatty tissues, fibrous tissues, ganglia, ligaments, lymphatic channels, muscle, nerves (spinal, sympathetic, peripheral), skeletal muscle, subcutaneous tissue, synovia, tendons, tendon sheaths, unidentified vessels and veins. Blood, cartilage and bone are *not* "connective tissues" in the Summary Staging manual.

"cortex", "cortical": the external or outer surface layer of an organ

"marrow", "medulla", "medullary": the interior central portion of an organ

"parenchyma": the functional portion of an organ, as distinguished from its framework or stroma; the place where most malignancies arise

"stroma": the cells and tissues that support, store nutrients, and maintain viability within an organ; consists of connective tissue, vessels and nerves; provides the framework of an organ

***In Situ* (Code 0)**

A diagnosis of "*in situ*" must be based on microscopic examination of tissue or cells. An *in-situ* tumor has all the characteristics of malignancy except invasion (i.e., the basement membrane has not been penetrated). A tumor that displays any degree of invasion is not classified as *in situ* (it is at least localized). For example, if a report states "carcinoma *in situ* of the cervix showing microinvasion of one area", then the tumor is not *in situ*. A primary tumor may involve more than one site (e.g., cervix and vagina, labial mucosa and gingiva) and still be *in situ* if it does not show any invasion. If a tumor is Summary Staged as *in situ*, its Behavior Code (see pages 97-98) is **2**. Organs and tissues that have no epithelial layer and basement membrane cannot be Summary Staged as *in situ*; only carcinomas and melanomas may be staged *in situ*. For carcinomas and melanomas, if all reports are negative for disease spread and the pathologist states that the cancer is noninvasive or noninfiltrating, code as **0**.

Certain terms indicate an *in situ* Summary Stage:

- confined to epithelium
- intracystic
- intraductal
- intraepidermal
- intraepithelial
- intrasquamous
- involvement up to but not including the basement membrane
- no penetration below the basement membrane
- no stromal invasion
- noninfiltrating
- noninvasive
- preinvasive
- Stage 0

Localized (Code 1)

A localized tumor invades beyond the basement membrane, but is still confined entirely to the organ of origin. For most sites, a localized tumor may be widely invasive or have spread within the organ, as long as it does not extend beyond its outer limits and there is no evidence of metastasis to other parts of the body. If all reports are negative for disease spread and the pathologist states that the cancer is invasive or infiltrating, use code **1**.

Inaccessible Sites - Clinical diagnosis alone may be insufficient for staging a tumor "localized" when the primary site and regional nodes are inaccessible, such as with the esophagus or lung. Without confirmation from surgery/autopsy, it is usually preferable to use code **9** ("unstageable"); but, if a physician stages the case "localized", or if clinical reports (like CT scans) provide enough information to rule out further disease spread, code **1** may be used; if surgery was done, study the operative report for evidence of direct extension or metastasis; if surgery and radiology have produced no such evidence, assign code **1**.

Vessel / Lymphatic Involvement -- Invasion of blood vessels, lymphatics and/or nerves *within* the primary site is localized, unless there is evidence of disease outside the site.

Microinvasive -- This term, used by pathologists to describe the earliest invasive stage, has precise meaning for cancer of certain sites. Microinvasive cancers are staged as "localized".

Regional (Codes 2, 3, 4, 5)

A tumor at the "regional" stage has grown beyond the limits of the organ of origin -- into adjacent organs or tissues by direct extension, and/or to regional lymph nodes by metastasis. Cancer becomes regional when there is the potential for spread by more than one lymphatic or vascular supply route. If *in situ*, localized and distant stage categories have been ruled out, then the stage may be assumed to be regional. Neoplasms appearing to be in the "regional" stage must be evaluated very carefully to make sure they have not spread any further.

Example: A malignant tumor of the stomach or gallbladder often passes through the wall of the primary organ into surrounding tissues. Before coding as regional, make certain that imaging scans do not reveal metastasis to lung or bone and that surgery did not reveal metastases to non-regional tissues. Check timely progress notes and discharge summary for any mention of metastases.

Regional, by Direct Extension or Contiguous Spread Only (Code **2**) -- Sometimes a cancer spreads to surrounding organs or tissue with no involvement of regional lymph nodes. The cancer invades through the wall of the organ of origin into surrounding organs and/or adjacent tissues. Before assigning code **2** to such a case, make sure that tissue adjacent to the original organ is actually involved. The terms "penetrating", "extension" and "metastases" are sometimes used to describe spreading within an organ, such as the large intestine or bladder, in which case the stage might still be "localized" (code **1**). The *Summary Staging Manual* lists organs and structures considered to be regional for each site.

Regional, to Lymph Nodes Only (Code **3**) -- If a cancer continues to grow after the onset of local invasion, regional lymph nodes draining the area usually become involved. The cancer invades the walls of lymphatics and may travel to and grow in nearby nodes. Enter code **3** if nodal involvement is indicated and there is no other evidence of extension beyond the organ of origin. For carcinomas, if there are lymph nodes involved, then the stage is at least regional. Words like "local" and "metastasis" appearing in medical records sometimes cause confusion in staging. Failure to recognize the names of regional lymph nodes might lead to incorrect staging. The *Summary Staging Manual* and the AJCC's *Cancer Staging Manual* contain helpful information about the names of regional and distant nodes.

Examples: "Carcinoma of the stomach with involvement of *local* lymph nodes" should, lacking further evidence, be considered "regional" and coded **3**.

Statements like "carcinoma of the breast with axillary lymph node *metastasis*" and "carcinoma of the stomach with *metastasis* to perigastric nodes" indicate metastasis to regional nodes and should be assigned code **3**.

Regional nodes are listed for each Summary Stage scheme. Consider the farthest specific node chain involved. Any nodes that are removed along with the resected primary site specimen that are not specifically identified should be considered "regional lymph nodes, NOS". If a specific node chain is named but is not listed in the staging scheme, first determine if the recorded name is synonymous with a listed regional chain (see page 284 in the *Summary Staging Manual*); otherwise, assume that these are *distant* lymph nodes (**7**). Unless stated to be contralateral or bilateral, assume that lymph nodes mentioned are ipsilateral (homolateral).

For lymphomas, *any mention* of lymph nodes indicates *involvement*. For solid tumors, the terms "fixed", "matted" and "mass in the mediastinum, retroperitoneum, and/or mesentery" without specific information as to the types of tissue involved are considered to indicate lymph node involvement. The terms "palpable", "enlarged", "visible swelling", "shotty" and "lymphadenopathy" are to be *ignored* except for lung primaries; for lung primaries, these terms *are* interpreted as regional lymph node involvement.

Bilateral lymph node metastases do not necessarily indicate distant spread. For primaries on the body's midline (e.g., esophagus), bilateral node involvement is regional. Check each staging scheme carefully.

Regional, Direct Extension and Lymph Nodes (Code **4**) -- Enter code **4** when a tumor has metastasized to regional lymph nodes *and also* has spread to regional tissue via direct extension, but there is no evidence of metastasis to a distant site or distant lymph nodes.

Regional, NOS (Code **5**) -- If available information states only that a cancer has spread regionally, Summary Stage to code **5**. This indicates that you cannot determine if the spread is to regional nodes only, by direct extension of the tumor only, or both. Some staging schemes have this as the only Regional code available because the "direct extension" and "regional lymph node" categories do not apply (for example, brain cancers and lymphomas).

Distant Site(s) and/or Distant Node(s) Involved (Code 7)

Distant metastases are tumor cells that have broken away from the primary tumor, traveled to other parts of the body, and have begun to grow there. This may be called "diffuse", "disseminated", "metastatic", "remote" or "secondary" disease. In most cases there is no continuous trail of tumor cells between the primary and distant sites. Cancer cells may travel from the primary site and grow distantly by several routes:

- by direct tumor extension from the primary organ through adjacent tissues into a non-regional organ;
- by travel in lymph channels beyond the first (regional) drainage area to distant nodes;
- invasion of blood vessels within the primary site, allowing hematogenous (blood-borne) disease spread to blood vessels in distant sites;
- by implantation or seeding through fluid within a body cavity.

Some distant sites and nodes are listed within a staging scheme, but obviously not *all* sites and nodes that are not regional can be listed. *Assume* that any site or node chain not listed as "regional" is distant, even if the site/node is not listed as "distant"; but be careful in case the terminology in the medical record is a *synonym* for one of the regional sites or node chains.

Common sites of distant spread are liver, lung, brain and bones, but these sites are not usually listed as distant in the staging schemes. Do not assume that involvement of these sites is distant spread for every case. For example, if the primary site is adjacent to the liver (like the gallbladder), then the liver may be regionally involved by direct extension of the primary tumor; determining if the *outside* surface of the secondary organ is involved or if the cancer grew discontinuously from *inside* the secondary organ is key.

Hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms are considered distant disease and are coded with **7** except as noted in each staging scheme.

Unstageable; Unknown; Unspecified; Unknown if Extension or Metastasis (Code 9)

If information in the medical record is insufficient to assign a Summary Stage, enter **9**. This code should be applied sparingly. If possible, contact a physician to see if there is information available about the case that is not included in the medical record.

The staging scheme for "Other and Ill-Defined Sites, Unknown Primary Site" (p. 281) includes *only* code **9**. If the primary site is unknown -- even if disease found is presumed metastatic -- the Summary Stage must be **9**.

Example: A patient is diagnosed with metastatic brain cancer. The primary site is not determined (C80.9). Although the cancer in the brain is presumed to be distant disease, the unknown primary site requires that the Summary Stage be coded **9**.

Use only the codes shown in the *SEER Summary Staging Manual 2000* for a specific staging scheme. The *general* code categories follow:

Extent of Disease	Code
In situ	**0**
localized only	**1**
regional, by direct extension only	**2**
regional, to lymph nodes only	**3**
regional (both **2** and **3**)	**4**
regional, NOS	**5**
distant site(s)/node(s) involved	**7**
unstageable, unknown, or unspecified; unknown if extension or metastasis; death certificate-only case	**9**

Not all of these codes apply to every staging scheme. For example, in the malignant Brain and Cerebral Meninges scheme (page 266), only codes **1**, **5**, **7** and **9** are applicable.

Regional Nodes Examined

NAACCR Version 10 Item 830, columns 541-542

NOTE: This field becomes involved in the Collaborative Staging system for diagnoses made beginning in 2004, but there are no major changes expected in its codes and categories. The MCR will continue to collect this field for ALL diagnosis years. The instructions below apply for diagnoses made before 2004. For diagnoses made beginning in 2004, and for any case abstracted after your software is updated for 2004 Collaborative Staging, follow the *Collaborative Staging Manual and Coding Instructions*.

This field describes the total number of regional lymph nodes *examined* by a pathologist. Include nodes considered "regional" and used in the pN Element according to the AJCC *Cancer Staging Manual, Sixth Ed*. (The MCR will re-code this field in our offices if the particular nodes coded are not regional in the SEER system.) Code *all* regional lymph nodes removed during the First Course of Therapy (see pages 169-170 for the definition of First Course of Therapy). If nodes were removed at different times during First Course of Treatment, be sure to include all of them here. Do not include nodes removed to just establish recurrence or disease progression (as these would be removed after First-Course Therapy). Do not include regional nodes that are only *clinically* evaluated as being involved by disease.

Ignore the effects of neoadjuvant therapy (Radiation, Chemotherapy, etc., done before surgery) on regional nodes. Record the total number of regional nodes examined during First Course of Therapy, even if the patient had pre-surgery therapy.

Use code **00** when no regional nodes were removed.

Use code **95** when a lymph node aspiration was performed and the cytology or histology was positive for malignant *cells*, but no *nodes* were actually removed.

Use code **99** if information about regional lymph node examination is completely unknown, and for sites and histologies for which regional lymph node removal is not applicable*:

cerebral meninges primary site (C70.0);
brain primary site (C71._);
ill-defined primary site (C76._);
lymphomas with lymph node primary site** (C77._ and 9590-9729);
unknown primary site (C80.9);
multiple myeloma (9732);
Letterer-Siwe disease (9754);
hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative diseases (primary sites C42.0, C42.1, C42.3, C42.4 or histologies 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989).

* This list changes slightly when Collaborative Staging goes into effect [with the addition of placenta (C58.9) and other central nervous system (C72._) primary sites]. Follow the *Collaborative Staging Manual and Coding Instructions* after your software is ready for Collaborative Staging.

** The *FORDS* Manual specifies this coding rule and accepts that a specific number of lymph nodes may be recorded here for lymphomas with a primary site other than C77._. SEER (who has the major responsibility for defining this field before Collaborative Staging takes effect) instructs that **99** should be recorded for *all* lymphomas regardless of primary site. The MCR will collect this field according to the COC's rules and will change the codes as necessary at the MCR to adhere to SEER rules.

The codes for Regional Nodes Examined follow:

No regional lymph nodes were removed.	**00**
One regional lymph node was removed.	**01**
Two regional lymph nodes were removed.	**02**
...exact number of regional lymph nodes removed…	**...**
Ninety *or more* regional lymph nodes were removed.	**90**
No regional lymph nodes removed, but a regional node *aspiration* was done.	**95**
Regional lymph node removal documented as a *sampling*, and # of regional nodes unknown/not stated.	**96**
Regional lymph node removal documented as *dissection*, and # of regional nodes unknown/not stated.	**97**
Regional lymph nodes surgically removed, but # of nodes unknown/not stated *and* their removal was not documented as a "sampling" or a "dissection". Unknown number of regional lymph nodes were examined.	**98**
unknown if any regional nodes were examined; not applicable*; not stated; death certificate-only case	**99**

* primary sites C42.0, C42.1, C42.3, C42.4, C70.0, C71._, C76._, C80.9; histologies 9732, 9754, 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989; C77._ with histologies 9590-9729

Regional Nodes Positive

NAACCR Version 10 Item 820, columns 539-540

NOTE: This field becomes involved in the Collaborative Staging system. Some of the **category/code definitions will change** for diagnoses made beginning in 2004. Until your software is updated for 2004 diagnoses, continue to code this field using the pre-2003 definitions. When you are able to fill in the other Collaborative Staging fields on your updated software, this field will undergo a coding conversion and the 2004 definitions and codes (as described in the *Collaborative Staging Manual and Coding Instructions*) should apply, regardless of diagnosis year. Although most of the Collaborative Staging fields only *begin to apply* with diagnoses made in 2004, the MCR will continue to collect this field for ALL diagnosis years.

I. For cases diagnosed before 2004 and abstracted before Collaborative Staging software updates (the old rules)**:**

This field describes the number of regional lymph nodes examined by a pathologist and reported as being positive for cancer involvement. Include all regional nodes removed during First Course of Treatment (see pages 169-170 for the definition of First Course of Treatment) and found to be positive by pathologic examination. Include nodes considered "regional" and used in the pN Element according to the AJCC *Cancer Staging Manual, Sixth Ed*. (The MCR will re-code this field when necessary to include only nodes considered regional in the SEER system.) Be sure that the number coded in this field (up to **89**) does not exceed the number coded for Regional Nodes Examined.

Only regional lymph nodes found to be positive by pathologic examination are counted here. If a regional lymph node is not found to be positive by pathologic examination, but the node is found to contain isolated tumor cells (≤ 2 mm in largest dimension or micrometastases), do NOT count the node as being positive here.

Examples: Pathology report reads "11/17 nodes examined contain metastatic squamous cell carcinoma". Enter **11** for "Regional Nodes Positive".

No regional lymph nodes were removed during first course of treatment. "Regional Nodes Examined" is **00**, and "Regional Nodes Positive" is **98**.

All regional lymph nodes examined are negative based on pathology. Two test positively under immunohistochemical staining or H&E. Record **00**.

Ignore the effects of neoadjuvant therapy (Radiation, Chemotherapy, etc., before Surgery) on regional node disease status. Record the number of regional nodes found to be positive even if the patient had treatment before their removal.

Example: A patient is diagnosed clinically with regional lymph node involvement. She has chemotherapy, and then regional nodes are removed during surgery. None are then found to be positive by pathology. Record **00**.

Use code **97** when the cytology or histology from a regional lymph node *aspiration* is positive for malignant cells. Use **97** when pathology reports positive regional nodes, but the exact number is not recorded.

Use code **98** when no regional lymph nodes were found positive because none were ever examined (rather than **00**).

Use code **99** if information about the regional lymph node status is unknown, or if regional lymph node removal is not applicable for the case:

cerebral meninges primary site (C70.0);
brain primary site (C71._);
ill-defined primary site (C76._);
lymphomas with lymph node primary site* (C77._ and 9590-9729);
unknown primary site (C80.9);
multiple myeloma (9732);
Letterer-Siwe disease (9754);
hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative diseases (primary sites C42.0, C42.1, C42.3, C42.4 or histologies 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989).

* The *FORDS* Manual specifies this rule and accepts that a specific number of lymph nodes may be recorded here for lymphomas with a primary site other than C77._. SEER (who has the major responsibility for defining this field until Collaborative Staging takes effect) instructs that **99** should be recorded for *all* lymphomas regardless of primary site. The MCR will collect this field according to COC rules and change the codes as necessary at the MCR to adhere to SEER rules.

For cases diagnosed before 2004 and abstracted before Collaborative Staging software updates, the codes for Regional Nodes Positive follow:

All regional nodes examined were negative.	**00**
one positive regional node	**01**
two positive regional nodes	**02**
...exact number of positive regional nodes…	**...**
ninety-six *or more* positive regional nodes	**96**
Positive regional nodes were reported, but the number was not specified. positive result from regional lymph node aspiration	**97**
No regional nodes were examined.	**98**
Regional nodes were examined, but it's unknown if they were positive or negative. not applicable*; unknown if regional nodes were examined; death certificate-only case	**99**

* primary sites C42.0, C42.1, C42.3, C42.4, C70.0, C71._, C76._, C80.9; histologies 9732, 9754, 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989; C77._ with histologies 9590-9729

II. For cases diagnosed beginning in 2004, and for pre-2004 diagnoses abstracted after Collaborative Staging software updates:

Code this field according to the rules in the *Collaborative Staging Manual and Instructions*.

EOD -- Extension

NAACCR Version 10 Item 790, columns 534-535

This field is not required for the MCR, but we will collect anything that we find in this field when you submit case records. If you use SEER Extent of Disease coding at your facility, you may fill this field according to the rules in the *SEER Extent of Disease, 1988: Codes and Coding Instructions, Third Ed*. (1998, plus updates). The field will be read at the MCR but not edited. The MCR plans to drop collection of this field beginning with 2004 diagnoses.

EOD -- Extension Prostate Pathology

NAACCR Version 10 field "EOD--Extension Prost Path", Item 800, columns 536-537

This field is not required for the MCR, but we will collect anything that's in this field when you submit cases. If you use SEER Extent of Disease coding, you may fill this field according to the rules in the *SEER Extent of Disease, 1988: Codes and Coding Instructions, Third Ed*. (1998 plus updates). The field will be read at the MCR, but not edited. The MCR plans to drop collection of this field beginning with 2004 diagnoses.

EOD -- Lymph Node Involvement

NAACCR Version 10 field "EOD--Lymph Node Involv", Item 810, column 538

This field is not required for the MCR, but we will collect anything that we find in this field when you submit case records. If you use SEER Extent of Disease coding at your facility you may fill in this field according to the rules in the *SEER Extent of Disease, 1988: Codes and Coding Instructions, Third Ed*. (1998 plus updates). The field will be read at the MCR but we will not edit it. The MCR plans to drop collection of this field starting with 2004 diagnoses.

Staging Narratives

The following seven fields are free text fields that should include information important to understanding and interpreting exactly how the case was diagnosed, evaluated and staged. Use standard abbreviations. Please be concise, but be sure to include relevant *details* such as the exact names of involved nodes and metastatic sites. Dates may be important to understand the order in which information about the case was accumulated. Dividing up the information among the given categories (clinical exams vs. pathologic assessments, for example) helps us interpret how to weigh all of the information reported. The information related to staging determination is most important to us, but please include anything else that *you* think will be important for us to know about the case. For diagnoses made beginning in 2004 under Collaborative Staging, NAACCR has made recommendations for the types of information that should be included in each narrative field; the MCR is adopting these content suggestions now because they seem to be sensible recommendations, independent of diagnosis year.

Because all Massachusetts facilities that diagnose and/or treat cancer are required to report to the MCR, we should eventually receive a complete account of all activities related to how each patient was diagnosed, evaluated and treated (through the beginning of first course of therapy). Your own facility is the *best* source of information about what went on *there*; the second-hand reporting of results obtained at other facilities is often less accurate than the information we should receive directly from those facilities. If you are including relevant information obtained from other facilities or physician offices, please indicate which information came from where. In case of conflicting information received from multiple facilities, this helps the MCR determine who actually did what to the patient and when.

Text--Physical Exam NAACCR Version 10 field "Text--DX Proc--PE", Item 2520, columns 2645-2844

This narrative field records information summarized from patient history and physical examinations. Up to 200 characters are allowed. Please put the information that is most pertinent to staging up front. Leave the field empty if the medical record includes no information relevant to this text category, but please note if this information seems to be *missing* from the record (i.e., you would expect to find physical exam notes for this case in the record). You don't have to repeat information that is already documented elsewhere in other narrative fields collected by the MCR.

Please do NOT record sensitive patient information that does not concern the central registry in this field! For example, information on HIV or AIDS status, alcohol or other drug abuse, mental illness, venereal disease, hepatitis and family cancer history do not belong in a data item collected by the MCR. If you wish to record such information on your data system, use a field that is not collected by the MCR. If your facility or Cancer Committee insists that such confidential information must be recorded in the history/physical exam narrative, the MCR will be glad to discuss this with someone from your facility.

NAACCR provides suggestions for the types of information to be recorded here:

- physical examination date(s)
- patient age, gender, race/ethnicity
- patient history related to cancer diagnoses
- primary site (if known at this time)
- histology (if known at this time)
- tumor location (other than primary site)
- approximate tumor size
- palpable lymph nodes
- positive clinical findings, followed by negative findings
- clinical impression(s) related to cancer
- treatment plan (if known at this time)

Text--X-Ray/Scan

NAACCR Version 10 field "Text--DX Proc--X-ray/Scan", Item 2530, columns 2845-3094

This narrative field records information summarized from imaging reports. Up to 250 characters are allowed.* Please put the information that is most pertinent to staging or cancer diagnosis up front. Leave the field empty if the medical record includes no information relevant to this text category, but please note if this information seems to be *missing* from the record (i.e., you would expect to find imaging results in this record). You don't have to repeat information that is already documented elsewhere in other narrative fields collected by the MCR. Do *not* include information that the MCR is not authorized to collect.

NAACCR provides suggestions for the types of information to be recorded here:

- X-ray/scan dates
- patient age, sex, race/ethnicity
- primary site (if known at this time)
- histology (if known at this time)
- tumor location (other than primary site)
- approximate tumor size
- lymph node notations
- positive clinical findings, followed by negative findings
- extent of disease (spread), metastases

* The CIMS Satellite system can only hold 200 characters in this field.

Text--Scopes

NAACCR Version 10 field "Text--DX Proc--Scopes", Item 2540, columns 3095-3344

This narrative field records information summarized from endoscopic examinations. Up to 250 characters are allowed.* Please put the information that is most pertinent to staging up front. Leave the field empty if the medical record includes no information relevant to this text category, but please note if this information seems to be *missing* from the record (i.e., you would expect to find endoscopy results in this record). You don't have to repeat information that is already documented elsewhere in other narrative fields collected by the MCR. Do *not* include information that the MCR is not authorized to collect.

NAACCR provides suggestions for the types of information to be recorded here:

- endoscopic examination dates
- primary site, tumor location
- histology (if known at this time)
- tumor size
- lymph node notations
- positive clinical findings, followed by negative findings

* The CIMS Satellite system can only hold 200 characters in this field.

Text--Lab Tests

NAACCR Version 10 field "Text--DX Proc--Lab Tests", Item 2550, columns 3345-3594

This narrative field records information summarized from laboratory results other than cytology or histopathology. Up to 250 characters are allowed.* Please put the information that is most pertinent to staging or cancer diagnosis up front. Leave the field empty if the medical record includes no information relevant to this text category, but please note if this information seems to be *missing* from the record (i.e., you would expect to find test results for this case in the record). You don't have to repeat information that is already documented elsewhere in other narrative fields collected by the MCR. Do *not* include information that the MCR is not authorized to collect.

NAACCR provides suggestions for the types of information to be recorded here:

- types of laboratory tests/tissue specimens
- positive results, followed by negative findings
- tumor markers, serum and urine electrophoresis, special studies
  - for breast cancer: Estrogen/Progesterone Receptor Assay (ERA, PRA), Her2/neu
  - for prostate cancer: Prostatic Specific Antigen (PSA)
  - for testicular cancer: Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP, αFP), Lactate Dehydrogenase (LDH)
  - other tests
- test dates

* The CIMS Satellite system can only hold 200 characters in this field.

Text--Operative

NAACCR Version 10 field "Text--DX Proc--Op", Item 2560, columns 3595-3844

This narrative field records information summarized from operative reports. Up to 250 characters are allowed.* Please put the information that is most pertinent to staging up front. Leave the field empty if the medical record includes no information relevant to this text category, but please note if surgical information seems to be *missing* from the record. You don't have to repeat information that is already documented elsewhere in other narrative fields collected by the MCR. Do *not* include information that the MCR is not authorized to collect.

NAACCR provides suggestions for the types of information to be recorded here:

- dates and descriptions of biopsies and all other surgical procedures from which staging information was derived
- number of lymph nodes removed (regardless of cancer involvement)
- gross size of tumor removed
- residual tumor status
- evidence of cancer invasion in areas surrounding the surgical sites

* The CIMS Satellite system can only hold 200 characters in this field.

Text--Pathology NAACCR Version 10 field "Text--DX Proc--Path", Item 2570, columns 3845-4094

This narrative field records information summarized from cytology and histopathology reports. Up to 250 characters are allowed.* Please put the information that is most pertinent to staging or cancer diagnosis up front. Leave the field empty if the medical record includes no information relevant to this text category, but please note if pathology information seems to be *missing* from the record. You don't have to repeat information that is already documented elsewhere in other narrative fields collected by the MCR. Do *not* include information that the MCR is not authorized to collect.

NAACCR provides suggestions for the types of information to be recorded here:

- procedure dates
- types of tissue specimens
- specific cell type and grade, including all important modifying phrases (e.g., "predominantly…", "with features of…", "with foci of…", "with elements of…", etc.)
- tumor size
- extent of disease (spread)
- surgical margin involvement
- number of lymph nodes examined and involved
- positive findings, followed by negative findings
- notation if pathology is reviewing slides from an outside source, providing a consult, providing a second opinion, etc.
- pathologist's comments on differential diagnoses, such as "…ruled out", "…favored", etc.

* The CIMS Satellite system can only hold 200 characters in this field.

Text--Staging NAACCR Version 10 Item 2600, columns 4175-4474

This narrative field records any information relevant to a case's staging that is not included elsewhere in the data and text fields collected by the MCR*. This might include the number of tumors in the primary site, risk factors not included in the patient history or physical examination, or disagreements/problems with physician staging decisions. If there is anything relevant to the staging that you could not fit into one of the other narrative categories, include it here (labeled, for example, as "Path Results continued...", or use asterisks or "…" to link two connected narratives). Also include anything relevant which you don't think really belongs in one of the other categories. Up to 300 characters are allowed.** Leave the field empty if it is not applicable to a particular case.

* Appreciate that there are many standard fields that may be on your data system that are **not** collected by the MCR which may include information related to the stage. For diagnoses made beginning in 2004, be sure that all information coded in the Collaborative Staging fields is documented in a Staging Narrative.

** The CIMS Satellite system can only hold 200 characters in this field.

NAACCR provides suggestions for the types of information to be recorded here:

- dates of procedures that provided additional information for staging
- organs/tissues found to be involved by direct tumor extension
- tumor size
- surgical margin status
- number and sites of positive lymph nodes (regional or distant)
- sites of distant metastases
- relevant physician comments or other comments from the record
- staging information from outside physicians or facilities

Staging Fields Collected in the Collaborative Staging Era

In the Collaborative Staging System, all of the information necessary to assess a cancer case's staging (both AJCC and SEER staging) is captured in many coded fields. A computer algorithm can then be used by a facility or central registry to produce "derived" stages based on the coded information.

Collaborative Staging goes into effect with diagnoses beginning in 2004. The MCR will collect ALL of the Collaborative Staging coded information fields (shown here) and will NOT collect any of the "derived" stage fields. (If your data system automatically outputs the "derived" fields when exporting case reports for the MCR, we will just ignore them when uploading the data.)

Specifically, the MCR does not plan to collect from reporting facilities the fields Derived AJCC M, Derived AJCC M Descriptor, Derived AJCC N, Derived AJCC N Descriptor, Derived AJCC Stage Group, Derived AJCC T, Derived AJCC T Descriptor, Derived AJCC--Flag, Derived SS1977, Derived SS1977--Flag, Derived SS2000, and Derived SS2000--Flag. We also are not planning to collect the new field CS Version Latest (added to the NAACCR Version 10.1 layout in October 2003).

For cases diagnosed beginning in 2004:

Probably 2004 diagnoses may be almost fully abstracted (except for most of the coded staging information) and held in suspense until your software is ready for 2004 diagnoses. Your vendor will know how you should proceed when the time comes, and the MCR will be addressing as many 2004-related issues as possible with you and the vendors.

When your software is ready for 2004 diagnoses, you must code these fifteen fields for the MCR: CS Tumor Size, CS Extension, CS Tumor Size/Ext Eval, CS Lymph Nodes, CS Reg Nodes Eval, Regional Nodes Examined, Regional Nodes Positive, CS Mets at DX, CS Mets Eval, and the six CS Site-Specific Factor fields. All of these fields, including Regional Nodes Examined and Regional Nodes Positive, should be coded using the detailed rules and instructions in the *Collaborative Staging Manual and Coding Instructions* book. A new field added late to the NAACCR Version 10.1 layout -- CS Version 1st -- must also be submitted to the MCR, but your software will probably fill this field automatically.

Do NOT code EOD -- Tumor Size and Summary Stage 2000 for cases diagnosed beginning in 2004. The "traditional" AJCC staging fields will also NOT be collected by the MCR for diagnoses made beginning in 2004: TNM Edition Number; Clinical Descriptor, TNM Elements and Stage Grouping; and Pathologic Descriptor, TNM Elements and Stage Grouping.

For cases diagnosed before 2004:

It will probably be most straightforward for reporting facilities if as many cases as possible diagnosed before 2004 are completely abstracted and exported for the MCR before your software is updated for 2004 diagnoses.

The fields having names starting with "CS" should not be filled for pre-2004 diagnoses. Collaborative Staging does not apply to pre-2004 diagnoses.

The "traditional" staging fields must be coded for the MCR: SEER Summary Stage 1977 for pre-2001 diagnoses; SEER Summary Stage 2000 for diagnoses made between January 1, 2001 and December 31, 2003; TNM Edition Number; Clinical Descriptor, TNM Elements and Stage Grouping; Pathologic Descriptor, TNM Elements and Stage Grouping; EOD -- Tumor Size; Regional Nodes Examined; and Regional Nodes Positive.

Do not confuse the separate fields EOD -- Tumor Size and CS Tumor Size. Fill in the EOD field for pre-2004 diagnoses using the rules in this manual or the *FORDS* Manual-- *not* the rules for CS Tumor Size in the *Collaborative Staging Manual and Coding Instructions*.

The "traditional" fields Regional Nodes Examined and Regional Nodes Positive are being absorbed into Collaborative Staging, and because these fields are required by the MCR for *all* diagnosis years, it's going to be a little confusing at first -- especially with regard to Regional Nodes Positive.

Some of the code/category definitions change for Regional Nodes Positive because of Collaborative Staging. Some codes must be converted:

90 changes from meaning "90 positive nodes" to "90 or more positive nodes".
91 - 94 and **96** (which meant "91-94 and 96 positive nodes") are no longer valid codes.
95 changes from meaning "95 positive nodes" to "positive node aspiration".
97 changes from meaning "an unknown # of positive nodes *or* positive node aspiration" to just "an unknown # of positive nodes".
Old codes **91 - 96** will be converted into the new code **90**.
Old code **97** will be converted to the new **95** when Regional Nodes Examined is coded **95** (indicating an aspiration).
Old code **97** becomes new code **97** whenever Regional Nodes Examined is not coded **95** (aspiration not indicated).

Your software vendor should be taking care of these conversions, but you must be aware of when these changes take place so that you can tell when to begin using the new coding categories. Before your software is converted/updated for Collaborative Staging, you should code this field using the OLD code categories shown in this manual under Regional Nodes Positive (page 156). But once your software is updated to accept the Collaborative Staging fields, we presume that you will have to code Regional Nodes Positive as specified in the *Collaborative Staging Manual and Coding Instructions* for ALL diagnosis years. Please make sure that you understand and follow this rule. This may be confusing and is an area where your vendor and the MCR both have to understand what each other is planning, so please contact the MCR (617-988-3382 or 617-988-3373) if you have any questions about how to code Regional Nodes Positive.

Note that for lymphomas, the *FORDS* Manual did not specify that all lymphomas (or just all nodal lymphomas) should be coded with **99** for Regional Nodes Examined and Regional Nodes Positive. Other subtle differences between the *FORDS* and Collaborative Staging instructions for these fields may be lurking. Before your software is updated for 2004 diagnoses, please code these two fields for lymphomas in accordance with the rules in this manual or the *FORDS*. After your 2004 software update, code both fields in accordance with the rules in the *Collaborative Staging Manual and Coding Instructions* regardless of diagnosis year.

CS Version 1st

NAACCR Version 10.1 Item 2935, columns 705-710

This field records the "version" of the Collaborative Staging instructions and codes used to fill the Collaborative Staging fields. That is, as changes are made in the future to any of the Collaborative Staging "schema", this will be tracked by creating a different version number for the new rules or codes. The field holds six digits: the first two document the main version; differences in the middle two digits represent minor changes that have occurred in the main version; and the last two digits signify insignificant changes. Your software (or the Collaborative Staging software) will almost certainly fill this field automatically with the correct version number. If you re-code a case for some reason with a newer set of Collaborative Staging rules or codes, you may need to manually update the original version number stored here. Note that this field was added to the NAACCR Version 10.1 layout in October 2003, so vendors, software users and the MCR have to make late adjustments for it.

CS Tumor Size

NAACCR Version 10 Item 2800, columns 629-631

This Collaborative Staging field replaces the EOD-Tumor Size field for diagnoses made beginning in 2004. Briefly, this field records the primary tumor's largest dimension in millimeters. Refer to the *Collaborative Staging Manual and Coding Instructions* for specific instructions and codes. Leave this item empty for diagnoses made before 2004.

CS Extension

NAACCR Version 10 Item 2810, columns 632-633

This Collaborative Staging field applies to diagnoses made beginning in 2004. It holds information describing the primary tumor's direct growth extension for most cancer types. Refer to the *Collaborative Staging Manual and Coding Instructions* for specific instructions and codes. Leave this item empty for diagnoses made before 2004.

CS Tumor Size/Ext Eval

NAACCR Version 10 Item 2820, column 634

This Collaborative Staging field applies to diagnoses made beginning in 2004. It describes the source of the primary tumor ("T") information -- CS Tumor Size and CS Extension. Refer to the *Collaborative Staging Manual and Coding Instructions* for specific instructions and codes. Leave this item empty for diagnoses made before 2004.

CS Lymph Nodes

NAACCR Version 10 Item 2830, columns 635-636

This Collaborative Staging field applies to diagnoses made beginning in 2004. (It replaces one of the EOD fields.) It records the furthest extent of regional lymph node involvement. Refer to the *Collaborative Staging Manual and Coding Instructions* for specific instructions and codes. Leave this item empty for diagnoses made before 2004.

CS Reg Nodes Eval

NAACCR Version 10 Item 2840, column 637

This Collaborative Staging field applies to diagnoses made beginning in 2004. It describes the source of the qualitative regional lymph node ("N") information -- CS Lymph Nodes. Refer to the *Collaborative Staging Manual and Coding Instructions* for specific instructions and codes. Leave this item empty for diagnoses made before 2004.

Note that the quantitative fields **Regional Nodes Examined** and **Regional Nodes Positive** are becoming part of Collaborative Staging, but the MCR collects these two fields for ALL diagnosis years so they are not *just* Collaborative Staging fields to us. These two fields are described on pages 152-156 of this manual; the rules and codes in the *Collaborative Staging Manual and Coding Instructions* replace the MCR's instructions once your software has been updated for Collaborative Staging.

CS Mets at DX

NAACCR Version 10 Item 2850, columns 638-639

This Collaborative Staging field applies to diagnoses made beginning in 2004. It records the extent of distant disease. Refer to the *Collaborative Staging Manual and Coding Instructions* for specific instructions and codes. Leave this field empty for diagnoses made before 2004.

CS Mets Eval

NAACCR Version 10 Item 2860, column 640

This Collaborative Staging field applies to diagnoses made beginning in 2004. It describes the source of the distant metastases ("M") information -- CS Mets at DX. Refer to the *Collaborative Staging Manual and Coding Instructions* for specific instructions and codes. Leave this item empty for diagnoses made before 2004.

CS Site-Specific Factor 1

NAACCR Version 10 Item 2880, columns 641-643

This Collaborative Staging field applies to diagnoses made beginning in 2004. It records specific information for many types of cancer, and holds **888** for cancer types to which it does not apply. Refer to the *Collaborative Staging Manual and Coding Instructions* for specific instructions and codes. Leave this item empty for diagnoses made before 2004.

CS Site-Specific Factor 2

NAACCR Version 10 Item 2890, columns 644-646

This Collaborative Staging field applies to diagnoses made beginning in 2004. It records specific information for certain types of cancer, and holds **888** for cancer types to which it does not apply. Refer to the *Collaborative Staging Manual and Coding Instructions* for specific instructions and codes. Leave this item empty for diagnoses made before 2004.

CS Site-Specific Factor 3

NAACCR Version 10 Item 2900, columns 647-649

See CS Site-Specific Factor 2. Refer to the *Collaborative Staging Manual and Coding Instructions* for specific instructions and codes. Leave empty for pre-2004 diagnoses.

CS Site-Specific Factor 4

NAACCR Version 10 Item 2910, columns 650-652

See CS Site-Specific Factor 2. Refer to the *Collaborative Staging Manual and Coding Instructions* for specific instructions and codes. Leave empty for pre-2004 diagnoses.

CS Site-Specific Factor 5

NAACCR Version 10 Item 2920, columns 653-655

See CS Site-Specific Factor 2. Refer to the *Collaborative Staging Manual and Coding Instructions* for specific instructions and codes. Leave empty for pre-2004 diagnoses.

CS Site-Specific Factor 6

NAACCR Version 10 Item 2930, columns 656-658

See CS Site-Specific Factor 2. Refer to the *Collaborative Staging Manual and Coding Instructions* for specific instructions and codes. Leave empty for pre-2004 diagnoses.

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SECTION V - TREATMENT DATA

First Course of Treatment or Therapy - General Instructions

First Course of Treatment (or Therapy) includes all methods of treatment recorded by the managing physician(s) in the treatment plan *and administered before disease progression or recurrence*. This may include the treatment choice "no therapy" (as when a patient refuses treatment, someone refuses for the patient, the patient died before treatment could begin, or a medical recommendation of "no treatment" was made). In general, only code treatments *actually administered* to the patient (the reason *why* some types of treatment did not occur is also coded). The MCR follows COC rules concerning what constitutes First-Course Treatment, and also uses SEER interpretations to augment and clarify the COC rules.

Treatment Plan

A treatment plan describes if and how medical care providers intend to modify or control the reported disease; Palliative Care may be included in the plan. All treatments specified in the treatment plan that are delivered to the patient are part of the First Course of Therapy. A treatment plan may specify one treatment/palliation method or a combination. A single "regimen" may include a combination of concurrent or adjuvant treatments. A recommendation of "no treatment" or "watchful waiting" is also a treatment plan; but if a type of treatment or palliation begins *after* a planned period of watchful waiting and is triggered by apparent disease progression, then this treatment/palliation is *subsequent therapy* and it is not reportable to the MCR.

A treatment plan's documentation may be fragmented and is frequently found in several different sources, including the hospital medical record, discharge plan, clinic record, consultation reports and outpatient records. Some information may only be recorded in a physician's office.

"First Course" Time Periods for All Malignancies Except Leukemias

Follow these rules in the order listed to determine the duration of the First Course of Treatment:

1. If there is a documented planned First Course of Treatment, it ends at completion of all the planned treatments.
2. If the patient is treated according to a facility's standards of practice or established protocol or is managed within accepted management guidelines for the given type of case, First Course ends with completion of these treatments.
3. If there is no documentation of a planned First Course of Treatment or standard of practice for the given case, try to get physician clarification. If that's not possible, First Course includes all treatments received before the disease progresses or the treatment fails. Assume that First Course begins within four months of diagnosis. If it's unclear whether there was disease progression or treatment failure and a treatment begins more than one year after diagnosis, assume that First Course *ended* before this treatment (i.e., it's subsequent treatment).

4. If all treatment is refused and the patient does not change his/her mind within a "reasonable time frame" (SEER wording), or if the physician recommends no treatment, then the First Course consists of no treatment.

Treatment failure or disease progression may cause the planned First-Course Therapy to be stopped mid-course. Any treatment or Palliative Care administered *after the discontinuation* of First-Course Therapy are considered *subsequent therapy* (don't record it for the MCR).

"First Course" Time Periods for Leukemias Only

First course of therapy includes all cancer treatments planned by the physician(s) during or after the first diagnosis of this leukemia. It ends when the "first remission" ends (a relapse). Record all remission-inducing or remission-maintaining therapy as First-Course. Treatment regimens may include multiple therapy modes, and their administration may encompass a year or more. The induction, consolidation and maintenance phases of treatment are all First-Course.

If a complete or partial remission is achieved during the First Course of Therapy, then include all definitive therapy considered "first remission-inducing" or "first remission-maintaining", such as maintenance chemotherapy or radiation to the central nervous system. Do NOT include any treatment given after relapse of the first remission.

A patient may relapse after a first remission. All treatment and Palliative Care administered after relapse are subsequent therapy (don't record this for the MCR).

If no remission is achieved during First Course of Therapy, record all treatments that attempted to induce a remission. Do NOT include any subsequent treatments that attempt to induce a remission.

Palliative Care vs. Treatment

Palliative Care is not therapeutic and is not done for diagnostic or staging purposes. Its purpose may be to relieve pain, make a patient more comfortable or prolong life by managing symptoms (symptomatic care). Palliative Care treats the *patient* rather than the cancer, and it is necessary to distinguish therapeutic treatments from palliation. Consult a physician if you can't determine whether a certain procedure was intended as treatment or palliation.

The MCR only collects information on Palliative Care planned and given during the First Course of Treatment time period.

Importantly, the COC has changed its position on how it wants Palliative Care (formerly called Palliative Procedures) coded. For diagnoses made in 2003, the *FORDS* Manual instructions had been that something done to a patient must be coded as EITHER treatment OR palliation, but not as both. The *FORDS* revisions issued in December 2003 instruct that for diagnoses made in 2004, Palliative Care that also fell into a standard treatment modality because its effect was to remove, modify or destroy cancer cells (such as palliative radiation) should be coded as BOTH Palliative Care and as Treatment (so First-Course palliative radiation would be coded as Radiation *and* Palliative Care). For diagnoses made in 2003 the COC offers a choice: a facility may choose to 1) code Palliative Care for all cases diagnosed in 2003 as *only* Palliative Care; or 2) double-code appropriate types of Palliative Care for all cases diagnosed in 2003 as *both* Palliative Care and Treatment. See Question #10257 (December 18, 2003) and related questions on the AJCC Inquiry and Response system (http://web.facs.org/coc/default.htm). It does NOT sound as if the COC will allow a switch in this coding procedure partway through 2003 diagnoses; they seem to be encouraging facilities to code ALL cases diagnosed in 2003 in either one way or the other.

The MCR will simply accept that, for diagnoses made in 2003, Palliative Care may be coded singly OR double-coded as Treatment when appropriate. For diagnoses made beginning in 2004, ONLY double-coding should be used. Note that Palliative Care in the category "pain management only" (code **4**) does not fall into one of the standard treatment modalities and is expected to be coded *only* as Palliative Care. The MCR has tried to integrate this last-minute change into this Manual, but some language herein may date from before the double-coding revision.

Realize that the Treatment Start Date fields must correspond to their respective treatment modality fields, so if you are double-coding Palliative Care for 2003 you must also enter the start date, narrative, etc. for the involved treatment modalities.

Treatment Data Items

Treatment - Summary / Treatment - At This Facility Codes -- Numerical codes are used to describe each treatment modality (surgery, radiation, chemotherapy, etc.). For each modality, there is a field used to code a Summary of the entire First Course of Treatment, and a field to assign a separate code to that portion of the treatment administered at the reporting hospital.

For the purposes of treatment coding, the office of a physician on the hospital's medical staff should be considered to be an extension of the hospital (i.e., when coding treatment given at the reporting hospital, include treatment administered in the office of a physician on the medical staff if you have information about what procedures were done there).

Treatment - Start Dates -- There is a *start* date field for each modality (but some start dates cover multiple modalities). Dates should be entered in MMDDCCYY format. For some modalities, **8**'s are used to specify that that type of treatment *has not yet* begun at the time you are abstracting/reporting that case. If a treatment began but an exact start date is not available, please record an *approximate* date. An estimated date is preferable to an unknown date -- and if you report an approximate date for us, please identify this in the appropriate Narrative field. If you only know that a treatment began in the spring of the year, code April; if in summer or mid-year, use July; if in fall or autumn, code October; if in winter, use December or January.

Example: You can only estimate that radiation began in early September 2003. Enter **09072003** as an approximate start date for Radiation Therapy, and include in the Radiation Narrative a phrase like "early Sept. start date estimated".

If the treatment was administered in courses (as in a radiation regional/boost series) or included different procedures (e.g., an excisional biopsy and a resection), always enter the date of the first procedure in the "start date" field.

For any type of treatment that is *not known to have been given*, fill the date field with zeroes. (For example, if the Chemotherapy -- Summary and Chemotherapy -- At This Facility fields are coded **00** because the First Course of Treatment included no Chemotherapy, then Chemotherapy -- Date Started should be coded **00000000**.) For autopsy-only cases (Class 5), the date fields should also be zero-filled. Do *not* leave any treatment date field empty.

If, however, a type of treatment *is known to have begun*, but its start date is not known, enter nines *if you cannot estimate* when it began; if the month or *year* can at least be estimated, however, it is important to enter this (such as **99992003**).

For death certificate-only cases, treatment start dates are **9**-filled.

Treatment Text -- There is a Narrative field for most treatment modalities (and some Narratives must cover more than one modality). These fields should be used to describe First Course of Treatment as concisely and specifically as possible. If more than one procedure was performed, list each in chronological order, including dates and the place where each procedure occurred. A text field may be left empty when that particular treatment modality was not provided; but, if that type of treatment was recommended or would normally have been given for this disease, please record the reason why it was not given in the appropriate Narrative field (for example, "mid-June patient refused lobectomy"). Use standard abbreviations and be aware of the maximum number of characters which can fit into each text field. Do NOT include information that the MCR is not authorized to collect.

Date of First-Course Treatment -- COC

NAACCR Version 10 field "Date of 1st Crs RX--COC", Item 1270, columns 843-850

This field records the beginning of First Course of Therapy (including Palliative Care that falls into one of the standard treatment modalities) for the case being reported (using the COC's and MCR's definition of what constitutes the "First Course"). Use the MMDDCCYY format.

This date should be either:

the earliest reported start date for one of the treatment modalities for a patient who received First-Course Treatment/palliation (Surgery, Radiation, systemic therapy including Chemotherapy, Hormone Therapy, Immunotherapy, Hematologic Transplants & Endocrine Procedures, Other Therapy, or Palliative Care that is also coded in a treatment modality)*

or, if the patient received no First-Course Therapy,

the date on which a decision was made to not treat the patient (including a date of refusal made by the patient or on the patient's behalf, a decision to follow "watchful waiting", or a decision to give palliation only). If you do not have exact information about when the decision to not treat was made, please estimate this date. Only use the unknown date codes (**99**) when absolutely necessary. A date of death may also be recorded.

For autopsy-only cases (Class 5), zero-fill the field.

The dates of Surgical Diagnostic/Staging Procedures (such as incisional biopsies or endoscopic examinations) are NOT recorded in this field. It is seldom appropriate to record the Date of Diagnosis in this field unless a case was deemed untreatable (including "no Palliative Care") when first diagnosed.

* Note that for Radiation Therapy and Systemic Therapy, the "start date" may be recorded as **88888888** to indicate that this type of treatment has not yet begun. Date of First-Course Treatment does NOT accept this special code, so use **99999999** in this field when the only First-Course Treatment has not yet begun.

Example: A brain tumor patient is only going to receive Radiation Therapy during First Course, but it has not yet begun when the case must be abstracted. Radiation -- Date Started is **88888888**, the remaining treatment "start dates" are **00000000**, and Date of First-Course Treatment is **99999999**.

SURGICAL DIAGNOSTIC and STAGING PROCEDURES

Surgical procedures done to diagnose or stage disease are Diagnostic/Staging Procedures. (They are included here under "Treatment" because they are surgical procedures and their field data standards parallel those governing the treatment fields.) The procedures performed are coded whether or not cancer is found in the specimens. They include the following:

- Biopsy, incisional (a tissue biopsy leaving gross residual disease)*

  (An *excisional* biopsy is treatment Surgery. A biopsy leaving only microscopic residual disease or no residual disease should be considered excisional.)

- Biopsy, NOS, except of lymph nodes*

  (Unless otherwise specified, if the specimen size is ≤1 cm, assume the biopsy to have been *in*cisional, and report it as a Surgical Diagnostic/Staging Procedure.)

- Dilation and curettage for *invasive* cervical cancer (see D&C note on p. 175)

- Dilation and curettage for invasive or *in-situ* cancers of the corpus uteri, including choriocarcinoma (see D&C note on page 175)

- Removal of fluid (paracentesis or thoracentesis), even if cancer cells are present, unless the fluid removal is for palliative purposes only

- Surgery in which tumor tissue is not intentionally removed*

  Example: exploratory surgery -- celiotomy, cystotomy, gastrotomy, laparotomy, nephrotomy, thoracotomy

- Removal of non-cancerous endocrine gland(s)

  (but the removal of testes, adrenals or pituitary is Endocrine Surgery for prostate primaries, and should be reported under Hematologic Transplants & Endocrine Procedures)

- Transurethral resection (TUR) without removal of tumor tissue

* Do NOT record surgical procedures that aspirate, biopsy or otherwise remove regional lymph nodes in an effort to diagnose and/or stage cancer in these data items. Such procedures should be recorded under Scope of Regional Lymph Node Surgery.

Exception: For lymphomas with a lymph node primary site (C77._, 9590-9729), the aspiration, biopsy or other removal of lymph nodes in an effort simply to diagnose and/or stage the disease *is* coded as a Surgical Diagnostic/Staging Procedure (and not as Surgery of Primary Site or other type of surgery). A needle biopsy of a lymph node for a lymphoma is coded (as for any other cancer type) as a Surgical Diagnostic/Staging Procedure.

Brushings, washings, aspiration of cells and hematologic findings (peripheral blood smears) may be involved in the diagnosis and staging of cancer, but these are not *surgical* procedures. Do not code these here for the MCR. Surgical procedures done for purely palliative purposes should also *not* be included here. Be careful with descriptions of "aspirations" in the medical record -- non-surgical cell aspirations are not coded here, but surgical biopsies in which tissue is aspirated *are* coded here (or under Scope of Regional Lymph Node Surgery for lymph node primaries); therefore do not automatically dismiss any "aspiration" procedure as being non-surgical. Determine what an aspiration procedure resulted in before making your coding decision.

The COC has some complicated advice regarding dilations and curettage (D&Cs). A D&C procedure may be done for different purposes while being called simply a "D&C" regardless of the circumstances. The dilation is not a surgical procedure, but what is done with the curette may or may *not* be considered a surgical procedure. If the curette is used to obtain an excisional biopsy, then the D&C was not done purely for diagnostic/staging purposes and it would be coded under Surgery of Primary Site. If the curette is used to perform an incisional biopsy, this would be coded here as **02**. If the curette is simply used to remove some cells, then this does not qualify as a surgical procedure at all and it is *not* coded as Surgery or a Surgical Diagnostic/Staging Procedure. Try to determine what kind of sample was obtained from the D&C, and use these guidelines in addition to the D&C examples above; there are also notes in Appendix D (under C53._ and C54._).

The code categories for Surgical Diagnostic/Staging Procedures do not specify needle type; they simple refer to needle biopsies. The MCR interprets this to include biopsies performed with core needles (wide enough to remove cells and tissue) and fine needles (usually only wide enough to remove cells) in an effort to diagnose or stage cancer. "FNA" (fine needle aspiration) seems to often be used in medical records for both a cell aspiration performed with a fine needle *and* as a shorthand for a fine needle aspiration *biopsy*. Where the term "FNA biopsy" is not usually specified in medical records, determine if a "FNA" simply extracted cells (generally *not* a surgical procedure) or resulted in an incisional biopsy (code **01** or **02**). If a needle biopsy was done with the intent of diagnosing or staging the disease but it actually removed the cancer entirely or left only microscopic disease behind, this was (accidentally) an *excisional* biopsy and it must be coded as Surgery rather than a Surgical Diagnostic/Staging Procedure.

The codes for Surgical Diagnostic/Staging Procedures are not site-specific:

no Diagnostic or Staging surgery done	**00**
incisional biopsy, needle biopsy, or aspiration biopsy of *other* than the primary site, leaving gross residual disease*; no exploratory surgery	**01**
incisional biopsy, needle biopsy, or aspiration biopsy of the *primary* site, leaving gross residual disease**; no exploratory surgery	**02**
exploratory surgery ONLY (no biopsy or treatment Surgery)	**03**
bypass surgery or ___ostomy ONLY (no biopsy or treatment Surgery; bypass/___ostomy *not* done for palliative purposes)***	**04**
exploratory surgery plus incisional/needle biopsy of primary site or other sites	**05**
bypass surgery plus incisional/needle biopsy of the primary site or other sites; ___ostomy plus incisional/needle biopsy of the primary site or other sites	**06**
surgical Diagnostic/Staging Procedure(s), NOS	**07**
unknown if any Surgical Diagnostic/Staging Procedure was done	**09**

* If there is only microscopic or no residual disease, then consider this to be an excisional biopsy of a non-primary site (treatment Surgery) and code this under Surgery of Other Sites.

** If there is only microscopic residual disease or no residual disease, then consider this to be an excisional biopsy of the primary site and code it under Surgery of Primary Site.

*** A bypass with no tissue sample is often for palliation rather than diagnostic/staging purposes. Consider carefully if such a bypass should be coded as Palliative Care (surgery) rather than here.

The code priorities for the Surgical Diagnostic/Staging Procedures fields are:

codes **01** - **07** have priority over **09**;
codes **01** - **06** have priority over **07**;
within **01** - **06**, the higher code number has priority.

Example: A patient has both an incisional biopsy of the primary site (02) and of a metastatic site (01). -- Code **02** because it is the higher code number.

Surgical Diagnostic/Staging Procedures -- Summary

NAACCR Version 10 field "RX Summ--DX/Stg Proc", Item 1350, columns 869-870

Using the code table above, report the Surgical Diagnostic/Staging Procedures performed during First Course of Treatment. Enter the best code to represent *all* such procedures performed -- include procedures done at the reporting facility plus all known procedures performed elsewhere. If multiple procedures were performed, follow the code priority rules above and list these procedures, with their dates and places, in the Surgery -- Narrative field.

Surgical Diagnostic/Staging Procedures -- At This Facility

NAACCR Version 10 field "RX Hosp--DX/Stg Proc", Item 740, columns 471-472

Using the code table on the previous page, enter the code for just the Surgical Diagnostic/Staging Procedures performed at the reporting facility (including any done in the office of a staff physician if the information is available to you). If multiple procedures were performed, follow the code priorities listed under the code table, and be sure that all the procedures, with their dates, are included in the Surgery -- Narrative field.

Surgical Diagnostic/Staging Procedures -- Summary

NAACCR Version 10 field "RX Date--DX/Stg Proc", Item 1280, columns 851-858

See the general instructions for treatment date fields on page 172. When multiple procedures were performed, record the earliest date.

NOTE: There is *not* a separate Narrative field for Surgical Diagnostic/Staging Procedures. The field Surgery -- Narrative records both Surgery and Surgical Diagnostic/Staging Procedures.

SURGERY

Surgical procedures performed solely to establish a diagnosis or stage disease are coded as Diagnostic/Staging Procedures rather than Surgery. Purely incidental surgeries (such as removing a rib to provide access during lung surgery) are NOT recorded in any field. The use of a laser simply to make an initial surgical incision is NOT recorded. Surgical procedures done for symptom relief which remove, destroy or modify cancer tissue are coded as Palliative Care AND Surgery.

Surgeries performed that are intended to remove possibly cancerous tissues for pathologic examination ARE recorded, even if these tissues are found to contain no cancer. For example, Scope of Regional Lymph Node Surgery records the extent of regional node surgery performed during the First Course of Therapy -- not just the removal of *positive* nodes.

Excisional biopsies are recorded as Surgery. If a surgeon states that the procedure was an excisional biopsy or that all gross tumor was removed, code it as excisional even if the pathology report shows marginal microscopic involvement (residual tumor). If there is no statement that the initial biopsy was "excisional", yet no residual tumor was found later, assume that the biopsy *was* excisional. If an excisional biopsy is followed by a "re-excision" or "wide excision" during First Course of Treatment, include the later procedure in coding Surgery. Record the date of an excisional biopsy as the surgical start

date, whether followed by further definitive surgery or not, and whether or not residual tumor was found in a later resection.

There are three types of Surgery codes for diagnoses made beginning in 2003: Surgery of the Primary Site (codes in Appendix D), Scope of Regional Lymph Node Surgery and Surgery of Other Sites. Only the Surgery of Primary Site codes in Appendix D are site-specific and histology-specific. The three types of Surgery are generally coded independently -- for example, a patient may have only a procedure coded for Scope of Regional Lymph Node Surgery and have no Primary Site nor Other Site procedures coded.

Do not choose Surgery codes based solely on operative report titles. The procedure *named* may not always coincide with the procedure that was actually done. Use all information in the surgical reports and pathologic reports to determine the most appropriate Surgery codes. If there is discrepancy between the operative and pathology reports as to exactly what tissues were removed, give priority to the pathology report information (unless it seems less reliable).

If a cancer surgical procedure removes the remaining portion of an organ that had been previously partly removed (not necessarily for a reason associated with cancer), code this as if the entire organ had been removed during this cancer surgery.

Examples: Removal of a cervical stump is considered total removal of the uterus.
Removal of the last remaining lobe of a lung is considered a pneumonectomy.

Surgery of Primary Site

Only record surgeries of the *primary site* in this section. Surgery to remove regional tissues or organs is coded in this section only if these tissues/organs are removed *along with* the primary site as part of a specified code definition (in Appendix D) or in an "en bloc resection". (An en bloc resection is the removal of multiple organs/tissues during the same surgery.)

Example: When a patient has a modified radical mastectomy, since the breast and axillary contents are all removed in this surgery (en bloc) by definition, Surgery of Primary Site is coded as a modified radical mastectomy (**50**) even if pathology finds no nodes in the specimen. (See the codes in Appendix D, page D-34.)

Record a non en bloc resection of a secondary or metastatic site in Surgery of Other Sites.

Note that lymphomas have no separate coding scheme in Appendix D based on their histology codes. When lymph nodes (C77._) are the primary site, refer to the lymph node coding scheme (page D-52). For an extranodal lymphoma, refer to the appropriate coding scheme for the primary site assigned.

A biopsy that removes all gross tumor or leaves only *micro*scopically involved margins should be coded here as excisional. A biopsy that is called *excisional* by the performing surgeon should be coded as such, even if residual disease is indicated when the margins are examined.

The operative report title alone may not include enough information to help you assign the best surgery code. Use all of the operative report text and the pathology report to confirm the procedure that was truly done. Use the information from the pathology report when an operative report is unclear or is inconsistent, unless the pathology report states that an accurate accounting of organs removed cannot be given (e.g., tumor encasement, crush artifact, etc.).

In the Surgery of Primary Site coding schemes, more physically extensive procedures are generally listed further/lower down in the code lists. In order to add new procedures into the pre-existing (*ROADS*) coding schemes, code *numbers* do not always increase in size as you move further down a list. Thus larger code *numbers* do not necessarily represent a more extensive surgery -- the *relative position* of the code numbers is what matters. Purely destructive procedures are generally coded in the range **10-19** when applicable, and tissue resections begin with code **20**. The general hierarchical rules for the Surgery of Primary Site codes in Appendix D are as follows:

code **98** has priority over **00**;

codes **00-79** have priority over **80**, **90** and **99**; only use **80**, **90** and **99** in the absence of more specific information;

within the code range **00-79**, a code that appears further down in the list of codes has priority over codes that appear before it (not necessarily the higher code number). For example, in the thyroid coding scheme (Appendix D, page D-50) a lobectomy (**21**) has priority over a local excision (**26**) because **21** appears below **26**.

If the patient has *multiple* surgeries of the *same* primary site, code the most invasive, definitive surgery (in general, the code listed *further down* in the site's coding scheme). Assign the best code that describes the total result (cumulative effect) of all First-Course Primary Site Surgeries.

Examples: A patient has a colonoscopy with removal of a polyp in the sigmoid colon (see the codes in Appendix D, page D-11, code **26**). A week later the patient has a hemicolectomy (Surgery of Primary Site code **40**) for residual disease. Record the hemicolectomy code because it is the most invasive, definitive surgery and because it is listed below the polypectomy code.

Patient has a lung wedge resection (code **21**, p. D-25); later in First-Course Surgery the remainder of that lobe is removed. Code a total lobectomy (**30**).

A lymph node dissection during First Course of Therapy that is performed separately from a Primary Site Surgery may be combined into a single code that represents both surgeries when the coding scheme allows. For example,

a simple mastectomy (code **40**, p. D-33) followed by the separate removal of the axillary nodes could be coded as a modified radical mastectomy (**50**).

Code the appropriate surgery for each site when *multiple primaries* are excised at the same time.

Examples: A total abdominal hysterectomy was performed for a patient who had cancer of the cervix and of the endometrium. Code a total abdominal hysterectomy for each of the two primaries.

Patient has a total colectomy for multiple primary cancers originating in three segments of the colon. Code a total colectomy for each primary.

In the Surgery -- Narrative field, record *all* known primary site surgical procedures done at the reporting institution **and** at other institutions.

Example: "11/15/2003 colonoscopy & polypectomy done here; 11/18/03 hemicolectomy at Hospital B".

Surgery of Primary Site -- Summary

NAACCR Version 10 field "RX Summ--Surg Prim Site", Item 1290, columns 859-860

Using the codes for the appropriate primary site in Appendix D, enter the best code for all Surgery of Primary Site performed as part of First Course of Treatment. This includes treatment given at the reporting facility, plus all *known* treatment given elsewhere. If multiple procedures were done, code the procedure that appears further down in the list of codes, and list *all* procedures, with their dates and places of performance, in the Surgery -- Narrative field.

Surgery of Primary Site -- At This Facility

NAACCR Version 10 field "RX Hosp--Surg Prim Site", Item 670, columns 457-458

Using the codes in Appendix D, enter the code for the Surgery of Primary Site performed only at the reporting facility. If multiple primary site procedures were performed at your facility, enter the code for the procedure that appears further down in the code list, and be sure that the Surgery -- Narrative field includes all the procedures, with their dates. Include procedures performed in a staff physician's office if you have this information.

Surgery -- Date Started NAACCR Version 10 field "RX Date--Surgery", Item 1200, columns 755-762

See the general instructions on page 172 for treatment date fields. Record the date of an excisional biopsy here, whether followed by further definitive surgery or not, and whether or not residual tumor was found later. Record the earliest date of *all* coded

Surgeries (of Primary Site, Regional Nodes and Other Sites) -- *not* just Surgery of the Primary Site.

