12th Edition

Abstract Code Manual

MISSOURI CANCER REGISTRY AND RESEARCH CENTER

University of Missouri – Columbia

2012
Revised

Missouri Cancer Registry and Research Center

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Acknowledgements

The Missouri Cancer Registry would like to thank the American College of Surgeons-Commission on Cancer for permission to include some Facility Oncology Registry Data Standards (FORDS) in this manual. Such sections include the sub-heading "Instructions for Coding" or the term "per FORDS".

ABOUT THIS MANUAL

Public Law 102-515 and the Missouri Cancer Registry

The primary purpose of the *Abstract Code Manual* is to assist hospital-based cancer registrars in reporting cancer cases to the Missouri Cancer Registry (MCR). This revision introduces changes in coding structures and requirements for cases diagnosed on or after January 1, 2011 established by the National Program of Cancer Registries (NPCR), the North American Association of Central Cancer Registries (NAACCR) and the Commission on Cancer (CoC). The 2011 updates are fully documented in *Facility Oncology Registry Data Standards* (FORDS) and *SEER Program Coding and Staging Manual 2011*.

Since the passage of Public Law 102-515, entitled the *Cancer Registries Amendment Act,* by the 102nd Congress in October 1992, there has been a tremendous effort by all agencies collecting cancer data to unify and standardize data sets. With the establishment of the National Program of Cancer Registries in 1994, all central registries funded by the Centers for Disease Control and Prevention (CDC) through NPCR are required to follow stringent data management procedures; provide training for state personnel and hospital registry staff; publish an annual report; and conduct case-finding and re-abstracting audits at selected facilities.

Although MCR began receiving CDC/NPCR funding in 1995, our index (reference) year is 1996. MCR collects data that: 1) are compliant with required NPCR data elements; 2) meet standard requirements designated by NAACCR for incidence reporting and endorsed by CDC; and 3) assist in determining data quality. MCR also uses the data to provide useful feedback to submitting facilities that can be used for quality assurance activities and administrative purposes.

Data is submitted annually to NAACCR for Registry Certification and publication in *Cancer in North America (CINA)*. Registries whose data meet established criteria, including criteria for timeliness, accuracy and completeness, are recognized annually as NAACCR Certified Registries. MCR data has been certified since 2001 (for 1998 data) and has received 'gold' status since 2003 (for 2000 data).

In 1999, the Department of Health and Senior Services (DHSS) entered into a cooperative agreement with the University of Missouri, Columbia (UMC) allowing UMC to be the recipient of data submitted by reporting facilities. This agreement is carried out under the auspices of the Health Management and Informatics Department of UMC. Usage of the data is regulated by DHSS policies.

In early 2011, the Missouri Cancer Registry became the Missouri Cancer Registry and Research Center (MCR-ARC). The change was made to better reflect our activities in research and data usage.

Changes for 2012

- Collaborative Stage Version 2.04 is required for cases diagnosed on or after January 1, 2012. (http://www.cancerstaging.org/cstage/manuals)
- Consult the MCR website Required Data Elements for new site-specific factor requirements (http://mcr.umh.edu/mcr-cancer-reporting-hospital.php).
- Explanations added to MCR Abstract Manual entries for 2012, are shown in blue font for your convenience.
- Clarifications were added per updates to the FORDS and CS manuals.
- Coding instructions for Personal History fields were revised for clarification.
- MCR policy on the coding of Grade was clarified.
- Type of Reporting Source definitions were updated.
- Other Treatment was updated to define the Hematopoietic Database and Manual as the authoritative source regarding treatment codes for certain hematopoietic diseases.

MISSOURI CANCER REPORTING REQUIREMENTS

Role of Reporting Facilities. Missouri Cancer Registry, Confidentiality and Audits

Missouri statutes, NPCR and NAACCR requirements, data quality and projected needs of the citizens of this state govern reporting requirements. In 1999, in an effort to establish a true population-based central cancer registry in Missouri, statues governing cancer reportability were expanded to include patients diagnosed and/or treated as hospital outpatients and in non-hospital facilities (e.g., pathology laboratories, ambulatory surgery centers, freestanding treatment centers, physician offices and long-term care facilities). This manual is intended for use in hospital-based registries.

In determining case reportability, MCR follows the rules of the Surveillance, Epidemiology and End Results (SEER) program of the National Cancer Institute. SEER guidelines are specified in GENERAL INSTRUCTIONS. Data items are based on fields required and/or recommended by NPCR for central registries collecting incidence data. Additional requirements include fields necessary for quality assurance purposes and ten Missouri-specific fields. A complete list of required data items is posted on the MCR website: http://mcr.umh.edu/mcr-cancer-reporting-hospital.php

Role of Hospitals

The primary source for obtaining epidemiological information is the hospital cancer registry. A registry is responsible for providing a listing of cancer patients and pertinent information regarding their diagnoses. A registry may be small or large, and the extent of information submitted varies, depending on hospital size and the reporting methods for each facility. Some hospitals have had their own registries for years in accordance with the American College of Surgeons-Commission on Cancer (ACoS-CoC) requirements, while others have limited registries and collect or provide only the state mandated reporting requirements.

Role of Missouri Cancer Registry

MCR's role is to gather information from hospitals and other sources to monitor the incidence of cancer in the state for epidemiological research that may be used to develop and evaluate cancer prevention and control activities in Missouri. The data is received electronically from hospitals that have on-site or contract registrars. Facilities without a registrar having an annual caseload of 75 or fewer cases are called low-volume facilities. Information from these facilities is accepted in paper chart form, and MCR staff complete the abstracts. The data collected is invaluable in targeting risk factors in certain populations, studying the impact of environmental factors, identifying ethnic and social variations and evaluating the effectiveness of state cancer control programs.

The MCR staff is available to answer registry-related questions and to provide workshops, educational presentations and one-on-one training. Please refer to the MCR website at http://mcr..umh.edu/ for complete information.

Confidentiality

Per Missouri statute (192.655, RSMo 1999), the "department of health shall protect the identity of the patient, physician, health care provider, hospital, pathology laboratory, ambulatory surgical center, residential care facilities I or II, intermediate care facilities or skilled nursing facilities, and free-standing cancer clinic or treatment center… and that such identity shall not be revealed except…only upon written consent…" This confidentiality provision is necessary to assure all reporting entities that neither their identity nor the confidential data they submit will be subject to unauthorized release.

In addition, MCR employees are required to sign confidentiality agreements and follow confidentiality procedures set forth in the Missouri Cancer Registry Policy and Procedure Manual. These regulations include the use of locked cabinets for confidential data, employing secure work station practices, adhering to procedures for handling requests for data, etc. MCR employees also recognize the importance of compliance with ARRA HITECH provisions.

Note: The Health Insurance Portability and Accountability Act known as HIPAA allows for the reporting of identifiable cancer data to public health entities. Because the Missouri Cancer Registry falls under the definition of a public health authority, HIPAA allows your facility to continue reporting cancer incidence data in compliance with state statutes (192.650-192.657 RSMo) and regulations (19 CSR 70-21). Written informed consent from each cancer patient reported to public health entities is not required under HIPAA nor is a Business Associate Agreement required; rather, hospitals must simply document that reporting has occurred.

Edits

A Missouri-specific edit set was first developed in 2008. The MCR edit set was updated in accordance with the NAACCR v12 data layout and made available to all registry software vendors. MCR recommends that you run these edits at the time of abstracting. These

edits are applied to all files submitted to MCR via Web Plus and errors exceeding a set threshold may be cause for rejection of the file. Questions regarding edits should be directed to MCR Quality Assurance staff at 1-800-392-2829.

