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 useable, 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 incidents 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 must report (including physician offices, laboratories, clinics, etc.) all eligible cancer cases that 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: http://ncleg.net/gascripts/statutes/Statutes.asp
- N.C. Administrative Codes: http://ncrules.state.nc.us/ncac.asp

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:
www.cdc.gov/cancer/npcr/amendmentact.htm

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.

REPORTING 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 the majority of cases.

Quarterly Call for Data/Minimum Reporting Schedule

<table>
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<th>Must be Submitted to the N.C. CCR by:</th>
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<td>First quarter (January – March)</td>
<td>October 1</td>
</tr>
<tr>
<td>Second quarter (April – June)</td>
<td>January 1</td>
</tr>
<tr>
<td>Third quarter (July – September)</td>
<td>April 1</td>
</tr>
<tr>
<td>Fourth quarter (October – December)</td>
<td>July 1</td>
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**Required Data Items**
All data items listed in the CCARM are required and must be coded as defined for each reportable case.

**EDITS**
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. 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.

**Rapid Case Ascertainment (RCA) Study Participation**
Participating in a RCA Study does not qualify as reporting those cases to the N.C. CCR. RCA and the N.C. CCR have separate reporting processes and reporting requirements. A case sent to RCA must also have a complete abstract prepared and reported to the N.C. CCR according to the N.C. CCR reporting standards.

**Capturing Complete First Course of Treatment**
There may be times when first course treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the necessary treatment information is collected. 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 includes 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 Correction or Updated Records)
The purpose of the correction record process is to provide a way for facilities to easily submit corrections to critical data items. The correction process can also be used to submit first course of treatment information for treatment plans that extend an unusually long period of time. 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 as complete as possible before transmitting the case. The modified records process should be reserved for submitting corrections to coded data.

DO NOT RESUBMIT A CASE AS A NEW CASE. Resubmitting cases does not effectively notify the N.C. CCR of changes and corrections. Every effort should be made to ensure that all cases are initially sent with the most complete and accurate information possible. The N.C. CCR database can accept and process correction records. If your software can create correction records, then utilize this function to submit corrected or updated information. Software vendors are provided a list of data items in 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 correction record file.

When uploading files to the N.C. CCR Web Portal, it is important that both the new case file AND the correction 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 correction file. Contact your software vendor for assistance in creating new case and correction files. If your software does not have the ability to create correction record files, then your CCR staff representative will work with you to address any facility-specific issues related to data completeness and quality.

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.

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 the following: sex, race, age, 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 site/histology or age/site/histology combinations. The purpose of text is to provide a method for validating coded values to ensure high quality data for hospitals, researchers, and central registries.

Examples of text and available text fields are included in Appendix C.

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 COMMUNICATION WITH THE N.C. CCR MUST NOT CONTAIN IDENTIFIABLE PATIENT INFORMATION.
Summary of Changes

The following describes the changes to required data items and coding instructions effective for cases diagnosed 1/1/2018 and after. Note that only the requirements for submission to the N.C. CCR are described. Additional changes required for CoC Accredited Cancer Programs can be found in the STORE. https://www.facs.org/~media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx

It is anticipated that these standards (based on NAACCR version 18) will be used through 2020. Major changes in data collection requirements are not anticipated until 2021.

There were no changes for 2017. NAACCR v16, SS2000 and the AJCC TNM 7th Ed. was continued through 2017 diagnoses. Therefore, a CCARM 2017 was not released. The majority of 2016 changes relate to the transition from CSv2 to directly assigned Summary Stage 2000 and AJCC TNM 7th Edition Clinical and Pathological Stage. See summary of staging requirements based on the year of diagnosis.

2018 CHANGES
2018 marks a time of significant change in data collection. It is crucial that you review the information in this manual thoroughly. Staging requirements for 2018 cases include: AJCC TNM 8th Edition, Summary Stage 2018 and the collection of Site-Specific Data Items (SSDI’s). In addition, several other significant changes to required data items have been made and are detailed below.

2018 Required Coding and Abstracting Manuals
For all cases diagnosed on or after January 1, 2018, the N.C. CCR will require reporting facilities to use the:

- CCARM 2018
- Site-Specific Data Items (SSDIs): https://apps.naaccr.org/ssdi/list/
- NAACCR Guidelines for ICD-O-3 Update Implementation
  - ICD-O-3 Histologies: http://codes.iarc.fr/
  - SEER Site/Histology Validation List: https://seer.cancer.gov/icd-o-3/
- SEER 2018 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/

Revisions to the reporting requirements for 2018 accommodate the transition from Collaborative Stage Site-Specific Factors to the new SSDI and Grade data items, as well as implementation of new data items for the collection of AJCC TNM 8th edition and Summary Stage 2018. Other than the below-specified revisions, all other data reporting requirements remain the same.

Summary of Major Changes in Required Data Items

- 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 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.
• Added AJCC 8th Edition Staging System: New data items specifically for collecting AJCC TNM 8th Edition have been added. Data items related to the AJCC TNM 7th Edition are applicable only to cases diagnosed 2010-2017.
• Added Summary Stage 2018 [764]: A new data item specifically for collecting SS2018 has been added.
• Added three new Grade data items (Grade Clinical, Grade Pathological and Post Therapy): These data items have been defined to collect grade at different points in the diagnosis of the cancer.
• Added Phase I Radiation Treatment Modality [1506]: Regional Treatment Modality [1570] has been replaced with Phase I Radiation Treatment Modality [1506].
  o To promote consistency across the clinical and registry community, new “phase” terminology has been adopted, replacing the traditional terms of “regional” and “boost.”
  o The first phase (Phase I) of a radiation treatment may be commonly referred to as an initial plan and a subsequent phase (Phase II) may be referred to as a boost or cone down.
  o A new phase begins when there is a change in the target volume of a body site, treatment fractions size, modality or treatment technique.
• Added Site-Specific Data Items (SSDIs): The Collaborative Stage (CS) Site-Specific Factors (SSF) have been discontinued. SSDIs are now used to collect site-specific information. Most of these data items have not changed in terms of the information collected, only the codes used to document the data. Each SSDI applies only to selected primary sites. SSDI’s that do not apply to that site can be left blank.
• Added Schema ID and AJCC ID: These data items are derived by the application based on the site and histology entered for the cancer. These data items are used to determine the appropriate AJCC and SSDI values to display in the abstract.
• Added Schema Discriminators: Due to the complexity of some staging systems, this data item is required for selected primary sites and will guide which AJCC and SSDI values to display in the abstract.
• Removed Comorbidities and Complications 1-10 based on ICD-9-CM codes: These data items will no longer be required for cases diagnosed 1/1/2018 and later. Only ICD-10-CM codes will be accepted. These codes are required to be collected in the ICD-10-CM code-based data items of Secondary Diagnosis 1-10.

New Data Items Required to be Collected for Cases Diagnosed 1/1/2018 and After

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<th>N.C. CCR/NAACCR Item Name - Other</th>
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**Data Items No Longer Required for 2018 Cases (still required for earlier years)**

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Summary of Minor Changes in Required Data Items

- Codes and coding instructions for LVI [1182] were updated.
  - New codes (2, 3, and 4) were added based on the AJCC 8th Edition staging manual for appropriate disease sites.
  - For cases diagnosed January 1, 2018 and later, new codes indicating lymphatic, small vessel, and/or large vessel invasion were added.
  - Revised CAP Protocols and 8th Edition chapters will indicate which chapters will 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.
- Minor coding clarifications were made to Tumor Size Summary [756].
- Added instructions to use the Ambiguous Terminology Lists in the CCARM as a last resort
- Additional guidelines for coding race have been added to the Race data item when:
  - multiple races are reported
  - or race is not reported but place of birth is known.

Summary of Staging Requirements by Year of Diagnosis

The transition from CS to the directly coded AJCC TNM and Summary Stage began in 2014. Below is a summary of the staging requirements (based on year of diagnosis) for cases diagnosed in 2004 and after:

- **2004-2014**: Collaborative Stage, CS SSFs
- **2015**: Collaborative Stage, SS2000, AJCC TNM 7th Edition (CoC Only), CS SSFs
- **2018**: SS2018, AJCC TNM 8th Edition, SSDIs

- **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.

- SSDIs:
  - [https://apps.naaccr.org/ssdi/list/](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 is not requiring EOD data items at this time.

Important Note: 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, the record the appropriate value for unknown.

Each piece 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.

**ICD-O-3 Histology Revisions for Cases Diagnosed January 1, 2018 and After**

Significant changes to the valid ICD-O-3 codes for 2018 cases have been implemented. This includes new codes, changes in behavior codes (and therefore reportability), and new terms associated with current codes. These changes reflect updates to the World Health Organization (WHO) Classifications for Tumors (Blue Books).

At this time, WHO has no plans to release an update to the ICD-O-3. The 2018 ICD-O-3 Histology and Behavior Code Update Table MUST be used jointly with the following manuals to determine reportability based on behavior code and to code the histology and behavior code data items in the abstract:


The 2018 ICD-O-3 Histology and Behavior Code Update Table includes four documents and one errata which can be found at: [https://www.naaccr.org/implementation-guidelines/#ICDO3](https://www.naaccr.org/implementation-guidelines/#ICDO3).

These documents address the valid ICD-O-3 codes for cases diagnosed on or after January 1, 2018 and MUST be used to determine reportability based on behavior code and to code the histology and behavior code data items. The new codes, new terms, and codes with changes to behavior are listed in both .pdf and Excel format. The information in each format is identical.

- **2018 ICD O 3 Coding Guidelines** – 1/10/18
- **2018 ICD O 3 Coding Table PDF** – 7/16/18 (sorted by numeric order)
- **2018 ICD O 3 Coding Table PDF** – 7/16/18 (sorted by alpha order)
- **2018 ICD O 3 Coding Table Excel** – 7/16/18
- **Errata** – 7/16/18
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 primary manuals are updated. For each, use the most current version applicable for the diagnosis year.

2018 Required Coding and Abstracting Manuals

For all cases diagnosed on or after January 1, 2018, the N.C. CCR will require reporting facilities to use the:

- CCARM 2018
- Site-Specific Data Items (SSDIs): https://apps.naaccr.org/ssdi/list/
- NAACCR Guidelines for ICD-O-3 Update Implementation
  - ICD-O-3 Histologies: http://codes.iarc.fr/
  - SEER Site/Histology Validation List: https://seer.cancer.gov/icd-o-3/
- SSER 2018 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/

References:

www.cancerstaging.org

AJCC Cancer Staging Manual, 8th ed.
https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx
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 is 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)
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
https://cancerstaging.org/cstage/Pages/default.aspx
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 T N M a n d Stage Group, SEER Summary Stage 1977 and SEER Summary Stage 2000.

Grade
Available at: https://www.naaccr.org/SSDI/Grade-Manual.pdf

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)
Available at: https://seer.cancer.gov/tools/heme/


The Hematopoietic and Lymphoid Neoplasm Coding Manual introduced significant changes for abstracting and coding hematopoietic and lymphoid neoplasms effective 1/1/2010. Implementation of these rules required the introduction of many new histology terms, new ICD-O-3 codes and newly reportable conditions where the behavior was changed from /1 (borderline malignancy) to /3 (malignant). ICD-O-3 codes included in this manual and database replace the ICD-O-3 for codes between 9590/3 and 9989/3. Disease transformation from a chronic to an acute condition and other disease transformations are abstracted as a new primary.

International Classification of Diseases for Oncology, 3rd ed
Online ICD-O-3 available at: http://codes.iarc.fr/usingicdo.php

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.
The Solid Tumor Coding 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 multiple primary 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. The rules apply to tumors diagnosed 1/1/2007 and after.

Summary Stage 2018
https://seer.cancer.gov/tools/ssm/

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

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. 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.

- 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 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.) your facility must report the case regardless of the Class of Case.
- Clinically diagnosed cases (not histologically confirmed) must also be reported.

**DEFINITION OF 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 for your hospital/facility. Any services or facilities covered under your Joint Commission accreditation 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.

**REPORTABLE VISIT TYPES**
Patients with a reportable neoplasm for the following visit types are reportable:
- Inpatients
- Outpatients
- 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 diagnosed and treated 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

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

Important Note: Determination of whether a given primary neoplasm is reportable to the N.C. CCR is determined by the N.C. CCR. Requirements for reportability for the ACoS CoC may be different.

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 (specified below) are included, regardless of the requirements specified by other standard setting agencies.

Behavior Code
Malignancies with an ICD-O-3 behavior code of 2 (in situ) or 3 (invasive) are required for all sites. 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 appropriate/indicated by the pathologist.

Carcinoid tumors (Effective 2015): Code 8240/1 for Carcinoid tumor, NOS of appendix (C18.1) became obsolete. Carcinoid tumors of the appendix (C18.1) must be coded to 8240/3. This is required and must be coded with a behavior code of /3. Prior appendix primaries coded 8240/1 were converted to 8240/3 by the implementation conversions for 2015.

Gastro-intestinal stromal tumors (GIST) and thymomas: GIST and thymomas are frequently non-malignant. However, they must be abstracted and assigned a Behavior Code of 3 if they are noted to have multiple foci, metastasis or positive lymph nodes.

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 (page 589). LCIS has a behavior code of 2 (8520/2) in the ICD-O-3 and therefore is still reportable to the N.C. CCR. Summary Stage is still 0. AJCC TNM stage may be left blank with a Stage Group 88.

Diagnostic Confirmation
The method of diagnosis does not affect reportability. 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.

Skin
Not all lesions of the skin are reportable. Review the criteria below and the criteria in the Non-Reportable Neoplasms section carefully to determine if the case should be reported.

The following specified malignant neoplasms of the skin ARE reportable:
- Cutaneous T-cell lymphoma (9709)
- Dermatofibrosarcoma protuberans (8832, 8833)
- 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.

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:
  o Lip C00.0 - C00.9  (Do not report lesions of the skin of the lip (C44.0).)
  o 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.
  o Labia C51.0 - C51.1  (Includes skin of the labia majora)
  o Clitoris C51.2
  o Vulva C51.8 – C51.9  (Includes external female genitalia of the vulva)
  o Vagina C52.9
  o Prepuce C60.0
  o Penis C60.1 - C60.9  (Includes skin of the penis and foreskin)
  o Scrotum C63.2  (Includes skin of the scrotum)

Intraepithelial neoplasia, grade III
Case eligibility and reporting requirements for certain sites with CIS and intraepithelial neoplasia (grade III) differ between CCR’s and the ACoS CoC. The following ARE reportable to the N.C. CCR:

Intraepithelial neoplasia grade III (8077/2) of the:
• Vulva (VIN III)
• Vagina (VAIN III)
• Anus (AIN III)
• Laryngeal (LIN III) (C320-C329)
• Squamous intraepithelial neoplasia, grade III (SIN III) of sites other than Cervix and Skin
  o High grade squamous intraepithelial lesion (HGSIL) of the vulva and vagina are reportable. Assign 8077/2. HGSIL is a synonym for SIN III for vulva and vagina only.

ICD-O-3 Histology Revisions for Cases Diagnosed January 1, 2018 and After
Significant changes to the valid ICD-O-3 codes for 2018 cases have been implemented. This includes new codes, changes in behavior codes (and therefore reportability), and new terms associated with current codes. These changes reflect updates to the World Health Organization (WHO) Classifications for Tumors (Blue Books).

At this time, WHO has no plans to release an update to the ICD-O-3. The 2018 ICD-O-3 Histology and Behavior Code Update Table MUST be used jointly with the following manuals to determine reportability based on behavior code and to code the histology and behavior code data items in the abstract:
• ICD-O-3 manual (https://seer.cancer.gov/icd-o-3/)
• Hematopoietic and Lymphoid Neoplasm Database (https://seer.cancer.gov/tools/heme/)
The 2018 ICD-O-3 Histology and Behavior Code Update Table includes four documents and one errata which can be found at: https://www.naaccr.org/implementation-guidelines/#ICDO3.

These documents address the valid ICD-O-3 codes for cases diagnosed on or after January 1, 2018 and MUST be used to determine reportability based on behavior code and to code the histology and behavior code data items. The new codes, new terms, and codes with changes to behavior are listed in both .pdf and Excel format. The information in each format is identical.

- **2018 ICD O 3 Coding Guidelines** – 1/10/18
- **2018 ICD O 3 Coding Table PDF** – 7/16/18 (sorted by numeric order)
- **2018 ICD O 3 Coding Table PDF** – 7/16/18 (sorted by alpha order)
- **2018 ICD O 3 Coding Table Excel** – 7/16/18
- **Errata** – 7/16/18

**ICD-O-3 New Reportable Histology Terms for Cases Diagnosed 1/1/2016 and After**

In 2014 and 2015 SEER added new reportable histology terms to their Program and Coding Manual. These terms had not been included in any ICD-O-3 errata or implementation guide and therefore were not addressed throughout the cancer surveillance community. CDC has reviewed the terms (reportable according to SEER) and made the following decisions regarding reportability. The N.C. CCR is requiring that the guidelines below be followed when determining reportability. While there has not been an official erratum to address these histology terms, it is recommended that these terms be added to your ICD-O-3 and to your reportability lists.

**Newly Reportable Conditions/Tumors:**

- **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**
  - 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. 9080/0 continues to be non-reportable in prepubescent children. The following provides additional guidance:
    - Adult is defined as post puberty.
    - Pubescence can take place over several years.
    - Do not rely solely on age to indicate pre or post pubertal status. Review all information (physical history, etc.) for documentation of pubertal status. When testicular teratomas occur in adult males, pubescent status is likely to be stated in the medical record because it is an important factor of the diagnosis.
Do not report the case if it is unknown whether the patient is pre or post pubescence. When testicular teratoma occurs in a male and there is no mention of pubescence, it is likely that the patient is a child, or pre-pubescent, and the tumor is benign.

**ICD-O-3 New Reportable Histology Codes and Terms for Cases Diagnosed 1/1/2015 and After**

Several changes to the ICD-O-3 have taken place since the book was printed. For 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. Not all newly-defined histologies can be used because they were not incorporated into CS version 02.05 and thus cannot be used at this time because no CS Stage Group will be derived. However, some changes will go into immediate use. The following are reportability changes effective for cases diagnosed 1/1/2015 and after. All cases meeting the criteria described below will use the new codes. Old codes will be obsolete.

**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. Prior appendix primaries coded 8240/1 will be converted to 8240/3 by the implementation conversions for 2015.

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.)

Note: 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.

**Enteroglucagonomas of the Pancreas—change in code:**
- 8157/1 (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 obsolete effective in 2015.
ICD-O-3 New Reportable Histology Terms for Cases Diagnosed 1/1/2014 and After

NAACCR approved 36 new terms to be added to existing codes in the ICD-O-3 for use in the United States and Canada. There are no new codes, only new terms. The changes are effective beginning with cases diagnosed 1/1/2014 and after. A document describing the changes is posted on the NAACCR website titled, “GUIDELINES FOR ICD-O-3 UPDATE IMPLEMENTATION.”

https://www.naaccr.org/implementation-guidelines/#PrevICDO3

- Table 1 provides a complete list the terms approved for use with 2014 diagnoses and forward.
- Table 2 provides a complete list the terms approved for use with 2015 diagnoses and forward. Until the new codes can be used, Table 2 includes a coding guideline for terms with a new code (which may appear in pathology reports) showing which existing codes to use.

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.

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.

Non-malignant 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 (9421/1 in ICD-O-3) IS required and should be coded as 9421/3 in the abstract.

Reportable Cyst and Tumor-Like Lesions
- Dermoid cyst (M9084/0) congenital cyst
- Granular cell tumor, NOS (M9580/0)
- Rathke pouch tumor also called craniopharyngioma (M9350/1) (C75.1)

Not Reportable Cyst and Tumor-Like Lesions
- Epidermoid cyst
- Colloid cyst
- Plasma cell granuloma
- Rathke cleft cyst (believed to originate from remnants of the Rathke pouch)
- Other conditions that do not have an ICD-O-3 morphology code in the WHO ICD coding resources
NON-REPORTABLE NEOPLASMS

Skin

Only the following neoplasms, when arising in the skin (C44.0-C44.9), are NOT reportable:
M 8000 – M 8005 Neoplasms, malignant, NOS of the skin
M 8010 – M 8046 Epithelial carcinoma, NOS of the skin
M 8050 – M 8084 Papillary and squamous cell neoplasms of the skin
M 8090 – M 8110 Basal cell carcinomas of the skin

Skin primaries with these histologies diagnosed prior to January 1, 2003 were reportable if the AJCC stage group at diagnosis was II, III or IV.

Note: See the Reportable Neoplasms section.
- Malignant tumors originating in mucoepidermoid or genital sites ARE reportable.
- All other malignant tumors of the skin must be reported. This includes but is not limited to malignant melanoma, Merkel cell carcinoma, lymphoma of skin and other non-squamous and non-basal cell skin cancers.

Carcinoma in situ (CIS) and intraepithelial neoplasia, grade III

- Carcinoma in situ of the cervix (CIS) is NOT required.
- Intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III) is NOT required.
- Intraepithelial neoplasia grade III (8077/2) of the prostate (PIN III) is NOT required.
- Squamous intraepithelial neoplasia, grade III (SINIII) (8077/2) of the Cervix and Skin only is NOT required *

Note 1: All other histologies arising in any site listed above ARE REQUIRED.
Note 2: See the Reportable Neoplasms section. Vulva (VIN III), vagina (VAIN III), anus (AIN III), larynx (LIN III) and SIN III in situ (other than cervix and skin) ARE REQUIRED.

High grade/severe dysplasia of the colon and esophagus

These cases should be discussed with the pathologist to understand the use of this terminology. The case is only reportable when the pathologist specifically states CIS. “Severe dysplasia” and “high grade dysplasia” are NOT to be staged.

The N.C. CCR does not specify if HGD should be reported as CIS. In addition, the AJCC does not define which cases should be reported. This is a decision of the group that the data is being reported to. As a general rule, HGD is not reportable unless the text specifies that the pathologist’s interpretation is synonymous with CIS (behavior code 2).

Each facility must determine if “high grade/severe dysplasia” is synonymous with “carcinoma in situ”. This decision should be determined through a cooperative effort with your Cancer Committee and your facility’s pathology department. The decision as to whether or not HGD is synonymous with CIS should be documented in your Cancer Committee minutes and included in the casefinding/case eligibility section in the cancer registry's policy and procedure manual. It is important that this decision is thoroughly documented to explain why these cases are (or are not) being abstracted even though the
final diagnosis did not specify carcinoma in situ.

If HGD is determined to be synonymous with CIS, then it is required to be reported with a behavior code of /2. These cases are to be staged using the AJCC Tis category. The text must specify that the facility’s interpretation is that HGD is to be reported as CIS. Otherwise, the case is at risk for being deleted since HGD alone is not reportable.

Comments from the CAForum to consider when discussing with your Cancer Committee:

• CoC and AJCC do have carcinoma in-situ as a stageable diagnosis. HOWEVER, just because the treatment for high-grade dysplasia and CIS are the same (resection vs polypectomy and surveillance), does not mean we (path) are obligated to use CIS terminology on these ultimate specimens. They should be categorized as benign/premalignant. Carcinoma-in-situ will not be used on any report coming out of our facility. This diagnosis labels patients with carcinoma when they do not have it. They are at risk of having higher health care premiums and bad adjustments on their life insurance.

• A handful of facilities in our state follow the practice of reporting high grade dysplasia as in-situ cancer cases (our facility included). Recently though, when comparing our rate of in-situ colon cancers with the NCDB rates, we were significantly higher based on this practice. We have revisited our process of reporting high grade dysplasia and our pathologists now have decided (based on discussions with an outside expert) that they do not want the terms reported as synonymous and no longer want the registry to include high grade dysplastic cases as in-situ cases in the registry. I know of a few other facilities who have also changed their practice related to this issue. It seems that there needs to be a consensus on a national level of how to report this so that when facilities are comparing their data, it is comparable, and it is not left to each individual facility as to how their registry will collect these cases.

Reportable-by-Agreement Neoplasms

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.

Examples of Reportable-by-Agreement tumors:

• 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.

• The Cancer Committee requires the hospital registry to abstract benign hemangiopericytoma (9150/0 and 9150/1). 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 whether a case should 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:**

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

- Tumor * (beginning with 1/1/1990 diagnoses and only for C70.0–C72.9, C75.1–75.3)
- Neoplasm* (beginning with 1/1/1990 diagnoses and only for C70.0–C72.9, C75.1–75.3)

* Reportable for non-malignant primary intracranial and central nervous system tumors only.

**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. If a phrase includes a modifier such as strongly suggestive or highly worrisome, disregard the modifier.
Exception:
If a cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician’s clinical impression of cancer supports the cytology findings.

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
- Likely
- Possible
- Potentially malignant
- Questionable
- Rule out
- 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.
- 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.
**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 status for your hospital/facility. Any services or facilities covered under your Joint Commission accreditation 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 patient’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:**
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.

<table>
<thead>
<tr>
<th>Class of Case</th>
<th>Definition</th>
<th>Notes from the N.C. CCR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>REPORTABLE</strong></td>
<td>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.</td>
</tr>
<tr>
<td>30</td>
<td>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)</td>
<td><strong>REPORTABLE</strong> “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 <em>Class of Case</em> 31. 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. 4. 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 <em>Class of Case</em> 21.</td>
</tr>
<tr>
<td>31</td>
<td>Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care</td>
<td><strong>REPORTABLE</strong></td>
</tr>
<tr>
<td>32</td>
<td>Diagnosis AND all first course</td>
<td><strong>REPORTABLE</strong></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Notes/Examples</td>
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<td>------</td>
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<td>----------------</td>
</tr>
</tbody>
</table>
| 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 through the death clearance process MUST BE REPORTED 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.
  - 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 non-CoC facilities, cases not required by the CoC, but ARE required to be reported to the CCR (e.g., VIN III, VAIN III, AIN III) should continue to be reported with the analytic class of case categories. |
| 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. |
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Reportability</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>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</td>
<td>REPORTABLE VIN III, VAIN III, AIN III are reportable. Cases not required by the CoC but ARE required to be reported to the CCR should continue to be reported with the analytic class of case categories.</td>
</tr>
<tr>
<td>37</td>
<td>Case diagnosed before the CoC Reference Date, having initial diagnosis elsewhere AND all or part of first course treatment by facility</td>
<td>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.</td>
</tr>
<tr>
<td>38</td>
<td>Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death</td>
<td>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.</td>
</tr>
</tbody>
</table>

**Patient does not appear in person at reporting facility**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Reportability</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>Diagnosis AND all first course treatment given at the same staff physician office</td>
<td>REPORTING REQUIRED FOR CERTAIN CIRCUMSTANCES The CCR encourages facilities to report cases that meet the criteria for class of case 40-43.</td>
</tr>
<tr>
<td>41</td>
<td>Diagnosis and all first course treatment given in two or more different staff physician offices</td>
<td>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.</td>
</tr>
</tbody>
</table>
| 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. | 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. |
| 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. |
| 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. Casefinding will identify both new cases and cases already abstracted. Multiple sources must be used to identify the eligible cases.

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

- 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 by the reporting facility.

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 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](http://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.
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 determined 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, the 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 THESE SPECIFIC SECTIONS IN THE CCARM FOR DETAILED INFORMATION.

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.

- 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
- Native American Tribe
- Height
- Weight
- Tobacco Use (4 data items)
- CoC Accredited Flag

Visit Types
Because the N.C. CCR requires non-analytic cases to be reported, additional visit types need to be included in casefinding efforts. 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.
**Intraepithelial neoplasia, grade III (8077/2)**

Case eligibility and reporting requirements for certain sites with intraepithelial neoplasia (grade III) differ between the CCR and the CoC. The following ARE reportable to the N.C. CCR:

- Vulva (VIN III)
- Vagina (VAIN III)
- Anus (AIN III)
- Laryngeal (LIN III) (C320-C329)
- Squamous intraepithelial neoplasia, grade III (SIN III) of sites other than Cervix and Skin
  - High grade squamous intraepithelial lesion (HGSIL) of the vulva and vagina are reportable. Assign 8077/2. HGSIL is a synonym for SIN III for vulva and vagina only.

Not Required to be reported the N.C. CCR:

- Carcinoma in situ of the cervix (CIS)
- 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 (SIN III) (8077/2) of the Cervix and Skin only

**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.

**Coding Dates in the Abstract**

The N.C. CCR prefers that abstractors make every attempt to code a complete date, estimating if needed, as opposed to coding partial dates of only what was “known” or using a flag field. Avoid an unknown diagnosis date if possible. The date of diagnosis puts the case into the year of evaluation. If the date is left blank, then the case cannot be included in statistics, publications, research studies, etc. Refer to the section on Coding Dates for helpful tips.

**Patient Address at Diagnosis**

It is important that the Patient Address at Diagnosis reflect 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 looking for any clues that the patient was living elsewhere at the time of diagnosis.

**Capturing Complete First Course of Treatment**

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. 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 includes 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.

**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 changes 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 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.

**Death Clearance Cases**
A broader spectrum of reporting criteria applies to death clearance cases. If there is ANY mention of the patient having cancer (currently or in the past), the case should be reported, regardless of class of case, visit type or disease status.
Additional Information for Abstracting

REVISING THE ORIGINAL DIAGNOSIS

Data are gathered from multiple sources using the most recent and complete information available. 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 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. Most cases that require revision are unknown primaries.

Important Note: 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: 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.

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 cavitory 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.
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 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 completeness of reporting by reviewing frequency distribution reports for each facility.

EDITS
All software vendors have integrated the EDITS engine into their system as their standard automatic edits solution and the edits metafile provided by N.C. CCR. Data edits verify that only acceptable values are used for codes. All identified edit errors must be resolved and cleared prior to transmission.

The N.C. CCR edits metafile is a modified version of the basic NAACCR edits. All software vendors have been notified and sent the N.C. CCR edits metafile to incorporate into their systems. All records must be edit error free prior to submitting the case to the N.C. CCR.

Incidence facilities entering cases directly into the N.C. CCR database must clear all edits. The case is considered reported when it has passed all edits. Staff at incidence facilities entering cases directly into should contact their N.C. CCR Staff Representative for assistance with this process.

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 Database to identify other facilities where that patient may have been seen with a cancer related billing code in the three 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 also 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.

Reportability Criteria
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 a Hospice 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 information.
- 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. Estimate if possible. It is understandable that many data items may be coded to unknown for non-analytic cases due to lack of 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 was not a reportable cancer/condition.
  - Example: The only cancer mentioned in the medical record was a squamous cell carcinoma of the skin. Since this is not a reportable cancer, it does not need to be abstracted.

If the case is non-reportable (using the criteria above), provide a detailed reason as to why the case is not reportable to your CCR Representative. This is especially important for non-reportable cancers/conditions. Include additional follow-back resources such as another facility, any other physician mentioned in the record, etc. The CCR staff must do further back to these other contacts on these cases 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.

**UNIQUE PATIENT IDENTIFIER CODES**

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.
**NATIONAL PROVIDER IDENTIFIER**

The National Provider Identifier (NPI) is a unique identification number for health care providers that was implemented in 2007 and 2008 by the Centers for Medicare and Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008. Individual item descriptions in Section Two should be consulted for specific coding instructions.

The NPI data items are:

- **NPI–Institution Referred From [2415]**
- **NPI–Institution Referred To [2425]**
- **NPI–Managing Physician [2465]**
- **NPI–Physician #3 [2495]**
- **NPI–Physician #4 [2505]**
- **NPI–Primary Surgeon [2485]**
- **NPI–Reporting Facility [545]**

**CODING DATES**

Beginning in 2010, the way dates are transmitted was changed to improve the interoperability of cancer registry data with other electronic record systems. The traditional format is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date. If a date is entirely blank, an associated date flag is used to explain why a date is not known.

The following table illustrates how interoperable dates and the flag field can be used in the abstract. Each lower case ‘b’ represents a blank space. However, for reporting to the N.C. CCR, estimating is preferred over coding any part of the date to unknown.

<table>
<thead>
<tr>
<th>Description</th>
<th>Date entered in CCYYMMDD format, leaving unknown portions blank (spaces)</th>
<th>Example</th>
<th>Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date is known</td>
<td>CCYYMMDD</td>
<td>20180218</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Only the Month and Year is known</td>
<td>CCYYMmbb</td>
<td>201802</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Only the Year is known</td>
<td>CCYYbbbb</td>
<td>2018</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Unknown if any surgery performed</td>
<td>Leave blank</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>No surgery performed</td>
<td>Leave blank</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Performed but Date is unknown</td>
<td>Leave blank</td>
<td></td>
<td>12</td>
</tr>
</tbody>
</table>

**Date of Diagnosis**

MAKE EVERY ATTEMPT TO CODE A COMPLETE DATE, ESTIMATING IF NEEDED. Avoid an unknown diagnosis date if possible. The date of diagnosis puts the case into the year of evaluation. If the date is left blank, then the case cannot be included in statistics, publications, research studies, etc.

**Estimating Dates**

The introduction of the “flag” fields allow dates to be left blank when an exact date is not known. Every attempt should be made to estimate the complete date. If it is not possible to estimate the complete date, estimating a date to only a month and year (e.g., June 2018) or to only a year (e.g., 2018) is preferred over a complete unknown date. Text should specify when a date has been estimated.
For analytic cases:

- **All applicable date fields, including date of diagnosis, cannot be blank.**
- If an exact date is unknown, the entire date MUST be estimated as these cases are in the initial workup and treatment phase of the diagnosis and these procedures are most likely very recent.
- Use any clues available to approximate the date, such as a “diagnosed last year,” “recent diagnosis,” “treatment began last month,” etc.

For non-analytic cases:

- **Avoid an unknown diagnosis date if possible. Make every attempt to at least determine the YEAR of diagnosis.**
- If the date is unknown and there is no indication to allow any part of the date to be estimated, the date may be left blank. Use the flag field to describe why the date is unknown.
- Estimating should be the first priority and recording a date as unknown is a last resort.

Examples for estimating the date:

<table>
<thead>
<tr>
<th>Description</th>
<th>Tips for Estimating</th>
<th>Record</th>
<th>Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only the Month and Year is known</td>
<td>Estimate the DAY if possible. If not, use the first day of the month “01”.</td>
<td>20180201</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Only the Year is known</td>
<td>Estimate the MONTH and DAY if possible. Use the date of diagnosis or other treatment dates as a clue. For example, date of diagnosis is 20180514. Estimate the surgery date as the 1st of the month for the following month.</td>
<td>20180601</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Surgery performed but Date is unknown</td>
<td>Use the date of diagnosis or other treatment dates as a clue. For example, date of diagnosis is 20180514. Estimate the surgery date as the 1st of the month for the following month.</td>
<td>20180601</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Information is limited to the description of “Spring”</td>
<td>Use current year and 0401 for Spring</td>
<td>20180401</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Information is limited to the description of “The middle of the year”</td>
<td>Use current year and 0701 for middle of the year</td>
<td>20180701</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Information is limited to the description of “Fall”</td>
<td>Use current year and 1001 for Fall</td>
<td>20181001</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Information is limited to the description of “Winter”</td>
<td>Try to determine if this means the beginning or the end of the year.</td>
<td>20181201 or 20190101</td>
<td>Leave blank</td>
</tr>
</tbody>
</table>

**PATIENT ADDRESS AND RESIDENCY RULES**

The patient’s address at diagnosis is the patient’s place of residence at the time of original diagnosis. It does not change if the patient moves. If the patient has more than one primary tumor, the address at diagnosis may be different for each primary.

The current address initially is the patient’s residence at the time the patient was first seen at the accessioning facility for this primary. The current address is updated if the patient moves. If the patient has more than one primary tumor, the current address should be the same for each primary.

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. Do not record residence from the death certificate. Review each case carefully.

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.

**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 edits metafile contains a table of validated city/zip/county code combinations. If the combination is not in the edits 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 edits metafile table for release in future metafiles.

**Rules for Persons with Ambiguous Residences**

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

**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:** The residence should be documented as 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:** 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 retarded or mentally 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.

**Coding Country and State (Effective 1/1/2013)**
“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.

**GRADE (Effective 1/1/2018)**
Collecting “Grade” information in the abstract has gone through many transformations throughout the years. The instructions in the CCARM 2018 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://www.naaccr.org/SSDI/Grade-Manual.pdf](https://www.naaccr.org/SSDI/Grade-Manual.pdf).

