CCARM

Cancer Collection and Reporting Manual

Effective with 1/1/2026 Diagnoses

North Carolina Central Cancer Registry
State Center for Health Statistics
Division of Public Health
Department of Health and Human Services
1908 Mail Service Center
Raleigh, NC 27699-1908
www.schs.state.nc.us

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This document details the cancer reporting guidelines, casefinding requirements for identifying reportable cancers and the data item collection requirements for reporting to the North Carolina Central Cancer Registry. The North Carolina Central Cancer Registry is charged with maintaining a high-quality database of usable, timely, complete, and accurate cancer data for every reportable case of cancer in the state of North Carolina. These guidelines have been established to achieve and maintain this objective.

All reporting facilities MUST adhere to these guidelines for cancer data reporting.
The instructions and codes in this manual take precedence over all previous instructions.
All data items listed in the CCARM are considered required and must be coded as defined.

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Overview

The North Carolina Central Cancer Registry (N.C. CCR) is a branch of the North Carolina State Center of Health Statistics (SCHS) within the Division of Public Health, Department of Health & Human Services (DHHS).

The CCR was founded by law as a statewide, population-based cancer registry in 1945 through the General Assembly Statute Article 7, Chronic Disease, Part 1, Cancer, 130A-205 to 130A-215 with the mission to "compile, tabulate and preserve statistical, clinical and other reports and records relating to the incidence, treatment and cure of cancer." [1] The N.C. CCR is also charged with providing assistance and consultation for public health work. Legislation and administrative rules have been passed in pursuant years clarifying roles and activities regarding the N.C. CCR's responsibilities to Federal government legislation, State legislation and health care facility and health care provider responsibilities.

For instance, in 1949, all health care facilities and health care providers that detect, diagnose, or treat cancer were required by law to report all cases of cancer diagnosis to the N.C. CCR within six months of diagnosis. Failure to report could lead to site visits and penalties. Legislation regarding confidentiality of records was passed in 1981 indicating "clinical records or reports of individual patients shall be confidential and shall not be public records open to inspection."[2] Authority was provided to use these records and reports for medical research, including under what conditions the records could be released. This same legislation included immunity of persons who report incidences of cancer to the N.C. CCR, making them immune from civil or criminal liability that might be imposed otherwise. In 1985, new legislation with appropriation allowed the N.C. CCR to negotiate with N.C. hospitals, help hospitals establish registries, and hire N.C. CCR staff.

We refer to 1990 as the reference date of the N.C. CCR because this is the year that statewide data collection began. Administrative codes were passed that built upon the authority given in 1945 (and pursuant amendments) and identified and clarified the responsibilities of the N.C. CCR. See Title 10A – Health and Human Services, Chapter 47 – Information Services, Subchapter B Cancer Registry (aka: 10A NCAC47B .0101 GENERAL). Included in the 1990 legislation is more detailed information on reporting structure, definitions, confidentiality, reporting of cancer, cooperation of the N.C. CCR with health facilities, release of N.C. CCR data for research and assistance, consultation for public health work and failure by health care facilities/providers to report.

Funding and partnership with the Centers for Disease Control and Prevention (CDC) began in 1992 when Federal law established the National Program of Cancer Registries (NPCR) through the Cancer Registries Amendment Act. The NPCR, administered by the CDC, was created to collect data on the occurrence of cancer, the type, extent, location of the cancer and the type of initial treatment. In 1995, the new CDC initiative provided standardization of data, collaboration and multi-state studies and additional funding. The N.C. CCR receives funding support and aligns itself with the education and reporting standards required by the NPCR as part of its grants.

In 1999, new legislation clarified that all health facilities (including physician offices, laboratories, clinics, etc.) must report all eligible cancer cases and included specified monetary penalties for not reporting those cases. 2004 legislation included the mandatory collection of benign and borderline tumors of the brain and central nervous system. The N.C. CCR had requested data collection of these tumors since the early 1990's, however, the Benign Brain Tumor Cancer Registries Amendment Act, public law 107-260 made the collection of benign and borderline intracranial and CNS tumors a requirement by all central cancer registries in the United States.

HOUSE BILL 399:

To support the N.C. CCR with the NPCR mandate for electronic reporting, N.C. House Bill #399 was signed by the Governor and became effective October 1, 2013. This bill supports the federal grant standards that require electronic reporting of cancer diagnosis and treatment to central cancer registries to increase efficiency and make cancer information available more quickly. The changes to the bill specific to the N.C. CCR are underlined below.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013
HOUSE BILL 399
Committee Substitute Favorable 4/3/13
Committee Substitute #2 Favorable 4/24/13
Fourth Edition Engrossed 4/30/13
Senate Health Care Committee Substitute Adopted 5/29/13
Senate Judiciary II Committee Substitute Adopted 7/1/13

Short Title: Amend Laws Pertaining to DHHS.-AB (Public)
Sponsors:
Referred to:

March 21, 2013
A BILL TO BE ENTITLED
AN ACT To make CHANGES requested by the department of health and human services TO LAWS PERTAINING TO CHILD ABUSE, NEGLECT, AND DEPENDENCY; MEDICAID; AND PUBLIC HEALTH.
The General Assembly of North Carolina enacts:

SECTION 9. G.S. 130A-209(a) reads as rewritten:
"§ 130A-209. Incidence reporting of cancer; charge for collection if failure to report.
(a) ~~All~~ By no later than October 1, 2014, all health care facilities and health care providers that detect, diagnose, or treat cancer or benign brain or central nervous system tumors shall submit by electronic transmission a report to the central cancer registry each diagnosis of cancer or benign brain or central nervous system tumors in any person who is screened, diagnosed, or treated by the facility or provider. The electronic transmission of these reports shall be in a format prescribed by the United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Program of Cancer Registries. The reports shall be made within six months ~~of~~ after diagnosis. Diagnostic, demographic and other information as prescribed by the rules of the Commission shall be included in the report."

PART IV. EFFECTIVE DATE
SECTION 10. This act becomes effective October 1, 2013.

For more information regarding N.C. CCR Legislation:

- N.C. General Statutes: https://www.ncleg.gov/Laws/GeneralStatutes
- N.C. Administrative Codes: http://ncrules.state.nc.us/ncac.asp
- N.C. General Assembly: www.ncleg.net/Sessions/2013/Bills/House/HTML/H399v10.html

Standard Setting Organizations:

Other Standard Setting Organizations that provide guidance and direction to the N.C. CCR are listed below.

- American Cancer Society (ACS)
- American College of Surgeons (ACoS)
- American Joint Committee on Cancer (AJCC)
- Centers for Medicare and Medicaid Services
- Central Brain Tumor Registry of the United States (CBTRUS)
- Council of State and Territorial Epidemiologists
- Indian Health Service
- International Association of Cancer Registries
- International Union Against Cancer
- National Cancer Institute (NCI)
- National Cancer Registrars Association (NCRA)
- National Coordinating Council for Cancer Surveillance
- National Governors Association
- National Program of Cancer Registries (NPCR)
- North American Association of Central Cancer Registries (NAACCR)
- Surveillance, Epidemiology and End Results (SEER)

For more information regarding the NPCR Legislation:

https://www.cdc.gov/national-program-cancer-registries/index.html

CDC - Cancer Registries Amendment Act: Congress established the National Program of Cancer Registries (NPCR) in 1992 by enacting the Cancer Registries Amendment Act**,** Public Law 102-515**.**

The Congressional Mandate Public Law (1998 Code) authorizes the Centers for Disease Control and Prevention (CDC) to provide funds to states and territories to

- Improve existing cancer registries.
- Plan and implement registries where they do not exist.
- Develop model legislation and regulations for states to enhance the viability of registry operations.
- Set standards for data completeness, timeliness, and quality.
- Provide training for registry personnel.
- Help establish a computerized reporting and data processing system.

[1, 2] http://ncleg.net/enactedlegislation/statutes/html/bysection/chapter_130a/gs_130a-208.html

Reporting Standards

STATE LAW

The North Carolina Central Cancer Registry (N.C. CCR) operates by state law Authority G. S. 130A: 205; 130A-208 through 130A-213.

FAILURE TO REPORT

The Administrative Code states: "The CCR shall monitor the reporting of health care facilities and providers on a quarterly basis. If a health care facility or provider has failed to report at least 90 percent of its cases within six months of diagnosis, the registry shall notify the facility or provider in writing of that fact within 30 days and the facility or provider shall be given another 30 days, or up to 60 days for good cause shown, to fulfill its reporting requirement."

"If a facility or provider is out of compliance for two consecutive quarters and is not demonstrating progress toward becoming compliant then the State Health Director shall direct the registry to collect the data and shall direct the facility or provider to reimburse the registry for all actual costs expended in order to obtain the data up to $100 per case abstracted."

See *Appendix A* for a copy of the N.C. State Law, House Bill 399 and Administrative Code.

N.C. CCR REFERENCE DATE

The N.C. CCR's reference date is January 1, 1990. The reference date is the start date after which all eligible cases must be included in the registry. This date is a reference point for many standards and activities in the cancer registry. All cases that meet the N.C. CCR's reporting and case eligibility requirements with a diagnosis date of 1/1/1990 or later are to be reported.

CASE SUBMISSION REQUIREMENTS

Abstracting Timeliness

Abstracting for analytic cases must be completed within six months from the date of initial diagnosis and submitted to the N.C. CCR according to the reporting schedule specified below. Non-analytic cases must be abstracted and submitted to the N.C. CCR within six months of first admission to reporting facility.

Required Upload/Submission Frequency

- Facilities that accession 500 or more cases each year are required to upload monthly.
- Facilities that accession less than 500 cases each year are required to upload completed cases according to quarterly call for data schedule but can upload more frequently if desired.
- All facilities, regardless of upload frequency requirements, must meet the abstracting timeliness specified in the minimum reporting schedule.
    - E.g.: Regardless if the facility is required to upload monthly or quarterly, all cases diagnosed (or first seen) in the first quarter of the year must be submitted by October 1 of that same year.

The exception is for incomplete cases on hold because more information is needed before the case can be completed. Every attempt should be made to ensure the case is as complete as possible, including stage and first course of treatment data items, before the case is submitted to the N.C. CCR. Incomplete cases should be reviewed routinely and submitted as soon as the information can be obtained to complete the abstract. Generally, this should not affect most cases.

Quarterly Call for Data/Minimum Reporting Schedule

Cases Diagnosed/1st Seen in the:	Must be Submitted to the N.C. CCR by:
First quarter (January – March)	October 1
Second quarter (April – June)	January 1
Third quarter (July – September)	April 1
Fourth quarter (October – December)	July 1

Required Data Items

All data items listed in the CCARM are required and must be coded as defined for each reportable case.

Abstracted Text

Text is required for all cases. Text that validates all critical data items must be a component of all cases reported to the N.C. CCR. This includes but is not limited to age, sex, race, all dates, primary site, histology, diagnosis date, AJCC TNM Stage, Summary Stage, place of diagnosis, physical exam, x-rays, scans, scopes, surgical procedures, laboratory, and treatment. Text is also used to document the unusual, for example, cases that are rare age, site, or histology combinations, delays in diagnosis and treatment and verification that delayed treatment is planned first course. The purpose of text is to provide a method for validating coded values to ensure high quality data. Complete text requirements and examples are provided in Appendix C.

EDITS

The N.C. CCR edits metafile is a modified version of the basic NAACCR edit metafile. All software vendors have integrated the EDITS engine into their system as their standard automatic edits solution. Data edits verify that only acceptable values are used for codes.

Cases reported to the N.C. CCR must be edit error free and must have passed all edits provided in the N.C. edit metafile. This includes new case files and modified (correction) record files. Files with edit errors will not be loaded and will be considered as not reported. The entire file will be returned to the reporting facility for correction and must be resubmitted after all edit errors are corrected.

Facilities entering cases directly into the N.C. CCR database must clear all edits before the system will allow the case to be released to the CCR. The case is considered reported when it has been released to the CCR. Facilities should contact their N.C. CCR Staff Representative for assistance with this process.

Capturing Complete First Course of Treatment

There may be times when first course treatment information is incomplete at the time of abstracting the case. It is important to continue follow-up efforts to be certain the necessary treatment information is collected and included in the abstract when it is submitted to the CCR as a new case. Incomplete cases are a part of the reporting process, so it is understandable that there will be cases from a particular quarter reported at a later date. Generally, this should only affect a small percent of cases. By the time the case is required to be reported in the quarterly call for data, the type of treatment given and the treatment start date are usually available.

Every attempt should be made to wait until all required information about the first course of treatment is known and can be recorded in the abstract before submitting the case. Utilize the treatment guidelines at your facility (such as the NCCN Treatment Guidelines) to determine the expected or recommended treatment plan. If treatment is indicated, make every effort to confirm the treatment plan and obtain the treatment details before sending that case to the N.C. CCR. If treatment is not indicated, or recommended treatment was not given, then code appropriately in the data (not recommended, contraindicated, refused, etc.) and denote in the text.

Do not wait until the year-end call for data to complete and send all incomplete cases. It is understandable that there will be cases in which obtaining complete treatment information is not possible. Reports should be run routinely on incomplete cases and any necessary follow-up performed throughout the year. When all information that could be obtained has been recorded, mark the case as complete so that it will be sent to the N.C. CCR with the next file transmitted. When all reasonable attempts have been exhausted and the information could not be obtained, then mark the case complete and send it with the next transmission. For cases with a Class of Case code of 00 and non-analytic cases, record as much information about the initial diagnosis, stage and treatment as is available from your routine resources. For non-analytic cases, be sure that any treatment being recorded was part of the planned first course of treatment.

The ENTIRE treatment plan does not have to be COMPLETE to submit the case. The required first course of treatment data items for the N.C. CCR include the type of treatment given and the START date of the treatment. Treatment, such as chemo, may still be ongoing. However, knowing the initial start date and whether the patient received single or multi-agent chemo is sufficient to code the required chemo-related data items. Your software may provide other data items to record additional treatment information. Data items not specified as required to be collected by the N.C. CCR should not delay reporting the case.

Modified Records (also referred to as M, Correction, or Updated Records)

The N.C. CCR database accepts modified (correction) records. If your software can create modified records, then utilize this function to submit corrected or updated information. The purpose of the modified record process is to provide a way for facilities to easily submit corrections to critical data items. Software vendors are provided a list of data items for which corrections are required. If any of these data items are changed after the case has been sent to the CCR, the software will include that case in a modified record file.

Do not use this process to routinely submit information about a case as the abstract is completed over time. Every attempt should be made to ensure the case is complete and includes all stage and first course of treatment information before transmitting the case the first time as a new case. The modified records process should be reserved for submitting corrections to coded data.

Do not submit a missed case in a modified record file. If the CCR requests that a case be resubmitted, submit the case as a new case in the NEW case file.

Do not submit a correction as a new case. This does not effectively notify the CCR of changes and corrections. Such cases will be identified as a duplicate submission and will not be processed.

When uploading files to the N.C. CCR Web Portal, it is important that both the new case file AND the modified file are uploaded. This requires that the upload process be completed twice for each submission to the portal - once for the new case file and once for the modified file. Contact your software vendor for assistance in creating these files. If your software does not have the ability to create modified record files, then your CCR staff representative will work with you to address any facility-specific issues related to data completeness and quality.

Confidentiality

Patient data, medical record, and healthcare facility confidentiality continues to be a concern regarding cancer and other disease reporting. Extreme care must be taken when mailing, faxing, and discussing cases over the phone. E-MAIL (WITHOUT PROPER ENCRYPTION MEASURES) MUST NOT CONTAIN IDENTIFIABLE PATIENT INFORMATION.

Quality Control

Accuracy and consistency are essential components of any hospital cancer program and central registry. The data must be accurate, complete, and timely. Visual editing is conducted at the N.C. CCR on a percentage of all reported cases. The N.C. CCR also conducts audits on quality and completeness of data at randomly selected facilities. These audits are a useful tool to identify consistent reporting problems and supply meaningful training throughout the state on cancer data collection. The goal of the N.C. CCR is to obtain complete reporting of all cancer cases in North Carolina and to exceed the accuracy rate of 95 percent. The N.C. CCR will monitor the completeness of reporting by reviewing monthly case count reports for each facility.

DEATH CLEARANCE CASES

Death clearance is a procedure performed in Central Cancer Registries that uses information recorded on death certificates to identify possible missed cases in the N.C. CCR database. The death data from the N.C. Vital Records department are matched with the N.C. CCR database. In addition, death clearance cases that have not been reported by any facility are matched to the N.C. Hospital Discharge Data set to identify other facilities where that patient may have been seen with a cancer related billing code in the five years preceding the patient's death. These cases are then sent to 1) the facility named as the place of death on the death certificate and 2) the facility where the patient had a cancer related admission. For death certificates where the place of death was not a hospital, Hospice, or nursing home, the physician who signed the death certificate is contacted.

A broader spectrum of reporting criteria applies to these death clearance cases. Every attempt should be made to abstract the case. If there is ANY mention of the patient having cancer (currently or in the past), the case should be reported.

The purpose for the expanded criteria is that with death clearance cases, the most important step is to have a medical practitioner confirm that the patient did indeed have cancer. And if possible, confirm the primary site and diagnosis year. The guidelines for coding the cause of death on a death certificate is different than the rules used to assign the primary site in the cancer registry. The cause of death is assigned by the physician who signed the death certificate. In many cases, this physician is on contract with the facility and may not have in-depth medical knowledge of the patient. As a result, central cancer registries are required to obtain confirmation from a medical practitioner on as many cases as possible to ensure the case is placed in the best possible group for analysis (diagnosis year, primary site, etc.). Even if the patient's cancer was in the past, the fact that cancer is mentioned in the medical record is enough to confirm that this patient did indeed have this cancer at some point in their lifetime. Below are a few guidelines to help determine reportability:

- Missed analytic cases should be a complete abstract including stage and first course of treatment.
- Non-analytic cases are reportable to the CCR. Report cases with a reportable condition regardless of the residence (city/state), disease status, class of case or visit type. For death clearance cases, ALL visit types are considered reportable, including patients seen only in the ER, for lab work only or for radiology only. Non-analytic cases will not affect your CoC/NCDB reporting. The definition for non-analytic takes into consideration the inclusion of death certificate cases.
- If there is ANY mention of the patient having a reportable cancer/condition (currently/active or in the past/history of), report the case. Abstract using all information available in the medical record. It is understandable that many data items may be coded to unknown for non-analytic cases due to lack of information.
- Date of diagnosis: For non-analytic cases, use every clue possible to determine at least the year of diagnosis (e.g., two years ago, recently, etc.). If it is impossible to approximate at least the year of

diagnosis, then record the FIRST encounter date with mention of cancer as the diagnosis date. Text must validate how the diagnosis date was determined. Refer to the section on Coding Dates in the CCARM for more information.
- Cases should be abstracted as soon as possible and included with the next transmission.

Examples of cases that would not be reportable are:
- There is NO mention of cancer anywhere in the medical record.
- The patient did have cancer, but the cancer mentioned is not a reportable cancer/condition.
    - Example: The only cancer mentioned in the medical record is a squamous cell carcinoma of the skin. Since this is not a reportable cancer, it does not need to be abstracted.
- The diagnosis is described using ambiguous terms that do not constitute a diagnosis. Note: These cases often have a definitive statement of cancer on the death certificate. Careful review of the medical record should be done before deeming the case not reportable.

If a DC-identified case is determined not to be reportable due to an ambiguous diagnosis or is otherwise considered non-reportable using the criteria above, a detailed reason must be provided to your CCR staff representative explaining why the case is not reportable. Details of the ambiguous diagnosis from the medical record are necessary for the CCR to resolve the case correctly, including making a final determination if the case should be included in the CCR database. Include additional follow-back resources such as other facilities or physicians mentioned in the record. The CCR staff must conduct further investigation with these other contacts before eliminating the case from the CCR database.

DEATH FILES FOR FOLLOW-UP

The N.C. CCR uploads the complete death file for each year to N.C. CCR Web Portal. These lists include all cancer deaths in the state of North Carolina for the given year. Hospital registries should use these lists to assist with case ascertainment as well as to provide vital status information for follow-up. Missed cases identified from these lists should be abstracted and submitted with the next transmission.

RAPID CASE ASCERTAINMENT (RCA) STUDY PARTICIPATION

The RCA program is a component of the UNC Lineberger Comprehensive Cancer Center. While the RCA program and the N.C. CCR share resources, they are separate entities with separate reporting processes, reporting requirements, and databases. For more information on the RCA program, go to: https://unclineberger.org/rapid-case-ascertainment/

Case Reporting: Cases reported through the participation in an RCA Study do not qualify as reporting those same cases to the N.C. CCR. Cases sent to RCA that are eligible for reporting to the N.C. CCR must also have a complete abstract prepared and reported to the N.C. CCR.

Additional Reporting Requirement: A broader spectrum of reporting criteria also applies to Rapid Case Ascertainment cases. The N.C. CCR links its data with the RCA database to identify cases not reported. The N.C. CCR will then notify the facility of cases they reported to RCA but were not reported directly to the CCR through any other means. To ensure that the N.C. CCR database contains the cases also reported to RCA, **cases identified through this linkage MUST BE REPORTED regardless of residence (city/state), disease status, class of case, or reason for encounter.** This includes specimens only, read either as the primary or the consultative laboratory service provider. The abstract should be completed with all information available. Class of Case 43 has been modified to reflect this RCA reporting requirement.

Summary of 2026 Changes

The following describes the changes to required data items and coding instructions effective for cases diagnosed 1/1/2026 and after. Refer to previous versions of the CCARM for a detailed summary of changes that went into effect in 2025 and earlier. Only the requirements for submission to the N.C. CCR are described in the CCARM. Additional changes required for CoC Accredited Cancer Programs can be found in the STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/ and the NAACCR Implementation Guidelines: naaccr.org/implementation-guidelines/.

ICD-O-3 Histology Revisions

The N.C. CCR follows the reportability indicators specified in the official ICD-O references **unless otherwise specified in the CCARM**. Using the ICD-O references on the NAACCR and SEER websites jointly with the CCARM is required to accurately determine which conditions are reportable and the codes for those conditions. **There are no ICD-O-3 code changes for 2026.** The 2024 Update should be used jointly with the ICD-O-3.2, the Hematopoietic and Lymphoid Neoplasm Database, and the Solid Tumor rules. Table 2 in the ICD-O-3 Implementations Guidelines web page lists all changes for 2024.

Refer to the ICD-O-3 Implementation Guidelines web page for details on the current changes as well as previous years: https://www.naaccr.org/icdo3/.

Refer to Appendix E in the CCARM for a summary of ICD-O-3 Histology Revisions for previous years.

Changes in Reportability

Reportability for cases diagnosed in 2026 is based on the ICD-O Third Edition, Second Revision Morphology (ICD-O-3.2) plus the ICD-O-3.2 updates posted on the NAACCR website.
There are no code changes for ICD-O-3 or changes to Reportability for cases diagnosed in 2026. New and related terms for ICD-O-3 are posted on the NAACCR website. https://www.naaccr.org/icdo3/

Data Item Changes

New Data Items

There are no new SSDIs required by the N.C. CCR. There may be SSDIs and other data items required by the CoC. There is one new data required by the N.C. CCR:

Item #	Section	Item Name	Requirement
225	Patient	Sex Assigned at Birth	Sex Assigned at Birth [225] replaces existing data item Sex [220] for all cases regardless of diagnosis year. Data in Sex [220] will be converted to populate Sex Assigned at Birth [225]. Sex [220] is retired in v26.

Changed Data Items

RX Summ-Surg Prim Site 2023: No site-specific surgery code updates were released for 2026.
Surgery codes and definitions are in Appendix B of the CCARM. Valid values are based on the year of diagnosis. A table is provided at the beginning of Appendix B in the CCARM with each site and the effective year for implementation of the B codes. For cases diagnosed prior to 2023, use RX Summ--Surg

03-2022 [1290] and refer to previous versions of the CCARM, STORE, or the drop-down menus in your software for valid surgery codes for these cases.

The following SSDIs have been revised to reflect changes in clinical management and/or staging and to improve clarity or to address questions that were raised in the various forums. Code changes for SSDIs are applicable to cases diagnosed January 1, 2018, and forward, but registrars are not required to update previously coded information.

Microsatellite Instability (MSI) [3890]	An existing SSDI for the Colon and Rectum (00200) schema. Added to the Corpus Carcinoma and Carcinosarcoma schema (00530). For Corpus Carcinoma and Carcinosarcoma cases diagnosed prior to January 1, 2026, Microsatellite Instability must be left blank.
Schema Discriminator 1 [3926] for Nasopharynx and Oropharynx	Revised to reflect the new names of the schemas and to limit the use of this discriminator with C11.1 to diagnosis years 2018-2024. This field was removed from Nasopharynx V9 (09090) which only includes cases diagnosed on January 1, 2025, or later.
Schema Discriminator 2 [3927] for Oropharynx	Revised to reflect the new names of the schemas and to include the Oropharynx HPV-Associated V9 schema in the validation table Schema ID column.
Percent Necrosis Post Neoadjuvant [3908]	Included in the Bone schemas (00381, 00382, 00382, 00383), will no longer be required by any standard setters as of January 1, 2026.
Oncotype DX Risk Level-Invasive [3906] Oncotype Dx Risk Level – DCIS [3905]	Included in the Breast Schema (00480), will no longer be required by any standard setters as of January 1, 2026.

Retired Data items

Several data items were retired in v26 including the following that may have been collected at some point in the past. Retired means that the data item is not maintained by a standard setting agency and is no longer in the data transmission layout; however, it does not impact the data previously collected and stored in a registry database.

v26 Retired Data Items		
Item #	**Item Name**	**Source of Standard**
3110	Comorbid/Complications 1	CoC
3120	Comorbid/Complications 2	CoC
3130	Comorbid/Complications 3	CoC
3140	Comorbid/Complications 4	CoC
3150	Comorbid/Complications 5	CoC
3160	Comorbid/Complications 6	CoC
3161	Comorbid/Complications 7	CoC
3162	Comorbid/Complications 8	CoC
3163	Comorbid/Complications 9	CoC
3164	Comorbid/Complications 10	CoC
3645	NPCR Derived AJCC 8 TNM Clin Stg Grp	NPCR
3646	NPCR Derived AJCC 8 TNM Path Stg Grp	NPCR
3647	NPCR Derived AJCC 8 TNM Post Therapy Stg Grp	NPCR
1120	Pediatric Stage	CoC
1130	Pediatric Staging System	CoC
1140	Pediatric Staged By	CoC
220	Sex	SEER/CoC

Changes in Treatment Coding Rules

Radiosensitizers

The special instruction for how to code radiosensitizers was deleted from the STORE 2025 and the SEER Program Manual 2025. Trying to determine if a drug was given as a radiosensitizers is no longer a factor when determining how a drug should be coded. Code as the drug as indicated in the SEER*Rx. For example, if chemotherapy is given, code as chemotherapy.

Changing the Drug during Treatment

The physician may change an agent or one of the agents in a combination regimen, to an agent belonging to a different subcategory due to reasons other than disease progression (e.g., patient cannot tolerate the original agent). This now is a continuation of the first course of therapy and does not automatically represent subsequent therapy.

Solid Tumor Rules

The Solid Tumor Rules Reformatting Work Group has implemented the following changes for the 2026 Solid Tumor Rules.

- The Specific Histologies, NOS/NST, and Subtypes/Variants tables have been reformatted from 3 columns to 2. Table notes have been moved to footnotes. Relevant M and H rules that refer to these tables have been updated.
- General Instructions have been reformatted. Redundant instructions from each site group module have been removed and added to the General Instructions.
- Ambiguous terminology for determining histology has been revised by a joint physician and oncology data specialist (ODS) panel. The associated instructions have been updated.
- Rule M10 in the breast site group has been removed, and subsequent rule numbering has been adjusted.

A revision history will be posted along with the manual. New site-specific modules are not planned for 2026.

Hematopoietic and Lymphoid Neoplasms Manual and Database

The Hematopoietic Database was updated to reflect the new terms from the WHO 5th edition. A complete list of these terms can be found in the ICD-O-3 Coding Updates for 2026 https://www.naaccr.org/icdo3/. In addition, the same primaries for histologies 9811-9819 were changed to reflect that all ALL's are the same primary. This was confirmed with a hematopoietic expert.

The manual was also updated with new formatting, updated sections and additional information. See the Hematopoietic Manual for a complete listing of changes.

Summary Stage 2018

Notes and code descriptions for some schemas, including Prostate, have been updated similarly to the EOD fields to improve clarity. Registrars are not required to update previously coded information.

AJCC Version 9 Protocols

Two Version 9 Protocols go into effect with cases diagnosed January 1, 2026, and forward. These Version 9 protocols replace the current AJCC 8th edition chapters for these disease sites.

- Salivary Glands (9017)
    - Major Salivary Glands name changed to Salivary Glands

        - Major Salivary Glands go into effect for 2026+
        - Minor Salivary Glands will go into effect for 2027+
- Oropharynx (HPV-Associated) (9018)
    - The two original Oropharynx chapters were renamed to align with current terminology. The new names are Oropharynx HPV-Associated [8th: 2018-2025] (AJCC ID: 10) and Oropharynx (HPV-Independent) and Hypopharynx (AJCC ID: 11.1). In addition, C11.1 was removed and C10.1 was added for Oropharynx (HPV-Associated) [8th Edition] (AJCC ID: 10) and Oropharynx (HPV-Independent) (AJCC ID: 11.1). C10.1 was removed from the Larynx [8th Edition] (AJCC ID: 13.1).

Refer to the section: Stage of Disease at Initial Diagnosis in the CCARM for a table that lists the staging system and version in effect based on diagnosis year.

Tables to Help Track Implementation Dates

In anticipation that keeping up with the various implementation years may be difficult as surgery codes are converted to B codes and AJCC TNM Chapters are converted to Protocols, two tables were added to the CCARM (starting with the CCARM 2024). This is in addition to Appendix E, which lists major data collection changes for each year. These tables will be maintained as additional sites are converted.

- AJCC TNM Protocols: A table has been added to the Stage of Disease at Initial Diagnosis in Section 1 with the site, protocol version and effective date.
- Surgery Codes: A table has been added to the beginning of Appendix B with the site and the implementation year of the B codes.

For more information on the 2026 changes, refer to the following resources:

- AJCC Cancer Staging System
- Commission on Cancer 2026 STORE Manual
    - CTR Guide to Coding Radiation Therapy Treatments (STORE Appendix R)
- Hematopoietic Manual and Database
- ICD O 3.2 (includes new codes, coding guidelines, and changes for 2024 implementation)
- NAACCR 2026 Implementation Guidelines
- NAACCR Data Standards and Data Dictionary (formerly Volume II)
- SEER Cancer PathCHART ICD-O-3 Site Morphology Validation List
- SEER Program Coding and Staging Manual (includes Summary of Changes)
- SEER Site/Histology Validation List
- Site Specific Data Items (SSDI) and Grade Manual (includes change log)
- Solid Tumor Rules (includes summary and changes)
- Summary Stage 2018 (includes revision history)

Differences in Reporting Requirements between the N.C. CCR and the CoC

The N.C. CCR requires complete abstracting of a few types of cases that the American College of Surgeons Commission on Cancer (ACoS CoC) may not require of its accredited cancer programs. Determination of whether a given condition is reportable to the N.C. CCR is made by the N.C. CCR. North Carolina facilities are legislatively mandated to report any case of cancer meeting the N.C. CCR's definition of reportability, regardless of affiliation or Class of Case.

In general, by following the guidelines and requirements of the CoC, most N.C. CCR reporting requirements will also be met. But there are a few differences. The following summarizes the case eligibility and other reporting requirements that must be done IN ADDITION to the CoC requirements to fully meet the N.C. CCR reporting requirements.

REFER TO SECTION I OF THE CCARM FOR DETAILED INFORMATION ON EACH TOPIC

N.C. CCR Reference Date

The N.C. CCR's reference date is January 1, 1990. The reference date is the start date after which all eligible cases must be included in the registry. This date is a reference point for many standards and activities in the cancer registry. All cases that meet the N.C. CCR's reporting and case eligibility requirements with a diagnosis date of 1/1/1990 or later are to be reported.

Required Data Items

All data items listed in the CCARM are required and must be coded as defined for each reportable case. The following data items are required to be collected in addition to the data items required by the CoC. You should review the coding instructions carefully in the CCARM to understand the data collection requirements for these data items.

- Patient demographics/identifiers
- Summary Stage 2018
- SSDI – Brain Molecular Markers
- Type of Reporting Source
- Casefinding Source
- Cause of Death
- Place of Death -- State
- Place of Death -- Country
- Text (all text fields)
- Text – Usual Occupation
- Text – Usual Industry
- Tobacco Use Smoking Status (eff 2022)
- CoC Accredited Flag
- NPI – Managing Physician

Note: The CCARM is intended for incidence and CoC accredited program facilities. For CoC facilities, additional data items are required to be collected by the CoC that are not specifically required by the N.C. CCR for incidence reporting and therefore are not listed in the CCARM. Data items not listed in the CCARM but are required by the CoC are to also be transmitted to the N.C. CCR. This allows the N.C. CCR to have all information collected by N.C. facilities should it ever be needed. Cancer registry software vendors are notified of this requirement and automatically include these data items in the transmit file. Data items not listed in the CCARM but are included in the transmit file must also pass all edits contained in the N.C. edit metafile.

STORE Manual Data Item Reduction

Effective with the STORE v2021, data items not collected by the NCDB were removed from the STORE. This included most patient identifiers. The following data items are still required by the N.C. CCR. Effective v2026, the patient name fields were added back to the STORE.

Item #	Name	Item #	Name
2300	Medical Record Number	2330	Patient Address (Number and Street) at Diagnosis
2320	Social Security Number	2335	Patient Address at Diagnosis-Supplemental
2230	Last Name (added back in v26)	2350	Patient Address (Number and Street) Current
2240	First Name (added back in v26)	2355	Patient Address Current-Supplemental
2250	Middle Name (added back in v26)	1810	City/Town-Current
161	Race 2	1820	State-Current
162	Race 3	1830	Postal Code-Current (Zip Code)
163	Race 4		
164	Race 5		

Reason for Visit

Because the N.C. CCR requires non-analytic cases to be reported, additional reasons for a visit need to be included in the facility's casefinding efforts. Refer to the class of case definitions for more details. This includes:

- Patients diagnosed at autopsy.
- Patients with a recurrence or progression of a reportable neoplasm.
- Patients with active disease of a reportable neoplasm. Visit to the facility may be for reasons other than management of the neoplasm.
- Review of pathology specimens only in pathology laboratories owned by the facility.
- Death clearance and RCA only cases.

LCIS IS REPORTABLE TO THE CCR

While the CoC made Lobular Carcinoma In Situ of the Breast (LCIS) not reportable, **LCIS IS REPORTABLE TO THE CCR**. Assign Class of Case according to the relationship between the patient and the reporting facility.

PI Rads, BI Rads, LI Rads

Reportability: The American College of Radiology Reporting and Data System (RADS) for Prostate (PI-RADS), Breast (BI-RADS), Liver (LI-RADS), and Lung (Lung-RADS) alone are not reportable. PI-Rads, BI-Rads, LI-Rads, or Lung-RADS confirmed with biopsy or physician statement ARE REPORTABLE.

Note: SEER requires Liver LR-4, LR-5, and LR-M and Prostate PI-RADS Category 4 and 5 to be reported. The NCDB does not require any RADS alone (without statement from a physician or positive biopsy) to be reported. Currently, the NC CCR requirement aligns with the instructions in the STORE 2023 (and later). Any clarifications from the NCDB on this topic will apply to reporting to the CCR as well.

Date of Diagnosis: It is the positive biopsy or physician statement that makes it reportable. If that is the case, then the date of diagnosis will be the date of the positive BIOPSY.

Intraepithelial neoplasia

Case eligibility and reporting requirements for certain sites with intraepithelial neoplasia differ between the CCR and the CoC. All terms listed in the ICD-O-3.2 Annotated Histology List (https://www.naaccr.org/icdo3/) for 8077/2 and 8148/2 are reportable. The exception is for skin (C44), cervix (C53) and prostate (C61) which is NOT reportable.

The following ARE reportable to the N.C. CCR:

- All terms listed in the ICD-O-3.2 Annotated Histology List (https://www.naaccr.org/icdo3/) for 8077/2 and 8148/2 of sites other than skin, cervix and prostate. Refer to the section on Case Eligibility for more examples.
- Vulva (VIN III)
- Vagina (VAIN III)
- Anus (AIN III)
- Laryngeal (LINIII) (C320-C329)
- Squamous intraepithelial neoplasia, grade III (SINIII) of sites other than Cervix and Skin
    - High grade squamous intraepithelial lesion (HSIL) of the vulva and vagina are reportable. HSIL VIN III is reportable. Assign 8077/2. HSIL is a synonym for SINIII for vulva and vagina only.

Consistent with the CoC, the following are also Not Required to be reported the N.C. CCR:

- Carcinoma in situ of the cervix (CIS). Includes:
    - squamous cell carcinoma in situ
    - adenocarcinoma in situ
    - 8483**/2** Adenocarcinoma **in situ**, HPV-associated (C53)
    - 8484**/2** Adenocarcinoma **in situ**, HPV-independent, NOS (C53)
- Intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III)
- Intraepithelial neoplasia grade III (8077/2) of the prostate (PIN III)
- Squamous intraepithelial neoplasia, grade III (SINIII) (8077/2) of the Cervix and Skin only

High grade dysplasia

Effective 1/1/2022: 8210/2 Adenomatous polyp, high grade dysplasia for stomach and small intestines ONLY (C16- & C17-) **IS** reportable to the CCR even though it is NOT reportable to the CoC.

Non-Malignant Primary Intracranial and CNS Tumors

The N.C. CCR has required reporting of benign brain (C71._) and meninges (C70._) since January 1, 1990. For reporting to the N.C. CCR, non-malignant primary intracranial and central nervous system tumors diagnosed on or after January 1, 1990, with an ICD-O-3 behavior code of 0 or 1 ARE reportable. If the date of diagnosis is unknown and the admission date is 01/01/1990 or later, the case is reportable.

Class of Case

The N.C. statutes require facilities to report all patients with active disease with a reportable malignancy. This includes cases that meet the criteria for:

- all analytic class of case categories (00, 10-14 and 20-22).
- certain non-analytic class of case categories, specifically class of case 30-32 and 34-38.

Note: Reporting is encouraged for class of case categories 33 and 40-43. Refer to the class of case definitions for more details.

Staging Requirements by Year of Diagnosis

A complete list of data collection changes based on year of diagnosis can be found in Appendix E. Below is a summary of the staging requirements based on the year of diagnosis:

2004-2014 Collaborative Stage, CS SSFs (SSFs cannot be blank)
2015 Collaborative Stage, SS2000, AJCC TNM 7th Edition, CS SSFs (SSFs cannot be blank)
2016-2017 SS2000, AJCC TNM 7th Edition, CS SSFs (designated SSFs cannot be blank)
2018-present SS2018, AJCC TNM 8th Edition (with chapter revisions and V9 protocols), SSDIs

Important: Assigning Summary Stage and AJCC Stage (all editions) is required for ALL cases. This includes non-analytic cases. If the Summary Stage or any component of the AJCC Stage AT DIAGNOSIS is known, then record in the appropriate data items. If the Summary Stage or any component of the AJCC Stage AT DIAGNOSIS is NOT known, then record the appropriate value for unknown.

Each component of the AJCC stage is important. Even if complete AJCC TNM information is not available in the record, any piece of staging information should be collected and reported. For example, if information to assign the T is available but no information is available on N, the T data item should be completed. Leave the N blank and document the reasoning for the TNM categories assigned in the text.

Summary Stage

SEER Summary Stage is required to be coded for all cases, regardless of class of case or year of diagnosis. Refer to the timeline below for the requirements for collecting Summary Stage based on year of diagnosis. Always check the site-specific Summary Staging guidelines before staging any case.

Year of Diagnosis	Required Manual	Data Item (cannot be blank)
prior to 1/1/2001	SEER Summary Staging Guide 1977 (SS1977)	Summary Stage 1977
1/1/2001 – 12/31/2017	SEER Summary Staging Guide 2000 (SS2000)	Summary Stage 2000
1/1/2018 and after	SEER Summary Staging Guide 2018 (SS2018)	Summary Stage 2018

In Situ/Invasive versus Tis

It is important to distinguish between the morphologic condition of in situ as it is represented in ICD-O behavior codes and Tis as it is defined for the purpose of prognostic staging in the AJCC Cancer Staging Manual. Some morphologic and disease descriptive terms that are invasive in ICD-O or localized in the SEER Summary Staging Manuals are Tis in the AJCC Cancer Staging Manual. Some examples are:

- Paget's disease of the nipple (8540/3) (an "invasive" code in ICD-O-2 and ICD-O-3) *with no underlying tumor* is classified as Tis in AJCC Eighth Edition.
- Lobular Carcinoma in situ (LCIS) is removed from TNM staging in the AJCC 8th Ed but is still reportable and must be abstracted and coded according to SS2018.
- For colon/rectum, "invasion of the lamina propria" (intramucosal) with no extension through the muscularis mucosae into the submucosa is classified as Tis according to AJCC 8th Ed but localized in SS2018.

Coding Dates in the Abstract

DATE OF BIRTH, DATE OF DIAGNOSIS, DATE OF FIRST CONTACT AND DATE OF LAST CANNOT BE BLANK FOR ANY CASE. IF TREATMENT WAS GIVEN, THE TREATMENT START DATE CANNOT BE BLANK.

Make every attempt to code a complete date (YYYYMMDD). Follow back to the physician if needed. For analytic cases, a complete (entire) date must be entered. No part of the date may be left blank. If a complete date cannot be determined, any part of the date that is unknown must be estimated. Refer to

the section on Coding and Estimating Dates in the CCARM for guidance on how to estimate dates and code unknown dates. Text MUST state when a date has been estimated.

Patient Address at Diagnosis

It is important that the Patient Address at Diagnosis reflects where the patient was living at the time of initial diagnosis. This may not be the same address in the patient record or the patient's current address. The abstractor should be mindful of this when reviewing the record and look for any clues that the patient was living elsewhere at the time of diagnosis.

If it was known that the patient was living in another city or state at the time of diagnosis, record as much of that address that is known. Record "UNKNOWN" in the address data item that is not known. The goal is to make every effort to identify as much as possible about where a patient was living at the time of initial diagnosis, especially if they were living at a different address. This is important for studies that look at geographical patterns.

In short, be mindful when reviewing the record and look for clues that the patient may have moved prior to coming to your facility. If there is no indication the patient was living elsewhere at the time of diagnosis, then record the address provided in the medical record.

Capturing Complete First Course of Treatment

Abstractors should wait until all required information about the first course of treatment and stage is known and can be recorded in the abstract before submitting the case. The ENTIRE treatment plan does not have to be COMPLETE to submit the case. The required first course of treatment data items for the N.C. CCR are listed in the CCARM (the type of treatment given and the START date of the treatment). Treatment, such as chemo, may still be ongoing. However, knowing the initial start date and whether the patient received single or multi-agent chemo is sufficient to code the required chemo-related data items.

The following appendices provided in the STORE were NOT added to the CCARM. Refer to the STORE for this information.

- CTR Guide to Coding Radiation Therapy (Appendix R in the STORE)
- Case Studies for Coding Melanoma (Appendix M in the STORE)

Abstracted Text

Text is required for all cases. Text that validates all critical data items must be a component of all cases reported to the N.C. CCR. This includes but is not limited to age, sex, race, all dates, primary site, histology, diagnosis date, AJCC TNM Stage, Summary Stage, place of diagnosis, physical exam, x-rays, scans, scopes, surgical procedures, laboratory, and treatment. Text is also used to document the unusual, for example, cases that are rare age, site, or histology combinations, delays in diagnosis and treatment and verification that delayed treatment is planned first course. The purpose of the text is to provide a method for validating coded values to ensure high quality data.

Complete text requirements and examples are provided in Appendix C.

EDITS

Rigorous data quality and edit standards apply to all cases, regardless of class of case. Cases reported to the N.C. CCR must be edit error free and have passed all edits provided in the current N.C. edit metafile.

Case Corrections and Deletions

It is important for the N.C. CCR to be aware of code changes and corrections to critical data items in the abstract. Software vendors have been notified about which changed data items are to be transmitted to the N.C. CCR. If your software can create a correction (M record) file, it must be uploaded along with your new case file each time you transmit a file to the N.C. CCR.

In addition, if a case is uploaded to the N.C. CCR, and later was deleted from your database, notify your CCR Staff Representative so that it may be deleted from the CCR database as well.

Death Clearance Cases

A broader spectrum of reporting criteria applies to cases identified through the death clearance process. The N.C. CCR links its data with the N.C. death file to identify cases not reported. The N.C. CCR will then notify the facility of cases not reported through any other means. For these cases, if there is ANY mention of the patient having cancer (currently or in the past), the case is to be reported, regardless of class of case, visit type or disease status. The abstract should be completed with all information available.

Rapid Case Ascertainment Cases

A broader spectrum of reporting criteria also applies to Rapid Case Ascertainment cases. The N.C. CCR links its data with the RCA database to identify cases not reported. The N.C. CCR will then notify the facility of cases they reported to RCA but resulted in not being reported directly to the CCR through any other means. To ensure that the N.C. CCR database contains the cases also reported to RCA, cases identified through this linkage are reportable. Cases identified through this linkage MUST BE REPORTED regardless of residence (city/state), disease status, class of case, or reason for encounter. This includes specimens only, read either as the primary or the consultative laboratory service provider. The abstract should be completed with all information available. Class of Case 43 has been modified to reflect this RCA reporting requirement.

Manuals and Coding References

The following references are required to code certain data items. Coding instructions for items from these sources are not reproduced in the CCARM to avoid redundancy and possible conflict when the manuals are updated. For each, use the most current version applicable for the diagnosis year.

2026 Required Coding and Abstracting Manuals

For all cases diagnosed on or after January 1, 2025, the N.C. CCR requires reporting facilities to use the following manuals and resources:

- CCARM 2026: https://schs.dph.ncdhhs.gov/units/ccr/reporting.htm
- ICD-O-3.2 (second revision morphology): https://www.naaccr.org/icdo3/
- AJCC Cancer Staging Manual, Eighth Edition (plus Chapter revisions and Version 9 Protocols): https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/
- Site-Specific Data Item (SSDI) Manual: https://apps.naaccr.org/ssdi/list/
- Grade Manual: https://apps.naaccr.org/ssdi/list/
- SEER Solid Tumor Coding Rules: https://seer.cancer.gov/tools/solidtumor/
- SEER Hematopoietic and Lymphoid Neoplasm Database: https://seer.cancer.gov/tools/heme/
- SEER Summary Stage 2018: https://seer.cancer.gov/tools/ssm/
- SEER*Rx – Interactive Drug Database: http://seer.cancer.gov/tools/seerrx
- SEER ICD-10-CM Casefinding Lists: https://seer.cancer.gov/tools/casefinding/
- CTR Guide to Coding Radiation Therapy Treatment (now available as Appendix R of the STORE manual): https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/cocmanuals/
- Surgery Codes Crosswalk: https://www.naaccr.org/crosswalks-interoperability/
    - These crosswalks are intended to be used for quality control, by registry software vendors, and by data analysts interested in reviewing surgery codes over time. The crosswalks should not be used to directly code the surgery fields.

References

***AJCC Cancer Staging Manual*, 8th ed (plus Chapter revisions and Version 9 Protocols)**
https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/
The AJCC Cancer Staging Manual is used by physicians and health care professionals throughout the world to facilitate the uniform description and reporting of neoplastic diseases. Proper classification and staging of cancer are essential for the physician to assign proper treatment, evaluate results of management and clinical trials, and to serve as the standard for local, regional and international reporting on cancer incidence and outcome.

ACoS STandards for Oncology Registry Entry (STORE)
https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/
Developed by the Commission on Cancer (CoC) of the American College of Surgeons (ACS) for its CoC accredited programs. It defines the data items and coding instructions required for CoC accredited programs.

***Collaborative Stage Data Collection System*, Version 02.05 (cases diagnosed 2004-2017)**
https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/collaborative-staging-schema-v0205/
CS is a group of data items set up by a joint task force including representatives from the American Joint Committee on Cancer (AJCC), Commission on Cancer (CoC), North American Association of Central Cancer Registries (NAACCR), National Cancer Registrars Association (NCRA), National Program of Cancer Registries (NPCR), and Surveillance Epidemiology and End Results Program (SEER) designed to provide a single uniform set of codes and rules for collecting extent of disease and staging information to meet the needs of all of the participating organizations. When CS data items are coded, a computer algorithm allows the generation of the AJCC 6th and 7th Edition TNM and Stage Group, SEER Summary Stage 1977 and SEER Summary Stage 2000.

Grade Manual
https://apps.naaccr.org/ssdi/list/
Ruhl J, Hofferkamp J, et al. (October 2022). Grade Manual. NAACCR, Springfield, IL 62704-4194

The Grade Coding Instructions and Tables (Grade Manual) is the primary resource for documentation and coding instructions for Grade for cases diagnosed on or after January 1, 2018.

***Hematopoietic and Lymphoid Neoplasm Coding Manual (*and Heme Database)**
https://seer.cancer.gov/tools/heme/
Ruhl J, Adamo M, Dickie L, Negoita S. (August 2021). *Hematopoietic and Lymphoid Neoplasm Coding Manual.* National Cancer Institute, Bethesda, MD, 2021.

The Hematopoietic and Lymphoid Neoplasm Coding Manual and Heme DB are designed to help the registrar understand and interpret the information written by pathologists and clinicians. The Heme DB will be updated as needed to ensure that the registrar has the most current information available to interpret and code hematopoietic or lymphoid neoplasms. Use this manual and the corresponding database to abstract and code cases diagnosed January 1, 2010 and forward. Some information for cases diagnosed prior to 2010 is also provided to assist registrars in coding those cases and in making multiple primary decisions.

The rules, guidelines, and the Hematopoietic Database follow the *World Health Organization (WHO) Classification of Tumours of Haematopoietic and Lymphoid Tissues.* Revised 4th ed. Swerdlow SH, Campo E, Harris NL, Jaffe ES, Pileri SA, Stein H, Thiele J, Vardiman JW, eds. WHO Classification of Tumours, Volume 2. IARC Press; 2016.

***International Classification of Diseases for Oncology*, 3rd ed**
ICD-O-3.2 (second revision morphology):
http://www.iacr.com.fr/index.php?option=com_content&view=category&layout=blog&id=100&Itemid=577
Fritz A, Percy C, Jack A, et al (eds). *ICD-O: International Classification of Diseases for Oncology*, 3rd ed. Geneva, World Health Organization: 2000.

Since it was first published in 1976, the International Classification of Diseases for Oncology (ICD-O) has been internationally recognized as the definitive classification of neoplasms. It is used by cancer registries throughout the world to record incidence of malignancy and survival rates, and the data produced are used to inform cancer control, research activity, treatment planning and health economics.

The classification of neoplasms used in ICD-O links closely to the definitions of neoplasms used in the WHO/IARC Classification of Tumours series which are compiled by consensus groups of international experts and, as such, the classification is underpinned by the highest level of scientific evidence and opinion.

SEER*Rx – Interactive Drug Database
https://seer.cancer.gov/tools/seerrx/
National Cancer Institute, Surveillance, Epidemiology and End Results Program, Bethesda MD.

SEER*Rx was developed as a one-step lookup for coding oncology drug and regimen treatment categories in cancer registries. The information in this database is effective for cancer diagnoses made on January 1, 2005 and after.

Site Specific Data Items (SSDI) Manual
https://apps.naaccr.org/ssdi/list/
Ruhl J, Hofferkamp J, et al. (October2022). Site-Specific Data Item (SSDI) Manual. NAACCR, Springfield, IL 62704-4194

The Site-Specific Data Item (SSDI) manual is the primary resource for documentation and coding instructions for site-specific data items introduced in 2018. Information in the SSDI Manual is similar to that provided in the Collaborative Stage v2 (CSv2) Manual Part I, Section II for Site Specific Factors (SSF).

Solid Tumor Coding Rules (MP/H)
https://seer.cancer.gov/tools/solidtumor/
Dickie L., Johnson, CH., Adams, S., Negoita, S. (June 2018). *Solid Tumor Rules*. National Cancer Institute, Rockville, MD 20850.

SEER rules have been the de facto standard for determining the number of primary cancers in the U.S. for both central and hospital-based registries. The *Solid Tumor Rules* contain site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder and malignant and non-malignant brain primaries. A separate set of rules addresses the specific and general rules for all other solid tumor sites. The SEER Solid Tumor Rules guide and standardize the process of determining the number of primary tumors or abstracts to be created. The histology rules contain detailed histology coding instructions.

A rule requiring that an invasive tumor diagnosed more than two months after an in situ tumor of the same site be reported as a subsequent primary was adopted on April 26, 1994, effective with tumors diagnosed in 1995 and later. This rule remains in effect and is incorporated into the current Solid Tumor Rules. The purpose of this rule is to ensure that the case is counted as an invasive case when incidence data are analyzed. This important rule affects how the tumor will be counted in published statistics. With the exception of bladder, *in situ* tumors are not usually included in published incidence rates. Without the reporting of these invasive cancers per the rules, rates, such as invasive breast cancer would be underreported. The CoC, with its emphasis on clinical data, did not adopt this exception to the general rule until the 2007 MP/H rules were implemented. **Be sure to review the site-specific set of the *Solid Tumor Coding Rules* to ensure this scenario is abstracted correctly.**

Summary Stage 2018

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

Ruhl JL, Callaghan C, Hurlbut, A, Ries LAG, Adamo P, Dickie L, Schussler N (eds.) Summary Stage 2018: Codes and Coding Instructions, National Cancer Institute, Bethesda, MD, 2018.

Summary Stage is the most basic way of categorizing how far a cancer has spread from its point of origin. Historically, Summary Stage has also been called General Stage, California Stage, historic stage, and SEER Stage. The 2018 version of Summary Stage applies to every site and/or histology combination, including lymphomas and leukemias. Summary Stage uses all information available in the medical record; in other words, it is a combination of the most precise clinical and pathological documentation of the extent of disease.

SECTION ONE:

Case Eligibility
and
Additional Information for Abstracting

Case Eligibility

Determination of whether a given primary neoplasm is reportable to the N.C. CCR is made by the N.C. CCR. Requirements for reportability for SEER or the NCDB may be different.

The N.C. CCR requires a few types of cases that the American College of Surgeons Commission on Cancer (ACoS CoC) may not require. North Carolina facilities are legislatively mandated to report any case of cancer meeting the N.C. CCR's definition of reportability, regardless of affiliation or Class of Case. Rigorous data quality and edit standards apply to all cases, regardless of class of case.

Definition of Reportable: Case meets the eligibility criteria defined in the CCARM for inclusion in the registry. Reportable cases are cases the registry is required to collect and report to the N.C. CCR. Reporting requirements for the N.C. CCR are established by N.C. CCR. The registry's reportable list must include cases required to be reported to the N.C. CCR.

N.C. CCR REFERENCE DATE

The N.C. CCR's reference date is January 1, 1990. The reference date is the start date after which all eligible cases must be included in the registry. This date is a reference point for many standards and activities in the cancer registry. All cases that meet the N.C. CCR's reporting and case eligibility requirements with a diagnosis date of 1/1/1990 or later are to be reported.

RESIDENCY

The patient's residency, both the current address and the address at diagnosis, is not a factor in determining case eligibility. If the patient and tumor meet the eligibility for inclusion, report the case regardless of residency. Refer to the section on *Patient Address and Residency Rules* for more information on recording the patient's address at diagnosis.

NETWORK CLINICS AND FACILITIES

A network clinic, outpatient center, or physician office belonging to the facility is part of the facility for determining class of case and reportability. This definition is aligned with the Joint Commission accreditation status (or Federal Employer Tax ID (FEIN)) for your hospital/facility. Any services or facilities covered under your Joint Commission accreditation (or Federal Employer Tax ID (FEIN)) are considered part of the reporting facility. This includes patients that are seen only in the clinic/office and never enter the hospital.

The reporting facility is responsible for including reportable cases from these network facilities in their submissions.

VISIT TYPES

Patients with a reportable neoplasm for the following visit types are reportable:

- Inpatients
- Outpatients
- Hospice units
- Long term care
- Patients diagnosed at autopsy

- Patients with a recurrence or progression of a reportable neoplasm
- Patients with active disease of a reportable neoplasm. Visit to the facility may be for reasons other than management of the neoplasm.
- Patients undergoing prophylactic or adjuvant therapy for a reportable neoplasm
- Review of pathology specimens only in pathology laboratories owned by the facility
- Patients seen solely in a clinic, center or office owned by the facility
- Patients seen in stand-alone centers (surgical, radiation therapy, etc.) owned by the facility
- If your facility participates in the diagnosis, staging, treatment, or continuing care for a patient during the first course of treatment, progression of disease or recurrence, then the case must be reported regardless of the Class of Case.
- If any additional studies are conducted at your facility (diagnostic imaging, re-biopsy, sentinel node biopsy, surgical resection or other staging or treatment, etc.), then your facility must report the case regardless of the Class of Case.

The following visit types are not reportable (exceptions apply to death certificate and RCA cases):
- Patients seen only in consultation to provide a second opinion to confirm a diagnosis or treatment plan
- Patients in remission or with no evidence of disease (NED) and are not receiving prophylactic or adjuvant therapy at the reporting facility.

Refer to the class of case definitions for more details.

DIAGNOSTIC CONFIRMATION

The method of diagnosis does not affect reportability. A reportable diagnosis made by a recognized medical practitioner may appear on a variety of medical documentation including, but not limited to:
- Pathology report
- Cytology report
- Imaging report
- Discharge diagnosis
- History and physical
- Other parts of medical record
- Death certificate
- Autopsy report

If the case meets any of the reportability criteria defined in the CCARM, the case must be reported, regardless of method of diagnosis.
- Diagnoses microscopically confirmed by review of cytology or histopathology are reportable.
- Clinically diagnosed cases (not microscopically confirmed) must be reported. Code the case based on the clinical diagnosis of a reportable neoplasm stated by the medical practitioner.
    - Note: A pathology report normally takes precedence over a clinical diagnosis. If the patient has a negative biopsy, the case would not be reported. Exceptions:
        - Patient receives treatment for cancer. Report the case.
        - It has been six months or longer since the negative biopsy, and the physician continues to call this a reportable disease. Report the case.
- Cytology diagnoses that are **positive for malignant cells** is reportable.
- **Urine cytology positive for malignancy** is reportable for diagnoses in 2013 and forward. Code the primary site to C689 in the absence of any other information.

- Exception: When a subsequent biopsy of a urinary site is negative, do not report.
- Do not implement new/additional casefinding methods to capture these cases.
- Do not report cytology cases with ambiguous terminology (see ambiguous terms).

- Positive tumor markers alone are not diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.

  Example 1: The patient has an elevated PSA and the physical examination is negative. The physician documents only that the patient is referred for a needle biopsy of the prostate. The biopsy is positive for adenocarcinoma. The date of diagnosis is the date of the biopsy (do not code the date of the PSA or the date the procedure was dictated or transcribed).

  Example 2: The patient has an elevated PSA and the physical examination is negative. The physician documents that he/she suspects that the patient has prostatic cancer and is referring the patient for a needle biopsy. The needle biopsy is positive, confirming the physician's suspicion of cancer. The date of diagnosis is the date the physician documented that he/she suspects that the patient has prostatic cancer. Note: Positive tumor markers alone are never used for case ascertainment.

ICD-O-3 HISTOLOGY

The N.C. CCR follows the reportability indicators in the official ICD-O references **unless otherwise specified in the CCARM**. Using the ICD-O references on the NAACCR and SEER websites jointly with the CCARM is required to accurately determine which conditions are reportable and the code for that condition. https://www.naaccr.org/icdo3/

- Refer to the Summary of Changes section in the CCARM for histology and behavior code changes affecting reportability for the current year.
- Refer to Appendix E in the CCARM for a summary of histology and behavior code changes for previous years. ***This section includes important information on reportability changes based on the year of diagnosis.***

Beginning with cases diagnosed January 1, 2021, the ICD-O-3.2 is the preferred morphology coding manual. The following manuals must be used jointly to accurately determine case reportability (based on behavior code and diagnosis year) and the final histology and behavior code for each case. It is recommended that these websites be bookmarked and used when abstracting each case.

How to use these references jointly:

1. Review the case eligibility requirements in the CCARM.
2. Review the SEER Hematopoietic/Lymphoid Database or the SEER Solid Tumor Rules (MP/H) – whichever is appropriate based on site and histology.
   a. SEER Heme Database: https://seer.cancer.gov/tools/heme/
   b. SEER Solid Tumor Coding Rules: https://seer.cancer.gov/tools/solidtumor/
3. If the SEER Heme Database or Solid Tumor Rules do not provide the coding instruction, review the current ICD-O-3.2 Coding Guidelines: https://www.naaccr.org/icdo3/. The current ICD-O-3.2 Coding Guidelines must be applied to efficiently use the ICD-O-3.2 Coding Table and current updates.
4. Review the current ICD-O-3.2 Update Table (1 or 2 based on your preference) to determine if the histology is listed and if there is a change (and effective year).

5. If the term is not found in the current Update Table, review the ICD-O-3.2 Coding Table Excel. Search for the term (or key letters/words from the term). Find the code that best matches the term.
6. If not in the Coding Table, look for the term in the ICD-O-3 (purple book or online version).
7. If not in any of the above resources, check SEER SINQ to see if the question has already been asked.
8. If not, submit a question to Ask a SEER Registrar.

Refer to SEER's Appendix E.1 for reportable examples and to the ICD-O-3.2 Updates for new/changed behaviors and terms

BEHAVIOR CODE

- Malignancies with a behavior code of /2 (in situ) or /3 (invasive) in the ICD-O-3, Second Revision Morphology (ICD-O-3.2), are required for all sites. There are a few exceptions noted below.
- If a tumor with an ICD-O-3 behavior code of /0 or /1 is determined to be in-situ or invasive by a pathologist, the case is reportable. Change the behavior code to /2 or /3 as indicated by the pathologist and report the case. (ICD-O-3 Rule F)
- Non-malignant primary intracranial and central nervous system tumors with an ICD-O-3 behavior code of 0 or 1 are reportable.
- "Carcinomatosis" (8010/9) and "metastatic" tumor or neoplasm (8000/6) indicate malignancy and could be indicative of a reportable neoplasm. Review all available information to determine the origin of the carcinomatosis or the origin of the metastases.

SKIN

Not all lesions of the skin are reportable. Review the criteria below carefully to determine if the case should be reported.

Histology

The following specified malignant neoplasms of the skin **ARE REPORTABLE**:

- Cutaneous T-cell lymphoma (9709)
- Dermatofibrosarcoma protuberans, fibrosarcomatous (8832/3)
- Dermatofibrosarcoma, sarcomatous (8832/3)
    - Note: Effective 1/1/2021, the behavior code for the following terms changed from 3 to 1 and is no longer reportable:
        - Dermatofibrosarcoma NOS 8832/1
        - Dermatofibrosarcoma protuberans NOS 8832/1
        - Pigmented dermatofibrosarcoma protuberans 8833/1
- Kaposi sarcoma (9140)
- Malignant melanoma (8720-8790)
- Merkel cell carcinoma (8247)
- Mycosis fungoides (9700)
- Sebaceous adenocarcinoma (8410)
- Sweat gland adenocarcinoma (8400)
- Any other malignant neoplasm of the skin that does not fall into the range of 8000–8110.

Only the following neoplasms, when arising in the skin (C44.0-C44.9), are **NOT REPORTABLE**:
8000 – 8005 Neoplasms, malignant, NOS of the skin

8010 – 8046 Epithelial carcinoma, NOS of the skin
8050 – 8086 Papillary and squamous cell neoplasms of the skin
8090 – 8110 Basal cell carcinomas of the skin
8077/2 Squamous intraepithelial neoplasia III (SIN III) of the skin (site is C44_)

Mucoepidermoid or Genital Sites

The following specified basal and squamous cell carcinomas originating in *mucoepidermoid or genital sites* **ARE REPORTABLE** to the N.C. CCR.

- Report lesions arising in the mucoepidermoid tissue only for:
  - Lip C00.0 - C00.9 (Do not report lesions of the skin of the lip (C44.0))
  - Anus C21.0 (Do not report lesions of the skin of the anus or perianal skin (C44.5))

- Report lesions arising in the mucoepidermoid tissue or in the skin for:
  Note: The skin for these sites in the ICD-O-3 do not have a C44_ site code.
  - Labia C51.0 - C51.1 (Includes skin of the labia majora)
  - Clitoris C51.2
  - Vulva C51.8 – C51.9 (Includes external female genitalia of the vulva)
  - Vagina C52.9
  - Prepuce C60.0
  - Penis C60.1 - C60.9 (Includes skin of the penis and foreskin)
  - Scrotum C63.2 (Includes skin of the scrotum)

AJCC Stage

Basal and squamous cell carcinomas (8000-8110) arising in the skin were reportable if the AJCC stage group at diagnosis was II, III or IV for cases diagnosed prior to January 1, 2003.

CARCINOMA IN SITU OF THE CERVIX

Carcinoma in situ (CIS) of the cervix (C53) is **NOT** reportable. This includes squamous cell carcinoma in situ and adenocarcinoma in situ of the cervix. Also **Not** reportable:

- 8483**/2** Adenocarcinoma **in situ**, HPV-associated (C53)
- 8484**/2** Adenocarcinoma **in situ**, HPV-independent, NOS (C53)

INTRAEPITHELIAL NEOPLASIA

Case eligibility and reporting requirements for certain sites with Carcinoma in situ (CIS) and intraepithelial neoplasia differ between the CCR and the CoC.

Reportable

Intraepithelial neoplasia stated as high grade, grade II or grade III is reportable. This includes:

- All terms listed in the ICD-O-3.2 Annotated Histology List (https://www.naaccr.org/icdo3/) for 8077/2 and 8148/2 are reportable. The exception is for skin (C44), cervix (C53) and prostate (C61) which is NOT reportable.
- Common Examples (as listed in the SEER Program Coding and Staging Manual) are below. This is not a complete list. If the term meets the definition for code 8077/2 or 8148/2 in the ICD-O-3.2 Annotated Histology List (except for skin (C44), cervix (C53) and prostate (C61)), then it is reportable.

- Anal intraepithelial neoplasia II (AIN II) of the anus or anal canal (C210-C211)
- Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211)
    - High-grade anal squamous intraepithelial neoplasia (ASIN-H) is synonymous with anal intraepithelial neoplasia, grade III (AIN III)
- Biliary intraepithelial neoplasia, high grade (BiiN III) of the gallbladder (C239)
- Conjunctival intraepithelial neoplasia with severe dysplasia, or Grade III; squamous intraepithelial neoplasia Grade II of conjunctiva, or conjunctival intraepithelial lesion (C-MIL)
- Differentiated vulvar intraepithelial neoplasia (VIN) or differentiated exophytic vulvar intraepithelial lesion (DEVIL)
- Endometrioid intraepithelial neoplasia (EIN) (C54.1) 8380/2 is reportable effective 1/1/2021.
  Note: Endometrial intraepithelial carcinoma (EIC) 8380/2 has always been reportable.
- Esophageal intraepithelial neoplasia (dysplasia), high grade or Grade III
- Glandular intraepithelial neoplasia, high grade
- High grade dysplasia of esophagus, stomach, small intestine
- High grade squamous dysplasia of larynx
- High grade squamous intraepithelial lesion (HGSIL) of the anus
- High grade vulvar intraepithelial neoplasia
- Intraductal papillary neoplasm with high grade intraepithelial neoplasia
- Intraepithelial neoplasia, grade III
- Laryngeal intraepithelial neoplasia II (LIN II) (C320-C329)
- Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)
- Lobular neoplasia grade II (LN II)/lobular intraepithelial neoplasia grade II (LIN II) breast (C500-C509)
- Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509)
- Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259)
- Penile intraepithelial neoplasia, grade II (PeIN II) (C600-C609)
- Penile intraepithelial neoplasia, grade III (PeIN III) and squamous cell carcinoma in situ of the penis (C600-C609)
- Squamous intraepithelial neoplasia, grade II excluding cervix (C53_) and skin sites coded to C44_
- Squamous intraepithelial neoplasia III (SIN III) excluding cervix (C53_) and skin sites coded to C44_
    - High grade squamous intraepithelial lesion (HGSIL) of the vulva and vagina are reportable. HGSIL is a synonym for SINIII for vulva and vagina only.
- Vaginal intraepithelial neoplasia II (VAIN II) (C529)
- Vaginal intraepithelial neoplasia III (VAIN III) (C529)
- Vulvar intraepithelial neoplasia II (VIN II) (C510-C519)
- Vulvar intraepithelial neoplasia III (VIN III) (C510-C519)

Use the appropriate site-specific module in the SEER Solid Tumor Rules manual to determine multiple primaries and histology for intraepithelial neoplasia.

Not Reportable

The following are **NOT REPORTABLE:**

- Intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III)
- Intraepithelial neoplasia grade II (8077/2) of the prostate (PIN II)

- Intraepithelial neoplasia grade III (8077/2) of the prostate (PIN III)
- Intraepithelial neoplasia grade III (8077/2) of the perineum (C445) and perianal skin (C445)
- Squamous intraepithelial neoplasia, grade III (SINIII) (8077/2) of the Cervix and Skin

HIGH GRADE DYSPLASIA

Refer to the SEER Solid Tumor Manual for specific histology coding instructions.

Pancreas:

- Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. For neoplasms of the pancreas (C250-C259), the term MCN with high grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive.
- Intraductal papillary mucinous neoplasm with high grade dysplasia (8453/2) of the pancreas is reportable based on imaging alone (Diagnostic Confirmation code 7); histologic confirmation is not required.

The following are reportable for stomach and small intestines ONLY (C16- & C17-) beginning 1/1/2022:

- 8144/2 Intestinal-type adenoma, high grade
- 8210/2 Adenomatous polyp, high grade dysplasia (This IS reportable to the CCR even though it is NOT reportable to the NCDB)
- 8213/2 Serrated dysplasia, high grade

High grade dysplasia of the colorectal sites (C18-C20) and esophagus (C15) is NOT reportable even though it has been designated as in situ (/2) in the latest WHO classification. Also NOT reportable:

- 8211/2 Tubular adenoma, high grade
- 8261/2 Villous adenoma, high grade
- 8263/2 Tubulovillous adenoma, high grade

NON-MALIGNANT PRIMARY INTRACRANIAL AND CNS TUMORS

The N.C. CCR has required reporting of benign brain (C71._) and meninges (C70._) since January 1, 1990. Public law 107-260 extends this requirement to include non-malignant intracranial and CNS tumors (C72._, C75.1-C75.3).

The Benign Brain Tumor Cancer Registries Amendment Act passed both the Senate and the House and was signed into law in October 2002. Public law 107-260 requires the collection of benign and borderline intracranial and CNS tumors. This law became effective and required all states and registries to report non-malignant CNS tumors with cases diagnosed from January 1, 2004 onward.

For reporting to the N.C. CCR, non-malignant primary intracranial and central nervous system tumors diagnosed on or after January 1, 1990, with an ICD-O-3 behavior code of 0 or 1 ARE reportable.

- If the date of diagnosis is unknown and the admission date is 01/01/1990 or later, the case is reportable.
- **"Neoplasm" and "tumor" are reportable terms** for intracranial and CNS because they are listed in ICD-O-3.2 with behavior codes of 0 and 1.
- **"Mass" and "lesion" are not reportable terms** for intracranial and CNS because they are not listed in ICD-O-3.2 with behavior codes of 0 or 1. Note: If the record uses the term "neoplasm" or "tumor"

at any time, the case is reportable. The date of diagnosis is the first date it was described as either a neoplasm or tumor.

Non-malignant **neoplasms and tumors** (ICD-O-3 behavior code of 0 or 1) in the following CNS sites ARE reportable:

- Meninges (C70._) (required as of 1/1/1990)
- Brain (C71._) (required as of 1/1/1990)
- Spinal cord, cranial nerves, and other parts of the central nervous system (C72._)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)
- Juvenile astrocytoma *IS required*. Code as 9421/1 for cases diagnosed 1/1/2023 forward. Code as 9421/3 for cases diagnosed before 1/1/2023. Exception: Site is the optic nerve (C723).

- Benign and borderline tumors of the cranial bones (C410) or peripheral nerves (C47_) are **not reportable**.

AJCC STAGE AND REPORTABILITY

In general, the AJCC Staging Manual does not determine reportability. Rules in the AJCC Staging Manuals are to be used for determining the AJCC TNM stage only. Facilities that report to the N.C. CCR must ensure that cases required to be reported to the N.C. CCR are included, regardless of the requirements specified by other standard setting agencies.

REPORTABLE-BY-AGREEMENT

The Cancer Committee at your facility may require the cancer registry to collect information about tumors that are not required to be reported by the ACoS CoC or the N.C. CCR. Reportable-by-agreement cases that are NOT reportable to the N.C. CCR should NOT be included in the submission files to the N.C. CCR. Cancer registrars should contact their software vendor for instructions on how to exclude these cases from the N.C. CCR submission files.

Example: The Cancer Committee at your facility requires the registry to abstract carcinoma in situ (CIS) of the cervix. These cases are not required by the N.C. CCR and should not be included in submission files.

USING THE AMBIGUOUS TERMINOLOGY LISTS: Use as a Last Resort

There are TWO lists of ambiguous terms provided in the CCARM that need to be used correctly:

1. Ambiguous Terms for Determining Reportability: Use to determine if the case should be abstracted.
2. Ambiguous Terms Describing Tumor Spread: Use to determine tumor spread for staging purposes.