Audits

MCR periodically conducts case completeness and data quality audits as required by the NPCR. The intent of the audits is to assist hospitals with casefinding and abstracting issues to ensure complete, high quality data is submitted to MCR. Each Missouri hospital is audited every five years. All electronic reporting hospitals are subject to case completeness and data quality audits, including some low volume facilities, while only case completeness audits are performed at other low volume hospitals that do not perform abstracting. Standard audits include casefinding and re-abstraction of data for a specific year. Alternatively, audits other than the standard method may also be performed periodically such as case completeness review based on hospital accession register matches with MCR's database, data quality re-coding audits to evaluate data quality and text, and other site specific or tumor specific data quality reviews. After completion of the audits, detailed summary reports are prepared and shared with the hospital registrar and other related hospital staff. **Per NPCR guidelines, the acceptable accuracy rate for all audits is 95 – 100%.**

Standard Casefinding Inpatient/Outpatient hospital disease indices, pathology reports and other pertinent casefinding documents are reviewed and matched to the MCR database. Any non-matched cases are returned to the registrar or hospital contact person for resolution. During routine casefinding, registrars can assist themselves and MCR by maintaining a non-reportable list (patient name, date of birth or social security number, ICD-9-CM code of the non-reportable malignancy, date seen and reason not reported). Another method is to note the reason a case is non-reportable on the registrar's casefinding source, such as the Medical Records Disease Index (MRDI). The listing or notations will help registrars avoid duplication of efforts related to casefinding and identification of non-reportable cases in the audit process.

Standard Abstraction The re-abstracting audit consists of review and re-abstraction of specific MCR required fields from the original hospital record with comparison to the original abstracted data. During resolution, registrars are given the opportunity to provide any additional information not available to the auditor that may justify the original coding. Discrepancies are discussed with the hospital registrar. Abstracting and coding guidelines are reviewed and reinforced. Further training may be recommended and, if warranted, MCR can provide assistance to individual registrars through conferencing and/or site visits.

NPCR Audits Case Completeness and data quality audits are periodically conducted by NPCR on the Missouri Cancer Registry. While a few hospitals are requested to provide the data, the audits are conducted on MCR, not on the individual facilities.

Chapter 1

GENERAL INSTRUCTIONS

Basic Reporting Rules for State Reporting

Important Items for Reporting

- All reportable cancer cases diagnosed and/or treated in your facility after August 28, 1984, must be abstracted and reported to MCR
- Completed cases should be submitted to the MCR within six months of date of initial contact for that facility
- Electronic reporting is required for all facilities with an annual caseload greater than 75 cases. MCR no longer accepts paper abstracts. MCR will provide free software (Abstract Plus) to facilities that have 76-150 cases annually. If your facility accessions 76-150 cases annually, please contact us at 1-800-392-2829 to inquire about Abstract Plus.
- Occasionally hospitals require special data reports from the central registry. Requests for studies, reports or information may be submitted to MCR staff by calling 1-800-392-2829 .
- Solid tumors diagnosed on or after January 1, 2007 MUST be abstracted according to reportability and coding instructions set forth in *The Multiple Primary and Histology Coding Rules Manual* which can be downloaded from: http://seer.cancer.gov/tools/mphrules/download.html
- The ICD-O-3 coding scheme must be used for site and histology of cases diagnosed on or after January 1, 2001. The ICD-0-2 coding scheme must be used for cases diagnosed prior to January 1, 2001 and may not be used for cases diagnosed on or after that date

  Note: Hematopoietic malignancies are coded according to the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database* for cases diagnosed on or after January 1, 2010.

Changing Information

It is possible that after a cancer case has been abstracted and submitted to MCR, additional information was added to the patient's chart, which may lead to changes in specific data items submitted on the initial abstract. It is permissible to change any data item, including the primary site and histology. Justification/explanation should accompany the change.

> **Example:** The patient is originally diagnosed with an unknown primary cancer and after further investigation it is determined that the cancer is a primary of the lung. It is correct to electronically submit a ***Change Of Information*** form ***(COI)*** to MCR and change the primary site code .

Hint: Changing the primary site will require review of site-specific fields (e.g., surgery codes, staging, laterality, etc.) to identify additional coding changes needed.

Note: COI forms and a list of fields which require changes to be reported can be found on the MCR website.

Please note that all COI's must be reported electronically via WebPlus. Use the non-NAACCR format as you do for transmittal forms. For assistance, please contact MCR staff at 1-800-392-2829.

Data Transmissions

Security of Data Transmissions — Electronic data are to be transmitted using the Web Plus upload. Instructions for the use of Web Plus can be found on the MCR website. If your facility has other required methods of data transmission, please contact MCR staff. **MCR requires that all data be submitted via a secure electronic method. Diskettes and CDs are no longer accepted**.

Protected Health Information (PHI) and other confidential data **MUST NOT** be included in e-mails to MCR. Do not include information either in the text of the e-mail or as an attachment. If this happens, MCR staff will alert the registrar, so that the information can be deleted from all e-mail.

Confidential information on individual cases may be uploaded using Web Plus non-NAACCR layout function, or it may be transmitted via fax. The MCR fax machine is in a locked office, accessible only to MCR personnel. The office is secure 24 hours a day.

Data Transmission Procedures — A completed transmittal form must accompany each data submission. **In addition, a completed transmittal form should be sent to MCR even if no data is submitted for the designated reporting period.** Required schedules for data submissions are as follows:

Annual caseload >500	**Monthly**
Annual caseload 300-500	**Monthly or quarterly**
Annual caseload <300	**Quarterly**

Proper Mailing Procedures

In the unlikely event that needed information absolutely cannot be sent electronically, documents containing confidential patient information must be double-wrapped, using tear resistant packaging as the outer layer, regardless of carrier. MCR is not responsible for torn or lost packages containing patient information. We recommend you contact the addressee at MCR so that he/she knows to be on the alert for a letter or package. Be sure to track the package to ensure that it has reached its destination. We also encourage you to keep a listing of patient names included in the mailing, in the event there is a problem.

U.S. Postal Service

You must use MCR's post office box address for items sent via the U.S. Postal Service. You may want to explore the added security of certified and registered mail options.

Missouri Cancer Registry
PO BOX 718
Columbia, MO 65205

Courier Service

For Federal Express, UPS, Airborne Express or other secure courier services, MCR's street address must be used. You may also want to explore the e-mail tracking and notification features that the courier of choice offers.

Missouri Cancer Registry
University of Missouri
401 Clark Hall
Columbia, MO 65211

Chapter 2

DETERMINING REPORTABILITY

Casefinding Techniques

Reportable Cases may be identified from a variety of sources.. The hospital pathology laboratory can provide cases diagnosed by histology, cytology, hematology, bone marrow or autopsy. Other resources include daily discharges and daily coding logs, disease indices, inpatient and outpatient surgery logs, radiotherapy consults, treatment reports and logs, and oncology clinic treatment reports and logs. *Never rely solely on the pathology department to provide reportable cases.* Doing so could exclude cases for which the hospital has no diagnostic tissue reports. Cases diagnosed elsewhere but treated at your facility and those diagnosed radio-graphically or clinically only, without tissue confirmation would be missed during casefinding unless additional resources are employed. It is essential to include review of the Medical Record Disease Index (usually provided by Health Information Management) and other tracking tools such as medical and radiation oncology clinic logs to ensure that all reportable cases are identified. You should form an alliance with staff from the aforementioned departments to establish and develop a systematic method to routinely receive necessary information from them.

Reportable List for Casefinding

A table listing reportable diagnoses for casefinding is posted on the MCR web site (http://mcr.umh.edu/mcr-cancer-reporting-hospital.php). Diagnoses are listed by ICD-9-CM codes which can be used by facilities to identify which cases to include on their MRDI casefinding lists. The list is updated annually to ensure that any new applicable ICD-9 codes are added.