**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.

**MULTIPLE PRIMARIES**
The most recent SEER Multiple Primary and Histology Coding 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. The multiple primary rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions.

If an invasive and an in situ tumor are identified as a single tumor according to the SEER Multiple Primary and Histology Coding Rules and they are located in different subsites, the primary site should be identified as the subsite in which the *invasive* tumor is located. If, however, the two tumors are both invasive, then code the subsite as "9.9".

The SEER Multiple Primary and Histology Coding Rules do not apply to hematopoietic and lymphoid tumors. Use the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic and Lymphoid Neoplasms Database to code hematopoietic primaries (lymphoma and leukemia M9590-9989) diagnosed on January 1, 2010, or later. Primary site and timing are not applicable for determining whether these malignancies represent one or more primaries.

A list of paired organ sites can be found in the Laterality data item. Refer to the SEER Multiple Primary and Histology Coding Rules to determine if involvement of paired sites is one or two primaries.

- If two primaries, complete two abstracts. Code each primary to the appropriate laterality and stage.
- If there is one primary, prepare one abstract and code the laterality to the side of origin.
- If there is a single primary and the side of origin cannot be identified, prepare a single abstract and code laterality as 3, one side involved, side of origin unknown.
- Bilateral involvement, side of origin unknown, stated to be a single primary, code to 4.

**IN UTERO DIAGNOSIS AND TREATMENT (Effective 1/1/2009):**
Diagnosis and treatment dates for a fetus prior to birth are to be assigned the actual date of the event. In the past, those dates were set by rule to the date the baby was born. The exact date may be used for cases diagnosed prior to 2009.
STAGE OF DISEASE AT INITIAL DIAGNOSIS

Stage: Data collection requirements for 2004-2018
The transition from Collaborative Stage to the directly coded AJCC TNM and Summary Stage began in 2014. Below is a summary of the staging requirements for cases diagnosed in 2004 and after:

2004-2014   Collaborative Stage, CS SSFs
2015        Collaborative Stage, SS2000, AJCC TNM 7th Edition (CoC Only), CS SSFs
2018        SS2018, AJCC TNM 8th Edition, SSDIs

- Collaborative Stage:
  o Required from all facilities, for all cases diagnosed 1/1/2004 – 12/31/2015
  o CS data items for these years cannot be blank. This includes analytic and non-analytic cases.

- Summary Stage 2000:
  o Required from all facilities, for all cases diagnosed 1/1/2015 – 12/31/2017
  o SS2000 for these years cannot be blank. This includes analytic and non-analytic cases.

- AJCC TNM 7th Edition (clinical and pathologic):
  o Required from all facilities, for all cases diagnosed 1/1/2016 – 12/31/2017
  o Note: Required from CoC facilities beginning with 1/1/2015 cases.

- CS SSFs:
  o Required from all facilities, for all cases diagnosed 1/1/2004 – 12/31/2017
  o 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.
  o A list of required SSFs for incidence reporting only will be provided to those facilities directly.
  o SSFs for 2004-2015 cannot be blank.
  o SSFs that are required by the N.C. CCR for 2016-2017 cannot be blank.

- Summary Stage 2018:
  o https://seer.cancer.gov/tools/ssm/
  o Required from all facilities, for all cases diagnosed 1/1/2018 and after
  o SS2018 for these years cannot be blank. This includes analytic and non-analytic cases.

- AJCC TNM 8th Edition (clinical and pathologic):
  o https://cancerstaging.org/Pages/default.aspx
  o Required from all facilities for all cases diagnosed 1/1/2018 and after
  o Incidence facilities will record any mention of TNM (at diagnosis) in the medical record.

- SSDIs:
  o https://apps.naaccr.org/ssdi/list/
  o Required from all facilities for all cases diagnosed 1/1/2018 and after
  o 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.
  o A list of required SSDIs for incidence reporting only will be provided to those facilities directly.
  o SSDIs that are not required by the N.C. CCR may be left blank.

- EOD:
  o The N.C. CCR is not requiring EOD data items at this time.
**AJCC TNM Stage**

Refer to the timeline above for the requirements for collecting AJCC TNM Staging. 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 (cTNM):** 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.
- **Pathologic staging (pTNM):** Includes any information obtained about the extent of cancer through completion of definitive surgery as part of first course treatment or identified within four months after the date of diagnosis, whichever is *longer*, as long as there is no systemic or radiation therapy initiated, or the cancer has not clearly progressed during that time frame.
- **Post therapy staging (ypTNM):** 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.

AJCC Stage also allows physicians to determine appropriate treatment, and a goal of cancer registry staging is to provide high-quality information about cancer stage before and after treatment. Systematic use of this established staging schema enables the reliable evaluation of treatment results and outcomes reported from various institutions on a local, regional and national basis. If the treating physician(s) has not recorded this information, registrars *will* code these items based on the best available information.

**Additional Instructions:**
- If a patient has multiple primaries, stage each primary independently.
- If the stage group cannot be determined from the recorded components, 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.
- 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 www.cancerstaging.org.
**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**

Refer to the timeline above for the requirements for collecting 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. The current 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 CS value and the 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:

<table>
<thead>
<tr>
<th>Terms that Constitute Tumor Involvement or Extension</th>
<th>Terms that Do Not Constitute Tumor Involvement or Extension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherent</td>
<td>Into</td>
</tr>
<tr>
<td>Apparent</td>
<td>Onto</td>
</tr>
<tr>
<td>Compatible with</td>
<td>Out onto</td>
</tr>
<tr>
<td>Consistent with</td>
<td>Probable</td>
</tr>
<tr>
<td>Encroaching upon</td>
<td>Suspect</td>
</tr>
<tr>
<td>Fixation, fixed</td>
<td>Suspicious</td>
</tr>
<tr>
<td>Induration</td>
<td>To</td>
</tr>
</tbody>
</table>

**Special Terms for Lymph Node Involvement in Solid Tumors**
The terms fixed, matted, and mass in the mediastinum, retroperitoneum, and/or mesentery, with no specific information as to tissue involvement are considered involvement of lymph nodes.

Terms such as palpable, enlarged, visible swelling, shotty or lymphadenopathy should be ignored (except for lung primaries). Look for clinical or pathological involvement. For lung primaries, these terms are interpreted as regional lymph node involvement.
**FIRST COURSE OF TREATMENT**

All treatment-related data items listed in the CCARM are required to be collected.

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence.

“Active surveillance” is a form of planned treatment for some patients; its use is coded in the new *RX Summ–Treatment Status* item.

“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. If the patient refuses all treatment, code “patient refused” (code 7 or 87) for all treatment modalities.

“Maintenance treatment” 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.

**Treatment Plan**

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.”

**Time Periods for First Course of Treatment**

If first course treatment was provided, the *Date of First Course of Treatment* [1270] is the earliest of *Date of First Surgical Procedure* [1200], *Date Radiation Started* [1210], *Date Systemic Therapy Started* [3230] or *Date Other Treatment Started* [1250].

- If no treatment is given, 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 selected, record the date of that decision.
- Additional data items further define the parameters for specific treatments and treatment modalities, as described in the following sections.

*RX Summ–Treatment Status* [1285], implemented in 2010, summarizes whether the patient received any first course treatment, no treatment or is being managed by active surveillance.
**All Malignancies except Leukemia**

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

**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, Palliative and Prophylactic Care**

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.

When first course surgery, systemic treatment, or radiation is undertaken to reduce the patient’s symptoms, that treatment is considered palliative care. An example is 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.

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.
Surgery

First course surgery items describe the most definitive 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 in Section Two: Instructions for Coding of this manual should be consulted for specific coding instructions. In addition, the site-specific surgery codes in Appendix B should be used.

Relationships among Surgical Items:
Surgical Procedure of Primary Site, 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:

- Surgical Procedure of Primary Site
- Scope of Regional Lymph Node Surgery
- Surgical Procedure/Other Site.

If surgery was the only type of first course treatment performed or was the first of multiple treatment modalities, Date of First Surgical Procedure is the same as Date of First Course of Treatment. Both dates can be used to describe lag time between diagnosis and initialization of specific aspects of treatment.

When multiple first course procedures coded under the same item are performed for a primary, the most extensive or definitive is the last performed, and the code represents the cumulative effect of the separate procedures. Do not rely on your registry software to accumulate separate surgeries into the correct code.

- Surgical Procedure of Primary Site is a site-specific item that describes the most invasive extent of local tumor destruction or surgical resection of the primary site and of surrounding tissues or organs that are removed in continuity with the primary site.

- Scope of Regional Lymph Node Surgery describes the removal, biopsy or aspiration of sentinel nodes and other regional lymph nodes that drain the primary site and may include surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease as well as removal of nodes for treatment of the disease. Scope of Regional Lymph Node Surgery distinguishes between sentinel lymph node biopsy and removal of other regional lymph nodes and distinguishes removal of regional lymph nodes during the same surgical procedure as a sentinel node biopsy from subsequent removal. The distinction between the number of nodes removed is not intended to reflect clinical significance when applied to a particular surgical procedure but rather to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than four nodes was not reflected in surgery codes.
• **Surgical Procedure/Other Site** describes first course resection of distant lymph node(s) and/or regional or distant tissue or organs beyond the **Surgical Procedure of the Primary Site** range. That is, it describes procedures that remove tissue or organs beyond the primary site, beyond the tissue removed in continuity with the primary site and beyond the regional lymph nodes that drain the primary site.

Additional surgery items augment the information recorded in **Surgical Procedure of Primary Site**. 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 **Surgical Procedure of Primary Site**. When no surgical procedure of the primary site is performed, the reason is recorded in the item **Reason for No Surgery of Primary Site**.

• **Date of Most Definitive Surgical Resection** is the date on which the specific procedure recorded in **Surgical Procedure of Primary Site** was performed. If only one first course surgical procedure was performed, then the date will be the same as that for **Date of First Surgical Procedure**.

• **Surgical Margins of the Primary Site** records the pathologist’s determination of the presence of microscopic or macroscopic involvement of cancer at the margins of resection following the surgical resection described by **Surgical Procedure of Primary Site**.

• **Reason for No Surgery** identifies why surgical therapy was not provided to the patient and distinguishes a physician’s not recommending surgical therapy due to contraindicating conditions from a patient’s refusal of a recommended treatment plan.

### Radiation Therapy

Effective 1/1/2018: The CoC has developed 24 new data items associated with radiation treatment in order 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]
- RX Date—Radiation Flag [1211]
- 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.
**Relationships among Radiation Items**

*Date Radiation Started* is the date that the first radiation therapy was delivered to the patient as part of the first course of therapy.

- If radiation was the only type of first course treatment performed or was the first of multiple treatment modalities, *Date Radiation Started* is the same as *Date of First Course of Treatment*. Both dates can be used to describe lag time between diagnosis and initialization of specific aspects of treatment.

Two items augment the information recorded in the radiation modality:

- *Radiation/Surgery Sequence* identifies those instances where radiation therapy and the surgical management of the patient are not discrete and overlap with respect to time. Radiation therapy can precede the surgical resection of a tumor and then be continued after the patient’s surgery, or radiation can be administered intraoperatively.

- *Reason for No Radiation* identifies why radiation therapy was not provided to the patient and distinguishes a physician’s not recommending this therapy due to contraindicating conditions from a patient’s refusal of a recommended treatment plan.

**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.

<table>
<thead>
<tr>
<th>Clarification of Systemic Therapy Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Term</strong></td>
</tr>
<tr>
<td>Chemotherapy</td>
</tr>
<tr>
<td>Hormone therapy</td>
</tr>
<tr>
<td>Immunotherapy</td>
</tr>
<tr>
<td>Endocrine therapy</td>
</tr>
<tr>
<td>Hematologic transplants</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Drug Name(s)</th>
<th>Category for cases diagnosed prior to 1/1/2013</th>
<th>Category for cases diagnosed after 1/1/2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alemtuzumab/Campath</td>
<td>Chemotherapy</td>
<td>BRM/Immunono</td>
</tr>
<tr>
<td>Bevacizumab/Avastin</td>
<td>Chemotherapy</td>
<td>BRM/Immunono</td>
</tr>
<tr>
<td>Rituximab</td>
<td>Chemotherapy</td>
<td>BRM/Immunono</td>
</tr>
<tr>
<td>Trastuzumab/Herceptin</td>
<td>Chemotherapy</td>
<td>BRM/Immunono</td>
</tr>
<tr>
<td>Pertuzumab/Perjeta</td>
<td>Chemotherapy</td>
<td>BRM/Immunono</td>
</tr>
<tr>
<td>Cetuximab/Erbitux</td>
<td>Chemotherapy</td>
<td>BRM/Immunono</td>
</tr>
</tbody>
</table>

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. If a patient has an adverse reaction, the managing physician may change one of the agents in a combination regimen.
• If the replacement agent belongs to the same group as the original agent, there is no change in the regimen.
• If the replacement agent is of a different group than the original agent, the new regimen represents the start of subsequent therapy. Record only the original agent or regimen as first course therapy.

Refer to the SEER*Rx Interactive Drug Database ([https://seer.cancer.gov/tools/seerrx/](https://seer.cancer.gov/tools/seerrx/)) for a list of chemotherapeutic agents, the category an agent should be recorded as in the abstract, and if a new agent belongs to the same group as the original agent.

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

<table>
<thead>
<tr>
<th>Method</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrathecal</td>
<td>Administered directly into the cerebrospinal fluid through a lumbar puncture needle into an implanted access device (for example, Ommaya reservoir).</td>
</tr>
<tr>
<td>Pleural/pericardial</td>
<td>Injected directly into pleural or pericardial space to control malignant effusions.</td>
</tr>
<tr>
<td>Intraperitoneal</td>
<td>Injected into the peritoneal cavity.</td>
</tr>
<tr>
<td>Hepatic artery</td>
<td>Injected into a catheter inserted into the artery that supplies blood to the liver.</td>
</tr>
</tbody>
</table>
**Relationships among Systemic Therapy Items**

The data item *Date Systemic Therapy Started* describes the first date on which any first course systemic treatment was administered to the patient. Nine out of 10 patients treated with systemic therapy receive only a single class of drugs (chemotherapy, hormone therapy, or immunotherapy). Of the remaining patients who receive a combined regimen of systemic therapies, two-thirds begin these combined regimens simultaneously. For the purposes of clinical surveillance, the collection of multiple dates to describe the sequence of systemic therapy administration is not necessary.

The data items *Chemotherapy*, *Hormone Therapy*, and *Immunotherapy* describe whether or not each respective class of agent(s) or drug(s) were administered to the patient as part of first course therapy, based on SEER*Rx. In the case of chemotherapy, additional distinction is allowed for instances where single or multiagent regimens were administered. Each of these three items includes code values that describe the reason a particular class of drugs is not administered to the patient and distinguishes a physician’s not recommending systemic therapy due to contraindicating conditions from a patient’s refusal of a recommended treatment plan. The associated date items were previously defined by CoC, though discontinued in FORDS from 2003 through 2009 and the same fields may be used to collect them now, if allowed by the registry software.

**Hematologic Transplant and Endocrine Procedures** captures those infrequent instances in which a medical, surgical or radiation procedure is performed on a patient that has an effect on the hormonal or immunologic balance of the patient. Hematologic procedures, such as bone marrow transplants or stem cell harvests, are typically employed in conjunction with administration of systemic agent(s), usually chemotherapy.

- Endocrine procedures, either radiologic or surgical, may be administered in combination with systemic agent(s), typically hormonal therapeutic agents.
- As first course therapy, hematologic procedures will rarely be administered in conjunction with endocrine radiation or surgery. The use of code 40 in response to this data item should be reviewed and confirmed with the managing physician(s).

**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.

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. Refer to the preceding discussion of the surgery, radiation and systemic therapy data items for specific coding guidelines. Because these treatments are less aggressive when given for palliation than for treatment, the treatment plan or treatment notes 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.
- Palliative care 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 orchietomy and systemic hormone therapy in combination with palliative radiation for bone metastasis.

**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/](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. Code *Radiation Modality* as brachytherapy when tumor embolization is performed using a radioactive agent or radioactive seeds.

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.
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.

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.

The following data items identify the individual and facility responsible for compiling the record.

- Abstracted By [570]
- Facility Identification Number (FIN) [540]
- NPI-Reporting Facility [545]

Note: A complete list of FINs is available on the American College of Surgeons Web site at https://www.facs.org/quality-programs/cancer/accredited/info/fin. NPI numbers are available through the facility’s billing or accounting department or at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

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.
SECTION TWO:
Instructions for Coding

Patient Identification
**SEQUENCE NUMBER**

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

**Description**  
Indicates the sequence of malignant and nonmalignant neoplasms over the lifetime of the patient.

**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.

**Instructions for Coding**  
- Codes 00–59 and 99 indicate neoplasms of in situ or invasive behavior (*Behavior* equals 2 or 3). Codes 60–88 indicate neoplasms of non-malignant behavior (*Behavior* equals 0 or 1).
- Code 00 only if the patient has a single malignant primary. 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.
- Code 60 only if the patient has a single nonmalignant primary. 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.
- 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.
- Any tumor in the patient’s past which is reportable or reportable-by-agreement at the time the current tumor is diagnosed must be considered when sequencing subsequently accessioned tumors. However, do not reassign sequence numbers if one of those tumors becomes non-reportable later.
- Sequence numbers should be reassigned if the facility learns later of an unreported tumor that affects the sequence.

**Malignant or In Situ Primaries**

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>One malignant or in situ primary only in the patient’s lifetime</td>
</tr>
<tr>
<td>01</td>
<td>First of two or more independent malignant or in situ primaries</td>
</tr>
<tr>
<td>02</td>
<td>Second of two or more independent or in situ primaries</td>
</tr>
<tr>
<td>...</td>
<td>(Actual sequence of this malignant or in situ primary)</td>
</tr>
<tr>
<td>59</td>
<td>Fifty-ninth of 59 or more independent malignant or in situ primaries</td>
</tr>
<tr>
<td>99</td>
<td>Unknown number of malignant or in situ primaries</td>
</tr>
</tbody>
</table>
### Non-Malignant Primaries

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>One nonmalignant primary only in the patient’s lifetime</td>
</tr>
<tr>
<td>61</td>
<td>First of two or more independent nonmalignant primaries</td>
</tr>
<tr>
<td>62</td>
<td>Second of two or more independent nonmalignant primaries</td>
</tr>
<tr>
<td></td>
<td>...</td>
</tr>
<tr>
<td></td>
<td>(Actual sequence of this nonmalignant primary)</td>
</tr>
<tr>
<td></td>
<td>...</td>
</tr>
<tr>
<td>87</td>
<td>Twenty-seventh of 27 or more independent nonmalignant primaries</td>
</tr>
<tr>
<td>88</td>
<td>Unspecified number of independent nonmalignant primaries</td>
</tr>
</tbody>
</table>

### Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Patient with no previous history of cancer diagnosed with <em>in situ</em> breast carcinoma on June 13, 2018</td>
</tr>
<tr>
<td>01</td>
<td>The sequence number is changed when the patient with an <em>in situ</em> breast carcinoma diagnosed June 13, 2018, is diagnosed with a subsequent melanoma on August 30, 2018</td>
</tr>
<tr>
<td>02</td>
<td>Sequence number assigned to the melanoma diagnosed on August 30, 2018, following a breast cancer <em>in situ</em> diagnosis on June 13, 2018</td>
</tr>
<tr>
<td>04</td>
<td>A nursing home patient is admitted to the hospital for first course surgery for a colon adenocarcinoma. The patient has a prior history of three malignant cancers of the type the registry is required to accession, though the patient was not seen for these cancers at the hospital. No sequence numbers 01, 02 or 03 are accessioned for this patient.</td>
</tr>
<tr>
<td>60</td>
<td>The sequence number assigned to a benign brain tumor diagnosed on November 1, 2017, following a breast carcinoma diagnosed on June 13, 2018, and a melanoma on August 30, 2018.</td>
</tr>
<tr>
<td>63</td>
<td>Myeloproliferative disease (9975/1) is diagnosed by the facility in 2018 and abstracted with a sequence code of 60. The patient comes to the facility in 2019 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 reportable but is still factored into the sequence number. It would be considered to have a sequence code of 61. Now that this new information is known about the earlier diagnosis, the sequence number for the myeloproliferative disease is updated to 62. The second benign brain tumor diagnosed in 2019 is assigned a sequence code of 63.</td>
</tr>
</tbody>
</table>
**MEDICAL RECORD NUMBER**

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

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**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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>——NNNN</td>
<td>If the medical record number is fewer than 11 characters, right justify the characters and allow leading blanks.</td>
</tr>
<tr>
<td>NNNNRT (Radiology)</td>
<td>Record standard abbreviations for departments that do not use HIM medical record numbers.</td>
</tr>
<tr>
<td>NNSU (One-day surgery clinic)</td>
<td>Record standard abbreviations for departments that do not use HIM medical record numbers.</td>
</tr>
<tr>
<td>UNK</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
SOCIAL SECURITY NUMBER

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 Social Security numbers that end with “B” or “D” as 999999999. 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>Record the patient’s Social Security number without dashes</td>
</tr>
<tr>
<td>9999999999</td>
<td>Patient does not have a Social Security number; SSN is not available.</td>
</tr>
</tbody>
</table>
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.

Rationale
This data item is used by hospitals 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; code as UNKNOWN if the patient’s last name is unknown.
• This field may be updated if the last name changes.

Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mc Donald</td>
<td>Recorded with space as Mc Donald</td>
</tr>
<tr>
<td>O’Hara</td>
<td>Recorded with apostrophe as O’Hara</td>
</tr>
<tr>
<td>Smith-Jones</td>
<td>Janet Smith marries Fred Jones and changes her last name to Smith-Jones</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>Patient’s last name is not known, use UNKNOWN</td>
</tr>
</tbody>
</table>
**FIRST NAME**

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

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**Description**
Identifies the first name of the patient.

**Rationale**
This data item is used by hospitals 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.

**Examples**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michael</td>
<td>Patient’s name is Michael David Hogan</td>
</tr>
<tr>
<td>(leave blank)</td>
<td>If patient’s first name is not known, do not fill in the space.</td>
</tr>
</tbody>
</table>
**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**
• 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.

**Examples**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>David</td>
<td>Patient’s name is Michael David Hogan</td>
</tr>
<tr>
<td>D</td>
<td>Patient’s name is Michael D. Hogan</td>
</tr>
<tr>
<td>(leave blank)</td>
<td>If patient’s middle name is not known or there is none, do not fill in the space.</td>
</tr>
</tbody>
</table>
**PATIENT 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.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to: AVE (avenue), BLVD (boulevard), CIR (circle), CT (court), DR (drive), PLZ (plaza), PARK (park), PKWY (parkway), RD (road), SQ (square), ST (street), APT (apartment), BLDG (building), FL (floor), STE (suite), UNIT (unit), RM (room), DEPT (department), N (north), NE (northeast), NW (northwest), S (south), SE (southeast), SW (southwest), E (east), W (west). A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub 28.
- 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). 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).
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not update this data item if the patient’s address changes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>103 FIRST AVE SW APT 102</td>
<td>Do not use punctuation, special characters, or numbers unless absolutely necessary to clarify an address. The use of capital letters is preferred by the UPSP; it also guarantees consistent results in queries and reporting. Abbreviate where necessary using acceptable, recognized USPS abbreviations. Leave blanks between numbers and words.</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>If the patient’s street address is unknown, then enter “UNKNOWN”</td>
</tr>
</tbody>
</table>
PATIENT ADDRESS AT DIAGNOSIS – SUPPLEMENTAL

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
• Record the place or facility (for example, a nursing home or name of an apartment complex) of the patient’s usual residence when the tumor was diagnosed.
• 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.
• Do not update this data item if the patient’s address changes.
• See “Residency Rules” in Section One for further instructions.

Examples:

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>VALLEYVIEW NURSING HOME</td>
<td>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.</td>
</tr>
<tr>
<td>Leave blank</td>
<td>If this address space is not needed, then leave blank.</td>
</tr>
</tbody>
</table>
CITY/TOWN AT DIAGNOSIS
(CITY OR TOWN)

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 the 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.

Instructions for Coding
• If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.
• 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.
• See “Residency Rules” in Section One for further instructions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CITY NAME</td>
<td>Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the UPSP; it also guarantees consistent results in queries and reporting. Abbreviate where necessary using acceptable, recognized abbreviations.</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>If the patient’s city or town is unknown, then enter “UNKNOWN”</td>
</tr>
</tbody>
</table>
**STATE 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.

**Instructions for Coding**

- Use 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL</td>
<td>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.</td>
</tr>
<tr>
<td>XX</td>
<td>Resident of a country other than the U.S. (including its territories, commonwealths or possessions) or Canada and the country is known.</td>
</tr>
<tr>
<td>YY</td>
<td>Resident of a country other than the U.S. (including its territories, commonwealths or possessions) or Canada and the country is unknown.</td>
</tr>
<tr>
<td>US</td>
<td>Resident of the U.S. (including its territories, commonwealths or possessions) and the state is unknown.</td>
</tr>
<tr>
<td>CD</td>
<td>Resident of Canada and the province is unknown.</td>
</tr>
<tr>
<td>ZZ</td>
<td>Residence unknown.</td>
</tr>
</tbody>
</table>
## Common Abbreviations

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

<table>
<thead>
<tr>
<th>State</th>
<th>State</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>AL</td>
<td>Massachusetts</td>
</tr>
<tr>
<td>Alaska</td>
<td>AK</td>
<td>Michigan</td>
</tr>
<tr>
<td>Arizona</td>
<td>AZ</td>
<td>Minnesota</td>
</tr>
<tr>
<td>Arkansas</td>
<td>AR</td>
<td>Mississippi</td>
</tr>
<tr>
<td>California</td>
<td>CA</td>
<td>Missouri</td>
</tr>
<tr>
<td>Colorado</td>
<td>CO</td>
<td>Montana</td>
</tr>
<tr>
<td>Connecticut</td>
<td>CT</td>
<td>Nebraska</td>
</tr>
<tr>
<td>Delaware</td>
<td>DE</td>
<td>Nevada</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>DC</td>
<td>New Hampshire</td>
</tr>
<tr>
<td>Florida</td>
<td>FL</td>
<td>New Jersey</td>
</tr>
<tr>
<td>Georgia</td>
<td>GA</td>
<td>New Mexico</td>
</tr>
<tr>
<td>Hawaii</td>
<td>HI</td>
<td>New York</td>
</tr>
<tr>
<td>Idaho</td>
<td>ID</td>
<td>North Carolina</td>
</tr>
<tr>
<td>Illinois</td>
<td>IL</td>
<td>North Dakota</td>
</tr>
<tr>
<td>Indiana</td>
<td>IN</td>
<td>Ohio</td>
</tr>
<tr>
<td>Iowa</td>
<td>IA</td>
<td>Oklahoma</td>
</tr>
<tr>
<td>Kansas</td>
<td>KS</td>
<td>Oregon</td>
</tr>
<tr>
<td>Kentucky</td>
<td>KY</td>
<td>Pennsylvania</td>
</tr>
<tr>
<td>Louisiana</td>
<td>LA</td>
<td>Rhode Island</td>
</tr>
<tr>
<td>Maine</td>
<td>ME</td>
<td>South Carolina</td>
</tr>
<tr>
<td>Maryland</td>
<td>MD</td>
<td>South Dakota</td>
</tr>
</tbody>
</table>

Canadian Provinces and Territory Abbreviations

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Province/Territory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta</td>
<td>AB</td>
</tr>
<tr>
<td>British Columbia</td>
<td>BC</td>
</tr>
<tr>
<td>Manitoba</td>
<td>MB</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>NB</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>NL</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>NT</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>NS</td>
</tr>
<tr>
<td>Nunavut</td>
<td>NU</td>
</tr>
<tr>
<td>Ontario</td>
<td>ON</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>PE</td>
</tr>
<tr>
<td>Quebec</td>
<td>QC</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>SK</td>
</tr>
<tr>
<td>Yukon</td>
<td>YT</td>
</tr>
<tr>
<td>Canada, province unknown</td>
<td>CD</td>
</tr>
</tbody>
</table>
POSTAL CODE AT DIAGNOSIS
(ZIP CODE)

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.

Instructions for Coding
• For U.S. residents, record the patient’s nine-digit extended postal code at the time of diagnosis and treatment.
• 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.
• See “Residency Rules” in Section One for further instructions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>60611_ _ _ _</td>
<td>When the nine-digit extended U.S. ZIP Code is not available, record the five-digit postal code, left justified, followed by four blanks.</td>
</tr>
<tr>
<td>M6G2S8_ _ _</td>
<td>The patient’s six-character Canadian postal code left justified, followed by three blanks.</td>
</tr>
<tr>
<td>88888_ _ _ _ or 8888888888</td>
<td>Permanent address in a country other than Canada, United States or U.S. possessions and postal code is unknown.</td>
</tr>
<tr>
<td>99999_ _ _ _ or 9999999999</td>
<td>Permanent address in Canada, United States or U.S. possession and postal code is unknown.</td>
</tr>
</tbody>
</table>
**ADDRESS AT DX--COUNTRY**

Item Length: 3
Uppercase
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.

**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 Addr at DX 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.
- This item was first defined for use in 2013; cases diagnosed before that date should be converted automatically by the registry’s software.

**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.

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>Country Code</th>
<th>State or Province Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States, NOS</td>
<td>USA</td>
<td>US</td>
</tr>
<tr>
<td>Canada, NOS</td>
<td>CAN</td>
<td>CD</td>
</tr>
<tr>
<td>Not U.S., but no other information</td>
<td>ZZX</td>
<td>YY</td>
</tr>
<tr>
<td>Unknown, no mention in patient record</td>
<td>ZZU</td>
<td>ZZ</td>
</tr>
</tbody>
</table>
COUNTY AT DIAGNOSIS

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>001–997</td>
<td>County at diagnosis</td>
<td>Valid FIPS code.</td>
</tr>
<tr>
<td>998</td>
<td>Outside state/county code unknown</td>
<td>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).</td>
</tr>
<tr>
<td>999</td>
<td>County unknown</td>
<td>The county of the patient is unknown. It is not documented in the patient’s medical record.</td>
</tr>
<tr>
<td>NC County</td>
<td>FIPS Code</td>
<td>NC County</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Alamance</td>
<td>001</td>
<td>Gaston</td>
</tr>
<tr>
<td>Alexander</td>
<td>003</td>
<td>Gates</td>
</tr>
<tr>
<td>Alleghany</td>
<td>005</td>
<td>Graham</td>
</tr>
<tr>
<td>Anson</td>
<td>007</td>
<td>Granville</td>
</tr>
<tr>
<td>Ashe</td>
<td>009</td>
<td>Greene</td>
</tr>
<tr>
<td>Avery</td>
<td>011</td>
<td>Guilford</td>
</tr>
<tr>
<td>Beaufort</td>
<td>013</td>
<td>Halifax</td>
</tr>
<tr>
<td>Bertie</td>
<td>015</td>
<td>Harnett</td>
</tr>
<tr>
<td>Bladen</td>
<td>017</td>
<td>Haywood</td>
</tr>
<tr>
<td>Brunswick</td>
<td>019</td>
<td>Henderson</td>
</tr>
<tr>
<td>Buncombe</td>
<td>021</td>
<td>Hertford</td>
</tr>
<tr>
<td>Burke</td>
<td>023</td>
<td>Hoke</td>
</tr>
<tr>
<td>Cabarrus</td>
<td>025</td>
<td>Hyde</td>
</tr>
<tr>
<td>Caldwell</td>
<td>027</td>
<td>Iredell</td>
</tr>
<tr>
<td>Camden</td>
<td>029</td>
<td>Scotland</td>
</tr>
<tr>
<td>Carteret</td>
<td>031</td>
<td>Jackson</td>
</tr>
<tr>
<td>Caswell</td>
<td>033</td>
<td>Johnston</td>
</tr>
<tr>
<td>Catawba</td>
<td>035</td>
<td>Jones</td>
</tr>
<tr>
<td>Chatham</td>
<td>037</td>
<td></td>
</tr>
<tr>
<td>Cherokee</td>
<td>039</td>
<td>Lee</td>
</tr>
<tr>
<td>Chowan</td>
<td>041</td>
<td>Lenoir</td>
</tr>
<tr>
<td>Clay</td>
<td>043</td>
<td>Lincoln</td>
</tr>
<tr>
<td>Cleveland</td>
<td>045</td>
<td></td>
</tr>
<tr>
<td>Columbus</td>
<td>047</td>
<td>McDowell</td>
</tr>
<tr>
<td>Craven</td>
<td>049</td>
<td>Macon</td>
</tr>
<tr>
<td>Cumberland</td>
<td>051</td>
<td>Madison</td>
</tr>
<tr>
<td>Currituck</td>
<td>053</td>
<td>Martin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mecklenburg</td>
</tr>
<tr>
<td>Dare</td>
<td>055</td>
<td>Mitchell</td>
</tr>
<tr>
<td>Davidson</td>
<td>057</td>
<td>Montgomery</td>
</tr>
<tr>
<td>Davie</td>
<td>059</td>
<td>Moore</td>
</tr>
<tr>
<td>Duplin</td>
<td>061</td>
<td></td>
</tr>
<tr>
<td>Durham</td>
<td>053</td>
<td>Nash</td>
</tr>
<tr>
<td></td>
<td></td>
<td>New Hanover</td>
</tr>
<tr>
<td>Edgecombe</td>
<td>065</td>
<td>Northampton</td>
</tr>
<tr>
<td>Forsyth</td>
<td>067</td>
<td>Onslow</td>
</tr>
<tr>
<td>Franklin</td>
<td>069</td>
<td>Orange</td>
</tr>
</tbody>
</table>
**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.
- See Appendix D for a list of state codes and their respective country codes.
- This item was first defined for use in 2013. Cases diagnosed before that date were converted from the former Place of Birth.

**Examples:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL</td>
<td>If the state in which the patient was born is Illinois, then use the USPS code for the state of Illinois.</td>
</tr>
<tr>
<td>XX</td>
<td>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).</td>
</tr>
<tr>
<td>YY</td>
<td>Born in a country other than the U.S. (including its territories, commonwealths or possessions) or Canada and the country is unknown.</td>
</tr>
<tr>
<td>US</td>
<td>Born in the U.S. (including its territories, commonwealths or possessions) and the state is unknown.</td>
</tr>
<tr>
<td>CD</td>
<td>Born in Canada and the province is unknown.</td>
</tr>
<tr>
<td>ZZ</td>
<td>Place of birth is unknown, not mentioned in patient record.</td>
</tr>
</tbody>
</table>
**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.
- See Appendix D for a list of country codes and their respective state codes.
- This item was first defined for use in 2013. Cases diagnosed before that date were converted.

**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.

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>Country Code</th>
<th>State or Province Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States, NOS</td>
<td>USA</td>
<td>US</td>
</tr>
<tr>
<td>Canada, NOS</td>
<td>CAN</td>
<td>CD</td>
</tr>
<tr>
<td>Not U.S., but no other information</td>
<td>ZZX</td>
<td>YY</td>
</tr>
<tr>
<td>Unknown, no mention in patient record</td>
<td>ZZU</td>
<td>ZZ</td>
</tr>
</tbody>
</table>
DATE OF BIRTH

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 single-digit day or month, record with a lead 0 (for example, September is 09). Use the full four-digit year for year.
- For in utero diagnosis and treatment, record the actual date of birth. It will follow one or both dates for those events.
- 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 2010 is calculated to have been born in 1950).
- If month is unknown, the day is coded unknown. If the year cannot be determined, the day and month are both coded unknown.
- If the date of birth cannot be determined at all, record the reason in Date of Birth Flag [241].
- Every attempt should be made to estimate the date. Estimating a date to only a month and year (e.g., June 2014) or to only a year (e.g., 2014) is preferred over a complete unknown date. Text should specify when a date has been estimated.
**DATE OF BIRTH FLAG**

Item Length: 2  
NAACCR Item #241  
Valid Codes: 12, Blank  
New Item: 1/1/2010

**Description**  
This flag explains why there is no appropriate value in the corresponding date field, *Date of Birth* [240].