The first and foremost resource for the abstractor for questionable cases is the physician who diagnosed and/or staged the tumor. If the physician is not available, the medical record, and any other pertinent reports (e.g., pathology, etc.) should be read closely for the required information. The purpose of the Ambiguous Terminology lists is to help abstractors make consistent decisions when wording in the patient record is ambiguous with respect to reportability or tumor spread, and no further information is available from any resource. When there is a clear statement of malignancy or tumor spread (i.e., the abstractor can determine malignancy or tumor spread from the resources available), they should not

refer to the Ambiguous Terminology lists. Abstractors should only rely on these lists when the situation is not clear, and the case cannot be discussed with the appropriate physician/pathologist. It is acknowledged that the physician who diagnosed and/or staged the tumor may not be available. As a result, the Ambiguous Terminology lists provided in the CCARM must be used as a "last resort."

AMBIGUOUS TERMS FOR DETERMINING REPORTABILITY

As part of the facility's casefinding activities, all diagnostic reports should be reviewed to confirm whether a case is required to be reported. This includes a review of all pathology and cytology reports. In most cases, a recognized medical practitioner clearly states the patient has cancer.

If the terminology is ambiguous, use the following guidelines to determine if the case is to be reported. The following terms are to be used to determine reportability only. Do not use these terms to determine stage. Refer to the Section: Ambiguous Terms Describing Tumor Spread provided later in this section.

Ambiguous Terms that Constitute a Diagnosis of Cancer:

- Report cases that use the words on this list even if the suffix is different such as "favored" rather than "favor."
- Do not substitute synonyms such as "supposed" for "presumed" or "equal" for "comparable".
- Do not substitute "likely" for "most likely."
- Use all available information first and seek clarification from clinicians whenever possible.
- Do not accession a case when a later resection, excision, biopsy, cytology, or physician's statement proves the ambiguous diagnosis is not reportable.
- There may be ambiguous terms preceded by a modifier, such as "mildly" suspicious. In general, ignore modifiers or other adjectives and accept the reportable ambiguous term.
- If there is no information to the contrary, report a case described as "malignant until proven otherwise." The patient should have further work up to prove or disprove the findings. When additional information becomes available, update as necessary.
- Use text fields to describe the details.

- Apparent(ly)
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing
- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical of

Equivalent to "Diagnostic for" [malignancy or reportable diagnosis]
These phrases are reportable when no other information is available:

- Considered to be [malignancy or reportable diagnosis]
- Characteristic of [malignancy or reportable diagnosis]
- Appears to be a [malignancy or reportable diagnosis]
- Most compatible with [malignancy or reportable diagnosis]
- Most certainly [malignancy or reportable diagnosis]
- In keeping with [malignancy or reportable diagnosis]

Reportable for non-malignant primary intracranial and central nervous system tumors (C70.0–C72.9, C75.1–75.3) only:

- "Tumor" and "neoplasm" are reportable terms. Report the case when any of the reportable ambiguous terms precede either the word "tumor" or "neoplasm".
- "Mass" and "lesion" are not reportable terms because they are not listed in ICD-O-3.2 with behavior codes of /0 or /1.

Examples of Diagnostic Terms:

- The inpatient discharge summary documents a chest x-ray consistent with carcinoma of the right upper lobe. The patient refused further work-up or treatment. Consistent with carcinoma is indicative of cancer.
- The pathology report states suspicious for malignancy. Suspicious for malignancy is indicative of cancer.

Ambiguous Terms that DO NOT Constitute a Diagnosis of Cancer:

Note: Further information may confirm the diagnosis of cancer.

- Cannot be ruled out
- Equivocal
- Potentially malignant
- Questionable
- Rule out
- Likely
- Possible
- Suggests
- Worrisome

Examples of Non-Diagnostic Terms:

- The inpatient discharge summary documents a chest x-ray *consistent with neoplasm* of the right upper lobe. The patient refused further work-up or treatment. Consistent with neoplasm is not indicative of cancer. While "consistent with" can indicate involvement, "neoplasm" without specification of malignancy is not diagnostic except for non-malignant primary intracranial and central nervous system tumors.
- Final diagnosis is *possible* carcinoma of the breast. Possible is not a diagnostic term for cancer.
- A patient was referred to your facility for a CT scan of the chest. The result of the scan was stated to be *worrisome* for carcinoma. Worrisome is not a diagnostic term for cancer. The patient did not return to the reporting facility for diagnostic confirmation or treatment. The physician did not confirm a diagnosis of cancer in the medical record.
- CT report states "mass in the right kidney, highly suspicious for renal cell carcinoma." CT-guided needle biopsy with final diagnosis "Neoplasm suggestive of oncocytoma. A malignant neoplasm cannot be excluded." Discharged back to the nursing home and no other information is available. Do not accession the case. The suspicious CT finding was biopsied and not proven to be malignant. "Suggestive of" is not a reportable ambiguous term.
- Patients with a precancerous or benign tumor, except for non-malignant brain and CNS tumors.
- Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only and do not constitute a diagnosis.

  Equivalent to "Not diagnostic for" [malignancy or reportable diagnosis].
  These phrases are NOT reportable when no other information is available:
  • Highly suspicious for, but not diagnostic of [malignancy or reportable diagnosis]
  • Most compatible with a [non-reportable diagnosis] such as a [reportable diagnosis]

• High probability for [malignancy or reportable diagnosis]

Equivalent to "Differential diagnoses"
• Differential consideration

EXCEPTION for Death Clearance cases:
When a case with non-reportable ambiguous terminology is identified through the Death Clearance process, often it is because a definitive statement of cancer is included on the death certificate. Details of the diagnosis from the medical record are necessary for the CCR to resolve the case correctly. If a Death Clearance case is not reportable due to an ambiguous diagnosis, detailed information MUST be provided to your CCR staff representative explaining why the case is not reportable.

Ambiguous Terms – Specific Scenarios:

Synonymous terms:
- Words or phrases that appear to be synonyms of these terms do not constitute a diagnosis. For example, "likely" alone does not constitute a diagnosis.
- There may be ambiguous terms preceded by a modifier, such as *mildly* suspicious, *strongly* suggestive or *highly* worrisome. Ignore the modifiers or other adjectives. Use the ambiguous term to determine if the case is to be reported.

Ambiguous term precedes a reportable term:
If any of the reportable ambiguous terms precede a word that is synonymous with a reportable in situ or invasive tumor (e.g., cancer, carcinoma, malignant neoplasm, etc.), report the case.

Reportable Example: The pathology report says: Prostate biopsy with markedly abnormal cells that are typical of adenocarcinoma. "Typical of" is an ambiguous term that constitutes a diagnosis. Report the case.

Non-reportable Example: The final diagnosis on the outpatient report reads: Rule out pancreatic cancer. "Rule out" is an ambiguous term that does NOT constitutes a diagnosis. Do not report the case if this is all of the information available as the findings were not definitively stated to be cancer. If the physician or a different report provides a definitive statement, the case is then reportable based on those other statements in the medical record. See next section below for examples.

Reportable and non-reportable ambiguous terminology are used:
Accession the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record.
- Do not accession a case when the original source document used a non-reportable ambiguous term and subsequent documents refer to history of cancer.
    - Example: Report from the dermatologist is "possible melanoma." Patient admitted later for unrelated procedure and physician listed history of melanoma. No further information available, no evidence of treatment for melanoma. Give priority to the information from the dermatologist and do not report this case. "Possible" is not a reportable ambiguous term. The later information is less reliable in this case.
- Accept the reportable term and report the case when there is a single report in which both reportable and non-reportable terms are used.

- Example: Abdominal CT reveals a 1 cm liver lesion. "The lesion is consistent with hepatocellular carcinoma" appears in the discussion section of the report. The final diagnosis is "1 cm liver lesion, possibly hepatocellular carcinoma." Report the case. "Consistent with" is a reportable ambiguous term. Accept "consistent with" over the non-reportable term "possibly."

- Do not report a case when a resection, excision, biopsy, cytology, or physician's statement proves the ambiguous diagnosis is not reportable.
  - Example 1: Mammogram shows calcifications suspicious for intraductal carcinoma. The biopsy of the area surrounding the calcifications is negative for malignancy. Do not report the case.
  - Example 2: CT report states "mass in the right kidney, highly suspicious for renal cell carcinoma." CT-guided needle biopsy with final diagnosis "Neoplasm suggestive of oncocytoma. A malignant neoplasm cannot be excluded." No other information is available. Do not report the case. The suspicious CT finding was biopsied and not proven to be malignant. "Suggestive of" is not a reportable ambiguous term.
  - Example 3: Stereotactic biopsy of the left breast is "focally suspicious for DCIS" and is followed by a negative needle localization excisional biopsy. Do not report the case. The needle localization excisional biopsy was performed to further evaluate the suspicious stereotactic biopsy finding. The suspicious diagnosis was proven to be false.
  - Example 4: Esophageal biopsy with diagnosis of "focal areas suspicious for adenocarcinoma in situ." Diagnosis on partial esophagectomy specimen "with foci of high grade dysplasia; no invasive carcinoma identified." Do not report the case. The esophagectomy proved that the suspicious biopsy result was false.

Suspicious Cytology:
Cytology refers to the microscopic examination of cells in body fluids obtained from aspirations, washings, scrapings, and smears; usually a function of the pathology department.

"Suspicious cytology" means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable on the preceding page. Further investigation for further studies and physician statements should be done on these cases before making a final determination on reportability.

- Report cases with cytology diagnoses that are "**positive for malignant cells"**. In this situation, the diagnosis of malignant cells was not described using an ambiguous term.
- **Urine cytology** "**positive for malignancy"** is reportable. Code the primary site to C689 in the absence of any other information. Exception: When a subsequent biopsy of a urinary site is negative, do not report.
- Do not accession a case based ONLY on suspicious cytology. If the diagnosis from a cytology report is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer. Investigate further. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings. Revised Rule in 2022: The date of diagnosis is the date of the suspicious cytology in this situation.

Ambiguous Terminology Describing Tumor Spread

Summary Stage: Refer to the section on Ambiguous Terminology in the SEER Summary Stage 2018 manual for instructions on using ambiguous terms to assign Summary Stage.

Special Terms for Lymph Node Involvement in Solid Tumors

(Summary Stage 2018 Manual, Code 3: Regional lymph nodes only, Rule 4) For solid tumors, the terms fixed, matted, and mass in the mediastinum, retroperitoneum, and/or mesentery (with no specific information as to tissue involved) are considered involvement of lymph nodes.

For solid tumors, other terms such as palpable, enlarged, visible swelling, shotty or lymphadenopathy should be ignored. If these terms are used and there is no treatment to indicate lymph node involvement, treat the case as having no lymph node involvement.

AJCC TNM Stage: AJCC does not define ambiguous terminology. These terms refer to tumor spread only. If the wording in the patient record is ambiguous with respect to tumor spread, use the following guidelines:

Terms that Constitute Tumor Involvement or Extension		Terms that *Do Not* Constitute Tumor Involvement or Extension
Adherent	Into	Approaching
Apparent(ly)	Onto	Equivocal
Compatible with	Out onto	Possible
Consistent with	Probable	Questionable
Encroaching upon	Suspect	Suggests
Fixation, fixed	Suspicious	Very close to
Induration	To	

Class of Case

Class of Case divides the data into analytic and non-analytic categories based on the involvement of the reporting facility in the care of the patient.

Definition of "staff physician": A staff physician is one who is employed by the facility, is under contract with it, or has routine admitting privileges there.

Analytic cases (Class of Case 00, 10-14 and 20-22)

- Cases diagnosed and/or administered any of the first course of treatment at the accessioning facility after the registry's reference date are analytic.
- A network clinic, outpatient center, or physician office belonging to the facility is part of the facility for determining class of case and reportability. This definition is aligned with the Joint Commission accreditation (or Federal Employer Tax ID (FEIN)) status for your hospital/facility. Any services or facilities covered under your Joint Commission accreditation (or Federal Employer Tax ID (FEIN)) are considered part of the reporting facility. This includes patients that are seen only in the clinic/office and never enter the hospital. The reporting facility is responsible for including reportable cases from these network facilities in their submissions.
- The codes distinguish cases diagnosed in a staff physician's office from those diagnosed initially by the facility, and patients fully treated at the facility from those partially treated by the reporting facility.
- Treatment in a staff physician's office is now considered as "treated elsewhere" because the hospital has no more responsibility over this treatment than it would if the patient were treated in another hospital.

Non-analytic cases (Class of Case 30-38, 40-43, 49, 99)

- Used to identify missed cases that were initially diagnosed and/or treated elsewhere.
- Non-analytic cases are distinguished by whether the patient received care at the facility or did not personally appear there.
- Patients who received care from the facility are distinguished by the reasons a case may not be analytic: diagnosed prior to the registry's reference date, type of cancer that is not required by CoC to be abstracted, consultation, in-transit care and care for recurrent or persistent disease.
- Patients who did not receive care from the reporting facility are distinguished by care given in one or more staff physician offices, care given through an agency whose cancer cases are abstracted by the reporting facility but are not part of it, pathology-only cases and death certificate-only cases.
- Collecting non-analytic cases can be beneficial for the central cancer registry and for the reporting facility. These cases allow facilities to track referral patterns and trends, and to produce reports for screening programs, radiation and oncology departments, administration and support services.

The North Carolina statutes require facilities to report all patients with active disease from a reportable malignancy to the CCR. This includes cases that meet the criteria for any analytic class of case category (00, 10-14 and 20-22) and certain non-analytic class of case categories. More information regarding which non-analytic cases are reportable is described in the table below.

A complete description of all class of case categories can be found in the data item description in Section Two.

Reportable Cases for the Non-Analytic Class of Case Categories:

Cases that meet the criteria for any analytic class of case category (00-22) are required to be reported. The following table provides additional information related to the non-analytic class of case categories.

Class of Case	Definition	Notes from the N.C. CCR
Patient appears in person at reporting facility		
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, staging workup after initial diagnosis elsewhere) EXCEPTION for Consult-only cases: A "consult only" case is a case where the facility provides a second opinion without additional testing. A second opinion can include re-reading pathology slides or re-reading diagnostic imaging studies. Patients seen only in consultation to confirm a diagnosis or treatment plan are NOT required to be reported. However, if you are already abstracting these cases, please submit them to the CCR.	REPORTABLE The CCR does not exempt radiology-only cases from being reportable. The North Carolina statutes specify that if the tumor is "detected, diagnosed, or treated" it should be reported by the facility. Because of the volume of radiology reports, the CCR does not expect every radiology report to be screened. However, if radiology-only cases are identified through other sources (for example, disease index or death clearance activities), then the hospital is required to abstract and submit the radiology-only cases to the CCR. Example: A patient comes into Hospital B from Hospital A because a PET scan is needed to complete tumor staging. Hospital A has already diagnosed a reportable tumor but needs additional work-up that is not available at their facility. The patient undergoes the PET scan and it is positive for malignancy. Hospital B would abstract whatever information was available and report the case as a class of case 30. The text fields would be utilized to indicate the reason for incomplete data. **Refer to Class of Case 43 for an exception for RCA cases.**
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care	REPORTABLE • "In-transit" care is care given to a patient who is temporarily away from the patient's usual practitioner for continuity of care. Abstract as *Class of Case* 31. Example: A patient receives one chemotherapy treatment while visiting the area on vacation. The patient then returns to their usual chemotherapy clinic for the remainder of their treatment. • If a patient begins first course radiation or chemotherapy (see below for oral medications) elsewhere and continues at the reporting facility, and the care is not in-transit, then the case is analytic. Abstract as *Class of Case* 21. In the situations above, the patient received the treatment at the facility. ORAL MEDICATIONS If the facility is monitoring oral medication (such as Tamoxifen for breast cancer) started elsewhere, use the following guidelines to determine if the case should be abstracted: • Patient is now under the care of your facility. Abstract as Class of Case 31.

		• Patient is now under the care of a "staff physician" in an office OWNED (or reported by agreement) by your facility. Abstract as Class of Case 31. • Patient is now under the care of a "staff physician" in an office NOT owned (or reported by agreement) by your facility. This is considered as "treatment elsewhere" and is not reportable. In the situations above, the facility is only monitoring the prescription for oral medication. The treatment was not delivered at the facility.
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence "ACTIVE disease only"	REPORTABLE If there is documentation that the patient has ACTIVE disease, the case must be abstracted and submitted to the CCR. Reportability for a patient with persistent (active) disease is not dependent on whether any treatment, palliative care or other cancer-related services are provided at your facility. It states only that the patient was diagnosed and treated elsewhere and comes to your facility with persistent (active) disease. ACTIVE DISEASE is the determining factor in whether a case is required to be reported. If the patient has active disease, the case must be reported to the CCR. These cases may have very little historical information. Abstract the case based on all information available. Document in the text the reason for incomplete data. Example 1: An elderly patient is admitted for supportive care. The patient receives no treatment at the facility but has documented metastatic disease at admission. This case should be abstracted and submitted to the CCR.
33	Diagnosis and all first course treatment provided elsewhere and patient presents at reporting facility with disease history only. "History only"	NOT REPORTABLE If the patient has only a history of cancer and NO active disease (clinically free of disease), the case does not have to be reported. Example: The history and physical noted history of cancer. The workup showed no evidence of cancer or no workup related to the cancer was done. This case is not reportable. EXCEPTION for Death Clearance cases: **Cases identified by the CCR through the death clearance process MUST BE REPORTED regardless of the residence (city/state), disease status, class of case, visit type or reason for encounter.** For death clearance cases, ALL encounters are considered reportable, including patients seen only in the ER, for lab work only or for radiology only. To reduce the number of cases that must be abstracted during the death clearance process, consider reviewing cases where the patient expired in your facility and cancer is listed as an underlying cause of death as part of your normal casefinding routine. Even if there is no information regarding disease status (active or history only), the case can be reported using all available information in the medical record. Abstracting these cases now may prevent the case from showing up later as a death clearance case requiring follow-back to your facility.

34	Case not required by CoC to be accessioned (i.e.: benign colon tumor) having initial diagnosis AND part or all of first course treatment by reporting facility	REPORTABLE For CoC facilities: Cases required by the CCR but not required by the CoC (e.g., VIN III, VAIN III, AIN III, LIN III) ARE required to be reported to the CCR and can be assigned class of case 34 to keep them out of analytic case counts. For non-CoC facilities: Do not use this code. Use the other class of case categories as appropriate for the case.
35	Case diagnosed before the CoC Reference Date, having initial diagnosis AND all or part of first course treatment by facility	REPORTABLE The reference date for the CCR is 1/1/1990. All eligible cases diagnosed 1/1/1990 or after are reportable. For non-CoC facilities: Do not use this code. Use the other class of case categories as appropriate for the case.
36	Case not required by CoC to be accessioned (i.e.: benign colon tumor) having initial diagnosis elsewhere AND all or part of first course treatment by reporting facility	REPORTABLE For CoC facilities: Cases required by the CCR but not required by the CoC (e.g., VIN III, VAIN III, AIN III, LIN III) ARE required to be reported to the CCR and can be assigned class of case 36 to keep them out of analytic case counts. For non-CoC facilities: Do not use this code. Use the other class of case categories as appropriate for the case.
37	Case diagnosed before the CoC Reference Date, having initial diagnosis elsewhere AND all or part of first course treatment by facility	REPORTABLE The reference date for the CCR is 1/1/1990. All eligible cases diagnosed 1/1/1990 or after are reportable. For non-CoC facilities, do not use this code. Use the other class of case categories as appropriate for the case.
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death	REPORTABLE Autopsy only cases are reportable. The registry should request all autopsy reports each year, screened for reportable tumors and abstracted if the case meets the reportability requirements.
Patient does not appear in person at reporting facility		
40	Diagnosis AND all first course treatment given at the same staff physician office	REPORTING REQUIRED FOR CERTAIN CIRCUMSTANCES The CCR encourages facilities to report cases that meet the criteria for class of case 40-43. These patients do not receive any part of their first course of treatment at the reporting facility. Generally, these cases are not required, but if they are collected for any physician offices, then the cases are required to be sent to the CCR. Notes: • Cases seen in physician offices or clinics owned by the reporting facility (reporting facility owns the medical records or is considered a single entity by the accrediting organization) are to be reported as an analytic case by the reporting facility. • Physician offices not owned by a N.C. hospital are required to report cases not reported by any N.C. hospital.
41	Diagnosis and all first course treatment given in two or more different staff physician offices	
42	Non-staff physician or non-CoC approved clinic or other facility, not part of reporting facility but accessioned by reporting facility for diagnosis and/or treatment by that entity. Example: Hospital abstracts cases from an independent radiation facility.	
43	Pathology report or other lab specimens only (specimen comes to your hospital, but the patient does not) This excludes autopsy only cases (see code 38).	REPORTING PREFERRED/REQUESTED There are instances when cases come to the attention of the hospital by way of its pathology department, but the patient was never admitted to the reporting facility nor is there any available evidence that the patient was diagnosed and/or treated outside the reporting facility by a physician on staff. Many pathology departments, especially at the larger facilities, provide consultation services (e.g.,

		re-read slides). These cases may have very little historical information. Abstract based on all information available. Note in the text explaining the reason for incomplete data. EXCEPTION for Rapid Case Ascertainment (RCA) linkage cases: **Facilities notified of cases identified through the RCA linkage MUST BE REPORTED by that facility regardless of the residence (city/state), disease status, class of case, or reason for encounter.** For these RCA cases, ALL encounters are considered reportable, including specimens only read either as the primary or consultative laboratory service provider.
49	Diagnosis was established by death certificate only.	DO NOT USE. This code is used only by the CCR staff.
99	Unknown if previously diagnosed or previously treated. Previously diagnosed but date unknown.	DO NOT USE. Facilities should be able to determine the relationship the facility had with the patient.

Casefinding

Casefinding is a systematic method of locating all eligible cases. The method of casefinding must include all points of service from which a patient may enter the health care delivery system for diagnostic and/or therapeutic services for the management of cancer. Multiple sources must be used to identify the eligible cases. Casefinding will identify:

- new reportable cases
- cases already abstracted
- cases determined not to be reportable after thorough review.

HIM/Medical Record Disease Indices or Unified Billing System Report

- Every patient record with a reportable ICD-9-CM or ICD-10-CM code must be reviewed to determine whether the case meets N.C. CCR criteria for case reporting. See the Screening Codes section below for the exact codes.
- Reports should include the primary diagnosis and at least the first five secondary diagnoses.
- It is essential that all patient service areas be included in these reports. This includes inpatient visits, outpatient visits, one-day surgery, radiology, long-term care, hospice, etc.

Pathology/Cytology/Autopsy

- All pathology for inpatients, outpatients and ambulatory care patients must be reviewed to determine whether a case is reportable. Most cancer patients will have a biopsy or operative resection performed at some point during the diagnosis, making review of all pathology reports critical for casefinding.
- This includes surgical pathology reports, bone marrow aspirations, needle biopsies and fine needle aspiration biopsies, diagnostic hematology, cytology and autopsy reports.
- Check with the pathology department to see if the department information system can be used to facilitate the review of these reports. Pathology reports must also be reviewed within each reporting facility at least annually to ensure that no cases have been missed.

Radiation Therapy Department

- New patient registration rosters (logs) and radiation therapy summaries are excellent casefinding sources for patients treated with radiation. Unified Billing System Reports may also identify these cases.

Outpatient Departments

- New patient registration rosters for single-day surgery departments, oncology-related service areas (specialty clinics, chemotherapy clinics, etc.), outpatient departments (including diagnostic radiology and laboratory service areas) and emergency rooms are additional casefinding sources for patients seen only in an ambulatory care setting. Unified Billing System Reports may also identify these cases.

Radiology/Nuclear Medicine Department

- New patient registration rosters for patients receiving diagnostic imaging services are an excellent source for identifying new cancer cases.
- This includes MRI, CT scan, PET scan, x-ray, mammogram, etc.

ICD-10-CM Required Screening Codes for Casefinding:

Screening lists are intended to assist in identifying reportable neoplasms in casefinding sources that use ICD-10-CM to codify the diagnoses. These comprehensive lists are intended to aid appropriate staff (IT, Data Management, etc.) in creating the disease index with the required reportable neoplasms and ICD-10-CM codes.

The N.C. CCR requires that the codes provided on the SEER website be used to create the disease index:

- To access the lists online or to download a PDF version of the lists, go to: www.seer.cancer.gov/tools/casefinding.
- Revisions and updates to codes are released annually and posted on the SEER website annually.
- The screening codes posted on the SEER website must be reviewed annually.
- The current list for the current abstracting year must be used.
- Any changes to the screening codes must be incorporated prior to creating the first disease index for the new year.

The current casefinding lists contain two sections: a comprehensive list and a supplementary list.

COMPREHENSIVE Casefinding Code List for Reportable Tumors (REQUIRED CODES)

- The comprehensive list contains the specific codes for reportable neoplasms and cancer treatment related visits.
- All codes contained in this list must be included in the disease index report.
- There must be a 100 percent review of the cases produced on this report.

SUPPLEMENTAL LIST

- The supplementary list contains neoplasm-related secondary conditions for which there should also be a primary diagnosis of a reportable neoplasm.
- The facility should decide as to which of these codes should be routinely screened. The supplementary list can be used to identify visits that were either missed or miscoded or that may provide follow-up information.
- Codes that are not required to be screened routinely can be screened when time allows or when performing casefinding audits to identify missed or incorrectly coded cases.
- Using the supplemental list can increase casefinding for benign brain and CNS, hematopoietic neoplasms, and other reportable diseases.

Stage of Disease at Initial Diagnosis

- If a patient has multiple primaries, stage each primary independently.
- If the stage cannot be determined, then record it as unknown.
- When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If later, the physician identifies which primary has metastasized, update the stage(s) as appropriate.

Stage: Data collection requirements based on year of diagnosis

Staging System, version, and data items required to be collected have experienced extensive changes over the years. Below is a summary of the staging requirements based on year of diagnosis:

1990-2000	SS1977
2001-2003	SS2000
2004-2014	SS2000, Collaborative Stage, CS SSFs
2015	SS2000, Collaborative Stage, CS SSFs, AJCC TNM 7th Edition (CoC Only)
2016-2017	SS2000, CS SSFs, AJCC TNM 7th Edition
2018-2020	SS2018, SSDIs, AJCC TNM 8th Edition
2021+	SS2018, SSDIs, AJCC TNM 8th Edition, AJCC TNM Protocols

AJCC TNM Protocols replace the current AJCC 8th edition chapters for these disease sites. The protocol version and implementation date are listed below:

Protocol Site	Protocol Version	Protocol Effective Date
Cervix Uteri	9	2021+
Appendix	9	2023+
Anus	9	2023+
Brain/Spinal Cord	9	2023+
Vulva	9	2024+
Neuroendocrine Tumors of the Stomach	9	2024+
Neuroendocrine Tumors of the Duodenum and Ampulla of Vater	9	2024+
Neuroendocrine Tumors of the Jejunum and Ileum	9	2024+
Neuroendocrine Tumors of the Appendix	9	2024+
Neuroendocrine Tumors of the Colon and Rectum	9	2024+
Neuroendocrine Tumors of the Pancreas	9	2024+
Thymus	9	2025+
Lung	9	2025+
Diffuse Pleural Mesothelioma	9	2025+
Nasopharynx	9	2025+
Salivary Glands Major Salivary Glands Minor Salivary Glands	9	 2026+ 2027+
Oropharynx (HPV-Associated)	9	2026+

Stage: Data collection requirements based on staging system

- Collaborative Stage:
  - Required from all facilities, for all cases diagnosed 1/1/2004 – 12/31/2015
  - CS data items for these years cannot be blank. This includes analytic and non-analytic cases.
- Summary Stage 2000:
  - Required from all facilities, for all cases diagnosed 1/1/2015 – 12/31/2017
  - SS2000 for these years cannot be blank. This includes analytic and non-analytic cases.
- AJCC TNM 7th Edition (clinical and pathologic):
  - Required from all facilities, for all cases diagnosed 1/1/2016 – 12/31/2017
  - Note: Required from CoC facilities beginning with 1/1/2015 cases.
- CS SSFs:
  - Required from all facilities, for all cases diagnosed 1/1/2004 – 12/31/2017
  - CoC facilities should collect the SSFs required by the CoC. The CoC required SSFs include the subset of SSFs that would be required for reporting to the N.C. CCR.
  - A list of required SSFs for incidence reporting only will be provided to those facilities directly.
  - SSFs for 2004-2015 cannot be blank.
  - SSFs that are required by the N.C. CCR for 2016-2017 cannot be blank.
- Summary Stage 2018:
  - https://seer.cancer.gov/tools/ssm/
  - Required from all facilities, for all cases diagnosed 1/1/2018 and after
  - SS2018 for these years cannot be blank. This includes analytic and non-analytic cases.
- AJCC TNM 8th Edition (clinical and pathologic):
  - https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/
  - Required from all facilities for all cases diagnosed 1/1/2018 and after
  - Incidence facilities will record any mention of TNM (at diagnosis) in the medical record.
- AJCC TNM Version 9 Protocols are required when implemented:
  - Required when implemented. First Version 9 protocol went into effect in 2021.
  - See the table above for sites and implementation dates. Version 9 protocols replace the current AJCC 8th edition chapters for these disease sites.
- SSDIs:
  - https://apps.naaccr.org/ssdi/list/
  - Required from all facilities for all cases diagnosed 1/1/2018 and after
  - CoC facilities should collect the SSDIs required by the CoC and the N.C. CCR.
    - CoC facilities must also collect "Brain Molecular Markers". This SSDI is required by CCR's but not by CoC.
  - A list of required SSDIs for incidence reporting only will be provided to those facilities directly.
  - SSDIs that are not required by the N.C. CCR may be left blank.
- EOD: The N.C. CCR does not require EOD data items at this time.

Staging Systems

AJCC Prognostic (TNM) Stage

AJCC TNM Stage is based on the clinical, operative and pathologic assessment of the anatomic extent of disease and is used to make appropriate treatment decisions, determine prognosis and measure end results. Use the rules in the current *AJCC Cancer Staging Manual* to assign AJCC T, N, M and Stage Group values. The following general rules apply to AJCC staging of all sites.

- Clinical staging includes any information obtained about the extent of cancer before initiation of definitive treatment (surgery, systemic or radiation therapy, active surveillance, or palliative care) or within four months after the date of diagnosis, whichever is shorter, as long as the cancer has not clearly progressed during that time frame. This stage classification is designated as cTNM.
- Pathological staging includes any information obtained about the extent of cancer through completion of definitive surgery as part of first course treatment or identified within 4 months after the date of diagnosis, whichever is longer, as long as there is no systemic or radiation therapy initiated or the cancer has not clearly progressed during that time frame. This stage classification is designated as pTNM.
- Post therapy staging (post-neoadjuvant therapy staging) includes any information obtained about the extent of cancer after completion of neoadjuvant therapy followed by surgery, and the time frame should be such that the post neoadjuvant surgery and staging occur within a time frame that accommodates disease specific circumstances. This stage classification is designated as ypTNM.
- If a patient has multiple primaries, stage each primary independently.
- If the stage group cannot be determined from the recorded categories, then record it as unknown.
- When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If, at a later time, the physician identifies which primary has metastasized, update the stage(s) as appropriate.
- For additional information on AJCC's general staging rules, download Chapter 1: Principles of Cancer Staging from www.cancerstaging.org.

Additional Instructions:

- If pediatric staging is used and AJCC staging is not applied, code 88 for clinical and pathological T, N, and M as well as stage group. If either clinical or pathological staging was applied for a pediatric tumor, enter the appropriate codes and do not code 88.
- Use of code 88:
    - If a site/histology combination is not defined in the AJCC Manual, record code 88 for the clinical and pathologic T, N and M data items as well as the stage group.
    - For in situ tumors that are considered as "impossible diagnoses" in the AJCC manual, record code 88 for the clinical and pathologic T, N and M data items as well as the stage group.

For additional information on the AJCC TNM general staging rules, review Chapter 1: Principles of Cancer Staging from https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/

Site Specific Data Items (SSDI)

- Each SSDI applies only to selected schemas. SSDI fields should be blank for schemas where they do not apply.
- The "Not applicable" code is only used when a data item is appropriate for a schema, but the standard setter does not require collection of the data item.
- For laboratory tests, values for "not applicable" and "unknown" differ based on length of data item; the codes for not applicable ALWAYS end in '8' and the codes for unknown ALWAYS end in '9'.

Summary Stage

Summary Stage uses all information available in the medical record(s). It is based on a combination of clinical and operative/pathological assessment. Summary Stage is required to be coded for all cases,

regardless of class of case or year of diagnosis. Refer to the timeline below for the requirements for collecting Summary Stage based on year of diagnosis.

For cases diagnosed prior to 1/1/2001:
Required Manual: SEER Summary Staging Guide 1977 (SS1977) must be used to stage these cases.
Data Item: Summary Stage 1977
Timing Rule: Include all information available through completion of surgery (ies) in the first course of treatment or within two months of diagnosis in the absence of disease progression, whichever is longer. Prostate cancer diagnoses from 1/1/1996 use the four-month rule.

For cases diagnosed 1/1/2001 – 12/31/2017:
Required Manual: SEER Summary Staging Guide 2000 (SS2000) must be used to stage these cases.
Data Item: Summary Stage 2000
Timing Rule: Include all information available through completion of surgery (ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.
Note: For cases diagnosed 2004-2015, SS2000 is derived when the CS data items are coded.

For cases diagnosed 1/1/2018 and after:
Required Manual: SEER Summary Staging Guide 2018 (SS2018) must be used to stage these cases.
Data Item: Summary Stage 2018
Timing Rule: Include all information available through completion of surgery (ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.
Always check the site-specific summary staging guidelines before staging any case.

Collaborative Stage Data Collection System (CS)
For cases diagnosed 1/1/2016 and after, CS has been retired. CS data items are to be used for cases diagnosed 1/1/2004 through 12/31/2015. It is not to be used for cases diagnosed prior to, or after those dates. For cases diagnosed from 2004-2015, these data items cannot be blank. All required CS data items are required to be completed for all cases and all class of case categories. For non-analytic cases, code the CS items based on the information available at the time the patient was diagnosed.

CS is a “best stage” system that makes use of the most complete information available to stage the tumor. AJCC Stage distinguishes between clinical and pathologic stage. It also has specific rules governing how the components gathered at different times in the process may be combined. The CS algorithm derives a clinical (c) or pathologic (p) descriptor for each of the T, N and M stage components based on the source of information used to validate the most extensive spread of the tumor and uses the components to derive a stage group without reference to the value of the descriptors. Some derived stage groups may involve combinations that are neither clinical nor pathologic according to AJCC rules, so a case that is unstageable for a physician applying AJCC rules may be assigned a Derived AJCC Stage Group value by the CS algorithm. Other cases may involve combinations that do not match either the physician-assigned clinical stage or the pathologic stage.

Because of the differences in the way that the CS algorithm operates and how the AJCC stage assignment rules are made, differences between the derived AJCC value from CS and the directly assigned AJCC stage can occur. Therefore, the values of one stage system should not be used or copied into a different stage system. Use the rules for each stage system to determine the values for each stage system independently.

Ambiguous Terminology Describing Tumor Spread

AJCC does not define ambiguous terminology. These terms refer to tumor spread only. If the wording in the patient record is ambiguous with respect to tumor spread, use the following guidelines:

Terms that Constitute Tumor Involvement or Extension		Terms that *Do Not* Constitute Tumor Involvement or Extension
Adherent	Into	Approaching
Apparent	Onto	Equivocal
Compatible with	Out onto	Possible
Consistent with	Probable	Questionable
Encroaching upon	Suspect	Suggests
Fixation, fixed	Suspicious	Very close to
Induration	To	

Special Terms for Lymph Node Involvement in Solid Tumors

(Summary Stage 2018 Manual, Code 3: Regional lymph nodes only, Rule 4) For solid tumors, the terms fixed, matted, and mass in the mediastinum, retroperitoneum, and/or mesentery (with no specific information as to tissue involved) are considered involvement of lymph nodes.

For solid tumors, other terms such as palpable, enlarged, visible swelling, shotty or lymphadenopathy should be ignored. If these terms are used and there is no treatment to indicate lymph node involvement, treat the case as having no lymph node involvement.

Treatment Plan

The first course of treatment includes all therapy planned and administered by the physician(s) during the first diagnosis of cancer and administered to the patient before disease progression or recurrence. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more. Any therapy administered after the discontinuation of first course treatment is subsequent treatment and is not required to be collected by the N.C. CCR.

A treatment plan describes the type(s) of therapies intended to modify, control, remove or destroy proliferating cancer cells. The documentation confirming a treatment plan may be found in several different sources; for example, medical or clinic records, consultation reports and outpatient records.

- All therapies specified in the physician(s) treatment plan are a part of the first course of treatment if they are actually administered to the patient.
- A discharge plan must be part of the patient's record in a JCAHO-accredited hospital and may contain part or all of the treatment plan.
- An established protocol or accepted management guidelines for the disease can be considered a treatment plan in the absence of other written documentation.
- If there is no treatment plan, established protocol or management guidelines, and consultation with a physician advisor is not possible, use the principle: "initial treatment must begin within four months of the date of initial diagnosis."

Any first course radiation or systemic treatment that acts to kill cancer cells is to be reported as treatment. For example, when total body irradiation (TBI) is given to prepare the patient for a bone marrow transplant (BMT), the TBI acts in two ways. First, it suppresses the immune system to reduce the body's ability to reject the BMT. Second, it contributes to the patient's treatment by destroying cancer cells in the bone marrow, though its use alone would generally not be sufficient to produce a cure. Both the TBI and the BMT should be coded as treatment. The situation is analogous to the use of breast-conserving surgery and adjuvant radiation when the surgery or radiation alone may not be sufficient to produce a cure, though together they are more effective.

If the first course of treatment plan changes due to an improvement in the tumor burden, the added treatment would still be considered first course. An example is palliative chemotherapy/radiation is recommended and administered per the first course treatment plan. Initially resection of primary tumor was contraindicated due to tumor size and location. Follow up imaging shows an improvement in tumor burden and treatment plan changed since tumor is now resectable to include surgery. Even though the primary tumor resection was not noted in the first course of treatment plan, the resection would be captured as first course of treatment since there was no progression of tumor.

Treatment Plan Definitions

Active surveillance/monitoring, deferred therapy, expectant management, watchful waiting: "Active surveillance" is a form of planned treatment for some patients; its use is coded in the *RX Summ–Treatment Status* [1285]. A treatment plan that involves closely watching a patient's condition but not giving any treatment unless there are changes in test results that show the condition is getting worse. May be used to avoid or delay the need for treatments such as radiation therapy or surgery, which can cause side effects or other problems. During this monitoring period, certain exams and tests are done on

a regular schedule. It may be used in the treatment of certain types of cancer, such as prostate cancer, urethral cancer, and intraocular (eye) melanoma. Sources:
Active surveillance: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/active-surveillance
Deferred therapy: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/deferred-therapy
Expectant management: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/expectant-management
Watchful waiting: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/watchful-waiting

Cancer tissue: Proliferating malignant cells; an area of active production of malignant cells. Cancer tissue includes primary tumor and metastatic sites where cancer tissue grows. Cells in fluid such as pleural fluid or ascitic fluid are not "cancer tissue" because the cells do not grow and proliferate in the fluid.

Concurrent therapy: A treatment that is given at the same time as another. Example: Chemotherapy and radiation therapy

Disease recurrence: For solid tumors, see the Solid Tumor Rules and for hematopoietic and lymphoid neoplasms see the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database to determine disease recurrence.

First course of therapy: All treatments administered to the patient after the original diagnosis of cancer in an attempt to destroy or modify the cancer tissue. See below for detailed information on timing and treatment plan documentation requirements.

Hospice: A program that provides special care for people who are near the end of life and for their families, either at home, in freestanding facilities, or within hospitals. Hospice care may include treatment that destroys or modifies cancer tissue. If performed as part of the first course, treatment that destroys or modifies cancer tissue is collected when given in a hospice setting. "Hospice, NOS" is not specific enough to be included as first course treatment.

Neoadjuvant therapy: Systemic therapy or radiation therapy given prior to surgery to shrink the tumor.

No therapy: A treatment option that occurs if the patient, family or guardian refuses treatment, the patient dies before treatment starts or the physician recommends no treatment be given. If the patient refuses all treatment, code "patient refused" (code 7 or 87) for all treatment modalities.

Maintenance treatment: If given as part of the first course of planned care (for example, for leukemia) is first course treatment and cases receiving that treatment are analytic.

Palliative treatment: The World Health Organization describes palliative care as treatment that improves the quality of life by preventing or relieving suffering. Note: Palliative therapy is part of the first course of therapy only when it destroys or modifies cancer tissue. Example: The patient was diagnosed with stage IV cancer of the prostate with painful bone metastases. The patient starts radiation treatment intended to shrink the tumor in the bone and relieve the intense pain. The radiation treatments are palliative because they relieve the bone pain; the radiation is also first course of therapy because it destroys proliferating cancer tissue.

Surgical procedure: Any surgical procedure coded in the data items Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional or Distant Sites.

Treatment: Procedures that destroy or modify primary (primary site) or secondary (metastatic) cancer tissue. Treatment failure: The treatment modalities did not destroy or modify the cancer cells. The tumor either became larger (disease progression) or stayed the same size after treatment.

Treatment Plan for Leukemia

The first course of treatment includes all therapies planned and administered by the physician(s) during the first diagnosis of leukemia.

- Record all remission-inducing or remission-maintaining therapy as the first course of treatment.
- Treatment regimens may include multiple modes of therapy.
- The administration of these therapies can span a year or more.
- A patient may relapse after achieving a first remission. All therapy administered after the relapse is secondary or subsequent treatment and is not required to be collected by the N.C. CCR.

Treatment Timing

Use the following instructions in hierarchical order:

1. Use the **documented** first course of therapy (treatment plan) from the medical record. First course of therapy **ends when the treatment plan is completed** no matter how long it takes to complete the plan unless there is documentation of disease progression, recurrence, or treatment failure.

   Example: Hormonal therapy (e.g., Tamoxifen) after surgery, radiation, and chemotherapy. First course ends when hormonal therapy is completed, even if this takes years, unless there is documentation of disease progression, recurrence, or treatment failure.

2. First course of therapy **ends when there is documentation of disease progression, recurrence, or treatment failure**

   Example 1: The documented treatment plan for sarcoma is pre-operative (neoadjuvant) chemotherapy, followed by surgery, then radiation or chemotherapy depending upon the pathology from surgery. Scans show the tumor is not regressing after pre-operative chemotherapy. Plans for surgery are cancelled, radiation was not administered, and a different type of chemotherapy is started. Code only the first chemotherapy as first course. Do not code the second chemotherapy as first course because it is administered after documented treatment failure.

   Example 2: The documented treatment plan for a patient with locally advanced breast cancer includes mastectomy, chemotherapy, radiation to the chest wall and axilla, and hormone therapy. The patient has the mastectomy and completes chemotherapy. During the course of radiation therapy, the liver enzymes are rising. Workup proves liver metastases. The physician stops the radiation and does not continue with hormone therapy (the treatment plan is altered). The patient is placed on a clinical trial to receive Herceptin for metastatic breast cancer. Code the mastectomy, chemotherapy, and radiation as first course of treatment. Do not code the Herceptin as first course of therapy because it is administered after documented disease progression.

Capturing Complete First Course of Treatment

Abstractors should wait until all required information for the first course of treatment and stage is known and can be recorded in the abstract before submitting the case. The ENTIRE treatment plan does not have to be COMPLETE to submit the case. The required first course of treatment data items for the N.C. CCR are listed in the CCARM (the type of treatment given and the START date of the treatment). Treatment, such as chemo, may still be ongoing. Knowing the initial start date and whether the patient received single or multi-agent chemo is sufficient to code the required chemo-related data items.

Surgery

First course surgery items describe the most definitive (most invasive) type of surgical treatment the patient received from any facility, when it was performed and its efficacy. When no surgical treatment is given, the reason is recorded. Major aspects of surgical care provided by the individual facility are also recorded so that hospital cancer programs can evaluate local patient care.

Individual item descriptions should be consulted for specific coding instructions. In addition, the site-specific surgery codes in Appendix B should be used.

Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year) , *Scope of Regional Lymph Node Surgery* and *Surgical Procedure/Other Site* record three distinct aspects of first course therapeutic surgical procedures that may be performed during one or multiple surgical events. If multiple primaries are treated by a single surgical event, code the appropriate surgical items separately for each primary.

Date of First Surgical Procedure is the date that the first of any of the following procedures were performed as part of the first course of treatment:

- *Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year)*
- *Scope of Regional Lymph Node Surgery*
- *Surgical Procedure/Other Site*.

Additional surgery items augment the information recorded in *Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year).* The items *Date of Most Definitive Surgical Resection of the Primary Site* and *Surgical Margins of the Primary Site* apply to the most definitive (most invasive) first course primary site surgery performed, that is, to the event recorded under *Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year)*. When no surgical procedure of the primary site is performed, the reason is recorded in the item *Reason for No Surgery of Primary Site*.

Radiation Therapy

Effective 1/1/2018: The CoC has developed 24 new data items associated with radiation treatment to update the way radiation treatment and the treatment target volumes are described to better reflect modern nomenclature and practice and to enable patterns of care, comparative effectiveness, clinical guideline concordance and other large database studies. The N.C. CCR does not require all radiation data items required by the CoC. Listed below are the required fields for the N.C. CCR:

Date Radiation Started [1210]
Phase I Radiation Treatment Modality [1506]
Radiation/Surgery Sequence [1380]
Reason for No Radiation [1430]

New Radiation Treatment Phase-specific Data Items

To promote consistency across the clinical and registry community, new "phase" terminology has been adopted, replacing the traditional terms of "regional" and "boost."

- Phase I: The first phase of a radiation treatment. May be commonly referred to as the initial plan.
- Phase II: A subsequent phase. May be referred to as a boost or cone down. A new/subsequent phase begins when there is a change in the target volume of a body site, treatment fraction size, modality or treatment technique. Up to three phases of radiation treatment can now be documented.

Systemic Therapy

Systemic therapy encompasses the treatment modalities captured by the items chemotherapy, hormone therapy and immunotherapy. The systemic therapy items separate the administration of systemic agents or drugs from medical procedures which affect the hormonal or immunologic balance of the patient.

Clarification of Systemic Therapy Terms	
Term	**Definition**
Chemotherapy	Cancer therapy that achieves its antitumor effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.
Hormone therapy	Cancer therapy that achieves its antitumor effect through changes in hormonal balance. This type of therapy includes the administration of hormones, agents acting via hormonal mechanisms, antihormones and steroids.
Immunotherapy	Cancer therapy that achieves its antitumor effect by altering the immune system or changing the host's response to the tumor cells.
Endocrine therapy	Cancer therapy that achieves its antitumor effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient (when the cancer occurs at another site) and, therefore, alter or affect the long-term control of the cancer's growth.
Hematologic transplants	Bone marrow or stem cell transplants performed to protect patients from myelosuppression or bone marrow ablation associated with the administration of high-dose chemotherapy or radiation therapy.

Changes to the classification of some systemic therapies (effective 1/1/2013)

A comprehensive review of chemotherapeutic drugs in SEER*RX was performed and, in keeping with the FDA, the drugs listed in the table below were changed from Chemotherapy to BRM/Immunotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs in the SEER*Rx Interactive Drug Database.

Drug Name(s)	Category for cases diagnosed prior to 1/1/2013	Category for cases diagnosed after 1/1/2013
Alemtuzumab/Campath	Chemotherapy	BRM/Immuno
Bevacizumab/Avastin	Chemotherapy	BRM/Immuno
Rituximab	Chemotherapy	BRM/Immuno

Trastuzumab/Herceptin	Chemotherapy	BRM/Immuno
Pertuzumab/Perjeta	Chemotherapy	BRM/Immuno
Cetuximab/Erbitux	Chemotherapy	BRM/Immuno

Changing the Drug during Treatment
Chemotherapy and hormone therapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more chemotherapy drugs. The physician may change an agent or one of the agents in a combination regimen, to an agent belonging to a different subcategory due to reasons other than disease progression (e.g., patient cannot tolerate the original agent). This is a continuation of the first course of therapy and does not automatically represent subsequent therapy. Use SEER*Rx to determine the classification of the agent.

Systemic agents may be administered by intravenous infusion or given orally. Other methods of administration include the following:

Method	Administration
Intrathecal	Administered directly into the cerebrospinal fluid through a lumbar puncture needle into an implanted access device (for example, Ommaya reservoir).
Pleural/pericardial	Injected directly into pleural or pericardial space to control malignant effusions.
Intraperitoneal	Injected into the peritoneal cavity.
Hepatic artery	Injected into a catheter inserted into the artery that supplies blood to the liver.

Other Treatment
Other Treatment encompasses first course treatment that cannot be described as surgery, radiation or systemic therapy according to the defined data items found in this manual.

This item is also used for supportive care treatment for reportable hematopoietic diseases that do not meet the usual definition in which treatment “modifies, controls, removes, or destroys proliferating cancer tissue.” Treatments such as phlebotomy, transfusions and aspirin are recorded in *Other Treatment* data item for certain hematopoietic diseases and should be coded 1. Consult the most recent version of the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual for instructions for coding care of specific hematopoietic neoplasms in this item.

Palliative Care
Palliative care is provided to prolong the patient's life by controlling symptoms, to alleviate persistent pain or to make the patient comfortable. Palliative care provided to relieve symptoms may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy or other systemic drugs) and/or other pain management therapy. Palliative care is not used to diagnose or stage the primary tumor.

> Example: radiation to bone metastases for prostate cancer to reduce bone pain, which is palliative when there is no expectation that the radiation will effectively reduce the cancer burden.

Palliative care involving surgery, systemic treatment or radiation is also coded as treatment. This treatment qualifies the patient as analytic if it is given as part of planned first course treatment.
Any surgical procedure, radiation therapy and/or systemic therapy that is provided to modify, control, remove or destroy primary or metastatic cancer tissue, is coded in the respective first course of treatment fields. Because these treatments are less aggressive when given for palliation than for treatment, the treatment plan will indicate when they are performed for palliative purposes.

- Record as first course therapy any palliative care that was provided to prolong the patient's life by managing the patient's symptoms, alleviating pain or making the patient more comfortable. This includes care received during hospice.
- Can involve pain management that may not include surgery, radiation or systemic treatment.
- It is possible for a patient to receive one or a combination of treatment modalities in conjunction with palliative care intended to reduce the burden of pain. For example, a patient with metastatic prostate cancer may receive an orchiectomy and systemic hormone therapy in combination with palliative radiation for bone metastasis.

Prophylactic Care

The term "prophylactic" is used in medical practice in a variety of ways. An action taken to prevent cancer from developing (such as a double mastectomy for a healthy woman who has several relatives diagnosed with breast cancer when they were young) is not reportable; there is no cancer to report. Actions taken as part of planned first course treatment to prevent spread or recurrence of the cancer are sometimes characterized as "prophylactic" (for example, performing an oophorectomy or providing Tamoxifen to a breast cancer mastectomy patient). These treatments are to be coded as treatment.

Embolization

The term *embolization* refers to the intentional blocking of an artery or vein. The mechanism and the reason for embolization determine how and whether it is to be recorded.

Chemoembolization

A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This procedure permits a higher concentration of drug to be in contact with the tumor for a longer period of time. Code chemoembolization as *Chemotherapy* when the embolizing agent(s) is a chemotherapeutic drug(s) or when the term *chemoembolization* is used with no reference to the agent. Use *SEER*Rx Interactive Drug Database (https://seer.cancer.gov/tools/seerrx/)* to determine whether the drugs used are classified as chemotherapeutic agents. Also, code as *Chemotherapy* when the patient has primary or metastatic cancer in the liver and the only information about embolization is a statement that the patient had chemoembolization, tumor embolization or embolization of the tumor in the liver. However, if alcohol is specified as the embolizing agent, even in the liver, code the treatment as *Other Therapy*.

Radioembolization

- Embolization combined with injection of small radioactive beads or coils into an organ or tumor. Assign Radiation Modality to code 13 Radioisotopes for radioembolization procedures (e.g. intravascular Yttrium-90) for cases diagnosed January 1, 2018, or later. For cases diagnosed prior to January 1, 2018, use code 07 Brachytherapy, NOS.
- Embolization is coded as *Other Therapy* (code 1) if the embolizing agent is alcohol, or if the embolized site is other than the liver and the only information in the record is that the patient was given "embolization" with no reference to the agent.

- Do not code presurgical embolization of hypervascular tumors with particles, coils or alcohol. These presurgical embolizations are typically performed to make the resection of the primary tumor easier. Examples where presurgical embolization is used include meningiomas, hemangioblastomas, paragangliomas and renal cell metastases in the brain.

Additional Information for Abstracting

PATIENT ADDRESS AND RESIDENCY RULES

The patient's place of residence at the time of original diagnosis **does not change if the patient moves**. If the patient has more than one primary, the address at diagnosis may be different for each primary. Use the current address fields to track changes in patient address after the address at the time of the original diagnosis has been determined.

Normally a residence is the home named by the patient. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with the rules of the Census Bureau whenever possible. The registry can resolve residency questions by using the **Census Bureau's definition, "the place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home."** State Vital Statistics rules may differ from Census rules.

Note: If it was known that the patient was living in another city or state at the time of diagnosis, record as much of that address that is known. Record "UNKNOWN" for any details that are not known. The goal is to make every effort to identify as much as possible about where a patient was living at the time of initial diagnosis, especially if they were living in another city/zip/state area. This is important for studies that look at geographical patterns. In short, be mindful when reviewing the record and look for clues that the patient may have moved prior to coming to your facility. If there is no indication the patient was living elsewhere at the time of diagnosis, then record the address provided in the medical record.

Address Validation Tool and Edit Conflicts

The N.C. CCR provides an Address Validation Tool that can be downloaded from the N. C. CCR website. Data reporters can use this stand-alone application to quickly determine whether an address is valid, using a drill down technique that is superior to the search methods available on commonly used address validation websites. The edit metafile contains a table of validated city/zip/county code combinations. If the combination is not in the edit metafile table, the case will receive an edit error. Confirm the city/zip/county combination, including the spelling of city names, using the Address Validation Tool or the US Postal Service website. The city may have acquired a new nickname, or a new town may have been incorporated. If the combination appears to be valid, notify your CCR staff representative for instructions on how to clear the edit. The combination will be validated through GIS and added to the edit metafile table for release in future metafiles.

Rules for Persons with Ambiguous Residences

PO Boxes: A post office box is not a reliable source to identify the residency at diagnosis. Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Use the post office box address only if no street address information is available after follow-back.

More than One Residence (summer and winter homes): Code the street address of the usual residence as stated by the patient. Use the address the patient specifies if a usual residence is not apparent.

Temporary address: Code the place of usual residence rather than the temporary address for:

- Migrant workers
- Educators temporarily assigned to a university
- Persons temporarily residing with family during cancer treatment

- Military personnel on temporary duty assignments (TDY)

Persons on Vacation or Business: For people temporarily away on vacation or a business trip on the day the cancer is documented, residence should be documented as their usual residence.

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

Persons Away at School: College students (living away from home) are residents of the school area. College students living at their parental home are documented as their parental address.
Boarding school students below the college level are residents of their parents' homes.

Children in Joint Custody: Document where they live most of the time. If time is equally divided, their residence is documented as where they are staying on the day the cancer is documented.

Live-Ins:
- Live-in nannies are residents of where they live most of the week.
- Foster children are residents of where they are living when diagnosed.
- Roomers or boarders are residents of where they are living when diagnosed.
- Roommates are residents of where they are living when diagnosed.

Persons in Institutions: Code the physical address of the institution. Do not code the post office box. The Census Bureau states, "Persons under formally authorized, supervised care or custody" are residents of the institution. This classification includes the following:
- Incarcerated persons
- Persons in nursing, convalescent and rest homes
- Persons in homes, schools, hospitals, or wards for the physically disabled, mentally challenged/ill.
- Long-term residents of other hospitals, such as Veterans Affairs (VA) hospitals.

Persons in the Armed Forces and on Maritime Ships: Military personnel may use the installation address or the surrounding community's address. The Census Bureau has detailed residency rules for Navy personnel, Coast Guard and maritime ships. Refer to Census Bureau publications for the detailed rules.
- Members of the armed forces are residents of the installation area. Use the stated address for military personnel and their families.
- Military residing in the United States: Residence should be documented as where they live and sleep most of the time even if it is off base.
- Military personnel may use the installation address or the surrounding community's address. The Census Bureau has detailed residency rules for Navy personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for the detailed rules.
- Crews of U.S. flag merchant vessels engaged in inland waterway transportation are residents of their usual onshore residence where they live and sleep most of the time when they are onshore.
- Crews of U.S. flag merchant vessels docked in a U.S. port or sailing from one U.S. port to another U.S. port are residents of their usual onshore residence if they report to one (the place where they live and sleep most of the time when they are onshore) or otherwise on the vessel.

Death Certificate Only: Use residency information from a death certificate only when the residency from other sources is coded as unknown.

IN UTERO DIAGNOSIS AND TREATMENT (Effective 1/1/2009):

Reportability requirements apply to diagnoses made in utero. Diagnoses made in utero are reportable only when the pregnancy results in a **live birth**. In the absence of documentation of stillbirth, abortion or fetal death, assume there was a live birth and report the case.

- Diagnosis and treatment dates for a fetus diagnosed prior to birth are to be assigned the actual date of the event.
- When a reportable diagnosis is confirmed prior to birth and disease is not evident at birth due to regression, code the case based on the pre-birth diagnosis.

DETERMINING MULTIPLE PRIMARIES

The SEER Solid Tumor Rules guide and standardize the process of determining the number of primaries. Apply the general instructions and site-specific instructions in the manuals below to determine the number of abstracts to prepare and report.

Solid Tumors

SEER Solid Tumor Coding Rules: https://seer.cancer.gov/tools/solidtumor/

The most recent SEER Solid Tumor Rules contain site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder and malignant and nonmalignant brain primaries. A separate set of rules addresses the specific and general rules for all other sites.

Hematopoietic and Lymphoid Neoplasms

SEER Hematopoietic and Lymphoid Neoplasm Database: https://seer.cancer.gov/tools/heme/

Use the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database to code hematopoietic primaries (lymphoma and leukemia M9590-9993).

REVISING THE ORIGINAL DIAGNOSIS

Over time, the patient's records may contain new information such as tests, scans, and consults. Change the primary site, laterality, histology, grade and stage as the information becomes more complete. If the primary site or histology is changed, it may also be necessary to revise stage and treatment codes.

There is no time limit for making revisions that:

- correct coding or abstracting errors (for example, errors found during quality control review)
- result from clarifications or rule changes that retroactively affect the data item code
- give better information about the original diagnosis or stage. However, if staging information is updated, it is important to adhere to the timing requirements for the respective staging system.

Example 1: Consults from specialty labs, pathology report addenda or comments or other information have been added to the chart. Reports done during the diagnostic workup and placed on the chart after the registrar abstracted the information may contain valuable information. Whenever these later reports give better information about the histology, grade of tumor, primary site, etc., change the codes to reflect the better information.

Example 2: The primary was recorded as unknown at the time of diagnosis. At a later date, the physician determines that the cancer is primary to the testis. Change the primary site from unknown to testis.

Example 3: The original diagnosis was in situ. Metastases are diagnosed at a later date. Change the behavior code for the original diagnosis from in situ to invasive when no new primary has been diagnosed in the interim.

Example 4: Patient seen in Hospital A. The pathologic diagnosis was negative for malignancy. Patient goes to Hospital B and the slides from Hospital A are re-read. The diagnosis at Hospital B is reportable. Hospital B sends their slide report back to Hospital A. Hospital A reports the case based on the info from Hospital B. Enter supporting documentation in a text field.

Example 5: The facility clinically diagnoses a patient with carcinomatosis. The registry enters the case as an unknown primary (C80.9), carcinoma, NOS (8010/3), stage of disease unknown. Nine months later, a paracentesis shows serous cystadenocarcinoma. The physician says that the patient has an ovarian primary. Change the primary site to ovary (C56.9), histology to serous cystadenocarcinoma (8441/3), and diagnostic confirmation to positive cytologic study, no positive histology (code 2). If enough information is available that meets the AJCC timing requirements for staging, change the stage to the appropriate staging basis, TNM elements and stage group based on the information available for the criteria for clinical and pathologic staging. If first course surgery was performed, the surgery codes should be reviewed.

Changing the Date of Diagnosis

It is possible that the date of diagnosis is confirmed, in retrospect, to be earlier than the original data abstracted. If the date of diagnosis is being changed, be sure the data items required for that year of diagnosis are completed. For cases diagnosed 2004-2015, the Collaborative Stage data items CANNOT be blank. Update the Collaborative Stage input items and rerun the derivation program.

Example: Patient has surgery for a benign argentaffin carcinoid (8240/1) of the sigmoid colon in May 2025. In January 2026, the patient is admitted with widespread metastasis consistent with malignant argentaffin carcinoid. The registrar accessions the malignant argentaffin carcinoid as a 2026 diagnosis. Two months later, the pathologist reviews the slides from the May 2025 surgery and concludes that the carcinoid diagnosed in 2025 was malignant. Change the date of diagnosis to May 2025 and histology to 8241 and the behavior code to malignant (/3).

Corrections

It is important for the N.C. CCR to be aware of changes to select data items especially data items such as primary site, histology and stage. If the primary site is changed, it may be necessary to revise site-specific staging and treatment codes. There is no time limit for making revisions that give better information about the *original* diagnosis or stage. However, if staging information is updated, it is important to adhere to the timing requirements for the respective staging system. Software vendors have been notified about which changed data items are to be transmitted to the N.C. CCR. Your software vendor will supply procedures for sending electronic corrections to the N.C. CCR.

Deletions

Cases uploaded to the N.C. CCR may at times need to be deleted. If a case is uploaded to the N.C. CCR, and later it was decided the case was non-reportable, notify your CCR Staff Representative.

Example: A physician may decide that a previously clinically diagnosed malignancy is a benign lesion. The patient is referred from a nursing home to the facility. The chest x-ray shows a cavitary lesion in the right lung. The family requests that the patient undergo no additional workup or treatment. Discharge diagnosis is “probable carcinoma of right lung.” The registry abstracts a lung primary (C34.9). Two years later, a chest X-ray shows an unchanged lesion. The physician documents “lung cancer ruled out.” Delete the case from the database. Adjust the sequence number(s) of any other primaries the patient may have. Do not reuse the accession number. Notify the N.C. CCR of the deleted case.

Coding and Estimating Dates

Date of First Contact and Date of Last Contact

DATE OF FIRST AND LAST CONTACT CANNOT BE BLANK ON ANY CASE SUBMITTED TO THE CCR, regardless of when the case is abstracted and the NAACCR version that was in effect. This applies to all diagnosis years and all classes of case. **A full date must be entered for all cases.** You should be able to determine the first and last date your facility had an encounter with the patient.

Date of Birth

DATE OF BIRTH CANNOT BE BLANK ON ANY CASE SUBMITTED TO THE CCR, regardless of when abstracted and the NAACCR version in effect. This applies to all diagnosis years and all classes of case.

- For analytic cases, a **full date of birth must be entered**. A partial date is not allowed. Follow-back is required if needed to obtain the information to assign the complete date of birth.
- For non-analytic cases:
    - Assign the full date of birth as first priority.
    - If only the patient age is available, calculate the year of birth from age and the year of diagnosis and leave day and month of birth unknown (for example, a 60-year-old patient diagnosed in 2023 is calculated to have been born in 1963).
    - If there is not enough information to assign at least the year of birth, follow-back must be done to obtain the necessary information.
    - A partial date is allowed if the full date cannot be determined for non-analytic cases only.
    - **Text should specify when a date has been calculated based on the patient's age.**

Date of Diagnosis

DATE OF DIAGNOSIS CANNOT BE BLANK FOR:

- **CASES DIAGNOSED IN 2023 FORWARD**
- **ANY CASE ABSTRACTED AFTER CONVERTING TO NAACCR VERSION 23.** This applies to all diagnosis years and classes of case.

Make every attempt to determine the complete date, including follow-back to the physician. If an exact date still cannot be determined, the date must be approximated. The requirements differ for analytic and non-analytic cases when an exact date is unknown. See the section on Estimating Dates below.

Pre-2023 cases abstracted prior to conversion to version 23 would have had access to the flag fields. Therefore, it is possible that the date may have been blank (with a flag code of 12) if abstracted in NAACCR version 22 or earlier. Recoding of these cases is not required.

- **MAKE EVERY ATTEMPT TO CODE A COMPLETE, EXACT DATE.**
- Estimate only as a last resort. If necessary, conduct further investigation or follow-back to the managing physician for more information.
- If an exact date cannot be determined, the date must be approximated.
- The requirements differ for analytic and non-analytic cases when an exact date is unknown. See the section on Estimating Dates below for instructions.

The date of diagnosis is a critical data point and puts the case into the year of evaluation. If this date is not accurate, then the case cannot be included in the appropriate statistics, research studies, etc.

Date of Treatment

WHEN TREATMENT IS GIVEN, THE TREATMENT START DATE CANNOT BE BLANK. This applies to all diagnosis years and all classes of case abstracted after conversion to NAACCR version 23. It is important to be able to differentiate between when a date was inadvertently omitted from the abstract, and when the exact date was unknown. Therefore, the N.C. CCR will require that if treatment was given, a start date must be entered.

- For analytic cases, the entire date must be entered. If the exact date cannot be obtained, it must be estimated. Follow-back is required if needed to obtain enough information to assign the treatment start date.
- For non-analytic cases, if the full date is not available, at least the YEAR must be estimated. Use the Date of Diagnosis to estimate the treatment start date if necessary.

Pre-2023 cases abstracted prior to conversion to version 23 would have had access to the flag fields. Therefore, it is possible that the treatment start date may have been blank (with a flag code of 12) if abstracted in NAACCR version 22 or earlier. Recoding of these cases is not required.

Estimating Dates

All applicable date fields, including the date of diagnosis, cannot be blank. For all cases, and all date fields, every attempt should be made to determine the complete, exact date. If it is impossible to determine the exact date, then the date should be estimated. The degree to which a date is allowed to be estimated is based on the class of case and is outlined below. Determining an exact date should be the first priority and estimating or coding a partial date is a last resort. Text should specify when a date has been estimated.

The requirements differ for analytic and non-analytic cases when an exact date is unknown.

For analytic cases:

- **An entire date must be recorded** as these cases are in the workup and treatment phase of the initial diagnosis and these procedures are most likely very recent.
- Follow-back and further investigation is required to obtain the necessary information to code the full date.
- If any part of the date is unknown, and further investigation did not yield sufficient information, it MUST be estimated.
- Use any clues available to approximate the date, such as “last year,” “recent” “treatment began last month,” etc. The table below provides more information on estimating dates.

  Example: The patient was admitted to your facility on 3/14/2026 for surgery following a positive biopsy. The record indicates the biopsy occurred “last month”. Last month is a clue that the biopsy was done in February 2063. If further investigation does not yield the exact day of the biopsy, it should be estimated as the 1st day of the month so that an entire date is recorded for the analytic case. Record 20260201.

For non-analytic cases:

- Every attempt should be made to obtain the full, exact date.
- If that is not possible, estimate and record as much of the date as possible.
  - Estimating and recording a month and year (e.g., 202606) is preferred to recording only a year (e.g., 2026).

    - For non-analytic cases, coding only a year or only a year and month is acceptable if it is not possible to estimate an entire date.
- If the month or month and day cannot be determined, at least the YEAR must be determined because this date field can no longer be left blank.
    - Use any clues available to approximate the date, such as a "diagnosed last year," "recent diagnosis," "treatment began last month," etc. The table below provides more information on estimating dates.
    - As the date cannot be left blank, and it is not useful to guess a speculative year, follow-back to the managing physician or other facility may be needed if there is absolutely no clue that would allow you to estimate at least the year.
- If all options have been exhausted and at least the year still cannot be estimated, then record the date of the first encounter that made the case reportable. This is a LAST RESORT and should be a RARE exception. Text must validate this decision.

Examples for estimating the date:

- Estimating is only done when all investigation fails to yield an exact date.
- Part of the date may be known, but only the day, or the day and month, need to be estimated. Use what is known and only estimate the unknown parts of the date.
- Estimating starts with determining the best year, then the best month, then the best day.
    - For analytic cases, the entire date must be recorded so the year, month and day must be estimated if an exact date is not known.
    - For non-analytic cases, at least the year must be recorded but every attempt should be made to estimate the entire date.

Estimating the **YEAR.** The diagnosis date was described as:	Tips for Estimating Analytic cases: If the month and day cannot be determined, it must be estimated. See estimating the month and day below on how to record the full date.	Use
A recent or new diagnosis	Use the current year	2026
Last Year	Use the previous year	2025
A couple of years ago	Use 2 years earlier	2024
A few years ago	Use 3 years earlier	2023

Estimating the **MONTH**	Tips for Estimating Analytic cases: If the day cannot be determined, it must be estimated. See estimating the day below on how to record the full date.	Use
Only the Year is known	Example: Patient was diagnosed in 2024 and presents in 2026 with recurrence. Analytic cases: If further investigation does not yield an exact month, it must be estimated. Use July (the middle of the year) and the first day of the month if there are no clues.	20240701
Clues are available to estimate the month	Example: Patient admitted for surgery following a positive biopsy. The exact date of the biopsy cannot be determined. Surgery performed 20260714. Use treatment dates as a clue. Estimate the diagnosis date as the 1st day of the same month.	20260701
Clues are available to estimate the month	Example: Patient admitted 3/7/2026 for surgery following a positive biopsy. The record indicates the biopsy occurred "last month". Last month is a clue that the biopsy was done in February 2026. If further investigation does not yield the exact day of the biopsy, the day should be estimated as the 1st day of the month so that an entire date is recorded for the analytic case.	20260201

Clues are available to estimate the month	Example: Admitted October 2026. History states that the patient was diagnosed 7 months ago. Subtract 7 from the month of admission and use the first day of the month.	20260301
Clues are available to estimate the month	Example: Outpatient bone scan done May 2026. The physician says the patient is newly diagnosed. Assume bone scan was part of initial work-up and use the 1st day of the same month as the bone scan.	20260501
Information is limited to description of "Spring"	Use the current year and April for Spring. If further investigation does not yield the exact day, the day should be estimated as the 1st day of the month so that an entire date is recorded for the analytic case.	20260401
Information is limited to description of "Summer" or "the middle of the year"	Use the current year and July for Summer or the middle of the year. If further investigation does not yield the exact day, the day should be estimated as the 1st day of the month so that an entire date is recorded for the analytic case.	20260701
Information is limited to the description of "Fall"	Use the current year and October for Fall. If further investigation does not yield the exact day, the day should be estimated as the 1st day of the month so that an entire date is recorded for the analytic case.	20261001
Information is limited to the description of "Winter"	Try to determine if this means the beginning (January) or the end (December) of the year as the year of diagnosis determines the year of evaluation for studies. If not enough information, use January. If further investigation does not yield the exact day, the day should be estimated as the 1st day of the month so that an entire date is recorded for the analytic case.	20251201 or 20260101

Estimating the **DAY**	Tips for Estimating	Use
Only the year and month are known	Example: Record states patient was diagnosed in February. If there are no clues and further investigation does not yield an exact date, use the first day of that month so that an entire date is recorded for the analytic case.	20260201
Clues are available to estimate the day	Example: Patient admitted 10/23/2026 for surgery following a positive biopsy. The record indicates the biopsy occurred "two weeks" ago. Using a calendar, determine the date for 14 days earlier.	20261009
Last week	Using a calendar, determine the date for 7 days earlier.	
Recently	Example: Patient admitted in June 2026. Record states patient was diagnosed recently. If further investigation does not yield the exact day, use the first day of the same month.	20260601
Treatment performed but the date is unknown	Example: Patient seen at your facility on 11/3/2026 to start radiation therapy. The patient had surgery following a positive biopsy on 8/14/2026. The exact date of the surgery could not be determined. Use the date of diagnosis or other treatment dates as a clue. The surgery would have been done between August 14th and November 3rd. If the date cannot be narrowed down any further, estimate the surgery date as the 1st day of the month following the biopsy (September 1st).	20260901

SECTION TWO:
Instructions for Coding

Patient Identification

MEDICAL RECORD NUMBER

Item Length: 11
Right Justified, Leading Blanks
NAACCR Item #2300
Revised 01/11

Description
Records the medical record number usually assigned by the reporting facility's health information management (HIM) department.

Rationale
This number identifies the patient within a reporting facility. It can be used to reference a patient record and it helps to identify multiple reports on the same patient.

Instructions for Coding
- Record the medical record number.

Examples

Code	Reason
——NNNN	If the medical record number is fewer than 11 characters, right justify the characters and allow leading blanks.
NNNNRT (Radiology) NNSU (One-day surgery clinic)	Record standard abbreviations for departments that do not use HIM medical record numbers.
UNK	Unknown

SOCIAL SECURITY NUMBER

Item Length: 9
NAACCR Item #2320

Make every attempt to obtain the SSN.
SSN is critical for patient matching at the CCR and linking patient with similar names.

Description
Records the patient's Social Security number.

Rationale
This data item can be used to identify patients with similar names.

Instructions for Coding
- Code the patient's Social Security number.
- A patient's Medicare claim number may not always be identical to the person's Social Security number.
- Code 999999999 for Social Security numbers that end with "B" or "D". The patient receives benefits under the spouse's number and this is the spouse's Social Security number.
- See https://www.ssa.gov/ for more information.

Code	Definition
(fill spaces)	Record the patient's Social Security number without dashes
999999999	Patient does not have a Social Security number; SSN is not available.