Cases That Must Be Reported

- Refer to the "MCR Reportable List for Casefinding" noted above when conducting casefinding activities. Depending on how casefinding is conducted, not all ICD-9-CM codes will be used by all facilities
- Malignancies with a behavior code (fifth digit of the morphology code) of 2 or 3 in ICD-O-2 (cases diagnosed **prior** to January 1, 2001) or ICD-O-3 (cases diagnosed **on or after** January 1, 2001) or the Hematopoietic Database Appendix D, except as otherwise noted in this manual
- Beginning with cases diagnosed **on or after** January 1, 2004, non-malignant primary intracranial and central nervous system tumors are required to be reported. See below for applicable site codes

Topography Codes for Intracranial and Central Nervous System Tumors

Codes	Description
C70.0 – C70.9	Meninges
C71.0 – C71.9	Brain
C72.0 – C71.1	Spinal cord
C72.3—C72.5	Cranial nerves
C72.8-C72.9	Overlapping brain and CNS; CNS, nos
C75.1	Pituitary gland
C75.2	Craniopharyngeal duct
C75.3	Pineal gland

- Beginning with cases diagnosed **on or after** January 1, 2002, the following squamous intraepithelial neoplasia, grade III (8077/2) are reportable (NPCR requirement)
    - AIN III (C21.1)
    - VIN III (C51. *)
    - VAIN III (C52. *)
- **Analytic cases**. Patients whose initial diagnosis was made at your facility and/or any part of the first course of treatment was delivered or prescribed at your facility. (Class of Case 00, 10, 11, 12, 13, 14, 20, 21, 22, 35, and 37)
- Patients diagnosed at a staff physician's office and receiving any or their entire first course of treatment in your facility (Class of Case 12)
- **Nonanalytic cases.** Patients diagnosed elsewhere who had all first course treatment elsewhere who were seen at your facility for diagnosis of recurrent disease or for treatment of relapsed, persistent or progressive disease; cases diagnosed prior to the facility's Reference Date and diagnosis or treatment was given by the reporting facility; diagnosis was established by autopsy at reporting facility and was unsuspected prior to death (Class of Case 32, 35, 37 and 38).Record all available information regarding the original diagnosis and treatment
- Malignant tumors of the skin such as adnexal carcinoma/adenocarcinoma (8390/3-8420/3), lymphoma, melanoma, sarcoma, and Merkel cell carcinoma **must be reported**. Any carcinoma arising in a hemorrhoid is reportable, since hemorrhoids arise in mucosa, not in the skin
- Adenocarcinoma in situ of the cervix is reportable
- Pilocytic/juvenile astrocytoma (9421) will continue to be collected as a /3 even though the behavior code changed to /1 in the ICD-O-3

Cases Not Required To Be Reported

- Skin cancers (site = C44._ and histology = 8000-8110) as of January 1, 2001
- Patients who have a history of cancer but diagnosis or treatment were not performed at your facility. (Class of case 33)
- Patients who receive transient care to avoid interruption of therapy started elsewhere. (Class of case 31)
- Patients seen only in consultation to confirm a diagnosis. (Class of case 30)
- Pathology cases that are consultative readings of slides submitted from outside facilities. (Class of case 43)
- Class of Case 40, 41, 42, 49 or 99
- Patients with **squamous cell carcinoma in situ or carcinoma in situ, nos of the cervix (as of 1/1/2003)**, cervical intraepithelial neoplasia (CIN) or prostatic intraepithelial neoplasia (PIN)
- Patients with a pre-cancerous condition or benign tumor (other than CNS sites stated above)
- Patients admitted to a hospice unit or home health care service
- Patients above who are not reportable for your facility, but who die at your facility with active cancer, although not required may be reported to MCR. Cases not reported at the time of death may appear later on a Death Certificate Only listing (list of patients who died at your facility with cancer but not listed in the MCR database), which requires additional follow-back by MCR and research by the registrar. A minimal abstract prepared with documentation of any available information regarding date of diagnosis, primary site, histology or treatment is very useful

Note: Your cancer committee may decide to require additional benign or borderline cases. Please do not submit these reportable-by-agreement cases to MCR.

Ambiguous Terms at Diagnosis

Reportable cases are usually based on unequivocal statements made by recognized medical practitioners that the patient has a reportable diagnosis. However, physicians sometimes use vague or ambiguous terms to describe a tumor when its behavior is uncertain. In instances where pathology or cytology findings cannot definitively confirm a cancer diagnosis or when imaging studies show inconclusive results, physicians often state the diagnosis in ambiguous terms. Reportability of such a diagnosis depends on the verbiage used. **For a cancer case to be reportable, the ambiguous term must always include a reference to the reportable diagnosis being described, eg., favors carcinoma or suspicious for malignancy.** When the diagnosis is stated in only ambiguous terms, use the following guidelines to determine whether a particular case should be reported. Note: Synonyms of these terms do not constitute diagnosis.

Ambiguous terms that constitute a diagnosis	
Apparent(ly)	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect (ed)
Consistent with tumor* (beginning with 2004 diagnosis and only for C70.0-C72.9, C75.1 - C75.3)	Suspicious (for)
Favors	Typical of
Malignant appearing	
Neoplasm* or Tumor (beginning with 2004 diagnosis and only for C70.0-C72.9, C75.1-C75.3)	

* additional terms for nonmalignant primary intracranial and central nervous system tumors only

Exception: If cytology is reported only using an ambiguous term (such as suspicious), 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.

Example: Discharge summary and X-ray results report "CT of the chest *compatible with* carcinoma of left lung." Although there may be no further work-up or treatment, the case is radiographically diagnosed and **is reportable**.

Example: The only documentation says "likely" carcinoma. Because it does not say "most likely," it **is not reportable.**

Terms that DO NOT constitute a diagnosis**	
Cannot be ruled out	Questionable
Equivocal	Rule out
Possible	Suggests
Potentially malignant	Worrisome

**unless supplemented by additional information

Example: Barium enema (BE) reveals a sigmoid mass *suspicious* for neoplasm. Colonoscopy reveals a sigmoid mass, "*possible* malignant neoplasm." The patient is referred for biopsy and colon resection at another facility revealing carcinoma. The case **is NOT reportable** for your facility because mass and neoplasm are not associated with a reportable malignant term, whereas if it had been stated "suspicious sigmoid mass, *probable* malignant neoplasm," it would be reportable.

Chapter 3

DETERMINING PRIMARY TUMORS

When potential cases are identified through the casefinding process, it is important to determine whether they represent new reportable primaries, or whether they are actually pointing to cases previously accessioned into the cancer registry database. The *Multiple Primaries and Histology Coding Manual* contains all rules for determining multiple primaries for solid tumors. These rules MUST be applied to all cases (except hematopoietic primaries) diagnosed on or after January 1, 2007. For cases diagnosed prior to 2007, multiple primaries are determined according to instructions which are included in Appendix A of this manual. For determining multiple primaries of hematopoietic origin diagnosed on or after January 1, 2010, refer to the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic Database which can be found at http://seer.cancer.gov/tools/heme/index.html.

Multiple Primaries for Solid Tumors

Multiple Primaries for Solid Tumors are determined according to the rules detailed in the *Multiple Primaries and Histology Coding Manual* (MP/H) for cases diagnosed **January 1, 2007** and after. The MP/H contains site-specific rules to apply in specific sequence for deciding whether multiple reportable primaries are present. Site-specific rules are subdivided into modules according to whether the case involves single or multiple tumors, or it is unknown whether multiple tumors are present in the primary site. The site-specific coding rules are presented in three different formats geared to suit the preferences of individual users: Flow chart, Matrix view and Text list. **It is essential** to read the General Instructions and the site-specific Equivalent Terms and Definitions on pages 5 - 31 of the MP/H Manual before using the site-specific coding rules. Further instructions for using the Multiple Primary Rules are listed below.

A. General Information

1. Use these rules to determine the number of reportable primaries. Do **not** use these rules to determine case reportability, stage, or grade.
2. The 2007 multiple primary and histology coding rules **replace all previous** multiple primary and histology coding rules.
3. The rules are **effective** for cases **diagnosed January 1, 2007** and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.
4. Read the **General Instructions** and the **site-specific Equivalent Terms and Definitions** before using the multiple primary rules.

5. The multiple primary and histology coding rules are available in **three formats**: flowchart, text, and matrix. The **rules are identical**, only the formats differ. Use the rules in the format that is easiest for you to follow.
6. **Notes** and **examples** are included with some of the rules to **highlight key points** or to add **clarity** to the rules.
7. **Do not use** a physician's statement to decide whether the patient has a recurrence of a previous cancer or a new primary. Use the multiple primary rules as written **unless** a **pathologist compares** the present tumor to the "original" tumor and states that this tumor is a recurrence of cancer from the previous primary.

B. How to Use the Multiple Primary Rules

1. Use the Multiple Primary rules to make a decision on the **number of primary malignancies** to be abstracted for reportable solid tumors.
2. Use the **site-specific rules** for the following primary sites:
   - Brain, malignant (intracranial and CNS)
   - Brain, benign/borderline (intracranial and CNS)
   - Breast
   - Colon
   - Head and neck
   - Kidney
   - Lung
   - Malignant melanoma of the skin
   - Renal pelvis, ureter, bladder, and other urinary

3. Use the **Other Sites** rules for solid malignant tumors that occur in primary sites not covered by the site-specific rules.
4. Each module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors) is an independent, complete set of coding rules.