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

**Instructions for Coding**  
- Leave this item blank if *Date of Birth* [240] has a full or partial date recorded.  
- Code 12 if the *Date of Birth* cannot be determined at all.  
- Every attempt should be made to estimate the date. Estimating a date to only a month and year (e.g., June 2014) or to only a year (e.g., 2014) is preferred over a complete unknown date. Text should specify when a date has been estimated.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>A proper value is applicable but not known (for example, birth date is unknown)</td>
</tr>
<tr>
<td>(Blank)</td>
<td>A valid date value is provided in item <em>Date of Birth</em> [240]</td>
</tr>
</tbody>
</table>
**AGE AT DIAGNOSIS**

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

**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**
If the patient has multiple primaries, then the age at diagnosis may be different for subsequent primaries.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>Less than 1 year old; diagnosed <em>in utero</em></td>
</tr>
<tr>
<td>001</td>
<td>One year old but less than 2 years old</td>
</tr>
<tr>
<td>002</td>
<td>Two years old</td>
</tr>
<tr>
<td>...</td>
<td>Actual age in years</td>
</tr>
<tr>
<td>120</td>
<td>One hundred twenty years old</td>
</tr>
<tr>
<td>999</td>
<td>Unknown age</td>
</tr>
</tbody>
</table>
**RACE 1**

Item length: 2
 NAACCR Item #160
 Revised 01/04, 09/08, 01/10, 01/12

**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 full coding system should be used to allow for an accurate national comparison.

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

**Document in Text:**

- 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. Use a text field to document why one race was coded rather than the other.
- Specifically, state in the text when no race information is available.

**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. For patients of multiple races, 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 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.

**Code 99:**

6. Avoid coding unknown in Race 1 (code 99). Exhaust all resources before coding unknown.
7. If Race 1 is code 99, then Race 2 through Race 5 must also be code 99.
8. 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 (either based on last name or statement in record) *and no further information on race or Indian tribe is available.*

  **Example:** 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:** If stated to be Indian, code 03.
9. Code race as **02** (Black) when:
   a. The stated race is African, African-American, Black, or Negro
   b. The patient is described as being from one of the following Caribbean islands and no further information on race is available: Barbados, Haiti, Jamaica, Bahama, Dominical Republic, Santo Domingo, Tobago, Trinidad.
      **Example:** Patient described as a black female. Code as 02 (Black).

10. Assign code **03** for any person stated to be:
   a. American Indian, Alaskan, Eskimo, Native American (western hemisphere)
   b. Indian and from North, Central, South, or Latin America

Asian:
11. Assign the specific code when a specific Asian race is stated. Do not use code 96 when a specific race is known.

   **Example 1:** Patient is described as Asian in a consult note and as second-generation Korean-American in the history. Code Race 1 as 08 (Korean) and Race 2 through Race 5 as 88.
   **Example 2:** Patient is stated to be Japanese. Code as 05 (Japanese).

12. Do not code 96 (Other Asian including Asian, NOS and Oriental, NOS) in a subsequent race field when a specific Asian race has been coded.

13. 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 1:** 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 2:** The person describes himself as an Asian-American born in Laos.
      Code race as 11 (Laotian) because it is more specific than 96.
      **Example 3:** The patient is described as Asian-American with Korean parents. Code race as 08 (Korean) because it is more specific than 96 (Asian, NOS).

14. Use the appropriate non-specific code of 96 (Other Asian including Asian, NOS and Oriental, NOS), 97 (Pacific Islander, NOS), or 98 (Other) when a specific race is stated, but there is no specific race code available for that race.

   **Note:** Document the specified race in a text field.

Coding race based on patient name and place of birth:
15. Do not use patient name as the basis for coding race.

16. In some cases, race may be inferred from the nationality. When race is unknown and birth place is recorded, use the "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" to identify nationalities from which race codes may be inferred.

   **Example 1:** Record states: “this native of Portugal...” Code race as 01 (White).
   **Example 2:** Record states: “this patient was Nigerian...” Code race as 02 (Black).
   **Example 3:** A patient was born in Mexico of Mexican parentage. Code race as 01 (White).
   Also code *Spanish/Hispanic Origin*.
   **Example 4:** Patient is stated to be German-Irish. Code as 01 (White).
   **Example 5:** Patient is described as Arabian. Code as 01 (White).

**Exception:** Code Race as 99 (Unknown) when patient’s name is incongruous with the race inferred on the basis of nationality.
   i. **Example 1:** Patient’s name is Siddhartha Patel and birthplace is England. Code 99.
   ii. **Example 2:** Patient’s name is Ping Chen and birthplace is Ethiopia. Code 99.
Priorities for Coding Multiple Races

1. Additional races reported by the person should be coded in Race 2, Race 3, Race 4 and Race 5.

2. Do not use code 96, 97, or 98 for “multi-racial.”

3. If the patient is multiracial, then code all races using Race 2 through Race 5, and code all remaining Race items 88.

   **Example 1:** 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 2:** Patient describes herself as multi-racial (nothing more specific) and nursing notes say “African-American.” Code Race 1 as 02 (Black) and Race 2 through Race 5 as 88.

4. 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:** Patient is described as Japanese and Hawaiian. Code Race 1 as 07 (Hawaiian), Race 2 as 05 (Japanese).

5. Codes 02-32, 96-98 take priority over code 01. 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:** A patient has a Japanese father and a Caucasian mother. Code 05. (Caucasian will be coded in Race 2).

6. Code only the 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 02-32 and 96-97 take priority over code 98.
   e. Code 98 takes priority over code 99.

7. Code in the order stated when no other priority applies.

   **Example:** Patient is Chinese and black. Code Race 1 as 04 (Chinese), code Race 2 as 02 (Black).

---

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Code</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>White</td>
<td>20</td>
<td>Micronesian, NOS</td>
</tr>
<tr>
<td>02</td>
<td>Black</td>
<td>21</td>
<td>Chamorro/Chamoru</td>
</tr>
<tr>
<td>03</td>
<td>American Indian, Aleutian or Eskimo (includes all indigenous populations of the Western hemisphere)</td>
<td>22</td>
<td>Guamanian, NOS</td>
</tr>
<tr>
<td>04</td>
<td>Chinese</td>
<td>25</td>
<td>Polynesian, NOS</td>
</tr>
<tr>
<td>05</td>
<td>Japanese</td>
<td>26</td>
<td>Tahitian</td>
</tr>
<tr>
<td>06</td>
<td>Filipino</td>
<td>27</td>
<td>Samoan</td>
</tr>
<tr>
<td>07</td>
<td>Hawaiian</td>
<td>28</td>
<td>Tongan</td>
</tr>
<tr>
<td>08</td>
<td>Korean</td>
<td>30</td>
<td>Melanesian, NOS</td>
</tr>
<tr>
<td>10</td>
<td>Vietnamese</td>
<td>31</td>
<td>Fiji Islander</td>
</tr>
<tr>
<td>11</td>
<td>Laotian</td>
<td>32</td>
<td>New Guinean</td>
</tr>
<tr>
<td>12</td>
<td>Hmong</td>
<td>96</td>
<td>Other Asian, including Asian, NOS and Oriental, NOS</td>
</tr>
<tr>
<td>13</td>
<td>Kampuchean (Cambodian)</td>
<td>97</td>
<td>Pacific Islander, NOS</td>
</tr>
<tr>
<td>14</td>
<td>Thai</td>
<td>98</td>
<td>Other</td>
</tr>
<tr>
<td>15</td>
<td>Asian Indian or Pakistani, NOS</td>
<td>99</td>
<td>Unknown</td>
</tr>
<tr>
<td>16</td>
<td>Asian Indian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Pakistani</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**RACE 2-5**

<table>
<thead>
<tr>
<th>Item Length: 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAACCR Item #’s 161-164</td>
</tr>
<tr>
<td>Revised 01/04, 09/08, 01/10, 01/12</td>
</tr>
</tbody>
</table>

---

**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.
- 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 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 Coding System–Current* must be six (6), and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.
Description
Identifies persons of Spanish or Hispanic origin.

Rationale
This code is used by hospital and central registries to identify whether or not 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 in the 01 (white category) of Race 1 through Race 5 [160–164].

Instructions for Coding
• Persons of Spanish or Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.
• Code 0 (Non-Spanish; non-Hispanic) for Portuguese and Brazilian persons.
• If the patient has multiple tumors, all records should have the same code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Non-Spanish; non-Hispanic</td>
</tr>
<tr>
<td>1</td>
<td>Mexican (includes Chicano)</td>
</tr>
<tr>
<td>2</td>
<td>Puerto Rican</td>
</tr>
<tr>
<td>3</td>
<td>Cuban</td>
</tr>
<tr>
<td>4</td>
<td>South or Central America (except Brazil)</td>
</tr>
<tr>
<td>5</td>
<td>Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)</td>
</tr>
<tr>
<td>6</td>
<td>Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1–5)</td>
</tr>
<tr>
<td>7</td>
<td>Spanish surname only (The only evidence of the person’s Hispanic origin is surname or maiden name, and there is no contrary evidence that the person is not Hispanic)</td>
</tr>
<tr>
<td>8</td>
<td>Dominican Republic (for use with patients who were diagnosed with cancer on January 1, 2005, or later)</td>
</tr>
<tr>
<td>9</td>
<td>Unknown whether Spanish or not; not stated in patient record</td>
</tr>
</tbody>
</table>
**SEX**

**Description**
Identifies the sex of the patient.

**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**
- Record the patient’s sex as indicated in the medical record.
- Natality for transsexuals was added for use in 2015 but may be applied for earlier diagnoses.
- Code 4 (formerly “Transsexual”) is now “Transsexual, NOS”. Transsexual, NOS may be used for new cases if the patient is known to be transsexual and natal sex is not known.
- The definition of code 3 was updated to “Other (intersex, disorders of sexual development/DSD)” in 2016.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
</tr>
<tr>
<td>3</td>
<td>Other (intersex, disorders of sexual development/DSD)</td>
</tr>
<tr>
<td>4</td>
<td>Transsexual, NOS</td>
</tr>
<tr>
<td>5</td>
<td>Transsexual, natal male</td>
</tr>
<tr>
<td>6</td>
<td>Transsexual, natal female</td>
</tr>
<tr>
<td>9</td>
<td>Not stated in patient record</td>
</tr>
</tbody>
</table>
**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**
- If the patient is diagnosed at the reporting facility, record the payer at the time of diagnosis.
- 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.
- Record the type of insurance reported on the patient’s admission page.
- Codes 21 and 65–68 are to be used for patients diagnosed on or after January 1, 2006.
- If more than one payer or insurance carrier is listed on the patient’s admission page record the first.
- If the patient’s payer or insurance carrier changes, do not change the initially recorded code.

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

**Examples**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>An indigent patient is admitted with no insurance coverage.</td>
</tr>
<tr>
<td>20</td>
<td>A patient is admitted for treatment and the patient admission page states the primary insurance carrier is an HMO.</td>
</tr>
<tr>
<td>62</td>
<td>A 65-year-old male patient is admitted for treatment and the patient admission page states the patient is covered by Medicare with additional insurance coverage from a PPO.</td>
</tr>
</tbody>
</table>
COMORBIDITIES AND COMPLICATIONS #1 (pre-2017 cases only)

Item Length: 5
Left Justified, Zero-filled
NAACCR Item #3110
Revised 6/05, 1/11, 1/12, 1/13, 1/15, 1/18

These items described the patient’s comorbid conditions and complications using ICD-9-CM codes. These data items are no longer required for cases diagnosed 1/1/2018 and after and may be left blank.

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-9-CM codes. All are considered secondary diagnoses.

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-9-CM codes. Use Secondary Diagnosis #1 [3780] to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- Secondary diagnoses are found on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available.
- Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility.
- 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-9-CM secondary diagnoses were documented, then code 00000 in this data item and leave the remaining Comorbidities and Complications data items blank.
- If fewer than 10 ICD-9-CM secondary diagnoses are listed, then code the diagnoses listed and leave the remaining Comorbidities and Complications data items blank.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition, specific instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>00000</td>
<td>No comorbid conditions or complications documented.</td>
</tr>
<tr>
<td>00100–13980, 24000–99990</td>
<td>Comorbid conditions: Omit the decimal point between the third and 1st digits</td>
</tr>
</tbody>
</table>

Cancer Collection and Reporting Manual
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fourth characters.

<table>
<thead>
<tr>
<th>E8700–E8799, E9300–E9499</th>
<th>Complications: Omit the decimal point between the fourth and fifth characters</th>
</tr>
</thead>
<tbody>
<tr>
<td>V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049</td>
<td>Factors affecting health status: Omit the decimal point between the fourth and fifth characters</td>
</tr>
</tbody>
</table>

**Examples**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>49600</td>
<td>COPD (ICD-9-CM code 496)</td>
</tr>
<tr>
<td>25001</td>
<td>Type 1 diabetes mellitus (ICD-9-CM code 250.01)</td>
</tr>
<tr>
<td>E8732</td>
<td>The patient was inadvertently exposed to an overdose of external beam radiation (ICD-9-CM code E873.2)</td>
</tr>
<tr>
<td>E9300</td>
<td>During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-9-CM code E930.0)</td>
</tr>
<tr>
<td>V1030</td>
<td>The patient has a personal history of breast cancer (ICD-9-CM code V10.3)</td>
</tr>
</tbody>
</table>
COMORBIDITIES AND COMPLICATIONS #2-10 (pre-2017 cases only)

Item Length: 5
Left Justified, Zero-filled
NAACCR Item #’s 3120, 3130, 3140, 3150, 3160, 3170, 3180, 3163, 3164
Revised 6/05, 1/11, 1/12, 1/13, 1/15, 1/18

These items described the patient’s comorbid conditions and complications using ICD-9-CM codes. These data items are no longer required for cases diagnosed 1/1/2018 and after and may be left blank.

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-9-CM codes. All are considered secondary diagnoses.

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-9-CM codes. Use Secondary Diagnosis #2 [3782] to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
• If only one comorbid condition or complication is listed, then leave this data item blank.
• If only two comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining Comorbidities and Complications items blank.
• For further instructions for Coding, see Comorbidities and Complications #1 [3110].

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
</table>
| (fill spaces) | Report the ICD-9-CM or ICD-10-CM codes for up to 10 comorbid conditions or complications.  
  Note: For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the third and fourth characters.  
  Note: For complications (ICD-9-CM “E” codes) and factors influencing health status (ICD-9-CM “V” codes) there is an assumed decimal point between the fourth and fifth characters. For ICD-10-CM codes there is an assumed decimal between the third and fourth characters. |
| (leave blank) | Fewer than two comorbid conditions or complications documented.              |
SECONDARY DIAGNOSIS #1

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

For cases diagnosed 1/1/2018 and after, only the Secondary Diagnosis data items are required.

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 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 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; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZ, Z8500-Z9989ZZ

Left Justified, omit decimals, all alpha characters capitalized, Trailing blanks allowed.

<table>
<thead>
<tr>
<th>Examples</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>J449</td>
<td>Chronic obstructive pulmonary disease, unspecified (ICD-10-CM code J44.9)</td>
</tr>
<tr>
<td>E119</td>
<td>Type 2 diabetes mellitus without complications (ICD-10-CM code E11.9)</td>
</tr>
<tr>
<td>Y632</td>
<td>The patient was inadvertently exposed to an overdose of radiation during a medical procedure (ICD-10-CM code E873.2)</td>
</tr>
<tr>
<td>T360X5</td>
<td>During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-10-CM code T36.0X5)</td>
</tr>
<tr>
<td>Z853</td>
<td>The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)</td>
</tr>
<tr>
<td>0000000</td>
<td>No applicable ICD-10-CM codes are recorded in this patient’s record</td>
</tr>
</tbody>
</table>
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; and the following ranges:
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://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do](https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do)
- 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>10-digit NPI number for the managing physician.</td>
</tr>
<tr>
<td>(leave blank)</td>
<td>NPI for the managing physician is unknown or not available.</td>
</tr>
</tbody>
</table>
MANAGING PHYSICIAN

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>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.</td>
</tr>
<tr>
<td>99999999</td>
<td>The physician is unknown or an identification number is not assigned.</td>
</tr>
</tbody>
</table>
**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://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do](https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do).
- 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>10-digit NPI number for the following physician.</td>
</tr>
<tr>
<td>(leave blank)</td>
<td>NPI for the following physician is unknown or not available.</td>
</tr>
</tbody>
</table>
**FOLLOWING PHYSICIAN**

**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>The identification number may include numbers and letters. <em>Note:</em> If the patient did not have surgery, use the code for the surgeon who performed any surgery or did a surgical consultation.</td>
</tr>
<tr>
<td>99999999</td>
<td>The physician is unknown or an identification number is not assigned.</td>
</tr>
</tbody>
</table>
**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 surgical procedure.
- Check with the billing or health information departments to determine the physician’s NPI or search at [https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do](https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do).
- 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>10-digit NPI number for the primary surgeon.</td>
</tr>
<tr>
<td>(leave blank)</td>
<td>The patient did not have surgery. NPI for the primary surgeon is unknown or</td>
</tr>
<tr>
<td></td>
<td>not Available. The physician who performed the surgical procedure was not</td>
</tr>
<tr>
<td></td>
<td>a surgeon (for example, general practitioner).</td>
</tr>
</tbody>
</table>
**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fill spaces</td>
<td>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.</td>
</tr>
<tr>
<td>00000000</td>
<td>Patient had no surgery and no surgical consultation.</td>
</tr>
<tr>
<td>88888888</td>
<td>Physician who performed a surgical procedure was not a surgeon, for example, radiation oncologist, diagnostic radiologist or general practitioner.</td>
</tr>
<tr>
<td>99999999</td>
<td>The primary surgeon is unknown or an identification number is not assigned.</td>
</tr>
</tbody>
</table>
**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://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do](https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do).
- 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>10-digit NPI number for the primary radiation oncologist.</td>
</tr>
<tr>
<td>(leave blank)</td>
<td>NPI for the primary radiation oncologist is unknown or not available.</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>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.</td>
</tr>
<tr>
<td>00000000</td>
<td>No additional physician. The patient did not receive radiation therapy and was not referred for a radiation therapy consult.</td>
</tr>
<tr>
<td>99999999</td>
<td>The physician is unknown or an identification number is not assigned.</td>
</tr>
</tbody>
</table>
**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://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do](https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do).
- 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>10-digit NPI number for the primary medical oncologist.</td>
</tr>
<tr>
<td>(leave blank)</td>
<td>NPI for the primary medical oncologist is unknown or not available.</td>
</tr>
</tbody>
</table>
**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>The identification number may include numbers and letters. <em>Note</em>: If the patient did not have surgery, use the code for the surgeon who performed any surgery or did a surgical consultation.</td>
</tr>
<tr>
<td>000000000</td>
<td>No additional physician. The patient did not receive systemic therapy and was not referred for a medical oncology consult.</td>
</tr>
<tr>
<td>999999999</td>
<td>The physician is unknown or an identification number is not assigned.</td>
</tr>
</tbody>
</table>
N.C. CCR State Specific Data Items
NC NATIVE AMERICAN TRIBE STATUS

Item Length: 2
Allowable Values: Blank, 10-30, 99
NAACCR Item #2220

Description
The CCR collects specific race codes for Cherokee and Lumbee Indians.

These codes must be included by your registry software vendor and collected by all reporting facilities in North Carolina.

Instructions for Coding
When a patient’s race is coded to 03 (American Indian) in the race code fields, the following additional codes must be completed. This field is left blank only if the race is not coded to 03.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Cherokee</td>
</tr>
<tr>
<td>20</td>
<td>Lumbee</td>
</tr>
<tr>
<td>30</td>
<td>American Indian, NOS</td>
</tr>
<tr>
<td>99</td>
<td>Unknown if Cherokee or Lumbee</td>
</tr>
</tbody>
</table>
**Description**
The N.C. CCR is designated a Specialty Registry through its participation in the 2011 CER Project. The N.C. CCR is required to continue the collection of seven data items from the CER Non-NAACCR Standard Data Set for cases diagnosed 1/1/2011 and beyond. Information for these data items must be collected (when available in the medical record) for all sites (C00.0 – C80.9). Blanks are not allowed in these data items for cases diagnosed 1/1/2011 or after.

Different tumors for the same patient may have different values. It should be collected from source records once for each cancer. Height should be taken from the Nursing Interview Guide, Flow Chart or Vital Stats section from the patient’s hospital medical record or physician office record. The height entered should be that listed at or around the time of diagnosis. If no height was listed on the date of diagnosis, please use the height recorded on the date closest to the date of diagnosis and before treatment was started.

**Instructions for Coding**
- Entered as a two-digit number
- Record value measured in inches (1 foot = 12 inches)
- All values should be rounded to the nearest whole number
- Values with decimal place of .5 and greater should be rounded up

**Example:** 62.5 inches would be recorded as 63

<table>
<thead>
<tr>
<th>Codes</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-97</td>
<td>Record the Height measured in inches</td>
</tr>
<tr>
<td>98</td>
<td>Patient is 98 inches or taller</td>
</tr>
<tr>
<td>99</td>
<td>Unknown Height</td>
</tr>
</tbody>
</table>

On-line conversion calculator: [http://manuelsweb.com/in_cm.htm](http://manuelsweb.com/in_cm.htm)
WEIGHT

Item Length: 3
Allowable Values: 001-999
NAACCR Item #9961

Description
The N.C. CCR is designated a Specialty Registry through its participation in the 2011 CER Project. The N.C. CCR is required to continue the collection of seven data items from the CER Non-NAACCR Standard Data Set for cases diagnosed 1/1/2011 and beyond. Information for these data items must be collected (when available in the medical record) for all sites (C00.0 – C80.9). Blanks are not allowed in these data items for cases diagnosed 1/1/2011 or after.

Different tumors for the same patient may have different values. It should be collected from source records once for each cancer. Weight should be taken from the Nursing Interview Guide, Flow Chart or Vital Stats section from the patient’s hospital medical record or physician office record. The weight entered should be that listed at or around the time of diagnosis. If no weight was listed on the date of diagnosis, please use the weight recorded on the date closest to the date of diagnosis and before treatment was started.

Instructions for Coding
- Entered as a three-digit number
- Record value measured in pounds (1 kg = 2.2 pounds)
- All values should be rounded to the nearest whole number
- Values with decimal place of .5 and greater should be rounded up

Example: 155.5 pounds would be recorded as 156

<table>
<thead>
<tr>
<th>Codes</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>001-099</td>
<td>Record the Weight measured in pounds. Patient with a weight of less than 100 pounds should be recorded with a leading 0.</td>
</tr>
<tr>
<td>100-998</td>
<td>Record the Weight measured in pounds.</td>
</tr>
<tr>
<td>999</td>
<td>Unknown Weight</td>
</tr>
</tbody>
</table>

On-line conversion calculator: [http://manuelsweb.com/kg_lbs.htm](http://manuelsweb.com/kg_lbs.htm)
**Tobacco Use (Separated into Four Categories)**

Item Length: 1  
Allowable Values: 0-4, 999  
NAACCR Item #9965-9968

<table>
<thead>
<tr>
<th>Alternate Name</th>
<th>Item #</th>
<th>Length</th>
<th>Source of Standard</th>
<th>Column #</th>
</tr>
</thead>
<tbody>
<tr>
<td>TobaccoUseCigarette</td>
<td>9965</td>
<td>1</td>
<td>CDC/NPCR-CER</td>
<td>1293</td>
</tr>
<tr>
<td>TobaccoUseOtherSmoke</td>
<td>9966</td>
<td>1</td>
<td>CDC/NPCR-CER</td>
<td>1294</td>
</tr>
<tr>
<td>TobaccoUseSmokeless</td>
<td>9967</td>
<td>1</td>
<td>CDC/NPCR-CER</td>
<td>1295</td>
</tr>
<tr>
<td>TobaccoUseNOS</td>
<td>9968</td>
<td>1</td>
<td>CDC/NPCR-CER</td>
<td>1296</td>
</tr>
</tbody>
</table>

**Description**

The N.C. CCR is designated a Specialty Registry through its participation in the 2011 CER Project. The N.C. CCR is required to continue the collection of seven data items from the CER Non-NAACCR Standard Data Set for cases diagnosed 1/1/2011 and beyond. Information for these data items must be collected (when available in the medical record) for all sites (C00.0 – C80.9). Blanks are not allowed in these data items for cases diagnosed 1/1/2011 or after.

**Instructions for Coding**

Record the patient’s past or current use of tobacco. Tobacco Use should be recorded from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats or Nursing Assessment section, or other available source from the patient’s hospital medical record or physician office record.

The collection of Tobacco Use is divided into four separate data items - three for specific types of tobacco products and one for when tobacco use is indicated, but type is not specified.

- Cigarette smoking
- Smoking tobacco products other than cigarettes (e.g., pipes, cigars, kreteks)
- Smokeless tobacco products (e.g., chewing tobacco, snuff, etc.)
- Tobacco, NOS

Electronic cigarettes are not considered as tobacco use. Electronic cigarettes use liquid nicotine and do not contain tobacco. However, these users may have a history of tobacco use that should be considered.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Never used tobacco. Includes when the record only states “None.”</td>
</tr>
<tr>
<td>1</td>
<td>Current user (as of date of diagnosis)</td>
</tr>
<tr>
<td>2</td>
<td>Former user. Quit within one year of the date of diagnosis.</td>
</tr>
<tr>
<td>3</td>
<td>Former user. Quit more than one year prior to the date of diagnosis.</td>
</tr>
<tr>
<td>4</td>
<td>Former user. Unknown when quit.</td>
</tr>
<tr>
<td>9</td>
<td>Unknown, not stated, or no smoking specifics provided. Includes when the record only states “No.”</td>
</tr>
</tbody>
</table>
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.

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).
• Do not record “retired.” If usual occupation is not available or is unknown, record the patient’s current or most recent occupation, or any available occupation.
• If later documentation in the patient’s record provides an occupation that is more likely to be the usual occupation than what was originally recorded, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with occupation information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.
• If the patient was a homemaker and also worked outside the home during most of his/her adult life, record the usual occupation outside the home.
• If the patient was a homemaker and did not work outside the home for most of his/her adult life, record “homemaker.”
• If the patient was not a student or homemaker and had never worked, record “never worked” as the usual occupation.
• If no information is available, record “unknown.”
• This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.
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.

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 carried on at the location where the patient worked is unknown, it may be sufficient for facility registrars to record the name of the company (with city or town) in which the patient performed his/her usual industry. In these situations, if resources permit, a central or regional registry may be able to use the employer name and city/town to determine the type of activity conducted at that location.
• 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, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with industry information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.
• There should be an entry for Text--Usual Industry if any occupation is recorded.
• If no information is available regarding the industry in which the reported occupation was carried out, record “unknown.”
• If the patient was not a student or homemaker and had never worked, record “never worked” as the usual industry.
• Usually collected only for patients who are age 14 years or older at the time of diagnosis.
Cancer Identification
CLASS OF CASE

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 FORDS/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.
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)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Initial diagnosis at reporting facility AND all treatment or a decision not to treat was done elsewhere</td>
</tr>
<tr>
<td>10</td>
<td>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 done at the reporting facility, NOS</td>
</tr>
<tr>
<td>11</td>
<td>Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility</td>
</tr>
<tr>
<td>12</td>
<td>Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment or a decision not to treat was done at the reporting facility</td>
</tr>
<tr>
<td>13</td>
<td>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.</td>
</tr>
<tr>
<td>14</td>
<td>Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS</td>
</tr>
<tr>
<td>21</td>
<td>Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.</td>
</tr>
<tr>
<td>22</td>
<td>Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility</td>
</tr>
</tbody>
</table>

Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Leukemia was diagnosed at the facility, and all care was given in an office of a physician with admitting privileges.</td>
</tr>
<tr>
<td>13</td>
<td>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.</td>
</tr>
<tr>
<td>10</td>
<td>Reporting hospital found cancer in a biopsy, but was unable to discover whether the homeless patient actually received any treatment elsewhere.</td>
</tr>
<tr>
<td>11</td>
<td>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</td>
</tr>
</tbody>
</table>
**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.

<table>
<thead>
<tr>
<th>Class of Case</th>
<th>Definition</th>
<th>Notes from the N.C. CCR</th>
</tr>
</thead>
</table>
| Patient appears in person at reporting facility | 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. |
| 30 | 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. |
<table>
<thead>
<tr>
<th>Case #</th>
<th>Description</th>
<th>Reportability</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence</td>
<td>REPORTABLE</td>
<td>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 or not 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 or not 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.</td>
</tr>
<tr>
<td>33</td>
<td>Diagnosis and all first course treatment provided elsewhere and patient presents at reporting facility with disease history only.</td>
<td>NOT REPORTABLE</td>
<td>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. EXCEPTON for Death Clearance cases: Cases identified through the death clearance process MUST BE REPORTED 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. 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.</td>
</tr>
<tr>
<td>34</td>
<td>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</td>
<td>REPORTABLE</td>
<td>For non-CoC facilities, cases not required by the CoC, but ARE required to be reported to the CCR (e.g., VIN III, VAIN III, AIN III) should continue to be reported with the analytic class of case</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Reporting Status</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>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</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>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</td>
<td>REPORTABLE. Note: VIN III, VAIN III, AIN III are reportable. Cases not required by the CoC, but ARE required to be reported to the CCR should continue to be reported with the analytic class of case categories.</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Case diagnosed before the program’s CoC Reference Date, having initial diagnosis elsewhere AND all or part of first course treatment by facility</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Diagnosis AND all first course treatment given at the same staff physician office</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Diagnosis and all first course treatment given in two or more different staff physician offices</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>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.</td>
<td>REPORTING PREFERRED/REQUESTED. 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.</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Pathology report or other lab specimens only (specimen comes to your hospital, but the patient does not)</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Diagnosis was established by death certificate only.</td>
<td>DO NOT USE. This code is used only by the CCR staff.</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------------------------</td>
<td>-----------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Unknown</td>
<td>DO NOT USE. Facilities should be able to determine the relationship the facility had with the patient.</td>
<td></td>
</tr>
</tbody>
</table>

**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://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do](https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do).

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>10-digit NPI number for the facility.</td>
</tr>
<tr>
<td>(leave blank)</td>
<td>NPI for the referring facility is unknown or not available.</td>
</tr>
<tr>
<td>(leave blank)</td>
<td>If the patient was not referred to the reporting facility from another facility.</td>
</tr>
</tbody>
</table>
FACILITY REFERRED FROM

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>Seven or eight-digit FIN.</td>
</tr>
<tr>
<td>0000000000</td>
<td>If the patient was not referred to the reporting facility from another facility.</td>
</tr>
<tr>
<td>0099999999</td>
<td>If the patient was referred, but the referring facility's ID number is unknown.</td>
</tr>
</tbody>
</table>

Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>0006439999</td>
<td>6439999, General Hospital, Anytown, Illinois</td>
</tr>
<tr>
<td>0010000099</td>
<td>10000099, Anytown Medical Center, Anytown, Illinois</td>
</tr>
</tbody>
</table>

Note: A complete list of FINs is available on the American College of Surgeons website at [www.facs.org/cancer/coc/fin.html](http://www.facs.org/cancer/coc/fin.html).
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://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>10-digit NPI number for the facility.</td>
</tr>
<tr>
<td>(leave blank)</td>
<td>NPI for the facility referred to is unknown or not available.</td>
</tr>
<tr>
<td>(leave blank)</td>
<td>If the patient was not referred to another facility.</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>Eight-digit facility ID number.</td>
</tr>
<tr>
<td>0000000000</td>
<td>If the patient was not referred to another facility.</td>
</tr>
<tr>
<td>009999999999</td>
<td>If the patient was referred, but the facility’s ID number is unknown.</td>
</tr>
</tbody>
</table>

Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>00064399999</td>
<td>64399999, General Hospital, Anytown, Illinois</td>
</tr>
<tr>
<td>001000009999</td>
<td>100000999, Anytown Medical Center, Anytown, Illinois</td>
</tr>
</tbody>
</table>

Note: A complete list of FINs is available on the American College of Surgeons website at www.facs.org/cancer/coc/fin.html.
**DATE OF FIRST CONTACT**

Item Length: 8  
NAACCR Item #580  
Revised 09/06, 01/04, 01/10, 01/11

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

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient was admitted for non-cancer-related reasons and diagnosed with cancer during the hospitalization</td>
<td>Use the date the cancer was first suspected during the hospitalization</td>
</tr>
<tr>
<td>Patient’s diagnosis or treatment was as an outpatient of the facility</td>
<td>Use the date the patient first appeared at the facility for that purpose</td>
</tr>
<tr>
<td>Patient was diagnosed at another facility and subsequently receives first course treatment at the reporting facility</td>
<td>Use the date the patient reported to the facility for the treatment</td>
</tr>
<tr>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td>Staff physician performs a biopsy off site and the specimen is not submitted to the facility to be read</td>
<td>The case is not required to be abstracted unless the patient receives some first course of treatment at the facility</td>
</tr>
<tr>
<td>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.</td>
<td>Use the date the patient reported to the facility for the treatment</td>
</tr>
</tbody>
</table>
For non-analytic cases, the *Date of First Contact* is the date the patient’s non-analytic status begins with respect to the cancer.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient was diagnosed at autopsy (Class of Case 38)</td>
<td>Use the date of death</td>
</tr>
<tr>
<td>Patient was diagnosed and treated entirely in the staff physician’s office (Class of Case 40)</td>
<td>Use the date the physician initially diagnosed the cancer</td>
</tr>
<tr>
<td>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)</td>
<td>Use the date the specimen was collected</td>
</tr>
<tr>
<td>Death Certificate only cases (Class of Case 49)</td>
<td>Use the date of death</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class of Case changes from non-analytic (i.e.: <em>Class of Case</em> 30) to analytic (i.e.: <em>Class of Case</em> 21)</td>
<td>Update to the date the case became analytic (the date the patient was admitted for treatment)</td>
</tr>
<tr>
<td>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)</td>
<td>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).</td>
</tr>
</tbody>
</table>

**Examples**

<table>
<thead>
<tr>
<th>Patient undergoes a biopsy in a staff physician’s office on September 8, 2018. 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, 2018 for wide excision.</th>
<th>20180914</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient has an MRI of the brain on December 7, 2018, for symptoms including severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery on December 19, 2018 removes all gross tumor.</td>
<td>20181207</td>
</tr>
</tbody>
</table>
**DATE OF FIRST CONTACT FLAG**

Item Length: 2  
NAACCR Item #581  
Valid codes: 12, Blank  
New Item: 1/1/2010

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**Description**  
This flag explains why there is no appropriate value in the corresponding date field, *Date of First Contact* [580].

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

**Instructions for Coding**  
- Leave this data item blank. 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>A proper value is applicable but not known (that is, the date of first contact is unknown)</td>
</tr>
<tr>
<td>(blank)</td>
<td>A valid date value is provided in item <em>Date of First Contact</em> [580]</td>
</tr>
</tbody>
</table>
DATE OF INITIAL DIAGNOSIS

Description
Records the date of initial diagnosis by a physician for the tumor being reported.

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

Instructions for Coding
• Use the first date of diagnosis whether clinically or histologically established.
• If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis.
• Refer to the list of “Ambiguous Terms for Determining Reportability” in Section One for language that represents a diagnosis of cancer. If a clinical diagnostic method is modified by an ambiguous term, then do not abstract the case (If the type of cancer is modified by an ambiguous term, but not the fact it is cancer, then the case should be abstracted).
• 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.
• The date of death is the date of diagnosis for a Class of Case [610] 38 (diagnosed at autopsy) or 49 (death certificate only).
• Use the actual date of diagnosis for an in utero diagnosis.

MAKE EVERY ATTEMPT TO DETERMINE THE COMPLETE DATE, ESTIMATING IF NEEDED. Avoid an unknown diagnosis date if possible. The date of diagnosis puts the case into the year of evaluation. If the date is left blank, then the case cannot be included in statistics, publications, research studies, etc.

Estimating Dates
The introduction of the “flag” fields allow dates to be left blank when an exact date is not known. Every attempt should be made to estimate the complete date. If it is not possible to estimate the complete date, estimating a date to only a month and year (e.g., June 2018) or to only a year (e.g., 2018) is preferred over a complete unknown date. Text should specify when a date has been estimated.

For analytic cases:
• All applicable date fields, including date of diagnosis, cannot be blank.
• If an exact date is unknown, the entire date MUST be estimated as these cases are in the initial workup and treatment phase of the diagnosis and these procedures are most likely very recent.
• Use any clues available to approximate the date, such as a “diagnosed last year,” “recent diagnosis,” “treatment began last month,” etc.