MEDICARE BENEFICIARY IDENTIFIER

Item Length: 11
NAACCR Item #2315
Effective: 1/1/2022

****NEW DATA ITEM added in the CCARM 2022 but should be collected on ALL cases when available.****

Description
Congress passed the Medicare Access and CHIP Reauthorization ACT to remove Social Security Number (SSN) from Medicare ID cards and replace the existing Medicare Health Insurance Claim Numbers (HICN) with a Medicare Beneficiary Identifier (MBI). The MBI will be a unique, randomly generated, non-intelligent (having no hidden meaning) identifier that will not include SSN or any personal identifiable information.

Rationale
The MBI is a step to minimize the risk of identity theft for Medicare beneficiaries and reduce opportunities for fraud. A HICN will still be assigned to each Medicare beneficiary but used only for internal data exchanges between CMS and the states. The new MBI must be used in all interactions with the beneficiary, the provider community, and all external partners.

The Centers for Medicare & Medicaid Services (CMS) has removed SSN-based HICNs from Medicare cards and are now using MBIs for Medicare transactions like billing, eligibility status, and claim status. Every person with Medicare has been assigned an MBI. The MBI is confidential like the SSN and should be protected as Personally Identifiable Information.

Providers must submit reimbursement claims using MBIs (with a few exceptions), no matter what date the service was performed. More information can be found on the CMS website: https://www.cms.gov/training-education/partner-outreach-resources/new-medicare-card/medical-beneficiary-identifiers-mbis

The collection of the MBI does not change the requirement for the collection of SSN. SSN must still be collected as specified in the CCARM.

Instructions for Coding
- The MBI is required if the patient has Medicare. (SSN is still required)
- Collect for all cases, regardless of diagnosis year.
- Enter the 11-character MBI (consisting of numbers and letters) without dashes. The MBI does not use the letters S, L, O, I, B and Z to avoid confusion with similar looking numbers (0 versus O).
- MBI format: https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI-with-Format.pdf
- Leave blank if not available, not applicable or unknown.

Code	Definition
blank	MBI is not available, not applicable or unknown
1A00AA0AA00	Example of a randomly generated 11-character MBI number

LAST NAME

Item Length: 40
Mixed Case, Left Justified
NAACCR Item #2230
Revised 01/04, 01/10

Description
Identifies the last name of the patient. Last name may also be referred to as surname.

Rationale
This data item is used as a patient identifier.

Instructions for Coding
- Truncate name if more than 40 letters long.
- Blanks spaces, hyphens and apostrophes are allowed. Do not use other punctuation.
- Do not leave blank.
- This field may be updated if the last name changes.

Examples

Code	Reason
Mc Donald	Recorded with space as Mc Donald
O'Hara	Recorded with apostrophe as O'Hara
Smith-Jones	Janet Smith marries Fred Jones and changes her last name to Smith-Jones. Recorded with the hyphen as Smith-Jones.

FIRST NAME

Item Length: 40
Mixed Case, Left Justified
NAACCR Item #2240
Revised 01/10, 01/11

Description
Identifies the first name, or given name, of the patient.

Rationale
This data item is used to differentiate between patients with the same last names.

Instructions for Coding
- Truncate name if more than 40 letters long.
- Blanks spaces, hyphens and apostrophes are allowed. Do not use other punctuation.
- This field may be updated if the name changes.
- Do not record nicknames in First Name.

Examples

Code	Reason
Michael	Patient's name is Michael David Hogan. Michael is the first name. Record Michael.
William	The patient's nickname is Bill and the first name is William. Record William.

MIDDLE NAME

(MIDDLE INITIAL)

Item Length: 40
Mixed Case, Left Justified
NAACCR Item #2250
Revised 01/10, 01/11

Description
Identifies the middle name or middle initial of the patient.

Rationale
This data item helps distinguish between patients with identical first and last names.

Instructions for Coding

- Make every attempt to identify and record the full middle name.
- Truncate name if more than 40 letters long.
- Blanks spaces, hyphens and apostrophes are allowed. Do not use other punctuation.
- Record the middle initial only if the full middle name cannot be determined.
- Leave blank if the patient's middle name is unknown or patient has no middle name.
- This field may be updated if the name changes.

Examples

Code	Reason
David	Patient's name is Michael David Hogan
D	Patient's name is Michael D. Hogan and the full middle name cannot be obtained
(leave blank)	If patient's middle name is not known or there is none, leave blank.

BIRTH SURNAME

Item Length: 40
Mixed Case, Left Justified
NAACCR Item #2232
Effective 1/1/2021

Description
Birth Surname, effective 01/01/2021, is a gender-neutral replacement for the NAACCR data item Name - Maiden [2390]. Birth Surname reflects the last name of the patient at birth regardless of gender or marital status. Allowable values for Birth Surname are identical to those used for Name--Maiden.

Rationale
This data item is used as a patient identifier.

Instructions for Coding
- Truncate name if more than 40 letters long.
  - Record when known regardless of value in the *Sex Assigned at Birth* data item
- Blanks spaces, hyphens and apostrophes are allowed. Do not use other punctuation.
- Leave blank if the birth surname is unknown or not applicable.

Examples

Code	Reason
Mc Donald	Recorded with space as Mc Donald
O'Hara	Recorded with apostrophe as O'Hara
Smith	Janet Smith marries Fred Jones and changes her last name to Jones

ADDRESS AT DIAGNOSIS--NUMBER AND STREET

Item Length: 60
Uppercase, Left Justified
NAACCR Item #2330
Revised 01/10, 01/12

Description
Identifies the patient's address (number and street) at the time of diagnosis.

Rationale
The address is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.
See "Patient Address and Residency Rules" in Section One for further instructions.

Note: If it was known that the patient was living in another city or state at the time of diagnosis, record as much of that address that is known. Record "UNKNOWN" for any details that are not known. The goal is to make every effort to identify as much as possible about where a patient was living at the time of initial diagnosis, especially if they were living in another city/zip/state area. This is important for studies that look at geographical patterns. In short, be mindful when reviewing the record and look for clues that the patient may have moved prior to coming to your facility.
If there is no indication that the patient was living elsewhere at the time of diagnosis, then record the address provided in the medical record.

Instructions for Coding
- Record the number and street address or the rural mailing address of the patient's usual residence when the tumor was diagnosed.
  Example: 103 FIRST AVE SW APT 102
- If the patient also has a Post Office (PO) Box address, record the PO Box in Address at DX--Supplemental.
- Use CAPITAL LETTERS.
- Leave a space between numbers and words.

- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2022 can be found at *http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf*. A complete list of recognized street abbreviations is provided in Appendix C. They include, but are not limited to:

AVE (avenue)	PKWY (parkway)	STE (suite)	S (south)
BLVD (boulevard)	RD (road)	UNIT (unit)	SE (southeast)
CIR (circle)	SQ (square)	RM (room)	SW (southwest)
CT (court)	ST (street)	DEPT (department)	E (east)
DR (drive)	APT (apartment)	N (north)	W (west)
PLZ (plaza)	BLDG (building)	NE (northeast)	
PARK (park)	FL (floor)	NW (northwest)	

- Do not use punctuation unless absolutely necessary to clarify an address. Punctuation is normally limited to periods (for example, 39.2 RD), slashes for fractional addresses (101 1/2 MAIN ST), and hyphens when a hyphen carries meaning (289-01 MONTGOMERY AVE). A period is not required after an abbreviation (such as RD., record only RD).
- Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (425 FLOWER BLVD # 72).
- Do not update this data item if the patient's address changes.
- If the patient's street address is unknown, then enter "UNKNOWN".

ADDRESS AT DIAGNOSIS--SUPPLEMENTAL

Item Length: 60
Uppercase, Left Justified
NAACCR Item #2335
Revised 09/06, 01/10, 01/12

Description
Provides the ability to store additional address information such as the name of a place or facility (for example, a nursing home or name of an apartment complex) at the time of diagnosis.

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

Instructions for Coding
- If the patient has a street address and a Post Office (PO) Box address, record the PO Box address in Address at Diagnosis--Supplemental.
- Record the place or facility where the patient resided when the tumor was diagnosed.
    - For example, a nursing home or name of an apartment complex of the patient's usual residence when the tumor was diagnosed.
- If the facility name is all that is provided as the patient's address, research the facility name to determine the street address. Record number and street in Address at Diagnosis--Number and Street. Record the facility name in Address at Diagnosis--Supplemental.
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not use this data item to record the number and street address of the patient. Record number and street in Address at Diagnosis--Number and Street.
- Do not update this data item if the patient's address changes.
- See "Residency Rules" in Section One for further instructions.

Examples:

Code	Definition
VALLEYVIEW NURSING HOME	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
Leave blank	If this address space is not needed, then leave blank.

ADDRESS AT DIAGNOSIS--CITY

Item Length: 50
Uppercase, Left Justified
NAACCR Item #70
Revised 01/10

Description
Identifies the name of the city or town in which the patient resides at the time THIS tumor is diagnosed and treated.

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

See "Patient Address and Residency Rules" in Section One for further instructions.

Note: If it was known that the patient was living in another city or state at the time of diagnosis, record as much of that address that is known. Record "UNKNOWN" for any details that are not known. The goal is to make every effort to identify as much as possible about where a patient was living at the time of initial diagnosis, especially if they were living in another city/zip/state area. This is important for studies that look at geographical patterns. In short, be mindful when reviewing the record and look for clues that the patient may have moved prior to coming to your facility.
If there is no indication that the patient was living elsewhere at the time of diagnosis, then record the address provided in the medical record.

N.C. CCR Address Validation Tool
Use this stand-alone application to quickly determine if an address is valid, using a drill down technique that is superior to the search methods available on commonly used address validation websites.

Instructions for Coding
- Record the full city name as listed on the USPS website (https://tools.usps.com/zip-code-lookup.htm) or in the Address Validation Tool provided on the NC CCR website.
- Do not use punctuation, special characters, or numbers.
- Use CAPITAL LETTERS.
- If the patient resides in a rural area, record the name of the city or town used in the mailing address.
- If the patient also has a Post Office (PO) Box address with a different city, record the PO Box address and that city in Address at Diagnosis--Supplemental.
- If the patient has multiple malignancies, the city or town may be different for subsequent primaries.
- Do not update this data item if the patient's city or town of residence changes.
- Abbreviations may only be used when absolutely necessary. For example, the city name is longer than the allowable characters provided for the field and there is no choice but to abbreviate. Abbreviations should not be used for the sake of brevity. For example, do not abbreviate Mountain to MTN. If abbreviating was necessary, this may generate an edit. Contact your CCR Staff Representative for instructions on how to clear the edit.
- If the patient's city or town is unknown, then enter "UNKNOWN"

ADDRESS AT DIAGNOSIS--STATE

Item Length: 2
Uppercase
NAACCR Item #80
Revised 09/06, 01/10, 01/11, 01/12

Description
Identifies the patient's state of residence at the time of diagnosis.

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

See "Patient Address and Residency Rules" in Section One for further instructions.

Note: If it was known that the patient was living in another city or state at the time of diagnosis, record as much of that address that is known. Record "UNKNOWN" for any details that are not known. The goal is to make every effort to identify as much as possible about where a patient was living at the time of initial diagnosis, especially if they were living in another city/zip/state area. This is important for studies that look at geographical patterns. In short, be mindful when reviewing the record and look for clues that the patient may have moved prior to coming to your facility.
If there is no indication that the patient was living elsewhere at the time of diagnosis, then record the address provided in the medical record.

Instructions for Coding
- Use the U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession or Canadian province or territory in which the patient resides at the time the tumor is diagnosed and treated.
- If the patient has multiple tumors, the state of residence may be different for subsequent primaries.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
- Do not update this data item if the patient's state of residence changes.

Code	Definition
IL	If the state in which the patient resides at the time of diagnosis and treatment is Illinois, then use the USPS code for the state of Illinois.
XX	Resident of a country other than the U.S. (including its territories, commonwealths or possessions) or Canada and the country is *known*.
YY	Resident of a country other than the U.S. (including its territories, commonwealths or possessions) or Canada and the country is *unknown*.
US	Resident of the U.S. (including its territories, commonwealths or possessions) and the state is *unknown*
CD	Resident of Canada and the province is *unknown*.
ZZ	Residence unknown.

Common Abbreviations

United States State and Territory Abbreviations (refer to the ZIP Code directory for further listings):

State		State		State	
Alabama	AL	Massachusetts	MA	Tennessee	TN
Alaska	AK	Michigan	MI	Texas	TX
Arizona	AZ	Minnesota	MN	Utah	UT
Arkansas	AR	Mississippi	MS	Vermont	VT
California	CA	Missouri	MO	Virginia	VA
Colorado	CO	Montana	MT	Washington	WA
Connecticut	CT	Nebraska	NE	West Virginia	WV
Delaware	DE	Nevada	NV	Wisconsin	WI
District of	DC	New Hampshire	NH	Wyoming	WY
Florida	FL	New Jersey	NJ	United States, state unknown	US
Georgia	GA	New Mexico	NM	American Samoa	AS
Hawaii	HI	New York	NY	Guam	GU
Idaho	ID	North Carolina	NC	Puerto Rico	PR
Illinois	IL	North Dakota	ND	Virgin Islands	VI
Indiana	IN	Ohio	OH	Palau	PW
Iowa	IA	Oklahoma	OK	Micronesia	FM
Kansas	KS	Oregon	OR	Marshall Islands	MH
Kentucky	KY	Pennsylvania	PA	Outlying Islands	UM
Louisiana	LA	Rhode Island	RI	APO/FPO	AA
Maine	ME	South Carolina	SC	APO/FPO	AE
Maryland	MD	South Dakota	SD	APO/FPO	AP

Canadian Provinces and Territory Abbreviations

Province/Territory		Province/Territory	
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NL	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS	Canada, province unknown	CD

ADDRESS AT DIAGNOSIS--POSTAL CODE

Item Length: 9
Left Justified
NAACCR Item #100
Revised 01/04

Description
Identifies the postal code of the patient's address at diagnosis.

Rationale
The postal code is part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies.

See "Patient Address and Residency Rules" in Section One for further instructions.

Note: If it was known that the patient was living in another city or state at the time of diagnosis, record as much of that address that is known. Record "UNKNOWN" for any details that are not known. The goal is to make every effort to identify as much as possible about where a patient was living at the time of initial diagnosis, especially if they were living in another city/zip/state area. This is important for studies that look at geographical patterns. In short, be mindful when reviewing the record and look for clues that the patient may have moved prior to coming to your facility.
If there is no indication that the patient was living elsewhere at the time of diagnosis, then record the address provided in the medical record.

Instructions for Coding
- For U.S. residents, record the patient's nine-digit extended postal code at the time of diagnosis.
- For Canadian residents, record the six-character postal code.
- When available, record the postal code for other countries.
- If the patient has multiple malignancies, the postal code may be different for subsequent primaries.
- Do not update this data item if the patient's postal code changes.

Code	Definition
(fill spaces)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
60611_ _ _ _	When the nine-digit extended U.S. ZIP Code is not available, record the five-digit postal code, left justified, followed by four blanks.
M6G2S8_ _ _	The patient's six-character Canadian postal code left justified, followed by three blanks.
88888_ _ _ _ or 888888888	Permanent address in a country other than Canada, United States or U.S. possessions **and** postal code is unknown.
99999_ _ _ _ or 999999999	Permanent address in Canada, United States or U.S. possession **and** postal code is unknown.

ADDRESS AT DIAGNOSIS--COUNTRY

Item Length: 3
NAACCR Item #102
Added 01/01/2013

Description
Identifies the country of the patient's residence at the time of diagnosis. The codes are based on International Organization for Standardization (ISO) 3166-1 alpha-3 country codes, with some custom codes.

"Country" fields accompany "state" fields in addresses. Appendix D has a list of all country codes and corresponding state codes. State codes for all states and possessions and all Canadian provinces are included in Appendix D. State codes for the U.S. and its possessions are those used by the United States Postal Service. Canadian province or territory codes are from Canada Post sources. Country codes are based on the International Standards Organization (IS) 3166-1 Country Three Character Code. State and country codes also include some custom codes, which are included in Appendix D.

The list in Appendix D is divided into three parts.

- The first part is the preferred codes to use when sufficient detail is known to identify the U.S. state, Canadian province, or other country to assign precise codes.
- The second part consists of codes for more general regions for use when a precise code cannot be assigned (for example, "Near East"). If there is no indication at all of location in the patient record, the country is coded ZZU and the state will be ZZ.
- The third section is a list of obsolete codes that may have been assigned when the registry data were upgraded from former codes. This information is provided to assist registries in interpreting their historic data, but the obsolete codes must not be assigned for current abstracting.

Rationale
The country code is part of the patient's demographic data and has multiple uses. It may be useful for understanding risk factors, assessment of patient prognosis and chances for survival.

Instructions for Coding

- This item corresponds to the other *Address at Diagnosis* items (state, postal code).
- Do not change if the patient moves to another country. Patients with more than one tumor may have different countries at diagnosis, however.
- See Appendix D for a list of country codes and their respective state codes.

Examples:
Specific codes can be found in Appendix D. The following are a few examples of the most common, general geographic areas. Use general codes in the absence of more specific information.

Geographic Area	Country Code	State or Province Code
United States, NOS	USA	US
Canada, NOS	CAN	CD
Not U.S., but no other information	ZZX	YY
Unknown, no mention in patient record	ZZU	ZZ

COUNTY AT DIAGNOSIS--REPORTED

Item Length: 3
Allowable Values: 001–997, 998, 999
NAACCR Item #90
Revised 09/06, 01/10, 01/15

Description
Identifies the county of the patient's residence at the time the reportable tumor is diagnosed.

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

Instructions for Coding
- For U.S. residents, use codes issued by the Federal Information Processing Standards (FIPS) publication *Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas*. This publication is available in a reference library or can be accessed on the Internet through the U.S. EPA's Envirofacts Data Warehouse and Applications website at www.epa.gov.
- If the patient has multiple tumors, the county codes may be different for each tumor.
- If the patient is a non-U.S. resident, use code 999.
- Do not update this data item if the patient's county of residence changes.

For NC reporting facilities, the specific FIPS county code is only required for cases diagnosed in NC (the State at Diagnosis data item is coded to 'NC'). For cases where the State at Diagnosis is not NC, assign County at Diagnosis to code 998.

State and county codes are also listed in Appendix D of this manual.

Code	Label	Definition
001–997	County at diagnosis	Valid FIPS code. See table below (also provided in Appendix D).
998	Non-NC state & county unknown	Known town, city, state or country of residence, but county code not known **and** a resident outside of the state of the reporting institution (must meet all criteria).
999	State is NC & County is unknown	The county of the patient is unknown. It is not documented in the patient's medical record.

NC County	*FIPS Code*	*NC County*	*FIPS Code*	*NC County*	*FIPS Code*
Alamance	001	Gaston	071	Pamlico	137
Alexander	003	Gates	073	Pasquotank	139
Alleghany	005	Graham	075	Pender	141
Anson	007	Granville	077	Perquimans	143
Ashe	009	Greene	079	Person	145
Avery	011	Guilford	081	Pitt	147
				Polk	149
Beaufort	013	Halifax	083		
Bertie	015	Harnett	085	Randolph	151
Bladen	017	Haywood	087	Richmond	153
Brunswick	019	Henderson	089	Robeson	155
Buncombe	021	Hertford	091	Rockingham	157
Burke	023	Hoke	093	Rowan	159
		Hyde	095	Rutherford	161
Cabarrus	025				
Caldwell	027	Iredell	097	Sampson	163
Camden	029			Scotland	165
Carteret	031	Jackson	099	Stanly	167
Caswell	033	Johnston	101	Stokes	169
Catawba	035	Jones	103	Surry	171
Chatham	037			Swain	173
Cherokee	039	Lee	105		
Chowan	041	Lenoir	107	Transylvania	175
Clay	043	Lincoln	109	Tyrrell	177
Cleveland	045				
Columbus	047	McDowell	111	Union	179
Craven	049	Macon	113		
Cumberland	051	Madison	115	Vance	181
Currituck	053	Martin	117		
		Mecklenburg	119	Wake	183
Dare	055	Mitchell	121	Warren	185
Davidson	057	Montgomery	123	Washington	187
Davie	059	Moore	125	Watauga	189
Duplin	061			Wayne	191
Durham	053	Nash	127	Wilkes	193
		New Hanover	129	Wilson	195
Edgecombe	065	Northampton	131		
				Yadkin	197
Forsyth	067	Onslow	133	Yancey	199
Franklin	069	Orange	135		
				Unknown	999

BIRTHPLACE--STATE

Item Length: 2
Uppercase
NAACCR Item #252
Added 01/13

Description
Records the patient's state of birth.

Rationale
This data item is used to evaluate medical care delivery to special populations and to identify populations at special risk for certain cancers.

Instructions for Coding
- Use the most specific code.
- This item corresponds to Birthplace--Country.
- This item was first defined for use in 2013. Cases diagnosed before that date were converted from the former *Place of Birth*.

See Appendix D for a list of state codes and their respective country codes.

Examples:

Code	Definition
IL	If the state in which the patient was born is Illinois, then use the USPS code for the state of Illinois.
XX	Born in a country other than the U.S. (including its territories, commonwealths or possessions) or Canada and the country *is known* (code the country in *Birthplace-Country*).
YY	Born in a country other than the U.S. (including its territories, commonwealths or possessions) or Canada and the country *is unknown*.
US	Born in the U.S. (including its territories, commonwealths or possessions) and the state is *unknown*
CD	Born in Canada and the province is *unknown*.
ZZ	Place of birth is unknown, not mentioned in patient record.

BIRTHPLACE--COUNTRY

Item Length: 3
Uppercase
NAACCR Item #254
Added 01/01/2013

Description
Identifies the country where the patient was born. The codes are based on International Organization for Standardization (ISO) 3166-1 alpha-3 country codes, with some custom codes.

Rationale
The country code is part of the patient's demographic data and has multiple uses. It may be useful for understanding risk factors, assessment of patient prognosis and chances for survival.

Instructions for Coding
- This item corresponds to Birthplace--State.
- This item was first defined for use in 2013. Cases diagnosed before that date were converted.

See Appendix D for a list of state codes and their respective country codes.

Examples:
Specific codes can be found in Appendix D. The following are a few examples of the most common, general geographic areas. Use general codes in the absence of more specific information.

Geographic Area	Country Code	State or Province Code
United States, NOS	USA	US
Canada, NOS	CAN	CD
Not U.S., but no other information	ZZX	YY
Unknown, no mention in patient record	ZZU	ZZ

Item Length: 8
NAACCR Item #240
Revised 1/10, 1/23

DATE OF BIRTH CANNOT BE BLANK

FOLLOW BACK AND FURTHER INVESTIGATION MUST BE DONE TO DETERMINE THE DATE.

Description
Identifies the date of birth of the patient.

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

Instructions for Coding

- Record the patient's date of birth as indicated in the patient record.
- For *in utero* diagnosis and treatment, record the actual date of birth. It will follow one or both dates for those events.
- For analytic cases, a **full date of birth must be entered**. A partial date is not allowed. Follow-back is required if needed to obtain the information to assign the complete date of birth.
- For non-analytic cases:
    - Assign the full date of birth as first priority.
    - If only the patient age is available, calculate the year of birth from age and the year of diagnosis and leave day and month of birth unknown (for example, a 60-year-old patient diagnosed in 2023 is calculated to have been born in 1963).
    - If there is not enough information to assign at least the year of birth, follow-back must be done to obtain the necessary information.
    - A partial date is allowed if the full date of birth cannot be determined for non-analytic cases only.
- **Text should specify when a date has been calculated based on the patient's age.**

AGE AT DIAGNOSIS

Item Length: 3
Allowable Values: 000–120, 999
Right Justified, Zero-filled
NAACCR Item #230
Revised 09/08

Patient's Age at Diagnosis MUST be documented in the Text—Physical Exam field.

Description
Records the age of the patient at his or her last birthday before diagnosis.

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

Instructions for Coding
- Measure the patient's age in completed years of life, i.e., age at the patient's last birthday
- Generally, the registry software program calculates the Age at Diagnosis using the Date of Birth and Date of Diagnosis
- If the patient's age is 000 or 100 years or older, check the accuracy of the date of birth and date of diagnosis, and document both in the Text—Physical Exam field.

Code	Definition
000	Less than 1 year old; diagnosed *in utero*
001	One year old but less than 2 years old
002	Two years old
...	Actual age in years
120	One hundred twenty years old
999	Unknown age

RACE 1

Item length: 2
Allowable Values: 01–08, 10–17, 20–22, 25–28, 30–32, 96–99
NAACCR Item #160
Revised 1/04, 9/08, 1/10, 1/12, 1/22, 1/23, 1/24

Patient's Race MUST be documented in the Text—Physical Exam field

Coding instructions were enhanced in the CCARM 2024 to incorporate more examples of how to apply certain race codes. The SEER Program Coding and Staging Manual has more detailed instructions and examples than the STORE. All instructions in the CCARM for coding Race and Hispanic Origin are in alignment with the SEER Program Coding and Staging Manual and should be used to code the most specific race possible.

Description
Identifies the primary race of the person.

Rationale
Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The five race data items (*Race 1 – Race 5*) make it possible to code multiple races for one person, consistent with the 2000 Census allowing for an accurate national comparison.

Race is analyzed with *Spanish/Hispanic Origin* [190]. Both items must be recorded and cannot be left blank.

Race and ethnicity are defined by specific physical, hereditary, and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship. 'Origin' is defined by the U.S. Census Bureau as the heritage, nationality group, lineage, or in some cases, the country of birth of the person or the person's parents or ancestors before their arrival in the United States. Refer to the U.S. Census Bureau's definition of the five major race categories below.

Race MUST be documented in the Text—Physical Exam field:

- The race(s) documented in the medical record.
- Clearly document, when the patient is of more than one race, why a particular race code was chosen when there are discrepancies in race information.
  Example: The patient is identified as Black in nursing notes and White in a dictated physical exam. Document in the Physical Exam Text field why one race was coded rather than the other.
- Specifically, state in the text when no race information is available. Examples of appropriate text: Race not stated. Patient refused to provide race. Race information not requested from the patient.
- "Other" Race in the medical record does NOT translate to code 98 in the abstract. Specifically state in the text when the record specified the race as "other" and there was **no other information** in the record to determine a specific race (see code 99 below).

Instructions for Coding

1. Race 1, Race 2, Race 3, Race 4, and Race 5 cannot be blank.
2. Code the race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5. When multiple races are reported, use the priority order below.
3. After all applicable races have been coded, record code **88** in the remaining race fields (Race 2 - 5). Code 88 is not allowed in Race 1.
4. Assign the same race code(s) for all tumors for one patient.
5. Codes (other than code 99) must not occur more than once. For example, do not code "Black" in *Race 1* for one parent and "Black" in *Race 2* for the other parent.
6. Code race using the highest priority source available according to the list below (a is the highest and c is the lowest) when race is reported differently by two or more sources.
   a. Self-reported race information takes precedence over genetic testing and over information obtained through linkages. Generally, race information is used from linkages when race data is missing or

unknown, or to enhance data. Self-reported information is the highest priority for coding race because the race information for the U.S. population comes from census data and that information is self-reported. For national cancer statistics, for the numerator (cancer cases) and the denominator (population) to be comparable, use self-reported race information whenever it is available.

b. Documentation in the medical record
c. Death certificate
   i. Note: If the death certificate identifies a more specific race than what is documented in the medical record, update the record with the more specific race. Example: *Race 1* is coded in the cancer record as 96 (Asian). Death certificate gives birthplace as China. Update *Race 1* in the cancer record to 04 (Chinese).
d. Do not use patient photographs or images from social media to code race.

Code 99:

7. Avoid coding unknown in Race 1 (code 99). Exhaust all resources before coding unknown.
8. If *Race 1* is code 99, then *Race 2* through *Race 5* must also be code 99.
9. When the patient face-sheet indicates the race of "Other," look for other descriptions of the patient's race. When **no further information can be obtained from anywhere in the medical record**, **code race as 99 (Unknown by patient)** and document in the text that the patient face-sheet indicated the race as "Other" and no further race information was available.
10. When race is unknown and birthplace is noted in the record, use Appendix D "Race and Nationality Descriptions" on the SEER website to identify nationalities from which race codes may be inferred. (Note: This is confirmed in SEER Question ID: 20091093)

Code 01:

10. Code as **01** (White) when:
    a. The race is described as White or Caucasian (regardless of place of birth).
    b. The patient is Hispanic, Latino, Central American or South American (based on statement in record) *and no further information on race* other than "Hispanic" or "Latino(a)," is available.
       i. A person of Spanish origin may be any race; however, for coding race **when there is no further information other than a statement of "Hispanic" or "Latino(a)," assign race as White as a last resort instead of coding unknown.**
       ii. This rule is confirmed in CAForum threads:
           a. 130933, 8-18-2022 https://cancerbulletin.facs.org/forums/node/130933?view=thread
           b. 1253, 1/18/2017 https://cancerbulletin.facs.org/forums/node/1253

    Example 1: Sabrina Fitzsimmons is a Latina. Code race as 01 (White).
    Note 1: **Do not code 98 (Other) in this situation.**
    Note 2: Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually White.
    Note 3: Do **not** use patient name as the basis for coding race. Look for any evidence of Hispanic, Latino, Central American or South American origin in the record. If not available, code 99.
    Note 4: Refer to the U.S. Census Bureau's explanation of Race versus Hispanic Origin below. If a person indicates their race as "Hispanic" on the census, census data will default this to "Other", not "White". However, the instruction from SEER tells us to code patients of Hispanic, Latino, Central American or South American origin (based on statement in record) as Code 01 (White).

Code 02:

11. Code race as **02** (Black) when:
    a. The stated race is African-American or Black
    Example 2: Patient described as a black female. Code as 02 (Black).

Code 03:

12. Assign code **03** for any person stated to be:
    a. Native Alaskan (includes all indigenous populations of the western hemisphere)

American Indian (including a specific band) and from North, Central, South, or Latin America
Example 3: Patient is stated to be Cherokee. Code 03.

Note: Information from IHS linkage can be used to override unknown race. Code 03 can be added based on IHS linkage. Follow the priority rules for recording race above.

Asian:

13. Assign the specific code when a specific Asian race is stated. Do not use code 96 when a specific race is known.
    Example 4: Patient is described as Asian in a consult note and as second-generation Korean-American (or with Korean parents) in the history. Code Race 1 as 08 (Korean) and Race 2 through Race 5 as 88.
    Example 5: Patient is stated to be Japanese. Code as 05 (Japanese).
14. Code the specific race code based on birthplace information when:
    a. Race is recorded as Oriental, Mongolian, or Asian AND
    b. Place of birth is recorded as China, Japan, the Philippines, or another Asian nation.
    Example 6: Race is recorded as Asian and the place of birth is recorded as Japan.
    Code race as 05 (Japanese) because it is more specific than 96.
    Example 7: The person describes himself as an Asian-American born in Laos.
    Code race as 11 (Laotian) because it is more specific than 96.
    Example 8: The patient is described as Asian-American with Korean parents. Code race as 08 (Korean) because it is more specific than 96 (Asian, NOS).

Codes 96 and 97:

15. Use code 96 (Other Asian including Asian, NOS) or 97 (Pacific Islander, NOS) when a specific Asian race is stated, but there is no specific Asian race code available for that race.
    ***Note*:** Document the specified race in a text field.
16. Do not use code 96 (Other Asian including Asian, NOS) when a specific Asian race is known.
17. Do not code 96 (Other Asian including Asian, NOS) in a subsequent race field when a specific Asian race has been coded.

Code 98:

18. Use code 98 (Some other race) when a specific non-Asian race is stated, but there is no specific race code available for that race.
    ***Note*:** Document the specified race in a text field.
19. Do not use code 98 when a specific race can be determined based on other factors/clues such as a statement of nationality.
    Example 9: Patient is "Belgian." Medical record indicates "non-hispanic, other race." Assign race code 01 for white. "Belgium" is classified as "European" in Appendix D on the SEER website and European is included under the descriptions for white.
20. Do not code 98 (Other) when there is no further information other than a statement of "Hispanic" or "Latino(a)." Assign race code 01 for white as a last resort instead of coding unknown.
21. Do not use codes 96, 97, or 98 for "multi-racial." See Multi-Racial section below.

Coding race based on patient name and place of birth:

22. Do **not** use patient name as the basis for coding race.
23. The race of parents, when known, may be used with caution to determine patient's race in the absence of other more specific information. See Example 8.
24. In some cases, race may be inferred from nationality. **When race is unknown and birthplace is recorded, use Appendix D** "Race and Nationality Descriptions" on the SEER website to identify nationalities from which race codes may be inferred. (Note: This is confirmed in SEER Question ID: 20091093)
    Example 10: Record states: "this native of Portugal..." Code race as 01 (White) per Appendix D.
    Example 11: Record states: "this patient was Nigerian..." Code race as 02 (Black) per Appendix D.

Example 12: A patient was born in Mexico of Mexican parentage. Code race as 01 (White) per Appendix D. Also code *Spanish/Hispanic Origin*.
Example 13: Patient is stated to be German-Irish. Code as 01 (White) per Appendix D.
Example 14: Patient is described as Arabian. Code as 01 (White).
Example 15: The patient is from one of the following Caribbean islands *and no further information on race is available*: Barbados, Haiti, Jamaica, Bahama, Dominican Republic, Santo Domingo, Tobago, Trinidad. Code race as 02 (Black).

25. **Exception:** Code Race as 99 (Unknown) when the patient's name is incongruous with the race inferred based on nationality.
Example 16: Patient's name is Siddhartha Patel and birthplace is England. Code 99.
Example 17: Patient's name is Ping Chen and birthplace is Ethiopia. Code 99.

Priorities for Coding Multiple Races

26. Additional races reported by the person should be coded in *Race 2, Race 3, Race 4* and *Race 5*.
27. Do not use code 96, 97, or 98 for "multi-racial."
28. If the patient is multiracial and there is no further information regarding race, the race is unknown. Race 1 - 5 must all be coded 99. (Reference: CAForum 94347, 8-8-2019)
29. If the patient is multiracial, then code all races using *Race 2* through *Race 5*, and code all remaining *Race* items 88.
Example 18: Patient states she has a Polynesian mother and Tahitian father. Code Race 1 as 25 (Polynesian), Race 2 as 26 (Tahitian) and Race 3 through Race 5 as 88.
Example 19: Patient describes herself as multi-racial (nothing more specific) and nursing notes say "African-American." Code Race 1 as 02 (Black). Code Race 2 as 98 (Some other race). Code Race 3 through Race 5 as 88.
30. Code **07** takes priority over all other codes. If the person is multiracial and one of the races is Hawaiian, code Hawaiian as Race 1, followed by the other race(s).
Example 20: Patient is described as Japanese and Hawaiian. Code Race 1 as 07 (Hawaiian), and Race 2 as 05 (Japanese).
31. Codes **02-32, 96-97** take priority over code **01 and 98.** If the person is multiracial and one of the races is white, code the other race(s) first with white in the next race field.
Example 21: A patient has a Japanese father and a Caucasian mother. Code Race 1 as 05 (Japanese), Race 2 as 01 (Caucasian).
32. Code the specific race before a non-specific race when both a specific race code and a non-specific race code apply.
a. Codes 04-17 take priority over code 96.
b. Codes 16-17 take priority over code 15.
c. Codes 20-32 take priority over code 97.
d. Codes 01-32 and 96-97 take priority over code 98.
e. Code 98 takes priority over code 99.

35. Code in the order stated when no other priority applies.
Example 22: Patient is stated to be Chinese and black. Code Race 1 based on the first stated race, code 04 (Chinese), code Race 2 as 02 (Black).

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black or African American	21	Chamorro
03	American Indian or Alaska Native	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Native Hawaiian Note: If patient is multi-racial, this code has priority over all other codes.	28	Tongan

08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	Papua New Guinean
12	Hmong	96	Other Asian, including Asian, NOS, Oriental, NOS
13	Cambodian	97	Pacific Islander, NOS
14	Thai	98	Some other race. A SPECIFIC RACE IS STATED, but there is no specific race code available for that race.
15	Asian Indian, NOS or Pakistani, NOS	99	• Unknown by patient. • Face-sheet indicates "Other" and no further race information is available. • Patient is multiracial and no further race information is available.
16	Asian Indian		
17	Pakistani		

Summary of Examples Used Above (see above for details of the rule):

Example	Patient stated to be (or is described as):	Race 1 Code	Race 2 Code	Race 3-5 Code
1	Sabrina Fitzsimmons is stated to be a Latina. Also code *Spanish/Hispanic Origin*.	01	88	88
2	Patient described as black	02	88	88
3	Patient is stated to be Cherokee	03	88	88
4	Patient is described as Asian in a consult note and as second-generation Korean-American in the history	08	88	88
5	Patient is stated to be Japanese	05	88	88
6	Race is recorded as Asian and the place of birth is recorded as Japan	05	88	88
7	Patient describes himself as an Asian-American born in Laos	11	88	88
8	Patient is described as Asian-American with Korean parents	08	88	88
9	Patient is "Belgian." Medical record indicates "non-hispanic, other race."	01	88	88
10	Record states: "this native of Portugal..."	01	88	88
11	Record states: "this patient was Nigerian..."	02	88	88
12	Patient was born in Mexico of Mexican parentage. Also code *Spanish/Hispanic Origin*.	01	88	88
13	Patient is stated to be German-Irish	01	88	88
14	Patient is described as Arabian	01	88	88
15	Patient is from one of the following Caribbean islands *and no further information on race is available*: Barbados, Haiti, Jamaica, Bahama, Dominican Republic, Santo Domingo, Tobago, Trinidad.	02	88	88
16	Patient's name is Siddhartha Patel and birthplace is England	99	99	99
17	Patient's name is Ping Chen and birthplace is Ethiopia	99	99	99
18	Patient states she has a Polynesian mother and Tahitian father	25	26	88
19	Patient describes herself as multi-racial (nothing more specific) and nursing notes say "African-American."	02	98	88
20	Patient is described as Japanese and Hawaiian	07	05	88
21	Patient has a Japanese father and a Caucasian mother	05	01	88
22	Patient is stated to be Chinese and black	04	02	88

RACE 2-5

Item Length: 2
Allowable Values: 01–08, 10–17, 20– 22, 25–28, 30–32, 88, 96–99
NAACCR Item #'s 161-164
Revised 01/04, 09/08, 01/10, 01/12

Patient's Race MUST be documented in the Text—Physical Exam field

Description
Identifies the patient's race.

Rationale
Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Instructions for Coding
- "Race" is analyzed with *Spanish/Hispanic Origin* [190]. Both items must be recorded.
- All tumors for the same patient should have the same race code in all race fields.
- If *Race 1* [160] is coded 99, then *Race 2-5* must be coded 99.
- See the instructions for *Race 1* [160] for coding sequences for entering multiple races.

Historical:
- *Race 1* is the field used to compare with race data on cases diagnosed prior to January 1, 2000.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was retired. All cases coded to 09 were converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991.
- If *Race Coding System–Current* [170] is less than six (6) for cases diagnosed prior to January 1, 2000, then *Race 2* through *Race 5* must be blank.
- If a patient diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race 1-5* must be identical on all records. *Race 2-5,* that do not have specific race recorded, must be coded 88.

SPANISH/HISPANIC ORIGIN

Allowable Values: 0–7, 9
NAACCR Item #190
Revised 9/04, 1/24

If of Spanish/Hispanic Origin, it MUST be stated in the Text—Physical Exam field

Description
Identifies persons with Spanish/Hispanic surname or of Spanish or Hispanic origin.

Rationale
Used to show the "best guess" as to whether the person should be classified as "Hispanic" for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included under code 01 in Race.

Instructions for Coding

- Persons of Spanish or Hispanic origin may be of any race, but these categories generally are not used for Native Americans, Filipinos, etc., who may have Spanish names.
- If a patient has a Hispanic name, but there is reason to believe they are not Hispanic (e.g., the patient is Filipino, or the patient is a woman known to be non-Hispanic who has a Hispanic married name), the code in this field should be 0 (non-Spanish, non-Hispanic).
- Use all information to determine the Spanish/Hispanic Origin, including:
    - Ethnicity stated in the medical record. Self-reported takes priority over other sources.
    - Hispanic origin stated on the death certificate
    - Birthplace
    - Information about life history and/or language spoken found in the abstracting process
    - A last name or maiden name (birth surname) found on a list of Hispanic/Spanish names.
- There is no hierarchy among the codes 1-5 or 8.
- Portuguese, Brazilians, and Filipinos are not presumed to be Spanish or non-Spanish
    - Assign code 7 when their name appears on a Hispanic surname list
    - Assign code 0 when their name does NOT appear on a Hispanic surname list

Code	Label
0	Non-Spanish; non-Hispanic.
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central America (except Brazil). See list of countries below.
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS Evidence **other than surname** that the person is Hispanic but cannot be assigned to codes 1–5. More than one ethnicity/origin (multiple codes), such as Mexican (code 1) and Dominican Republic (code 8).
7	Spanish surname only **ONLY** evidence of Hispanic origin is surname and there is no contrary evidence that the person is not Hispanic.
8	Dominican Republic
9	• Unknown whether Spanish or not • Not stated in patient record • No indication of Spanish origin • Patient declined to answer their Spanish origin • Patient does not know their Spanish origin. ***Example***: The patient's race is white or black, they were born in the United States, their last name is not on a Spanish surname list, and there is no mention of Spanish origin in the patient record.

Coding Examples

Example 1: Married female, no married name, born in Mexico, surname is not on Spanish surname list. Code as 1 (Mexican) based on birthplace.

Example 2: Married female, no maiden name (birth surname), born in Philippines, married last name not on Spanish surname list and medical record states “Hispanic.” Code as 6 (Hispanic, NOS) based on ethnicity stated in the record.

Example 3: Married female, no maiden name (birth surname), born in Peru, married last name is on Spanish surname list, no statement regarding ethnicity available. Code as 4 (South or Central America) based on birthplace.

Example 4: Patient has two last names, one of the last names is on the Spanish surname list. Code as 7 (Spanish surname only).

Countries in Central America

- Belize
- Costa Rica
- El Salvador
- Guatemala
- Honduras
- Nicaragua
- Panama

Countries in South America

- Argentina
- Bolivia
- Brazil [Not included in code 4]
- Chile
- Colombia
- Ecuador
- Guyana
- Paraguay
- Peru
- Suriname
- Uruguay
- Venezuela

SEX ASSIGNED AT BIRTH

Item Length: 1
Allowable Values: 1–2, 9
NAACCR Item #225
Revised 01/15, 01/16, 1/26

Patient's Gender MUST be documented in the Text—Physical Exam field

Description
Identifies the sex of the patient.

Effective 1/1/2026, Sex Assigned at Birth [225] replaced Sex [220] for all cases regardless of diagnosis year. Data in Sex [220] was converted to populate Sex Assigned at Birth [225]. Codes 3-6 (Other/Transexual) were eliminated.

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

Instructions for Coding

- Assign the sex of the patient assigned at birth
- Assign code 1 or 2 when the patient's sex is documented as male or female, respectively, and there is no other information to indicate the patient was assigned a different sex at birth
- When sex is not known
    a. Assign code 1 when the primary site is C600-C639
    b. Assign code 2 when the primary site is C510-C589
    c. Assign code 9 for primary sites not included above
- Assign code 9
    a. When sex is unknown (excluding Coding Instructions a and b above) or sex is not yet determined
        i. Do not assign code 9 when sex is documented as male or female and there is no other information about sex assigned at birth
    b. If patient is born with Disorders of Sexual Development (DSD) and sex is not clearly defined
    c. When patient's sex is documented as other than male or female (e.g., non-binary, transsexual), and there is no additional information about sex assigned at birth

Code	Label
1	Male
2	Female
9	Not stated in patient record

PRIMARY PAYER AT DIAGNOSIS

Item Length: 2
Allowable Values: 01, 02, 10, 20, 21, 31, 35, 60–68, 99
NAACCR Item #630
Revised 06/05, 01/10

Description
Identifies the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

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

Instructions for Coding
- Code the type of insurance reported on the patient's admission record.
- Code the **first** insurance mentioned when:
    - multiple insurance carriers are listed on one admission record.
    - there is more than one type of insurance specified during the initial diagnosis and/or treatment
- Code the type of insurance reported closest to the date of diagnosis when there are multiple insurance carriers reported for multiple admissions and/or multiple physician encounters.
- Code the patient's insurance at the time of initial diagnosis and/or treatment. Do not change the insurance information based on subsequent information.
- If the patient is diagnosed elsewhere or the payer at the time of diagnosis is not known record the payer when the patient is initially admitted for treatment.
- If the patient's payer or insurance carrier changes, do not change the initially recorded code.

Code	Label	Definition
01	Not insured	Patient has no insurance and is declared a charity write-off.
02	Not insured, self-pay	Patient has no insurance and is declared responsible for charges. Only information is "self pay".
10	Insurance, NOS	Type of insurance unknown or other than the types listed in codes 20, 21, 31, 35, 60–68. Includes prisoners when no further information is available.
20	Private insurance: Managed Care, HMO or PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network or a staff model. "Gate-keeper model" is another term for describing this type of insurance.
21	Private insurance: Fee-for-Service	An insurance plan that does not have a negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level or covered under entitlement programs. Medicaid other than described in code 35.
35	Medicaid administered through a Managed Care plan	Patient is enrolled in **Medicaid** through a Managed Care program (for example, HMO or PPO). The Managed Care plan pays for all incurred costs.

60	Medicare without supplement, Medicare, NOS	Federal government funded insurance for persons who are 65 years of age or older, or are chronically disabled (Social Security insurance eligible), or are dialysis patients. Includes Medicare without supplement. Not described in codes 61, 62 or 63.
61	Medicare with supplement, NOS	Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare. Example: Patient is known to have Medicare with a supplement, but the type of Medicare supplement is unknown.
62	Medicare administered through a Managed Care plan	Patient is enrolled in **Medicare** through a Managed Care plan (for example, HMO or PPO). The Managed Care plan pays for all incurred costs. Example: Patient has a Medicare managed plan (also known as Medicare C or Medicare Advantage). The Medicare managed care plan takes the place of original Medicare plan and will be listed as the first and usually only insurance as a HMO, PPO, etc.
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare. Example: Patient has Medicare A (inpatient) and B (outpatient and durable medical equipment) with a private supplement to cover costs outside of Medicare A and B. Medicare with be listed on the patient's face sheet as the first insurance with the commercial insurance (Medicare supplement) listed second. If Medicare is listed first with Medicaid listed second, capture under code 64.
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with State Medicaid administered supplement.
65	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees and their dependents. Formally CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).
66	Military	Military personnel or their dependents who are treated at a military facility.
67	Veterans Affairs	Veterans who are treated in Veterans Affairs facilities.
68	Indian/Public Health Service	Patient who receives care at an Indian Health Service facility or at another facility, and the medical costs are reimbursed by the Indian Health Service. Patient receives care at a Public Health Service facility or at another facility, and medical costs are reimbursed by the Public Health Service.
99	Insurance status unknown	It is unknown from the patient's medical record whether or not the patient is insured.

Examples

Code	Reason
01	An indigent patient is admitted with no insurance coverage.
20	A patient is admitted for treatment and the patient admission page states the primary insurance carrier is an HMO.

TOBACCO USE SMOKING STATUS

Item Length: 1
Allowable Values: 0-3, 9
NAACCR Item #344
Effective 1/1/2022

Description
Effective 1/1/2022, captures the patient's past or current use of tobacco (cigarette, cigar and/or pipe).

Instructions for Coding
Tobacco smoking history can be obtained from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats or Nursing Assessment section, or other available sources from the hospital or physician office record.

- Record the past or current use of tobacco. Tobacco use includes cigarettes, cigar, and/or pipe.
- Tobacco use does not include chewing tobacco, marijuana, e-cigarettes, or vaping devices. Do not record the patient's past or current use of these products.*
- Assign code 1 when
    - The patient currently smokes
    - Record only states "current tobacco use"
    - It is known that the patient stopped smoking within 30 days prior to diagnosis. The risks associated with smoking decrease as the time from cessation increases which means a person who stopped smoking within the last 30 days has the same risks as a current smoker.
- Assign code 2 when the medical record indicates
    - "Former smoker"
    - "Prior tobacco use"
    - Patient has smoked tobacco in the past (greater than 31 days prior) but does not smoke now

  Note: If there is evidence in the medical record that the patient quit recently (within 30 days prior to diagnosis), assign code 1, current smoker. The 30 days prior information, if available, is intended to differentiate patients who may have quit recently due to symptoms that lead to a cancer diagnosis.
- Assign code 3 when
    - The patient is noted to have smoked, but the current smoking status is not known.
    - It is known that the patient "recently" stopped smoking but it is not known how long ago the patient stopped smoking
    - It cannot be determined whether the patient currently smokes or formerly smoked. For example, the medical record only indicates "Yes" for smoking without further information.
- Assign code 9 when
    - The medical record only indicates "No" for tobacco use.
    - There is no information about smoking status or history.
    - It is documented that the patient uses or used smokeless or chewing tobacco or e-cigarettes or vapes, but specific statement of tobacco use is not mentioned.

*This data item is for the specific use of tobacco products. Electronic cigarettes are not considered tobacco use as they use liquid nicotine and do not contain tobacco. However, these users may have a history of tobacco use that should be considered. Smoking, vaping or consuming products other than tobacco, such as liquid nicotine, CBD or marijuana is not included and should be noted in the text only.

Code	Label
0	Never smoker
1	Current some day smoker
2	Former smoker (must have quit 31 or more days prior to cancer diagnosis)
3	Smoker, current status unknown
9	Unknown if ever smoked tobacco; tobacco use status not stated

SECONDARY DIAGNOSIS #1

Item Length: 7
NAACCR Item #3780
New 01/01/2013, Revised: 01/15, 01/22

For cases diagnosed 1/1/2018 and after, only the Secondary Diagnosis data items are required.
Refer to previous versions of the CCARM for collecting Comorbid Conditions/Complication data items for pre-2018 cases.

Description
Records the patient's preexisting medical conditions, factors influencing health status and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-10-CM values.

Rationale
Preexisting medical conditions, factors influencing health status and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Three general categories of information are collected:

- Comorbidities: Preexisting medical conditions or conditions that were present at the time the patient was diagnosed with this cancer (for example, chronic conditions such as COPD, diabetes and hypertension).
- Complications: Conditions that occur during the hospital stay, while the patient is being treated for the cancer (for example, postoperative urinary tract infection or pneumonia). Complications may also occur following the completion of therapy and be a cause for readmission to the hospital. Complications are identified by codes which classify environmental events, circumstances and conditions as the cause of injury, poisoning and other adverse effects. Only complication codes that describe adverse effects occurring during medical care are collected in this data item. They include misadventures to patients during surgical and medical care, and drugs and medicinal and biologic substances causing adverse effects in therapeutic use.
- Factors influencing the health status of patients: Circumstances or problems that are not themselves a current illness or injury (for example, women receiving postmenopausal hormone replacement therapy or a history of malignant neoplasm). Only specific codes which describe health characteristics are collected in this data item. They include prophylactic measures, personal health history, pregnancy, contraception, artificial opening and other post-surgical states, and prophylactic organ removal.

The N.C. CCR requires that the facility record all eligible secondary diagnoses (up to 10). This information is recorded in International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code form. These codes are to be copied from the patient record. The abstractor does not need to review the record to determine these codes. Typically, this information can be found in the patient's discharge or face sheet of the billing record.

Instructions for Coding

- Use this item to record ICD-10-CM codes.
- Omit the decimal points when coding.
- Secondary diagnoses are found on the discharge abstract or from the billing department.
- Code the secondary diagnoses in the sequence in which they appear on the discharge abstract.
- Report the secondary diagnoses for this cancer using the following priority rules:
  - -Surgically treated patients:
    - a) following the most definitive (most invasive) surgery of the primary site (procedure recorded in the RxSumm-Surg 2023 data item)
    - b) following other non-primary site surgeries
  - -Non-surgically treated patients: following the first treatment encounter/episode
  - -In cases of non-treatment: following the last diagnostic/evaluative encounter

- If no ICD-10-CM secondary diagnoses were documented, then code 0000000 in this data item and leave the remaining *Secondary Diagnosis* data items blank.
- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed and leave the remaining *Secondary Diagnosis* data items blank.

Allowable Values: 0000000; all values beginning with A-B, E, G-P, R-S, U; and the following ranges: T36-T50996ZZ, U070-U071, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ
Left Justified, omit decimals, all alpha characters capitalized, Trailing blanks allowed.

Examples	Reason
J449	Chronic obstructive pulmonary disease, unspecified (ICD-10-CM code J44.9)
E119	Type 2 diabetes mellitus without complications (ICD-10-CM code E11.9)
Y632	The patient was inadvertently exposed to an overdose of radiation during a medical procedure (ICD-10-CM code E873.2)
T360X5	During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-10-CM code T36.0X5)
Z853	The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)
0000000	No applicable ICD-10-CM codes are recorded in this patient's record

SECONDARY DIAGNOSIS #2-10

Item Length: 7
NAACCR Item #'s 3782, 3784, 3786, 3788, 3790, 3792, 3794, 3796, 3798
New 01/01/2013

Description
Records the patient's preexisting medical conditions, factors influencing health status and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-10-CM values.

Rationale
Preexisting medical conditions, factors influencing health status and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Instructions for Coding
- Use this item to record ICD-10-CM codes.
- Omit the decimal points when coding.
- Secondary diagnoses are found on the discharge abstract or from the billing department.
- Code the secondary diagnoses in the sequence in which they appear on the discharge abstract.
- Report the secondary diagnoses for this cancer using the following priority rules:
  -Surgically treated patients:
    a) following the most definitive surgery of the primary site
    b) following other non-primary site surgeries
  -Non-surgically treated patients: following the first treatment encounter/episode
  -In cases of non-treatment: following the last diagnostic/evaluative encounter
- If no ICD-10-CM secondary diagnoses were documented, then code 0000000 in the Secondary Diagnosis #1 data item and leave the remaining *Secondary Diagnosis* data items blank.
- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed and leave the remaining *Secondary Diagnosis* data items blank.

Allowable Values: 0000000; all values beginning with A-B, E, G-P, R-S, U; and the following ranges:
T36-T50996ZZ, U070-U071, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ
Left Justified, omit decimals, all alpha characters capitalized, Trailing blanks allowed.

Examples: Refer to examples provided in the Secondary Diagnosis #1 data item.

NPI–MANAGING PHYSICIAN

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2465
Revised 04/07, 09/08

Description
Identifies the physician who is responsible for the overall management of the patient during diagnosis and/or treatment of this cancer.

Rationale
The managing physician is responsible for the patient's work-up, plans the treatment and directs the delivery of patient care. In most cases, the managing physician is responsible for AJCC staging.

Instructions for Coding
- Record the 10-digit NPI for the physician responsible for managing the patient's care.
- Check with the billing or health information departments to determine the physician's NPI or search at https://npiregistry.cms.hhs.gov/search
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Do not update this item. Once the registry has designated a managing physician for the patient, this item should not be changed even if a different managing physician is assigned.

Code	Definition
(fill spaces)	10-digit NPI number for the managing physician.
(leave blank)	NPI for the managing physician is unknown or not available.

MANAGING PHYSICIAN

Item Length: 8
Left Justified
NAACCR Item #2460

Description
Code for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer. Registry may use physicians' medical license numbers or may create individual numbering systems.

Rationale
The managing physician is responsible for the patient's work-up, plans the treatment and directs the delivery of patient care. In most cases, the managing physician is responsible for AJCC staging.

Instructions for Coding
- The registry assigns a unique number to the physician. Many registries use the physician's state medical license number or create an individual numbering system.
- For incidence facilities where a number system is not available, the physician's last name can be entered. Enter as many characters as allowed (up to eight).
- Once the registry has designated a managing physician for the patient, the information should not be changed or updated.

Code	Definition
(fill spaces)	The identification number may include numbers and letters. *Note:* If the patient did not have surgery, use the code for the surgeon who performed any surgery or did a surgical consultation.
99999999	The physician is unknown or an identification number is not assigned.

NPI–FOLLOWING PHYSICIAN

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2475
Revised 04/07, 09/08, 01/11

Description
Records the NPI for the physician currently responsible for the patient's medical care.

Rationale
The following physician is the first contact for obtaining information on a patient's status and subsequent treatment. This information may be used for outcomes studies.

Instructions for Coding
- Record the 10-digit NPI for the physician currently responsible for the patient's medical care.
- Check with the billing or health information departments to determine the physician's NPI or search at https://npiregistry.cms.hhs.gov/search
- Change this data item when patient follow-up becomes the responsibility of another physician.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definition
(fill spaces)	10-digit NPI number for the following physician.
(leave blank)	NPI for the following physician is unknown or not available.

FOLLOWING PHYSICIAN

Item Length: 8
Left Justified
NAACCR Item #2470

Description
Code for the physician currently responsible for the patient's medical care. Registry may use physicians' medical license numbers or may create individual numbering systems.

Rationale
The following physician is the first contact for obtaining information on a patient's status and subsequent treatment. This information may be used for outcomes studies.

Instructions for Coding

- The registry assigns a unique number to the physician. Many registries use the physician's state medical license number or create an individual numbering system.
- For incidence facilities where a number system is not available, the physician's last name can be entered. Enter as many characters as allowed (up to eight).
- Once the registry has designated a following physician for the patient, the information should not be changed or updated.

Code	Definition
(fill spaces)	The identification number may include numbers and letters. *Note:* If the patient did not have surgery, use the code for the surgeon who performed any surgery or did a surgical consultation.
99999999	The physician is unknown or an identification number is not assigned.

NPI–PRIMARY SURGEON

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2485
Revised 04/07, 09/08, 01/11

Description
Identifies the physician who performed the most definitive surgical procedure.

Rationale
Administrative, physician and service referral reports are based on this item.

Instructions for Coding
- Record the 10-digit NPI for the physician who performed the most definitive (most invasive) surgical procedure.
- Check with the billing or health information departments to determine the physician's NPI or search at https://npiregistry.cms.hhs.gov/search
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Do not update this item. Once the registry has designated a primary surgeon for the patient, the information should not be changed or updated even if the patient receives care from another surgeon.

Code	Definitions
(fill spaces)	10-digit NPI number for the primary surgeon.
(leave blank)	The patient did not have surgery. NPI for the primary surgeon is unknown or not Available. The physician who performed the surgical procedure was not a surgeon (for example, general practitioner).

PRIMARY SURGEON

Item Length: 8
Left Justified
NAACCR Item #2480

Description
Records the identification number of the physician who performed the most definitive surgical procedure.

Rationale
Administrative, physician and service referral reports are based on this data item. Used to monitor patient surgical care.

Instructions for Coding

- The registry assigns a unique number to the primary surgeon. Many registries use the physician's state medical license number or create an individual numbering system.
- Incidence facilities where a number system is not available, the physician's last name can be entered. Enter as many characters as allowed (up to eight).
- If the patient did not have surgery, use the code for the surgeon who performed any surgery or did a surgical consultation.
- Once the registry has designated a primary surgeon for the patient, the information should not be changed or updated even if the patient receives care from another surgeon.

Code	Definition
(fill spaces)	The identification number may include numbers and letters. *Note:* If the patient did not have surgery, use the code for the surgeon who performed any surgery or did a surgical consultation.
00000000	Patient had no surgery and no surgical consultation.
88888888	Physician who performed a surgical procedure was not a surgeon, for example, radiation oncologist, diagnostic radiologist or general practitioner.
99999999	The primary surgeon is unknown or an identification number is not assigned.

NPI–PHYSICIAN #3

(Radiation Oncologist–Preferred Use)

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2495
Revised 04/07, 09/08, 01/10, 01/11

Description

Records the NPI for a physician involved in the care of the patient. Use this item to identify the physician who performed the most definitive radiation therapy or provided the radiation consult.

Rationale

Administrative, physician and service referral reports are based on this data item. It also can be used for follow-up purposes.

Instructions for Coding

- Record the 10-digit NPI for the physician.
- Check with the billing or health information departments to determine the physician's NPI or search at https://npiregistry.cms.hhs.gov/search.
- Do not update this item. If the registry has designated a primary radiation oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another radiation oncologist.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definition
(fill spaces)	10-digit NPI number for the primary radiation oncologist.
(leave blank)	NPI for the primary radiation oncologist is unknown or not available.

PHYSICIAN #3

(Radiation Oncologist–Preferred Use)

Item Length: 8
Left Justified
NAACCR Item #2490

Description

Code for another physician involved in the care of the patient. Use this item to identify the physician who performed the most definitive radiation therapy or provided the radiation consult. Registry may use physicians' medical license numbers or may create individual numbering systems.

Rationale

Administrative, physician and service referral reports are based on this data item. It also can be used for follow-up purposes.

Instructions for Coding

- The registry assigns a unique number to the physician. Many registries use the physician's state medical license number or create an individual numbering system.
- For incidence facilities where a number system is not available, the physician's last name can be entered. Enter as many characters as allowed (up to eight).
- If the patient received radiation therapy (or a consult for radiation therapy), enter the primary radiation oncologist.
- Do not update this data item even if the physician changes.

Code	Definition
(fill spaces)	The identification number may include numbers and letters. *Note:* If the patient did not have surgery, use the code for the surgeon who performed any surgery or did a surgical consultation.
00000000	No additional physician. The patient did not receive radiation therapy and was not referred for a radiation therapy consult.
99999999	The physician is unknown or an identification number is not assigned.

NPI–PHYSICIAN #4

(Medical Oncologist–Preferred Use)

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2505
Revised 09/08, 01/10, 01/11, 01/12

Description

Records the NPI for a physician involved in the care of the patient. It is recommended that this data item identify the physician who gives the most definitive systemic therapy.

Rationale

Administrative, physician and service referral reports are based on this data item. It also can be used for follow-up purposes.

Instructions for Coding

- Record the 10-digit NPI for the physician.
- Check with the billing or health information departments to determine the physician's NPI or search at https://npiregistry.cms.hhs.gov/search.
- Do not update this item. If the registry has designated a primary medical oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another medical oncologist.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definition
(fill spaces)	10-digit NPI number for the primary medical oncologist.
(leave blank)	NPI for the primary medical oncologist is unknown or not available.

PHYSICIAN #4

(Medical Oncologist–Preferred Use)

Item Length: 8
Left Justified
NAACCR Item #2500

Description

Code for another physician involved in the care of the patient. Use this item to identify the physician who provided system therapy or provided the medical oncology consult. Registry may use physicians' medical license numbers or may create individual numbering systems.

Rationale

Administrative, physician and service referral reports are based on this data item. It also can be used for follow-up purposes.

Instructions for Coding

- The registry assigns a unique number to the physician. Many registries use the physician's state medical license number or create an individual numbering system.
- For incidence facilities where a number system is not available, the physician's last name can be entered. Enter as many characters as allowed (up to eight).
- If the patient received systemic therapy (or a consult for systemic therapy), enter the primary medical oncologist.
- Do not update this data item even if the physician changes.

Code	Definition
(fill spaces)	The identification number may include numbers and letters. *Note:* If the patient did not have surgery, use the code for the surgeon who performed any surgery or did a surgical consultation.
00000000	No additional physician. The patient did not receive systemic therapy and was not referred for a medical oncology consult.
99999999	The physician is unknown or an identification number is not assigned.

TEXT--USUAL OCCUPATION

Item Length: 100
NAACCR Item #310

Description
Text area for information about the patient's usual occupation, also known as usual type of job or work.

Rationale
Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies occupational groups in which cancer screening or prevention activities may be beneficial.

The data item "usual occupation" is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death. See also*: Guidelines for Reporting Occupation and Industry on Death Certificates*, National Center for Health Statistics, CDC, DHHS Pub. No. (PHS) 88-1149.

For more information on collecting Industry and Occupation information, refer to A Cancer Registrar's Guide to Collecting Industry and Occupation, https://www.cdc.gov/niosh/docs/2011-173/.

Instructions for Coding
- Record the patient's usual occupation (i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor).
- If no information is available on the usual occupation, record the most recent occupation.
- If later documentation provides an occupation that is more likely to be the usual occupation than what was originally recorded, update the abstract with the new information. It is not necessary to update abstracts with occupation information provided on death certificates. Comparison with death certificate information will be done by the central cancer registry.

If the patient:	Occupation is:	Industry is:
Retired	DO NOT RECORD RETIRED. If the usual occupation is not available, record the most recent occupation, or any available occupation.	DO NOT RECORD RETIRED. If the usual industry is not available, record the most recent or any available.
Is a homemaker and did not work outside the home for most of his/her adult life	HOMEMAKER	OWN HOME
Worked at someone else's home	HOUSEKEEPER, NURSE, BABYSITTER, etc.	PRIVATE HOME
Is a homemaker and also worked outside the home during most of his/her adult life	Usual occupation outside the home	Usual industry outside the home
Ever worked outside of the home	Longest held occupation outside the home	Longest held industry outside the home
Is under 14 years of age	CHILD	CHILD
Is a student > 14 years of age at the time of diagnosis and never held a job	STUDENT	Type of School (HIGH SCHOOL, COLLEGE, etc.)
Is not a student or homemaker and has never worked	NEVER WORKED	NEVER WORKED
Was part of the military most of their adult life	MILITARY	MILITARY
Institutionalized, Disabled or Unemployed	Longest held occupation	Longest held industry
Self-employed	Usual occupation. Do not record "Self-employed"	Usual occupation. Do not record "Self-employed"
No information is available on the usual or most recent occupation/industry	UNKNOWN	UNKNOWN

TEXT--USUAL INDUSTRY

Item Length: 100
Mixed Case, Left Justified
NAACCR Item #320

Description
Text area for information about the patient's usual industry, also known as usual kind of business/industry.

Rationale
Both occupation and business/industry are required to accurately describe an individual's occupation. Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

The data item "usual industry" is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death. See also: *Guidelines for Reporting Occupation and Industry of Death Certificates*, National Center for Health Statistics, CDC, DHHS Pub. No. (PHS) 88-1149.

For more information on collecting Industry and Occupation information, refer to A Cancer Registrar's Guide to Collecting Industry and Occupation, https://www.cdc.gov/niosh/docs/2011-173/.

Instructions for Coding
- Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that performs more than one of these components.
- If the primary activity is unknown or cannot be determined based on the occupation, record the name of the company in which the patient performed his/her usual occupation.
- In those situations where the usual occupation is not known, the patient's current or most recent occupation is recorded. The information for industry should be based upon the information in occupation. Therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient's current or most recent business/industry.
- If later documentation provides an industry that is more likely to be the usual industry than what was originally recorded, update the abstract with the new information. It is not necessary to update abstracts with occupation information provided on death certificates. Comparison with death certificate information will be done by the central cancer registry.
- There should be an entry for Text--Usual Industry if any occupation is recorded.
- Refer to the Special Cases listed in the Usual Occupation data item for what to record as the Industry for those special cases.

Cancer Identification

SEQUENCE NUMBER

Item Length: 2
Allowable Values: 00–88, 99
NAACCR Item #560
Revised 06/05, 04/07, 01/10, 01/13

Description
Sequence Number describes the number and sequence of all reportable malignant, in situ, benign, and borderline primary tumors that occur over the lifetime of a patient. This sequence number counts all tumors that were reportable in the year they were diagnosed even if the tumors occurred before the registry existed.

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

Accession Number [550] and Sequence Number [560] uniquely identify the patient and tumor. Each patient is assigned a unique accession number, and each primary tumor diagnosed for that patient is assigned a sequence number. The accession number never changes.

- Accession numbers are never reassigned, even if a patient is removed from the registry.
- The sequence number is the sequence of all tumors over the lifetime of a patient and is counted throughout the patient's lifetime.
- Only tumors that would have been reportable at the time of diagnosis are required to be counted when assigning sequence numbers.

Note: Accession numbers are not required for incidence facilities or cases reported by physician offices. Sequence number is required.

Instructions for Coding

- Rules for Determining Multiple Primaries and the N.C. CCR reportability requirements for each diagnosis year should be used to decide how primaries need to be sequenced.
  - Intraepithelial neoplasia that is reportable to the N.C. CCR, such as VIN III, would be included in when determining sequence number.
  - Cancers that are not reportable, such as CIS of the Cervix, would not be included in when determining sequence number.
- Any tumor in the patient's past which was reportable at the time the current tumor is diagnosed must be considered when sequencing the current tumor.

  Example: Borderline tumors of the ovary were reported for 1992-2000. If the patient was diagnosed with a borderline tumor of the ovary in this timeframe, include that primary when determining the sequence number for later diagnoses.
- Do not change the sequence number for neoplasms whose histology codes were associated with behavior codes that changed from in situ/malignant to benign/borderline or vice versa during the conversion from ICD-O-2 to ICD-O-3 or the conversion from ICD-O-3 to ICD-O-3.2. For example, do not reassign sequence numbers if a tumor later becomes non-reportable.
- Sequence numbers should be reassigned if the facility learns later of an unreported tumor that affects the sequence.

Sequence numbers are divided into two groups:

1. Codes 00–59 and 99 indicate neoplasms of *in situ* or invasive behavior (*Behavior* equals 2 or 3).
2. Codes 60–88 indicate neoplasms of non-malignant behavior (*Behavior* equals 0 or 1). Reportable benign and borderline intracranial/CNS tumors are restricted to primary site codes C700-C729, C751-C753 with behavior codes of /0 or /1 diagnosed in 1990 and forward.

Assign the sequence number for each group independently.

- Consider only neoplasms of *in situ* or *invasive* behavior (*Behavior* equals 2 or 3) when assigning a sequence code in the 00-59 range.
- Consider only neoplasms of *non-malignant* behavior (*Behavior* equals 0 or 1) when assigning a sequence code in the 60-88 range.

  Example: A patient with a history of a malignant lung cancer is diagnosed with a benign meningioma.

  Lung cancer sequence number: 00
  Meningioma sequence number: 60

  The sequence number for the non-malignant tumor is not affected by the patient's history of a malignant tumor.

Malignant or In Situ Primaries

- Use codes 00–59 and 99.
- Count all previous and current in situ/malignant reportable primaries which occur(red) over the lifetime of the patient, regardless of where the cancer was diagnosed and treated. A 'reportable' primary refers to the site/histology/behavior of the tumor and the years when reporting was required. Review of the reportability requirements in effect during the diagnosis year will be needed.

  Example 1: Assign sequence number 02 to a melanoma diagnosed on August 30, 2026, following a breast cancer *in situ* diagnosis on June 13, 2026.

  Example 2: A patient is admitted for first course surgery for a colon adenocarcinoma. The patient has a prior history of three malignant cancers that are considered reportable cancers. Assign sequence number 04 to the colon primary. Since the facility did not manage the three previous cancers, they will not be abstracted. Include a note in the text (preferably Text--Remarks) regarding the previous history of cancer(s).

- Code 00 when there is only one primary in the patient's lifetime. There are no prior or subsequent malignant or in situ tumors.

  Example: Patient with no history of cancer is diagnosed with *in situ* breast carcinoma on June 13, 2026. Assign sequence number 00.

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

- If the patient develops a subsequent malignant or *in situ* primary tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially: 01 (first of one or more), 02 (second primary), 03 (third primary), etc.

  Example 1: The patient has a history of breast cancer in 1999. The breast cancer would have been original abstracted with a sequence of 00. She has colon cancer in 2010. Assign sequence number 02 to the colon cancer and change the sequence number on the breast cancer from 00 to 01.

  Example 2: In 1987, patient was diagnosed and treated for childhood leukemia in another state. After moving to NC, the patient develops bladder cancer. Assigns a sequence number of 02 to the bladder cancer. Document the first diagnosis in a text field (preferably Text--Remarks).

Code	Definition
00	One malignant or *in situ* primary only in the patient's lifetime
01	First of two or more independent malignant or *in situ* primaries
02	Second of two or more independent or *in situ* primaries
…	
…	(Actual sequence of this malignant or *in situ* primary)
…	
59	Fifty-ninth of 59 or more independent malignant or *in situ* primaries
99	Unknown number of malignant or *in situ* primaries

Non-Malignant Primaries
Reportable benign and borderline intracranial/CNS tumors are restricted to primary site codes C700-C729, C751-C753 with behavior codes of /0 or /1 diagnosed in 1990 and forward.

- Use codes 60–88.
- Count all previous and current non-malignant primary intracranial /CNS tumors diagnosed in 1990 and forward, regardless of where the cancer was diagnosed and treated.
- Code 60 only if the patient has a single nonmalignant primary. There are no prior or subsequent non-malignant intracranial/CNS tumors.
- If the patient develops a subsequent non-malignant primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent nonmalignant primaries sequentially.
- Assign sequence numbers in chronological order according to the order in which they occur(red).

  Example: Myeloproliferative disease (9975/1) is diagnosed by the facility in 2015 and abstracted with a sequence code of 60. The patient comes to the facility in 2021 and diagnosed with a benign brain tumor. The patient's history indicates that a separate, independent benign brain tumor was also diagnosed and treated elsewhere in 2017.

  The benign brain tumor diagnosed in 2017 is not required to be abstracted by the reporting facility but is still factored into the sequence number. It would be considered to have a sequence code of 62. The sequence number for the myeloproliferative disease is updated to 61. The second benign

brain tumor diagnosed in 2021 is assigned a sequence code of 63. Details regarding the first benign brain tumor in 2017 will be noted in the text (preferably Text--Remarks).