Date of Most Definitive Resection

NAACCR Version 10 field "RX Date--Most Defin Surg", Item 3170, columns 763-770

Record the date on which the most definitive or extensive surgery was performed on the Primary Site, regardless of the disease status of the specimen(s) removed. This should correspond to the procedure that is coded under Surgery of Primary Site -- Summary. This will often be the same date that is recorded in Surgery -- Date Started, but it may be a later date.

If no primary site surgery took place (Surgery of Primary Site – Summary is **00** or **98**), this field is zero-filled (**00000000**).

If Surgery of Primary Site -- Summary is coded **99** (unknown if performed, or death certificate-only case), then **9**-fill this date.

Surgery -- Narrative

NAACCR Version 10 field "RX Text--Surgery", Item 2610, columns 4475-4624

This field holds up to 150 characters only, yet it often has to include lots of important information. Continue this important narrative in an empty treatment text field or in the Comments/Narrative Remarks field if necessary. See the general instructions on page 172 for Treatment Text fields. Include all known Diagnostic/Staging Procedures, Palliative Care surgery, and Surgery (of primary site, regional nodes, regional sites, distant sites, distant nodes) performed in chronological order, with dates and places where the surgeries were done (for example, "1/18/2003 sigmoidoscopy done here; 1/20/03 excision of rectal mass at Hospl B; 1/25/03 liver mets ablation at Hospl C"). Include reconstructive procedures when appropriate. If no Primary Site Surgery was done, give a reason here if known to you (for example, "mid-November 2003 pt refused lobectomy"). Be specific about describing any Diagnostic/Staging Procedures; do not enter vague text like "bx of other than primary site" -- tell us what site was actually biopsied. If the Surgery Date and/or Date of Most Definitive Resection reported are estimated, note that here.

Reason For No Primary Site Surgery

NAACCR Version 10 field "Reason for No Surgery", Item 1340, column 868

For *all* cancers, this field records if First-Course Surgery of Primary Site was done; and if it was *not* done (Surgery of Primary Site – Summary is coded **00** or **98**) it records a reason *why* it was not done. Include all (Summary) Surgery of Primary Site that is known to you.
Record a reason why Surgery of Primary Site was not performed for this case; or, if it was performed, enter **0**.

Assign code **1** whenever Surgery of Primary Site -- Summary is coded **98** to indicate that primary site surgery is not applicable for this diagnosis.

Enter the most applicable number from the following codes:

Surgery of Primary Site was performed.	**0**
Surgery of Primary Site was not recommended. (includes inoperable cancer; widespread cancer; conditions not treated surgically, such as leukemia, etc.; unknown primary site; multiple treatment types were offered and primary site surgery was not chosen)	**1**
Surgery of Primary Site was contraindicated because of other conditions; autopsy-only cases (includes advanced age and other conditions or diseases that contraindicate surgery)	**2**
Patient died before planned/recommended Surgery of Primary Site could be performed.	**5**
The reason for no Surgery of Primary Site is unknown. (Surgery would have been the treatment of choice but it was not performed, and a reason is not given.)	**6**
patient/guardian refused Surgery of Primary Site (Surgery was recommended but patient/family/guardian refused; a blanket refusal of all treatment was made before or after treatment recommendations.)	**7**
Surgery of Primary Site was recommended, but it's not known if it was performed. (Surgery was recommended; no follow-up information is available to confirm if it was performed.)	**8**
unknown if Surgery of Primary Site recommended or performed; death certificate-only cases (No confirmation if Surgery of Primary Site was recommended or performed.)	**9**

Scope of Regional Lymph Node Surgery

These fields define the removal of regional lymph nodes. Refer to the AJCC TNM staging manual, *Sixth Edition* to determine which nodes are considered regional for a given primary site or subsite. Nodes not listed as regional in the *Sixth Edition* should be considered distant nodes, and their removal should be coded in Surgery of Other Sites rather than here. Regional lymph node surgeries done for purely palliative purposes should ALSO be coded in the Palliative Care fields.

Except for lymphomas with lymph node primary sites (C77._, 9590-9729), record here any surgical procedures which aspirate, biopsy or remove regional lymph nodes -- even if the purpose is simply to diagnose or stage disease. For *lymphomas* with C77._ primary sites, lymph nodes surgically aspirated, biopsied or otherwise removed for diagnostic or staging purposes should be coded in Surgical Diagnostic/Staging Procedures. (The Surgery of Primary Site codes in Appendix D for lymph node primaries do NOT refer to procedures done simply for diagnostic or staging purposes.) Scope of Regional Lymph Node Removal is automatically coded **9** for lymphomas with C77 primary sites.

Remember that lymph node Surgery procedures are recorded here. Whether the nodes are positive or negative for disease does not matter. When there is discrepancy between the number of nodes reported removed by the surgeon and the number of nodes reported examined by the pathologist, the pathology information takes priority (unless it seems less reliable than the operative information).

Examples: A sentinel node biopsy is performed for a breast cancer and the nodes are reported to be negative. Use code **2** to describe the procedure performed.

Surgeon reports a regional node dissection with four nodes taken for a colon cancer; pathologist finds only three nodes in the specimen. Use code **4** to record the actual removal of three nodes for dissection.

The codes are hierarchical. Codes **0-7** have priority over **9**. Within **0-7**, if more than one procedure was performed or if more than one code applies, code the procedure that is numerically higher. However, when just a sentinel node biopsy (**2**) is performed, code **2** has priority over the number of nodes taken. Codes **3-5** refer to the number of nodes taken but do not pertain to sentinel node biopsies. (See details in the code table.)

The following types of case are automatically coded **9** for Scope of Regional Lymph Node Surgery:

lymphomas with lymph node primary sites;

hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative diseases of any primary site;

primaries of the blood, bone marrow, reticuloendothelial system, hematopoietic system, meninges, brain, other CNS sites, ill-defined sites and unknown primary site.

The codes for all primary sites and types of cancer follow:

no regional lymph node surgery; no nodes found in a pathology specimen; autopsy-only case	**0**
regional lymph node biopsy or aspiration, NOS; Use **1** if the procedure is described as the biopsy or aspiration of a regional lymph node (compare with **4** below). Use **1** if the procedure is described as regional node biopsy or aspiration and there is no number of nodes specified.	**1**
sentinel lymph node biopsy Use **2** when just a sentinel node biopsy is specified, regardless of the number of nodes taken.	**2**
regional lymph node removal, sampling or dissection, NOS (number of nodes not specified)	**3**
1 - 3 regional lymph nodes removed (by sampling or dissection) and found in the specimen If 1-3 nodes were described as being removed but no nodes were found in the pathology specimen, use code **0** to indicate that no nodes were actually taken. Do not use **4** for a sentinel node biopsy of 1-3 nodes. Use **2** for all sentinel node biopsies unaccompanied by further node removal. Use **4** if a procedure is described as the removal of one regional node (compare with code **1**).	**4**
4 or more regional lymph nodes removed (by sampling or dissection) and found in the specimen If 4 or more nodes were described as being removed but only 1-3 were found in the pathology specimen, use code **4** for the actual number of nodes removed. Do not use **5** for a sentinel node biopsy of more than 3 nodes. Use **2** for all sentinel node biopsies unaccompanied by further node removal.	**5**
sentinel lymph node biopsy (**2**) AND regional lymph node removal (**3**, **4** or **5**) performed at the same time (during the same surgery); sentinel lymph node biopsy AND regional lymph node removal performed, but the timing of the procedures was not recorded	**6**
sentinel lymph node biopsy (**2**) AND regional lymph node removal (**3**, **4** or **5**) performed at different times (during different surgeries)	**7**
unknown/not stated if regional lymph node surgery was performed; primary site C77._ with histologic types 9590-9729; histologic types 9750, 9760-9764, 9800-9820, 9831-9920, 9931-9964, 9980-9989; primary sites C42.0, C42.1, C42.3, C42.4, C70._, C71._, C72._, C76._, C80.9; death certificate-only case	**9**

Scope of Regional Lymph Node Surgery -- Summary

NAACCR Version 10 field "RX Summ--Scope Reg LN Sur", Item 1292, column 861

Record the Scope of Regional Lymph Node Surgery done at your facility and elsewhere if known to you.

Scope of Regional Lymph Node Surgery -- At This Facility

NAACCR Version 10 field "RX Hosp--Scope Reg LN Sur", Item 672, column 459

Code just the Scope of Regional Lymph Node Surgery done at your facility. Include procedures done in a staff physician's office (if available).

Surgery of Other Sites

These fields record surgeries of any tissue, node or organ other than the primary site and regional lymph nodes. Use the AJCC TNM staging manual *Sixth Edition* to determine whether specified lymph nodes and other sites are regional or distant (distant tissues are counted in the M element). If a regional or distant site was removed in continuity with the primary site (en bloc, during the same surgery), this is recorded only in the Surgery of Primary Site fields. Only regional or distant sites/nodes removed separately from the primary site should be recorded here. The types of surgeries included here reflect those in the Surgery of Primary Site categories, so both surgical tissue destruction (such as radiofrequency ablation, alcohol ablation and chemoembolization) and tissue removal are included. Palliative surgeries of sites other than the primary site and regional lymph nodes should be coded here AND in the Palliative Care fields if the surgery removed, destroyed or modified cancer tissue.

Include tissues, organs and distant lymph nodes that are removed because they are known to be cancerous or suspicious for cancer; and record the surgical procedure even if no cancer is found. Do not record incidental removals when there was no suspicion of cancer there.

Surgery of Other Sites records (with code **1**) any surgeries done for ill-defined primary sites, an unknown primary site, or hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative diseases. Whenever no surgery was performed for these cases, use code **0**.

Codes **1-5** have priority over code **9**. Within the range **1-5** when multiple codes apply or when multiple procedures are performed, the higher code number has priority.

The codes for all primary sites and types of cancer follow:

no surgical procedure of a non-primary site or distant lymph node; autopsy-only case	**0**
surgery of other site, NOS; surgery when the primary site is C42.0, C42.1, C42.3, C42.4, C76._ or C80.9; surgery when the histologic type is 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964 or 9800-9989; surgery of other site was performed, but it's unknown if this was a regional or distant site*	**1**
surgery of regional site(s) (not regional lymph node)	**2**
surgery to distant lymph node(s)	**3**
surgery of distant site(s) (not lymph nodes)	**4**
combination non-primary surgery (any combination of **2**, **3**, **4**)	**5**
unknown if a non-primary, non-regional node surgery was performed; death certificate-only case	**9**

* For example, a tumor known to be non-primary is removed from the liver but the primary site is unknown, so it's unknown if the liver is a regional or distant site.

Surgery of Other Sites -- Summary

NAACCR Version 10 field "RX Summ--Surg Oth Reg/Dis", Item 1294, column 862

Report the Surgery of Other Sites performed at your facility and elsewhere (if known to you).

Surgery of Other Sites -- At This Facility

NAACCR Version 10 field "RX Hosp--Surg Oth Reg/Dis", Item 674, column 460

Report just the Surgery of Other Sites performed at your facility as part of First Course of Therapy. Include procedures performed in a staff physician's office if known to you.

ROADS SURGERY CODES

For cases diagnosed before 2003 that are reported using the NAACCR Version 10 or 10.1 layouts, both *ROADS* and *FORDS* surgery codes must be entered for certain fields for the sake of information continuity. This practice is specified by the COC, NAACCR, SEER and the CDC/NPCR. Complete *ROADS* surgery codes can be found in the updated *ROADS* Manual and in the *MCR Abstracting and Coding Manual for Hospitals, Fourth Edition*, so they are not repeated here. This *ROADS*/*FORDS* "double coding" will not be a problem when reporting Class 3 cases diagnosed before 2003 to the MCR because First Course of Treatment does not have to be completed for such cases (use **0**'s and **9**'s as appropriate). The six *ROADS* surgery fields collected by the MCR follow. (The "1998-2002" in the field titles refer to the diagnosis years of the *ROADS* expanded surgery codes.)

For primary site surgeries, the *ROADS* and *FORDS* codes for the same procedure will often be identical. Because the regional node and "other site" surgeries were site-specific in ROADS, their codes will sometimes differ from the corresponding *FORDS* codes.

Example: A lung cancer patient diagnosed on December 20, 2002 undergoes a lobectomy on December 29th and has a sentinel lymph node biopsy and ablation of a liver metastasis on January 3, 2003. The Summary *ROADS* codes for Surgery of Primary Site, Scope of Regional Lymph Node Surgery and Surgery of Other Sites are **31**, **1** and **6**. The *FORDS* codes for the same procedures are **30**, **2** and **4**.

Surgery of Primary Site, 1998-2002 -- Summary

NAACCR Version 10 field "RX Summ--Surg Site 98-02", Item 1646, columns 939-940

Using the codes in the *ROADS* manual or Appendix D of the Fourth Edition of the *MCR Abstracting and Coding Manual for Hospitals*, record the Summary Surgery of the Primary Site (done at your facility and elsewhere).

Surgery of Primary Site, 1998-2002 -- At This Facility

NAACCR Version 10 field "RX Hosp--Surg Site 98-02", Item 746, columns 478-479

Using the codes in the *ROADS* Manual or Appendix D of the Fourth Edition of the *MCR Abstracting and Coding Manual for Hospitals*, record the Surgery of the Primary Site done at your facility (including surgery in staff physicians' offices if known to you).

Scope of Regional Lymph Node Surgery, 1998-2002 -- Summary

NAACCR Version 10 field "RX Summ--Scope Reg 98-02", Item 1647, column 941

Using the codes in the *ROADS* Manual or Appendix D of the Fourth Edition of the *MCR Abstracting and Coding Manual for Hospitals*, record the Summary Regional Node Surgery (done at your facility and elsewhere).

Scope of Regional Lymph Node Surgery, 1998-2002 -- At This Facility

NAACCR Version 10 field "RX Hosp--Scope Reg 98-02", Item 747, column 480

Using the codes in the *ROADS* Manual or Appendix D of the Fourth Edition of the *MCR Abstracting and Coding Manual for Hospitals*, record the Scope of Regional Lymph Node Surgery done at your facility (including surgery in staff physicians' offices if known to you).

Surgery of Other Sites, 1998-2002 -- Summary

NAACCR Version 10 field "RX Summ--Surg Oth 98-02", Item 1648, column 942

Using the codes in the *ROADS* Manual or Appendix D of the Fourth Edition of the *MCR Abstracting and Coding Manual for Hospitals*, record the Summary Surgery of Other Regional or Distant Sites (done at your facility and elsewhere).

Surgery of Other Sites, 1998-2002 -- At This Facility

NAACCR Version 10 field "RX Hosp--Surg Oth 98-02", Item 748, column 481

Using the codes in the *ROADS* Manual or Appendix D of the Fourth Edition of the *MCR Abstracting and Coding Manual for Hospitals*, record the Surgery of Other Sites done at your facility (including surgery in staff physicians' offices if known to you).

RADIATION THERAPY

First-Course Radiation Therapy may be delivered to any part of the body (primary site, regional tissues or metastatic sites). Radiation for purely palliative purposes should be coded in Palliative Care AND here when the radiation affected cancer cells/tissue. Do not include radiation for hormonal effect such as irradiation of non-cancerous endocrine glands; (code endocrine radiation for breast or prostate cancers as Endocrine Procedures). Do not include radiation to the male breast to prevent gynecomastia. First-course prophylactic radiation (for example, whole-brain radiation for leukemia or lung cancer patients) may be included. If both palliative and therapeutic radiation are given, code just the non-palliative Radiation Therapy. The MCR collects relatively few of the COC's many detailed Radiation fields.

Types of Radiation

The primary types of Radiation Therapy include the external administration of radioactive beams, implantation of radioactive material (brachytherapy), and the internal administration of radioisotopes by means other than implantation. Radioactive materials include the following:

- Gold $(Au)^{198}$
- Cobalt $(Co)^{60}$
- chromic phosphate (CrO_4P)
- phosphocol ($Cr^{32}PO_4$)
- cesium (Cs)
- iodine $(I)^{125}$ and I^{131}
- iridium $(Ir)^{192}$
- phosphorus $(P)^{32}$
- lead $(Pb)^{210}$
- radium $(Ra)^{226}$
- radon $(Rn)^{222}$
- ruthenium $(Ru)^{106}$
- strontium $(Sr)^{89}$ and Sr^{90}
- yttrium $(Y)^{90}$

Beam (Teletherapy) -- The source of radiation is outside the patient, as in a cobalt machine or linear accelerator. Examples of beam radiation include the following:

- Betatron
- Brachytron
- Cobalt
- Cyclotron
- Grenz ray
- Helium ion or other heavy particle beam
- Linear accelerator (LINAC)
- Neutron beam
- Spray radiation
- Stereotactic radiosurgery (gamma knife, proton beam)
- X-ray

Brachytherapy (implants) -- Radioactive materials are administered by interstitial implants, molds, seeds, needles or intracavitary applicators. (Heyman capsules, Fletcher suit, and Fletcher after-loader are methods of radioisotope application. Interpret these terms as radioactive implants.)

Radioisotopes (other internal radiation) -- Record the name or chemical symbol and administration method of any radioactive material given internally (orally, intracavitarily or by intravenous injection) but not implanted.

Regional Modality

NAACCR Version 10 field "Rad--Regional RX Modality", Item 1570, columns 909-910

If multiple types of radiation are delivered during First Course of Therapy, record only the most dominant modality here -- the most significant for the treatment/palliation of the cancer. Although regional radiation is usually given before a boost (supplemental) dose, this is not always the case. First-course prophylactic radiation may be considered the Regional Modality if no therapeutic radiation is given. Determine which type of radiation was the most important for treating the cancer or patient; consult physicians when this is not clear. Note that no code can be entered to represent a *combination* of different radiation modalities (such as beam radiation plus implants) for cases diagnosed beginning in 2003.

Examples: A patient first has stereotactic radiosurgery for a single metastasis in the brain, followed by beam radiation to the primary site and involved regional tissues. The earlier stereotactic surgery is less significant to treating the primary volume of disease, so record the later beam radiation as the Regional Modality.

For a prostate cancer, when a course of beam radiation is delivered to the prostate area and seed implants are also used during First Course of Therapy, the beam radiation has more significance than the brachytherapy (unless a physician states otherwise). Record the beam radiation as Regional Modality.

If only one type of Radiation Therapy was given, that is recorded as Regional Modality regardless of anatomic area targeted, regardless of its therapeutic significance, and even if it was done for purely palliative intent. Everyone receiving treatment Radiation should have Regional Modality specified, but not everyone has "boost" treatment. (The MCR does not collect Boost Modality.)

Note that there are not separate fields for "Summary" and "At-This-Facility" Regional Modality. Record here the dominant type of Radiation Therapy known to you regardless of whether or not it was given at your facility (as for a Summary treatment field).

Distinguish the energy of the beam (the type of therapy, counted in volts) from the amount of total radiation reaching the targeted tissues [the therapeutic dose delivered, counted in centigrays (cGy) or rads]. The amount of radiation delivered to the tissues is recorded in a different COC field (not collected by the MCR). Codes **21** and **23-27** refer to the energy of the radiation beams *outside* the body (generated by the particular device). Within radiation categories, the "NOS" code (for example, **20**, **41**, **50**, **60**) is listed first, followed by specific types. Note that voltage or volts (V) may also be recorded as electron-volts (eV).

Brachytherapy is coded based on dose rate (low or high) source and whether the radiation sources are placed within the targeted tissues or in a space adjacent to those tissues. The COC states that low dose rate brachytherapy is usually given over several days as an inpatient procedure. High dose rate brachytherapy is usually more limited in scope; iridium (Ir)-192 is a high dose rate source.

Radioimmunotherapy, radioimmunoconjugates: Radioisotopes delivered via a monoclonal antibody (Zevalin, Bexxar) should be coded here (**60**) rather than as Immunotherapy. Bexxar (not yet added by SEER as a *Book 8* drug) delivers iodine (I)-131, and Zevalin delivers yttrium (Y)-90. [Zevalin is also used to deliver indium (In)-111 for *imaging* purposes rather than treatment.] Similarly, iodine-labeled immunoglobin (especially for thyroid cancers) was formerly coded as both a radioisotope and Immunotherapy, but SEER has recently changed this instruction to specify that the antibody is simply being used to deliver radiation to the tumor and this therapy should be coded *only* as Radiation.

Record the most specific category or highest applicable code number within a modality type (general beam radiation, proton/stereotactic radiosurgery, brachytherapy, radioisotopes).

Examples: 3-D conformal radiation with beam strength 6 MV: Use 32 for conformal therapy because this code is higher than the beam energy's code (24).

Categories and codes for Regional Modality Radiation Therapy follow:

no radiation treatment; autopsy-only case	**00**
General Beam Radiation	
external beam, NOS [a]	**20**
orthovoltage [b]	**21**
Cobalt (Co)-60 or Cesium (Cs)-137 [c]	**22**
photons or X-rays, beam energy of 2 - 5 megavolts (MV)	**23**
photons or X-rays, beam energy 6 - 10 megavolts (MV)	**24**
photons or X-rays, beam energy 11 - 19 MV	**25**
photons or X-rays, beam energy of more than 19 MV	**26**
photon or X-ray beams of mixed energies; beams of multiple energy levels (combination of **23** - **26**)	**27**
electron beam	**28**
photon or X-ray AND electron beams (combination of **23** - **27** and **28**)	**29**
neutron beam (may also include photons, X-rays and/or electrons)	**30**
IMRT (intensity modulated radiation therapy)	**31**
conformal radiation therapy; 3-D (three-dimensional) radiation therapy (Fixed portals produce beams conforming to the targeted volume's shape.)	**32**

[table continued…]

[a] Don't confuse this with **98**. Use **20** when external beam was used but you cannot assign a specific code **21**-**43**.

[b] The equipment produces a beam of less than 1 million (mega) volts (< 1 MV) [less than 1000 kilovolts (< 1000 kV)]. Orthovoltage is usually counted in thousands of volts (kilovolts, kV) rather than megavolts (millions of volts, MV).

[c] The equipment producing the beam has one of these materials as the radiation source. (If Co-60 or Cs-137 is introduced into the patient's body rather than used to produce an external beam, it is coded as brachytherapy.)

[…table continued]

Stereotactic Radiotherapy	
proton beam; proton therapy	**40**
stereotactic radiosurgery, NOS (specific type not recorded, or some type of radiosurgery other than **42** or **43**)	**41**
LINAC radiosurgery (linear accelerator produces the beam)	**42**
gamma knife radiosurgery	**43**
Brachytherapy (radioactive implants, molds, seeds or needles)	
brachytherapy, NOS	**50**
low dose rate (LDR) intracavitary brachytherapy (LDR applicators and radiation sources [for example, Fletcher Applicator and Cesium (Cs)-137] inserted into a cavity near the targeted tissues)	**51**
high dose rate (HDR) intracavitary brachytherapy (HDR after-loading applicators and radiation sources inserted into a cavity next to the targeted tissues)	**52**
low dose rate (LDR) interstitial brachytherapy (LDR radiation sources inserted into targeted tissues)	**53**
high dose rate (HDR) interstitial brachytherapy (HDR radiation sources inserted into targeted tissues)	**54**
radium (Ra) implant	**55**
Radioisotopes [unstable isotopes of elements which don't normally emit radiation, such as Iodine (I)-131 or Phosphorus (P)-32]	
radioisotope, NOS; any radioisotope other than **61** and **62**	**60**
strontium (Sr)-89	**61**
strontium (Sr)-90	**62**
Conversion Combinations (only used for pre-2003 diagnoses)	
specified combination modalities (beam & brachytherapy/radioisotopes)	**80**[d]
combination modalities, NOS (combination therapies not covered by **80**)	**85**[d]
Radiation Therapy, NOS	
type of radiation not specified/unknown;[e] type of radiation that cannot be coded using the given codes (Radiation Therapy *was* given, but the type is not known to you.)	**98**
Unknown	
unknown if Radiation Therapy was given (*not* radiation type unknown); death certificate-only case	**99**

[d] **80** and **85** may only be used for diagnoses made before 2003 -- resulting from conversion of *ROADS* combination radiation codes or manually assigned to pre-2003 diagnoses. Starting with 2003 diagnoses you cannot record **80** or **85** -- you must choose just the one type of radiation most important to treating the cancer, using the highest applicable code number within a category.

[e] Distinguish **20** from **98**. Use **98** when some type of radiation was given but you can't tell if it was beam or not.

Radiation Therapy -- Date Started

NAACCR Version 10 field "RX Date--Radiation", Item 1210, columns 779-786

See the Treatment Date instructions on page 172. This is the first start date of *any* type of Radiation given -- usually, but not necessarily, the date on which the Regional Modality therapy began.

If Radiation Therapy is part of the planned First Course of Therapy but it has not yet begun when you abstract the case for the MCR, enter the special code **88888888**. If your facility is administering this Radiation Therapy, please tell the MCR when it does eventually begin (or that for some reason it never takes place) so that we can update the **8**'s in our data system.

Radiation Therapy -- Narrative

NAACCR Version 10 field "RX Text--Radiation (Beam)", Item 2620, columns 4625-4774

This field holds up to 150 characters. See the Treatment Text instructions on page 172. Although this NAACCR field is meant to contain only information on beam radiation, please note that the MCR does *not* collect the companion field "RX Text--Radiation Other" (NAACCR Item 2630) where any non-beam radiation would be described. Please describe all types of radiation given to the patient in Item 2620 for the MCR. For your own purposes you may also separately describe non-beam radiation in Item 2630, but remember that anything you record there will not be seen by the MCR. If we see any type of radiation coded that is not documented in Item 2620, we may have to call you to clarify the apparent discrepancy. If the Radiation Date reported is an estimate, note that here. Include a summary of all types of radiation given -- NOT just the Regional Modality. Include enough specific information to help us verify the Regional Modality code. Other information covered by fields that are not collected by the MCR (Elapsed Days, Treatment Volume, etc.) should follow after the start date and Regional Modality description.

The MCR does not collect the field "Reason for No Radiation". If Radiation Therapy was planned during First-Course Therapy but it was not done, you may record a reason here (optional).

Radiation / Surgery Sequence

NAACCR Version 10 field "RX Summ--Surg/Rad Seq", Item 1380, column 875

This field defines the order in which First-Course Radiation and Surgery were delivered. Include Radiation (regional and boost) and Surgery (Primary Site, Regional Nodes and Other Sites) given at your facility and elsewhere. Palliative Radiation and Palliative Surgery also count. Surgical Diagnostic/Staging procedures do *not* count. Enter **2-9** if the patient had both Radiation and Surgery during First-Course Treatment.

Codes for Radiation / Surgery Sequence follow:

no Radiation Therapy and/or Surgery; autopsy-only case	**0**
Radiation Therapy before Surgery	**2**
Radiation Therapy after Surgery	**3**
Radiation Therapy both before and after Surgery	**4**
intraoperative Radiation Therapy alone	**5**
intraoperative Radiation Therapy with other Radiation Therapy given before or after Surgery	**6**
sequence unknown, but both Radiation Therapy and Surgery were done; it's unknown if both were done; death certificate-only case	**9**

SYSTEMIC THERAPY

Systemic therapies include Chemotherapy, Hormone Therapy, Immunotherapy and Hematologic Transplants & Endocrine Procedures. *Drugs* and other agents acting on bodily systems at large (Chemotherapy, Hormone Therapy, Biological Response Modifiers) are coded separately from *procedures* affecting a patient's hormone or immunologic systems (Hematologic Transplants & Endocrine Procedures). There is one "start date" field covering all these modalities. Note that Hematologic Transplants & Endocrine Procedures do not have a separate Narrative field, nor an "At-This-Facility" field.

Systemic drugs and agents may be given intravenously, orally or by injection into the cerebrospinal fluid, pleural cavity, pericardial space, peritoneal cavity or hepatic artery.

Systemic Therapy -- Date Started

NAACCR Version 10 field "RX Date--Systemic", Item 3230, columns 795-802

See the Treatment Date instructions on page 172. Enter the earliest start date for First-Course Chemotherapy, Hormone Therapy, Immunotherapy and Hematologic Transplants & Endocrine Procedures. If Systemic Therapy is planned but hasn't yet begun when the case is abstracted, fill the field with **88888888**; if your facility or staff physician administers the treatment, let the MCR know when it begins (or if it never actually takes place) so that we can update this field on our data system.

CHEMOTHERAPY

Chemotherapy agents are anticancer drugs inhibiting cancer cell reproduction -- usually by interfering with DNA synthesis and mitosis, causing the cells to stop growing or die. Chemotherapy may be given by intravenously or orally; agents may also be topical, intrathecal, intracavitary or intra-arterial. Chemotherapy is often given in cycles over weeks or months. Only record First-Course Chemotherapy. Chemotherapy for palliative purposes is coded in Palliative Care AND here.

Chemotherapy agents may be administered singly or in combination regimens of two or more drugs. The drugs are frequently given in combinations referred to by acronyms or protocols codes. You may use standard acronyms and abbreviations, but do not enter protocol numbers alone. Two or more single agents given at separate times during First Course of Therapy are considered to be a *combination* regimen. See the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed*. (1993) for a list of the standard acronyms used for combination regimens (pages 29-31).

Record Chemotherapy delivered *concurrently* or as *adjuvant* or *neoadjuvant* treatment. Concurrent Chemotherapy is used in combination with other modes of therapy (Surgery, Radiation, etc.). In adjuvant therapy, when other methods have already destroyed clinically detectable cancer cells, Chemotherapy is then given to prevent or delay recurrence by destroying micrometastases. Neoadjuvant therapy is given before Surgery to help reduce a tumor's size (bulk).

For primary liver and intrahepatic bile duct cancers, chemoembolization is coded in Surgery of Primary Site (code **10**), and *also* code the Chemotherapy agents used here. Chemo-embolization of liver metastases may be coded in Surgery of Other Sites *and* Chemotherapy.

Chemotherapy may be divided into the following four groups:

Group I: Alkylating Agents

Busulfan (Myleran)
Carmustine (Lomustine)
Carmustine + implant (Gliadel Wafer with BCNU)
Chlorambucil (Leukeran)
Cyclophosphamide (Cytoxan, Neosar)
Dacarbazine (DTIC-Dome)
Mechlorethamine (Mustargen)
Phenylalanine mustard (Alkeran, Melphalan)
Temozolomide (Temodar, Temodol)
Triethylene-thiophosphoramide (Thio-TEPA)

Group II: Antimetabolites

Folic acid analogs: Methotrexate (Amethopterin, Folex, Mexate, MTX)
Pyrimidine analogs: Capecitabine (Xeloda), 5-Fluorouracil (5-FU), Gemcitabine HCl (Gemzar)
Purine analogs: 6-Mercaptopurine (6-MP, Purethinol)
Cytarabine liposomal (Cytosar, DepoCyt)

Group III: Natural Products

Antitumor antibiotics:	Bleomycin (Blenoxane)
	Dactinomycin (Actinomycin D, Cosmegen)
	Daunorubicin (Cerubidine, Daunomycin, DaunoXome)
	Docetaxel (Taxotere)
	Doxorubicin (Adriamycin, Caelyx, Doxil, RUBEX)
	Mitomycin C (Mutamycin)
	Paclitaxel (Onxol, Paxene, Taxol)
	Pentostatin (Nipent)*
Vinca (plant) alkaloids:	Irinotecan HCl (Camptosar, CPT-11)
	Vinblastine (VBL, Velban)
	Vincristine (Oncovin, VCR, Vincasar)
Enzymes:	L-Asparaginase (Elspar, Kidrolase)*

Group IV: Miscellaneous Agents

Cis-diammine dichloroplatinum II (Cisplatin, Platinol)
Hydroxyurea (Hydrea)
Oxaliplatin (Eloxatin)
Procarbazine (Matulane, Natulan)

See the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed*. (1993) for a comprehensive list of Chemotherapy agents (pages 5-28, plus updates).

When a patient has an adverse reaction to initial chemotherapy a physician may change one of the agents being administered. If the replacement drug belongs to the same group (Groups I-IV shown above) as the original drug, there is considered to have been *no change in the regimen* and this is just a continuation of the planned First Course of Therapy; but if the replacement agent falls into a different group than the original drug, then this is considered a *new regimen* and *subsequent therapy* (i.e., not First-Course and not collected by the MCR). If the treatment plan *includes* a planned change in drugs, however, this is all considered to be part of First Course of Therapy. Note that for newer drugs added to *Book 8* through updates, SEER has not always specified the type (Group I - IV) of Chemotherapy agent for each drug. The MCR has tried to list some of the newer drugs here in the Group that our research shows is most appropriate, but we may have it wrong. Please use additional sources if you need to know in which "Group" a Chemotherapy drug is.

* Pentostatin and L-Asparaginase are listed in *Book 8* as Biological Response Modifiers, but updates issued by SEER changed their category to Chemotherapy.

{Ancillary Drugs and Differentiation-Inducing Agents

Ancillary drugs may be given to a cancer patient, sometimes in combination with other drugs or treatment; but they do not directly treat cancer. Some ancillary drugs may treat side effects of cancer treatment; others enhance the effectiveness of Chemotherapy drugs; and some are radiosensitizers. See pages 35-46 (plus updates) in the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed*. (1993) for a list of ancillary drugs. These drugs are not coded as cancer treatment, but they may be recorded in the Chemotherapy -- Narrative field and they may (if being given for symptom relief) be recorded under Palliative Care. Differentiation-inducing agents (*SEER Book 8* pages 50-51 plus updates) also are not considered to be directly treating cancer and so are NOT coded as treatment; record their names in the Chemotherapy -- Narrative field.

Examples: 5-FU and Leucovorin are given as part of First Course of Therapy. The Leucovorin enhances the 5-FU's effectiveness. If there are no additional Chemotherapy agents given, the correct Chemotherapy code is **2** (single agent). Chemotherapy -- Narrative could say "5-FU (+ Leucovorin)".

Procrit is given to someone with chronic lymphocytic leukemia. Procrit is a colony-stimulating factor which relieves symptoms but does not help "cure" the leukemia. Record the Procrit under Palliative Care (code **7**) only.

Some normally ancillary drugs (adrenocorticotrophic hormones like Decadron) are coded as Hormone Therapy agents if given to treat myelomas, lymphomas or lymphoid leukemias. See p. 37 in *SEER Book 8*.

Ancillary drugs and differentiation-inducing agents include the following:

Albuterol (Proventil)
Alitretinoin (Panretin)
Allopurinol
Amifostine (Ethyol)
Benzidiazole
Bromodeoxyuridine (5-Bromouracil, BUdR)
Clonidine
Desmethylmisonidazole
Epogen
Erythropoietin (Procrit)
Idoxuridine
Leucovorin (Wellcovorin)
Metronidazole
Filgrastim (Neupogen)
Oprelvekin (Neumega)
Pamidronate disodium (Aredia)
Quinidine
Tretinoin (AT retanoic acid, Vesanoid)
Zoledronic acid (Zometa)}

When Prednisone is given in combination with a Chemotherapy agent, the Prednisone is coded as Hormone Therapy and the Chemotherapy agent alone is coded here. This usually pertains to the treatment of myelomas, lymphoid leukemias or lymphomas. Prednisone given without Chemotherapy is usually ancillary (not coded, unless used for palliative purposes). Prednisolone is recorded in the same manner. April Fritz has allowed that Sandostatin may be considered Hormone Therapy for neuroendocrine tumors of the pancreas.

When Chemotherapy was not used, if it is normally recommended for the given type of cancer and stage of disease, use **00**. If Chemotherapy was not given but it is normally recommended for this cancer type/stage, code the reason why it wasn't given using **82-87**.

Use the following codes for First-Course Chemotherapy:

no Chemotherapy given because it wasn't planned (Chemotherapy is not normally given for this type/stage of cancer; multiple treatment types were offered and something other than Chemotherapy was chosen.) autopsy-only case	**00**
Chemotherapy, NOS (number of agents unknown)	**01**
Chemotherapy, single agent	**02**
Chemotherapy, multiple agents (combination regimen)	**03**
Chemotherapy not given/recommended because of contraindications (such as age or comorbid conditions).	**82**
Chemotherapy not given because patient died before planned/recommended therapy.	**85**
Chemotherapy recommended but it wasn't given; the reason why is not recorded.	**86**
Chemotherapy refused* by patient/family/guardian.	**87**
Chemotherapy was recommended but it's unknown if it was given.	**88**
unknown if Chemotherapy recommended or administered; unknown if Chemotherapy normally recommended for this cancer type/stage; death certificate-only case	**99**

* Code **87** should be used when Chemotherapy is normally recommended for this type of cancer and stage of disease, and any of the following situations applies:

any and all treatment was refused before specific treatment recommendations could be made;
there was a blanket refusal of all recommended treatment;
recommended Chemotherapy was specifically refused.

Note: In the range **01-03**, the higher code number has priority.

Chemotherapy -- Summary

NAACCR Version 10 field "RX Summ--Chemo", Item 1390, column 878-879

Using the code table on the preceding page, report all the Chemotherapy given to the patient as part of First Course of Therapy. Include Chemotherapy given at your institution *and* at all others (if known to you).

Chemotherapy -- At This Facility

NAACCR Version 10 field "RX Hosp--Chemo", Item 700, column 464-465

Using the code table on the preceding page, report just the Chemotherapy administered at your facility as part of First Course of Therapy. Include treatment delivered in a staff physician's office if this is recorded in your facility's medical record.

Chemotherapy -- Date Started

NAACCR Version 10 field "RX Date--Chemo", Item 1220, columns 803-810

See the Treatment Date instructions on page 172. The MCR continues to collect individual Systemic Treatment start dates at this time. The special code **88888888** may be used here when Chemotherapy has not yet started.

Chemotherapy -- Narrative

NAACCR Version 10 field "RX Text--Chemo", Item 2640, columns 4925-5124

This field may contain up to 200 characters. Record the generic or trade names of the Chemotherapy agents used. Include those that are in the investigative or clinical trial phase if identified as Chemotherapy agents. See the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed*. (pages 5-31) (with updates) for a comprehensive list of chemotherapeutic agents and regimens. You may use standard abbreviations and acronyms (such as "5-FU" and "MOPP"), but avoid entering protocol numbers alone. See pages 29-31 in *SEER Book 8* for combination regimen standard acronyms. The names of (uncoded) ancillary drugs given along with Chemotherapy agents may also be included here. If the Chemotherapy Date reported is an estimate, note that here. If Chemotherapy was planned or recommended as First-Course Treatment but was not carried out, please record a reason why here. Agents given for First-Course Palliative chemotherapeutic care should be recorded here.

HORMONE / STEROID THERAPY

Hormones promote hormonal withdrawal or hormonal interface to alter cancer growth. Hormone Therapy achieves its effects on cancer cells by changing hormone balance. It includes administration of hormones, antihormones, steroids and other agents acting via hormonal mechanisms. Hormonal therapy may effect a long-term control of cancer, but it is not usually used to "cure" cancer.

Record surgery done for hormonal effect (such as orchiectomy) and radiation given for hormonal effect as Endocrine Procedures rather than here. If Hormone Therapy is given for purely palliative reasons and it modifies cancer cells/tissue, code in Palliative Care AND here.

If cancer or treatment has decreased the functions of hormone-producing tissues, hormone replacement therapy (HRT, not normally coded as Hormone Therapy) may be used. Thyroid hormone replacement is not usually tumor-directed; but if a cancer patient receives a thyroid hormone preparation like Synthroid to inhibit the pituitary from making thyroid-stimulating hormone (TSH, which could cause tumor growth), then this *is* coded as Hormone Therapy.

Report use of adrenocorticotrophic hormones for the treatment of leukemias, lymphomas, multiple myeloma, and breast and prostate cancers. Code Prednisone as Hormone Therapy when given in combination with Chemotherapy (e.g., MOPP or COPP) for cancer of *any* site. If administered for other reasons, do *not* code such agents as Hormone Therapy.

Examples: Prednisone to stimulate appetite -- Do *not* code this.

A patient has brain metastases. Decadron is used to reduce brain edema and relieve neurologic symptoms. This palliative Decadron use is not altering cancer cells, so code as Palliative Care (**7**) (*not* Hormone Therapy).

Decadron to treat multiple myeloma -- Code as Hormone Therapy (**01**).

For a complete list of hormonal agents, see the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed*. (1993, plus updates). They include the following classifications:

adrenocorticosteroids (Decadron, Prednisolone, Prednisone)*
androgens (Halotestin)
antiestrogens (Arimidex, Fareston, Faslodex, Femara, Nolvadex, Tamoxifen)
estrogens (diethylstilbestrol, DES)
hormone synthesis inhibitors (Cytadren, Elipten)
progestins (Megace, Provera)

* Prednisone (Deltasone), Prednisolone and Dexamethasone (Decadron) are usually ancillary (not coded at all unless used for palliation). These are coded in Hormone Therapy when used to treat myelomas, lymphomas and lymphoid leukemias or when used as Hormone agents with Chemotherapy. April Fritz has allowed that Sandostatin may be considered Hormone Therapy for neuroendocrine tumors of the pancreas.

All First-Course Hormone Therapy is coded **01**. If Hormone Therapy was recommended or planned but was NOT carried out, this field records a reason why it wasn't done (**82-87**). Use the following codes for Hormone Therapy:

No Hormone Therapy given because it was not recommended/-planned; Hormone Therapy is not normally given for this cancer type/stage; multiple treatment types were offered and something other than Hormone Therapy was chosen; autopsy-only case	**00**
Hormone Therapy given.	**01**
Hormone Therapy not recommended or done because of contraindications (such as age or comorbid conditions).	**82**
Hormone Therapy recommended/planned but not administered because the patient died.	**85**
Hormone Therapy recommended/planned but not administered. The reason why is not known to you.	**86**
Hormone Therapy recommended/planned but refused by patient, family or guardian.*	**87**
Hormone Therapy recommended, but unknown if it was done.	**88**
unknown if Hormone Therapy recommended or administered; unknown if Hormone Therapy is usually recommended for this type/stage of cancer; death certificate-only case	**99**

* Code **87** includes the following situations: Hormone Therapy is normally recommended for this type of cancer/stage of disease and

the recommended Hormone Therapy was refused; or

there was a blanket refusal of any/all recommended treatment; or

any/all treatment was refused before specific recommendations were made.

Hormone Therapy -- Summary

NAACCR Version 10 field "RX Summ--Hormone", Item 1400, column 880-881

Using the code table above, report *all* Hormone Therapy performed at your facility *and* elsewhere (if known to you) as part of First Course of Treatment.

Hormone Therapy -- At This Facility

NAACCR Version 10 field "RX Hosp--Hormone", Item 710, column 466-467

Using the code table above, report just the First Course of Therapy Hormone Therapy received at your facility. Include treatment given in a staff physician's office (if known to you).

Hormone Therapy -- Date Started

NAACCR Version 10 field "RX Date--Hormone", Item 1230, columns 811-818

See the Treatment Date instructions on page 172. The MCR collects individual Systemic Treatment start dates. Code **88888888** may be used when Hormone Therapy has not started. If the first "hormone therapy" was an Endocrine Procedure, please record its date here.

Hormone Therapy -- Narrative

NAACCR Version 10 field "RX Text--Hormone", Item 2650, columns 5125-5324

This field may contain up to 200 characters. See the Treatment Text instructions on page 172. If the Hormone Therapy date reported is estimated, note that here. In addition to Hormone Therapy agents used, include narrative for First-Course Endocrine Procedures (surgery/
radiation) here. If Hormone Therapy and/or an Endocrine Procedure was planned or recommended as part of First-Course Therapy but it was not carried out, record the reason why. Describe Palliative Hormone Therapy and palliative Endocrine Procedures here.

IMMUNOTHERAPY

Immunotherapy (biological response modifier therapy, BRM) consists of biological or chemical agents that alter the immune system or change a patient's response to tumor cells. Code only Immunotherapy that the patient receives as part of First Course of Therapy. If Immunotherapy should be given for purely palliative reasons and it modifies cancer cells/tissue, code it in the Palliative Care fields AND here. *Procedures* done to alter the immune system (such as a bone marrow transplant) are coded under Hematologic Transplants.

Refer to the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed*. (1993), pages 55-67 (plus updates) for a complete list of Immunotherapy agents. They include:

- bacillus Calmette-Guérin vaccine (BCG, TheraCys, Tice)*
- Bevacizumab (Avastin)
- C-Parvum
- Gefitinib (Iressa)
- Imiquimod (Aldara)
- Interferons
- Interleukins
- Levamisole (Ergamisol)
- MVE-2
- Pegaspargase (Oncaspar)
- Pyran copolymer
- Rituximab (Rituxan)
- Thymosin
- Trastuzumab (Herceptin)
- vaccine therapy
- virus therapy

* BCG or other Immunotherapy for bladder cancer delivered via surgical installation is also coded in Surgery of Primary Site (**16**) unless more extensive bladder surgery occurred. Other types of bladder cancer intravesical therapy (e.g., Chemotherapy or Other Therapy) with surgical installation is also coded as Surgery of Primary Site (**15**) unless more extensive bladder surgery occurred.

Note: *Book 8* lists Epoetin Alfa (Epogen, Procrit), Filgrastim (Neupogen) and Octreotide (Sandostatin) as BRM agents, but errata issued by SEER corrected these to the ancillary drug category. Epogen, Neupogen and Sandostatin should not normally be coded in any First Course of Treatment modality, although they may be given for Palliative Care. (April Fritz has allowed that Sandostatin may be considered Hormone Therapy for neuroendocrine tumors of the pancreas). *Book 8* also lists Pentostatin and L-Asparaginase as BRM agents, but SEER errata corrected these to be Chemotherapy agents. Ibritumomab tiuxetan (Zevalin) delivers radiation via a monoclonal antibody agent, and SEER specifies that this should be coded as a radioisotope under Radiation Therapy *only*; Tositumomab (Bexxar) and iodine-labeled immunoglobin are similar agents. Monoclonal antibodies may also be used to deliver Chemotherapy agents (Gleevec, Mylotarg); these are coded under Chemotherapy only.

Record any First-Course Treatment Immunotherapy done with code **01**. If Immunotherapy is normally recommended for this type of cancer and stage of disease but Immunotherapy was *not* done, code the reason why (**82-87**). Use the following codes for Immunotherapy:

No Immunotherapy given because it was not planned/recommended; it is not usually planned/recommended for this type/stage of cancer; multiple treatment types were offered and something other than Immunotherapy was chosen; autopsy-only case	**00**
Immunotherapy given.	**01**
Immunotherapy not recommended/given because it was contraindicated (comorbidities, advanced age, etc.).	**82**
Immunotherapy recommended/planned but not given because patient died.	**85**
Immunotherapy recommended/planned but not given; the reason is not known.	**86**
Immunotherapy refused.*	**87**
Immunotherapy recommended, but unknown if given.	**88**
unknown if Immunotherapy recommended or given; unknown if Immunotherapy is normally recommended for this type of case; death certificate-only case	**99**

* Code **87** includes the following situations: Immunotherapy is normally recommended for this type of cancer and stage of disease but…

patient/family/guardian refused the recommended Immunotherapy; or

there was a blanket refusal of all recommended treatment; or

all/any treatment was refused before any specific recommendations were made.

Immunotherapy -- Summary

NAACCR Version 10 field "RX Summ--BRM", Item 1410, column 882-883

Using the code table on the preceding page, record all First Course of Therapy Immunotherapy done at your institution, and at all other institutions if known to you.

Immunotherapy -- At This Facility

NAACCR Version 10 field "RX Hosp--BRM", Item 720, column 468-469

Using the code table on the preceding page, record just the Immunotherapy done at your facility. Include treatment given in a staff physician's office (if known to you).

Immunotherapy -- Date Started

NAACCR Version 10 field "RX Date--BRM", Item 1240, columns 819-826

See the Treatment Date instructions on page 172. The MCR continues to collect individual Systemic Treatment start dates at this time. The special code **88888888** may be used here when Immunotherapy has not yet started. If the first "immunotherapy" received was a Hematologic Transplant, please record its date here.

Immunotherapy -- Narrative

NAACCR Version 10 field "RX Text--BRM", Item 2660, columns 5325-5424

This field may contain up to 100 characters. See the Treatment Text instructions on page 172. If the Immunotherapy Date reported is an estimate, note that here.

Include the start date, Immunotherapy agents given, and Hematologic Transplants that are coded under Hematologic Transplants & Endocrine Procedures. If Immunotherapy or a Hematologic Transplant was planned or recommended as part of First-Course Therapy but were not carried out, please record the reason why. Palliative Immunotherapy and palliative Hematologic Transplant procedures should be described here.

HEMATOLOGIC TRANSPLANTS & ENDOCRINE PROCEDURES

Immunotherapy and Hormone Therapy procedures done to alter the patient's immunologic system or hormone balance are coded separately from drugs or agents administered to produce these effects. Bone marrow transplants, stem cell transplants, endocrine surgery and endocrine radiation are included. Bone marrow and stem cell transplants are intended to help a patient recover from myelosuppression or bone marrow ablation caused by high-dose Chemotherapy and/or Radiation.

Endocrine therapy achieves antitumor effects by using surgery or radiation to suppress hormonal activity, thereby controlling tumor growth. For reporting purposes, endocrine surgery/radiation is defined as the total removal/irradiation of an endocrine gland (*both* glands or all of one remaining gland for paired glands). Record endocrine surgery/radiation for treatment of cancer of the breast or prostate only. Endocrine surgical procedures are adrenalectomy, hypophysectomy, oophorectomy and orchiectomy. For breast and prostate cancers, record any radiation to endocrine glands to affect hormone balance. The codes do not distinguish endocrine surgery from radiation.

If cancer is incidentally found in a gland that was removed in an Endocrine Procedure, record the procedure as Surgery of Other Site also. (For example, if the testes are removed as endocrine therapy for a prostate cancer patient and it is discovered that the cancer had spread there, record **30** for the Endocrine Procedure and **4** for Surgery of Other Site.)

The date of a Hematologic Transplant usually follows Chemotherapy, so its date will not ordinarily be recorded in Systemic Therapy -- Date Started. Record the date of a Hematologic Transplant in the Immunotherapy -- Date Started field (when it was the first "immunotherapy" given) and in the Immunotherapy -- Narrative field. If an Endocrine Procedure is the first or only systemic therapy received, record its start date in Systemic Therapy -- Date Started and in the Hormone Therapy -- Date Started field (when it was the first "hormone therapy" given).

There is not a separate text field for these procedures. Record the supporting text for Hematologic Transplants in the Immunotherapy -- Narrative field. Record supporting text for Endocrine Procedures in the Hormone Therapy -- Narrative field.

Hematologic Transplants & Endocrine Procedures

NAACCR Version 10 field "RX Summ--Transplnt/Endocr", Item 3250, columns 876-877

This field records First-Course Treatments formerly coded as Immunotherapy (bone marrow and stem cell transplants) and Hormone Therapy (endocrine radiation and surgery). The reason why such recommended procedures were not given is also coded here. There are not separate Summary and At-This-Facility fields, so this is essentially a Summary field. Record

all Hematologic Transplants & Endocrine Procedures known to you, whether or not done at your facility.

Codes **82-99** apply to Hematologic Transplants and/or Endocrine Procedures. Codes **82-87** record a reason why a Hematologic Transplant and/or Endocrine Procedure was not done for cases in which one of these would normally be recommended. The codes follow:

No Hematologic Transplant and no Endocrine Procedure done because they are not normally done for this type of cancer/stage of disease; multiple treatment types were offered and something other than the Transplant and/or Endocrine Procedure was chosen; autopsy-only case	**00**
bone marrow transplant, NOS	**10**
autologous bone marrow transplant (from patient)	**11**
allogeneic bone marrow transplant (from other person); syngeneic bone marrow transplant (from patient's identical twin)	**12**
stem cell transplant; stem cell harvest and infusion	**20**
endocrine surgery and/or endocrine radiation	**30**
Hematologic Transplant (**10-20**) AND Endocrine Procedure (**30**)	**40**
Transplant/Endocrine Procedure not recommended/done because of contraindications (such as comorbid conditions or age).	**82**
Transplant/Endocrine Procedure recommended/planned but not done because the patient died.	**85**
Transplant/Endocrine Procedure recommended but not done; no reason recorded.	**86**
Transplant/Endocrine Procedure recommended but refused by patient/ family/guardian.*	**87**
Transplant/Endocrine Procedure recommended, but unknown if done during First Course of Treatment.	**88**
unknown if Hematologic Transplant and/or Endocrine Procedure recommended; unknown if a Transplant or Endocrine Procedure is usually done for the given type/stage of cancer; death certificate-only case	**99**

* Code **87** includes situations in which a Hematologic Transplant and/or Endocrine Procedure would normally be recommended for the given cancer type and stage of disease, but….

the patient/family/guardian refused the recommended procedure; or

a blanket refusal of all recommended treatments was made; or

any/all treatment was refused before any specific recommendations could be made.

OTHER THERAPY

Other Therapy includes treatments given as part of First Course of Therapy designed to modify or control cancer cells (cancer-directed) that are not defined in the other modality fields. Other Therapy which is given for palliative purposes should be coded as Palliative Care AND here.

Examples:

- tumor embolization (arterial block) if the intent is to kill tumor cells (This applies only to physical embolization. *Chemo*embolization is coded under Chemotherapy and, for liver and intrahepatic bile duct cancers, as Surgery of Primary Site; *chemo*embolization of liver metastases may be coded under Surgery of Other Sites and Chemotherapy.)
- hyperbaric oxygen (as an adjunct to definitive treatment)
- hyperthermia (given alone or in combination with Chemotherapy, as in isolated heated limb perfusion for melanoma)
- PUVA (psoralen and ultraviolet light therapy); photopheresis
- antibiotic to treat bacterial infection related to a cancer (as in *Helicobacter pylori* related to a stomach cancer or stomach lymphoma)
- any cancer-directed experimental drug that cannot be classified as Chemotherapy, Hormone Therapy or Immunotherapy (code **2**), including Angiostatin, Endostatin, Marmistat and Thalidomide when used as anti-angiogenesis agents. (If an experimental drug *can* be classified as Chemotherapy, Hormone Therapy, etc. based on its mechanism of action, code it in the appropriate treatment modality rather than as Other Therapy.)
- double-blind clinical trial information where the type of agent administered is unknown and/or there is use of a placebo (code **3**). After the code is broken, report the treatment under the appropriate modality (e.g., if the agent is revealed to be a Chemotherapy agent, code it as Chemotherapy and delete the Other Therapy code that had been applied temporarily). (To report changes to data already submitted to the MCR, call a cancer registrar at 617-988-3382 or 617-988-3381). If a clinical trial patient is known to receive a drug that *can* be classified as Chemotherapy, Hormone Therapy, etc., code this in the appropriate treatment modality field rather than as Other Therapy.
- unorthodox and unproven treatments if these are the *only* treatment received (code **6**). These include but are not limited to: Laetrile, Krebiozen, Iscador; acupuncture/ pressure; homeopathic or herbal medicine, nutritional supplements; bioelectromagnetic applications; relaxation techniques, humor therapy. If a patient receives a combination of unorthodox treatments in addition to therapeutic Surgery, Radiation, Chemotherapy, Hormone Therapy, Immunotherapy, Hematologic Transplant or Endocrine Procedure, then do *not* code the unorthodox treatments. See the *SEER Program Code Manual*, *3rd Ed*. (1998), pages 140-141, for a fuller discussion of kinds of Other Therapy.

{Do *not* code ancillary drugs and differentiation-inducing agents (non cancer-directed drugs) as Other therapy. Ancillary drugs are NOT treating cancer. Differentiation-inducing agents may be given to try to prevent recurrences or the transition of slightly abnormal cells into full-fledged cancer. Record ancillary drugs under Palliative Care (code **7**) when appropriate. Also include the names, start dates, etc. of ancillary drugs and differentiation-inducing agents in a treatment Narrative field. Examples are Allopurinol, Aredia**, Epogen*, G-CSF (granulocyte colony stimulating factor), Leucovorin, Neupogen* and Sandostatin*.
Note: This is a partial list. Refer to the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed.*, pages 35-46 plus updates, for a more complete listing.

* Epogen (Procrit), Neupogen and Sandostatin were incorrectly listed in *Book 8* as BRM agents. SEER errata corrected these listings to the "ancillary" drug category. If used for palliative purposes, code them under Palliative Care (**7**). April Fritz has allowed that Sandostatin may be considered Hormone Therapy for neuroendocrine tumors of the pancreas.

** Aredia (Pamidronate Disodium) is not listed in *Book 8*, but SEER issued updates which stated that this should be classified as an ancillary drug.}

Special Rules for Hematopoietic Diseases

For many of the hematopoietic diseases that became reportable for diagnoses made as of 2001 (such as refractory anemias), the principal treatment given may not meet the standard definition of cancer therapy. The following treatments may be recorded as Other Therapy for "newly reportable" hematopoietic diseases diagnosed after January 1, 2001 only:

- blood transfusion [of whole blood, red blood cells (RBC), platelets, fresh frozen plasma (FFP); includes cryoprecipitation, plasmapheresis, plateletpheresis]
- phlebotomy (blood removal, bloodletting, venesection)
- aspirin* [acetylsalicylic acid (ASA)]
- supportive care (when the disease has no standard treatment; actually rarely coded under SEER guidelines)
- observation (watchful waiting)

* especially used to treat essential thrombocythemia; if the *reason* aspirin is given is not recorded, use the following guidelines:

if low-dose (70-100 mg/day), assume this is intended to thin the blood to help treat the disease and *record this* as Other Therapy;

if dosage is at least 160 mg/day but is not as high as the category below, assume this is for cardiovascular protection and do *not* code as Other Therapy;

if dose is higher (325-1000 mg every 3-4 hours), assume this is for pain control and do *not* record as Other Therapy; (record in Palliative Care as pain management).

Refer to SEER's orange booklet, *Abstracting and Coding Guide for the Hematopoietic Diseases*, for more specific guidance on what to record for a given disease. (But note that this booklet was published in 2002, so it uses *ROADS* rather than *FORDS* treatment codes and categories.) Do NOT code a treatment listed on the previous page for a lymphoma or leukemia/other hematologic disease which has been reportable for many years (i.e., was reportable under ICD-O-2 and still is under ICD-O-3). These rules only apply to hematopoietic diseases which became newly reportable under ICD-O-3. Do NOT record these treatments for newly reportable diseases diagnosed before 2001.

Examples: Waldenstrom macroglobulinemia diagnosed in 2003, patient receiving transfusions -- Do *not* code the transfusions here because the disease is not "newly reportable".

Refractory anemia first diagnosed in 2000, patient receiving transfusions in 2001 -- Do *not* code the transfusions here because the anemia was not reportable at diagnosis.

Refractory anemia diagnosed in 2003, receiving transfusions. -- Record **1**.

Standard therapy for hematopoietic diseases (Surgery, Radiation, Chemotherapy, etc.) such as phosphorus (P)-32 Radiation for polycythemia vera or splenectomy for myelofibrosis should be recorded as usual in the appropriate treatment modality categories.

The distinction between palliation and cancer treatment may be especially unclear for the hematopoietic diseases. Consult with physicians when necessary.

Use the following codes for Other Therapy:

no Other Therapy given; autopsy-only case	**0**
Other Therapy, NOS; non-standard treatments for newly reportable hematopoietic diseases	**1**
Other *experimental* Therapy (not included elsewhere)	**2**
double-blind clinical trial, code not yet broken (Code and report* the treatment actually given when revealed.)	**3**
only unproven therapy/therapies given (includes Laetrile, Krebiozen, treatment given by nonmedical personnel, etc.)	**6**
patient/guardian refused therapy which, if given, would have been coded as **1-3**	**7**
Other Therapy recommended, but unknown if administered	**8**
unknown** if Other Therapy recommended or given; death certificate-only case	**9**

* Call us (617-988-3382 or 617-988-3381) to report changes to case reports already submitted.

** There is reason to believe that Other Therapy was recommended or given, but there's no information to confirm this.

Other Therapy -- Summary NAACCR Version 10 field "RX Summ--Other", Item 1420, column 884

Using the code table, record Other Therapy received by the patient as part of First-Course Therapy. Record all procedures done at your institution and all others (if known).

Other Therapy -- At This Facility NAACCR Version 10 field "RX Hosp--Other", Item 730, column 470

Using the code table, record only Other Therapy given at your facility. Include treatment given in a staff physician's office (if available).

Other Therapy -- Date Started

NAACCR Version 10 field "RX Date--Other", Item 1250, columns 827-834

See the Treatment Date instructions on page 172 and the discussion of what constitutes Other Therapy on pages 207-209.

Other Therapy -- Narrative

NAACCR Version 10 field "RX Text--Other", Item 2670, columns 5425-5524

This field holds up to 100 characters. See the Treatment Text instructions on page 172 and the discussion of what constitutes Other Therapy on pages 207-209.

PALLIATIVE CARE

Palliative Care is not therapeutic and is not done for diagnostic or staging purposes. These items record procedures done during the First Course of Treatment time period to prolong a patient's life by managing symptoms (symptomatic care), to relieve pain and/or to make the patient more comfortable. Palliative Care treats the *patient* rather than the cancer. Consult a physician if you can't determine whether a certain procedure was done as treatment or for palliative purposes.

Palliative Care may be given during or instead of First Course of Treatment. Do NOT record Palliative Care planned or given after First Course of Treatment ends.

For Palliative Care that also falls under a standard treatment modality (Surgery, Radiation, Chemotherapy, Hormone Therapy, Immunotherapy, Hematologic Transplants & Endocrine Procedures, Other Therapy) that removes, destroys or modifies cancer cells/tissue, code this as Palliative Care AND as treatment. Some Palliative Care (such as surgical placement of a drainage shunt, pain management methods and ancillary drugs) will ONLY be coded here.

When First-Course Treatment AND Palliative Care in a given modality are both given, do NOT record the Palliative Care.

Example: Radiation is given to the primary site and to painful bone metastases. Record the therapeutic Radiation, but do NOT record the palliative radiation.

Some ancillary drugs may be used for symptom relief. Record such use with code **7**.

The Palliative Care codes follow:

no Palliative Care; autopsy-only case	**0**
Palliative Surgery	**1**
Palliative Radiation	**2**
Palliative Chemotherapy, Hormone Therapy or other systemic drug(s)	**3**
pain management* (given or referred) with no other Palliative Care	**4**
combination Palliative Care without pain management* (**1**, **2** and/or **3**, without **4**)	**5**
combination Palliative Care with pain management* (**1**, **2** and/or **3**, with **4**)	**6**
Palliative Care, NOS (unknown type or some type other than **1-6**); Palliative ancillary drug use	**7**
cancer type/stage would probably receive Palliative Care, but it's unknown if Palliative Care was performed or referred; death certificate-only case	**9**

* "Pain management" may include non-standard (unorthodox) techniques to relieve a patient's pain.

Palliative Care -- Summary

NAACCR Version 10 field "RX Summ--Palliative Proc", Item 3270, column 871

Record First-Course Palliative Care given at your facility and elsewhere using the code table.

Palliative Care -- At This Facility

NAACCR Version 10 field "RX Hosp--Palliative Proc", Item 3280, column 473

Record First-Course Palliative Care given at your facility using the code table. Include any given in a staff physician's office if known to you.

There are NOT specific start date and narrative fields for Palliative Care. Please note the start date and supportive text for Palliative Care in the corresponding treatment narrative field (for example, use the Chemotherapy -- Narrative field to support palliative chemotherapy codes). For types of Palliative Care not falling into a standard treatment modality, please use the Other Therapy -- Narrative field or some other MCR-collected text field.

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FIRST RECURRENCE

See the **REPORTABILITY** section (pages 8-10) for the situations in which a cancer recurrence is reportable to the MCR. If you are *not* going to report MCR-reportable recurrences as new primaries (new abstract records), then the fields Type of First Recurrence and Date of First Recurrence should be used to submit MCR-reportable recurrences. (Users of the MCR-CIMS Satellite system cannot at this time use these fields if the original *in-situ* case was already submitted to the MCR.) There must be a clinically disease-free interval between the *in-situ* case and the recurrence. At least two months must pass between the two diagnoses. Only the *first* invasive recurrence of an *in-situ* cancer is MCR-reportable.