For non-analytic cases:
• Avoid an unknown diagnosis date if possible. Make every attempt to at least determine the YEAR of diagnosis.
• Estimating should be the first priority and recording a date as unknown is a last resort.
• Leave the date **blank only** when there are absolutely no clues that would allow you to estimate at least the year. It is not useful to assign (guess) a speculative year.

Examples for estimating the date:

<table>
<thead>
<tr>
<th>Description</th>
<th>Tips for Estimating</th>
<th>Record</th>
<th>Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only the Month and Year is known</td>
<td>Estimate the DAY if possible. If not, use the first day of the month “01”.</td>
<td>20180201</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Only the Year is known</td>
<td>Estimate the MONTH and DAY if possible. Use the date of diagnosis or other treatment dates as a clue. For example, date of diagnosis is 20180514. Estimate the surgery date as the 1st of the month for the following month.</td>
<td>20180601</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Surgery performed but Date is unknown</td>
<td>Use the date of diagnosis or other treatment dates as a clue. For example, date of diagnosis is 20180514. Estimate the surgery date as the 1st of the month for the following month.</td>
<td>20180601</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Information is limited to the description of “Spring”</td>
<td>Use current year and 0401 for Spring</td>
<td>20180401</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Information is limited to the description of “The middle of the year”</td>
<td>Use current year and 0701 for middle of the year</td>
<td>20180701</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Information is limited to the description of “Fall”</td>
<td>Use current year and 1001 for Fall</td>
<td>20181001</td>
<td>Leave blank</td>
</tr>
<tr>
<td>Information is limited to the description of “Winter”</td>
<td>Try to determine if this means the beginning or the end of the year.</td>
<td>20181201 or 20190101</td>
<td>Leave blank</td>
</tr>
</tbody>
</table>

**Examples**

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>20180702</td>
<td>Cytology “suspicious” for cancer June 12, 2018; pathology positive July 2, 2018. Do not consider cytology with ambiguous terms to be diagnostic.</td>
</tr>
<tr>
<td>20180517</td>
<td>Pathology “suspicious” for cancer May 17, 2018; confirmed positive May 22, 2018.</td>
</tr>
<tr>
<td>20180401</td>
<td>Physician’s referral notes dated July 5, 2018, indicate the patient was diagnosed with cancer spring of 2018. Use April for “spring”, July for “summer” or “mid-year,” October for “fall” or “autumn.” In winter, attempt to determine whether the diagnosis was “late in the year” (use December with the applicable year) or “early in year” (use January with the respective year).</td>
</tr>
</tbody>
</table>
**PRIMARY SITE**

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

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**Description**
Identifies the primary site.

**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**

- Record the ICD-O-3 topography code for the site of origin.
- Consult the physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.
- Topography codes are indicated by a “C” preceding the three-digit code number. Example: C449
- Follow the Instructions in the ICD-O-3 and in the SEER Solid Tumor Rules to assign site for solid tumors.
- 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 lymphomas, leukemia and other hematopoietic neoplasms.
- Use subcategory 8 for single tumors that overlap the boundaries of two or more sub-sites and the point of origin is not known.
- Use subcategory 9 for multiple tumors that originate in different subsites of one organ.

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). The following guidelines should be followed for consistent analysis of primary sites for particular histologies.

**Occult Cervical Lymph Node (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 if the neck node has not been tested or is negative for both HPV and EBV.
  - AJCC Chapter: Cervical Lymph Nodes and Unknown Primary Tumor of the Head and Neck
- C10.9 if the neck node is p16 positive indicating human papillomavirus (HPV).
  - AJCC Chapter: Oropharyngeal Cancer - HPV Mediated (p16+)
- C11.9 if the neck node is EBER positive, or both EBER and p16 positive, indicating Epstein Barr Virus.
  - 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. Cases coded to C44.8 represent 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.
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).

Melanoma
- Code to Skin, NOS (C44.9) if a patient is diagnosed with metastatic melanoma and the primary site is not identified.

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 ICD-O-3 to assign the most specific site if only a general location is specified in the record.

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

Examples (Refer to the SEER Solid Tumor Manual and Heme DB for more information)

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>C108</td>
<td>Overlapping lesion of oropharynx. Code C108 when a large tumor involves both the lateral wall of the oropharynx (C10.2) and the posterior wall of the oropharynx (C10.3) and the point of origin is not stated.</td>
</tr>
<tr>
<td>C678</td>
<td>Overlapping lesion of bladder. Code C678 when a single lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated.</td>
</tr>
<tr>
<td>C189</td>
<td>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).</td>
</tr>
<tr>
<td>C16-</td>
<td>Stomach (sub-site as identified). An extranodal lymphoma of the stomach is coded to C16.– (sub-site as identified).</td>
</tr>
</tbody>
</table>
**LATERALITY**

Item Length: 1  
Allowable Values: 0–4, 9  
NAACCR Item #410  
Revised 01/10, 05/10, 01/13

**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**
Laterality 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. 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Primary site is not listed in the table below (it is not a paired site)</td>
</tr>
<tr>
<td>1</td>
<td>Primary site is a paired organ and the origin of the tumor is the RIGHT side</td>
</tr>
<tr>
<td>2</td>
<td>Primary site is a paired organ and the origin of the tumor is the LEFT side</td>
</tr>
<tr>
<td>3</td>
<td>Primary site is a paired organ. Only one side is involved but right or left origin 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. Assign code 3.</td>
</tr>
</tbody>
</table>
| 4    | • 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.  
  • Example 1: Both lungs have tumors and the lung of origin is not known, assign code 4.  
  • Example 2: Both ovaries involved simultaneously with a single histology, assign 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 trunk can have a midline tumor, but the breasts cannot. |
| 9    | Paired site, but no information concerning laterality |
Paired Organ Sites (Laterality must be 1-5 or 9)

<table>
<thead>
<tr>
<th>ICD-O-3</th>
<th>Site</th>
<th>ICD-O-3</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>C07.9</td>
<td>Parotid gland</td>
<td>C44.1</td>
<td>Skin of eyelid</td>
</tr>
<tr>
<td>C08.0</td>
<td>Submandibular gland</td>
<td>C44.2</td>
<td>Skin of external ear</td>
</tr>
<tr>
<td>C08.1</td>
<td>Sublingual gland</td>
<td>C44.3</td>
<td>Skin of other and unspecified parts of face</td>
</tr>
<tr>
<td>C09.0</td>
<td>Tonsillar fossa</td>
<td>C44.5</td>
<td>Skin of trunk</td>
</tr>
<tr>
<td>C09.1</td>
<td>Tonsillar pillar</td>
<td>C44.6</td>
<td>Skin of upper limb and shoulder</td>
</tr>
<tr>
<td>C09.8</td>
<td>Overlapping lesion of tonsil</td>
<td>C44.7</td>
<td>Skin of lower limb and hip</td>
</tr>
<tr>
<td>C09.9</td>
<td>Tonsil, NOS</td>
<td>C47.1</td>
<td>Peripheral nerves and autonomic nervous system of upper limb and shoulder</td>
</tr>
<tr>
<td>C30.0</td>
<td>Nasal cavity (excluding nasal cartilage and nasal septum)</td>
<td>C47.2</td>
<td>Peripheral nerves and autonomic nervous system of lower limb and hip</td>
</tr>
<tr>
<td>C30.1</td>
<td>Middle ear</td>
<td>C49.1</td>
<td>Connective, subcutaneous, and other soft tissues of upper limb and shoulder</td>
</tr>
<tr>
<td>C31.0</td>
<td>Maxillary sinus</td>
<td>C49.2</td>
<td>Connective, subcutaneous, and other soft tissues of lower limb and hip</td>
</tr>
<tr>
<td>C31.2</td>
<td>Frontal sinus</td>
<td>C50.0–C50.9</td>
<td>Breast</td>
</tr>
<tr>
<td>C34.0–C34.9</td>
<td>Main bronchus (excluding carina)</td>
<td>C56.9</td>
<td>Ovary</td>
</tr>
<tr>
<td>C34.4</td>
<td>Pleura</td>
<td>C57.0</td>
<td>Fallopian tube</td>
</tr>
<tr>
<td>C40.0</td>
<td>Long bones of upper limb and scapula</td>
<td>C63.0</td>
<td>Epididymis</td>
</tr>
<tr>
<td>C40.1</td>
<td>Short bones of upper limb</td>
<td>C63.1</td>
<td>Spermatic cord</td>
</tr>
<tr>
<td>C40.2</td>
<td>Long bones of lower limb</td>
<td>C64.9</td>
<td>Kidney, NOS</td>
</tr>
<tr>
<td>C40.3</td>
<td>Short bones of lower limb</td>
<td>C65.9</td>
<td>Renal pelvis</td>
</tr>
<tr>
<td>C41.3</td>
<td>Rib and clavicle (excluding sternum)</td>
<td>C66.9</td>
<td>Ureter</td>
</tr>
<tr>
<td>C41.4</td>
<td>Pelvic bones (excluding sacrum, coccyx and symphysis pubis)</td>
<td>C69.0–C69.9</td>
<td>Eye and lacrimal gland</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C74.0–C74.9</td>
<td>Adrenal gland</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C75.4</td>
<td>Carotid body</td>
</tr>
</tbody>
</table>

For the following CNS sites, only record laterality for cases diagnosed 1/1/2004 and after.

<table>
<thead>
<tr>
<th>ICD-O-3</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>C70.0</td>
<td>Cerebral meninges, NOS</td>
</tr>
<tr>
<td>C71.0</td>
<td>Cerebrum</td>
</tr>
<tr>
<td>C71.1</td>
<td>Frontal lobe</td>
</tr>
<tr>
<td>C71.2</td>
<td>Temporal lobe</td>
</tr>
<tr>
<td>C71.3</td>
<td>Parietal lobe</td>
</tr>
<tr>
<td>C71.4</td>
<td>Occipital lobe</td>
</tr>
<tr>
<td>C72.2</td>
<td>Olfactory nerve</td>
</tr>
<tr>
<td>C72.3</td>
<td>Optic nerve</td>
</tr>
<tr>
<td>C72.4</td>
<td>Acoustic nerve</td>
</tr>
<tr>
<td>C72.5</td>
<td>Cranial nerve, NOS</td>
</tr>
</tbody>
</table>
**HISTOLOGY**

Item Length: 4  
NAACCR Item #522  
Revised 09/06, 01/10, 03/10

**Description**  
Identifies the microscopic anatomy of cells.

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

**Instructions for Coding**
- ICD-O-3 identifies morphology codes with an “M” preceding the code number. Do not record the “M.”
- Review all pathology reports.
- Code the final pathologic diagnosis for solid tumors.
- The codes for cancer, NOS (8000) and carcinoma, NOS (8010) are not interchangeable. If the physician says that the patient has carcinoma, then code carcinoma, NOS (8010).

**Solid Tumors**

- Use the current SEER Solid Tumor Rules when coding the histology for all reportable solid tumors. These rules are effective for cases diagnosed January 1, 2007, or later.
- To code multiple or mixed histologies present in one primary, the most recent SEER Solid Tumor Coding Rules replaces all previous multiple histology rules.
- Record histology using the ICD-O-3 codes in the Numeric Lists/Morphology section (ICD-O-3, pp. 69–104) and in the Alphabetic Index (ICD-O-3, pp. 105–218).

- 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 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.

**Hematopoietic and Lymphoid Cancers**

SEER Hematopoietic and Lymphoid Neoplasm Database: [https://seer.cancer.gov/tools/heme/](https://seer.cancer.gov/tools/heme/)
Beginning with cases diagnosed in 2010, the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual is to be used for coding primary site, histology and grade of lymphoma, leukemia and all other hematopoietic and lymphoid tumors (M-9590-9992) and to determine whether multiple conditions represent one or more tumors to be abstracted.

**Examples**

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>8140</td>
<td>Adenocarcinoma</td>
<td>Final pathologic diagnosis is carcinoma, NOS (8010) of the prostate. Microscopic diagnosis specifies adenocarcinoma (8140) of the prostate.</td>
</tr>
<tr>
<td>9680</td>
<td>Diffuse large B-cell lymphoma</td>
<td>Diffuse large B-cell lymphoma, per the WHO Classification of Hematopoietic and Lymphoid Neoplasms.</td>
</tr>
</tbody>
</table>
**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**
- Code 3 if any *malignant* invasion is present, no matter how limited.
- Code 3 if any *malignant* metastasis to nodes or tissue beyond the primary is present.
- If the specimen is from a metastatic site, code the histology of the metastatic site and code 3 for behavior.
- The ICD-O-3 behavior code for juvenile astrocytoma (9421/1) is coded as 3 by agreement of North American registry standard-setters.
- Gastro-intestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, they must be abstracted and assigned a Behavior Code of 3 if they are noted to have multiple foci, metastasis or positive lymph nodes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Benign</td>
<td>Benign</td>
</tr>
<tr>
<td>1</td>
<td>Borderline</td>
<td>Uncertain whether benign or malignant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Borderline malignancy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low malignant potential</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uncertain malignant potential</td>
</tr>
<tr>
<td>2</td>
<td>In situ and synonymous with in situ</td>
<td>Adenocarcinoma in an adenomatous polyp with no invasion of stalk</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bowen disease (not reportable for C44._)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clark level 1 for melanoma (limited to epithelium)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comedocarcinoma, noninfiltrating (C50.–)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Confined to epithelium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hutchinson melanotic freckle, NOS (C44.–)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intracystic, noninfiltrating.(carcinoma)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intraductal.(carcinoma)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intraepidermal, NOS (carcinoma)</td>
</tr>
<tr>
<td>Code</td>
<td>Label</td>
<td>Definition</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Intraepithelial, NOS (carcinoma)</td>
<td>Involvement up to, but not including the basement membrane</td>
</tr>
<tr>
<td></td>
<td>Lentigo maligna (C44.—)</td>
<td>Lobular neoplasia (C50.—)</td>
</tr>
<tr>
<td></td>
<td>Lobular, noninfiltrating (C50.—) (carcinoma)</td>
<td>Noninfiltrating (carcinoma)</td>
</tr>
<tr>
<td></td>
<td>Noninvasive (carcinoma only)</td>
<td>No stromal invasion or involvement</td>
</tr>
<tr>
<td></td>
<td>Papillary, noninfiltrating or intraductal (carcinoma)</td>
<td>Precancerous melanosis (C44.—)</td>
</tr>
<tr>
<td></td>
<td>Queyrat erythroplasia (C60.—)</td>
<td>Invasive</td>
</tr>
<tr>
<td></td>
<td>Invasive</td>
<td>Microinvasive</td>
</tr>
<tr>
<td></td>
<td>Foci of invasion</td>
<td></td>
</tr>
</tbody>
</table>

### Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Intraductal carcinoma (8500/2) with focal areas of invasion</td>
</tr>
<tr>
<td>3</td>
<td>Atypical thymoma (8585/1) with malignant metastasis in one lymph node</td>
</tr>
<tr>
<td>1</td>
<td>Atypical meningioma (9539/1) invading bone of skull (the meninges, which line the skull, are capable of invading into the bone without being malignant; do not code as malignant unless it is specifically mentioned)</td>
</tr>
<tr>
<td>1</td>
<td>GIST (with no mention whether malignant or benign)</td>
</tr>
<tr>
<td>3</td>
<td>Malignant GIST</td>
</tr>
</tbody>
</table>
GRADE CLINICAL (EFFECTIVE 1/1/2018)

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 AFTER TO 2018***

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.

For some sites, grade is required to assign the stage group.

For those cases that are eligible for AJCC staging, the recommended grading system is specified in the AJCC 8th Edition Chapter. The AJCC 8th Edition Chapter-specific grading systems (codes 1-5, L, H, M, S) take priority over the generic grade definitions (codes A-E, 8, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Instructions for Coding

Please see the following URL for detailed coding instructions and site-specific coding rules:
GRADE PATHOLOGICAL (EFFECTIVE 1/1/2018)

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 AFTER TO 2018***

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.

For some sites, grade is required to assign the stage group.

For those cases that are eligible for AJCC staging, the recommended grading system is specified in the AJCC 8th Edition Chapter. The AJCC 8th Edition Chapter-specific grading systems (codes 1-5, L, H, M, S) take priority over the generic grade definitions (codes A-E, 8, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Instructions for Coding

Please see the following URL for detailed coding instructions and site-specific coding rules:
**GRADE POST THERAPY (EFFECTIVE 1/1/2018)**

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 AFTER TO 2018***

**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. Record the highest grade documented from the surgical treatment resection specimen of the primary site following neoadjuvant therapy.

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.

For some sites, grade is required to assign the stage group.

For those cases that are eligible for AJCC staging, the recommended grading system is specified in the AJCC 8th Edition Chapter. The AJCC 8th Edition Chapter-specific grading systems (codes 1-5, L, H, M, S) take priority over the generic grade definitions (codes A-E, 8, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

**Instructions for Coding**
Please see the following URL for detailed coding instructions and site-specific coding rules:
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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Well differentiated; differentiated, NOS</td>
</tr>
<tr>
<td>2</td>
<td>Moderately differentiated; moderately well differentiated; intermediate differentiation</td>
</tr>
<tr>
<td>3</td>
<td>Poorly differentiated; dedifferentiated</td>
</tr>
<tr>
<td>4</td>
<td>Undifferentiated; anaplastic</td>
</tr>
<tr>
<td>5</td>
<td>T cell; T-precursor</td>
</tr>
<tr>
<td>6</td>
<td>B cell; pre-B; B-precursor</td>
</tr>
<tr>
<td>7</td>
<td>Null cell; non T-non B</td>
</tr>
<tr>
<td>8</td>
<td>NK (natural killer) cell (effective with diagnosis 1/1/95 and after)</td>
</tr>
<tr>
<td>9</td>
<td>Cell type not determined, not stated or not applicable; unknown primary; high grade dysplasia (adenocarcinoma in situ)</td>
</tr>
</tbody>
</table>
**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.

**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 M9590-9992)**

- These instructions apply to “Codes for Solid Tumors”. See the following section for “Coding Hematopoietic or Lymphoid Tumors (9590-9992).”
- 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.
  - This data item must be changed to the lower (higher priority) code if a more definitive method confirms the diagnosis at any time during the course of the disease.
  - Assign code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy or D&C or from aspiration of biopsy of bone marrow specimens.
  - Assign code 2 when the microscopic diagnosis is based on cytologic examination of cells 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.
  - Code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer.
  - Code 6 when the 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.
  - Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient’s clinical presentation.
## Codes for Solid Tumors

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Positive histology</td>
<td>Histologic confirmation (tissue microscopically examined).</td>
</tr>
<tr>
<td>2</td>
<td>Positive cytology</td>
<td>Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).</td>
</tr>
<tr>
<td>4</td>
<td>Positive microscopic confirmation, method not specified</td>
<td>Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.</td>
</tr>
<tr>
<td>5</td>
<td>Positive laboratory test(marker study)</td>
<td>A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. Examples include alpha-fetoprotein for liver primaries. Elevated PSA 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.</td>
</tr>
<tr>
<td>6</td>
<td>Direct visualization without microscopic confirmation</td>
<td>The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.</td>
</tr>
<tr>
<td>7</td>
<td>Radiography and other imaging techniques without microscopic confirmation</td>
<td>The malignancy was reported by the physician from an imaging technique report only.</td>
</tr>
<tr>
<td>8</td>
<td>Clinical diagnosis only, other than 5, 6 or 7</td>
<td>The malignancy was reported by the physician in the medical record.</td>
</tr>
<tr>
<td>9</td>
<td>Unknown whether or not microscopically confirmed</td>
<td>A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).</td>
</tr>
</tbody>
</table>

### Instructions for Coding Hematopoietic or Lymphoid Tumors (9590-9992)

- 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)](https://example.com) for information on the definitive diagnostic confirmation for specific types of tumors.
- Code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, or autopsy or bone marrow specimens from aspiration or biopsy.
- For leukemia only, code 1 when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear. Do not use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow or blood.
- Use code 2 when the microscopic diagnosis is based on cytologic examination of cells (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears or from paraffin block specimens from concentrated spinal, pleural or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.
- Assign code 3 when there is a histology positive for cancer AND positive immunophenotyping and/or positive genetic testing results. Do not use code 3 for neoplasms diagnosed prior to January 1, 2010.
- Assign code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are...
clinically diagnostic for that specific cancer, but no positive histologic confirmation.

- Assign code 6 when the diagnosis is based only on the surgeon’s report from a surgical exploration or endoscopy or from gross autopsy findings without tissue or cytological findings.
- Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes.

A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient’s clinical presentation.

**Codes for Hematopoietic and Lymphoid Neoplasms**

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Positive histology</td>
<td>Histologic confirmation (tissue microscopically examined).</td>
</tr>
<tr>
<td>2</td>
<td>Positive cytology</td>
<td>Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).</td>
</tr>
<tr>
<td>3</td>
<td>Positive histology PLUS Positive immunophenotyping AND/OR Positive genetic studies</td>
<td>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).</td>
</tr>
<tr>
<td>4</td>
<td>Positive microscopic confirmation, method not specified</td>
<td>Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.</td>
</tr>
<tr>
<td>5</td>
<td>Positive laboratory test/marker study</td>
<td>A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer.</td>
</tr>
<tr>
<td>6</td>
<td>Direct visualization without microscopic confirmation</td>
<td>The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.</td>
</tr>
<tr>
<td>7</td>
<td>Radiography and other imaging techniques without microscopic confirmation</td>
<td>The malignancy was reported by the physician from an imaging technique report only.</td>
</tr>
<tr>
<td>8</td>
<td>Clinical diagnosis only, other than 5, 6 or 7</td>
<td>The malignancy was reported by the physician in the medical record.</td>
</tr>
<tr>
<td>9</td>
<td>Unknown whether or not microscopically confirmed</td>
<td>A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).</td>
</tr>
</tbody>
</table>
TYPE OF REPORTING SOURCE

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, for central registries, death certificate only cases have unknown values for many data items, so may be excluded from some analyses.

Coding Instructions:
- Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. This is a change to reflect the addition of codes 2 and 8 and to prioritize laboratory reports over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are 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 and given the code with 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hospital inpatient; Managed health plans with comprehensive, unified medical records.</td>
</tr>
<tr>
<td>2</td>
<td>Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent).</td>
</tr>
<tr>
<td>3</td>
<td>Laboratory only (hospital-affiliated or independent).</td>
</tr>
<tr>
<td>4</td>
<td>Physician's office/private medical practitioner.</td>
</tr>
<tr>
<td>5</td>
<td>Nursing/convalescent home/hospice.</td>
</tr>
<tr>
<td>6</td>
<td>Autopsy only.</td>
</tr>
<tr>
<td>7</td>
<td>Death certificate only.</td>
</tr>
<tr>
<td>8</td>
<td>Other hospital outpatient units/surgery centers.</td>
</tr>
</tbody>
</table>
CASEFINDING SOURCE

Item Length: 2
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 pathology laboratory report, consultation-only report from a hospital or other report was used to identify a case that was then abstracted from a different source, 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Reporting Hospital, NOS</td>
</tr>
<tr>
<td>20</td>
<td>Pathology Department Review (surgical pathology reports, autopsies or cytology reports)</td>
</tr>
<tr>
<td>21</td>
<td>Daily Discharge Review (daily screening of charts of discharged patients in the medical records department)</td>
</tr>
<tr>
<td>22</td>
<td>Disease Index Review (review of disease index in the medical records department)</td>
</tr>
<tr>
<td>23</td>
<td>Radiation Therapy Department/Center</td>
</tr>
<tr>
<td>24</td>
<td>Laboratory Reports (other than pathology reports, code 20)</td>
</tr>
<tr>
<td>25</td>
<td>Outpatient Chemotherapy</td>
</tr>
<tr>
<td>26</td>
<td>Diagnostic Imaging/Radiology (other than radiation therapy, codes 23; includes nuclear medicine)</td>
</tr>
<tr>
<td>27</td>
<td>Tumor Board</td>
</tr>
<tr>
<td>28</td>
<td>Hospital Rehabilitation Service or Clinic</td>
</tr>
<tr>
<td>29</td>
<td>Other Hospital Source (including clinic, NOS or outpatient department, NOS)</td>
</tr>
<tr>
<td></td>
<td>Case first identified by source other than a reporting facility covered in the codes above</td>
</tr>
<tr>
<td>30</td>
<td>Physician-Initiated Case</td>
</tr>
<tr>
<td>40</td>
<td>Consultation-only or Pathology-only Report (not abstracted by reporting hospital)</td>
</tr>
<tr>
<td>50</td>
<td>Independent (non-hospital) Pathology-Laboratory Report</td>
</tr>
<tr>
<td>60</td>
<td>Nursing Home-Initiated Case</td>
</tr>
<tr>
<td>70</td>
<td>Coroner's Office Records Review</td>
</tr>
<tr>
<td>75</td>
<td>Managed Care Organization (MCO) or Insurance Records</td>
</tr>
<tr>
<td>80</td>
<td>Death Certificate (case identified through death clearance)</td>
</tr>
<tr>
<td>85</td>
<td>Out-of-State Case Sharing</td>
</tr>
<tr>
<td>90</td>
<td>Other Non-Reporting Hospital Source</td>
</tr>
<tr>
<td>95</td>
<td>Quality Control Review (case initially identified through QC activities such as casefinding audit)</td>
</tr>
<tr>
<td>99</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
Stage of Disease at Diagnosis
**DATE OF SURGICAL DIAGNOSTIC AND STAGING PROCEDURE**

Item Length: 8
NAACCR Item #1280
Revised 01/10, 01/11

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**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:**
- 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.
- The *RX Date-DX/Stg Proc Flag* [1281] is used to explain why *Date of Surgical Diagnostic and Staging Procedure* is not a known date. See *RX Date-DX/Stg Proc Flag* for an illustration of the relationships among these items.

**Surgical Diagnostic and Staging Procedures**

*Surgical Diagnostic and Staging Procedure* [1350] refers solely to surgical procedures performed specifically for diagnosis or staging of the tumor and do not apply to surgical treatment. *Date of Surgical Diagnostic and Staging Procedure* [1280] refers to the date on which the surgical diagnostic and/or staging procedure was performed at any facility.

If a needle biopsy preceded an excisional biopsy or more extensive surgery, even if no tumor remained at the time of surgery, both the needle biopsy (*Surgical Diagnostic and Staging Procedure*) and the *Surgical Procedure of the Primary Site* are to be reported. That is because 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.

**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 the data item *Surgical Diagnostic and Staging Procedure* [1350]. Use the data item *Scope of Regional Lymph Node Surgery* [1292] to code these procedures. 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.
Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Surgical Diagnostic and Staging Procedure* [1280].

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

Coding Instructions
- Leave this item blank if *Date of Surgical Diagnostic and Staging Procedure* [1280] has a full or partial date recorded.
- Code 10 if it is unknown whether a surgical diagnostic or staging procedure was performed.
- Code 11 if no surgical diagnostic or staging procedure was performed.
- Code 12 if the *Date of Surgical Diagnostic and Staging Procedure* cannot be determined, but a surgical diagnostic or staging procedure was performed for the patient.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>No information whatsoever can be inferred from this exceptional value (that is, unknown if any diagnostic or staging procedure performed).</td>
</tr>
<tr>
<td>11</td>
<td>No proper value is applicable in this context (for example, no diagnostic or staging procedure performed; autopsy only case).</td>
</tr>
<tr>
<td>12</td>
<td>A proper value is applicable but not known. This event occurred, but the date is unknown (for example, diagnostic or staging procedure performed but date is unknown).</td>
</tr>
<tr>
<td>(blank)</td>
<td>A valid date value is provided in item <em>Date of Surgical Diagnostic and Staging Procedure</em> [1280]. Case was diagnosed prior to January 1, 2007.</td>
</tr>
</tbody>
</table>
**SURGICAL DIAGNOSTIC AND STAGING PROCEDURE**

*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 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).
- 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 *Surgical Procedure of Primary Site* [1290] to code these procedures.
- Do not code surgical procedures which aspirate, biopsy or remove regional lymph nodes in an effort to diagnose and/or stage disease in this data item. Use the data item *Scope of Regional Lymph Node Surgery* [1292] to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure* [1280]. See instructions for *Scope of Regional Lymph Node Surgery* [1292].
- 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.
- Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site* [1290] to code these procedures.
- 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. The needle biopsy should be recorded as such in the Surgical Diagnostic and Staging Procedure [1350] data item and the excisional biopsy or more extensive surgery in the Surgical Procedure of the Primary Site [1290]. 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.
- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure* [3270] to code these procedures.

**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.
<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No surgical diagnostic or staging procedure was performed.</td>
</tr>
<tr>
<td>01</td>
<td>A biopsy (incisional, needle or aspiration) was done to a site other than the primary site. No exploratory procedure was done.</td>
</tr>
<tr>
<td>02</td>
<td>A biopsy (incisional, needle or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.</td>
</tr>
<tr>
<td>03</td>
<td>A surgical exploration only. The patient was not biopsied or treated.</td>
</tr>
<tr>
<td>04</td>
<td>A surgical procedure with a bypass was performed, but no biopsy was done.</td>
</tr>
<tr>
<td>05</td>
<td>An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.</td>
</tr>
<tr>
<td>06</td>
<td>A bypass procedure was performed, and a biopsy of either the primary site or another site was done.</td>
</tr>
<tr>
<td>07</td>
<td>A procedure was done, but the type of procedure is unknown.</td>
</tr>
<tr>
<td>09</td>
<td>No information of whether a diagnostic or staging procedure was performed.</td>
</tr>
</tbody>
</table>

**Examples:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>A lung cancer primary was diagnosed by CT scan. The patient expired. No surgical diagnostic or staging surgical procedure was performed.</td>
</tr>
<tr>
<td>00</td>
<td>A sputum sample is examined cytologically to confirm a diagnosis of suspected lung cancer. The procedure is not surgical.</td>
</tr>
<tr>
<td>01</td>
<td>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.</td>
</tr>
<tr>
<td>03</td>
<td>During abdominal exploratory surgery, a gastric lesion and suspicious retroperitoneal lymph nodes were observed. No biopsy or treatment was done.</td>
</tr>
<tr>
<td>04</td>
<td>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.</td>
</tr>
<tr>
<td>05</td>
<td>An exploratory procedure was performed for primary colon carcinoma with biopsy of suspicious liver lesions.</td>
</tr>
<tr>
<td>06</td>
<td>Esophagogastrotomy was performed for infiltrating gastric tumor following a biopsy of the primary site.</td>
</tr>
<tr>
<td>07</td>
<td>Stage III lung carcinoma was diagnosed and staged prior to admission.</td>
</tr>
<tr>
<td>09</td>
<td>A patient expires in the emergency room with recently diagnosed metastatic melanoma. It is unknown whether a diagnostic or staging procedure was done.</td>
</tr>
</tbody>
</table>
**REGионаl lymph nodes examinerd**

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
- Brain and Cerebral Meninges
- Other Parts of Central Nervous System
- Intracranial Gland
- Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
- Hodgkin and non-Hodgkin Lymphoma
- Myeloma and PlasmaCell Disorders
- Other and Ill-Defined Primary Sites
- Unknown Primary Site

**Instructions for Coding**

- If Regional Nodes Positive is coded as 98, Regional Nodes Examined must be code 00.
- **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.
- 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 positive 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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No nodes examined</td>
</tr>
<tr>
<td>01 - 89</td>
<td>1 to 89 nodes examined (code the exact number of regional nodes examined)</td>
</tr>
<tr>
<td>90</td>
<td>90 or more nodes examined</td>
</tr>
<tr>
<td>95</td>
<td>No regional nodes removed, but aspiration or core biopsy of regional nodes performed.</td>
</tr>
<tr>
<td>96</td>
<td>Regional lymph node removal documented as a sampling, and the number of nodes unknown/not stated.</td>
</tr>
<tr>
<td>97</td>
<td>Regional lymph node removal documented as dissection, and the number of nodes unknown/not stated.</td>
</tr>
<tr>
<td>98</td>
<td>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.</td>
</tr>
<tr>
<td>99</td>
<td>Unknown whether nodes were examined (not documented in patient record) Not applicable based on primary site</td>
</tr>
</tbody>
</table>

**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 multiple primary 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 LYMPH NODES POSITIVE**

Item Length: 2

Allowable Values: 00–99

Right Justified, Zero-filled

NAACCR Item #820

Revised 09/06, 01/10

**Description**
Records the exact number of regional lymph nodes examined by the 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
- Brain and Cerebral Meninges
- Other Parts of Central Nervous System
- Intracranial Gland
- Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
- Hodgkin and non-Hodgkin Lymphoma
- Myeloma and PlasmaCell Disorders
- Other and Ill-Defined Primary Sites
- Unknown Primary Site

**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, so 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.
- 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 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 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:
  o Count only lymph nodes that contain micrometastases or larger (metastases > 0.2 mm in size).
  o Do not include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs).
  o 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 lymph nodes.

Special Codes:

• Code 95. Use code 95 when:
  o the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).
  o a positive lymph node is aspirated and there are no surgically resected lymph nodes.
  o 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.
  o Code 97 includes positive lymph nodes diagnosed by either cytology or histology.
  o 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:
  o When the assessment of lymph nodes is clinical only.
  o When no lymph nodes are removed and examined.
  o 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>All nodes examined negative</td>
</tr>
<tr>
<td>01 - 89</td>
<td>1 to 89 nodes positive (code exact number of nodes positive)</td>
</tr>
<tr>
<td>90</td>
<td>90 or more nodes positive</td>
</tr>
<tr>
<td>95</td>
<td>Positive aspiration or core biopsy of lymph node(s) only</td>
</tr>
<tr>
<td>97</td>
<td>Positive nodes are documented but the number positive is not specified</td>
</tr>
<tr>
<td>98</td>
<td>No nodes were examined</td>
</tr>
<tr>
<td>99</td>
<td>Unknown whether nodes are positive (not documented in patient record)</td>
</tr>
<tr>
<td></td>
<td>Not applicable based on primary site</td>
</tr>
</tbody>
</table>
**LYMPHOVASCULAR INVASION (Revised for 2018)**

**Item Length:** 1  
**Allowable Values:** 0-1, 8-9  
**NAACCR Item #1182**  
Revised 01/11, 01/18

### 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.

### 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.

**Update (Effective 1/1/2018):** This coding convention has been updated with new codes (2, 3, and 4) based on the AJCC 8th Edition staging manual for appropriate disease sites. For cases diagnosed January 1, 2018 and later, new codes indicating lymphatic, small vessel, and/or large vessel invasion were added. Revised CAP Protocols and 8th Edition chapters will indicate which chapters will 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.

**Note:** This field is *required* for mapping of T in some sites.

### Instructions for Coding
- Assign code 0 (Not Present) for purely in situ tumors
- Assign code 8 (Not Applicable) for:
  - Benign/borderline brain and CNS tumors
  - Hodgkin and Non-Hodgkin lymphoma
  - Leukemias
  - Hematopoietic and reticuloendothelial disorders
  - Myelodysplastic syndromes including refractory anemia and refractory cytopenia
  - Myeloproliferative disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Lymphovascular invasion not present (absent)/Not identified</td>
</tr>
<tr>
<td>1</td>
<td>Lymphovascular invasion present/Identified</td>
</tr>
<tr>
<td>2</td>
<td>Lymphatic and small vessel invasion only (L)</td>
</tr>
<tr>
<td>3</td>
<td>Venous (large vessel) invasion only (V)</td>
</tr>
<tr>
<td>4</td>
<td>BOTH lymphatic and small vessel AND venous (large vessel) invasion</td>
</tr>
<tr>
<td>8</td>
<td>Not applicable</td>
</tr>
<tr>
<td>9</td>
<td>Unknown if lymphovascular invasion present. Indeterminate</td>
</tr>
</tbody>
</table>
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.
   b. Do not code perineural invasion in this field.
   c. Information to code this field can be taken from any specimen from the primary tumor (biopsy or resection.)
   d. If lymphovascular invasion is identified in any specimen, it should be coded as present/identified.
   e. For cases with benign or borderline behavior, code the lymphovascular invasion documented (negative or positive) and, if not documented, code unknown.
   f. 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.