To determine which set of primary site rules to use:

a. When there is no tumor in the primary site, only metastatic lesions are present:

I. Use the primary site documented by a physician and use the multiple primary and histology coding rules for that primary site.

II. If no primary site is documented, code the primary site as unknown and use the general multiple primary and histology coding rules. Use the "Unknown if Single or Multiple Tumors" module to determine multiple primaries.

b. To choose the appropriate module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors):

I. Use the multiple primary and histology coding rules for the primary site.

II. Determine the number of tumors.

i. Do not count metastatic lesions.

ii. When the tumor is only described as multicentric or multifocal and the number of tumors is not mentioned, use the "Unknown if Single or Multiple Tumors" module.

iii. When there is a tumor or tumors with separate microscopic foci, ignore the separate microscopic foci and use the "Single Tumor" or "Multiple Tumor" modules as appropriate.

iv. When the patient has a single tumor, use the "Single Tumor" module.

v. If there are multiple tumors, use the "Multiple Tumor" module.

III. See the Equivalent Terms and Definitions for Head and Neck for guidance in coding the primary site.

IV. Use the primary site documented by the physician on the medical record

5. If a **single primary**, prepare **one abstract**.
6. If there are **multiple primaries**, prepare **two or more abstracts**.
7. Rules are in hierarchical order within each module (Unknown if Single or Multiple Tumors, Single Tumor, and Multiple Tumors). Use the first rule that applies and **STOP.**

Multiple Primary Rules for Hematopoietic Cases

Beginning with cases diagnosed January 1, 2010, multiple primaries for hematopoietic cases are determined according to rules set forth in the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic Database which can be found at http://seer.cancer.gov/tools/heme/index.html Training modules are also available at this site and are highly recommended.

The rules manual is navigated in a 5 step process:

1. Search the database for a provisional site and histology code
2. Use the Case Reportability Instructions to determine if the case is reportable
3. If so, go to the Multiple Primary Rules
4. Go to the Primary Site & Histology Rules (for every primary). Consult the database only when the rules specify to do so
5. Use the Grade of Tumor Rules

For hematopoietic cases diagnosed prior to 2010, use the tables in Appendix A of *FORDS* to decide whether differing hematopoietic histologies represent one or more primaries. Primary site and timing are not applicable for determining whether these malignancies represent one or more primaries.

Chapter 4

FIRST COURSE OF THERAPY

Definitions

Treatment or therapy for cancer is meant to modify, control, remove, or destroy cancer tissue (cancer-directed treatment). Therapy can be used to treat cancer tissue in primary or metastatic site(s), regardless of the patient's response to that treatment. The first course of therapy should include all cancer-directed treatments indicated in the initial treatment plan and delivered to the patient after initial diagnosis of cancer. Multiple modalities of treatment may be included and therapy may include regimens lasting a year or more. The treatment plan specifies the types of cancer-directed therapies proposed to eliminate or control the patient's disease. Treatment intentions may be found in discharge summaries, consultations, and outpatient records. All cancer-directed therapies (surgery, radiation, chemotherapy, hormone therapy, immunotherapy, or other therapy) documented in the physician's treatment plan and administered are included in the first course of therapy.

All Malignancies Except Leukemias

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. Treatment given specifically for tumor progression or recurrence, and treatment started when there is failure of the initial course of therapy are considered subsequent treatment.

Leukemias

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.

Time Periods for First Course of Treatment (FCT)

The Date of First Course of Treatment is the earliest of *Date of First Surgical Procedure*, *Date Radiation Started*, *Date Systemic Therapy Started*, *Date Other Treatment Started* or the date the decision for no treatment was documented.

- No treatment: No treatment is considered a treatment option and may represent the first course of therapy. Reason for no treatment should be entered in the appropriate treatment field
- If there is no documented treatment plan and no other treatment guidelines are established, evaluate the therapy and the time it began in relation to the diagnosis date. If the therapy is a part of an established protocol or within accepted guidelines for the disease, consider it the first course of therapy
- 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"
- If FCT systemic treatment regimen is changed due to an adverse reaction, follow these guidelines:
  - If the new chemotherapy drug(s) is in the same group as the initial therapy (i.e.: anti-metabolite, alkylating agent, etc.) it is considered continuation of the first course of treatment
  - If the drug(s) is not in the same group it is no longer the first course of therapy
  - If the patient fails to respond to treatment and the regimen is changed, it is no longer first course of treatment. Lists of drugs and their classification(s) are available at http://www.seer.cancer.gov/tools/seerrx/

Example: Physician plans a combination regimen of chemotherapy. Velban is one of the drugs but, after several cycles, it is replaced with Oncovin due to adverse reaction. The treatment continues as first course of therapy because Oncovin and Velban are both alkaloids. Conversely, if Velban had been replaced with Fludara, it is no longer first course of therapy because Fludara is an anti-metabolite

Example: Physician plans a regimen of Adriamycin/Cytoxan. The patient does not respond so the treatment is changed to Methotrexate/5FU. Because the initial treatment failed, the new chemotherapy regimen is coded as subsequent treatment

Rx Summ—Treatment Status

Per FORDS, this new data item summarizes whether the patient received any treatment or if the tumor was under active surveillance. The item was added to document active surveillance (watchful waiting) and to eliminate searching each treatment modality to determine whether treatment was given. It is used in conjunction with *Date of First Course of Treatment* to document whether treatment was or was not given, it is unknown if treatment was given, or treatment was given on an unknown date.

Surgical Diagnostic and Staging Procedures (Non Cancer-Directed Surgery)

Surgical diagnostic and staging procedures such as biopsies, thoracentesis, and bypasses do not modify or destroy cancer cells. Surgical procedures that aspirate, biopsy or remove regional lymph nodes to diagnose and/or stage disease are to be entered in *Scope of Regional Lymph Node Surgery,* not in this field.

Palliative Procedure:

Procedures performed to palliate or alleviate symptoms may include surgery, radiation, systemic therapy and/or other pain management therapy. This data element allows the tracking of procedures that are considered palliative rather than therapeutic, diagnostic or used for staging. Examples of palliative procedures include: bypass/stent for pancreatic carcinoma; radiation for bone metastasis; palliative chemo for advanced lung cancer. Palliative procedures are to be coded in Palliative Procedure and First Course of Therapy. When palliative care is given as first course of therapy, the case is considered analytic.

> **Note:** Palliative radiation would be coded as '2' in Palliative Procedure field. The appropriate code would also be entered in the Radiation field.

Chapter 5

INITIAL ABSTRACT

Identification Information

In the chapters that follow, this manual lists both standard field names and Abstract Plus software field names where there are differences. Please be aware that a given standard setter or software may display field names slightly differently.

Reporting Hospital/Facility Number (Reporting Facility)

The number entered in this data field is used by the central registry to identify the facility reporting the case(s). The 10-digit institution ID number assigned by the Cancer Department of the American College of Surgeons (ACoS) **must** be right justified and preceded by zeros if less than 10 characters. For facilities with a 7-digit number (6-digit number preceded by a constant 6), this number would be right justified and preceded by 3 zeros. A list of Missouri hospital ID numbers is located on the MCR website at http://mcr.umh.edu/. Some software can be programmed to autocode this field.

NPI—Reporting Facility

Enter the NPI number assigned to the facility identified above. The software vendor may have set this to code automatically.

Accession Number + Sequence Number

The accession number is assigned by the reporting facility and provides a unique identifier for the patient consisting of the year in which the patient was first seen at the reporting facility and the consecutive order in which the tumor was abstracted. This data item protects patient identity and allows cases to be identified on a local, state, and national level.

Instructions for Coding

- The first four digits specify the **year** in which the patient was first diagnosed or treated for cancer at the reporting hospital. The next **five** digits designate the numerical order in which the patient was entered into the registry database

- The reporting facility assigns **only one** accession number to each patient for life, even if additional primary cancers are diagnosed. Additional primary cancers are represented by the "sequence number" component of the accession number. The sequence number represents the number of **primary cancers** a patient may have during his lifetime. **'00'** indicates the first and only primary cancer; '**01'** would indicate the first of more than one primary cancer; '**02'** indicates the second of two or more primary cancers; '**03'** denotes the third of three or more cancers; etc
- A patient's accession number is not reassigned after a case is voided
- A patient retains the original accession number even when the registry reference year changes. If a new primary is then discovered, the sequence number is updated accordingly

Sequence Number(s)

This data item indicates the sequence of malignant and nonmalignant neoplasms over the lifetime of the patient.