Example: A non-invasive transitional cell carcinoma of the bladder is diagnosed in January 2001 and successfully treated. Invasive recurrences of this cancer are found in January 2002 and January 2003. The original 2001 diagnosis and the first invasive recurrence (2002) are reportable to the MCR. Any subsequent recurrences are *not* MCR-reportable.

Type of First Recurrence

NAACCR Version 10 field "Recurrence Type--1st", Item 1880, columns 1353-1354

Use the highest applicable code number. Only the following codes are reportable to the MCR:

local recurrence, NOS, of an *in-situ* tumor	**16**
local and trocar* recurrence of an *in-situ* tumor	**17**
regional recurrence, NOS, of an *in situ* tumor	**26**
regional recurrence of an *in-situ* tumor -- in adjacent tissues or organs and in regional lymph nodes	**27**
regional recurrence of an *in-situ* tumor -- in adjacent tissues or organs and/or regional lymph nodes and a local and/or trocar* recurrence [(**26** or **27**) with (**16** or **17**)]	**36**
distant recurrence of an *in-situ* tumor	**46**

* along the path of a medical instrument, including the site of an incision for its insertion/extraction

Date of First Recurrence

NAACCR Version 10 field "Recurrence Date -- 1st", Item 1860, columns 1342-1349

For the MCR, record the date on which a medical practitioner diagnosed a first invasive recurrence of an *in-situ* (non-invasive) cancer. This should correspond to the disease coded under Type of First Recurrence. Use MMDDCCYY format. Estimate the recurrence diagnosis

date if necessary in the same manner used for other date fields. If an unsuspected invasive recurrence of a non-invasive cancer is found on autopsy after two months, record **00000000**.

Date of Last Contact

NAACCR Version 10 Item 1750, columns 1294-1301

Enter the date, in MMDDCCYY format, of last contact with the patient. This is not limited to contact between *your* facility and the patient; for example, if your facility's last contact was in March but you know the patient was seen elsewhere in April, then the April date should be filled in. For hospitals without follow-up registries, the date entered in this field is probably your facility's discharge date.

Follow-up registries are requested to enter the Date of Last Contact learned from follow-up efforts through your submission of the case to the MCR. If no follow-up information has been received by the time the case is abstracted, enter the date discharged from the hospital. Do not use the date that information was received in the mail, nor the date information was requested from a patient, physician or other follow-up source.

If the patient is dead, this field records the date of death.

Never use the code for unknown year (**9999**), and do not leave this field empty. You may use the unknown codes for month and day (**99**) if necessary.

Vital Status

NAACCR Version 10 Item 1760, column 1302

Enter the patient's Vital Status as of the date entered in Date of Last Contact. Remember that if the patient has died, the Date of Last Contact should contain the date of death. Use the most accurate information available. Use the following codes:

Status	Code
dead	**0**
alive	**1**

Place of Death

NAACCR Version 10 Item 1940, columns 1394-1396

If the patient has died, enter the code for the U.S. state, Canadian province, or country where the death occurred. Use the codes for Birthplace (Appendix A). (The Massachusetts code is **005**.)

If you know that the patient is dead but you don't know where the death occurred, enter **999**.

If the patient is alive as of the Date of Last Contact, enter **997** -- do not leave this field empty.

Comments / Narrative Remarks

NAACCR Version 10 field "Text--Remarks", Item 2680, columns 5525-5874

This is a free text field holding up to 350 characters*. It should be used to communicate any details about a case that would help the MCR staff to understand its particulars. Is there anything especially noteworthy about the case? Clear up anything that you know we might have to question. Tell us anything about the case that you think is important for us to know, and that is not recorded elsewhere in the fields that we collect. Note when over-rideable edits have been verified. Avoid a call from the MCR by using this field!

For example, this field may contain:

- overflow text from other Narrative fields;
- the patient's own cancer history (known primaries dating from before and after the case that you're reporting); multiple tumors being reported simultaneously
- verification of an unusual primary site/histology combination;
- verification of an unusual behavior/histology or behavior/stage combination;
- verification of an unusual age/diagnosis combination;
- verification of an unusual gender/first name combination;
- notes about a diagnosis that was uncertain as to primary site or histology;
- notes about any uncertain dates that you have had to estimate;
- details about the patient's address that might be important to the central registry -- such as whether the patient was homeless or was from another state or foreign country (tell us the country here); if the only address you had for the patient was a *current* rather than at-diagnosis address, please tell us that here if you filled a Current Address into the At-Diagnosis Address fields.

NAACCR also provides suggestions for further code-supporting information that can be included here (if not already recorded in other text fields collected by the MCR):

- patient tobacco history
- patient birthplace
- patient marital status

Please do NOT record sensitive patient information that does not concern the central registry in this field! For example, information on HIV or AIDS status, alcohol or other drug abuse, mental illness, venereal disease, hepatitis and family cancer history do not belong in a data item collected by the MCR. If you wish to record such information on your data system, use a field that is not collected by the MCR.

* For the CIMS Satellite system, the field can contain no more than 200 characters.

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SECTION VII - CASE ADMINISTRATION / METADATA

Date Case Completed

NAACCR Version 10 Item 2090, columns 1174-1181

Record the date that the case was completed and passed all edits that were applied at the hospital level. The date should be recorded in MMDDCCYY format.

For facilities reporting cases to the MCR on paper abstracts or via the CIMS Satellite system, please fill in the date on which you finished abstracting the case.

Date Case Report Exported

NAACCR Version 10 Item 2110, columns 1190-1197

(This field does not apply to facilities reporting cases to the MCR on paper abstracts.)

This field records the date on which the electronic abstract was exported from your data system to a file for transmission to the central registry. As with all dates, it is recorded in MMDDCCYY format. Your data system probably fills in this date automatically.

Vendor Name / Version Number

NAACCR Version 10 field "Vendor Name", Item 2170, columns 1204-1213

(This field does not apply to facilities reporting cases to the MCR on paper abstracts.)

This field is used by the MCR to track which vendor and software version submitted the case. It helps define the source and extent of a problem discovered in data sent by a software provider.

This field should be filled automatically by your data system. It records the name of the computer services vendor who programmed the system submitting the data. The software version number should be included. This field holds up to 10 alphanumeric characters.

Example: Version 3 of the CanDo Registry System might appear as "Cando V3"

Date Case Report Received

NAACCR Version 10 Item 2111, columns 1219-1226

[This field is not collected from your electronic case records. The MCR records the date on which we receive each data submission in our offices.]

These fields provide information about the type of records being received or the types of codes that are stored in a case record. It can be important for the data recipient to know if code conversions have taken place, especially during times of layout or coding transitions when different reporting facilities may be in different stages of conversion. The MCR normally knows the types of codes it will receive from regular data reporters like hospitals using software vendors, but data received from non-hospital sources may contain unexpected code types. Your data system probably fills these fields automatically.

Record Type

NAACCR Version 10 Item 10, column 1

This field documents the type and length of NAACCR record being received. The MCR accepts records of Type **A** (case abstracts). At this time, the MCR accepts records of Type **M** (modifications) *only* for recurrences that are reportable to the MCR. Aside from reporting the First Type of Recurrence fields for MCR-reportable recurrences, please do not send **M** records for changes to data already submitted to the MCR.

NAACCR Record Version

NAACCR Version 10 Item 50, column 19

This field specifies the NAACCR layout version of the record being received. The MCR accepts only records in Version 10 or 10.1 at this time. The appropriate code for both versions is **A**.

Morphology Coding System -- Current

NAACCR Version 10 field "Morph Coding Sys--Current", Item 470, column 309

This field describes the type of morphology codes that are in the record received. Complete codes appear on page 230 of the *FORDS* Manual, but the MCR expects to receive only codes **7** (for ICD-O-3) or **6** (final version of the ICD-O-2) for most diagnosis years we now receive.

Morphology Coding System -- Original

NAACCR Version 10 field "Morph Coding Sys--Originl", Item 480, column 310

This field describes the type of morphology codes that were in an exported record when it was on your data system. Complete codes appear on page 231 of the *FORDS* Manual, but the MCR expects to receive only codes **7** (for ICD-O-3) or **6** (for final version of the ICD-O-2) for most diagnosis years we now receive.

Coding System for EOD

NAACCR Version 10 Item 870, column 562

This field is optional. It defines the instructions and codes used for EOD coding (if you submit EOD coding to the MCR). We would expect to receive code **4** for current EOD coding. EOD coding will not be collected by the MCR beginning in 2004.

COC Coding System -- Current

NAACCR Version 10 field "COC Coding Sys--Current", Item 2140, columns 1200-1201

The code in this field describes the type of COC codes the MCR is receiving in the case record (referring to COC fields that do not have their own metadata fields). If your data system has undergone a conversion or your software performed code conversions when the case record was exported, the codes we receive may not be identical to those on your system.

The *FORDS* Manual (p. 222) contains the complete set of codes used in this field. The code the MCR expects to receive for Version 10 or 10.1 records is **08** (for *FORDS* Manual codes).

Receipt of code **07** (updated *ROADS* Manual codes) or other codes will cause us to question whether we can correctly interpret the data received.

COC Coding System -- Original

NAACCR Version 10 field "COC Coding Sys--Original", Item 2150, columns 1202-1203

This field records the type of codes originally entered on your data system for COC fields. The complete set of codes is available in the *FORDS* Manual (p. 224). The codes the MCR expects to receive for most Version 10 and 10.1 records are:

ROADS Manual codes (1998 revisions and later updates)	**07**
FORDS Manual codes	**08**

Treatment Coding System -- Current

NAACCR Version 10 field "RX Coding System--Current", Item 1460, columns 888-889

This field specifies the type of codes in the treatment fields in a case record received at the MCR. (It does not refer to the *"ROADS"* surgery fields required for pre-2003 diagnoses.) The complete set of codes can be found in the *FORDS* Manual, p. 235. Given that pre-2003 diagnoses should have been converted to *FORDS* coding, the code we expect to receive for 2004, 2003 and earlier diagnoses is **06** (for *FORDS* Manual codes).

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Appendix A

Codes for Data Fields

"Birthplace" and

"Place of Death"

BIRTHPLACE and PLACE OF DEATH Codes -- *numerical list*

CONTINENTAL UNITED STATES and HAWAII

Codes for the United States are by section of the country. The second digit represents the first digit of the ZIP Code. For convenience, U.S. postal abbreviations are shown in square brackets, but remember that "Birthplace" and "Place of Death" hold the *numeric* codes shown at the left.

000 United States, NOS

001 Northeast states, NOS; New England, NOS

002 Maine [ME]
003 New Hampshire [NH]
004 Vermont [VT]
005 Massachusetts [MA]
006 Rhode Island [RI]
007 Connecticut [CT]
008 New Jersey [NJ]

010 North Mid-Atlantic states, NOS

011 New York [NY]
014 Pennsylvania [PA]
017 Delaware [DE]

020 South Mid-Atlantic states, NOS

021 Maryland [MD]
022 District of Columbia [DC]; Washington, DC
023 Virginia [VA]
024 West Virginia [WV]
025 North Carolina [NC]
026 South Carolina [SC]

030 Southeastern states, NOS

031 Tennessee [TN]
033 Georgia [GA]
035 Florida [FL]
037 Alabama [AL]
039 Mississippi [MS]

040 North Central states, NOS

041 Michigan [MI]
043 Ohio [OH]
045 Indiana [IN]
047 Kentucky [KY]

050 Northern Midwest states, NOS

051 Wisconsin [WI]
052 Minnesota [MN]
053 Iowa [IA]
054 North Dakota [ND]
055 South Dakota [SD]
056 Montana [MT]

060 Central Midwest states, NOS

061 Illinois [IL]
063 Missouri [MO]
065 Kansas [KS]
067 Nebraska [NE]

070 Southern Midwest states, NOS

071 Arkansas [AR]
073 Louisiana [LA]
075 Oklahoma [OK]
077 Texas [TX]

080 Mountain states, NOS

081 Idaho [ID]
082 Wyoming [WY]
083 Colorado [CO]
084 Utah [UT]
085 Nevada [NV]
086 New Mexico [NM]
087 Arizona [AZ]

090 Pacific Coast states, NOS

091 Alaska [AK]
093 Washington [WA]
095 Oregon [OR]
097 California [CA]
099 Hawaii [HI]

UNITED STATES POSSESSIONS

When these codes were originally assigned during the 1970's, the United States owned or controlled islands in the Pacific. Many of these islands have been either granted independence or control has been returned to another country. To be consistent, these islands are still coded to the original codes. The names have been annotated to indicate the new political designation. Some US Postal abbreviations are shown in square brackets for convenience, but remember that "Birthplace" and "Place of Death" hold the *numeric* codes shown at the left.

100 Atlantic/Caribbean area, U.S. possessions, NOS

101 Puerto Rico [PR]

102 U.S. Virgin Islands [VI]

109 other Atlantic/Caribbean area

See codes **240** - **249** for non-U.S. possessions in this region.

110 Canal Zone

120 Pacific area, U.S. possessions, NOS

121 American Samoa [AS]

122 Kiribati; Canton and Enderbury Islands; Gilbert Islands; Phoenix Islands; Southern Line Islands

123 Micronesia*, Federated States of [FM]; Caroline Islands (Trust Territory of Pacific Islands)

124 Cook Islands (New Zealand)

125 Tuvalu; Ellice Islands

126 Guam [GU]

127 Johnston Atoll

129 Mariana Islands [MP], Northern (Trust Territory of Pacific Islands)

131 Marshall Islands [MH] (Trust Territory of Pacific Islands)

132 Midway Islands

133 Nampo-Shoto, Southern

134 Ryukyu Islands (Japan)

135 Swan Islands

136 Tokelau Islands (New Zealand)

137 Wake Island

139 Palau [PW] (Belau) (Trust Territory of Pacific Islands)

See codes **711** - **725** for non-U.S. possessions in this region.

* Do not confuse with code **723** (=Micronesian Islands, *not* U.S. possession)

NORTH and SOUTH AMERICA, Exclusive of the U.S. and its Possessions

210 Greenland

220 Canada, NOS (Canadian postal abbreviations for provinces/territories are shown in square brackets.)

221 Labrador [NL]; Maritime provinces; New Brunswick [NB]; Newfoundland [NL]; Nova Scotia [NS]; Prince Edward Island [PE]

222 Quebec [QC]

223 Ontario [ON]

224 Prairie provinces; Alberta [AB]; Manitoba [MB]; Saskatchewan [SK]

225 Northwest Territories [NT]; Yukon Territory [YT]

226 British Columbia [BC]

227 Nunavut [NU]

230 Mexico

240 North American Islands, NOS

241 Cuba

242 Haiti

243 Dominican Republic

244 Jamaica

245 other Caribbean islands; Anguilla; Antigua; Antilles, NOS; Aruba; Barbados; Barbuda; British Virgin Islands; British West Indies; Caicos Islands; Caribbean, NOS; Cayman Islands; Curacao; Dominica; French West Indies; Grenada; Grenadines; Guadeloupe; Leeward Islands, NOS; Martinique; Montserrat; Netherlands Antilles; Nevis; St. Christopher-Nevis; St. Kitts; St. Lucia; St. Vincent; Tobago; Trinidad; Turks Islands; West Indies, NOS; Windward Islands, NOS

246 Bermuda

247 Bahamas

249 Miquelon; St. Pierre

250 Central America, NOS

251 Guatemala

252 Belize; British Honduras

253 Honduras, NOS

254 El Salvador

255 Nicaragua

256 Costa Rica

257 Panama

260 North America, NOS

265 Latin America, NOS

300 South America, NOS

311 Colombia

321 Venezuela

331 Guyana; British Guiana

332 Surinam; Dutch Guiana; Netherlands Guiana

333 French Guiana

341 Brazil

345 Ecuador; Galapagos Islands

351 Peru

355 Bolivia

361 Chile

365 Argentina

371 Paraguay

375 Uruguay

380 Other South American islands

381 Falkland Islands

EUROPE

Europe, NOS (See code **499**.)

400 United Kingdom, NOS; Great Britain, NOS

401 England; Channel Islands; Guernsey; Isle of Man; Jersey

402 Wales

403 Scotland; Orkney Islands; Shetland Islands

404 Northern Ireland; Ulster

410 Ireland, NOS; Eire; Republic of Ireland

420 Scandinavia, NOS; Lapland, NOS

421 Iceland

423 Norway; Jan Mayen; Svalbard

425 Denmark; Faeroe (Faroe) Islands

427 Sweden

429 Finland

430 Germanic countries, NOS

431 Germany (East and West); Bavaria; Federal Republic of Germany; German Democratic Republic

432 Netherlands; Holland

433 Belgium

434 Luxembourg

435 Switzerland

436 Austria

437 Liechtenstein

440 Romance-language countries, NOS

441 France; Corsica; Monaco

443 Spain; Andorra; Balearic Islands; Canary Islands

445 Portugal; Azores; Cape Verde Islands; Madeira Islands

447 Italy; Holy See; San Marino; Sardinia; Sicily; Vatican City

449 Romania (Rumania); Dobruja; Romanian Moldavia; Transylvania; Wallachia

450 Slavic countries, NOS

451 Poland

452 former Czechoslovakia region; Bohemia; Czech Republic; Moravia; Slovak Republic; Slovakia

453 former Yugoslavia region; Bosnia-Herzogovina; Croatia; Dalmatia; Macedonia; Montenegro; Serbia; Slavonia; Slovenia

454 Bulgaria

455 Russia, NOS; former Russian Federation S.F.S.R.; former U.S.S.R., NOS

456 Moldavia, NOS; Ukraine; Bessarabia; former Moldavian S.S.R.; former Ukrainian S.S.R.; former U.S.S.R. Moldavia

457 Belarus; former Byelorussian S.S.R.; White Russia

458 Estonia; former Estonian S.S.R.

459 Latvia; former Latvian S.S.R.

461 Lithuania; former Lithuanian S.S.R.

463 Baltic Republic(s), NOS; Baltic State(s), NOS

470 Other mainland Europe, NOS

471 Crete; Greece

475 Hungary

481 Albania

485 Gibraltar

490 Other Mediterranean islands, NOS

491 Malta

495 Cyprus

499 Europe, NOS; Central Europe, NOS; Eastern Europe, NOS; Northern Europe, NOS; Southern Europe, NOS; Western Europe, NOS

AFRICA

500 Africa, NOS; Central Africa, NOS; Equatorial Africa, NOS

510 North Africa, NOS

511 Morocco

513 Algeria

515 Tunisia

517 Libya; Cyrenaica; Tripoli; Tripolitania

519 Egypt; United Arab Republic

520 Sudanese countries

Anglo-Egyptian Sudan; Burkina Faso; Chad; Mali; Mauritania; Niger; Spanish Sahara; Sudan; Western Sahara; Upper Volta

530 West Africa, NOS; French West Africa, NOS

531 Nigeria

539 Other West African countries

Benin; Bioko; Cameroon (Kameroon); Central African Republic; Congo, NOS; Congo-Brazzaville; Cote d'Ivoire (Ivory Coast); Dahomey; Equatorial Guinea; Fernando Po; French Congo; French Equatorial Africa; Gabon; Gambia; Ghana; Guinea, NOS; Guinea-Bissau; Liberia; Portuguese Guinea; Rio Muni; Senegal; Sierra Leone; Spanish Guinea; Togo

540 South Africa, NOS

541 Zaire; Belgian Congo; Congo-Kinshasa; Congo-Leopoldville

543 Angola; Cabinda; Principe; Sao Tome

545 Republic of South Africa; Basutoland; Bechuanaland; Bophuthatswana; Botswana; Cape Colony; Ciskei; Free State; Lesotho; Namibia; Natal; Orange Free State; South West Africa; Swaziland; Transkei; Transvaal; Union of South Africa; Venda

547 Zimbabwe; Rhodesia, NOS; Southern Rhodesia

549 Zambia; Northern Rhodesia

551 Malawi; Nyasaland

553 Mozambique

555 Madagascar; Malagasy Republic

570 East Africa, NOS

571 Tanzania; Tanganyika; Tanzanyika; Zanzibar

573 Uganda

575 Kenya

577 Rwanda (Ruanda)

579 Burundi; Urundi

581 Somalia; Somali Republic; Somaliland, NOS

583 Djibouti; French Somaliland; French Territory of the Afars and Issas

585 Ethiopia; Abyssinia; Eritrea

580 African Coastal islands, NOS

Comoros; Mauritius; Mayotte; Reunion; St. Helena; Seychelles

ASIA

600 Asia, NOS

610 Near East, NOS; Mesopotamia, NOS
611 Turkey; Anatolia; Asia Minor, NOS; Turkish Armenia

620 Asian Arab countries, NOS; Iraq-Saudi Arabia Neutral Zone; Middle East, NOS
621 Syria
623 Lebanon
625 Jordan; former Arab Palestine; Transjordan
627 Iraq
629 Arabian Peninsula; Aden; Arabia, NOS; Bahrain; Kuwait; Muscat; Oman; People's Democratic Republic of Yemen; Persian Gulf States, NOS; Qatar; Saudi Arabia; Southern Yemen; Trucial States; United Arab Emirates; Yemen
631 Israel and former Jewish Palestine; Gaza; Palestine, NOS; Palestinian National Authority (PNA); West Bank
633 Caucasian Republics of the former U.S.S.R.; Armenia; Azerbaijan; Azerbaizhan (Azerbaidzhan) S.S.R.; Georgia; Nagorno-Karabakh
634 other Asian Republics of the former U.S.S.R.; Kazakh S.S.R.; Kazakhstan; Kirghiz S.S.R.; Kyrgystan; Kyrgyz; Tadzhik S.S.R.; Tajikistan; Turkmen S.S.R.; Turkmenistan; Uzbek S.S.R.; Uzbekistan
637 Iran; Persia
638 Afghanistan
639 Pakistan, NOS; West Pakistan

640 Mid-East Asia, NOS; Maldives
641 India; Andaman Islands
643 Bhutan; Nepal; Sikkim
645 Bangladesh; East Pakistan
647 Sri Lanka; Ceylon
649 Myanmar; Burma

650 Southeast Asia, NOS
651 Thailand; Siam

660 Indochina, NOS
661 Laos
663 Cambodia; Kampuchea
665 Vietnam; Annam; Cochin China; Tonkin
671 Malay Peninsula; Brunei; Malaysia; North Borneo; Singapore
673 Indonesia; Borneo, NOS; Dutch East Indies; Java; New Guinea, NOS; Sumatra
675 Philippines; Philippine Islands

680 East Asia, NOS
681 China, NOS
682 People's Republic of China
683 Hong Kong
684 Taiwan; Formosa; Republic of China
685 Tibet
686 Macao (Macau)
691 Mongolia
693 Japan; Okinawa
695 Korea (North and South)

AUSTRALIA and OCEANIA

711 Australia, NOS;
Australian New Guinea; Cartier Islands; Cocos (Keeling) Islands; Norfolk Islands; Northeast New Guinea; Papua New Guinea

715 New Zealand; Niue

720 Pacific Islands, NOS*; Oceania, NOS*; Polynesia, NOS*

721 Melanesian Islands*; Fiji; Futuna Islands; Melanesia; New Hebrides; Solomon Islands; Vanuatu; Wallis Islands

723 Micronesian Islands*; Christmas Island; Micronesia*; Nauru

725 Polynesian Islands*; French Polynesia; New Caledonia; Pitcairn; Tonga; Western Samoa

750 Antarctica

* Except possessions of the U.S. -- See codes **120 - 139** for these.

"PLACE OF DEATH" FOR LIVING PATIENTS

997 Use this code in the "Place of Death" field when the patient was alive as of the Date of Last Contact.

PLACE OF BIRTH/DEATH UNKNOWN

998 Not U.S., NOS
(Birth or death place is stated to be *not* in the United States, but no other information is available.)

999 Place of birth/death completely unknown

BIRTHPLACE and PLACE OF DEATH codes -- *alphabetical list*

A

224 AB (Alberta)
585 Abyssinia
629 Aden
583 Afars and Issas (French Territory)
638 Afghanistan
500 Africa
500 Africa, Central
570 Africa, East
500 Africa, Equatorial, NOS
539 Africa, French Equatorial
510 Africa, North
540 Africa, South, NOS
545 Africa, South, Republic of
545 Africa, South, Union of
545 Africa, South West
530 Africa, West
530 Africa, West, French
580 African Coastal islands, NOS
539 African Republic, Central
091 AK (Alaska)
037 AL (Alabama)
037 Alabama
091 Alaska
481 Albania
224 Alberta
513 Algeria
250 America, Central
260 America, North
300 America, South
121 American Samoa
611 Anatolia
641 Andaman Islands
443 Andorra
520 Anglo-Egyptian Sudan
543 Angola
245 Anguilla
665 Annam
750 Antarctica
245 Antigua
245 Antilles, Netherlands
245 Antilles, NOS
071 AR (Arkansas)
620 Arab countries, Asian
629 Arab Emirates, United
625 Arab Palestine, former
519 Arab Republic, United (Egypt)
629 Arabia
629 Arabia, Saudi
629 Arabian Peninsula
365 Argentina
087 Arizona
071 Arkansas
633 Armenia (former U.S.S.R.)
611 Armenia, Turkish
245 Aruba
121 AS (American Samoa)
680 Asia, East
640 Asia, Mid-East
610 Asia, Near East
600 Asia, NOS
650 Asia, Southeast
611 Asia Minor
620 Asian Arab countries
634 Asian Republics of the former U.S.S.R., other
109 Atlantic/Caribbean area, other U.S. possessions
100 Atlantic/Caribbean area, U.S. possessions
711 Australia
711 Australian New Guinea
436 Austria
087 AZ (Arizona)
633 Azerbaidzhan S.S.R.
633 Azerbaijan
633 Azerbaizhan S.S.R.
445 Azores

B

247 Bahamas
629 Bahrain
443 Balearic Islands
463 Baltic Republic(s)
463 Baltic State(s)
645 Bangladesh
631 Bank, West
245 Barbados
245 Barbuda
545 Basutoland
431 Bavaria
226 BC (British Columbia)
545 Bechuanaland
457 Belarus
139 Belau
541 Belgian Congo
433 Belgium
252 Belize
539 Benin
246 Bermuda
456 Bessarabia
643 Bhutan
539 Bioko
452 Bohemia
355 Bolivia
545 Bophuthatswana
671 Borneo, North
673 Borneo, NOS
453 Bosnia-Herzogovina
545 Botswana
341 Brazil
226 British Columbia
331 British Guiana

252 British Honduras
245 British Virgin Islands
245 British West Indies, NOS
671 Brunei
454 Bulgaria
520 Burkina Faso
649 Burma
579 Burundi
457 Byelorussian S.S.R.

C

097 CA (California)
543 Cabinda
245 Caicos Islands
097 California
663 Cambodia
539 Cameroon
220 Canada
110 Canal Zone
443 Canary Islands
122 Canton and Enderbury Islands
545 Cape Colony
445 Cape Verde Islands
245 Caribbean, NOS
245 Caribbean islands, other
123 Caroline Islands
711 Cartier Islands
633 Caucasian Republics of the former U.S.S.R.
245 Cayman Islands
500 Central Africa
539 Central African Republic
250 Central America
499 Central Europe
060 Central Midwest U.S.
647 Ceylon
520 Chad
401 Channel Islands (British)
361 Chile
665 China, Cochin
681 China, NOS
682 China, People's Republic of
684 China, Republic of
723 Christmas Island
545 Ciskei
083 CO (Colorado)
665 Cochin China
711 Cocos Islands
311 Colombia
083 Colorado
580 Comoros
226 Columbia, British
022 Columbia, District of
541 Congo, Belgian
539 Congo, French
539 Congo, NOS
539 Congo-Brazzaville
541 Congo-Kinshasa
541 Congo-Leopoldville
007 Connecticut
124 Cook Islands
441 Corsica
256 Costa Rica
539 Cote d'Ivoire
471 Crete
453 Croatia
007 CT (Connecticut)
241 Cuba
245 Curacao
495 Cyprus
517 Cyrenaica
452 Czech Republic
452 Czechoslovakia

D

539 Dahomey
453 Dalmatia
022 DC (District of Columbia)
017 DE (Delaware)
017 Delaware
431 Democratic Republic, German
425 Denmark
022 District of Columbia
583 Djibouti
449 Dobruja
245 Dominica
243 Dominican Republic
673 Dutch East Indies
332 Dutch Guiana

E

570 East Africa
680 East Asia
431 East Germany
673 East Indies, Dutch
645 East Pakistan
499 Eastern Europe
345 Ecuador
519 Egypt
410 Eire
254 El Salvador
125 Ellice Islands
122 Enderbury Islands, Canton and
401 England
539 Equatorial Africa, French
500 Equatorial Africa, NOS
539 Equatorial Guinea
585 Eritrea
458 Estonia
458 Estonian S.S.R.
585 Ethiopia
499 Europe
499 Europe, Central
499 Europe, Eastern
499 Europe, Northern
470 Europe, other mainland
499 Europe, Southern
499 Europe, Western

F

425 Faeroe Islands
381 Falkland Islands
425 Faroe Islands
431 Federal Republic of Germany
123 Federated States of Micronesia, U.S. possession
539 Fernando Po
721 Fiji
429 Finland
035 FL (Florida)
035 Florida
123 FM (Federated States of Micronesia, U.S. possession)
684 Formosa
441 France
545 Free State (Orange)
539 French Congo
539 French Equatorial Africa
333 French Guiana
725 French Polynesia
583 French Somaliland
583 French Territory of the Afars and Issas
530 French West Africa
245 French West Indies
721 Futuna Islands

G

033 GA (Georgia, U.S.)
539 Gabon
345 Galapagos Islands
539 Gambia
631 Gaza
033 Georgia (U.S.)
633 Georgia (former U.S.S.R.)
431 German Democratic Republic
430 Germanic countries
431 Germany
431 Germany, East
431 Germany, Federal Republic of
431 Germany, West
539 Ghana
485 Gibraltar
122 Gilbert Islands
400 Great Britain
471 Greece
210 Greenland
245 Grenada
245 Grenadines
126 GU (Guam)
245 Guadeloupe
126 Guam
251 Guatemala
401 Guernsey
331 Guiana, British
332 Guiana, Dutch
333 Guiana, French
332 Guiana, Netherlands
539 Guinea
539 Guinea-Bissau
539 Guinea, Equatorial
539 Guinea, Portuguese
539 Guinea, Spanish
331 Guyana

H

242 Haiti
099 Hawaii
099 HI (Hawaii)
432 Holland
447 Holy See
252 Honduras, British
253 Honduras, NOS
683 Hong Kong
475 Hungary

I

053 IA (Iowa)
421 Iceland
081 ID (Idaho)
081 Idaho
061 IL (Illinois)
061 Illinois
045 IN (Indiana)
641 India
045 Indiana
673 Indies, Dutch East
660 Indochina
673 Indonesia
053 Iowa
637 Iran
627 Iraq
620 Iraq-Saudi Arabia Neutral Zone
404 Ireland, Northern
410 Ireland, NOS
410 Ireland, Republic of
583 Issas, Afars and
401 Isle of Man
631 Israel
583 Issas
447 Italy
539 Ivory Coast

J

244 Jamaica
423 Jan Mayen
693 Japan
673 Java
401 Jersey
631 Jewish Palestine (former)
127 Johnston Atoll
625 Jordan
453 Jugoslavia

K

539 Kameroon
663 Kampuchea
065 Kansas
634 Kazakh S.S.R.
634 Kazakhstan

711 Keeling Islands
047 Kentucky
575 Kenya
634 Kirghiz S.S.R.
122 Kiribati
695 Korea
695 Korea, North
695 Korea, South
065 KS (Kansas)
629 Kuwait
047 KY (Kentucky)
634 Kyrgystan
634 Kyrgyz

L

073 LA (Louisiana)
221 Labrador
661 Laos
420 Lapland
265 Latin America, NOS
459 Latvia
459 Latvian S.S.R.
623 Lebanon
245 Leeward Islands, NOS
545 Lesotho
539 Liberia
517 Libya
437 Liechtenstein
122 Line Islands, Southern
461 Lithuania
461 Lithuanian S.S.R.
073 Louisiana
434 Luxembourg

M

005 MA (Massachusetts)
686 Macao
686 Macau
453 Macedonia
555 Madagascar
445 Madeira Islands
002 Maine
470 Mainland Europe, other
555 Malagasy Republic
551 Malawi
671 Malay Peninsula
671 Malaysia
640 Maldives
520 Mali
491 Malta
224 Manitoba
129 Mariana Islands, Northern
221 Maritime provinces
131 Marshall Islands
245 Martinique
021 Maryland
005 Massachusetts
520 Mauritania
580 Mauritius
580 Mayotte
224 MB (Manitoba)
021 MD (Maryland)
002 ME (Maine)
490 Mediterranean islands, other
721 Melanesia
721 Melanesian Islands (except U.S. possessions, codes 120-139)
610 Mesopotamia
230 Mexico
131 MH (Marshall Islands)
041 MI (Michigan)
041 Michigan
723 Micronesia (except U.S. possessions, codes 120-139)
123 Micronesia, Federated States of (U.S. possession)
723 Micronesian Islands (except U.S. possessions, codes 120-139)
640 Mid-East Asia
620 Middle East, NOS
132 Midway Islands
060 Midwest U.S., Central
050 Midwest U.S., Northern
070 Midwest U.S., Southern
052 Minnesota
249 Miquelon
039 Mississippi
063 Missouri
052 MN (Minnesota)
063 MO (Missouri)
456 Moldavia, former U.S.S.R.
456 Moldavia, NOS
449 Moldavia, Romanian
456 Moldavian S.S.R.
456 Moldova
441 Monaco
691 Mongolia
056 Montana
453 Montenegro
245 Montserrat
452 Moravia
511 Morocco
080 Mountain states, U.S.
553 Mozambique
129 MP (Northern Mariana Islands)
039 MS (Mississippi)
056 MT (Montana)
629 Muscat, Oman and
649 Myanmar

N

633 Nagorno-Karabakh
545 Namibia
133 Nampo-Shoto, Southern
545 Natal
723 Nauru
221 NB (New Brunswick)
025 NC (North Carolina)
054 ND (North Dakota)

067 NE (Nebraska)
610 Near East
067 Nebraska
643 Nepal
432 Netherlands
245 Netherlands Antilles
332 Netherlands Guiana
620 Neutral Zone, Iraq-Saudi Arabia
085 Nevada
245 Nevis
221 New Brunswick
725 New Caledonia
001 New England
711 New Guinea, Australian
711 New Guinea, Northeast
673 New Guinea, NOS
711 New Guinea, Papua
003 New Hampshire
721 New Hebrides
008 New Jersey
086 New Mexico
011 New York
715 New Zealand
221 Newfoundland
003 NH (New Hampshire)
255 Nicaragua
520 Niger
531 Nigeria
715 Niue
008 NJ (New Jersey)
221 NL (Newfoundland/ Labrador)
086 NM (New Mexico)
711 Norfolk Islands
510 North Africa
260 North America
240 North American islands, NOS
671 North Borneo
025 North Carolina
040 North Central U.S.
054 North Dakota
695 North Korea
010 North Mid-Atlantic U.S.
711 Northeast New Guinea
001 Northeast U.S.
499 Northern Europe
404 Northern Ireland
129 Northern Mariana Islands
050 Northern Midwest U.S.
549 Northern Rhodesia
225 Northwest Territories
423 Norway
998 Not United States, NOS
221 Nova Scotia
221 NS (Nova Scotia)
225 NT (Northwest Territories)
227 NU (Nunavut)
227 Nunavut
085 NV (Nevada)
011 NY (New York)
551 Nyasaland

O

720 Oceania (except U.S. possessions, codes 120-139)
043 OH (Ohio)
043 Ohio
075 OK (Oklahoma)
693 Okinawa
075 Oklahoma
629 Oman and Muscat
223 ON (Ontario)
223 Ontario
095 OR (Oregon)
545 Orange Free State
095 Oregon
403 Orkney Islands

P

014 PA (Pennsylvania)
120 Pacific area, U.S. possessions
090 Pacific Coast U.S.
720 Pacific islands, NOS (except U.S. possessions, codes 120-139)
123 Pacific islands, Trust Territory of the
645 Pakistan, East
639 Pakistan, NOS
639 Pakistan, West
139 Palau
625 Palestine, Arab (former)
631 Palestine, Jewish (former)
631 Palestine National Authority
631 Palestine, NOS
257 Panama
711 Papua New Guinea
371 Paraguay
221 PE (Prince Edward Island)
014 Pennsylvania
629 People's Democratic Republic of Yemen
682 People's Republic of China
637 Persia
629 Persian Gulf States, NOS
351 Peru
675 Philippine Islands
675 Philippines
122 Phoenix Islands
725 Pitcairn
631 PNA (Palestine National Authority)
451 Poland
725 Polynesia, French

720 Polynesia, NOS (except U.S. possessions, codes 120-139)
725 Polynesian islands (except U.S. possessions, codes 120-139)
445 Portugal
539 Portuguese Guinea
101 PR (Puerto Rico)
224 Prairie provinces
221 Prince Edward Island
543 Principe
101 Puerto Rico
139 PW (Palau)

Q

629 Qatar
222 QC (Quebec)
222 Quebec

R

684 Republic of China
682 Republic of China, People's
410 Republic of Ireland
545 Republic of South Africa
629 Republic of Yemen, People's Democratic
580 Reunion
006 Rhode Island
549 Rhodesia, Northern
547 Rhodesia, NOS
547 Rhodesia, Southern
006 RI (Rhode Island)
539 Rio Muni
440 Romance-language countries
449 Romania
449 Romanian Moldavia
577 Ruanda
449 Rumania
455 Russia, NOS
457 Russia, White
455 Russian Federation, former U.S.S.R.
445 Russian S.F.S.R.
577 Rwanda
134 Ryukyu Islands

S

520 Sahara, Spanish
520 Sahara, Western
245 St. Christopher-Nevis
580 St. Helena
245 St. Kitts
245 St. Lucia
249 St. Pierre
245 St. Vincent
121 Samoa, American
725 Samoa, Western
447 San Marino
543 Sao Tome
447 Sardinia
224 Saskatchewan
629 Saudi Arabia
026 SC (South Carolina)
420 Scandinavia
403 Scotland
055 SD (South Dakota)
539 Senegal
453 Serbia
580 Seychelles
403 Shetland Islands
651 Siam
447 Sicily
539 Sierra Leone
643 Sikkim
671 Singapore
224 SK (Saskatchewan)
450 Slavic countries
453 Slavonia
452 Slovak Republic
452 Slovakia
453 Slovenia
721 Solomon Islands
581 Somali Republic
581 Somalia
583 Somaliland, French
581 Somaliland, NOS
540 South Africa, NOS
545 South Africa, Republic of
545 South Africa, Union of
300 South America
380 South American islands
026 South Carolina
055 South Dakota
695 South Korea
020 South Mid-Atlantic U.S.
545 South West Africa
650 Southeast Asia
030 Southeastern U.S.
499 Southern Europe
122 Southern Line Islands
070 Southern Midwest U.S.
133 Southern Nampo-Shoto
547 Southern Rhodesia
629 Southern Yemen
- - - Soviet Union, former (See individual republics.)
443 Spain
539 Spanish Guinea
520 Spanish Sahara
647 Sri Lanka
- - - St.____: listed as if "Saint____"
520 Sudan
520 Sudan, Anglo-Egyptian
520 Sudanese countries
673 Sumatra
332 Surinam
423 Svalbard
135 Swan Islands
545 Swaziland
427 Sweden

435 Switzerland
621 Syria

T

634 Tadzhik S.S.R.
684 Taiwan
634 Tajikistan
571 Tanganyika
571 Tanzania
571 Tanzanyika
031 Tennessee
077 Texas
651 Thailand
685 Tibet
031 TN (Tennessee)
245 Tobago
539 Togo
136 Tokelau Islands
725 Tonga
665 Tonkin
625 Transjordan
545 Transkei
545 Transvaal
449 Transylvania
245 Trinidad
517 Tripoli
517 Tripolitania
629 Trucial States
- - - Trust Territory of Pacific Islands (U.S. possessions): See individual island groups (codes 123, 129, 131 and 139).
515 Tunisia
611 Turkey
611 Turkish Armenia
634 Turkmen S.S.R.
634 Turkmenistan
245 Turks Islands
125 Tuvalu
077 TX (Texas)

U

573 Uganda
456 Ukraine
456 Ukrainian S.S.R.
404 Ulster
545 Union of South Africa
- - - Union of Soviet Socialist Republics (U.S.S.R., former) (See individual republics.)
629 United Arab Emirates
519 United Arab Republic
400 United Kingdom
000 United States
999 Unknown (completely)
520 Upper Volta
375 Uruguay
579 Urundi
000 U.S.
060 U.S., Central Midwest
080 U.S., Mountain States
040 U.S., North Central
010 U.S., North Mid-Atlantic
001 U.S., Northeastern
050 U.S., Northern Midwest
090 U.S., Pacific Coast
020 U.S., South Mid-Atlantic
030 U.S., Southeastern
070 U.S., Southern Midwest
102 U.S. Virgin Islands
456 U.S.S.R. Moldavia, former
084 UT (Utah)
084 Utah
634 Uzbek S.S.R.
634 Uzbekistan

V

023 VA (Virginia)
721 Vanuatu
447 Vatican City
545 Venda
321 Venezuela
004 Vermont
102 VI (Virgin Islands, U.S.)
665 Vietnam
245 Virgin Islands, British
102 Virgin Islands (U.S.)
023 Virginia
520 Volta, Upper
004 VT (Vermont)

W

093 WA (Washington, state)
137 Wake Island
402 Wales
449 Wallachia
721 Wallis Islands
093 Washington (state)
022 Washington, D.C.
530 West Africa, French
530 West Africa, NOS
545 West Africa, South
539 West African countries, other
631 West Bank
431 West Germany
245 West Indies
245 West Indies, British
245 West Indies, French
639 West Pakistan
024 West Virginia
499 Western Europe
520 Western Sahara
725 Western Samoa
457 White Russia
051 WI (Wisconsin)
245 Windward Islands, NOS
051 Wisconsin
024 WV (West Virginia)
082 WY (Wyoming)
082 Wyoming

Y

629 Yemen

629 Yemen, People's Democratic Republic of

629 Yemen, Southern

225 YT (Yukon Territory)

453 Yugoslavia

225 Yukon Territory

Z

541 Zaire

549 Zambia

571 Zanzibar

547 Zimbabwe

Appendix B

Paired Organ Sites

These tables have been moved into the Manual's text (under Laterality, page 83).

Appendix C

Common Acceptable Abbreviations

sources: California Cancer Registry, Florida Cancer Data System, *ICD-O-3*, *Merriam-Webster's Medical Desk Dictionary*, NAACCR Recommendations, *Stedman's Medical Dictionary, 27th Ed.*

Common Acceptable Abbreviations
(in order of term)

Abdomen; Abdominal	ABD
Abdominal Perineal	AP
Abelson Murine Leukemia Oncogene	ABL
Abnormal	ABN
Above Knee (Amputation)	AK(A)
Absent; Absence	ABS
Abstract; Abstracted	ABST
Achilles Tendon Reflex	ATR
Acid Phosphatase	ACID PHOS
Acquired Idiopathic Sideroblastic Anemia	AISA
Acquired Immune Deficiency Syndrome	AIDS
Activities of Daily Living/Life	ADL
Acute Granulocytic Leukemia	AGL
Acute Lymphocytic Leukemia	ALL
Acute Myeloid Leukemia	AML
Acute Myocardial Infarction	AMI
Acute Renal Failure	ARF
Acute Respiratory Distress/Disease Syndrome	ARDS
Acute Tubular Necrosis	ATN
Adenocarcinoma	ADENOCA
Adenosine Triphosphate	ATP
Adjacent	ADJ
Admission; Admit	ADM
Adrenal Cortical Hormone	ACH
Adrenal Cortex	AC
Adrenocorticotrophic Hormone	ACTH
Adult-Onset Diabetes Mellitus	AODM
Affirmative	AFF
Against Medical Advice	AMA
Aggressive Systemic Mastocytosis	ASM
Agnogenic Myeloid Metaplasia	AMM
AIDS-Related Complex/Condition	ARC
AIDS-Related Disease	ARD
Air Contrast Barium Enema	ACBE
Albumin	ALB
Alcohol	ETOH
Alkaline Phosphatase	ALK PHOS
Alpha-Fetoprotein	AFP, αFP
Also Known As	AKA
Ambulatory	AMB
Amount	AMT
Amputation	AMP
Amyotrophic Lateral Sclerosis	ALS
Anal Intraepithelial Neoplasia	AIN
Anaplastic	ANAP
Angiography; Angiogram	ANGIO
Angioimmunoblastic Lymphadenopathy	AIL
Angioimmunoblastic Lymphadenopathy with Dysproteinemia	AILD
Anterior	ANT
Anteroposterior	AP
Antidiuretic Hormone	ADH
Antigen	AG
Aortic Stenosis	A-STEN
Apparently	APPL'Y
Appendix	APP
Approximately	APPROX
Arrhythmia	ARRHY
Arterial Blood Gases	ABG
Arteriosclerotic Cardiovascular Disease	ASCVD
Arteriosclerotic Heart Disease	ASHD
Arteriosclerotic Peripheral Vascular Disease	ASPVD
Arteriosclerosis; Arteriosclerotic	AS
Arteriovenous	AV
Arteriovenous Malformation	AVM
Artery; Arterial	ART
As Soon As Possible	ASAP
Aspiration	ASP
Aspirin (Acetylsalicylic Acid)	ASA
Atrial Fibrillation	A FIB
Atrial Flutter	A FLUTTER
Atrial Insufficiency/Incompetance	AI
Atrial Premature Complexes	APC
Atrial Stenosis (Insufficiency)	AI
Auscultation and Percussion	A&P
Autoimmuno Hemolytic Anemia	AIHA
Autonomic Nervous System	ANS
Autopsy	AUT
Average	AVG
Axilla(ry)	AX
B-cell Chronic Lymphocytic Leukemia	BCLL

Bacillus Calmette-Guérin	BCG
Barium	BA
Barium Enema	BE
Bartholin, Urethral, & Skene Glands	BUS
Basal Cell Carcinoma	BCC
Before Noon	AM
Below Knee (Amputation)	BK(A)
Benign Prostatic Hypertrophy/Hyperplasia	BPH
Bilateral	BIL
Bilateral Salpingo-Oophorectomy	BSO
Bile Duct	BD
Biological Response Modifier	BRM
Biopsy	BX
Bipolar Affective Disorder	BAD
Black Female	B/F
Black Male	B/M
Bladder Tumor	BT
Blood Pressure	BP
Blood Urea Nitrogen	BUN
Blood Volume	BV
Bone Marrow	BM
Bone Scan	BSC
Bowel Movement	BM
Bowel Sounds	BS
Breakpoint Cluster Region	BCR
Breath Sounds	BS, BRS
Bright Red Blood	BRB
Bright Red Blood (per Rectum)	BRB(PR)
Bronchial-Associated Lymphoid Tissue	BALT
Brother	BRO
Burkitt type Acute Lymphoblastic Leukemia	B-ALL
Calcium	CA
Capsule(s)	CAP(S)
Carcinoembryonic Antigen	CEA
Carcinoma	CA
Carcinoma *in Situ*	CIS
Carcinoma Showing Thymus-Like Element	CASTLE
Cardiovascular Disease	CVD
CAT Scan	CAT; CT; CT SC
Centimeter	CM; cm
Central Nervous System	CNS
Central Primitive Neuroectodermal Tumor	CPNET
Cerebrospinal Fluid	CSF

Cerebrovascular Accident	CVA
Cervical Intraepithelial Neoplasia	CIN
Cervical Vertebrae	C1-C7
Cervix	CX
Cesium	CS
Change	CHG
Chemotherapy	CHEMO
Chest X-Ray	CXR
Chief Complaint	CC
Chronic	CHR
Chronic Granulocytic Leukemia	CGL
Chronic Lymphocytic Leukemia	CLL
Chronic Myeloid Leukemia	CML
Chronic Myleomonocytic Leukemia	CMML
Chronic Myeloproliferative Disease	CMD
Chronic Obstructive Lung Disease	COLD
Chronic Obstructive Pulmonary Disease	COPD
Chronic Renal Failure	CRF
Chronic Ulcerative Colitis	CUC
Cigarettes	CIG
Clear	CLR
Cluster of Differentiation	CD
Cobalt-60	CO60
Colon	
Ascending	A-COLON
Descending	D-COLON
Sigmoid	S-COLON; SIG COLON
Transverse	T-COLON; TRANS COLON
Colony-Stimulating Factor	C-SF
Common Acute Lymphocytic Leukemia	C-ALL
Common Bile Duct	CBD
Complaining/Complaint Of	C/O
Complete Blood Count	CBC
Computerized Axial Tomography Scan	CT, CAT SCAN
Congenital Heart Disease	CHD
Congestive Heart Failure	CHF
Consistent With	C/W
Continue; Continuous	CONT
Contralateral	CONTRA
Core Binding Factor	CBF
Coronary Artery Bypass Graft	CABG
Coronary Artery Disease	CAD
Coronary Care Unit	CCU

Costal Margin	CM
Cubic Centimeter	CC
Cystic Fibrosis	CF
Cystoscopy	CYSTO
Cytology	CYTO
Cytomegalovirus	CMV
Date of Birth	DOB
Date of Death	DOD
Dead on Arrival	DOA
Decrease(d)	DECR (or <)
Deep Tendon Reflex	DTR
Deep Vein Thrombosis	DVT
Deoxyribonucleic Acid	DNA
Dermatology	DERM
Diabetes Mellitus	DM
Diagnosis	DX
Diameter	DIAM
Died; Expired	EXP
Diethylstilbrestrol	DES
Differentiated; Differential	DIFF
Digital Rectal Exam	DRE
Dilation (Dilatation) and Curettage	D&C
Discharge	DIS, DISCH, DS
Discontinue(d)	DC
Disease	DZ, DIS
Disseminated Intravascular Coagulopathy	DIC
Doctor	DR, MD
Ductal Carcinoma *in Situ*	DCIS
Ductal Intraepithelial Neoplasia	DIN
Dyspnea On Exertion	DOE
Ear(s), Nose, and Throat	ENT
Eight; Twenty-One (8;21)	ETO
Electrocardiogram	ECG; EKG
Electroencephalogram	EEG
Electromyogram	EMG
Emergency Room	ER
End Stage Renal Disease	ESRD
Endoscopic Retrograde	ENDO
Endoscopic Retrograde Cholangiopancreatography	ERCP
Enlarged	ENL; ENLGD
Enterochromaffin	EC
Enterochromaffin-Like	ECL
Esophagogastroduodenoscopy	EGD
Estrogen Receptor (Assay)	ER(A)
Evaluation	EVAL
Every	Q
Every Day	QD
Examination	EXAM
Examination Under Anesthesia	EUA
Excision; Excise(d)	EXC(D)
Expired; Died	EXP
Exploratory	EXPL
Exploratory Laparotomy	EXP LAP; EXPL LAP
Extend; Extension	EXT
Extended Care Facility	ECF
External	EXT
Extramedullary Plasmacytoma	EMP
Extremity	EXT
Eyes, Ears, Nose, and Throat	EENT
Family (Medical) History	F(M)H
Fever of Unknown Origin	FUO
Fine Needle Aspiration	FNA
Fine Needle Aspiration Biopsy	FNAB
Fingerbreadth	FB
Floor Of Mouth	FOM
Fluid	FL
Fluorescent In Situ Hybridization	FISH
Fluoroscopy	FLURO
Follicular Dendritic Cell	FDC
Follicular Dendritic Cell Tumor	FDCT
Follow-Up	FU
For Example	e.g. (E.G.)
Fracture	FX
Frequent; Frequency	FREQ
Frozen Section	FS
Full Thickness Skin Graft	FTSG
Gallbladder	GB
Gastrin cell	G CELL
Gastroenterostomy	GE
Gastroesophageal	GE
Gastroesophageal Reflux Disease	GERD
Gastrointestinal	GI
Gastrointestinal Autonomic Nerve Tumor	GANT
Gastrointestinal Stromal Tumor	GIST
General; Generalized	GEN
Genitourinary	GU
Grade	GR
Gram	GM
Gynecology	GYN
Head, Eyes, Ears, Nose, Throat	HEENT

Heavy Chain Disease	HCD
Hematocrit	HCT
Hemoglobin	HGB
Hepatitis A/B/C/D Virus	HAV; HBV; HCV; HDV
Hepatosplenomegaly	HSM
History	HX
History and Physical	H&P
History Of	HO; H/O
History of Present Illness	HPI
Hormone	HORM
Hospital	HOSP
Hour(s)	HR; HRS
Human Chorionic Gonadotropin	HCG, hCG
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymophotrophic Virus (Type III)	HTLV(-III)
Hypereosinophilic Syndrome	HES
Hypertension	HTN
Hypertensive Cardiovascular Disease	HCVD
Hypertensive Vascular Disease	HVD
Hysterectomy	HYST
Idiopathic Hypereosinophilic Syndrome	IHS, IHES
Idiopathic Hypertrophic Subaortic Stenosis	IHSS
Idiopathic Thrombocytopenia	ITP
Immunoblastic Lymphadenopathy	IBL
Immunoglobulin	IG
Immunohistochemical	IHC
Immunoproliferative Small Intestinal Disease	IPSID
Impression	IMP
Incision and Drainage	I&D
Includes, Including	INCL
Increase(d)	INCR (or >)
Indolent Systemic Mastocytosis	ISM
Inferior	INF
Inferior Vena Cava	IVC
Infiltrating	INFILT
Inflammatory Bowel Disease	IBD
Inpatient	IP
Insulin-Dependent Diabetes Mellitus	IDDM
Intensive Care Unit	ICU
Intercostal Margin	ICM
Intercostal Space	ICS
Interdigitating Dendritic Cell Sarcoma	IDCS
Intermittent Positive Pressure Breathing	IPPB
Internal	INT
Internal Mammary Artery	IMA
Interstitial Lung Disease	ILD
Intramuscular	IM
Intrathecal	IT
Intravenous	IV
Intravenous Cholangiogram	IVCA
Intravenous Pyelogram	IVP
Invade(s); Invading; Invasion	INV
Involve(s); Involving; Involvement	INVL
Iodine	I, IOD
Ipsilateral	IPSI
Irregular	IRREG
Jugular Venous Distention	JVD
Juvenile Myelomonocytic Leukemia	JMML
Juvenile Rheumatic Arthritis	JRA
Kaposi Sarcoma	KS
Kidneys, Ureters, Bladder	KUB
Kilogram	KG
Kilovolt	KV
Lactic/Lactate Dehydrogenase	LDH
Laparotomy	LAP
Large	LG
Last Menstrual Period	LMP
Lateral	LAT
Lactic Dehydrogenase	LDH
Langerhans Cell Histiocytosis	LCH
Large	LRG
Last Menstrual Period	LMP
Lateral	LAT
Left	L, LT
Left Bundle Branch Block	LBBB
Left Costal Margin	LCM
Left Lower Extremity	LLE
Left Lower Lobe	LLL
Left Lower Quadrant	LLQ
Left Salpingo-oophorectomy	LSO
Left Upper Extremity	LUE
Left Upper Lobe	LUL
Left Upper Outer Quadrant	LUOQ
Left Upper Quadrant	LUQ
Linear Accelerator	LINAC
Liter	L
Liver, Kidney, Spleen (Bladder)	LKS(B)

Liver/Spleen Scan	LS SCAN
Lobular Carcinoma *in Situ*	LCIS
Local M.D.	LMD
Long-Term Care Facility	LTCF
Lower Extremity	LE
Lower Inner Quadrant	LIQ
Lower Outer Quadrant	LOQ
Lumbar Puncture	LP
Lumbar Spine	L-SPINE
Lumbar Vertebrae	L1-L5
Lumbosacral	LS
Lupus Erythematosus	LUP ERYTH
Lymphadenophy-Associated Virus	LAV
Lymph Node(s)	LN(S)
Lymph Node Dissection	LND
Macrophage Colony-Stimulating Factor	M-CSF
Magnetic Resonance Imaging	MRI
Magnetic Resonance Cholangiopancreatography	MRCP
Main Stem Bronchus	MSB
Malignant	MALIG, MAL
Malignant Histiocytosis	MH
Malignant Peripheral Nerve Sheath Tumor	MPNST
Mandible; Mandibular	MAND
Mast Cell Leukemia	MCL
Mast Cell Sarcoma	MCS
Mastectomy	MAST
Maxilla(ry)	MAX
Maximum	MAX
Medical Doctor	DR, MD
Medication(s); Medicine	MED(S)
Metastatic; Metastases; Metastasis	MET; METS
Methicillin Resistant Staphylococcus Aureus	MRSA
Microgram	MCG; µg
Microscopic	MICRO
Midclavicular Line	MCL
Middle Lobe	ML
Millicurie (hours)	MC(H); mC(H)
Milligram (hours)	MG(H); mg(H)
Milliliter	ML; ml
Millimeter	MM; mm
Million Electron Volts	MEV
Minimum	MIN
Minute	MIN
Mitral Valve Prolapse	MVP
Mixed Combined Immunodeficiency	MCID
Mixed Connective Tissue Disease	MCTD
Moderate(ly)	MOD
Moderately Differentiated	MD, MOD DIFF
Modified Radical Mastectomy	MRM
Monoclonal Gammopathy of Undetermined Significance	MGUS
Multifocal Arterial Tachycardia	MAT
Mucosal-Associated Lymphoid Tissue	MALT
Myelodysplastic Syndrome	MDS
Myosin, Heavy Polypeptide 11	MYH11
Natural Killer	NK
Nausea and Vomiting	N&V
Neck Vein Distention	NVD
Negative	NEG (or -)
Neurology	NEURO
No Evidence of Disease	NED
Normal	NL
No Significant Findings	NSF
Not Applicable	NA
Not Otherwise Specified	NOS
Not Recorded	NR
Obstructed (-ing, ion)	OBST
Operating Room	OR
Operation	OP
Operative Report	OP REPORT
Ounce	OZ
Outpatient	OP
Packs per Day	PPD
Palpated (-able)	PALP
Papanicolaou Smear	PAP
Papillary	PAP
Past Medical History	PMH
Pathology	PATH
Patient	PT
Pelvic Inflammatory Disease	PID
Percussion and Auscultation	P&A
Percutaneous	PERC
Percutaneous Ethanol Injection	PEI
Peripheral Primitive Neuroectodermal Tumor	PPNET
Personal/Primary Medical Doctor	PMD
Photodynamic Therapy	PDT
Physical Examination	PE
Plasma Cell Labeling Index	PCLI
Plasma Cell Leukemia	PCL

Platelets	PLT
Polymerase Chain Reaction	PCR
Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal gammopathy, Skin changes	POEMS
Poorly Differentiated	PD, POOR DIFF
Positive	POS (or +)
Positron Emission Tomography	PET
Possible	POSS
Posterior	POST
Posteroanterior	PA
Postmortem Examination	POST
Postoperative (-ly)	PO, POSTOP
Postoperative Day	POD
Preoperative (-ly)	PREOP
Present Illness	PI
Primary Myelofibrosis	PMF
Primitive Neuroectodermal Tumor	PNET
Prior to Admission	PTA
Probable (-ly)	PROB
Progesterone Receptor (Assay)	PR(A)
Promyelocytic Leukemia	PML
Prostatic Intraepithelial Neoplasia	PIN
Psoralen, Ultraviolet-A light	PUVA
Pulmonary	PULM
Pulmonary Artery	PA
Radiation	RAD
Radiation Absorbed Dose	RAD
Radiation Therapy	RT
Radical	RAD
Radiofrequency Interstitial Tissue Ablation	RITA
Radioimmunoassay	RIA
Radium	RA
Red Blood Cells	RBC
Refractory Anemia	RA
Refractory Anemia with Excess Blasts	RAEB
Refractory Anemia with Excess Blasts in Transformation	RAEB-T
Refractory Anemia with Ringed Sideroblasts	RARS
Refractory Anemia with Sideroblasts	RAS
Refractory Cytopenia with Multilineage Dysplasia	RCMD
Resection	RESEC
Respiratory	RESPIR
Retinoic Acid Receptor, Alpha	RARA
Review of Outside Films	ROF
Review of Outside Slides	ROS
Review of Systems	ROS
Right	R, RT
Right Costal Margin	RCM
Right Lower Extremity	RLE
Right Lower Lobe	RLL
Right Lower Quadrant	RLQ
Right Middle Lobe	RML
Right Salpingo-oophorectomy	RSO
Right Upper Extremity	RUE
Right Upper Lobe	RUL
Right Upper Quadrant	RUQ
Rule(s) Out	RO, R/O
Sacral Vertebra	S1-S5
Salpingo-oophorectomy	SO
Sequential Multiple Analysis (Biochem Profile)	SMA
Serum Glutamic Oxaloacetic Transaminase	SGOT
Serum Glutamic Pyruvic Transaminase	SGPT
Shortness of Breath	SOB
Skilled Nursing Facility	SNF
Skin-Associated Lymphoid Tissue	SALT
Specimen	SPEC
Split Thickness Skin Graft	STSG
Small	SM, SML
Small Bowel	SB, SML BWL
Spindle Epithelial Tumor with Thymus-Like Element	SETTLE
Spine	
Cervical	C-SPINE
Lumbar	L-SPINE
Sacral	S-SPINE
Thoracic	T-SPINE
Squamous	SQ, SQUAM
Squamous Cell Carcinoma	SCC
Status Post	S/P
Subcutaneous	SUB-Q, SUBQ, SQ
Superior Vena Cava	SVC
Surgery, Surgical	SURG
Symptoms	SX
Systemic Mastocytosis with Associated clonal, Hematological Non-Mast-cell lineage Disease	SM-AHNMD
Systemic tissue Mast Cell Disease	SMCD

Thoracic	T
Thoracic Vertebra	T1-T12
Total Abdominal Hysterectomy-Bilateral Salpingo-oophorectomy	TAH-BSO
Total Parenteral Nutrition	TPN
Total Vaginal Hysterectomy	TVH
Transitional Cell Carcinoma	TCC
Transurethral Resection	TUR
Transurethral Resection Bladder (Tumor)	TURB(T)
Transurethral Resection Prostate	TURP
Treatment	RX, TX
Tumor Size	TS
Undifferentiated	UNDIFF
Upper Extremity	UE
Upper Gastrointestinal	UGI
Upper Inner Quadrant	UIQ
Upper Outer Quadrant	UOQ
Vagina, Vaginal	VAG
Vaginal Hysterectomy	VAG HYST
Vaginal Intraepithelial Neoplasia	VAIN
Vascular	VASC
Vulvar Intraepithelial Neoplasia	VIN
Waldenstrom Macroglobulinemia	WM
Well Differentiated	WD, WELL DIFF
White Blood Cells	WBC
With	W/
Within Normal Limits	WNL
Without	W/O
Work-Up	W/U
X-Ray	XR
Year	YR

Symbols

above, elevated, increased, superior (position), upper	^, ↑
below, decreased, inferior (position), lower	V, ↓
causes, distal, greater than, toward	>
caused by, less than, proximal	<
causes, distal, toward	→
caused by, proximal	←
negative, through	-
positive	+
left upper quadrant	¯¯┐
left lower quadrant	___|
right upper quadrant	┌¯¯
right lower quadrant	|___
at	@
comparison	/
equal	=
number (before numeral), pounds (after numeral)	#
times	X

Common Acceptable Abbreviations
(in order of abbreviation)