<table>
<thead>
<tr>
<th>LVI on pathology report PRIOR to neoadjuvant therapy</th>
<th>LVI on pathology report AFTER neoadjuvant therapy</th>
<th>Code LVI to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Not present/Not identified</td>
<td>0 - Not present/Not identified</td>
<td>0 - Not present/Not identified</td>
</tr>
<tr>
<td>0 - Not present/Not identified</td>
<td>1 - Present/Identified</td>
<td>1 - Present/Identified</td>
</tr>
<tr>
<td>0 - Not present/Not identified</td>
<td>9 - Unknown/Indeterminate</td>
<td>9 - Unknown/Indeterminate</td>
</tr>
<tr>
<td>1 - Present/Identified</td>
<td>0 - Not present/Not identified</td>
<td>1 - Present/Identified</td>
</tr>
<tr>
<td>1 - Present/Identified</td>
<td>1 - Present/Identified</td>
<td>1 - Present/Identified</td>
</tr>
<tr>
<td>1 - Present/Identified</td>
<td>9 - Unknown/Indeterminate</td>
<td>1 - Present/Identified</td>
</tr>
<tr>
<td>9 - Unknown/Indeterminate</td>
<td>0 - Not present/Not identified</td>
<td>9 - Unknown/Indeterminate</td>
</tr>
<tr>
<td>9 - Unknown/Indeterminate</td>
<td>1 - Present/Identified</td>
<td>9 - Unknown/Indeterminate</td>
</tr>
<tr>
<td>9 - Unknown/Indeterminate</td>
<td>9 - Unknown/Indeterminate</td>
<td>9 - Unknown/Indeterminate</td>
</tr>
</tbody>
</table>

2. **Use of codes.**
   a. 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.
   b. 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.
   c. Lymphovascular invasion must be coded 0, 1, 2, 3, 4, or 9 for the Schema IDs in the following list:

- 00071 Lip
- 00072 Tongue Anterior
- 00073 Gum
- 00074 Floor of Mouth
- 00075 Palate Hard
- 00076 Buccal Mucosa
- 00077 Muzzle Other
- 00080 Major Salivary Glands
- 00100 Oropharynx (p16+)
- 00111 Oropharynx (p16-)
- 00112 Hypopharynx
- 00121 Maxillary Sinus
- 00122 Nasal Cav/Ethm Sinus
- 00130 Larynx Other
- 00131 Larynx Supraglottic
- 00132 Larynx Glottic
- 00133 Larynx Subglottic
- 00161 Esoph/GJE Squamous
- 00169 Esophagus/GJE (excl Squamous)
- 00170 Stomach
- 00180 Small Intestine
- 00190 Appendix
- 00190 Appendice
- 00200 Colon and Rectum
- 00210 Small Intestine Intramural
dystrophy
- 00220 Bile Ducts Intrahepatic
- 00230 Bile Ducts Intrahepatic
dystrophy
- 00250 Bile Ducts Perihilar
- 00260 Bile Ducts Distal
- 00270 Ampulla Vater
- 00280 Pancreas
- 00290 NET Stomach
- 00301 NET Ampulla of Vater
- 00302 NET Ampulla of Vater
- 00310 NET Duodenum
- 00320 NET Appendix
- 00330 NET Colon/Rectum
- 00340 NET Pancreas
- 00350 Thymus
- 00360 Lung
- 00460 Merkel Cell Skin
- 00470 Melanoma Skin
d. Lymphovascular invasion must be coded 0, 1, 2, 3, 4, 8, or 9 for Schema IDs in the following list:

- 00210 Anus
- 00220 Liver
- 00241 Gallbladder
- 00242 Cystic Duct
- 00381 Bone Appendicular Skeleton
- 00382 Bone Spine
- 00400 Soft Tissue Head/Neck
- 00410 Soft Tissue Trunk and Extremities
- 00421 Soft Tissue Abdomen and Thorax
- 00422 Heart, Mediastinum, and Pleura
- 00440 Retroperitoneum
- 00570 Penis
- 00580 Prostate
- 00600 Kidney Parenchyma
- 00610 Kidney Renal Pelvis
- 00631 Urethra
- 00632 Urethra-Prostatic
- 00640 Kidney Renal Pelvis
- 00650 Conjunctiva
- 00660 Melanoma Eyelid
- 00670 Melanoma Iris and Ciliary Body
- 00680 Retinoblastoma
- 00690 Lacrimal Gland
- 00698 Lacrimal Sac
- 00710 Lymphoma Ocular
- 00718 Eye Other
- 00719 Brain
- 00720 CNS Other
- 00722 Intracranial Gland
- 00770 NET Adrenal Gland
- 00778 Endocrine Other
- 00790 Lymphoma non MF
- 00795 Lymphoma (CLL/SLL)
- 00810 Mycosis Fungoides
- 00812 Primary Cutaneous Lymphoma
- 00818 Non Hodgkin’s Lymphoma
- 00820 Plasma Cell Myeloma
- 00822 Plasma Cell Disorders
- 00830 Heme/Retic
- 009999 Ill-Defined Other

e. Lymphovascular invasion must be coded 8 for all other Schema IDs:

- 00060 Cervical Lymph Nodes, Occult Head/Neck
- 00118 Pharynx Other
- 00119 Middle Ear
- 00128 Sinus Other
- 00140 Melanoma Head/Neck
- 00150 Cutaneous Carcinoma Head and Neck
- 00278 Biliary Other
- 00288 Digestive Other
- 00358 Trachea
- 00370 Pleural
- 00378 Respiratory Other
- 00458 Kaposi Sarcoma

f. Use code 9 when
   i. there is no microscopic examination of a primary tissue specimen
   ii. the primary site specimen is cytology only or a fine needle aspiration
   iii. the biopsy is only a very small tissue sample
   iv. it is not possible to determine whether lymphovascular invasion is present
   v. the pathologist indicates the specimen is insufficient to determine lymphovascular invasion
   vi. lymphovascular invasion is not mentioned in the pathology report
   vii. primary site is unknown

   g. Clarification between codes 8 and 9:
      i. Code 8 for those histologies noted above described in code 8 for which LVI is always not applicable.
      ii. Code 9 for those cases where LVI is applicable but there is no documentation from the pathology report or other sources.
**TUMOR SIZE SUMMARY (Effective 1/1/2016)**

Item Length: 3
Allowable Values: 000–990, 998, 999
NAACCR Item #756

Revised 01/16

**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 2.8 cm. 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 unknown code 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, 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 recorded 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 < 1 cm which is coded as 009.

<table>
<thead>
<tr>
<th>Tumor size is reported as:</th>
<th>Record as:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than (&lt;) 1 mm</td>
<td>001</td>
</tr>
<tr>
<td>Less than (&lt;) 10 mm</td>
<td>009</td>
</tr>
<tr>
<td>Less than (&lt;) 1 cm</td>
<td>009</td>
</tr>
<tr>
<td>Less than (&lt;) 2 cm</td>
<td>019</td>
</tr>
<tr>
<td>Less than (&lt;) 3 cm</td>
<td>029</td>
</tr>
<tr>
<td>Less than (&lt;) 4 cm</td>
<td>039</td>
</tr>
<tr>
<td>Less than (&lt;) 5 cm</td>
<td>049</td>
</tr>
</tbody>
</table>

   b. If tumor size is reported as more than x mm or more than x cm, the reported tumor size should be recorded 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 > 1 cm which is coded as 011.

<table>
<thead>
<tr>
<th>Tumor size is reported as:</th>
<th>Record as:</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than (&gt;) 10 mm</td>
<td>011</td>
</tr>
<tr>
<td>More than (&gt;) 1 cm</td>
<td>011</td>
</tr>
<tr>
<td>More than (&gt;) 2 cm</td>
<td>021</td>
</tr>
<tr>
<td>More than (&gt;) 3 cm</td>
<td>031</td>
</tr>
<tr>
<td>More than (&gt;) 4 cm</td>
<td>041</td>
</tr>
<tr>
<td>More than (&gt;) 5 cm</td>
<td>051</td>
</tr>
<tr>
<td>Anything &gt; 98.0 cm</td>
<td>989</td>
</tr>
</tbody>
</table>

   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

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, but it should be taken as low priority, 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 distant 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 recorded 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 (determined 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 (9590-9992)
   - Kaposi Sarcoma
   - Melanoma Choroid
   - Melanoma Ciliary Body
   - Melanoma Iris

14. **Document the information to support coded tumor size in the appropriate text data item of the abstract.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>No mass/tumor found</td>
</tr>
<tr>
<td>001</td>
<td>1 mm or described as less than 1 mm</td>
</tr>
<tr>
<td>002-988</td>
<td>Exact size in millimeters (2mm-988mm)</td>
</tr>
<tr>
<td>998</td>
<td>989 millimeters or larger</td>
</tr>
<tr>
<td>990</td>
<td>Microscopic focus or foci only and no size of focus is given</td>
</tr>
</tbody>
</table>

**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 mainstem bronchus (C34.0 C34.3, C34.8 C34.9)

- Diffuse:
  - Breast (C50.0 C50.6, C50.8 C50.9)

- 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)

Required 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>In Situ</td>
</tr>
<tr>
<td>1</td>
<td>Localized</td>
</tr>
<tr>
<td>2</td>
<td>Regional by direct extension only</td>
</tr>
<tr>
<td>3</td>
<td>Regional lymph nodes only involved</td>
</tr>
<tr>
<td>4</td>
<td>Regional by both direct extension and to regional lymph nodes (combination of codes 2 and 3)</td>
</tr>
<tr>
<td>7</td>
<td>Distant metastasis (sites or nodes); Systemic disease</td>
</tr>
<tr>
<td>8</td>
<td>Benign and borderline. Use for Brain, CNS Other, Intracranial Gland cases only.</td>
</tr>
<tr>
<td>9</td>
<td>Unknown if involvement is from extension or metastasis; Unstaged, unknown or unspecified; Death certificate only cases</td>
</tr>
</tbody>
</table>
**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.
- 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.

Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.
**AJCC TNM CLIN T Suffix**

Item Length: 4  
Allowable Values: (m), (s), Blank  
NAACCR Item #1031  
Added 01/18

**Required 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:**  
https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(blank)</td>
<td>No information available; not recorded</td>
</tr>
</tbody>
</table>
| (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

**Required 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:*  
[https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx](https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx)

**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.

Refer to the most current list of valid codes and labels: [https://cancerstaging.org/Pages/Vendors.aspx](https://cancerstaging.org/Pages/Vendors.aspx).
**AJCC TNM CLIN N Suffix**

Item Length: 4  
Allowable Values: (sn), (f), Blank  
NAACCR Item #1034  
Added 01/18

Required 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:  
https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(blank)</td>
<td>No information available; not recorded</td>
</tr>
<tr>
<td>(sn)</td>
<td>Sentinel node procedure with or without FNA or core needle biopsy</td>
</tr>
<tr>
<td>(f)</td>
<td>FNA or core needle biopsy only</td>
</tr>
</tbody>
</table>
**AJCC TNM CLIN M**

Item Length: 15
Alphanumeric, Left-Justified
NAACCR Item #1003
Added 01/18

Required 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:*
https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

**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.

Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.
Required 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:
https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

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.

Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.
**AJCC TNM PATH T**

**Item Length:** 15  
**Alphanumeric, Left-Justified**  
**NAACCR Item #1011**  
**Added 01/18**

**Required 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:**  
[https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx](https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx)

**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.

Refer to the most current list of valid codes and labels: [https://cancerstaging.org/Pages/Vendors.aspx](https://cancerstaging.org/Pages/Vendors.aspx).
**AJCC TNM PATH T Suffix**

Item Length: 4  
Allowable Values: (m), (s), Blank  
NAACCR Item #1032  
Added 01/18

Required 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:  
https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

**Description**  
Identifies the AJCC TNM 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(blank)</td>
<td>No information available; not recorded</td>
</tr>
<tr>
<td>(m)</td>
<td>Multiple synchronous tumors OR Multifocal tumor (differentiated and anaplastic thyroid only)</td>
</tr>
<tr>
<td>(s)</td>
<td>Solitary tumor (differentiated and anaplastic thyroid only)</td>
</tr>
</tbody>
</table>
**AJCC TNM PATH N**

Item Length: 15  
Alphanumeric, Left-Justified  
NAACCR Item #1012  
Added 01/18

Required 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:*  
[https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx](https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx)

**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.

Refer to the most current list of valid codes and labels: [https://cancerstaging.org/Pages/Vendors.aspx](https://cancerstaging.org/Pages/Vendors.aspx).
**AJCC TNM PATH N Suffix**

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(blank)</td>
<td>No information available; not recorded</td>
</tr>
<tr>
<td>(sn)</td>
<td>Sentinel node procedure with or without FNA or core needle biopsy</td>
</tr>
<tr>
<td>(f)</td>
<td>FNA or core needle biopsy only</td>
</tr>
</tbody>
</table>

**Required 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:*

https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

**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.
**AJCC TNM PATH M**

Item Length: 15  
Alphanumeric, Left-Justified  
NAACCR Item #1013  
Added 01/18

**Required 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:  
https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

**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.

Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.
**AJCC TNM PATH STAGE GROUP**

Item Length: 15  
Alphanumeric, Left-Justified  
NAACCR Item #1014  
Added 01/18

**Required 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:*  
[https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx](https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx)

**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.

Refer to the most current list of valid codes and labels: [https://cancerstaging.org/Pages/Vendors.aspx](https://cancerstaging.org/Pages/Vendors.aspx).
Required 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: https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

**Description**

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

**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 post therapy T category staging data item must be assigned for Class of Case 10-22.
- Assign post therapy T category as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded post therapy 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.
- 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.

Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.
**AJCC TNM POST THERAPY T Suffix**

Item Length: 4  
Allowable Values: (m), (s), Blank  
NAACCR Item #1033  
Added 01/18

**Required 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:  
[https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx](https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx)

**Description**

Identifies the AJCC TNM post therapy T category suffix for the known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection. 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 post therapy 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 post therapy T category suffix, 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(blank)</td>
<td>No information available; not recorded</td>
</tr>
<tr>
<td>(m)</td>
<td>Multiple synchronous tumors OR Multifocal tumor (differentiated and anaplastic thyroid only)</td>
</tr>
<tr>
<td>(s)</td>
<td>Solitary tumor (differentiated and anaplastic thyroid only)</td>
</tr>
</tbody>
</table>
**AJCC TNM POST THERAPY N**

Required 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:*
[https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx](https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx)

**Description**
Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of lymph node metastasis of the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

**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 post therapy N category staging data item must be assigned for Class of Case 10-22.
- Assign post therapy N category as documented by the treating physician(s) or managing physician in the medical record.
- If the managing physician has not recorded post therapy 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](mailto:ajcc@facs.org) for permission.

Refer to the most current list of valid codes and labels: [https://cancerstaging.org/Pages/Vendors.aspx](https://cancerstaging.org/Pages/Vendors.aspx).
**AJCC TNM POST THERAPY N Suffix**

Item Length: 4  
Allowable Values: (sn), (f), Blank  
NAACCR Item #1036  
Added 01/18

**Required 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: [https://cancerstaging.org/reference-tools/deskreferences/Pages/default.aspx](https://cancerstaging.org/reference-tools/deskreferences/Pages/default.aspx)*

**Description**  
Identifies the AJCC TNM post therapy N suffix for the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection. 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 post therapy 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 post therapy N category suffix, 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(blank)</td>
<td>No information available; not recorded</td>
</tr>
<tr>
<td>(sn)</td>
<td>Sentinel node procedure with or without FNA or core needle biopsy</td>
</tr>
<tr>
<td>(f)</td>
<td>FNA or core needle biopsy only</td>
</tr>
</tbody>
</table>
**AJCC TNM POST THERAPY M**

Item Length: 15  
Alphanumeric, Left-Justified  
NAACCR Item #1023  
Added 01/18

**Required 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:*  
https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

**Description**  
Identifies the presence or absence of distant metastasis (M) of the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned postneoadjuvant therapy surgical resection.

**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 post therapy M category staging data item must be assigned for *Class of Case* 10-22.  
- Assign post therapy M category as documented by the treating physician(s) or the managing physician in the medical record.  
- If the managing physician has not recorded post therapy 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.

Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.
**AJCC TNM POST THERAPY STAGE GROUP**

- Item Length: 15
- Alphanumeric, Left-Justified
- NAACCR Item #1024
- Added 01/18

**Required 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:**
https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

**Description**
Identifies the anatomic extent of disease based on the T, N, and M category data items of the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

**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 post therapy 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 post therapy 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.

Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.
SITE SPECIFIC DATA ITEMS (SSDI)

Item Length: Varies
Allowable Values: Varies
NAACCR Item #’s (see SSDI Manual)
Added 01/18

Required for cases diagnosed 1/1/2018 and after.
Refer to Section I on the Stage data collection requirements based on year of diagnosis.

- For cases diagnosed on January 1, 2018 and later, the SSDIs in the table below are required to be reported to the N.C. CCR.
- The table below provides a quick reference to the most common codes for each required SSDI. Refer to the SSDI Manual for detailed descriptions, rationales, coding instructions and site-specific coding rules: https://www.naaccr.org/SSDI/SSDI-Manual.pdf.

<table>
<thead>
<tr>
<th>Site/Chapter</th>
<th>SSDI</th>
<th>Most Common Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brain/Spinal Cord</td>
<td>Brain Molecular Markers</td>
<td>01 = Diffuse astrocytoma, IDH-mutant (9400/3)</td>
</tr>
<tr>
<td>(CH 72)</td>
<td></td>
<td>02 = Diffuse astrocytoma, IDH-wildtype (9400/3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>03 = Anaplastic astrocytoma, IDH-mutant (9401/3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>04 = Anaplastic astrocytoma, IDH-wildtype (9401/3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>05 = Glioblastoma, IDH-wildtype (9440/3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>06 = Oligodendroglioma, IDH-mutant and 1 p/19q co-deleted (9450/3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>07 = Anaplastic oligodendroglioma, IDH-mutant and 1p/19q co-deleted (9451/3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>08 = Medulloblastoma, SHH-activated and TP53-wildtype (9471/3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>09 = Embryonal tumor with multilayered rosettes, C19MC-altered (9478/3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>85 = NA: Microscopic Conf and Hist is not 9400, 9401, 9440, 9450, 9451, 9471, 9478</td>
</tr>
<tr>
<td></td>
<td></td>
<td>86 = Benign Brain Tumor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>87 = Ordered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99 = Tumor was not microscopically confirmed (clinical dx only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99 = Histology is one of those above but molecular studies were not done.</td>
</tr>
<tr>
<td>Breast (CH 48)</td>
<td>Estrogen Receptor Summary</td>
<td>0 = ER Neg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 = ER Pos</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 = Ordered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9 = Not Done, Not Documented</td>
</tr>
<tr>
<td></td>
<td>Progesterone Receptor Summary</td>
<td>0 = PR Neg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 = PR Pos</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 = Ordered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9 = Not Done, Not Documented</td>
</tr>
<tr>
<td></td>
<td>HER2 Overall Summary</td>
<td>0 = HER2 Neg; equivocal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 = HER2 Pos</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 = Ordered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9 = Not Done, Not Documented</td>
</tr>
<tr>
<td>Appendix (CH 19)</td>
<td>CEA Pretreatment Lab Value</td>
<td>0.0 = 0.0 ng/ml exactly</td>
</tr>
<tr>
<td>Colon and Rectum (CH</td>
<td></td>
<td>0.1 - 9999.9 = exact value to nearest tenth in ng/ml</td>
</tr>
<tr>
<td>20)</td>
<td></td>
<td>XXXX.1 = 10,000 ng/ml or greater</td>
</tr>
<tr>
<td></td>
<td></td>
<td>XXXX.7 = Ordered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>XXXX.9 Not Documented</td>
</tr>
</tbody>
</table>
| CEA Pretreatment Interpretation | 0 = Neg  
1 = Pos, Elevated  
2 = Borderline  
3 = Undetermined  
7 = Ordered  
9 = Not Done; Documented |
|-------------------------------|--------------------------------------------------|
| Microsatellite Instability (MSI) | 0 = Stable, Neg, MMR intact, no loss of MMR proteins  
1 = MSI-L, unstable Low  
2 = MSI=H, unstable High, loss of MMR proteins, MMR-D protein deficient  
9 = Not Done; Not Documented |
| Esoph/EGJ (CH 16) | Esophagus and EGJ Tumor Epicenter | 0 = U: Upper, Cervical, Proximal  
1 = M: Middle  
2 = L: Lower, incl GEJ  
9 = X: Not Documented |
| Liver (CH 22) | IHBD (CH 23) | Fibrosis Score | 0 = No to moderate fibrosis (See Manual for more descriptions)  
1 = Advanced/severe fibrosis; Cirrhosis, NOS (See Manual)  
7 = Clinical statement of advanced/severe fibrosis or cirrhosis AND not histologically confirmed  
9 = Not Done; Not Documented |
| Lung (CH 36) | Separate Tumor Nodules | Only code separate tumor nodules of the same histologic type as the primary tumor.  
Exclude: Second/synchronous primary tumors with a DIFFERENT histology; multifocal lung adenocarcinoma with ground glass/lepidic features; diffuse pneumonic adenocarcinoma.  
0 = Single Tumor. No mention of multiple tumors.  
1 = same histology type in same lung, same lobe  
2 = same histology type in same lung, different lobe  
3 = same histology type in same lung, same AND different lobes  
4 = same histology type in same lung, unknown if same or different lobes  
7 = Multiple nodules/foci present. Information is not sufficient to determine if histology is the same or different. Do not include in assignment of T category.  
9 = Not Documented, Primary tumor is all in situ |
| Breslow Tumor Thickness | 0.2 - 99.9 = Record Breslow depth/thickness in nearest tenth of MM.  
0.0 = No tumor  
0.1 = > 0.0 and <= 0.1  
XX.1 = >= 100.0 mm  
A0.1 - A9.9 = Stated as "at least". Record the "at least" value.  
AX.0 = Stated as "at least" and the value is > 9.9 mm  
XX.9 = Not documented  
Examples:  
0.40 mm. Code 0.4  
1.00 mm. Code 1.0  
2.56 mm. Round, code 2.6  
11.00 mm. Code 11.0  
12.35 mm. Round, code 12.4 |
| Ulceration | 0 = Not identified; not present on path report  
1 = Present on path report  
9 = Not Done; Not Documented. Path report does not mention ulceration. |
| Mitotic Rate Melanoma | 00 = 0/mm2; mitosis absent; no mitosis  
01-99 = Record exact mitosis/mm2  
X1 = >= 100 mitosis/mm2  
X2 = Stated as less than 1/mm2; non-mitogenic  
X3 = Stated as at least 1/mm2; mitogenic  
X4 = Denominator other than mm2  
X7 = Ordered  
X9 = Not documented |
<table>
<thead>
<tr>
<th>Test</th>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LDH Pretreatment</strong>&lt;br&gt;Lab Value</td>
<td>0.0 = 0.0 u/L 0.1-99999.9 = Record exact value XXXX.X1 = &gt;= 100,000 u/L XXXX.X7 = Ordered XXXX.X9 Not Done; Not Documented</td>
<td></td>
</tr>
<tr>
<td><strong>Prostate</strong>&lt;br&gt;(CH 58)</td>
<td><strong>PSA Lab Value</strong></td>
<td>0.2 - 999.9 = Record exact PSA value 0.1 = 0.1 or less XXX.X1 = 1,000 or greater XXX.X7 = Ordered XXX.X9 = Not Documented</td>
</tr>
<tr>
<td><strong>Examples:</strong></td>
<td>7.2 code 7.2 10.0 code 10.0 8.56 code 8.6 110.35 code 110.4</td>
<td></td>
</tr>
<tr>
<td><strong>Gleason Patterns Clinical</strong></td>
<td>02 = Primary 2, secondary 2 03 = Primary 3, secondary unknown</td>
<td></td>
</tr>
<tr>
<td><strong>Gleason Score Clinical</strong></td>
<td>02 = Primary 2, secondary 2 03 = Primary 3, secondary unknown</td>
<td></td>
</tr>
<tr>
<td><strong>Testis</strong>&lt;br&gt;(CH 59)</td>
<td><strong>S Category Clinical (Pre-Orchiectomy)</strong></td>
<td>All 3 lab values are needed for S0-S2. Only one elevated test is needed to assign S3. 0 = S0: WNL. All AFP, hCG or LDH SSDI's are coded to 0 1 = S1: All AFP, hCG and LDH SSDI's are coded to 1 2 = S2: At least one of the AFP, hCG or LDH SSDI's is coded to 2 3 = S3: Any one of the AFP, hCG or LDH SSDI's is coded to 3 9 = SX: Not documented. One of above lab values are unknown (excludes S3)</td>
</tr>
<tr>
<td><strong>S Category Pathological (Post-Orchiectomy)</strong></td>
<td>0 = Not present 1 = Present 7 = Ordered 9 = Not documented</td>
<td></td>
</tr>
<tr>
<td><strong>Peripheral Blood Involvement</strong></td>
<td>0-6 = See Manual for detailed description 9 = Not Done; Not Documented</td>
<td></td>
</tr>
</tbody>
</table>
| **Cutaneous Lymphoma/Mycosis Fungoides (CH 81)** | **Cancer Collection and Reporting Manual**
North Carolina Central Cancer Registry May 2019 
N.C. Division of Public Health |
<p>| <strong>Plasma Cell/ Multiple Myeloma (CH 82)</strong> | <strong>High Risk Cytogenetics</strong> | 0 = Not present 1 = Present 7 = Ordered 9 = Not documented |
| <strong>LDH Pretreatment Level</strong> | 0 = Normal, low, below normal 1 = High, above normal 7 = Ordered 9 = Not Documented |</p>
<table>
<thead>
<tr>
<th></th>
<th>Serum Albumin Pretreatment Level</th>
<th>Serum Beta-2 Microglobulin Pretreatment Level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 = &lt; 3.5 g/dL</td>
<td>0 = &lt; 3.5 mg/L</td>
</tr>
<tr>
<td></td>
<td>1 = &gt;= 3.5 g/dL</td>
<td>1 = &gt;= 3.5 and &lt; 5.5 mg/L</td>
</tr>
<tr>
<td></td>
<td>7 = Ordered</td>
<td>2 = &gt;= 5.5 mg/L</td>
</tr>
<tr>
<td></td>
<td>9 = Not documented</td>
<td>7 = Ordered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9 = Not documented</td>
</tr>
</tbody>
</table>

**Schema Discriminators code choices will appear in the software only for the sites specified below.**

<table>
<thead>
<tr>
<th>Required for these sites:</th>
<th>Schema Discriminator 1</th>
<th>Required for these sites:</th>
<th>Schema Discriminator 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BileDuctsDistal/BileDuctsPerihilar/CysticDuct</td>
<td>Histology Discriminator for 8020</td>
<td>Ch 10/11 Oropharyngeal</td>
</tr>
<tr>
<td></td>
<td>Histology Discriminator for 9591/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Melanoma Ciliary Body/Melanoma Iris</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occult Head and Neck Lymph Nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary Peritoneum Tumor</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urethra/Prostatic Urethra</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Esophagus,EGJ/Stomach</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lacrimal Gland/Sac</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nasopharynx/Pharyng Tonsil</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plasma Cell Myeloma</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thyroid Gland/Thyrogloss Duct</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.
- If the year of diagnosis is 2004 – 2015, the Collaborative Stage and Site Specific Factor data items CANNOT be left blank.
- Refer to the following manuals for site-specific coding instructions:
  - CCARM 2016
  - Collaborative Stage Data Collection System: https://cancerstaging.org/cstage/Pages/default.aspx

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)

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item Name</th>
<th>Item #</th>
<th>Item Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>2880</td>
<td>CS Site-Specific Factor 1</td>
<td>2867</td>
<td>CS Site-Specific Factor13</td>
</tr>
<tr>
<td>2890</td>
<td>CS Site-Specific Factor 2</td>
<td>2868</td>
<td>CS Site-Specific Factor14</td>
</tr>
<tr>
<td>2900</td>
<td>CS Site-Specific Factor 3</td>
<td>2869</td>
<td>CS Site-Specific Factor15</td>
</tr>
<tr>
<td>2910</td>
<td>CS Site-Specific Factor 4</td>
<td>2870</td>
<td>CS Site-Specific Factor16</td>
</tr>
<tr>
<td>2920</td>
<td>CS Site-Specific Factor 5</td>
<td>2871</td>
<td>CS Site-Specific Factor17</td>
</tr>
<tr>
<td>2930</td>
<td>CS Site-Specific Factor 6</td>
<td>2872</td>
<td>CS Site-Specific Factor18</td>
</tr>
<tr>
<td>2861</td>
<td>CS Site-Specific Factor 7</td>
<td>2873</td>
<td>CS Site-Specific Factor19</td>
</tr>
<tr>
<td>2862</td>
<td>CS Site-Specific Factor 8</td>
<td>2874</td>
<td>CS Site-Specific Factor20</td>
</tr>
<tr>
<td>2863</td>
<td>CS Site-Specific Factor 9</td>
<td>2875</td>
<td>CS Site-Specific Factor21</td>
</tr>
<tr>
<td>2864</td>
<td>CS Site-Specific Factor10</td>
<td>2876</td>
<td>CS Site-Specific Factor22</td>
</tr>
<tr>
<td>2865</td>
<td>CS Site-Specific Factor11</td>
<td>2877</td>
<td>CS Site-Specific Factor23</td>
</tr>
<tr>
<td>2866</td>
<td>CS Site-Specific Factor12</td>
<td>2878</td>
<td>CS Site-Specific Factor24</td>
</tr>
<tr>
<td>2867</td>
<td>CS Site-Specific Factor13</td>
<td>2879</td>
<td>CS Site-Specific Factor25</td>
</tr>
</tbody>
</table>
First Course of Treatment
**DATE OF FIRST COURSE OF TREATMENT**

**Item Length:** 8  
**NAACCR Item #1270**  
**Revised 01/10, 01/11**

**Description**
Records the date on which treatment (surgery, radiation, systemic or other therapy) of the patient 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.
- 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, the date of first course of treatment is the date this decision was made.
- Leave this item blank if the cancer was diagnosed at autopsy and not suspected prior to that.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Course of Treatment* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Course of Treatment* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date 1st Crs Rx Flag [1271]* is used to explain why *Date of First Course of Treatment* is not a known date. See *Date 1st Crs Rx Flag* for an illustration of the relationships among these items.

**Examples**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A patient has a core biopsy on February 12, 2018, and subsequently undergoes an excisional biopsy on February 14, 2018</td>
<td>20180214</td>
</tr>
<tr>
<td>A patient begins receiving preoperative radiation therapy elsewhere on April 21, 2018, and subsequent surgical therapy at this facility on June 2, 2018</td>
<td>20180421</td>
</tr>
</tbody>
</table>
**DATE 1st CRS RX FLAG**

---

**Item Length:** 2  
**NAACCR Item #1271**  
**Valid Codes:** 10-12, Blank  
**Revised 01/12, 01/15**

---

**Description**  
This flag explains why there is no appropriate value in the corresponding date field, *Date of First Course of Treatment [1270]*.

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

**Coding Instructions**

- Leave this item blank if *Date of First Course of Treatment [1270]* has a full or partial date recorded.
- Code 12 if any part of the *Date of First Course of Treatment* cannot be determined or estimated, but the patient did receive first course treatment.
- Code 12 if a decision not to treat was made, but the date is unknown and any part of the date cannot be estimated.
- Code 12 if a decision to use active surveillance was made, but the date is unknown and any part of the date cannot be estimated.
- Code 10 if it is unknown whether any treatment was administered.
- Code 11 if the initial diagnosis was at autopsy.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>No information whatsoever can be inferred from this exceptional value (that is, unknown if any treatment was given).</td>
</tr>
<tr>
<td>11</td>
<td>No proper value is applicable in this context (that is, no treatment was given or autopsy only).</td>
</tr>
<tr>
<td>12</td>
<td>A proper value is applicable but not known. This event occurred, but the date is unknown (for example, treatment was given but the date is unknown).</td>
</tr>
<tr>
<td>(blank)</td>
<td>A valid date value is provided in item <em>Date of First Course of Treatment [1270]</em>.</td>
</tr>
</tbody>
</table>
**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**
- This item may be left blank for cases diagnosed prior to 2010.
- 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No treatment given</td>
</tr>
<tr>
<td>1</td>
<td>Treatment given</td>
</tr>
<tr>
<td>2</td>
<td>Active surveillance (watchful waiting)</td>
</tr>
<tr>
<td>9</td>
<td>Unknown if treatment was given</td>
</tr>
</tbody>
</table>

**Examples:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>An elderly patient with pancreatic cancer requested no treatment.</td>
</tr>
<tr>
<td>0</td>
<td>Patient is expected to receive radiation, but it has not occurred yet <em>(Reason for No Radiation [1430] = 8)</em></td>
</tr>
<tr>
<td>2</td>
<td>Treatment plan for a lymphoma patient is active surveillance.</td>
</tr>
</tbody>
</table>
**DATE OF FIRST SURGICAL PROCEDURE**

**Item Length:** 8  
**NAACCR Item #1200**  
**Revised 01/10, 01/11**

**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**

- Record the date of the first surgical procedure of the types coded as *Surgical Procedure of Primary Site* [1290], *Scope of Regional Lymph Node Surgery* [1292] or *Surgical Procedure/Other Site* [1294] performed at this or any facility.
- 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].
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Surgical Procedure* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Surgical Procedure* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Rx Date–Surgery Flag* [1201] is used to explain why *Date of First Surgical Procedure* is not a known date. See *Rx Date–Surgery Flag* for an illustration of the relationships among these items.

**Examples**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A melanoma patient had an excisional biopsy on March 23, 2018, then a wide excision on March 28, 2018.</td>
<td>20180323</td>
</tr>
<tr>
<td>The patient had a small (0.5 cm) lump removed from her breast on November 16, 2018.</td>
<td>20181116</td>
</tr>
<tr>
<td>The patient’s primary tumor was treated with radiation beginning on April 16, 2018, after a distant metastasis was removed surgically on March 27, 2018.</td>
<td>20180327</td>
</tr>
</tbody>
</table>
**RX DATE–SURGERY FLAG**

Item Length: 2  
NAACCR Item #1201  
Valid Codes: 10-12, Blank  
New Item: 1/1/2010

**Description**

This flag explains why there is no appropriate value in the corresponding date field, *Date of First Surgical Procedure* [1200].

**Rationale**

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

**Coding Instructions**

- Leave this item blank if *Date of First Surgical Procedure* [1200] has a full or partial date recorded.
- Code 12 if the *Date of First Surgical Procedure* cannot be determined, but the patient did receive first course surgery.
- Code 10 if it is unknown whether any surgery was performed.
- Code 11 if no surgical procedure was performed.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).</td>
</tr>
<tr>
<td>11</td>
<td>No proper value is applicable in this context (for example, no surgery performed).</td>
</tr>
<tr>
<td>12</td>
<td>A proper value is applicable but not known. This event occurred, but the date is unknown (that is, surgery was performed but the date is unknown).</td>
</tr>
<tr>
<td>(blank)</td>
<td>A valid date value is provided in item <em>Date of First Surgical Procedure</em> [1200].</td>
</tr>
</tbody>
</table>
Description
Records the date of the most definitive surgical procedure of the primary site performed as part of the first course of treatment.

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
• Record the date on which the surgery described by Surgical Procedure of Primary Site [1290] was performed at this or any facility.
• Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for Date of Most Definitive Surgical Resection of the Primary Site is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of Date of Most Definitive Surgical Resection of the Primary Site transmits in CCYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The RX Date Mst Defn Srg Flag [3171] is used to explain why Date of Most Definitive Surgical Resection of the Primary Site is not a known date. See RX Date Mst Defn Srg Flag for an illustration of the relationships among these items.
**RX DATE MST DEFN SRG FLAG**

Item Length: 2  
NAACCR Item #3171  
Valid Codes: 10-12, Blank  
Revised: 01/11

**Description**
This flag explains why there is no appropriate value in the corresponding date field, *Date of Most Definitive Surgical Resection of the Primary Site* [3170].