The **sequence** (first, second, third, etc., primary) for the particular primary cancer being reported is represented by a **two**-digit number.

Note: Accession number - 201000034-00 signifies that the patient was first diagnosed or treated at the reporting hospital in calendar year 2010 and that this patient is the 34th patient entered into that hospital's registry for the year 2010. The 00 (sequence number) denotes that this cancer is the first and only primary malignant or in situ cancer for this patient.

Note: Patient is diagnosed and treated for breast cancer in 2010. The patient has a documented history of cervical cancer in 2007. The sequence number for the breast cancer is 02.

Note: A patient is first diagnosed at the reporting facility in 2005 with breast cancer. The accession number assigned is 200500032-00. In 2010, the patient is seen at the same facility for treatment of a newly-diagnosed colon cancer. The accession number remains 200500032, but the sequence number is coded 02 for the colon cancer. Sequence 00 (the breast cancer) should be changed to 01 (first of more than one primary cancer).

Instructions for Coding

The decision regarding which sequence number to assign a neoplasm depends upon its behavior code at the time of diagnosis. Codes 00-35 and 99 indicate the sequence of neoplasms of *in situ* or malignant behavior (2 or 3) at the time of diagnosis. Codes 60-88 indicate the sequence of non-malignant tumors. Neoplasms which are reportable by agreement, either by MCR or your facility's cancer committee, follow these same guidelines

- Codes 00-59 and 99 indicate neoplasms of in situ or malignant 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 in situ or 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 non-malignant 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 non-malignant primaries sequentially

- Sequence numbers are assigned in the order diagnosed. 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 that meets the reportable code criteria for MCR must be taken into account when sequencing subsequently accessioned tumors, regardless of where it was diagnosed. If the prior tumor had a behavior code of 2 (in situ) or 3 (malignant), and the current tumor is also behavior code 2 or 3, assign a sequence code in the 02-59 range. An intracranial or central nervous system tumor (diagnosed 01/01/2004 or later) with a behavior code of 0 (benign) or 1 (borderline) is assigned a sequence code in the range of 60-88
- Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence

Personal History 1 & 2 (MO Personal Hx 1, 2)

These data items record up to two reportable primary tumors diagnosed prior to the case currently being reported. Record the ICD-O-3 primary site code of the patient's first primary site in the Personal History 1 field and, if applicable, the second primary in the Personal History 2 field. Record any additional primaries in the Remarks text field. When there is no past history of cancer, the fields must be left blank.

MCR requires personal history to be recorded any time you are entering a case with a sequence other than 00 or 60. This means that when you enter concurrent primaries, sequence numbers 01 and 02, you enter personal history in the abstract of the other tumor. The site of the primary being abstracted is not recorded in this field.

Year 1 & 2 (MO Year 1, 2)

Record the 4-digit year of diagnosis of the primary coded in the Personal History 1 field and, if applicable, the year of diagnosis for the Personal History 2 field. Record any additional primaries in the Remarks text field. Year is required when Personal History is required, as above. It is left blank when there is no previous history. If the year is unknown it may be coded 9999. The year for the primary site being abstracted is not recorded here.

Name - Last

Record the patient's last name. Mixed-case, embedded spaces hyphens and apostrophes are allowed.

Name - First

Record the patient's first name. Mixed-case, embedded spaces are allowed. Special characters are not allowed.

Name - Middle

Record the patient's middle name. Middle initial may be used if full middle name is not available. Leave blank if no middle name/initial is given. Mixed case and embedded spaces are allowed, special characters are not.

Name - Maiden

Record the patient's maiden name of married female patients. If the patient has no maiden name or the information is not available, leave blank. Mixed case, embedded spaces, hyphens and apostrophes are allowed.

Name - Alias

Many patients use a name different from their given name. If the patient uses an alias for the first name, record only the first name alias. If a patient uses an alias for the last name, record the last name alias. If a patient uses an alias for the first and last name, record both the last name and first name alias. Do not use commas.

Address at Diagnosis - Number and Street

The address at diagnosis can provide information to identify possible cancer clusters for environmental and epidemiological studies and provide essential information for public health activities.

- Record the patient's number and street address at the time the cancer was diagnosed or treated. Mixed case and embedded spaces are allowed. Special characters are limited to periods, slashes, hyphens, and pound signs Standard abbreviations may be used. If no street address is available, record "UNKNOWN." **DO NOT LEAVE BLANK**
- It may be necessary to use "UNKNOWN" if the correct Address at Diagnosis is not known. (e.g., Class of Case is 30, 31, 32, 43, or 49)
- Do not indicate a temporary residence
- Use the school address for college students
- Children in boarding schools (below college level) are considered residents of their parents' home
- Use the address where a transient or homeless person resided at the time of cancer diagnosis, i.e., shelter or diagnosing facility

Address at Diagnosis – Supplemental

Record any additional address at diagnosis information such as name of nursing home or apartment complex.

Address at Diagnosis – City/Town

Record the city or town of the patient's address at the time of cancer diagnosis. If the city is unknown, record UNKNOWN. **DO NOT LEAVE BLANK.**

State at Diagnosis

Record the U. S. postal service two-letter state abbreviation for the state of residence at cancer diagnosis. Use the two-letter abbreviation for patients whose residence at diagnosis was a Canadian province:

Abbreviations for Canadian province and (territories)

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

Use the following codes when the state or province is unknown or not applicable:

- US = Resident of United States, NOS (state/commonwealth/territory/possession unk)
- XX = Resident of country other than U.S. (including its territories, commonwealths, or possessions) or Canada and the country is known
- YY = Resident of country other than U.S. (including its territories, commonwealths, or possessions) or Canada and country is unknown
- ZZ = Resident of the U.S., NOS; Canada, NOS; residence unknown

Postal Code at Diagnosis

For U.S. residents record the 5-digit zip code and the 4-digit extension (if known) for the patient's address at diagnosis, left justify the field. For Canadian residents, use the 6-character alphanumeric postal code; left justify the field. Record 888888888 if the patient is a resident of a country other than Canada, United States or U.S. possessions and the postal code is not known. Record 999999999 if the patient is a resident of Canada, United States or U.S. possessions but the postal code is unknown or residence is unknown. Consult the zip code list at: http://health.mo.gov/data/geocodes/index.php.

County at Diagnosis

Code the county of the patient's residence at the time the tumor was diagnosed. For U.S. residents, standard codes are those of the FIPS publication "Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas." If the patient has multiple tumors, the county codes may be different for each tumor. A list of DHSS geocodes for Missouri counties is posted at http://mcr.umh.edu/mcr-absresources.php.

- Code 998 If known town, city, state, or country of residence but county code not known AND a residence is outside of the state of Missouri. (must meet all criteria)
- Code 999 if county of residence at diagnosis is unknown
- Use code 186 for Ste. Genevieve county (per FIPS – 12/15/1979)

Address Current
Patient Address Current— (Number and Street)
City/Town Current
State—Current
Postal Code – Current (Zip Code)
County—Current

These data items provide a current address, otherwise the rules for coding are as above. It may be a different address from *Patient Address at Diagnosis.*

Medical Record Number

The medical record number is assigned by the reporting facility and identifies the patient. This field may contain numbers, letters, or a combination of both. If the record number is less than 11 characters, right justify the entry.

- If number is unknown record 9s. If no number, record zeros
- Departments within the hospital not using the hospital record number may be recorded using standard abbreviations:

Radiation Therapy - - - - - - - - - **RT** Out-patient Surgery - - - - - - - - - **SU**

Name of Spouse / Parent / Contact Person

Record the name (last and first) of the patient's spouse. If the patient is a minor child, record the name of one parent (last, first). If the patient is not a minor child or has no spouse, a relative, friend, or other contact person may be entered. Leave blank if not given. (This is not a required field.)

Abstracted By

This is a three-character field used to identify the hospital registrar that abstracted the cancer case. **Do not leave blank or use 'XXX' or other indications for Unknown.** In some software this field will fill automatically based on your log-in.