Code	Definition
60	One nonmalignant primary only in the patient's lifetime
61	First of two or more independent nonmalignant primaries
62	Second of two or more independent nonmalignant primaries
…	
…	(Actual sequence of this nonmalignant primary)
…	
87	Twenty-seventh of 27 or more independent nonmalignant primaries
88	Unspecified number of independent nonmalignant primaries

CLASS OF CASE

Item Length: 2
Allowable Values: 00, 10-14,
20-22, 30-38, 40-43, 49, 99
NAACCR Item #610
Revised 1/10, 5/10, 1/11, 1/12, 1/15, 1/22

Description
Class of Case divides cases into two groups:

- Analytic cases (codes 00–22) are those that are required by CoC to be abstracted because of the program's primary responsibility in managing the cancer. Analytic cases are grouped according to the location of diagnosis and first course of treatment.
- Nonanalytic cases (codes 30–49 and 99) must be abstracted by the facility to meet central registry requirements or in response to a request by the facility's cancer program. Nonanalytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.

Rationale
Class of Case reflects the facility's role in managing the cancer.

N.C. CCR REQUIREMENTS:
These instructions were adopted from the STORE which applies to CoC accredited cancer programs. The N.C. statutes require facilities to report all patients with active disease from a reportable malignancy. This includes cases that meet the criteria for:

- any analytic class of case category (00, 10-14 and 20-22)
- certain non-analytic class of case categories (30-32 and 34-38)
- reporting is encouraged for class of case categories 33 and 40-43.

REFER TO SECTION ONE: CASE ELIGIBILITY FOR DETAILED INFORMATION ON REPORTING NON-ANALYTIC CLASS OF CASE CATEGORIES.

Instructions for Coding

- Code the *Class of Case* that most precisely describes the patient's relationship to the facility.
- It is possible that information for coding *Class of Case* will change during the patient's first course of care. If that occurs, change the code accordingly.
- Physicians who are not employed by the hospital but are under contract with it or have routine admitting privileges there are described in codes 10-12 and 41 as physicians with admitting privileges.
- Treatment provided in the office of a physician with admitting privileges is considered "elsewhere". That is because care given in the physician's office is not within the hospital's realm of responsibility.
- If the hospital has purchased a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (its activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved are staff physicians or not, as with any other physician.

Oral Medication

- Monitoring of oral medication started elsewhere is coded Class of Case 31.

- If the treatment the patient receives at your facility is part of the first course of treatment plan and is administered before disease progression or recurrence, this is an analytic case for your facility. For example, if a patient is diagnosed and treated at another facility and is started on hormone therapy at another facility and then presents to our facility with continuation of hormone therapy, if the first course of treatment plan includes tamoxifen for 5 years, assign class of case 21 (part of first course treatment elsewhere, part of first course of treatment at the reporting facility) even if there is no longer active disease.

Additional Notes for Class of Case 00 and 10:

- Code 00 is reserved for patients who are originally diagnosed by the reporting facility and it is known that the patient received all of their treatment elsewhere (or a decision not to treat is made elsewhere).
    - If the patient receives no treatment, either because the patient refuses recommended treatment or a decision is made not to treat, the *Class of Case* is 14.
    - If there is no information about whether or where the patient was treated, the *Class of Case* is *10*.

- Code 10 applies to the following situations:
    - Patients diagnosed at the reporting facility whose treatment plan is either not to treat or watchful waiting. An example would be early stage prostate cancer.
    - Patients diagnosed at the reporting facility that refuse treatment.
    - Patients diagnosed at the reporting facility that are not treatable due to age, advanced disease or their medical conditions.
    - Patients diagnosed at the reporting facility for which treatment was recommended, but it is unknown whether treatment was administered.

Analytic Class of Case Categories (Required to be abstracted by all reporting sources)

		Initial diagnosis at reporting facility or in a staff physician's office
00		Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10		Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
11		Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility
12		Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility
13		Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.
14		Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility
		Initial diagnosis elsewhere
20		Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21		Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere. Patient begins first course radiation or chemotherapy infusion elsewhere and continues at the reporting facility, and the care is not in-transit, then the case is analytic (Class of Case 21).
22		Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility

Examples

Code	Reason
00	Leukemia was diagnosed at the facility, and all care was given in an office of a physician with admitting privileges.
13	Breast cancer was diagnosed at the reporting hospital and surgery performed there. Radiation was given at the hospital across the street with which the reporting hospital has an agreement.
10	Reporting hospital found cancer in a biopsy, but was unable to discover whether the homeless patient actually received any treatment elsewhere.
11	Patient was diagnosed in an office of a physician with admitting privileges, received neoadjuvant radiation at another facility, then underwent surgical resection at the reporting facility

Reportable Non-Analytic Class of Case Categories:

Note: Cases that meet the criteria for any analytic class of case category is required to be reported. This includes Class of Case 00-22. The following table provides additional information related to the non-analytic class of case categories diagnosed after 1/1/1990.

Class of Case	Definition	Notes from the N.C. CCR
Patient appears in person at reporting facility		
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere) EXCEPTION for Consult-only cases: A "consult only" case is a case where the facility provides a second opinion without additional testing. A second opinion can include re-reading pathology slides or re-reading diagnostic imaging studies. Patients seen only in consultation to confirm a diagnosis or treatment plan are NOT required to be reported. However, if you are already abstracting these cases, please submit them to the CCR.	REPORTABLE The CCR does not exempt radiology-only cases from being reportable. The North Carolina statutes specify that if the tumor is "detected, diagnosed, or treated" it should be reported by the facility. Because of the volume of radiology reports, the CCR does not expect every radiology report to be screened. However, if radiology-only cases are identified through other sources (for example, disease index or death clearance activities), then the hospital is required to abstract and submit the radiology-only cases to the CCR. Example: A patient comes into Hospital B from Hospital A because a PET scan is needed to complete tumor staging. Hospital A has already diagnosed a reportable tumor but needs additional work-up that is not available at their facility. The patient undergoes the PET scan and it is positive for malignancy. Hospital B would abstract whatever information was available, and report the case as a class of case 30. The text fields would be utilized to indicate the reason for incomplete data.
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; Or reporting facility provided care that facilitated treatment elsewhere Example: Stent or port placement. These patients are actively being managed for their cancer and are to be reported to the CCR.	REPORTABLE • "In-transit" care is care given to a patient who is temporarily away from the patient's usual practitioner for continuity of care. Abstract as *Class of Case* 31. Example: Patient received chemotherapy while attending daughter's wedding in the reporting hospital's city, then returned to the originating hospital for subsequent treatments. • If a patient begins first course radiation or chemotherapy elsewhere and continues at the reporting facility, and the care

		is not in-transit, then the case is analytic. Abstract as *Class of Case* 21. • Monitoring of oral medication (such as Tamoxifen for breast cancer) started elsewhere, use the following guidelines to determine if the case should be abstracted: 1. Patient is now under the care of your facility. Abstract as Class of Case 31. 2. Patient is now under the care of a "staff physician" in an office OWNED (or reported by agreement) by your facility. Abstract as Class of Case 31. 3. Patient is now under the care of a "staff physician" in an office NOT owned (or reported by agreement) by your facility. This is considered as "treatment elsewhere" and is not reportable.
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence "ACTIVE disease only"	REPORTABLE If there is documentation that the patient has ACTIVE disease, the case must be abstracted and submitted to the CCR. Reportability for a patient with persistent (active) disease is not dependent on whether any treatment, palliative care or other cancer-related services are provided at your facility. It states only that the patient was diagnosed and treated elsewhere and comes to your facility with persistent (active) disease. ACTIVE DISEASE is the determining factor in whether a case is required to be reported. If the patient has active disease, the case must be reported to the CCR. These cases may have very little historical information. Abstract the case based on all information available. Document in the text the reason for incomplete data. Example: Patient is admitted for supportive care only. The patient receives no treatment but has documented metastatic disease at admission. This case is to be abstracted and submitted to the CCR because the patient has active disease.
33	Diagnosis and all first course treatment provided elsewhere and patient presents at reporting facility with disease history only. "History only" (disease is not active)	NOT REPORTABLE If the patient has only a history of cancer and NO active disease (clinically free of disease), the case does not have to be reported. Example: The history and physical noted history of cancer. The workup showed no evidence of cancer or no workup related to the cancer was done. This case is not reportable. EXCEPTION for Death Clearance cases: **Cases identified by the CCR through the death clearance process MUST BE REPORTED regardless of the residence (city/state), disease status, class of case, visit type or reason for encounter.** For death clearance cases, ALL encounters are considered reportable, including patients seen only in the ER, for lab work only or for radiology only. To reduce the number of cases that must be abstracted during the death clearance process, consider reviewing cases where the patient expired in your facility and cancer is listed as an underlying cause of death as part of your normal casefinding routine. Even if there is no information regarding disease status (active or history only), the case can be reported using all

		available information in the medical record. Abstracting these cases now may prevent the case from showing up later as a death clearance case requiring follow-back to your facility.
34	Case not required by CoC to be accessioned (i.e.: benign colon tumor) but initial diagnosis AND part or all of first course treatment was done at the reporting facility	REPORTABLE For CoC facilities: Cases required by the CCR but not required by the CoC (e.g., VIN III, VAIN III, AIN III, LIN III) ARE required to be reported to the CCR and can be assigned class of case 34 to keep them out of analytic case counts. For non-CoC facilities: Do not use this code. Use the other class of case categories as appropriate for the case.
35	Case diagnosed before the program's CoC Reference Date, but initial diagnosis AND all or part of first course treatment was done at the reporting facility	REPORTABLE if diagnosed 1/1/1990 and after The reference date for the CCR is 1/1/1990. All eligible cases diagnosed 1/1/1990 or after are reportable. For non-CoC facilities, do not use this code. Use the other class of case categories as appropriate for the case.
36	Case not required by CoC to be accessioned (i.e.: benign colon tumor), and the initial diagnosis was elsewhere BUT all or part of first course treatment by facility	REPORTABLE For CoC facilities: Cases required by the CCR but not required by the CoC (e.g., VIN III, VAIN III, AIN III, LIN III) ARE required to be reported to the CCR and can be assigned class of case 36 to keep them out of analytic case counts. For non-CoC facilities: Do not use this code. Use the other class of case categories as appropriate for the case.
37	Case diagnosed before the program's CoC Reference Date, having initial diagnosis elsewhere AND all or part of first course treatment by facility	REPORTABLE if diagnosed 1/1/1990 and after The reference date for the CCR is 1/1/1990. All eligible cases diagnosed 1/1/1990 or after are reportable. For non-CoC facilities, do not use this code. Use the other class of case categories as appropriate for the case.
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death	REPORTABLE Autopsy only cases are reportable. The registrar should request all autopsy reports each year, screened for reportable tumors and abstracted if the case meets the reportability requirements.
Patient does not appear in person at reporting facility		
40	Diagnosis AND all first course treatment given at the same staff physician office	REPORTING REQUIRED FOR CERTAIN CIRCUMSTANCES The CCR encourages facilities to report cases that meet the criteria for class of case 40-43. Generally, these cases are not required to be abstracted, but if reporting facility does any abstracting for any physician offices or clinics, then the cases are required to be sent to the CCR. Example: Reporting facility *voluntarily or through a special agreement* abstracts cases for an unaffiliated, free-standing clinic because many physicians work at the clinic and the hospital. These cases are to be submitted to the CCR. Note: Cases in physician offices or clinics owned by the reporting facility (reporting facility owns the medical record or is considered a single entity by the accrediting organization) are to be reported as an analytic case by the reporting facility.
41	Diagnosis and all first course treatment given in two or more different staff physician offices	
42	Non-staff physician or non-CoC approved clinic or other facility, not part of reporting facility but accessioned by reporting facility for diagnosis and/or treatment by that entity.	

43	Pathology report or other lab specimens only (specimen comes to your hospital, but the patient does not) This excludes autopsy only cases (see code 38).	REPORTING PREFERRED/REQUESTED There are instances when cases come to the attention of the hospital by way of its pathology department but the patient was never admitted to the reporting facility nor is there any available evidence that the patient was diagnosed and/or treated outside the reporting facility by a physician on staff. Many pathology departments, especially at the larger facilities, provide consultation services (e.g., re-read slides). These cases may have very little historical information. Abstract based on all information available. Note in the text explaining the reason for incomplete data. EXCEPTION for Rapid Case Ascertainment (RCA) linkage cases: **Facilities notified of cases identified through the RCA linkage MUST BE REPORTED by that facility regardless of the residence (city/state), disease status, class of case, or reason for encounter.** For these RCA cases, ALL encounters are considered reportable, including specimens only read either as the primary or consultative laboratory service provider.
49	Diagnosis was established by death certificate only.	DO NOT USE. This code is used only by the CCR staff.
99	Unknown	DO NOT USE. This code is used only by the CCR staff. Facilities should be able to determine the relationship the facility had with the patient.

NPI–INSTITUTION REFERRED FROM

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2415
Revised 04/07, 09/08, 01/11

Description
Identifies the facility that referred the patient to the reporting facility.

Rationale
Each facility's NPI is unique. This number is used to document and monitor referral patterns.

Instructions for Coding
- Record the 10-digit NPI for the referring facility.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Check with the registry, billing or health information departments of the facility to determine its NPI or search on https://npiregistry.cms.hhs.gov/search.

Code	Definition
(fill spaces)	10-digit NPI number for the facility.
(leave blank)	NPI for the referring facility is unknown or not available.
(leave blank)	If the patient was not referred to the reporting facility from another facility.

FACILITY REFERRED FROM

Item Length: 10
Right Justified, Zero-filled
NAACCR Item #2410
Revised 09/08

Description
Identifies the facility that referred the patient to the reporting facility.

Rationale
Each facility's identification number (FIN) is unique. This number is used to document and monitor referral patterns.

Instructions for Coding

- For facilities with seven-digit FINs in the range of 6020009–6953290 that were assigned by the CoC before January 1, 2001, the coded FIN will consist of three leading zeros followed by the full seven-digit number.
- For facilities with eight-digit FINs greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded FIN will consist of two leading zeros followed by the full eight-digit number.

Code	Definition
(fill spaces)	Seven or eight-digit FIN.
0000000000	If the patient was not referred to the reporting facility from another facility.
0099999999	If the patient was referred, but the referring facility's ID number is unknown.

Examples

Code	Reason
0006439999	6439999, General Hospital, Anytown, Illinois
0010000099	10000099, Anytown Medical Center, Anytown, Illinois

NPI–INSTITUTION REFERRED TO

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2425
Revised 04/07, 09/08, 01/11

Description
Identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

Rationale
Each facility's NPI is unique. This number is used to document and monitor referral patterns.

Instructions for Coding

- Record the 10-digit NPI for the facility to which the patient was referred.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Check with the registry, billing or health information departments of the facility to determine its NPI or search on https://npiregistry.cms.hhs.gov/search

Code	Definition
(fill spaces)	10-digit NPI number for the facility.
(leave blank)	NPI for the facility referred to is unknown or not available.
(leave blank)	If the patient was not referred to another facility.

FACILITY REFERRED TO

Item Length: 10
Right Justified, Zero-filled
NAACCR Item #2420
Revised 09/08

Description
Identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

Rationale
Each facility's identification number (FIN) is unique. This number is used to document and monitor referral patterns.

Instructions for Coding

- For facilities with seven-digit FINs in the range of 6020009–6953290 that were assigned by the CoC before January 1, 2001, the coded FIN will consist of three leading zeros followed by the full seven-digit number.
- For facilities with eight-digit FINs greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded FIN will consist of two leading zeros followed by the full eight-digit number.

Code	Definition
(fill spaces)	Eight-digit facility ID number.
0000000000	If the patient was not referred to another facility.
0099999999	If the patient was referred, but the facility's ID number is unknown.

Examples

Code	Reason
0006439999	6439999, General Hospital, Anytown, Illinois
0010000099	10000099, Anytown Medical Center, Anytown, Illinois

Item Length: 8
NAACCR Item #580
Revised 9/06, 1/04, 1/10, 1/11

DATE OF FIRST CONTACT CANNOT BE BLANK

FOLLOW BACK AND FURTHER INVESTIGATION MUST BE DONE TO DETERMINE THE DATE.

Description
Date of first contact with the reporting facility for diagnosis and/or treatment of this cancer.

Rationale
This data item can be used to measure the time between first contact and the date that the case was abstracted. It can also be used to measure the length of time between the first contact and treatment for quality of care reports.

Instructions for Coding
- Record the date the patient first had contact with the facility for diagnosis and/or first course treatment of a reportable tumor. The date may be the date of any type of visit such as an outpatient visit, office visit date, or the date a pathology specimen was collected at the hospital.
- Date of First Contact cannot be blank, cannot be a partial date and cannot be an estimate. The date the patient was first seen at the reporting facility can always be determined.

Instructions based on Various Scenarios
- For analytic cases, *Date of First Contact* is the date the patient qualifies as an analytic case (*Class of Case* 00-22). Usually, *Date of First Contact* is the date of admission or visit for diagnosis or for treatment.

Scenario	Instruction
Patient was admitted for non-cancer-related reasons and diagnosed with cancer during the hospitalization	Use the date the cancer was first suspected during the hospitalization
Patient's diagnosis or treatment was as an outpatient of the facility	Use the date the patient first appeared at the facility for that purpose
Patient was diagnosed at another facility and subsequently receives first course treatment at the reporting facility	Use the date the patient reported to the facility for the treatment
Patient was initially diagnosed at the facility and went elsewhere for treatment (Class of Case 00), but then returned for treatment that was initially expected to occur elsewhere	Update Class of Case to 13 or 14. Date of First Contact is not changed because it still represents the date the patient became analytic
Staff physician performs a biopsy off site and the specimen is not submitted to the facility to be read	The case is not required to be abstracted unless the patient receives some first course of treatment at the facility
Patient was diagnosed in a staff physician's office (and the office is not owned by the facility). The patient subsequently comes to the facility for first course treatment.	Use the date the patient reported to the facility for the treatment

- For non-analytic cases, the *Date of First Contact* is the date the patient's non-analytic status begins with respect to the cancer.

Scenario	Instruction
Patient was diagnosed at autopsy (Class of Case 38)	Use the date of death
Patient was diagnosed and treated entirely in the staff physician's office (Class of Case 40)	Use the date the physician initially diagnosed the cancer
Pathology specimen is collected off site and submitted to the facility to be read (and the specimen is positive for cancer) (Class of Case 43)	Use the date the specimen was collected
Death Certificate only cases (Class of Case 49)	Use the date of death

- *Class of Case* changes from non-analytic (i.e.: *Class of Case* 30) to analytic (i.e.: *Class of Case* 21)

Scenario	Instruction
Class of Case changes from non-analytic (i.e.: Class of Case 30) to analytic (i.e.: Class of Case 21)	Update to the date the case became analytic (the date the patient was admitted for treatment)
Case was originally abstracted as a non-analytic case. Patient is subsequently seen at the facility that qualifies as an analytic case (Class of Case 00-22)	Update the Class of Case to the analytic code. Update the Date of First Contact to reflect the date the case became analytic (the patient's first in-person contact with the facility for this cancer).

Examples

Patient undergoes a biopsy in a staff physician's office on September 8, 2026. The pathology specimen was sent to the reporting facility and was read as malignant melanoma. The patient enters that same reporting facility on September 14, 2026 for wide excision.	20260914
Patient has an MRI of the brain on December 7, 2026, for symptoms including severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery on December 19, 2026 removes all gross tumor.	20261207

Item Length: 8
NAACCR Item #390
Revised 09/08, 1/10, 01/11, 01/13, 01/22, 1/23

DATE OF DIAGNOSIS CANNOT BE BLANK

FOLLOW BACK AND FURTHER INVESTIGATION MUST BE DONE TO DETERMINE THE DATE.

Description
The date of diagnosis is the month, day, and year the reportable neoplasm was first identified, clinically or microscopically, by a recognized medical practitioner. Medical practitioners include physician, physician assistant, nurse practitioner, nurse midwife, residents, fellows, medical trainees, and licensed recognized medical practitioner as determined by a state.

Rationale
The timing for staging and treatment of cancer begins with the date of initial diagnosis for cancer. The date of diagnosis puts the case into the year of evaluation. If the YEAR is inaccurate, then the case cannot be included in the appropriate statistics, publications, research studies, etc.

- **DATE OF DIAGNOSIS CANNOT BE BLANK FOR CASES DIAGNOSED IN 2023 FORWARD.**
- **Date of Diagnosis cannot be blank on any case abstracted after converting to NAACCR version 23. This applies to all diagnosis years and classes of case.**
- **Make every attempt to determine the complete date, including follow-back to the physician.**
- **If an exact date cannot be determined, the date must be approximated using all available clues.**
- **The requirements differ for analytic and non-analytic cases when an exact date is unknown. See the section on Estimating Dates below.**

Instructions for Coding
- Use the first date of diagnosis whether clinically or microscopically established.
  - When the first diagnosis includes reportable ambiguous terminology, record the date of that diagnosis.
  - Rule revised in 2022: Use the date of **suspicious cytology** when the diagnosis is proven by subsequent biopsy, excision, or other means.
    - Note 1: "Suspicious" cytology means that the diagnosis is preceded by an ambiguous term such as apparently, appears, compatible with, etc.
    - Note 2: Do not use ambiguous cytology alone for case ascertainment.

    Example: Cytology is suspicious for malignancy 01/12/20xx. Diagnosis of carcinoma per biopsy on 02/06/20xx. Record 01/12/20xx as the date of diagnosis.
- When the only information available is a positive pathology or cytology report, code the date the procedure was done, not the date the report was dictated or transcribed.
- Code the date the procedure was done, not the date the specimen was received or read as positive by the pathologist when the date of diagnosis is coded from a pathology report
- The first diagnosis of cancer may be **clinical** (i.e., based on clinical findings or physician's documentation). Do not change the date of diagnosis when a clinical diagnosis is subsequently confirmed by positive histology or cytology.
- Code the earlier date as the date of diagnosis when

- If the physician states that in **retrospect** the patient had cancer at an earlier date.
- The original slides are reviewed and the pathologist documents that cancer was present. Code the date of the original procedure as the diagnosis date.

Note: Do not back-date the diagnosis when:
• The information on the previous tumor is unclear AND/OR
• There is no review of previous slides AND/OR
• There is no physician's statement that, in retrospect, the previous tumor was malignant.

- Use the **date treatment** was started as the date of diagnosis if the patient receives a first course of treatment before a diagnosis is documented.
- Use the date of death for cases diagnosed at **autopsy**
- For **death certificate only** (DCO) cases:
  - Make every attempt to follow-back to the physician or other source to determine an accurate year of diagnosis.
  - Use information on the death certificate to estimate the date of diagnosis if available.
  - Record the date of death as the date of diagnosis when there is not enough information available to estimate the date of diagnosis; for example, the time from onset to the date of death was only described as 'years'.
  - If no information is available, record the date of death as the date of diagnosis.
- Use the actual date of diagnosis for an ***in utero*** diagnosis even though this date will precede the date of birth.
- **Tumor Markers:**
  - Reportability: Positive tumor markers alone are not diagnostic of cancer and are not reportable.
  - Date of Diagnosis: Use the date of clinical, histologic, or positive cytologic confirmation.
- **PI-Rads, BI-Rads, LI-Rads, Lung-Rads (added 1/1/2023):**
  - Reportability: PI Rads, BI Rads, LI Rads, or Lung-Rads alone are not reportable. Report when confirmed with positive biopsy or physician statement.
  - Date of Diagnosis: It is the positive biopsy that makes it reportable. If that is the case, then the date of diagnosis will be the date of the positive BIOPSY.
  - Note: All Rads are still being discussed amongst the standard setters. The instructions in the CCARM 2023 (and later) align with the instructions in the STORE. Any clarifications from the CoC on this topic will apply to reporting to the NC CCR as well.

  Example: Radiologist reports Liver Imaging Reporting and Data System (LI-RADS) Category 5 on imaging. Later biopsy confirms hepatocellular carcinoma (HCC). Record date of diagnosis as date of the biopsy.

Examples

Date	Reason
20260112	Suspicious cytology: Cytology suspicious for malignancy 01/12/2026. Diagnosis of carcinoma per biopsy on 02/06/2026. Record 01/12/2026 as the date of diagnosis.
20260517	Ambiguous terminology: Pathology "suspicious" for cancer 5/17/2026. Surgery on 5/22/2026 confirmed the diagnosis. Suspicious is an ambiguous term that is diagnostic. Code the date of the biopsy as the date of diagnosis.
20260213	Ambiguous terminology: Area of microcalcifications in breast suspicious for malignancy on 02/13/2026. Biopsy positive for ductal carcinoma on 02/28/2026. Suspicious is an ambiguous term that is diagnostic. The date of diagnosis

	02/13/2026.
20260515	First diagnosis is clinical: On 5/15/2026, the physician states that the patient has lung cancer based on clinical findings. The patient has a positive biopsy of the lung on 6/3/2026. The date of diagnosis remains 5/15/2026.
20260821	Tumor Markers: 08/14/2026 the patient has an elevated PSA and the physical examination is negative. The physician documents only that the patient is referred for a needle biopsy of the prostate. 08/21/2026 the biopsy is positive for adenocarcinoma. The date of diagnosis 08/21/2026. The date of diagnosis is the date of the biopsy (do not code the date of the PSA or the date the procedure was dictated or transcribed).
20260316	Tumor Markers: 03/16/2026 the patient has an elevated PSA and the physical examination is negative. The physician documents that he/she suspects that the patient has prostatic cancer and is referring the patient for a needle biopsy. 04/01/2026 the needle biopsy is positive, confirming the physician's suspicion of cancer. The date of diagnosis is the date the physician documented that he/she suspects that the patient has prostatic cancer. Note: Positive tumor markers alone are never used for case ascertainment.
20260105	Diagnosis in retrospect: The patient had an excision of a benign fibrous histiocytoma on 01/05/2026. Six months later, a wide re-excision was positive for malignant fibrous histiocytoma. The physician documents in the chart that the previous tumor must have been malignant. Code the diagnosis date as 01/05/2026.
20260130	Diagnosis in utero: Fetal intrahepatic mass consistent with hepatoblastoma diagnosed via ultrasound at 39 weeks gestation (01/30/2026). Live birth by C-section 02/04/2026. Code the date of diagnosis as 01/30/2026.

Estimating Dates

Every attempt should be made to record the full, exact date. If it is not possible to obtain an exact date, then the date should be estimated using all available clues such as "diagnosed last year," "recent diagnosis," "treatment began last month," etc. Text should specify when a date has been estimated.

The requirements differ for analytic and non-analytic cases when an exact date is unknown.

For analytic cases:

- **An entire date must be recorded** as these cases are in the workup and treatment phase of the initial diagnosis and these procedures are most likely very recent.
- Follow-back and further investigation is required to obtain the necessary information to code the full date of diagnosis.
- If any part of the date is unknown, and further investigation did not yield sufficient information, it MUST be estimated.

  Example: The patient was admitted to your facility on 3/14/2026 for surgery following a positive biopsy. The record indicates the biopsy occurred "last month". Last month is a clue that the biopsy was done in February 2026. If further investigation does not yield the exact day of the biopsy, it should be estimated as the 1st day of the month so that an entire date is recorded for the analytic case. Record 20260201.

For non-analytic cases:

- Every attempt should be made to obtain the full, exact date.
- If that is not possible, estimate and record as much of the date as possible.
    - Estimating and recording a month and year (e.g., 202606) is preferred to recording only a year (e.g., 2026).
    - For non-analytic cases, coding only a year or only a year and month is acceptable.
- If the month or month and day cannot be determined, at least the YEAR must be determined because this date field can no longer be left blank.
    - Use any clues available to approximate the year, such as "diagnosed two years ago."
    - As the date cannot be left blank, and it is not useful to guess a speculative year, follow-back to the managing physician or other facility may be needed if there is absolutely no clue that would allow you to estimate at least the year.
- If all options have been exhausted and at least the year still cannot be estimated, then record the date of the first encounter that made the case reportable. This is a LAST RESORT and should be a RARE exception. Text must validate this decision.

Examples for estimating the date:

- Estimating is only done when all investigation fails to yield an exact date.
- Part of the date may be known, but only the day. or the day and month. need to be estimated. Use what is known and only estimate the unknown parts of the date.
- Estimating starts with determining the best year, then the best month, then the best day.
    - For analytic cases, the entire date must be recorded so the year, month and day must be estimated if an exact date is not known.
    - For non-analytic cases, at least the year must be recorded but every attempt should be made to estimate the entire date.

Estimating the **YEAR.** The diagnosis date was described as:	Tips for Estimating Analytic cases: If the month and day cannot be determined, it must be estimated. See estimating the month and day below on how to record the full date.	Use
A recent or new diagnosis	Use the current year	2026
Last Year	Use the previous year	2025
A couple of years ago	Use 2 years earlier	2024
A few years ago	Use 3 years earlier	2023

Estimating the **MONTH**	Tips for Estimating Analytic cases: If the day cannot be determined, it must be estimated. See estimating the day below on how to record the full date.	Use
Only the Year is known	Example: Patient was diagnosed in 2024 and presents in 2026 with recurrence. Analytic cases: If further investigation does not yield an exact month, it must be estimated. Use July (the middle of the year) and the first day of the month if there are no clues.	20240701
Clues are available to estimate the month	Example: Patient admitted for surgery following a positive biopsy. The exact date of the biopsy cannot be determined. Surgery performed 20260714. Use treatment dates as a clue. Estimate the diagnosis date as the 1st day of the same month.	20260701
Clues are available to estimate the month	Example: Patient admitted 3/7/2026 for surgery following a positive biopsy. The record indicates the biopsy occurred "last month". Last month is a clue that the biopsy was done in February 2026. If further investigation does not	20260201

	yield the exact day of the biopsy, the day should be estimated as the 1st day of the month so that an entire date is recorded for the analytic case.	
Clues are available to estimate the month	Example: Admitted October 2026. History states that the patient was diagnosed 7 months ago. Subtract 7 from the month of admission and use the first day of the month.	20260301
Clues are available to estimate the month	Example: Outpatient bone scan done May 2026. The physician says the patient is newly diagnosed. Assume bone scan was part of initial work-up and use the 1st day of the same month as the bone scan.	20260501
Information is limited to description of "Spring"	Use the current year and April for Spring. If further investigation does not yield the exact day, the day should be estimated as the 1st day of the month so that an entire date is recorded for the analytic case.	20260401
Information is limited to description of "Summer" or "the middle of the year"	Use the current year and July for Summer or the middle of the year. If further investigation does not yield the exact day, the day should be estimated as the 1st day of the month so that an entire date is recorded for the analytic case.	20260701
Information is limited to the description of "Fall"	Use the current year and October for Fall. If further investigation does not yield the exact day, the day should be estimated as the 1st day of the month so that an entire date is recorded for the analytic case.	20261001
Information is limited to the description of "Winter"	Try to determine if this means the beginning (January) or the end (December) of the year as the year of diagnosis determines the year of evaluation for studies. If not enough information, use January. If further investigation does not yield the exact day, the day should be estimated as the 1st day of the month so that an entire date is recorded for the analytic case.	20251201 or 20260101

Estimating the **DAY**	Tips for Estimating	Use
Only the year and month are known	Example: Record states patient was diagnosed in February. If there are no clues and further investigation does not yield an exact date, use the first day of that month so that an entire date is recorded for the analytic case.	20260201
Clues are available to estimate the day	Example: Patient admitted 10/23/2026 for surgery following a positive biopsy. The record indicates the biopsy occurred "two weeks" ago. Using a calendar, determine the date for 14 days earlier.	20261009
Last week	Using a calendar, determine the date for 7 days earlier.	
Recently	Example: Patient admitted in June 2026. Record states patient was diagnosed recently. If further investigation does not yield the exact day, use the first day of the same month.	20260601

PRIMARY SITE

Item Length: 4
NAACCR Item #400
Revised 01/04, 09/08, 01/10. 01/18

Description
Identifies the primary site. Topography codes are indicated by a "C" preceding the three-digit code number. Example: C449.

Rationale
Primary site is a basis for staging and the determination of treatment options. It also affects the prognosis and course of the disease.

Instructions for Coding
- Follow the Instructions in the ICD-O-3 and in the *SEER Solid Tumor Rules* to assign site for solid tumors. The instructions for coding primary site are found in the "Topography" section of the ICD-O-3 "Coding Guidelines for Topography and Morphology" (ICD-O-3 pp. 23–26).
- Follow the instructions in *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic and Lymphoid Neoplasms Database (Hematopoietic DB) for assigning site for lymphoma, leukemia, and other hematopoietic neoplasms.
- Unless otherwise instructed, use all available information in the medical record to code the site. Consult the physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.
- Do not adjust the primary site code to fit staging or any other data items.

- Code the site in which the primary tumor **originated**, even if it extends onto/into an adjacent subsite
    - Primary site should always be coded to reflect the site of origin according to the medical opinion on the case. Look for information about where the neoplasm originated. Always code the primary site based on where the tumor arose / site of origin.
    - Site of origin may be indicated by terms such as "tumor arose from…," "tumor originated in…," or similar statements.
    - Site of origin is not necessarily the site of a biopsy. Review all information to determine site of origin.
        - Tumors may involve many sites. The primary site code should reflect the site where the tumor arose rather than all sites of involvement.

    - Example 1: Final diagnosis is adenocarcinoma of upper lobe of right lung. Code lung, upper lobe (C341).
    - Example 2: Patient has a 4 cm tumor in the right breast. The tumor originated in the upper inner quadrant and extends into the lower inner quadrant. Code upper inner quadrant of breast (C502).
    - Example 3: Patient has a right branchial cleft cyst; the pathology report identifies an adenocarcinoma arising in an ectopic focus of thyroid tissue within the branchial cleft cyst. Thyroidectomy pathology is negative. Code branchial cleft (C104).
    - Example 4: Patient had a TAH/BSO ten years ago for non-cancer reasons. She now has widespread cystadenocarcinoma in the peritoneum. Code peritoneum, NOS (C482).
    - Example 5: Pathology report shows adenocarcinoma arising in a patch of endometriosis on the sigmoid colon. Code sigmoid colon (C187), the site in which the cancer originated.
    - Example 6: Patient has a left lower lip wedge excision showing invasive squamous cell carcinoma at the mucocutaneous junction. There is no further information in operative report or pathology report

regarding the location of this tumor that would indicate this is a skin primary. Assign C001, external lower lip. C001 includes vermilion border of lower lip. Vermilion border is synonymous with mucocutaneous junction.

- Code the primary site, not the metastatic site. If a tumor is metastatic and the primary site is unknown, code the primary site as unknown (C809).

- Code the site of the invasive tumor when there is an invasive tumor and an in situ tumor in different subsites of the same anatomic site

  Example 1: Invasive breast tumor in the upper-outer quadrant of the left breast and in situ tumor in multiple quadrants of the left breast. Code the primary site to C504 (upper outer quadrant of breast).
  Example 2: In situ Paget disease of the right nipple and invasive duct carcinoma of the lower inner quadrant of the right breast. Code the primary site to C503 (lower inner quadrant).

- C__ __8: Code the last digit of the primary site code to '8' when a **single tumor overlaps** an adjacent subsite(s) of an organ and the **point of origin cannot be determined.**

  Example 1: Primary tumor of the cervicothoracic esophagus and the point of origin is unknown. Code the primary site to C158.
  Example 2: Overlapping lesion of oropharynx. Code C108 when a large tumor involves both the lateral wall of the oropharynx (C10.2) and posterior wall of the oropharynx (C10.3) and the point of origin is not stated.

  Note: Skin cancers overlapping sites in the head and neck ONLY. Assign the primary site code for the site where the bulk of the tumor is or where the epicenter is; do not use code C448.

  Single tumor overlapping a reportable site and a non-reportable site: Determine the site of origin or the site with the greatest involvement
  - If the site of origin/site with greatest involvement is the reportable site, report the case and assign the appropriate topography code
  - If the site of origin/site with greatest involvement is the non-reportable site, do not report the case
  - If the site of origin/site with greatest involvement cannot be determined, do not report the case because you cannot confirm reportability
  - Example: Squamous cell carcinoma overlapping skin and vermillion of upper lip. If the site of origin is the vermillion, report the case. If the site of origin cannot be determined and more than 50% of the lesion is on the vermillion, report the case. If less than 50% of the lesion is on the vermillion, do not report the case. If the site with the greatest involvement cannot be determined, do not report the case.

- C__ __ 9: Code the last digit of the primary site code to '9' for single primaries, when multiple tumors arise in different subsites of the same anatomic site and the point of origin cannot be determined

  Example 1: During a transurethral resection of the bladder (TURB), the physician describes multiple papillary tumors in the bladder neck (C675) and the lateral wall of the bladder (C672). Code the primary site as bladder, NOS (C679).

Example 2: Patient has an infiltrating duct tumor in the upper outer quadrant (C504) of the right breast and another infiltrating duct carcinoma in the lower inner (C503) quadrant of the right breast. Code the primary site as breast, NOS (C509).

Example 3: Colon, NOS. Familial polyposis with carcinoma and carcinoma in situ throughout the transverse (C18.4) and descending colon (C18.6) would be one primary and coded to colon, NOS (C18.9).

- Some histology/behavior terms in ICD-O-3.2 have a **related site code in parentheses**; for example, hepatoma (C220).
    - Code the site as documented in the medical record and ignore the suggested ICD-O-3.2 code when a primary site is specified in the medical record

      Example: The path report says "infiltrating duct carcinoma of the head of pancreas." The listing in ICD-O-3.2 is infiltrating duct carcinoma 8500/3 (C50_). Code the primary site to head of pancreas (C250), NOT to breast (C50_) as suggested by the ICD-O-3.2.

    - Use the site code suggested by ICD-O-3.2 when the primary site is the same as the site code suggested or the primary site is unknown

      Example 1: The biopsy is positive for hepatoma, and no information is available about the primary site. Code the primary site to liver (C220) as suggested by ICD-O-3.2.

      Example 2: Excision of the right axillary nodes reveals metastatic infiltrating duct carcinoma. The right breast is negative. ICD-O-3.2 shows infiltrating duct carcinoma (8500) with a suggested site of breast (C50_). Code the primary site as breast, NOS (C509).

    - Use the site code suggested by ICD-O-3.2 when there is no information available indicating a different primary site

      Example: Biopsy of lymph node diagnosed as metastatic non-small cell carcinoma. Patient expired and there is no information available about the primary site. Assign C349 based on the site code suggested in ICD-O-3.2. 7.

When the medical record does not contain enough information to assign a primary

- Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site.
- Assign the NOS code for the body system when there are two or more possible primary sites documented and all are within the same system.
    - Example: Two possible sites are documented in the GI system such as colon and small intestine; code to the GI tract, NOS (C269). Document the possible primary sites in a text field.
- C809: Code unknown primary site when there is:
    - a physician statement of unknown primary site ONLY when none of the above instructions can be applied.
    - not enough information to assign an NOS or Ill-Defined Site category.

Site-specific coding guidelines:

Positive Cervical Lymph Nodes (Occult Tumors of the Head and Neck) (effective 1/1/2018)

For lymph node involvement in the neck with no primary head or neck tumor found or specified by a physician (i.e., Occult Head and Neck Lymph Node), code the primary site to:

- C76.0 for positive cervical lymph nodes but the node has not been tested or is negative for both HPV and EBV. Schema Discriminator 1 is used to discriminate between these cases and other uses of C76.0.
    - AJCC Chapter: Cervical Lymph Nodes and Unknown Primary Tumor of the Head and Neck
- C10.9 (oropharynx) for cervical lymph node metastasis in Levels I-VII and other group lymph nodes is p16 positive with histology consistent with HPV-mediated oropharyngeal carcinoma (OPC).
    - AJCC Chapter: Oropharyngeal Cancer - HPV Mediated (p16+)
- C11.9 (nasopharynx) for cervical lymph node metastasis in Levels I-VII and other group lymph nodes positive for Epstein–Barr virus (EBV+) (regardless of p16 status) encoded small RNAs (EBER) identified by in situ hybridization.
    - AJCC Chapter: Nasopharynx
- Follow the instructions in the SSDI Manual schema discriminators to assign the final primary site.

Cutaneous Carcinoma of the Head and Neck (effective 1/1/2018)

For skin cancers overlapping sites in the head and neck ONLY:

- Assign primary site based on the site where the bulk of the tumor is or where the epicenter is.
- AJCC Chapter: Cutaneous Carcinoma of the Head and Neck.
- Do not use code C44.8 Overlapping lesion of skin. C44.8 represents skin lesions overlapping between head and neck sites AND/OR skin in other parts of the body. These cases will not be staged with AJCC 8th Edition.

Merkel Cell Carcinoma

Assign primary site code C449, skin NOS, for a Merkel cell carcinoma presenting in a nodal or distant metastatic site and site of origin is unknown.

Melanoma

Assign primary site code C449, skin NOS, for a Melanoma presenting in a nodal or distant metastatic site and site of origin is unknown and there is no information suggesting that the melanoma originated in a non-skin site. Assign C809 when the site of origin is unknown and there is some indication that the primary site of the melanoma is not skin.

Angiosarcoma

- Code C422 (spleen) as the primary site for angiosarcoma of spleen
- Code C50_ (breast) for angiosarcoma of breast. Although angiosarcoma originates in the lining of the blood vessels, an angiosarcoma originating in the breast has a poorer prognosis than many other breast tumors.

Sarcoma

The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system, which includes the fat, muscles, blood vessels, deep skin tissues, nerves, bones, and cartilage.

- The default code for sarcomas of unknown primary site is C499 rather than C809.
- Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. Code the primary site to the organ of origin.
  Example 1: Pathology identifies a carcinosarcoma of the uterine corpus. Code to corpus uteri (C549).
  Example 2: Rhabdomyosarcoma of ethmoid sinus.

- Code primary site to C311. Code the organ of origin as the primary site when leiomyosarcoma arises in an organ. Do not code soft tissue as the primary site in this situation.
  Example 1: Leiomyosarcoma arises in kidney. Code the primary site to kidney (C649).
  Example 2: Leiomyosarcoma arises in prostate. Code primary site to prostate (C619).

Kaposi Sarcoma

Kaposi sarcoma is a rare condition. When not AIDS-related, it usually presents as localized disease with an easily recognized primary site. AIDS-related Kaposi sarcoma usually presents as a disseminated disease with involvement of mucosal surfaces, visceral surfaces of organs and skin. It is important to review consecutive records carefully to determine the extent of involvement at diagnosis. Review of a single record may reveal only the site being treated during that admission.

- Code Kaposi sarcoma to the site in which it arises.
- Code to Skin, NOS (C44.9) if Kaposi sarcoma arises simultaneously in the skin and another site or the primary site is not identified.
- If the primary site is unknown or cannot be determined, code Skin, NOS (C44.9).

Gastrointestinal Stromal Tumors (GIST)

Code the primary site to the location where the GIST originated.

Ovary, fallopian tube, primary peritoneal *(added in 2024 per SEER PCSM)*

When the choice is between ovary, fallopian tube, or primary peritoneal without designation of the site of origin, any indication of fallopian tube involvement indicates the primary tumor is a tubal primary. Fallopian tube primary carcinomas can be confirmed by reviewing the fallopian tube sections as described on the pathology report to document the presence of either serous tubal intraepithelial carcinoma (STIC) and/or tubal mucosal invasive serous carcinoma. In the absence of fallopian tube involvement, refer to the histology and look at the treatment plans for the patient. If all else fails, assign C579 as a last resort. For additional information, see the CAP Gynecologic protocol, Ovary, Fallopian Tube, or Peritoneum, Table 1: Criteria for Assignment of Primary Site in High-Grade Serous Carcinoma (HGSC).

Transitional/urothelial cell carcinoma

Transitional/urothelial cell carcinoma originates in the urethra, bladder, ureters, and renal pelvis.

- Code the primary site to renal pelvis (C659) when transitional/urothelial cell carcinoma originates in the "kidney."

- C680 is the only ICD-O-3 code available for urethra. Assign C680 for penile urethra and for prostatic urethra. Code the primary site to urethra (C680) when transitional/urothelial cell carcinoma involves the "prostate and the urethra".

Transplants

Code the primary site to the location of the transplanted organ when a malignancy arises in a transplanted organ, i.e., code the primary site to where the malignancy resides or lies.
Example: There is a diagnosis of malignancy in transplanted section of colon serving as esophagus. Code the primary site as esophagus. Document the situation in a text field.

Specific Tissues with Ill-Defined Sites

If any of the following histologies appears only with an ill-defined site description (e.g., "abdominal" or "arm"), code it to the tissue in which such tumors arise rather than the ill-defined region (C76._) of the body, which contains multiple tissues. Use the alphabetic index in the **ICD-O-3** to assign the most specific site if only a general location is specified in the record.

Histology	Description	Code to This Site
8720–8790	Melanoma	C44._, Skin
8890-8891	Cutaneous leiomyosarcoma	C44._, Skin
8800–8811, 8813–8830, 8840–8921, 9040–9044	Sarcoma (except periosteal fibrosarcoma and dermatofibrosarcoma)	C49._, Connective, Subcutaneous and Other Soft Tissues
8990–8991	Mesenchymoma	
9120–9170	Blood vessel tumors, lymphatic vessel tumors	
9580–9582	Granular cell tumor and alveolar soft part sarcoma	
9240–9252	Mesenchymal chondrosarcoma and giant cell tumors	C40._, C41._ Bone and Cartilage C49._, Connective, Subcutaneous and Other Soft Tissues
8940–8941	Mixed tumor, salivary gland type	C07._ Parotid Gland C08._ Other Major Salivary Glands

In the absence of additional information about the primary site, assign the codes listed for these primary sites:

Ampullary/peri-ampullary	C241
Anal margin	C445
Anal verge	C211
Angle of the stomach	C162
Angular incisura of stomach	C163
Back of tongue	C019
Book-leaf lesion (mouth)	C068
Clavicular skin	C445
Colored / lipstick portion of upper lip	C000
Distal conus	C720
Edge of tongue	C021
Frontoparietal (brain)	C718
Gastric angular notch (incisura)	C163
Gastrohepatic ligament	C481
Genu of pancreas	C250
Glossotonsillar sulcus	C109
Incisura, incisura angularis	C163
Infrahilar area of lung	C349
Interarytenoid space	C329
Interhemispheric fissure (cerebrum)	C710
Intracranial	C719
Lateral tongue	C023
Leptomeninges	C709

Masticator space	C760
Mastoid or mastoid complex	C301
Nail bed, thumb	C446
Pancreatobiliary	C269
Parapharyngeal space	C139
Periareolar (breast)	C501
Periclitoral	C511
Perihilar bile duct	C240
Porta hepatis	C220
Postauricular region	C444
Pterygomandibular raphé	C069
Preauricular (skin)	C443
Prostatic sinus (urethra)	C680
Testis, descended post orchiopexy	C621
True vocal folds	C320
Uncinate of pancreas	C250
Ureterovesical junction (UVJ)	C669

LATERALITY

Item Length: 1
Allowable Values: 0–4, 9
NAACCR Item #410
Revised 01/10, 05/10, 01/13, 01/22

Description
Identifies the side of a paired organ or the side of the body on which the reportable tumor originated. This applies to the primary site only.

Rationale
Supplements staging and extent of disease information and defines the number of primaries involved.

Instructions for Coding
- Code laterality (1-5 or 9) for all paired sites. Paired sites are listed in the table below.
- Laterality is based on the primary tumor only (where the primary tumor originated). Do not include metastatic sites when determining laterality.
- Organs that are not listed as a paired site in the table below are coded 0.
- Special codes: Codes 3, 4 and 5 describe special situations. Review the notes in the table below for instructions on when to use these codes.

Code	Definition
0	Primary site is not listed in the table below (it is not a paired site) Primary site is unknown (C809) Laterality is unknown for a DCO case and the primary site is **NOT** a paired organ
1	Primary site is a paired organ and the origin of the tumor is the RIGHT side
2	Primary site is a paired organ and the origin of the tumor is the LEFT side
3	Primary site is a paired organ. Only one side is involved but laterality (right or left) of where the tumor originated is not specified. Example: Melanoma of the skin of the arm. Only 1 arm is involved, but it is not known if it is the left or right arm.

4	Seldom used except for the following situations:
	• Bilateral involvement of a paired organ at the time of diagnosis, the Solid Tumor Rules state the situation is a single primary and the side of origin is unknown.
	  • Both lungs have tumors, and the lung of origin is not known.
	  • Both ovaries are involved simultaneously with a single histology; a single primary according to the Solid Tumor Rules
	  • Both breasts when inflammatory carcinoma is bilateral at diagnosis.
	  • Both arms are involved with Kaposi sarcoma and no other sites are involved. It is not known on which arm the Kaposi sarcoma originated. Assign Laterality code 4.
	• Bilateral retinoblastomas
	• Bilateral Wilms tumors

5	Midline tumor of a paired organ. • “Midline” in this context refers to the point where the “right” and “left” sides of paired organs come into direct contact and a tumor forms at that point. • Most paired sites cannot develop midline tumors. For example, skin of the face or trunk and cerebral meninges can have a midline tumor, but the breasts cannot.
9	Paired site, but no information concerning laterality. Laterality is unknown for a death certificate only (DCO) case and primary site IS a paired organ.

Paired Organ Sites (Laterality must be 1-5 or 9)

ICD-O-3	Site	ICD-O-3	Site
C07.9	Parotid gland	C44.1	Skin of eyelid
C08.0	Submandibular gland	C44.2	Skin of external ear
C08.1	Sublingual gland	C44.3	Skin of other and unspecified parts of face
C09.0	Tonsillar fossa	C44.4	Skin of scalp and neck (Added in 2022)
C09.1	Tonsillar pillar	C44.5	Skin of trunk
C09.8	Overlapping lesion of tonsil	C44.6	Skin of upper limb and shoulder
C09.9	Tonsil, NOS	C44.7	Skin of lower limb and hip
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)	C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C30.1	Middle ear	C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C31.0	Maxillary sinus	C49.1	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C31.2	Frontal sinus	C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C34.0	Main bronchus (excluding carina)	C50.0–C50.9	Breast
C34.1–C34.9	Lung	C56.9	Ovary
C38.4	Pleura	C57.0	Fallopian tube
C40.0	Long bones of upper limb and scapula	C62.0–C62.9	Testis
C40.1	Short bones of upper limb	C63.0	Epididymis
C40.2	Long bones of lower limb	C63.1	Spermatic cord
C40.3	Short bones of lower limb	C64.9	Kidney, NOS
C41.3	Rib and clavicle (excluding sternum)	C65.9	Renal pelvis
C41.4	Pelvic bones (excluding sacrum, coccyx and symphysis pubis)	C66.9	Ureter
		C69.0–C69.9 C74.0-C74.9 C75.4	Eye and lacrimal gland Adrenal gland Carotid body
For the following CNS sites, only record laterality for cases diagnosed 1/1/2004 and after.			
C70.0	Cerebral meninges, NOS		
C71.0	Cerebrum		
C71.1	Frontal lobe		
C71.2	Temporal lobe		
C71.3	Parietal lobe		
C71.4	Occipital lobe		
C72.2	Olfactory nerve		
C72.3	Optic nerve		
C72.4	Acoustic nerve		
C72.5	Cranial nerve, NOS		

HISTOLOGIC TYPE ICD-0-3

Item Length: 4
NAACCR Item #522
Revised 09/06, 01/10, 03/10, 01/21

Description
Identifies the microscopic composition of cells and/or tissue for a specific primary.

Rationale
Histology is a basis for staging and determination of treatment options. It also affects the prognosis and course of the disease.

Instructions for Coding
The current SEER Solid Tumor Rules, the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database, and the International Classification of Diseases for Oncology, Third Edition, Second Revision Morphology (ICD-O-3.2) are the standard references for histology codes.

Standard setters have agreed to implement new histology terms and codes for ICD-O-3 based on the current versions of the World Health Organization Classification of Tumors. The update, referred to as ICD-O-3.2, includes comprehensive tables listing histology codes and behavior codes in effect beginning with cases diagnosed in 2021, or as designated. The new codes, new terms, and codes with changes to behavior are available at the NAACCR website: https://www.naaccr.org/icdo3/.

Refer to Appendix E in this CCARM for a summary of ICD-O-3 Histology Revisions for previous years.

The N.C. CCR follows the reportability indicators in the official ICD-O-3 references unless otherwise specified in the CCARM. Using the ICD-O-3 references on the NAACCR and SEER websites jointly with the CCARM is required to accurately determine case reportability (based on behavior code and diagnosis year) and the final histology and behavior code for each case.

1. Review the case eligibility requirements in the CCARM.
2. Review the SEER Hematopoietic/Lymphoid Database or the SEER Solid Tumor Rules (MP/H) – whichever is appropriate based on site and histology.
    a. SEER Heme Database: https://seer.cancer.gov/tools/heme/
    b. SEER Solid Tumor Coding Rules: https://seer.cancer.gov/tools/solidtumor/
3. If the SEER Heme Database or Solid Tumor Rules do not provide the coding instruction, review the ICD-O-3.2 Coding Guidelines: https://www.naaccr.org/icdo3/. The ICD-O-3.2 Coding Guidelines must be applied to efficiently use the ICD-O-3.2 Coding Table and updates.
4. Review the current ICD-O-3.2 Update Table (1 or 2 based on your preference) to determine if the histology is listed and if there is a change effective for that diagnosis year.
5. If the term is not found in the current Update Table, review the ICD-O-3.2 Coding Table Excel. Search for the term (or key letters from the term). Find the code that best matches the term.
6. If not in any of the above resources, check SEER SINQ to see if the question has already been asked.
7. If not, submit a question to Ask a SEER Registrar.

BEHAVIOR CODE

Item Length: 1
Allowable Values: 0–3
NAACCR Item #523
Revised 4/04, 1/10, 1/12, 1/13, 1/15, 1/21, 1/24

Description
Records the behavior of the tumor being reported. The fifth digit of the morphology code is the behavior code.

Rationale
The behavior code is used by pathologists to describe whether tissue samples are benign (0), borderline (1), in situ (2), or invasive (3).

Instructions for Coding
Behavior is the fifth digit of the morphology code after the slash (/). The standard reference for coding behavior is the ICD-O-3.2. Pages 27 through 30 in ICD-O-3 discuss behavior. The following general rules are found on pages 29-30 in ICD-O-3.

Beginning with cases diagnosed January 1, 2021, the ICD-O-3.2 is the preferred morphology coding reference manual. Refer to Appendix E for a summary of ICD-O-3 Histology Revisions for previous years.

- Code behavior prior to neoadjuvant therapy when given.
- Usually a histologic term carries a clear indication of the likely behavior of the tumor, whether malignant or benign, and this is reflected in the behavior code assigned to it in the ICD-O
- Although only a few histologic types of in situ neoplasms are actually listed in the ICD-O, the behavior code /2 could be attached to any histology code if an in situ form of the neoplasm is diagnosed
- If the pathologist disagrees with the ICD-O behavior assignment in a particular case, code the behavior according to the pathologist's description of the behavior even if that histology/behavior combination is not listed in the ICD-O.

  Rule F: The pathologist has the final say on the behavior of the tumor. ICD-O-3 may have only one behavior code, in situ (/2) or malignant (/3), listed for a specific histology. If the pathology report describes the histology as in situ and the ICD-O-3 histology code is listed only with a malignant behavior code (/3), assign the in situ behavior code (/2). If the pathology report describes histology as malignant and the ICD-O-3 histology code is listed only with an in situ behavior code (/2), assign the malignant behavior code (/3). See the Morphology and Behavior Code Matrix discussion on page 29 in ICD-O-3.

  Example: The pathology report says large cell carcinoma in situ. The ICD-O-3 only lists a malignant behavior (8012/3). Code the histology and behavior as 8012/2 as specified by the pathologist.

Intracranial and CNS tumors
See Section I: Case Eligibility for more information. Intracranial and CNS tumors with behavior codes 0 (benign) and 1 (borderline malignancy) are reportable beginning with January 1, 1990 diagnoses. Code the behavior from the CT scan, Magnetic Resonance Imaging (MRI), or Positron Emission Tomography (PET) report when *there is no tissue diagnosis (pathology or cytology report)*. Code the behavior listed on the scan. Do not use the WHO grade to code behavior.

In Situ
Clinical evidence alone cannot identify the behavior as in situ; a behavior code of /2 (in situ) must be based on pathologic examination.

Exception (added in 2024 per SEER PCSM): Intraductal papillary mucinous neoplasm with high grade dysplasia (8453/2) of the pancreas is reportable based on imaging alone; histologic confirmation is not required.

In Situ and Invasive
Code the behavior as malignant (/3) if any portion of the primary tumor is invasive no matter how limited, i.e., microinvasion.

Example: Pathology from mastectomy: Large mass composed of intraductal carcinoma with a single focus of invasion. Code the behavior as malignant (/3).

Re-code the behavior as malignant (/3) when metastases are attributed to a tumor originally thought to be in situ.

Example: Right colon biopsy reveals tubulovillous adenoma with microfocal carcinoma in situ; right hemicolectomy is negative for residual disease. Later core liver biopsy consistent with metastatic adenocarcinoma of gastrointestinal origin. Oncologist states most likely colon primary. Change the behavior code for the colon primary from /2 to /3. There were no other colon primaries in this case.

Per SEER SINQ and Bladder Coding Guidelines ***(added in 2024 per SEER PCSM)***:
Low grade urothelial carcinoma with no other information: Code to /2.
High grade urothelial carcinoma with no other information: Code to /3.
https://seer.cancer.gov/tools/codingmanuals/
(drill down to the current version of the Appendix C, Coding Guidelines for Bladder

Metastatic or Non-primary Sites
Cases cannot have a metastatic (/6) behavior code. The primary site and its metastatic site(s) will have the same histology. If the only pathologic specimen is from a metastatic site, code the appropriate histology code and the malignant behavior code (/3).

Code the behavior as malignant (/3) when malignant metastasis is present. Metastasis could be regional, nodal, or distant.

Example: Adenocarcinoma in situ with lymph nodes positive for malignancy. Code the behavior as malignant (/3). When the invasive component cannot be found and there are positive lymph nodes, assign behavior code of /3 based on the positive lymph nodes.

Exception: For in situ breast cancer; code as non-invasive (/2) in the presence of isolated tumor cells or if cells are artifactually displaced from a previous procedure.

Code	Label	Definition
0	Benign	Benign
1	Borderline	Uncertain whether benign or malignant
		Borderline malignancy
		Low malignant potential
		Uncertain malignant potential

Code	Label	Definition
2	In situ and synonymous with in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk
		Bowen disease (not reportable for C44._)
		Clark level 1 for melanoma (limited to epithelium)
		Confined to epithelium
		Hutchinson melanotic freckle, NOS (C44.–)
		Intracystic, noninfiltrating.(carcinoma)
		Intraductal.(carcinoma)
		Intraepidermal, NOS (carcinoma)
		Intraepithelial neoplasia, Grade III (e.g., AIN III, LIN III, SIN III, VAIN III, VIN III)
		Intraepithelial, NOS (carcinoma)
		Involvement up to, but not including the basement membrane
		Lentigo maligna (C44.–)
		Lobular, noninfiltrating (C50.–) (carcinoma)
		Noninfiltrating (carcinoma)
		Noninvasive (carcinoma only)
		No stromal invasion or involvement
		Papillary, noninfiltrating or intraductal (carcinoma)
		Precancerous melanosis (C44.–)
		Queyrat erythroplasia (C60.–)
		Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria)
3	Invasive	Invasive
		Microinvasive
		Foci of invasion

GRADE DATA ITEMS

GRADE (Effective 1/1/2021 and after)

- A new Grade Post Therapy Clin (yc) [1068] data item has been added.
- Grade Post Therapy [3845] was renamed to Grade Post Therapy Path (yp) for clarity.

GRADE (Effective 1/1/2018 and after)

Collecting "Grade" information in the abstract has gone through many transformations throughout the years. The instructions in the CCARM 2021 apply to cases diagnosed 1/1/2018 and after. The AJCC 8th Edition has specific grade tables listed for many chapters. Some, but not all, followed the definitions in the previous grade data item *Grade/Differentiation* [440] and therefore, was discontinued for 2018. Three new data items have been defined for cases diagnosed 1/1/2018 and after:

- *Grade Clinical* [3843]
- *Grade Pathological* [3844]
- *Grade Post Therapy* [3845].

New grade values were developed following the AJCC 8th Edition, where definitions differ based on the schema. Each schema-specific grade table includes the standard grade definition for those cases where the schema-specific grading system is not available in the medical documentation. A new Grade Manual effective 1/1/2018 has been developed. This manual provides information and coding instructions on the new grade data items and site/schema-specific grade tables. The Grade Manual can be downloaded from the NAACCR website at: https://apps.naaccr.org/ssdi/list/.

Grade/Differentiation (for cases diagnosed before 2018)

If you are abstracting a case with a diagnosis date before 2018, refer to the CCARM 2016 for detailed coding rules on how to assign the Grade/Differentiation data item. To avoid confusion, detailed rules have been removed from the CCARM 2018 & later versions.

GRADE CLINICAL

Item Length: 1
Allowable Values: 1-5, 8, 9, A, B, C, D, E, L, H, M, S
NAACCR Item #3843
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Description
This data item records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant).

For cases diagnosed January 1, 2018 and later, this data item, along with *Grade Pathological* [3844] and *Grade Post-Therapy* [3845], replaces *Grade/Differentiation* [440].

Rationale
Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers**.**

Instructions for Coding

Please see the following URL for detailed coding instructions and site-specific coding rules: https://apps.naaccr.org/ssdi/list/.

GRADE POST THERAPY CLIN (yc)

Item Length: 1
Allowable Values: 1-5, 8, 9, A, B, C, D, E, L, H, M, S
NAACCR Item #1068
Added 01/21

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2021 AND AFTER*****

Description
This data item records the grade of a solid primary tumor that has been microscopically sampled following neoadjuvant therapy or primary systemic/radiation therapy.

Rationale
Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers**.**

Instructions for Coding

Please see the following URL for detailed coding instructions and site-specific coding rules: https://apps.naaccr.org/ssdi/list/.

GRADE PATHOLOGICAL

Item Length: 1
Allowable Values: 1-5, 8, 9, A, B, C, D, E, L, H, M, S
NAACCR Item #3844
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Description
This data item records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup since all clinical information is used in pathological staging. Record the highest grade documented from any microscopic specimen of the primary site whether from the clinical workup or the surgical resection.

For cases diagnosed January 1, 2018 and later, this data item, along with *Grade Pathological* [3844] and *Grade Post-Therapy* [3845], replaces *Grade/Differentiation* [440].

Rationale
Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers**.**

Instructions for Coding

Please see the following URL for detailed coding instructions and site-specific coding rules: https://apps.naaccr.org/ssdi/list/.

GRADE POST THERAPY PATH (yp)

Item Length: 1
Allowable Values: 1-5, 8, 9, A, B, C, D, E, L, H, M, S
NAACCR Item #3845
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Description
This data item records the grade of a solid primary tumor that has been resected following neoadjuvant therapy. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. For some sites, grade is required to assign the post-neoadjuvant stage group.

For cases diagnosed January 1, 2018 and later, this data item, along with *Grade Pathological* [3844] and *Grade Post-Therapy* [3845], replaces *Grade/Differentiation* [440].

The name was updated from Grade Post Therapy to Grade Post Therapy Path (yp) in 2021.

Rationale
Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers**.**

Instructions for Coding

Please see the following URL for detailed coding instructions and site-specific coding rules: https://apps.naaccr.org/ssdi/list/.

GRADE/DIFFERENTIATION (Pre-2018)

Item Length: 1
Allowable Values: 1–9
NAACCR Item #440
Revised 09/08, 01/10, 01/11, 01/12, 01/13, 01/15

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED PRIOR TO 2018 ONLY*****

Description
Describes the tumor's resemblance to normal tissue. Well differentiated (Grade 1) is the most like normal tissue, and undifferentiated (Grade 4) is the least like normal tissue. Grades 5–8 define particular cell lines for lymphoma and leukemia.

Rationale
This data item is useful for prognosis.

Instructions for Coding

- See the CCARM 2016 for detailed instructions.
- Code the grade or differentiation as stated in the **final** pathologic diagnosis. If grade is not stated in the final pathologic diagnosis, use the information from the microscopic description or comments.
- If more than one grade is stated, code to the highest grade, even if the highest grade is only a focus.
- Code the grade from the primary tumor only. If unknown, code 9.
- If the primary site is unknown, code *Grade/Differentiation* as 9 (Unknown).
- Code the grade prior to any neoadjuvant treatment. If unknown, code 9.
- When there is no tissue diagnosis, it may be possible to establish grade MRI or PET. When available, code grade based on the recorded findings from these imaging reports.
- Code the grade for in situ lesions if the information is available. If the lesion is both invasive and in situ, code only the invasive portion. If the invasive component grade is unknown, then code 9.
- Codes 5–8 define T- or B-cell origin for leukemia and lymphoma. Do not use codes 1-4 for these cases.
- Do not code "high grade dysplasia" as Grade; this reference to "grade" has a different meaning.

Code	Label
1	Well differentiated; differentiated, NOS
2	Moderately differentiated; moderately well differentiated; intermediate differentiation
3	Poorly differentiated; dedifferentiated
4	Undifferentiated; anaplastic
5	T cell; T-precursor
6	B cell; pre-B; B-precursor
7	Null cell; non T-non B
8	NK (natural killer) cell (effective with diagnosis 1/1/95 and after)
9	Cell type not determined, not stated or not applicable; unknown primary; high grade dysplasia (adenocarcinoma in situ)

DIAGNOSTIC CONFIRMATION

Item Length: 1
Allowable Values: 1, 2, 4–9
NAACCR Item #490
Revised 1/04, 1/10, 1/11, 1/12, 1/13

Description
Records the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history. **The best method could occur at any time throughout the entire course of the disease. It is not limited to the confirmation at the time of initial diagnosis.**

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

The rules for coding differ between solid tumors and hematopoietic and lymphoid neoplasms.

- **Instructions for Coding Solid Tumors (all tumors *except* M9590-9993)**
- See the following section for Coding Hematopoietic or Lymphoid Tumors (9590-9993).
- The codes are in **priority order.**
- Code 1 has the highest priority.
- Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods.
- Do not include liquid biopsy as a diagnostic confirmation method. Liquid biopsies are not diagnostic. They are used for screening and detection of minimal residual disease.
- **This data item must be changed to a higher priority code if a more definitive method confirms the diagnosis *at any time during* the course of the disease.**

  Example: Benign brain tumor diagnosed on MRI. Assign code 7. Patient later becomes symptomatic and the tumor is surgically removed. Change diagnostic confirmation code to 1. The correction will be sent to the CCR through a modification record during the next transmission to the CCR.

Codes for Solid Tumors

Microscopically Confirmed

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined). Microscopic diagnosis is based on: • **tissue** specimens from fine needle aspirate, biopsy, surgery, autopsy or D&C • bone marrow specimens (aspiration or biopsy).

2	Positive cytology	Microscopic diagnosis is based on cytologic examination of ***cells*** **(no tissue microscopically examined)** such as sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears or from paraffin block specimens from concentrated spinal, pleural or peritoneal fluid. Note: If the only diagnosis was from cytology, the N.C. CCR does not require programs to report cases where the diagnosis on the cytology was made using ambiguous terminology only. Look elsewhere in the record for other statements of a diagnosis, such as a physician statement, before eliminating the case.
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.

Not Microscopically Confirmed

Code	Label	Definition
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer (e.g., imaging). Examples include alpha-fetoprotein for liver primaries. Example: Workup for prostate cancer is limited to a highly elevated PSA (no DRE and no imaging) and the physician diagnoses and/or treats the patient based only on that PSA. Elevated PSA alone is not diagnostic of cancer. However, if the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination. Diagnosis is based only on the surgeon's operative report from a surgical exploration or endoscopy or from gross autopsy findings in the absence of tissue or cytological findings.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only, other than 5, 6 or 7	Diagnosed by any clinical method not mentioned in preceding codes. Example: CT diagnosis is possible lung cancer. Patient returns to the nursing home with a Do Not Resuscitate (DNR) order. Physician enters a diagnosis of lung cancer in the medical record. Code the diagnostic confirmation to 8: there is a physician's clinical diagnosis – clinical diagnosis made by the physician using the information available for the case.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).

Instructions for Coding Hematopoietic or Lymphoid Tumors (9590-9993)

There is no priority hierarchy for coding *Diagnostic Confirmation* for hematopoietic and lymphoid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing. See the *Hematopoietic Database (DB)* for information on the definitive diagnostic confirmation for specific types of tumors. https://seer.cancer.gov/tools/heme/index.html

Codes for Hematopoietic and Lymphoid Neoplasms

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined.
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
3	Positive histology PLUS Positive immunophenotyping AND/OR Positive genetic studies	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results. For example, bone marrow examination is positive for acute myeloid leukemia. (9861/3) Genetic testing shows AML with inv(16)(p13.1q22) (9871/3). Do not use code 3 for neoplasms diagnosed prior to January 1, 2010.
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer, but no positive histologic confirmation.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination. Diagnosis is based only on the surgeon's report from a surgical exploration or endoscopy or from gross autopsy findings without tissue or cytological findings.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only, other than 5, 6 or 7	The malignancy was reported by the physician in the medical record. Diagnosed by any clinical method not mentioned in preceding codes. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).

Stage of Disease at Diagnosis

DATE OF SURGICAL DIAGNOSTIC AND STAGING PROCEDURE

Item Length: 8
NAACCR Item #1280
Revised 01/10, 01/11, 01/23

If a surgical diagnostic and staging procedure was performed, this date cannot be blank.

Description
Records the date on which the surgical diagnostic and/or staging procedure was performed.

Rationale:
This data item is used to track the use of surgical procedure resources that are not considered treatment.

Coding Instructions:
- If this procedure was performed, this date cannot be blank.
- Record the date on which the surgical diagnostic and/or staging procedure described in *Surgical Diagnostic and Staging Procedure* [1350] was performed at this or any facility.

SURGICAL DIAGNOSTIC AND STAGING PROCEDURE

Item Length: 2
Allowable Values: 00–07, 09
NAACCR Item #1350
Revised 9/06, 9/08, 1/12, 1/15, 1/16. 1/23

Description
Identifies the positive surgical procedure(s) performed to diagnose and/or stage disease.

Rationale
This data item is used to track the use of surgical procedure resources that are not considered treatment.

Instructions for Coding:
- Record only surgical procedures performed specifically for diagnosis or staging of the tumor and do not apply to surgical treatment.
- Record the type of procedure performed as part of the initial diagnosis and workup, whether this is done at your institution or another facility.
- Only record positive procedures.
    - For benign and borderline reportable tumors, report the biopsies positive for those conditions.
    - For malignant tumors, report procedures if they were positive for malignancy.
- If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy of primary site).
- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure* [3270] to code these procedures.

Brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears)
- Aspirations can be a biopsy (tissue) or cytology (cells).
    - Code tissue biopsy in Surgical Diagnostic and Staging Procedure [1350].
    - Code cytology cell aspiration in Diagnostic Confirmation [490].
- Do not code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) in this data item. This positive cytologic diagnostic confirmation is captured in the data item Diagnostic Confirmation [490]. Code brushings, washings, cell aspiration and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* [490]. These are not considered surgical procedures and should not be coded in this item.

Aspirate, biopsy or remove regional lymph nodes
- Do not code surgical procedures that aspirate, biopsy or remove regional lymph nodes in an effort to diagnose and/or stage disease in this data item except for lymphoma as described below.
- Use the data item *Scope of Regional Lymph Node Surgery* [1292] to code these procedures. See instructions for *Scope of Regional Lymph Node Surgery* [1292].
- Additionally, do not record the date of surgical procedures that aspirate, biopsy or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure* [1280]. Record the date of this surgical procedure in the data item *Date of First Course of Treatment* [1270] and/or *Date of First Surgical Procedure* [1200], as appropriate.

Lymphoma

- If a lymph node is biopsied or removed to diagnose or stage lymphoma, and that node is NOT the only node involved with lymphoma, use code 02.
- If there is only a single lymph node involved with lymphoma, use the data item Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year) to code these procedures.

Incisional versus excisional biopsies (and using margin status)

- If there are negative or microscopically positive margins (visible with a microscope only/not visible to the naked eye) then capture the procedure in *Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year)*. Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year)* to code these procedures.
- If there are macroscopic positive margins (visible with the naked eye) then capture the procedure as a Surgical Diagnostic and Staging Procedure [1350].
- If a needle biopsy preceded an excisional biopsy or more extensive surgery, and upon the excisional biopsy or more extensive surgery no tumor remains, DO NOT consider the needle biopsy to be an excisional biopsy. Both the needle biopsy and the more extensive surgery are to be reported. Surgical margins must be examined to determine whether a biopsy intended as incisional is excisional instead, and margins cannot be evaluated for a needle biopsy.
    - The needle biopsy should be recorded as such in the Surgical Diagnostic and Staging Procedure [1350] data item
    - Code the excisional biopsy or more extensive surgery in the Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year).

Melanoma of the Skin:

Refer to Appendix B: Site-Specific Surgery Codes for Skin (C44.0-C44.9) for detailed guidelines on coding biopsies and excisions for melanoma of the skin effective 1/1/2023.

Code	Definition
00	No surgical diagnostic or staging procedure was performed.
01	A biopsy (incisional, needle or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02	A biopsy (incisional, needle or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.
03	A surgical exploration only. The patient was not biopsied or treated.
04	A surgical procedure with a bypass was performed, but no biopsy was done.
05	An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06	A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07	A procedure was done, but the type of procedure is unknown.
09	No information of whether a diagnostic or staging procedure was performed.