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

**Coding Instructions**
- Leave this item blank if *Date of Most Definitive Surgical Resection of the Primary Site* [3170] has a full or partial date recorded.
- Code 12 if the *Date of Most Definitive Surgical Resection of the Primary Site* cannot be determined, but the patient did receive first course surgery.
- Code 10 if it is unknown whether any surgery was performed.
- Code 11 if no surgical procedure was performed.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave blank for cases diagnosed prior to January 1, 2003.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).</td>
</tr>
<tr>
<td>11</td>
<td>No proper value is applicable in this context (for example, no surgery performed).</td>
</tr>
<tr>
<td>12</td>
<td>A proper value is applicable but not known. This event occurred, but the date is unknown (that is, surgery was performed but the date is unknown).</td>
</tr>
<tr>
<td>(blank)</td>
<td>A valid date value is provided in item <em>Date of Most Definitive Surgical Resection of the Primary Site</em> [3170]. Case was diagnosed prior to January 1, 2018.</td>
</tr>
</tbody>
</table>
**SURGICAL PROCEDURE OF PRIMARY SITE**

<table>
<thead>
<tr>
<th>Item Length: 2</th>
<th>Allowable Values: 00, 10-80, 90, 98, 99</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAACCR Item #1290</td>
<td>Revised: 06/05, 01/10, 01/12, 01/15, 01/16</td>
</tr>
</tbody>
</table>

**Description**
Records the surgical procedure(s) performed to the primary site.

Code ranges are grouped according to the general nature of the procedure:
- Codes 10 through 19 include procedures that do not produce a pathologic specimen.
- Codes 20 through 80 include descriptions of resection procedures (a pathologic specimen is produced).

**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 the specific codes to be used for each primary site.
- Code 98 is a special code that applies to certain sites only. For these sites, code 98 is the only allowable code. This includes:
  - Hematopoietic primary sites (C42._)
  - Ill-defined primary sites (C76._)
  - Unknown primary site (C80.9)
- Excisional biopsies (those that remove the entire tumor and/or leave only microscopic margins) are to be coded in this item.
  - 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.
- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results.
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- Code the surgery that best describes the surgical procedure performed, whether or not any cancer was found in the resected portion.
- 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, except where noted in Appendix B.
- 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.

**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: 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 take precedence over the earlier-listed code.

20  Local tumor excision, NOS
26  Polypectomy
27  Excisional biopsy
    Combination of 20 or 26–27 WITH
    21  Photodynamic therapy (PDT)
    22  Electrocautery
    23  Cryosurgery
    24  Laser ablation
    25  Laser excision

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>None</td>
<td>No surgical procedure of primary site. Diagnosed at autopsy.</td>
</tr>
<tr>
<td>10–19</td>
<td>Site-specific codes; tumor destruction</td>
<td>Tumor destruction, no pathologic specimen produced. Refer to Appendix B for the correct site-specific code for the procedure.</td>
</tr>
<tr>
<td>20–80</td>
<td>Site-specific codes; resection</td>
<td>Refer to Appendix B for the correct site-specific code for the procedure.</td>
</tr>
<tr>
<td>90</td>
<td>Surgery, NOS</td>
<td>A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.</td>
</tr>
<tr>
<td>98</td>
<td>Site-specific codes; special</td>
<td>Special code. Refer to Appendix B for the correct site-specific code for the procedure.</td>
</tr>
<tr>
<td>99</td>
<td>Unknown</td>
<td>Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.</td>
</tr>
</tbody>
</table>
SCOPE OF REGIONAL LYMPH NODE SURGERY

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 or stage 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.
- Code 9 for:
  - Intracranial and central nervous system primaries (C70.0–C70.9, C71.0–C71.9, C72.0–C72.9, C75.1–C75.3)
  - Lymphomas (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971) with a lymph node primary site (C77.0–C77.9)
  - Unknown or ill-defined primary site (C76.0–C76.8, C80.9) or for 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 9975-9992)
- 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.

Note: One important use of registry data is the tracking of treatment patterns over time. In order to compare contemporary treatment with previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is very important to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than 4 lymph nodes was not reflected in surgery codes. It is not intended to reflect clinical significance when applied to a particular surgical procedure. It is important to avoid inferring, by data presentation or other methods, that one category is preferable to another within the intent of these items.
**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>General Instructions Applying to All Sites</th>
<th>Additional Notes Specific to Breast (C50.x)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No regional lymph node surgery</td>
<td>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.</td>
<td>Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), an axillary 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 a ALND.</td>
</tr>
<tr>
<td>1</td>
<td>Biopsy or aspiration of regional lymph node(s)</td>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>
| 2    | Sentinel Lymph Node Biopsy | - The operative report states that a SLNBx was performed.  
- Code 2 SLNBx 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.  
- When a SLNBx is performed, additional non-sentinel nodes can be taken during | - 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).  
- Infrequently, a SLNBx is attempted and the patient fails to map (i.e., no sentinel lymph nodes are identified by |
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.

3 Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS

- 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 with a regional lymph node dissection (code 6 or 7).

4 1-3 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).
- Infrequently, a SLNBx is attempted and the patient fails to map (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. 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.

5 4 or more regional lymph nodes removed

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).

6 Sentinel • **SNLBx and regional lymph node dissection** • Generally, SLNBx followed by ALND
<table>
<thead>
<tr>
<th>Code</th>
<th>Sentinel node biopsy and code 3, 4, or 5 at different times</th>
<th>SNLBox and regional lymph node dissection (code 3, 4, or 5) in separate surgical events.</th>
<th>Generally, SLNBox followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Sentinel node biopsy and code 3, 4, or 5 at different times</td>
<td>SNLBox and regional lymph node dissection (code 3, 4, or 5) in separate surgical events.</td>
<td>Generally, SLNBox followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes.</td>
</tr>
<tr>
<td></td>
<td>Generally, SLNBox 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.</td>
<td>Generally, SLNBox followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes.</td>
<td>If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBox or whether a SLNBox plus an ALND was performed.</td>
</tr>
<tr>
<td></td>
<td>If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBox only.</td>
<td>If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBox only.</td>
<td>If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBox only.</td>
</tr>
<tr>
<td></td>
<td>Infrequently, a SLNBox is attempted and the patient fails to map (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection.) When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6.</td>
<td>If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBox only.</td>
<td>If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBox only.</td>
</tr>
<tr>
<td>9</td>
<td>Unknown or not applicable</td>
<td>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 [1290]). Review surgically treated cases coded 9 in Scope of Regional Lymph Node Surgery to confirm the code.</td>
<td>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 [1290]). Review surgically treated cases coded 9 in Scope of Regional Lymph Node Surgery to confirm the code.</td>
</tr>
</tbody>
</table>

**Examples**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No effort was made to locate sentinel lymph nodes and no nodes were found in pathologic analysis.</td>
</tr>
<tr>
<td>2</td>
<td><strong>(C50.1-Breast)</strong> There was an attempt at sentinel lymph node dissection, but no lymph nodes were found in the pathological specimen.</td>
</tr>
<tr>
<td>1</td>
<td><strong>(C14.0-Pharynx)</strong> Aspiration of regional lymph node to confirm histology of widely metastatic disease.</td>
</tr>
<tr>
<td>2</td>
<td><strong>(C44.5-Skin of Back)</strong> 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.</td>
</tr>
<tr>
<td>3</td>
<td><strong>(C61.9-Prostate)</strong> Bilateral pelvic lymph node dissection for prostate cancer.</td>
</tr>
<tr>
<td>6</td>
<td><strong>(C50.3-Breast)</strong> Sentinel lymph node biopsy (SLNBox) of right axilla, followed by right axillary lymph node dissection (ALND) during the same surgical event.</td>
</tr>
<tr>
<td>7</td>
<td><strong>(50.4-Breast)</strong> Sentinel lymph node biopsy (SLNBox) of left axilla, followed in a second procedure 5 days later by a left axillary lymph node dissection (ALND).</td>
</tr>
<tr>
<td>9</td>
<td><strong>(C34.9-Lung)</strong> 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.</td>
</tr>
</tbody>
</table>
**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**

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**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.

**Instructions for Coding**  
- Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- If other tissue or organs are removed during primary site surgery that are not specifically defined by the site-specific *Surgical Procedure of the Primary Site* [1290 or 670] code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code. 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 ill-defined primary sites (C76.0–76.8, C80.9) or for 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 9975-9992).

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
<td>No surgical procedure of nonprimary site was performed. Diagnosed at autopsy.</td>
</tr>
<tr>
<td>1</td>
<td>Nonprimary surgical procedure performed</td>
<td>Nonprimary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.</td>
</tr>
<tr>
<td>2</td>
<td>Nonprimary surgical procedure to other regional sites</td>
<td>Resection of regional site.</td>
</tr>
<tr>
<td>3</td>
<td>Nonprimary surgical procedure to <em>distant lymph node(s)</em></td>
<td>Resection of <em>distant lymph node(s)</em>.</td>
</tr>
<tr>
<td>4</td>
<td>Nonprimary surgical procedure to distant site</td>
<td>Resection of distant site.</td>
</tr>
<tr>
<td>5</td>
<td>Combination of codes</td>
<td>Any combination of surgical procedures 2, 3, or 4.</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
<td>It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only.</td>
</tr>
</tbody>
</table>
### Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>(C18.1–Colon) The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon.</td>
</tr>
<tr>
<td>1</td>
<td>Surgical removal of metastatic lesion from liver; unknown primary.</td>
</tr>
<tr>
<td>2</td>
<td>(C18.3–Colon) Surgical ablation of solitary liver metastasis, hepatic flexure primary.</td>
</tr>
<tr>
<td>4</td>
<td>(C34.9–Lung) Removal of solitary brain metastasis.</td>
</tr>
<tr>
<td>5</td>
<td>(C21.0–Anus) Excision of solitary liver metastasis and one large hilar lymph node.</td>
</tr>
</tbody>
</table>
**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 *Surgical Procedure of Primary Site* [1290] is coded 00, 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 *Surgical Procedure of Primary Site* [1290] is coded 98.
- 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 definitive code as appropriate.
- Code 9 if the treatment plan offered multiple choices, but it is unknown which, if any was provided.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Surgery of the primary site was performed.</td>
</tr>
<tr>
<td>1</td>
<td>Surgery of the primary site was not performed because it was not part of the planned first course treatment. Diagnosed at autopsy.</td>
</tr>
<tr>
<td>2</td>
<td>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.)</td>
</tr>
<tr>
<td>5</td>
<td>Surgery of primary site was not performed because patient died prior to planned or recommended surgery.</td>
</tr>
<tr>
<td>6</td>
<td>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.</td>
</tr>
<tr>
<td>7</td>
<td>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.</td>
</tr>
<tr>
<td>8</td>
<td>Surgery of primary site was recommended, but it is unknown if performed. Follow-up is recommended.</td>
</tr>
<tr>
<td>9</td>
<td>It is unknown whether surgery of the primary site was recommended or performed. Death certificate only.</td>
</tr>
</tbody>
</table>

**Examples**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>A patient with a primary tumor of the liver is not recommended for surgery due to advanced cirrhosis.</td>
</tr>
<tr>
<td>8</td>
<td>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.</td>
</tr>
</tbody>
</table>
**DATE RADIATION STARTED**

**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 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. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for Date Radiation Started is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of Date Radiation Started transmits in CCYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The RX Date–Radiation Flag [1211] is used to explain why Date Radiation Started is not a known date. See RX Date–Radiation Flag for an illustration of the relationships among these items.

**Examples**

<table>
<thead>
<tr>
<th>A patient has external beam radiation on December 15, 2018.</th>
<th>December Dec. 15, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on October 12, 2018.</td>
<td>October 12, 2018</td>
</tr>
<tr>
<td>A patient enters the facility for interstitial radiation boost for prostate cancer that is performed on August 6, 2018. Just prior to this, the patient had external beam therapy to the lower pelvis that was started on June 2, 2018, at another facility.</td>
<td>June 2, 2018</td>
</tr>
</tbody>
</table>
**RX DATE–RADIATION FLAG**

Item Length: 2  
NAACCR Item #1211  
Valid Codes: 10-12, 15, Blank  
New Item: 01/2010

**Description**  
This flag explains why there is no appropriate value in the corresponding date field, *Date Radiation Started* [1210].

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

**Coding Instructions**  
- Leave this item blank if *Date Radiation Started* [1210] has a full or partial date recorded.  
- Code 12 if the *Date Radiation Started* cannot be determined, but the patient did receive first course radiation.  
- Code 10 if it is unknown whether any radiation was given.  
- Code 11 if no radiation is planned or given.  
- Code 15 if radiation is planned, but has not yet started and the start date is not yet available. Follow this patient for radiation treatment and update this item, *Date Radiation Started*, and all other radiation items.  
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>No information whatsoever can be inferred from this exceptional value (that is, unknown if any radiation was given).</td>
</tr>
<tr>
<td>11</td>
<td>No proper value is applicable in this context (for example, no radiation given).</td>
</tr>
<tr>
<td>12</td>
<td>A proper value is applicable but not known. This event occurred, but the date is unknown (that is, radiation was given but the date is unknown).</td>
</tr>
<tr>
<td>15</td>
<td>Information is not available at this time, but it is expected that it will be available later (for example, radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).</td>
</tr>
<tr>
<td>(blank)</td>
<td>A valid date value is provided in item <em>Date Radiation Started</em> [1210].</td>
</tr>
</tbody>
</table>
**PHASE I RADIATION TREATMENT MODALITY**

Item Length: 2
Allowable Values: 00–16, 99
NAACCR Item #1506
Added 01/18

This data item, in conjunction with *Phase I Radiation External Beam Planning Technique* [1502], replaces the *Rad--Regional RX Modality* [1570]. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

**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.
- 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No radiation treatment</td>
</tr>
<tr>
<td>01</td>
<td>External beam, NOS</td>
</tr>
<tr>
<td>02</td>
<td>External beam, photons</td>
</tr>
<tr>
<td>03</td>
<td>External beam, protons</td>
</tr>
<tr>
<td>04</td>
<td>External beam, electrons</td>
</tr>
<tr>
<td>05</td>
<td>External beam, neutrons</td>
</tr>
<tr>
<td>06</td>
<td>External beam, carbon ions</td>
</tr>
<tr>
<td>07</td>
<td>Brachytherapy, NOS</td>
</tr>
<tr>
<td>08</td>
<td>Brachytherapy, intracavitary, LDR</td>
</tr>
<tr>
<td>09</td>
<td>Brachytherapy, intracavitary, HDR</td>
</tr>
<tr>
<td>10</td>
<td>Brachytherapy, Interstitial, LDR</td>
</tr>
<tr>
<td>11</td>
<td>Brachytherapy, Interstitial, HDR</td>
</tr>
<tr>
<td>12</td>
<td>Brachytherapy, electronic</td>
</tr>
<tr>
<td>13</td>
<td>Radioisotopes, NOS</td>
</tr>
<tr>
<td>14</td>
<td>Radioisotopes, Radium-223</td>
</tr>
<tr>
<td>15</td>
<td>Radioisotopes, Strontium-89</td>
</tr>
<tr>
<td>16</td>
<td>Radioisotopes, Strontium-90</td>
</tr>
<tr>
<td>99</td>
<td>Radiation treatment modality unknown; Unknown if radiation treatment administered</td>
</tr>
</tbody>
</table>
**RADIATION/SURGERY SEQUENCE**

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 *Surgical Procedure of Primary Site* [1290]; *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.
- If the patient received both radiation therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site*, *Regional Lymph Node Surgery* or *Surgical Procedure/Other Site*, 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No radiation therapy and/or surgical</td>
<td>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.</td>
</tr>
<tr>
<td>2</td>
<td>Radiation therapy before surgery</td>
<td>Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s).</td>
</tr>
<tr>
<td>3</td>
<td>Radiation therapy after surgery</td>
<td>Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s).</td>
</tr>
<tr>
<td>4</td>
<td>Radiation therapy both before and after</td>
<td>At least two courses 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).</td>
</tr>
<tr>
<td>5</td>
<td>Intraoperative radiation therapy</td>
<td>Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s).</td>
</tr>
<tr>
<td>Code</td>
<td>Label</td>
<td>Definition</td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>6</td>
<td>Intraoperative radiation therapy with other therapy administered before or after surgery</td>
<td>Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s).</td>
</tr>
<tr>
<td>7</td>
<td>Surgery both before and after radiation</td>
<td>Radiation was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s) or distant lymph node(s).</td>
</tr>
<tr>
<td>9</td>
<td>Sequence unknown</td>
<td>Administration of radiation therapy and surgery to primary site, scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.</td>
</tr>
<tr>
<td>2</td>
<td>A large lung lesion received radiation therapy prior to resection.</td>
</tr>
<tr>
<td>3</td>
<td>A patient received a wedge resection of a right breast mass with axillary lymph node dissection followed by radiation to right breast.</td>
</tr>
<tr>
<td>4</td>
<td>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.</td>
</tr>
<tr>
<td>5</td>
<td>A cone biopsy of the cervix was followed by intracavitary implant for IIIB cervical carcinoma.</td>
</tr>
<tr>
<td>6</td>
<td>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.</td>
</tr>
<tr>
<td>9</td>
<td>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.</td>
</tr>
</tbody>
</table>
**REASON FOR NO RADIATION**

**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Radiation therapy was administered.</td>
</tr>
<tr>
<td>1</td>
<td>Radiation therapy was not administered because it was not part of the planned first course treatment. Diagnosed at autopsy.</td>
</tr>
<tr>
<td>2</td>
<td>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.).</td>
</tr>
<tr>
<td>5</td>
<td>Radiation therapy was not administered because the patient died prior to planned or recommended therapy.</td>
</tr>
<tr>
<td>6</td>
<td>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.</td>
</tr>
<tr>
<td>7</td>
<td>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.</td>
</tr>
<tr>
<td>8</td>
<td>Radiation therapy was recommended, but it is unknown whether it was administered.</td>
</tr>
<tr>
<td>9</td>
<td>It is unknown if radiation therapy was recommended or administered. Death certificate cases only.</td>
</tr>
</tbody>
</table>

**Example**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A patient with Stage I prostate cancer is offered either surgery or brachytherapy to treat his disease. The patient elects to be surgically treated.</td>
</tr>
</tbody>
</table>
**DATE SYSTEMIC THERAPY STARTED**

Item Length: 8  
NAACCR Item #3230  
Revised 01/10, 01/11

**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**  
• 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].  
• Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for Date Systemic Therapy Started is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of Date Systemic Therapy Started transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The RX Date Systemic Flag [3231] is used to explain why Date Systemic Therapy Started is not a known date. See RX Date Systemic Flag for an illustration of the relationships among these items.

**Examples**

<table>
<thead>
<tr>
<th>Date Systemic Therapy Started</th>
<th>RX Date Systemic Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>A patient with breast cancer begins her regimen of chemotherapy on December 15, 2018, and is subsequently given Tamoxifen on January 20, 2019.</td>
<td>20181215</td>
</tr>
<tr>
<td>A patient with Stage IV prostate cancer has an orchiectomy on June 2, 2018. He is then started on a regime of hormonal agents on June 9, 2018.</td>
<td>20180602</td>
</tr>
</tbody>
</table>
**RX DATE SYSTEMIC FLAG**

**Description**
This flag explains why there is no appropriate value in the corresponding date field, *Date Systemic Therapy Started* [3230].

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

**Coding Instructions**
- Leave this item blank if *Date Systemic Therapy Started* [3230] has a full or partial date recorded.
- Code 12 if the *Date Systemic Therapy Started* cannot be determined, but the patient did receive first course systemic therapy.
- Code 10 if it is unknown whether any systemic therapy was given.
- Code 11 if no systemic therapy is planned or given.
- Code 15 if systemic therapy is planned, but not yet started. Follow this patient for systemic therapy and update this item, *Date Systemic Therapy Started*, and all relevant systemic therapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>No information whatsoever can be inferred from this exceptional value (that is, unknown if any systemic therapy was given).</td>
</tr>
<tr>
<td>11</td>
<td>No proper value is applicable in this context (for example, no systemic therapy given).</td>
</tr>
<tr>
<td>12</td>
<td>A proper value is applicable but not known. This event occurred, but the date is unknown (that is, systemic therapy was given but the date is unknown).</td>
</tr>
<tr>
<td>15</td>
<td>Information is not available at this time, but it is expected that it will be available later (that is, systemic therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).</td>
</tr>
<tr>
<td>(blank)</td>
<td>A valid date value is provided in item <em>Date Systemic Therapy Started</em> [3230].</td>
</tr>
</tbody>
</table>
**DATE CHEMOTHERAPY STARTED**

Item Length: 8  
NAACCR Item #1220  
Revised: 01/11

**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**
- 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].
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Chemotherapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Chemotherapy Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date–Chemo Flag* [1221] is used to explain why *Date Chemotherapy Started* is not a known date. See *RX Date–Chemo Flag* for an illustration of the relationships among these items.
**RX DATE–CHEMO FLAG**

Item Length: 2  
NAACCR Item #1221  
Valid Codes: 10-12, 15, Blank  
New Item: 01/2010

**Description**  
This flag explains why there is no appropriate value in the corresponding date field, *Date Chemotherapy Started* [1220].

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

**Coding Instructions**

- Leave this item blank if *Date Chemotherapy Started* [1220] has a full or partial date recorded.
- Code 12 if the *Date Chemotherapy Started* cannot be determined, but the patient did receive first course chemotherapy.
- Code 10 if it is unknown whether any chemotherapy was given.
- Code 11 if no chemotherapy is planned or given.
- Code 15 if chemotherapy is planned, but not yet started. Follow this patient for chemotherapy and update this item, *Date Chemotherapy Started*, and the relevant chemotherapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave this item blank for diagnoses between 2003 and 2009 (inclusive) if this facility did not collect *Date Chemotherapy Started* at that time.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>No information whatsoever can be inferred from this exceptional value (that is, unknown if any chemotherapy was given).</td>
</tr>
<tr>
<td>11</td>
<td>No proper value is applicable in this context (for example, no chemotherapy given).</td>
</tr>
<tr>
<td>12</td>
<td>A proper value is applicable but not known. This event occurred, but the date is unknown (that is, chemotherapy was given but the date is unknown).</td>
</tr>
<tr>
<td>15</td>
<td>Information is not available at this time, but it is expected that it will be available later (that is, chemotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).</td>
</tr>
<tr>
<td>(blank)</td>
<td>A valid date value is provided in item <em>Date Chemotherapy Started</em> [1220]. Case was diagnosed between 2003 and 2009 and the facility did not record <em>Date Chemotherapy Started</em> [1220] at that time.</td>
</tr>
</tbody>
</table>
CHEMOTHERAPY

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.

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 chemotherapeutic 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 chemotherapy was not administered.

Instructions for Coding
• Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
• Code 00 if 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 by the patient.
• 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 if it is known that a physician recommended the patient receive chemotherapy but no further documentation is available yet to confirm its administration.
• Code 88 to indicate referral was made medical oncologist and the registry must follow to determine whether it was given. If follow-up with the 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.
• 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.
• Code chemoembolization as 01, 02 or 03 depending on the number of chemotherapeutic agents involved.
• If chemotherapy was provided as a radiosensitizer or radioprotectant DO NOT code as chemotherapy treatment. When chemotherapy is given for radiosensitization or radioprotection it is given in low doses that do not affect the cancer.
• If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy and only the original agent or regimen is recorded as first course therapy.
• Refer to the SEER*Rx Interactive Drug Database (http://seer.cancer.gov) for a list of chemotherapeutic agents.
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.

<table>
<thead>
<tr>
<th>Drug Name(s)</th>
<th>Previous Category</th>
<th>New Category</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alemtuzumab/Campath</td>
<td>Chemotherapy</td>
<td>BRM/Immuno</td>
<td>1/1/2013</td>
</tr>
<tr>
<td>Bevacizumab/Avastin</td>
<td>Chemotherapy</td>
<td>BRM/Immuno</td>
<td>1/1/2013</td>
</tr>
<tr>
<td>Rituximab</td>
<td>Chemotherapy</td>
<td>BRM/Immuno</td>
<td>1/1/2013</td>
</tr>
<tr>
<td>Trastuzumab/Herceptin</td>
<td>Chemotherapy</td>
<td>BRM/Immuno</td>
<td>1/1/2013</td>
</tr>
<tr>
<td>Pertuzumab/Perjeta</td>
<td>Chemotherapy</td>
<td>BRM/Immuno</td>
<td>1/1/2013</td>
</tr>
<tr>
<td>Cetuximab/Erbitux</td>
<td>Chemotherapy</td>
<td>BRM/Immuno</td>
<td>1/1/2013</td>
</tr>
</tbody>
</table>

**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.                                                                                                                                              |
03        | Multiagent chemotherapy administered as first course therapy.                                                                                                                                               |
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. |
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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>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.</td>
</tr>
<tr>
<td>02</td>
<td>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.</td>
</tr>
<tr>
<td>02</td>
<td>A patient with non-Hodgkin’s lymphoma is treated with fludarabine.</td>
</tr>
<tr>
<td>03</td>
<td>A patient with early stage breast cancer receives chemotherapy. The patient chart indicates that a regimen containing doxorubicin is to be administered.</td>
</tr>
<tr>
<td>86</td>
<td>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.</td>
</tr>
</tbody>
</table>
**DATE HORMONE THERAPY STARTED**

**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**
- 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].
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for Date Hormone Therapy Started is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of Date Hormone Therapy Started transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The RX Date—Hormone Flag [1231] is used to explain why Date Hormone Therapy Started is not a known date. See RX Date—Hormone Flag for an illustration of the relationships among these items.
**RX DATE–HORMONE FLAG**

Item Length: 2  
NAACCR Item #1231  
Valid Codes: 10-12, 15, Blank  
New Item: 01/2010

**Description**
This flag explains why there is no appropriate value in the corresponding date field, *Date Hormone Therapy Started* [1230].

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

**Coding Instructions**
- Leave this item blank if *Date Hormone Therapy Started* [1230] has a full or partial date recorded.
- Code 12 if the *Date Hormone Therapy Started* cannot be determined, but the patient did receive first course hormone therapy.
- Code 10 if it is unknown whether any hormone therapy was given.
- Code 11 if no hormone therapy is planned or given.
- Code 15 if hormone therapy is planned, but not yet started. Follow this patient for hormone therapy and update this item, *Date Hormone Therapy Started* and the relevant hormone therapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave this item blank for diagnoses between 2003 and 2009 if this facility did not collect *Date Hormone Therapy Started* at that time.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>No information whatsoever can be inferred from this exceptional value (that is, unknown if any hormone therapy was given).</td>
</tr>
<tr>
<td>11</td>
<td>No proper value is applicable in this context (for example, no hormone therapy given).</td>
</tr>
<tr>
<td>12</td>
<td>A proper value is applicable but not known. This event occurred, but the date is unknown (that is, hormone therapy was given but the date is unknown).</td>
</tr>
<tr>
<td>15</td>
<td>Information is not available at this time, but it is expected that it will be available later (that is, hormone therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).</td>
</tr>
<tr>
<td>(blank)</td>
<td>A valid date value is provided in item <em>Date Hormone Therapy Started</em> [1230]. Case was diagnosed between 2003 and 2009 and the facility did not record <em>Date Hormone Therapy Started</em> [1230] at that time.</td>
</tr>
</tbody>
</table>
**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**

**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**
- 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 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 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.
- Refer to the **SEER*Rx Interactive Drug Database** ([http://seer.cancer.gov](http://seer.cancer.gov)) for a list of hormonal agents.
<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.</td>
</tr>
<tr>
<td>01</td>
<td>Hormone therapy administered as first course therapy.</td>
</tr>
<tr>
<td>82</td>
<td>Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).</td>
</tr>
<tr>
<td>85</td>
<td>Hormone therapy was not administered because the patient died prior to planned or recommended therapy.</td>
</tr>
<tr>
<td>86</td>
<td>Hormone therapy was not administered. It was recommended by the patient’s physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.</td>
</tr>
<tr>
<td>87</td>
<td>Hormone therapy was not administered. It was recommended by the patient’s physician, but this treatment was refused by the patient, a patient’s family member or the patient’s guardian. The refusal was noted in patient record.</td>
</tr>
<tr>
<td>88</td>
<td>Hormone therapy was recommended, but it is unknown if it was administered.</td>
</tr>
<tr>
<td>99</td>
<td>It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.</td>
</tr>
</tbody>
</table>

**Examples**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>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.</td>
</tr>
<tr>
<td>00</td>
<td>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.</td>
</tr>
<tr>
<td>00</td>
<td>A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy.</td>
</tr>
<tr>
<td>01</td>
<td>A patient with metastatic prostate cancer is administered flutamide (an antiestrogen).</td>
</tr>
<tr>
<td>87</td>
<td>A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) and the refusal is noted in the patient record.</td>
</tr>
</tbody>
</table>
**DATE IMMUNOTHERAPY STARTED**

Item Length: 8  
NAACCR Item #1240  
Valid Codes: 10-12, 15, Blank  
Revised: 01/11

**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**
- 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].
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for Date Immunotherapy Started is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of Date Immunotherapy Started transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The RX Date–BRM Flag [1241] is used to explain why Date Immunotherapy Started is not a known date. See RX Date–BRM Flag for an illustration of the relationships among these items.
**RX DATE–BRM FLAG**

Item Length: 2  
NAACCR Item #1241  
Valid Codes: 10-12, 15, Blank  
New Item: 01/2010

**Description**  
This flag explains why there is no appropriate value in the corresponding date field, *Date Immunotherapy Started* [1240].

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

**Coding Instructions**  
- Leave this item blank if *Date Immunotherapy Started* [1240] has a full or partial date recorded.  
- Code 12 if the *Date Immunotherapy Started* cannot be determined, but the patient did receive first course immunotherapy or a biologic response modifier.  
- Code 10 if it is unknown whether any immunotherapy or a biologic response modifier was given.  
- Code 11 if no immunotherapy or biologic response modifier is planned or given.  
- Code 15 if immunotherapy or a biologic response modifier is planned, but not yet started. Follow this patient for immunotherapy and update this item, *Date Immunotherapy Started*, and the relevant immunotherapy items.  
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.  
- Leave this item blank for diagnoses between 2003 and 2009 if this facility did not collect *Date Immunotherapy Started* at that time.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>No information whatsoever can be inferred from this exceptional value (that is, unknown if any immunotherapy was given).</td>
</tr>
<tr>
<td>11</td>
<td>No proper value is applicable in this context (for example, no immunotherapy given).</td>
</tr>
<tr>
<td>12</td>
<td>A proper value is applicable but not known. This event occurred, but the date is unknown (that is, immunotherapy was given but the date is unknown).</td>
</tr>
<tr>
<td>15</td>
<td>Information is not available at this time, but it is expected that it will be available later (that is, immunotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).</td>
</tr>
<tr>
<td>(blank)</td>
<td>A valid date value is provided in item <em>Date Immunotherapy Started</em> [1240]. Case was diagnosed between 2003 and 2009 and the facility did not record <em>Date Immunotherapy Started</em> [1240] at that time.</td>
</tr>
</tbody>
</table>
**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

**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**
- 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.
- 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:
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.

<table>
<thead>
<tr>
<th>Drug Name(s)</th>
<th>Previous Category</th>
<th>New Category</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alemtuzumab/Campath</td>
<td>Chemotherapy</td>
<td>BRM/Immunoto</td>
<td>1/1/2013</td>
</tr>
<tr>
<td>Bevacizumab/Avastin</td>
<td>Chemotherapy</td>
<td>BRM/Immunoto</td>
<td>1/1/2013</td>
</tr>
<tr>
<td>Rituximab</td>
<td>Chemotherapy</td>
<td>BRM/Immunoto</td>
<td>1/1/2013</td>
</tr>
<tr>
<td>Trastuzumab/Herceptin</td>
<td>Chemotherapy</td>
<td>BRM/Immunoto</td>
<td>1/1/2013</td>
</tr>
<tr>
<td>Pertuzumab/Perjeta</td>
<td>Chemotherapy</td>
<td>BRM/Immunoto</td>
<td>1/1/2013</td>
</tr>
<tr>
<td>Cetuximab/Erbitux</td>
<td>Chemotherapy</td>
<td>BRM/Immunoto</td>
<td>1/1/2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>None, immunotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.</td>
</tr>
<tr>
<td>01</td>
<td>Immunotherapy administered as first course therapy.</td>
</tr>
<tr>
<td>82</td>
<td>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.).</td>
</tr>
<tr>
<td>85</td>
<td>Immunotherapy was not administered because the patient died prior to planned or recommended therapy.</td>
</tr>
<tr>
<td>86</td>
<td>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.</td>
</tr>
<tr>
<td>87</td>
<td>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.</td>
</tr>
<tr>
<td>88</td>
<td>Immunotherapy was recommended, but it is unknown if it was administered.</td>
</tr>
<tr>
<td>99</td>
<td>It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.</td>
</tr>
</tbody>
</table>

Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>A patient with malignant melanoma is treated with interferon.</td>
</tr>
<tr>
<td>85</td>
<td>Before recommended immunotherapy could be administered, the patient died from cancer.</td>
</tr>
</tbody>
</table>
HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURES

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.
<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No transplant procedure or endocrine therapy was administered as part of first course therapy. Diagnosed at autopsy.</td>
</tr>
<tr>
<td>10</td>
<td>A bone marrow transplant procedure was administered, but the type was not specified.</td>
</tr>
<tr>
<td>11</td>
<td>Bone marrow transplant–autologous.</td>
</tr>
<tr>
<td>12</td>
<td>Bone marrow transplant–allogeneic.</td>
</tr>
<tr>
<td>20</td>
<td>Stem cell harvest and infusion. Umbilical cord stem cell transplant, with blood from one or multiple umbilical cords</td>
</tr>
<tr>
<td>30</td>
<td>Endocrine surgery and/or endocrine radiation therapy.</td>
</tr>
<tr>
<td>40</td>
<td>Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12 or 20.)</td>
</tr>
<tr>
<td>82</td>
<td>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.).</td>
</tr>
<tr>
<td>85</td>
<td>Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.</td>
</tr>
<tr>
<td>86</td>
<td>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.</td>
</tr>
<tr>
<td>87</td>
<td>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.</td>
</tr>
<tr>
<td>88</td>
<td>Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.</td>
</tr>
<tr>
<td>99</td>
<td>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.</td>
</tr>
</tbody>
</table>
**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: *Surgical Procedure of Primary Site* [1290], *Scope of Regional Lymph Node Surgery* [1292], *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: *Surgical Procedure of the Primary Site* [1290], *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.”

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No systemic therapy and/or surgical procedures</td>
<td>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.</td>
</tr>
<tr>
<td>2</td>
<td>Systemic therapy before surgery</td>
<td>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.</td>
</tr>
<tr>
<td>3</td>
<td>Systemic therapy after surgery</td>
<td>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.</td>
</tr>
<tr>
<td>4</td>
<td>Systemic therapy both before and after surgery</td>
<td>At least two courses of systemic therapy were given before and at least two 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.</td>
</tr>
</tbody>
</table>
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).

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.

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).

Both surgery and systemic therapy were provided, but the sequence is unknown.

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.</td>
</tr>
<tr>
<td>2</td>
<td>Patient with prostate cancer received hormone therapy prior to a radical prostatectomy.</td>
</tr>
<tr>
<td>3</td>
<td>Patient underwent a colon resection followed by a 5-FU based chemotherapy regimen.</td>
</tr>
<tr>
<td>4</td>
<td>Patient with breast cancer receives pre-operative chemotherapy followed by post-operative Tamoxifen.</td>
</tr>
<tr>
<td>5</td>
<td>Patient with an intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity.</td>
</tr>
<tr>
<td>6</td>
<td>Patient with metastatic colon cancer receives intraoperative chemotherapy to the liver.</td>
</tr>
<tr>
<td>9</td>
<td>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.</td>
</tr>
</tbody>
</table>
**DATE OTHER TREATMENT STARTED**

Item Length: 8  
NAACCR Item #1250  
Revised 01/10, 01/11

**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**

- 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].
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for Date Other Treatment Started is MMDDCCYY, with 99 identifying unknown month or day and 99999999 representing an entirely unknown date. The interoperable form of Date Other Treatment Started transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The RX Date—Other Flag [1251] is used to explain why Date Other Treatment Started is not a known date. See RX Date—Other Flag for an illustration of the relationships among these items.

**Examples**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A patient with metastatic disease was started on an experimental therapy on March 16, 2018</td>
<td>20180316</td>
</tr>
<tr>
<td>Alcohol was used as an embolizing agent for a patient on August 1, 2018</td>
<td>20180801</td>
</tr>
<tr>
<td>A polycythemia vera patient was given several phlebotomies, the first being on September 17, 2018</td>
<td>20180917</td>
</tr>
</tbody>
</table>
**RX DATE–OTHER FLAG**

Item Length: 2  
NAACCR Item #1251  
Valid Codes: 10-12, Blank  
Revised: 01/15

**Description**  
This flag explains why there is no appropriate value in the corresponding date field, *Date Other Treatment Started* [1250].