A FIB	Atrial Fibrillation
A FLUTTER	Atrial Flutter
A&P	Auscultation and Percussion
ABD	Abdomen; Abdominal
ABG	Arterial Blood Gases
ABL	Abelson Murine Leukemia oncogene
ABN	Abnormal
ABS	Absent; Absence
ABST	Abstract; Abstracted
AC	Adrenal Cortex
ACBE	Air Contrast Barium Enema
ACH	Adrenal Cortical Hormone
ACID PHOS	Acid Phosphatase
A-COLON	Ascending Colon
ACTH	Adrenocorticotrophic Hormone
ADENOCA	Adenocarcinoma
ADH	Antidiuretic Hormone
ADJ	Adjacent
ADL	Activities of Daily Living/Life
ADM	Admission; Admit
AFF	Affirmative
AFP, αFP	Alpha-Fetoprotein
AG	Antigen
AGL	Acute Granulocytic Leukemia
AI	Atrial Insufficiency/-Incompetence/Stensosis
AIDS	Acquired Immune Deficiency Syndrome
AIHA	Autoimmuno Hemolytic Anemia
AIL	Angioimmunoblastic Lymphadenopathy
AILD	Angioimmunoblastic Lymphadenopathy with Dysproteinemia
AIN	Anal Intraepithelial Neoplasia
AISA	Acquired Idiopathic Sideroblastic Anemia
AK(A)	Above Knee (Amputation)
AKA	Also Known As
ALB	Albumin
ALK PHOS	Alkaline Phosphatase
ALL	Acute Lymphocytic Leukemia
ALS	Amyotrophic Lateral Sclerosis
AM	Before Noon
AMA	Against Medical Advice
AMB	Ambulatory
AMI	Acute Myocardial Infarction
AML	Acute Myeloid Leukemia
AMM	Agnogenic Myeloid Metaplasia
AMP	Amputation
AMT	Amount
ANAP	Anaplastic
ANGIO	Angiography; Angiogram
ANS	Autonomic Nervous System
ANT	Anterior
AODM	Adult-Onset Diabetes Mellitus
AP	Abdominal Perineal; Anteroposterior
APC	Atrial Premature Complexes
APP	Appendix
APPL'Y	Apparently
APPROX	Approximately
ARC	AIDS-Related Complex/Condition
ARF	Acute Renal Failure
ARD	AIDS-Related Disease
ARDS	Acute Respiratory Distress/Disease Syndrome
ARRHY	Arrhythmia
ART	Artery; Arterial
AS	Arteriosclerosis; Arteriosclerotic
ASA	Aspirin (Acetylsalicylic Acid)
ASAP	As Soon As Possible
ASCVD	Arteriorsclerotic Cardiovascular Disease
ASHD	Arteriosclerotic Heart Disease
ASM	Aggressive Systemic Mastocytosis
ASP	Aspiration
ASPVD	Arteriosclerotic Peripheral Vascular Disease
A-STEN	Aortic Stenosis
ATN	Acute Tubular Necrosis
ATP	Adenosine Triphosphate
ATR	Achilles Tendon Reflex
AUT	Autopsy
AV	Arteriovenous
AVG	Average
AVM	Arteriovenous Malformation
AX	Axilla(ry)

BA	Barium
BAD	Bipolar Affective Disorder
B-ALL	Burkitt type Acute Lymphocytic Leukemia
BALT	Bronchial-Associated Lymphoid Tissue
BCC	Basal Cell Carcinoma
BCG	Bacillus Calmette-Guerin
BCLL	B-cell Chronic Lymphocytic Leukemia
BCR	Breakpoint Cluster Region
BD	Bile Duct
BE	Barium Enema
B/F	Black Female
BIL	Bilateral
BK(A)	Below Knee (Amputation)
B/M	Black Male
BM	Bone Marrow; Bowel Movement
BP	Blood Pressure
BPH	Benign Prostatic Hypertrophy/Hyperplasia
BRB	Bright Red Blood
BRB(PR)	Bright Red Blood (per Rectum)
BRM	Biological Response Modifier
BRO	Brother
BRS	Breath Sounds
BS	Breath Sounds; Bowell Sounds
BSC	Bone Scan
BSO	Bilateral Salpingo-Oophorectomy
BT	Bladder Tumor
BUN	Blood Urea Nitrogen
BUS	Bartholin, Urethral, & Skene Glands
BV	Blood Volume
BX	Biopsy
C	With
C1-C7	Cervical Vertebrae
CA	Calcium; Carcinoma
CABG	Coronary Artery Bypass Graft
CAD	Coronary Artery Disease
C-ALL	Common Acute Lymphocytic Leukemia
CAP(S)	Capsule(s)
CASTLE	Carcinoma Showing Thymus-Like Element
CAT; CAT SCAN	Computerized Axial Tomography Scan
CBC	Complete Blood Count
CBD	Common Bile Duct
CBF	Core Binding Factor
CC	Chief Complaint; Cubic Centimeter
CCU	Corony Care Unit
CD	Cluster of Differentiation
CEA	Carcinoembryonic Antigen
CF	Cystic Fibrosis
CGL	Chronic Granulocytic Leukemia
CHD	Congenital Heart Disease
CHEMO	Chemotherapy
CHF	Congestive Heart Failure
CHG	Change
CHR	Chronic
CIG	Cigarettes
CIN	Cervical Intraepithelial Neoplasia
CIS	Carcinoma In Situ
CLL	Chronic Lymphocytic Leukemia
CLR	Clear
CM	Centimeter; Costal Margin
CMD	Chronic Myeloproliferative Disease
CML	Chronic Myeloid Leukemia
CMML	Chronic Myleomonocytic Leukemia
CMV	Cytomegalovirus
CNS	Central Nervous System
C/O	Complaining/Complaint Of
CO60	Cobalt-60
COLD	Chronic Obstructive Lung Disease
CONT	Continue; Continuous
CONTRA	Contralateral
COPD	Chronic Obstructive Pulmonary Disease
CPNE	Central Primitive Neuroectodermal Tumor
CRF	Chronic Renal Failure
CS	Cesium
C-SF	Colony-Stimulating Factor
CSF	Cerebrospinal Fluid
C-SPINE	Cervical Spine
CT; CT SC	Computerized Axial Tomography Scan
CUC	Chronic Ulcerative Colitis
CVA	Cerebrovascular Accident
CVD	Cardiovascular Disease
C/W	Consistent With
CX	Cervix
CXR	Chest X-Ray
CYSTO	Cystoscopy

CYTO	Cytology
D&C	Dilatation (Dilation) and Curettage
DC	Discontinue(d)
DCIS	Ductal Carcinoma *in Situ*
D-COLON	Descending Colon
DECR (or <)	Decrease(d)
DERM	Dermatology
DES	Diethylstilbrestrol
DIAM	Diameter
DIC	Disseminated Intravascular Coagulopathy
DIFF	Differentiated; Differential
DIN	Ductal Intraepithelial Neoplasia
DIS	Disease
DIS	Discharge
DM	Diabetes Mellitus
DNA	Deoxyribonucleic Acid
DISCH	Discharge
DOA	Dead on Arrival
DOB	Date of Birth
DOD	Date of Death
DOE	Dyspnea On Exertion
DR	Doctor
DRE	Digital Rectal Exam
DS	Discharge
DTR	Deep Tendon Reflex
DVT	Deep Vein Thrombosis
DX	Diagnosis
DZ	Disease
EC	Enterochromaffin
ECF	Extended Care Facility
ECG	Electrocardiogram
ECL	Enterochromaffin-Like
EEG	Electroencephalogram
EENT	Eye(s), Ear(s), Nose, and Throat
E.G. (e.g.)	For Example
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
EMG	Electromyogram
EMP	Extramedullary Plasmacytoma
ENDO	Endoscopic Retrograde
ENL; ENLGD	Enlarged
ENT	Ear(s), Nose, and Throat
ER	Emergency Room
ER(A)	Estrogen Receptor (Assay)
ERCP	Endoscopic Retrograde Cholangiopancreatography

ESRD	End Stage Renal Disease
ETO	Eight; Twenty-One (8;21)
ETOH	Alcohol
EUA	Examination Under Anesthesia
EVAL	Evaluation
EXAM	Examination
EXC(D)	Excision; Excise(d)
EXP	Expired; Died
EXP LAP	Exploratory Laparotomy
EXPL	Exploratory
EXPL LAP	Exploratory Laparotomy
EXT	Extend; Extension; External; Extremity
FB	Fingerbreadth
FDC	Follicular Dendritic Cell
FDCT	Follicular Dendritic Cell Tumor
FISH	Fluorescent In Situ Hybridization
FL	Fluid
FLURO	Fluoroscopy
F(M)H	Family (Medical) History
FNA	Fine Needle Aspiration
FNAB	Fine Needle Aspiration Biopsy
FOM	Floor of Mouth
FREQ	Frequent; Frequency
FS	Frozen Section
FTSG	Full Thickness Skin Graft
FU	Follow-up
FUO	Fever of Unknown Origin
FX	Fracture
G CELL	Gastrin cell
GANT	Gastrointestinal Autonomic Nerve Tumor
GB	Gallbladder
GE	Gastroenterostomy; Gastroesophageal
GEN	General; Generalized
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
GIST	Gastrointestinal Stromal Tumor
GM	Gram
GR	Grade
GU	Genitourinary
GYN	Gynecology
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCD	Heavy Chain Disease
HCG, hCG	Human Chorionic Gonadotropin

HCT	Hematocrit
HCV	Hepatitis C Virus
HCVD	Hypertensive Cardiovascular Disease
HDV	Hepatitis D Virus
HEENT	Head, Eyes, Ears, Nose, Throat
HES	Hypereosinophilic Syndrome
HGB	Hemoglobin
HIV	Human Immunodeficiency Virus
HO; H/O	History of
HORM	Hormone
HOSP	Hospital
H&P	History and Physical
HPI	History of Present Illness
HPV	Human Papilloma Virus
HR	Hour
HRS	Hours
HSM	Hepatosplenomegaly
HTLV(-III)	Human T-Lymophotrophic Virus (Type III)
HTN	Hypertension
HVD	Hypertensive Vascular Disease
HX	History
HYST	Hysterectomy
I	Iodine
I&D	Incision and Drainage
IBD	Inflammatory Bowel Disease
IBL	Immunoblastic Lymphadenopathy
ICM	Intercostal Margin
ICS	Intercostal Space
ICU	Intensive Care Unit
IDCS	Interdigitating Dendritic Cell Sarcoma
IDDM	Insulin-Dependent Diabetes Mellitus
IG	Immunoglobulin
IHC	Immunohistochemical
IHES, IHS	Idiopathic Hypereosinophilic Syndrome
IHSS	Idiopathic Hypertrophic Subaortic Stenosis
ILD	Interstitial Lung Disease
IM	Intramuscular
IMA	Internal Mammary Artery
IMP	Impression
INCL	Includes, Including
INCR (or >)	Increase(d)
INF	Inferior
INFILT	Infiltrating
INT	Internal
INV	Invade(s); Invading; Invasion
INVL	Involve(s); Involving; Involvement
IOD	Iodine
IP	Inpatient
IPPB	Intermittent Positive Pressure Breathing
IPSI	Ipsilateral
IPSID	Immunoproliferative Small Intestinal Disease
IRREG	Irregular
ISM	Indolent Systemic Mastocytosis
IT	Intrathecal
ITP	Idiopathic Thrombocytopenia
IV	Intravenous
IVC	Inferior Vena Cava
IVCA	Intravenous Cholangiogram
IVP	Intravenous Pyelogram
JMML	Juvenile Myelomonocytic Leukemia
JVD	Jugular Venous Distention
JRA	Juvenile Rheumatic Arthritis
KG	Kilogram
KS	Kaposi Sarcoma
KUB	Kidneys, Ureters, Bladder
KV	Kilovolt
L	Left; Liter
L1-L5	Lumbar Vertebrae
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenophy-Associated Virus
LBBB	Left Bundle Branch Block
LCH	Langerhans Cell Histiocytosis
LCIS	Lobular Carcinoma *in Situ*
LCM	Left Costal Margin
LDH	Lactic/Lactate Dehydrogenase
LE	Lower Extremity
LG	Large
LIQ	Lower Inner Quadrant
LINAC	Linear Accelerator
LKS(B)	Liver, Kidney, Spleen (Bladder)
LLE	Left Lower Extremity
LLL	Left Lower Lobe
LLQ	Left Lower Quadrant
LMD	Local Medical Doctor
LMP	Last Menstrual Period
LN	Lymph Node

LND	Lymph Node Dissection
LNS	Lymph Nodes
LOQ	Lower Outer Quadrant
LP	Lumbar Puncture
LRG	Large
LS	Lumbosacral
L-SPINE	Lumbar Spine
LS SCAN	Liver/Spleen Scan
LSO	Left Salpingo-oophorectomy
L-SPINE	Lumbar Spine
LT	Left
LTCF	Long-Term Care Facility
LUE	Left Upper Extremity
LUL	Left Upper Lobe
LUOQ	Left Upper Outer Quadrant
LUQ	Left Upper Quadrant
LUP ERYTH	Lupus Erythematosus
M-CSF	Macrophage Colony-Stimulating Factor
MAL	Malignant
MALIG	Malignant
MALT	Mucosal-Associated Lymphoid Tissue
MAND	Mandible; Mandibular
MAST	Mastectomy
MAT	Multifocal Arterial Tachycardia
MAX	Maxilla(ry); Maximum
MC(H); mC(H)	Millicurie(hours)
MCG; µg	Microgram
MCID	Mixed Combined Immunodeficiency
MCL	Midclavicular Line; Mast Cell Leukemia
MCS	Mast Cell Sarcoma
MCTD	Mixed Connective Tissue Disease
MD	Medical Doctor; Moderately Differentiated
MDS	Myelodysplastic Syndrome
MED(S)	Medication(s); Medicine
MET; METS	Metastases; Metastasis; Metastatic
MEV	Million Electron Volts
MG(H); mg(H)	Milligram(hours)
MGUS	Monoclonal Gammopathy of Undetermined Significance
MH	Malignant Histiocytosis
MICRO	Microscopic
MIN	Minimum; Minute
ML; ml	Middle Lobe; Milliliter
MM; mm	Millimeter
MOD	Moderate(ly)
MOD DIFF	Moderately Differentiated
MPNST	Malignant Peripheral Nerve Sheath Tumor
MRCP	Magnetic Resonance Cholangiopancreatography
MRI	Magnetic Resonance Imaging
MRM	Modified Radical Mastectomy
MRSA	Methicillin Resistant Staphylococcus Aureus
MSB	Main Stem Bronchus
MVP	Mitral Valve Prolapse
MYH11	Myosin, Heavy Polypeptide 11
NA	Not Applicable
NED	No Evidence of Disease
NEG (or --)	Negative
NEURO	Neurology
NK	Natural Killer
NL	Normal
NOS	Not Otherwise Specified
NR	Not Recorded
NSF	No Significant Findings
N&V	Nausea and Vomiting
NVD	Neck Vein Distention
OBST	Obstructed (-ing, ion)
OP	Operation
OP	Outpatient
OP REPORT	Operative Report
OR	Operating Room
OZ	Ounce
P&A	Percussion and Auscultation
PA	Posteroanterior
PA	Pulmonary Artery
PALP	Palpated (-able)
PAP	Papanicolaou Smear
PAP	Papillary
PATH	Pathology
PCL	Plasma Cell Leukemia
PCLI	Plasma Cell Labeling Index
PCR	Polymerase Chain Reaction
PD	Poorly Differentiated
PDT	Photodynamic Therapy
PE	Physical Examination
PEI	Percutaneous Ethanol Injection
PERC	Percutaneous
PET	Positron Emission Tomography
PI	Present Illness

PID	Pelvic Inflammatory Disease
PIN	Prostatic Intraepithelial Neoplasia
PLT	Platelets
PMD	Personal/Primary Medical Doctor
PMF	Primary Myelofibrosis
PMH	Past Medical History
PML	Promyelocytic Leukemia
PNET	Primitive Neuroectodermal Tumor
PO	Postoperative (-ly)
POD	Postoperative Day
POEMS	Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal gammopathy, Skin changes
POOR DIFF	Poorly Differentiated
POS (or +)	Positive
POSS	Possible
POST	Posterior
POST	Postmortem Examination
POSTOP	Postoperative (-ly)
PPD	Packs per Day
PPNET	Peripheral Primitive Neuroectodermal Tumor
PR(A)	Progesterone Receptor (Assay)
PREOP	Preoperative (-ly)
PROB	Probable (-ly)
PTA	Prior to Admission
PULM	Pulmonary
PUVA	Psoralen, Ultraviolet-A light
Q	Every
QD	Every Day
R	Right
RA	Radium; Refractory Anemia
RAD	Radiation; Radiation Absorbed Dose; Radical
RAEB	Refractory Anemia with Excess Blasts
RAEB-T	Refractory Anemia with Excess Blasts in Transformation
RARA	Retinoic Acid Receptor, Alpha
RARS	Refractory Anemia with Ringed Sideroblasts
RAS	Refractory Anemia with Sideroblasts
RBC	Red Blood Cells
RCM	Right Costal Margin
RCMD	Refractory Cytopenia with Multilineage Dysplasia
RESEC	Resection
RESPIR	Respiratory
RIA	Radioimmunoassay
RITA	Radiofrequency Interstitial Tissue Ablation
RLE	Right Lower Extremity
RLL	Right Lower Lobe
RLQ	Right Lower Quadrant
RML	Right Middle Lobe
RO, R/O	Rule Out
ROF	Review of Outside Films
ROS	Review of Outside Slides
ROS	Review of Systems
RSO	Right Salpingo-oophorectomy
RT	Radiation Therapy
RT	Right
RUE	Right Upper Extremity
RUL	Right Upper Lobe
RUQ	Right Upper Quadrant
RX	Treatment
S1-S5	Sacral Vertebra
SALT	Skin-Associated Lymphoid Tissue
SB	Small Bowel
SCC	Squamous Cell Carcinoma
S-COLON	Sigmoid Colon
SETTLE	Spindle Epithelial Tumor with Thymus-Like Element
SGOT	Serum Glutamic Oxaloacetic Transaminase
SGPT	Serum Glutamic Pyruvic Transaminase
SIG COLON	Sigmoid Colon
SM	Small
SM-AHNMD	Systemic Mastocytosis with Associated clonal, Hematological Non-Mast-cell lineage Disease
SMA	Sequential Multiple Analysis (Biochem Profile)
SMCD	Systemic tissue Mast Cell Disease
SML	Small
SML BWL	Small Bowel
SNF	Skilled Nursing Facility
SO	Salpingo-oophorectomy
SOB	Shortness of Breath
S/P	Status Post
SPEC	Specimen
SQ	Subcutaneous
SQ, SQUAM	Squamous
S-SPINE	Sacral Spine
STSG	Split Thickness Skin Graft

SUB-Q, SUBQ	Subcutaneous
SURG	Surgery, Surgical
SVC	Superior Vena Cava
SX	Symptoms
T	Thoracic
T1-T12	Thoracic Vertebra
TAH-BSO	Total Abdominal Hysterectomy-Bilateral Salpingo-oophorectomy
TCC	Transitional Cell Carcinoma
T-COLON	Transverse Colon
TPN	Total Parenteral Nutrition
TRANS COLON	Transverse Colon
TS	Tumor Size
T-SPINE	Thoracic Size
TUR	Transurethral Resection
TURB(T)	Transurethral Resection Bladder (Tumor)
TURP	Transurethral Resection Prostate
TVH	Total Vaginal Hysterectomy
TX	Treatment
UE	Upper Extremity
UGI	Upper Gastrointestinal
UIQ	Upper Inner Quadrant
UNDIFF	Undifferentiated
UOQ	Upper Outer Quadrant
VAG	Vagina, Vaginal
VAG HYST	Vaginal Hysterectomy
VAIN	Vaginal Intraepithelial Neoplasia
VASC	Vascular
VIN	Vulvar Intraepithelial Neoplasia
W/	With
WBC	White Blood Cells
WD	Well Differentiated
WELL DIFF	Well Differentiated
WM	Waldenstrom Macroglobulinemia
WNL	Within Normal Limits
W/O	Without
W/U	Work-Up
XR	X-Ray
YR	Year

Symbols

^, ↑	above, elevated, increased, superior (position), upper
V, ↓	below, decreased, inferior (position), lower
>	causes, distal, greater than, toward
<	caused by, less than, proximal
→	causes, distal, toward
←	caused by, proximal
-	negative, through
+	positive
¯¯¬	left upper quadrant
___|	left lower quadrant
¯¯¬	right upper quadrant
|___	right lower quadrant
@	at
/	comparison
=	equal
#	number (before numeral), pounds (after numeral)
X	times

Appendix D

Codes for:

Surgery of Primary Site -- At This Facility

and

Surgery of Primary Site -- Summary

Note: In this appendix, odd-numbered pages are on the left so that codes for cancer types spreading over two pages will face each other, and extra blank pages need not be inserted at the front.

LIP and ORAL CAVITY

C00.0 - C00.9	**Lip**
C01.9	**Base of Tongue**
C02.0 - C02.9	**Other Parts of Tongue**
C03.0 - C03.9	**Gum**
C04.0 - C04.9	**Floor of Mouth**
C05.0 - C05.9	**Palate**
C06.0 - C06.9	**Other Parts of Mouth**

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-14:**

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (used for tumor destruction)
- **13** Cryosurgery
- **14** Laser

Shave and **Wedge Resections** are included in procedures coded **20-27**, and a specimen is sent to pathology from these procedures:

20 Local tumor excision, NOS
- **26** Polypectomy
- **27** Excisional biopsy
  - **21** Photodynamic therapy (PDT) that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **22** Electrocautery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **23** Cryosurgery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **24** Laser ablation that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **25*** Laser excision that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)

30 Wide excision, NOS;
Hemiglossectomy;
Partial glossectomy

* The MCR has followed the SEER *Program Coding Manual* in indenting code **25** and inferring that it includes **20**, **26** or **27** procedures. The *FORDS* Manual presents the **25** indented at the level of codes **26** and **27** and therefore is probably not including procedures **20**, **26** and **27** in category **25**.

LIP and ORAL CAVITY [cont.]
C00.0 - C06.9

Radical Glossectomy and **Total Glossectomy** are included in procedures coded **40-43**:

40 Radical excision of tumor, NOS
- **41** Radical excision of tumor only
- **42** Combination of **41** with an en bloc* mandibulectomy (a resection in continuity with the mandible, including a marginal, segmental, hemi-, or total mandibulectomy)
- **43** Combination of **41** with an en bloc* maxillectomy (a resection in continuity with the maxilla, including a partial, subtotal or total maxillectomy)

* "En bloc" or "resection in continuity with" means that all these tissues were removed in the same surgery, but not necessarily in a single piece or specimen.

90 Primary site surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

PAROTID GLAND and MAJOR SALIVARY GLANDS
C07.9 C08.0 - C08.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-14:**

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (used for tumor destruction)
- **13** Cryosurgery
- **14** Laser

A specimen is sent to pathology from procedures coded **20-27**:

20 Local tumor excision, NOS
- **26** Polypectomy
- **27** Excisional biopsy
  - **21** Photodynamic therapy (PDT) that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **22** Electrocautery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **23** Cryosurgery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **24** Laser ablation that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **25*** Laser excision that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)

30 Less than total parotidectomy, NOS;
Less than total removal of major salivary gland, NOS
- **31** with facial nerve spared
- **32** with facial nerve sacrificed
- **33** Superficial lobe removed only
  - **34** with facial nerve spared
  - **35** with facial nerve sacrificed
- **36** Deep lobe (total) removed (with or without the superficial lobe)
  - **37** with facial nerve spared
  - **38** with facial nerve sacrificed

* The MCR has followed the SEER *Program Coding Manual* in indenting code **25** and inferring that it includes **20**, **26** or **27** procedures. The *FORDS* Manual presents the **25** indented at the level of codes **26** and **27** and therefore is probably not including procedures **20**, **26** and **27** in category **25**.

PAROTID GLAND and MAJOR SALIVARY GLANDS [cont.]
C07.9 C08.0 - C08.9

40 Total parotidectomy, NOS;
Total removal of major salivary gland, NOS
41 with facial nerve spared
42 with 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 (requiring a graft or flap coverage)

80 Parotidectomy, NOS;
Removal of major salivary gland, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

PHARYNX

C09.0 - C09.9	**Tonsil**
C10.0 - C10.9	**Oropharynx**
C11.0 - C11.9	**Nasopharynx**
C12.9	**Pyriform Sinus**
C13.0 - C13.9	**Hypopharynx**
C14.0	**Pharynx**

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-15:**

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (used for tumor destruction)
- **13** Cryosurgery
- **14** Laser
- **15** Stripping

A specimen is sent to pathology from procedures coded **20-28**:

20 Local tumor excision, NOS
- **26** Polypectomy
- **27** Excisional biopsy
  - **21** Photodynamic therapy (PDT) that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **22** Electrocautery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **23** Cryosurgery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **24** Laser ablation that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **25*** Laser excision that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **28*** Stripping that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)

30 Pharyngectomy, NOS
- **31** Limited pharyngectomy;
  Partial pharyngectomy;
  Bilateral tonsillectomy;
  Tonsillectomy, NOS
- **32** Total pharyngectomy

* The MCR has followed the SEER *Program Coding Manual* in indenting codes **25** and **28** and inferring that they include **20**, **26** or **27** procedures. The *FORDS* Manual presents the **25** and **28** indented at the level of codes **26** and **27** and therefore is probably not including procedures **20**, **26** and **27** in these categories.

PHARYNX [cont.]
C09.0 - C14.0

40 Pharyngectomy with laryngectomy and/or mandibulectomy*, NOS
- **41** Pharyngectomy with laryngectomy (laryngopharyngectomy)
- **42** Pharyngectomy with mandibulectomy (i.e., with removal of contiguous bone tissue, but *not* a total mandibular resection)
- **43** Pharyngectomy with laryngectomy and mandibulectomy (**41** and **42)**

* includes a marginal mandibulectomy, segmental mandibulectomy or hemimandibulectomy; but *not* a total mandibular resection

50 Radical pharyngectomy, NOS (includes a total mandibular resection)
- **51** without laryngectomy
- **52** with laryngectomy

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

ESOPHAGUS
C15.0 - C15.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-14:**

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (used for tumor destruction)
- **13** Cryosurgery
- **14** Laser

A specimen is sent to pathology from procedures coded **20-27**:

20 Local tumor excision, NOS
- **26** Polypectomy
- **27** Excisional biopsy
  - **21** Photodynamic therapy (PDT) that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **22** Electrocautery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **23** Cryosurgery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **24** Laser ablation that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **25*** Laser excision that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)

30 Partial esophagectomy

40 Total esophagectomy, NOS

50 Esophagectomy*, NOS with laryngectomy and/or gastrectomy, NOS
- **51** Esophagectomy with laryngectomy
- **52** Esophagectomy with gastrectomy, NOS
  - **53** Esophagectomy with a partial gastrectomy
  - **54** Esophagectomy with a total gastrectomy
- **55** Combination of esophagectomy, laryngectomy *and* gastrectomy (**51** with any of **52-54**)

* The "esophagectomy" in **50-55** may be a partial esophagectomy, total esophagectomy, or an esophagectomy, NOS.

* The MCR has followed the SEER *Program Coding Manual* in indenting code **25** and inferring that it includes **20**, **26** or **27** procedures. The *FORDS* Manual presents the **25** indented at the level of codes **26** and **27** and therefore is probably not including procedures **20**, **26** and **27** in category **25**.

ESOPHAGUS [cont.]
C15.0 - C15.9

80 Esophagectomy, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

STOMACH
C16.0 - C16.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-14:**

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (used for tumor destruction)
- **13** Cryosurgery
- **14** Laser

A specimen is sent to pathology from procedures coded **20-27**:

20 Local tumor excision, NOS
- **26** Polypectomy
- **27** Excisional biopsy
  - **21** Photodynamic therapy (PDT) that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **22** Electrocautery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **23** Cryosurgery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **24** Laser ablation that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **25*** Laser excision that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)

30 Gastrectomy, NOS (partial, subtotal or hemigastrectomy);
Sleeve resection of stomach;
Billroth I (anastomosis to duodenum, or duodenostomy);
Billroth II (anastomosis to jejunum, or jejunostomy)
- **31** Antrectomy, lower (distal, resection of < 40% of the stomach) (An incidental splenectomy is *not* included here.)
- **32** Lower (distal) gastrectomy (partial, subtotal or hemigastrectomy)
- **33** Upper (proximal) gastrectomy (partial, subtotal or hemigastrectomy)

40 Near-total or total gastrectomy, NOS (If a previous partial gastric resection is followed by the removal of the remaining stomach, code as **40-42**.)
- **41** Near-total gastrectomy
- **42** Total gastrectomy

* The MCR has followed the SEER *Program Coding Manual* in indenting code **25** and inferring that it includes **20**, **26** or **27** procedures. The *FORDS* Manual presents the **25** indented at the level of codes **26** and **27** and therefore is probably not including procedures **20**, **26** and **27** in category **25**.

STOMACH [cont.]
C16.0 - C16.9

50 Gastrectomy, NOS, with removal of a portion of the esophagus only
- **51** Partial or subtotal gastrectomy with a portion of the esophagus
- **52** Near-total or total gastrectomy with a portion of the esophagus

Procedures coded **60-63** are for gastric resections that include organs other than just the esophagus. Portions of the esophagus *may* be included in these resections. An omentectomy may be included. An incidental splenectomy is *not* included here:

60 Gastrectomy with en bloc* resection of other organ(s), NOS
- **61** Partial or subtotal gastrectomy with en bloc* resection of other organ(s)
- **62** Near total or total gastrectomy with en bloc* resection of other organ(s)
- **63** Radical gastrectomy with en bloc* resection of other organ(s)

* The other organ(s) are removed in continuity with the stomach during the same surgical procedure, but not necessarily in a single piece or specimen; also known as a resection in continuity with the other organ(s).

80 Gastrectomy, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

COLON
C18.0 - C18.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

Note: Code the removal or surgical ablation of single or multiple liver metastases in the data items "Surgical Procedure of Other Site -- At This Facility" and/or "Surgical Procedure of Other Site -- Summary".

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-14:**

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (used for tumor destruction)
- **13** Cryosurgery
- **14** Laser

A specimen is sent to pathology from procedures coded **20-29**:

20 Local tumor excision, NOS
- **27** Excisional biopsy
- **26** Polypectomy, NOS
- **28** Endoscopic polypectomy
- **29** Surgical excision polypectomy
  - **21** Photodynamic therapy (PDT) that includes local tumor excision (**20**), excisional biopsy (**27**) or polypectomy (**26**, **28**, **29**)
  - **22** Electrocautery that includes local tumor excision (**20**), excisional biopsy (**27**) or polypectomy (**26**, **28**, **29**)
  - **23** Cryosurgery that includes local tumor excision (**20**), excisional biopsy (**27**) or polypectomy (**26**, **28**, **29**)
  - **24** Laser ablation that includes local tumor excision (**20**), excisional biopsy (**27**) or polypectomy (**26**, **28**, **29**)
  - **25*** Laser excision that includes local tumor excision (**20**), excisional biopsy (**27**) or polypectomy (**26**, **28**, **29**)

* The MCR has followed the SEER *Program Coding Manual* in indenting code **25** and inferring that it includes **20** and **26 - 29** procedures. The *FORDS* Manual presents the **25** indented at the level of codes **26 - 29** and therefore is probably not including procedures **20** and **26 - 29** in category **25**.

COLON [cont.]
C18.0 - C18.9

Procedures coded **30** and **32** include, but are not limited to:

Appendectomy (for an appendix primary only)
Enterocolectomy
Ileocolectomy
Partial colectomy, NOS
Partial resection of transverse colon and flexures
Segmental resection (for example, cecectomy or sigmoidectomy)

30 Partial colectomy, but less than hemicolectomy;
Segmental resection
32 Partial colectomy or segmental resection with the resection of a contiguous organ (e.g., small bowel or bladder)

40 Subtotal colectomy;
Hemicolectomy (total right or left colectomy with a portion of the transverse colon);
Greater than hemicolectomy but less than total colectomy
41 Subtotal colectomy/hemicolectomy with the resection of a contiguous organ (e.g., small bowel or bladder)

50 Total colectomy (removal of the colon from cecum to rectosigmoid junction); may also include a *portion* of the rectum
51 Total colectomy with the resection of a contiguous organ (e.g., small bowel or bladder)

60 Total proctocolectomy (removal of the colon from cecum to rectosigmoid junction and removal of the entire rectum; (commonly used for familial polyposis or polyposis coli)
61 Total proctocolectomy with the resection of a contiguous organ (e.g., small bowel or bladder)

Procedures coded **70** include any colectomy (partial, hemi- or total) with a resection of any other organs in continuity with the primary site (en bloc). The other organ(s) may be partially or totally removed. Such procedures include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, and pelvic exenteration. The organs are removed during a single surgery but not necessarily in one piece or specimen.

70 Colectomy or coloproctotectomy with resection of contiguous organ(s), NOS (not enough information about what was removed to code as **32**, **41**, **51** or **61**)

80 Colectomy, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

RECTOSIGMOID JUNCTION
C19.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

Note: Code the removal or surgical ablation of single or multiple liver metastases in the data items "Surgical Procedure of Other Site -- Summary" and/or "Surgical Procedure of Other Site -- At This Facility".

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-14:**

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (used for tumor destruction)
- **13** Cryosurgery
- **14** Laser ablation

A specimen is sent to pathology from procedures coded **20-27**:

20 Local tumor excision, NOS
- **26** Polypectomy
- **27** Excisional biopsy
  - **21** Photodynamic therapy (PDT) that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **22** Electrocautery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **23** Cryosurgery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **24** Laser ablation that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **25*** Laser excision that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)

Procedures in codes **30** and **31** include, but are not limited to:
Anterior resection
Hartmann's operation
Low anterior resection (LAR)
Partial colectomy, NOS
Rectosigmoidectomy, NOS
Sigmoidectomy

30 Wedge or segmental resection;
Partial proctosigmoidectomy, NOS
- **31** Wedge or segmental resection or partial proctosigmoidectomy with the resection of contiguous organ(s) (e.g., small bowel, bladder)

* The MCR has followed the SEER *Program Coding Manual* in indenting code **25** and inferring that it includes **20**, **26** or **27** procedures. The *FORDS* Manual presents the **25** indented at the level of codes **26** and **27** and therefore is probably not including procedures **20**, **26** and **27** in category **25**.

RECTOSIGMOID JUNCTION [cont.]
C19.9

Procedures coded **40** include, but are not limited to:
Altemeier's operation
Duhamel's operation
Soave's submucosal resection
Swenson's operation
Turnbull's operation

40 Pull through with sphincter preservation (colo-anal anastomosis)

Procedures coded **50** include, but are not limited to:
Abdominoperineal resection (A & P resection)
Anterior/posterior resection (A/P resection) / Miles' operation
Rankin's operation

50 Total proctectomy

51 Total colectomy (removal of the colon from cecum to rectosigmoid junction; a *portion* of the rectum may also be removed)

55 Total colectomy with ileostomy, NOS
56 Total colectomy with ileorectal reconstruction
57 Total colectomy with other pouch (for example, Koch pouch)

60 Total proctocolectomy, NOS (removal of colon from cecum to rectosigmoid junction and the entire rectum; combination of **50** and **51**)
65 Total proctocolectomy with ileostomy, NOS
66 Total proctocolectomy with ileostomy and pouch

Procedures coded **70** include proctocolectomy or any colectomy (partial, hemi- or total) with an en bloc (in continuity) resection of other organs (except the rectum). The other organs may be partially or totally removed. This is done in one procedure but not necessarily in a single specimen. Procedures may include an oophorectomy or rectal mucosectomy.

70 Colectomy or proctocolectomy with a resection in continuity with other organs (en bloc);
Pelvic exenteration

80 Colectomy, NOS;
Proctectomy, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

RECTUM
C20.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

Note: Code the removal or surgical ablation of single or multiple liver metastases in the data items "Surgical Procedure of Other Site -- At This Facility" and/or "Surgical Procedure of Other Site -- Summary".

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-14:**

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (used for tumor destruction)
- **13** Cryosurgery
- **14** Laser

A specimen is sent to pathology from procedures coded **20-28**:

20 Local tumor excision, NOS
- **27** Excisional biopsy
- **26** Polypectomy
  - **21** Photodynamic therapy (PDT) that includes local tumor excision (**20**), excisional biopsy (**27**) or polypectomy (**26**)
  - **22** Electrocautery that includes local tumor excision (**20**), excisional biopsy (**27**) or polypectomy (**26**)
  - **23** Cryosurgery that includes local tumor excision (**20**), excisional biopsy (**27**) or polypectomy (**26**)
  - **24** Laser ablation that includes local tumor excision (**20**), excisional biopsy (**27**) or polypectomy (**26**)
  - **25*** Laser excision that includes local tumor excision (**20**), excisional biopsy (**27**) or polypectomy (**26**)
  - **28*** Curette and fulguration that includes local tumor excision (**20**), excisional biopsy (**27**) or polypectomy (**26**)

Procedures coded **30** include, but are not limited to:
Anterior resection
Hartmann's operation
Low anterior resection (LAR)
Trans-sacral rectosigmoidectomy

30 Wedge or segmental resection;
Partial proctectomy, NOS

* The MCR has followed the SEER *Program Coding Manual* in indenting codes **25** and **28** and inferring that they include **20**, **26** or **27** procedures. The *FORDS* Manual presents the **25** and **28** indented at the level of codes **26** and **27** and therefore is probably not including procedures **20**, **26** and **27** in these categories.

RECTUM [cont.]
C20.9

Procedures coded **40** include, but are not limited to:
Altemeier's operation
Duhamel's operation
Soave's submucosal resection
Swenson's operation
Turnbull's operation

40 Pull through with sphincter preservation (colo-anal anastomosis)

Procedures coded **50** include, but are not limited to:
Abdominoperineal resection (A & P resection, A/P resection)
Miles' procedure
Rankin's operation

50 Total proctectomy

60 Total proctocolectomy, NOS

In procedures coded **70**, all of the tissues are removed in one surgical procedure, but not necessarily in one piece or specimen.

70 Proctectomy or proctocolectomy with resection in continuity with other organs (en bloc);
Pelvic exenteration

80 Proctectomy, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

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ANUS and ANAL CANAL
C21.0 - C21.8

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-15:**

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (used for tumor destruction)
- **13** Cryosurgery
- **14** Laser
- **15** Thermal ablation

A specimen is sent to pathology from procedures coded **20-27**. Margins *may* have microscopic involvement.

20 Local tumor excision, NOS
- **26** Polypectomy
- **27** Excisional biopsy
  - **21** Photodynamic therapy (PDT) that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **22** Electrocautery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **23** Cryosurgery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **24** Laser ablation that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **25*** Laser excision that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)

60 Abdominal perineal resection, NOS (APR, Miles' procedure)
- **61** APR with sentinel node excision
- **62** APR with unilateral inguinal lymph node dissection
- **63** APR with bilateral inguinal lymph node dissection

(Note: For procedures coded **61-63**, also include the node removal in the "Scope of Regional Lymph Node Surgery" fields.)

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

* The MCR has followed the SEER *Program Coding Manual* in indenting code **25** and inferring that it includes **20**, **26** or **27** procedures. The *FORDS* Manual presents the **25** indented at the level of codes **26** and **27** and therefore is probably not including procedures **20**, **26** and **27** in category **25**.

LIVER and INTRAHEPATIC BILE DUCTS
C22.0, C22.1

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-17:**

10 Local tumor destruction, NOS;
Chemoembolization (Also code the agents used under Chemotherapy.)
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (for tumor destruction)
- **13** Cryosurgery
- **14** Laser
- **15** Alcohol (percutaneous ethanol injection, PEI)
- **16** Heat;
  Radiofrequency ablation (RFA)
- **17** Other (for example, ultrasound or acetic acid)

A specimen is sent to pathology from procedures coded **20-26**:

20 Wedge resection, NOS;
Segmental resection, NOS
- **21** Wedge resection
- **22** Segmental resection, NOS
  - **23** Segmental resection of one segment
  - **24** Segmental resection of two segments
  - **25** Segmental resection of three segments
  - **26** Segmental resection and local tumor destruction

30 Simple lobectomy;
Lobectomy, NOS
- **36** Right lobectomy
- **37** Left lobectomy
- **38** Lobectomy and local tumor destruction

50 Extended lobectomy (resection of a single lobe plus a segment of another lobe), NOS
- **51** Extended right lobectomy
- **52** Extended left lobectomy
- **59** Extended lobectomy and local tumor destruction

60 Hepatectomy, NOS
- **61** Total hepatectomy and transplant

LIVER and INTRAHEPATIC BILE DUCTS [cont.]

C22.0, C22.1

65 Excision of a bile duct (for an intrahepatic bile duct primary only)

66 Excision of a bile duct plus a partial hepatectomy

75 Bile duct and hepatectomy with a transplant

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

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PANCREAS
C25.0 - C25.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

25 Local excision of tumor, NOS

30 Partial pancreatectomy, NOS (for example, a distal pancreatectomy)

35 Local or partial pancreatectomy and duodenectomy
- **36** without a distal or partial gastrectomy
- **37** with a partial gastrectomy (Whipple procedure)

40 Total pancreatectomy

60 Total pancreatectomy with subtotal gastrectomy or duodenectomy

70 Extended pancreatoduodenectomy

80 Pancreatectomy, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

LARYNX
C32.0 - C32.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-15:**

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (for tumor destruction)
- **13** Cryosurgery
- **14** Laser
- **15** Stripping

A specimen is sent to pathology from procedures coded **20-28**:

20 Local tumor excision, NOS
- **26** Polypectomy
- **27** Excisional biopsy
  - **21** Photodynamic therapy (PDT) that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **22** Electrocautery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **23** Cryosurgery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **24** Laser ablation that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **25*** Laser excision that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **28*** Stripping that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)

30 Partial excision of the primary site, NOS;
Subtotal or 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

* The MCR has followed the SEER *Program Coding Manual* in indenting codes **25** and **28** and inferring that they include **20**, **26** or **27** procedures. The *FORDS* Manual presents the **25** and **28** indented at the level of codes **26** and **27** and therefore is probably not including procedures **20**, **26** and **27** in these categories.

LARYNX [cont.]
C32.0 - C32.9

50 Pharyngolaryngectomy

80 Laryngectomy, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

BRONCHUS and LUNG
C34.0 - C34.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

19 Local tumor destruction *or* excision, NOS; unknown if a specimen was sent to pathology

No specimen is sent to pathology from procedures coded **15**, **12** and **13**:

15 Local tumor destruction, NOS;
Photodynamic therapy (PDT)
- **12** Cryosurgery;
  Laser ablation
- **13** Electrocautery;
  Fulguration;
  Hot forceps (for tumor destruction)

A specimen is sent to pathology from procedures coded **20-25**:

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 (includes lingulectomy)

30 Resection of at least one lobe, but less than the whole lung (lobectomy, bilobectomy or partial pneumonectomy, NOS)
- **33** Lobectomy with mediastinal lymph node dissection (Also code the node dissection in the "Scope of Regional Lymph Node Surgery" fields.)

45 Extended lobectomy/bilobectomy, NOS
- **46** with chest wall
- **47** with pericardium
- **48** with diaphragm

55 Pneumonectomy, NOS
- **56** Pneumonectomy with mediastinal lymph node dissection (i.e., radical pneumonectomy) (Also code the node dissection in the "Scope of Regional Lymph Node Surgery" fields.)

65 Extended pneumonectomy
- **66** with pleura or diaphragm removal

BRONCHUS and LUNG [cont.]
C34.0 - C34.9

70 Extended radical pneumonectomy (radical pneumonectomy, including removal of mediastinal nodes, with the removal of other tissues or nodes) (Also code the node dissection in the "Scope of Regional Lymph Node Surgery" fields.)

80 Resection of lung, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed
Death certificate-only case

BONES, JOINTS and ARTICULAR CARTILAGE
C40.0 - C40.9, C41.0 - C41.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

19 Local tumor destruction *or* excision, NOS; unknown if a specimen was sent to pathology

15 Local tumor destruction; no specimen is sent to pathology

25 Local excision; specimen is sent to pathology

26 Partial resection; specimen is sent to pathology

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 amputation, including scapula
- **52** Hindquarter amputation, including ilium/hip bone
- **53** Hemipelvectomy, NOS
- **54** Internal hemipelvectomy

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

BLOOD, BONE MARROW, and RETICULOENDOTHELIAL SYSTEM
C42.0, C42.1, C42.3, C42.4

for all ICD-O-3 Histologic Type Codes

98 Use this code whether or not any primary site surgery took place, unless a death certificate-only case.

99 Death certificate-only case

Surgical procedures for these primary sites are recorded in the data items "Surgical Procedure of Other Site -- At This Facility" and/or "Surgical Procedure of Other Site -- Summary".

SPLEEN
C42.2

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

19 Local tumor destruction, NOS; no specimen sent to pathology or unknown if specimen sent
Local tumor excision, NOS; no specimen sent to pathology or unknown if specimen sent

21 Partial splenectomy

22 Total splenectomy

80 Splenectomy, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

SKIN
C44.0 - C44.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-14:**

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (used for tumor destruction)
- **13** Cryosurgery
- **14** Laser ablation

A specimen is sent to pathology from procedures coded **20-27**:

20 Local tumor excision, NOS
- **26** Polypectomy
- **27** Excisional biopsy
  - **21** Photodynamic therapy (PDT) that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **22** Electrocautery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **23** Cryosurgery that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **24** Laser ablation that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **25*** Laser excision that includes local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)

30 Biopsy of the primary tumor followed by a gross excision of the lesion (both not necessarily 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' surgery with margin $\leq$ 1 cm
- **36** Mohs' surgery with margin > 1 cm

* The MCR has followed the SEER *Program Coding Manual* in indenting code **25** and inferring that it includes **20**, **26** or **27** procedures. The *FORDS* Manual presents the **25** indented at the level of codes **26** and **27** and therefore is probably not including procedures **20**, **26** and **27** in category **25**.

SKIN
C44.0 - C44.9

45 Wide excision or re-excision of lesion or minor (local) amputation*, NOS with margins > 1 cm**
(Margins must be microscopically negative.**)
46 with margins > 1 cm and ≤ 2 cm
47 with margins > 2 cm

* Local amputation is the surgical resection of digits, ear, eyelid, lip or nose.

** If margins are ≤ 1 cm, or if there is residual microscopic disease, use the most appropriate code from **20 - 36**.

60 Major amputation, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

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PERIPHERAL NERVES and SOFT TISSUES

C47.0 - C47.9 Peripheral Nerves and Autonomic Nervous System
C49.0 - C49.9 Connective, Subcutaneous, and Other Soft Tissues

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

19 Local tumor destruction *or* excision, NOS; unknown if a specimen was sent to pathology

15 Local tumor destruction; no specimen is sent to pathology

25 Local excision; specimen is sent to pathology

26 Partial resection; specimen is sent to pathology

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 amputation, including scapula
- **52** Hindquarter amputation, including ilium/hip bone
- **53** Hemipelvectomy, NOS
- **54** Internal hemipelvectomy

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

BREAST
C50.0 - C50.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

19 Local tumor destruction, NOS; no specimen sent to pathology

Procedures coded **20-24** remove the gross primary tumor and some breast tissue (a breast-conserving or breast-preserving procedure). There may be *micro*scopic residual tumor.

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;
  Wedge resection;
  Quadrantectomy;
  Tylectomy

30 Subcutaneous mastectomy (the removal of breast tissue *without* the nipple, areolar complex and overlying skin) (This procedure is rarely performed to treat malignancies.)

40 Total simple mastectomy, NOS (removes all breast tissue, nipple and areolar complex; axillary node dissection is not done, but sentinel nodes may be taken)
- **41** Simple mastectomy without removal of *un*involved contralateral breast
  - **43** with reconstruction, NOS
    - **44** using human tissue (such as muscle or skin)
    - **45** using implant (artificial)
    - **46** using tissue and implant
- **42** Simple mastectomy with removal of *un*involved contralateral breast
  - **47** with reconstruction, NOS
    - **48** using human tissue (such as muscle or skin)
    - **49** using implant (artificial)
    - **75** using tissue and implant

If the contralateral breast is involved:

for a single primary (that is, the contralateral breast has distant disease), removal of the contralateral breast would be coded in the "Surgery of Other Site" fields and code **41** might be the appropriate code for the primary site surgery;

if an independent second primary is discovered in the contralateral breast, code the surgeries for each primary independently (that is, the primary site surgery could be coded **46** on both abstracts if two simple mastectomies with combination reconstruction were performed).

50 Modified radical mastectomy [removes all breast tissue, nipple, areolar complex and amounts of breast skin in continuity with the axilla (en bloc); may include part of pectoralis major muscle] All must be removed in one procedure, but not necessarily in one piece/specimen. If some nodes were taken (e.g., sentinel nodes) *but a true axillary node dissection was not done*, use a code from the group **40-49**, **75**. If it's unclear whether the node surgery should be counted as a dissection (e.g., only 1-2 axillary nodes taken), just rely on the surgeon's description of whether it was a simple or modified radical mastectomy.

- **51** Modified radical mastectomy without removal of *un*involved contralateral breast
  - **53** with reconstruction, NOS
    - **54** using human tissue (such as muscle or skin)
    - **55** using implant (artificial)
    - **56** using tissue and implant
- **52** Modified radical mastectomy with removal of *un*involved contralateral breast
  - **57** with reconstruction, NOS
    - **58** using human tissue (such as muscle or skin)
    - **59** using implant (artificial)
    - **63** using tissue and implant

For single primaries, code removal of involved contralateral breast in the "Surgery of Other Site" fields. If the contralateral involvement is a second primary, use **51** for the first primary and code the other primary's surgery independently.

60 Radical mastectomy, NOS (removal of all breast tissue, nipple, areolar complex, variable amounts of skin, pectoralis minor and major muscles, with an en bloc axillary node dissection) The nodes must be taken in the same procedure but not necessarily in a single piece or specimen. If some nodes were taken (such as sentinel nodes) but an axillary node dissection was not done, use a code from the group **40-49**, **75**.

- **61** Radical mastectomy without removal of *un*involved contralateral breast
  - **64** with reconstruction, NOS
    - **65** using human tissue (such as muscle or skin)
    - **66** using implant (artificial)
    - **67** using tissue and implant
- **62** Radical mastectomy with removal of *un*involved contralateral breast
  - **68** with reconstruction, NOS
    - **69** using human tissue (such as muscle or skin)
    - **73** using implant (artificial)
    - **74** using tissue and implant

For single primaries only, code removal of an involved contralateral breast in the "Surgery of Other Site" fields. For a second primary in the contralateral breast, code the surgery for each primary independently.

70 Extended radical mastectomy (removal of all breast tissue, nipple, areolar complex, variable amounts of skin, pectoralis minor, pectoralis major and internal mammary nodes with an en bloc axillary node dissection) The nodes must be removed in the same procedure but not necessarily in the same specimen.

- **71** Extended radical mastectomy without removal of *un*involved contralateral breast
- **72** Extended radical mastectomy with removal of *un*involved contralateral breast

For single primaries only, code removal of an involved contralateral breast in the "Surgery of Other Site" fields; if the contralateral involvement is a second primary, code the surgery for each independently.

80 Mastectomy, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed; Death certificate-only case

CERVIX UTERI
C53.0 - C53.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-17:**

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery (but not LEEP);
  Fulguration;
  Hot forceps (used for tumor destruction)
- **13** Cryosurgery
- **14** Laser (not ablation)*
- **15** Loop electrocautery excision procedure (LEEP)
- **16** Laser ablation*
- **17** Thermal ablation

* To distinguish between codes **14** and **16**: Both involve laser use with no pathology specimen obtained. Use **16** when the record specifies "ablation" with laser, and use **14** when simple destruction not termed "ablation" occurs via the laser. If laser is used without a "destruction" vs. "ablation" distinction (laser use, NOS) and no pathology specimen is obtained, assume that the laser use was simply destructive and use **14**.

A specimen is sent to pathology from procedures coded **20-29**:

20 Local tumor excision, NOS
- **26** Excisional biopsy, NOS
- **27** Cone biopsy
- **24** Cone biopsy with gross excision of lesion
- **29** Trachelectomy;
  Removal of cervical stump;
  Cervicectomy
  - **21** Electrocautery that includes local tumor excision (**20**), an excisional biopsy (**26**), cone biopsy (**27**, **24**) or trachelectomy (**29**)
  - **22** Cryosurgery that includes local tumor excision (**20**), an excisional biopsy (**26**), cone biopsy (**27**, **24**) or trachelectomy (**29**)
  - **23** Laser ablation or laser excision that includes local tumor excision (**20**), an excisional biopsy (**26**), cone biopsy (**27**, **24**) or trachelectomy (**29**)
- **25*** Dilation (dilatation) and curettage (D&C); endocervical curettage (for *in situ* only)
- **28** Loop electrocautery excision procedure (LEEP)

* For invasive cervical cancers, a D&C is usually coded as an incisional biopsy (**02**) under Surgical Diagnostic/Staging Procedures. A D&C is *not* usually coded as Surgery of Primary Site for invasive tumors unless the curette is used to perform an excisional biopsy. **25** would normally be used only for *in-situ* disease in registries recording such cancers.

30 Total hysterectomy (simple, pan-) without removal of tubes and ovaries (removal of the corpus and cervix uteri; a portion of the vaginal cuff *may* be included)

CERVIX UTERI [cont.]
C53.0 - C53.9

40 Total hysterectomy (simple, pan-) with removal of tubes and/or ovary

50 Modified radical, radical, extended or extended radical hysterectomy
- **51** Modified radical hysterectomy
- **52** Extended hysterectomy
- **53** Radical hysterectomy;
  Wertheim procedure
- **54** Extended radical hysterectomy

60 Hysterectomy, NOS (with or without removal of tubes and ovaries)
- **61** Hysterectomy without removal of tubes and ovaries
- **62** Hysterectomy with removal of tubes and ovaries

70 Pelvic exenteration, NOS
- **71** Anterior exenteration (includes removal of bladder, distal ureters, and genital organs with their ligamentous attachments and pelvic lymph nodes) [Also code the pelvic (distant) node removal in the "Surgery of Other Sites" fields.]
- **72** Posterior exenteration (includes removal of rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes) [Also code the pelvic (distant) node removal in the "Surgery of Other Sites" fields.]
- **73** Total exenteration (includes removal of all pelvic contents and pelvic lymph nodes) [Also code the pelvic (distant) node removal in the "Surgery of Other Sites" fields.]
- **74** Extended exenteration (includes removal of pelvic blood vessels or bony pelvis)

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

CORPUS UTERI and UTERUS, NOS
C54.0 - C54.9, C55.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

For invasive uterine cancers, dilation (dilatation) and curettage is usually coded as an incisional biopsy (**02**) under Surgical Diagnostic/Staging Procedures. A D&C is not usually coded as Surgery of Primary Site for invasive tumors (unless the curette is used to perform an excisional biopsy).

00 No surgery of primary site;
Autopsy-only case

19 Local tumor destruction or excision, NOS (unknown if a specimen was sent to pathology)

No specimen is sent to pathology from procedures coded **10-16:**

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery (but not LEEP);
  Fulguration;
  Hot forceps (used for tumor destruction)
- **13** Cryosurgery
- **14** Laser
- **15** Loop electrocautery excision procedure (LEEP)
- **16** Thermal ablation

Procedures in code **20** include, but are not limited to:
- Cryosurgery
- Electrocautery
- Excisional biopsy
- Laser ablation
- Thermal ablation

A specimen is sent to pathology from procedures coded **20-26**. Margins of resection *may* have microscopic involvement.

20 Local tumor excision, NOS;
Simple excision, NOS
- **24** Excisional biopsy, NOS
- **25** Polypectomy
- **26** Myomectomy
  - **21** Electrocautery that includes local tumor or simple excision (**20**), excisional biopsy (**24**), polypectomy (**25**) or myomectomy (**26**)
  - **22** Cryosurgery that includes local tumor or simple excision (**20**), excisional biopsy (**24**), polypectomy (**25**) or myomectomy (**26**)
  - **23** Laser ablation or laser excision that includes local tumor or simple excision (**20**), excisional biopsy (**24**), polypectomy (**25**) or myomectomy (**26**)

CORPUS UTERI and UTERUS, NOS [cont.]
C54.0 - C54.9, C55.9

30 Subtotal hysterectomy / supracervical hysterectomy / fundectomy [with or without removal of tube(s) and ovary(ies)]; The cervix is *not* removed.
- **31** without removal of tube(s) and ovary (ies)
- **32** with removal of tube(s) and ovary (ies)

40 Total hysterectomy (simple, pan-) without removal of tube(s) and ovary (ies) (removal of corpus and cervix uteri) A portion of the vaginal cuff *may* be included.

50 Total hysterectomy (simple, pan-) with removal of tube(s) and/or ovary (ies)

60 Modified radical or extended hysterectomy;
Radical or extended radical hysterectomy
- **61** Modified radical hysterectomy
- **62** Extended hysterectomy
- **63** Radical hysterectomy;
  Wertheim procedure
- **64** Extended radical hysterectomy

65 Hysterectomy, NOS [with or without removal of tube(s) and ovary(ies)]
- **66** Hysterectomy without removal of tube(s) and ovary(ies)
- **67** Hysterectomy with removal of tube(s) and ovary(ies)

75 Pelvic exenteration, NOS
- **76** Anterior exenteration (includes removal of bladder, distal ureters, and genital organs with their ligamentous attachments and pelvic lymph nodes) (The pelvic node removal is also coded in the "Scope of Regional Lymph Node Surgery" fields.)
- **77** Posterior exenteration (includes removal of rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes) (The pelvic node removal is also coded in the "Scope of Regional Lymph Node Surgery" fields.)
- **78** Total exenteration (includes removal of all pelvic contents and pelvic lymph nodes) (Also code the pelvic node removal in the "Scope of Regional Lymph Node Surgery" fields.)
- **79** Extended exenteration (includes removal of pelvic blood vessels or bony pelvis)

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

OVARY
C56.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

17 Local tumor destruction, NOS (no specimen sent to pathology)

A specimen is sent to pathology from procedures coded **25-28**:

25 Total removal of tumor or single ovary, NOS
- **26** Resection (wedge, subtotal or partial) of ovary only, NOS; unknown if a hysterectomy was done
- **27** with*out* a hysterectomy
- **28** with a hysterectomy

35 Unilateral (salpingo-)oophorectomy; unknown if a hysterectomy was done
- **36** Unilateral oophorectomy with*out* a hysterectomy
- **37** Unilateral oophorectomy with a hysterectomy

50 Bilateral (salpingo-)oophorectomy; unknown if a hysterectomy was done
- **51** Bilateral oophorectomy with*out* a hysterectomy
- **52** Bilateral oophorectomy with a hysterectomy

55 Unilateral or bilateral (salpingo-) oophorectomy with omentectomy, NOS (partial or total), unknown if a hysterectomy was done
- **56** without a hysterectomy
- **57** with a hysterectomy

60 Debulking*;
Cytoreductive surgery, NOS
- **61** with removal of colon (including appendix) and/or small intestine resection (not incidental)
- **62** with partial resection of urinary tract (not incidental)
- **63** Debulking of tumor with colon removal, partial resection of urinary tract, and/or small intestine resection (**61** and **62**)

* Debulking is partial or total removal of the tumor mass and *may* involve the removal of multiple organs. It may include removal of ovaries and/or uterus (a hysterectomy). The pathology report may or may not specifically identify ovarian tissue. Debulking is usually followed by another treatment modality, such as Chemotherapy.

OVARY [cont.]
C56.9

70 Pelvic exenteration, NOS
- **71** Anterior exenteration (includes removal of bladder, distal ureters, and genital organs with their ligamentous attachments and pelvic lymph nodes) (The pelvic node removal is also coded in the "Scope of Regional Lymph Node Surgery" fields.)
- **72** Posterior exenteration (includes removal of rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes) The pelvic node removal is also coded in the "Scope of Regional Lymph Node Surgery" fields.)
- **73** Total exenteration (includes removal of all pelvic contents and pelvic lymph nodes) The pelvic node removal is also coded in the "Scope of Regional Lymph Node Surgery" fields.)
- **74** Extended exenteration (includes removal of pelvic blood vessels or bony pelvis)

80 (Salpingo-) oophorectomy, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

PROSTATE GLAND
C61.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

Note: Do *not* code an orchiectomy in this field. For prostate primaries, bilateral orchiectomies are recorded as endocrine surgery in the data item "Hematologic Transplant and Endocrine Procedures".

00 No surgery of primary site;
Autopsy-only case

18 Local tumor destruction, NOS (unknown if a specimen was sent to pathology)

19 Transurethral resection (TURP), NOS (unknown if a specimen was sent to pathology)

No specimen is sent to pathology from procedures coded **10-17:**

10 Local tumor destruction *or* excision, NOS
- **14** Cryoprostatectomy
- **15** Laser ablation
- **16** Hyperthermia
- **17** Other method of local destruction or excision

A specimen is sent to pathology from procedures coded **20-26**:

20 Local tumor excision, NOS
- **21** Transurethral resection (TURP), NOS
  - **22** TURP where cancer was an incidental finding during surgery for benign disease
  - **23** TURP where the patient had suspected or known cancer
- **24** Cryosurgery with local tumor excision (**20**) or TURP (**21-23**)
- **25** Laser with local tumor excision (**20**) or TURP (**21-23**)
- **26** Hyperthermia with local tumor excision (**20**) or TURP (**21-23**)

30 Subtotal, segmental or simple prostatectomy (all or part of the prostatic capsule may remain)

50 Total prostatectomy, NOS;
Radical prostatectomy, NOS (excision of prostate, prostatic capsule, ejaculatory ducts and seminal vesicle(s); *may* include a narrow cuff of the bladder neck)

70 Prostatectomy with resection in continuity with other organs* (en bloc);
Pelvic exenteration

* The other organs may be partially or totally removed. They must be removed in the same procedure, but not necessarily in a single piece or specimen. Procedures that may involve an en bloc resection include, but are not limited to: cystoprostatectomy, radical cystectomy and prostatectomy.

PROSTATE GLAND [cont.]
C61.9

80 Prostatectomy, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

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TESTIS
C62.0 - C62.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

12 Local tumor destruction, NOS (no specimen is sent to pathology)

20 Local or partial excision of testicle (specimen is sent to pathology)

30 Excision of testicle, NOS with*out* cord

40 Excision of testicle, NOS with cord;
Excision of testicle, NOS with no mention of the cord;
Radical orchiectomy

80 Orchiectomy, NOS (unknown if partial or total testicle was removed)

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

KIDNEY, RENAL PELVIS and URETER
C64.9, C65.9, C66.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-15**:

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (for tumor destruction)
- **13** Cryosurgery
- **14** Laser
- **15** Thermal ablation

A specimen is sent to pathology from procedures coded **20-27**:

20 Local tumor excision, NOS
- **26** Polypectomy
- **27** Excisional biopsy
  - **21** Photodynamic therapy (PDT) with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **22** Electrocautery with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **23** Cryosurgery with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **24** Laser ablation with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **25*** Laser excision with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)

Procedures coded **30** include, but are not limited to, segmental resection and wedge resection. Resection margins are grossly negative. There *may* be microsopic involvement.

30 Partial or subtotal nephrectomy (for kidney or renal pelvis primary);
Partial ureterectomy (for ureter primary)

40 Complete, total or simple nephrectomy (for kidney parenchyma);
Nephroureterectomy (for renal pelvis or ureter) (includes bladder cuff removal)

50 Radical nephrectomy (may include removal of a portion of the vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial / total ureter)

* The MCR has followed the SEER *Program Coding Manual* in indenting code **25** and inferring that it includes **20**, **26** or **27** procedures. The *FORDS* Manual presents the **25** indented at the level of codes **26** and **27** and therefore is probably not including procedures **20**, **26** and **27** in category **25**.

KIDNEY, RENAL PELVIS and URETER [cont.]
C64.9, C65.9, C66.9

70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with (en bloc) the resection of other organ(s) (such as colon or bladder)

The other organs may be partially or totally removed. They must be removed in the same procedure but not necessarily in one specimen.

80 Nephrectomy, NOS;
Ureterectomy, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

BLADDER
C67.0 - C67.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-16**:

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (for tumor destruction)
- **13** Cryosurgery
- **14** Laser
- **15** Intravesical therapy, NOS (If this surgical procedure is delivering a Chemotherapy agent or "Other Therapy" agent, also code this under Chemotherapy or Other Therapy.)
- **16** Bacillus Calmette-Guérin (BCG) installation or other Immunotherapy agent (Also code this under Immunotherapy.)