Social Security Number

Record the patient's Social Security Number, if known. Use **9's** if the patient does not have a social security number or if the social security number is not available. Please double check your entry for accuracy.

Telephone Number

This field records the current telephone number with area code for the patient, when available.

Code	Definition
(fill spaces)	Number is entered without dashes.
0000000000	Patient does not have a telephone.
9999999999	Telephone number is unavailable or unknown.

MO Alcohol History

Code the patient's current or past use of alcoholic beverages, such as wine or beer, using the following codes:

Code	Definition
0	No history of alcohol usage
1	Current use of alcohol (any use of alcohol including social use)
2	Past history of alcohol usage, no current usage
9	Unknown

MO Tobacco History

Code the patient's current or past usage of tobacco, using the codes:

Code	Definition
0	Never smoked
1	Cigarette smoker, current
2	Cigar/pipe smoker, current
3	Snuff, chew, smokeless tobacco, current
4	Combination use, current
5	Previous tobacco usage
9	Unknown

Years of Tobacco Use

Record the number of years the patient has smoked or used tobacco products, using 2 digits. Record actual years of tobacco use. (Pack years can be used only if it is also documented the patient smoked 1 pack per day). The number of years can be estimated based on available information and using 16 years old as the starting age (e.g., if the patient is 76 y.o. and has smoked his entire life, then 60 years would be a conservative estimate). If no information is available, enter 9s and if the patient has never smoked, enter 0s.

Toxic Exposure

- List, as text, any reported exposure to known carcinogens when documentation is available in the medical record.
- Enter up to 3 types of toxic exposures.
- Leave blank if unknown. For instance, when there is no reference to or documentation of toxic exposure in the medical record.

Marital Status at Diagnosis

Code the patient's marital status at time of initial diagnosis. Marital status may be a different status for each primary a patient may have. This item can also be useful in patient identification. Use the following codes:

Code	Definition
1	Single (never married)
2	Married (includes common law)
3	Separated
4	Divorced
5	Widowed
6	Unmarried or Domestic Partner (same or opposite sex, registered or unregistered, other than common law marriage)
9	Unknown

Sex

Code the patient's sex. Use the following codes:

Code	Definition
1	Male
2	Female
3	Other (hermaphrodite)
4	Transsexual
9	Not Stated

For rarely used codes, please make a note in the physical exam or remarks text section to substantiate the choice.

Race 1 – 5

Race 1 identifies the primary race of the person and is the field used to compare with race data on cases diagnosed prior to January 1, 2000. For multi-racial patients, use Race 2-5 fields to code additional races following the instructions below. The race codes listed below correlate closely to categories used by the U.S. Census Bureau to allow calculation of race specific incidence rates.

- If only one race is reported for the person, enter the appropriate code from the table below and enter 88 in the Race 2 – Race 5 fields
- "Race" is analyzed with *Spanish/Hispanic Origin*. Both items must be separately recorded
- All tumors for the same patient should have the same race codes
- If Race 1 is coded 99, Unknown, Race 2 through Race 5 must be coded 99
- Persons of Mexican, Puerto Rican, or Cuban origin are usually white
- If a person's race is recorded as a combination of white and any other race, code to the appropriate other race in the Race 1 field and code white in the next race field
- If a person's race is recorded as a combination of Hawaiian and any other race (s), code the person's primary race as Hawaiian and code the other races in Race 2, Race 3, Race 4, and Race 5 as appropriate
- Otherwise, code Race 1 to the first stated non-white race (codes 02-98)
- When the race is recorded as "Oriental" or "Asian" and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on birth place information. For example: If the person's race is recorded as "Asian," and the place of birth is recorded as "Japan," code race as 05
- Do not code "Asian" in a subsequent race field if a specific Asian race has already been coded
- A specific race code (other than blank, 88, or 99) must not occur more than once

Code	Label	Code	Label
01	White	**17**	Pakistani
02	Black	**20**	Micronesian, NOS
03	American Indian, Aleutian, Eskimo (includes all indigenous populations of the Western hemisphere)	**21**	Chamorro/Chamoru
04	Chinese	**22**	Guamanian, NOS
05	Japanese	**25**	Polynesian, NOS
06	Filipino	**26**	Tahitian
07	Hawaiian	**27**	Samoan
08	Korean	**28**	Tongan
10	Vietnamese	**30**	Melanesian, NOS
11	Laotian	**31**	Fiji Islander
12	Hmong	**32**	New Guinean
13	Kampuchean (Cambodian)	**96**	Other Asian, including Asian, NOS, Oriental, NOS
14	Thai	**97**	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	**98**	Other
16	Asian Indian	**99**	Unknown

Examples:

Code	Reason
01	A patient was born in Mexico of Mexican parentage. Code also Spanish/Hispanic Origin
02	A black female patient
05	A patient has a Japanese father and a Caucasian mother. (Caucasian will be coded in Race 2)

Spanish/Hispanic Origin

This code identifies whether or not the person should be classified as "Hispanic."

Code	Description
0	Non-Spanish; Non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS; (There is evidence other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to categories 1-5)
7	**MCR use only**
8	Dominican Republic (for use with patients who were diagnosed with cancer on January 1, 2005 or later)
9	Unknown whether Spanish/Hispanic or not; not stated in patient record

Date of Birth (Birth Date)

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. Please doublecheck your entry for accuracy.
- 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 i.e., blank

  Example: A 60 year old patient diagnosed in 2010 is calculated to have been born in 1950. CCYY = 1950, MM = blank and DD = blank
- If month is unknown, the day is coded unknown (left blank)
- If the year can not be determined, the day and month are both coded unknown (left blank)
- If the date of birth can not be determined at all the entire field is left blank. Record the reason in *Date of Birth Flag*

Date of Birth Flag

This flag explains why there is no appropriate value in the corresponding date field, *Date of Birth*. 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 Birth* has a full or partial date recorded
- Code 12 if the *Date of Birth* cannot be determined at all
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software
- See *FORDS 2011*: *Section Two Coding Instructions* for additional information

Birthplace

When available, record the patient's place of birth, (state or country) using the SEER Geo Codes (http://seer.cancer.gov/tools/codingmanuals/)

- Use **000** for an unknown birthplace within the United States
- Use **998** for an unknown birthplace outside the United States
- Use **999** for an unknown birthplace

Age at Diagnosis

This field is generally programmed by software vendors to be auto-calculated once date of birth and date of initial diagnosis are entered

Lifetime Occupation

This data item is applicable to patients who are **14** years or older at the time of diagnosis and is reported in text only.

- As available, record the patient's usual (longest held) occupation before diagnosis of this tumor
- If the patient had several jobs over a lifetime, record the occupation engaged in for the longest period of time
- If the patient is retired and the lifetime occupation is not known, do not record retired, record "unknown"
- If the patient was a housewife/househusband and also worked outside the home, record the occupation outside the home
- If the patient was a housewife/househusband and never worked outside of the home, record "homemaker," "housewife," or "househusband" (Industry: "own home")

- If the patient was NOT a student or homemaker, and never worked, record "never worked," or "never employed" (Industry: "none")
- Record "unknown" if no information is available. **DO NOT LEAVE BLANK**

Type of Industry

This data item pertains to patients **14** years or older at the time of diagnosis and is reported in text only.

- As available, record the primary type of business activity performed by the company where the patient was employed for the most number of years
- Distinguish whether the industry is involved in manufacturing, wholesale, retail, or service, etc
- If the primary activity is unknown, it may be appropriate to record the name of the company and the city or town. The central registry office may use the name of the company and the city or town to determine the type of business activity performed
- Record "unknown" if no information is available. **DO NOT LEAVE BLANK**

Date of 1st Contact

Record the date of first contact with the reporting facility for diagnosis and/or treatment of this cancer. The date may be the date of an outpatient visit for a biopsy, x-ray, or laboratory test, or the date a pathology specimen was collected at the hospital.