Examples:

Code	Reason
00	A lung cancer primary was diagnosed by CT scan. The patient expired. No surgical diagnostic or staging surgical procedure was performed.
00	A sputum sample is examined cytologically to confirm a diagnosis of suspected lung cancer. The procedure is not surgical.
01	A needle biopsy of a liver metastasis in a patient with suspected widespread colon cancer was done. Gross residual tumor is left at the biopsy site.
03	During abdominal exploratory surgery, a gastric lesion and suspicious retroperitoneal lymph nodes were observed. No biopsy or treatment was done.
04	An abdominal exploration of a patient revealed pancreatic carcinoma with extension into surrounding organs and arteries. No attempt to treat. A bypass was performed to alleviate symptoms.
05	An exploratory procedure was performed for primary colon carcinoma with biopsy of suspicious liver lesions.
06	Esophagogastrostomy was performed for infiltrating gastric tumor following a biopsy of the primary site.
07	Stage III lung carcinoma was diagnosed and staged prior to admission.
09	A patient expires in the emergency room with recently diagnosed metastatic melanoma. It is unknown whether a diagnostic or staging procedure was done.

REGIONAL NODES EXAMINED

Item Length: 2
Allowable Values: 00–90, 95–99
NAACCR Item #830
Revised 09/06, 01/10

Description
Records the total number of regional lymph nodes that were removed and examined by the pathologist.

Rationale
This data item serves as a quality measure of the pathologic and surgical evaluation and treatment of the patient.

Quick coding reference:
- When NO lymph nodes are removed: Regional Nodes Examined = 00. Regional Nodes Positive = 98.
- Regional Nodes Examined and Regional Nodes Positive are always coded as 99 for:
  - Placenta (C589)
  - Brain and Cerebral Meninges (C700-C709)
  - Other Parts of Central Nervous System (C710-C729, C751-C753)
  - Intracranial Gland
  - Other and Ill-Defined Primary Sites (C76_)
  - Unknown Primary Site (C809)
  - Any case coded to primary site C420, C421, C423, C424, C770-C779
    - Lymphoma 00790
    - Lymphoma-CLL/SLL 00795
    - HemeRetic 00830 (excluding primary sites C420, C421, C423, C424)
    - Myeloma and Plasma Cell Disorders 00822 (Excludes 9734)
  - Cases with no information about positive regional lymph nodes

Instructions for Coding
- **Regional lymph nodes only.** Record information about regional lymph nodes only in this field according to the current AJCC Staging Manual. Distant lymph node information should not be coded in this field.
- Record information **based on pathologic information only**, including autopsy.
- Information from the autopsy may be used to code Regional Nodes Examined. Use text fields to explain the situation.
- This field is to be recorded regardless of whether the patient received preoperative treatment.

- **Use Code 00 when:**
  - the assessment of lymph nodes is clinical.
  - no lymph nodes are removed and examined.
  - a “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.

- **Cumulative nodes removed and examined:**
  - Record the total number of regional lymph nodes removed and examined by the pathologist.
  - The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

- Exception: Aspiration or core biopsies coded to 95. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Examined.
- If the location of the lymph node that is aspirated or core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Examined.
- If the aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Examined.

- **Priority of lymph node counts.** If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.

- **Lymph node biopsy.** If a lymph node biopsy was performed, code the number of nodes removed, if known.

Special Codes:
- **Code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).
- **Code 96.** Use code 96 when a limited number (sampling) of nodes are removed but the number is unknown.
    - **Definition of "sampling".** A lymph node "sampling" is removal of a limited number of lymph nodes.
    - Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy, selective dissection.
- **Code 97.** Use code 97 when more than a limited number (dissection) of lymph nodes are removed and the number is unknown.
    - **Definition of "dissection".** A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor.
    - Other terms include lymphadenectomy, radical node dissection, lymph node stripping.
    - If both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown, use code 97.
- **Code 98.** Use code 98 when neither the type of lymph node removal procedure nor the number of lymph nodes examined is known.
- **Code 99.** Use code 99 if it is unknown whether nodes were removed or examined. Or is one of the sites listed in the Quick Reference section listed above.

Codes

Code	Description
00	No nodes examined
01 - 89	1 to 89 nodes examined (code the exact number of regional nodes examined)
90	90 or more nodes examined
95	No regional nodes removed, but aspiration or core biopsy of regional nodes performed.
96	Regional lymph node removal documented as a sampling, and the number of nodes unknown/not stated.
97	Regional lymph node removal documented as dissection, and the number of nodes unknown/not stated.

98	Regional lymph nodes surgically removed, but number of lymph nodes unknown/not stated and not documented as sampling or dissection; nodes examined, but the number unknown.
99	Unknown whether nodes were examined (not documented in patient record) Not applicable based on primary site

***Example*:** Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected.
Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.

***Example*:** Positive right cervical lymph node aspiration followed by right cervical lymph node dissection showing 1 of 6 nodes positive.
Code Regional Nodes Positive as 01 and Regional Nodes Examined as 06.

***Example*:** Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive.
Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.

***Example*:** Patient record states that core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection.
Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.

***Example*:** Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery.
Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.

***Example*:** Lung cancer patient has aspiration of suspicious hilar mass, which shows metastatic squamous carcinoma in lymph node tissue. Patient undergoes preoperative radiation therapy followed by lobectomy showing 6 negative hilar lymph nodes.
Code Regional Nodes Positive as 95 and Regional Nodes Examined as the 06 nodes surgically resected.

***Example*:** Patient with carcinoma of the pyriform sinus has a mass in the mid neck. Fine needle aspiration (FNA) of one node is positive. The patient has neoadjuvant chemotherapy, then resection of the primary tumor and a radical neck dissection. In the radical neck dissection “several” of 10 nodes are positive; the remainder of the nodes show chemotherapy effect.
Code Regional Nodes Positive as 97 because the total number of positive nodes biopsied and removed is unknown, and code Regional Nodes Examined as 10.

Example: A breast cancer has two separate primaries as determined by the SEER Solid Tumor Rules. The pathology report states "3 of 11 lymph nodes positive for metastasis" with no further information available.
Code Regional Nodes Positive as 03 and Regional Nodes Examined as 11 for both primaries.

REGIONAL NODES POSITIVE

Item Length: 2
Allowable Values: 00–90, 95, 97, 99
NAACCR Item #820
Revised 09/06, 01/10

Description
Records the exact number of regional lymph nodes examined by a pathologist and found to contain metastases

Rationale
This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient.

Quick coding reference:
- When NO lymph nodes are removed: Regional Nodes Examined = 00. Regional Nodes Positive = 98.
- Regional Nodes Examined and Regional Nodes Positive are always coded as 99 for:
    - Placenta (C589)
    - Brain and Cerebral Meninges (C700-C709)
    - Other Parts of Central Nervous System (C710-C729, C751-C753)
    - Intracranial Gland
    - Other and Ill-Defined Primary Sites (C76_)
    - Unknown Primary Site (C809)
    - Any case coded to primary site C420, C421, C423, C424, C770-C779
        - Lymphoma 00790
        - Lymphoma-CLL/SLL 00795
        - HemeRetic 00830 (excluding primary sites C420, C421, C423, C424)
        - Myeloma and Plasma Cell Disorders 00822 (Excludes 9734)
    - Cases with no information about positive regional lymph nodes

Instructions for Coding
- If Regional Nodes Examined is coded as 00, Regional Nodes Positive must be code 98.
- **In Situ.** True in situ cases cannot have positive lymph nodes. The only allowable codes are 00 (all nodes negative) or 98 (nodes not examined).
- **Regional lymph nodes only.** Record information about only regional lymph nodes in this field. Distant lymph node information should not be coded in this field.
- Record information **based on pathologic information only**, including autopsy. Information from the autopsy may be used to code Regional Nodes Positive. Use text fields to explain the situation.
- This field is to be recorded regardless of whether the patient received preoperative treatment.
- **Cumulative nodes removed and examined:**
    - Record the total number of regional lymph nodes removed and examined by the pathologist.
    - The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
        - Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection. In other words, if there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also Use of Code 95 below.
        - If the location of the node aspirated or core-biopsied is not known, assume it is part of the chain surgically removed, and do not include it in the count of Regional Nodes Positive.

    - If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Positive.
- **Priority of lymph node counts.** If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.
- **Positive Nodes in Multiple Primaries in Same Organ.** If there are multiple primary cancers with different histologic types in the same organ and the pathology report just states the number of nodes positive, the registrar should first try to determine the histology of the metastases in the nodes and code the nodes as positive for the primary with that histology. If no further information is available, code the nodes as positive for all primaries.
- **Isolated tumor cells (ITCs) in lymph nodes.** For all primary sites except cutaneous melanoma and Merkel cell carcinoma of skin:
    - Count only lymph nodes that contain micrometastases or larger (metastases > 0.2 mm in size).
    - Do not include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs).
    - If the path report indicates that nodes are positive but the size of metastasis is not stated, assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive.
- **For cutaneous melanoma and Merkel cell carcinoma**, count nodes with ITCs as positive nodes.

Special Codes:

- **Code 95.** Use code 95 when:
    - the only procedure for regional nodes is a needle aspiration (cytology) or core biopsy (tissue).
    - a positive lymph node is aspirated and there are no surgically resected lymph nodes.
    - a positive lymph node is aspirated and surgically resected lymph nodes are negative.
- **Code 97.** Use code 97 for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology.
    - Code 97 includes positive lymph nodes diagnosed by either cytology or histology.
    - Note: If the aspirated node is the only one that is microscopically positive, use code 95.
- **Code 98.** Code 98 may be used in several situations:
    - When the assessment of lymph nodes is clinical only.
    - When no lymph nodes are removed and examined.
    - When a “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
- **Code 99.** Use code 99 if it is unknown whether regional lymph nodes are positive. Or is one of the sites listed in the Quick Reference section listed above.

Codes

Code	Description
00	All nodes examined negative
01 - 89	1 to 89 nodes positive (code exact number of nodes positive)
90	90 or more nodes positive
95	Positive aspiration or core biopsy of lymph node(s) only
97	Positive nodes are documented but the number positive is not specified
98	No nodes were examined
99	Unknown whether nodes are positive (not documented in patient record) Not applicable based on primary site

LYMPHOVASCULAR INVASION

Item Length: 1
Allowable Values: 0-1, 8-9
NAACCR Item #1182
Revised 01/11, 01/18, 01/22

Description
Indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist. This field is *required* for mapping of the AJCC T category in some sites.

Rationale
Lymphovascular invasion (LVI) is an indicator of prognosis.

Definition
Lymphovascular invasion is defined as the presence of tumor cells found inside small blood vessels or lymphatic channels within the tumor and surrounding tissues in the primary site. The tumor cells have broken free of the primary tumor and now have the capability to float throughout the body. Other names for lymphovascular invasion are LVI, lymph-vascular invasion, vascular invasion, blood vessel invasion, and lymphatic invasion. Vascular invasion is not the same as direct tumor extension from the primary tumor into adjacent blood vessels; LVI cells are not attached to or growing into the wall of the blood vessel. Lymphatic invasion is not the same as involvement of regional lymph nodes. Lymphovascular invasion does not include perineural invasion. Do not code perineural invasion in this data item.

Effective 1/1/2018: New codes (2, 3, and 4) added based on the AJCC 8th Edition staging manual for appropriate disease sites. Revised CAP Protocols and 8th Edition chapters will indicate which chapters can use the new codes (2, 3, and 4) and which will only use the existing codes (0, 1, 8, 9), as there are some disease sites where distinguishing between L and V is not medically appropriate.

Effective 1/1/2022: Wording for codes 2-4 were updated to align with the CAP protocol. Instructions were modified to code lymph vascular invasion to codes 0, 2, 3, 4, or 9 for the following Schema IDs: thyroid (schema ID 00730), thyroid medullary (schema ID 00740), and adrenal gland (schema ID 00760).

Instructions for Coding

Code	Description
0	Lymphovascular invasion not present (absent)/Not identified, **In Situ** Tumors Use code 0 when the pathology report indicates that there is no lymphovascular invasion. This includes cases of purely in situ carcinoma, which biologically have no access to lymphatic or vascular channels below the basement membrane.
1	Lymphovascular invasion present/Identified Use code 1 when the pathology report or a physician's statement indicates that lymphovascular invasion (or one of its synonyms) is present in the specimen. Synonyms include, but are not limited to:

	• Angiolymphatic invasion • Blood vessel invasion • Lymph vascular emboli • Lymphatic invasion • Lymphvascular invasion • Lymphvascular space invasion • Vascular invasion
2	Lymphatic and small vessel invasion only (L) OR Lymphatic invasion only (thyroid and adrenal only)
3	Venous (large vessel) invasion only (V) OR Angioinvasion (thyroid and adrenal only)
4	BOTH lymphatic and small vessel AND venous (large vessel) invasion OR BOTH lymphatic AND angioinvasion (thyroid and adrenal only)
8	Not applicable Use code 8 for the following Schemas/Schema IDs GIST 00430 HemeRetic 00830 Lymphoma 00790 Lymphoma-CLL/SLL 00795 Lymphoma Ocular Adnexa 00710 Mycosis Fungoides (MF) 00811 Plasma Cell Disorders 00822 Plasma Cell Myeloma 00821 Primary Cutaneous Lymphoma (excluding MF and SS) 00812 Non-malignant brain (intracranial) and CNS tumors including C751, C752, and C753
9	Unknown if lymphovascular invasion present. Indeterminate Use code 9 when: • there is no microscopic examination of a primary tissue specimen • the primary site specimen is cytology only or a fine needle aspiration • the biopsy is only a very small tissue sample • it is not possible to determine whether lymphovascular invasion is present • the pathologist indicates the specimen is insufficient to determine lymphovascular invasion • lymphovascular invasion is not mentioned in the pathology report • there is no information from the pathology report or other sources • primary site is unknown • Ambiguous terminology is used. Example: “suspicious LVI”

1. **Code from pathology report(s)**. Code the absence or presence of lymphovascular invasion as described in the medical record.
   a. The primary sources of information about lymphovascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from the pathology report or a physician’s statement, in that order.

2. Code lymphovascular invasion to 0, 2, 3, 4, or 9 for the following Schema IDs: Thyroid 00730, Thyroid Medullary 00740, and Adrenal Gland 00760.
3. Do not code perineural invasion in this field.
4. Use the pathology report for any specimen from the primary site to code this data item (biopsy or resection).
5. Code as present/identified when lymphovascular invasion is identified in any primary tumor specimen except as noted in Coding Instruction 2.
6. For cases with benign or borderline behavior, code the lymphovascular invasion documented (negative or positive) and, if not documented, code unknown.

Coding LVI for neoadjuvant therapy:

7. For cases treated with neoadjuvant therapy, refer to table below to code this field. However, if documentation in the medical record indicates information that conflicts with this table, code lymphovascular invasion with the documentation in the medical record. Code the presence of LVI from the pathology report and/or medical information.
8. If LVI was present prior to neoadjuvant therapy (codes 1-4) but LVI was not present after neoadjuvant therapy (codes 0 or 9), code LVI to present (codes 1-4).
9. If LVI was not present prior to neoadjuvant therapy (codes 0 or 9), but LVI was present after neoadjuvant therapy (codes 1-4), code LVI to present (codes 1-4).

LVI on pathology report PRIOR to neoadjuvant therapy	LVI on pathology report AFTER neoadjuvant therapy	Code LVI to:
0 - Not present/Not identified	0 - Not present/Not identified	0 - Not present/Not identified
0 - Not present/Not identified	1 - Present/Identified	1 - Present/Identified
0 - Not present/Not identified	9 - Unknown/Indeterminate	9 - Unknown/Indeterminate
1 - Present/Identified	0 - Not present/Not identified	1 - Present/Identified
1 - Present/Identified	1 - Present/Identified	1 - Present/Identified
1 - Present/Identified	9 - Unknown/Indeterminate	1 - Present/Identified
9 - Unknown/Indeterminate	0 - Not present/Not identified	9 - Unknown/Indeterminate
9 - Unknown/Indeterminate	1 - Present/Identified	1 - Present/Identified
9 - Unknown/Indeterminate	9 - Unknown/Indeterminate	9 - Unknown/Indeterminate

10. Clarification between codes 8 and 9:
    - Code 8 for those histologies noted above described in code 8 for which LVI is always not applicable.
    - Code 9 for those cases where LVI is applicable but there is no documentation from the pathology report or other sources.

TUMOR SIZE SUMMARY

Item Length: 3
Allowable Values: 000–990, 998, 999
NAACCR Item #756
Effective 1/1/2016

Description
This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.

Rationale
Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Instructions for Coding

Note: All measurements should be in millimeters (mm).

Record size in specified order:

1. Record the size measured on the surgical resection specimen, when **surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered**.
    a. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (also known as CAP protocol or pathology report checklist). If only a text report is available, use: final diagnosis, microscopic, or gross examination, in that order.

    Example: Chest x-ray shows a 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8cm. Record tumor size as 028 (28 mm).

    Example: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.3 cm. Record tumor size as 032 (32 mm).

2. If neoadjuvant therapy followed by surgery, do not record the size of the pathologic specimen. Code the largest size of the tumor prior to neoadjuvant treatment. If it is unknown code the size as 999.

    Example: Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size after total resection is 2.8 cm. Record tumor size as 022 (22 mm).

3. If no surgical resection, or surgical resection was done but no size was reported on the path report, then code the largest measurement of the tumor from the physical exam, imaging or other diagnostic procedures prior to any other form of treatment (see coding rules below).

4. If 1, 2 or 3 do not apply, code the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

Coding Rules:

1. Tumor size is the **diameter** of the tumor, **not the depth or thickness** of the tumor.

2. Recording less than/greater than Tumor Size:
    a. If tumor size is reported as less than x mm or less than x cm, the reported tumor size should be record as 1 mm less than the stated size. For example, if size is < 10 mm, code size as 009. Often these are given in cm such as < 1cm which is coded as 009.

Tumor size is reported as:	**Record as:**
Less than (<) 1 mm	001
Less than (<) 10 mm	009
Less than (<) 1 cm	009
Less than (<) 2 cm	019
Less than (<) 3 cm	029
Less than (<) 4 cm	039
Less than (<) 5 cm	049

    b. If tumor size is reported as more than x mm or more than x cm, the reported tumor size should be record as 1 mm more than the stated size. For example, if size is > 10 mm, code size as 011. Often these are given in cm such as > 1cm which is coded as 011.

Tumor size is reported as:	**Record as:**
More than (>) 10 mm	011
More than (>) 1 cm	011
More than (>) 2 cm	021
More than (>) 3 cm	031
More than (>) 4 cm	041
More than (>) 5 cm	051
Anything > 98.0 cm	989

    c. If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two. Add the two sizes together and then divide by 2. For example, “between 2 and 3 cm” is coded as 025.

3. **Rounding:** Round the tumor size only if it is described in fractions of millimeters.
    a. Largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm):
        i. record size as 001 (do not round down to 000)
    b. Largest dimension of a tumor size is greater than 1 millimeter:
        i. If the tenth of mm is in the 1-4 range, round down to the nearest whole mm
            1. Example: Tumor is described as 1.4 mm. Round down and record as 001
            2. Example: Tumor is described as 2.3 mm. Round down and record as 002
            3. Example: Tumor is described as 5.2 mm. Round down and record as 005
        ii. If the tenth of mm is in the 5-9 range, round up to the nearest whole millimeter
            1. Example: Tumor is described as 6.5 mm. Round up and record as 007
    c. Tumor size is expressed in centimeters:

i. Do not round to the nearest whole centimeter
ii. Move the decimal point one space to the right, converting the measurement to millimeters

Exception to rounding rules for BREAST primaries:
Round tumor sizes greater than 1.0 mm and up to 2.4 mm to 2 mm (002). The purpose of this exception is so that the size recorded in the Tumor Size Summary data item will derive the correct AJCC TNM Primary Tumor (T) category for breast primaries. Do not apply this instruction to any other site.

Examples:
Breast cancer described as 6.5 millimeters in size. Round up to 7 mm and code as 007.
Breast cancer described as 1.3 mm in size. Round up to 2 mm and code as 002.
5.2 cm breast cancer. Convert to millimeters and code 052.
2.5 cm rectal cancer. Do not round, record as 025 millimeters.
2.3 millimeters cancer in a polyp. Round down to 2 mm and code 002.
Hypopharynx: Focus of cancer described as 1.4 mm in size. Round down to 1 mm and code as 001.

4. **Priority of imaging/radiographic techniques:** Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report. It should be taken as a lower priority, but over a physical exam.

5. **Tumor size discrepancies among imaging and radiographic reports:** If there is a difference in the reported tumor size among imaging and radiographic techniques, unless the physician specifies which imaging is most accurate, record the largest size in the record, regardless of which imaging technique reports it.

6. **Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or metastasis.**

   Exception: If the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

7. **Record the size of the invasive component, if given.**
   a. If both an in situ and an invasive component are present and the invasive component is measured, record the size of the invasive component (even if it is smaller).

      Example: Tumor is mixed in situ and invasive adenocarcinoma. Total tumor size is 3.7 cm, of which 1.4 cm is invasive. Record as 014 (14 mm).

   b. If the size of the invasive component is not given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

      Example: Tumor has an extensive in situ component. Total tumor size is 2.3 cm. Size of invasive component is not stated. Record as 023 (23 mm).

      Example: Tumor has an in situ component measuring 1.9 cm with an area of invasive tumor. Size of invasive component is not stated. Record as 019 (19 mm).

8. **Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.**

   Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).

9. **Record the size as stated for purely in situ lesions.**

10. **Disregard microscopic residual or positive surgical margins when coding tumor size.** Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be record in a separate data item.

11. **Do not add the size of pieces or chips together to create a whole.** They may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determine d by fitting the tumor pieces together and measuring the total size), record that size. If the only measurement describes pieces or chips, record tumor size as 999.

12. **Multifocal/multicentric tumors:**
    a. If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor.
    b. If all of the tumors are in situ, code the size of the largest in situ tumor.

13. **Tumor size code 999 is used when size is unknown or not applicable.** Sites/morphologies where tumor size is not applicable are listed here.
    - Hematopoietic, Reticuloendothelial and Myeloproliferative neoplasms (9590-9993)
      - Excludes: Lymphoma Ocular Adnexa, Primary Cutaneous Lymphomas, Mycosis Fungoides and lymphomas that are collected in the Brain, CNS Other and Intracranial Gland Schemas
    - Kaposi Sarcoma
    - Melanoma Choroid
    - Melanoma Ciliary Body
    - Melanoma Iris

14. **Document the information to support tumor size in the appropriate text data item of the abstract.**

Code	Description
000	No mass/tumor found. Occult Cervical Lymph Node.
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2mm-988mm)
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
998	SITE-SPECIFIC CODES/Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-C18.9)

	If no size is documented: Circumferential: Esophagus (C15.0 C15.5, C15.8 C15.9) Diffuse; widespread; 3/4s or more; linitis plastica: Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9) Diffuse, entire lung or NOS: Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9) Diffuse: Breast (C50.0 C50.6, C50.8 C50.9)
999	Unknown; Size not stated; Not documented in patient record; Size of tumor cannot be assessed; Not applicable

2018 Stage Data Items

Recorded for Cases Diagnosed 1/1/2018 and after

SUMMARY STAGE 2018 (Effective 1/1/2018)

Item Length: 1
Allowable Values: 0–4, 7-9
NAACCR Item #759
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Refer to Section I on the Stage data collection requirements based on year of diagnosis.

Description

This item stores the directly coded Summary Stage 2018. Effective for cases diagnosed 1/1/2018+. Code summary stage at the initial diagnosis or treatment of the reportable tumor.

Timing Rule

Summary stage should include all information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.

Rationale

Summary Stage groups cases into broad categories of in situ, local, regional, and distant. Summary Stage can be used to evaluate disease spread at diagnosis, treatment patterns and outcomes over time. Stage information is important when evaluating the effects of cancer control programs. It is crucial in understanding whether changes over time in incidence rates or outcomes are due to earlier detection of the cancers. In addition, cancer treatment cannot be studied without knowing the stage at diagnosis.

Instructions for Coding

- Refer to the SEER Summary Staging Manual 2018 for site-specific coding instructions.
- This information can be found at: https://seer.cancer.gov/tools/ssm/
- Use Code 8 for benign and borderline brain and CNS tumors.
- For cases diagnosed 1/1/2018 and after, code 5 (Regional, NOS) can no longer be used.

Code	Definition
0	In Situ
1	Localized
2	Regional by direct extension only
3	Regional lymph nodes only involved
4	Regional by both direct extension and to regional lymph nodes (combination of codes 2 and 3)
7	Distant metastasis (sites or nodes); Systemic disease
8	Benign and borderline. Use for Brain, CNS Other, Intracranial Gland cases only.
9	Unknown if involvement is from extension or metastasis; Unstaged, unknown or unspecified; Death certificate only cases

AJCC TNM CLIN T

Item Length: 15
Alphanumeric, Left-Justified
NAACCR Item #1001
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Refer to Section I on the Stage data collection requirements based on year of diagnosis.
***Use the AJCC Cancer Staging Manual*, 8th ed to assign this data item.**

Description
Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known ***prior*** to the start of any therapy.

Rationale
The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results. With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88).

Instructions for Coding
• The clinical T category staging data item must be recorded for *Class of Case* 10-22.
• It is strongly recommended that the clinical T category staging data item be recorded for *Class of Case* 00 cases if the patient's workup at the facility allows assigning of clinical T.
• Assign clinical T category as documented by the first treating physician or the managing physician in the medical record.
• If the managing physician has not recorded clinical T, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
• Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
• If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
• Refer to the current AJCC Cancer Staging Manual, Eighth Edition for detailed staging rules.
• The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission.

AJCC TNM CLIN T Suffix

Item Length: 4
Allowable Values: (m), (s), Blank
NAACCR Item #1031
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Refer to Section I on the Stage data collection requirements based on year of diagnosis.
***Use the AJCC Cancer Staging Manual*, 8th ed to assign this data item.**

Description
Identifies the AJCC TNM clinical T category suffix for the tumor ***prior*** to the start of any therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale
The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results. With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88).

Instructions for Coding
• Record the clinical T category suffix as documented by the first treating physician or the managing physician in the medical record.
• If the managing physician has not recorded the suffix when applicable, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
• If the tumor is not staged according to the AJCC manual, leave this data item blank.
• Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition
(blank)	No information available; not recorded
(m)	Multiple synchronous tumors OR Multifocal tumor (differentiated and anaplastic thyroid only)
(s)	Solitary tumor (differentiated and anaplastic thyroid only)

AJCC TNM CLIN N

Item Length: 15
Alphanumeric, Left-Justified
NAACCR Item #1002
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Refer to Section I on the Stage data collection requirements based on year of diagnosis.
***Use the AJCC Cancer Staging Manual*, 8th ed to assign this data item.**

Description
Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known ***prior*** to the start of any therapy. Detailed site-specific
values for the clinical N category as defined by the current AJCC edition.

Rationale
The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results. With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88).

Instructions for Coding
• The clinical N category staging data item must be assigned for *Class of Case* 10-22.
• It is strongly recommended that the clinical N category staging data item be recorded for *Class of Case* 00 cases if the patient's workup at the facility allows assigned of clinical N category.
• Record clinical N category as documented by the first treating physician or the managing physician in the medical record.
• If the managing physician has not recorded clinical N, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
• Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
• If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
• Refer to the current *AJCC Cancer Staging Manual* for staging rules.
• The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission.

AJCC TNM CLIN N Suffix

Item Length: 4
Allowable Values: (sn), (f), Blank
NAACCR Item #1034
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Refer to Section I on the Stage data collection requirements based on year of diagnosis.
***Use the AJCC Cancer Staging Manual*, 8th ed to assign this data item.**

Description
Identifies the AJCC TNM clinical N category suffix for the tumor ***prior*** to the start of any therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale
The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results. With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88).

Instructions for Coding
• Record the clinical N category suffix as documented by the first treating physician or the managing physician in the medical record.
• If the managing physician has not recorded the suffix when applicable, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
• If the tumor is not staged according to the AJCC manual, leave this data item blank.
• Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition
(blank)	No information available; not recorded
(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only

AJCC TNM CLIN M

Item Length: 15
Alphanumeric, Left-Justified
NAACCR Item #1003
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Refer to Section I on the Stage data collection requirements based on year of diagnosis.
***Use the AJCC Cancer Staging Manual*, 8th ed to assign this data item.**

Description
Identifies the presence or absence of distant metastasis (M) of the tumor known ***prior*** to the start of any therapy. Detailed site-specific values for the clinical T category suffix as defined by the current AJCC edition.

Rationale
The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results. With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88).

Instructions for Coding
• The clinical M category staging data item must be assigned for *Class of Case* 10-22.
• It is strongly recommended that the clinical M category staging data item be recorded for *Class of Case* 00 cases if the patient's workup at the facility allows assigning of clinical M.
• Record clinical M category as documented by the first treating physician or managing physician in the medical record.
• If the managing physician has not recorded clinical M category, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
• Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
• If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
• The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission.

AJCC TNM CLIN STAGE GROUP

Item Length: 15
Alphanumeric, Left-Justified
NAACCR Item #1004
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Refer to Section I on the Stage data collection requirements based on year of diagnosis.
***Use the AJCC Cancer Staging Manual*, 8th ed to assign this data item.**

Description
Identifies the anatomic extent of disease based on the T, N, and M category data items known ***prior*** to the start of any therapy. Detailed site-specific values for the clinical stage group as defined by the current AJCC edition.

Rationale
The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results. With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88).

Instructions for Coding
• Record the clinical stage group as documented by the first treating physician or the managing physician in the medical record.
• If the managing physician has not recorded the clinical stage, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
• Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
• If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
• Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
• Refer to the current *AJCC Cancer Staging Manual* for staging rules.
• The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission.

AJCC TNM PATH T

Item Length: 15
Alphanumeric, Left-Justified
NAACCR Item #1011
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Refer to Section I on the Stage data collection requirements based on year of diagnosis.
***Use the AJCC Cancer Staging Manual*, 8th ed to assign this data item.**

Description
Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known ***following*** the completion of surgical therapy. Detailed site-specific values for the pathological tumor (T) as defined by the current AJCC edition.

Rationale
The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results. With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88).

Instructions for Coding
• The pathological T category staging data item must be assigned for *Class of Case* 10-22.
• Assign pathological T as documented by the treating physician(s) or the managing physician in the medical record.
• If the managing physician has not recorded pathological T category, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
• Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
• For lung, occult carcinoma is assigned TX.
• If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
• The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission.

AJCC TNM PATH T Suffix

Item Length: 4
Allowable Values: (m), (s), Blank
NAACCR Item #1032
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Refer to Section I on the Stage data collection requirements based on year of diagnosis.
***Use the AJCC Cancer Staging Manual*, 8th ed to assign this data item.**

Description
Identifies the AJCC TMN pathological T category suffix for the tumor ***following*** the completion of surgical therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale
The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results. With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88).

Instructions for Coding
• Record the pathological stage T category suffix as documented by the first treating physician or the managing physician in the medical record.
• If the managing physician has not recorded the descriptor, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
• If the tumor is not staged according to the AJCC manual, leave this data item blank.
• Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition
(blank)	No information available; not recorded
(m)	Multiple synchronous tumors OR Multifocal tumor (differentiated and anaplastic thyroid only)
(s)	Solitary tumor (differentiated and anaplastic thyroid only)

AJCC TNM PATH N

Item Length: 15
Alphanumeric, Left-Justified
NAACCR Item #1012
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Refer to Section I on the Stage data collection requirements based on year of diagnosis.
***Use the AJCC Cancer Staging Manual*, 8th ed to assign this data item.**

Description
Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known ***following*** the completion of surgical therapy.

Rationale
The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results. With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88).

Instructions for Coding
• The pathological N category staging data item must be assigned for *Class of Case* 10-22.
• Assign pathological N category as documented by the treating physician(s) or managing physician in the medical record.
• If the managing physician has not recorded pathological N category, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
• Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
• If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
• Refer to the current *AJCC Cancer Staging Manual* for staging rules.
• The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission.

AJCC TNM PATH N Suffix

Item Length: 4
Allowable Values: (sn), (f), Blank
NAACCR Item #1035
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Refer to Section I on the Stage data collection requirements based on year of diagnosis.
***Use the AJCC Cancer Staging Manual*, 8th ed to assign this data item.**

Description
Identifies the AJCC TNM pathological N suffix for the tumor ***following*** the completion of surgical therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale
The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results. With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88).

Instructions for Coding
• Record the pathological N category suffix as documented by the first treating physician or the managing physician in the medical record.
• If the managing physician has not recorded the descriptor, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
• If the tumor is not staged according to the AJCC manual, leave this data item blank.
• Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition
(blank)	No information available; not recorded
(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only

AJCC TNM PATH M

Item Length: 15
Alphanumeric, Left-Justified
NAACCR Item #1013
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Refer to Section I on the Stage data collection requirements based on year of diagnosis.
***Use the AJCC Cancer Staging Manual*, 8th ed to assign this data item.**

Description
Identifies the presence or absence of distant metastasis (M) of the tumor known ***following*** the completion of surgical therapy.

Rationale
The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results. With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88).

Instructions for Coding
• The pathological M category staging data item must be assigned for *Class of Case* 10-22.
• Assign pathological M category as documented by the treating physician(s) or the managing physician in the medical record.
• If the managing physician has not recorded pathological M category, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
• Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
• If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
• Refer to the current *AJCC Cancer Staging Manual* for staging rules.
• The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission.

AJCC TNM PATH STAGE GROUP

Item Length: 15
Alphanumeric, Left-Justified
NAACCR Item #1014
Added 01/18

*****THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER*****

Refer to Section I on the Stage data collection requirements based on year of diagnosis.
***Use the AJCC Cancer Staging Manual*, 8th ed to assign this data item.**

Description
Identifies the anatomic extent of disease based on the T, N, and M category data items known ***following*** the completion of surgical therapy.

Rationale
The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results. With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88).

Instructions for Coding
• Record the pathological stage group as documented by the treating physician(s) or the managing physician in the medical record.
• If the managing physician has not recorded the pathological stage, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician(s).
• Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
• If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
• Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
• Refer to the current *AJCC Cancer Staging Manual* for staging rules.
• The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission.

Item Length: Varies
Allowable Values: Varies
NAACCR Item #'s (see SSDI Manual)
Revised 01/18, 01/23, 01/24

THIS DATA ITEM IS USED FOR CASES DIAGNOSED 1/1/2018 AND AFTER

Refer to Section I on the Stage data collection requirements based on year of diagnosis.

- The SSDIs in the table below are required to be reported to the N.C. CCR for cases diagnosed 1/1/2018 and after (unless a later year is noted in red).
- Note: CoC facilities are to report all SSDIs required to be collected by the CoC PLUS any additional ones below required by the N.C. CCR.
- Refer to the SSDI Manual for detailed descriptions, rationales, coding instructions and site-specific coding rules: https://apps.naaccr.org/ssdi/list/

Schema_ID_Name	NAACCR Item No	SSDI_Name	Start Dx Year
Anus	3956	p16	2023
Appendix	3819	CEA Pretreatment Interpretation	2018
Appendix	3820	CEA Pretreatment Lab Value	2018
Appendix	3960	Histologic Subtype	2023
Bile Ducts Intrahepatic	3835	Fibrosis Score	2018
Brain	3816	Brain Molecular Markers	2018
Brain	3964	Brain Primary Tumor Location (2024+)	2024
Breast	3827	Estrogen Receptor Summary	2018
Breast	3855	HER2 Overall Summary	2018
Breast	3915	Progesterone Receptor Summary	2018
Cervix	3956	p16	2021
CNS Other	3816	Brain Molecular Markers	2018
Colon and Rectum	3819	CEA Pretreatment Interpretation	2018
Colon and Rectum	3820	CEA Pretreatment Lab Value	2018
Colon and Rectum	3890	Microsatellite Instability (MSI)	2018
Corpus Carcinoma and Carcinosarcoma	3890	Microsatellite Instability (MSI)	2026
Esophagus (& GE junction) Squamous	3829	Esophagus and EGJ Tumor Epicenter	2018
Liver	3835	Fibrosis Score	2018
Lung	3929	Separate Tumor Nodules	2018
Lung V9 (09360)	1174	PD-L1	2025
Lymphoma (00790) Lymphoma-CLL/SLL (00795) Plasma Cell Disorders (00822) Plasma Cell Myeloma (00821) Primary Cutaneous Lymphoma (00812)	1172	Post Transplant Lymphoproliferative Disorder	2025
Medulloblastoma	3816	Brain Molecular Markers	2023
Melanoma Skin	3817	Breslow Tumor Thickness	2018
Melanoma Skin	3961	Clinical Margin Width	2023

Melanoma Skin	3869	LDH Level	2018
Melanoma Skin	3932	LDH Pretreatment Lab Value	2018
Melanoma Skin	3893	Mitotic Rate Melanoma	2018
Melanoma Skin	3936	Ulceration	2018
Mycosis Fungoides	3910	Peripheral Blood Involvement	2018
Plasma Cell Myeloma	3857	High Risk Cytogenetics	2018
Plasma Cell Myeloma	3869	LDH Level	2018
Plasma Cell Myeloma	3930	Serum Albumin Pretreatment Level	2018
Plasma Cell Myeloma	3931	Serum Beta-2 Microglobulin Pretreatment Level	2018
Prostate	3838	Gleason Patterns Clinical	2018
Prostate	3839	Gleason Patterns Pathological	2018
Prostate	3840	Gleason Score Clinical	2018
Prostate	3841	Gleason Score Pathological	2018
Prostate	3842	Gleason Tertiary Pattern	2021
Prostate	3920	PSA Lab Value	2018
Testis	3923	S Category Clinical	2018
Testis	3924	S Category Pathological	2018
Vulva (v9)	3956	p16	2024

Pre-2018 Stage Data Items

Instructions for Coding

- Refer to Section I for stage-related data item collection requirements based on year of diagnosis.
- If the date of diagnosis is before 1/1/2018, the staging system required for that year of diagnosis MUST be used for that case.
- For 2004–2015, Collaborative Stage and Site Specific Factor data items CANNOT be left blank.
- Refer to the following manuals for site-specific coding instructions:
    - SEER Summary Staging Manual 2000: https://seer.cancer.gov/tools/ssm/ssm2000/
    - AJCC Cancer Staging Manual, 7th ed: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/
    - Collaborative Stage Data Collection System: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/collaborative-staging-schema-v0205/

Required Data Items

Recorded for Cases Diagnosed 2001 - 2017

SUMMARY STAGE 2000 [759]

Recorded for Cases Diagnosed 2010 – 2017 (AJCC 7th Edition)

CLINICAL T [940]
CLINICAL N [950]
CLINICAL M [960]
CLINICAL STAGE GROUP [970]
TNM CLIN DESCRIPTOR [980]
STAGED BY (CLINICAL STAGE) [990]
PATHOLOGIC T [880]
PATHOLOGIC N [890]
PATHOLOGIC M [900]
PATHOLOGIC STAGE GROUP [910]
TNM PATH DESCRIPTOR [920]
STAGED BY (PATHOLOGIC STAGE) [930]

Recorded for Cases Diagnosed 2004 – 2015 (Collaborative Stage)

CS TUMOR SIZE [2800]

CS EXTENSION [2810]
CS TUMOR SIZE/EXT EVAL [2820]
CS LYMPH NODES [2830]
CS LYMPH NODES EVAL [2840]
CS METS AT DX [2850]
CS METS AT DX–BONE [2851]
CS METS AT DX–BRAIN [2852]
CS METS AT DX–LIVER [2853]
CS METS AT DX–LUNG [2854]
CS METS EVAL [2860]

Recorded for Cases Diagnosed 2004 – 2017 (SSFs)

Item #	Item Name	Item #	Item Name
2880	CS Site-Specific Factor 1	2867	CS Site-Specific Factor13
2890	CS Site-Specific Factor 2	2868	CS Site-Specific Factor14
2900	CS Site-Specific Factor 3	2869	CS Site-Specific Factor15
2910	CS Site-Specific Factor 4	2870	CS Site-Specific Factor16
2920	CS Site-Specific Factor 5	2871	CS Site-Specific Factor17
2930	CS Site-Specific Factor 6	2872	CS Site-Specific Factor18
2861	CS Site-Specific Factor 7	2873	CS Site-Specific Factor19
2862	CS Site-Specific Factor 8	2874	CS Site-Specific Factor20
2863	CS Site-Specific Factor 9	2875	CS Site-Specific Factor21
2864	CS Site-Specific Factor10	2876	CS Site-Specific Factor22
2865	CS Site-Specific Factor11	2877	CS Site-Specific Factor23
2866	CS Site-Specific Factor12	2878	CS Site-Specific Factor24
2867	CS Site-Specific Factor13	2879	CS Site-Specific Factor25

First Course of Treatment

GENERAL CODING INSTRUCTIONS FOR FIRST COURSE OF TREATMENT DATA ITEMS

When treatment is given, the treatment start date cannot be blank. This applies to all diagnosis years and all classes of case abstracted after conversion to NAACCR version 23. It is important to be able to differentiate between when a date was inadvertently omitted from the abstract, and when the exact date was unknown. Therefore, the N.C. CCR will require that if treatment was given, a start date must be entered.

- For analytic cases, the entire date must be entered. If the exact date cannot be obtained, it must be estimated. Follow-back is required if needed to obtain enough information to assign the treatment start date.
- For non-analytic cases, if the full date is not available, at least the YEAR must be estimated. Use the Date of Diagnosis to estimate the treatment start date if necessary.
- No Treatment (active surveillance, deferred therapy, expectant management, or watchful waiting): Code all treatment data items to 0 or 00 (Not done). Code Treatment Status (RX Summ--Treatment Status) to 2.
    - When the disease progresses or the patient becomes symptomatic, any prescribed treatment is second course and should be noted in the text only.
- Patient/family refuses: Code all treatment data items to Refused.
    - Keep the refused codes even if the patient later changes his/her mind and decides to have the prescribed treatment, regardless of the time delay (per STORE, CAForum: 04-10-20 Initially Refuses Treatment, Later Changes Mind)
- Treatment discontinuation: Code all treatment that was started and administered, whether completed or not. Document treatment discontinuation in text fields.
  Example: The patient completed only the first dose of a planned 30-day chemotherapy regimen. Code chemotherapy as administered.
- Multiple Primaries:
    - Code the treatment on each abstract when a patient has multiple primaries and the treatment given for one primary also affects/treats another primary
      Example 1: The patient had prostate and bladder cancer. The bladder cancer was treated with a TURB. The prostate cancer was treated with radiation to the prostate and pelvis. The pelvic radiation includes the regional lymph nodes for the bladder. Code the radiation as treatment for both the bladder and prostate cases.
      Example 2: The patient had a hysterectomy for ovarian cancer. The pathology report reveals a previously unsuspected microinvasive cancer of the cervix. Code the hysterectomy as surgical treatment for both the ovarian and cervix primaries.
    - Code the treatments only for the site that is affected when a patient has multiple primaries and the treatment affects only one of the primaries Example: The patient has colon and tonsil primaries. The colon cancer is treated with a hemicolectomy and the tonsil primary is treated with radiation to the tonsil and regional nodes. Do not code the radiation for the colon. Do not code the hemicolectomy for the tonsil.
- Unknown Primaries: Code the treatment given as first course even if the correct primary is identified later when a patient is diagnosed with an unknown primary Example: The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Code the chemotherapy as first course of treatment.
    - Do not code treatment as first course when it is <u>added to the plan</u> after the primary site is discovered. This is a change in the treatment plan. Example: The patient is diagnosed with

metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Hormonal treatment is started. Code the chemotherapy as first course of treatment. The hormone therapy is second course because it was not part of the initial treatment plan.

- Hematopoietic and lymphoid neoplasms: Refer to the NCI SEER Hematopoietic and Lymphoid Neoplasm Coding Manual.

DATE OF FIRST COURSE OF TREATMENT

Item Length: 8
NAACCR Item #1270
Revised 01/10, 01/11, 01/21, 01/23

If first course treatment was given, this date cannot be blank.
Refer to Section 1: Coding and Estimating Dates for guidance on estimating dates

Description
Records the date on which treatment (surgery, radiation, systemic or other therapy) began at any facility.

Rationale
It is important to be able to measure the delay between diagnosis and the onset of treatment. A secondary use for this date is as a starting point for survival statistics (rather than using the diagnosis date). This date cannot be calculated from the respective first course treatment modality dates if no treatment was given. Therefore, providing the date on which active surveillance is chosen, a physician decides not to treat a patient, or a patient's family or guardian declines treatment is important.

Instructions for Coding
- This data item may be auto-derived by the software.
- If treatment is given, this date cannot be blank.
- All dates should be estimated as closely as possible when an exact date is not known.
- Record the earliest of the following dates: *Date of First Surgical Procedure* [1200], *Date Radiation Started* [1210], *Date Systemic Therapy Started* [3230] or *Date Other Treatment Started* [1250].
- If active surveillance or watchful waiting is selected as the first course of treatment (*RX Summ–Treatment Status* [1285] = 2) record the date this decision is made.
- In cases of non-treatment (*RX Summ–Treatment Status* [1285] = 0), in which a physician decides not to treat a patient or a patient's family or guardian declines all treatment, record the date of the decision not to treat, the date of patient refusal or the date the patient expired if the patient died before treatment could be given.
- If active surveillance ("watchful waiting") was the only treatment selected (RX Summ– Treatment Status [1285] = 2), record the date of that decision.
- Leave this item blank if the cancer was diagnosed at autopsy and not suspected prior to that.
- When a patient receives palliative care for pain management only with no other cancer-directed treatment, Date of First Course of Treatment [1270], would be the date in which a patient decides on palliative care for pain management only, as recommended by the physician. "No therapy" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given, or the physician recommends palliative care for pain management only.
- Leave blank when:
  - No treatment is given during the first course.
  - Treatment Status is coded 9, unknown whether the patient had treatment.
  - *Scope of Regional Lymph Node Surgery* [1292] is coded to 1 and no other treatment was given. Removal of less than 1 lymph node is not considered as surgery for this data item.
  - For death certificate only (DCO) cases when the date is unknown and cannot be estimated.
  - Autopsy only cases.

Examples

Core biopsy on 2/12/2026. Subsequent excisional biopsy on 2/14/2026.	20260214
A patient begins receiving preoperative radiation therapy elsewhere on April 21, 2026, and subsequent surgical therapy at this facility on June 2, 2061	20260421

RX SUMM – TREATMENT STATUS

Item Length: 1
Allowable Values: 0-2, 9
NAACCR Item #1285
Revised: 01/11

Description
This data item summarizes whether the patient received any treatment or the tumor was under active surveillance.

Rationale
This item documents active surveillance (watchful waiting) and eliminate searching each treatment modality to determine whether treatment was given. It is used in conjunction with *Date of First Course of Treatment* [1270] to document whether treatment was or was not given, it is unknown if treatment was given or treatment was given on an unknown date.

Instructions for Coding
- Treatment given after a period of active surveillance is considered subsequent treatment and it not coded in this item.
- Use code 0 when treatment is refused or the physician decides not to treat for any reason such as the presence of comorbidities. Scope of Regional Lymph Node Surgery may be coded 0, 1-7, or 9.
- Use code 0 when *Scope of Regional Lymph Node Surgery* [1292] is coded to 1 and no other treatment was given. Removal of less than 1 lymph node is not coded as surgery for this data item.

Code	Definition
0	No treatment given
1	Treatment given (Surgery of Primary Site, Surgical Procedure of Other Site, Radiation, Chemotherapy, Hormone Therapy, Immunotherapy, Hematologic Transplant and Endocrine Procedures, Other Therapy)
2	Active surveillance (watchful waiting) is the ONLY treatment administered. There is documentation that the patient is being monitored using **active surveillance/watchful waiting/deferred therapy or other similar options.**
9	Unknown if treatment was given

Examples:

Code	Reason
0	An elderly patient with pancreatic cancer requested no treatment.
0	Patient is expected to receive radiation, but it has not occurred yet (*Reason for No Radiation* [1430] = 8)
2	Treatment plan for a lymphoma patient is active surveillance.

DATE OF FIRST SURGICAL PROCEDURE

Item Length: 8
NAACCR Item #1200
Revised 01/10, 01/11, 01/23

If surgery was performed, this date cannot be blank.
Refer to Section 1: Coding and Estimating Dates for guidance on estimating dates

Description
Records the earliest date on which any first course surgical procedure was performed. Formerly called "Date of Cancer-Directed Surgery."

Rationale
This item can be used to sequence multiple treatment modalities and to evaluate the time intervals between treatments.

Instructions for Coding
- If surgery was done, this date cannot be blank.
- Record the date of the first surgical procedure of the types coded as *Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year)* , *Scope of Regional Lymph Node Surgery* [1292] (excluding code 1) or *Surgical Procedure/Other Site* [1294] performed at this or any facility.
    - Note: Removal of less than 1 lymph node (*Scope of Regional Lymph Node Surgery* [1292] is coded to 1) is not coded as surgery for this data item.
- The date in this item may be the same as that in *Date of Most Definitive Surgical Resection of the Primary Site* [3170], if the patient received only one surgical procedure and it was a resection of the primary site.
- If surgery is the first or only treatment administered to the patient, then the date of surgery should be the same as the date entered into the item *Date of First Course Treatment* [1270].

Examples

A melanoma patient had an excisional biopsy on March 23, 2026, then a wide excision on March 28, 2026.	20260323
The patient had a small (0.5 cm) lump removed from her breast on November 16, 2026.	20261116
The patient's primary tumor was treated with radiation beginning on April 16, 2026, after a distant metastasis was removed surgically on March 27, 2026.	20260327

DATE OF MOST DEFINITIVE SURGICAL RESECTION OF THE PRIMARY SITE

Item Length: 8
NAACCR Item #3170
Revised 09/08, 01/10, 01/11, 01/23

If surgery was performed, this date cannot be blank.
Refer to Section 1: Coding and Estimating Dates for guidance on estimating dates

Description
Records the date of the most definitive (most invasive) surgical procedure of the primary site performed as part of the first course of treatment as described in Rx Summ-Surg 2023 [1291].

Rationale
This item is used to measure the lag time between diagnosis and the most definitive surgery of the primary site. It is also used in conjunction with *Date of Surgical Discharge* [3180] to calculate the duration of hospitalization following the most definitive primary site surgical procedure. This can then be used to evaluate treatment efficacy.

Instructions for Coding
- If surgery was done, this date cannot be blank.
- Record the date on which the surgery described by *Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year)* was performed at this or any facility.

RX SUMM- SURG PRIM SITE 03-2022

Item Length: 2
Allowable Values: 00, 10-80, 90, 98, 99
NAACCR Item #1290
Revised: 6/05, 1/10, 1/12, 1/15, 1/16, 1/23

Use this data item for cases DIAGNOSED in 2022 or earlier.

For diagnosis years 2023 forward, leave this data item blank. Use the Rx Summ – Surg 2023 data item.

Description
Records the surgical procedure(s) performed to the primary site.

Rationale
This data item can be used to compare the efficacy of treatment options.

Instructions for Coding
- Surgery codes are site specific. Refer to previous versions of the CCARM or your software drop-down menus for specific codes to be used for each primary site. (TIP: If the new surgery code is an "A" code, the middle 2 numbers are the old code. Example: New code is A**20**0. Old code will be 20.)
- There may be times when the first course of treatment information is incomplete. Continue follow-up efforts to be certain the complete treatment information is collected BEFORE transmitting to the CCR as a new case.
- Code the surgery that best describes the surgical procedure performed, whether or not any cancer was found in the resected portion.

Needle biopsies:
- If a needle biopsy preceded an excisional biopsy (or more extensive surgery), and upon the later surgery no tumor remains, DO NOT consider the needle biopsy to be an excisional biopsy. Surgical margins must be examined to determine if the biopsy was intended as excisional, and margins cannot be evaluated for a needle biopsy.
- The needle biopsy should be recorded in the Surgical Diagnostic and Staging Procedure [1350] data item.
- The later surgery (the excisional biopsy or more extensive surgery) is to be coded in this date item.

Excisional biopsies:
- Excisional biopsies (those that remove the entire tumor and/or leave only microscopic margins) are to be coded in this item.
- Code an excisional biopsy, even when documented as incisional, when:
  - All disease is removed (margins free), OR
  - All gross disease is removed and there is only microscopic residual at the margin

Note 1: Do not code an incisional biopsy as an excisional biopsy when there is macroscopic residual disease.
Note 2: Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins meet the criteria in either above.
Example: Shave biopsy performed for a suspicious lesion on the skin of the right arm that has been changing in size and color. The shave biopsy pathology report showed malignant melanoma with only microscopically positive margins. Code the shave biopsy as an excisional biopsy.

Multiple Surgical Procedures:

- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total/cumulative effect/final results. Assign the code that reflects the **cumulative effect** of all surgeries to the primary site.

  Example 1: Left thyroidectomy for suspicious nodules. Path showed papillary carcinoma. Completion thyroidectomy was performed. Code surgery of primary site as total thyroidectomy (50).

  Example 2: The patient underwent a partial mastectomy and sentinel lymph node biopsy, followed by an axillary lymph node dissection for the first right breast primary in 2011. The separate 2020 right breast primary was treated with a total mastectomy and removal of one involved axillary lymph node. The operative report only refers to this as a non-sentinel lymph node, with no mention of other axillary findings. Cumulatively, this patient has undergone a modified radical mastectomy since there were likely no remaining axillary lymph nodes. For the 2020 primary, code the cumulative effect of the surgery done in 2011 plus the surgery performed in 2020. Use text fields on both abstracts to record the details.

Extra-lymphatic lymphoma:

- Code surgery for extra-lymphatic lymphoma using the site-specific surgery coding scheme for the primary site. Do not use the lymph node scheme.

Removal of Regional Tissue/Organs:

- Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site and included in the site-specific surgery code, except where noted in Appendix B.
  Example: Code an en bloc removal when the patient has a hysterectomy and an omentectomy.
- Specimens from an en bloc resection may be submitted to pathology separately.
- Incidental removal of tissue or organs, when it is not performed as part of cancer treatment (for example, incidental removal of an appendix), does not alter code assignment.

Surgery Aborted:

- Assign the surgery code(s) that best represents the extent of the surgical procedure that was actually carried out when surgery is aborted. If the procedure was aborted before anything took place, assign code 00.

Melanoma of the Skin:
Refer to Appendix B: Site-Specific Surgery Codes for Skin (C44.0-C44.9) for detailed guidelines on coding biopsies and excisions for melanoma of the skin.

Document the most invasive surgical procedure for the primary site:
For codes 00 through 79, surgical procedures are listed in hierarchical order based on logical sequence, not numerical sequence. Within groups of codes, procedures are defined with increasing degrees of descriptive precision. Succeeding groups of codes define progressively more extensive forms of resection.

Last-listed codes take precedence over earlier-listed codes (regardless of the code or numeric value). Exception: Use codes 80 and 90 only if more precise information about the surgery is not available.

Example 1: A rectosigmoid primary is surgically treated by polypectomy with electrocautery. Electrocautery has a code of 22. Polypectomy has a code of 26. Assign code 22. An excision with electrocautery is listed *after* a polypectomy alone. The last-listed codes takes precedence over the earlier-listed code.

20 Local tumor excision, NOS
26 Polypectomy
27 Excisional biopsy
Combination of 20 or 26–27 WITH 22 Electrocautery

Example 2: Patient has a needle biopsy of prostate that is positive for adenocarcinoma. The patient chooses to have a radical prostatectomy. The pathologic examination of the prostatectomy specimen shows no residual tumor. Code the radical prostatectomy.

Code	Label	Definition
00	None	No surgical procedure of primary site. First course of treatment was active surveillance/watchful waiting. Diagnosed at autopsy.
10–19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to Appendix B for the correct site-specific code for the procedure.
20–80	Site-specific codes; resection	Refer to Appendix B for the correct site-specific code for the procedure.
90	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Site-specific codes; special	Special code. Refer to Appendix B for the correct site-specific code for the procedure. This includes: ○ Hematopoietic primary sites (C42._) ○ Ill-defined primary sites (C76._) ○ Unknown primary site (C80.9) ○ Cervical Lymph Nodes and Unknown Primary 00060 (C760)
99	Unknown	Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only and unknown if surgery done.

Item Length: 4
Allowable Values: A000, B000, A200-A990, B000-B990
NAACCR Item #1291
Effective: 1/23

Use this data item for cases DIAGNOSED in 2023 forward.

For diagnosis years 2022 and earlier, leave this data item blank. Use the Surgery of Primary Site (pre-2023) data item.

Description
Records the surgical procedure(s) performed to the primary site with a diagnosis year of 2023 and forward.

Rationale
This data item can be used to compare the efficacy of treatment options.

Instructions for Coding
- Surgery codes are site specific. Refer to Appendix B for specific codes to be used for each primary site.
- There may be times when the first course of treatment information is incomplete. Continue follow-up efforts to be certain the complete treatment information is collected BEFORE transmitting to the CCR as a new case.
- Code the surgery that best describes the surgical procedure performed, whether or not any cancer was found in the resected portion.

Needle biopsies:
- If a needle biopsy preceded an excisional biopsy (or more extensive surgery), and upon the later surgery no tumor remains, DO NOT consider the needle biopsy to be an excisional biopsy. Surgical margins must be examined to determine if the biopsy was intended as excisional, and margins cannot be evaluated for a needle biopsy.
- The needle biopsy should be recorded in the Surgical Diagnostic and Staging Procedure [1350] data item.
- The later surgery (the excisional biopsy or more extensive surgery) is to be coded in this date item.

Excisional biopsies:
- Excisional biopsies (those that remove the entire tumor and/or leave only microscopic margins) are to be coded in this item.
- Code an excisional biopsy, even when documented as incisional, when:
  - All disease is removed (margins free), OR
  - All gross disease is removed and there is only microscopic residual at the margin

Note: Do not code an incisional biopsy as an excisional biopsy when there is macroscopic residual disease.

Multiple Surgical Procedures:
- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total/cumulative effect/final results. Assign the code that reflects the **cumulative effect** of all surgeries to the primary site.

  Example 1: Left thyroidectomy for suspicious nodules. Path showed papillary carcinoma. Completion

thyroidectomy was performed. Code surgery of primary site as total thyroidectomy (B500).

Example 2: The patient underwent a partial mastectomy and sentinel lymph node biopsy, followed by an axillary lymph node dissection for the first right breast primary in 2015. The separate 2026 right breast primary was treated with a total mastectomy and removal of one involved axillary lymph node. The operative report only refers to this as a non-sentinel lymph node, with no mention of other axillary findings. Cumulatively, this patient has undergone a modified radical mastectomy since there were likely no remaining axillary lymph nodes. For the 2026 primary, code the cumulative effect of the surgery done in 2015 plus the surgery performed in 2026. Use text fields on both abstracts to record the details.

Extra-lymphatic lymphoma:

- Code surgery for extra-lymphatic lymphoma using the site-specific surgery coding scheme for the primary site. Do not use the lymph node scheme.

Removal of Regional Tissue/Organs:

- Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site and included in the site-specific surgery code, except where noted in Appendix B.
  Example: Code an en bloc removal when the patient has a hysterectomy and an omentectomy.
- Specimens from an en bloc resection may be submitted to pathology separately.
- Incidental removal of tissue or organs, when it is not performed as part of cancer treatment (for example, incidental removal of an appendix), does not alter code assignment.

Surgery Aborted:

- Assign the surgery code(s) that best represents the extent of the surgical procedure that was actually performed based on the surgeon's description of the procedure. Avoid assigning a code based on the procedure that was intended to be performed when there is a difference between the planned procedure and the actual procedure performed. If the procedure was aborted before anything took place, assign code A000/B000.

Melanoma of the Skin:
Refer to Appendix B: Site-Specific Surgery Codes for Skin (C44.0-C44.9) for detailed guidelines on coding biopsies and excisions for melanoma of the skin.

Document the most invasive surgical procedure for the primary site:
For codes A000 - A790 and B000 – B790, surgical procedures are listed in hierarchical order based on logical sequence, not numerical sequence. Within groups of codes, procedures are defined with increasing degrees of descriptive precision. Succeeding groups of codes define progressively more extensive forms of resection.

Last-listed codes take precedence over earlier-listed codes (regardless of the code or numeric value). Exception: Use codes A800/B800 and A900/B900 only if more precise information about the surgery is not available.

Example 1: A rectosigmoid primary is surgically treated by polypectomy with electrocautery. Electrocautery has a code of A220. Polypectomy has a code of A260. Assign code A220. An excision with

electrocautery is listed *after* a polypectomy alone. The last-listed code takes precedence over the earlier-listed code.

A200 Local tumor excision, NOS
A260 Polypectomy
A270 Excisional biopsy
Combination of A200 or A260–A270 WITH A220 Electrocautery

Example 2: Patient has a needle biopsy of prostate that is positive for adenocarcinoma. The patient chooses to have a radical prostatectomy. The pathologic examination of the prostatectomy specimen shows no residual tumor. Code the radical prostatectomy.

Code	Code	Label	Definition
A000	B000	None	No surgical procedure of primary site. First course of treatment was active surveillance/watchful waiting. Diagnosed at autopsy.
A100–A190	B100–B190	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to Appendix B for the correct site-specific code for the procedure.
A200–A800	B200–B800	Site-specific codes; resection	Refer to Appendix B for the correct site-specific code for the procedure.
A900	B900	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
A980	NA	Site-specific codes; special	Special code. Refer to Appendix B for the correct site-specific code for the procedure. Death certificate cases use code A990/B990. Code A980 for the following sites/schema: • Hematopoietic primary sites (C42._) • Ill-defined primary sites (C76._) • Unknown primary site (C80.9) • Cervical Lymph Nodes WITH an Unknown Primary 00060 (C760)
A990	B990	Unknown	Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

SCOPE OF REGIONAL LYMPH NODE SURGERY

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #1292
Revised 01/04, 09/08, 02/10, 01/11, 01/12, 04/12, 01/13, 01/15

Description
Identifies the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

Rationale
This data item can be used to compare and evaluate the extent of surgical treatment.

Instructions for Coding
- The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.
- Record surgical procedures which aspirate, biopsy or remove regional lymph nodes in an effort to diagnose, stage, or treat disease in this data item. Record the date of this surgical procedure in data item *Date of First Course of Treatment* [1270] and/or *Date of First Surgical Procedure* [1200] if applicable.
- Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
    - If two or more surgical procedures of regional lymph nodes are performed, the codes entered in the registry for each subsequent procedure must include the cumulative effect of all preceding procedures. For example, a sentinel lymph node biopsy followed by a regional lymph node dissection at a later time is coded 7. Do not rely on registry software to determine the cumulative code.
- Lymph node aspirations:
    - Do not double-count when a regional lymph node is aspirated and that node is in the resection field. Do not add the aspirated node to the total number.
    - Count as an additional node when a regional lymph node is aspirated and that node is NOT in the resection field. Add it to the total number.
    - Assume the lymph node that is aspirated is part of the lymph node chain surgically removed and do not include it in the count when its location is not known
- Code the removal of regional nodes for both primaries when the patient has two primaries with common regional lymph nodes Example: Patient has a cystoprostatectomy and pelvic lymph node dissection for bladder cancer. Pathology identifies prostate cancer as well as the bladder cancer and 4/21 nodes positive for metastatic adenocarcinoma. Code Scope of Regional Lymph Node Surgery to 5 (4 or more regional lymph nodes removed) for both primaries.
- Assign the appropriate code for occult head and neck primaries with positive cervical lymph nodes (schema 00060). Do not default to code 9 for this schema.
- Code 9 for:
    - Any case coded to C589
    - Intracranial and central nervous system primaries (C70.0–C70.9, C71.0–C71.9, C72.0–C72.9, C75.1–C75.3)Any Schema ID with primary site: C420, C421, C423, C424, C761-C768, C770-C779, C809

- Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field *Surgical Procedure/Other Site* [1294].
- Refer to the current *AJCC Cancer Staging Manual* for site-specific identification of regional lymph nodes.
- The instructions related to code 1 were revised in 2021. Removal of less than 1 lymph node is assigned code 1. Do not consider code 1 as surgery for the purpose of coding the following data items:
  - Date First Course Treatment [CoC]
  - Treatment Status
  - Date of First Surgical Procedure
  - Radiation Sequence with Surgery
  - Systemic Sequence with Surgery

  For example, if Scope of Regional Lymph Node Surgery = code 1, and no other treatment was given, then the above data items would reflect the appropriate code for "none, no treatment".

Codes and Labels

The following instructions should be applied to all surgically treated cases for all types of cancers. The treatment of breast and skin cancer is where the distinction between sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes is most frequently encountered. For all other sites, non-sentinel regional node dissections are typical, and codes 2, 6 and 7 are infrequently used.

Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.

Additional notes specific to breast (C50): Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), an axillary lymph node dissection (ALND), or a combination of both SLNBx and ALND. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and ALND, or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and an ALND.

Infrequently, a SLNBx is attempted and fails to map (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. Review the operative report to confirm that an axillary incision was made and a node exploration was conducted. Code these cases as 2 if no further dissection of regional lymph nodes was undertaken or 6 when regional lymph nodes were dissected during the same operative event. *Enter the appropriate number of nodes examined and positive in the data items* Regional Nodes Examined *[830] and* Regional Nodes Positive *[820]*.

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
0	No regional lymph node surgery	No regional lymph node surgery. First course of treatment was active surveillance/watchful waiting. The operative report lists a lymph node dissection, but **no nodes were found** by the pathologist.	
1	Biopsy or aspiration of regional lymph node(s)	Less than 1 FULL lymph node was removed. Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed. If additional procedures were performed on the lymph nodes, use the appropriate code 2-7.	Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report of to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7.
2	Sentinel Lymph Node Biopsy	• The operative report states that a SLNBx was performed. • Code 2 when the operative report describes a procedure using injection of a dye, radio label or combination to identify a lymph node (possibly more than one) for removal/examination (even if no nodes are identified by the dye). • When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. Code this as a SLNBx (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.	If a relatively large number of lymph nodes, more than 5, are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an axillary lymph node dissection (ALND).
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	• At least 1 FULL node must be removed. • The operative report states that a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure). • Code 3 (Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS). Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx	Generally, ALND removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same procedure (code 6 or 7).
4	1-3 regional		

	lymph nodes removed	with a regional lymph node dissection (code 6 or 7).	
5	4 or more regional lymph nodes removed	• Code 4 (1-3 regional lymph nodes removed) should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only. • Code 5 (4 or more regional lymph nodes removed). If a relatively small number of nodes was examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes was examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7).	
6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated	• SLNBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known • Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.	• Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx or whether a SLNBx plus an ALND was performed.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	• SLNBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events. • Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.	• Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only or whether a SLNBx plus an ALND was performed.
9	Unknown or not applicable	The status of regional lymph node evaluation should be known for surgically-treated cases (i.e., cases coded 19-90 in the data item *Surgery of Primary Site*). Review surgically treated cases coded 9 in *Scope of Regional Lymph Node Surgery* to confirm the code.	

Examples

Code	Reason
0	No effort was made to locate sentinel lymph nodes and no nodes were found in pathologic analysis.
2	**(C50.1-Breast)** There was an attempt at sentinel lymph node dissection, but no lymph nodes were found in the pathological specimen.
1	**(C14.0-Pharynx)** Aspiration of regional lymph node to confirm histology of widely metastatic disease.

Code	Reason
2	**(C44.5-Skin of Back)** Patient has melanoma of the back. A sentinel lymph node dissection was done with the removal of one lymph node. This node was negative for disease.
3	**(C61.9-Prostate**) Bilateral pelvic lymph node dissection for prostate cancer.
6	**(C50.3-Breast)** Sentinel lymph node biopsy (SLNBx) of right axilla, followed by right axillary lymph node dissection (ALND) during the same surgical event.
7	**(50.4-Breast)** Sentinel lymph node biopsy (SLNBx) of left axilla, followed in a second procedure 5 days later by a left axillary lymph node dissection (ALND).
9	**(C34.9-Lung)** Patient was admitted for radiation therapy following surgery for lung cancer. There is no documentation on the extent of lymph node surgery in patient record.

SURGICAL PROCEDURE/OTHER SITE

Item Length: 1
Allowable Values: 0–5, 9
NAACCR Item #1294
Revised 09/08, 01/10, 02/10, 01/12, 1/13

Description
Records the surgical removal of *distant lymph nodes* or other tissue(s) or organ(s) removed beyond the primary site

Rationale
The removal of nonprimary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement and in documenting whether surgery was performed for tumors having unknown or ill-defined primary sites or hematolymphoid malignancies.

Instructions for Coding
- Refer to the Summary Stage manual to determine if lymph nodes or other sites are regional or distant. Removal of *regional* lymph nodes is not coded in this data item.
- Do not include organs beyond the primary site that are included in the Surgery of Primary Site codes. Example: A hemicolectomy including removal of the small bowel. Surgery of Primary Site code 41 for colon includes resection of contiguous organ such as small bowel or bladder. Do not code removal of small bowel or bladder performed with a subtotal colectomy/hemicolectomy in Surgical Procedure of Other Site.
- If other tissue or organs are removed during primary site surgery that are not specifically defined by the site-specific *Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year)* code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond what is defined in the site-specific surgery codes.
- Assign the highest numbered code that describes the surgical resection of *distant lymph node(s).*
- Incidental removal of tissue or organs is not coded in this or any other data item.
- If multiple first course surgical procedures coded in this item are performed for a single primary, the code should represent the cumulative effect of those surgeries. Do not rely on registry software to perform this task for you.
- *Surgical Procedure/Other Site* is collected for each surgical event even if surgery of the primary site was not performed.
- Code 1 if any surgery is performed to treat tumors of
  - Unknown or (C80.9)
  - Ill-defined primary sites (C76.0–76.8)
  - Hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967 and 9975-9993).

Code	Label	Definition
0	None	No surgical procedure of nonprimary site was performed. Diagnosed at autopsy.
1	Nonprimary surgical procedure performed	Nonprimary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.

Code	Label	Definition
2	Nonprimary surgical procedure to other regional sites	Resection of regional site.
3	Nonprimary surgical procedure to *DISTANT lymph node(s)*	Resection of *distant lymph node(s)*. REGIONAL lymph nodes are coded in Scope of Regional Lymph Node Surgery
4	Nonprimary surgical procedure to distant site	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only.

Examples

Code	Reason
0	**(C18.1–Colon)** The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon.
1	Surgical removal of metastatic lesion from liver; unknown primary.
2	**(C18.3–Colon)** Surgical ablation of solitary liver metastasis, hepatic flexure primary.
4	**(C34.9–Lung)** Removal of solitary brain metastasis.
5	**(C21.0–Anus)** Excision of solitary liver metastasis and one large hilar lymph node.

REASON FOR NO SURGERY OF PRIMARY SITE

Item Length: 1
Allowable Values: 0–2, 5–9
NAACCR Item #1340
Revised 01/04, 01/13

Description Records the reason that no surgery was performed on the primary site.

Rationale This data item provides information related to the quality of care and describes why primary site surgery was not performed.

Instructions for Coding

- If *Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year)* is coded 00/A000, then record the reason based on documentation in the patient record.
- Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include surgery of the primary site or if the option of "no treatment" was accepted by the patient.
- Code 1 if *Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year)* is coded 98/A980.
- Code 1 for C420, C421, C423, C424, C760-C768, C809.
- Code 2 when surgery of the primary site was contraindicated due to factors including, but not limited to, comorbid conditions, advanced age, and progression of tumor prior to planned surgery.
  Example: The patient with metastatic cancer of the right kidney to the lung has a history of prior nephrectomy of the left kidney with a current history of congestive heart disease and smoking. The patient is considered a surgical risk.
- Code 7 if the patient refused recommended surgical treatment, made a blanket refusal of all recommended treatment or refused all treatment before any was recommended.
- Code 8 if it is known that a physician recommended primary site surgery, but no further documentation is available yet to determine whether surgery was performed.
- Cases coded 8 should be followed and updated to a more specific code as appropriate.
- Code 9 if the treatment plan offered multiple choices, but it is unknown which, if any was provided.

Note: **Referral** to a surgeon **is equivalent** to a recommendation for surgery.

Code	Definition
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment. Diagnosed at autopsy.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned surgery, etc.)
5	Surgery of primary site was not performed because patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in patient record.
7	Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member or the patient's guardian. The refusal was noted in patient record.

8	Surgery of primary site was recommended, but it is unknown if performed. Follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Death certificate only.

Examples

Code	Reason
2	A patient with a primary tumor of the liver is not recommended for surgery due to advanced cirrhosis.
8	A patient is referred to another facility for recommended surgical resection of a gastric carcinoma, but further information from the facility to which the patient was referred is not available.

DATE RADIATION STARTED

Item Length: 8
NAACCR Item #1210
Revised 06/05, 01/10, 01/11, 01/23

If radiation therapy was given as part of first course of treatment, this date cannot be blank.
Refer to Section 1: Coding and Estimating Dates for guidance on estimating dates

Description
Records the date on which radiation therapy began at any facility that is part of the first course of treatment.

Rationale
It is important to be able to sequence the use of multiple treatment modalities and to evaluate the time intervals between the treatments. For some diseases, the sequence of radiation and surgical therapy is important when determining the analytic utility of pathologic stage information.

Instructions for Coding
- If this treatment was given, the date cannot be blank.
- If radiation therapy is the first or only treatment administered to the patient, then the date radiation started should be the same as the date entered into the item *Date of First Course of Treatment* [1270].
- The date when treatment started will typically be found in the radiation oncologist's summary letter for the first course of treatment.
- There may be times when the first course of treatment information is incomplete. Continue follow-up efforts to be certain the complete treatment information is collected BEFORE transmitting to the CCR as a new case.

Examples

A patient has external beam radiation on December 15, 2026.	20261215
A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on October 12, 2026.	20261012
A patient enters the facility for interstitial radiation boost for prostate cancer that is performed on August 6, 2026. Just prior to this, the patient had external beam therapy to the lower pelvis that was started on June 2, 2026, at another facility.	20260602

PHASE I RADIATION TREATMENT MODALITY

Item Length: 2
Allowable Values: 00–16, 99
NAACCR Item #1506
Added 01/18

There may be times when the first course of treatment information is incomplete. Continue follow-up efforts to be certain complete treatment is collected BEFORE transmitting to the CCR as a new case.