A specimen is sent to pathology from procedures coded **20-27**:

20 Local tumor excision, NOS
- **26** Polypectomy
- **27** Excisional biopsy
  - **21** Photodynamic therapy (PDT) with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **22** Electrocautery with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **23** Cryosurgery with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **24** Laser ablation with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **25*** Laser excision with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)

30 Partial cystectomy

50 Simple cystectomy;
Complete cystectomy;
Total cystectomy

* The MCR has followed the SEER *Program Coding Manual* in indenting code **25** and inferring that it includes **20**, **26** or **27** procedures. The *FORDS* Manual presents the **25** indented at the level of codes **26** and **27** and therefore is probably not including procedures **20**, **26** and **27** in category **25**.

BLADDER [cont.]
C67.0 - C67.9

60 Radical cystectomy;
Cystoprostatectomy (for a male patient *only*; includes removal of the bladder and prostate with or without urethrectomy) If a radical cystectomy is performed on a female, use code **71**.
- **61** Cystoprostatectomy with ilial conduit
- **62** Cystoprostatectomy with continent reservoir or pouch, NOS
- **63** Cystoprostatectomy with abdominal pouch (cutaneous)
- **64** Cystoprostatectomy with *in-situ* pouch (orthotopic)

70 Pelvic exenteration, NOS
- **71** Radical cystectomy (for a female patient *only*; includes removal of the bladder, uterus, ovaries, the entire vaginal wall and entire urethra);
  Anterior exenteration
  If a radical cystectomy is performed on a male, use code **60**.
- **72** Posterior exenteration
- **73** Total exenteration (includes removal of all pelvic contents and pelvic lymph nodes) (Also code the pelvic node removal in the "Scope of Regional Lymph Node Surgery" fields.)
- **74** Extended exenteration (includes removal of pelvic blood vessels or bony pelvis)

80 Cystectomy, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

CENTRAL NERVOUS SYSTEM

C70.0 - C70.9 Meninges
C71.0 - C71.9 Brain
C72.0 - C72.9 Other Parts of Central Nervous System

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

Do not code laminectomies for spinal cord primaries. Stereotactic radiosurgery used for tumor destruction in these sites should be coded as Radiation Therapy rather than surgery.

00 No surgery of primary site;
Autopsy-only case

10 Local tumor destruction, NOS (No specimen is sent to pathology.)

A specimen is sent to pathology from procedures coded in **20**:

20 Local excision of tumor, lesion or mass;
Excisional biopsy of tumor, lesion or mass

40 Partial resection, NOS

55 Gross total resection

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

THYROID GLAND
C73.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

13 Local tumor destruction, NOS (no specimen was sent to pathology)

A specimen is sent to pathology from procedures coded **25-27**:
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 thyroidectomy;
Near-total thyroidectomy

50 Total thyroidectomy

80 Thyroidectomy, NOS

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

ILL-DEFINED PRIMARY SITE
C76.0 - C76.8

for all ICD-O-3 Histologic Types

98 Use this code whether or not any surgery took place, unless a death certificate-only case.

99 Death certificate-only case

Surgical procedures for a case with an ill-defined primary site are recorded in the data items "Surgical Procedure/Other Site -- Summary" and/or "Surgical Procedure/Other Site -- At This Facility".

LYMPH NODES
C77.0 - 77.9

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

19 Local tumor destruction *or* excision, NOS (unknown if a specimen was sent to pathology)

15 Local tumor destruction, NOS (No specimen was sent to pathology.)

25 Local tumor excision, NOS;
Lymph node biopsy (less than a full chain)

30 Lymph node dissection, NOS
- **31** Dissection of one chain
- **32** Dissection of multiple chains

40 Lymph node dissection, NOS with a splenectomy
- **41** Dissection of one chain plus splenectomy
- **42** Dissection of multiple chains plus splenectomy

50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
- **51** Dissection of one chain plus partial or total removal of adjacent organ(s)
- **52** Dissection of multiple chains plus partial or total removal of adjacent organ(s)

60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) with splenectomy (includes a staging laparotomy)
- **61** Dissection of one chain plus splenectomy and partial or total removal of adjacent organ(s)
- **62** Dissection of multiple chains plus splenectomy and partial or total removal of adjacent organ(s)

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

UNKNOWN PRIMARY SITE
C80.9

for all ICD-O-3 Histologic Types

98 Use this code whether or not any surgery took place, unless a death certificate-only case.

99 Death certificate-only case

Surgical procedures for a case with an unknown primary site are recorded in the data items "Surgical Procedure/Other Site -- Summary" and/or "Surgical Procedure/Other Site -- At This Facility".

HEMATOPOIETIC, RETICULOENDOTHELIAL, IMMUNOPROLIFERATIVE AND MYELOPROLIFERATIVE DISEASES

ICD-O-3 Histologic Types:
9750
9760-9764
9800-9820
9826
9831-9920
9931-9964
9980-9989

for all primary sites

98 Use this code whether or not any primary site surgery took place, unless a death certificate-only case.

99 Death certificate-only case

Surgical procedures for these diseases are recorded in the data items "Surgical Procedure/Other Site -- Summary" and/or "Surgical Procedure/Other Site -- At This Facility".

ALL OTHER PRIMARY SITES

C14.2; C14.8	**Waldeyer ring; Overlapping lesion of lip, oral cavity and pharynx**
C17.0 - C17.9	**Small Intestine**
C23.9	**Gallbladder**
C24.0 - C24.9	**Other and Unspecified Parts of Biliary Tract**
C26.0 - C26.9	**Other and Ill-Defined Digestive Organs**
C30.0 - C30.1	**Nasal Cavity and Middle Ear**
C31.0 - C31.9	**Accessory Sinuses**
C33.9	**Trachea**
C37.9	**Thymus**
C38.0 - C38.8	**Heart, Mediastinum, and Pleura**
C39.0 - C39.9	**Other and Ill-Defined Sites Within Respiratory System and Intrathoracic Organs**
C48.0 - C48.8	**Retroperitoneum and Peritoneum**
C51.0 - C51.9	**Vulva**
C52.9	**Vagina**
C57.0 - C57.9	**Other and Unspecified Female Genital Organs**
C58.9	**Placenta**
C60.0 - C60.9	**Penis**
C63.0 - C63.9	**Other and Unspecified Male Genital Organs**
C68.0 - C68.9	**Other and Unspecified Urinary Organs**
C69.0 - C69.9	**Eye and Adnexa**
C74.0 - C74.9	**Adrenal Gland**
C75.0 - C75.9	**Other Endocrine Glands and Related Structures**

for all ICD-O-3 Histologic Types except 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989
[Use code **98** for the excepted histologies listed above (or **99** for any death certificate-only case).]

00 No surgery of primary site;
Autopsy-only case

No specimen is sent to pathology from procedures coded **10-14**:

10 Local tumor destruction, NOS
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery;
  Fulguration;
  Hot forceps (for tumor destruction)
- **13** Cryosurgery
- **14** Laser

ALL OTHER PRIMARY SITES [cont.]

A specimen is sent to pathology from procedures coded **20-27**:

20 Local tumor excision, NOS
- **26** Polypectomy
- **27** Excisional biopsy
  - **21** Photodynamic therapy (PDT) with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **22** Electrocautery with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **23** Cryosurgery with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **24** Laser ablation with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)
  - **25*** Laser excision with local tumor excision (**20**), polypectomy (**26**) or excisional biopsy (**27**)

30 Simple surgical removal of the primary site;
Partial surgical removal of the primary site

40 Total surgical removal of the primary site;
Enucleation
- **41** Total enucleation (for eye surgeries only)

50 Surgical debulking

60 Radical surgery [partial or total removal of the primary site with a resection in continuity* (partial or total removal) with other organ(s) (en bloc)]

* The removal must be done in one procedure but not necessarily in a single specimen.

90 Surgery, NOS

99 Unknown if primary site surgery performed;
Death certificate-only case

* The MCR has followed the SEER *Program Coding Manual* in indenting code **25** and inferring that it includes **20**, **26** or **27** procedures. The *FORDS* Manual presents the **25** indented at the level of codes **26** and **27** and therefore is probably not including procedures **20**, **26** and **27** in category **25**.

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Appendix E

Massachusetts Cancer Registry

Automated Edits Reference Guide

NAACCR Layout 10; EDITS Version 10A

November 2003

This appendix will be replaced for diagnoses made in 2004.

INTRODUCTION

The EDITS Edits System

The Massachusetts Cancer Registry (MCR) uses automated (computerized) edits as part of our quality assurance efforts. These edits originate in the "EDITS" software system developed by the Centers for Disease Control and Prevention.

The edits themselves come from the standard-setting organizations like the SEER program, COC and NPCR. Each of these groups, having different data needs and (sometimes) different requirements for the same data, have contributed slightly different versions of some edits. Registries may choose which edits and edit versions within the EDITS system that they wish to use to check their data by creating their own sets of edits to run. Most of the data fields collected by SEER, COC and NPCR registries have at least one edit to check them. There are over 800 standard edits from which to choose. The MCR has also created some specialized edits for our own use, and has modified some of the other groups' edits to better check MCR data. (The names of these edits usually include "MCR" or "MCR-CIMS".) We collect about 100 data fields and use about 200 automated edits. The MCR runs edits in "batch mode", i.e., we run the edits on batches of finished case records. Edits from the EDITS system may also be run "interactively", i.e., during data entry as fields are filled.

Automated edits are a useful tool for quickly checking the data quality of large numbers of case records. A case record that passes all automated edits, however, may still contain problems. Even if a registry were to run one version of each of the hundreds of edits available in the EDITS system, its data quality would not necessarily be perfect. Automated edits can only check coded fields easily; they do not "read" narratives, even to search for certain key words; they do not interpret or make decisions; they cannot replace the careful review of a knowledgeable cancer registrar.

MCR Edit Reports

Automated edits are used at different points during MCR operations. When a floppy diskette is received from one of our data reporters, the case records are first "scanned" to see if the data are in the correct file format (NAACCR Case Record Layout 10) to be used by our data system, the Massachusetts Cancer Registry - Cancer Information System (CIMS). If the format is correct, a set of automated edits are then used to test the quality of the data. We call this set of edits a "scan edit set". A printed edit report identifies case records that have not passed at least one edit, the names of the edits that were not passed for each case record, and the total number of times each edit failed in the whole data submission. A copy of this edit report is sent back to the reporting facility. If too many problems are detected by this process, the MCR may reject the entire data submission.

If the data submission is accepted, the case records are uploaded into the Holding Database of our data system. When the case records are processed by MCR staff, another set of edits is run to identify problems. We call this set of edits our Production Edit Set (it is almost identical to the Scan Edit Set). Our staff also visually review the cases to look for problems that the automated edits do not check, and text fields (narratives) are read and compared with coded fields. A case record cannot be saved into our main (Master) database until it has passed all of our automated edits and has been visually reviewed. Certain edits in the Production Edit Set identify diagnoses that are not reportable to the MCR, were diagnosed before 1995, or occurred in non-Massachusetts residents. Such cases are not allowed into our Master Database, but they are flagged appropriately and remain in our Holding Database.

When you receive an edit report from the MCR, we hope that this Appendix will help you determine what may have been questionable or incorrect in your data submissions. You may later receive additional feedback about your data quality from our staff as they process and visually review your case records.

The NAACCR Version 10 Layouts

The MCR accepts case records in the NAACCR Case Record Layout Version 10 ("V10"). This layout is intended for cases diagnosed in 2003 and pre-2003 diagnoses converted to V10 data standards, and it may also be referred to as the "2003" NAACCR formats or layouts. A case record in V10 layout contains a total of 6694 characters in more than 300 data fields. The value for each field is kept in an assigned location within the layout. For example, the 2-digit code for Primary Payer at Diagnosis is kept in the 445th and 446th character positions (columns). When you create a data file for submission to the MCR, your data system outputs the case records in V10 by selecting the appropriate fields and placing them in the proper locations. This process is probably invisible to you.

The MCR only collects about 100 data fields from the V10 layout. Our data system searches your outputted case records by looking in the appropriate locations to find the fields that we want. For example, our system selects the 445th and 446th characters from each of your case records and copies them into our Primary Payer at Diagnosis field. If your data system does not have certain fields that the MCR collects, your system should fill these fields with something automatically (appropriate default values) when you create your MCR data file.

If your case records do not come out of your system in V10 layout, our system will not be able to process them and the data will be rejected. If a data field ends up in the wrong place within the case records that you send us, or if our data system looks in the wrong location to find some data field, then the data that we see at the MCR may not make sense. Having all of the fields in exactly the correct locations is crucial.

How to Use This Appendix

When you receive an edit report from the MCR, you may need help in understanding what was questionable or incorrect in your case records. Each edit that appears on your edit report has a certain name in our Scan Edit Set. The edit names are listed alphabetically on pages 7-12 in this Appendix with the page number where a description of each edit can be found. Each edit is also given a "MCR Edit #"; if you have questions about a particular edit, it may be easier to refer to this number rather than the long edit name when talking to us.

When a case record has failed an edit, the edit report lists the name of each data field involved in that edit. These are the V10 field names. If you are not familiar with a field name or are not sure of the corresponding field in your data system, each field name is listed alphabetically on pages 13-16 of this Appendix with its NAACCR Item Number and its starting and ending positions in the V10 layout. The corresponding fields in the *MCR Abstracting and Coding Manual* and *FORDS* Manual are given. Within the main body of the MCR Manual, each field is also listed with its V10 name (if different than the MCR name), Item # and position.

The edits that involve each field are listed on pages E-17-32 in this Appendix. The fields are listed alphabetically by their V10 field names. The validity check or character check on each field is listed first, followed alphabetically by any other edits that involve that field. The number next to each edit name is the MCR Edit #.

Pages 7-12 in this Appendix provide the page where each edit's description can be found. The edit descriptions begin on page E-35, ordered alphabetically by edit name. The edit names are bold. All fields involved with the edit are listed, using their V10 names. For single-field edits, that field's length follows its name.

When you have a question about why a case record failed a certain edit, consult the edit's description. Use pages 13-16 if you're not sure about the field(s) involved. Some terms and symbols used in the edit descriptions may be unfamiliar and are included on pages 3-4.

Edit reports include the value (usually a code) that our data system found in each data field involved in each edit. If the value for a field shown on your edit report differs from the value you find on your data system, there may be a problem with your data system or ours; or the field may have been changed on your system after the case record was sent to the MCR.

Strange Terms/Definitions Used in this Appendix

blank check	not a generous gift; rather, an edit that checks whether a data field is empty or not; a blank check fails if the field is empty when it should contain something
blank-filled	when a filled-in data field does not contain enough characters to fill it completely, your data system may automatically fill the remainder of the field with blanks; example -- the AJCC Clinical Stage Group field must contain 2 characters, so if you fill in only the first character, your system may fill the second character in with a blank space for you because the field must be completely filled
case record	the electronic version of a MCR Cancer Patient Abstract; a data record that contains the data pertaining to one cancer case; 6694 characters long in V10
character check	an edit that checks the type of characters in a data field; if a field should only contain a number, for example, a character check run on that field would fail if the field contained a letter, punctuation mark, etc.
data field	also known as a data item or just "field"; a particular category of data within a data table, database or data record (row in a data table); for example, in a MCR case record, there are data fields that contain codes for "Place of Death" and "Birth Place"
digit	a single number (**0-9**)
embedded hyphen	a hyphen (dash) (-) in a data field that is not the first character in the field; in "A-B", the hyphen is embedded
embedded space	a space character (as when you have hit the spacebar on a keyboard) within a data field that is not the first character in that field; if a field contains **a_b**, there is an embedded space between the **a** and **b** characters
empty field	when nothing whatsoever is in a data field, it is empty; we try to avoid calling this a "blank field" because that could imply that blanks (spacebars) have been entered into it or that it was automatically blank-filled
error message	a short phrase that is produced automatically when an edit fails; the message may indicate what the edit found and did not like about the data being checked; some edits produce several different error messages, depending on exactly what problem was detected
field	same as data field
leading space	a space character that is the first character in a data field; if a field contains **_2**, the **2** is preceded by a leading space
length	the number of characters that fill a data field completely; the MCR data field for patient's age, for example, is 3 digits long; the field for patient's usual occupation has a 40-character length
look-up table	when an edit is checking for certain values in a data field and the number of acceptable values for the field is very lengthy, those acceptable values may be stored in a data table in the EDITS system rather than within the edit itself; for example, the many standard codes for "Place of Birth" are kept in a look-up table, while the two standard codes for "Vital Status" are written right into its validity check

V10 — the North American Association of Central Cancer Registries Case Record Layout Version 10, dating from March 2002; may also be called the "2003" formats because they are meant to apply to cases diagnosed in 2003; a case record in V10 format contains 6694 characters

over-ride — a way to bypass a certain edit or edits for a case record by using "flag" fields; if the over-ride flag associated with an edit contains a certain value (usually **1**), that edit skips that case record; example -- if a prostate cancer is diagnosed in a very young man, and if the edit named "Age, Primary Site, Morphology (SEER IF15)" finds its over-ride flag field empty, it will ask that the coding of the case be double-checked; if the age and diagnosis are correct, check the appropriate flag on your system to over-ride the edit; when the edit runs again on that case, the edit will see a **1** in its flag field and will then stop checking that case record

symbol — any keyboard character that is not a letter or number

validity check — an edit that compares the contents of a single data field with a set of acceptable standard codes; it fails when the field's contents do not match one of the acceptable codes; the validity check on Vital Status checks that the field contains either **0** or **1**, for example

Standard Symbols Used Strangely in this Appendix

Some mathematical symbols are used to show relations in numeric codes, even when these codes do not represent *counting* numbers.

> "is greater than"
example: "Histologic Type > **8790**" means "The Histologic Type Code has a value greater than **8790**."

< "is less than"
example: "Histologic Type < **9590**" means "The Histologic Type Code has a value less than **9590**."

≥ "is greater than or equal to"
example: "Histologic Type ≥ **9590**" means "The Histologic Type Code has a value of at least **9590**."

≤ "is less than or equal to"
example: "Histologic Type ≤ **9804**" means "The Histologic Type Code has a value of **9804** at most."

- "through...inclusive"
example: "Behavior = **0 - 3**" means "The Behavior Code has a value of **0, 1**, **2** or **3**."

= "is equal to" or "may be equal to"
example: "Laterality = **0 - 4** or **9**" means "The Laterality Code has a value of **0**, **1**, **2**, **3**, **4** or **9**."

<> "is not equal to"
example: "Behavior Code <> **0** or **1**" means "The Behavior Code has a value that is neither **0** nor **1**."

_ a space character, as in the (usually) invisible character produced when you hit the spacebar on a keyboard; example: "**1**_" indicates that there are two characters here -- a code **1** followed by a space; it does not indicate a code **1** followed by an underlined space.

Types of Edits

Single-Field Edits

A single-field edit examines the contents of one data field only.

Some edits are described as "blank checks" or emptiness checks. This type of edit merely checks whether a data field is blank (empty) or contains something. The only narrative (free text) fields which may be empty are the Comments/Narrative Remarks field, treatment narratives for which that type of therapy was not performed during the first course of treatment, and Staging Narratives if they do not apply to a certain case. For nonanalytic cases, all narrative fields may be empty. To avoid leaving fields empty, use unknown/not applicable codes and the text "Unknown" as necessary.

Some single-field edits are "character checks". This kind of edit examines the type of characters entered into a field. It may check if each character is a letter, number, space, or symbol (all of the other characters on a keyboard, like !@#$%<>?,.;}). For example, there is an edit which checks if the Middle Name field contains anything but letters.

Most single-field edits are "validity checks". Each of these looks for certain values in a field; anything else found in the field will cause the edit to fail. For example, the validity check on Vital Status only accepts the codes **0** or **1**. Validity checks on date fields are more complex because different values for day, month and year must be evaluated, and the entire date as a whole is also checked.

Interfield and Multifield Edits

These more complex edits check the values in two or more fields at once, looking for incompatibility among the codes in the different fields. For example, an interfield edit between the fields Vital Status and Place of Death checks that a patient is not coded as "alive" <u>and</u> coded as having died somewhere.

Unlike single-field edits, these edits are not implying that there is an error in any one field. They are saying, "The codes in these fields don't make sense together. One or all of them may be wrong."

Some interfield and multifield edits are set to skip over a case record if the fields involved contain invalid codes or empty fields. For example, if a case record contains a bad Behavior Code of "**8**", then many of the interfield and multifield edits that involve Behavior will not bother to check that case. Suppose edits are run on a case and there is only one error reported -- an invalid Primary Site Code. If you fix that one bad code and re-run the edits, you may find that there are several new errors reported -- because many multifield edits involving Primary Site Code did not touch the case before. This is why <u>edits should be re-run</u> whenever changes are made in a case. Furthermore, changing the value in one field to satisfy one edit may then cause a different edit to complain.

Inter-Record Edits

This type of edit looks at codes in two or more cases at once. For example, if you have a patient on your data system recorded with two primary tumors, you might use an inter-record edit to check that the patient's gender is coded consistently in both records; another inter-record edit might check that the two diagnoses are not considered a single primary. Although the SEER registries have experience running edits between case records, the EDITS system at present ordinarily just examines what is in a *single* case record. The MCR occasionally runs some SEER inter-record edits outside the EDITS system -- but not on incoming data from our reporting facilities at this time.

Pass/Fail/Skip, Warnings and Error Messages

Most edits are "pass/fail". That is, the edit checks the appropriate field(s) in a case record and the edit either passes or fails for that case. An edit may begin to check a record, detect a certain code that tells it to not bother checking any further, and then immediately halt and "skip" that record.

Some edits may pass, fail or produce a "warning" instead of failing. When the edits are run, these may be set to produce warnings instead of failures. The MCR sets its edit reports to suppress warnings (i.e., to produce failures rather than warnings).

When an edit fails for a case record, an "error message" is produced. This message is an English phrase and will appear when an edit report is printed. The error messages are supposed to provide some indication of what the edit did not like about the case, although they are not always helpful for figuring out what is wrong. Some edits will produce one of several different error messages, depending on exactly what type of problem was found.

Over-Rides

The failure of a few interfield edits can be over-ridden. When these edits fail, they are not indicating that something is definitely wrong with the case. They are instead saying, "I question this combination of codes. It's very unusual." Someone must examine the fields in question and change or verify them. If the codes entered are indeed correct, an "over-ride flag" field can be used to make the edit pass.

For example, an over-rideable edit compares a patient's age with his/her diagnosis. If a 40-year old man has prostate cancer, this edit will question this combination because he's unusually young for this disease. If the age and diagnosis are indeed accurate, the over-ride for this edit can be set so that the edit will pass the case.

The edits that can be over-ridden look at the codes in certain fields (over-ride "flags") within the case record itself to decide if they have been over-ridden or not for that case. Once an edit is over-ridden for a case, it will continue to always pass that case unless someone changes its over-ride flag to cause the edit to fail again. Even if you have set over-ride flags on your data system to pass certain edits for certain cases, the MCR cannot "take your word" automatically that those flags should really have been set. We must verify unusual code combinations ourselves and set our own over-ride flags appropriately on our system. We rely on remarks in Narrative fields to confirm that *you* have indeed verified any unusual code combinations at your facility. We do not look at the over-ride flags you have set when we review your cases!

NAACCR 10A Automated Edits
Being Run by the Massachusetts Cancer Registry
sorted by Name of Edit
November 2003

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Data Fields Collected by Massachusetts Cancer Registry from NAACCR V10 Layout
and Corresponding Fields in MCR and *FORDS* Manuals

(arranged alphabetically by NAACCR field name*)

November 2003

V10 Field Name	Item #	Position	Field in the MCR Manual	Field in the *FORDS* Manual
Abstracted By	570	413-415	Abstracted By, p. 46	Abstracted by, p. 207
Accession Number--Hosp	550	402-410	Accession Number, p. 37	Accession number, p. 33
Addr at DX--City	70	52-71	City / Town at Diagnosis, p. 57	City/town at diagnosis, p. 44
Addr at DX--No & Street	2330	2108-2147	Street Address at Diagnosis, p. 55	Patient address (number and street) at diagnosis, p. 42
Addr at DX--Postal Code	100	74-82	ZIP / Postal Code at Diagnosis, p. 59	Postal code at diagnosis, p. 47
Addr at DX--State	80	72-73	State at Diagnosis, p. 57	State at diagnosis, p. 45
Addr at DX--Supplementl	2335	2148-2187	Street Address at Diagnosis -- Supplemental, p. 56	Patient address (number and street) at diagnosis--supplemental, p. 43
Addr Current--City	1810	1307-1326	City / Town -- Current, p. 59	City/town--current, p. 51
Addr Current--No & Street	2350	2188-2227	Street Address -- Current, p. 59	Patient address (number and street)--current, p. 49
Addr Current--Postal Code	1830	1329-1337	ZIP / Postal Code -- Current, p. 59	Postal code--current, p. 54
Addr Current--State	1820	1327-1328	State -- Current, p. 59	State--current, p. 52
Addr Current--Supplementl	2355	2228-2267	Street Address -- Current -- Supplemental, p. 59	Patient address (number and street) current-supplemental, p. 50
Age at Diagnosis	230	119-121	Age at Diagnosis, p. 51	Age at diagnosis, p. 58
Behavior (92-00) ICD-O-2	430	300	ICD-O-2 Behavior Code p. 94	not in *FORDS*
Behavior Code ICD-O-3	523	305	ICD-O-3 Behavior Code, p. 95	Behavior code, p. 94
Birth Date	240	122-129	Birth Date, p. 50	Date of birth, p. 57
Birthplace	250	130-132	Birthplace, p. 52	Place of birth, p. 56
Class of Case	610	440	Class of Case, p. 111	Class of case, p. 83
COC Coding Sys--Current	2140	1200-1201	COC Coding System -- Current, p. 219	COC coding system--current, p. 222
COC Coding Sys--Original	2150	1202-1203	COC Coding System -- Original, p. 219	COC coding system--original, p. 224
Coding System for EOD	870	562	Coding System for EOD, p. 219	not in *FORDS*
Date Case Completed	2090	1174-1181	Date Case Completed, p. 217	not in *FORDS*
Date Case Report Exported	2110	1190-1197	Date Case Report Exported, p. 217	not in *FORDS*
Date of 1st Contact	580	416-423	Date of First Contact, p. 46	Date of first contact, p. 87
Date of 1st Crs RX--COC	1270	843-850	Date of First-Course Treatment -- COC, p. 173	Date of first course treatment, p. 129
Date of Diagnosis	390	283-290	Date of Diagnosis, p. 109	Date of initial diagnosis, p. 89
Date of Last Contact	1750	1294-1301	Date of Last Contact, p. 214	Date of last contact or death, p. 199
Diagnostic Confirmation	490	311	Diagnostic Confirmation, p. 121	Diagnostic confirmation, p. 99
EOD--Extension	790	534-535	EOD -- Extension, p. 157	not in *FORDS*
EOD--Extension Prost Path	800	536-537	EOD -- Extension Prostate Pathology, p. 157	not in *FORDS*
EOD--Lymph Node Involv	810	538	EOD -- Lymph Node Involvement, p. 157	not in *FORDS*
EOD--Tumor Size	780	531-533	EOD -- Tumor Size, p. 116	Tumor size, p. 100

V10 Field Name	Item #	Position	Field in the MCR Manual	Field in the *FORDS* Manual
State/Requestor Items	2220	1447-1506	Following Physician Name, p. 47	text equivalent of Following physician, p. 76
Grade	440	306	Grade / Differentiation / Immunophenotype Code, p. 100	Grade/differentiation, p. 96
Histologic Type ICD-O-3	522	301-304	ICD-O-3 Histologic Type Code, p. 87	Histology, p. 93
Histology (92-00) ICD-O-2	420	296-299	ICD-O-2 Histologic Type Code, p. 87	not in *FORDS*
ICD-O-2 Conversion Flag	1980	1147	ICD-O-2 Conversion Flag, p. 99	ICD-O-2 conversion flag, p. 232
ICD-O-3 Conversion Flag	2116	1243	ICD-O-3 Conversion Flag, p. 99	ICD-O-3 conversion flag, p. 233
Institution Referred From	2410	2485-2494	Institution Referred From, p. 114	Facility referred from, p. 85
Institution Referred To	2420	2495-2504	Institution Referred To, p. 115	Facility referred to, p. 86
Laterality	410	295	Laterality, p. 82	Laterality, p. 92
Marital Status at DX	150	102	Marital Status at Diagnosis, p. 60	not in *FORDS*
Medical Record Number	2300	2086-2096	Medical Record Number, p. 39	Medical record number, p. 36
Morph Coding Sys--Current	470	309	Morphology Coding System -- Current, p. 218	Morphology coding system--current, p. 230
Morph Coding Sys--Originl	480	310	Morphology Coding System -- Original, p. 218	Morphology coding system--original, p. 231
NAACCR Record Version	50	19	NAACCR Record Version, p. 218	not in *FORDS*
Name--Alias	2280	2006-2020	Patient Alias Name, p. 50	not in *FORDS*
Name--First	2240	1972-1985	Patient First Name, p. 49	First name, p. 40
Name--Last	2230	1947-1971	Patient Last Name, p. 48	Last name, p. 39
Name--Maiden	2390	2021-2035	Patient Maiden Name, p. 49	not in *FORDS*
Name--Middle	2250	1986-1999	Patient Middle Name, p. 49	Middle name, p. 41
Name--Spouse/Parent	2290	2036-2085	Name -- Spouse/Parent, p. 76	not in *FORDS*
Name--Suffix	2270	2003-2005	Patient Name Suffix, p. 48	not in *FORDS*
Place of Death	1940	1394-1396	Place of Death, p. 214	not in *FORDS*
Primary Payer at DX	630	445-446	Primary Payer at Diagnosis, p. 45	Primary payer at diagnosis, p. 67
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Race 3	162	107-108	Race 3, p. 65	Race 3, p. 62
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* except State/Requestor Items is listed as if under MCR field name Following Physician Name

V10 Field Name	Item #	Position	Field in the MCR Manual	Field in the *FORDS* Manual
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RX Date--Chemo	1220	803-810	Chemotherapy -- Date Started, p. 199	not in *FORDS*
RX Date--DX/Stg/Proc	1280	851-858	Surgical Diagnostic/Staging Procedures -- Date Started, p. 177	Date of surgical diagnostic and staging procedure, p. 107
RX Date--Hormone	1230	811-818	Hormone Therapy -- Date Started, p. 202	not in *FORDS*
RX Date--Most Defin Surg	3170	763-770	Date of Most Definitive Resection, p. 181	Date of most definitive surgical resection of the primary site, p. 133
RX Date--Other	1250	827-834	Other Therapy -- Date Started, p. 210	Date other treatment started, p. 184
RX Date--Radiation	1210	779-786	Radiation Therapy -- Date Started, p. 193	Date radiation started, p. 148
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RX Date--Systemic	3230	795-802	Systemic Therapy -- Date Started, p. 194	Date systemic therapy started, p. 169
RX Hosp--BRM	720	468-469	Immunotherapy -- At This Facility, p. 204	Immunotherapy at this facility, p. 181
RX Hosp--Chemo	700	464-465	Chemotherapy -- At This Facility, p. 199	Chemotherapy at this facility, p. 173
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RX Hosp--Palliative Proc	3280	473	Palliative Care -- At This Facility, p. 211	Palliative care at this facility, p. 191
RX Hosp--Scope Reg LN Sur	672	459	Scope of Regional Lymph Node Surgery -- At This Facility, p. 185	Scope of regional lymph node surgery at this facility, p. 140
RX Hosp--Scope Reg 98-02	747	480	Scope of Regional Lymph Node Surgery, 1998-2002 -- At This Facility, p. 188	not in *FORDS*
RX Hosp--Surg Oth Reg/Dis	674	460	Surgery of Other Sites -- At This Facility, p. 186	Surgical procedure/other site at this facility, p. 143
RX Hosp--Surg Oth 98-02	748	481	Surgery of Other Sites, 1998-2002 -- At This Facility, p. 188	not in *FORDS*
RX Hosp--Surg Prim Site	670	457-458	Surgery of Primary Site -- At This Facility, p. 180	Surgical procedure of primary site at this facility, p. 136
RX Hosp--Surg Site 98-02	746	478-479	Surgery of Primary Site, 1998-2002 -- At This Facility, p. 187	not in *FORDS*
RX Summ--BRM	1410	882-883	Immunotherapy -- Summary, p. 204	Immunotherapy, p. 179
RX Summ--Chemo	1390	878-879	Chemotherapy -- Summary, p. 199	Chemotherapy, p. 171
RX Summ--DX/Stg/Proc	1350	869-870	Surgical Diagnostic/Staging Procedures -- Summary, p. 176	Surgical diagnostic and staging procedure, p. 109
RX Summ--Hormone	1400	880-881	Hormone Therapy -- Summary, p. 201	Hormone therapy, p. 175
RX Summ--Other	1420	884	Other Therapy -- Summary, p. 210	Other treatment, p. 186
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RX Summ--Scope Reg 98-02	1647	941	Scope of Regional Lymph Node Surgery, 1998-2002, -- Summary, p. 188	not in *FORDS*
RX Summ--Surg Oth Reg/Dis	1294	862	Surgery of Other Sites -- Summary, p. 186	Surgical procedure/other site, p. 142
RX Summ--Surg Oth 98-02	1648	942	Surgery of Other Sites, 1998-2002 -- Summary, p. 188	not in *FORDS*
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V10 Field Name	Item #	Position	Field in the MCR Manual	Field in the *FORDS* Manual
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RX Summ--Surg/Rad Seq	1380	875	Radiation / Surgery Sequence, p. 193	Radiation/surgery sequence, p. 164
RX Summ--Transplnt/Endocr	3250	876-877	Hematologic Transplants & Endocrine Procedures, p. 205	Hematologic transplant and endocrine procedures, p. 182
RX Text--BRM	2660	5325-5424	Immunotherapy -- Narrative, p. 177	not in *FORDS*
RX Text--Chemo	2640	4925-5124	Chemotherapy -- Narrative, p. 199	not in *FORDS*
RX Text--Hormone	2650	5125-5324	Hormone Therapy -- Narrative, p. 202	not in *FORDS*
RX Text--Other	2670	5425-5524	Other Therapy -- Narrative, p. 210	not in *FORDS*
RX Text--Radiation (Beam)	2620	4625-4774	Radiation Therapy -- Narrative, p. 193	not in *FORDS*
RX Text--Surgery	2610	4475-4624	Surgery -- Narrative, p. 181	not in *FORDS*
SEER Summary Stage 1977	760	529	SEER Summary Stage 1977, p. 143	not in *FORDS*
SEER Summary Stage 2000	759	528	SEER Summary Stage 2000, p. 144	SEER summary stage 2000, p. 124
Sequence Number--Hospital	560	411-412	Sequence Number--Hospital, p. 39	Sequence number, p. 34
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Text--DX Proc--Op	2560	3595-3844	Text--Operative, p. 160	not in *FORDS*
Text--DX Proc--Path	2570	3845-4094	Text--Pathology, p. 161	not in *FORDS*
Text--DX Proc--PE	2520	2645-2844	Text--Physical Exam, p. 158	not in *FORDS*
Text--DX Proc--Scopes	2540	3095-3344	Text--Scopes, p. 159	not in *FORDS*
Text--DX Proc--X-Ray/Scan	2530	2845-3094	Text---X-Ray/Scan, p. 159	not in *FORDS*
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Text--Primary Site Title	2580	4095-4134	Narrative Primary Site, p. 86	not in *FORDS*
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Text--Staging	2600	4175-4474	Text--Staging, p. 161	not in *FORDS*
Text--Usual Industry	320	183-222	Usual Industry / Type of Business, p. 75	not in *FORDS*
Text--Usual Occupation	310	143-182	Usual Occupation, p. 74	not in *FORDS*
TNM Clin Descriptor	980	581	Clinical Descriptor, p. 127	Clinical stage (prefix/suffix) descriptor, p. 116
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TNM Clin N	950	575-576	Clinical N, p. 130	Clinical N, p. 113
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TNM Path N	890	565-566	Pathologic N, p. 138	Pathologic N, p. 119
TNM Path Stage Group	910	569-570	Pathologic Stage Grouping, p. 141	Pathologic stage group, p. 121
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Vendor Name	2170	1204-1213	Vendor Name / Version Number, p. 217	not in *FORDS*
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NAACCR V10 Field Names and Associated MCR Automated Edits

field: **Abstracted By**
edit: 1. Abstracted By (NAACCR) p. E-35

field: **Accession Number--Hosp** (called Accession Number in MCR Manual)
edits: none

field: **Addr at DX--City** (called City / Town at Diagnosis in MCR Manual)
edits: 2. Addr at DX--City (NAACCR) p. E-35
47. Invalid City/Town Name (MCR-CIMS) p. E-53

field: **Addr at DX--No & Street** (called Street Address at Diagnosis in MCR Manual)
edit: 3. Address at DX--No & Street (MCR-CIMS) p. E-35

field: **Addr at DX--Postal Code** (called ZIP / Postal Code at Diagnosis in MCR Manual)
edits: 4A. Addr at DX--Postal Code (NAACCR) p. E-35
4B. Addr at DX--Postal Code (NAACCR/MCR-CIMS) p. E-35
48. Invalid Zipcode (MCR-CIMS) p. E-54

field: **Addr at DX--State** (called State at Diagnosis in MCR Manual)
edits: 5. Addr at DX--State (NAACCR) p. E-36
56. MCR-CIMS Master Db Edits p. E-58

field: **Addr at DX--Supplementl** (called Street Address at Diagnosis -- Supplemental in MCR Manual)
edits: none

field: **Addr Current--City** (called City / Town -- Current in MCR Manual)
edits: none

field: **Addr Current--No & Street** (called Street Address -- Current in MCR Manual)
edits: none

field: **Addr Current--Postal Code** (called ZIP / Postal Code -- Current in MCR Manual)
edits: none

field: **Addr Current--State** (called State -- Current in MCR Manual)
edits: none

field: **Addr Current--Supplemental** (called Street Address -- Current -- Supplemental)
edits: none

field: **Age at Diagnosis**
edits: 6. Age at Diagnosis (SEER AGEDX) p. E-36
7. Age at Diagnosis, Text--Usual Industry (NAACCR) p. E-36
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9. Age, Birth Date, Date of Diagnosis (NAACCR IF13) p. E-37
10A. Age, Primary Site, Morphology (SEER IF15) p. E-38
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55. Marital Status at DX, Age at Diagnosis (SEER IF14) p. E-58

field: **Behavior (92-00) ICD-O-2** (called ICD-O-2 Behavior Code in MCR Manual)

edits:
- 11A. Behavior (COC) p. E-39
- 10A. Age, Primary Site, Morphology (SEER IF15) p. E-38
- 12A. Behavior Code, Histologic Type (NAACCR/MCR-CIMS) p. E-40
- 13A. Behavior ICDO2, Date of Diagnosis (NAACCR) p. E-40
- 35A. Diagnostic Confirmation, Behavior Code (SEER IF31) p. E-47
- 37B. EOD--Primary Site, Histology, Behavior (NAACCR) p. E-49
- 38. EOD--Reg Nodes Ex,Reg Nodes Pos,Prim Site (NAACCR) p. E-50
- 51B. Laterality, Primary Site, Morphology (SEER IF42) p. E-57
- 57. MCR-CIMS (NOT REPORTABLE CASE) p. E-59
- 61A. Morphology--Type&Behavior (SEER MORPH) p. E-60
- 72B. Primary Site, AJCC Stage Group - Edition 5 (COC) p. E-68
- 73. Primary Site, AJCC Stage Group - Edition 3/4(COC) p. E-66
- 74A. Primary Site, Behavior Code (MCR-CIMS/SEER IF39) p. E-70
- 207. Verify ICDO2 to ICDO3 Conversion (NAACCR) p. E-116

field: **Behavior Code ICD-O-3** (called ICD-O-3 Behavior Code in MCR Manual)

edits:
- 11B. Behavior ICDO3 (COC) p. E-40
- 10B. Age, Primary Site, Morphology ICDO3 (SEER IF15) p. E-39
- 13B. Behavior ICDO3, Date of Diagnosis (NAACCR) p. E-40
- 12B. Behavior ICDO3, Histologic Type ICDO3 (NAACCR/MCR) p. E-41
- 35B. Diagnostic Confirmation, Behavior ICD03 (SEER IF31) p. E-47
- 37A. EOD--Primary Site, Histology, Behav ICDO3 (NAACCR) p. E-49
- 51A. Laterality, Primary Site, Morph ICDO3 (SEER IF42) p. E-56
- 57. MCR-CIMS (NOT REPORTABLE CASE) p. E-59
- 61B. Morphology--Type&Behavior ICDO3 (SEER MORPH) p. E-62
- 72A. Primary Site, AJCC Stage Group - Ed 5, ICDO3 (COC) p. E-64
- 74B. Primary Site, Behavior Code ICDO3 (SEER IF39/MCR- p. E-70
- 180. Summary Stage 2000, Site, Hist, Class (NAACCR) p. E-102
- 207. Verify ICDO2 to ICDO3 Conversion (NAACCR) p. E-116

field: **Birth Date**

edits:
- 14. Birth Date (NAACCR DATEEDIT) p. E-41
- 7. Age at Diagnosis, Text--Usual Industry (NAACCR) p. E-36
- 8. Age at Diagnosis, Text--Usual Occupation (NAACCR) p. E-36
- 9. Age, Birth Date, Date of Diagnosis (NAACCR IF13) p. E-37
- 15. Birth Date, Date of Diagnosis (NAACCR IF47) p. E-42

field: **Birthplace**

edit:
- 16. Birthplace (SEER POB) p. E-42

field: **Class of Case**

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- 19. Class of Case (COC) p. E-43
- 20. Class, Date Diag, Date Last Cont, Vit Stat (COC) p. E-43
- 41. Hemato, Summ Stage, Class of Case (NAACCR) p. E-51
- 42A. Hematopoietic, TNM (NAACCR) p. E-51
- 42B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
- 57. MCR-CIMS (NOT REPORTABLE CASE) p. E-59
- 108. RX Date--Surgery, RX Text--Surgery (NAA/MCR-CIMS) p. E-83
- 140. RX Summ--BRM, RX Text--BRM (NAACCR/MCR-CIMS) p. E-91
- 143. RX Summ--Chemo, RX Text--Chemo (NAACR/MCR-CIMS) p. E-92
- 148. RX Summ--Hormone, RX Text--Hormone (NAAC/MCR-CIMS) p. E-93
- 152. RX Summ--Other, RX Text--Other (NAA/MCR-CIMS) p. E-94
- 180. Summary Stage 2000, Site, Hist, Class (NAACCR) p. E-102
- 183. Summary Stage, Class of Case (COC) p. E-104
- 184. Summary Stage, Histology (COC) p. E-105

field: **COC Coding Sys--Current** (called COC Coding System -- Current in MCR Manual)
edit: 21. COC Coding Sys--Current (COC) p. E-43

field: **COC Coding Sys--Original** (called COC Coding System -- Original in MCR Manual)
edits: 22. COC Coding Sys--Original (COC) p. E-43
23. COC Coding Sys--Original, Date of Diagnosis (COC) p. E-44

field: **Coding System for EOD**
edits: none

field: **Date Case Completed**
edit: 24. Date Case Completed (MCR-CIMS) p. E-44

field: **Date Case Report Exported**
edit: 25. Date Case Exported (NAACCR DATEEDIT) p. E-44

field: **Date of 1st Contact** (called Date of First Contact in MCR Manual)
edits: 26. Date of 1st Contact (COC) p. E-44
44A. Histology ICD02, Date DX, Date 1st Contact (NAACCR) p. E-52
44B. Histology ICDO3, Date DX, Date 1st Cont (NAACCR) p. E-53
178A. Summary Stage 2000, Date DX, Date 1st Cont (NAACCR p. E-101
178B. Summary Stage, Date DX, Date 1st Contact (NAACCR) p. E-104

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edits: none

field: **EOD--Extension Prost Path** (called EOD -- Extension Prostate Pathology in MCR Manual)
edits: none

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edits: none

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edits: none

field: **Institution Referred To**
edits: none

field: **Laterality**
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edits: none

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field: **NAACCR Record Version**
edits: none

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field: **Record Type**
edits: none

field: **Recurrence Date--1st** (called Date of First Recurrence in MCR Manual)
edits: none

field: **Recurrence Type--1st** (called Type of First Recurrence in MCR Manual)
edits: none

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field: **Registry ID** (called Registry Code in MCR Manual)
edits: none

field: **Reporting Hospital** (called Reporting Facility Code in MCR Manual)
edits: none (but must be the same for each case record in a data submission)

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field: **RX Date--BRM** (called Immunotherapy -- Date Started in MCR Manual)
edits: none

field: **RX Date--Chemo** (called Chemotherapy -- Date Started in MCR Manual)
edits: none

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edits: none

field: **RX Date--Most Defin Surg** (called Date of Most Definitive Resection in MCR Manual)
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17. Bladder, RX Hosp--Surg Prim Site, BRM (COC) p. E-42
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field: **RX Hosp--Chemo** (called Chemotherapy -- At This Facility in MCR Manual)
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field: **RX Hosp--Other** (called Other Therapy--At This Facility in MCR Manual)
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edits: 126. RX Hosp--Scope Reg 98-02 (COC) p. E-87
127A. RX Hosp--Scope Reg 98-02, Primary Site (COC) p. E-87
127B. RX Hosp--Scope Reg 98-02, Primary Site, ICDO3(COC) p. E-88

field: **RX Hosp--Surg Oth Reg/Dis** (called Surgery of Other Sites -- At This Facility in MCR Manual)
edits: 133. RX Hosp--Surg Oth Reg/Dis (COC) p. E-89
132. RX Hosp--Surg Oth Reg, RX Summ--Surg Oth Reg (COC) p. E-89

field: **RX Hosp--Surg Oth 98-02** (called Surgery of Other Sites, 1998-2002--At This Facility in MCR Manual)
edits: 130. RX Hosp--Surg Oth 98-02 (COC) p. E-89
131. RX Hosp--Surg Oth 98-02, Primary Site (COC) p. E-89

field: **RX Hosp--Surg Prim Site** (called Surgery of Primary Site -- At This Facility in MCR Manual)
edits: 135. RX Hosp--Surg Prim Site (COC) p. E-90
17. Bladder, RX Hosp--Surg Prim Site, BRM (COC) p. E-42
134. RX Hosp--Surg Pri Sit, RX Summ--Surg Pri Sit (COC) p. E-90
136A. RX Hosp--Surg Prim Site, Primary Site, ICDO2 (MCR) p. E-90
136B. RX Hosp--Surg Prim Site, Primary Site, ICDO3 (MCR) p. E-90

field: **RX Hosp--Surg Site 98-02** (called Surgery of Primary Site, 1998-2002--At This Facility in MCR Manual)
edits: 137. RX Hosp--Surg Site 98-02 (COC) p. E-91
138. RX Hosp--Surg Site 98-02, Primary Site (COC) p. E-91

field: **RX Summ--BRM** (called Immunotherapy -- Summary in MCR Manual)
edits: 139. RX Summ--BRM (COC) p. E-91
18. Bladder, RX Summ--Surg Prim Site, BRM (COC) p. E-42
111. RX Date--Systemic, Systemic RX (COC) p. E-84
114. RX Hosp--BRM, RX Summ--BRM (COC) p. E-84
140. RX Summ--BRM, RX Text--BRM (NAACCR/MCR-CIMS) p. E-91
141. RX Summ--BRM, Vital Status (COC) p. E-91

field: **RX Summ--Chemo** (called Chemotherapy -- Summary in MCR Manual)
edits: 142. RX Summ--Chemo (COC) p. E-92
111. RX Date--Systemic, Systemic RX (COC) p. E-84
116. RX Hosp--Chemo, RX Summ--Chemo (COC) p. E-85
143. RX Summ--Chemo, RX Text--Chemo (NAACR/MCR-CIMS) p. E-92
144. RX Summ--Chemo, Vital Status (COC) p. E-92

field: **RX Summ--DX/Stg Proc** (called Surgical Diagnostic/Staging Procedures--Summary in MCR Manual)
edits: 145. RX Summ--DX/Stg Proc (COC) p. E-92
118. RX Hosp--DX/Stg Proc, RX Summ--DX/Stg Proc (COC) p. E-85
146. RX Summ--DX/Stg Proc, RX Date--DX/Stg Proc (COC) p. E-92

field: **RX Summ--Hormone** (called Hormone Therapy -- Summary in MCR Manual)
edits: 147. RX Summ--Hormone (COC) p. E-93
111. RX Date--Systemic, Systemic RX (COC) p. E-84
120. RX Hosp--Hormone, RX Summ--Hormone (COC) p. E-86
148. RX Summ--Hormone, RX Text--Hormone (NAAC/MCR-CIMS) p. E-93
149. RX Summ--Hormone, Vital Status (COC) p. E-93

field: **RX Summ--Other** (called Other Therapy -- Summary in MCR Manual)
edits: 150. RX Summ--Other (SEER OTHERRX) p. E-93
122. RX Hosp--Other, RX Summ--Other (COC) p. E-86
151. RX Summ--Other, RX Date--Other (COC) p. E-94
152. RX Summ--Other, RX Text--Other (NAA/MCR-CIMS) p. E-94

field: **RX Summ--Palliative Proc** (called Palliative Care -- Summary in MCR Manual)
edits: 153. RX Summ--Palliative Proc (COC) p. E-94
124. RX Hosp--Palliative Proc, RX Summ--Pall Proc (COC) p. E-87

field: **RX Summ--Scope Reg LN Sur** (called Scope of Regional Lymph Node Surgery--Summary in MCR Manual)

edits: 157. RX Summ--Scope Reg LN Sur (COC) p. E-95
125. RX Hosp--Scope LN Sur, RX Summ--Scope LN Sur(COC) p. E-87
158A. RX Summ--Scope Reg LN Sur, Primary Site (COC) MCR p. E-96
158B. RX Summ--Scope Reg LN Sur,Prim Site,ICDO3(COC)MCR p. E-96
186. Surgery, Rad, Surg/Rad Seq (COC) p. E-108
188A. Surgery, RX Date--Surgery (COC) p. E-109
188B. Surgery, RX Date--Surgery, ICDO3 (COC) p. E-109

field: **RX Summ--Scope Reg 98-02** (called Scope of Regional Lymph Node Surgery, 1998-2002--Summary in MCR Manual)

edits: 154. RX Summ--Scope Reg 98-02 (COC) p. E-94
155. RX Summ--Scope Reg 98-02, Date of DX (COC) p. E-95
156A. RX Summ--Scope Reg 98-02, Primary Site (COC) p. E-95
156B. RX Summ--Scope Reg 98-02, Primary Site, ICDO3(COC) p. E-95

field: **RX Summ--Surg Oth Reg/Dis** (called Surgery of Other Sites -- Summary in MCR Manual)

edits: 162. RX Summ--Surg Oth Reg/Dis (COC) p. E-97
132. RX Hosp--Surg Oth Reg, RX Summ--Surg Oth Reg (COC) p. E-89
186. Surgery, Rad, Surg/Rad Seq (COC) p. E-108
188A. Surgery, RX Date--Surgery (COC) p. E-109
188B. Surgery, RX Date--Surgery, ICDO3 (COC) p. E-109

field: **RX Summ--Surg Oth 98-02** (called Surgery of Other Sites, 1998-2002 -- Summary in MCR Manual)

edits: 159. RX Summ--Surg Oth 98-02 (COC) p. E-96
160. RX Summ--Surg Oth 98-02, Date of DX (COC) p. E-96
161. RX Summ--Surg Oth 98-02, Primary Site (COC) p. E-96

field: **RX Summ--Surg Prim Site** (called Surgery of Primary Site--Summary in MCR Manual)

edits: 163. RX Summ--Surg Prim Site (COC) p. E-97
18. Bladder, RX Summ--Surg Prim Site, BRM (COC) p. E-42
102. RX Date--Most Defin Surg, Surg Prim Site (COC) p. E-82
134. RX Hosp--Surg Pri Sit, RX Summ--Surg Pri Sit (COC) p. E-90
164. RX Summ--Surg Prim Site, Diag Conf (SEER IF76) p. E-97
165A. RX Summ--Surg Prim Site, Primary Site (SEER IF108) p. E-97
165B. RX Summ--Surg Prim Site, Primary Site, ICDO2 (MCR) p. E-98
186. Surgery, Rad, Surg/Rad Seq (COC) p. E-108
187. Surgery, Reason No Surg (COC) p. E-108
188A. Surgery, RX Date--Surgery (COC) p. E-109
188B. Surgery, RX Date--Surgery, ICDO3 (COC) p. E-109

field: **RX Summ--Surg Site 98-02** (called Surgery of Primary Site, 1998-2002--Summary in MCR Manual)

edits: 166. RX Summ--Surg Site 98-02 (COC) p. E-98
167. RX Summ--Surg Site 98-02, Date of DX (COC) p. E-98
168. RX Summ--Surg Site 98-02, Primary Site (COC) p. E-98

field: **RX Summ--Surg/Rad Seq** (called Radiation / Surgery Sequence in MCR Manual)

edits: 169. RX Summ--Surg/Rad Seq (SEER RADSEQ) p. E-98
186. Surgery, Rad, Surg/Rad Seq (COC) p. E-108

field: **RX Summ--Transplnt/Endocr** (called Hematologic Transplants & Endocrine Procedures in MCR Manual)

edits: 170. RX Summ--Transplnt/Endocr (COC) p. E-99
111. RX Date--Systemic, Systemic RX (COC) p. E-84
171. RX Summ--Transplnt/Endocr, Primary Site (SEER IF28 p. E-99

172. RX Summ--Transplnt/Endocr, Vital Status (COC) p. E-99

field: **RX Text--BRM** (called Immunotherapy -- Narrative in MCR Manual)
edit: 140. RX Summ--BRM, RX Text--BRM (NAACCR/MCR-CIMS) p. E-91

field: **RX Text--Chemo** (called Chemotherapy -- Narrative in MCR Manual)
edit: 143. RX Summ--Chemo, RX Text--Chemo (NAACR/MCR-CIMS) p. E-92

field: **RX Text--Hormone** (called Hormone Therapy -- Narrative in MCR Manual)
edit: 148. RX Summ--Hormone, RX Text--Hormone (NAAC/MCR-CIMS) p. E-93

field: **RX Text--Other** (called Other Therapy -- Narrative in MCR Manual)
edit: 152. RX Summ--Other, RX Text--Other (NAA/MCR-CIMS) p. E-94

field: **RX Text--Radiation (Beam)** (called Radiation Therapy -- Narrative in MCR Manual)
edits: none

field: **RX Text--Surgery** (called Surgery -- Narrative in MCR Manual)
edit: 108. RX Date--Surgery, RX Text--Surgery (NAA/MCR-CIMS) p. E-83

field: **SEER Summary Stage 1977**
edits: 177A. Summary Stage (NAACCR) p. E-100
41. Hemato, Summ Stage, Class of Case (NAACCR) p. E-51
52. Lymphoma, Primary Site, Summary Stage (NAACCR) p. E-57
178B. Summary Stage, Date DX, Date 1st Contact (NAACCR) p. E-104
179B. Summary Stage, Regional Nodes Pos (NAACCR) p. E-105
181B. Summary Stage, TNM M (NAACCR) p. E-106
182B. Summary Stage, TNM N (NAACCR) p. E-107
183. Summary Stage, Class of Case (COC) p. E-104
184. Summary Stage, Histology (COC) p. E-105
206. Unknown Site, Summary Stage (NAACCR) p. 115

field: **SEER Summary Stage 2000**
edits: 177B. Summary Stage 2000 (NAACCR) p. E-101
178A. Summary Stage 2000, Date DX, Date 1st Cont (NAACCR) p. E-101
179A. Summary Stage 2000, Regional Nodes Pos (NAACCR) p. E-101
180. Summary Stage 2000, Site, Hist, Class (NAACCR) p. E-102
181A. Summary Stage 2000, TNM M (NAACCR) p. E-103
182A. Summary Stage 2000, TNM N (NAACCR) p. E-104
185. Summary Stage, Summary Stage 2000 (NAACCR/MCR p. E-105

field: **Sequence Number--Hospital**
edits: none

field: **Sex**
edits: 173. Sex (SEER SEX) p. E-99
174. Sex, Primary Site (SEER IF17) p. E-100

field: **Social Security Number**
edit: 175. Social Security Number (NAACCR) p. E-100

field: **Spanish/Hispanic Origin**
edit: 176. Spanish/Hispanic Origin (SEER SPANORIG) p. E-100

field: **Text--DX Proc--Lab Tests** (called Text--Lab Tests in MCR Manual)
edits: none

field: **Text--DX Proc--Op** (called Text--Operative in MCR Manual)

edits: none

field: **Text--DX Proc--Path** (called Text--Pathology in MCR Manual)
edits: none

field: **Text--DX Proc--PE** (called Text--Physical Exam in MCR Manual)
edits: none

field: **Text--DX Proc--Scopes** (called Text--Scopes in MCR Manual)
edits: none

field: **Text--DX Proc--X-Ray/Scan** (called Text--X-Ray/Scan in MCR Manual)
edits: none

field: **Text--Histology Title** (called Narrative Histology/Behavior/Grade in MCR Manual)
edit: 189. Text--Histology Title (NAACCR) p. E-109

field: **Text--Primary Site Title** (called Narrative Primary Site in MCR Manual)
edit: 190. Text--Primary Site Title (NAACCR) p. E-110

field: **Text--Remarks** (called Comments / Narrative Remarks in MCR Manual)
edits: none

field: **Text--Staging**
edits: none

field: **Text--Usual Industry** (called Usual Industry / Type of Business in MCR Manual)
edit: 7. Age at Diagnosis, Text--Usual Industry (NAACCR) p. E-36

field: **Text--Usual Occupation** (called Usual Occupation in MCR Manual)
edit: 8. Age at Diagnosis, Text--Usual Occupation (NAACCR) p. E-36

field: **TNM Clin Descriptor** (called Clinical Descriptor in MCR Manual)
edit: 191. TNM Clin Descriptor (COC) p. E-110

field: **TNM Clin M** (called Clinical M in MCR Manual)
edit: 192. TNM Clin M (COC) p. E-110
42A. Hematopoietic, TNM (NAACCR) p. E-51
42B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
53A. Lymphoma, TNM (NAACCR) p. E-57
53B. Lymphoma, TNM, ICDO3 (NAACCR) p. E-58
181A. Summary Stage 2000, TNM M (NAACCR) p. E-103
181B. Summary Stage, TNM M (NAACCR) p. E-106
203. TNM-Emptiness Check (MCR-CIMS) p. E-115

field: **TNM Clin N** (called Clinical N in MCR Manual)
edit: 193. TNM Clin N (COC) p. E-110
42A. Hematopoietic, TNM (NAACCR) p. E-51
42B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
53A. Lymphoma, TNM (NAACCR) p. E-57
53B. Lymphoma, TNM, ICDO3 (NAACCR) p. E-58
182A. Summary Stage 2000, TNM N (NAACCR) p. E-104
182B. Summary Stage, TNM N (NAACCR) p. E-107
203. TNM-Emptiness Check (MCR-CIMS) p. E-115

field: **TNM Clin Stage Group** (called Clinical Stage Grouping in MCR Manual)
edits: 194. TNM Clin Stage Group (COC) p. E-111
42A. Hematopoietic, TNM (NAACCR) p. E-51
42B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
72A. Primary Site, AJCC Stage Group - Ed 5, ICDO3 (COC) p. E-64
72B. Primary Site, AJCC Stage Group - Edition 5 (COC) p. E-68
73. Primary Site, AJCC Stage Group - Edition 3/4(COC) p. E-66
195. TNM Clin Stage Group, TNM Path Stage Group (COC) p. E-111
203. TNM-Emptiness Check (MCR-CIMS) p. E-115

field: **TNM Clin T** (called Clinical T in MCR Manual)
edits: 196. TNM Clin T (COC) p. E-112
42A. Hematopoietic, TNM (NAACCR) p. E-51
42B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
53A. Lymphoma, TNM (NAACCR) p. E-57
53B. Lymphoma, TNM, ICDO3 (NAACCR) p. E-58
203. TNM-Emptiness Check (MCR-CIMS) p. E-115

field: **TNM Edition Number**
edits: 197. TNM Edition Number (NAACCR) p. E-112
72A. Primary Site, AJCC Stage Group - Ed 5, ICDO3 (COC) p. E-64
72B. Primary Site, AJCC Stage Group - Edition 5 (COC) p. E-68
73. Primary Site, AJCC Stage Group - Edition 3/4(COC) p. E-66

field: **TNM Path Descriptor** (called Pathologic Descriptor in MCR Manual)
edit: 198. TNM Path Descriptor (COC) p. E-112

field: **TNM Path M** (called Pathologic M in MCR Manual)
edits: 199. TNM Path M (COC) p. E-113
42A. Hematopoietic, TNM (NAACCR) p. E-51
42B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
53A. Lymphoma, TNM (NAACCR) p. E-57
53B. Lymphoma, TNM, ICDO3 (NAACCR) p. E-58
181A. Summary Stage 2000, TNM M (NAACCR) p. E-103
181B. Summary Stage, TNM M (NAACCR) p. E-106
203. TNM-Emptiness Check (MCR-CIMS) p. E-115

field: **TNM Path N** (called Pathologic N in MCR Manual)
edits: 200. TNM Path N (COC/MCR) p. E-113
42A. Hematopoietic, TNM (NAACCR) p. E-51
42B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
53A. Lymphoma, TNM (NAACCR) p. E-57
53B. Lymphoma, TNM, ICDO3 (NAACCR) p. E-58
182A. Summary Stage 2000, TNM N (NAACCR) p. E-104
182B. Summary Stage, TNM N (NAACCR) p. E-107
203. TNM-Emptiness Check (MCR-CIMS) p. E-115

field: **TNM Path Stage Group** (called Pathologic Stage Grouping in MCR Manual)
edits: 201. TNM Path Stage Group (COC) p. E-114
42A. Hematopoietic, TNM (NAACCR) p. E-51
42B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
72A. Primary Site, AJCC Stage Group - Ed 5, ICDO3 (COC) p. E-64
72B. Primary Site, AJCC Stage Group - Edition 5 (COC) p. E-68
73. Primary Site, AJCC Stage Group - Edition 3/4(COC) p. E-66
195. TNM Clin Stage Group, TNM Path Stage Group (COC) p. E-111
203. TNM-Emptiness Check (MCR-CIMS) p. E-115

field: **TNM Path T** (called Pathologic T in MCR Manual)

edits: 202. TNM Path T (COC) p. E-114
42A. Hematopoietic, TNM (NAACCR) p. E-51
42B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
53A. Lymphoma, TNM (NAACCR) p. E-57
53B. Lymphoma, TNM, ICDO3 (NAACCR) p. E-58
203. TNM-Emptiness Check (MCR-CIMS) p. E-115

field: **Tobacco History**

edit: 204. Tobacco History (MCR-CIMS) p. E-115

field: **Vendor Name** (called Vendor Name / Version Number in MCR Manual)

edits: none

field: **Vital Status**

edits: 208. Vital Status (COC) p. E-116
20. Class, Date Diag, Date Last Cont, Vit Stat (COC) p. E-43
69. Place of Death, Vital Status (NAACCR) p. E-64
91. Reason for No Surgery, Vital Status (COC) p. E-78
112. RX Date--Systemic, Vital Status (COC) p. E-84
141. RX Summ--BRM, Vital Status (COC) p. E-91
144. RX Summ--Chemo, Vital Status (COC) p. E-92
149. RX Summ--Hormone, Vital Status (COC) p. E-93
172. RX Summ--Transplnt/Endocr, Vital Status (COC) p. E-99

Descriptions of MCR Automated Edits

1. **Abstracted By (NAACCR)**

field involved: Abstracted By (3 characters long)

This edit is a simple character check.

The field cannot contain symbols or leading spaces.

The field cannot be empty.

We ordinarily expect this field to contain only uppercase letters, but this edit will also allow lowercase letters, numbers and embedded spaces. We would not normally expect to alter what you have sent us in this field, but we run this edit so that we can detect problems with the field (such as being sent in empty).

---

2. **Addr at DX--City (NAACCR)**

field involved: Addr at DX--City (20 characters long)

This is a simple character check.