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 as completely as possible. Leave any unknown portions of the date blank
- Record the date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and or first course treatment of a reportable tumor. The date may be the date of an outpatient visit for a biopsy, x-ray, or laboratory test, or the date a pathology specimen was collected at the hospital

  Example: Patient with a self-detected breast lump **c**omes into your facility for a mammogram on 7/1/2010 , and results are suspicious for malignancy. On 7/5/2010, patient returns for excisional biopsy which reveals ductal carcinoma. Date of 1st Contact will be 7/1/2010 (date of mammogram)
- For autopsy-only or death certificate-only cases, use the date of death
- When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility
- For analytic cases (Class of Case 00-22), the Date of First Contact is the date the patient became analytic. For non-analytic cases, it is the date the patient first qualified for the Class of Case that causes the case to be abstracted.

Date of First Contact Flag (Date of 1st Contact Flag)

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

- Leave this item blank if *Date of First Contact* has a full or partial date recorded
- Code 12 if the *Date of First Contact* cannot be determined at all
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software

Institution Referred To

Institution Referred From

The hospital referred to/from fields uses a 10-digit FIN to record the institution to or from which the patient was referred for further care. Number must be right justified with leading zeroes (i.e., 0006630999).

Enter the appropriate code from the following table. For a complete list of Hospital FIN numbers, refer to the MCR web site at http://mcr.umh.edu/.

Code	Description
0000000000	Patient was not referred by or to another facility
0000999998	Unspecified in-state hospital
0000999994	Unspecified out of state hospital
0000999996	Physician office
0000999995	Non-hospital, NOS
9999999999	It is unknown whether the patient was referred from or to another facility; The patient was referred, but referring facility is unknown

Primary Payer at Diagnosis

Identify the primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

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 21and 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

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

Class of Case

This data element is designed to separate the reporting registry's cancer cases into ***analytic*** and ***nonanalytic*** categories. MCR requires facilities to report both analytic and non-analytic cases with Class of Case codes 00, 10,11,12,13, 14, 20, 21, 22, 32, 35, 37, and 38.

Instructions for Coding

- Code the *Class of Case* that most precisely describes the patient's relationship to the facility
- Code 00 applies only when it is known the patient went elsewhere for treatment. If it is not known that the patient actually went somewhere else, code *Class of Case* 10
- It is possible that information for coding *Class of Case* will change during the patient's first course of care. If that occurs during the abstracting process, change the code accordingly as new information becomes available in the patient record or from other facilities
- Document *Facility Referred To* for patients coded 00 to establish that the patient went elsewhere for treatment

- A staff physician (codes 10-12, 41) is a physician who is employed by the reporting facility, under contract with it, or a physician who has routine practice privileges there
- 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 (their activity is coded as the hospitals) 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

Analytic Classes of Case

Initial diagnosis at reporting facility or staff physician's office

Code	MCR status	Definition
00	Reportable	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10	Reportable	Initial diagnosis at the reporting facility or in a staff physician's office AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
11	Reportable	Initial diagnosis in staff physician's office AND part of first course treatment was done at the reporting facility
12	Reportable	Initial diagnosis in staff physician's office AND all first course treatment or a decision not to treat was done at the reporting facility
13	Reportable	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere
14	Reportable	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility

Initial diagnosis elsewhere

Code	MCR status	Definition
20	Reportable	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21	Reportable	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere
22	Reportable	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility

Nonanalytic Classes of Case

Patient appears in person at reporting facility

Code	MCR status	Definition
30	Not reportable	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)
31	Not reportable	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided transient (temporary) care or hospital provided care that facilitated treatment elsewhere (for example, stent placement)
32	Reportable	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active diease)
33	Not reportable	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active)
34	Not reportable	Type of case not required by MCR to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility
35	Reportable	Case diagnosed before program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility
36	Not reportble	Type of case not required by MCR to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37	Reportable	Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
38	Reportable	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death

(Table continued on next page)

Nonanalytic Classes of Case *(continued from previous page)*

Patient does not appear in person at reporting facility (could be reportable by agreement for your facility)

Code	MCR status	Definition
36	Not reportble	Type of case not required by MCR to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37	Reportable	Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
38	Reportable	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death
40	Not reportable	Diagnosis AND all first course treatment given at the same staff physician's office
41	Not reportable	Diagnosis and all first course treatment given in two or more different staff physician offices
42	Not reportable	Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43	Not reportable	Pathology or other lab specimens only
49	By MCR request	Death certificate only (registry will receive notice from MCR if needed for a case)
99	Not reportable	Nonanalytic case of unknown relationship to facility

Examples:

Code	MCR status	Case Description
00	Reportable	During an Emergency Department visit for seizure, CT showed a high grade brain lesion, probable glioblastoma. Patient was transferred to a local cancer hospital for further work-up and treatment
10	Reportable	Patient underwent TRUSP with biopsies in his physician's office, and the pathology showed Gleason 3-3 adenocarcinoma. He was admitted to the reporting facility for DiVinci prostatectomy
31	Not Reportable	Patient receiving 5 day a week XRT at an outside facility was seen at the reporting facility for two of her scheduled treatments due to equipment failure at the referring hospital. She completed her treatments at the original facility after repairs were made

Type of Reporting Source

Code the source of information used to abstract the majority of information on the tumor being reported. This data item is used by the central registry to assist in the measurement of case reporting from all facilities.

Code	Definition
1	Hospital inpatient, managed healthplans with comprehensive, unified medical records (incl. VA)
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
3	Laboratory only (hospital-affiliated or independent)
4	Physician office/private medical practitioner (LMD)
5	Nursing/convalescent home; hospice
6	Autopsy only
7	Death certificate only (used by MCR)
8	Other hospital outpatient units and surgery centers equipped with general anesthesia

Chapter 6

TEXT FIELDS

MCR frequently receives abstracts from multiple facilities that must be consolidated into one case. Thus, abstracts must contain corroborating text in order for MCR to assure that what is entered into the MCR database is the most accurate information for each case reported. The operative concept here is "corroborating." That is, text must provide the rationale for selecting the codes assigned to primary site, histology, extent of disease and treatment fields. It's not necessary to strive for great literary expression. Brief, meaningful comments are all it takes to tell us what we need to know.

Text is also evaluated in some data quality audits to ensure coding accuracy and completeness. Missing or inadequate text to support the coded fields results in unnecessary errors affecting final statistical results of an audit.

One way to improve your text is to fill in the text fields first as you abstract, then code fields from that information. While it may feel awkward at first, it will show you how important accurate text is to MCR. These required text fields are considered in our QA and auditing processes, so good text entries may save you questions later.

Tips:

- Enter relevant information only
- Include only information that the registry is authorized to collect (Think HIPAA)
- If information is unavailable, state so in the text

Text – Dx Procedure - Physical Exam (Text–DX Proc– PE)

Enter findings from the physical exams which are pertinent to the primary being reported. Key findings to record include:

- The size and location of any obvious lesions or palpable masses
- The size and location of any palpable lymphadenopathy or the absence of palpable lymph nodes
- For lymphomas, the presence of any 'B' symptoms
- For prostate, DRE results which support the CS Clinical Extension code
- For melanomas, the diameter of the primary lesion, if no primary skin lesion is found, state this
- State age, race and sex. If the patient's first name is not typical for the sex, please make a note that sex has been verified correct
    - **Example 1:** 61 yo WM, DRE – ca not suspected; no LAD

- **Example 2:** 35 yo BF, 1 cm mass UOQ rt breast; no palp axillary LAD
- **Example 3:** 54 yo bilat cervical nodes; axillary nodes on left; no groin LAD, night sweats
- **Example 4:** [for unknown primary] 25 yo WM, PE-WNL

Text – Dx Procedure - X-rays/Scans (Text – DX Proc – X-ray/scan)

State the date and results of imaging studies used to diagnose and/or stage the primary. Just listing the tests without describing the findings is not at all useful. Key findings to record include:

- Name of the exam, including the body parts being imaged and the date the test was done
- Size and/or location of any positive findings that support the values coded for primary site, collaborative stage, surgery to primary or other sites
- When no positive findings are found, state so
- Telling where the test was done may support class of case
  - **Example 1:** 3/17/10 brain MRI here – 2 cm probable meningioma R temporal lobe
  - **Example 2:** 1/20/10 CT Boone: 3 cm RUL lesion; pleural effusion; mediastinal LAD; multi liver mets
  - **Example 3:** 2/1/10 CT Barnes – multi liver mets; PET showed uptake in liver only; no primary found
  - **Example 4:** 2/15/10 mamm locally – lg irregular mass outer left breast susp for malignancy ; 2/22/10 here - bone scan neg

Text – Dx Procedure – Scopes (Text – DX Proc – Scopes)

State any findings (including negative findings) that support values coded for primary site, collaborative stage, surgery to primary or other sites. Key elements to record include:

- Name of exam and date it was done
- Location and nature of tumor involvement
- Note whether a biopsy was taken during the procedure and what the results showed
  - **Example 1:** 4/9/10 colonoscopy showed obstructing lesion in proximal sigmoid. bx pos
  - **Example 2:** 5/11/10 endo showed ulcerating mass in upper esophagus. bx pos

Text - Lab Tests (Text – Dx Proc – Lab Tests)

Record only the findings relevant to confirming the diagnosis or collaborative stage. For sites where lab tests don't have particular bearing on diagnosis or stage, enter n/a. Types of cases where lab results are pertinent are listed below.