This data item replaced *Rad--Regional RX Modality* [1570]. Conversion took place upon upgrade to NAACCR v18. As of 2018 this data item is required for all cases regardless of diagnosis year.

Refer to the current CTR Guide to Coding Radiation Therapy Treatment in the STORE Manual, Appendix R for detailed coding instructions. https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/cocmanuals/

Description
Identifies the radiation modality administered during the first phase of radiation treatment delivered during the first course of treatment. This data item is required as of 01/01/2018.

Rationale
Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities. This data item should be used to indicate the radiation modality administered during the first phase of radiation.

Historically, the previously named *Regional Treatment Modality* [1570] utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of radiation modality and external beam radiation treatment planning techniques is to clarify this information and implement mutually exclusive categories.

Instructions for Coding
- Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into Phases and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (I.e. dose given during a session), modality or treatment technique. Any one of these changes will mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.
- For purposes of this data item, photons, x-rays and gamma-rays are equivalent.
- Use code 13 - Radioisotopes, NOS for radioembolization procedures, e.g. intravascular Yttrium-90 or lutetium-177, for cases diagnosed January 1, 2018 or later. For cases diagnosed prior to January 1, 2018, use code 07 – Brachytherapy, NOS.

- This data item intentionally does not include reference to various MV energies because this is not a clinically important aspect of technique. A change in MV energy (e.g., 6MV to 12MV) is not clinically relevant and does not represent a change in treatment technique. It is rare for change in MV energy to occur during any phase of radiation therapy.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.
- If this data item is coded to any of the External beam codes (01-06), the planning technique must be recorded in the data item Phase I External Beam Radiation Planning Technique [1502].
- If this data item is coded to any of the Brachytherapy or Radioisotopes codes (07-16) the code of 88 must be recorded in the data item *Phase I External Beam Radiation Planning Technique* [1502].
- Do not confuse a radioiodine scan with treatment. Only treatment is recorded in this item.
- Clarification for Coding SAVI equipment for Brachytherapy; In the CTR Radiation Coding Guide (page 22), the Modality code for SAVI, is coded (11), Brachytherapy, Interstitial, HDR, which is incorrect. The correct modality code is (09), Brachytherapy, Intracavitary, HDR. The code will change from 11 to 09. This change will be reflected in the updated v2.0 release.
- If any phase of treatment to a volume has the Treatment Modality coded to anything between 07 and 16, the dose for that phase should be coded in cGy, when available. If there is only one phase in the entire course of radiation, then the phase dose can be used to record the course Total Dose. However, if there are multiple phases in a radiation course and any of the phases use a brachytherapy, radioisotopes or infusion therapy, then the Total Dose should be coded to 999998 (five 9s). Effective with any cases diagnosed January 1, 2020, that received brachytherapy, we prefer the dosage be entered but will allow code 99998. The expectation is not a recoding of cases with diagnosis date prior to January 1, 2020.

Code	Label
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-223
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
98	Radiation treatment administered; modality unknown
99	Unknown if radiation treatment administered (includes Recommended, unknown if given)

RADIATION/SURGERY SEQUENCE

Item Length: 1
Allowable Values: 0, 2–6, 9
NAACCR Item #1380
Revised 01/04, 01/10, 01/11, 01/12

Description
Records the sequencing of radiation and surgical procedures given as part of the first course of treatment.

Rationale
The sequence of radiation and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Instructions for Coding
- Surgical procedures include *Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year)* ; *Scope of Regional Lymph Node Surgery* [1292]; *Surgical Procedure/Other Site* [1294]. If all of these procedures are coded 0, or it is not known whether the patient received both surgery and radiation, then this item should be coded 0.
- Surgical procedures include *Scope of Regional Lymph Node Surgery* [1292] (codes 2-7). If coded to 0 or 1, or it is not known whether the patient received both surgery and radiation, then this item should be coded 0.
- If the patient received both radiation therapy and any one or a combination of the following surgical procedures: *Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year) , Regional Lymph Node Surgery* or *Surgical Procedure/Other Site*, then code this item 2–9, as appropriate.
- If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

Code	Label	Definition
0	No radiation therapy and/or surgical procedures	No radiation therapy given or unknown if radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s) or distant lymph node(s) or it is unknown whether any surgery given.
2	Radiation therapy before surgery	Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s).
3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s).
4	Radiation therapy both before and after surgery	At least two courses/episodes/fractions of radiation therapy are given before and at least two more after surgery to the primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s).

Code	Label	Definition
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s).
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s).
7	Surgery both before and after radiation	Radiation was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s) or distant lymph node(s).
9	Sequence unknown	Administration of radiation therapy and surgery to primary site, scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record.

Code	Reason
0	Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.
2	A large lung lesion received radiation therapy prior to resection.
3	A patient received a wedge resection of a right breast mass with axillary lymph node dissection followed by radiation to right breast.
4	Preoperative radiation therapy was given to a large, bulky vulvar lesion and was followed by a lymph node dissection. This was then followed by radiation therapy to treat positive lymph nodes.
5	A cone biopsy of the cervix was followed by intracavitary implant for IIIB cervical carcinoma.
6	Stage IV vaginal carcinoma was treated with 5,000 cGy to the pelvis followed by a lymph node dissection and 2,500 cGy of intracavitary brachytherapy.
9	An unknown primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. The patient enters for chemotherapy.

REASON FOR NO RADIATION

Item Length: 1
Allowable Values: 0–2, 5–9
NAACCR Item #1430
Revised 09/04, 01/13

Description Records the reason that no regional radiation therapy was administered to the patient.

Rationale When evaluating the quality of care, it is useful to know the reason that various methods of therapy were not used, and whether the failure to provide a given type of therapy was due to the physician's failure to recommend that treatment or due to the refusal of the patient, a family member or the patient's guardian.

Instructions for Coding

- If *Modality* [1506] is coded 00, then record the reason based on documentation in patient record.
- Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include radiation therapy.
- Code 7 if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment or refused all treatment before any was recommended.
- Code 8 if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.
- Code 8 to indicate referral to a radiation oncologist was made and the registry should follow to determine whether radiation was administered. If follow-up to the specialist or facility determines the patient was never there and no other documentation can be found, code 1.
- Cases coded 8 should be followed and updated to a more definitive code as appropriate.
- Code 9 if the treatment plan offered multiple alternative treatment options, but it is unknown which treatment, if any, was provided.

Code	Definition
0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first course treatment. Diagnosed at autopsy.
2	Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation, etc.).
5	Radiation therapy was not administered because the patient died prior to planned or recommended therapy.
6	Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.
7	Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member or the patient's guardian. The refusal was noted in patient record.
8	Radiation therapy was recommended, but it is unknown whether it was administered.
9	It is unknown if radiation therapy was recommended or administered. Death certificate cases only.

Example

Code	Reason
1	A patient with Stage I prostate cancer is offered either surgery or brachytherapy to treat his disease. The patient elects to be surgically treated.

DATE SYSTEMIC THERAPY STARTED

Item Length: 8
NAACCR Item #3230
Revised 01/10, 01/11, 01/23

If systemic therapy was given as part of first course of treatment, this date cannot be blank.
Refer to Section 1: Coding and Estimating Dates for guidance on estimating dates

Description
Records the date of initiation for systemic therapy that is part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormonal agents, biological response modifiers, bone marrow transplants, stem cell harvests and surgical and/or radiation endocrine therapy.

Rationale
Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Instructions for Coding
- If this treatment was given, the date cannot be blank.
- Record the first or earliest date on which systemic therapy was administered. Systemic therapy includes *Chemotherapy* [1390], *Hormone Therapy* [1400], *Immunotherapy* [1410] and *Hematologic Transplant and Endocrine Procedures* [3250].

Examples

A patient with breast cancer begins her regimen of chemotherapy on December 15, 2025, and is subsequently given Tamoxifen on January 20, 2026.	20251215
A patient with Stage IV prostate cancer has an orchiectomy on June 2, 2026. He is then started on a regime of hormonal agents on June 9, 2026.	20260602

SYSTEMIC/SURGERY SEQUENCE

Item Length: 1
Allowable Values: 0, 2–6, 9
NAACCR Item #1639
Revised 01/10, 01/11, 01/12

Description
Records the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment.

Rationale
The sequence of systemic therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Instructions for Coding
- *Systemic/Surgery Sequence* is to be used for patients diagnosed on or after January 1, 2006.
- Code the administration of systemic therapy in sequence with the first surgery performed, described in the item *Date of First Surgical Procedure* [1200].
- If none of the following surgical procedures was performed: *Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year) , Scope of Regional Lymph Node Surgery* [1292] (codes 0 and 1), *Surgical Procedure/Other Site* [1294], then this item should be coded 0.
- If the patient received both systemic therapy and any one or a combination of the following surgical procedures: *Rx Summ- Surg Prim Site 03-2022/Rx Summ- Surg 2023 (based on diagnosis year) , Scope of Regional Lymph Node Surgery* [1292] or *Surgical Procedure/Other Site* [1294], then code this item 2-9, as appropriate.
- If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies. For example: the sequence, chemo then surgery then hormone therapy then surgery is coded 4 for “chemo then surgery then hormone.”

Code	Label	Definition
0	No systemic therapy and/or surgical procedures	The patient did not have both systemic therapy and surgery. No systemic therapy was given; and/or no surgical procedure of primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s) or distant lymph node(s) or no reconstructive surgery was performed. It is unknown whether both surgery and systemic treatment were provided.
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s) or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s) or distant lymph node(s) was performed.
4	Systemic therapy both	At least 1 course of systemic therapy were given before and at

	before and after surgery	least 1 more after a surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s) or distant lymph node(s) was performed.
5	Intraoperative systemic therapy	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s) or distant lymph node(s).
6	Intraoperative systemic therapy with other systemic therapy administered before or after surgery	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s) or distant lymph node(s) with other systemic therapy administered before or after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s) or distant lymph node(s) was performed. Note: The systemic therapy administered before and/or after surgery does not have to be the same type as the intraoperative systemic therapy.
7	Surgery both before and after systemic therapy	Systemic therapy was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s) or distant lymph node(s). Example: Patient has LN dissection, followed by chemo, followed by primary site surgery.
9	Sequence unknown	Both surgery and systemic therapy were provided, but the sequence is unknown.

Examples

Code	Reason
0	Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.
2	Patient with prostate cancer received hormone therapy prior to a radical prostatectomy.
3	Patient underwent a colon resection followed by a 5-FU based chemotherapy regimen.
4	Patient with breast cancer receives pre-operative chemotherapy followed by post-operative Tamoxifen.
5	Patient with an intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity.
6	Patient with metastatic colon cancer receives intraoperative chemotherapy to the liver.
9	An unknown primary of the head and neck was treated with surgery and chemotherapy prior to admission, but the sequence is unknown. The patient enters for radiation therapy.

DATE CHEMOTHERAPY STARTED

Item Length: 8
NAACCR Item #1220
Revised: 01/11, 01/23

If chemotherapy was given as part of first course of treatment, this date cannot be blank.
Refer to Section 1: Coding and Estimating Dates for guidance on estimating dates

Description
Records the date of initiation of chemotherapy that is part of the first course of treatment.

Rationale
Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Instructions for Coding
- If this treatment was given, the date cannot be blank.
- Record the first or earliest date on which chemotherapy was administered by any facility. This date corresponds to administration of the agents coded in *Chemotherapy* [1390].

CHEMOTHERAPY

Item Length: 2
Allowable Values: 00–03, 82, 85–88, 99
NAACCR Item #1390
Revised 06/05, 09/08, 01/10, 01/15

There may be times when the first course of treatment information is incomplete. Continue follow-up efforts to be certain complete treatment is collected BEFORE transmitting to the CCR as a new case.

Description
Records the type of chemotherapy administered as first course treatment at this and all other facilities. If chemotherapy was not administered, then this item records the reason it was not administered to the patient. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Chemotherapy recommended: A consult recommended chemotherapy, or the attending physician documented that chemotherapy was recommended. A referral to a clinical oncologist is equivalent to a recommendation.

Rationale
Systemic therapy may involve the administration of one or a combination of agents. Allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy. When evaluating the quality of care, it is useful to know the reason if chemotherapy was not administered.

Instructions for Coding
- Code 00 when:
  - chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
  - there is no reason to suspect that the patient would have had chemotherapy.
  - the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include chemotherapy or if the option of “no treatment” was accepted.
- Do not code combination of ancillary drugs administered with single agent chemotherapeutic agents as multiple chemotherapy. For example, the administration of 5-FU (antimetabolite) and Leucovorin (ancillary drug) is coded to single agent (Code 02).
- If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86 or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment or refused all treatment before any was recommended.
- Code 88 when
  - It is known that a physician recommended the patient receive chemotherapy but no further documentation is available yet to confirm its administration.
  - Insertion of a port-a-cath
  - To indicate referral was made to a medical oncologist and the registry must follow to determine whether it was given. If follow-up with the specified specialist or facility indicates the patient was never there, code 00.
  - Cases coded 88 must be followed to determine what kind of chemotherapy was administered or why it was not and the code updated accordingly.

- Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.
  - The physician may change a chemotherapy agent or one of the agents in a combination regimen, to an agent belonging to a different subcategory (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) due to reasons other than disease progression (e.g., patient cannot tolerate the original agent)

    a. This is a continuation of the first course of therapy and does not automatically represent subsequent therapy

    b. Use SEER*Rx to determine whether the drugs used are classified as chemotherapeutic agents

    c. Code a chemotherapeutic agent listed in SEER*Rx as Chemotherapy regardless of the primary site(s) listed in SEER*Rx for that agent. Use SEER*Rx to determine whether the drugs used are classified as chemotherapeutic agents.

    Example: Patient is diagnosed with a sarcoma. Neoadjuvant chemotherapy is administered (Alectinib). Alectinib is listed in SEER*Rx as a chemotherapeutic agent for Lung and Lymphoma. Code the chemotherapeutic agent under *Chemotherapy* [NAACCR #1390] regardless of the primary site(s) listed for that agent in SEER*Rx.
  - Code as treatment for both primaries when the patient receives chemotherapy for invasive carcinoma in one breast and also has an invasive or in situ carcinoma in the other breast. Chemotherapy would likely affect both primaries.
  - Refer to the *SEER*Rx Interactive Drug Database* (https://seer.cancer.gov/seertools/seerrx/) for a list of chemotherapeutic agents.

Coding for Tumor Embolization

The American College of Surgeons Commission on Cancer (CoC), the Centers for Disease Control and Prevention National Program of Cancer Registries (NPCR), and the SEER Program have collaborated to clarify and refine coding directives for tumor embolization and are jointly issuing the following instructions.

Definitions

Chemoembolization: A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.

Radioembolization: Tumor embolization combined with the injection of small radioactive beads or coils into an organ or tumor.

Tumor embolization: The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

Coding Instructions

- Code as Chemotherapy when the embolizing agent(s) is a chemotherapeutic drug(s) or when the term chemoembolization is used with no reference to the agent. Use SEER*Rx to determine whether the drugs used are classified as chemotherapeutic agents. Use codes 01, 02, 03 as specific information regarding the agent(s) is documented.
  - Example: The patient has hepatocellular carcinoma (primary liver cancer). From a procedure report: Under x-ray guidance, a small catheter is inserted into an artery in the groin. The catheter's tip is threaded into the artery in the liver that supplies blood flow to the tumor. Chemotherapy is injected through the catheter into the tumor and mixed with particles that embolize or block the flow of blood to the tumor.

- A drug administered to a patient for treatment, listed in SEER*Rx as a chemotherapeutic agent should be coded as chemotherapy regardless of primary sites listed in SEER*Rx for that agent. Do not code under *Other Therapy* [NAACCR #1420]. Do not code pre-surgical (pre-operative) embolization of hypervascular tumors with agents such as particles, coils, or alcohol as a treatment. Pre-surgical embolization is typically performed to prevent excess bleeding during the resection of the primary tumor. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

Radiosensitizers

The special instruction for radiosensitizers was deleted from the STORE 2025 and the SEER Program Manual 2025. Radiosensitizers are no longer a factor. If chemotherapy is given, code as chemotherapy. Code as the drug indicated in the SEER*Rx.

Changes in the classification of some systemic therapies:

A comprehensive review of chemotherapeutic drugs currently found in SEER*RX has been completed and in keeping with the FDA, the following drugs listed in the table below have changed categories from Chemotherapy to BRM/Immunotherapy. This change is effective with diagnosis date January 1, 2013 forward. For cases diagnosed prior to January 1, 2013 continue coding these six drugs as chemotherapy. Use the **date of diagnosis**, not the date of treatment, to determine whether to code these drugs as chemotherapy or BRM/Immunotherapy.

- Alemtuzumab/Campath
- Bevacizumab/Avastin
- Rituximab/Rituxan
- Trastuzumab/Herceptin
- Pertuzumab/Perjeta
- Cetuximab/Erbitux

Code	Definition
00	None, chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented.
02	Single-agent chemotherapy administered as first course therapy. Only one chemotherapeutic agent was administered to destroy cancer tissue during the first course of therapy. The chemotherapeutic agent may or may not have been administered with other drugs classified as immunotherapy, hormone therapy, ancillary, or other treatment.
03	Multiagent chemotherapy administered as first course therapy. Planned first course of therapy included two or more chemotherapeutic agents and those agents were administered. The planned first course of therapy may or may not have included other agents such as hormone therapy, immunotherapy, or other treatment in addition to the chemotherapeutic agents.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.

Code	Definition
87	Chemotherapy was not administered. It was recommended by patient's physician, but treatment was refused by the patient, a patient's family member or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples

Code	Reason
01	A patient with primary liver cancer is known to have received chemotherapy, however, the name(s) of agent(s) administered is not stated in patient record.
02	A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the fluorouracil as single agent chemotherapy and levamisole as an immunotherapeutic agent.
02	A patient with non-Hodgkin's lymphoma is treated with fludarabine.
03	A patient with early stage breast cancer receives chemotherapy. The patient chart indicates that a regimen containing doxorubicin is to be administered.
86	After surgical resection of an ovarian mass the following physician recommends chemotherapy. The patient record states that chemotherapy was not subsequently administered to the patient, but the reason why chemotherapy was not administered is not given.

DATE HORMONE THERAPY STARTED

Item Length: 8
NAACCR Item #1230
Revised: 01/11, 01/12, 01/23

If hormone therapy was given as part of first course of treatment, this date cannot be blank.
Refer to Section 1: Coding and Estimating Dates for guidance on estimating dates

Description
Records the date of initiation of hormone therapy that is part of the first course of treatment.

Rationale
Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Instructions for Coding
- If this treatment was given, the date cannot be blank.
- Record the first or earliest date on which hormone therapy was administered by any facility. This date corresponds to administration of the agents coded in *Hormone Therapy* [1400].

HORMONE THERAPY

(HORMONE/STEROID THERAPY)

Item Length: 2
Allowable Values: 00, 01, 82, 85–88, 99
NAACCR Item #1400
Revised 06/05, 09/08, 01/10, 01/13

There may be times when the first course of treatment information is incomplete. Continue follow-up efforts to be certain complete treatment is collected BEFORE transmitting to the CCR as a new case.

Description

Records the type of hormone therapy administered as first course treatment at this and all other facilities. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if hormone therapy was not administered.

Instructions for Coding

- Refer to SEER*Rx to determine whether the drugs used are classified as hormonal agents. A drug administered to a patient for treatment, listed in SEER*Rx as a hormonal agent should be coded as hormone therapy regardless of the primary site(s) listed in SEER*Rx for that agent. Do **not** code under the data item, *Other Therapy* [NAACCR #1420].
- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.
- Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include hormone therapy or if the option of "no treatment" was accepted by the patient.
- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
- If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered, use code 82, 85, 86 or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration.
- Code 88 to indicate the patient was referred to a medical oncologist and the registry should follow the

case for hormone therapy. If follow-up with the specified specialist or facility indicates the patient was never there, code 00.

- Cases coded 88 should be followed to determine whether they received hormone therapy or why not.
- Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.

Code	Definition
00	None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Hormone therapy administered as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples

Code	Reason
00	A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormonal therapy.
00	A patient with breast cancer may be treated with aminoglutethimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. This patient must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (Florinef) as a replacement therapy.
00	A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy.
01	A patient with metastatic prostate cancer is administered flutamide (an antiestrogen).
87	A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) and the refusal is noted in the patient record.

DATE IMMUNOTHERAPY STARTED

Item Length: 8
NAACCR Item #1240
Valid Codes: 10-12, 15, Blank
Revised: 01/11, 01/23

If immunotherapy was given as part of first course of treatment, this date cannot be blank.
Refer to Section 1: Coding and Estimating Dates for guidance on estimating dates

Description
Records the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of treatment.

Rationale
Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Instructions for Coding
- If this treatment was given, the date cannot be blank.
- Record the first or earliest date on which immunotherapy or a biologic response modifier was administered by any facility. This date corresponds to administration of the agents coded in *Immunotherapy* [1410].

IMMUNOTHERAPY

Item Length: 2
Allowable Values: 00, 01, 82, 85–88, 99
NAACCR Item #1410
Revised 06/05, 09/08, 01/10, 01/13, 01/15

There may be times when the first course of treatment information is incomplete. Continue follow-up efforts to be certain complete treatment is collected BEFORE transmitting to the CCR as a new case.

Description
Records the type of immunotherapy administered as first course treatment at this and all other facilities. If immunotherapy was not administered, then this item records the reason it was not administered to the patient. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Rationale
Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of immunotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if immunotherapy was not administered.

Instructions for Coding
- Refer to SEER*Rx to determine whether the drugs used are classified as immunotherapeutic agents. A drug administered to a patient for treatment, listed in SEER*Rx as an immunotherapeutic agent should be coded as immunotherapy regardless of the primary site(s) listed in SEER*Rx for that agent. Do **not** code under *Other Therapy* [NAACCR #1420].
- Code 00 if immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include immunotherapy or if the option of "no treatment" was accepted by the patient.
- Anti-thymocyte globulin treatment is given. Anti-thymocyte globulin is used to treat transplant rejection. Do not code as immunotherapy.
- If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86 or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended immunotherapy but no further documentation is available yet to confirm its administration.
- Code 88 to indicate a referral was made to a medical oncologist about immunotherapy and the registry should follow the case to determine whether it was given or why not. If follow-up to the specialist or facility determines the patient was never there, code 00.
- Cases coded 88 should be followed and the code updated as appropriate.
- Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.

Important information affecting the classification of some systemic therapies (effective 1/1/2013):
A comprehensive review of chemotherapeutic drugs currently found in SEER*RX has been completed and

in keeping with the FDA, the following drugs listed in the table below have changed categories from Chemotherapy to BRM/Immunotherapy. This change is effective with diagnosis date January 1, 2013 forward. For cases diagnosed prior to January 1, 2013 continue coding these six drugs as chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs in the SEER*Rx Interactive Drug Database.

Drug Name(s)	Previous Category	New Category	Effective Date
Alemtuzumab/Campath	Chemotherapy	BRM/Immuno	1/1/2013
Bevacizumab/Avastin	Chemotherapy	BRM/Immuno	1/1/2013
Rituximab	Chemotherapy	BRM/Immuno	1/1/2013
Trastuzumab/Herceptin	Chemotherapy	BRM/Immuno	1/1/2013
Pertuzumab/Perjeta	Chemotherapy	BRM/Immuno	1/1/2013
Cetuximab/Erbitux	Chemotherapy	BRM/Immuno	1/1/2013

Code	Definition
00	None, immunotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Immunotherapy administered as first course therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member or patient's guardian. The refusal was noted in patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples

Code	Reason
01	A patient with malignant melanoma is treated with interferon.
85	Before recommended immunotherapy could be administered, the patient died from cancer.

Definitions

Immunotherapy is designed to:

1. Make cancer cells more recognizable and therefore more susceptible to destruction by the immune system.
2. Boost the killing power of immune system cells, such as T-cells, NK-cells, and macrophages.
3. Alter the growth patterns of cancer cells to promote behavior like that of healthy cells.
4. Block or reverse the process that changes a normal cell or a pre-cancerous cell into a cancerous cell.
5. Enhance the body's ability to repair or replace normal cells damaged or destroyed by other forms of cancer treatment, such as chemotherapy or radiation.
6. Prevent cancer cells from spreading to other parts of the body.

Types of Immunotherapy
Cancer Treatment Vaccines: Also called therapeutic vaccines, are a type of immunotherapy. The vaccines work to boost the body's natural defenses to fight a cancer. Doctors give treatment vaccines to people already diagnosed with cancer. The vaccines may: • Prevent cancer from returning • Destroy any cancer cells still in the body after other treatment • Stop a tumor from growing or spreading Please refer to SEER*Rx to determine how to code non-FDA approved vaccines.

Interferons: Interferons belong to a group of proteins called cytokines. They are produced naturally by the white blood cells in the body. Interferon-alpha is able to slow tumor growth directly as well as activate the immune system. It is used for a number of cancers including multiple myeloma, chronic myelogenous leukemia (CML), hairy cell leukemia, and malignant melanoma.

Interleukins (IL-2) are often used to treat kidney cancer and melanoma.

Monoclonal Antibodies: Monoclonal antibodies (Mab) are produced in a laboratory. The artificial antibodies are used in a variety of ways in systemic therapy and can be chemotherapy, immunotherapy, or ancillary drugs. Some are injected into the patient to seek out and disrupt cancer cell activities. When the monoclonal antibody disrupts tumor growth, it is coded as chemotherapy. Other Mabs are linked to radioisotopes (conjugated monoclonal antibodies). The Mab finds and attaches to the target tumor cells and brings with it the radioisotope that actually kills the tumor cell. The monoclonal antibody itself does nothing to enhance the immune system. Conjugated monoclonal antibodies such as tositumomab (Bexxar) or ibritumomab (Zevalin) are coded to the part of the drug that actually kills the cells, usually radioisotopes. A third function of Mab is to enhance the immune response against the cancer, either by identifying tumor cells that are mimicking normal cells, or by boosting the body's natural defenses that destroy foreign cells. Consult SEER*Rx for the treatment category in which each monoclonal antibody should be coded.

HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURES

Item Length: 2
Allowable Values: 00, 10–12, 20, 30, 40, 82, 85–8, 99
NAACCR Item #3250
Revised 06/05, 01/10, 01/12, 01/13

There may be times when the first course of treatment information is incomplete. Continue follow-up efforts to be certain complete treatment is collected BEFORE transmitting to the CCR as a new case.

Description
Identifies systemic therapeutic *procedures* administered as part of the first course of treatment at this and all other facilities. If none of these *procedures* were administered, then this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

Rationale
This data item allows the evaluation of patterns of treatment which involve the alteration of the immune system or change the patient's response to tumor cells but does not involve the administration of antineoplastic agents. In addition, when evaluating the quality of care, it is useful to know the reason if these *procedures* were not performed.

Instructions for Coding
- Bone marrow transplants should be coded as either autologous (taken from the patient) or allogeneic (donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.
- Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.
- Endocrine irradiation and/or endocrine surgery are procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or affect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualify as endocrine surgery or endocrine radiation.
- Code 00 if a transplant or endocrine procedure was not administered to the patient and it is known that these procedures are not usually administered for this type and stage of cancer.
- Code 00 if the plan offered multiple alternative treatment options and the patient selected treatment that did not include a transplant or endocrine procedure or if the option of "no treatment" was accepted.
- If it is known that a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86 or 87 to record the reason why it was not administered.
- Code 87 if the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended a hematologic transplant or endocrine procedure, but no further documentation is available yet to confirm its administration.
- Code 88 to indicate referral to a specialist for hematologic transplant or endocrine procedures and the registry should follow the case. If follow-up to the specified specialist or facility determines the patient was never there, code 00.
- Use code 88 if a bone marrow or stem cell harvest was undertaken, but was not followed by a rescue or

re-infusion as part of first course treatment.

- Cases coded 88 should be followed to determine whether they were given a hematologic transplant or endocrine procedure or why not.
- Code 99 if it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention whether it was recommended or administered.

Code	Definition
00	No transplant procedure or endocrine therapy was administered as part of first course therapy. Diagnosed at autopsy.
10	A bone marrow transplant procedure was administered, but the type was not specified. It is unknown if autologous or allogeneic (BMT, NOS) or "mixed chimera transplant (mini-transplant or non- myeloablative transplant). These transplants are a mixture of the patient's cells and donor cells. Codes 11 and 12 have priority over code 10.
11	Bone marrow transplant–autologous.
12	Bone marrow transplant–allogeneic, for a syngeneic bone marrow transplant (from an identical twin) or for a transplant from any person other than the patient.
20	Stem cell harvest and infusion. Assign code 20 for all stem cell transplants. - Umbilical cord stem cell transplant, with blood from one or multiple umbilical cords) - Peripheral blood stem cell transplant - Allogeneic stem cell transplant - Autologous stem cell transplant Note: If the patient does not have a rescue, code the stem cell harvest as 88, (recommended, unknown if administered) or if harvested but unknown if infused.
30	Endocrine surgery and/or endocrine radiation therapy. Endocrine organs are testes and ovaries. Endocrine radiation and/or surgical procedures must be bilateral, or must remove the remaining paired organ for hormonal effect. Note: Bilateral oophorectomy is coded 30 when it is performed for hormonal effect for breast, endometrial, vaginal, and other primary cancers.
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12 or 20.)
82	Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of disease prior to administration, etc.).
85	Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member or the patient's guardian. The refusal was noted in patient record.

Code	Definition
88	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered. A bone marrow or stem cell harvest was undertaken, but it was not followed by a rescue or reinfusion as part of first course treatment.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record. Death certificate only.

Definitions

Bone marrow transplant (BMT): Procedure where bone marrow is used to restore stem cells that were destroyed by chemotherapy and/or radiation. Replacing the stem cells allows the patient to undergo higher doses of chemotherapy.

- BMT Allogeneic: Receives bone marrow from a donor. This includes haploidentical (or half-matched) transplants.
- BMT Autologous: Uses the patient's own bone marrow. The tumor cells are filtered out and the purified blood and stem cells are returned to the patient.
- BMT Syngeneic: Bone marrow received from an identical twin.

Conditioning: High-dose chemotherapy with or without radiation administered prior to transplant such as BMT and stem cells to kill cancer cells. This conditioning also destroys normal bone marrow cells so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the Chemotherapy data item and the radiation is coded in the Radiation Treatment Modality—Phase I, II, III data items.

Hematopoietic growth factors: A group of substances that support hematopoietic (blood cell) colony formation. The group includes erythropoietin, interleukin-3, and colony-stimulating factors (CSFs). The growth-stimulating substances are ancillary drugs and not coded.

Non-myeloablative therapy: Uses immunosuppressive drugs pre- and post-transplant to ablate (destroy) the bone marrow. These are not recorded as therapeutic agents.

Peripheral Blood Stem Cell Transplantation (PBSCT): Rescue that uses peripheral blood stem cells to replace stem cells after conditioning.

Rescue: Rescue is the actual BMT or PBSCT done after conditioning.

Stem cells: Immature cells found in bone marrow, blood stream, placenta, and umbilical cords. The stem cells mature into blood cells.

Stem cell transplant: Procedure to replenish supply of healthy blood-forming cells. Also known as bone marrow transplant, PBSCT, or umbilical cord blood transplant, depending on the source of the stem cells. When stem cells are collected from bone marrow and transplanted into a patient, the procedure is known as a bone marrow transplant. If the transplanted stem cells came from the bloodstream, the procedure is called a peripheral blood stem cell transplant, sometimes shortened to stem cell transplant.

Umbilical cord stem cell transplant: Treatment with stem cells harvested from umbilical cord blood.

DATE OTHER TREATMENT STARTED

Item Length: 8
NAACCR Item #1250
Revised 01/10, 01/11, 01/23

If other therapy was given as part of first course of treatment, this date cannot be blank.
Refer to Section 1: Coding and Estimating Dates for guidance on estimating dates

Description
Records the date on which other treatment began at any facility.

Rationale
Collecting dates for each treatment modality allows for the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Instructions for Coding
- If this treatment was given, the date cannot be blank.
- Record the date on which the care coded as *Other Treatment* [1420] was initiated.
- If other treatment is the first or only treatment administered to the patient, then the date other treatment started should be the same as the *Date of First Course of Treatment* [1270].

Examples

A patient with metastatic disease was started on an experimental therapy on March 16, 2026.	20266316
Alcohol was used as an embolizing agent for a patient on August 1, 2026	20260801
A polycythemia vera patient was given several phlebotomies, the first being on September 17, 2026	20260917

OTHER TREATMENT

Item Length: 1
Allowable Values: 0–3, 6–9
NAACCR Item #1420
Revised 06/05, 09/08, 01/10, 01/11, 01/12,01/15

Description
Identifies other treatment that cannot be defined as surgery, radiation or systemic therapy according to the defined data items in this manual.

Rationale
Information on other therapy is used to describe and evaluate the quality of care and treatment practices.

Instructions for Coding
- The principal treatment for certain reportable hematopoietic diseases could be supportive care that does not meet the usual definition of treatment that "modifies, controls, removes or destroys" proliferating cancer tissue. Supportive care may include phlebotomy, transfusion or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the Commission on Cancer have agreed to record treatments such as phlebotomy or aspirin as "Other Treatment" (Code 1) for certain hematopoietic diseases ONLY. Consult the most recent version of the **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** for instructions for coding care of specific hematopoietic neoplasms in this item.
- Do not code blood transfusion as treatment. Rationale: Blood transfusions may be used for any medical condition that causes anemia. It would be virtually impossible for the registrar to differentiate between blood transfusions used for a co-morbidity (i.e., anemia) from those given as prophylactic treatment of a hematopoietic neoplasm.
- ***Note***: Do not code *Other Therapy* when a chemotherapeutic agent listed in SEER*Rx was administered to a patient for treatment but the primary site(s) is(are) not listed for that agent in SEER*Rx. Code treatment as *Chemotherapy* [NAACCR #1390].

Code	Label	Definition
0	None	• The treatment plan offered multiple treatment options and the patient selected treatment that did not include other therapy • First course of treatment was active surveillance/watchful waiting • Patient received no cancer treatment. There is no reason to suspect that the patient would have had other therapy. • Diagnosed at autopsy

1	Other	• Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy). • Hematopoietic treatments such as: phlebotomy or aspirin (See SEER*Rx and *Hematopoietic and Lymphoid Neoplasm Coding Manual* and *Database* for specific guidance on coding). ***Note***: Do **not** code blood transfusion as treatment. • PUVA (psoralen and long-wave ultraviolet radiation) in the RARE event that it is used as treatment for extremely thin melanomas or cutaneous T-cell lymphomas (e.g., mycosis fungoides) • Note: Code UVB phototherapy for mycosis fungoides as photodynamic therapy under Surgery of Primary Site 2023 for skin. Assign code B110 [Photodynamic therapy (PDT)] when there is no pathology specimen. • Photophoresis. This treatment is used ONLY for thin melanoma or cutaneous T-cell lymphoma (mycosis fungoides).
2	Other–Experimental	This code is not defined. It may be used to record participation in institution-based clinical trials. Use for any experimental or newly developed treatment, such as a clinical trial, that differs greatly from proven types of cancer therapy. Note: Hyperbaric oxygen has been used to treat cancer in clinical trials, but it is also used to promote tissue healing following head and neck surgeries. Do not code the administration of hyperbaric oxygen to promote healing as an experimental treatment.
3	Other–Double Blind	A patient is involved in a double-blind clinical trial. Review and recode the treatment actually administered when the double-blind trial code is broken.

6	Other–Unproven	• Cancer treatments administered by nonmedical personnel.
		• Example: Cannabis oil or medical marijuana that is used for treatment.
		• Unconventional methods whether they are the only therapy or are given in combination with conventional therapy Example: DC vax given for brain cancer. Assign code 6. DC vax is not an approved treatment for brain cancer and should not be coded in the immunotherapy or any of the other treatment data items.
		• Complementary and Alternative Medicine (CAM) as any medical system, practice, or product that is not thought of as “western medicine” or standard medical care. CAM treatments may include dietary supplements, megadose vitamins, herbal preparations, acupuncture, massage therapy, magnet therapy, spiritual healing, and meditation.
		  • Alternative medicine is treatment that is used instead of standard medical treatments. Alternative therapy is when the patient receives no other type of standard treatment.
		  • Complementary medicine. Treatments that are used along with standard medical treatments but are not standard treatments; also called conventional medicine. One example is using acupuncture to help lessen some side effects of cancer treatment in conjunction with standard treatment.
		• Integrative medicine. A total approach to medical care that combines standard medicine with the CAM practices that have shown to be safe and effective. They treat the patient's mind, body, and spirit.

7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2 or 3) was refused by the patient, a patient's family member or the patient's guardian. The refusal was noted in the patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but it is unknown whether it was administered. Referral to a specialist for Other Treatment and the registry should follow. If follow-up with the specialist or facility determines the patient was never there, code 0.
9	Unknown	It is unknown whether other treatment was recommended or administered and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.

Coding for Tumor Embolization

The American College of Surgeons Commission on Cancer (CoC), the Centers for Disease Control and Prevention National Program of Cancer Registries (NPCR), and the SEER Program have collaborated to clarify and refine coding directives for tumor embolization and are jointly issuing the following instructions.

Definitions

- Chemoembolization: A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.
- Radioembolization: Tumor embolization combined with injecting small radioactive beads or coils into an organ or tumor.
- Tumor embolization: The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

Coding Instructions

- Code as "Other Therapy" when tumor embolization is performed using alcohol as the embolizing agent. Use code 1.
  Example: For head and neck primaries: Ideally, an embolic agent is chosen that will block the very small vessels within the tumor but spare the adjacent normal tissue. Liquid embolic agents, such as ethanol or acrylic, and powdered particulate materials can penetrate into the smallest blood vessels of the tumor.
- Use code 1 for embolization of a tumor in a site other than the liver when the embolizing agent is unknown.
- Do not code pre-surgical (pre-operative) embolization of hypervascular tumors with agents such as particles, coils, or alcohol as a treatment. Pre-surgical embolization is typically performed to prevent excess bleeding during the resection of the primary tumor. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

Outcomes

The outcomes data items describe the known clinical and vital status of the patient. Data should reflect the most recent information available to the abstractor that originates from reported hospitalizations, known patient readmissions, contact with the patient's physician, and/or direct contact with the patient. Refer to the individual data items in Section Two of this manual for specific coding instructions.

Item Length: 8
NAACCR Item #1750
Revised 06/05, 01/10, 01/11, 01/15

DATE OF LAST CONTACT CANNOT BE BLANK

FOLLOW BACK AND FURTHER INVESTIGATION MUST BE DONE TO DETERMINE THE DATE.

Description
Records the date of last contact with the patient or the date of death.

Rationale
This information is used for patient follow-up and outcomes studies.

Instructions for Coding

- Record the last date on which the patient was known to be alive or the date of death.
- Failure to find a patient on a list of deceased individuals does not constitute evidence that the patient is alive. *Vital Status* and *Date of Last Contact or Death* is not changed.
- If a patient has multiple primaries, all records should have the same date of last contact.

VITAL STATUS

Item Length: 1
Allowable Values: 0, 1
NAACCR Item #1760
Revised: 01/15

Description
Records the vital status of the patient as of the date entered in *Date of Last Contact or Death* [1750].

Rationale
This information is used for patient follow-up and outcomes studies.

Instructions for Coding
- This item is collected during the follow-up process with *Date of Last Contact or Death* [1750].
- If a patient has multiple primaries, all records should have the same vital status.
- If the patient is deceased, also code *Cause of Death, Place of Death – State*, and *Place of Death – Country*.

Code	Label
0	Dead
1	Alive

Example

Code	Reason
0	Death clearance information obtained from a state central registry confirms the death of the patient within the past year.
1	In response to a follow-up letter to a patient's following physician, it is learned the patient is alive.

CAUSE OF DEATH

Item Length: 4
Allowable Values: ICD-9, ICD-10 codes
NAACCR Item #1910

Description
Official cause of death as coded from the death certificate in valid ICD-9 and ICD-10 codes.

Rationale
Cause of death is used for calculation of adjusted survival rates by the life table method. The adjustment corrects for deaths other than from the diagnosed cancer.

Instructions for Coding
- Code the primary cause of death as stated on the death certificate.
- When the death certificate is not available, and the patient is deceased, code Cause of Death to 7777.

Codes	Definition
0000	Patient alive at last contact
7777	State death certificate not available
7797	State death certificate available but underlying cause of death is not coded

PLACE OF DEATH -- STATE

Item Length: 2
Allowable Values: Blank, USPS state codes
NAACCR Item #1942
Added 01/13

Description
State or Province where the patient died and where certificate of death is filed. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item PLACE OF DEATH--COUNTRY [1944]. It replaces the use of PLACE OF DEATH [1940].

Rationale
This field also helps carry out death clearance. When a reporting facility reports a place of death, the information can help in death certificate matching. It can also signal an out-of-state death for which the death certificate is to be requested.

Instructions for Coding
- Use the most specific code.
- See Appendix D for a list of state codes and their respective country codes.

Examples:

Code	Definition
Blank	Not applicable, Patient alive at last contact
IL	If the state in which the patient died is Illinois, then use the USPS code for the state of Illinois.
XX	Died in a country other than the U.S. (including its territories, commonwealths or possessions) or Canada and the country *is known* (code the country in P*lace of Death-Country*).
YY	Died in a country other than the U.S. (including its territories, commonwealths or possessions) or Canada and the country *is unknown*.
US	Died in the U.S. (including its territories, commonwealths or possessions) and the state is *unknown*
CD	Died in Canada and the province is *unknown*.
ZZ	Place of death is unknown, not mentioned in patient record.

PLACE OF DEATH -- COUNTRY

Item Length: 2
Allowable Values: Blank, ISO Country 3-character codes
NAACCR Item #1944
Added 01/13

Description
Code for the country in which the patient died and where certificate of death is filed. If the patient has multiple tumors, all records should contain the same code. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item Place of Death--State [1942]. It replaces the use of Place of Death [1940].

Rationale
Place of death is helpful for carrying out death clearance. When a reporting facility reports a place of death that is outside of the registry's country, the information can signal a death for which the death certificate will not be available from another state or through the NDI linkage.

Instructions for Coding
- Use the most specific code.
- Use general codes in the absence of more specific information.
- See Appendix D for a list of state codes and their respective country codes.
- Leave the field blank if the patient was alive at last contact.

Examples:
The following are a few examples of the most common, general geographic areas.

Geographic Area	Country Code	State or Province Code
United States, NOS	USA	US
Canada, NOS	CAN	CD
Not U.S., but no other information	ZZX	YY
Unknown, no mention in patient record	ZZU	ZZ

CANCER STATUS

Item Length: 1
Allowable Values: 1, 2, 9
NAACCR Item #1770
Revised 01/04

Description
Records the presence or absence of clinical evidence of the patient's malignant or non-malignant tumor as of the *Date of Last Contact or Death* [1750].

Rationale
This information is used for patient follow-up and outcomes studies.

Instructions for Coding
- Use information from an official source such as a health care provider, the patient's physician, or other information such as a death certificate
  Example 1: Margin status along with additional information that determine cancer status.
  Example 2: Stage and outcome of neoadjuvant or other therapy.
- The patient's cancer status should be changed **only** if new information is received from the patient's physician or other official source. If information is obtained from the patient, a family member or other non-physician, then cancer status is not updated.
- Cancer status changes if the patient has a recurrence or relapse.
- If a patient has multiple primaries, each primary could have a different cancer status.

Code	Label
1	No evidence of this tumor
2	Evidence of this tumor There is an indication of this tumor, for example, patient died or is continuing active treatment for this tumor
9	Unknown, indeterminate whether this tumor is present; not stated in patient record

Example

Code	Reason
1	Patient with hematopoietic disease who is in remission.
1	A patient is seen by the physician on February 2, 2025 with no evidence of this tumor. The patient did not return to the physician. The patient was then called by the registry on August 29, 2026. The *Date of Last Contact or Death* [1750] is updated, but the cancer status is not.
2	A patient with prostate cancer is diagnosed with bone metastasis in April 2026. The registrar finds an obituary documenting the patient's death in a nursing home in June 2026.

Case Administration

Correct and timely management of case records in a registry data set are necessary to describe the nature of the data in the cancer record and to facilitate meaningful analysis of data, and it is necessary to understand each item's respective purpose to ensure its accuracy and how to use it in facility analysis.

Note: NPI numbers are available through the facility's billing or accounting department or at: https://npiregistry.cms.hhs.gov/search.

EDITS OVERRIDES

Some edits identify rare, but possible, code combinations. For these edits, an override flag can be set if, upon review, the unusual combination is verified as being correct. Once set, the error message will not be repeated on subsequent EDITS passes.

Review of these cases requires investigating whether the combination is biologically implausible or there are cancer registry coding conventions that would dictate different codes for the diagnosis. Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.

Basal and squamous cell carcinomas of non-genital skin sites are not reportable to the CoC or the CCR. It is preferable to set your registry software flag to *do not transmit* so these cases are not uploaded.

If an override is set, text must be included in the abstract to justify the reason for the override.

- When no error message is generated by an edit that uses an override item, no action by the registrar is needed.
- If an error message is generated, the problem can often be resolved by checking the accuracy of the entry for each item that contributes to the edit and correcting any problems identified. If correction of data entry errors resolves the problem, do not make an override entry. If the codes reflect the information in the patient record, check for physician notes indicating the unusual combination of circumstances (for example, a colon adenocarcinoma in a child) has been confirmed.
- Enter the override code according to the instructions for the data item. If no comment regarding the unusual circumstances can be found in the record, it may be necessary to check with the managing physician or pathologist to determine whether it is appropriate to override the edit.

ABSTRACTED BY

Item Length: 3
Left Justified Alphanumeric
NAACCR Item #570

Description
Records the initials or assigned code of the individual abstracting the case.

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

Instructions for Coding
Code the initials of the abstractor. Full three letter initials are preferred.

Code	Definition
(fill spaces)	Initials or code of abstractor.

FACILITY IDENTIFICATION NUMBER (FIN)

Item Length: 10
Right Justified, Zero-filled
NAACCR Item #540
Revised 09/08, 01/12

Description
Identifies the facility reporting the case.

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

Instructions for Coding
- *Facility Identification Number* is automatically coded by the software provider.
- For facilities with seven-digit FINs in the range of 6020009–6953290 that were assigned by the CoC before January 1, 2001, the coded FIN will consist of three leading zeros followed by the full seven-digit number.
- For facilities with eight-digit FINs greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded FIN will consist of two leading zeros followed by the full eight-digit number.
- Facilities that are part of an Integrated Network Cancer Program (INCP) *must* use the hospital-specific FIN in their data for submission to the National Cancer Data Base.
- Facilities that merge are legally a single hospital. Consult NCDB for instructions for recording the FIN for newly-merged programs.

Examples

Code	Reason
0006439999	6439999, General Hospital, Anytown, Illinois
0010000099	10000099, Anytown Medical Center, Anytown, Illinois

NPI–REPORTING FACILITY

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #545
Revised 04/07, 09/08, 01/10, 01/12

Description
Identifies the facility whose data are in the record.

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

NPI–Reporting Facility is the NPI equivalent of *Facility Identification Number* [540]. Both are required during a period of transition.

Instructions for Coding
- *NPI–Reporting Facility* is automatically coded by the software provider.
- The facility's NPI can be obtained from the billing or accounting department or searched at https://npiregistry.cms.hhs.gov/search
- If the facility has more than one NPI number assigned, use the "umbrella" number that applies to the entire facility.
- Facilities that are part of an Integrated Network Cancer Program (INCP) must use the hospital-specific NPI number in their data for submission to the National Cancer Data Base.
- Facilities that merge are legally a single hospital. Use the NPI number for the merged hospital.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definitions
(fill spaces)	Ten-digit NPI number for the facility.
(leave blank)	NPI for the facility is unknown or not available.

TYPE OF REPORTING SOURCE

Item Length: 1
Allowable Values: 1-8
NAACCR Item #500

Description
The Type of Reporting Source identifies the *source documents* that provided the best information when abstracting the case. This is not necessarily the original document that identified the case; rather, it is the source that provided the best information.

The code in this field can be used to explain why information may be incomplete on a tumor. For example, laboratory only cases have unknown values for many data items, so may be excluded from some analyses.

Coding Instructions:

- Code the source that *provided the best information used to abstract the case*.
- Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. This prioritizes laboratory reports over nursing home reports. Effective 2006, the source facilities included in the previous code 1 (hospital inpatient and outpatient) were split between codes 1, 2, and 8.
- This data item is intended to indicate the completeness of information available to the abstractor.
- Reports from health plans (e.g., Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally and is available to the abstractor are expected to be at least as complete as reports for hospital inpatients. This is the reason these sources are grouped with inpatients in code 1 and given the highest priority.
- Sources coded with '8' would include, but would not be limited to, outpatient surgery and nuclear medicine services. A physician's office that calls itself a surgery center should be coded as a physician's office.
- Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia.
- If a physician's office calls itself a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

Code	Definition	Source Documents
1	Hospital inpatient; Managed health plan with a comprehensive, unified medical record	Hospital inpatient Offices/facilities with a comprehensive, unified record • HMO physician office or group • HMO-affiliated freestanding laboratory, surgery, radiation, or oncology clinic Includes outpatient services of HMOs and large multispecialty physician group practices with unified records.
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)	Facilities with a stand-alone medical record: • Radiation treatment centers • Medical oncology centers (hospital affiliated or independent) There were no source documents from code 1.

3	Laboratory only (hospital-affiliated or independent)	Laboratory with a stand-alone medical record. There were no source documents from codes 1, 2, 8, or 4.
4	Physician's office/private medical practitioner	Physician's office that is NOT an HMO or large multispecialty physician group practice. There were no source documents from codes 1, 2, or 8.
5	Nursing/convalescent home/ Hospice	Nursing or convalescent home or a hospice. There were no source documents from codes 1, 2, 8, 4, or 3.
6	Autopsy only	Autopsy The cancer was first diagnosed on autopsy. There were no source documents from 1, 2, 8, 4, 3, or 5.
7	Death certificate only	For use by CCR's only.
8	Other hospital outpatient units/ surgery centers	Other hospital outpatient units/surgery centers. Includes, but not limited to, outpatient surgery and nuclear medicine services. There were no source documents from codes 1 or 2.

Definitions:

- Comprehensive, unified medical record: A hospital or managed health care system that maintains a single record for each patient. That record includes all encounters in affiliated locations.
- Stand-alone medical record: An independent health care facility's record where the facility is not a part of a hospital or managed care system
- Managed health plan: Any practice and/or facility where all of the diagnostic and treatment information is maintained in one unit record. The abstractor is able to use the unit record when abstracting the case Examples of such facilities: HMOs or other health plan such as Kaiser, Veterans Administration, or military facilities
- Physician's office: A physician office performs examinations and tests. Physician offices may perform limited surgical procedures. *Note:* The category "physician's office" also includes facilities that are called surgery centers when surgical procedures under general anesthesia cannot be performed in these facilities.
- Surgery center: Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. The patient usually does not stay overnight. *Note:* If the facility cannot perform surgical procedures under general anesthesia, code as physician's office.
- Unit record: All records for the patient from all departments, clinics, offices, etc. in a single file with the same medical record number

Example 1: Case is identified through a pathology laboratory report review and all source documents used to abstract the case are from the physician's office. Assign code 4.

Example 2: The only patient record available for a physician office biopsy is the pathology report identified from a freestanding laboratory. Reporting source should reflect the lab where this case was identified. The MD office added nothing to the case, not even a confirmation of malignancy. Assign code 3.

CASEFINDING SOURCE

Item Length: 2
Allowable Values: 1-8
NAACCR Item #501

Description

This data item will help reporting facilities and central registries in prioritizing their casefinding activities. It will identify reportable tumors that were first found through sources other than traditional reporting facilities. It provides more detail than "Type of Reporting Source."

Coding Instructions

This variable is intended to code the source that first identified the tumor. Determine where the case was first identified and enter the appropriate code. For cases identified by a source other than reporting facilities (such as through death clearance or as a result of an audit), this variable codes the type of source through which the tumor was first identified.

If a death certificate, independent path laboratory report, consultation-only report from a hospital or other report was used to identify a case that was then abstracted from a different source, enter the code for the source that first identified the case, not the source from which it was subsequently abstracted. If a regional or central registry identifies a case and asks a reporting facility to abstract it, enter the code that corresponds to the initial source, not the code that corresponds to the eventual reporting facility.

Codes

10	Reporting Hospital, NOS
20	Pathology Department Review (surgical pathology reports, autopsies or cytology reports)
21	Daily Discharge Review (daily screening of charts of discharged patients in the HIM department)
22	Disease Index Review (review of disease index in the medical records department)
23	Radiation Therapy Department/Center
24	Laboratory Reports (other than pathology reports, code 20)
25	Outpatient Chemotherapy
26	Diagnostic Imaging/Radiology (other than radiation therapy, codes 23; includes nuclear medicine)
27	Tumor Board
28	Hospital Rehabilitation Service or Clinic
29	Other Hospital Source (including clinic, NOS or outpatient department, NOS) Case first identified by source other than a reporting facility covered in the codes above
30	Physician-Initiated Case
40	Consultation-only or Pathology-only Report (not abstracted by reporting hospital)
50	Independent (non-hospital) Pathology-Laboratory Report
60	Nursing Home-Initiated Case
70	Coroner's Office Records Review
75	Managed Care Organization (MCO) or Insurance Records
80	Death Certificate (case identified through death clearance)
85	Out-of-State Case Sharing
90	Other Non-Reporting Hospital Source
95	Quality Control Review (case initially identified through QC activities such as casefinding audit)
99	Unknown

CoC ACCREDITED FLAG

Item Length: 1
Allowable Value: 0, 1, 2, blank
NAACCR Item #2152
Added 01/18

Description
CoC Accredited Flag is assigned at the point and time of data abstraction to label an abstract being prepared for an analytic cancer case at a facility accredited by the Commission on Cancer (CoC).

Rationale
CoC-accredited facilities are required to collect certain data items including TNM staging. It is burdensome for central registries to maintain a list of accredited facilities, and the list changes frequently. The flag is a means of incorporating the accredited status into abstracts at the time of abstraction by someone who has knowledge of the status. The flag thus simplifies validating that required items have been abstracted by CoC-accredited facilities. NPCR will use this flag to for validating and consolidating TNM.

Instructions for Coding
Assign at the time of data abstraction. May be assigned manually or can be defaulted by the registry's software.

Code	Definitions
0	Abstract prepared at a facility WITHOUT CoC accreditation of its cancer program
1	ANALYTIC abstract prepared at facility WITH CoC accreditation of its cancer program (Includes Class of Case codes 10-22)
2	NON-ANALYTIC abstract prepared at facility WITH CoC accreditation of its cancer program (Includes Class of Case codes 30-43 and 99, plus code 00 which CoC considers analytic but does not require to be staged)
Blank	Not applicable; DCO cases

OVERRIDE AGE/SITE/MORPH

Item Length: 1
Allowable Values: 1
NAACCR Item #1990
Revised 04/07, 09/08, 01/10

Description
Used with the EDITS software to override edits of the type *Age, Primary Site, Morphology; Age, Primary Site, Morph ICDO3–Adult,* and *Age, Primary Site, Morph ICDO3–Pediatric.*

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
Edits of the type *Age*, *Primary Site*, *Morphology; Age, Primary Site, Morph ICDO3–Adult;* and *Age, Primary Site, Morph ICDO3–Pediatric* require review if a site-morphology combination occurs in an age group for which it is extremely rare or if the cancer was diagnosed in utero.

If the edit generates an error or warning message, check that the primary site and histologic type are coded correctly and that the age, date of birth and date of diagnosis are correct.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for the *Age, Primary Site, Morphology*; *Age, Primary Site, Morph ICDO3–Adult*, and *Age, Primary Site, Morph ICDO3–Pediatric* edits.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 for an unusual occurrence of a particular age/site/histology combination for a given age has been confirmed by review to be correct.
- Code 2 if the case was diagnosed in utero.
- Code 3 if both conditions apply.

Code	Description
Leave Blank	Not Reviewed. Or, Reviewed and corrected.
1	Reviewed. Combinations as reported.
2	Reviewed. Diagnosis in Utero.
2	Reviewed. Both combinations apply.

OVERRIDE HISTOLOGY

(Override Hist/Behav)

Item Length: 1
Allowable Values: 1, 2, 3
NAACCR Item #2040
Revised 04/07, 09/08

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Over-ride Flags as Used in the EDITS Software Package

Edits of the type Diagnostic Confirmation, Behavior differ in the use of ICD-O-2 or ICD-O-3 and check that, for *in situ* cases (Behavior = 2), Diagnostic Confirmation specifies microscopic confirmation (1,2,4).

The distinction between *in situ* and invasive is very important to a registry, since prognosis is so different. Since the determination that a neoplasm has not invaded surrounding tissues, i.e., *in situ*, is made microscopically, cases coded *in situ* in behavior should have a microscopic confirmation code. However, very rarely, a physician will designate a case noninvasive or *in situ* without microscopic evidence.

If an edit of the type, Diagnostic Confirmation, Behavior, gives an error message or warning, check that Behavior and Diagnostic Confirmation have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding.

Edits of the type, Morphology--Type/Behavior, perform the following check:

1. Codes listed in ICD-O-2 or ICD-O-3 with behavior codes of only 0 or 1 are considered valid, since the behavior matrix of ICD-O-2 and ICD-O-3 allows for the elevation of the behavior of such histologies when the tumor is *in situ* or malignant. This edit forces review of these rare cases to verify that they are indeed *in situ* or malignant.

2. The following histologies are generally not accepted as *in situ*: ICD-O-2 histologies 8000-8004, 8020, 8021, 8331, 8332, 8800-9054, 9062, 9082, 9083, 9110-9491, 9501-9989, ICD-O-3 histologies 8000-8005, 8020, 8021, 8331, 8332, 8800-9055, 9062, 9082, 9083, 9110-9493, 9501-9989. This edit forces review of these cases.

3. If a Morphology-Type/Behavior edit produces an error or warning message and the case is one in which the four-digit morphology code is one that appears in ICD-O-2 or ICD-O-3 only with behavior codes of 0 or 1, or the case is one in which the four-digit morphology code is not generally accepted with a behavior code of 2, verify the coding of morphology and that the behavior should be coded malignant or *in situ*. The registrar may need to consult a pathologist or medical advisor in problem cases.

   Exceptions:
   - If year of Date of Diagnosis > 2000, then a behavior code of 1 is valid for the following ICD-O-2 histologies and no over-ride flag is needed: 8931, 9393, 9538, 9950, 9960-9962, 9980-9984, 9989.
   - Similarly, the following ICD-O-3 histologies are valid with a behavior code of 1: 8442, 8451, 8462, 8472 and 8473.

- If year of Date of Diagnosis > 2003, the following ICD-O-3 benign histologies will pass without review: 8146, 8271, 8861, 8897, 9121, 9122, 9131, 9161, 9350, 9351, 9352, 9360, 9361, 9383, 9384, 9394, 9412, 9413, 9444, 9492, 9493, 9506, 9531, 9532, 9533, 9534, 9537, 9541, 9550, 9562 and 9570.

4. Grade 5-8 with histologies not in the range of 9590-9948 is impossible.

5. Some terms in ICD-O-2 and ICD-O-3 carry an implied statement of grade. These histologies must be reported with the correct grade as stated below. An error of this type cannot be over-ridden.

ICD-O-2
8020/34 Carcinoma, undifferentiated
8021/34 Carcinoma, anaplastic
8331/31 Follicular adenocarc, well diff
8851/31 Liposarcoma, well differentiated
9062/34 Seminoma, anaplastic
9082/34 Malignant teratoma, undifferentiated
9083/32 Malignant teratoma, intermediate type
9401/34 Astrocytoma, anaplastic
9451/34 Oligodendroglioma, anaplastic
9511/31 Retinoblastoma, differentiated
9512/34 Retinoblastoma, undifferentiated

ICD-O-3
8020/34 Carcinoma, undifferentiated
8021/34 Carcinoma, anaplastic
8331/31 Follicular adenocarc, well diff
9082/34 Malignant teratoma, undifferentiated
9083/32 Malignant teratoma, intermediate type
9401/34 Astrocytoma, anaplastic
9451/34 Oligodendroglioma, anaplastic
9511/31 Retinoblastoma, differentiated
9512/34 Retinoblastoma, undifferentiated

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for the edits of the types *Diagnostic Confirmation* or *Morph* or *Morphology–Type/Behavior.*
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1, 2 or 3 as indicated if review of all items in the error message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed; confirmed as reported for edits of the type *Morphology–Type/Behavior*.
2	Reviewed; confirmed as reported for edits of the type *Diag Confirmation, Behavior Code*.
3	Reviewed; conditions 1 and 2 above both apply.

OVERRIDE HOSPSEQ/SITE

Item Length: 1
Allowable Values: 1
NAACCR Item #1988
Revised 09/06 09/08, 02/10

Description
Used with the EDITS software to override the edit *Seq Num–Hosp*, *Primary Site*, *Morph ICDO2 (CoC)* and/or the edit *Seq Num–Hosp*, *Primary Site*, *Morph ICDO3 (CoC)*.

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
Edits of the type, *Seq Num–Hosp, Primary Site, Morph,* differ in use of ICD-O-2 or ICD-O-3 morphology. They force review of multiple primary cancers when one of the primaries is coded to a site-morphology combination that could indicate a metastatic site rather than a primary site. If *Sequence Number–Hospital* indicates the person has had more than one primary, then any case with one of the following site-histology combinations requires review:

- C76.0–C76.8 (Ill-defined sites) or C80.9 (unknown primary) and ICD-O-2 or ICD-O-3 histology < 9590. (Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of “abdominal carcinomatosis” may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry and should not be entered as a second primary.)
- Lymph node primary sites (C77.0-C77.9) for histologies other than lymphomas or hematopoietic primary sites for histologies not in range for hematopoietic diseases. (That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.)
- Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741 or ICD-O-3 histology in the range 9740-9758. (Verify that these diagnoses are coded correctly and are indeed separate primaries.)

If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases and correct the coding on the original case as necessary.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for an edit of the type *Seq Num–Hosp, Primary Site, Morph*
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed; confirmed as reported.

OVERRIDE ILL-DEFINED SITE

Item Length 1
Allowable Values 1
NAACCR Item # 2060

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Seq Num--Central, Primary Site, Morph differ in use of ICD-O-2 or ICD-O-3 morphology. They force review of multiple primary cancers when one of the primaries is coded to a site/morphology combination that could indicate a metastatic site rather than a primary site.

1. If Sequence Number-Central indicates the person has had more than one primary, then any case with one of the following site/histology combinations requires review:
   - C760-C768 (ill-defined sites) or C809 (unknown primary) and ICD-O-2 or ICD-O-3 histology < 9590. Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry and should not be entered as a second primary.
   - C770-C779 (lymph nodes) and ICD-O-2 histology not in the range 9590-9717 or ICD-O-3 histology not in the range 9590-9729; or C420-C424 and ICD-O-2 histology not in the range 9590-9941 or ICD-O-3 histology not in the range 9590-9989. That combination is most likely a metastatic lesion. Check if the lesion could be a manifestation of one of the patient's other cancers.
   - Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741 or ICD-O-3 histology in the range 9740-9758. Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.
2. If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases and correct the coding on the original case as necessary.

Coding Instructions
- Code 1 can be used if a second or subsequent primary reporting with an ill-defined primary site has been reviewed and is indeed an independent primary.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

Code	Description
Leave Blank	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported: a second or subsequent primary reported with an ill-defined primary site (C76.0-C76.8, C80.9) has been reviewed and is an independent primary

OVERRIDE LEUK, LYMPHOMA

Item Length: 1
Allowable Values: 1
NAACCR Item #2070
Revised 09/06, 09/08, 01/10

Description
Used with the EDITS software to override edits of the type *Diagnostic Confirmation*, *Histology*.

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
Edits of the type *Diagnostic Confirmation*, *Histology* differ in use of ICD-O-2 [420] or ICD-O-3 [522] and check the following:

- Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma that have diagnostic confirmation of direct visualization or clinical and any leukemia with a diagnostic confirmation of direct visualization.
- For lymphomas, *Diagnostic Confirmation* [490] cannot be 6 (direct visualization) or 8 (clinical).
- For leukemia and other hematopoietic neoplasms, *Diagnostic Confirmation* cannot be 6 (direct visualization).

If an edit of the type, *Diagnostic Confirmation*, *Histology*, produces an error or warning message, check that the *Histology* and *Diagnostic Confirmation* items are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in *Diagnostic Confirmation*) for leukemia.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for the edits of the type *Diagnostic Confirmation*, *Histology*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed; confirmed as reported.

OVERRIDE NAME/SEX ASSIGNED AT BIRTH

Item Length: 1
Allowable Values: 1
NAACCR Item #2078
Added 01/18

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software: Sex, Name-First, Date of Birth (NAACCR)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

This over-ride flag does not allow extremely rare or nonexistent combinations of first name and sex, such as John/female.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for this edit.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed; confirmed as reported.

OVERRIDE REPORT SOURCE

Item Length: 1
Allowable Values: 1, 2, 3
NAACCR Item #2050

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type 'Type of Rep Srce(DC), Seq Num--Cent' checks that if the case is a death-certificate-only case and the histology is not a lymphoma, leukemia, immunoproliferative or myeloproliferative disease (ICD-O-2 or ICD-O-3 histology is less than 9590), then the tumor sequence number must specify one primary only (sequence '00').

Instructions for Coding
- Leave blank if the program does not generate an error message for the report source edit.
- Code 1 if review of type of reporting source, histologic type and tumor sequence number verified that a second or subsequent primary with a reporting source of death-certificate-only has been reviewed and is indeed an independent primary.

Code	Definition
Leave	Not reviewed; or reviewed and corrected
1	Reviewed. Case coded correctly.

OVERRIDE SEQNO/DXCONF

Item Length: 1
Allowable Values: 1
NAACCR Item #2000

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are impossible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
- The edit checks if the case is one of multiple primaries and is not microscopically confirmed or has only positive lab test/marker studies (i.e., Diagnostic Confirmation >5) and tumor sequence number >00 (more than one primary).
- The edit is skipped if the Sequence Number--Central is in the range of 60-99.

Instructions for Coding
- Leave blank if the program does not generate an error message for the Diagnostic Confirmation and Sequence Number Central edit.
- Code 1 if the cases have been reviewed and it is verified that there are multiple primaries of specific sites in which at least one diagnosis has not been microscopically confirmed.

Code	Definition
Leave	Not reviewed; or reviewed and corrected
1	Reviewed. Case coded correctly.

OVERRIDE SITE/BEHAVIOR

Item Length: 1
Allowable Values: 1
NAACCR Item #2071
Revised 09/06, 09/08

Description
Used with the EDITS software to override the edits of the type *Primary Site, Behavior Code.*

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS.

EDITS Use
Edits of the type, *Primary Site, Behavior*, require review of the following primary sites with a behavior of in situ (ICD-O-2 or ICD-O-3 behavior = 2):

C26.9 Gastrointestinal tract, NOS
C39.9 Ill-defined sites within respiratory system
C55.9 Uterus, NOS
C57.9 Female genital tract, NOS
C63.9 Male genital organs, NOS
C68.9 Urinary system, NOS
C72.9 Nervous system, NOS
C75.9 Endocrine gland, NOS
C76.0-C76.8 Ill-defined sites
C80.9 Unknown primary site

Since the designation of in situ is very specific and almost always requires microscopic confirmation, ordinarily specific information should also be available regarding the primary site. If inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being in situ is reliable.

- If a specific in situ diagnosis is provided, try to obtain a more specific primary site. A primary site within an organ system can sometimes be identified based on the diagnostic procedure or treatment given or on the histologic type. If a more specific site cannot be determined, it is usually preferable to code a behavior code of 3. In the exceedingly rare situation in which it is certain that the behavior is in situ and no more specific-site code is applicable, set *Override Site/Behavior* to 1.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for *Primary Site, Behavior* edits.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed; confirmed as reported.

OVERRIDE SITE/LAT/MORPH

Item Length: 1
Allowable Values: 1
NAACCR Item #2074
Revised 09/06, 09/08

Description
Used with the EDITS software to override edits of the type *Laterality, Primary Site, Morph.*

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
Edits of the type *Laterality, Primary Site, Morph* differ in whether they produce a warning or an error message and in use of ICD-O-2 or ICD-O-3 morphology and do the following:

- If the *Primary Site* [400] is a paired organ and *Behavior Code* [523] is in situ (2), then *Laterality* [410] must be 1, 2, 3 or 5.
- If diagnosis year is less than 1988 and *Histology* [522] is greater than or equal to 9590, then no further editing is performed. If diagnosis year is greater than 1987 and *Histology* equals 9140, 9700, 9701, 9590-9980, then no further editing is performed.

The intent of this edit is to force a review of in situ cases for which *Laterality* is coded 4 (bilateral) or 9 (unknown laterality) as to origin.

- In rare instances when the tumor is truly midline and the case was diagnosed prior to 2010 (when midline was coded 9), either change the *Laterality* code to 5 and leave the override blank or enter code 1 for *Override Site/Lat/Morph.* For cases diagnosed in 2010 or later, *Laterality* must be coded 5 for midline tumors.
- If the rare combination is otherwise confirmed correct, enter code 1 for *Override Site/Lat/Morph.*

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for the *Laterality, Primary Site, Morphology* edits.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed, confirmed as reported.

OVERRIDE SITE/LAT/SEQNO

Item Length: 1
Allowable Values: 1
NAACCR Item #2010

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Verify Same Primary Not Reported Twice for a Person (SEER IR09) applies to paired organs and does not allow two cases with the same primary site group, laterality and three digit histology code. This edit verifies that the same primary is not reported twice for a person.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Verify Same Primary Not Reported Twice for a Person (SEER IR09).
- Code 1 if the case has been reviewed and it has been verified that the patient had multiple primaries of the same histology (three digit) in the same primary site group.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed; confirmed as reported.

OVERRIDE SITE/TYPE

Item Length: 1
Allowable Values: 1
NAACCR Item #2030
Revised 9/06, 9/08, 1/10, 1/24

TEXT MUST VALIDATE THAT THE SITE/TYPE COMBINATION HAS BEEN CONFIRMED WHEN THE OVERRIDE IS SET TO CODE 1.

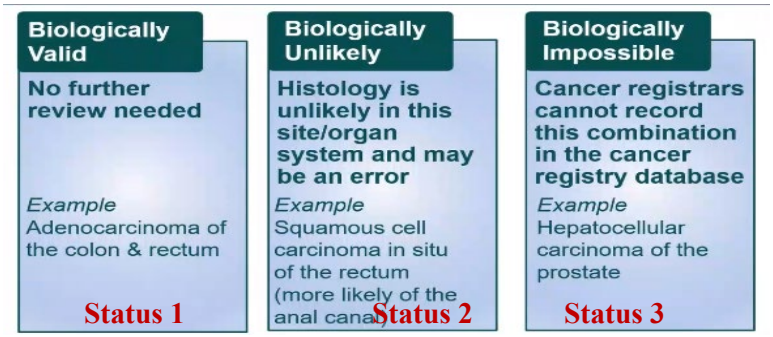
Description
Used with the EDITS software to override edits of the type *Primary Site, Morphology-Type* and *Primary Site, Morphology-Type, Behavior ICDO3.*

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Cancer PathCHART Site-Morphology Combination Standards
The ***Cancer PathCHART ICD-O-3 Site Morphology Validation List (CPC SMVL)*** went into effect for 2024+ diagnoses. This list outputs directly from the Cancer PathCHART database and replaces both the ICD-O-3 SEER Site/Histology Validation List and the list of impossible site and histology combinations included in the previous Primary Site, Morphology-Imposs ICDO3 (SEER IF38) edit. These lists are available in several formats at: https://seer.cancer.gov/cancerpathchart/products.html.

For cases diagnosed 2024+, site and morphology combinations are passed through the edit: Primary Site, Morphology-Type, Beh ICDO3 2024 (N7040). The correction required is based on status:

1. Status 1: Valid: combination will not trigger an edit error. No correction is needed.
2. Status 2: Unlikely: combination will trigger an edit error. Primary site, histology and behavior MUST be confirmed by thoroughly reviewing the medical record. If the combination is determined to be correct as coded, the Site/Type Interfield Review override flag must be set in the abstract. Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.
   TEXT MUST JUSTIFY THAT THE COMBINATION HAS BEEN REVIEWED AND IS CORRECT.
3. Status 3: Impossible: Site-type combination will trigger an edit error. This site-type combination is not allowed. An alternative site, histology, and behavior combination will need to be coded. Review of these cases requires investigating whether the combination is biologically implausible or there are cancer registry coding conventions that would dictate different codes for the diagnosis.



See the Cancer PathCHART website for further information: https://seer.cancer.gov/cancerpathchart/.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for edits of the type *Primary Site, Morphology-Type.*
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed, confirmed as reported.

OVERRIDE SITE/TNM-STG-GRP

Item Length: 1
Allowable Values: 1
NAACCR Item #1989
Revised 09/06 09/08, 02/10, 01/12

Description
Used with the EDITS software to override the "*Primary Site*, *AJCC Stage Group"* edits for AJCC staging editions 6 and later.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit in the future.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type *Primary Site, AJCC Stage Group - Ed 6* and *Primary Site, AJCC Stage Group - Ed 7* check that the pathologic and clinical AJCC stage group codes are valid for the site and histology group according to the AJCC Cancer Staging Manual Sixth Edition and AJCC Cancer Staging Manual Seventh Edition, using the codes described for the items TNM Clin Stage Group [970] and TNM Path Stage Group [910]. Combinations of site and histology not represented in any AJCC schema must be coded 88. Unknown stage groups must be coded 99. Blanks are not permitted.