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

**Coding Instructions**  
- Leave this item blank if *Date Other Treatment Started* [1250] has a full or partial date recorded.  
- Code 12 if the *Date Other Treatment Started* cannot be determined, but the patient did receive first course other treatment.  
- Code 10 if it is unknown whether any other treatment was given (*Other Treatment* [1420] is 9).  
- Code 11 if no other treatment is planned or given (*Other Treatment* [1420] is 0, 7 or 8).  
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>No information whatsoever can be inferred from this exceptional value (that is, unknown if any Other Treatment was given).</td>
</tr>
<tr>
<td>11</td>
<td>No proper value is applicable in this context (for example, no Other Treatment given).</td>
</tr>
<tr>
<td>12</td>
<td>A proper value is applicable but not known. This event occurred, but the date is unknown (that is, Other Treatment was given but the date is unknown).</td>
</tr>
<tr>
<td>15</td>
<td>Other therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up.</td>
</tr>
<tr>
<td>(blank)</td>
<td>A valid date value is provided in item <em>Date Other Treatment Started</em> [1250].</td>
</tr>
</tbody>
</table>
**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, transfusion 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.
- Code 1 for embolization using alcohol as an embolizing agent.
- Code 1 for embolization to a site other than the liver where the embolizing agent is unknown.
- Code 1 for PUVA (psoralen and long-wave ultraviolet radiation)
- Do not code presurgical embolization that given for a purpose to shrink the tumor.
- Code 8 if it is known that a physician recommended treatment coded as Other Treatment and no further documentation is available yet to confirm its administration
- Code 8 to indicate 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
<td>All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.</td>
</tr>
<tr>
<td>1</td>
<td>Other</td>
<td>Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy).</td>
</tr>
<tr>
<td>2</td>
<td>Other–Experimental</td>
<td>This code is not defined. It may be used to record participation in institution-based clinical trials.</td>
</tr>
<tr>
<td>3</td>
<td>Other–Double Blind</td>
<td>A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.</td>
</tr>
<tr>
<td>6</td>
<td>Other–Unproven</td>
<td>Cancer treatments administered by nonmedical personnel.</td>
</tr>
<tr>
<td>7</td>
<td>Refusal</td>
<td>Other treatment was not administered. It was recommended by the patient’s physician, but this treatment (which would have been coded 1, 2 or 3) was refused by the patient, a patient’s family member or the patient’s guardian. The refusal was noted in the patient record.</td>
</tr>
<tr>
<td>8</td>
<td>Recommended; unknown if administered</td>
<td>Other treatment was recommended, but it is unknown whether it was administered.</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
<td>It is unknown whether other treatment was recommended or administered and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.</td>
</tr>
</tbody>
</table>
Outcomes
**DATE OF LAST CONTACT OR DEATH**

Item Length: 8  
NAACCR Item #1750  
Revised 06/05, 01/10, 01/11, 01/15

**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.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Last Contact or Death* is MMDDCCYY, with 99 identifying unknown month or day and 99999999 representing an entirely unknown date. The interoperable form of *Date of Last Contact or Death* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of Last Contact Flag* [1751] is used to explain why *Date of Last Contact or Death* is not a known date. See *Date of Last Contact Flag* for an illustration of the relationships among these items.
**DATE OF LAST CONTACT FLAG**

Item Length: 2  
NAACCR #1751  
Valid Codes: 12, Blank  
New Item: 01/2010

**Description**  
This flag explains why there is no appropriate value in the corresponding date field, *Date of Last Contact or Death* [1750].

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

**Instructions for Coding**  
- Leave this item blank if *Date of Last Contact or Death* [1750] has a full or partial date recorded.
- Code 12 if the *Date of Last Contact or Death* cannot be determined.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>A proper value is applicable but not known. This event occurred, but the date is unknown (that is, the date of last contact is unknown).</td>
</tr>
<tr>
<td>(blank)</td>
<td>A valid date value is provided in item <em>Date of Last Contact or Death</em> [1750].</td>
</tr>
</tbody>
</table>

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Last Contact or Death* [1750] and *Date of Last Contact Flag* [1751]. *In this table, the lower-case letter “b” is used to represent each blank space.*

<table>
<thead>
<tr>
<th>Description</th>
<th>Traditional Date of Last Contact or Death</th>
<th>Interoperable Date of Last Contact or Death</th>
<th>Date of Last Contact Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full date known</td>
<td>MMDDCCYY</td>
<td>CCYYMMDD</td>
<td>bb</td>
</tr>
<tr>
<td></td>
<td>(example: 02182018)</td>
<td>(example: 20180218)</td>
<td></td>
</tr>
<tr>
<td>Month and year known</td>
<td>MM99CCYY</td>
<td>CCYMMbb</td>
<td>bb</td>
</tr>
<tr>
<td></td>
<td>(example: 02992018)</td>
<td>(example: 201802bb)</td>
<td></td>
</tr>
<tr>
<td>Year only known</td>
<td>9999CCYY</td>
<td>CCYYbbbb</td>
<td>bb</td>
</tr>
<tr>
<td></td>
<td>(example: 99992018)</td>
<td>(example: 2018bbbb)</td>
<td></td>
</tr>
<tr>
<td>Date is unknown</td>
<td>99999999</td>
<td>bbbbbbb</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>(example: 99999999)</td>
<td>(example: bbbbbbbb)</td>
<td></td>
</tr>
</tbody>
</table>
**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*.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Dead</td>
</tr>
<tr>
<td>1</td>
<td>Alive</td>
</tr>
</tbody>
</table>

**Example**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Death clearance information obtained from a state central registry confirms the death of the patient within the past year.</td>
</tr>
<tr>
<td>1</td>
<td>In response to a follow-up letter to a patient’s following physician, it is learned the patient is alive.</td>
</tr>
</tbody>
</table>
**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.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0000</td>
<td>Patient alive at last contact</td>
</tr>
<tr>
<td>7777</td>
<td>State death certificate not available</td>
</tr>
<tr>
<td>7797</td>
<td>State death certificate available but underlying cause of death is not coded</td>
</tr>
</tbody>
</table>
PLACE OF DEATH -- STATE

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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Not applicable, Patient alive at last contact</td>
</tr>
<tr>
<td>IL</td>
<td>If the state in which the patient died is Illinois, then use the USPS code for the state of Illinois.</td>
</tr>
<tr>
<td>XX</td>
<td>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 Place of Death-Country).</td>
</tr>
<tr>
<td>YY</td>
<td>Died in a country other than the U.S. (including its territories, commonwealths or possessions) or Canada and the country is unknown.</td>
</tr>
<tr>
<td>US</td>
<td>Died in the U.S. (including its territories, commonwealths or possessions) and the state is unknown.</td>
</tr>
<tr>
<td>CD</td>
<td>Died in Canada and the province is unknown.</td>
</tr>
<tr>
<td>ZZ</td>
<td>Place of death is unknown, not mentioned in patient record.</td>
</tr>
</tbody>
</table>


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.

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>Country Code</th>
<th>State or Province Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States, NOS</td>
<td>USA</td>
<td>US</td>
</tr>
<tr>
<td>Canada, NOS</td>
<td>CAN</td>
<td>CD</td>
</tr>
<tr>
<td>Not U.S., but no other information</td>
<td>ZZX</td>
<td>YY</td>
</tr>
<tr>
<td>Unknown, no mention in patient record</td>
<td>ZZU</td>
<td>ZZ</td>
</tr>
</tbody>
</table>
**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**
- Cancer status is based on information from the patient’s physician or other official source such as a death certificate.
- 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No evidence of this tumor</td>
</tr>
<tr>
<td>2</td>
<td>Evidence of this tumor</td>
</tr>
<tr>
<td>9</td>
<td>Unknown, indeterminate whether this tumor is present; not stated in patient record</td>
</tr>
</tbody>
</table>

**Example**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Patient with hematopoietic disease who is in remission.</td>
</tr>
<tr>
<td>1</td>
<td>A patient is seen by the physician on February 2, 2004 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, 2005. The <em>Date of Last Contact or Death</em> [1750] is updated, but the cancer status is not.</td>
</tr>
<tr>
<td>2</td>
<td>A patient with prostate cancer is diagnosed with bone metastasis in April 2018. The registrar finds an obituary documenting the patient’s death in a nursing home in June 2018.</td>
</tr>
</tbody>
</table>
Case Administration
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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>Initials or code of abstractor.</td>
</tr>
</tbody>
</table>
**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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>0006439999</td>
<td>6439999, General Hospital, Anytown, Illinois</td>
</tr>
<tr>
<td>0010000099</td>
<td>10000099, Anytown Medical Center, Anytown, Illinois</td>
</tr>
</tbody>
</table>

*Note: A complete list of FINs is available on the American College of Surgeons website at [https://www.facs.org/quality-programs/cancer/coc/info/accredited/fin](https://www.facs.org/quality-programs/cancer/coc/info/accredited/fin)*
**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://nppes.cms.hhs.gov/NPPES/NPRIregistryHome.do](https://nppes.cms.hhs.gov/NPPES/NPRIregistryHome.do).
- 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>(fill spaces)</td>
<td>Ten-digit NPI number for the facility.</td>
</tr>
<tr>
<td>(leave blank)</td>
<td>NPI for the facility is unknown or not available.</td>
</tr>
</tbody>
</table>

Cancer Collection and Reporting Manual  
North Carolina Central Cancer Registry  
May 2019  
N.C. Division of Public Health
**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). The flag may be assigned manually or can be defaulted by the registry’s software.

**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Abstract prepared at a facility WITHOUT CoC accreditation of its cancer program</td>
</tr>
</tbody>
</table>
| 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 |
OVERRIDE AGE/SITE/MORPH

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Not Reviewed. Or, Reviewed and corrected.</td>
</tr>
<tr>
<td>1</td>
<td>Reviewed. Combinations as reported.</td>
</tr>
<tr>
<td>2</td>
<td>Reviewed. Diagnosis in Utero.</td>
</tr>
<tr>
<td>2</td>
<td>Reviewed. Both combinations apply.</td>
</tr>
</tbody>
</table>
**Override Histology**  
*(Override Hist/Behav)*

<table>
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<tr>
<td>Allowable Values: 1, 2, 3</td>
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<tr>
<td>NAACCR Item #2040</td>
</tr>
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<td>Revised 04/07, 09/08</td>
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</table>

**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.

Grade 5-8 with histologies not in the range of 9590-9948 is impossible.

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.

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
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<td>Not reviewed; or reviewed and corrected.</td>
</tr>
<tr>
<td>1</td>
<td>Reviewed; confirmed as reported for edits of the type Morphology–Type/Behavior.</td>
</tr>
<tr>
<td>2</td>
<td>Reviewed; confirmed as reported for edits of the type Diag Confirmation, Behavior Code.</td>
</tr>
<tr>
<td>3</td>
<td>Reviewed; conditions 1 and 2 above both apply.</td>
</tr>
</tbody>
</table>
**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.

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<tr>
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<tr>
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<td>1</td>
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</table>
**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.

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>1</td>
<td>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</td>
</tr>
</tbody>
</table>
**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
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<tbody>
<tr>
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<td>Not reviewed; or reviewed and corrected.</td>
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<tr>
<td>1</td>
<td>Reviewed; confirmed as reported.</td>
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</table>
**OVERRIDE NAME/SEX**

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. Over-ride flag as used in the EDITS Software Package Edits of the type Sex, Name 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.

<table>
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<th>Definition</th>
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<tbody>
<tr>
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<td>Not reviewed; or reviewed and corrected.</td>
</tr>
<tr>
<td>1</td>
<td>Reviewed; confirmed as reported.</td>
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**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
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<tbody>
<tr>
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<td>Not reviewed; or reviewed and corrected</td>
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<tr>
<td>1</td>
<td>Reviewed. Case coded correctly.</td>
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</table>
**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.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Leave blank</td>
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</tr>
<tr>
<td>1</td>
<td>Reviewed. Case coded correctly.</td>
</tr>
</tbody>
</table>
**OVERRIDE SITE/BEHAVIOR**

**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.

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
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<tr>
<td>1</td>
<td>Reviewed; confirmed as reported.</td>
</tr>
</tbody>
</table>
**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.

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<tbody>
<tr>
<td>(leave blank)</td>
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<tr>
<td>1</td>
<td>Reviewed, confirmed as reported.</td>
</tr>
</tbody>
</table>
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.

<table>
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<tbody>
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</table>
**OVERRIDE SITE/TYP**

**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.

**EDITS Use**
There are multiple versions of edits of the type, Primary Site, Morphology-Type, which check for “usual” combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different override flag. The CoC version of the edit will accept Override CoC-Site/Type or Override Site/Type as equivalent.

- The Site/Histology Validation List (available on the SEER website) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not be included. These edits require review of all combinations not listed.
- Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if Primary Site [400] is in the range C440-C449 (skin) and the ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas) or 8090-8110 (basal cell carcinomas), no further editing is done. No override is necessary for these cases in the CoC version of the edit.

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 Cancer Identification in Section I). 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.

**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.

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<tr>
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</table>
**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(leave blank)</td>
<td>Not reviewed; or reviewed and corrected.</td>
</tr>
<tr>
<td>1</td>
<td>Reviewed; and confirmed as reported.</td>
</tr>
</tbody>
</table>
**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(leave blank)</td>
<td>Not reviewed; or reviewed and corrected.</td>
</tr>
<tr>
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**ICD-O-3 CONVERSION FLAG**

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<tr>
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<td>Morphology (Morph–Type&amp;Behav ICD-O-3, NAACCR Item #521) originally coded in ICD-O-3.</td>
</tr>
<tr>
<td>1</td>
<td>Morphology (Morph–Type&amp;Behav ICD-O-3, NAACCR Item #521) converted from (Morph–Type&amp;Behav ICD-O-2, NAACCR Item #419) without review.</td>
</tr>
<tr>
<td>3</td>
<td>Morphology (Morph–Type&amp;Behav ICD-O-3, NAACCR Item #521) converted from (Morph–Type&amp;Behav ICD-O-2, NAACCR Item #419) with review.</td>
</tr>
</tbody>
</table>
**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
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</thead>
<tbody>
<tr>
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<td>Not staged (cases that have an AJCC staging scheme and staging was not done).</td>
</tr>
<tr>
<td>01</td>
<td>First Edition</td>
</tr>
<tr>
<td>02</td>
<td>Second Edition</td>
</tr>
<tr>
<td>03</td>
<td>Third Edition</td>
</tr>
<tr>
<td>04</td>
<td>Fourth Edition</td>
</tr>
<tr>
<td>05</td>
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<td>Sixth Edition</td>
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<td>07</td>
<td>Seventh Edition</td>
</tr>
<tr>
<td>08</td>
<td>Eighth Edition</td>
</tr>
<tr>
<td>88</td>
<td>Not applicable (cases that do not have an AJCC staging scheme).</td>
</tr>
<tr>
<td>99</td>
<td>Staged, but the edition is unknown.</td>
</tr>
</tbody>
</table>
Appendix A: N.C. State Law
GENERAL STATUTE 130A-205 through 130A-215

Article 7.

Chronic Disease.


§ 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.)

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.)
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.
.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.


.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;
.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;  

.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;  
Appendix B: Site-Specific Surgery 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

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
   26 Polypectomy
   27 Excisional biopsy
   Any combination of 20 or 26–27 WITH
   21 Photodynamic therapy (PDT)
   22 Electrocautery
   23 Cryosurgery
   24 Laser ablation
   25 Laser excision

30 Wide excision, NOS

Code 30 includes:
   Hemiglossectomy
   Partial glossectomy

40 Radical excision of tumor, NOS
   41 Radical excision of tumor ONLY
   42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or
      total resection)
   43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

Codes 40–43 include:
   Total glossectomy
   Radical glossectomy

Specimen sent to pathology from surgical events 20–43.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 12/4/02, 01/10, 02/10)
**PAROTID AND OTHER UNSPECIFIED GLANDS**

*Parotid Gland C07.9, Major Salivary Glands C08.0–C08.9*

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
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<tr>
<td>00</td>
<td>None; no surgery of primary site; autopsy ONLY</td>
</tr>
<tr>
<td>10</td>
<td>Local tumor destruction, NOS</td>
</tr>
<tr>
<td>11</td>
<td>Photodynamic therapy (PDT)</td>
</tr>
<tr>
<td>12</td>
<td>Electrocautery; fulguration (includes use of hot forceps for tumor destruction)</td>
</tr>
<tr>
<td>13</td>
<td>Cryosurgery</td>
</tr>
<tr>
<td>14</td>
<td>Laser</td>
</tr>
</tbody>
</table>

*No specimen sent to pathology from surgical events 10–14.*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Local tumor excision, NOS</td>
</tr>
<tr>
<td>26</td>
<td>Polypectomy</td>
</tr>
<tr>
<td>27</td>
<td>Excisional biopsy</td>
</tr>
<tr>
<td>30</td>
<td>Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS</td>
</tr>
<tr>
<td>31</td>
<td>Facial nerve spared</td>
</tr>
<tr>
<td>32</td>
<td>Facial nerve sacrificed</td>
</tr>
<tr>
<td>33</td>
<td>Superficial lobe ONLY</td>
</tr>
<tr>
<td>34</td>
<td>Facial nerve spared</td>
</tr>
<tr>
<td>35</td>
<td>Facial nerve sacrificed</td>
</tr>
<tr>
<td>36</td>
<td>Deep lobe (Total)</td>
</tr>
<tr>
<td>37</td>
<td>Facial nerve spared</td>
</tr>
<tr>
<td>38</td>
<td>Facial nerve sacrificed</td>
</tr>
<tr>
<td>40</td>
<td>Total parotidectomy, NOS; total removal of major salivary gland, NOS</td>
</tr>
<tr>
<td>41</td>
<td>Facial nerve spared</td>
</tr>
<tr>
<td>42</td>
<td>Facial nerve sacrificed</td>
</tr>
<tr>
<td>50</td>
<td>Radical parotidectomy, NOS; radical removal of major salivary gland, NOS</td>
</tr>
<tr>
<td>51</td>
<td>WITHOUT removal of temporal bone</td>
</tr>
<tr>
<td>52</td>
<td>WITH removal of temporal bone</td>
</tr>
<tr>
<td>53</td>
<td>WITH removal of overlying skin (requires graft or flap coverage)</td>
</tr>
<tr>
<td>80</td>
<td>Parotidectomy, NOS</td>
</tr>
<tr>
<td>90</td>
<td>Surgery, NOS</td>
</tr>
<tr>
<td>99</td>
<td>Unknown if surgery performed; death certificate</td>
</tr>
</tbody>
</table>

(Revised 01/10, 02/10)
Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser
   15 Stripping

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS
26 Polypectomy
27 Excisional biopsy
Any combination of 20 or 26–27 WITH
   21 Photodynamic therapy (PDT)
   22 Electrocautery
   23 Cryosurgery
   24 Laser ablation
25 Laser excision
28 Stripping

30 Pharyngectomy, NOS
31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
32 Total pharyngectomy

40 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)
41 WITH Laryngectomy (laryngopharyngectomy)
42 WITH bone
43 WITH both 41 and 42

50 Radical pharyngectomy (includes total mandibular resection), NOS
51 WITHOUT laryngectomy
52 WITH laryngectomy

Specimen sent to pathology from surgical events 20–52.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)
ESOPHAGUS
C15.0–C15.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00  None; no surgery of primary site; autopsy ONLY

10  Local tumor destruction, NOS
   11  Photodynamic therapy (PDT)
   12  Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13  Cryosurgery
   14  Laser

No specimen sent to pathology from surgical events 10–14.

20  Local tumor excision, NOS
26  Polypectomy
27  Excisional biopsy
Any combination of 20 or 26–27 WITH
   21  Photodynamic therapy (PDT)
   22  Electrocautery
   23  Cryosurgery
   24  Laser ablation
25  Laser excision

30  Partial esophagectomy

40  Total esophagectomy, NOS

50  Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
   51  WITH laryngectomy
   52  WITH gastrectomy, NOS
   53  Partial gastrectomy
   54  Total gastrectomy
   55  Combination of 51 WITH any of 52–54

80  Esophagectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)
STOMACH
C16.0–C16.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
   26 Polypectomy
   27 Excisional biopsy

Any combination of 20 or 26–27 WITH
   21 Photodynamic therapy (PDT)
   22 Electrocautery
   23 Cryosurgery
   24 Laser ablation
   25 Laser excision

30 Gastrectomy, NOS (partial, subtotal, hemi-)
   31 Antrectomy, lower (distal-less than 40% of stomach)***
   32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
   33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:
   Partial gastrectomy, including a sleeve resection of the stomach
   Billroth I: anastomosis to duodenum (duodenostomy)
   Billroth II: anastomosis to jejunum (jejunostomy)

40 Near-total or total gastrectomy, NOS
   41 Near-total gastrectomy
   42 Total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach.

50 Gastrectomy, NOS WITH removal of a portion of esophagus
   51 Partial or subtotal gastrectomy
   52 Near total or total gastrectomy

Codes 50–52 are used for gastrectomy resection when only portions of esophagus are included in procedure.

60 Gastrectomy with a resection in continuity with the resection of other organs, NOS***
   61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***
   62 Near total or total gastrectomy, in continuity with the resection of other organs***
   63 Radical gastrectomy, in continuity with the resection of other organs***
Codes 60–63 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection.

80  Gastrectomy, NOS
Specimen sent to pathology from surgical events 20–80.

90  Surgery, NOS
99  Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included

(Revised 01/10, 02/10)
Code removal/surgical ablation of single or multiple liver metastases under the data item Surgical Procedure/Other Site [1294].

Codes

00 None; no surgery of primary site; autopsy ONLY
10 Local tumor destruction, NOS
  11 Photodynamic therapy (PDT)
  12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
  13 Cryosurgery
  14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
  27 Excisional biopsy
  26 Polypectomy, NOS
  28 Polypectomy-endoscopic
  29 Polypectomy-surgical excision
Any combination of 20 or 26–29 WITH
  21 Photodynamic therapy (PDT)
  22 Electrocautery
  23 Cryosurgery
  24 Laser ablation
  25 Laser excision

30 Partial colectomy, segmental resection
  32 Plus resection of contiguous organ; example: small bowel, bladder

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)
  41 Plus resection of contiguous organ; example: small bowel, bladder

50 Total colectomy (removal of colon from cecum to rectosigmoid junction; may include portion of rectum)
  51 Plus resection of contiguous organ; example: small bowel, bladder

60 Total proctocolectomy (removal of colon from cecum to rectosigmoid junction, including the entire rectum)
  61 Plus resection of contiguous organ; example: small bowel, bladder

70 Colectomy or coloproctectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)

Code 70 includes: Any colectomy (partial, hemicolecction, 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.

80 Colectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS
99 Unknown if surgery performed; death certificate ONLY (Revised 01/10, 02/10)
Code removal/surgical ablation of single or multiple liver metastases under the data item Surgical Procedure/Other Site [1294].

Codes

00  None; no surgery of primary site; autopsy ONLY

10  Local tumor destruction, NOS
   11  Photodynamic therapy (PDT)
   12  Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13  Cryosurgery
   14  Laser ablation

No specimen sent to pathology from surgical events 10–14.

20  Local tumor excision, NOS
   26  Polypectomy
   27  Excisional biopsy
   Combination of 20 or 26–27 WITH
      21  Photodynamic therapy (PDT)
      22  Electrocautery
      23  Cryosurgery
      24  Laser ablation
   25  Laser excision

30  Wedge or segmental resection; partial proctosigmoidectomy, NOS
31  Plus resection of contiguous organs; example: small bowel, bladder

Procedures coded 30 include, but are not limited to:
   Anterior resection
   Hartmann operation
   Low anterior resection (LAR)
   Partial colectomy, NOS
   Rectosigmoidectomy, NOS
   Sigmoidectomy

40  Pull through WITH sphincter preservation (colo-anal anastomosis)

50  Total proctectomy

51  Total colectomy

55  Total colectomy WITH ileostomy, NOS
56  Ileorectal reconstruction
57  Total colectomy WITH other pouch; example: Koch pouch
60  Total proctocolectomy, NOS
65  Total proctocolectomy WITH ileostomy, NOS
66  Total proctocolectomy WITH ileostomy and pouch

Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.

70  Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration

80  Colectomy, NOS; Proctectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)
RECTUM
C20.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

**Code** removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* [1294].

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser

**No specimen sent to pathology from surgical events 10-14.**

20 Local tumor excision, NOS
   27 Excisional biopsy
   26 Polypectomy
   Any combination of 20 or 26–27 WITH
   21 Photodynamic therapy (PDT)
   22 Electrocautery
   23 Cryosurgery
   24 Laser ablation
   25 Laser excision
   28 Curette and fulguration

30 Wedge or segmental resection; partial proctectomy, NOS
   **Procedures coded 30 include, but are not limited to:**
   Anterior resection
   Hartmann’s operation
   Low anterior resection (LAR)
   Transsacral rectosigmoidectomy
   Total mesorectal excision (TME)

40 Pull through WITH sphincter preservation (coloanal anastomosis)

50 Total proctectomy
   **Procedure coded 50 includes, but is not limited to:**
   Abdominoperineal resection (Miles Procedure)

60 Total proctocolectomy, NOS
70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration
80 Proctectomy, NOS
90 Surgery, NOS
99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10, 05/10)
**ANUS**
**C21.0–C21.8**

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

### Codes

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>00</td>
<td>None; no surgery of primary site; autopsy ONLY</td>
</tr>
<tr>
<td>10</td>
<td>Local tumor destruction, NOS</td>
</tr>
<tr>
<td>11</td>
<td>Photodynamic therapy (PDT)</td>
</tr>
<tr>
<td>12</td>
<td>Electrocautery; fulguration (includes use of hot forceps for tumor destruction)</td>
</tr>
<tr>
<td>13</td>
<td>Cryosurgery</td>
</tr>
<tr>
<td>14</td>
<td>Laser</td>
</tr>
<tr>
<td>15</td>
<td>Thermal Ablation</td>
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</table>

No specimen sent to pathology from surgical events 10–15.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Local tumor excision, NOS</td>
</tr>
<tr>
<td>26</td>
<td>Polypectomy</td>
</tr>
<tr>
<td>27</td>
<td>Excisional biopsy</td>
</tr>
<tr>
<td>21</td>
<td>Photodynamic therapy (PDT)</td>
</tr>
<tr>
<td>22</td>
<td>Electrocautery</td>
</tr>
<tr>
<td>23</td>
<td>Cryosurgery</td>
</tr>
<tr>
<td>24</td>
<td>Laser ablation</td>
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<tr>
<td>25</td>
<td>Laser excision</td>
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</table>

Any combination of 20 or 26–27 WITH

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>21</td>
<td>Photodynamic therapy (PDT)</td>
</tr>
<tr>
<td>22</td>
<td>Electrocautery</td>
</tr>
<tr>
<td>23</td>
<td>Cryosurgery</td>
</tr>
<tr>
<td>24</td>
<td>Laser ablation</td>
</tr>
<tr>
<td>25</td>
<td>Laser excision</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>Abdominal perineal resection, NOS (APR; Miles procedure)</td>
</tr>
<tr>
<td>61</td>
<td>APR and sentinel node excision</td>
</tr>
<tr>
<td>62</td>
<td>APR and unilateral inguinal lymph node dissection</td>
</tr>
<tr>
<td>63</td>
<td>APR and bilateral inguinal lymph node dissection</td>
</tr>
</tbody>
</table>

The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery [1292] or Scope of Regional Lymph Node Surgery at This Facility [672].

Specimen sent to pathology from surgical events 20–63.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>Surgery, NOS</td>
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<tr>
<td>99</td>
<td>Unknown if surgery performed; death certificate ONLY</td>
</tr>
</tbody>
</table>

(Revised 01/04, 01/10, 02/10)
LIVER AND INTRAHEPATIC BILE DUCTS
C22.0–C22.1
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00  None; no surgery of primary site; autopsy ONLY
10  Local tumor destruction, NOS
   11  Photodynamic therapy (PDT)
   12  Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13  Cryosurgery
   14  Laser
   15  Alcohol (Percutaneous Ethanol Injection-PEI)
   16  Heat-Radio-frequency ablation (RFA)
   17  Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events 10–17.

20  Wedge or segmental resection, NOS
   21  Wedge resection
   22  Segmental resection, NOS
      23  One
      24  Two
      25  Three
      26  Segmental resection AND local tumor destruction

30  Lobectomy, NOS
   36  Right lobectomy
   37  Left lobectomy
   38  Lobectomy AND local tumor destruction

50  Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe)
   51  Right lobectomy
   52  Left lobectomy
   59  Extended lobectomy AND local tumor destruction

60  Hepatectomy, NOS
   61  Total hepatectomy and transplant

65  Excision of a bile duct (for an intra-hepatic bile duct primary only)
   66  Excision of an intrahepatic bile duct PLUS partial hepatectomy

75  Extrahepatic bile duct and hepatectomy WITH transplant

90  Surgery, NOS
99  Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10, 01/11)
PANCREAS
C25.0–C25.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00 None; no surgery of primary site; autopsy ONLY
25 Local excision of tumor, NOS
30 Partial pancreatectomy, NOS; example: distal
35 Local or partial pancreatectomy and duodenectomy
   36 WITHOUT distal/partial gastrectomy
   37 WITH partial gastrectomy (Whipple)
40 Total pancreatectomy
60 Total pancreatectomy and subtotal gastrectomy or duodenectomy
70 Extended pancreatectoduodenectomy
80 Pancreatectomy, NOS
90 Surgery, NOS
99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)
LARYNX
C32.0–C32.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00  None; no surgery of primary site; autopsy ONLY

10  Local tumor destruction, NOS
11  Photodynamic therapy (PDT)
12  Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13  Cryosurgery
14  Laser
15  Stripping

No specimen sent to pathology from surgical events 10–15.

20  Local tumor excision, NOS
26  Polypectomy
27  Excisional biopsy
Any combination of 20 or 26–27 WITH
   21  Photodynamic therapy (PDT)
   22  Electrocautery
   23  Cryosurgery
   24  Laser ablation
25  Laser excision
28  Stripping

30  Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy NOS
31  Vertical laryngectomy
32  Anterior commissure laryngectomy
33  Supraglottic laryngectomy

40  Total or radical laryngectomy, NOS
41  Total laryngectomy ONLY
42  Radical laryngectomy ONLY

50  Pharyngolaryngectomy

80  Laryngectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)
LUNG
C34.0–C34.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00  None; no surgery of primary site; autopsy ONLY

19  Local tumor destruction or excision, NOS
    Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

15  Local tumor destruction, NOS
12  Laser ablation or cryosurgery
13  Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
    No specimen sent to pathology from surgical events 12–13 and 15.

20  Excision or resection of less than one lobe, NOS
23  Excision, NOS
24  Laser excision
25  Bronchial sleeve resection ONLY
21  Wedge resection
22  Segmental resection, including lingulectomy

30  Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)
33  Lobectomy WITH mediastinal lymph node dissection
    The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery.

45  Lobe or bilobectomy extended, NOS
46  WITH chest wall
47  WITH pericardium
48  WITH diaphragm

55  Pneumonectomy, NOS
56  WITH mediastinal lymph node dissection (radical pneumonectomy)
    The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery.

65  Extended pneumonectomy
66  Extended pneumonectomy plus pleura or diaphragm

70  Extended radical pneumonectomy
    The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery.

80  Resection of lung, NOS

90  Surgery, NOS
99  Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10)
HEMATOPOIETIC/RETICULOENDOTHELIAL/
IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE
C42.0, C42.1, C42.3, C42.4 (with any histology)

or

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)  (with any site)

Code

98   All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment.

   Surgical procedures for hematopoietic/reticuloendothelial/immunoproliferative/ myeloproliferative primaries are to be recorded using the data item Surgical Procedure/Other Site [1294].

(Revised 01/04, 01/10, 02/10)
Codes

00  None; no surgery of primary site; autopsy ONLY

19  Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

15  Local tumor destruction

No specimen sent to pathology from surgical event 15.

25  Local excision

26  Partial resection

30  Radical excision or resection of lesion WITH limb salvage

40  Amputation of limb
   41  Partial amputation of limb
   42  Total amputation of limb

50  Major amputation, NOS
   51  Forequarter, including scapula
   52  Hindquarter, including ilium/hip bone
   53  Hemipelvectomy, NOS
   54  Internal hemipelvectomy

Specimen sent to pathology from surgical events 25–54.

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY

(Revised 8/17/02, 01/10, 02/10)
SPLEEN
Spleen C42.2
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00  None; no surgery of primary site; autopsy ONLY

19  Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

21  Partial splenectomy

22  Total splenectomy

80  Splenectomy, NOS

Specimen sent to pathology for surgical events 21-80.

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10)
SKIN
C44.0–C44.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Special Instructions for Melanoma of the Skin:

Below are tips for coding melanoma of the skin, particularly those that are diagnosed first by a biopsy and then receive a wider excision.

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.

Gross/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. The exact code depends on the documented microscopically negative margin stated on the pathology report and distance to the tumor:
- Microscopically negative margins are 1 cm or less. Assign code 30-33 (depending on type of initial biopsy).
- Microscopically negative margins are > 1 cm. Assign code 45-47 (depending on distance to the tumor).

Brief description of common procedures used to remove skin lesions:
- Shave Biopsy: Scraping off lesion. Use of Scalpel or Razor. Outermost layers. No stitches.
- 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.
- Conventional Mohs: Thin layer of tissue removed. Margins are processed in frozen sections.
- Slow Mohs: Margins are processed as rush permanent 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.
  - If following a biopsy, use codes 30-33.
  - If this is the initial procedure and microscopic margins are negative, use codes 45-47.
  - Example: Shave biopsy followed by amputation of upper 4th toe. Code 31.
- Amputation (code 60): Removal of the entire involved limb/digit.

The abstractor should look for following and include a detailed description of the findings in the TEXT:
Intent: The intent of the initial shave, punch or incisional biopsy, along with the margin status on the pathology report from the biopsy, is important for determining if the procedure is to be coded as a biopsy (code 02) or an excision (code 27).
Text: Try to determine the intent and note that, along with the margin status from the pathology report.
Margins: Margins are important in the management and treatment of melanomas and are a key factor in determining the appropriate surgery code. Several references to margins will be made during the surgical treatment of the tumor. The common references are:

- Gross/visible/MACROscopic margins – what the physician observes during the procedure. The physician will often comment if all visible tumor was removed. The physician knows if the intent is to try to remove the entire tumor or to only take a sample for diagnostic purposes (common for large lesions). Statements such as these provide an indication to the intent of the procedure and may provide the needed documentation to consider the margins as MACROscopically negative.
- MICROscopic margins - the margin status (the negative margin measurement) specified by the pathologist on the pathology report. For biopsies, this microscopic margin is used to help determine if the biopsy is coded in the Surgical Diagnostic and Staging Procedure data item or the Surgical Procedure of the Primary Site data item. For the wider excision, this microscopic margin measurement is used to determine if the procedure falls into the 30-36 range or the 45-47 range.

Text: Look for mention of margins in the pathology report from ALL procedures and note those in the text. If margins were not stated on the pathology report or are not available in the medical record, then state “margins not stated”. For quality review, this differentiates a specific circumstance for the case where the margin status was not stated in the record versus the abstractor failing to include the margin status in the text.

Procedure: Document the procedure name specified by the physician. Such as: WLE w/ 2cm margins; Re-excision with <1cm margins; etc. The margins intended by the physician for the procedure and the margin status confirmed on the pathology report by the pathologist are two separate measurements.

Text: BOTH margin measurements should be noted in the text.

Example of Ideal Text:
PE Text: 65y WF. 1cm lesion on Rt thigh. No other suspicious lesions or adenopathy. No hx of melanoma.
Pathology Text: 3/4/20xx, Shave bx, Rt thigh: Malignant Melanoma. BT .13mm. Margins involved. Re-exc recommended. 3/15/20xx, Rt thigh WLE: Focal residual invasive melanoma. BT .01mm. No ulceration, LVSI. Mitotic Rate 1/mm2. Closest margin 1.8cm.
Surgery Text: 3/4/20xx, My Town Dermatologist: Shave bx, Rt thigh. All visible tumor removed. 3/15/20xx, My Town Hospital: Rt thigh WLE w/ 2cm margins.