The field may only contain letters and embedded spaces.

The field cannot contain symbols or leading spaces.

The field cannot be empty, even for non-analytic cases. (Please remember to enter "Unknown" when necessary.)

---

3. **Address at DX--No & Street (MCR-CIMS)**

field involved: Addr at DX--No & Street (40 characters long)

This is a simple blank check.

The field can contain any type of character -- letters, numbers, symbols, a leading space, and embedded spaces.

The field cannot be empty.

The MCR modified a standard version of this edit to allow any kind of symbol that may make the address easier for us to interpret.

4A. **Addr at DX--Postal Code (NAACCR)**
4B. **Addr at DX--Postal Code (NAACCR/MCR-CIMS)**

field involved: Addr at DX--Postal Code (9 characters long)

The standard NAACCR edit (4A.) is a simple character check.

The field may only contain letters and numbers. (Allowing letters makes it possible to include the Canadian Postal Codes, for example.)

The field cannot contain symbols or spaces.

The field cannot be empty.

The MCR-modified version of the edit (4B.) is run only in the Scan Edit Set. It complains when the postal code starts with five **9**'s. This unknown code is valid, but we have had a problem in the past with files being sent in with a *large* percentage of unknown postal codes. We use this edit to identify files with too many unknown postal codes.

---

5. **Addr at DX--State (NAACCR)**

field involved: Addr at DX--State (2 letters long)

This is a validity check.

The field can only contain a valid 2-letter code for U.S. states, Canadian provinces, or the special codes **XX**, **YY** or **ZZ**. Valid codes are on page 58 in the MCR Manual and page 46 in the *FORDS* Manual. The edit uses a look-up table of valid codes.

The field cannot be empty.

---

6. **Age at Diagnosis (SEER AGEDX)**

field involved: Age at Diagnosis (3 digits long)

This is a validity check.

The field can only contain a 3-digit number from **000** through **120**, or the special code **999**.

The field cannot contain letters, symbols or spaces.

The field cannot be empty.

---

7. **Age at Diagnosis, Text--Usual Industry (NAACCR)**

fields involved: Age at Diagnosis
Birth Date
Date of Diagnosis
Text--Usual Industry

This edit runs only in the MCR Scan Edit Set. This edit checks that the industry narrative is filled for any patient old enough to have worked (fourteen years old). Please fill in the text "unknown" if you have checked the medical record and could find no usual type of industry. Fill in "student" if a teen has no job or you can't find one in the record.

If the patient's age > **013** then the narrative usual industry cannot be empty.

The edit skips whenever the year of diagnosis is before **1996**. If the patient's age is empty for a case record, the edit uses Birth Date and Date of Diagnosis to calculate it so that it need not skip.

---

8. **Age at Diagnosis, Text--Usual Occupation (NAACCR)**

fields involved: Age at Diagnosis
Birth Date
Date of Diagnosis
Text--Usual Occupation

This is a companion to the preceding edit and it also runs only in the Scan Edit Set. This edit checks that the occupation narrative is filled for any patient old enough to have worked (fourteen). Please fill in the text "unknown" if you have checked the medical record and could find no usual occupation. Fill in "student" if a teen has no job or you can't find one in the record.

If the patient's age > **013** then the narrative usual occupation cannot be empty.

The edit skips whenever the year of diagnosis is before **1996**. If the patient's age is empty for a case record, the edit uses Birth Date and Date of Diagnosis to calculate it so that it need not skip.

---

9. **Age, Birth Date, Date of Diagnosis (NAACCR IF13)**

fields involved: Age at Diagnosis
Birth Date
Date of Diagnosis

This edit checks that these three fields are in agreement.

If both dates are known (that is, no unknown years or months or days), then the edit uses all of these elements (even down to the days) to calculate an age; then it checks that the coded age is the same. If either date is partially or completely unknown, then just the known parts are used to calculate the age.

The patient's age can only be coded as completely unknown (**999**) if the birth year or diagnosis year (or both) is coded as unknown (**9999**). (Remember that we would prefer an estimated age to a complete unknown; also, an unknown diagnosis year is discouraged by the MCR because we cannot even determine if that case is reportable to us.)

10A. **Age, Primary Site, Morphology (SEER IF15)**

fields involved: Age at Diagnosis
Behavior (92-00) ICD-O-2
Histology (92-00) ICD-O-2
Primary Site

This edit looks at the patient's age and ICD-O-2 diagnosis. If the disease is unusual for someone of this age, the edit asks for a double-check of the data.

This edit is skipped for a case record if the ICD-O-2 Behavior and Histology are empty.

The following combinations of age and diagnosis require review:

Age	**Primary Site**	**Histologic Type**	**Behavior**
under 15 years	cervix uteri (**C530-C539**)	any	*in situ* (**2**)
	placenta (**C589**)	choriocarcinoma (**9100**)	any
under 20 years	colon (**C180-C189**) trachea (**C339**) lung and bronchus (**C340-C349**)	any except carcinoid tumor (**8240-8244**)	any
	esophagus (**C150-C159**) small intestine (**C170-C179**) rectosigmoid (**C199**) rectum (**C209**) anus and anal canal (**C210-C218**) gallbladder (**C239**) other biliary tract (**C240-C249**) pancreas (**C250-C259**) pleura (**C384**) breast (**C500-C509**) corpus uteri (**C540-C549**) uterus, NOS (**C559**)	any	any
	cervix uteri (**C530-C539**)	any	invasive (**3**)
under 30 years	any	multiple myeloma (**9732**) chronic lymphocytic leukemia (**9823**) chronic myeloid leukemia (**9863**, **9868**) monocytic leukemia, NOS (**9890**)	invasive (**3**)
	penis (**C609**)	any	any
under 45 years	prostate (**C619**)	adenocarcinoma, NOS (**8140**)	any
over 5 years	eye (**C690-C699**)	retinoblastoma (**9510-9512**)	any
over 14 years	any	Wilms's tumor (**8960**)	any
over 45 years	placenta (**C589**)	choriocarcinoma (**9100**)	any

This edit has an over-ride ("Age/Site/Morph").

10B. **Age, Primary Site, Morphology ICDO3 (SEER IF15)**

fields involved: Age at Diagnosis
Behavior Code ICD-O-3
Histologic Type ICD-O-3
Primary Site

This is the ICD-O-3 version of the preceding edit

This edit is skipped for a case record if the ICD-O-3 behavior and histology are empty.

The following combinations of age and diagnosis require review:

Age	**Primary Site**	**Histologic Type**	**Behavior**
under 15 years	cervix uteri (**C530-C539**)	any	*in situ* (**2**)
	placenta (**C589**)	choriocarcinoma (**9100**)	any
under 20 years	colon (**C180-C189**) trachea (**C339**) lung and bronchus (**C340-C349**)	any except carcinoid tumor (**8240-8245**)	any
	esophagus (**C150-C159**) small intestine (**C170-C179**) rectosigmoid (**C199**) rectum (**C209**) anus and anal canal (**C210-C218**) gallbladder (**C239**) other biliary tract (**C240-C249**) pancreas (**C250-C259**) pleura (**C384**) breast (**C500-C509**) corpus uteri (**C540-C549**) uterus, NOS (**C559**)	any	any
	cervix uteri (**C530-C539**)	any	invasive (**3**)
under 30 years	any	multiple myeloma (**9732**) chronic lymphocytic leukemia (**9823**) chronic myeloid leukemia (**9863**, **9875**, **9876**, **9945**) monocytic leukemia, NOS (**9946**)	invasive (**3**)
	penis (**C609**)	any	any
under 45 years	prostate (**C619**)	adenocarcinoma, NOS (**8140**)	any
over 5 years	eye (**C690-C699**)	retinoblastoma (**9510-9514**)	any
over 14 years	any	Wilms tumor (**8960**)	any
over 45 years	placenta (**C589**)	choriocarcinoma (**9100**)	any

This edit has an over-ride ("Age/Site/Morph").

11A. **Behavior (COC)**

field involved: Behavior (92-00) ICD-O-2 (1 digit long)

This is a simple validity check.

Valid codes are **0**, **1**, **2** and **3**.

The field cannot be empty.

12A. **Behavior Code, Histologic Type (NAACCR/MCR-CIMS)**

fields involved: Behavior (92-00) ICD-O-2
Date of Diagnosis (year only)
Histology (92-00) ICD-O-2
Primary Site

The only morphologies with borderline/uncertain (/**1**) behaviors in ICD-O-2 that should appear in *most* central registry data systems are those that now appear in ICD-O-3 with an invasive (/**3**) behavior:

8931	endolymphatic stromal myosis	**9980**	refractory anemia
9393	papillary ependymoma	**9981**	refractory anemia without sideroblasts
9538	papillary meningioma	**9982**	refractory anemia with sideroblasts
9950	polycythemia vera	**9983**	refractory anemia with excess of blasts
9960	chronic myeloproliferative disease	**9984**	refractory anemia with excess of blasts in transformation
9961	myelosclerosis with myeloid metaplasia		
9962	idiopathic thrombocythemia	**9989**	myelodysplastic syndrome

If the diagnosis year>**2000** and the ICD-O-2 behavior=**1** and the ICD-O-2 histologic type code is one of those listed above, the standard version of this edit passes; otherwise it fails.

Because the MCR collects CNS cancers having benign and borderline behaviors, however, our data system has many other ICD-O-2 borderline morphologies than just those that have become invasive. The standard version of this edit would reject all of those borderline cases that are reportable to the MCR. Our modification of the edit does this: if ICD-O-2 behavior=**1** and diagnosis year<**2001** and ICD-O-2 histologic type is one of those above (except **9393** or **9538**, which may typically appear in the CNS sites), the edit fails.

13A. **Behavior ICDO2, Date of Diagnosis (NAACCR)**

fields involved: Behavior (92-00) ICD-O-2
Date of Diagnosis (year only)

This edit is not run in the MCR Scan Edit Set.

This edit checks that the ICD-O-2 Behavior code is not empty for any diagnosis made before 2001. If the year of diagnosis<**2001** and the ICD-O-2 Behavior is empty, the edit fails.

11B. **Behavior ICDO3 (COC)**

field involved: Behavior Code ICD-O-3 (1 digit long)

This is a simple validity check.

Valid codes are **0 - 3**. The field may also be empty (as for pre-2001 diagnoses).

13B. **Behavior ICDO3, Date of Diagnosis (NAACCR)**

fields involved: Behavior Code ICD-O-3
Date of Diagnosis (year only)

This edit does not run in the MCR Scan Edit Set.

This edit checks that the ICD-O-3 Behavior code is not empty for any diagnosis made after 2000.

If the year of diagnosis>**2000** (but not **9999**) and the ICD-O-3 Behavior is empty, the edit fails.

12B. **Behavior ICDO3, Histologic Type ICDO3 (NAACCR/MCR)**

fields involved: Behavior Code ICD-O-3
Date of Diagnosis (year only)
Histologic Type ICD-O-3
Primary Site

The only morphologies with borderline/uncertain (/**1**) behaviors in ICD-O-3 that should appear in *most* central registry data systems are those that appeared in ICD-O-2 with an invasive (/**3**) behavior:

8442 serous cystadenoma, borderline malignancy
8451 papillary cystadenoma, borderline malignancy
8462 serous papillary cystic tumor of borderline malignancy
8472 mucinous cystic tumor of borderline malignancy
8473 papillary mucinous cystadenoma, borderline malignancy

If the diagnosis year<**2001** and the ICD-O-3 behavior=**1** and the ICD-O-3 histologic type code is one of those listed above, the standard version of this edit passes; otherwise it fails.

Because the MCR collects CNS cancers having benign and borderline behaviors, however, our data system has many other ICD-O-3 borderline morphologies than just those above. The standard version of this edit rejects all borderline cases that are MCR-reportable. Our modification is: if ICD-O-3 behavior=**1** and diagnosis year>**2000** and ICD-O-3 histologic type is one of those above, the edit fails.

---

14. **Birth Date (NAACCR DATEEDIT)**

field involved: Birth Date (8 digits long)

This is a validity check, but it's not simple.

Valid day codes are **01-31** and **99**. The edit is smart enough to know which months have no 31st's and which years have February 29th's. Valid month codes are **01-12** and **99**. Valid year codes are **9999** and any year between 150 years ago* and today.

The edit only allows sensible use of the unknown codes. If the year is unknown, then the entire date must be unknown. If the year is known but the month is unknown, then the day must also be unknown.

The edit checks year first, then month, and then day; and it stops checking as soon as it finds something wrong. For example, if the year is OK but both the day and month are badly coded (**77771999**, for example), the edit will validate the year, then detect the bad month code, and then stop -- it will not bother to check the day, so you will only get an error message complaining about the bad month code. This does not mean that the edit thinks that a day of **77** is valid -- it just did not bother to check the day code because it found the month problem first.

No part of the field may be blank (empty). No letters, symbols or spaces are accepted. If the month or day is coded **00**, then the month or day is considered to be "missing" entirely.

This edit produces a variety of error messages, depending on what type of error the edit had detected when it stopped.

Invalid parts of the date are checked for first (year, then month, then day), and "missing" parts of the date are checked for after this (year, then month, then day). For example, if the year is valid but the month is **00** and the day is **33** (**00331999**), the edit will detect the invalid day code first and complain about that; having stopped there, the edit will not get around to detecting the "missing" month code.

* even though the maximum age that can be coded is 120 years

---

15. **Birth Date, Date of Diagnosis (NAACCR IF47)**

fields involved: Birth Date
Date of Diagnosis

This edit compares the two dates to see if they make sense together. The two dates may be identical, but diagnosis date cannot be earlier than birth date.*

This edit is skipped if either field has failed its validity check. It also skips if either year is coded unknown (**9999**).

If one or both dates is partially unknown, the edit only compares the known parts of the two dates. For example, if the birth date is **99991944** and the diagnosis date is **03032000**, the edit will only compare the two years.

* Although cancer diagnoses are being made before birth, the edit will not allow this. If your data system allows you to store a diagnosis date that precedes the birth date, we must ask that the diagnosis date be changed to equal the eventual birth date when such cases are exported for the MCR; otherwise, please explain the situation in a narrative field.

---

16. **Birthplace (SEER POB)**

field involved: Birthplace (3 digits long)

This is a simple validity check. It uses a look-up table of valid codes.

Valid codes are in MCR Manual Appendix A.

The field cannot be empty.

---

17. **Bladder, RX Hosp--Surg Prim Site, BRM (COC)**

fields involved: Primary Site
RX Hosp--BRM
RX Hosp--Surg Prim Site

This edit checks that surgical installations to deliver immunotherapy to the bladder also have the immunotherapy coded.

If the primary site code = **C67_** (bladder) and the at-this-facility primary site surgery code = **16** (BCG or other immunotherapy installation), then the at-this-facility immunotherapy code must = **01** (immunotherapy given).

---

18. **Bladder, RX Summ--Surg Prim Site, BRM (COC)**

fields involved: Primary Site
RX Summ--BRM
RX Summ--Surg Prim Site

This is just like the preceding edit, but it checks the summary treatment fields.

If the primary site code = **C67_** and the summary primary site surgery code = **16** (BCG or other immunotherapy installation), then the summary immunotherapy code must = **01** (immunotherapy given).

---

19. **Class of Case (COC)**

field involved: Class of Case (1 digit long)

This is a simple validity check.

Valid codes are **0** - **9***.

The field cannot be empty.

* Although Class **8** cases (death certificate-only cases) should not be reported *to* the MCR, we enter them onto our data system ourselves. When we do so, this edit allows that code onto our system. If a facility reports a case to us coded with a Class of **8** our system will not detect anything unusual and will process that case like any other.

---

20. **Class, Date Diag, Date Last Cont, Vit Stat (COC)**

fields involved: Class of Case
Date of Diagnosis (year only)
Date of Last Contact (year only)
Vital Status

If a case wasn't diagnosed until death (on autopsy or death certificate), then the patient must be dead and the diagnosis and last contact dates should be the same (the death date). The edit checks the 4 fields for this agreement (well, really only the years of diagnosis and last contact have to be the same for the edit to be happy).

If Class of Case=**5** (autopsy) or Class=**8** (death certificate only), then year of last contact=diagnosis year and Vital Status=**0** (dead).

This edit produces a single error message saying that the 4 fields are in conflict. It does not specify, for example, if just the Vital Status code conflicts with the Class.

---

21. **COC Coding Sys--Current (COC)**

field involved: COC Coding Sys--Current (2 digits long)

This is a validity check. on the metadata field for current COC coding. It runs only in the MCR Scan Edit Set.

The only valid code is **08**, indicating that COC coding in the record follows the *FORDS* Manual for V10.

---

22. **COC Coding Sys--Original (COC)**

field involved: COC Coding Sys--Original (2 digits long)

This is a validity check. on the way COC fields were originally coded on your data system for the record being edited. It runs only in the MCR Scan Edit Set.

Valid codes are **00** - **08** and **99**. The field may also be empty (because the field was not required by the COC until 2003 diagnoses).

---

23. **COC Coding Sys--Original, Date of Diagnosis (COC)**

fields involved: COC Coding Sys--Original
Date of Diagnosis (year only)

This edit runs only the MCR Scan Edit Set.

It checks that the original COC coding system metadata field is filled for the appropriate diagnosis years.

If the year of diagnosis > **2002** and not unknown, then COC Coding Sys--Original cannot be empty.

---

24. **Date Case Completed (MCR-CIMS)**

field involved: Date Case Completed (8 digits long)

This is a date validity check. See Edit #14 on page E-41 for a description of what a date validity check does.

Although you may not have to fill this field in on your data system (your system may fill the field in for you), we need to run a validity check on it to be sure that the field is being filled correctly. The edit runs only in our Scan Set.

The field cannot be empty.

---

25. **Date Case Report Exported (NAACCR DATEEDIT)**

field involved: Date Case Record Exported (8 digits long)

This is a date validity check. See Edit #14 on page E-41 for a description of what a date validity check does.

This edit runs only in the Scan Edit Set. Your data system should be filling this field with the date on which each case record was put onto a floppy diskette for us. MCR staff cannot change the values in this field from within our data system. If you receive reports of cases failing this edit, then your data system is not putting some valid date into this field.

The field cannot be empty.

---

26. **Date of 1st Contact (COC)**

field involved: Date of First Contact (8 digits long)

This is a date validity check. See Edit #14 on page E-41 for a description of what a date validity check does.

---

27. **Date of 1st Crs RX--COC (COC)**

field involved: Date of 1st Crs RX--COC (8 digits long)

This is a treatment date validity check.

A *treatment* date validity check is similar to the date validity check Edit #14 on page E-41, but it allows the date to be zero-filled; that is, if the year is **0000**, then the entire date must be zeroes; if *only* the month and/or day is **00**, or if *only* the year is **0000**, the edit will complain.

The field cannot be empty.

---

28. **Date of 1st Crs RX--COC, Date Last Contact (COC)**

involved fields: Date of 1st Crs RX--COC
Date of Last Contact

This is a date comparison edit. The last contact date can be identical to the starting date for first-course cancer-directed treatment, but the last contact date cannot precede the other date.

The edit is skipped for a case record if either date has failed its validity check.

If no first-course treatment was given (Date of 1st Crs RX--COC is coded **00000000**), then this edit is skipped for that case record.

If either year is coded unknown (**9999**), then the edit is skipped for that case record.

If either date is partially unknown (or both), then the edit only compares the known parts of the two dates.

Note that this edit is not checking Date of Last Contact against the *latest* starting treatment date that may be recorded, but rather against the *earliest* starting treatment date.

---

29. **Date of 1st Crs RX--COC, Date of DX (COC)**

fields involved: Date of 1st Crs RX--COC
Date of Diagnosis

This is a date comparison edit. The diagnosis date can be identical to the treatment starting date, but treatment cannot start before diagnosis.

If either date is empty, the edit is skipped for that case record.

If no first-course cancer-directed treatment was given (Date of 1st Crs RX--COC is coded **00000000**), then this edit is skipped for that case record.

If either year is coded unknown (**9999**), then the edit is skipped for that case record.

If either date is partially unknown (or both), then the edit only compares the known parts of the two dates.

---

30. **Date of 1st Crs RX--COC, Dates of RX (COC)**

fields involved: Date of 1st Crs RX--COC
RX Date--Other
RX Date--Radiation
RX Date--Surgery
RX Date--Systemic

This edit compares the starting treatment date with the start dates of each treatment modality. The *overall* starting date cannot be later than any of the individual start dates.

The edit skips for a case record if any of the dates involved is empty. It skips if all of the treatment modality dates are **zero**-filled (because, if no treatment was done, the Date of 1st Crs RX may be **zero**-filled or may be some real date on which it was decided to do no treatment). It skips if all the modality dates are **8**-filled (treatment not yet begun).

If any of the treatment modality dates is not zero-filled, then the Date of 1st Crs RX can't be **zero**-filled.

The Date of 1st Crs RX must be the earliest non-zero-filled treatment modality start date.

Unknown parts of dates are given consideration. You may know, for example, that the surgery was done first of all treatments, yet its exact date is unknown to you. If *any* of the modality dates is **9**-filled, then the treatment start date may be **9**-filled. If unknown modality month or day are coded, these may be coded unknown in the start date.

---

31. **Date of Diagnosis (NAACCR DATEEDIT)**

field involved: Date of Diagnosis (8 digits long)

This is a date validity check. See Edit #14 on page E-41 for a description of what a date validity check does.

---

32. **Date of Last Contact (NAACCR DATEEDIT)**

field involved: Date of Last Contact (8 digits long)

This is a date validity check. See Edit #14 on page E-41 for a description of what a date validity check does.

---

33. **Date of Last Contact, Date of Diag. (NAACCR IF19)**

fields involved: Date of Diagnosis
Date of Last Contact

This is a date comparison edit. The two dates may be identical, but the last contact cannot precede the diagnosis.

If either date has failed its validity check, this edit is skipped for that case record.

If either year (or both) is unknown (**9999**), the edit is skipped for that case record.

If either date (or both) is partially unknown, then only the known parts of the dates are compared.

---

34. **Diagnostic Confirmation (SEER DXCONF)**

field involved: Diagnostic Confirmation (1 digit long)

This is a simple validity check.

Valid codes are **1**, **2**, **4 - 9**.

The field cannot be empty.

35A. **Diagnostic Confirmation, Behavior Code (SEER IF31)**

fields involved: Behavior (92-00) ICD-O-2
Diagnostic Confirmation

This edit checks that cases coded with an *in situ* ICD-O-2 behavior have been microscopically confirmed.

The edit is skipped for a case record if either field has failed its validity check or if the ICD-O-2 behavior is empty.

If the ICD-O-2 behavior=**2** and the Diagnostic Confirmation is *not* **1**, **2** or **4**, the edit asks that the data be reviewed.

There is an over-ride for this edit (the "Histology" over-ride flag must be set to **2** or **3**).

If you know that a case was specified as *in situ* and yet you do not know exactly how it was confirmed, it is probably acceptable to assume that it must have been histologically confirmed at some point (**4**). The edit text offers this advice on cases questioned by the edit:

> "The distinction between *in situ* and invasive is very important to a registry, since prognosis is so different, and *in situ* cases are usually excluded from incidence rate calculations. Since the determination that a neoplasm has not invaded surrounding tissue, i.e., is not *in situ*, is made via the microscope, cases coded *in situ* in behavior should have a microscopic confirmation code. However, very rarely, a physician will designate a case non-invasive or *in situ* without microscopic evidence. Check carefully for any cytologic or histologic evidence that may have been missed in coding. Correction of errors may require inspection of the abstracted text.... Review of the original medical record may also be required. If upon review all items are correct as coded, an over-ride flag may be set so that the case will not be considered in error when the edit is run again. Set the Over-ride--Histology field to **2** (or **3**, if the flag is also being set for the Morphology--Type&Behavior (SEER MORPH) edit)."

Note that staging codes are not checked by this edit. The edit uses only the ICD-O-2 behavior to determine if a case has been categorized as *in situ*.

35B. **Diagnostic Confirmation, Behavior ICD03 (SEER IF31)**

fields involved: Behavior Code ICD-O-3
Diagnostic Confirmation

This is the ICD-O-3 version of the preceding edit. The edit checks that cases coded with an *in situ* ICD-O-3 behavior have been microscopically confirmed.

If the ICD-O-3 behavior=**2** and the Diagnostic Confirmation is *not* **1**, **2** or **4**, the edit asks that the data be reviewed.

There is an over-ride for this edit (the "Histology" over-ride flag must be set to **2** or **3**).

The edit text offers the same advice for passing this edit as in the preceding edit.

36A. **Diagnostic Confirmation, Histologic Typ(SEER IF48)**

fields involved: Diagnostic Confirmation
Histology (92-00) ICD-O-2

The edit checks that diagnoses of lymphomas, leukemias, other lymphoreticular neoplasms, plasma cell tumors, mast cell tumors, and immunoproliferative diseases have been adequately confirmed.

If a lymphoma has been diagnosed by direct visualization (Diagnostic Confirmation = **6**) or clinically (Diagnostic Confirmation = **8**), the edit asks for review of the data.

If a leukemia (or other high-coded histology) has been diagnosed by direct visualization, the edit questions the data. Remember that positive hematologic findings and bone marrow specimens are considered histologic confirmation for leukemias (Diagnostic Confirmation = **1**).

The edit requires review of the following code combinations:

Histology ICD-O-2 = **9590 - 9717**	and	Diagnostic Confirmation = **6** or **8**
Histology ICD-O-2 = **9720 - 9941**	and	Diagnostic Confirmation = **6**

The edit is skipped for a case record if either field has failed its validity check or if the ICD-O-2 histology is empty.

There is an over-ride for this edit ("Leuk, Lymphoma".

36B. **Diagnostic Confirmation, Histology ICD03(SEER IF48**

fields involved: Diagnostic Confirmation
Histologic Type ICD-O-3

This is the ICD-O-3 version of the preceding edit. It works exactly the same way. Lymphomas are defined with ICD-O-3 code range **9590 - 9729**, and leukemias and the other high-coded histologies are defined by **9731 - 9948**.

The edit is skipped for a case record if either field has failed its validity check or if the ICD-O-3 histology is empty.

There is an over-ride for this edit ("Leuk, Lymphoma".

37A. **EOD--Primary Site, Histology, Behav ICDO3 (NAACCR)**

fields involved: Behavior Code ICD-O-3
Histologic Type ICD-O-3
Primary Site

This edit checks that certain kinds of cancer do NOT have *in situ* behavior.

The edit skips if the ICD-O-3 Histology is empty.

These primary site codes should not have Behavior Code = **2**:

C38_	heart, pleura and mediastinum
C39_	other and ill-defined respiratory sites and intrathoracic organs
C40_	bones, joints and articular cartilage of limbs
C41_	bones, joints and articular cartilage of other and unspecified sites
C42_	hematopoietic and reticuloendothelial systems
C47_	peripheral nerves and autonomic nervous system
C48_	retroperitoneum and peritoneum
C49_	connective, subcutaneous and other soft tissues
C701, **C709**	spinal meninges and meninges, NOS
C72_	other parts of central nervous system
C76_	other and ill-defined sites
C77_	lymph nodes
C809	unknown primary site

These diseases should not have Behavior Code = **2**:

(Histologic Type = **9700** or **9701**) with (primary site **C44_**, **C51_**, **C600**. **C601**, **C608**, **C609**, **C632**) (mycosis fungoides or Sezary diseases of skin, vulva, prepuce, glans penis, overlapping lesion of penis, penis NOS, scrotum)

Histologic Type = **9140** (Kaposi sarcoma)

Histologic Type = **9510 - 9514** with primary site **C692** (retinoblastoma)

Histologic Type = **9590 - 9699**, **9702 - 9729** (Hodgkin and non-Hodgkin lymphomas)

Histologic Type = **9731 - 9989** (hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative diseases)

37B. **EOD--Primary Site, Histology, Behavior (NAACCR)**

fields involved: Behavior (92-00) ICD-O-2
Histology (92-00) ICD-O-2
Primary Site

This is the ICD-O-2 version of the preceding edit.

The edit skips if the ICD-O-2 Histology is empty.

The same primary sites as for Edit #37A should not have Behavior Code = **2**.

The same diseases as for Edit #37A should not have Behavior Code = **2** with the following code changes:

Histologic Type = **9510 - 9512** with primary site **C692** (retinoblastoma)

Histologic Type = **9590 - 9698**, **9702 - 9717** (Hodgkin and non-Hodgkin lymphomas)

Histologic Type = **9720 - 9989** (hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative diseases)

---

38. **EOD--Reg Nodes Ex,Reg Nodes Pos,Prim Site (NAACCR)**

fields involved: Behavior (92-00) ICD-O-2
Date of Diagnosis (year only)
Histology (92-00) ICD-O-2
Regional Nodes Examined
Regional Nodes Positive
Type of Reporting Source

This edit does not run in the MCR Scan Edit Set.

The edit skips if the ICD-O-2 histology, Regional Nodes Examined or Regional Nodes Positive is empty.

It skips for diagnoses made before **1998** and for any case record without an ICD-O-2 *in situ* (/**2**) or invasive (/**3**) behavior.

If Regional Nodes Examined=**00** (none examined), then Regional Nodes Positive=**98** (none examined).

If Regional Nodes Examined=**01 - 89** (specified number examined), then Regional Nodes Positive≤Regional Nodes Examined or Nodes Positive=**97** or **99** (an uncertain number positive, or you don't know if any were positive).

If Regional Nodes Examined=**90** (90+ examined), then Regional Nodes Positive=**00 - 97**, **99** (none or any number positive is OK; you don't know if any were positive is also OK).

If Regional Nodes Examined=**95** (aspiration), then Regional Nodes Positive=**00**, **97** or **99** (none were positive, an unknown number were positive, or you don't know if any nodes examined were positive).

If Regional Nodes Examined=**96-98** (uncertain number examined), then Regional Nodes Positive=**00 - 97**, **99** (none or any number positive is OK; you don't know if any were positive is also OK).

If Regional Nodes Examined=**99** then Regional Nodes Positive=**99**.

Regional Nodes Examined and Regional Nodes Positive must both be coded **99** for these cases:

death certificate-only cases (Type of Reporting Source=**7**);
ICD-O-2 hematopoietic diseases (**9720 - 9989**);
ICD-O-2 lymphomas (**9590 - 9698**, **9702 - 9717**);
brain and other CNS primaries (**C700-C729**) except Kaposi sarcomas (**9140**);
other/ill-defined sites (**C420-C424**, **C76_**, **C77_**, **C809**) except Kaposi sarcomas (**9140**).

For all other cases, if *in situ* (ICD-O-2 behavior=**2**), Regional Nodes Positive must indicate that no nodes were positive (**00** or **98**) and Regional Nodes Examined <>**99**.

---

39. **EOD--Tumor Size (COC)**

field involved: EOD--Tumor Size (3 digits long)

This edit is a simple character check.

The field should contain 3 numbers.

The field cannot contain letters, symbols or spaces. It should not contain only 1 or 2 digits.

The field cannot be empty.

---

40. **Grade (COC)**

field involved: Grade (1 digit long)

This is a simple validity check.

Valid codes are **1** - **9** (any single digit).

The field cannot be empty.

---

41. **Hemato, Summ Stage, Class of Case (NAACCR)**

fields involved: Class of Case
Histology (92-00) ICD-O-2
SEER Summary Stage 1977

This edit checks that Summary Stage 1977 = **7** (systemic disease) for these ICD-O-2 hematopoietic and reticuloendothelial neoplasms: **9720**, **9722**, **9723**, **9732**, **9741**, **9760-9763**, **9765-9910**, **9931-9989**.

Summary Stage 1977 should = **1**, **7** or **9** for these histologic types: **9731**, **9740**, **9764**, **9930**.

The edit skips if Summary Stage 1977 is empty. It also skips for death certificate-only cases (Class of Case=**8**).

42A. **Hematopoietic, TNM (NAACCR)**

fields involved: Class of Case
Date of Diagnosis (year only)
Histology (92-00) ICD-O-2
TNM Clin T
TNM Clin N
TNM Clin M
TNM Clin Stage Group
TNM Path T
TNM Path N
TNM Path M
TNM Path Stage Group
Type of Reporting Source

This edit checks that the TNM fields are coded correctly for certain ICD-O-2 cases.

Hematopoietic and reticuloendothelial neoplasms (ICD-O-2 histologies **9720**, **9722-9723**, **9731-9732**, **9740-9741**, **9760-9989**) have no AJCC staging schemes, so all of the TNM fields above must be coded **88**.

The edit skips when the diagnosis year<**1996**. It also skips if all of the TNM fields above are empty. It also skips for death certificate-only cases (Class of Case=**8** or Type of Reporting Source=**7**).

42B. **Hematopoietic, TNM, ICDO3 (NAACCR)**

fields involved: Class of Case
Date of Diagnosis (year only)
Histologic Type ICD-O-3
TNM Clin T
TNM Clin N
TNM Clin M
TNM Clin Stage Group
TNM Path T
TNM Path N
TNM Path M
TNM Path Stage Group
Type of Reporting Source

This is the ICD-O-3 version of the preceding edit. It does exactly what the preceding edit does, but it defines the diagnoses using ICD-O-3 histologies: **9731 - 9989**.

43A. **Histologic Type (COC)**

field involved: Histology (92-00) ICD-O-2 (4 digits)

This is a very simple validity check (just a code range check, really).

The edit checks that the ICD-O-2 histology code is within the range **8000 - 9989** or is empty (as it could be for diagnoses made after 2000).

43B. **Histologic Type ICDO3 (COC)**

field involved: Histologic Type ICD-O-3 (4 digits)

This is a very simple validity check. It's the ICD-O-3 version of the preceding edit.

The edit checks that the ICD-O-3 histology code is within the range **8000 - 9989** or is empty (as it could be for diagnoses made before 2001).

44A. **Histology ICD02, Date DX, Date 1st Contact (NAACCR)**

fields involved: Date of Diagnosis (year only)
Date of 1st Contact (year only)
Histology (92-00) ICD-O-2

This is a blank check. It checks that the ICD-O-2 histology is not empty for diagnosis years<**2001**. If the diagnosis year is unknown (**9999**), it uses the year of Date of First Contact.

---

45. **Histology ICDO2, Histology ICDO3 (SEER IF94)**

fields involved: Histologic Type ICD-O-3
Histology (92-00) ICD-O-2

This is a double blank check. If both ICD-O-2 and ICD-O-3 histology fields are empty, the edit fails.

44B. **Histology ICDO3, Date DX, Date 1st Cont (NAACCR)**

fields involved: Date of Diagnosis (year only)
Date of 1st Contact (year only)
Histologic Type ICD-O-3

This is a blank check, checking that the ICD-O-3 histology is not empty for diagnosis years>**2000** (except unknown year code **9999**). It uses the year of Date of First Contact if the diagnosis year is unknown.

46A. **Histology, Primary Site, Tumor Size (COC)**

fields involved: EOD--Tumor Size
Histology (92-00) ICD-O-2
Primary Site

This edit checks that EOD--Tumor Size is coded **999** for cancer types specified in the *FORDS* Manual.

Tumor Size must be **999** for the following diseases:
primary site = **C42_** OR histologic type = **9720**, **9760-9764**, **9800-9820**, **9826**, **9840-9894**, **9910**, **9931-9962**, **9980-9989** (hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative diseases)
histologic types **9722**, **9732** (Letterer-Siwe disease, multiple myeloma)
primary sites **C76_**, **C809** (other and ill-defined sites, unknown primary site)

The edit is skipped if the ICD-O-2 histologic type is empty.

46B. **Histology, Primary Site, Tumor Size, ICDO3 (COC)**

fields involved: EOD--Tumor Size
Histologic Type ICD-O-3
Primary Site

This is the ICD-O-3 version of the preceding edit.

The edit is skipped if the ICD-O-3 histologic type is empty.

Tumor Size must be **999** for the following diseases:
primary site = C42._ OR histologic type = **9750**, **9760-9764**, **9800-9820**, **9826**, **9831-9920**, **9931-9964**, **9980-9989** (hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative diseases)
histologic types 9732, 9754 (multiple myeloma, Letterer-Siwe disease)
primary sites C76._, C80.9 (other and ill-defined sites, unknown primary site)

---

47. **Invalid City/Town Name (MCR-CIMS)**

field involved: Addr at DX--City (20 characters long)

This edit is run only when a case record in the MCR's data system is submitted to the system's "master database" by one of our staff. The edit is not in our Scan Edit Set and should not be of concern to our reporting facilities.

This edit prevents non-Massachusetts residents' cases from getting onto our "master database". It also prevents misspellings of town names and non-standard spellings. (Mass. city/town names are standardized during upload to MCR-CIMS.) The edit compares the reported city/town name with a look-up table of Massachusetts city/town names that we consider to be valid.

---

48. **Invalid Zipcode (MCR-CIMS)**

field involved: Addr at DX--Postal Code (9 characters long)

This edit is run only when a case record in the MCR's data system is submitted to the system's "master database" by one of our staff. The edit is not in our Scan Edit Set and should not be of concern to our reporting facilities.

This edit prevents non-Massachusetts residents' cases from getting onto our "master database". The edit compares the reported Postal Code with a look-up table of Massachusetts ZIP Codes that we consider to be valid.

---

49. **Laterality (SEER LATERAL)**

field involved: Laterality (1 digit long)

This is a simple validity check.

Valid codes are **0** - **4** and **9**.

The field cannot be empty.

---

50. **Laterality, Primary Site (NAACCR IF24)**

fields involved: Laterality
Primary Site

The edit checks that the laterality is *not* coded "not paired" for purely paired primary sites. That is, for paired sites, the Laterality code cannot be **0**.

The edit is skipped for a case record if either field has failed its validity check.

The primary sites that are considered "paired" for this edit follow:

C079	parotid gland	**C443**	skin, other and unspecified parts of face
C080	submandibular gland	**C445**	skin, trunk
C081	sublingual gland	**C446**	skin, upper limb, shoulder
C090	tonsillar fossa	**C447**	skin, lower limb, hip
C091	tonsillar pillar	**C471**	peripheral nerves & autonomic nervous system, upper limb, shoulder
C098	tonsil, overlapping	**C472**	peripheral nerves & autonomic nervous system, lower limb, hip
C099	tonsil, NOS	**C491**	connective, subcutaneous & other soft tissues, upper limb, shoulder
C301	middle ear	**C492**	connective, subcutaneous & other soft tissues, lower limb, hip
C310	maxillary sinus	**C50_**	breast
C312	frontal sinus	**C569**	ovary
C341	lung, upper lobe	**C570**	fallopian tube
C342	lung, middle lobe*	**C62_**	testis
C343	lung, lower lobe	**C630**	epididymis
C348	lung, overlapping	**C631**	spermatic cord
C349	lung, NOS	**C649**	kidney, NOS
C384	pleura, NOS	**C659**	renal pelvis
C400	long bones of upper limb, scapula, joints	**C669**	ureter
C401	short bones of upper limb, joints	**C69_**	eye & adnexa
C402	long bones of lower limb, joints	**C74_**	adrenal gland
C403	short bones of lower limb, joints	**C754**	carotid body
C441	skin, eyelid		
C442	skin, external ear		

Site codes which may or may not be paired, depending on the exact part of the site where the tumor began, are not checked by this edit because *any* valid laterality code may be appropriate for those site codes. For example, if the primary site is the carina (**C340**), the site is not paired and laterality should be coded **0**; but if the primary site is the main bronchus (also coded **C340**), the site is paired and laterality may be any valid code except **0**.

The edit ignores all purely unpaired primary sites. That is, if the site is coded **C169** for stomach and the laterality is coded **1** for "right side origin", this incorrect combination is not checked by the edit at all.

* Although a middle lung lobe is found on the right side only, this is considered a paired site by this edit.

51A. **Laterality, Primary Site, Morph ICDO3 (SEER IF42)**

fields involved: Behavior Code ICD-O-3
Date of Diagnosis (year only)
Histologic Type ICD-O-3
Laterality
Primary Site

This edit checks that *in situ* (ICD-O-3 Behavior = **2**) lesions in purely paired primary sites are specified as originating in one side only (Laterality = **1 - 3**).

The edit skips if the ICD-O-3 histology is empty. It skips if any of the involved fields has failed its validity check. It skips for ICD-O-3 lymphomas and leukemias (any histology ≥ **9590**). It skips for Kaposi sarcoma (**9140**), mycosis fungoides (**9700**), and Sezary syndrome (**9701**) diagnosed after 1987.

The edit asks for the data to be reviewed for the following code combinations:
ICD-O-2 behavior = **2** and Laterality <> **1**, **2** or **3** and Primary Site below:

C079 parotid gland
C080 submandibular gland
C081 sublingual gland
C090 tonsillar fossa
C091 tonsillar pillar
C098 tonsil, overlapping
C099 tonsil, NOS
C301 middle ear
C310 maxillary sinus
C312 frontal sinus
C341 lung, upper lobe
C342 lung, middle lobe*
C343 lung, lower lobe
C348 lung, overlapping
C349 lung, NOS
C384 pleura, NOS
C400 long bones of upper limb, scapula, joints
C401 short bones of upper limb, joints
C402 long bones of lower limb, joints
C403 short bones of lower limb, joints
C441 skin, eyelid
C442 skin, external ear
C446 skin, upper limb, shoulder
C447 skin, lower limb, hip
C471 peripheral nerves & autonomic nervous system, upper limb, shoulder
C472 peripheral nerves & autonomic nervous system, lower limb, hip
C491 connective, subcutaneous & other soft tissues, upper limb, shoulder
C492 connective, subcutaneous & other soft tissues, lower limb, hip
C50_ breast
C569 ovary
C570 fallopian
C62_ testis
C630 epididymis
C631 spermatic cord
C649 kidney, NOS
C659 renal pelvis
C669 ureter
C69_ eye & adnexa
C74_ adrenal gland
C754 carotid body

Site codes which may or may not be paired, depending on the exact part of the site where the tumor began, are not checked by this edit. For example, a non-invasive lesion said to originate in the nostril (site **C300**) with a Laterality code of **4** or **9** would not be questioned by this edit because the same site code could be indicating origin in the unpaired nasal septum.

The edit ignores all purely unpaired primary sites. That is, an *in-situ* lesion with site coded **C189** for left colon and laterality coded **4** for "side of origin is unknown but both sides are involved" would not be questioned by this edit.

Staging is not checked by this edit. Only the Behavior Code is used to determine if a case has been called *in situ*.

This edit has an over-ride ("Site/Lat/Morph").

* Although a middle lung lobe is found on the right side only, this is considered a paired site by this edit.

51B. **Laterality, Primary Site, Morphology (SEER IF42)**

fields involved: Behavior (92-00) ICD-O-2
Date of Diagnosis (just the year)
Histology (92-00) ICD-O-2
Laterality
Primary Site

This is the ICD-O-2 version of the preceding edit.

This edit is skipped for a case record if any of the involved fields has failed its validity check or if the ICD-O-2 Histology is empty.

The edit asks for the data to be reviewed for the same code combinations that appear in the preceding edit, but it is the ICD-O-2 Behavior that is being checked here.

The ICD-O-2 Histology and Date of Diagnosis are involved because lymphomas, leukemias, etc. (ICD-O-3 histology ≥ **9590**) are not checked by this edit. The edit does not check Kaposi sarcomas (**9140**), mycosis fungoides (**9700**) or Sezary syndrome (**9701**) diagnosed in 1988 or afterward.

This edit has an over-ride ("Site/Lat/Morph").

---

52. **Lymphoma, Primary Site, Summary Stage (NAACCR)**

fields involved: Histology (92-00) ICD-O-2
Primary Site
SEER Summary Stage 1977

This edit checks that the Summary Stage 1977 code makes sense for ICD-O-2 nodal lymphomas.

If Primary Site=**C770-C779** (lymph nodes) and ICD-O-2 histology=**9590-9595**, **9650-9698**, **9702-9717**, then Summary Stage 1977<>**3**, **4** (regional nodes involved).

If Primary Site=**C778** (multiple node regions involved) and histology=as above, then Summary Stage 1977<>**1** (localized).

The edit skips if the Summary Stage 1977 is empty.

53A. **Lymphoma, TNM (NAACCR)**

fields involved: Histology (92-00) ICD-O-2
TNM Clin T
TNM Clin N
TNM Clin M
TNM Path T
TNM Path N
TNM Path M

This edit checks that all of the TNM elements are coded **88** for ICD-O-2 lymphomas (**9590-9698**, **9702-9717**) because the TNM elements do not apply to these cases.

The edit skips if the ICD-O-2 histology is empty. It also skips if all of the TNM elements are empty.

53B. **Lymphoma, TNM, ICDO3 (NAACCR)**

fields involved: Histologic Type ICD-O-3
TNM Clin T
TNM Clin N
TNM Clin M
TNM Path T
TNM Path N
TNM Path M

This is the ICD-O-3 version of the preceding edit. This edit checks that all of the TNM elements are coded **88** for ICD-O-3 lymphomas (**9590-9699**, **9702-9729**) because the TNM elements do not apply to these cases.

The edit skips if the ICD-O-3 histology is empty. It also skips if all of the TNM elements are empty.

---

54. **Marital Status at DX (SEER MARITAL)**

field involved: Marital Status at DX (1 digit long)

This is a simple validity check.

Valid codes are **1** - **5** and **9**.

The field cannot be empty.

---

55. **Marital Status at DX, Age at Diagnosis (SEER IF14)**

fields involved: Age at Diagnosis
Marital Status at DX

This edit checks that patients under 15 years of age are coded as being "never married". Even if a marital status is not specified in the medical record, assume that someone this young has never married and code Marital Status as **0** rather than **9**. Finding any Marital Status code other than **0** with an age under 15 makes us suspect that there may have been a typographical error in entering the patient's birth date, leading to an erroneous Age at Diagnosis.

The edit is skipped for a case record if either field has failed its validity check.

---

56. **MCR-CIMS Master Db Edits**

fields involved: Addr at DX--State
Date of Diagnosis (year only)

This edit is run only when a case record in the MCR's data system is submitted to the system's "master database" by one of our staff. The edit is not in our Scan Edit Set and should not be of concern to our reporting facilities.

This edit prevents case records from being added to our data system's master database if they are not cases that we want stored there. Our master database is meant to contain only cases diagnosed in Massachusetts residents as of January 1, 1995. All other cases are stored in different areas on our data systems.

The edit fails for all cases with State not coded as **MA**, **ma**, **Ma** or **Am**. If the state was incorrectly coded as "MA" (for Maine, for example), the edit would assume that this was Mass. case. If Massachusetts was incorrectly coded (as "MS", for example), the edit would assume that this was a non-Mass. resident.

The edit fails for all diagnosis years less than **1995**.

---

57. **MCR-CIMS (NOT REPORTABLE CASE)**

fields involved: Behavior Code ICD-O-3 and Behavior (92-00) ICD-O-2
Class of Case
Date of Diagnosis (year only)
Histologic Type ICD-O-3 and Histology (92-00) ICD-O-2
Primary Site

This edit only runs when a case record in the MCR data system is submitted to our "master database" by our staff. The edit should not concern reporting facilities, unless we find that you are sending in many cases that are non-reportable to us.

The Class of Case code **6** became valid as of 1996. Any Class **6** case diagnosed before 1996 is not reportable to us.

The MCR stopped collecting certain diseases diagnosed as of January 1, 1998. This edit is supposed to prevent such cases diagnosed after 1997 from being stored on our data system's master database. (There are standard edits which stop other types of disease that are not reportable to the MCR, such as non-melanoma skin cancers.)

For diagnoses made in 1998 and afterward, the MCR stopped collect cases of *in situ* carcinoma of the cervix (CIS), cervical intraepithelial neoplasia (CIN), prostatic intraepithelial neoplasia (PIN), vaginal intraepithelial neoplasia (VAIN), and vulvar intraepithelial neoplasia (VIN). When the diagnosis year is 1998 or afterward, the following code combinations are used by the edit to identify these unwanted cases:

site = **C51_** or **C529**	and	behavior = **2** or **3**	and	histology = **8077**
site = **C53_**	and	behavior = **2**	and	histology = **8000-8110**
site = **C619**	and	behavior = **2** (combination over-rideable)		

The last part of this edit has an over-ride because a valid *in situ* prostate case is possible. PIN does not have specific codes to represent its diagnosis (that is, it may be reported with different histologies). If a case is coded in this way, our staff must determine if the disease being reported is PIN or *in situ*.

This edit will need to be updated for reportability changes beginning with 2004 diagnoses.

---

58. **Morph Coding Sys--Current (NAACCR)**

field involved: Morph Coding Sys--Current (1 digit)

This is a validity check on the metadata field describing the current coding of morphology in the edited record.

Valid codes are **2** - **7**. We only expect code **7** (for ICD-O-3 coding).

---

59. **Morph Coding Sys--Originl (NAACCR)**

field involved: Morph Coding Sys--Originl (1 digit)

This is a validity check on the metadata field describing the original morphology coding on your data system.

Valid codes are **1** - **7** or **9**. The field may also be empty because the COC did not require the field until 2003 diagnoses.

---

60. **Morph Coding Sys--Originl, Date of Diagnosis (COC)**

fields involved: Date of Diagnosis (year only)
Morph Coding Sys--Originl

This edit checks that the original morphology metadata field is not empty for diagnoses made beginning in **2003**. It may be empty if the year of diagnosis is unknown (**9999**).

61A. **Morphology--Type&Behavior (SEER MORPH)**

fields involved: Behavior (92-00) ICD-O-2
Date of Diagnosis (year only)
Grade
Histology (92-00) ICD-O-2 (4 digits long)

This edit serves as the validity check on histology, but it's a complex edit that does several other things. There are different error messages attached to the edit, and the error message(s) you may see is determined by exactly what went wrong. One specific check performed by the edit is over-rideable (Part 2c below), while all other checks are pass/fail.

1.) The edit first checks that the histologic type code is any 4 digits between **8000** and **9999**. Any other code generates the error message "Histologic Type not valid".

2.) The edit then checks that only a valid code between **8000** and **9999** has been entered for histologic type. What does the edit consider to be a "valid" code? The edit goes to a huge look-up bin of codes that represents the entire ICD-O-2 coding system for histologic type, behavior and grade. Note that this part of the edit is only examining the 4-digit histologic type code and its default behaviors as listed in ICD-O-2. It is not looking at the Behavior Code reported in the case record.

a.) Any code not listed at all in ICD-O-2 generates the "Histologic Type not valid" error message.
example: Code **8005** is invalid because it does not appear in ICD-O-2.

b.) Any code listed in ICD-O-2 with a default behavior code of **2** or **3** (or both) is considered valid by the edit.
example: Code **8000** (for neoplasm) is valid because it appears in the book followed by a behavior of **3**.

c.) The edit questions the validity of any code in ICD-O-2 that only appears with a default behavior of **0** or **1**. There is an over-ride to allow the code to pass the edit if the data are reviewed and found to be correct. For year of diagnosis > **2000**, codes **8931**, **9393**, **9538**, **9950**, **9960-9962**, **9980-9984**, and **9989** are considered valid if the ICD-O-2 behavior is **1** (because the ICD-O-3 behavior will be **3** for them).

example: code **8040** (for tumorlet) generates the error message "Benign Histology - Please Review" because it only appears in ICD-O-2 with a "/1".

If our staff examines the case record and finds that this is a benign/borderline CNS cancer being reported, we can use the over-ride to accept the code; or, if a histology usually considered to be benign or uncertain in behavior is being "elevated" to a non-invasive or invasive behavior, we can use the over-ride to accept the code.

3.) Next, the edit looks at the Grade code reported in the case record in combination with the histology type code reported.*

a.) T-cell, B-cell, Null cell and Natural Killer cell origins (Grade codes **5 - 8**) are only allowed with lymphomas, leukemias and related diseases (ICD-O-2 histologies **9590 - 9941**). The error message "Grade not valid" will be generated if this part of the edit fails. Note that the edit is limiting Grade codes **5 - 8** to this histology range but, conversely, lymphomas and leukemias are allowed to have any valid Grade code (**1 - 9**).

b.) Histologies having a specific degree of differentiation implicit in their ICD-O-2 definitions must be reported with the appropriate Grade code only. The following histologies are limited to their implied grades:

8020/3**4** **undifferentiated** carcinoma
8021/3**4** **anaplastic** carcinoma
8331/3**1** **well differentiated** follicular adenocarcinoma
8851/3**1** **well differentiated** liposarcoma
9062/3**4** **anaplastic** seminoma
9082/3**4** **undifferentiated** malignant teratoma
9083/3**2** **intermediate type** malignant teratoma
9401/3**4** **anaplastic** astrocytoma
9451/3**4** **anaplastic** oligodendroglioma
9511/3**1** **differentiated** retinoblastoma
9512/3**4** **undifferentiated** retinoblastoma

One of these histologies reported with a different Grade code generates the error message "Grade & Histology conflict".

c.) Lymphoma/leukemia Grade codes can describe the cell type in which the disease originated or the degree of differentiation of the involved cells. (If both the cell type origin and differentiation are known, the cell type code has priority.) Lymphoma histologies having a specific degree of differentiation implicit in their ICD-O-2 definitions must be reported with that corresponding differentiation Grade code or one of the cell type origin Grade codes ("5"-"8"). The following histologies are limited to the following Grade codes by this part of the edit:

9693/3	malignant lymphoma, lymphocytic, **well differentiated**, nodular	valid Grade codes **5-8** or **1**
9696/3	malignant lymphoma, lymphocytic, **poorly differentiated**, nodular	valid Grade codes **5-8** or **3**

4.) Finally, the edit looks at the reported Behavior Code and reported Histologic Type code. Only certain histologies are listed in ICD-O-2 with a default behavior of "/2". Other histologies cannot be assigned an in situ or non-invasive behavior in the ICD-O-2 coding system. SEER provides the following explanation for this part of the edit:

> "*In situ*" is a concept that only pertains to epithelial neoplasms; therefore, an in situ behavior is not allowed with non-epithelial morphologies, such as sarcomas, leukemias, and lymphomas. *In situ* behavior is also disallowed for a handful of codes representing epithelial neoplasms which, by their nature, cannot be *in situ*.

The following Histologic Type codes combined with a Behavior Code of **2** will produce the error message "Invalid Histology for In Situ":

8000.....neoplasm
8001.....tumor cells
8002.....small cell type malignant tumor
8003.....giant cell type malignant tumor
8004.....fusiform cell type malignant tumor
8020.....undifferentiated carcinoma
8021.....anaplastic carcinoma
8331.....well differentiated follicular adenocarcinoma
8332.....trabecular follicular adenocarcinoma
8800-9054 .....sarcomas, fibromas, myomas, mixed & stromal neoplasms, fibroepithelial neoplasms, synovial-like neoplasms, mesothelial neoplasms except cystic mesotheliomas
9062.....anaplastic seminoma
9082.....undifferentiated malignant teratoma
9083.....intermediate malignant teratoma
9110-9491, 9501-9989..mesonephromas, blood vessel and lymphatic vessel tumors, bone and tooth tumors, miscellaneous tumors, gliomas, neuroepitheliomatous neoplasms except neuroblastomas, meningiomas, nerve sheath tumors, granular cell tumors & alveolar soft part sarcoma, lymphomas, leukemias, and other related diseases

Only Part 2c of the edit has an over-ride ["Histology" is set to **1** if just this edit is being overridden; it's set to **3** if this edit and the SEER IF31 edits (on behavior/diagnostic confirmation) are being overriden].

The edit skips if the ICD-O-2 histology is empty.

* Note that the AJCC staging system includes grade codes (GX and G1-G3 or G1-G4), but these are not necessarily identical to the ICD-O Grade code collected by the MCR.

61B. **Morphology--Type&Behavior ICDO3 (SEER MORPH)**

fields involved: Behavior Code ICD-O-3
Date of Diagnosis (year only)
Grade
Histologic Type ICD-O-3

This is the ICD-O-3 version of the preceding edit.

Part 1) is the same as in the preceding edit.

Part 2) is basically the same, i.e., it checks for valid ICD-O-3 4-digit histologic type codes. In part 2c), instead of allowing ICD-O-2 codes which became invasive in ICD-O-3, this edit considers codes **8442**, **8451**, **8462**, **8472** and **8473** to be valid if the diagnosis year < **2001** even though their ICD-O-3 behavior is **1** (because their ICD-O-2 behavior was **3**).

Part 3a) allows Grades **5 - 8** with ICD-O-3 histologies **9590 - 9948**.

Part 3b) has not been updated for new ICD-O-3 terms with an implied grade. It may be updated in future editions of the edits. ICD-O-2 code **9062/34** has been eliminated from this portion of the edit.

Part 3c) does not apply to this ICD-O-3 version of the edit.

Part 4) is the same, with the corresponding ICD-O-3 codes that cannot be *in situ* being:

8000-8005	**8331-8332**	**9062**	**9110-9989**
8020-8021	**8800-9055**	**9082-9083**	

Only Part 2c of the edit has an over-ride [Histology" is set to **1** if just this edit is being overridden; it's set to **3** if this edit and the SEER IF31 edits (on behavior and diagnostic confirmation) are being overriden]

The edit skips if the ICD-O-3 histology is empty.

---

62. **Name--Alias (SEER)**

field involved: Name--Alias (15 characters long)

This is a simple character check.

The field may contain letters (upper or lower case), embedded spaces, embedded hyphens and apostrophes. The field cannot contain other symbols or numbers.

The field may be empty.

---

63. **Name--First (MCR-CIMS)**

field involved: Name--First (14 letters long)

This is a simple character check.

The field may contain letters (upper or lower case) and embedded spaces. The field cannot contain a leading space, symbols or numbers.

The field cannot be empty.

The *FORDS* Manual allows you to leave this field blank if you don't know the patient's first name, and the COC's version of this edit allows the field to be empty. The MCR's data system relies heavily on this field, so a blank first name is useless to us. We modified the COC edit to disallow an empty first name.

---

64. **Name--Last (MCR-CIMS)**

field involved: Name--Last (25 characters long)

This is a simple character check.

The patient's last name can contain only letters (upper and lower case). It cannot contain numbers, spaces or symbols (including hyphens). If your data systems allows you to enter hyphens or embedded spaces in this field, your system should remove them in the MCR's version of your records (i.e., as cases are exported for the MCR, these unwanted characters are taken out. The hyphens and spaces remain entered on your system, but the MCR does not have to remove these characters from your patients' names so that our system can accept them and match them against other facilities' patient names.)

The field cannot be empty.

---

65. **Name--Maiden (MCR-CIMS)**

field involved: Name--Maiden (15 letters long)

This is a simple character check.

If a maiden name is being reported, the field may contain letters only (upper and lower case). The field cannot contain numbers, spaces or symbols.

The field may be empty.

Note that no edits check this field against Sex, Marital Status or Age to see if the field is only being filled for appropriate patients only.

---

66. **Name--Middle (COC)**

field involved: Name--Middle (14 characters long)

This is a simple character check.

If a middle name (or initial) is being reported, the field may contain letters (upper and lower case) and embedded spaces. The field cannot contain symbols or numbers.

The field may be empty.

---

67. **Name--Suffix (COC)**

field involved: Name--Suffix (3 letters long)

This is a simple character check.

If a name suffix is being reported, the field may contain letters only (upper and lower case). The field cannot contain spaces, symbols or numbers.

The field may be empty.

---

68. **Place of Death (NAACCR)**

field involved: Place of Death (3 digits long)

This is a simple validity check. It uses a look-up table. Valid codes are in MCR Manual Appendix A.

The field cannot be empty, even for living patients (enter code **997** for them).

---

69. **Place of Death, Vital Status (NAACCR)**

fields involved: Place of Death
Vital Status

This edit looks for agreement between death place and vital status. It checks that living patients have a death place of "still alive" (**997**), and that dead patients have any other death place.

If Place of Death is coded **997**, Vital Status must be coded **1**. If Place of Death is *not* **997**, Vital Status must be coded **0**.

---

70. **Primary Payer at DX (COC)**

field involved: Primary Payer at DX (2 digits)

This is a simple validity check.

Valid codes are: **01**, **02**, **10**, **20**, **31**, **35**, **36**, **50-56** and **99**.

The field cannot be empty.

---

71. **Primary Site (SEER SITE)**

field involved: Primary Site (letter "C" followed by 3 digits)

This is a simple validity check. The code reported must be a topography code listed in ICD-O-3.

The edit uses a look-up table of all valid codes.

The field cannot be empty.

72A. **Primary Site, AJCC Stage Group - Ed 5, ICDO3 (COC)**

fields involved: Behavior Code ICD-O-3
Date of Diagnosis (year only)
Histologic Type ICD-O-3
Pediatric Staging System
Primary Site
TNM Clin Stage Group
TNM Edition Number
TNM Path Stage Group

This edit checks that Fifth Edition AJCC stage grouping codes are valid for the given type of cancer.

The edit skips for a record under many circumstances -- to avoid unnecessarily editing a record that does not have Fifth Edition staging. The edit is skipped if the ICD-O-3 histology is empty. It is skipped if TNM Edition Number <> (**00**, **05** or **99**). It is skipped if TNM Edition Number = **05** (Fifth Edition AJCC coding) and the diagnosis year < **1996**. It is skipped if TNM Edition Number = **00** or **99** (not staged, unknown stage) and the diagnosis year (< **1997** or > **2002**). It is skipped if Pediatric Staging System is filled in and <> **88**. (Note: the MCR no longer collects Pediatric Staging System, so we expect that field to be empty.) It is skipped if both Clinical and Pathologic stage grouping are empty and the ICD-O-3 behavior = (**0**, **1** or **9**) (benign, borderline, unknown). The edit skips for most leukemias, plasma cell tumors, Kaposi sarcoma and dermatofibrosarcoma (**9800-9949**, **9730-9739**, **9140**, **8832**, **8833**).

The edit accepts codes **88** (AJCC stage grouping not applicable) and **99** (an unknown stage grouping) interchangeably "due to historical ambiguities".