Since pediatric cancers whose sites and histologies have an AJCC scheme may be coded according to a pediatric scheme instead, *Override Site/TNM-Stage Group* is used to indicate pediatric cases not coded according to the AJCC manual. Pediatric Stage groups should *not* be recorded in the *TNM Clin Stage Group* or *TNM Path Stage Group* items. When neither clinical nor pathologic AJCC staging is used for pediatric cases, code all AJCC items 88. When any components of either is used to stage a pediatric case, follow the instructions for coding AJCC items and leave *Override Site/TNM-Stage Group* blank.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for the edits of the type *Primary Site, AJCC Stage Group - Ed 6* and *Primary Site, AJCC Stage Group - Ed 7*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case is confirmed to be a pediatric case that was coded using a pediatric coding system.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed; and confirmed as reported.

OVERRIDE SURG/DXCONF

Item Length: 1
Allowable Values: 1
NAACCR Item #2020
Revised 09/06, 09/08

Description
Used with the EDITS software to override the edits *RX Summ–Surg Prim Site, Diag Conf (SEER IF76); RX Summ–Surgery Type, Diag Conf (SEER IF46);* and/or the edit *RX Summ–Surg Site 98-02, Diag Conf (SEER 106).*

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
Edits of the type, *RX Summ–Surg Prim Site*, *Diag Conf*, check that cases with a primary site surgical procedure coded 20-90 are histologically confirmed.

If the patient had a surgical procedure, most likely there was a microscopic examination of the cancer.

- Verify the surgery and diagnostic confirmation codes and correct any errors.
- Sometimes there are valid reasons why no microscopic confirmation is achieved with the surgery, for example, the tissue removed may be inadequate for evaluation.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for edits of the type, *RX Summ–Surg Prim Site*, *Diag Conf*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed; confirmed as reported.

ICD-O-3 CONVERSION FLAG

Item Length: 1
Allowable Values: 0, 1, 3,
blank

NAACCR Item #2116
Revised 01/04

Description
Identifies how the conversion of morphology codes from ICD-O-2 to ICD-O-3 was accomplished.

Rationale
This information is used for some data analysis and for further item conversions. New versions of the codes used for recording histology and behavior reflect advances in medical and pathologic knowledge, and converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Instructions for Coding
- Codes 0 and 1 are auto-coded by the software provider.
- Code 3 is manually entered following review of the automated morphology conversion from ICD-O-2 to ICD-O-3.

Code	Definition
(leave blank)	Not converted.
0	Morphology (Morph–Type&Behav ICD-O-3, NAACCR Item #521) originally coded in ICD-O-3.
1	Morphology (Morph–Type&Behav ICD-O-3, NAACCR Item #521) converted from (Morph–Type&Behav ICD-O-2, NAACCR Item #419) without review.
3	Morphology (Morph–Type&Behav ICD-O-3, NAACCR Item #521) converted from (Morph–Type&Behav ICD-O-2, NAACCR Item #419) with review.

TNM EDITION NUMBER

Item Length: 2
Allowable Values: 00–08, 88, 99
NAACCR Item #1060
Revised 01/04, 01/10, 01/18

Refer to the "Transition timeline – Data collection requirements for 2014-2016" in Section 1: Overview of Coding Principles

Description
Identifies the edition of the *AJCC Cancer Staging Manual* used to stage the case.

Rationale
AJCC stage and component T, N and M codes and rules have changed over time. This item enables the analysis of cases grouped by edition number.

Instructions for Coding
This item is auto-coded by the software provider.

Code	Label
00	Not staged (cases that have an AJCC staging scheme and staging was not done).
01	First Edition
02	Second Edition
03	Third Edition
04	Fourth Edition
05	Fifth Edition
06	Sixth Edition
07	Seventh Edition
08	Eighth Edition
88	Not applicable (cases that do not have an AJCC staging scheme).
99	Staged, but the edition is unknown.

Appendix A: N.C. State Law

GENERAL STATUTE 130A-205 through 130A-215

Article 7.

Chronic Disease.

Part 1. Cancer.

§ 130A-205. Administration of program; rules.

(a) The Department shall establish and administer a program for the prevention and detection of cancer and the care and treatment of persons with cancer.

(b) The Commission shall adopt rules necessary to implement the program. (1945, c. 1050, s. 1; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-206. Financial aid for diagnosis and treatment.

The Department shall provide financial aid for diagnosis and treatment of cancer to indigent citizens of this State having or suspected of having cancer. The Department may make facilities for diagnosis and treatment of cancer available to all citizens. Reimbursement shall only be provided for diagnosis and treatment performed in a medical facility which meets the minimum requirements for cancer control established by the Commission. The Commission shall adopt rules specifying the terms and conditions by which the patients may receive financial aid. (1945, c. 1050, s. 2; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-207. Cancer clinics.

The Department is authorized to provide financial aid to sponsored cancer clinics in medical facilities and local health departments. The Commission shall adopt rules to establish minimum standards for the staffing, equipment and operation of the clinics sponsored by the Department. (1945, c. 1050, s. 3; 1949, c. 1071; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-208. Central cancer registry.

A central cancer registry is established within the Department. The central cancer registry shall compile, tabulate and preserve statistical, clinical and other reports and records relating to the incidence, treatment and cure of cancer received pursuant to this Part. The central cancer registry shall provide assistance and consultation for public health work. (1945, c. 1050, s. 7; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-209. Incidence reporting of cancer; charge for collection if failure to report.

(a) All health care facilities and health care providers that detect, diagnose, or treat cancer or benign brain or central nervous system tumors shall report to the central cancer registry each diagnosis of cancer or benign brain or central nervous system tumors in any person who is screened, diagnosed, or treated by the facility or provider. The reports shall be made within six months of diagnosis. Diagnostic, demographic and other information as prescribed by the rules of the Commission shall be included in the report.

(b) If a health care facility or health care provider fails to report as required under this section, then the central cancer registry may conduct a site visit to the facility or provider or be provided access to the information from the facility or provider and report it in the appropriate format. The Commission may adopt rules requiring that the facility or provider reimburse the registry for its cost to access and report the information in an amount not to exceed one hundred dollars ($100.00) per case. Thirty days after the expiration of the six-month period for reporting under subsection (a) of this section, the registry shall send notice to each facility and provider that has not submitted a report as of that date that failure to file a report within 30 days shall result in collection of the data by the registry and liability for reimbursement imposed under this section. Failure to receive or send the notice required under this section shall not be construed as a waiver of the reporting requirement. For good cause, the central cancer registry may grant an additional 30 days for reporting.

(c) As used in this section, the term:

(1) "Health care facility" or "facility" means any hospital, clinic, or other facility that is licensed to administer medical treatment or the primary function of which is to provide medical treatment in this State. The term includes health care facility laboratories and independent pathology laboratories;

(2) "Health care provider" or "provider" means any person who is licensed or certified to practice a health profession or occupation under Chapter 90 of the General Statutes and who diagnoses or treats cancer or benign brain or central nervous system tumors. (1949, c. 499; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2; 1999-33, s. 1; 2005-373, s. 1.)

§ 130A-210. Repealed by Session Laws 1999-33, s. 2.

§ 130A-211. Immunity of persons who report cancer.

A person who makes a report pursuant to G.S. 130A-209 or 130A-210 to the central cancer registry shall be immune from any civil or criminal liability that might otherwise be incurred or imposed. (1967, c. 859; 1969, c. 5; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-212. Confidentiality of records.

The clinical records or reports of individual patients shall be confidential and shall not be public records open to inspection. The Commission shall provide by rule for the use of the records and reports for medical research. (1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-213. Cancer Committee of the North Carolina Medical Society.

In implementing this Part, the Department shall consult with the Cancer Committee of the North Carolina Medical Society. The Committee shall consist of at least one physician from each congressional district. Any proposed rules or reports affecting the operation of the cancer control program shall be reviewed by the Committee for comment prior to adoption. (1945, c. 1050, s. 9; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-214. Duties of Department.

The Department shall study the entire problem of cancer including its causes, including environmental factors; prevention; detection; diagnosis and treatment. The Department shall provide or assure the availability of cancer educational resources to health professionals, interested private or public organizations and the public. (1967, c. 186, s. 2; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-215. Reports.

The Secretary shall make a report to the Governor and the General Assembly specifying the activities of the cancer control program and its budget. The report shall be made to the Governor annually and to the General Assembly biennially. (1981, c. 345, s. 2; 1983, c. 891, s. 2.)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2013

HOUSE BILL 399

SECTION 9. G.S. 130A-209(a) reads as rewritten:

"**§ 130A-209. Incidence reporting of cancer; charge for collection if failure to report.**

(a) All By no later than October 1, 2014, all health care facilities and health care providers that detect, diagnose, or treat cancer or benign brain or central nervous system tumors shall submit by electronic transmission a report to the central cancer registry each diagnosis of cancer or benign brain or central nervous system tumors in any person who is screened, diagnosed, or treated by the facility or provider. The electronic transmission of these reports shall be in a format prescribed by the United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Program of Cancer Registries. The reports shall be made within six months of after diagnosis. Diagnostic, demographic and other information as prescribed by the rules of the Commission shall be included in the report."

PART IV. EFFECTIVE DATE

SECTION 10. This act becomes effective October 1, 2013.

ADMINISTRATIVE CODE

CHAPTER 26 – INFORMATION SERVICES
SUBCHAPTER 26B – CANCER REGISTRY
SECTION .0100 – SCOPE

.0101 GENERAL

(a) The purpose of the central cancer registry is to receive and to compile, tabulate, and preserve statistical, clinical, and other reports and records relating to the incidence, treatment and cure of cancer, and to provide assistance and consultation for public health work. The statistical reports and records, and the assistance rendered to health care facilities, health planning agencies and research facilities are intended to improve cancer treatment, extend the life of the cancer patient, identify high risk groups or areas of the state and attempt to lower the morbidity and mortality of cancer in North Carolina.

(b) The central cancer registry is administered by the State Center for Health Statistics, Division of Public Health, North Carolina Department of Health and Human Services, 1908 Mail Service Center, Raleigh, North Carolina 27699-1908.

History Note: Authority G.S. 130A-205; 130A-208 through 130A-213;
Eff. January 1, 1982;
Amended Eff. July 1, 1985;
Transferred and Recodified from 10 NCAC 8A .0801 Eff. April 4, 1990;
Amended Eff. April 1, 2001; December 1, 1990.

.0102 DEFINITIONS

The following definitions shall apply throughout this Section:

(1) "Abstract" refers to a document or documents, including electronic documents and files, containing information drawn from a cancer patient's medical record.

(2) “Cancer registrar” is a registrar who abstracts information from the medical records of cancer patients.

(3) "Death match" refers to the procedure of comparing registry cases with death certificate information, for confirmation of the reported death of any cancer patient, to determine if the cancer constituted the cause of death, and for identification of cases missed in routine reporting procedures.

(4) "Definitive treatment" refers to all methods of treatment intended to modify or control the cancer including no treatment, palliative care, and follow-up care.

(5) "Follow-up information" is information on the post-treatment status of a cancer patient whose abstract was submitted to the registry previously.

(6) "Identifying information" is any portion of any abstract that might reveal the personal identity of a cancer patient.

(7) “Morphologic information" refers to pathology, cytology, tumor markers, or laboratory tests that identify cell types of malignant neoplasms.

(8) "Palliative treatment" refers to treatment that is not intended to effect a cure, but the treatment procedure is expected to improve "quality of life" by temporarily relieving distressing symptoms.

(9) "Participating facility" is a health care facility that submits abstracts to the registry.

(10) "Pathology report" is the written report generated by a pathologist, stating the diagnostic interpretation of tissue samples or cellular material examined by the pathologist.

(11) "Personnel" means persons who are employees of the Department of Health and Human Services, or who are persons who provide services to the central cancer registry through a written contract.

(12) "Positive pathology report" is a pathology report confirming the presence of cancer.

(13) "Registrar" is an employee of a health care facility who prepares abstracts of medical records.

(14) "Registry" is the central cancer registry. The registry is administratively assigned to the State Center for Health Statistics, Department of Health and Human Services.

(15) "Statistical report" refers to a report generated by the registry for informational or educational purposes. A statistical report contains aggregated data and does not contain identifying information.

History Note: Authority G.S. 130A-205; 130A-208 through 130A-213;
Eff. January 1, 1982;
Amended Eff. October 1, 1983;
Transferred and Recodified from 10 NCAC 8A .0802 Eff. April 4, 1990;
Amended Eff. April 1, 2001; December 1, 1990.

.0103 CONFIDENTIALITY

(a) The clinical records of individual patients submitted to the registry shall be confidential and shall not be public records open to inspection. Only personnel authorized by the director of the State Center for Health Statistics and other individuals authorized by the director of the State Center for Health Statistics or his/her designee pursuant to Paragraph (c) of this Rule shall have access to the records.
(b) The information contained in the clinical records of individual patients submitted to the registry may be transferred to computer-compatible means of data entry. Only personnel authorized by the director of the State Center for Health Statistics to use computers, terminals, programs, data files, and other computer hardware or software involved in maintaining patient information shall have access to them.
(c) Clinical information in possession of the registry may be disclosed in the following circumstances when authorized by the director of the State Center for Health Statistics or his/her designee:
(1) A patient shall have access to review or obtain copies of his/her records;
(2) Information may be disclosed in response to a valid court order;
(3) Information may be disclosed as provided in Rule .0106 of this Section;
(4) Information contained in death certificates on file with the division (but not actual copies of death certificates) may be released to a participating facility when the facility requests a death match for confirmation of the reported or suspected deaths of cancer patients treated at that facility. Death match information released by the registry shall include only that information contained in the death certificates.
(d) The State Center for Health Statistics may release statistical information and data based on client information so long as no information identifying individual patients is released.
(e) Photocopying or other reproduction of any clinical records or reports containing identifying information, except as may be required in the conduct of the official business of the registry, is prohibited.
(f) Any legible documents other than the original abstracts, such as computer printouts or photocopies of any documents containing identifying information, shall also be considered confidential material while in active use, and shall be destroyed immediately upon termination of their use by the registry.
(g) Original copies of reports and abstracts, and follow-up information received thereunto, shall be retained for 5 years by the registry.
(h) The director of the State Center for Health Statistics shall make known to all individuals with access to patient information submitted to the registry the privileged and confidential nature of such information.

History Note: Authority G.S. 130A-205; 130A-208 through 130A-213;
Eff. January 1, 1982;
Amended Eff. October 1, 1982;
Transferred and Recodified from 10 NCAC 8A .0803 Eff. April 4, 1990;
Amended Eff. April 1, 2001; December 1, 1990.

.0104 REPORTING OF CANCER

(a) Health care facilities and providers shall submit a complete abstract for each cancer case that is screened, diagnosed, treated, or followed by its staff and that was initially diagnosed with cancer subsequent to May 7, 1999. A complete abstract is defined as one that adheres to the standards and definitions of the North American Association of Central Cancer Registries (NAACCR), the World Health Organization (WHO), the American College of Surgeons Commission on Cancer (COC), and the National Cancer Institute Surveillance, Epidemiology, and End Results Program (SEER). These standards and definitions are delineated in the following publications: the NAACCR *Standards for Cancer Registries,* the WHO *International Classification of Diseases for Oncology;* the COC *Standards of the Commission on Cancer, Volume II, Registry Operations and*

Data Standards (ROADS); and the SEER Coding Manuals. Subsequent amendments and editions of these publications are included. NAACCR documents are free of charge and may be obtained from the North American Association of Central Cancer Registries, 2121 West White Oaks Drive, Springfield, Illinois 62704. The *International Classification of Diseases for Oncology* may be purchased for twenty-seven dollars ($27.00) from WHO Publications Center USA, 49 Sheridan Avenue, New York, NY 12210. The *ROADS* publication may be purchased for twenty dollars ($20.00) from ACS Publications Fulfillment Section, Box 92425, Chicago, IL 60675-2425. SEER publications are free of charge and may be obtained from the National Cancer Institute, Publications Ordering Service, P.O. Box 24128, Baltimore, MD 21227.
(b) A health care provider or facility may delegate the tasks of reporting cancer cases to office or hospital staff, but the provider or facility shall not delegate the legal responsibility for the reporting of cancer to others.
(c) A report of cancer shall be submitted to the registry by health care facilities and providers by one of the following methods:
(1) by submission of an electronic file containing the information required in Paragraph (a) of this Rule; or
(2) for pathology laboratories, by submission of a positive electronic pathology report containing the information required in Paragraph (a) of this Rule; or
(3) facilities or providers that have fewer than 30 reportable cases per year may submit photocopies of the medical record sufficient to complete a full abstract of the case.
(d) The following documents shall not constitute a report of cancer:
(1) a death certificate;
(2) a request for authorization submitted to the Cancer program requesting third party reimbursement for treatment of cancer, although a positive pathology report is required by 10 NCAC 8A .0408(f).
(e) Reports shall be forwarded to the following address: Central Cancer Registry, State Center for Health Statistics, 1908 Mail Service Center, Raleigh, North Carolina 27699-1908.

History Note: Authority G.S. 130A-205; 130A-208 through 130A-213;
Eff. January 1, 1982;
Amended Eff. October 1, 1984; October 1, 1982;
Transferred and Recodified from 10 NCAC 8A .0804 Eff. April 4, 1990;
Amended Eff. April 1, 2001; December 1, 1990.

.0105 COOPERATION OF THE CENTRAL CANCER REGISTRY WITH HEALTH FACILITIES
(a) Any health care facility that is staffed and equipped for the diagnosis, treatment or follow-up care of cancer patients may participate with the registry in the exchange of information regarding the referral, treatment, maintenance or cure of cancer.
(b) The registry shall cooperate and consult with participating health care facilities and providers to the end that cancer registries in such facilities may provide the most accurate data available and may otherwise operate in the best interest of the cancer patients being treated therein. The registry will provide:
(1) Quality control reports to assure that computerized data utilized for statistical information and data compilation are correct;
(2) The most accurate and effective treatment, survival and comparative information available;
(3) Educational information available from registry, morbidity and mortality statistics upon request of a professional staff;
(4) Assistance to health care facilities by providing appropriate data and consultation to help the facilities meet the requirements for accreditation as a cancer treatment center, and to assist in the maintenance of such accreditation;
(5) Confirmation of the reported or presumed deaths (including such causes of deaths) of cancer patients to assist health care facilities to more accurately assess patient survival and to conduct more efficient long-term follow-up of cancer patients.
(6) Other information for the purpose of follow-up of a patient. This information is limited to the name of another facility or physician providing services to the patient, the date of last contact with the patient, and the vital status.

History Note: Authority G.S. 130A-205; 130A-208 through 130A-213;
Eff. January 1, 1982;
Amended Eff. October 1, 1983; October 1, 1982;
Transferred and Recodified from 10 NCAC 8A .0805 Eff. April 4, 1990;
Amended Eff. April 1, 2001; December 1, 1990.

.0106 RELEASE OF CENTRAL CANCER REGISTRY DATA FOR RESEARCH

(a) The registry may release statistical data to any person or agency for the following purposes:
(1) medical research or education;
(2) epidemiological studies;
(3) health education;
(4) health planning or administration;
(5) required statistical reports; and
(6) other statistical reports by written request for research, information or education.

(b) A researcher may request the release of medical records from the registry by the submission of a written research proposal. This request must adhere to the requirements pertaining to release of medical records by the State Center for Health Statistics as defined by NCAC 26A .0002.

(c) The medical records or reports of the individual patients may be disclosed to research staff for the purpose of medical research, provided that the registry has determined that:
(1) disclosure of this information is deemed necessary to accomplish the purposes of the research;
(2) the research warrants the risk to individual patients of the potential disclosure of their medical records; and
(3) adequate safeguards to protect the medical records or identifying information are established or maintained.

(d) The registry shall provide regular reports of research activity and data released to the cancer committee of the North Carolina Medical Society. Where there exists the potential for direct patient contact, the registry shall consult with the chairman of the Committee on Cancer of the North Carolina Medical Society before determining to release information for research as provided in Paragraphs (b) and (c) of this Rule. The registry shall forward the research proposal to the chairman for review. The chairman may forward the proposal to any or all members of the committee for comment.

History Note: Authority G.S. 130A-205; 130A-208 through 130A-213;
Eff. January 1, 1982;
Amended Eff. October 1, 1983;
Transferred and Recodified from 10 NCAC 8A .0806 Eff. April 4, 1990;
Amended Eff. April 1, 2001.

.0107 CODING OF INCIDENCE REPORTS AND ABSTRACTS (REPEALED)

History Note: Authority G.S. 130A-205; 130A-208 through 130A-213;
Eff. January 1, 1982;
Amended Eff. October 1, 1983;
Transferred and Recodified from 10 NCAC 8A .0806 Eff. April 4, 1990;
Repealed Eff. April 1, 2001.

.0108 ASSISTANCE AND CONSULTATION FOR PUBLIC HEALTH WORK

(a) The registry shall provide assistance and consultation for public health work.

(b) The registry shall accept requests for assistance and consultation for any agency, facility or organization actively engaged in the effort to reduce the incidence of cancer, whether through direct service to or the education of cancer patients and their families, the public, or the professions.

(c) The registry may accept requests from students requesting assistance with research projects in accordance with the provisions of .0106 of this Subchapter and the availability of staff time and resources.

History Note: Authority G.S. 130A-205; 130A-208 through 130A-213;
Eff. January 1, 1982;
Transferred and Recodified from 10 NCAC 8A .0807 Eff. April 4, 1990;
Amended Eff April 1, 2001.

.0109 FAILURE TO REPORT

(a) The registry shall monitor the reporting of health care facilities and providers on a quarterly basis. If a health care facility or provider has failed to report at least 90 percent of its cases within six months of diagnosis, the registry shall notify the facility or provider in writing of that fact within 30 days and the facility or provider shall be given another 30 days, or up to 60 days for good cause shown, to fulfill its reporting requirement.

(b) If a facility or provider is out of compliance for two consecutive quarters and is not demonstrating progress toward becoming compliant, then the State Health Director shall direct the registry to collect the data and shall direct the facility or provider to reimburse the registry for all actual costs expended in order to obtain the data up to $100 per case abstracted. The amount of the reimbursement shall include both travel expenses and the full cost of personnel time.

(c) Facilities or providers may request the director of the registry for abstracting assistance at no cost to them. The decision as to what assistance will be provided shall be based on the following:

(1) Size of the facility.
(2) Consistency of non-compliance.
(3) Staffing of the registry.
(4) Duration of needed assistance. The registry shall not provide long term abstracting assistance to any facility that has greater than 100 cases per year.
(5) The potential for compromising the registry's data quality.
(6) Plans of the facility to reach compliance.

History Note: Authority G.S. 130A-205; 130A-208 through 130A-213;
Adoption Eff. April 1, 2001.

Appendix B: Site-Specific Surgery Codes

*****THESE CODES ARE USED FOR CASES DIAGNOSED 1/1/2023 AND AFTER AND RECORDED IN RX SUMM-SURG 2023 [1291]*****

For diagnosis years 2022 and earlier, Rx Summ- Surg Prim Site 03-2022 [NAACCR data item #1290] should be used. Refer to previous versions of the CCARM, STORE, SEER Program Coding and Staging Manual, or your software dropdown lists for a list of applicable surgery codes.

All site-specific surgery codes begin with a letter A except for the primary sites indicated in red below, which start with a letter B to indicate a significate change in coding. The effective year for the implementation of the B codes for that set of surgery codes is specified in the last column.

For now, both the A codes and the B codes will be available in the CCARM. The A codes that have been replaced with B codes will be in grey font to help identify them as old codes.

Site	ICD-O-3 Codes	Effective Year for New B Codes
ORAL CAVITY	Lip C00.0–C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0–C02.9, Gum C03.0–C03.9, Floor of Mouth C04.0–C04.9, Palate C05.0–C05.9, Other Parts of Mouth C06.0–C06.9	
PAROTID AND OTHER UNSPECIFIED GLANDS	Parotid Gland C07.9 Major Salivary Glands C08.0–C08.9	
PHARYNX	Tonsil C09.0–C09.9, Oropharynx C10.0–C10.9, Nasopharynx C11.0–C11.9, Pyriform Sinus C12.9, Hypopharynx C13.0–C13.9, Pharynx C14.0	
ESOPHAGUS	C15.0–C15.9	
STOMACH	C16.0–C16.9	
COLON	C18.0–C18.9	2024
RECTOSIGMOID	C19.9	
RECTUM	C20.9	
ANUS	C21.0–C21.8	
LIVER AND INTRAHEPATIC BILE DUCTS	C22.0–C22.1	
PANCREAS	C25.0–C25.9	2024
LARYNX	C32.0–C32.9	
LUNG	C34.0–C34.9	2024
HEMATOPOIETIC, RETICULOENDOTHELIAL, IMMUNOPROLIFERATIVE, MYELOPROLIFERATIVE DISEASE	C42.0, C42.1, C42.3, C42.4 (with any histology)	
BONES, JOINTS, AND ARTICULAR CARTILAGE PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES	C40.0–C41.9 C47.0–C47.9 C49.0–C49.9	
SPLEEN	C42.2	
SKIN	C44.0–C44.9	2023
BREAST	C50.0–C50.9	2024

CERVIX UTERI	C53.0–C53.9	
CORPUS UTERI	C54.0–C55.9	
OVARY	C56.9	
PROSTATE	C61.9	
TESTIS	C62.0–C62.9	
KIDNEY, RENAL PELVIS, AND URETER	Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9	
BLADDER	C67.0–C67.9	
BRAIN	Meninges C70.0–C70.9, Brain C71.0–C71.9, Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C72.0–C72.9	
THYROID GLAND	C73.9	2024
LYMPH NODES	C77.0–C77.9	
ALL OTHER SITES	C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9	
UNKNOWN AND ILL-DEFINED PRIMARY SITES	C76.0–C76.8, C80.9	

ORAL CAVITY

Lip C00.0–C00.9
Base of Tongue C01.9
Other Parts of Tongue C02.0–C02.9
Gum C03.0–C03.9
Floor of Mouth C04.0–C04.9
Palate C05.0–C05.9
Other Parts of Mouth C06.0–C06.9

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
A110 Photodynamic therapy (PDT)
A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
A130 Cryosurgery
A140 Laser
No specimen sent to pathology from surgical events A100–A140.

A200 Local tumor excision, NOS A260 Polypectomy
A270 Excisional biopsy

Any combination of A200 or A260–A270 WITH
A210 Photodynamic therapy (PDT)
A220 Electrocautery
A230 Cryosurgery
A240 Laser ablation

A250 Laser excision
[SEER Note: Codes A200-A270 include shave and wedge resection.]

A300 Wide excision, NOS
Code A300 includes: Hemiglossectomy, Partial glossectomy

A400 Radical excision of tumor, NOS
A410 Radical excision of tumor ONLY
A420 Combination of A410 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
A430 Combination of A410 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

Codes A400–A430 include: Total glossectomy. Radical glossectomy
[SEER Note: "In continuity with" or "en bloc" means all tissues were removed during the same procedure, but not necessarily in a single specimen.]

Specimen sent to pathology from surgical events A200–A430.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

PAROTID AND OTHER UNSPECIFIED GLANDS

Parotid Gland C07.9
Major Salivary Glands C08.0–C08.9

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS A110 Photodynamic therapy (PDT)
A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
A130 Cryosurgery
A140 Laser
No specimen sent to pathology from surgical events A100–A140.

A200 Local tumor excision, NOS A260 Polypectomy
A270 Excisional biopsy
Any combination of A200 or A260–A270 WITH
A210 Photodynamic therapy (PDT)
A220 Electrocautery
A230 Cryosurgery
A240 Laser ablation
A250 Laser excision

[SEER Note: Codes A300-A800 include major salivary gland, NOS.
Codes A300-A360 are with or without superficial lobe. Codes A400-A800 may include submandibulectomy and submaxillectomy.]

A300 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS
A310 Facial nerve spared
A320 Facial nerve sacrificed A330 Superficial lobe ONLY
A340 Facial nerve spared A350 Facial nerve sacrificed
A360 Deep lobe (Total)
A370 Facial nerve spared A380 Facial nerve sacrificed

A400 Total parotidectomy, NOS; total removal of major salivary gland, NOS
A410 Facial nerve spared
A420 Facial nerve sacrificed

A500 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
A510 WITHOUT removal of temporal bone
A520 WITH removal of temporal bone
A530 WITH removal of overlying skin (requires graft or flap coverage)

A800 Parotidectomy, NOS

Specimen sent to pathology from surgical events A200–A800.

A900 Surgery, NOS
A990 Unknown if surgery performed; death certificate ONLY

PHARYNX

Tonsil C09.0–C09.9, Oropharynx C10.0–C10.9, Nasopharynx C11.0–C11.9
Pyriform Sinus C12.9, Hypopharynx C13.0–C13.9, Pharynx C14.0

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
A110 Photodynamic therapy (PDT)
A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
A130 Cryosurgery
A140 Laser
A150 Stripping
No specimen sent to pathology from surgical events A100–A150.

A200 Local tumor excision, NOS
A260 Polypectomy
A270 Excisional biopsy
Any combination of A200 or A260–A270 WITH
A210 Photodynamic therapy (PDT)
A220 Electrocautery
A230 Cryosurgery
A240 Laser ablation
A250 Laser excision
A280 Stripping

A300 Pharyngectomy, NOS
A310 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
A320 Total pharyngectomy

A400 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)
[SEER Note: Code A400 includes mandibulectomy (marginal, segmental, hemi-, and/or laryngectomy) NOS. Contiguous bone tissue refers to the mandible. Use code A400 when the patient had a pharyngectomy and maybe some sort of mandibulectomy and/or maybe a laryngectomy, but the exact procedures are not clear.]

A410 WITH Laryngectomy (laryngopharyngectomy) [pharyngectomy and laryngectomy but no mandibulectomy]
A420 WITH bone [pharyngectomy and mandibulectomy but no laryngectomy]
A430 WITH both A410 and A420 [both a mandibulectomy and laryngectomy in addition to the pharyngectomy]

A500 Radical pharyngectomy (includes total mandibular resection), NOS
A510 WITHOUT laryngectomy
A520 WITH laryngectomy
Specimen sent to pathology from surgical events A200–A520.

A900 Surgery, NOS
A990 Unknown if surgery performed; death certificate ONLY

ESOPHAGUS

C15.0–C15.9

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
A110 Photodynamic therapy (PDT)
A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
A130 Cryosurgery
A140 Laser

No specimen sent to pathology from surgical events A100–A140.

A200 Local tumor excision, NOS A260 Polypectomy
A270 Excisional biopsy
Any combination of A200 or A260–A270 WITH
A210 Photodynamic therapy (PDT)
A220 Electrocautery
A230 Cryosurgery
A240 Laser ablation
A250 Laser excision

A300 Partial esophagectomy

A400 Total esophagectomy, NOS

A500 Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
[SEER Note: Codes A500-A550 include partial esophagectomy, total esophagectomy, or esophagectomy, NOS.]
A510 WITH laryngectomy
A520 WITH gastrectomy, NOS A530 Partial gastrectomy
A540 Total gastrectomy
A550 Combination of A510 WITH any of A520–A540

A800 Esophagectomy, NOS

Specimen sent to pathology from surgical events A200–A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

[SEER Note: Code a transhiatal esophagectomy depending on the extent of the esophagectomy. Read the entire operative report and pathology report carefully. If a partial esophagectomy was performed, assign code A300. If a total esophagectomy was performed, assign code A400. If you do not have enough information to determine whether a partial or a total esophagectomy was performed, assign code A800. The transhiatal esophagectomy does not usually include removal of a portion of the stomach, but if a portion of stomach is removed, assign code A520 or A530. If the entire stomach was removed (not likely) assign code A540. Use text fields to record the details.]

STOMACH

C16.0–C16.9

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser

No specimen sent to pathology from surgical events A100–A140.

A200 Local tumor excision, NOS A260 Polypectomy
- A270 Excisional biopsy
- Any combination of A200 or A260–A270 WITH
  - A210 Photodynamic therapy (PDT)
  - A220 Electrocautery
  - A230 Cryosurgery
  - A240 Laser ablation
  - A250 Laser excision

A300 Gastrectomy, NOS (partial, subtotal, hemi-)
- A310 Antrectomy, lower (distal-less than 40% of stomach)***
- A320 Lower (distal) gastrectomy (partial, subtotal, hemi-)
- A330 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code A300 includes:
Partial gastrectomy, including a sleeve resection of the stomach
Billroth I: anastomosis to duodenum (duodenostomy)
Billroth II: anastomosis to jejunum (jejunostomy)

A400 Near-total or total gastrectomy, NOS
- A410 Near-total gastrectomy
- A420 Total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach.

A500 Gastrectomy, NOS WITH removal of a portion of esophagus
- A510 Partial or subtotal gastrectomy
- A520 Near total or total gastrectomy

Codes A500–A520 are used for gastrectomy resection when only portions of esophagus are included in procedure.

A600 Gastrectomy with a resection in continuity with the resection of other organs, NOS***
- A610 Partial or subtotal gastrectomy, in continuity with the resection of otherorgans***
- A620 Near total or total gastrectomy, in continuity with the resection of other organs***
- A630 Radical gastrectomy, in continuity with the resection of other organs***

Codes A600–A630 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection.

STOMACH, continued

[SEER Note: Codes A600-A630 may include omentectomy among the organs/tissues removed. “In continuity with” or “en bloc” means all tissues were removed during the same procedure, but not necessarily in a single specimen.]

A800 Gastrectomy, NOS

Specimen sent to pathology from surgical events A200–A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included

COLON (B Codes 2024+)

C18.0–C18.9

Surgery codes start with a letter B (effective 1/1/2024) to indicate a significate change in coding.

Code removal/surgical ablation of single or multiple **liver metastases** under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

[SEER Note: Do not code a colostomy, with no colon tissue removed, as surgery. If colostomy is the only procedure performed, assign surgery code B000.]

Codes

B000 None; no surgery of primary site; autopsy ONLY

B100 Local tumor destruction, NOS. Any form of local tumor destruction, includes electrocautery and/or fulguration (includes use of hot forceps for tumor destruction).

B200 Local tumor excision, NOS

B260 Polypectomy, NOS

B270 Excisional biopsy

B280 Polypectomy-endoscopic

Note: Code B280 includes a polypectomy during an initial colonoscopy for screening or symptoms without knowledge of whether the polyp is benign or malignant.

B281 Polypectomy-endoscopic mucosal resection or dissection

Note: Code B281 includes a more complicated polypectomy performed during a colonoscopy. Usually, the polyp is known to be a superficial malignancy.

B290 Polypectomy-open approach surgical excision or laparoscopic

Any combination of B200 or B260-B290 WITH

B220 Electrocautery

Note: Code B220 should be used when electrocautery is used to destroy the tumor but there is still tumor sent to pathology.

B291 Wide Local Excision with Tumor

Note: Code B291 includes procedures focused on just removing the primary tumor and not removing a portion of colon or rectum. In these local procedures the adjacent colon, rectum and lymph nodes are not removed, just the tumor with a bit of margin. Procedures are typically reserved for removal of early tumors that are superficial and not known to be associated with lymph node involvement. Alternate names for B291 include: Wide local excision, Wide excision, Local tumor resection, or Transanal resection.

COLON, continued (C18.0–C18.9)

B300 Partial colectomy, removal of one or more segments with colon resection but less than half of colon is removed

Note: Code B300 includes removal of one or more colon segments, but **less than half** of the colon. Segments include cecum, ascending colon, hepatic flexure, transverse colon, splenic flexure, sigmoid colon, and/or the descending colon.
- Transverse colectomy includes transverse colon
- Splenic flexure colectomy includes transverse colon and the splenic flexure
- Sigmoidectomy includes removal of sigmoid colon and descending colon

[SEER Note: Code B300 includes but is not limited to the following procedures: Enterocolectomy, ileocolectomy, partial colectomy, NOS, partial resection of transverse colon and flexures, and segmental resection (such as cecectomy or sigmoidectomy).]

B320 Plus resection of contiguous organ; example: small bowel, bladder
[SEER Note: Removal of a short portion of the distal ileum is not "removal of a contiguous organ."]

B330 Appendectomy for an appendix primary only, includes incidental findings
Note: When an appendix primary is found incidentally during resection for a colon primary, code the extent of the surgical resection for the colon primary. Assign B330 for the appendix primary site.

B400 Hemicolectomy (total right or left colon and a portion of transverse colon)
B401 Subtotal colectomy (total right or left colon and entire/all of transverse colon)
Note:
- A total left hemicolectomy includes removal of the splenic flexure, descending colon, and the sigmoid colon
- A total right hemicolectomy includes removal of the cecum (with appendix, if present), ascending colon and the hepatic flexure

[SEER Note: Code B400 includes extended (but less than total) right or left colectomy.]

B410 Plus resection of contiguous organ; example: small bowel, bladder
[SEER Note: Removal of a short portion of the distal ileum is not "removal of a contiguous organ."]

B500 Total colectomy (removal of all segments of colon from cecum to the rectosigmoid junction); may include a portion of rectum (but not the entire rectum)

A510 Plus resection of contiguous organ; example: small bowel, bladder
[SEER Note: Removal of a short portion of the distal ileum is not "removal of a contiguous organ."]

B600 Total proctocolectomy (removal of entire colon from cecum to the rectosigmoid junction, including the entire rectum)
[SEER Note: Commonly used for familial polyposis or polyposis coli.]

B610 Plus resection of contiguous organ; example: small bowel, bladder
[SEER Note: Removal of a short portion of the distal ileum is not "removal of a contiguous organ."]

COLON, continued (C18.0–C18.9)

B700 Colectomy or proctocolectomy with resection of contiguous organ(s), NOS

Note: Use code B700 when there is not enough information to code B320, B410, B510, or B610.

Code B700 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site (en bloc resection). Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

[SEER Note: "In continuity with" or "en bloc" means all tissues were removed during the same procedure, but not necessarily in a single specimen.]

B800 Colectomy, NOS

Specimen sent to pathology from surgical events B200–B800.

B900 Surgery, NOS

B990 Unknown if surgery performed; death certificate ONLY

COLON (A Codes 2023)

C18.0–C18.9

These A Codes are effective for 2023 diagnoses. See B Codes on previous page for 2024+ cases.

Code removal/surgical ablation of single or multiple **liver metastases** under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

[SEER Note: Do not code a colostomy, with no colon tissue removed, as surgery. If colostomy is the only procedure performed, assign surgery code A000.]

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
No specimen sent to pathology from surgical events A100–A120.

A200 Local tumor excision, NOS A260 Polypectomy, NOS
A270 Excisional biopsy
A280 Polypectomy-endoscopic
A290 Polypectomy-surgical excision
A220 Any combination of A200 or A260-A290 WITH Electrocautery

A300 Partial colectomy, segmental resection
A320 Plus resection of contiguous organ; example: small bowel, bladder

[SEER Note: Code A300 includes but is not limited to the following procedures: Appendectomy (for an appendix primary only), enterocolectomy, ileocolectomy, partial colectomy, NOS, partial resection of transverse colon and flexures, and segmental resection (such as cecectomy or sigmoidectomy). Note that the removal of a short portion of the distal ileum is not "removal of a contiguous organ."]

A400 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon) A410 Plus resection of contiguous organ; example: small bowel, bladder

[SEER Note: Code A400 includes extended (but less than total) right or left colectomy. Note that the removal of a short portion of the distal ileum is not "removal of a contiguous organ."]

A500 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of rectum)
A510 Plus resection of contiguous organ; example: small bowel, bladder

[SEER Note: Removal of a short portion of the distal ileum is not "removal of a contiguous organ."]

A600 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
[SEER Note: Commonly used for familial polyposis or polyposis coli.]

A610 Plus resection of contiguous organ; example: small bowel, bladder
[SEER Note: Removal of a short portion of the distal ileum is not "removal of a contiguous organ."]

A700 Colectomy or coloproctotectomy with resection of contiguous organ(s), NOS (when there is not enough information to code A320, A410, A510, or A610)

Code A700 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

[SEER Note: "In continuity with" or "en bloc" means all tissues were removed during the same procedure, but not necessarily in a single specimen.]

A800 Colectomy, NOS

Specimen sent to pathology from surgical events A200–A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

RECTOSIGMOID

C19.9

Code removal/surgical ablation of single or multiple **liver metastases** under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
No specimen sent to pathology from surgical events A100–A120.

A200 Local tumor excision, NOS
A260 Polypectomy, NOS
A270 Excisional biopsy
A220 Any combination of A200 or A260-A270 WITH Electrocautery

A300 Segmental resection; partial proctosigmoidectomy, NOS
A310 Plus resection of contiguous organs; example: small bowel, bladder
Procedures coded A300 include, but are not limited to:
Anterior resection Hartmann's operation
Low anterior resection (LAR)
Partial colectomy, NOS
Rectosigmoidectomy, NOS
Sigmoidectomy

A400 Pull through WITH sphincter preservation (colo-anal anastomosis)
[SEER Note: Procedures coded A400 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbull's operation.]

A500 Total proctectomy
[SEER Note: Procedures coded A500 include but are not limited to: Abdominoperineal resection (A & P resection), anterior/posterior resection (A/P resection)/Miles' operation, Rankin's operation.]

A510 Total colectomy
[SEER Note: Removal of the colon from cecum to rectosigmoid or portion of rectum.]

A550 Total colectomy WITH ileostomy, NOS A560 Ileorectal reconstruction
A570 Total colectomy WITH other pouch; example: Koch pouch

A600 Total proctocolectomy, NOS
A650 Total proctocolectomy WITH ileostomy, NOS A660 Total proctocolectomy WITH ileostomy and pouch
Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.

RECTOSIGMOID, continued (C19.9)

A700 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration

[SEER Note: Procedures that may be part of an en bloc resection include, but are not limited to, an oophorectomy and a rectal mucosectomy. Code A700 includes any colectomy (partial, hemicolectomy or total) with an en bloc resection of any other organs. The "other organs" may be partially or totally resected. "In continuity with" or "en bloc" means all tissues were removed during the same procedure, but not necessarily in a single specimen.]

A800 Colectomy, NOS; Proctectomy, NOS

Specimen sent to pathology from surgical events A200–A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

RECTUM
C20.9

Code removal/surgical ablation of single or multiple **liver metastases** under the data item Surgical *Procedure/Other Site* (NAACCR Item #1294).

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
No specimen sent to pathology from surgical events A100-A120

A200 Local tumor excision, NOS
- A260 Polypectomy
- A270 Excisional biopsy
- Any combination of A200 or A260–A270 WITH
  - A220 Electrocautery
  - A280 Curette and fulguration

A300 Segmental resection; partial proctectomy, NOS

Procedures coded A300 include, but are not limited to:
- Anterior resection
- Hartmann's operation
- Low anterior resection (LAR)
- Transsacral rectosigmoidectomy

A400 Pull through WITH sphincter preservation (coloanal anastomosis)
[SEER Note: Procedures coded A400 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbull's operation.]

A500 Total proctectomy

Procedure coded A500 includes, but is not limited to:
- Abdominoperineal resection [SEER Note: Also called A & P resection, anterior/posterior (A/P) resection/Miles' operation, Rankin's operation.]

A600 Total proctocolectomy, NOS

A700 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration
[SEER Note: "In continuity with" or "en bloc" means all tissues were removed during the same procedure, but not necessarily in a single specimen.]

A800 Proctectomy, NOS

Specimen sent to pathology from surgical events A200–A800.

A900 Surgery, NOS
A990 Unknown if surgery performed; death certificate ONLY

ANUS

C21.0–C21.8

[SEER Note: Do not code infrared coagulation as treatment.]

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
A120 Electrocautery; fulguration (includes use of hot forceps for tumordestruction)
A150 Thermal Ablation
No specimen sent to pathology from surgical events A100, A120 and A150.

A200 Local tumor excision, NOS
A260 Polypectomy
A270 Excisional biopsy
A220 Any combination of A200 or A260–A270 WITH Electrocautery
[SEER Note: Margins of resection may have microscopic involvement.]

A600 Abdominal perineal resection, NOS (APR)
A610 APR and sentinel node excision
A620 APR and unilateral inguinal lymph node dissection
A630 APR and bilateral inguinal lymph node dissection

Note: The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292)

Specimen sent to pathology from surgical events A200–A630.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

LIVER AND INTRAHEPATIC BILE DUCTS

C22.0–C22.1

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser
- A150 Alcohol (Percutaneous Ethanol Injection-PEI)
  - [SEER Note: Code A150 can also be described as an "intratumoral injection of alcohol" or "alcohol ablation."]
- A160 Heat-Radio-frequency ablation (RFA)
- A170 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events A100–A170.

A200 Wedge or segmental resection, NOS

A210 Wedge resection

A220 Segmental resection, NOS
- A230 One [wedge or segment of the liver removed]
- A240 Two [wedges or segments of the liver removed]
- A250 Three [wedges or segments of the liver removed]
- A260 Segmental resection AND local tumor destruction

A300 Lobectomy, NOS [SEER Note: Also referred to as simple lobectomy]
- A360 Right lobectomy
- A370 Left lobectomy
- A380 Lobectomy AND local tumor destruction

A500 Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe) A510 Right lobectomy
- A520 Left lobectomy
- A590 Extended lobectomy AND local tumor destruction

A600 Hepatectomy, NOS
- A610 Total hepatectomy and transplant

A650 Excision of a bile duct (for an intra-hepatic bile duct primary only)
- A660 Excision of an intrahepatic bile duct PLUS partial hepatectomy

A750 Extrahepatic bile duct and hepatectomy WITH transplant

Specimen sent to pathology from surgical events A200–A750.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

PANCREAS (B Codes 2024+)

C25.0–C25.9

Surgery codes start with a letter B (effective 1/1/2024) to indicate a significate change in coding.

Codes

B000 None; no surgery of primary site; autopsy ONLY

B250 Local excision of tumor, NOS
Example: Enucleation, laser tumor destruction, thermal therapy, or ablation

B300 Partial pancreatectomy, NOS
Example: Distal pancreatectomy or subtotal pancreatectomy

B350 Local or partial pancreatectomy and duodenectomy
Example: Pancreaticoduodenectomy (Whipple Procedure)

B351 WITHOUT distal/partial gastrectomy
B352 WITH partial gastrectomy, Classic Whipple

Note: Use code B350 when it is not specified where the stomach was cut.

B400 Total pancreatectomy

B600 Total pancreatectomy and subtotal gastrectomy and/or duodenectomy
Extended pancreatoduodenectomy

B800 Pancreatectomy, NOS

B900 Surgery, NOS
[SEER Note: Assign code B900 for NanoKnife, or irreversible electroporation (IRE).]

B990 Unknown if surgery performed; death certificate ONLY

PANCREAS (A Codes 2023)
C25.0–C25.9

These A Codes are effective for 2023 diagnoses. See B Codes on previous page for 2024+ cases.

Codes

A000 None; no surgery of primary site; autopsy ONLY

A250 Local excision of tumor, NOS

A300 Partial pancreatectomy, NOS; example: distal

A350 Local or partial pancreatectomy and duodenectomy
A360 WITHOUT distal/partial gastrectomy
A370 WITH partial gastrectomy (Whipple)

A400 Total pancreatectomy

A600 Total pancreatectomy and subtotal gastrectomy or duodenectomy

A700 Extended pancreatoduodenectomy

A800 Pancreatectomy, NOS

A900 Surgery, NOS
[SEER Note: Assign code A900 for NanoKnife, or irreversible electroporation (IRE).]

A990 Unknown if surgery performed; death certificate ONLY

LARYNX

C32.0–C32.9

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS A110 Photodynamic therapy (PDT)
A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
A130 Cryosurgery
A140 Laser
A150 Stripping

No specimen sent to pathology from surgical events A100–A150.

A200 Local tumor excision, NOS A260 Polypectomy
A270 Excisional biopsy
Any combination of A200 or A260–A270 WITH
A210 Photodynamic therapy (PDT)
A220 Electrocautery
A230 Cryosurgery
A240 Laser ablation
A250 Laser excision
A280 Stripping

A300 Partial excision of primary site NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy NOS
A310 Vertical laryngectomy
A320 Anterior commissure laryngectomy
A330 Supraglottic laryngectomy

[SEER Note: **Vertical laryngectomy:** Removal of involved true vocal cord, ipsilateral false vocal cord, intervening ventricle, and/or ipsilateral thyroid and may include removal of the arytenoids. **Supraglottic laryngectomy:** Conservative surgery intended to preserve the laryngeal function. Standard procedure involves removal of epiglottis, false vocal cords, aryepiglottic folds, arytenoid cartilages, ventricle, upper one third of thyroid cartilage, and/or thyroid membrane. The true vocal cords and arytenoids remain in place to allow vocalization and deglutition.]

A400 Total or radical laryngectomy, NOS
A410 Total laryngectomy ONLY
A420 Radical laryngectomy ONLY
[SEER Note: Radical laryngectomy: Includes removal of adjacent sites. Do not code the removal of adjacent sites in Surgical Procedure of Other Site (NAACCR #1294).]

A500 Pharyngolaryngectomy

A800 Laryngectomy, NOS

Specimen sent to pathology from surgical events A200–A800.

A900 Surgery, NOS
A990 Unknown if surgery performed; death certificate ONLY

LUNG (B Codes 2024+)

C34.0–C34.9

Surgery codes start with a letter B (effective 1/1/2024) to indicate a significate change in coding.

Codes

B000 None; no surgery of primary site; autopsy ONLY

B190 Local tumor destruction or excision, NOS. **Unknown if specimen sent to pathology.**

B150 Local tumor destruction, NOS [SEER Note: Assign code A150 for radiofrequency ablation (RFA).]

B120 Laser ablation or cryosurgery

B130 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

No specimen sent to pathology from surgical events B120, B130 and B150.

B200 Excision or resection of less than one lobe, NOS {SEER NOTE: Includes cryodebulking]

B210 Wedge resection

B220 Segmental resection, including lingulectomy

(Includes lingula sparing lobectomy – NAACCR Webinar Oct 2023)

B230 Excision, NOS

B240 Laser excision

B250 Bronchial sleeve resection ONLY

B300 Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)

B320 Bronchial sleeve lobectomy/bilobectomy

Note: A sleeve lobectomy/bilobectomy includes resection of the entire lobe(s) in addition to part of the bronchus. A sleeve lobectomy is distinct from a typical lobectomy or bilobectomy, in which the bronchus is not resected.

B330 Lobectomy WITH mediastinal lymph node dissection

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery.*

[SEER Note: Assign code B300 when lymph node dissection is not performed, but lymph nodes are obtained as part of the lobectomy specimen.]

B450 Lobe or bilobectomy extended, NOS

B460 WITH chest wall

B470 WITH pericardium

B480 WITH diaphragm

B550 Pneumonectomy, NOS

B560 WITH mediastinal lymph node dissection (radical pneumonectomy)

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery*

[SEER Note: Code B550 includes the following procedures: complete pneumonectomy, sleeve pneumonectomy, standard pneumonectomy, total pneumonectomy, resection of whole lung.]

B650 Extended pneumonectomy, NOS

B660 Extended pneumonectomy plus pleura or diaphragm

Note: An extended pneumonectomy is the resection of the entire lung in addition to one or more of the following structures: superior vena cava, carina, left atrium, aorta, or chest wall.

B800 Resection of lung, NOS

Specimen sent to pathology from surgical events B200–B800.

B900 Surgery, NOS

B990 Unknown if surgery performed; death certificate ONLY

LUNG (A Codes 2023)

C34.0–C34.9

These A Codes are effective for 2023 diagnoses. See B Codes on previous page for 2024+ cases.

Codes

A000 None; no surgery of primary site; autopsy ONLY

A190 Local tumor destruction or excision, NOS

Unknown if specimen sent to pathology for surgical events coded A190 (cases dx'd < 1/1/2003)

A150 Local tumor destruction, NOS [SEER Note: Assign code A150 for radiofrequency ablation (RFA).]

A120 Laser ablation or cryosurgery

A130 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

No specimen sent to pathology from surgical events A120, A130 and A150.

A200 Excision or resection of less than one lobe, NOS

A230 Excision, NOS

A240 Laser excision

A250 Bronchial sleeve resection ONLY

A210 Wedge resection

A220 Segmental resection, including lingulectomy

(Includes lingula sparing lobectomy – NAACCR Webinar Oct 2023)

A300 Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS) A330 Lobectomy WITH mediastinal lymph node dissection

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery*

[SEER Note: Assign code A300 when lymph node dissection is not performed, but lymph nodes are obtained as part of the lobectomy specimen.]

A450 Lobe or bilobectomy extended, NOS

A460 WITH chest wall

A470 WITH pericardium

A480 WITH diaphragm

A550 Pneumonectomy, NOS

A560 WITH mediastinal lymph node dissection (radical pneumonectomy)

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery*

[SEER Note: Code A550 includes the following procedures: complete pneumonectomy, sleeve pneumonectomy, standard pneumonectomy, total pneumonectomy, resection of whole lung.]

A650 Extended pneumonectomy

A660 Extended pneumonectomy plus pleura or diaphragm

A700 Extended radical pneumonectomy

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery*

[SEER Note: An extended radical pneumonectomy is a radical pneumonectomy (including removal of mediastinal nodes) and the removal of other tissues or nodes.]

A800 Resection of lung, NOS

Specimen sent to pathology from surgical events A200–A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

HEMATOPOIETIC/RETICULOENDOTHELIAL/IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE

C42.0, C42.1, C42.3, C42.4 (with any histology)

Code

A980 All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment.

Surgical procedures for hematopoietic/ reticuloendothelial/ immunoproliferative/ myeloproliferative primaries are to be recorded using the data item *Surgical Procedure/Other Site* (NAACCR Item #1294)

BONES, JOINTS, AND ARTICULAR CARTILAGE
C40.0–C41.9

PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM
C47.0–C47.9

CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES
C49.0–C49.9

Codes

A000 None; no surgery of primary site; autopsy ONLY

A190 Local tumor destruction or excision, NOS
Unknown if specimen was sent to pathology for surgical events coded A190 (cases dx'd < 1/1/2003)

A150 Local tumor destruction
No specimen sent to pathology from surgical event A150.

A250 Local excision

A260 Partial resection

A300 Radical excision or resection of lesion WITH limb salvage

A400 Amputation of limb
- A410 Partial amputation of limb
- A420 Total amputation of limb

A500 Major amputation, NOS
- A510 Forequarter, including scapula
- A520 Hindquarter, including ilium/hip bone
- A530 Hemipelvectomy, NOS
- A540 Internal hemipelvectomy

Specimen sent to pathology from surgical events A250–A540.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

SPLEEN
C42.2

Codes

A000 None; no surgery of primary site; autopsy ONLY

A190 Local tumor destruction or excision, NOS
Unknown if specimen was sent to pathology for surgical events coded A190 (cases dx'd < 1/1/2003)

A210 Partial splenectomy

A220 Total splenectomy

A800 Splenectomy, NOS

Specimen sent to pathology for surgical events A210-A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

SKIN (B Codes 2023+)

C44.0–C44.9

Surgery codes start with a letter B (effective 1/1/2023) to indicate a significate change in coding. There are no A codes for this site.

One significant change to the coding rules for cases diagnosed 2023 and after is that shave, punch, or elliptical biopsies are coded in *RX Summ- Surg 2023* regardless of margin status.

The priority order for sources used to assign surgery codes is: operative report, statement from a physician, description of the surgical procedure on a pathology report, results of the pathology report.

Code based on the **description of the procedure**. Do not code based on the intent of the procedure or the margin status documented in the pathology report. Assign the HIGHEST code applicable (margins are NOT a factor).

For codes B500-B540, the margins of resection (the measurement of clear skin around the lesion stated by the surgeon PRIOR to this procedure) MUST BE STATED IN THE TEXT and coded in the *Wide/Re-Excision Margin Width* site specific data item. The clinical surgical margin should be coded from the operative report or physician documentation. Do not code clinical surgical margins from the pathology report.

Additional information regarding surgical procedures for melanoma:

Shave/Punch/Incisional/Excisional Biopsies:

Generally, if a melanoma of the skin is suspected, a physician will try to excise the tumor. The tumor may be excised using a standard excisional technique, a punch biopsy, or shave biopsy. For the initial biopsy, the physician will usually try to remove the entire tumor but leave very close margins. This will allow mapping of the lymphatics in the future. If the tumor is very large or in a place that makes an excisional biopsy difficult, the physician may just take a sample to confirm that it is melanoma, leaving gross or visible tumor.

Wide/Re-Excision:

If the suspicious lesion is found to be melanoma, the physician will usually perform a wider excision. Based on depth of invasion, ulceration, mitotic rate, and other factors, the physician will try to get a margin of healthy skin not involved with melanoma. For example, if the melanoma has a Breslow's depth of 1cm the physician may want to get a 1cm margin of healthy tissue surrounding the tumor by performing a wide or re-excision.

Brief description of common procedures used to remove skin lesions:

- Incisional Biopsy: A needle or core biopsy. (Coded in *Diagnostic Staging Procedure (NAACCR Item 1350)*).
- Excisional Biopsy: Uses a knife (scalpel) to remove an entire lesion or an area of abnormality, including a portion of normal skin around and down to or through the fatty layer of skin.
- Shave Biopsy: Scraping off lesion. Use of Scalpel or Razor. Outermost layers. No stitches.
- Punch Biopsy: Skin punch tool. Removes deeper layers of skin. May need stiches.
- Mohs: Thin layer of tissue removed. Margins are processed in frozen sections.
- Wide Local Excision (WLE): Usually a 1-2cm margin. Depends on depth of invasion. Removes adjacent melanocytes that may turn into melanoma. Skin grafts may be necessary but not always.
- Minor/Local amputation: While the resection is extensive, the entire involved limb/digit is not removed.
- Amputation: Removal of the entire involved limb/digit. Example: Amputation of entire 3rd toe. Code B600.

Refer to Appendix M: Cases Studies for Coding Melanoma in the STORE for examples of using the new codes.

SKIN, continued (C44.0–C44.9)

Codes

B000 None; no surgery of primary site; autopsy ONLY

B100 Local tumor destruction, NOS
- B110 Photodynamic therapy (PDT)
- B120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- B130 Cryosurgery
- B140 Laser

[SEER Note: No specimen sent to pathology from surgical events B100–B140.]

B200 Local tumor excision, NOS; Excisional biopsy, NOS
- B220 Shave Biopsy, NOS
- B230 Punch Biopsy, NOS
- B240 Elliptical Biopsy (aka fusiform)

Note: An incisional biopsy would be a needle or core biopsy and is not coded in this data item. Code an incisional biopsy in Diagnostic Staging Procedure (NAACCR Item 1350).

B300 Mohs surgery (Mohs surgery performed but unknown if on the same day or different days)
- B310 All Mohs procedures performed on the same day
- B320 Each Mohs procedure performed on different days, slow Mohs

B500 Biopsy of primary tumor followed a wide excision or re-excision of the lesion

Use code B500 if a wide/re-excision followed a biopsy but the exact type of biopsy is not known. Procedures do not have to be done at the same time.

- B510 Incisional Biopsy followed by wide excision
- B520 Shave Biopsy followed by wide excision
- B530 Punch Biopsy followed by wide excision
- B540 Elliptical Biopsy (aka fusiform) followed by wide excision

Note: An incisional biopsy would be a needle or core biopsy and is not coded in this data item. Code an incisional biopsy in Diagnostic Staging Procedure (NAACCR Item 1350).

B600 Major Amputation (toe, finger, limb)

B900 Surgery, NOS

B990 Unknown if surgery performed; Death certificate ONLY

BREAST (B Codes 2024+)

C50.0–C50.9

Surgery codes start with a letter B (effective 1/1/2024) to indicate a significate change in coding.

Reconstruction is no longer coded in this data item. Related codes have been removed. Code only the procedure.

If the **contralateral** breast reveals a **second (separate) primary**, each breast is abstracted separately.

Code the most invasive, extensive, or definitive surgery. For example: Assign code B510 or B520 if a patient has an excisional biopsy followed by an areolar-sparing mastectomy during the first course of therapy. Code the cumulative result of the surgeries, which is the areolar-sparing mastectomy in this case.

Codes

B000 None; no surgery of primary site; autopsy ONLY

B200 Partial mastectomy; less than total mastectomy; lumpectomy, segmental mastectomy, quadrantectomy, tylectomy, with or without nipple resection

Note: Use code B200 when there is a previous positive biopsy (either core or FNA).

B210 Excisional breast biopsy - Diagnostic excision, no pre-operative biopsy proven diagnosis of cancer

Note: Use code B210 when a surgeon removes the (positive) mass and there was no biopsy (either core or FNA) done prior to the mass being removed. An excisional biopsy can occur when the nodule was previously not expected to be cancer.

B215 Excisional breast biopsy, for atypia

Note: Use code B215 when patient has biopsy that shows atypical ductal hyperplasia (ADH), an excision is then performed, and pathology shows in situ or invasive cancer. The excisional breast biopsy for ADH diagnosed the cancer, not the core biopsy. An excisional breast biopsy removes the entire tumor and/or leaves only microscopic margins. This surgical code was added for situations when atypia tissue is excised and found to be reportable. Approx. 10-15% of excised atypia are cancer and reportable.

B240 Re-excision of margins from primary tumor site for gross or microscopic residual disease when less than total mastectomy performed

B290 Central lumpectomy, only performed for a prior diagnosis of cancer, which includes removal of the nipple areolar complex

Note: Use code B290 when the nipple areolar complex needs to be removed for patients with Paget disease or cancer directly involving the nipple areolar complex. A central lumpectomy removes the nipple areolar complex, whereas a lumpectomy does not. Central lumpectomy and central portion lumpectomy, central portion excision, central partial mastectomy are interchangeable terms.

B300 Skin-sparing mastectomy

Note: A skin-sparing mastectomy removes all breast tissue and the nipple areolar complex and preserves native breast skin. It is performed with and without sentinel node biopsy or axillary lymph node dissection (ALND).

[SEER Note: Breast surgery code B300 seems to be the best available choice for "Goldilocks" mastectomy. It is essentially a skin-sparing mastectomy with breast reconstruction. The choice between code B300 and codes in the B400-B420 range depends on the extent of the breast removal. Review the operative report carefully and assign the code that best reflects the extent of the breast removal.]

B400 Nipple-sparing mastectomy
- B410 WITHOUT removal of uninvolved contralateral breast
- B420 WITH removal of uninvolved contralateral breast

Note: A nipple-sparing mastectomy removes all breast tissue but preserves the nipple areolar complex and breast skin. It is performed with and without sentinel node biopsy or ALND.

B500 Areolar-sparing mastectomy
- B510 WITHOUT removal of uninvolved contralateral breast
- B520 WITH removal of uninvolved contralateral breast

Note: An areolar-sparing mastectomy removes all breast tissue and the nipple but preserves the areola and breast skin. It is performed with and without sentinel node biopsy or ALND.

B600 Total (simple) mastectomy; modified radical mastectomy
- B610 WITHOUT removal of uninvolved contralateral breast
- B620 WITH removal of uninvolved contralateral breast

Note: A total (simple) mastectomy removes all breast tissue, the nipple, areolar complex, and breast skin**. It is performed with and without sentinel node biopsy or ALND.**

A MRM removes of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin **in continuity with the axilla**. The specimen may or may not include **a portion of the pectoralis major muscle**.

B700 Radical mastectomy, NOS
- B710 WITHOUT removal of uninvolved contralateral breast
- B720 WITH removal of uninvolved contralateral breast
- B760 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma

A radical mastectomy removes all breast tissue, nipple, areolar complex, breast skin, **pectoralis muscle.** It is performed with level l-III ALND.

[SEER Note: Assign code B760 for a more extensive bilateral mastectomy for a single primary involving both breasts. Assign code 0 in Surgical Procedure of Other Site (NAACCR #1294).]

B800 Mastectomy, NOS (including extended radical mastectomy)

An extended radical mastectomy involves removal of breast tissue, nipple, areolar complex, variable amounts of skin, pectoralis minor, and/or pectoralis major, as well as **removal of internal mammary nodes** and en bloc axillary dissection

B900 Surgery, NOS
B990 Unknown if surgery performed; death certificate ONLY

BREAST (A Codes 2023)
C50.0–C50.9

These A Codes are effective for 2023 diagnoses. See B Codes on previous page for 2024+ cases.

Codes

A000 None; no surgery of primary site; autopsy ONLY

A190 Local tumor destruction, NOS
No specimen sent to pathology for surgical events coded A190 (principally cases diagnosed prior to 2003)

(Also see the long list of SEER Notes associated with codes A200-A700 at the bottom of the list.)

A200 Partial mastectomy, NOS; less than total mastectomy, NOS
A210 Partial mastectomy WITH nipple resection
A220 Lumpectomy or excisional biopsy
A230 Re-excision of the biopsy site for gross or microscopic residual disease
A240 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded A200–A240 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

A300 Subcutaneous mastectomy
A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded A300 may be considered to have undergone breast reconstruction.

A400 Total (simple) mastectomy
A410 WITHOUT removal of uninvolved contralateral breast
A430 With reconstruction NOS
A440 Tissue
A450 Implant
A460 Combined (Tissue and Implant)

A420 WITH removal of uninvolved contralateral breast
A470 With reconstruction NOS
A480 Tissue
A490 Implant
A750 Combined (Tissue and Implant)

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex**. An axillary dissection is not done**, but sentinel lymph nodes may be removed.

For a **single** primary involving **both** breasts use code A760.
[Example: Inflammatory carcinoma involving both breasts. Bilateral simple mastectomies performed.]

If the **contralateral** breast reveals a **second (separate) primary**, each breast is abstracted separately. The surgical procedure is coded A410 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

Reconstruction that is planned as part of first course treatment is coded A430-A490 or A750, whether it is done at the time of mastectomy or later.

A760 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.

A500 Modified radical mastectomy
- A510 WITHOUT removal of uninvolved contralateral breast
  - A530 Reconstruction, NOS
    - A540 Tissue
    - A550 Implant
    - A560 Combined (Tissue and Implant)
- A520 WITH removal of uninvolved contralateral breast
  - A570 Reconstruction, NOS
    - A580 Tissue
    - A590 Implant
    - A630 Combined (Tissue and Implant)

A MRM removes of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin **in continuity with the axilla**. The specimen may or may not include **a portion of the pectoralis major muscle**.

If the **contralateral** breast reveals a **second (separate) primary**, each breast is abstracted separately. The surgical procedure is coded A510 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

A600 Radical mastectomy, NOS
- A610 WITHOUT removal of uninvolved contralateral breast
  - A640 Reconstruction, NOS
    - A650 Tissue A660 Implant
    - A670 Combined (Tissue and Implant)
- A620 WITH removal of uninvolved contralateral breast
  - A680 Reconstruction, NOS A690 Tissue
    - A730 Implant
    - A740 Combined (Tissue and Implant)

A radical mastectomy involves removal of breast tissue, nipple, areolar complex, variable amount of skin, **pectoralis minor, and/or pectoralis major**, as well as en bloc axillary dissection.

A700 Extended radical mastectomy
- A710 WITHOUT removal of uninvolved contralateral breast
- A720 WITH removal of uninvolved contralateral breast

An extended radical mastectomy involves removal of breast tissue, nipple, areolar complex, variable amounts of skin, pectoralis minor, and/or pectoralis major, as well as **removal of internal mammary nodes** and en bloc axillary dissection

A800 Mastectomy, NOS
Specimen sent to pathology for surgical events coded A200-A800.

A900 Surgery, NOS
A990 Unknown if surgery performed; death certificate ONLY

BREAST, continued (C50.0–C50.9)

SEER Notes:

When a patient has a procedure coded to A200-A240 (e.g., lumpectomy) with reconstruction, code only the procedure (e.g., lumpectomy, code A220) as the surgery.

Assign code A220 when a patient has a lumpectomy and an additional margin excision during the same procedure. According to the Commission on Cancer, re-excision of the margins intraoperatively during same surgical event does not require additional resources; it is still A220. Subsequent re-excision of lumpectomy margins during separate surgical event requires additional resources: anesthesia, op room, and surgical staff; it qualifies for code A230.

Code A300 seems to be the best available choice for "Goldilocks" mastectomy. It is essentially a skin-sparing mastectomy with breast reconstruction. The choice between code A300 and codes in the A400-A490 range depends on the extent of the breast removal. Review the operative report carefully and assign the code that best reflects the extent of the breast removal.

"Tissue" for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants). Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment.

Assign code A430 for a simple mastectomy with tissue expanders and acellular dermal matrix/AlloDerm. The tissue expander indicates preparation for reconstruction. The acellular dermal matrix/AlloDerm is not coded because, while they often accompany an implant procedure, they are not the principle element of reconstructive procedures. The principle elements would be tissue from the patient and/or prosthetics (e.g., gel implants).]

Placement of a tissue expander at the time of original surgery means that reconstruction is planned as part of the first course of treatment. When an expander is placed, code the mastectomy and reconstruction.

Reconstruction may be done at the same time as the mastectomy or may be done later. Code A430-A490, or A750 if the operative report or medical record states reconstruction will be done later, or if a tissue expander is inserted during the mastectomy procedure. Tissue expander insertion precedes reconstruction.

Assign code A760 for a more extensive bilateral mastectomy. Assign code 0 in Surgical Procedure of Other Site (NAACCR #1294).

For a simple bilateral mastectomy, assign code A410 with code 1 in Surgical Procedure of Other Site (NAACCR #1294).

Codes A500-A520: "In continuity with" or "en bloc" means that all the tissues were removed during the same procedure, but not necessarily in a single specimen.

Assign code A510 or A520 if a patient has an excisional biopsy and axillary dissection followed by a simple mastectomy during the first course of therapy. Code the cumulative result of the surgeries, which is a modified radical mastectomy in this case.

CERVIX UTERI

C53.0–C53.9

For invasive cancers, dilation and curettage is coded as an incisional biopsy (Code 02) under the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350).

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS A110 Photodynamic therapy (PDT)
A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
A130 Cryosurgery
A140 Laser
A150 Loop Electrocautery Excision Procedure (LEEP)
A160 Laser ablation
A170 Thermal ablation
No specimen sent to pathology from surgical events A100–A170.

A200 Local tumor excision, NOS
[SEER Note: Margins of resection may have microscopic involvement. Procedures in code A200 include but are not limited to: cryosurgery, electrocautery, excisional biopsy, laser ablation, or thermal ablation.]

A260 Excisional biopsy, NOS
A270 Cone biopsy
A240 Cone biopsy WITH gross excision of lesion
A290 Trachelectomy; removal of cervical stump; cervicectomy
Any combination of A200, A240, A260, A270 or A290 WITH
A210 Electrocautery
A220 Cryosurgery
A230 Laser ablation or excision
A250 Dilatation and curettage; endocervical curettage (for in situ only)
A280 Loop electrocautery excision procedure (LEEP)

A300 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

A400 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

A500 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
A510 Modified radical hysterectomy
A520 Extended hysterectomy
A530 Radical hysterectomy; Wertheim procedure
A540 Extended radical hysterectomy

A600 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
A610 WITHOUT removal of tubes and ovaries
A620 WITH removal of tubes and ovaries

A700 Pelvic exenteration

A710 Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

A720 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

A730 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

A740 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

[SEER Note: For Codes A700-A740: Do not code removal of pelvic lymph nodes under Surgical Procedure of Other Site (NAACCR #1294).]

Specimen sent to pathology from surgical events A200–A740.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

CORPUS UTERI

C54.0–C55.9

For invasive cancers, dilation and curettage is coded as an incisional biopsy (Code 02) under the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350).

Codes

A000 None; no surgery of primary site; autopsy ONLY

A190 Local tumor destruction or excision, NOS
Unknown if specimen was sent to pathology for surgical events coded A190 (cases dx'd < 1/1/2003)

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser
- A150 Loop Electrocautery Excision Procedure (LEEP)
- A160 Thermal ablation

No specimen sent to pathology from surgical events A100–A160.

A200 Local tumor excision, NOS; simple excision, NOS
- A240 Excisional biopsy
- A250 Polypectomy
- A260 Myomectomy
- Any combination of A200 or A240–A260 WITH
  - A210 Electrocautery
  - A220 Cryosurgery
  - A230 Laser ablation or excision

[SEER Note: Margins of resection may have microscopic involvement.]

A300 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies).
- A310 WITHOUT tube(s) and ovary(ies)
- A320 WITH tube(s) and ovary(ies)

[SEER Note: For these procedures, the cervix is left in place.]

A400 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

A500 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

A600 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- A610 Modified radical hysterectomy
- A620 Extended hysterectomy
- A630 Radical hysterectomy; Wertheim procedure [SEER Note: Use code A630 for "Type III" hysterectomy.]
- A640 Extended radical hysterectomy

A650 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies) A660 WITHOUT removal of tube(s) and ovary(ies)
A670 WITH removal of tube(s) and ovary(ies)

A750 Pelvic exenteration
A760 Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

A770 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

A780 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

A790 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

[SEER Note: For Codes A750-A790: Do not code removal of pelvic lymph nodes under Surgical Procedure of Other Site (NAACCR #1294).]

