SECTION VI - FOLLOW-UP INFORMATION

FIRST RECURRENCE

Beginning with 2007 diagnoses and the 2007 MP/H Manual rules, there should no longer be differences between hospital registries and the MCR on which recurrences are abstracted as new primaries. If everyone follows the MP/H rules successfully, then the following two First Recurrence fields will probably no longer be needed by the MCR as of 2007, and we will assess whether we do still need them by 2008. See the **REPORTABILITY** section (pages 8-10) for the situations in which a cancer recurrence is reportable to the MCR.

Rules for pre-2007 diagnoses follow:

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.

Type of First Recurrence

NAACCR Version 11.1 field "Recurrence Type--1st", Item 1880, columns 1353-1354

Use the highest applicable code number. Only the following codes are reportable to 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 11.1 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, corresponding to the disease coded in Type of First Recurrence. Use MMDDCCYY format. Estimate the recurrence diagnosis date if necessary. If an unsuspected invasive recurrence of a non-invasive cancer is found on autopsy after two months, record **00000000**.

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FOLLOW-UP INFORMATION cont.

Date of Last Contact

NAACCR Version 11.1 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. For an autopsy-only case, this field should still record the date of death (not necessarily the autopsy date).

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 11.1 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 11.1 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 11.1 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 does 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.

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SECTION VII - CASE ADMINISTRATION / METADATA

Date Case Completed

NAACCR Version 11.1 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 via the CIMS Satellite system, please fill in the date on which you finished abstracting the case.

Date Case Report Exported

NAACCR Version 11.1 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 11.1 field "Vendor Name", Item 2170, columns 1204-1213

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 11.1 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 (such as other state registries) may contain unexpected code types. Your data system probably fills these fields automatically.

Record Type

NAACCR Version 11.1 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. We will let you know when we are able to routinely accept and process **M** records.

NAACCR Record Version

NAACCR Version 11.1 Item 50, column 19

This field specifies the NAACCR layout version of the record being received. The appropriate code for Version 11 or 11.1 records is **B**.

Deleted: The MCR accepts only records in Version 10, 10.1 or 10.2 at this time.

Deleted: these versions is **A**. When we accept

Deleted: , the code will be

Morphology Coding System -- Current

NAACCR Version 11.1 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 11.1 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.

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Coding System for EOD

NAACCR Version 11.1 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 11.1 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 later records is **08** (for *FORDS* Manual codes).

Receipt of code **07** (revised *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 11.1 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 later records are:

ROADS Manual codes (1998 revisions and later updates)	**07**
FORDS Manual codes	**08**

Treatment Coding System -- Current

NAACCR Version 11.1 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 all diagnosis years is now **06** (for *FORDS* Manual codes).

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