…continuation of Edit #72A. **Primary Site, AJCC Stage Group - Ed 5, ICDO3 (COC)**

For the primary sites listed below, the histologies listed require one of the AJCC stage grouping codes shown for Clinical and Pathologic stage grouping. Other histologies may have stage grouping assigned for the given primary site, but the stage grouping codes are still limited to those shown. Note that the edit is NOT checking the stage groupings against the TNM elements -- it is just checking that the stage grouping is some code that is defined for the given cancer type.

lip and oral cavity: C00_, C020-C023, C028, C029, C03_, C04_, C050, C058, C059, C06_
histologic types: 8010-8573, 8940, 8941
valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **4C**, **99**

pharynx: C019, C024, C051, C052, C09_, C100, C102-C109, C11_, C129, C13_, C14_
histologic types: 8010-8573, 8940, 8941
valid stage grouping codes: **0_**, **1_**, **2_**, **2A**, **2B**, **3_**, **4_**, **4A**, **4B**, **4C**, **99**

larynx: C101, C32_; 8010-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **4C**, **99**
paranasal sinuses: C310, C311; 8010-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **4C**, **99**
salivary glands: C079, C08_; 8010-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
thyroid: C739; 8020, 8021, 8050-8053, 8330-8340, 8510-8512; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
esophagus: C15_; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **2A**, **2B**, **3_**, **4_**, **4A**, **4B**, **99**
stomach: C16_; 8010-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **2_**, **3_**, **3A**, **3B**, **4_**, **99**
small intestine: C170-C172, C178, C179; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
colon & rectum: C180-C209; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
anal canal: C21_; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **3A**, **3B**, **4_**, **99**
liver: C22_; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **3A**, **3B**, **4_**, **4A**, **4B**, **99**
gallbladder: C239; 8000-8231, 8245-8263, 8320, 8401, 8480-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
extrahepatic bile ducts: C240, C248, C249; 8000-8231, 8245-8263, 8320, 8401, 8480-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
ampulla of vater: C241; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
pancreas: C250-C253, C257-C259; 8000-8231, 8250-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
lung: C34_; 8000-8231, 8250-8573, 8940, 8941; valid stage grouping codes: **OC**, **0_**, **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **4_**, **99**
pleural mesothelioma: C384; 9050-9053; valid stage grouping codes: **1_**, **2_**, **3_**, **4_**, **99**
bone: C40_, C41_; 8810-8814, 8850-8855, 9180-9340; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **3_**, **4_**, **4A**, **4B**, **99**
soft tissue: C380-C383, C388, C47_, C48_, C49_; 8800-8830, 8840-8920, 8933, 8963, 8980-8991, 9040-9044, 9050-9055, 9120-9340, 9370, 9490, 9500-9504, 9540-9580; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **2C**, **3_**, **4_**, **99**
carcinoma of skin: C440, C442-C449, C632; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
melanoma of skin: C44_, C510, C609, C632; 8720-8790; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
breast: C50_; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **4_**, **99**
vulva: C51_; 8000-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
vagina: C529; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
cervix uteri: C53_; 8000-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **1A**, **A1**, **A2**, **1B**, **B1**, **B2**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **4_**, **4A**, **4B**, **99**
corpus uteri: C54_, C559; 8000-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **1C**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **3C**, **4_**, **4A**, **4B**, **99**
ovary: C569; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **1C**, **2_**, **2A**, **2B**, **2C**, **3_**, **3A**, **3B**, **3C**, **4_**, **99**
fallopian tube: C570; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **1C**, **2_**, **2A**, **2B**, **2C**, **3_**, **3A**, **3B**, **3C**, **4_**, **99**
gestational trophoblastic tumors: C589; 9100-9104; valid stage grouping codes: **1_**, **1A**, **1B**, **1C**, **2_**, **2A**, **2B**, **2C**, **3_**, **3A**, **3B**, **3C**, **4_**, **4A**, **4B**, **4C**, **99**
penis: C60_; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**

…continuation of Edit #72A. **Primary Site, AJCC Stage Group - Ed 5, ICDO3 (COC)**

prostate: C619; 8010-8110, 8140-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
testis: C62_; 9060-9102; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **1S**, **2_**, **2A**, **2B**, **2C**, **3_**, **3A**, **3B**, **3C**, **99**
kidney: C649; 8010-8230, 8250-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
renal pelvis & ureter: C659, C669; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **0A**, **0S**, **1_**, **2_**, **3_**, **4_**, **99**
bladder: C67_; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **0A**, **0S**, **1_**, **2_**, **3_**, **4_**, **99**
urethra: C68_; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **0A**, **0S**, **1_**, **2_**, **3_**, **4_**, **99**
prostatic urethra: C619, 8120-8130; valid stage grouping codes: **0_**, **0A**, **0S**, **1_**, **2_**, **3_**, **4_**, **99**
carcinoma of eyelid: C441; 8010-8230; 8244-8573; 8940, 8941; valid stage grouping code: **88**
carcinoma of conjunctiva: C690; 8010-8230; 8244-8573; 8940, 8941; valid stage grouping code: **88**
melanoma of conjunctiva: C690; 8720-8790; valid stage grouping code: **88**
melanoma of choroid: C693; 8720-8790; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
melanoma of ciliary body & iris: C694; 8720-8790; valid stage grouping codes: **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
retinoblastoma: C692; 9510-9512; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **2C**, **3_**, **3A**, **3B**, **4_**, **99**
carcinoma of lacrimal gland: C695; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping code: **88**
sarcoma of orbit: C696, C698; 8800-8830, 8840-8920, 8933, 8963, 8980, 8981, 9040-9044, 9050-9055, 9120-9340, 9370, 9490, 9500-9504, 9540-9580; valid stage grouping code: **88**
CNS: C700, C71_, C720-C728; 9380-9570; valid stage grouping code: **88**
Hodgkin lymphoma: all primary sites; 9650-9667; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **4_**, **4A**, **4B**, **99**
non-Hodgkin lymphoma: all primary sites; 9590-9599, 9670-9729; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **4_**, **4A**, **4B**, **99**

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73. **Primary Site, AJCC Stage Group - Edition 3/4(COC)**

fields involved: Behavior (92-00) ICD-O-2
Date of Diagnosis (year only)
Histology (92-00) ICD-O-2
Pediatric Staging System
Primary Site
TNM Clin Stage Group
TNM Edition Number
TNM Path Stage Group

This edit checks that Third or Fourth Edition AJCC stage grouping codes are valid for the given type of cancer.

The edit skips for a record under many circumstances -- to avoid unnecessarily editing a record that does not have Third or Fourth Edition staging. The edit is skipped if the ICD-O-2 histology is empty. It is skipped if TNM Edition Number <> (**00**, **03**, **04** or **99**). It is skipped if TNM Edition Number = **03** or **04** (Third or Fourth Edition AJCC coding) and the diagnosis year < **1987**. It is skipped if TNM Edition Number = **00** or **99** (not staged, unknown stage) and the diagnosis year (< **1991** or > **1996**). It is skipped if Pediatric Staging System is filled in and <> **88**. (Note: the MCR no longer collects Pediatric Staging System, so we expect that field to be empty.) It is skipped if both Clinical and Pathologic stage grouping are empty and the diagnosis year < **1991**. It is skipped if both stage groupings are empty and the ICD-O-2 behavior = (**0**, **1** or **9**) (benign, borderline, unknown). The edit skips for most leukemias, plasma cell tumors, Kaposi sarcoma and dermatofibrosarcoma (**9800-9949**, **9730-9739**, **9140**, **8832**, **8833**) because these should have AJCC codes of **88** regardless of primary site.

The edit accepts codes **88** (AJCC stage grouping not applicable) and **99** (an unknown stage grouping) interchangeably "due to historical ambiguities". Note that stage grouping codes with "E" and "S" are included for lymphomas because the TNM Descriptor fields were not required during the years of Third and Fourth Edition coding.

For the primary sites listed below, the histologies listed <u>require</u> one of the AJCC stage grouping codes shown for Clinical and Pathologic stage grouping. Other histologies <u>may</u> have stage grouping assigned for the given primary site, but the stage grouping codes are still limited to those shown. Note that the edit is NOT checking the stage groupings against the TNM elements -- it is just checking that the stage grouping is some code that is defined for the given cancer type.

…continuation of Edit #73. **Primary Site, AJCC Stage Group - Edition 3/4(COC)**

lip and oral cavity: C00_, C02_, C03_, C04_, C050, C058, C059, C06_
histologic types: 8010-8573, 8940, 8941
valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**

pharynx: C019, C051, C052, C09_, C100, C102-C109, C11_, C129, C13_, C14_
histologic types: 8010-8573, 8940, 8941
valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**

larynx: C101, C321-C329; 8010-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
glottis: C321; 8010-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
maxillary sinus: C310; 8010-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
salivary glands: C079, C08_; 8010-8573, 8940, 8941; valid stage grouping codes: **1_**, **2_**, **3_**, **4_**, **99**
thyroid: C739; 8020, 8021, 8050-8053, 8330-8340, 8510-8512; valid stage grouping codes: **1_**, **2_**, **3_**, **4_**, **99**
esophagus: C15_; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **2A**, **2B**, **3_**, **4_**, **99**
stomach: C16_; 8010-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **2_**, **3_**, **3A**, **3B**, **4_**, **99**
small intestine: C170-C172, C178, C179; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
colon & rectum: C180-C209; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
anal canal: C21_; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **3A**, **3B**, **4_**, **99**
liver: C22_; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
gallbladder: C239; 8000-8231, 8245-8263, 8320, 8401, 8480-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
extrahepatic bile ducts: C240, C248, C249; 8000-8231, 8245-8263, 8320, 8401, 8480-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
ampulla of vater: C241; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
pancreas: C250-C253, C257-C259; 8000-8231, 8250-8573, 8930-8941; valid stage grouping codes: **1_**, **2_**, **3_**, **4_**, **99**
lung: C34_; 8000-8231, 8250-8573, 8940, 8941; valid stage grouping codes: **OC**, **0_**, **1_**, **2_**, **3_**, **3A**, **3B**, **4_**, **99**
pleural mesothelioma: C384; 9050-9053; valid stage grouping codes: **1_**, **2_**, **3_**, **4_**, **99**
bone: C40_, C41_; 9180-9340; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **4_**, **4A**, **4B**, **99**
soft tissue: C380-C383, C388, C47_, C48_, C49_; 8800-8830, 8840-8920, 8933, 8963, 8980-8991, 9040-9044, 9050-9055, 9120-9340, 9370, 9490, 9500-9504, 9540-9580; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **4_**, **4A**, **4B**, **99**
carcinoma of skin: C440, C442-C449, C632; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
melanoma of skin: C440, C442-C449, C51_, C60_, C632; 8720-8790; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
breast: C50_; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **4_**, **99**
cervix uteri: C53_; 8000-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **4_**, **4A**, **4B**, **99**
corpus uteri: C54_, C559; 8000-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **1C**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **3C**, **4_**, **4A**, **4B**, **99**
ovary: C569; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **1_**, **1A**, **1B**, **1C**, **2_**, **2A**, **2B**, **2C**, **3_**, **3A**, **3B**, **3C**, **4_**, **99**
vagina: C529; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
vulva: C51_; 8000-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
prostate: C619; 8010-8110, 8140-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
testis: C62_; 9060-9102; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
penis: C60_; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
bladder: C67_; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **0A**, **0S**, **1_**, **2_**, **3_**, **4_**, **99**
kidney: C649; 8010-8230, 8250-8573, 8940, 8941; valid stage grouping codes: **1_**, **2_**, **3_**, **4_**, **99**
renal pelvis & ureter: C659, C669; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **0A**, **0S**, **1_**, **2_**, **3_**, **4_**, **99**
urethra: C68_; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **0A**, **0S**, **1_**, **2_**, **3_**, **4_**, **99**
carcinoma of eyelid: C441; 8010-8230; 8244-8573; 8940, 8941; valid stage grouping code: **88**
melanoma of eyelid: C441; 8720-8790; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
carcinoma of conjunctiva: C690; 8010-8230; 8244-8573; 8940, 8941; valid stage grouping code: **88**
melanoma of conjunctiva: C690; 8720-8790; valid stage grouping code: **88**

…continuation of Edit #73. **Primary Site, AJCC Stage Group - Edition 3/4(COC)**

melanoma of choroid: C693; 8720-8790; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
melanoma of ciliary body & iris: C694; 8720-8790; valid stage grouping codes: **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
retinoblastoma: C692; 9510-9512; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **2C**, **3_**, **3A**, **3B**, **4_**, **99**
sarcoma of orbit: C696, C698; 8800-8830, 8840-8920, 8933, 8963, 8980, 8981, 9040-9044, 9050-9055, 9120-9340, 9370, 9490, 9500-9504, 9540-9580; valid stage grouping code: **88**
carcinoma of lacrimal gland: C695; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping code: **88**
CNS: C700, C71_; 9380-9570; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **4_**, **99**
Hodgkin lymphoma: all primary sites; 9650-9667; valid stage grouping codes: **1_**, **1A**, **1B**, **1E**, **1S**, **2_**, **2A**, **2B**, **2E**, **2S**, **3_**, **3A**, **3B**, **3E**, **3S**, **4_**, **4A**, **4B**, **4E**, **4S**, **99**
non-Hodgkin lymphoma: all primary sites; 9590-9595, 9670-9717; valid stage grouping codes: **1_**, **1A**, **1B**, **1E**, **1S**, **2_**, **2A**, **2B**, **2E**, **2S**, **3_**, **3A**, **3B**, **3E**, **3S**, **4_**, **4A**, **4B**, **4E**, **4S**, **99**

72B. **Primary Site, AJCC Stage Group - Edition 5 (COC)**

fields involved: Behavior (92-00) ICD-O-2
Date of Diagnosis (year only)
Histology (92-00) ICD-O-2
Pediatric Staging System
Primary Site
TNM Clin Stage Group
TNM Edition Number
TNM Path Stage Group

This is the ICD-O-2 version of edit #72A. It checks that Fifth Ed. AJCC stage group codes are valid for the type of cancer.

The edit skips for a record under many circumstances -- to avoid unnecessarily editing a record that does not have Fifth Edition staging. The edit is skipped if the ICD-O-2 histology is empty. It is skipped if TNM Edition Number <> (**00**, **05** or **99**). It is skipped if TNM Edition Number = **05** (Fifth Edition AJCC coding) and the diagnosis year < **1996**. It is skipped if TNM Edition Number = **00** or **99** (not staged, unknown stage) and the diagnosis year (< **1997** or > **2002**). It is skipped if Pediatric Staging System is filled in and <> **88**. (Note: the MCR no longer collects Pediatric Staging System, so we expect that field to be empty.) It is skipped if the ICD-O-2 behavior = (**0**, **1** or **9**) (benign, borderline, unknown). The edit skips for most leukemias, plasma cell tumors, Kaposi sarcoma and dermatofibrosarcoma (**9800-9949**, **9730-9739**, **9140**, **8832**, **8833**).

Codes **88** and **99** (stage group not applicable, unknown stage group) are accepted interchangeably "due to historical ambiguities".

For the primary sites listed below, the histologies listed <u>require</u> one of the AJCC stage grouping codes shown for Clinical and Pathologic stage grouping. Other histologies <u>may</u> have stage grouping assigned for the given primary site, but the stage grouping codes are still limited to those shown. Note that the edit is NOT checking the stage groupings against the TNM elements -- it is just checking that the stage grouping is some code that is defined for the given cancer type.

lip and oral cavity: C00_, C020-C023, C028, C029, C03_, C04_, C050, C058, C059, C06_
histologic types: 8010-8573, 8940, 8941 valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **4C**, **99**

pharynx: C019, C024, C051, C052, C09_, C100, C102-C109, C11_, C129, C13_, C14_
histologic types: 8010-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **2A**, **2B**, **3_**, **4_**, **4A**, **4B**, **4C**, **99**

larynx: C10.1, C32._; 8010-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **4C**, **99**
paranasal sinuses: C310, C311; 8010-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **4C**, **99**
salivary glands: C079, C08_; 8010-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
thyroid: C739; 8020, 8021, 8050-8053, 8330-8340, 8510-8512; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
esophagus: C15_; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **2A**, **2B**, **3_**, **4_**, **4A**, **4B**, **99**
stomach: C16_; 8010-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **2_**, **3_**, **3A**, **3B**, **4_**, **99**

small intestine: C170-C172, C178, C179; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**

…continuation of Edit #72B. **Primary Site, AJCC Stage Group - Edition 5 (COC)**

colon & rectum: C180-C209; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
anal canal: C21_; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **3A**, **3B**, **4_**, **99**
liver: C22_; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **3A**, **3B**, **4_**, **4A**, **4B**, **99**
gallbladder: C239; 8000-8231, 8245-8263, 8320, 8401, 8480-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
extrahepatic bile ducts: C240, C248, C249; 8000-8231, 8245-8263, 8320, 8401, 8480-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
ampulla of vater: C241; 8000-8231, 8244-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
pancreas: C250-C253, C257-C259; 8000-8231, 8250-8573, 8930-8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
lung: C34_; 8000-8231, 8250-8573, 8940, 8941; valid stage grouping codes: **OC**, **0_**, **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **4_**, **99**
pleural mesothelioma: C384; 9050-9053; valid stage grouping codes: **1_**, **2_**, **3_**, **4_**, **99**
bone: C40_, C41_; 8810-8814, 8850-8855, 9180-9340; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **3_**, **4_**, **4A**, **4B**, **99**
soft tissue: C380-C383, C388, C47_, C48_, C49_; 8800-8830, 8840-8920, 8933, 8963, 8980-8991, 9040-9044, 9050-9055, 9120-9340, 9370, 9490, 9500-9504, 9540-9580; valid stage group codes: **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **2C**, **3_**, **4_**, **99**
carcinoma of skin: C440, C442-C449, C632; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
melanoma of skin: C44_, C510, C609, C632; 8720-8790; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
breast: C50_; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **4_**, **99**
vulva: C51_; 8000-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
vagina: C529; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
cervix uteri: C53_; 8000-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **1A**, **A1**, **A2**, **1B**, **B1**, **B2**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **4_**, **4A**, **4B**, **99**
corpus uteri: C54_, C559; 8000-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **1C**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **3C**, **4_**, **4A**, **4B**, **99**
ovary: C569; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **1C**, **2_**, **2A**, **2B**, **2C**, **3_**, **3A**, **3B**, **3C**, **4_**, **99**
fallopian tube: C570; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **1C**, **2_**, **2A**, **2B**, **2C**, **3_**, **3A**, **3B**, **3C**, **4_**, **99**
gestational trophoblastic tumors: C589; 9100-9104; valid stage grouping codes: **1_**, **1A**, **1B**, **1C**, **2_**, **2A**, **2B**, **2C**, **3_**, **3A**, **3B**, **3C**, **4_**, **4A**, **4B**, **4C**, **99**
penis: C60_; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
prostate: C619; 8010-8110, 8140-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
testis: C62_; 9060-9102; valid stage grouping codes: **0_**, **1_**, **1A**, **1B**, **1S**, **2_**, **2A**, **2B**, **2C**, **3_**, **3A**, **3B**, **3C**, **99**
kidney: C649; 8010-8230, 8250-8573, 8940, 8941; valid stage grouping codes: **0_**, **1_**, **2_**, **3_**, **4_**, **99**
renal pelvis & ureter: C659, C669; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **0A**, **0S**, **1_**, **2_**, **3_**, **4_**, **99**
bladder: C67_; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **0A**, **0S**, **1_**, **2_**, **3_**, **4_**, **99**
urethra: C68_; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping codes: **0_**, **0A**, **0S**, **1_**, **2_**, **3_**, **4_**, **99**
prostatic urethra: C619, 8120-8130; valid stage grouping codes: **0_**, **0A**, **0S**, **1_**, **2_**, **3_**, **4_**, **99**
carcinoma of eyelid: C441; 8010-8230; 8244-8573; 8940, 8941; valid stage grouping code: **88**
carcinoma of conjunctiva: C690; 8010-8230; 8244-8573; 8940, 8941; valid stage grouping code: **88**
melanoma of conjunctiva: C690; 8720-8790; valid stage grouping code: **88**
melanoma of choroid: C693; 8720-8790; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
melanoma of ciliary body & iris: C694; 8720-8790; valid stage grouping codes: **1_**, **2_**, **3_**, **4_**, **4A**, **4B**, **99**
retinoblastoma: C692; 9510-9512; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **2C**, **3_**, **3A**, **3B**, **4_**, **99**
carcinoma of lacrimal gland: C695; 8010-8230, 8244-8573, 8940, 8941; valid stage grouping code: **88**
sarcoma of orbit: C696, C698; 8800-8830, 8840-8920, 8933, 8963, 8980, 8981, 9040-9044, 9050-9055, 9120-9340, 9370, 9490, 9500-9504, 9540-9580; valid stage grouping code: **88**
CNS: C700, C71_, C720-C728; 9380-9570; valid stage grouping code: **88**
Hodgkin lymphoma: all primary sites; 9650-9667; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **4_**, **4A**, **4B**, **99**

non-Hodgkin lymphoma: all primary sites; 9590-9595, 9670-9717; valid stage grouping codes: **1_**, **1A**, **1B**, **2_**, **2A**, **2B**, **3_**, **3A**, **3B**, **4_**, **4A**, **4B**, **99**

74A. **Primary Site, Behavior Code (MCR-CIMS/SEER IF39)**

fields involved: Behavior (92-00) ICD-O-2
Histology (92-00) ICD-O-2
Primary Site

The edit is skipped for a case record if the ICD-O-2 histologic type code is empty.

This edit does two different things. It has a SEER check, and a MCR check.

The SEER part of this edit questions a combination of *in situ* behavior and a vague primary site. SEER provides the following explanation and advice:

> Since the designation of *in situ* is very specific and almost always requires microscopic confirmation, it is assumed that specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being *in situ* is reliable. Therefore this edit does not allow an *in situ* behavior code to be used with specified organ systems and ill-defined site codes.
> ...Check the information available about primary site and histologic type carefully. If a specific *in situ* diagnosis is provided, try to obtain a more specific primary site. A primary site within an organ system may sometimes be assumed based on the diagnostic procedure or treatment given or on the histologic type. If no more specific site can be determined, it is probably preferable to code a behavior code of **3**.

The edit questions the following primary sites when reported with an ICD-O-2 Behavior of **2**:

C269	gastrointestinal tract, NOS	**C689**	urinary system, NOS
C399	ill-defined sites within respiratory system	**C729**	nervous system, NOS
C42.1	bone marrow		
C559	uterus, NOS	**C759**	endocrine gland, NOS
C579	female genital tract, NOS	**C76_**	ill-defined sites
C639	male genital organs, NOS	**C809**	unknown primary site

Note that the edit does not look at staging fields. It solely uses the ICD-O-2 Behavior code to determine if the case is being called *in situ* or non-invasive.

The MCR part of this edit questions an uncertain or benign ICD-O-2 behavior with any non-CNS primary site. Because the MCR collects cases with these behaviors *only* for certain primary sites, we need an edit to check that these behaviors are not submitted for other sites. The following code combinations are questioned by this part of the edit:

ICD-O-2 Behavior = **0** or **1** and Primary Site <> **C700 - C729** (meninges, brain, other parts of CNS)

This edit has an over-ride (for both parts) called "Site/Behavior".

(There is no logical relationship between the SEER and MCR parts of this edit. The MCR needed an edit to limit certain behaviors to certain primary sites, and this SEER edit just happened to involve the fields necessary to do that. When a histology that is invasive in ICD-O-3 coding has a /**1** ICD-O-2 behavior, this edit is over-ridden.)

74B. **Primary Site, Behavior Code ICDO3 (SEER IF39/MCR-**

fields involved: Behavior Code ICD-O-3
Histologic Type ICD-O-3
Primary Site

This is the ICD-O-3 version of the preceding edit.

It skips if the ICD-O-3 Histology is empty.

It works just like the preceding SEER/MCR edit, using the ICD-O-3 Behavior instead of the ICD-O-2. It does not question bone marrow (**C421**) with behavior **2**.

The same over-ride ("Site/Behavior") applies to this edit. When an histology that is invasive under ICD-O-2 coding is /**1** under ICD-O-3 coding, the edit is over-ridden.

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75. **Primary Site, Laterality (SEER IF82)**

fields involved: Laterality
Primary Site

Only the right lung is considered to have a middle lobe. This edit simply checks that primary site "middle lobe" of lung is not coded with left Laterality. Any other Laterality (including unknown) is considered OK by the edit. We would expect that if you know a cancer originated in a middle lobe, then you must assume that the Primary Site must be the right lung!

If Primary Site = **C342** and Laterality = **2**, then this edit fails.

76A. **Primary Site, Morphology-Imposs ICDO3 (SEER IF38)**

fields involved: Histologic Type ICD-O-3
Primary Site

This edit skips if the ICD-O-3 Histologic Type code is empty. It skips if either field has failed its validity check.

This edit checks that the ICD-O-3 site/histology codes in a case record do not represent a biologically "impossible" combination. It uses a look-up table of site/histology combinations that SEER considers impossible:

	Primary Site		**ICD-O-3 Histologic Type**	
1.	**C000-C009**	Lip	**8090-8098**	Basal cell carcinoma
2.	**C199** **C209** **C210-C218**	Rectosigmoid junction Rectum Anus and anal canal	**8090-8098**	Basal cell carcinoma
3.	**C480-C488**	Retroperitoneum and peritoneum	**8720-8790**	Melanomas
4.	**C300** **C301** **C310-C319**	Nasal cavity Middle ear Accessory sinuses	**9250-9342**	Osteosarcomas (Giant cell, Ewing, ondontogenic)
5.	**C381-C388**	Pleura and mediastinum	**8010-8671, 8940-8941** **8720-8790**	Carcinomas Melanomas
6.	**C470-C479** **C490-C499**	Peripheral nerves Connective tissue	**8010-8671, 8940-8941** **8720-8790**	Carcinomas Melanomas
7.	**C700-C709** **C710-C719** **C720-C729**	Meninges Brain Other central nervous system	**8010-8671, 8940-8941**	Carcinomas
8.	**C400-C419**	Bone	**8010-8060, 8075-8671, 8940-8941** **8720-8790**	Carcinomas (except squamous cell) Melanomas
9.	**C760-C768**	Ill-defined sites	**8720-8790** **8800-8811, 8813-8830, 8840-8921, 9040-9044** **8990-8991** **8940, 8941** **9120-9170** **9240-9252** **9540-9560** **9580-9582**	Melanomas Sarcoma except periosteal fibrosarcoma, dermatofibrosarcoma Mesenchymoma Mixed tumor, salivary gland type Blood vessel tumor Mesenchymal chondrosarcoma and giant cell tumors Nerve sheath tumor Granular cell tumor and alveolar soft part sarcoma

SEER offers lots of explanation and repetitive advice to help fix errors found by this edit (numbers in the "Specific Guidelines" section correspond to the row numbers in the table of bad code combinations above):

…continuation of Edit #72B. **Primary Site, AJCC Stage Group - Edition 5 (COC)**

Combinations of site and type are designated as impossible by this edit because the combination is biologically impossible, i.e., the particular form of cancer does not arise in the specified site, or because standard cancer registry conventions have been established to code certain combinations in certain ways.

…The suggestions below are a starting point for analyzing an error, but are not a substitute for a medical decision.

General Guidelines:

First review the case for the following: 1.) Is the histologic type correctly coded?…Note that the code for "Cancer" and "Malignancy" (8000/3) is NOT interchangeable with the code for "Carcinoma, NOS" (8010/3), which refers only to a malignancy of epithelial origin. 2.) Is the primary site coded correctly? Check whether the site coded…could be instead the site of metastatic spread or the site where a biopsy was performed. If so, check for a more appropriate site.

Specific Guidelines:

1. Lip and Basal Cell Carcinoma: The codes for lip, C00.0-C00.9, are reserved for the vermilion border of the lip and specifically exclude skip of lip (the skin surrounding the vermilion of the lip proper) which has the code C44.0….The two tissues, vermilion and skin of lip, are distinct, and basal cell carcinoma does not arise on the vermilion portion of the lip. A basal cell carcinoma of the lip should be assumed to have arisen on the skip of lip and be coded to C44.0. This will not be reportable to most cancer registries which do not collect basal cell skin cancers.

2. Rectosigmoid/Rectum/Anus and Basal Cell Carcinoma: There is a form of anal cancer called cloacogenic carcinoma, which is also called basaloid carcinoma, coded 8124 and 8123, respectively, in ICD-O-3. Try to determine if the case has arisen within the anal canal and should be coded 8123 or 8124. It is also possible that the cancer is a basal cell cancer of the SKIN of the anus (perianal skin surrounding the anal opening, which is histologically distinct from the mucous membrane in the interior of the anus). A basal cell carcinoma of the skin of the anus should be coded C44.5, skin of trunk, and is generally not reportable in cancer registries.

3. Retroperitoneum/Peritoneum and Melanomas: If melanoma is identified in peritoneal or retroperitoneal tissue, it is almost certainly metastatic to that site. Try to identify the primary site of the melanoma. If not primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

4. Nasal Cavity/Middle Ear/Accessory Sinuses and Osteosarcomas: Osteosarcomas arise in bone, and the specified site code in ICD-O-3 is C40._ or C41._. Osteosarcomas arising in the areas of the nose, middle ear, and sinuses should be assumed to have arisen in the bones of the skull and their primary site coded C41.0.

5. Pleura/Mediastinum and Carcinomas or Melanomas: If a carcinoma or melanoma is identified in the pleura or mediastinum, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma or melanoma. For a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

6. Peripheral Nerves/Connective Tissue and Carcinomas or Melanomas: If a carcinoma or melanoma is identified in peripheral nerves or connective tissue, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma or melanoma. For a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

7. Meninges/Brain/Other CNS and Carcinomas: If a carcinoma is identified in the brain, meninges, or other central nervous system, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma. Check that the tumor is indeed a carcinoma and not "Cancer" or "Malignancy" which would be coded 8000/3. If it is a carcinoma and no primary can be determined, code "Unknown primary site", C80.9.

8. Bone and Carcinomas or Melanomas: If a carcinoma or melanoma is identified in bone, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma or melanoma. For a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

9. Ill-defined Sites and Various Histologies: Some histologic types are by convention more appropriately coded to a code representing the tissue in which such tumors arise rather than the ill-defined region of the body, which contains multiple tissues.

…continuation of Edit #72B. **Primary Site, AJCC Stage Group - Edition 5 (COC)**

The following table shows for the histologic types addressed in this edit which site should be used instead of an ill-defined site in the range C76.0-C76.8.

Histologic Type Codes	Histologic Types	Preferred Site Codes for Ill-Defined Primary Sites
8720-8790	melanoma	**C44._**, skin
8800-8811, 8813-8830, 8840-8921, 9040-9044	sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	**C49._**, connective, subcutaneous & other soft tissues
8990-8991	mesenchymoma	**C49._**, connective, subcutaneous & other soft tissues
8940-8941	mixed tumor, salivary gland type	**C07._** for parotid gland; **C08._** for other & unspecified major salivary glands
9120-9170	blood vessel tumors, lymphatic vessel tumors	**C49._**, connective, subcutaneous & other soft tissues
9240-9252	mesenchymal chondrosarcoma and giant cell tumors	**C40._**, **C41._** for bone & cartilage; **C49._**, connective, subcutaneous & other soft tissues
9580-9582	granular cell tumor and alveolar soft part sarcoma	**C49._**, connective, subcutaneous & other soft tissues

Note that there is NO OVER-RIDE for this edit. When SEER says "impossible", they mean it.

76B. **Primary Site, Morphology-Impossible (SEER IF38)**

fields involved: Histology (92-00) ICD-O-2
Primary Site

This is the ICD-O-2 version of the preceding edit. It skips if ICD-O-2 Histology is empty. It skips if either field has failed its validity check. This is the ICD-O-2 version of the table of site/histology combinations that SEER considers impossible:

	Primary Site		Histologic Type	
1.	**C000-C009**	Lip	**8090-8096**	Basal cell carcinoma
2.	**C199** **C209** **C210-C218**	Rectosigmoid junction Rectum Anus and anal canal	**8090-8096**	Basal cell carcinoma
3.	**C480-C488**	Retroperitoneum and peritoneum	**8720-8790**	Melanomas
4.	**C300** **C301** **C310-C319**	Nasal cavity Middle ear Accessory sinuses	**9250-9340**	Osteosarcomas (Giant cell, Ewing's, ondontogenic)
5.	**C381-C388**	Pleura and mediastinum	**8010-8671, 8940-8941** **8720-8790**	Carcinomas Melanomas
6.	**C470-C479** **C490-C499**	Peripheral nerves Connective tissue	**8010-8671, 8940-8941** **8720-8790**	Carcinomas Melanomas
7.	**C700-C709** **C710-C719** **C720-C729**	Meninges Brain Other central nervous system	**8010-8671, 8940-8941**	Carcinomas
8.	**C400-C419**	Bone	**8010-8060, 8075-8671, 8940-8941** **8720-8790**	Carcinomas (except squamous cell) Melanomas
9.	**C760-C768**	Ill-defined sites	**8720-8790** **8800-8811, 8813-8830, 8840-8920, 9040-9044** **8990-8991** **8940, 8941** **9120-9170** **9240-9251** **9540-9560** **9580-9581**	Melanomas Sarcoma except periosteal fibrosarcoma, dermatofibrosarcoma Mesenchymoma Mixed tumor, salivary gland type Blood vessel tumor Mesenchymal chondrosarcoma and giant cell tumors Nerve sheath tumor Granular cell tumor and alveolar soft

				part sarcoma

…continuation of Edit #76B. **Primary Site, Morphology-Impossible (SEER IF38)**

The ICD-O-2 version of the "preferred site" table to replace C76._ looks like this:

Histologic Type Codes	Histologic Types	Preferred Site Codes for Ill-Defined Primary Sites
8720-8790	melanoma	**C44._**, skin
8800-8811, 8813-8830, 8840-8920, 9040-9044	sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	**C49._**, connective, subcutaneous & other soft tissues
8990-8991	mesenchymoma	**C49._**, connective, subcutaneous & other soft tissues
8940-8941	mixed tumor, salivary gland type	**C07._** for parotid gland; **C08._** for other & unspecified major salivary glands
9120-9170	blood vessel tumors, lymphatic vessel tumors	**C49._**, connective, subcutaneous & other soft tissues
9240-9251	mesenchymal chondrosarcoma and giant cell tumors	**C40._**, **C41._** for bone & cartilage; **C49._**, connective, subcutaneous & other soft tissues
9580-9581	granular cell tumor and alveolar soft part sarcoma	**C49._**, connective, subcutaneous & other soft tissues

Note that there is NO OVER-RIDE for this edit.

77A. **Primary Site, Morphology-Type Check (SEER IF25)**

fields involved: Histology (92-00) ICD-O-2
Primary Site

This edit compares the reported ICD-O-2 site/histology code combination with huge look-up tables of site/histology combinations that SEER considers to be compatible (i.e., diagnoses typical for that site). If it does not find the reported site/histology combination in the look-up tables, it questions the reported code combination as "not typical".

The list of "typical" site/histology combinations is too big to include here. It is available on the COC website.

The edit skips if the ICD-O-2 Histology code is empty. The edit skips if either field has failed its validity check.

The edit has an over-ride called "Site/Type". For the SEER typical site/histology combinations, see the COC website -- under National Cancer Data Base, Information for Registrars, ICD-O-2 SEER Site/Histology Validation List, www.facs.org/cancer/ncdb/icdO2sitetype.pdf.

The COC version of this edit considers basal and squamous cell carcinomas of non-genital skin sites to be valid site/histology combinations (because these skin cancers were reportable under COC rules for some ICD-O-2 diagnosis years, depending on the stage of disease). This SEER version of the edit does *not* consider such cancers to be valid site/histology combinations because they are not reportable to SEER. The MCR uses the SEER version of the edit because these skins cancers are also non-reportable to us. We rely on this edit to stop those diagnoses from getting onto our main data system.

77B. **Primary Site, Morphology-Type ICDO3 (SEER IF25)**

fields involved: Histologic Type ICD-O-3
Primary Site

This is the ICD-O-3 version of the preceding edit. It skips if the ICD-O-3 Histologic Type code is empty or if either field has failed its validity check.

Updated tables (in .pdf and Excel versions) representing the ICD-O-3 site/histology combinations that SEER considers typical is available at the SEER website -- under Data Collection Tools, ICD-O-3 Coding Materials, http://seer.cancer.gov/icd-o-3/.

The "Site/Type" over-ride also applies to this edit.

78. **Race 1 (SEER RACE)**

field involved: Race 1 (2 digits long)

This is a simple validation check.

Valid codes are: **01 - 14**
20 - 22
25 - 28
30 - 32
96 - 99
The field cannot be empty.

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79. **Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR)**

fields involved: Race 1
Race 2
Race 3
Race 4
Race 5

This edit compares the codes in all five race fields to see if any of their basic coding rules are violated. Race 1 cannot be empty, but it is possible to fill only Race 1 and leave the remaining Race fields empty (for pre-2000 diagnoses). If Race 1 is unknown and the other Race fields are filled in, they must also be unknown. When the patient's races have been specified fully, then all subsequent Race fields must be coded "no further races documented" (**88**). A particular Race code (other than spaces, **88** or **99**) can only be used once.

If Race 2 is empty, then Race 3, Race 4 and Race 5 must be empty.

If Race 1=**99** and the other Race fields are not empty, they must all be **99**.

If Race 2=**88** then Race 3 must be **88**; if Race 3=**88** then Race 4 must be **88**; if Race 4=**88** then Race 5 must be **88**.

Unless it's **99**, the Race 1 code cannot be identical to Race 2, Race 3, Race 4 or Race 5; unless it's **88** or empty, the Race 2 code cannot be identical to Race 3, Race 4 or Race 5; except for **88** or empty fields, the Race 3 code cannot be identical to Race 4 or Race 5; except for **88** or empty fields, the Race 4 code cannot be identical to the Race 5 code.

---

80. **Race 2 (NAACCR)**

field involved: Race 2 (2 digits long)

This is a simple validation check.

Valid codes are: **01 - 14**
20 - 22
25 - 28
30 – 32
88
96 - 99

The field can also be empty or consist of two spacebars (blank spaces).

---

81. **Race 2, Date of DX (SEER IF89)**

fields involved: Date of Diagnosis (year only)
Race 2

Multiracial coding became valid as of diagnosis year 2000. This edit checks that Race 2 is filled for diagnosis years 2000 and thereafter. (For diagnoses made before 2000, the field may be empty or filled.)

If the year of Diagnosis > **1999**, Race 2 must not be empty.

If the Date of Diagnosis is completely unknown (year = **9999**), the edit skips.

---

82. **Race 3 (NAACCR)**

field involved: Race 3 (2 digits long)

This is a simple validation check.

Valid codes are: **01 - 14**
20 - 22
25 - 28
30 – 32
88
96 - 99

The field can also be empty or two spacebars (blank spaces).

---

83. **Race 3, Date of DX (SEER IF90)**

fields involved: Date of Diagnosis (year only)
Race 3

Multiracial coding became valid as of diagnosis year 2000. This edit checks that Race 3 is filled for diagnosis years 2000 and thereafter. (For diagnoses made before 2000, the field may be empty or filled.)

If the year of Diagnosis > **1999**, Race 3 must not be empty.

If the Date of Diagnosis is completely unknown (year = **9999**), the edit skips.

---

84. **Race 4 (NAACCR)**

field involved: Race 4 (2 digits long)

This is a simple validation check.

Valid codes are: **01 - 14**
20 - 22
25 - 28
30 – 32
88
96 - 99

The field can also be empty or two spacebars (blank spaces).

---

85. **Race 4, Date of DX (SEER IF91)**

fields involved: Date of Diagnosis (year only)
Race 4

Multiracial coding became valid as of diagnosis year 2000. This edit checks that Race 4 is filled for diagnosis years 2000 and thereafter. (For diagnoses made before 2000, the field may be empty or filled.)

If the year of Diagnosis > **1999**, Race 4 must not be empty.

If the Date of Diagnosis is completely unknown (year = **9999**), the edit skips.

---

86. **Race 5 (NAACCR)**

field involved: Race 5 (2 digits long)

This is a simple validation check.

Valid codes are: **01 - 14**
20 - 22
25 - 28
30 – 32
88
96 - 99

The field can also be empty or 2 spacebars (blank spaces).

---

87. **Race 5, Date of DX (SEER IF92)**

fields involved: Date of Diagnosis (year only)
Race 5

Multiracial coding became valid as of diagnosis year 2000. This edit checks that Race 5 is filled for diagnosis years 2000 and thereafter. (For diagnoses made before 2000, the field may be empty or filled.)

If the year of Diagnosis > **1999**, Race 5 must not be empty.

If the Date of Diagnosis is completely unknown (year = **9999**), the edit skips.

---

88. **Rad--Regional RX Modality (COC)**

fields involved: Rad--Regional RX Modality (2 digits)

This is a simple validity check on the type of regional radiation treatment given.

Valid codes are **00**, **20-32**, **40-43**, **50-55**, **60-62**, **80**, **85**, **98** and **99**.

The field cannot be empty.

---

89. **Rad--Regional RX Modality, Date of Diagnosis (COC)**

fields involved: Date of Diagnosis (year only)
Rad--Regional RX Modality

This edit checks that regional radiation modality codes **80** and **85** are NOT used when the year of diagnosis > **2002** (and not unknown). Those two codes represent *combination* radiation types (such as beam + seeds) and can only be used for pre-2003 diagnoses. Beginning with 2003 diagnoses, only *single* types of radiation may be coded here.

If year of diagnosis > **2002** and <> **9999**, the regional radiation modality code cannot be **80** or **85**.

---

90. **Reason for No Surgery (SEER NCDSURG)**

field involved: Reason for No Surgery (1 digit long)

This is a simple validity check.

Valid codes are **0**, **1**, **2**, **5**, **6**, **7**, **8** and **9**.

The field cannot be empty.

---

91. **Reason for No Surgery, Vital Status (COC)**

fields involved: Reason for No Surgery
Vital Status

This edit checks that only dead patients are coded as having no primary site surgery because they died before it could be performed.

If Reason for No Surgery = **5** (died before primary site surgery) and Vital Status = **1** (living), the edit fails.

---

92. **Record Type (NAACCR)**

field involved: Record Type (1 letter)

This is a validity check. It is only run in the MCR's Scan Edit Set.

Valid codes are **A**, **C**, **I**, **M**, **R** and **U**. (The MCR only accepts records of type **A** and -- for reportable recurrences only -- **M**.)

---

93. **Regional Nodes Ex, Reg Nodes Pos (COC)**

fields involved: Regional Nodes Examined
Regional Nodes Positive

This COC edit is only run in the MCR's Scan Edit Set.

This edit fails if there is a conflict between the codes in these two fields. Basically, the total number of nodes found to be positive cannot exceed the total number of nodes that were examined. The edit is quite complex, however, because the coding systems for the two fields do not correspond as much as one might expect (for pre-Collaborative Staging years).

Listed below are all possible code combinations between the two fields. They are listed numerically by the code in Regional Nodes Examined, followed by the code(s) for Regional Nodes Positive that the edit will accept in that situation.

If Regional Nodes Examined is **00** (no nodes removed), then Regional Nodes Positive can only be **98** (no nodes removed).

If Regional Nodes Examined is **01 - 89** (a specific number of nodes were removed), then Regional Nodes Positive may be

00 - 89 (that specific number of nodes were positive) or
97 (there were positive nodes, but the exact number is unknown) or
99 (nodes were examined, but it's unknown if any were positive).

If both fields contain specific numbers of nodes, then Regional Nodes Examined must be ≥ Regional Nodes Positive.

If Regional Nodes Examined = **90** (ninety or more nodes were removed), then Regional Nodes Examined may be

00 - 95 (that specific number of nodes were positive) or
96 (ninety-six or more nodes were positive) or
97 (there were positive nodes, but the exact number is unknown) or
99 (nodes were examined, but it's unknown if any were positive).

That is, Regional Nodes Positive may be any code <u>except</u> **98** (no nodes were removed).

If Regional Nodes Examined is **95** (node aspiration), then Regional Nodes Positive may be

00 (all nodes examined were negative) or
97 (there were positive nodes, but the exact number is unknown) or
99 (nodes were examined, but it's unknown if any were positive).

If Regional Nodes Examined is coded

96 (nodes were sampled, exact number unknown) or
97 (nodes were dissected, exact number unknown) or
98 (nodes were removed surgically, sampling/dissection not specified, exact number unknown),

then Regional Nodes Positive may be any code <u>except</u> **98** (no nodes were removed).

If Regional Nodes Examined is **99** (not applicable, complete unknown), then Regional Nodes Positive can only be **99** also.

Given the limitations of the codes, this is as specific as the edit can get in looking for conflict between the two fields.

Note that the edit performs no comparisons against the fields RX Summ--Reg LN Removed and RX Hosp--Reg LN Removed because the values in the surgical fields are not expected to always agree with the staging node fields. The rules for coding the two sets of fields are quite different for pre-Collaborative Staging years.

94. **Regional Nodes Examined (COC)**

field involved: Regional Nodes Examined (2 digits long)

This is a simple validity check.

Valid codes are **00** - **90** or **95** - **99** (any 2 digits but **91** - **94**).

The field cannot be empty.

---

95. **Regional Nodes Positive (COC)**

field involved: Regional Nodes Positive (2 digits long)

This is a simple validity check.

Valid codes are **00** - **99** (any 2 digits) for pre-Collaborative Staging years.

The field cannot be empty.

---

96. **RX Coding System--Current (COC)**

field involved: RX Coding System--Current (2 digits)

This is a simple validity check run only in the MCR's Scan Edit Set.

The only valid code when sending a record in Version 10 or 10.1 is **06** (meaning treatment is coded according to the *FORDS* Manual.

---

97. **RX Date—DX/Stg Proc (COC)**

field involved: RX Date—DX/Stg Proc (8 digits long)

This is a "treatment-style" date validity check (because it has to deal with valid **00** codes that are not allowed in some data fields).

If the year = **0000**, then month and day must = **00**. If month = **00**, then day must = **00**.

If the year = **9999**, then month and day must = **99**. If month = **99**, then day must = **99**.

The date cannot be in the future. The year must be ≤ the current year. If the year = the current year, then the month must be ≤ the current month. If the year and month are the current year and month, then the day must be ≤ the current day.

Dates up to 150 years ago are allowed.

No part of the date may be empty or blank-filled.

Only numbers are allowed (**00-31** or **99** for day; **00-12** or **99** for month; **0000**, **1854-2003** or **9999** for year). Leap years and the number of days in each month are accounted for when valid codes are checked.

---

98. **RX Date--Most Defin Surg (COC)**

field involved: RX Date--Most Defin Surg (8 digits long)

This is a treatment date validity check.

See the description of Edit #97 on page E-80. It does the same thing using a different treatment date field, only this date field may also be empty (blanks) because it was not required until 2003 diagnoses.

---

99. **RX Date--Most Defin Surg, Date Last Contact (COC)**

fields involved: Date of Last Contact
RX Date--Most Defin Surg

This is a date comparison edit.

The date of most definitive primary site surgery cannot exceed the Date of Last Contact. If either month is unknown (**99**), then only the years are compared. If either day is unknown, then only the months and years are compared.

This edit skips for a record if either date is empty (blank) or unknown (year = **9999**).

---

100. **RX Date--Most Defin Surg, Date of DX (COC)**

fields involved: Date of Diagnosis
RX Date--Most Defin Surg

This edit checks that RX Date--Most Defin Surg is filled for diagnosis years beginning with 2003. Then it checks that the surgery date does not come before the diagnosis date.

If (year of diagnosis > **2002** and <> **9999**) and (RX Date--Most Defin Surg is empty), the edit fails.

When both dates are filled, they are compared. Date of Diagnosis must be ≤ surgery date. If either year is unknown, the comparison is skipped. If either month is unknown, only years are compared. If either day is unknown, only months and years are compared.

---

101. **RX Date--Most Defin Surg, RX Date--Surgery (COC)**

fields involved: RX Date--Most Defin Surg
RX Date--Surgery

This is a date comparison edit. The date of the first primary site surgery should not come after the date of the most definitive primary site surgery.

The edit skips for a record if either date is empty (blank). It skips if the most definitive surgery date = **00000000** (no primary site surgery took place). It skips if either year is unknown (**9999**).

If RX Date--Most Defin Surg <> **00000000**, then this date must be ≥ RX Date--Surgery. If either month is unknown, then just the years are compared. If either day is unknown, then just the months and years are compared.

---

102. **RX Date--Most Defin Surg, Surg Prim Site (COC)**

fields involved: RX Date--Most Defin Surg
RX Summ--Surg Prim Site

This edit checks that the date of most definitive primary site surgery and the primary site surgery are in basic agreement.

If RX Summ--Surg Prim Site = **00** or **98** (no primary site surgery), then the date field must = **00000000**.

If RX Date--Most Defin Surg = **00000000** (no primary site surgery), then the surgery field must = **00** or **98**.

If RX Summ--Surg Prim Site = **99**, then RX Date--Most Defin Surg = **99999999**.

The edit skips for a record if either field is empty.

---

103. **RX Date--Other (COC)**

field involved: RX Date--Other (8 digits long)

This is a treatment date validity check. See the description of Edit #97 on page E-80.

This edit allows the date to be empty because the field was not required until 1996 diagnoses.

---

104. **RX Date--Other, Date of Diagnosis (COC)**

fields involved: Date of Diagnosis (year only)
RX Date--Other

This edit checks that the Other treatment date is filled for the appropriate diagnosis years. If the year of diagnosis > **1995** and <> **9999**, then RX Date--Other cannot be empty (blank).

---

105. **RX Date--Radiation (COC)**

field involved: RX Date--Radiation

This is a treatment date validity check, but it has to take the special **88888888** codes into account. See the description of Edit #97 on page E-80, and add this wrinkle: If the year = **8888**, then the month and day must = **88**.

---

106. **RX Date--Radiation, Rad--Regional RX Modality (COC**

fields involved: Rad--Regional RX Modality
RX Date--Radiation

This edit checks that if the radiation start date indicates no radiation given, then the regional modality field must also.

If RX Date--Radiation = **00000000**, then Rad--Regional RX Modality = **00**.

---

107. **RX Date--Surgery (NAACCR)**

field involved: RX Date--Surgery (8 digits long)

This is a treatment date validity check. See the description of Edit #97 on page E-80.

---

108. **RX Date--Surgery, RX Text--Surgery (NAA/MCR-CIMS)**

fields involved: Class of Case
Date of Diagnosis (year only)
RX Date--Surgery
RX Text--Surgery

This edit checks that the surgery narrative has been filled in when surgery has been done. For simplicity, the edit uses just the surgery date field to determine if surgery has been done. This edit runs only in our Scan Edit Set.

If the surgery date is zero-filled (surgery was not done) or is 9-filled (completely unknown date), the edit passes without checking to see if there is any surgery narrative. The edit skips if the year of diagnosis < **2001** (because the MCR did not strictly require narratives by using edits until this point).

If the date is anything but **00000000** or **99999999**, the narrative cannot be empty.

Because the MCR does not require narratives for most non-analytic cases, the edit skips whenever Class of Case = **3**, **4**, **5**, **6** or **9**. It also skips if the surgery start date is empty.

Note that this narrative field should also contain text describing any diagnostic/staging surgical procedures. If no surgery was done, the edit does not check to see if diagnostic/staging procedures were done; the edit will allow the narrative field to be empty in such cases.

---

109. **RX Date--Systemic (COC)**

field involved: RX Date--Systemic (8 digits long)

This is a treatment date validity check for a field that may be **8**-filled. See Edit #105 on page E-82 for a description.

---

110. **RX Date--Systemic, Date Last Contact (COC)**

fields involved: Date of Last Contact
RX Date--Systemic

This field checks that the systemic start date does not come after the Date of Last Contact.

If either year is unknown (**9999**), the edit skips for the record. The edit skips for a record if the systemic date is **88888888**.

If either month = **99**, then just the years are compared. If either day = **99**, then just the years and months are compared.

---

111. **RX Date--Systemic, Systemic RX (COC)**

fields involved: RX Date--Systemic
RX Summ--BRM
RX Summ--Chemo
RX Summ--Hormone
RX Summ--Transplnt/Endocr

This edit checks that the overall systemic treatment start date is in basic agreement with the summary systemic modalities.

The edit skips for a record if any of the fields is empty (blank).

If RX Date--Systemic = **00000000** (no systemic therapy), then the Chemotherapy, Hormone, Immunotherapy and Transplant/Endocrine Procedures must all be coded **00** or **82-87** (treatment not done).

If all of the four summary treatment fields = **00** or **82-87**, then RX Date--Systemic must = **00000000**.

If RX Summ--Chemo = **01-03** or RX Summ--Hormone = **01** or RX Summ--BRM = **01** or RX Summ--Transplnt/Endocr = **10-40** (at least one of the systemic treatments was done), then RX Date--Systemic <> **00000000** (no systemic treatment) or **88888888** (systemic treatment has not yet begun).

---

112. **RX Date--Systemic, Vital Status (COC)**

fields involved: RX Date--Systemic
Vital Status

This edit runs only the MCR Scan Edit Set.

It checks that if a patient has died, the treatment date cannot indicate "treatment has not yet begun".

If either field is empty, the edit skips for that record.

If Vital Status = **0** (dead), then RX Date--Systemic <> **88888888** (treatment hasn't started).

---

113. **RX Hosp--BRM (COC)**

field involved: RX Hosp--BRM (2 digits long)

This is a simple validity check.

Valid codes are **00**, **01**, **82**, **85-88** and **99**.

The field cannot be empty.

---

114. **RX Hosp--BRM, RX Summ--BRM (COC)**

fields involved: RX Hosp--BRM
RX Summ--BRM

This edit checks for basic agreement between the two fields. The edit is skipped for a case record if either field is empty.

If the hospital field indicates that some treatment was done, then the summary field must indicate that some was done. That is, if the hospital field = **01** then the summary field must also = **01**.

---

115. **RX Hosp--Chemo (NAACCR)**

field involved: RX Hosp--Chemo (2 digits long)

This is a simple validity check.

Valid codes are **00 - 03**, **82**, **85-88** and **99**.

The field cannot be empty.

---

116. **RX Hosp--Chemo, RX Summ--Chemo (COC)**

fields involved: RX Hosp--Chemo
RX Summ--Chemo

This edit checks for basic agreement between the two fields.

The edit is skipped for a case record if either field is empty.

If the hospital code indicates that some kind of chemo was done, then the summary code must also indicate that chemo was done. That is, if the hospital code = **01 - 03**, then the summary code must also = **01 - 03**.

The edit does not look for any further consistency between the fields. For example, if the hospital indicates that multiple agents were given here (**03**) and the summary indicates that a single agent was given (**02**), the edit does not mind.

---

117. **RX Hosp--DX/Stg Proc (COC)**

field involved: RX Hosp—DX/Stg Proc (2 digits long)

This is a simple validity check.

Valid codes are **00 - 07** or **09**.

The field cannot be empty.

---

118. **RX Hosp--DX/Stg Proc, RX Summ--DX/Stg Proc (COC)**

fields involved: RX Hosp--DX/Stg Proc
RX Summ--DX/Stg Proc

This edit looks for basic agreement between the two fields.

If the hospital field indicates that some kind of procedure(s) was done, then the summary field must also indicate that some was done. That is, if the hospital field = **01 - 07**, then the summary field must also = **01 - 07**.

The edit does not look for any greater consistency between the two fields. For example, if the hospital field indicates a biopsy plus a bypass and the summary field indicates just a biopsy, the edit does not mind.

---

119. **RX Hosp--Hormone (COC)**

field involved: RX Hosp--Hormone (2 digits long)

This is a simple validity check.

Valid codes are **00**, **01**, **82**, **85-88** and **99**.

The field cannot be empty.

---

120. **RX Hosp--Hormone, RX Summ--Hormone (COC)**

fields involved: RX Hosp--Hormone
RX Summ--Hormone

This edit checks for basic agreement between the two fields.

If the hospital code indicates that some treatment was done, then the summary code must also indicate that some was done. That is, if the hospital code = **01**, then the summary code must = **01**.

---

121. **RX Hosp--Other (COC)**

field involved: RX Hosp--Other (1 digit long)

This is a simple validity check.

Valid codes are **0 - 3** and **6 - 9**.

The field cannot be empty.

---

122. **RX Hosp--Other, RX Summ--Other (COC)**

fields involved: RX Hosp--Other
RX Summ--Other

This edit checks for basic agreement between the two fields.

If the hospital field indicates that some therapy was given (**1 - 6**), then the summary field must also indicate that some was given (**1 - 6**).

---

123. **RX Hosp--Palliative Proc (COC)**

field involved: RX Hosp--Palliative Proc (1 digit long)

This is a simple validity check.

Valid codes are **0 - 7** and **9**.

The field cannot be empty.

---

124. **RX Hosp--Palliative Proc, RX Summ--Pall Proc (COC)**

fields involved: RX Hosp--Palliative Proc
RX Summ--Palliative Proc

This edit looks for basic agreement between the two fields.

If the hospital field indicates that Palliative Care was given (**1 - 7**), then the summary field must also indicate that Palliative Care was given (**1 - 7**).

The edit does not look for any more detail in the agreement.

---

125. **RX Hosp--Scope LN Sur, RX Summ--Scope LN Sur(COC)**

fields involved: RX Hosp--Scope Reg LN Sur
RX Summ--Scope Reg LN Sur

This edit checks for basic agreement between the two fields. The edit skips for a case record if the hospital field is empty.

If the hospital code indicates that regional lymph node surgery was done or is **9**, then the summary code cannot indicate that no node surgery was done. That is, if the hospital code is > **0**, then the summary code <> **0**.

If the hospital code indicates that regional lymph node surgery was done (**1 - 7**), then the summary code cannot indicate that none was done (**0**) or that it's unknown (**9**).

---

126. **RX Hosp--Scope Reg 98-02 (COC)**

field involved: RX Hosp--Scope Reg 98-02 (1 digit long)

This is a simple validity check.

Valid codes are **0 - 9** (any single digit). The field may also be empty (for diagnoses made beginning in 2003).

127A. **RX Hosp--Scope Reg 98-02, Primary Site (COC)**

fields involved: Date of Diagnosis (year only)
Histology (92-00) ICD-O-2
Primary Site
RX Hosp--Scope Reg 98-02

The edit checks that the ROADS RX Hosp--Scope Reg LN Sur is a valid code for the primary site. Valid codes are in Appendix D of the *ROADS* Manual. The edit consults a look-up table of valid codes.

The edit is skipped for a case record if the ROADS RX Hosp--Scope Reg LN Sur field is empty. The edit skips if the ICD-O-2 histology code is empty.

If the year of diagnosis > **1999**, then the lymph node surgery must be coded **9** for these cancers:
lymph node lymphomas (ICD-O-2 histologies **9590-9698**, **9702-9717** and primary sites **C77_**;
leukemias (**9800-9989**); cerebral meninges (**C700**); brain (**C71_**); unknown primary (**C809**)

127B. **RX Hosp--Scope Reg 98-02, Primary Site, ICDO3(COC)**

fields involved: Date of Diagnosis (year only)
Histologic Type ICD-O-3
Primary Site
RX Hosp--Scope Reg 98-02

This is the ICD-O-3 version of the preceding edit.

It skips for records if the ICD-O-3 histology is empty. It skips when the *ROADS* hospital lymph node surgery field is empty.

The cancer types that must be coded with **9** for lymph node surgery are:
9590-9699, **9702-9729** with **C77_**; **9800-9989**; **C700**; **C71_**; **C809**.

---

128. **RX Hosp--Scope Reg LN Sur (COC)**

field involved: RX Hosp--Scope Reg LN Sur (1 digit long)

This is a simple validity check.

Valid codes are **0** - **7** and **9**.

The field cannot be empty.

129A. **RX Hosp--Scope Reg LN Sur, Primary Site (COC)**

fields involved: Histology (92-00) ICD-O-2
Primary Site
RX Hosp--Scope Reg LN Sur

The edit checks that the RX Hosp--Scope Reg LN Sur is coded **9** for certain types of cancer: CNS, hematopoietic, reticuloendothelial, immunoproliferative, myeloproliferative, lymph node lymphomas, ill-defined sites, unknown primary site.

primary sites **C700-C729**
primary sites **C420**, **C421**, **C423**, **C424**
histologies **9720**, **9760-9764**, **9800-9820**, **9826**, **9840-9894**, **9910**, **9931-9962**, **9980-9989**
histologies **9590-9595**, **9650-9698**, **9702-9717** with primary sites **C77_**
primary sites **C76_**
primary site **C809**

The edit is skipped for a case record if the ICD-O-2 histology is empty.

129B. **RX Hosp--Scope Reg LN Sur, Primary Site,ICDO3(COC)**

fields involved: Histologic Type ICD-O-3
Primary Site
RX Hosp--Scope Reg LN Sur

This is the ICD-O-3 version of the preceding edit. The only difference is in the definition of the hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative diseases and the lymph node lymphomas:
histologies **9750**, **9760-9764**, **9800-9820**, **9826**, **9831-9920**, **9931-9964**, **9980-9989**
histologies **9590-9699**, **9702-9729** with primary sites **C77_**

The edit is skipped for a case record if the ICD-O-3 histology is empty.

---

130. **RX Hosp--Surg Oth 98-02 (COC)**

field involved: RX Hosp--Surg Oth 98-02 (1 digit long)

This is a simple validity check,

Valid codes are **0 - 9** (any single digit). The field may also be empty (as for diagnoses beginning in 2003).

---

131. **RX Hosp--Surg Oth 98-02, Primary Site (COC)**

fields involved: Primary Site
RX Hosp--Surg Oth 98-02

The edit checks that the ROADS RX Hosp--Surg Oth field is a valid code for the given primary site. Valid codes are in Appendix D of the *ROADS* Manual. The edit consults a look-up table of valid codes.

The edit is skipped for a case record if the surgical field is empty.

---

132. **RX Hosp--Surg Oth Reg, RX Summ--Surg Oth Reg (COC)**

fields involved: RX Hosp--Surg Oth Reg/Dis
RX Summ--Surg Oth Reg/Dis

This edit looks for basic agreement between the two fields.

If the hospital code indicates that surgery was done, then the summary code must also indicate that surgery was done. That is, if RX Hosp--Surg Oth Reg/Dis = **1 - 5**, then RX Summ--Surg Oth Reg/Dis must = **1 - 5**.

The edit does not look for any more detailed consistency between the two codes.

---

133. **RX Hosp--Surg Oth Reg/Dis (COC)**

field involved: RX Hosp--Surg Oth Reg/Dis (1 digit long)

This is a simple validity check.

Valid codes are **0 - 5** and **9**.

The field cannot be empty.

---

134. **RX Hosp--Surg Pri Sit, RX Summ--Surg Pri Sit (COC)**

fields involved: RX Hosp--Surg Prim Site
RX Summ--Surg Prim Site

This edit checks for basic agreement between the two fields.

The edit is skipped for a case record if the hospital field is empty.

If the hospital code indicates that primary site surgery was done or if it's unknown (any code greater than **00**), then the summary code cannot indicate that none was done (<> **00**).

If the hospital code indicates that primary site surgery was done (**10 - 90**), then the summary code cannot indicate that none was done (**00**) or that it's unknown if it was done (**99**).

The edit does not do any more detailed checking. If the hospital code indicates that an extensive procedure was performed and the summary code indicates that only a small excision was done, the edit does not mind.

---

135. **RX Hosp--Surg Prim Site (COC)**

field involved: RX Hosp--Surg Prim Site (2 digits long)

This is a simple validity check.

Valid codes are **00**, **10 - 90**, **98** and **99**.

The field cannot be empty.

136A. **RX Hosp--Surg Prim Site, Primary Site, ICDO2 (MCR)**

fields involved: Histology (92-00) ICD-O-2
Primary Site
RX Hosp--Surg Prim Site

The edit checks that the RX Hosp--Surg Prim Site is a valid code for the cancer type. Valid codes are in Appendix D of the MCR Manual and Appendix B of the *FORDS* Manual. The edit consults a look-up table of valid codes.

The MCR version of this edit considers code **99** to be valid for any cancer type (even hematopoietic, reticuloendothelial, etc. diseases) because this code should be used for all death certificate-only cases.

The edit is skipped for a case record if the ICD-O-2 histology is empty.

136B. **RX Hosp--Surg Prim Site, Primary Site, ICDO3 (MCR)**

fields involved: Histologic Type ICD-O-3
Primary Site
RX Hosp--Surg Prim Site

This is the ICD-O-3 version of the preceding edit.

The edit is skipped for a case record if the ICD-O-3 histology is empty.

---

137. **RX Hosp--Surg Site 98-02 (COC)**

field involved: RX Hosp--Surg Site 98-02 (2 digits long)

This is a simple validity check.

Valid codes are **00**, **10-90** and **99**. The field may also be empty (as for diagnoses made beginning in 2003).

---

138. **RX Hosp--Surg Site 98-02, Primary Site (COC)**

fields involved: Primary Site
RX Hosp--Surg Site 98-02

This edit checks that the hospital ROADS primary site surgery code is valid for the given primary site.

Valid codes are in the *ROADS* Manual. The edit uses a look-up table of valid codes.

The edit skips for a record if the surgery field is empty.

---

139. **RX Summ--BRM (COC)**

field involved: RX Summ--BRM (2 digits long)

This is a simple validity check.

Valid codes are **00**, **01**, **82**, **85-88** and **99**.

The field cannot be empty.

---

140. **RX Summ--BRM, RX Text--BRM (NAACCR/MCR-CIMS)**

fields involved: Class of Case
Date of Diagnosis (year only)
RX Summ--BRM
RX Text--BRM

This edit checks that the immunotherapy narrative has been filled in when Immunotherapy was given. It runs only in our Scan Edit Set but needs to be updated. A problem in this edit will be taken care of in the MCR's 2004 edits.

If the summary code indicates that immunotherapy was given (**01**), then the narrative cannot be empty.

Because the MCR does not require narrative for most nonanalytic cases, the edit skips when Class of Case = **3**, **4**, **5**, **6** or **9**. It skips for diagnoses made before 2001 (because the MCR only started enforcing narrative checks with edits at that time).

---

141. **RX Summ--BRM, Vital Status (COC)**

fields involved: RX Summ--BRM
Vital Status

This edit checks that a patient coded as not having received Immunotherapy because of death is not also coded as alive.