Specimen sent to pathology from surgical events A200–A790.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

OVARY
C56.9

Codes

A000 None; no surgery of primary site; autopsy ONLY

A170 Local tumor destruction, NOS **(No specimen sent to pathology from surgical event A170.)**

A250 Total removal of tumor or (single) ovary, NOS
- A260 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
- A270 WITHOUT hysterectomy
- A280 WITH hysterectomy [current unilateral (salpingo-) oophorectomy with previous history of hysterectomy]

A350 Unilateral (salpingo-)oophorectomy; unknown if hysterectomy done
- A360 WITHOUT hysterectomy
- A370 WITH hysterectomy [includes previous history of hysterectomy]

A500 Bilateral (salpingo-)oophorectomy; unknown if hysterectomy done
- A510 WITHOUT hysterectomy
- A520 WITH hysterectomy [includes previous history of hysterectomy]

A550 Unilateral or bilateral (salpingo-)oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done
- A560 WITHOUT hysterectomy
- A570 WITH hysterectomy [includes previous history of hysterectomy]

A600 Debulking; cytoreductive surgery, NOS
- A610 WITH colon (including appendix) and/or small intestine resection (not incidental)
- A620 WITH partial resection of urinary tract (not incidental)
- A630 Combination of A610 and A620

Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.

[SEER Note: Debulking or cytoreductive surgery is implied by the following phrases in the operative report, pathology report, discharge summary, or consultation. (This is not intended to be a complete list. Other phrases may also imply debulking.)
- Adjuvant treatment pending surgical reduction of tumor
- Ovaries, tubes buried in tumor
- Tumor burden
- Tumor cakes
- Very large tumor mass

Do not code debulking or cytoreductive surgery based on: multiple biopsies alone, the mention of “multiple tissue fragments” or “removal of multiple implants.” Multiple biopsies and multiple specimens confirm the presence or absence of metastasis.]

A700 Pelvic exenteration, NOS A710 Anterior exenteration

Includes bladder, distal ureters, genital organs WITH their ligamentous attachments and pelvic nodes.

A720 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

A730 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

A740 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

[SEER Note: For Codes A710-A730: Do not code removal of pelvic lymph nodes under Surgical Procedure of Other Site (NAACCR #1294).]

A800 (Salpingo-)oophorectomy, NOS

Specimen sent to pathology from surgical events A250–A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

PROSTATE

C61.9

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item *Hematologic Transplant and Endocrine Procedures* (NAACCR Item #3250).

Codes

A000 None; no surgery of primary site; autopsy ONLY
A180 Local tumor destruction or excision, NOS
A190 Transurethral resection (TURP), NOS, and no specimen sent to pathology or unknown if sent
Unknown if specimen sent to pathology for surgical events coded A180 or A190 (< 1/1/2003).

A100 Local tumor destruction, NOS
- A140 Cryoprostatectomy
- A150 Laser ablation [SEER Note: Assign for Niagara laser photovaporization of the prostate]
- A160 Hyperthermia [SEER Note: Assign for Transurethral Microwave Thermotherapy (TUMT)]
- A170 Other method of local tumor destruction
  [SEER Note: Assign code A170 for High Intensity Focused Ultrasonography (HIFU) and for Transurethral Needle Ablation (TUNA)]

No specimen sent to pathology from surgical events A100–A170.

A200 Local tumor excision, NOS
- A210 Transurethral resection (TURP), NOS, with specimen sent to pathology
- A220 TURP–cancer is incidental finding during surgery for benign disease
  [SEER Note: Assign code A220 for aqua ablation water jet (or other tumor destruction procedure), described on pathology as a TURP, that identified adenocarcinoma as an incidental finding. Use text fields to document the details.]
- A230 TURP–patient has suspected/known cancer

Any combination of A200–A230 WITH
- A240 Cryosurgery
- A250 Laser [SEER Note: Assign for Holmium laser enucleation of the prostate when a specimen is sent to pathology]
- A260 Hyperthermia

A300 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact
[SEER Note: May include suprapubic prostatectomy]

A500 Radical prostatectomy, NOS; total prostatectomy, NOS
Includes excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

A700 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
Surgeries coded A700 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.
[SEER Note: "In continuity with" or "en bloc" means that all tissues were removed during the same procedure, but not necessarily in a single specimen.]

A800 Prostatectomy, NOS
Specimen sent to pathology from surgical events A200–A800.
A900 Surgery, NOS
A990 Unknown if surgery performed; death certificate ONLY

TESTIS
C62.0–C62.9

Codes

A000 None; no surgery of primary site; autopsy ONLY

A120 Local tumor destruction, NOS
No specimen sent to pathology from surgical event A120.

A200 Local or partial excision of testicle

A300 Excision of testicle WITHOUT cord
[SEER Note: Orchiectomy not including spermatic cord.]

A400 Excision of testicle WITH cord or cord not mentioned (radical orchiectomy)
[SEER Note: Orchiectomy with or without spermatic cord.]

A800 Orchiectomy, NOS (unspecified whether partial or total testicle removed)

Specimen sent to pathology from surgical events A200–A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

KIDNEY, RENAL PELVIS, AND URETER

Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser
- A150 Thermal ablation

No specimen sent to pathology from this surgical event A100–A150.

A200 Local tumor excision, NOS
- A260 Polypectomy
- A270 Excisional biopsy
- Any combination of A200 or A260–A270 WITH
  - A210 Photodynamic therapy (PDT)
  - A220 Electrocautery
  - A230 Cryosurgery
  - A240 Laser ablation
- A250 Laser excision

A300 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)

Procedures coded A300 include, but are not limited to:

Segmental resection Wedge resection

A400 Complete/total/simple nephrectomy–for kidney parenchyma Nephroureterectomy

Includes bladder cuff for renal pelvis or ureter.

A500 Radical nephrectomy

May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter.

A700 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with the resection of other organ(s) (colon, bladder)

The other organs, such as colon or bladder, may be partially or totally removed.

[SEER Note: "In continuity with" or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen.]

A800 Nephrectomy, NOS
Ureterectomy, NOS

Specimen sent to pathology from surgical events A200–A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

BLADDER

C67.0–C67.9

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS A110 Photodynamic therapy (PDT)
A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
A130 Cryosurgery
A140 Laser
A150 Intravesical therapy
A160 Bacillus Calmette-Guerin (BCG) or other immunotherapy
[SEER Note: Code BCG as both surgery and immunotherapy.]
Also code the introduction of immunotherapy in the immunotherapy items.
If immunotherapy is followed by a surgery specified in codes A200-A800 code that surgery instead and code the immunotherapy only as immunotherapy.
No specimen sent to pathology from surgical events A100–A160.

A200 Local tumor excision, NOS
A260 Polypectomy
A270 Excisional biopsy [SEER Note: Code TURB as A270.]
Combination of A200 or A260-A270 WITH
A210 Photodynamic therapy (PDT)
A220 Electrocautery
A230 Cryosurgery
A240 Laser ablation
A250 Laser excision

A300 Partial cystectomy

A500 Simple/total/complete cystectomy

A600 Complete cystectomy with reconstruction
A610 Radical cystectomy PLUS ileal conduit
A620 Radical cystectomy PLUS continent reservoir or pouch, NOS
A630 Radical cystectomy PLUS abdominal pouch (cutaneous)
A640 Radical cystectomy PLUS in situ pouch (orthotopic)
When the procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code A600-A640).
[SEER Note: Use code A710 for cystoprostatectomy and for cystectomy with hysterectomy.]

A700 Pelvic exenteration, NOS
A710 Radical cystectomy including anterior exenteration
For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra. For males, includes removal of the prostate. When a procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code A600-A640).

[SEER Note: Use code A710 for cystoprostatectomy. Use code A710 for cystectomy with hysterectomy.] [SEER Note: If a cystectomy is done and the prostatectomy/hysterectomy is not done, any organs other than the bladder removed during the procedure should be coded in Surgical Procedure of Other Site (NAACCR

#1294). If a cystectomy is done along with prostatectomy/hysterectomy, all pelvic organs removed during the procedure are included in codes A700-A740. Any non-pelvic organs or tissues removed during the procedure should be coded to Surgical Procedure of Other Site (NAACCR #1294).]

A720 Posterior exenteration
For females, also includes removal of vagina, rectum and anus.
For males, also includes prostate, rectum and anus.

A730 Total exenteration
Includes all tissue and organs removed for an anterior and posterior exenteration.
[SEER Note: Includes removal of all pelvic contents and pelvic lymph nodes. The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery (NAACCR item #1292).]

A740 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

A800 Cystectomy, NOS

Specimen sent to pathology from surgical events A200–A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

BRAIN

Meninges C70.0–C70.9
Brain C71.0–C71.9,
Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C72.0–C72.9

Do not code laminectomies for spinal cord primaries.

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Tumor destruction, NOS
[SEER Note: Local tumor destruction, NOS; laser interstitial thermal therapy (LITT) - code A100 if no specimen sent to pathology.]
No specimen sent to pathology from surgical event A100.

Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as surgical tumor destruction. These modalities are recorded in the radiation treatment fields.

A200 Local excision of tumor, lesion or mass; excisional biopsy
[SEER Note: Assign code A200 for stereotactic biopsy of brain tumor. This includes a Stealth or StealthStation guided needle biopsy, a type of stereotactic biopsy.]
A210 Subtotal resection of tumor, lesion or mass in brain
A220 Resection of tumor of spinal cord or nerve

A300 Radical, total, gross resection of tumor, lesion or mass in brain

A400 Partial resection of lobe of brain, when the surgery cannot be coded as A200-A300.

A550 Gross total resection of lobe of brain (lobectomy)

Codes A300-A550 are not applicable for spinal cord or spinal nerve primary sites.

Specimen sent to pathology from surgical events A200–A550.

A900 Surgery, NOS
[SEER Note: Laser interstitial thermal therapy (LITT) - code A900 if specimen sent to pathology.]

A990 Unknown if surgery performed; death certificate ONLY

THYROID GLAND (B Codes 2024+)

C73.9

Surgery codes start with a letter B (effective 1/1/2024) to indicate a significate change in coding.

Please note the order of the Codes B200-B253 have changed from STORE 2023

Codes

B000 None; no surgery of primary site; autopsy ONLY

B130 Local tumor destruction, NOS
No specimen sent to pathology from surgical event B130.

B200 Removal of less than a lobe, NOS
- B210 Local surgical excision
- B220 Removal of a partial lobe ONLY

B250 Lobectomy and/or isthmectomy
- B251 Lobectomy ONLY (right or left)
- B252 Isthmectomy ONLY
- B253 Lobectomy WITH isthmus

B300 Removal of a lobe and partial removal of the contralateral lobe

B400 Subtotal or near total thyroidectomy

B500 Total thyroidectomy

B800 Thyroidectomy, NOS

Specimen sent to pathology from surgical events B200–B800.

B900 Surgery, NOS

B990 Unknown if surgery performed; death certificate ONLY

THYROID GLAND (A Codes 2023)

C73.9

These A Codes are effective for 2023 diagnoses. See B Codes on previous page for 2024+ cases.

Codes

A000 None; no surgery of primary site; autopsy ONLY

A130 Local tumor destruction, NOS
No specimen sent to pathology from surgical event A130.

A250 Removal of less than a lobe, NOS
- A260 Local surgical excision
- A270 Removal of a partial lobe ONLY

A200 Lobectomy and/or isthmectomy
- A210 Lobectomy ONLY
- A220 Isthmectomy ONLY
- A230 Lobectomy WITH isthmus

A300 Removal of a lobe and partial removal of the contralateral lobe

A400 Subtotal or near total thyroidectomy

A500 Total thyroidectomy

A800 Thyroidectomy, NOS

Specimen sent to pathology from surgical events A200–A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

LYMPH NODES

C77.0–C77.9

Codes

A000 None; no surgery of primary site; autopsy ONLY

A190 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded to A190 (principally for cases diagnosed prior to January 1, 2003).

A150 Local tumor destruction, NOS
No specimen sent to pathology from surgical event A150.

A250 Local tumor excision, NOS
Less than a full chain, includes an excisional biopsy of a single lymph node.
[SEER Note: The use of code A250 in Surgery of Primary Site 2023 [NAACCR #1291] is for a primary in one and only one lymph node. The single involved lymph node is removed by an excisional biopsy only. CDC-NPCR, CoC, and SEER are in agreement on the wording of code A250.]

A300 Lymph node dissection, NOS
A310 One chain
A320 Two or more chains

A400 Lymph node dissection, NOS PLUS splenectomy
A410 One chain
A420 Two or more chains

A500 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
A510 One chain
A520 Two or more chains

A600 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy (Includes staging laparotomy for lymphoma)
A610 One chain
A620 Two or more chains

Specimen sent to pathology for surgical events A250-A620.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

ALL OTHER SITES

C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9,
C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8,
C51.0–C51.9, C52.9, C57.0–C57.9, C58.9,
C60.0–C60.9, C63.0–C63.9, C68.0–C68.9,
C69.0–C69.9, C74.0–C74.9, C75.0–C75.9

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser [SEER Note: Assign code A140 for laser hyperthermia of eye for retinoblastoma.]

No specimen sent to pathology from surgical events A100–A140.

A200 Local tumor excision, NOS
- A260 Polypectomy
- A270 Excisional biopsy
- Any combination of A200 or A260–A270 WITH
  - A210 Photodynamic therapy (PDT)
  - A220 Electrocautery
  - A230 Cryosurgery
  - A240 Laser ablation
- A250 Laser excision

A300 Simple/partial surgical removal of primary site

A400 Total surgical removal of primary site; enucleation
- A410 Total enucleation (for eye surgery only)

A500 Surgery stated to be “debulking”

A600 Radical surgery
- **Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.**

[SEER Note: In continuity with or “en bloc” means all tissues were removed during the same procedure, but not necessarily in a single specimen.]

Specimen sent to pathology from surgical events A200–A600.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

UNKNOWN AND ILL-DEFINED PRIMARY SITES

C76.0–C76.8, C80.9

Code

A980 All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Appendix C:
Guidelines for Abstracted Text

Guidelines for Abstracted Text

Text is a required component of a complete abstract. The primary purpose of text is for quality assurance. Abstracts must contain corroborating text that validates the selection of codes assigned to age, sex, race, ethnicity, primary site, histology, extent of disease and treatment fields.

Text is used to:

- corroborate coded data items
- identify potential errors in coding
- clarify and explain difficult coding decisions and unusual scenarios
- confirm decisions related to single versus multiple primaries
- reconcile data item discrepancies when the same cancer is reported by several facilities.

Audience

The intended audience for the abstract text is NOT the abstractor! Text should justify the accuracy of the data so that **anyone** reviewing the abstract will be able to validate the coded information. As the abstractor, you are in the role of the reporter, telling the *who, what, where, when and why*. It is your job to take the information from your sources (the medical record) and ensure that others understand the story of this patient's cancer. Others will not have the source record, so it is important to fill in the blanks. What discussions outside of the radiology or pathology report were available that guided your decisions? Why was this abstracted as a recurrence and not a new primary? Why was treatment started a year after diagnosis coded as first course and not subsequent treatment? What documentation did you have that led you to code the abstract this way? Did you use a multiple primary rule, or was there a physician statement that guided the decision?

When completing the abstract, think about what someone else would need to know to validate your decisions. The CCR receives many more "abstracts" than "cases" which means some cases are reported by two or more facilities. One of the key functions of the CCR is to ensure that each reported malignancy is represented by only one "best abstract" in our database. How do we decide which codes are in the final abstract when there is a discrepancy between facility abstracts? Factors such as class of cases and treating facility play a part, but most decisions are based on the best text documentation.

Amount of Text

Excellent text, if done correctly, could take less time than you think. The abstract provides ample space to record a lot of information. Do not copy entire reports from the source record. This is counterproductive to the quality assurance process. Imagine performing an audit on 1000 prostate cases and having to read through long, wordy narratives for each abstract to validate the coded data items. Imagine if after reading through all that information, it still doesn't explain why a certain code was selected. Quantity does not equal quality. A lot of "words" does not necessarily mean sufficient text.

> For example, text lists 15 different PSA values taken over the past several years but it is not possible to tell which PSA test met the rules for coding the PSA SSDI. A lot of information was certainly provided. Unfortunately, it was not useful in accomplishing the goal of text which was to validate the PSA SSDI.

Example: Isolate the PSA that should be coded in the SSDI (keep in mind you are doing an audit on 1000 cases and have to do this for all 1000 cases so this is something that you would want to be able to validate quickly). The first biopsy date was 5/27/2022:

> DECIPHER PROSTATE GENOMIC: DECIPHER SCORE 0.68, GENOMIC RISK HIGH, RISK OF METS W/ RT OR RP 5 YR 6.5% 10 YR 12.6%, RISK PROSTATE CA MORTALITY W/ RT OR RP (15 YR) 20.4% PSA: 4.3 7/31/18 5.1 2/2/21 4.76 9/28/21 7.32 2/7/22 25.97 5/31/22 14.9 7/4/22

Ideal text: 2/7/2022, MAIN ST UROLOGY, PSA: 7.32 ELEVATED

The most useful text is complete, concise, clear and has the required content. Text should summarize the pertinent findings used to make coding decisions. For example, take a paragraph from the source document and try summarizing it into something that would fit into a bullet point. Eliminate unnecessary words. Be brief but do not eliminate the detail that justifies a coding decision (such as ambiguous terminology used to describe the histology or tumor involvement).

Text Format

Using the following format will go a long way in making sure your text is brief and useful. Using a consistent format allows others to navigate through the content in a more efficient manner.

Always state the: When, Where (if not YOUR facility) and What for every exam, test, procedure, and treatment. If applicable (such as for lab tests, radiology, pathology, etc.), add the findings.

For the "Where", stating "OSF" or "elsewhere" is NOT helpful. State the other facility's name (abbreviations are ok). If a facility name is not stated, the assumption is that it was provided by the reporting facility.

Examples:

- 8/19/20xx, ACROSS TOWN ONCOLOGY: PT DECLINED CHEMO. 12/14/20xx, ATO: TUCATINIB ADDED DUE TO PROGRESSION (SUBSEQUENT RX).
- 11/9/20xx, MY TOWN ENDO CTR, COLONOSCOPY: FUNGATING AND INFILTRATIVE PARTIALLY OBSTRUCTING LARGE MASS IN SIGMOID COLON ABOUT 35CM FROM ANAL VERGE. MASS WAS CIRCUMFERENTIAL AND COULD NOT BE TRAVERSED. BIOPSIES TAKEN.

MUST Dos of Texting

- State AGE/RACE/SEX in the Physical Exam text field. Example: 57Y BM
- Justify ALL dates, including the month, day and year. Always include the date for each exam, test, procedure or treatment.
- Indicate if any date is an estimate. Example: 1/1/20xx (est)
- Prioritize information. Enter findings in chronological order with the most important findings first.
- If additional space is required, continue additional text to any other available text field.
- State when critical information is missing. Example: PSA value not provided. Only stated to be elevated.
- Use recognized abbreviations (NAACCR Appendix G: Recommended Abbreviations for Abstractors)
- Special characters are allowed, including punctuation such as periods, commas, dashes, and slashes.
- Clearly separate findings with punctuation. A period goes a long way in text to clarify where one finding stops and another begins!
- Clearly differentiate when information is related to a recurrence or progression after the initial diagnosis and treatment plan has been established.

For Race and Sex:

- For Race:
    - Codes 01 and 02: W for White and B for Black are the preferred (and most used) abbreviations.
    - Codes 03-97: A little more than a letter abbreviation is often needed to describe the race.
    - Code 98: An explanation of why the race is "Other" is needed.
    - Code 99: If race is not provided (and there are no clues to indicate race), text should specifically state this. For example, 78Y M. RACE NOT STATED.
- For Sex: M for Male and F for Female are the allowable abbreviations.

- The preferred (and most used) format is ##Y RS. For example, 78Y BM. Minor variations such as 78YO BM or 78Y B/M would also be acceptable.
- Make sure the meaning of the abbreviation is clear, especially if varying from the preferred format and abbreviation. Marital status is not required to be stated in the text. If included, be sure it cannot be confused with race. In an audit of cases coded to 98 (Other), the following are examples that raised questions as to the meaning of the abbreviation and the accuracy of the code:
  i. WF. Is this a white female or a widowed female? If race had been coded to 01, the interpretation of white female would be obvious. But, with it coded to 98, it raises questions as to what the "W" means. Is the race code an error? If not, what information was used to determine the race was "Other"?
  ii. SM. Is this a Spanish male or a single male? Was Hispanic coded to 98 in error?
  iii. AIF. Is this an Asian Indian Female or an American Indian Female? Does a more specific code 03 or 15 apply? While the patient's name may provide a clue, it is not definitive. A better description should be provided.
  iv. 78Y OM. Is this an Oriental male or is the race Other? Or is the space in the wrong place and it means "old" for a 78-Year-Old Male? If the race is "Other", what information was used to make this determination? Was Oriental coded to 98 instead of 96 in error?

  As you can see, once reference to the source record is no longer available, some abbreviations become less obvious and instead can raise questions. For race codes 03-98, details should be provided to ensure the interpretation is clear.

Don't Dos of Texting

- Do not copy and paste full reports from the medical record. Summarize key points. You may use Word or Notepad (or similar) to construct your text content and then copy that into the text field.
- Do not repeat information from other text fields.
- Do not include irrelevant information (e.g., in bicycle accident as a child). Family history is not required unless it is pertinent to the patient's diagnosis (such as a familial condition).
- Auto-generated text from a coded data item does not count as text. Wrong code = wrong text.
- Avoid using the return key inside of a text field. It is unclear at this time if this causes problems when files are uploaded and is best to avoid.

Example of pertinent versus non-pertinent text and using a standardized format, abbreviations and helpful punctuation to clarify where one statement ends and another begins:

Too wordy with non-pertinent information: HE WAS STAGED WITH A BONE SCAN ON 01/15/202x WHICH WAS READ AS `NO EVIDENCE OF OSTEOBLASTIC METASTASIS`. THERE WERE DEGENERATIVE CHANGES. HE UNDERWENT AN MRI OF HIS PELVIS 02/03/202x WHICH SHOWED A 34.3 ML PROSTATE. HE CONTAINED A LARGE LESION IN THE CENTRAL GLAND ASYMMETRICALLY ON THE RIGHT WITH EXTENSION ACROSS MIDLINE. THE LESION MEASURED 3.5 X 2.8 X 3.1 CM IN BOTH THE ANTERIOR FIBROMUSCULAR STROMA IN THE MID GLAND TOWARDS THE APEX, FELT TO REPRESENT EXTRACAPSULAR EXTENSION. THERE WERE NO ENLARGED LYMPH NODES.

More concise, pertinent summary: 1/15/202x, BONE SCAN: NEG. 2/3/202X, MRI PELVIS: 34.3ML PROSTATE. LARGE LESION IN CENTRAL GLAND MEAS 3.5 X 2.8 X 3.1 CM. ASYMMETRY ON RIGHT WITH EXT ACROSS MIDLINE. EXTRACAPSULAR EXTENSION WITH LESION IN BOTH THE ANTERIOR FIBROMUSCULAR STROMA IN THE MID GLAND TOWARDS THE APEX. NO ENLARGED LYMPH NODES.

Document the "unusual"

The biggest gap in text is when the case does not fall into the normal pattern of what is expected. Always try to answer the question of WHY. Why did you code it this way? What information did you use to come to that decision?

If treatment is delayed, add a statement to explain the reason:

Pt did not return for treatment. PSA now rising. Resection done as subsequent treatment due to progression per Dr. XYZ.

Communicate that an unusual age is correct:

43 yr WM with prostate cancer (age verified).

Estimating dates is better than recording unknown:

7/20xx (est), Dr. XYZ, Tamoxifen.

Patient diagnosed "5 years ago". Estimated date of diagnosis as 20180101.

N.C. CCR Required Text Fields and Examples

Text Field	Suggestions for Text	Example
Physical Exam	This field should begin with the age, race and sex of the patient. Include the history of the current tumor and the clinical description of the tumor. Date of physical exam, tumor location, tumor size, palpable nodes, any history that relates to cancer diagnosis. DRE results for prostate; size and location of skin primaries.	45Y WF. 4x4 cm hard mass, UIQ Lt breast. Skin dimpled w/edema and peau d'orange. Palpable susp nodes in lower axilla. 65Y BM. Rectal exam: Prostate 3+ enlarged, nontender. No nodularity. 70Y Asian M. DRE - smooth nodule occupying less than half lobe rt side of prostate.
Primary Site	Primary site, subsite and laterality	Rt breast, UOQ RLL Lung
Histology	Histologic type, behavior and grade Also record scoring systems like Gleason's Score, Bloom Richardson Grade, etc.	Mod. Diff Adenoca Adenoca, Gleason score 3+4
Staging	Findings for the basis of Collaborative Stage. Organs involved by direct extension. Tumor Size. Number of positive lymph nodes. Sites of distant metastasis.	RLL Lung – tumor 3cm on CXR, no mediastinal adenopathy, no distant mets on CT abd/pelvis. MRI brain WNL Rad Onc staged T3N2M0
X-rays/Scans	Date of report, name of x-ray/scan and both positive and negative findings. Tumor location, tumor size, lymph nodes, distant disease or metastasis. Other findings that contribute to Collaborative Staging	9-24-20xx CT abd and pelvis: no lymphadenopathy or abnormality seen
Lab Tests	Documentation from laboratory examinations other than cytology and histopathology. Any values that are reported in Collaborative Stage fields or contribute to the diagnostic process. Include dates and results – positive and negative findings.	ER/PR pos PSA in MD office elevated at 6.7 CEA elevated at 5.6

	Tumor markers: • ERA, PRA, Her2/neu for breast ca • PSA for prostate ca • CEA for colon/rectal ca • hCG for testicular ca • AFP for hepatocellular ca • CA125 for ovarian ca	
Scopes	Date and type of endoscopic exam along with pertinent findings. Tumor location, tumor size, lymph nodes. Record positive and negative clinical findings. Any findings that contribute to Collaborative Stage.	5-13-20xx, NCMC, Colonoscopy: colon mass at 146cm prob colon ca and most likely etiology of GI bleed. 11-12-20xx, NCMC, Mediastinoscopy and bx: tumor mass extending from RUL involving pleura and soft tissues of chest wall but not ribs. 9-26-20xx, NCMC, Cystoscopy: large friable tumor of post and lat wall, actively bleeding. Bx done.
Operative Findings	Documentation the intra-operative findings from of all surgical procedures that provide information for staging. Number of lymph nodes, size of tumor, residual tumor, invasion of surrounding areas. Record both positive and negative findings from the operative report.	6-22-20xx, NCMC, TAH/BSO: Peritoneal metastasis beyond pelvis 1 cm in greatest dimension.
Pathology	Information from cytology and histopathology. Date, type of tissue, tumor type and grade, tumor size, nodes involved and examined, extent of tumor spread and resection margins. Number of lymph nodes examined and involved. Sentinel LNs and/or regional lymph nodes. Record comments from pathologist including differential diagnoses and any ruled out or favored.	8-20-20xx, NCMC, needle loc and exc bx, lt breast; sentinel LN bx. Non-infiltrating ca completely within margins of specimen. Sentinel LN (1) neg on HandE, neg for pankeratin by immunohistochemistry. Tissue insufficient to process hormone receptors.
Surgery	Date, type of procedure, facility if done elsewhere.	12-2-20xx TRUS in Dr. Doctor's office 1-5-xx, NCMC, Rad retropubic prostatectomy and pelvic LN bx
Radiation Beam	Start and Stop dates, site, number of treatments, type of radiation. Modality and volume treated. Where treated.	2/1/20xx – 3/1/20xx, NCMC, XRT (6-10MV) to prostate, 4500 cGy, 1500 boost
Radiation Other	Date of treatment, type of treatment, modality, volume treated	6-6-xx, NCMC, HDR brachytherapy (iridium 192)
Chemotherapy	Date chemo started, name of agents and/or regimen.	6-23- 9-17-20xx at Dr Doctor's office Cytoxan, Adriamycin, 5FU (CAF) and Herceptin x3 cycles
Hormone Therapy	Date treatment started, type of hormone (e.g., Tamoxifen) or endocrine surgery or radiation (e.g., orchiectomy)	12/12/20xx Lupron in Dr. Doctor's office. 3/7/20xx Pt started on Tamoxifen
Immunotherapy	Date of treatment, type of BRM (e.g., BCG, Interferon)	2-4-20xx at Dr. office interferon

or BRM		8/8/20xx at NCMC autologous BMT
Other Therapy	Date treatment started, type of other treatment (e.g., blinded clinical trial)	3/1/20xx, NCMC, red cell transfusions for refractory anemia
Remarks	Document **ALL** known previous primaries including site, laterality, histology and diagnosis date if available. Family History. Smoking History. Information that explains unusual circumstances, use of estimated dates, etc.	#1 hx of prostate ca 2019 treated with XRT #2 hx of bladder ca 2021 TURBT
Place of Diagnosis	Record where the patient was diagnosed	Office of P.C. Physician Dr. Doctor office NC Medical Center
Industry	Longest held occupation	Education
Occupation	Longest held occupation	Elementary school teacher Do not use “retired”

Appendix D: County, State and Country and Codes

FIPS County Codes for NC Counties

County	FIPS
Alamance	001
Alexander	003
Alleghany	005
Anson	007
Ashe	009
Avery	011
Beaufort	013
Bertie	015
Bladen	017
Brunswick	019
Buncombe	021
Burke	023
Cabarrus	025
Caldwell	027
Camden	029
Carteret	031
Caswell	033
Catawba	035
Chatham	037
Cherokee	039
Chowan	041
Clay	043
Cleveland	045
Columbus	047
Craven	049
Cumberland	051
Currituck	053
Dare	055
Davidson	057
Davie	059
Duplin	061
Durham	053
Edgecombe	065
Forsyth	067
Franklin	069
Gaston	071
Gates	073
Graham	075
Granville	077
Greene	079
Guilford	081
Halifax	083
Harnett	085
Haywood	087
Henderson	089
Hertford	091
Hoke	093
Hyde	095
Iredell	097
Jackson	099
Johnston	101
Jones	103
Lee	105
Lenoir	107
Lincoln	109
McDowell	111
Macon	113
Madison	115
Martin	117
Mecklenburg	119
Mitchell	121
Montgomery	123
Moore	125
Nash	127
New Hanover	129
Northampton	131
Onslow	133
Orange	135
Pamlico	137
Pasquotank	139
Pender	141
Perquimans	143
Person	145
Pitt	147
Polk	149
Randolph	151
Richmond	153
Robeson	155
Rockingham	157
Rowan	159
Rutherford	161
Sampson	163
Scotland	165
Stanly	167
Stokes	169
Surry	171
Swain	173
Transylvania	175
Tyrrell	177
Union	179
Vance	181
Wake	183
Warren	185
Washington	187
Watauga	189
Wayne	191
Wilkes	193
Wilson	195
Yadkin	197
Yancey	199
Unknown	999

Source: https://www.naaccr.org/data-standards-data-dictionary/; ISO Country Codes, v13, July 2016

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

Geographic Area	Country Code	State Code
United States		
Utah	USA	UT
Vermont	USA	VT
Virginia	USA	VA
Washington	USA	WA
West Virginia	USA	WV
Wisconsin	USA	WI
Wyoming	USA	WY
Armed Forces Americas	USA	AA
Armed Forces Canada, Europe, Middle East, Africa	USA	AE
Armed Forces Pacific	USA	AP
Central Midwest States	USA	US
Mountain States	USA	US
New England and New Jersey	USA	NN
North Central States	USA	US
North Mid-Atlantic States	USA	US
Northern Midwest States	USA	US
Pacific Coast States	USA	US
South Mid-Atlantic States	USA	US
Southeastern States	USA	US
Southern Midwest States	USA	US
United States	USA	US

Geographic Area	Country Code	State Code
Canada		
Alberta	CAN	AB
British Columbia	CAN	BC
Canada	CAN	CD
Manitoba	CAN	MB
Maritime Provinces (New Brunsw, Newfound, Nova Scotia, PE)	CAN	MM
New Brunswick	CAN	NB
Newfoundland and Labrador	CAN	NL
Northwest Territories	CAN	NT
Northwest Territories, Yukon Territory	CAN	YN
Nova Scotia	CAN	NS
Nunavut	CAN	NU
Ontario	CAN	ON
Prairie Provinces (Alberta, Manitoba, Saskatchewan)	CAN	PP
Prince Edward Island	CAN	PE
Quebec	CAN	QC
Saskatchewan	CAN	SK
Yukon Territory	CAN	YT

Geographic Area	Country Code	State Code
Continental Geographical Areas		
Africa, NOS	ZZF	YY
Asia, NOS	ZZA	YY
Central America, NOS	ZZC	YY
Europe, NOS	ZZE	YY
Latin America, NOS	ZZU	YY
Non-US/Canada NOS	ZZX	YY
North America, NOS	ZZN	YY
Pacific, NOS	ZZP	YY
South America, NOS	ZZS	YY
Unknown	ZZU	ZZ

Geographic Area	Country Code	State Code
Other Countries/Geographical Areas		
Afghanistan	AFG	XX
African Coastal Islands (previously in South Africa, NOS)	XIF	YY
Aland Islands	ALA	XX
Albania	ALB	XX
Algeria	DZA	XX
American Samoa	ASM	AS
Andorra	AND	XX
Angola	AGO	XX
Anguilla	AIA	XX
Antarctica	ATA	XX
Antigua and Barbuda	ATG	XX
Arabian Peninsula	XAP	YY
Argentina	ARG	XX
Armenia	ARM	XX
Aruba	ABW	XX
Australia	AUS	XX
Australia	AUS	XX
Austria	AUT	XX
Azerbaijan	AZE	XX
Bahamas	BHS	XX
Bahrain	BHR	XX
Bangladesh	BGD	XX
Barbados	BRB	XX
Belarus	BLR	XX
Belgium	BEL	XX
Belize	BLZ	XX
Benin	BEN	XX
Bermuda	BMU	XX
Bhutan	BTN	XX
Bolivia	BOL	XX
Bonaire, Saint Eustatius and Saba	BES	XX
Bosnia and Herzegovina	BIH	XX
Botswana	BWA	XX

Geographic Area	Country Code	State Code
Other Countries/Geographical Areas		
Bouvet Island	BVT	XX
Brazil	BRA	XX
British Indian Ocean Territory	IOT	XX
British Virgin Islands	VGB	XX
Brunei	BRN	XX
Bulgaria	BGR	XX
Burkina Faso	BFA	XX
Burundi	BDI	XX
Cambodia	KHM	XX
Cameroon	CMR	XX
Cape Verde	CPV	XX
Caucasian Republics of the USSR	XCR	YY
Cayman Islands	CYM	XX
Central African Republic	CAF	XX
Chad	TCD	XX
Chile	CHL	XX
China	CHN	XX
China, NOS	XCH	YY
Christmas Island	CXR	XX
Cocos (Keeling) Islands	CCK	XX
Colombia	COL	XX
Comoros	COM	XX
Congo	COG	XX
Congo, Democratic Republic of	COD	XX
Cook Islands	COK	XX
Costa Rica	CRI	XX
Cote d'Ivoire	CIV	XX
Croatia	HRV	XX
Cuba	CUB	XX
Curacao	CUW	XX
Cyprus	CYP	XX
Czech Republic	CZE	XX
Czechoslovakia (former)	XCZ	YY
Denmark	DNK	XX
Djibouti	DJI	XX
Dominica	DMA	XX
Dominican Republic	DOM	XX
East Africa	XEF	YY
Ecuador	ECU	XX
Egypt	EGY	XX
El Salvador	SLV	XX
England	ENG	XX
England, Channel Islands, Isle of Man	XEN	XX
Equatorial Guinea	GNQ	XX
Eritrea	ERI	XX
Estonia	EST	XX

Geographic Area	Country Code	State Code
Other Countries/Geographical Areas		
Ethiopia	ETH	XX
Ethiopia (Abyssinia), Eritrea	XET	YY
Falkland Islands	FLK	XX
Faroe Islands	FRO	XX
Fiji	FJI	XX
Finland	FIN	XX
France	FRA	XX
French Guiana	GUF	XX
French Polynesia	PYF	XX
French Southern Territories	ATF	XX
Gabon	GAB	XX
Gambia	GMB	XX
Georgia	GEO	XX
Germanic Countries	XGR	YY
Germany	DEU	XX
Ghana	GHA	XX
Gibraltar	GIB	XX
Greece	GRC	XX
Greenland	GRL	XX
Grenada	GRD	XX
Guadeloupe	GLP	XX
Guam	GUM	GU
Guatemala	GTM	XX
Guernsey	GGY	XX
Guinea	GIN	XX
Guinea Bissau	GNB	XX
Guyana	GUY	XX
Haiti	HTI	XX
Heard Island and McDonald Islands	HMD	XX
Honduras	HND	XX
Hong Kong	HKG	XX
Hungary	HUN	XX
Iceland	ISL	XX
India	IND	XX
Indochina	XSE	YY
Indonesia (Dutch East Indies)	IDN	XX
Iran	IRN	XX
Iraq	IRQ	XX
Ireland	IRL	XX
Isle of Man	IMN	XX
Israel	ISR	XX
Israel and former Jewish Palestine	XIS	YY
Italy	ITA	XX
Jamaica	JAM	XX
Japan	JPN	XX
Jersey	JEY	XX

Geographic Area	Country Code	State Code
Other Countries/Geographical Areas		
Jordan	JOR	XX
Kazakhstan	KAZ	XX
Kenya	KEN	XX
Kiribati	KIR	XX
Kuwait	KWT	XX
Kyrgyzstan	KGZ	XX
Laos	LAO	XX
Latvia	LVA	XX
Lebanon	LBN	XX
Lesotho	LSO	XX
Liberia	LBR	XX
Libya	LBY	XX
Liechtenstein	LIE	XX
Lithuania	LTU	XX
Luxembourg	LUX	XX
Macao	MAC	XX
Macedonia	MKD	XX
Madagascar	MDG	XX
Malawi	MWI	XX
Malaysia	MYS	XX
Malaysia, Singapore, Brunei	XMS	YY
Maldives	MDV	XX
Mali	MLI	XX
Malta	MLT	XX
Marshall Islands	MHL	MH
Martinique	MTQ	XX
Mauritania	MRT	XX
Mauritius	MUS	XX
Mayotte	MYT	XX
Melanesian Islands, Solomon Islands	XML	YY
Mexico	MEX	XX
Micronesia	FSM	FM
Micronesian Islands	XMC	YY
Moldova	MDA	XX
Monaco	MCO	XX
Mongolia	MNG	XX
Montenegro	MNE	XX
Montserrat	MSR	XX
Morocco	MAR	XX
Mozambique	MOZ	XX
Myanmar	MMR	XX
Namibia	NAM	XX
Nauru	NRU	XX
Nepal	NPL	XX
Netherlands	NLD	XX
New Caledonia	NCL	XX

Geographic Area	Country Code	State Code
Other Countries/Geographical Areas		
New Zealand	NZL	XX
Nicaragua	NIC	XX
Niger	NER	XX
Nigeria	NGA	XX
Niue	NIU	XX
Norfolk Island	NFK	XX
North Africa	XNF	YY
North American Islands	XNI	YY
North Korea	PRK	XX
Northern Ireland (Ulster)	NIR	XX
Northern Mariana Islands	MNP	MP
Norway	NOR	XX
Oman	OMN	XX
Other Asian Republics of the USSR	XOR	YY
Other Caribbean Islands	XCB	YY
Other West African Countries	XWF	YY
Pakistan	PAK	XX
Palau (Trust Territory of Pacific Islands)	PLW	PW
Palestine	PSE	XX
Panama	PAN	XX
Papua New Guinea	PNG	XX
Paraguay	PRY	XX
Peru	PER	XX
Philippines	PHL	XX
Pitcairn Islands	PCN	XX
Poland	POL	XX
Polynesian Islands	XPL	YY
Portugal	PRT	XX
Puerto Rico	PRI	PR
Qatar	QAT	XX
Republic of South Africa	ZAF	XX
Republic of South Africa, Botswana, Lesotho, Namibia, Swaziland	XSF	YY
Réunion	REU	XX
Romania	ROU	XX
Russia	RUS	XX
Rwanda	RWA	XX
Saint Martin	MAF	XX
Samoa	WSM	XX
San Marino	SMR	XX
Sao Tome & Principe	STP	XX
Saudi Arabia	SAU	XX
Scandinavia	XSC	YY
Scotland	SCT	XX
Senegal	SEN	XX
Serbia	SRB	XX
Seychelles	SYC	XX

Geographic Area	Country Code	State Code
Other Countries/Geographical Areas		
Sierra Leone	SLE	XX
Singapore	SGP	XX
Sint-Maarten	SXM	XX
Slavic Countries	XSL	YY
Slovakia	SVK	XX
Slovenia	SVN	XX
Solomon Islands	SLB	XX
Somalia	SOM	XX
South Africa, NOS	XSF	YY
South Georgia and the South Sandwich Islands	SGS	XX
South Korea	KOR	XX
South Sudan	SSD	XX
Southeast Asia	XSE	YY
Spain	ESP	XX
Sri Lanka	LKA	XX
St Pierre and Miquelon	SPM	XX
St. Barthelemy	BLM	XX
St. Helena	SHN	XX
St. Kitts and Nevis	KNA	XX
St. Lucia	LCA	XX
St. Vincent and the Grenadines	VCT	XX
Sudan	SDN	XX
Sudanese Countries	XSD	YY
Suriname	SUR	XX
Svalbard and Jan Mayen	SJM	XX
Swaziland	SWZ	XX
Sweden	SWE	XX
Switzerland	CHE	XX
Syria	SYR	XX
Taiwan	TWN	XX
Tajikistan	TJK	XX
Tanzania	TZA	XX
Thailand	THA	XX
Timor-Leste	TLS	XX
Togo	TGO	XX
Tokelau Islands (New Zealand)	TKL	XX
Tonga	TON	XX
Trinidad and Tobago	TTO	XX
Trust Territories	ZZP	TT
Tunisia	TUN	XX
Turkey	TUR	XX
Turkmenistan	TKM	XX
Turks and Caicos	TCA	XX
Tuvalu	TUV	XX
U.S. Minor Outlying Islands	UMI	UM
U.S. Virgin Islands	VIR	VI

Geographic Area	Country Code	State Code
Other Countries/Geographical Areas		
Uganda	UGA	XX
Ukraine	UKR	XX
Ukraine and Moldavia	XUM	YY
United Arab Emirates	ARE	XX
United Kingdom	GBR	XX
Uruguay	URY	XX
Uzbekistan	UZB	XX
Vanuatu	VUT	XX
Vatican City	VAT	XX
Venezuela	VEN	XX
Vietnam	VNM	XX
Wales	WLS	XX
Wallis and Fotuna	WLF	XX
West Africa, NOS (French Africa, NOS)	XWF	YY
Western Sahara	ESH	XX
Yemen	YEM	XX
Yugoslavia (former)	YUG	YY
Zambia	ZMB	XX
Zimbabwe	ZWE	XX

Appendix E: Data Collection Changes Based on Year of Diagnosis

REPORTABILITY OF CERTAIN CONDITIONS

Source: NAACCR Data Dictionary, Chapter III: Standards for Tumor Inclusion and Reportability

The following is a summary of reportability changes related to certain conditions. Refer to the reference manual in effect for that year for detailed data collection and coding instructions.

Sequence number: Unless otherwise specified, only conditions that were reportable at the time it was diagnosed are to be factored into the sequence number. If a condition was diagnosed at a time when it was not reportable, then it is not to be included in the assignment of the sequence number.

1990-2000 International Classification of Diseases for Oncology, Second Edition (ICD-O-2)

For tumors diagnosed 1/1/1992 through 12/31/2000, the inclusion of all neoplasms in the *International Classification of Diseases for Oncology, Second Edition (ICD-O-2)* with a behavior code of 2 or 3 (in situ or malignant) is required, with the following exceptions:

1/1/1990 Non-malignant Brain and CNS tumors, behavior code 0 or 1 (benign or borderline), are required to be reported to the NC CCR for cases diagnosed 1/1/1990 and after.

- Required Sites: C70 – C72, C75.1-C75.3
- Note: These became reportable nation-wide effective 1/1/2004 but have always been reportable in North Carolina.
- Sequence Number: All previous non-malignant CNS tumors are considered when assigning sequence regardless of year of diagnosis.

1/1/1996 Carcinoma in situ (CIS) of the cervix and cervical intraepithelial neoplasia (CIN) III are no longer required. This includes squamous cell carcinoma in situ and adenocarcinoma in situ of the cervix. Sequence Number: Do not include in the assignment of the sequence number, regardless of year of diagnosis.

1990 – 2002 Malignant primary skin cancers (C44._) with histology codes 8000-8110 were required <u>only</u> if the AJCC stage group at diagnosis was <u>II, III, or IV</u>.

Malignant primary skin cancers (C44._) with histology codes 8000-8110 and AJCC stage group I or II have not been required at least since 1990 and have never been reportable to the NC CCR. Sequence Number: Do not include in the assignment of the sequence number, regardless of year of diagnosis.

Cystadenomas of the ovary (C56):
These terms have changed to malignant and back to borderline over the years. Depending on when the condition was diagnosed, determines if it was reportable and/or should be considered when assigning the sequence number to other primaries.

ICD-O-1* 1976 – 1991 Not Reportable	ICD-O-2 1992 – 2000 Reportable	ICD-O-3 2001 – present Not Reportable
8441/1	8442/3	8442/1
8450/1	8451/3	8451/1
8460/1	8462/3	8462/1
8470/1	8472/3	8472/1
8471/1	8473/3	8473/1

*Some of the morphology codes changed from ICD-O-1 to ICD-O-2.

2001-2020 International Classification of Diseases for Oncology, Third Edition (ICD-O-3)

For all tumors diagnosed on or after January 1, 2001, the inclusion of all neoplasms in the *International Classification of Diseases for Oncology, Third Edition (ICD-O-3)* with a behavior code of 2 or 3 (in situ or malignant) is required, with the following exceptions:

1/1/2001 Prostate Intraepithelial neoplasia grade III is no longer required.
VIN III, VAIN III, and AIN III **are still required** by central cancer registries.
Sequence Number: Include in the assignment of the sequence number.
Note: PIN, VIN, VAIN, AIN became non-reportable to the CoC effective 1/1/1996.

Certain blood disorders and syndromes are now reportable with a behavior code of /3 with the implementation of the ICD-O-3. This includes polycythemia vera, refractory anemia and others listed in the 995-998 range. Refer to the ICD-O-3 appendices for more information.

9421 (juvenile astrocytoma, pilocytic astrocytoma, or piloid astrocytoma), with a behavior code of 1 (borderline) in ICD-O-3, is now reportable as 9421/3. (Note: this was revised again, effective 2023. Juvenile pilocytic astrocytoma is reportable as 9421/1 for 1/1/2023 forward.

1/1/2003 Malignant primary skin cancers (C44._) with histology codes 8000-8110 are no longer required, regardless of stage.

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Major histology changes have been occurring since 2010. The N.C. CCR follows the reportability indicators in the official ICD-O references unless otherwise specified in the CCARM. Using the ICD-O references on the NAACCR and SEER websites jointly with the CCARM is required to accurately determine which conditions are reportable (based on diagnosis year) and the code for that condition. For complete list of changes, review the NAACCR Implementation Guidelines.

https://www.naaccr.org/icdo3/
https://www.naaccr.org/implementation-guidelines/

1/1/2010
Some changes in reportability of a few blood disorders and syndromes occurred with the implementation of the SEER Hematopoietic Database and Coding Manual. A few of the conditions that are now reportable are listed below. Always use the SEER Heme DB to determine reportability.

9751 Langerhans cell histiocytosis NOS
9831 T-cell large granular lymphocytic leukemia/Chronic lymphoproliferative disorder of NK-cells
9975 Myeloproliferative /Myelodysplastic/Myeloproliferative neoplasms

1/1/2014
NAACCR approved 36 new *terms* to be added to existing codes in the ICD-O-3. There are no new codes or changes in reportability, only new terms.

1/1/2015
16 new codes and terms were proposed for addition to ICD-O-3. Of these, 7 are reportable malignant (/3) tumors and 4 are reportable borderline (/1) tumors of the central nervous system. Most of these new codes and terms are rare or very site-specific. Reportable as of 1/1/2015.

Carcinoid tumors of the appendix– change in behavior code and reportability:

- Code 8240/1 for Carcinoid tumor, NOS of appendix (C18.1) is now obsolete.
- Carcinoid tumors of the appendix (C18.1) are now classified as well-differentiated neuroendocrine tumors (WD NET) and grade 1 neuroendocrine tumors of the appendix.
- Reporting carcinoid/WD NET tumors of the appendix is now *required* and *must* be coded with a behavior code of /3 because these tumors have a morphology code 8240/3 per the WHO Classification of Tumors of the Digestive System.
- Use code 8246 when the mass/lesion is referred to as neuroendocrine "carcinoma" (or NEC).
- Use code 8240 when the mass/lesion is referred to as a neuroendocrine "tumor" (or WD NET, NET G1). The difference is the use of the word *tumor* versus *carcinoma*. Carcinoid is most often used interchangeably with neuroendocrine tumor and not with neuroendocrine carcinoma.
- Reportable appendix tumors (8240/3):
    - Carcinoid
    - Well-differentiated neuroendocrine tumor (WD NET)
    - Grade 1 neuroendocrine tumor (NET G1)
    - Well-differentiated neuroendocrine tumor/carcinoid (Pathologist uses both terms in reporting the diagnosis and does not want to choose one diagnosis over the other.)

Enteroglucagonomas of the Pancreas– change in code:

- 8157/1 (enteroglucagonomas of uncertain behavior and enteroglucagonomas, NOS) must now be coded as 8152/1 (glucagonomas of uncertain behavior). Enteroglucagonoma is now a related term for glucagonoma.
- 8157/3 (malignant enteroglucagonomas) must now be recorded as 8152/3 (malignant glucagonomas). Enteroglucagonoma, malignant is now a related term for glucagonoma, malignant.
- Codes 8157/1 and 8157/3 are now obsolete effective in 2015.

1/1/2016

Reportable as of 1/1/2016.

- Pancreas (C25._)
    - 8470/2: Non-invasive mucinous cystic neoplasm of the pancreas with high-grade dysplasia
    - 8452/3: Solid pseudopapillary neoplasm of pancreas (synonymous with solid pseudopapillary carcinoma)
    - 8150/3: Cystic pancreatic endocrine neoplasm (CPEN)
        - Assign 8150/3 unless specified as a neuroendocrine tumor, Grade 1 (8240/3) or neuroendocrine tumor, Grade 2 (8249/3).
- Larynx (C32._): 8077/2 Laryngeal intraepithelial neoplasia, grade III (LINIII)
- Sites other than Cervix and Skin (including perineum): 8077/2 Squamous intraepithelial neoplasia, grade III (SINIII)
  Note: The CoC lists LIN III and SIN III as not reportable. These ARE REPORTABLE to the N.C. CCR.
- Testis (C62._): 9080/3 Mature teratoma of the testes in adults.
- Penile (PeIN III) and squamous cell carcinoma in situ of the penis (C609)
- Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259)
- Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509)

1/1/2018

Significant changes to the valid ICD-O-3 codes for 2018 cases were implemented. This includes new codes, changes in behavior codes (and therefore reportability), and new terms associated with current codes. These changes reflected updates to the World Health Organization (WHO) Classifications for Tumors (Blue Books). Refer to the SEER and NAACCR websites for more information.

For complete list of changes, review the NAACCR Implementation Guidelines.
https://www.naaccr.org/icdo3/
https://www.naaccr.org/implementation-guidelines/

The *2018 ICD-O-3 Histology and Behavior Code Update* Table MUST be used jointly with the *CCARM, ICD-O-3* manual, *Hematopoietic and Lymphoid Neoplasm Database*, and the *Solid Tumor (MP/H)* manual to determine reportability based on behavior code and to code the histology and behavior code data items in the abstract.

COLON POLYPS: When a tumor arises in a polyp, assigning the specific code for arising in a polyp is no longer required. Studies have indicated that this specification has no clinical relevance or value to management of colon cancers. Refer to the Colon Rules in the Solid Tumor Manual for the coding instruction. Example: Adenocarcinoma arising in a polyp. Code 8140/3

Lobular Carcinoma In Situ (LCIS) of the Breast:
- Effective 1/1/2018 with the AJCC 8th Edition: LCIS of the breast is no longer listed as a histology that can be staged in Chapter 48: Breast. LCIS has a behavior code of 2 (8520/2) in the ICD-O-3 and therefore **IS REPORTABLE** to the N.C. CCR. Summary Stage is still 0. AJCC TNM stage may be left blank with a Stage Group 88.
- Effective 1/1/2023: LCIS is no longer reportable to the CoC. However, it continues to be **REPORTABLE** to the N.C. CCR. Class of Case is assigned according to the relationship between the patient and the reporting facility.

2021-present ICD-O-3.2

1/1/2021
Beginning with cases diagnosed in 2021, the *ICD-O-3.2* is the preferred morphology coding reference manual. The *ICD-O-3.2* must be used jointly with the *CCARM, 2021 ICD-O Histology and Behavior Code Update* tables, *Hematopoietic and Lymphoid Neoplasm Database*, and *Solid Tumor (MP/H)* rules.

A few of the major changes are listed below. **You must refer to the 2021 ICD-O Histology and Behavior Code Update tables for a complete list of changes.** https://www.naaccr.org/icdo3/

Now Reportable as of 1/1/2021 (not reportable prior to 2021)
- Early or evolving melanoma in situ (8720/2) and early or evolving melanoma (8720/3) is now reportable. Previously only reportable if stated to be a Clarks Level 1.
- Most GIST tumors (8936/3) are now behavior code 3. Only GIST tumors stated to be benign are not reportable. GIST with a Behavior Code of 3 is reportable. The Date of Initial Diagnosis is the earliest date the GIST is found malignant, noted to have multiple foci, metastasis of positive lymph nodes.
- Nearly all neuroendocrine tumors are now behavior code 3.
- Nearly all thymomas (8580/3-8585/3) are now behavior code 3. Previously thymomas were only reportable if stated to be malignant. Now they are not reportable only if specifically stated to be benign.
    - The exceptions are: Microscopic thymoma or thymoma, benign (8580/0); Micronodular thymoma with lymphoid stroma (8580/1); Ectopic hamartomatous thymoma (8587/0)
- Lymphomatoid granulomatosis: Grades have been introduced. Grade 3 now has a behavior of 3 (9766/3) and is reportable. Grades 1 and 2 still have a behavior of 1 (9766/1) and are not reportable.
- 8380/2 Endometrioid intraepithelial neoplasia (C54.1) is now reportable.

Approved Histology Codes for Cervix effective 1/1/2021

The following histologies have been approved for cervix (C53) for diagnosis year 2021. Previously, registrars had been instructed to use these histologies for cervical primaries for cases diagnosed January 1, 2022, and forward. It is recommended that cervix cases diagnosed in 2021 be reviewed to see if one of the newly approved codes below can be used.

- 8085 Squamous cell carcinoma, HPV-associated C51.9; C52.9; C53.X_
- 8086 Squamous cell carcinoma, HPV-independent C51.9; C52.9; C53.X_
- 8483 Adenocarcinoma, HPV-associated
- 8484 Adenocarcinoma, HPV-independent, NOS
- 8482 Adenocarcinoma, HPV-independent, gastric type
- 8310 Adenocarcinoma, HPV-independent, clear cell type
- 9110 Adenocarcinoma, HPV-independent, mesonephric type C53.X; C56.9

p16 is a valid test to determine HPV status and can be used to code HPV associated (p16+) and HPV independent histologies (p16-).

> Example: 1/1/2021 Squamous cell carcinoma of cervix, p16+. Assign 8085 Squamous cell carcinoma, HPV associated. Source: STR 2023, Table 17: Uterine Cervix Histologies.

No longer Reportable (behavior changed to 1) for cases diagnosed 1/1/2021 and after.

Term(s)	ICD-O-3.2 2021 Code	Pre-2021 Code
Follicular carcinoma, encapsulated	8335/1	8335/3
Non-invasive EFVPTC; Non-invasive encapsulated follicular variant of papillary thyroid carcinoma EFVPTC (C73.9)	8343/1	8343/2 (2017-2020)
Non-invasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP); Non-invasive FTP (C73.9)	8349/1	8343/2 (2017-2020)
Immature teratoma of the lung (C34. _); thymus (C37.9); thyroid (C73.9)	9080/1	9080/3
Primary cutaneous CD4-positive small/medium T-cell lymphoma (C44. _)	9709/1	9709/3
Primary cutaneous CD30+ T cell lymphoproliferative disorder (C44. _)	9718/1	9718/3
Lymphoid papulosis (C44. _)	9718/1	9718/3
Hydroa vacciniforme-like lymphoproliferative disorder	9725/1	9725/3
Langerhans cell histiocytosis, (NOS, monostotic, polystotic)	9751/1	9751/3
Post-transplant lymphoproliferative disorder, NOS; PTLD, NOS	9971/1	9971/3

Code Changes

- Dermatofibrosarcoma protuberans (C44)
  - Behavior code for two terms changed from 3 to 1 and is no longer reportable.
    - Dermatofibrosarcoma protuberans NOS and Dermatofibrosarcoma NOS 8832/1
    - Pigmented dermatofibrosarcoma protuberans 8833/1
  - Two new terms and codes have been introduced under 8832/3 and ARE reportable.
    - Dermatofibrosarcoma protuberans, fibrosarcomatous 8832/3
    - Dermatofibrosarcoma, sarcomatous 8832/3

- Other code changes are provided in the table below:

Term(s)	ICD-O-3.2 2021 Code	Pre-2021 Code (CODE DELETED IN ICD-O.3.2)
Hemangiopericytoma, malignant	8815/3	9150/3
Burkitt cell leukemia (see also M-9687/3) (All terms – See Heme Database)	9687/3	9826/3
Precursor B-cell lymphoblastic lymphoma (*see also M-9836/3*)	9811/3	9728/3
Precursor B-cell lymphoblastic leukemia (see also M-9728/3)	9811/3	9836/3
Common ALL; c-ALL; Common precursor B ALL; Pre-B ALL; Pre-pre-B ALL; Pro-B ALL	9811/3	9836/3
Malignant lymphoma, small B lymphocytic, NOS (see also M-9823/3) (All terms – See Heme Database)	9823/3	9670/3
Precursor T-cell lymphoblastic lymphoma (see also M-9837/3)	9837/3	9729/3
Refractory neutropenia	9980/3	9991/3 (2010-2020)
Refractory thrombocytopenia	9980/3	9992/3 (2010-2020)

1/1/2022

- p16 test results can be used to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086).
    - Non-keratinizing squamous cell carcinoma, HPV positive is coded 8085 for sites listed in Head and Neck Solid Tumor Rules Table 5 only. A diagnosis of non-keratinizing squamous cell carcinoma, NOS is coded 8072.
    - Keratinizing squamous cell carcinoma, HPV negative is coded 8086 for sites listed in Head and Neck Solid Tumor Rules Table 5 only. A diagnosis of keratinizing squamous cell carcinoma, NOS is coded 8071

New Codes/Terms that are reportable:

- 8455/2 Intraductal oncocytic papillary neoplasm, NOS
- 8455/3 Intraductal oncocytic papillary neoplasm with associated invasive carcinoma
- 8483/3 Adenocarcinoma, HPV-associated
- 8484/3 Adenocarcinoma, HPV-independent, NOS
- 8859/3 Myxoid pleomorphic liposarcoma
- 8976/3 Gastroblastoma (C16)
- 9111/3 Mesonephric-like adenocarcinoma
- 9366/3 Round cell sarcoma with EWSR1-non-ETS fusions
- 9367/3 CIC-rearranged sarcoma
- 9368/3 Sarcoma with BCOR genetic alterations

Note: **Adenocarcinoma IN SITU of the cervix** (C53) is NOT REPORTABLE so the fact that there are new codes for HPV associated (P16+) is not a factor. **Not** reportable:

- 8483**/2** Adenocarcinoma **in situ**, HPV-associated (C53)
- 8484**/2** Adenocarcinoma **in situ**, HPV-independent, NOS (C53)

Behavior Code changes:

- 9222/3 **Chondrosarcoma, grade 1**. Behavior changed to 1. Reportable 1/1/2022 forward.

- 8323/3 **Clear cell papillary renal cell carcinoma IS** reportable. The 2016 WHO Classification of Tumors of the Urinary System and Male Genital Organs, 4th Edition, has reclassified this histology as a /1 because it is low nuclear grade and is now thought to be a neoplasia. This change has not yet been implemented and it remains reportable.
- Low-grade **appendiceal mucinous neoplasm** (LAMN) and high grade appendiceal mucinous neoplasm (HAMN) now has a behavior of /2 and /3 making it reportable for cases diagnosed 1/1/2022 forward. These are slow-growing neoplasms that have the potential for peritoneal spread and can result in patient death. LAMN is a distinctive histologic subtype of mucinous appendiceal neoplasm and can be in-situ or invasive. Please reference the AJCC Appendix Protocol Version 9 for further information. Instructions have been added to the Colon Solid Tumor Rules (H5).

    - 8480/2 = LAMN/HAMN
        - Behavior is stated to be in situ, non-invasive, or behavior not indicated.
        - Tis(LAMN) = confined by muscularis propria. T1-T2 are not used for LAMN and are, therefore; designated as Tis.
    - 8480/3 = Appendiceal mucinous neoplasm with extra-appendiceal spread
        - Stated to be invasive or malignant. Both LAMN and HAMN can be invasive and have extra-appendiceal spread.
        - T3-T4 extending into subserosa or serosa.
    - A diagnosis of LAMN or HAMN does not require the pathology report to state the tumor is comprised of great than 50% mucinous.
    - Pay attention to reportable/effective dates in Solid Tumor Rules manual for LAMN/HAMN.

High grade dysplasia:
The following are reportable for stomach and small intestines ONLY (C16- & C17-) beginning 1/1/2022:

- 8144/2 Intestinal-type adenoma, high grade
- 8210/2 Adenomatous polyp, high grade dysplasia (This IS reportable to the CCR even though it is NOT reportable to the CoC)
- 8213/2 Serrated dysplasia, high grade

High grade dysplasia of the colorectal sites (C18-C20) and esophagus (C15) is NOT reportable even though it has been designated as in situ (/2) in the latest WHO classification. Also not reportable:

- 8211/2 Tubular adenoma, high grade
- 8261/2 Villous adenoma, high grade
- 8263/2 Tubulovillous adenoma, high grade

1/1/2023
Effective 1/1/2023, LCIS became non-reportable to the CoC but **LCIS IS still reportable to the CCR**. The decision for the CoC to not collect LCIS was made to align the STORE with the AJCC 8th Edition. Please see the AJCC 8th Edition for complete details. SEER and NPCR still require reporting of LCIS.

The follow table reflects changes affecting case reportability. For a complete list of the 41 new terms for existing codes, review ICD-O-3.2 Table 2. All the following terms and codes are reportable:

ICD-O Code	Type of Change	Term	Remarks
9421/1	Behavior code change from 3 to 1	Diffuse astrocytoma, *MYB*- or *MYBL1*-altered	New preferred term for "pilocytic astrocytoma". All cases diagnosed with pilocytic astrocytoma/ juvenile pilocytic astrocytoma and related

			terminology are to be reported with behavior /1. **Cases diagnosed prior to 1/1/2023 are still to be coded to 9421/3.**
9421/3	New term	High-grade astrocytoma with piloid features (HGAP)	Beginning 1/1/2023, 9421/3 applies ONLY to cases diagnosed as *high-grade astrocytoma with piloid features (HGAP).*
9174/3	Behavior code change from 1 to 3	Lymphangioleiomyomatosis	Reportable for cases diagnosed 1/1/2023 forward
9050/2	New code	Mesothelioma in situ (C38.4)	Reportable for cases diagnosed 1/1/2023 forward
9509/0	New code	Multinodular and vacuolating neuronal tumor	Cases diagnosed prior to 1/1/2023 use code 9505/0. Cases diagnosed 1/1/2023 forward use code 9509/0.
9509/3	New code	Diffuse leptomeningeal glioneuronal tumor	Reportable for cases diagnosed 1/1/2023 forward
9749/1	New code	Juvenile xanthogranuloma (C71.5)	Reportable for cases diagnosed 1/1/2023 forward

1/1/2024

The follow table reflects changes affecting case reportability effective for cases diagnosed 1/1/2024 and after. Majority of changes for 2024 are new related terms for existing codes. There are 5 new ICD-O codes (4 reportable and 1 non-reportable), and 1 histology that has changed behaviors and is now reportable. For a complete list of the new terms for existing codes, review ICD-O-3.2 Table 2. All the following terms and codes are reportable:

ICD-O Code	Type of Change	Term	Remarks
8085/3	Added C60 & C63	Squamous cell carcinoma, HPV-associated (C53._) [2021+]; (C60._, C63.2) [2024+]	Valid for C53 beginning 1/1/2021. Valid for C60._; C63.2 beginning 1/1/2024. p16 is a valid test to determine HPV status and can be used to code HPV associated and HPV independent histologies.
8086/3	Added C60 & C63	Squamous cell carcinoma, HPV-independent (C53._) [2021+] (C60._, C63.2) [2024+]	Valid for C53 beginning 1/1/2021. Valid for C60._; C63.2 beginning 1/1/2024. p16 is a valid test to determine HPV status and can be used to code HPV associated and HPV independent histologies.
9061/2	New term and behavior	Intratubular seminoma (C62._) [2024+]	Reportable for cases diagnosed 1/1/2024 forward for TESTIS ONLY
9070/2	New term and behavior	Intratubular embryonal carcinoma	Reportable for cases diagnosed 1/1/2024 forward
9071/2	New term and behavior	Intratubular yolk sac tumor	Reportable for cases diagnosed 1/1/2024 forward
9080/2	New term and behavior	Intratubular teratoma	Reportable for cases diagnosed 1/1/2024 forward
9104/3	Behavior code change from 1 to 3	Placental site trophoblastic tumor of testis (C62)	Reportable for cases diagnosed 1/1/2024 forward for TESTIS ONLY

1/1/2025

Post Transplant Lymphoproliferative Disorder (PTLD) was previously reportable as 9971/3 for 2010-2020 when it was the only diagnosis. In 2021, based on the 4th edition of WHO Hematopoietic Blue Book, PTLD became 9971/1, where it was only reportable if it occurred in the brain. Starting in 2025, PTLD as the only diagnosis will become a /3 (malignant) again and will be reportable for all cases.

In addition, a new SSDI has been added to several schemas for when a PTLD is diagnosed WITH a lymphoma, plasmacytoma, or multiple myeloma. (See the Hematopoietic Manual, Rules M14, PH1).

1/1/2026

There were no code changes for ICD-O-3 or changes to Reportability for cases diagnosed in 2026.

N.C. CCR STAGING REQUIREMENTS BY STAGING SYSTEM AND YEAR OF DIAGNOSIS

The following outlines the staging requirements by year of diagnosis for reporting to the N.C. CCR.

- Collaborative Stage:
  - Required from all facilities, for all cases diagnosed 1/1/2004 – 12/31/2015
  - CS data items for these years cannot be blank. This includes analytic and non-analytic cases.
- Summary Stage 2000:
  - Required from all facilities, for all cases diagnosed 1/1/2015 – 12/31/2017
  - SS2000 for these years cannot be blank. This includes analytic and non-analytic cases.
- AJCC TNM 7th Edition (clinical and pathologic):
  - Required from all facilities, for all cases diagnosed 1/1/2016 – 12/31/2017
  - Note: Required from CoC facilities beginning with 1/1/2015 cases.
- CS SSFs:
  - Required from all facilities, for all cases diagnosed 1/1/2004 – 12/31/2017
  - CoC facilities should collect the SSFs required by the CoC. The CoC required SSFs include the subset of SSFs that would be required for reporting to the N.C. CCR.
  - A list of required SSFs for incidence reporting only will be provided to those facilities directly.
  - SSFs for 2004-2015 cannot be blank.
  - SSFs that are required by the N.C. CCR for 2016-2017 cannot be blank.
- Summary Stage 2018:
  - Required from all facilities, for all cases diagnosed 1/1/2018 and after
  - SS2018 for these years cannot be blank. This includes analytic and non-analytic cases.
- AJCC TNM 8th Edition (clinical and pathologic):
  - Required from all facilities for all cases diagnosed 1/1/2018 and after
  - Incidence facilities will record any mention of TNM (at diagnosis) in the medical record.
  - Version 9 Protocols replace the chapter in the AJCC TNM 8th edition for that site and are required when implemented. Refer to Section 1: Stage of Disease at Initial Diagnosis for a table of protocol versions and implementation year.

- SSDIs:
  - Required for all cases diagnosed 1/1/2018 and after
  - Registries in a CoC Accredited Cancer Program must collect the SSDIs required by the CoC and include those data items in their abstracts reported to the N.C. CCR.
    - In addition to the CoC required SSDIs, these registries must also collect and report the Brain Molecular Markers SSDI to the NC CCR. This SSDI is required by all CCR's in the U.S. (including the N.C. CCR).
  - A list of required SSDIs for incidence reporting only will be provided to those facilities directly. For these facilities, SSDIs that are not required by the N.C. CCR may be left blank.
- EOD: The N.C. CCR does not require EOD data items at this time.

EFFECTIVE DATES FOR CANCER REGISTRY REFERENCE MANUALS

These are the official dates of implementation for various coding references. Remember that your registry may have varied from these dates. *Includes information pertaining up through 2021 diagnoses*.

SITE and HISTOLOGY CODING

International Classification of Diseases for Oncology

First edition	1976 - 1991
Second edition	1992 - 2000
Third edition (plus periodic changes - see above)	2001 -
ICD O 3.2 (used jointly with the ICD-O-3)	2021 -

STAGING

American Joint Committee on Cancer TNM Staging System **

Second edition	1983 (breast only) -1988
Third edition	1989 - 1992
Fourth edition	1993 - 1997
Fifth edition	1998 - 2002
Sixth edition	2003 - 2009
Seventh edition	2010 - 2017
Eighth edition	2018 –
Chapter revisions (Version 9 Protocols)	2021 –

Version 9 Protocols replace the chapter in the AJCC TNM 8th edition for that site and are required when implemented. Refer to Section 1: Stage of Disease at Initial Diagnosis for a table of protocol versions and implementation year.

Collaborative Staging System 2004 - 2015

SEER Extent of Disease Manual

First edition	1988 - 1991
Second edition	1992 - 1997
Third edition	1998 - 2003
Collected through Collaborative Stage	2004 – 2017
EOD 2018	2018 -

Summary Staging

Summary Staging Guide	1977 - 2000
SEER Summary Staging Manual 2000	2001 – 2017
Summary Stage 2018	2018 -

DATA COLLECTION

CoC

Data Acquisition Manual (DAM) 1st rev 10/89; 2nd rev 10/90	1988 - 1994
Data Acquisition Manual (Revised)	1994 - 1995
Registry Operations and Data Standards (ROADS) Manual	1986 – 1987
ROADS with 2-digit surgery codes	1988 - 1997

ROADS with "new" surgery codes	1998 – 2002
Facility Oncology Registry Data Standards (FORDS)	2003 – 2017
STandards for Oncology Registry Entry (STORE) (current version)	2018 –
SEER Program Code Manual	
Previous versions (see SEER Website)	1988 - 2020
SEER Program Coding and Staging Manual (current version)	2021 -
SEER Rx Interactive Antineoplastic Drug Database	All Years
SEER Hematopoietic & Lymphoid Neoplasm Database & Coding Manual	2010 -
Multiple Primary Rules	
As listed in the FORDS and SEER Program Manuals	- 2006
SEER 2007 Multiple Primary and Histology Coding Rules	2007 – 2017
SEER 2018 Solid Tumor Manual	2018 -
Site Specific Data Items (SSDI)	2018 -
Replaces SSF's collected in the CS data set	
Grade (Major Revisions only)	
Grade, Differentiation or Cell Indicator (NAACCR Item #440)	2014-2017
Clinical Grade, Pathological Grade, and Post-Therapy Grade	2018 -

* Effective with cases diagnosed on or after January 1 of the initial stated year and ending with cases diagnosed on December 31 of the closing year.

** TNM staging of breast cancer was required as of 1982, prior to the second edition. The Commission on Cancer urged implementation of TNM staging of all sites as of 1989 but did not require it until 1991.

Special note: Most manuals in use today will have updated pages, errata and clarifications that were released after publication. Contact the publishing organization's web site to ensure that all manuals have the most up-to-date information.

CODING AND REFERENCE MANUALS BASED ON YEAR OF DIAGNOSIS

Major Manual Change Highlighted in Red

1998 – 2000
ROADS
ICD-O-2
TNM 5th Edition
Summary Stage 1977

2001-2002
ROADS
ICD-O-3
TNM 5th Edition
Summary Stage 2000

2003
FORDS
ICD-O-3
TNM 6th Edition
Summary Stage 2000

2004
FORDS revised for 2004
ICD-O-3
TNM 6th Edition
Summary Stage 2000
Collaborative Stage v1
(Non-malignant CNS Tumors now reportable across U.S. but reportable since 1990 in N.C.)

2005 – 2006
FORDS (current year)
ICD-O-3
TNM 6th Edition
Summary Stage 2000
Collaborative Stage v1
SEER Rx Database

2007 - 2009
FORDS (current year)
ICD-O-3
TNM 6th Edition
Summary Stage 2000
Collaborative Stage v1
SEER Rx Database
SEER MP/H Rules

2010 - 2015
FORDS (current year)
ICD-O-3
TNM 7th Edition
Summary Stage 2000
Collaborative Stage v2 (current version)
SEER Rx Database
SEER MP/H Rules
SEER Hematopoietic Database

2016 - 2017
FORDS (current year)
ICD-O-3
TNM 7th Edition
Summary Stage 2000
SEER Rx Database
SEER MP/H Rules
SEER Hematopoietic Database

2018 –
STORE (current year)
ICD-O-3.2 (with annual updates)
TNM 8th Edition (plus v9 protocols)
Summary Stage 2018
SEER Rx Database
SEER Solid Tumor Manual
SEER Hematopoietic Database
SSDI
Grade

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State Center for Health Statistics
Division of Public Health
Department of Health and Human Services
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