Shave/Punch/Incisional Biopsies: Code 02 or 27?
Consider the intent of the biopsy and the margin status of the biopsy on the pathology report. Did the physician intend to remove all of the tumor? Was all gross tumor removed?
Do not use the findings from the wider excision to determine if the previous biopsy removed all of the tumor. Use only the pathology report from the biopsy specimen.

Code based on various scenario options:

<table>
<thead>
<tr>
<th>Margin Status/Intent</th>
<th>SDSP</th>
<th>Surgery</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>MACROscopic margins positive; or Physician stated that gross/visible tumor remained</td>
<td>02</td>
<td>00 *</td>
<td>The physician’s intent was to only get a sample of the tumor. As the entire tumor was not removed, this biopsy cannot be coded as an excisional biopsy (code 27).</td>
</tr>
<tr>
<td>Tumor was large or in a site that was difficult to biopsy. The physician only took a sample of the tumor. Margins were grossly positive.</td>
<td>02</td>
<td>00 *</td>
<td>The physician’s intent was to only get a sample of the tumor. As the entire tumor was not removed, this biopsy cannot be coded as an excisional biopsy (code 27).</td>
</tr>
<tr>
<td>Margins not mentioned anywhere in the medical record or path report, and the physician did not comment if all visible</td>
<td>02</td>
<td>00 *</td>
<td>This equates to UNKNOWN margins. In this situation, the intent of the biopsy is not known. There is not enough information to justify that all tumor was removed.</td>
</tr>
</tbody>
</table>
tumor was removed | removed for a code of 27.
MACROscopic margins grossly negative | 00 27 * | The physician’s intent was to remove the entire tumor. Regardless of approach (incisional, shave, punch), all visible tumor was removed. This is considered an excisional biopsy (code 27).
Margins not mentioned anywhere in the medical record or path report, but physician stated all visible tumor removed | 00 27 * | By the physician stating that all visible tumor was removed, this equates to the intent being an excisional biopsy.
MICROscopic margins positive only on the path report | 00 27 * | This is the same as saying that the MACROscopic margins are negative. Regardless of approach (incisional, shave, punch), all visible tumor was removed. This is an excisional biopsy (code 27).
MICROscopic margins are negative on the path report | 00 27 * | All tumor was removed, both macro and microscopically.
Procedure was called an “Excisional biopsy” | 00 27 * | By definition, an excisional biopsy removes all of the tumor.

* These scenarios are looking at how to code shave/punch biopsies only. This code is based on the biopsy only, for now. The final code assigned in the Surgery of Primary Site data item will depend on the details of the wider excision. If a wider excision is done, the code should be updated to the appropriate code based on the procedure type and margins.

**Example 1 (using the text from the above scenario):**
SDSP: 00. The intent was to remove the entire tumor. The physician stated that all visible tumor was removed. Initial Surgery of Primary Site: 27. All visible tumor was removed. Final Surgery of Primary Site: 46. Now that a further excision has been done, the code is updated to reflect this excision. The physician attempted to remove a 2cm margin. However, the microscopically confirmed negative margin on the pathology report was only 1.8cm, therefore, code 47 does not apply.

**Example 2:**
3/24/20xx, Shave bx L calf: Malignant melanoma, BT 0.5mm. No ulceration. Margins are involved < 5mm.
4/12/20xx, L calf excision: Focal residual melanoma, 0.8cm. BT 0.5mm. No ulceration. Margins negative.
SDSP: 00, none.
Initial Surgery of Primary Site: 27. The margins were only microscopically positive on the shave biopsy.
Final Surgery of Primary Site: 31, shave biopsy followed by gross excision. Now that a further excision has been done, the code is updated to reflect this excision. The margins were negative on the re-excision, but the measurement of the clear margin was not stated. Therefore, codes 45-47 cannot be used. Use the appropriate code in the 20-36 range.

**Example 3:**
1/23/20xx, R arm shave bx: Malignant melanoma, unable to give accurate depth invasion.
2/15/20xx, R arm WLE: Malignant melanoma, depth 1.1mm, no ulceration. Margins neg, 1.7cm.
SDSP: 02. The margins were not stated on shave biopsy. Because we don’t know the intent of the shave biopsy or the status of the margins, it must be coded as a biopsy (code 02).
Final Surgery of Primary Site: 46, wide excision with microscopically confirmed negative margins measuring between 1 and 2cm.

**Surgery and Staging:**
The rules for coding surgery are different than the rules for assigning the AJCC Stage. To assign the pTNM, a further excision (gross, wide, re-) to evaluate margins must be done (codes 30-60). Code 27 does not meet the surgical resection requirements for pathologic staging. Assign the clinical TNM only for excisional biopsies.
Codes (Skin, C44.0 – C44.9)

00  None; no surgery of primary site; autopsy ONLY

10  Local tumor destruction, NOS (No specimen is sent to pathology from surgical events 10–14)
    11  Photodynamic therapy (PDT)
    12  Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
    13  Cryosurgery
    14  Laser ablation

20  Local tumor excision, NOS
    26  Polypectomy
    27  Excisional biopsy

Any combination of 20 or 26–27 WITH
    21  Photodynamic therapy (PDT)
    22  Electrocautery
    23  Cryosurgery
    24  Laser ablation

25  Laser excision

30-36  Biopsy of the primary lesion followed by wider excision. Negative margin is LESS than 1cm.
    •  The microscopically negative margin of the wider excision determines the surgery code. Use the negative margin measurement stated on the pathology report for the gross/wide/re-excision to determine if the procedure falls into the 30-36 range or the 45-47 range.
    •  Use this range if the excision (gross, wide, re-) has microscopically confirmed negative margins LESS than 1 cm.
    •  Use this range if the margin of the wider excision is not stated in the pathology report.
    •  Use this range if the record specified the procedure included margins that are 1 cm or more but those margins are not microscopically confirmed/stated on the pathology report.
    •  The biopsy and the wider excision do not have to be done under the same anesthesia.
    •  Example: Procedure: Previous shave biopsy. Wide excision, malignant melanoma Rt arm (2x3cm). An elliptical incision was made with 1cm margins. Pathology: Residual melanoma within 5mm of margin. The microscopically negative margin on the wider excision is <1cm. Assign code 31.

30  Biopsy of primary tumor followed by a gross excision of the lesion, NOS. The type of initial biopsy is not known.
31  Shave biopsy followed by a gross excision of the lesion
32  Punch biopsy followed by a gross excision of the lesion
33  Incisional biopsy followed by a gross excision of the lesion. This code includes “excisional” biopsy that are followed by a gross excision with margins <1cm.

34  Mohs surgery, NOS (margins not stated or are unknown)
35  Mohs with 1cm margin or less
36  Mohs with more than 1cm margin
45-47  **Excision of primary lesion and the microscopically negative margin is 1cm or MORE.**

- The microscopically negative margin of the excision determines the surgery code. Use the margins stated on the pathology report for the gross, wide, re-excision.
- Use this range if the excision has microscopically confirmed negative margins of 1cm or MORE. The 1cm+ margin MUST be known and must microscopically negative. If the margin is not known, use codes 20-36.
- This excision may be proceeded by shave/punch/incisional/excisional biopsy or excision. The previous biopsy and the wider excision do not have to be done under the same anesthesia.

45  Wide excision or re-excision of lesion or minor (local, less the complete) amputation. It is known that the microscopically negative margin is at least 1cm but there is not enough information to assign the more specific code of 46 or 47.

46  Wide excision or re-excision of lesion or minor (local) amputation WITH microscopically negative margin measuring more than 1 cm and less than or equal to 2 cm

47  Wide excision or re-excision of lesion or minor (local) amputation WITH microscopically negative margin measuring greater than 2 cm

60  Major amputation (complete removal of limb or digit)
90  Surgery, NOS
99  Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 01/15, 01/16)
BREAST
C50.0–C50.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS

No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

20 Partial mastectomy, NOS; less than total mastectomy, NOS
   21 Partial mastectomy WITH nipple resection
   22 Lumpectomy or excisional biopsy
   23 Reexcision of the biopsy site for gross or microscopic residual disease
   24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

30 Subcutaneous mastectomy
   A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.

40 Total (simple) mastectomy
   41 WITHOUT removal of uninvolved contralateral breast
      43 With reconstruction NOS
         44 Tissue
         45 Implant
         46 Combined (Tissue and Implant)
   42 WITH removal of uninvolved contralateral breast
      47 With reconstruction NOS
         48 Tissue
         49 Implant
         75 Combined (Tissue and Implant)

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed.

For single primaries only, code removal of the involved contralateral breast under the data item Surgical Procedure/Other Site [1294] and/or Surgical Procedure/Other Site at This Facility [674].

If the contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

Reconstruction that is planned as part of first course treatment is coded 43-49 or 75, whether it is done at the time of mastectomy or later.
Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.

Modified radical mastectomy
51  WITHOUT removal of uninvolved contralateral breast
   53  Reconstruction, NOS
       54  Tissue
       55  Implant
       56  Combined (Tissue and Implant)
52  WITH removal of uninvolved contralateral breast
   57  Reconstruction, NOS
       58  Tissue
       59  Implant
       63  Combined (Tissue and Implant)

Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle.

If contralateral breast reveals a second primary, it is abstracted separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For single primaries only, code removal of involved contralateral breast under the data item Surgical Procedure/Other Site [1294] or Surgical Procedure/Other Site at This Facility [674].

Radical mastectomy, NOS
61  WITHOUT removal of uninvolved contralateral breast
   64  Reconstruction, NOS
       65  Tissue
       66  Implant
       67  Combined (Tissue and Implant)
62  WITH removal of uninvolved contralateral breast
   68  Reconstruction, NOS
       69  Tissue
       73  Implant
       74  Combined (Tissue and Implant)

Extended radical mastectomy
70  Extended radical mastectomy
71  WITHOUT removal of uninvolved contralateral breast
72  WITH removal of uninvolved contralateral breast

Mastectomy, NOS

Specimen sent to pathology for surgical events coded 20-80.
90  Surgery, NOS
99  Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 05/10, 01/11, 01/13)
CERVIX UTERI
C53.0–C53.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item Surgical Diagnostic and Staging Procedure [1350].

Codes

00  None; no surgery of primary site; autopsy ONLY
10  Local tumor destruction, NOS
   11  Photodynamic therapy (PDT)
   12  Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13  Cryosurgery
   14  Laser
   15  Loop Electrocautery Excision Procedure (LEEP)
   16  Laser ablation
   17  Thermal ablation

No specimen sent to pathology from surgical events 10–17.

20  Local tumor excision, NOS
   26  Excisional biopsy, NOS
   27  Cone biopsy
   24  Cone biopsy WITH gross excision of lesion
   29  Trachelectomy; removal of cervical stump; cervicectomy
Any combination of 20, 24, 26, 27 or 29 WITH
   21  Electrocautery
   22  Cryosurgery
   23  Laser ablation or excision
   25  Dilatation and curettage; endocervical curettage (for in situ only)
   28  Loop electrocautery excision procedure (LEEP)

30  Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries
    Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

40  Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary
    Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

50  Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
   51  Modified radical hysterectomy
   52  Extended hysterectomy
   53  Radical hysterectomy; Wertheim procedure
   54  Extended radical hysterectomy

60  Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
   61  WITHOUT removal of tubes and ovaries
   62  WITH removal of tubes and ovaries
Pelvic exenteration
Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

Extended exenteration
Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20–74.

Surgery, NOS
Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10)
CORPUS UTERI
C54.0–C55.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item Surgical Diagnostic and Staging Procedure [1350].

Codes
00 None; no surgery of primary site; autopsy ONLY
19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser
15 Loop Electocautery Excision Procedure (LEEP)
16 Thermal ablation

No specimen sent to pathology from surgical events 10–16.

20 Local tumor excision, NOS; simple excision, NOS
24 Excisional biopsy
25 Polypectomy
26 Myomectomy
Any combination of 20 or 24--26 WITH
21 Electrocautery
22 Cryosurgery
23 Laser ablation or excision

30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies).
31 WITHOUT tube(s) and ovary(ies)
32 WITH tube(s) and ovary(ies)

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
61 Modified radical hysterectomy
62 Extended hysterectomy
Radical hysterectomy; Wertheim procedure
Extended radical hysterectomy

Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)
WITHOUT removal of tube(s) and ovary(ies)
WITH removal of tube(s) and ovary(ies)

Pelvic exenteration
Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

Extended exenteration
Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20–79.

Surgery, NOS

Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10)
OVARY C56.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00  None; no surgery of primary site; autopsy ONLY
17  Local tumor destruction, NOS
   No specimen sent to pathology from surgical event 17.

25  Total removal of tumor or (single) ovary, NOS
26  Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
27  WITHOUT hysterectomy
28  WITH hysterectomy

35  Unilateral (salpingo-)oophorectomy; unknown if hysterectomy done
36  WITHOUT hysterectomy
37  WITH hysterectomy

50  Bilateral (salpingo-)oophorectomy; unknown if hysterectomy done
51  WITHOUT hysterectomy
52  WITH hysterectomy

55  Unilateral or bilateral (salpingo-)oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done
56  WITHOUT hysterectomy
57  WITH hysterectomy

60  Debulking; cytoreductive surgery, NOS
61  WITH colon (including appendix) and/or small intestine resection (not incidental)
62  WITH partial resection of urinary tract (not incidental)
63  Combination of 61 and 62
   Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.

70  Pelvic exenteration, NOS
71  Anterior exenteration
   Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.
72  Posterior exenteration
   Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.
73  Total exenteration
   Includes removal of all pelvic contents and pelvic lymph nodes.
74  Extended exenteration
   Includes pelvic blood vessels or bony pelvis.

80  (Salpingo-)oophorectomy, NOS
90  Surgery, NOS
99  Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10)
**PROSTATE**

C61.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

**Do not code** an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item *Hematologic Transplant and Endocrine Procedures* [3250].

**Codes**

00 None; no surgery of primary site; autopsy ONLY

18 Local tumor destruction or excision, NOS

19 Transurethral resection (TURP), NOS, and no specimen sent to pathology or unknown if sent

unknown whether a specimen was sent to pathology for surgical events coded 18 or 19 (principally for cases diagnosed prior to January 1, 2003).

10 Local tumor destruction, NOS

14 Cryoprostatectomy

15 Laser ablation

16 Hyperthermia

17 Other method of local tumor destruction

**No specimen sent to pathology from surgical events 10–17.**

20 Local tumor excision, NOS

21 Transurethral resection (TURP), NOS, with specimen sent to pathology

22 TURP–cancer is incidental finding during surgery for benign disease

23 TURP–patient has suspected/known cancer

Any combination of 20–23 WITH

24 Cryosurgery

25 Laser

26 Hyperthermia

30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

50 Radical prostatectomy, NOS; total prostatectomy, NOS

**Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.**

70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration

**Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.**

80 Prostatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 12/4/02, 01/10, 02/10, 1/11)
TESTIS
C62.0–C62.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>None; no surgery of primary site; autopsy ONLY</td>
</tr>
<tr>
<td>12</td>
<td>Local tumor destruction, NOS</td>
</tr>
</tbody>
</table>

**No specimen sent to pathology from surgical event 12.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Local or partial excision of testicle</td>
</tr>
<tr>
<td>30</td>
<td>Excision of testicle WITHOUT cord</td>
</tr>
<tr>
<td>40</td>
<td>Excision of testicle WITH cord or cord not mentioned (radical orchiectomy)</td>
</tr>
<tr>
<td>80</td>
<td>Orchiectomy, NOS (unspecified whether partial or total testicle removed)</td>
</tr>
</tbody>
</table>

**Specimen sent to pathology from surgical events 20–80.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>Surgery, NOS</td>
</tr>
<tr>
<td>99</td>
<td>Unknown if surgery performed; death certificate ONLY</td>
</tr>
</tbody>
</table>

(Revised 01/04, 01/10, 02/10)
KIDNEY, RENAL PELVIS, AND URETER

Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser
   15 Thermal ablation

No specimen sent to pathology from this surgical event 10–15.

20 Local tumor excision, NOS
26 Polypectomy
27 Excisional biopsy

Any combination of 20 or 26–27 WITH
   21 Photodynamic therapy (PDT)
   22 Electrocautery
   23 Cryosurgery
   24 Laser ablation
25 Laser excision

30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)

Procedures coded 30 include, but are not limited to:
   Segmental resection
   Wedge resection

40 Complete/total/simple nephrectomy—for kidney parenchyma
Nephroureterectomy
Includes bladder cuff for renal pelvis or ureter.

50 Radical nephrectomy
May include removal of a portion of vena cava, adrenal gland(s), Gerota’s fascia, perinephric fat, or partial/total ureter.

70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with the resection of other organ(s) (colon, bladder)
The other organs, such as colon or bladder, may be partially or totally removed.

80 Nephrectomy, NOS
Ureterectomy, NOS
90 Surgery, NOS
99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)
BLADDER
C67.0–C67.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY
10 Local tumor destruction, NOS
   11 Photodynamic therapy (PDT)
   12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
   13 Cryosurgery
   14 Laser
   15 Photodynamic therapy (PDT)
   16 Bacillus Calmette-Guerin (BCG) or other immunotherapy

   Also code the introduction of immunotherapy in the immunotherapy items.
   If immunotherapy is followed by surgery of the type coded 20-80 code that surgery instead and
   code the immunotherapy only as immunotherapy.

No specimen sent to pathology from surgical events 10–16.

20 Local tumor excision, NOS
26 Polypectomy
27 Excisional biopsy
   Combination of 20 or 26–27 WITH
   21 Photodynamic therapy (PDT)
   22 Electrocautery
   23 Cryosurgery
   24 Laser ablation
   25 Laser excision

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Complete cystectomy with reconstruction
   61 Radical cystectomy PLUS ileal conduit
   62 Radical cystectomy PLUS continent reservoir or pouch, NOS
   63 Radical cystectomy PLUS abdominal pouch (cutaneous)
   64 Radical cystectomy PLUS in situ pouch (orthotopic)

   When the procedure is described as a pelvic exenteration for males, but the prostate is not
   removed, the surgery should be coded as a cystectomy (code 60-64).

70 Pelvic exenteration, NOS

71 Radical cystectomy including anterior exenteration
   For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and
   entire urethra. For males, includes removal of the prostate. When 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 60-64).

72 Posterior exenteration
For females, also includes removal of vagina, rectum and anus.
For males, also includes prostate, rectum and anus.

73 Total exenteration
Includes all tissue and organs removed for an anterior and posterior exenteration.

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

80 Cystectomy, NOS
Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 01/12)
**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

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code laminectomies for spinal cord primaries.

**Codes**

00  None; no surgery of primary site; autopsy ONLY

10  Tumor destruction, NOS

**No specimen sent to pathology from surgical event 10.**

Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as surgical tumor destruction. All of these modalities are recorded in the radiation treatment fields.

20  Local excision of tumor, lesion or mass; excisional biopsy

   21  Subtotal resection of tumor, lesion or mass in brain

   22  Resection of tumor of spinal cord or nerve

30  Radical, total, gross total resection of TUMOR, lesion or mass in brain

40  Partial resection of lobe of brain, when the surgery cannot be coded as 20-30.

55  Gross total resection of LOBE OF BRAIN (lobectomy)

**Codes 30 - 55 are not applicable for spinal cord or spinal nerve primary sites.**

Specimen sent to pathology from surgical events 20–55.

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10)
THYROID GLAND
C73.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes
00 None; no surgery of primary site; autopsy ONLY
13 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 13.

25 Removal of less than a lobe, NOS
26 Local surgical excision
27 Removal of a partial lobe ONLY

20 Lobectomy and/or isthmectomy
21 Lobectomy ONLY
22 Isthmectomy ONLY
23 Lobectomy WITH isthmus

30 Removal of a lobe and partial removal of the contralateral lobe
40 Subtotal or near total thyroidectomy
50 Total thyroidectomy
80 Thyroidectomy, NOS

Specimen sent to pathology from surgical events 25–80.

90 Surgery, NOS
99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)
LYMPH NODES
C77.0–C77.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00  None; no surgery of primary site; autopsy ONLY

19  Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003).

15  Local tumor destruction, NOS

No specimen sent to pathology from surgical event 15.

25  Local tumor excision, NOS
Less than a full chain, includes an excisional biopsy of a single lymph node.

30  Lymph node dissection, NOS
31  One chain
32  Two or more chains

40  Lymph node dissection, NOS PLUS splenectomy
41  One chain
42  Two or more chains

50  Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
51  One chain
52  Two or more chains

60  Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy
(Includes staging laparotomy for lymphoma.)
61  One chain
62  Two or more chains

Specimen sent to pathology for surgical events 25-62.

90  Surgery, NOS

99  Unknown if surgery performed; death certificate ONLY

(Revised 09/04, 01/10, 02/10)
### ALL OTHER SITES

C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C30.1, 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>None; no surgery of primary site; autopsy ONLY</td>
</tr>
<tr>
<td>10</td>
<td>Local tumor destruction, NOS</td>
</tr>
<tr>
<td>11</td>
<td>Photodynamic therapy (PDT)</td>
</tr>
<tr>
<td>12</td>
<td>Electrocautery; fulguration (includes use of hot forceps for tumor destruction)</td>
</tr>
<tr>
<td>13</td>
<td>Cryosurgery</td>
</tr>
<tr>
<td>14</td>
<td>Laser</td>
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**No specimen sent to pathology from surgical events 10–14.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>20</td>
<td>Local tumor excision, NOS</td>
</tr>
<tr>
<td>26</td>
<td>Polypectomy</td>
</tr>
<tr>
<td>27</td>
<td>Excisional biopsy</td>
</tr>
<tr>
<td></td>
<td>Any combination of 20 or 26–27 WITH</td>
</tr>
<tr>
<td>21</td>
<td>Photodynamic therapy (PDT)</td>
</tr>
<tr>
<td>22</td>
<td>Electrocautery</td>
</tr>
<tr>
<td>23</td>
<td>Cryosurgery</td>
</tr>
<tr>
<td>24</td>
<td>Laser ablation</td>
</tr>
<tr>
<td>25</td>
<td>Laser excision</td>
</tr>
<tr>
<td>30</td>
<td>Simple/partial surgical removal of primary site</td>
</tr>
<tr>
<td>40</td>
<td>Total surgical removal of primary site; enucleation</td>
</tr>
<tr>
<td>41</td>
<td>Total enucleation (for eye surgery only)</td>
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<tr>
<td>50</td>
<td>Surgery stated to be “debulking”</td>
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<tr>
<td>60</td>
<td>Radical surgery</td>
</tr>
<tr>
<td></td>
<td>Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.</td>
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</tbody>
</table>

**Specimen sent to pathology from surgical events 20–60.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>90</td>
<td>Surgery, NOS</td>
</tr>
<tr>
<td>99</td>
<td>Unknown if surgery performed; death certificate ONLY</td>
</tr>
</tbody>
</table>

(Revised 01/04, 01/10, 02/10)
UNKNOWN AND ILL-DEFINED PRIMARY SITES
C76.0–C76.8, C80.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code

98  All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item Surgical Procedure/Other Site [1294] or Surgical Procedure/Other Site at This Facility [674].

(Revised 01/04, 01/10, 02/10)
Appendix C: Guidelines for Abstracted Text
Guidelines for Abstracted Text

Text is an essential component of a complete electronic abstract and is required to support coded data items. The purpose of reporting text is quality control; abstracts must contain corroborating text that validates the selection of codes assigned to primary site, histology, extent of disease and treatment fields.

Text is used to:
- corroborate coded data items
- verify potential errors identified through standard edits
- document clarifications
- determine multiple primaries and
- reconcile data item discrepancies when the same patient is reported by several facilities.

Text fields should be used to document information that will support the accuracy of the data so that anyone reviewing the cancer registry abstract will be able to justify the coded information.

Amount of Text

Registrars should provide enough information to give a clinical picture of the patient. The most useful text is brief, concise and addresses pertinent issues. Since the NAACCR record has limitations on the amount of text that one can provide, it is important to document the most important findings in the beginning of the text fields. It is often necessary to use abbreviations due to limited size of the text fields. Registrars should use standard medical abbreviations whenever possible (see NAACCR Recommended Abbreviations for Abstractors). For those cases that have multiple x-rays/scans, surgical procedures, etc., the registrar can document additional comments in any empty text field or the Remarks section. Registrars continuing text from one to another section should use CONT to indicate the connection between text fields.

Dos and Don’ts of Texting

- Do justify ALL dates, including the month, day and year
- Do indicate if any date is an estimate
- Do prioritize information to be entered (most important findings, first)
- Do continue additional comments from one text field to another
- Do state that information is missing from the record, if unavailable
- Do utilize NAACCR-approved abbreviations
- Do document if a particular therapy was recommended but uncertain if given
- Do not repeat information from other text fields
- Do not include irrelevant information (e.g., in bicycle accident as a child)
- Do not include information that the registry is not authorized to collect
- Do not rely on text automatically generated from coded data to replace your text
**Special characters and “copy and paste”**

Please do not “copy and paste” or “cut and paste” from other source documents into text fields. Often this practice will copy embedded characters that cause an error message when uploaded to the N.C. CCR. Examples of embedded/encrypted characters include:

- Carriage Returns (CR)
- Line Feeds (LF)
- Single quotes (’), e.g., O’CLOCK
- Double quotes (”)

Also, avoid all punctuation except periods, commas, dashes and slashes. Characters like ampersand (&) and asterisk (*) may also create upload problems.

**Document the “unusual”**

If treatment is delayed, please 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. Doctor.

To communicate that an unusual age is correct:

> 43 yr WM with prostate cancer (age verified)

Estimating dates is better than recording unknown:

> 7/20xx (estimate) Dr. Doctor office Tamoxifen

*Estimated date of diagnosis 2010; patient diagnosed 5 years ago.*

**Preferred format of text that supports procedures or treatment**

When, Where, What, Outcome

Examples:

- 8/19/20xx Dr. Doctor’s office. Lupron given.
- 11/9/20xx NCMC sigmoidoscopy: ulcerated, constricting lesion from 7 to 9 cm. Mult bxs taken.
- 7/4/20xx Dr. MD’s office. PE: 4x4cm hard mass UIQ Lt breast. Skin dimpled w/evid of edema and peau d’orange. Palp susp nodes in lower axilla.

The CCR receives many more “abstracts” than “cases” which of course, 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 to accept when there is a discrepancy between what one hospital and another reports? Factors such as class of cases and treating facility play a part, but most decisions are based on the best text documentation.
# N.C. CCR Required Text Fields and Examples

<table>
<thead>
<tr>
<th>Text Field</th>
<th>Suggestions for Text</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Site</td>
<td>Primary site, subsite and laterality</td>
<td>Rt breast, UOQ RLL Lung</td>
</tr>
<tr>
<td>Histology</td>
<td>Histologic type, behavior and grade Also record scoring systems like Gleason’s Score, Bloom Richardson Grade, etc.</td>
<td>Mod. Diff Adenoca Adenoca, Gleason score 3+4</td>
</tr>
<tr>
<td>Staging</td>
<td>Findings for the basis of Collaborative Stage. Organs involved by direct extension. Tumor Size. Number of positive lymph nodes. Sites of distant metastasis.</td>
<td>RLL Lung – tumor 3cm on CXR, no mediastinal adenopathy, no distant mets on CT abd/pelvis. MRI brain WNL Rad Onc staged T3N2M0</td>
</tr>
<tr>
<td>Physical Exam</td>
<td>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.</td>
<td>45 yo WF with 4x4 cm hard mass, UIQ Lt breast. Skin dimpled w/edema and peau d’orange. Palpable susp nodes in lower axilla. 65 yo BM Rectal exam: Prostate 3+ enlarged, nontender. No nodularity. 70 yo WM DRE - smooth nodule occupying less than half lobe rt side of prostate.</td>
</tr>
<tr>
<td>X-rays/Scans</td>
<td>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.</td>
<td>9-24-20xx CT abd and pelvis: no lymphadenopathy or abnormality seen</td>
</tr>
<tr>
<td>Lab Tests</td>
<td>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. 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</td>
<td>ER/PR pos PSA in MD office elevated at 6.7 CEA elevated at 5.6</td>
</tr>
<tr>
<td>Scopes</td>
<td>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.</td>
<td>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,</td>
</tr>
</tbody>
</table>
### 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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-22-20xx</td>
<td>NCMC, TAH/BSO: Peritoneal metastasis beyond pelvis 1 cm in greatest dimension.</td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-20-20xx</td>
<td>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.</td>
</tr>
</tbody>
</table>

### Surgery
Date, type of procedure, facility if done elsewhere.

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-2-20xx</td>
<td>TRUS in Dr. Doctor’s office</td>
</tr>
<tr>
<td>1-5-xx</td>
<td>NCMC, Rad retropubic prostatectomy and pelvic LN bx</td>
</tr>
</tbody>
</table>

### Radiation Beam
Start and Stop dates, site, number of treatments, type of radiation. Modality and volume treated. Where treated.

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/1/20xx</td>
<td>3/1/20xx, NCMC, XRT (6-10MV) to prostate, 4500 cGy, 1500 boost</td>
</tr>
</tbody>
</table>

### Radiation Other
Date of treatment, type of treatment, modality, volume treated.

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-6-xx</td>
<td>NCMC, HDR brachytherapy (iridium 192)</td>
</tr>
</tbody>
</table>

### Chemotherapy
Date chemo started, name of agents and/or regimen.

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-23-9-17-20xx</td>
<td>Dr Doctor’s office Cytotoxan, Adriamycin, 5FU (CAF) and Herceptin x3 cycles</td>
</tr>
</tbody>
</table>

### Hormone Therapy
Date treatment started, type of hormone (e.g., Tamoxifen) or endocrine surgery or radiation (e.g., orchectomy)

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/12/20xx</td>
<td>Lupron in Dr. Doctor’s office</td>
</tr>
<tr>
<td>3/7/20xx</td>
<td>Pt started on Tamoxifen</td>
</tr>
</tbody>
</table>

### Immunotherapy or BRM
Date of treatment, type of BRM (e.g., BCG, Interferon)

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-4-20xx</td>
<td>Dr. office interferon</td>
</tr>
<tr>
<td>8/8/20xx</td>
<td>NCMC autologous BMT</td>
</tr>
</tbody>
</table>

### Other Therapy
Date treatment started, type of other treatment (e.g., blinded clinical trial)

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/1/20xx</td>
<td>NCMC, red cell transfusions for refractory anemia</td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 hx of prostate ca 2009 treated with XRT</td>
<td></td>
</tr>
<tr>
<td>#2 hx of bladder ca 2011 TURBT</td>
<td></td>
</tr>
</tbody>
</table>

### Place of Diagnosis
Record where the patient was diagnosed

<table>
<thead>
<tr>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office of P.C. Physician</td>
</tr>
<tr>
<td>Dr. Doctor office</td>
</tr>
<tr>
<td>NC Medical Center</td>
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</table>

### Industry
Longest held occupation

<table>
<thead>
<tr>
<th>Procedure Description</th>
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<tbody>
<tr>
<td>Education</td>
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### Occupation
Longest held occupation

<table>
<thead>
<tr>
<th>Procedure Description</th>
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<tbody>
<tr>
<td>Elementary school teacher</td>
</tr>
<tr>
<td>Do not use “retired”</td>
</tr>
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</table>
Appendix D: Country and State Codes
<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>Country Code</th>
<th>State or Province Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>United States (state and armed forces codes)</strong></td>
<td></td>
<td></td>
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<tr>
<td>Alabama</td>
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Appendix E: Data Collection Changes Based on Year of Diagnosis
REPORTABILITY OF CERTAIN CONDITIONS

The following is a summary of the changes related to certain conditions. Some conditions have changed from reportable to non-reportable. Some have changed from non-reportable to reportable. Refer to the reference manual in effect for that year for detailed data collection and coding instructions.

Sequence number: 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.

1/1/1990  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.

1/1/1996  • CIS of the Cervix is no longer required:
  ▪ CIS of the Cervix diagnosed prior to 1/1/96 is included in the assignment of the sequence number.
  • Intraepithelial neoplasia grade III:
  ▪ PIN, CIN, VIN, VAIN, AIN are not required by the CoC after 1/1/1996
  ▪ PIN is not required by central cancer registries after 1/1/2001
  ▪ VIN III, VAIN III, and AIN III are still required by central cancer registries. Include in the assignment of the sequence number.

1996 - 2002 Malignant primary skin cancers (C44._) with histology codes 8000-8110 were required only if the AJCC stage group at diagnosis was II, III, or IV.

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.

<table>
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<th>ICD-O-1*</th>
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<th>ICD-O-3</th>
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<td>8471/1</td>
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</table>

*Some of the morphology codes changed from ICD-O-1 to ICD-O-2.

1/1/2001 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.

1/1/2003 Malignant primary skin cancers (C44._) with histology codes 8000-8110 are no longer required, regardless of stage.

1/1/2004 Non-malignant Brain and CNS is required.
• Sites include C70 – C72, C75.1-C75.3
• Some states or other registries may have required these prior to 2004.
  • Note: The N.C. CCR has always required these cases.
• Special sequence rule: All previous non-malignant CNS tumors are considered when assigning sequence regardless of year of diagnosis.

1/1/2010
Some changes in reportability of a few blood disorders and syndromes with the implementation of the SEER Hematopoietic Database and Coding Manual. Refer to the SEER website and Heme DB for more information.

1/1/2015
A number of changes to the ICD-O-3 have taken place since the book was printed. For 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. Not all newly-defined histologies can be used because they were not incorporated into CS version 02.05 and thus cannot be used at this time because no CS Stage Group will be derived. However, some changes will go into immediate use. The following are reportability changes effective for 2015. All cases meeting the criteria described below will use the new codes. Old codes will be obsolete.

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. Prior appendix primaries coded 8240/1 will be converted to 8240/3 by the implementation conversions for 2015.

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.)

Note: 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.

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 obsolete effective in 2015.

1/1/2016 In 2014 and 2015 SEER added new reportable histology terms to their Program and Coding Manual. These terms had not been included in any ICD-O-3 errata or implementation guide and therefore were not addressed throughout the cancer surveillance community. CDC reviewed the terms and made the following decisions regarding reportability.
• Pancreas (C25._)
  o 8470/2: Non-invasive mucinous cystic neoplasm of the pancreas with high-grade dysplasia
  o 8452/3: Solid pseudopapillary neoplasm of pancreas (synonymous with solid pseudopapillary carcinoma)
  o 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: 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.

1/1/2018 Significant changes to the valid ICD-O-3 codes for 2018 cases have been implemented. This includes new codes, changes in behavior codes (and therefore reportability), and new terms associated with current codes. These changes reflect updates to the World Health Organization (WHO) Classifications for Tumors (Blue Books). The 2018 ICD-O-3 Histology and Behavior Code Update Table MUST be used jointly with the 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. Refer to the SEER and NAACCR websites for more information.
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 2018 diagnoses.

SITE and HISTOLOGY CODING

International Classification of Diseases for Oncology
- Third edition: 2001 –
  - Plus periodic changes (see above): 2010, 2015, 2016
  - With WHO changes (online reference only): 2018 -

STAGING

American Joint Committee on Cancer TNM Staging System
- Second edition: 1983 (breast only**)-1988
- Third edition: 1989 - 1992 (all sites***)
- Sixth edition: 2003 - 2009
- Seventh edition: 2010 - 2017
- Eight edition: 2018 -

SEER Extent of Disease Manual
- Collected through Collaborative Stage: 2004 – 2017
- EOD 2018: 2018 -

Summary Staging
- Summary Stage 2018: 2018 -

DATA COLLECTION

CoC
Data Acquisition Manual (Revised) 1994 - 1995
ROADS with 2-digit surgery codes 1988 - 1997
ROADS with “new” surgery codes 1998 – 2002
Facility Oncology Registry Data Standards (FORDS): Revised for 2016 2003 –
Each version of FORDS was designed to replace existing versions.
STORE 2018 -

SEER Program Code Manual
Previous versions (see SEER Website) 1988 - 2015
SEER Program Coding and Staging Manual 2016 2016 - 2017

SEER Self-instructional Manuals for Cancer Registrars

SEER Rx Interactive Antineoplastic Drug Database 2005 -

SEER Hematopoietic Database 2010 -

Multiple Primary Rules
As listed in the FORDS and SEER Program Manuals - 2006
SEER Multiple Primary and Histology Coding Rules 2007 – 2017
SEER 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 your manual has 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 w/ online WHO changes
TNM 8th Edition
Summary Stage 2018
SEER Rx Database
SEER Solid Tumor Manual
SEER Hematopoietic Database
SSDI
Grade