If RX Summ--BRM = **85** (Immunotherapy not given because patient died), then Vital Status <> **1** (alive).

---

142. **RX Summ--Chemo (COC)**

field involved: RX Summ--Chemo (2 digits long)

This is a simple validity check. Valid codes are **00 - 03**, **82**, **85-88** and **99**.

The field cannot be empty.

---

143. **RX Summ--Chemo, RX Text--Chemo (NAACCR/MCR-CIMS)**

fields involved: Class of Case
Date of Diagnosis (year only)
RX Summ--Chemo
RX Text--Chemo

This edit checks that the chemotherapy narrative has been filled in when chemotherapy was given. It runs only in the MCR Scan Edit Set. It will need to be further updated for 2004.

If the summary code indicates that chemotherapy was given (**01 - 03**), then the narrative cannot be empty.

Because the MCR does not require narrative for most nonanalytic cases, the edit skips when Class of Case = **3**, **4**, **5**, **6** or **9**. It skips if the diagnosis year < **2001** (because the MCR did not begin enforcing narrative checks with edits until this time.)

---

144. **RX Summ--Chemo, Vital Status (COC)**

fields involved: RX Summ--Chemo
Vital Status

This edit checks that a patient coded as not having received Chemotherapy because of death is not also coded as alive.

If RX Summ--Chemo = **85** (Chemo not given because patient died), then Vital Status <> **1** (alive).

---

145. **RX Summ--DX/Stg Proc (COC)**

field involved: RX Summ--DX/Stg Proc (2 digits long)

This is a simple validity check. Valid codes are **00 - 07** and **09**.

The field cannot be empty.

---

146. **RX Summ--DX/Stg Proc, RX Date--DX/Stg Proc (COC)**

fields involved: RX Date--DX/Stg Proc (year only)
RX Summ--DX/Stg Proc

This edit checks that there is not conflict between the date field and summary code. It skips if the date field is empty.

If the summary code indicates no diagnostic/staging procedure (**00**), then the year must also indicate none was done (**0000**).

If the summary code indicates that a procedure was done (**01 - 07**), then the year cannot indicate that it wasn't (i.e., the date must not be zero-filled).

If the summary code indicates that it's unknown if a procedure was done (**09**), then the date must be **9**-filled.

---

147. **RX Summ--Hormone (COC)**

field involved: RX Summ--Hormone (2 digits long)

This is a simple validity check.

Valid codes are **00**, **01**, **82**, **85-88** and **9**.

The field cannot be empty.

---

148. **RX Summ--Hormone, RX Text--Hormone (NAAC/MCR-CIMS)**

fields involved: Class of Case
Date of Diagnosis (year only)
RX Summ--Hormone
RX Text--Hormone

This edit checks that the hormone therapy narrative has been filled in when such therapy was given. It runs only in the MCR Scan Edit Set. It needs to be updated for 2004.

If the summary code indicates that hormone therapy was given (**01**), then the narrative cannot be empty.

Because the MCR does not require narratives for most nonanalytic cases, the edit skips when Class of Case = **3**, **4**, **5**, **6** or **9**. It also skips for diagnoses made before 2001 (when the MCR began enforcing narratives with edits).

---

149. **RX Summ--Hormone, Vital Status (COC)**

fields involved: RX Summ--Hormone
Vital Status

This edit checks that a patient coded as not having received Hormone Therapy because of death is not also coded as alive.

If RX Summ--Hormone = **85** (treatment not given because patient died), then Vital Status <> **1** (alive).

---

150. **RX Summ--Other (SEER OTHERRX)**

field involved: RX Summ--Other (1 digit long)

This is a simple validity check.

Valid codes are **0 - 3** and **6 - 9**.

The field cannot be empty.

---

151. **RX Summ--Other, RX Date--Other (COC)**

fields involved: RX Date--Other (year only)
RX Summ--Other

This edit checks that there is not conflict between the Other Therapy start date and the summary code. It skips for a case record if the date field is empty.

If the summary code indicates that other cancer-directed therapy was not done (**0**) or was not done because it was refused (**7**), then the year coded must also indicate that none was done (**0000**).

If the summary code indicates that other cancer-directed therapy was done (**1** - **3** or **6**), then the year coded cannot indicate that it wasn't done (that is, the date must not be zero-filled).

If the summary code indicates that other cancer-directed therapy was recommended but it's unknown whether it was ever done (**8**), then the year coded may be zero-filled or **9**-filled.

If the summary code indicates that it's unknown if other cancer-directed therapy was recommended/done (**9**), then the date must be **9**-filled.

---

152. **RX Summ--Other, RX Text--Other (NAA/MCR-CIMS)**

fields involved: Class of Case
Date of Diagnosis (year only)
RX Summ--Other
RX Text--Other

This edit checks that the Other Therapy narrative has been filled in when such therapy was given. It runs only in our Scan Edit Set.

If the summary code indicates that therapy was given (**1** – **3** or **6**), then the narrative cannot be empty.

Because the MCR does not require narratives for most nonanalytic cases, the edit skips when Class of Case = **3**, **4**, **5**, **6** or **9**. It skips for diagnoses made before 2001 (when the MCR began enforcing narrative checks using edits).

---

153. **RX Summ--Palliative Proc (COC)**

field involved: RX Summ--Palliative Proc (1 digit long)

This is a simple validity check.

Valid codes are **0** - **7** and **9**.

The field cannot be empty.

---

154. **RX Summ--Scope Reg 98-02 (COC)**

field involved: RX Summ--Scope Reg 98-02 (1 digit long)

This is a simple validity check.

Valid codes are **0** - **9** (any single digit). The field may also be empty (as for pre-2003 diagnoses).

---

155. **RX Summ--Scope Reg 98-02, Date of DX (COC)**

fields involved: Date of Diagnosis (year only)
RX Summ--Scope Reg 98-02

This edit checks that the ROADS lymph node surgery code is filled in for pre-2003 diagnoses.

If diagnosis year < **2003**, then RX Summ--Scope Reg 98-02 cannot be empty.

156A. **RX Summ--Scope Reg 98-02, Primary Site (COC)**

fields involved: Date of Diagnosis (year only)
Histology (92-00) ICD-O-2
Primary Site
RX Summ--Scope Reg 98-02

This edit checks that the ROADS lymph node surgery code is valid for the given cancer type.

Valid codes are in the *ROADS* Manual. The edit consults a look-up table of codes.

For diagnosis years after **1999**, the edit checks that RX Summ--Scope Reg 98-02 = **9** for these cancers:
lymphomas with lymph node primaries (**9590-9698**, **9702-9717** with **C77_**)
leukemias (**9800-9989**)
cerebral meninges (**C700**)
brain (**C71_**)
unknown primary site (**C809**)

The edit skips if the ICD-O-2 histology or surgery field is empty.

156B. **RX Summ--Scope Reg 98-02, Primary Site, ICDO3(COC)**

fields involved: Date of Diagnosis (year only)
Histologic Type ICD-O-3
Primary Site
RX Summ--Scope Reg 98-02

This is the ICD-O-3 version of the preceding edit. The lymphoma definition is **9590-9699**, **9702-9729** with **C77_**.

The edit skips if the ICD-O-3 histology or surgery code is empty.

---

157. **RX Summ--Scope Reg LN Sur (COC)**

field involved: RX Summ--Scope Reg LN Sur (1 digit long)

This is a simple validity check.

Valid codes are **0** - **7** and **9**.

The field cannot be empty.

158A. **RX Summ--Scope Reg LN Sur, Primary Site (COC)**

fields involved: Histology (92-00) ICD-O-2
Primary Site
RX Summ--Scope Reg LN Sur

This edit checks that the summary regional node surgery code = **9** for certain cancers:

CNS (**C700-C729**)
hematopoietic, reticuloendothelial, immunoproliferative, myeloproliferative diseases (**9720**, **9760-9764**, **9800-9820**, **9826**, **9840-9894**, **9910**, **9931-9962**, **9980-9989** or primary site **C420**, **C421**, **C423**, **C424**
lymphomas with lymph node site (**9590-9595**, **9650-9698**, **9702-9717** with **C77_**)
ill-defined site (**C76_**)
unknown primary site (**C809**)

The edit skips for a case record if the ICD-O-2 histology code is empty.

158B. **RX Summ--Scope Reg LN Sur,Prim Site,ICDO3(COC)**

fields involved: Histologic Type ICD-O-3
Primary Site
RX Summ--Scope Reg LN Sur

This is the ICD-O-3 version of the preceding edit. The hematopoietic, etc. diseases are defined by **9750**, **9760-9764**, **9800-9820**, **9826**, **9831-9920**, **9931-9964**, **9980-9989** and the lymphomas are defined by **9590-9699**, **9702-9729**.

The edit skips if the ICD-O-3 histology code is empty.

---

159. **RX Summ--Surg Oth 98-02 (COC)**

field involved: RX Summ--Surg 98-02 (1 digit long)

This is a simple validity check.

Valid codes are **0** - **9** (any single digit). The field may also be empty (as for pre-2003 diagnoses).

---

160. **RX Summ--Surg Oth 98-02, Date of DX (COC)**

fields involved: Date of Diagnosis (year only)
RX Summ--Surg Oth 98-02

This edit checks that the ROADS "other site" surgery is filled for pre-2003 diagnoses.

If year of diagnosis < **2003**, then RX Summ--Surg Oth 98-02 cannot be empty.

---

161. **RX Summ--Surg Oth 98-02, Primary Site (COC)**

fields involved: Primary Site
RX Summ--Surg Oth 98-02

This edit checks that the ROADS "other site" surgery is a valid code for the given primary site. Valid codes are in the *ROADS* Manual. The edit uses a look-up table of codes.

The edit skips for a record when the surgery field is empty.

---

162. **RX Summ--Surg Oth Reg/Dis (COC)**

field involved: RX Summ--Surg Oth Reg/Dis (1 digit long)

This is a simple validity check.

Valid codes are **0** - **5** and **9**.

The field cannot be empty.

---

163. **RX Summ--Surg Prim Site (COC)**

field involved: RX Summ--Surg Prim Site (2 digits long)

This is a simple validity check.

Valid codes are **00**, **10** - **90**, **98** and **99**.

The field cannot be empty.

---

164. **RX Summ--Surg Prim Site, Diag Conf (SEER IF76)**

fields involved: Diagnostic Confirmation
RX Summ--Surg Prim Site

This edit questions a case record whenever non-destructive primary site surgery was done but the diagnosis was not microscopically confirmed. The edit asks for review of a case when it sees this combination of codes:

RX Summ--Surg Prim Site = **20-90** <u>and</u> Diagnostic Confirmation <> **1**, **2**, or **4**

The edit skips for a record if the surgery field is empty.

This edit has an over-ride ("Surg/DxConf").

165A. **RX Summ--Surg Prim Site, Primary Site (SEER IF108)**

fields involved: Histologic Type ICD-O-3
Primary Site
RX Summ--Surg Prim Site

This edit checks that the summary primary site surgery code is valid for the cancer type. Valid codes are in Appendix D of the MCR Manual and Appendix B of the *FORDS* Manual. The edit consults a look-up table of valid codes.

This SEER edit allows code **99** to be a valid surgery code for any primary site and the hematopoietic, etc. diseases (**9750**, **9760-9764**, **9800-9820**, **9826**, **9831-9920**, **9931-9964**, **9980-9989**) (because **99** would be valid for any death certificate-only case).

The edit also does one extra check. If the primary site is one of the "all other sites" at the end of the surgery code appendix, and if the surgery code = **41** (enucleation for eye surgeries), then the primary site can only be eye (**C69_**).

The edit skips if the ICD-O-3 histology or surgery field is empty.

165B. **RX Summ--Surg Prim Site, Primary Site, ICDO2 (MCR)**

fields involved: Histology (92-00) ICD-O-2
Primary Site
RX Summ--Surg Prim Site

This is the ICD-O-2 version of the preceding edit.

The MCR version of this SEER edit allows surgery code **99** for any primary site (as for death certificate-only cases). It will be further modified for 2004. The hematopoietic etc. list is **9720**, **9760-9764**, **9800-9820**, **9826**, **9840-9894**, **9910**, **9931-9962**, **9980-9989**.

The edit skips for a record if the ICD-O-2 histology is empty.

---

166. **RX Summ--Surg Site 98-02 (COC)**

field involved: RX Summ--Surg Site 98-02 (2 digits long)

This is a simple validity check.

Valid codes are **00**, **10 - 90** and **99**. The field may also be empty (as for diagnoses beginning in 2003).

---

167. **RX Summ--Surg Site 98-02, Date of DX (COC)**

fields involved: Date of Diagnosis (year only)
RX Summ--Surg Site 98-02

This edit checks that the ROADS surgery field is filled for pre-2003 diagnoses.

If diagnosis year < **2003**, then RX Summ--Surg Site 09-02 cannot be empty.

---

168. **RX Summ--Surg Site 98-02, Primary Site (COC)**

fields involved: Primary Site
RX Summ--Surg Site 98-02

This edit checks that the surgery code is valid for the given primary site.

Valid codes are in the *ROADS* Manual. The edit uses a look-up table of codes.

The edit skips for a record if the surgery field is empty.

---

169. **RX Summ--Surg/Rad Seq (SEER RADSEQ)**

field involved: RX Summ--Surg/Rad Seq (1 digit long)

This is a simple validity check.

Valid codes are **0**, **2 - 6** and **9**.

The field cannot be empty.

---

170. **RX Summ--Transplnt/Endocr (COC)**

field involved: RX Summ--Transplnt/Endocr (2 digits long)

This is a simple validity check.

Valid codes are **00**, **10 - 12**, **20**, **30**, **40**, **82**, **85 - 88** and **99**. (The edit will also allow code **80** but this will be fixed in the future.)

The field cannot be empty.

---

171. **RX Summ--Transplnt/Endocr, Primary Site (SEER IF28**

fields involved: Primary Site
RX Summ--Transplnt/Endocr

This edit checks that Endocrine Procedures are only reported being done for breast and prostate primaries.

If RX Summ--Transplnt/Endocr = **30** (endocrine procedure) or **40** (endocrine procedure + transplant) and primary site <> **C50_** or **C619**, then the edit fails.

---

172. **RX Summ--Transplnt/Endocr, Vital Status (COC)**

fields involved: RX Summ--Transplnt/Endocr
Vital Status

This edit checks that a patient coded as not having received a Hematologic Transplant & Endocrine Procedure because of death is not also coded as being alive.

If RX Summ--Transplnt/Endocr = **85** (treatment not given because patient died), then Vital Status <> **1** (alive).

---

173. **Sex (SEER SEX)**

field involved: Sex (1 digit long)

This is a simple validity check.

Valid codes are **1** - **4** and **9**.

The field cannot be empty.

---

174. **Sex, Primary Site (SEER IF17)**

fields involved: Primary Site
Sex

This edit checks that primary site codes considered to be "single-sex" are not combined with the opposite sex code.

The edit is skipped for a case record if either field has failed its validity check.

The edit fails when the sex is coded male (**1**) for primary site codes **C510 - C589** (vulva; vagina; cervix uteri; corpus uteri; uterus, NOS; ovary; other and unspecified female genital organs; placenta).

The edit fails when the sex is coded female (**2**) for primary site codes **C600 - C639** (penis; prostate gland; testis; other and unspecified male genital organs).

Note that the edit accepts any sex *except* male for the female-only sites, and any sex *except* female is OK for the male-only sites. That is, if the sex is coded as unknown (**9**) and the site is prostate or cervix, the edit does not mind.

The other sex codes (**3**, **4**) are also accepted with any site.

---

175. **Social Security Number (NAACCR)**

field involved: Social Security Number (9 digits long)

This is mainly a character check. It also considers one code invalid.

The field can only contain nine numbers. Any other type of character will fail. Fewer than nine numbers will fail.

A zero-filled Social Security number (**000000000**) is not valid.

Any other nine numbers, even something suspiciously invalid-looking like **555555555** or **000000001**, will pass the edit.

The field cannot be empty.

---

176. **Spanish/Hispanic Origin (SEER SPANORIG)**

field involved: Spanish/Hispanic Origin (1 digit long)

This is a simple validity check.

Valid codes are **0** - **7** and **9**.

The field cannot be empty.

177A. **Summary Stage (NAACCR)**

field involved: SEER Summary Stage 1977 (1 digit long)

This is a simple validity check.

Valid codes are **0** - **5**, **7** and **9**. The field may be empty.

The edit will not accept a code of **6** for a stage of non-localized, NOS.

177B. **Summary Stage 2000 (NAACCR)**

field involved: SEER Summary Stage 2000 (1 digit long)

This is a simple validity check.

Valid codes are **0** - **5**, **7** and **9**. The field may be empty.

178A. **Summary Stage 2000, Date DX, Date 1st Cont (NAACCR**

fields involved: Date of Diagnosis (year only)
Date of First Contact (year only)
SEER Summary Stage 2000

This edit checks that Summary Stage 2000 is filled for diagnoses made in 2001 and thereafter.

If the year of diagnosis > **2000** (but not **9999**) and Summary Stage 2000 is empty, the edit fails. If the year of diagnosis is unknown (**9999**), the edit uses the year of Date of First Contact instead.

179A. **Summary Stage 2000, Regional Nodes Pos (NAACCR)**

fields involved: Regional Nodes Positive
Summary Stage 2000

This edit looks for basic compatibility between the positive node status and the Summary Stage 2000 coded. It skips any case record in which the Summary Stage 2000 is regional, NOS (**5**), distant (**7**) or unknown/unstageable (**9**).

The edit questions the following combinations of Summary Stage 2000 and Regional Nodes Positive:

Summary Stage *in situ* (**0**), localized (**1**), or regional by direct extension only (**2**) and at least one Regional Node Positive **01** - **97**;

Summary Stage regional to nodes only (**3**) or regional by direct extension plus regional nodes (**4**) and no Regional Nodes Positive (**00**) or it's unknown if any nodes examined were positive (**99**)*.

* (The combination of Summary Stage **3** or **4** and Regional Nodes Positive **99** produces a warning instead of an error.)

This NAACCR edit includes the following advice for the central registry:

"Most of the time, a discrepancy between SEER Summary Stage and Regional Nodes Positive will indicate a coding error in one of the two data items. Check the coding of each field carefully and correct any errors. Occasionally, however, there may be a legitimate discrepancy, most likely due to differences in the time period rules used to code the two items. ...SEER rules for collection of Regional Nodes Positive included a 2-month time period rule until 1998 when a 4-month rules was implemented. ROADS instructions for Regional Nodes Positive specify to record lymph nodes removed as part of the first course of therapy. Registries may differ in which rules were used, and when they were used. Ascertain the time period rules used by the registry a the time the case was collected, and verify that the appropriate time period rules were used to code the data items involved. If the discrepancy remains, set the over-ride flag ... to indicate that the case is correct as coded."

This edit skips for a case record if either field is empty.

This edit has an over-ride ("SS/Nodes Pos").

---

180. **Summary Stage 2000, Site, Hist, Class (NAACCR)**

fields involved: Behavior Code ICD-O-3
Class of Case
Histologic Type ICD-O-3
Primary Site
SEER Summary Stage 2000

Not all of the general Summary Stage codes (0-5,7,9) are applicable to all sites and histologies. This edit carefully checks that the Summary Stage 2000 field contains a code that is valid for the diagnosis coded.

The edit allows any Summary Stage 2000 code (**0 - 5**, **7**, **9**) for any site and histology, with the following exceptions:

ICD-O-3 histologies **8800-9055**, **9110-9136**, **9141-9508**, **9520-9582** cannot be *in situ* (stage **0**); codes **1-5**, **7**, **9** are OK;

the following staging schemes cannot have an *in situ* stage (**0**); codes **1 - 5**, **7**, **9** are OK:
- heart and mediastinum (**C380 - C383**, **C388**)
- pleura (**C384**)
- other and ill-defined respiratory sites and intrathoracic organs (**C390 - C399**)
- bones, joints and articular cartilage (**C400 - C419**)
- mycosis fungoides and Sezary syndrome of skin, vulva, penis, scrotum (**C440-C449**, **C510-C519**, **C600-C601**, **C608-C609**, **C632**, **9700-9701**)
- peripheral nerves and autonomic nervous system; connective, subcutaneous, and other soft tissues (**C470-C479**, **C490 - C499**)
- retroperitoneum and peritoneum (**C480 - C488**)
- retinoblastomas (**C692**, **C699**, **9510 - 9514**);

the following staging schemes cannot be *in situ* (**0**), regional by direct extension (**2**) or have regional node involvement (**3**, **4**); codes **1**, **5**, **7**, **9** are OK:
- brain and cerebral meninges (**C700**, **C710 - C719**)
- other parts of central nervous system (**C701**, **C709**, **C720 - C729**);

inflammatory carcinomas of the breast (**C500 - C509**, **8530**) are at least regional by direct extension, so they cannot be *in situ* (**0**), localized (**1**), regional to nodes only (**3**) or regional NOS (**5**); codes **2**, **4**, **7**, **9** are OK;

the staging scheme for pituitary gland, craniopharyngeal duct and pineal gland (**C751 - C753**) cannot have regional node involvement (**3**, **4**); codes **0 - 2**, **5**, **7**, **9** are OK

Kaposi sarcoma (**9140**, any site) cannot be *in situ* (**0**) or regional NOS (**5**); codes **1 - 4**, **7**, **9** are OK;

Hodgkin and non-Hodgkin lymphomas except mycosis fungoides and Sezary syndrome (**9590-9699**, **9702-9719**, **9727-9729**, any site) cannot be *in situ* (**0**) or a specific regional stage (**2-4**); they can only be localized (**1**), regional NOS (**5**), distant (**7**) or unstaged (**9**);
- further, if multiple node regions were involved for a nodal lymphoma (**C778**), the disease cannot be localized (**1**) -- only codes **5**, **7**, **9** are OK;

plasmacytoma NOS (**9731**), extramedullary plasmacytoma (**9734**), malignant histiocytosis (**9750**), Langerhans cell histiocytosis NOS (**9751**) and unifocal Langerhans cell histiocytosis (**9752**) (any site) can only be localized (**1**) or distant (**7**);

all other hematopoietic and myeloproliferative diseases except those above (**9732**, **9733**, **9740-9742**, **9753-9989**) (any site) can only be distant (**7**);

the staging scheme for other and ill defined sites and unknown primary site (**C760-C768**, **C809**, **C420-C424**, **C770-C779**, all histologies except **9140**, **9590-9699**, **9702-9729**, **9731-9989**) can only be staged **9**.

For any death certificate-only case (Class **8**, entered at the MCR only), the Summary Stage 2000 must be coded **9**. This applies to *all* sites and histologies.

The edit skips for a case record if any of the fields involved is empty. It skips if the behavior = **0** or **1** (benign, borderline).

This edit has NO over-ride. Check the *SEER Summary Staging Manual 2000* carefully to see which codes are valid for each staging scheme.

181A. **Summary Stage 2000, TNM M (NAACCR)**

fields involved: SEER Summary Stage 2000
TNM Clin M
TNM Path M

This edit checks for basic compatibility between the Summary Stage 2000 code and the AJCC M elements.

The Summary Stage 2000 is checked against only one of the M elements. The pathologic M is used unless it is empty, **X_** or **88**; if the pM is empty, **X_** or **88**, and the clinical M is *not* empty/**X_**/**88**, then the cM is checked against the Summary Stage 2000. After checking for **88**s and choosing whether pM or cM is going to be used by the edit, only the first (leftmost) character of the 2-character M element is used.

The edit questions* these code combinations:

a Summary Stage 2000 that's anything but distant (**0 - 5**, **9**) and M=**1** (distant disease);

a Summary Stage 2000 that's distant (**7**) and M=**0** (no distant disease).

* (Summary Stage codes **0**, **1**, **3**, **9** produce an outright error with M=**1**; codes **2**, **4**, **5** produce a warning with M=**1**; Summary Stage **7** with M=**0** produces a warning.)

This NAACCR edit includes the following advice for the central registry:

"Most of the time, a discrepancy between SEER Summary Stage and the M code in TNM will indicate a coding error in one of the data items. Check the coding of each field carefully and correct any errors. Occasionally, however, there may be a legitimate discrepancy, most likely due to differences in the time period rules used to code the two items. .... AJCC rules for TNM often stipulate specific test results to be included in coding for clinical and pathological staging separately, and relate time periods of coding to the initiation of therapy. Rules are provided for each primary site. Registries may differ in which rules were used, and when they were used. Ascertain the time period rules used by the registry a the time the case was collected, and verify that the appropriate time period rules were used to code the data items involved. If the discrepancy remains, set the over-ride flag ... to indicate that the case is correct as coded."

The edit skips any case record where the Summary Stage 2000 is empty or both of the M elements are empty; it also skips when both M elements are **88** (not stageable in the *AJCC Cancer Staging Manual, Fifth Edition*).

This edit has an over-ride ("SS/TNM-M").

182A. **Summary Stage 2000, TNM N (NAACCR)**

fields involved: SEER Summary Stage 2000
TNM Clin N
TNM Path N

This edit checks for basic compatibility between the Summary Stage 2000 code and the AJCC N elements.

The Summary Stage 2000 is checked against only one of the N elements. The pathologic N is used unless it is empty, **X_** or **88**; if the pN is empty, **X_** or **88**, and the clinical N is *not* empty/**X_**/**88**, then the cN is checked against the Summary Stage 2000. After checking for **88**s and choosing whether pN or cN is going to be used by the edit, only the first (leftmost) character of the 2-character N element is used.

The edit questions these code combinations:

a Summary Stage 2000 that indicates no regional node involvement (**0 - 2**) and N=**1 - 3** (regional node involvement);

a Summary Stage 2000 that indicates regional node involvement (**3**, **4**) and N=**0_** (no regional nodes involved).

This NAACCR edit includes the following advice for the central registry:

> "Most of the time, a discrepancy between SEER Summary Stage and the M code in TNM will indicate a coding error in one of the data items. Check the coding of each field carefully and correct any errors. Occasionally, however, there may be a legitimate discrepancy, most likely due to differences in the time period rules used to code the two items. .... AJCC rules for TNM often stipulate specific test results to be included in coding for clinical and pathological staging separately, and relate time periods of coding to the initiation of therapy. Rules are provided for each primary site. Registries may differ in which rules were used, and when they were used. Ascertain the time period rules used by the registry a the time the case was collected, and verify that the appropriate time period rules were used to code the data items involved. If the discrepancy remains, set the over-ride flag ... to indicate that the case is correct as coded."

The edit skips any case record in which the Summary Stage 2000 is coded **5**, **7** or **9** or is empty. It skips whenever both of the N elements are empty. It also skips when both N elements are **88** (not AJCC stageable).

This edit has an over-ride ("SS/TNM-N").

---

183. **Summary Stage, Class of Case (COC)**

fields involved: Class of Case
SEER Summary Stage 1977

This edit only runs at the MCR offices on data already on our system. It does not run in the Scan Edit Set.

This edit checks that death certificate-only cases (Class = **8**) have Summary Stage = **9**.

The edit skips if Summary Stage 1977 is empty.

178B. **Summary Stage, Date DX, Date 1st Contact (NAACCR)**

fields involved: Date of Diagnosis (year only)
Date of First Contact (year only)
SEER Summary Stage 1977

This edit checks that the 1977 Summary Stage is filled in for appropriate diagnosis years (before 2001).

If the year of diagnosis<**2001**, SEER Summary Stage 1977 cannot be empty.

If the year of diagnosis is unknown (**9999**), then the year of first contact is used instead.

---

184. **Summary Stage, Histology (COC)**

fields involved: Class of Case
Date of Diagnosis (year only)
Histology (92-00) ICD-O-2
SEER Summary Stage 1977

This edit just checks that the 1977 Summary Stage is coded distant for Letterer-Siwe disease, multiple myeloma and leukemias (using ICD-O-2 codes).

The edit skips for any case record diagnosed in 2001 or thereafter. It skips for death certificate-only cases (Class = **8**).

If the ICD-O-2 histology=**9722**, **9732**, **9800 - 9941**, then SEER Summary Stage 1977 must be **7**.

179B. **Summary Stage, Regional Nodes Pos (NAACCR)**

fields involved: Regional Nodes Positive
SEER Summary Stage 1977

This is the Summary Stage 1977 version of Edit# 179A.

This edit looks for basic compatibility between the positive node status and the Summary Stage 1977 coded. It skips any case record in which the Summary Stage 1977 is regional, NOS (**5**), distant (**7**) or unknown/unstageable (**9**).

The edit questions the following combinations of Summary Stage 1977 and Regional Nodes Positive:

Summary Stage *in situ* (**0**), localized (**1**), or regional by direct extension only (**2**) and at least one Regional Node Positive **01 - 97**;

Summary Stage regional to nodes only (**3**) or regional by direct extension plus regional nodes (**4**) and no Regional Nodes Positive (**00**) or it's unknown if any nodes examined were positive (**99**)*.

* (The combination of Summary Stage **3** or **4** and Regional Nodes Positive **99** produces a warning instead of an error.)

This NAACCR edit includes the following advice for the central registry:

"Most of the time, a discrepancy between SEER Summary Stage and Regional Nodes Positive will indicate a coding error in one of the two data items….. Occasionally, however, there may be a legitimate discrepancy, most likely due to differences in the time period rules used to code the two items. SEER Summary Stage 1977 has been variously coded using all information available within 2 …or within 4 months of diagnosis. SEER rules for collection of Regional Nodes Positive included a 2-month time period rule until 1998 when a 4-month rule was implemented. ROADS instructions for Regional Nodes Positive specified to record nodes removed as part of the first course of therapy. Registries may differ in which rules were used, and when….. Ascertain the time period rules used by the registry at the time the case was collected, and verify that the appropriate…rules were used…. If the discrepancy remains, set the over-ride flag ... to indicate that the case is correct as coded."

This edit skips for a case record if either field is empty.

This edit has an over-ride ("SS/Nodes Pos").

---

185. **Summary Stage, Summary Stage 2000 (NAACCR/MCR)**

fields involved: SEER Summary Stage 1977
SEER Summary Stage 2000

Only the Summary Stage appropriate for the diagnosis year (or first contact year if diagnosis year is unknown). This edit checks that both Summary Stages are not empty, and it checks that both are not full.

181B. **Summary Stage, TNM M (NAACCR)**

fields involved: SEER Summary Stage 1977
TNM Clin M
TNM Path M

This is the Summary Stage 1977 version of Edit# 181A. This edit checks for basic compatibility between the Summary Stage 1977 code and the AJCC M elements.

Summary Stage 1977 is checked against only one of the M elements. The pathologic M is used unless it is empty, **X_** or **88**; if the pM is empty, **X_** or **88**, and the clinical M is *not* empty/**X_**/**88**, then the cM is checked against the Summary Stage 1977. After checking for **88**s and choosing whether pM or cM is going to be used by the edit, only the first (leftmost) character of the 2-character M element is used.

The edit questions* these code combinations:

a Summary Stage 1977 that's anything but distant (**0 - 5**, **9**) and M=**1** (distant disease);

a Summary Stage 1977 that's distant (**7**) and M=**0** (no distant disease).

* (Summary Stage codes **0**, **1**, **3**, **9** produce an outright error with M=**1**; codes **2**, **4**, **5** produce a warning with M=**1**; Summary Stage **7** with M=**0** produces a warning.)

This NAACCR edit includes the following advice for the central registry:

"Most of the time, a discrepancy between SEER Summary Stage and the M code in TNM will indicate a coding error in one of the data items. Check the coding of each field carefully and correct any errors. Occasionally, however, there may be a legitimate discrepancy, most likely due to differences in the time period rules used to code the two items. SEER Summary Stage 1977 has been variously coded using all information available within 2 months of diagnosis or within 4 months of diagnosis. AJCC rules for TNM often stipulate specific test results to be included in coding for clinical and pathological staging separately, and relate time periods of coding to the initiation of therapy. Rules are provided for each primary site. Registries may differ in which rules were used, and when they were used. Ascertain the time period rules used by the registry a the time the case was collected, and verify that the appropriate time period rules were used to code the data items involved. If the discrepancy remains, set the over-ride flag ... to indicate that the case is correct as coded."

The edit skips any case record where the Summary Stage 1977 is empty or both of the M elements are empty; it also skips when both M elements are **88** (not AJCC stageable).

This edit has an over-ride ("SS/TNM-M").

182B. **Summary Stage, TNM N (NAACCR)**

fields involved: SEER Summary Stage 1977
TNM Clin N
TNM Path N

This is the Summary Stage 1977 version of Edit #182A. This edit checks for basic compatibility between the Summary Stage 1977 code and the AJCC N elements.

The Summary Stage 1977 is checked against only one of the N elements. The pathologic N is used unless it is empty, **X_** or **88**; if the pN is empty, **X_** or **88**, and the clinical N is *not* empty/**X_**/**88**, then the cN is checked against the Summary Stage 1977. After checking for **88**s and choosing whether pN or cN is going to be used by the edit, only the first (leftmost) character of the 2-character N element is used.

The edit questions these code combinations:

a Summary Stage 1977 that indicates no regional node involvement (**0 - 2**) and N=**1 - 3** (regional node involvement);

a Summary Stage 1977 that indicates regional node involvement (**3**, **4**) and N=**0_** (no regional nodes involved).

This NAACCR edit includes the following advice for the central registry:

"Most of the time, a discrepancy between SEER Summary Stage and the M code in TNM will indicate a coding error in one of the data items. Check the coding of each field carefully and correct any errors. Occasionally, however, there may be a legitimate discrepancy, most likely due to differences in the time period rules used to code the two items. SEER Summary Stage 1977 has been variously coded using all information available within 2 months of diagnosis or within 4 months of diagnosis. AJCC rules for TNM often stipulate specific test results to be included in coding for clinical and pathological staging separately, and relate time periods of coding to the initiation of therapy. Rules are provided for each primary site. Registries may differ in which rules were used, and when they were used. Ascertain the time period rules used by the registry a the time the case was collected, and verify that the appropriate time period rules were used to code the data items involved. If the discrepancy remains, set the over-ride flag ... to indicate that the case is correct as coded."

The edit skips any case record in which the Summary Stage 1977 is coded **5**, **7** or **9** or is empty. It skips whenever both of the N elements are empty. It also skips when both N elements are **88** (not AJCC stageable).

This edit has an over-ride ("SS/TNM-N").

---

186. **Surgery, Rad, Surg/Rad Seq (COC)**

fields involved: Rad--Regional RX Modality
RX Summ--Scope Reg LN Sur
RX Summ--Surg Oth Reg/Dis
RX Summ--Surg Prim Site
RX Summ--Surg/Rad Seq

The edit checks for basic agreement among surgery, radiation and their sequencing field.

The edit is skipped for a case record if any of the fields is empty.

If the summary treatment codes indicate that both surgery and radiation were done, then the sequencing field must specify that both were done. That is, the edit wants these code combinations:

Regional RX Modality=**20-98** and [RX Summ--Scope Reg LN Sur=**1-8**
or RX Summ--Surg Oth Reg/Dis=**1-8**
or RX Summ--Surg Prim Site=**10-90**]
and Rx Summ--Surg/Rad Seq=**2-6** or **9**

If the summary codes indicate that at least one of these treatment modalities was not done, then the sequencing field can only indicate that both were not done. That is, the edit wants these code combinations:

Regional RX Modality=**00** or [RX Summ--Scope Reg LN Sur=**0**
and RX Summ--Surg Oth Reg/Dis=**0**
and RX Summ--Surg Prim Site=**00** or **98**]
and Rx Summ--Surg/Rad Seq=**0**

Note that unknown codes are missing from these checks. That is, if the radiation code is **99** or all of the surgery summaries are **9**/**99**, then the edit will not look at the sequencing field at all. (Code **9** in the sequencing field now indicates it's unknown if both radiation and surgery were done.) Thus, the edit will pass this combination of codes:

Regional RX Modality=**99** or [RX Summ--Scope Reg LN Sur=**9**
and RX Summ--Surg Oth Reg/Dis=**9**
and RX Summ--Surg Prim Site=**99**]
and Rx Summ--Surg/Rad Seq=**0**, **2-6**, **9**

Note that this edit does not look at any dates, so it is not checking that the sequencing field makes sense in terms of time.

---

187. **Surgery, Reason No Surg (COC)**

fields involved: Reason for No Surgery
RX Summ--Surg Prim Site

This edit checks for agreement between the "Reason for No" field and the summary primary site surgery.

The edit is skipped for a case record if either field is empty.

If the summary code indicates that surgery was not done, then the "Reason for No" code cannot indicate that it was done. That is, the edit wants this code combination:

RX Summ--Surg Prim Site = **00** or **98**] and Reason for No Surgery <> **0**

If the summary code indicates that some surgery was done, then the "Reason for No" code must also indicate that it was done. That is, the edit wants this code combination:

RX Summ--Surg Prim Site = **10-90**] and Reason for No Surgery = **0**

Note that unknown codes are missing from these checks. If it's unknown whether any surgery was done, the "Reason for No" field is not checked and can contain any code. That is, the edit will pass this combination of codes:

RX Summ--Surg Prim Site = **99**] and Reason for No Surgery = **0-2**, **6-9**

188A. **Surgery, RX Date--Surgery (COC)**

fields involved: Histology (92-00) ICD-O-2
Primary Site
RX Date--Surgery (year only)
RX Summ--Scope Reg LN Sur
RX Summ--Surg Oth Reg/Dis
RX Summ--Surg Prim Site

This edit checks that the year surgery started is not coded in conflict with the surgery summary codes.

If the summary codes indicate surgery was done, then the year can't be zero-filled. The edits wants this code combination:

[RX Summ--Scope Reg LN Sur = **1-8**
and RX Summ--Surg Oth Reg/Dis = **1-8**
and RX Summ--Surg Prim Site = **10-90**] and RX Date--Surgery <> **00000000**

If the summary codes indicate that no surgery was done, then the year must be zero-filled to indicate that none was done. That is, the edit wants this combination of codes:

[RX Summ--Scope Reg LN Sur = **0** (or **9** for certain diseases*)
and RX Summ--Surg Oth Reg/Dis = **0**
and RX Summ--Surg Prim Site = **00** or **98**] and RX Date--Surgery = **00000000**

Note that if the Primary Site Surgery or Surgery of Other… summary codes are **99**/**9**, then the date does not have to be **9**-filled -- it can be any date except **00000000**.

The edit skips any case record in which any of the involved fields is empty.

* lymph node lymphomas (9590-9595, 9650-9698, 9702-9717 with C77._), hematopoietic, reticuloendothelial, immunoproliferative, myeloproliferative diseases (C42.0, C42.1, C42.3, C42.4 or 9720, 9760-9764, 9800-9820, 9826, 9840-9894, 9910, 9931-9962, 9980-9989), ill-defined sites (C76._), unknown primary site (C80.9), CNS (C70.0-C72.9).

188B. **Surgery, RX Date—Surgery, ICDO3 (COC)**

fields involved: Histologic Type ICD-O-3
Primary Site
RX Date--Surgery
RX Summ--Scope Reg LN Sur
RX Summ--Surg Oth Reg/Dis
RX Summ--Surg Prim Site

This is an ICD-O-3 version of the preceding edit. It works exactly like the preceding edit, but the hematopoietic, etc. diseases are defined by the ICD-O-3 histology code ranges **9750**, **9760-9764**, **9800-9820**, **9826**, **9831-9920**, **9931-9964**, **9980-9989**, and the lymphomas are **9590-9699**, **9702-9729**.

---

189. **Text--Histology Title (NAACCR)**

field involved: Text--Histology Title

This is a blank-check. It runs only in the MCR Scan Edit Set.

If the histology/behavior/grade narrative is empty, the edit fails.

---

190. **Text--Primary Site Title (NAACCR)**

field involved: Text--Primary Site Title

This is a blank-check. It runs only in the MCR Scan Edit Set.

If the primary site narrative is empty, this edit fails.

---

191. **TNM Clin Descriptor (COC)**

field involved: TNM Clin Descriptor (1 digit long)

This is a simple validity check.

Valid codes are **0** - **6** and **9**. The field may also be empty.

---

192. **TNM Clin M (COC)**

field involved: TNM Clin M (2 characters long)

This is a simple validity check.

Valid codes are:

X_
0_
1_
1A
1B
1C
88

Letters entered cannot be lower case. The field can also be empty.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your M field comes to us containing just an **X** without that second space being filled in, the field will fail the edit.

---

193. **TNM Clin N (COC)**

field involved: TNM Clin N (2 characters long)

This is a simple validity check.

Valid codes are:

X_	**2_**	**3_**	**88**
0_	**2A**	**3A**	
1_	**2B**	**3B**	
1A	**2C**	**3C**	
1B			

Letters entered cannot be lower case. The field can also be empty.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field), at least when the case is exported for the MCR.

---

194. **TNM Clin Stage Group (COC)**

field involved TNM Clin Stage Group (2 characters long)

This is a simple validity check.

Valid codes are :

0_	**1_**	**2_**	**3_**	**4_**	**88**
0A	**1A**	**2A**	**3A**	**4A**	**99**
0S	**A1**	**2B**	**3B**	**4B**	**OC** (letter "oh", not zero)
	A2	**2C**	**3C**	**4C**	
	1B	**2E***	**3E***	**4E***	
	B1	**2S***	**3S***	**4S***	
	B2				
	1C				
	1E*				
	1S				

* These codes can be used for cases coded according to AJCC Third and Fourth Edition staging (before the descriptor fields were required).

Letters entered cannot be lower case. The field can also be empty.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your Stage Group field comes to us containing just a zero without that second space being filled in, the field will fail the edit.

Note that the Stage Group field is not checked for consistency against the corresponding Clinical T, N and M fields for the diagnosis coded.

---

195. **TNM Clin Stage Group, TNM Path Stage Group (COC)**

fields involved: TNM Clin Stage Group
TNM Path Stage Group

This edit simply checks that if one Stage Group code indicates that the case is not stageable under the AJCC staging system (**88**), then the other code must also indicate this.

That is, if the clinical Stage Group = **88**, then the pathologic Stage Group must = **88**. If the pathologic Stage Group = **88**, then the clinical Stage Group must = **88**.

This is all that the edit checks.

---

196. **TNM Clin T (COC)**

field involved: TNM Clin T (2 characters long)

This is a simple validity check.

Valid codes are:

X_	**2_**
0_	**2A**
A_	**2B**
IS	**2C**
SU	**3_**
SD	**3A**
1M	**3B**
1_	**3C**
1A	**4_**
A1	**4A**
A2	**4B**
1B	**4C**
B1	**4D**
B2	**88**
1C	

Letters entered cannot be lower case. The field may also be empty.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your T field comes to us containing just a **2** without that second space being filled in, the field will fail the edit.

---

197. **TNM Edition Number (NAACCR)**

field involved: TNM Edition Number (2 digits long)

This is a simple validity check.

Valid codes are **00** - **06**, **88** and **99**.

The field cannot be empty.

---

198. **TNM Path Descriptor (COC)**

field involved: TNM Path Descriptor (1 digit long)

This is a simple validity check.

Valid codes are **0** - **6** and **9**. The field may also be empty.

---

199. **TNM Path M (COC)**

field involved: TNM Path M (2 characters long)

This is a simple validity check.

Valid codes are:

X_
0_
1_
1A
1B
1C
1M
3C
88

Letters entered cannot be lower case. The field can also be empty.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your M field comes to us containing just a **1** without that second space being filled in, the field will fail the edit.

---

200. **TNM Path N (COC/MCR)**

field involved: TNM Path N (2 characters long)

This is a simple validity check.

Valid codes are:

X_
0_
1_
1A
1B
1M
2_
2A
2B
2C
3_
3A
3B
3C
88

Letters entered cannot be lower case. The field can also be empty.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your N field comes to us containing just a **3** without that second space being filled in, the field will fail the edit.

---

201. **TNM Path Stage Group (COC)**

field involved: TNM Path Stage Group (2 characters long)

This is a simple validity check.

Valid codes are :

0_	**2_**	**4_**	
0A	**2A**	**4A**	
0S	**2B**	**4B**	
1_	**2C**	**4C**	
1A	**2E***	**4E***	
A1	**2S***	**4S***	
A2	**3_**	**88**	
1B	**3A**	**99**	
B1	**3B**	**OC**	(*letter* "Oh" -- *not* zero.)
B2	**3C**		
1C	**3E***		
1E*	**3S***		
1S			

* These codes may be used for AJCC Third and Fourth Edition staging.

Letters entered cannot be lower case. The field can also be empty.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your Stage Group field comes to us containing just a "1" without that second space being filled in, the field will fail the edit.

Note: The codes considered valid by the clinical Stage Group edit are identical to these.

Note that this field is not checked against the corresponding Pathologic T, N and M fields for the diagnosis coded.

---

202. **TNM Path T (COC)**

field involved: TNM Path T (2 characters long)

This is a simple validity check.

Valid codes are:

X_	**1A**	**2_**	**4_**
0_	**A1**	**2A**	**4A**
A_	**A2**	**2B**	**4B**
IS	**1B**	**2C**	**4C**
SU	**B1**	**3_**	**4D**
SD	**B2**	**3A**	**88**
1M	**1C**	**3B**	
1_		**3C**	

Letters entered cannot be lower case. The field can also be empty.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your T field comes to us containing just a **X** without that second space being filled in, the field will fail the edit.

The field can be empty. (The edit skips for a case record if the pathologic T is empty.)

---

203. **TNM-Emptiness Check (MCR-CIMS)**

fields involved: TNM Clin M
TNM Clin N
TNM Clin Stage Group
TNM Clin T
TNM Path M
TNM Path N
TNM Path Stage Group
TNM Path T

This is a simple blank check. None of the above fields may be empty for the MCR. Unknown or "not applicable" codes should be filled in when necessary.

If any of the fields is empty, the edit will complain with a long message. It will not indicate which field(s) are empty.

---

204. **Tobacco History (MCR-CIMS)**

field involved: Tobacco History (1 digit long)

This is a simple validity check.

Valid codes are **0** - **5** and **9**.

The field cannot be empty.

Note that this field is not checked against patient age. A 3-year old patient coded as a cigar-smoker would not fail any edit.

---

205. **Unknown Site, Laterality (NAACCR/MCR)**

fields involved: Laterality
Primary Site

This edit checks that Laterality is coded "not a paired site" when the Primary Site is unknown.

If Primary Site=**C809** then Laterality must = **0**.

The MCR adds many additional non-paired sites to this edit: **C000-C069**, **C100-C269**, **C320-C339**, **C379-C383**, **C410-C412**, **C420-C440**, **C473-C476**, **C480-C496**, **C510-C559**, **C571-C577**, **C600-C619**.

---

206. **Unknown Site, Summary Stage (NAACCR)**

fields involved: Histology (92-00) ICD-O-2
Primary Site
SEER Summary Stage 1977

This edit checks that the Summary Stage 1977 is coded "unstageable" when the Primary Site is unknown

If Primary Site=**C809** then Summary Stage 1977 must = **9**.

The edit skips for a case record if the Summary Stage 1977 is empty. It also skips for Kaposi sarcoma (9140), lymphomas (9590-9698, 9702-9717), hematopoietic and myeloproliferative diseases (9720-9989) (because staging based on the histology rather than the primary site could apply for these diseases).

---

207. **Verify ICDO2 to ICDO3 Conversion (NAACCR)**

fields involved: Behavior (92-00) ICD-O-2
Behavior Code ICD-O-3
Date of Diagnosis (year only)
Histologic Type ICD-O-3
Histology (92-00) ICD-O-2
ICD-O-3 Conversion Flag
Primary Site

This edit does not run in the MCR Scan Edit Set. It runs at the MCR on data already on our system.

This edit checks that the ICD-O-2 morphology code and ICD-O-3 morphology code are compatible for a case record. It only checks records in which the diagnosis was made before 2001, both ICD-O-2 and ICD-O-3 morphologies (behavior and histology) are filled in, and the ICD-O-3 Conversion Flag indicates that a manual review of the two sets of codes has not been performed (codes **0**, **1**, **2** or empty).

The edit skips if the year of diagnosis > **2000**. It skips if the ICD-O-2 behavior and histology are empty. It skips if the ICD-O-3 behavior and histology are empty. It skips if the ICD-O-3 Conversion Flag is coded **3** (manual review of the morphology codes was done) or **4** (this amounts to the same thing as a code **3**).

The edit uses a look-up table of valid ICD-O-2 codes and the corresponding ICD-O-3 code conversions (histologic type codes plus behavior codes). If the ICD-O-2 morphology coded in the case record is found in the table, then the ICD-O-3 morphology coded in the record is compared with the corresponding codes in the look-up table. When discrepancies between the case record and the look-up table are encountered, different warning messages are produced: "Morph--Type&Behav ICD-O-2 not found in conversion table" if the ICD-O-2 codes in the case are not considered valid; "Morph--Type&Behav ICD-O-3 not found in conversion table" if the ICD-O-3 codes in the case are not considered valid; and "ICD-O-2/ICD-O-3 behavior conflict" if the behavior codes do not match the valid conversions. (The behavior codes are actually compared first; if they conflict, then the edit stops without bothering to check if the histologic type codes conflict.)

The edit tries to take into consideration that the ICD-O "matrix" rule may have been applied (the rule that any valid behavior code may be assigned to a morphology to reflect the cancer's true behavior, even if the morphology code printed in the ICD-O manual does not specifically include that behavior code).

The Primary Site code is also involved in the conversion of some morphologies.

The look-up table used by this edit to check the code conversions is based on the ICD-O-2/ICD-O-3 conversion materials available on the SEER website (http://seer.cancer.gov). These are the same conversions used by the MCR on our own case records, except that we convert pilocytic astrocytomas (**9421**) to behavior /**3** rather than /1.

---

208. **Vital Status (COC)**

field involved: Vital Status (1 digit long)

This is a simple validity check.

Valid codes are **0** and **1**.

This is one of the rare coded fields which have no code for "unknown". Because this field records the patient's Vital Status as of the Date of Last Contact entered, it is expected that you must know a specific Vital Status.

The field cannot be empty.

Appendix F

U.S. Postal Service Standard Abbreviations

(Street Types and Units)

U.S. Postal Service Standard Abbreviations

Alley	Aly	Curve	Curv	Hill	Hl	Park	Park	Spring	Spg
Annex	Anx	Dale	Dl	Hills	Hls	Parkway	Pkwy	Springs	Spgs
Apartment	Apt	Dam	Dm	Hollow	Holw	Parkways	Pkwy	Spur	Spur
Arcade	Arc	Department	Dept	Inlet	Inlt	Pass	Pass	Spurs	Spur
Avenue	Ave	Divide	Dv	Island	Is	Passage	Psge	Square	Sq
Basement	Bsmt	Drive	Dr	Islands	Iss	Path	Path	Squares	Sqs
Bayoo	Byu	Drives	Drs	Isle	Isle	Penthouse	Ph	Station	Sta
Beach	Bch	Estate	Est	Junction	Jct	Pier	Pier	Stop	Stop
Bend	Bnd	Estates	Ests	Junctions	Jcts	Pike	Pike	Stravenue	Stra
Bluff	Blf	Expressway	Expy	Key	Ky	Pine	Pne	Stream	Strm
Bluffs	Blfs	Extension	Ext	Keys	Kys	Pines	Pnes	Street	St
Bottom	Btm	Extensions	Exts	Knoll	Knl	Place	Pl	Streets	Sts
Boulevard	Blvd	Fall	Fall	Knolls	Knls	Plain	Pln	Suite	Ste
Branch	Br	Falls	Fls	Lake	Lk	Plains	Plns	Summit	Smt
Bridge	Brg	Ferry	Fry	Lakes	Lks	Plaza	Plz	Terrace	Ter
Brook	Brk	Field	Fld	Land	Land	Point	Pt	Throughway	Trwy
Brooks	Brks	Fields	Flds	Landing	Lndg	Points	Pts	Trace	Trce
Building	Bldg	Flat	Flt	Lane	Ln	Port	Prt	Track	Trak
Burg	Bg	Flats	Flts	Light	Lgt	Ports	Prts	Trafficway	Trfy
Burgs	Bgs	Floor	Fl	Lights	Lgts	Prairie	Pr	Trail	Trl
Bypass	Byp	Ford	Frd	Lobby	Lbby	Radial	Radl	Trailer	Trlr
Camp	Cp	Fords	Frds	Lock	Lck	Ramp	Ramp	Tunnel	Tunl
Canyon	Cyn	Forest	Frst	Locks	Lcks	Ranch	Rnch	Turnpike	Tpke
Cape	Cpe	Forge	Frg	Lodge	Ldg	Rapid	Rpd	Underpass	Upas
Causeway	Cswy	Forges	Frgs	Loop	Loop	Rapids	Rpds	Union	Un
Center	Ctr	Fork	Frk	Lot	Lot	Rear	Rear	Unions	Uns
Centers	Ctrs	Forks	Frks	Lower	Lowr	Rest	Rst	Unit	Unit
Circle	Cir	Fort	Ft	Mall	Mall	Ridge	Rdg	Upper	Uppr
Circles	Cirs	Freeway	Fwy	Manor	Mnr	Ridges	Rdgs	Valley	Vly
Cliff	Clf	Front	Frnt	Manors	Mnrs	River	Riv	Valleys	Vlys
Cliffs	Clfs	Garden	Gdn	Meadow	Mdw	Road	Rd	Viaduct	Via
Club	Clb	Gardens	Gdns	Meadows	Mdws	Roads	Rds	View	Vw
Common	Cmn	Gateway	Gtwy	Mews	Mews	Room	Rm	Views	Vws
Corner	Cor	Glen	Gln	Mill	Ml	Route	Rte	Village	Vlg
Corners	Cors	Glens	Glns	Mills	Mls	Row	Row	Villages	Vlgs
Course	Crse	Green	Grn	Mission	Msn	Rue	Rue	Ville	Vl
Court	Ct	Greens	Grns	Motorway	Mtwy	Run	Run	Vista	Vis
Courts	Cts	Grove	Grv	Mount	Mt	Shoal	Shl	Walk	Walk
Cove	Cv	Groves	Grvs	Mountain	Mtn	Shoals	Shls	Walks	Walk
Coves	Cvs	Hangar	Hngr	Mountains	Mtns	Shore	Shr	Wall	Wall
Creek	Crk	Harbor	Hbr	Neck	Nck	Shores	Shrs	Way	Way
Crescent	Cres	Harbors	Hbrs	Office	Ofc	Side	Side	Ways	Ways
Crest	Crst	Haven	Hvn	Orchard	Orch	Skyway	Skwy	Well	Wl
Crossing	Xing	Heights	Hts	Oval	Oval	Slip	Slip	Wells	Wls
Crossroad	Xrd	Highway	Hwy	Overpass	Opas	Space	Spc		

source: *Official U.S. Postal Service Abbreviations* --http://www.usps.com/ncsc/lookups/abbreviations.html#suffix

Appendix G

Facility Codes for fields

"Institution Referred From"

and

"Institution Referred To"

This Appendix contains MCR codes and ACoS codes for facilities that report (or have reported) cancer cases to the MCR.

Also included are NAACCR codes for other state central registries which may be used for patients referred from or to a facility in another state. These are listed as "facility in Alabama", for example.

Also included are some long-term care facilities, health maintenance organizations and other entities which report/ed cases to the MCR.

Also included are some entities for which we obtained an ACoS code that do not report to the MCR.

The facility names in this table are not the formal names of the institutions. They are just short "in-house" names.

MCR Codes or the standard ACoS/NAACCR codes may be used for case reports sent to the MCR. Not all facilities have a known ACoS code.

Facility (short name)	MCR Code	ACoS Code
Aberjona Nursing Ctr	3848	
Addison Gilbert	2016	
Amesbury Hospital	2078	0006140030
Anna Jaques	2006	0006141500
Annemark NH	3864	
Apple Valley NH	3915	
Athol Memorial	2226	0006140065
Baystate Med Ctr	2339	0006141955
Bear Hill Nursing Ctr	3861	
Beaumont Rehab Northbridge	3160	
Beaumont Rehab Westboro	3865	
Belmont Mnr Nurs Rehab	3208	
Berkshire Med Ctr	2313	0006141705
Beth Israel Deaconess	2069	0006140170
Beverly	2007	0006140130
Boston Med Ctr	2084	0006140440
Boston Regional Med Ctr	2060	0006141350
Braintree Rehab	2333	
Brewster Senior Care	3837	
Brigham & Women's	2341	0006140218
Brockton	2118	0006140630
Brook Farm Rehab & Nurs Ctr	3539	
Cambridge	2108	0006140730
Cambridge Health Alliance		0010000145
Cape Cod	2135	0006141130
Caritas Good Samaritan	2101	0006140631
Caritas Norwood (Southwood)	2114	0006141630
Carney	2003	0006140255
Charlene Mnr	3894	
Chelsea/Jewish NH	3559	
CHEM Ctr for Radiation	1340	0006143098
Children's Hospital (DFCI)	2139	0006140270
Choate Health System Caufield Ctr	2089	0006140045
Christopher House Worc	3693	
Clinton	2126	0006140840
Cooley Dickinson	2155	0006141570

Facility (short name)	MCR Code	ACoS/NAACCR Code
Cozy Corner NH	3039	
Crawford SN & Rehab	3716	
Ctr for Extended Care	3024	
Ctr for Optimum Care	3905	
Ctr for Rehab & Nurs Care	3069	
Dana-Farber	2335	0006140583
Deaconess Nashoba	2298	0006140090
Den Mar NH	3297	
Don Orione NH	3479	
D'Youville Senior Care	3176	
Eastpointe Nursing Care Ctr	3939	
Elihue White NH	3414	
Elizabeth Seton Residence	3853	
Ellis Nursing & Rehab	3793	
Emerson	2018	0006140850
facility in Alabama	8037	00003700
facility in Alaska	8091	00009100
facility in Arizona	8087	00008700
facility in Arkansas	8071	00007100
facility in California	8097	00009700
facility in Colorado	8083	00008300
facility in Connecticut	8007	00000700
facility in Delaware	8017	00001700
facility in District of Columbia	8022	00002200
facility in Florida	8035	00003500
facility in Georgia	8033	00003300
facility in Hawaii	8099	00009900
facility in Idaho	8081	00008100
facility in Illinois	8061	00006100
facility in Indiana	8045	00004500
facility in Iowa	8053	00005300
facility in Kansas	8065	00006500
facility in Kentucky	8047	00004700
facility in Louisiana	8073	00007300

Facility (short name)	MCR Code	ACoS/NAACCR Code
facility in Maine	8002	00000200
facility in Maryland	8021	00002100
facility in Michigan	8041	00004100
facility in Minnesota	8052	00005200
facility in Mississippi	8039	00003900
facility in Missouri	8063	00006300
facility in Montana	8056	00005600
facility in Nebraska	8067	00006700
facility in Nevada	8085	00008500
facility in New Hampshire	8003	00000300
facility in New Jersey	8008	00000800
facility in New Mexico	8086	00008600
facility in New York	8011	00001100
facility in N. Carolina	8025	00002500
facility in N. Dakota	8054	00005400
facility in Ohio	8043	00004300
facility in Oklahoma	8075	00007500
facility in Oregon	8095	00009500
facility in Pennsylvania	8014	00001400
facility in Puerto Rico	8101	10100000
facility in Rhode Island	8006	00000600
facility in S. Carolina	8026	00002600
facility in S. Dakota	8055	00005500
facility in Tennessee	8031	00003100
facility in Texas	8077	00007700
facility in Utah	8084	00008400
facility in Vermont	8004	00000400
facility in Virginia	8023	00002300
facility in W. Virginia	8024	00002400
facility in Washington State	8093	00009300
facility in Wisconsin	8051	00005100
facility in Wyoming	8082	00008200
Fairlawn Hosp	2098	0006142320
Fairview	2052	0006141010
Fallon Health Care	5002	
Falmouth	2289	0006140923
Farren Care Ctr	3926	

Facility (short name)	MCR Code	ACoS Code
Faulkner	2048	0006140310
Forestview NH	3904	
Franklin Med Ctr	2120	0006141020
Glen Ridge NH	3919	
Glover Needham	2054	0006141450
Hahnemann Hosp - Boston	2091	0006140340
Harrington Memorial	2143	0006141890
Harvard Vanguard	5001	
Health Alliance	2127	0006141190
Henry Heywood	2036	0006140980
Hillcrest (Berkshire)	2313	
Holy Family	2225	0006141355
Holyoke	2145	0006141110
Hubbard Regional	2157	0006142130
Island Terrace NH	3614	
Jewish NH of Western MA	3772	
Jewish Rehab Ctr	3776	
JML Care Ctr	3917	
Jordan	2082	0006141720
Joseph P. Kennedy Jr. Meml Hosp	2221	0006140610
Lafayette Convalescent	3291	
Lahey Clinic Hosp (Hitchcock)	2342	0006140690
Laurel Ridge NH	3711	
Lawrence F. Quigley Meml Hosp	2827	0006140815
Lawrence General	2099	0006141170
Lawrence Memorial	2038	0006141330
Lemuel Shattuck State Hosp	2821	
Life Care Ctr Attleboro	3942	
Life Care Ctr Auburn	3978	
Life Care Ctr Merrimac Valley	3725	
Lowell General	2040	0006141200
Ludlow Hospital	2160	0006141250
Lutheran Home of Worc	3121	
Malden	2041	0006141280
Marian Mnr	3506	
Mariner Health SE	3796	
Marlborough	2103	0006141300

Facility (short name)	MCR Code	ACoS Code
Martha's Vineyard	2042	0006141640
Mary Lane	2148	0006142100
Maryann Morse NH	3936	
Mass. Eye & Ear (MGH)	2168	0006140420
Mass. General	2168	0006140430
Mass. Respiratory	2282	
Med Ctr of Central Mass/Umass	2841	
Melrose-Wakefield	2058	0006141340
Mercy	2149	0006141940
Merrimac Valley	2131	0006141080
MetroWest	2020	0006140960
Milford-Whitinsville	2105	0006141395
Milton	2227	0006141410
Morton	2022	0006142000
Mt. Auburn	2071	0006140780
Nantucket Cottage	2044	0006141430
New England Baptist	2059	0006140460
New England Medical Center	2299	0006140465
Newton-Wellesley	2075	0006141530
Noble	2076	0006142200
North Adams	2061	0006141560
North Shore Cancer Ctr/Salem	2014	0006141820
North Shore Children's Hosp	2113	0006141810
Norwell Knoll NH	3722	
Oak Hill Nurs & Rehab	3621	
Odd Fellows Home	3126	
Olympus Specialty Hosp	2223	
Oostermans Rest Home	1241	
Penacook Place	3739	
Prescott House	3839	
Providence Extended Care	3726	
Quaboag on the Common NH	3144	
Quincy	2151	0006141740
Saints Memorial	2029	0006141220
Sancta Maria Nursing Facility	2213	0006140785
Shrewsbury Nurs Rehab Ctr	3694	
Shriners Hosp for Crippled Children	2152	0006141950

Facility (short name)	MCR Code	ACoS Code
Soldiers Home Holyoke	2828	0006141122
Somerville	2001	0006141860
South Shore	2107	0006141900
Southcoast Charlton	2337	0006140905
Southcoast St. Luke's	2010	0006141460
Spaulding Rehab	2321	
St. Anne's Hosp	2011	0006140900
St. Elizabeth's	2085	0006140620
St. Margaret's Hosp for Women	2065	0006140520
St. Patricks Mnr	3699	
St. Vincent's	2128	0006142350
Sturdy Memorial	2100	0006140080
Sunny Acres NH	3170	
Sweet Brook Care Ctr	3080	
Tewksbury State Hosp	2825	
Tobey	2106	0006142110
UMass Medical Center/Memorial	2841	0010000086
Union Atlanticare	2073	0006141260
VA Healthcare System (Boston)	2988	0010000090
Valley Cancer Ctr		0010000019
Waltham	2067	0006142090
Westridge Healthcare Ctr	3376	
Whidden	2046	0006140880
Willow Mnr	3701	
Willowood of N. Adams	3013	
Winchester	2094	0006142280
Winchester Nursing Ctr	3828	
Wing Memorial	2181	0006141660
Winthrop Hospital	2013	0006142290
Woburn Nursing Ctr	3207	
Woodlawn Nursing Rehab	3340	

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