- Colon/rectum (CEA)
- Liver (AFP)
- Skin melanoma (LDH)
- Mycosis fungoides (Peripheral Blood Involvement)
- Breast (ERA/PRA/HER2)
- Ovary (CA-125)
- Prostate (PSA)
- Testis (AFP/ hCG/LDH)
- Hematopoietic (When no bone marrow exam is done) - (Heme profile/peripheral blood smear)

Rx Text - Surgery (Rx Text – Surgery)

State the surgery date and the specific name of the procedure(s) reflected in the coded values in the surgery fields. It is also helpful to include the name of the facility where the procedure was done.

- **Example 1:** [Lung - Code 33] 5/21/10 - RLL lobectomy w/medias LN dissec @ St John's
- **Example 2:** [Ovary - Code 57] 1/22/10 TAH-BSO w/omentectomy @ Mayo Clinic
- **Example 3:** [Bladder – Code 22] 8/11/10 TURB w/fulguration @ Skaggs

Text- OP (Text – Dx Procedure – OP)

This field is used to record details about findings from the operative procedure(s) and may include the following:

- Information from the operative report describing extent of disease and/or the extent of the surgery. Describe any findings that reflect date of diagnosis, the coded values for collaborative stage and treatment codes.
  - **Example 1:** 2/15/10 at colon resection, wedge excision of liver met was performed
  - **Example 2:** 1/27/10 omental mass and tumor studding debulked with 3 cm residual disease on diaphragm
- Sequence of surgical events that explains unusual circumstances
  - **Example:** 2/10/10 core needle bx; MRM planned but was delayed due to acute pancreatitis. MRM done 6/28/10

Text - Dx Procedure – Pathology (Text – DX Proc – Path)

Describe the pathology findings from all procedures that serve to confirm the diagnosis date, histology, collaborative stage, surgery primary site, surgery other site and scope of regional lymph node surgery. When available, the following should be included:

- Type of specimen (i.e., biopsy or resection) and anatomical source of tissue
- Histologic type stated in the final diagnosis from the pathology report
- Tumor size and extent
- Number of regional lymph nodes examined and number of positive nodes
- Status of non-primary tissue submitted, i.e., involved/not involved
- Status of final surgical margins
- Any comments by the pathologist that clarifies the final diagnosis
  - Example 1: RUL lobectomy – 3.2 cm MD sq cell ca; pleura not involved; 1/6 mediastinal nodes pos. margins free
  - Example 2: left lobectomy - .7 cm follicular ca ext thru thyroid capsule; 2/26/10 completion thyroidectomy - .5 cm rt lobe papillary ca; no node exam; margins free
  - Example 3: rt cervical node excision – follicular b-cell lymphoma; bone marrow pos
  - Example 4: sigmoid w/3.5 cm mucinous adenoca exts into pericolonic fat; 2/10 nodes pos. liver bx neg
  - Example 5: per pathologist, tumor is identical to that seen in the original resection specimen

Text - Staging

State the findings that are the basis for each value coded in the MCR required collaborative stage fields. It is only necessary to address the criteria met for the code assigned, e.g., if a lung primary has both supraclavicular (N3) and hilar (N1) nodes involved, mention only the N3 nodes in the text. TNM statements may also be recorded here to supplement CS summary text.

- Example 1: 2.3 cm, confined to breast tissue; 0/3 SLN involved
- Example 2: Malig pleural effusion, mediastinal LN pos, liver mets on CT
- Example 3: No info on primary tumor; nodes clinically neg; no dist mets

Text - Remarks

This field can be used to describe information coded but not described elsewhere in the text, for example as smoking and alcohol use, personal cancer history and family cancer history. Coding problems, unavailable information, unusual circumstances regarding treatment timing and the like can be discussed here. This field can also be used for overflow text from other fields.

- **Example 1:** Pt seen in ER 5/1/10 and CT chest dx'd multiple bilat lung nodules, probable malignancy. Pt expired in ER; no other info available
- **Example 2:** Pt Hx of mantle RT for Hodgkin's; 20 yrs tob use, quit 1988
- **Example 3:** Outside path says sigmoid, outside op note states descending colon so site was coded C18.8

Text - Place of Diagnosis

Record the facility where the initial diagnosis was made, if known.

Rx Text - Radiation (Beam) and Rx Text -Radiation Other

State the treatment dates, modality, dose, volumes (sites) treated and place RT was given. If treatment was planned but it is unknown whether it was given, state this in the text. If no RT was given, state the reason.

- **Example 1:** [Prostate] 6/8/10 Pd-103 seed implant @ St John's
- **Example 2:** 4/2 – 4/12 3000 cGy to brain mets @ St John's
- **Example 3:** RT not recommended

RX Text - Chemo, RX Text - Hormone, RX Text - BRM, and RX Text - Other

State the treatment date, agents given and place treatment was given.

- **Example 1:** CHOP x 4 plus Rituxan started 5/6/07; Rx @ Skaggs
- **Example 2:** Pt declined recommended Arimidex

Primary Site Title (Text – Primary Site Title)

Describe in text the exact site as coded in the Primary Site field. Include laterality if applicable.

- **Example:** Site code is C16.9 *description* = stomach, NOS
- **Example:** Site code is C71.1 and laterality code is 2. *Description* = right frontal lobe, brain

Histology Title (Text – Histology Title)

Describe the specific histology type as coded in the histologic type field. Include grade, if applicable.

- **Example:** Patient diagnosed with adenocarcinoma, poorly differentiated - Code: 8140/33 description = "adenocarcinoma, poorly differentiated"

Sample Text Entries

Here is what the text section of your finished abstract should look like:

- Text—DX Proc-PE: 83 yo white male w/2 week hx R supraclavicular node
- Text—DX Proc—X-ray/Scan: 5/7/10 CT chest – 5 cm malignant appearing R hilar mass; 3 cm supraclavicular node; liver, adrenals WNL
- Text—DX Proc—Scopes: 5/10/10 bronch bx: mass originating in RUL bronchus extending into R MSB
- Text—DX Proc—Lab Tests: n/a
- Text—DX Proc—Op: 5/10/10 local excision of supraclavicular node only; patient not otherwise a surgical candidate
- Text—DX Proc-Path: endobronch bx – PD sq cell ca; LN exc pos for mets sq cell
- Text—Staging: hilar tumor extn into MSB; positive N3 node; no distant mets
- RX Text—Surgery:supraclavicular node excision only
- RX Text—Radiation (Beam): 6300 total cGy to thorax; 5/24/10 – 7/2/10 at St. Paul's
- RX Text—Radiation Other: none
- RX Text—Chemo:refused
- RX Text—Hormone:none
- RX Text—BRM: none
- RX Text—Other: none
- RX Text—Remarks: smoker x 60 yrs; pt has had CLL since 2003 – no Rx
- Text—Place of Diagnosis: St Paul's

Chapter 7

CANCER IDENTIFICATION

(for cases diagnosed before 2010, see also Appendix A)

Primary Site

The primary site is defined as the organ or site in which the cancer originated or began. A ***metastatic*** site indicates that the primary (originating) tumor has spread from the original site to other areas in the body. Cancer registries **code only the primary site** in this field, using the ICD-O-3 manual to determine the correct site code. Indications of metastatic sites are used in the registry for identifying the extent of the patient's disease and for staging purposes. Coding the primary site properly is very important, as many other field codes stem from it.

- Follow the Instructions for Coding in ICD-O-3, pages 20–40 and in the current SEER Multiple Primary and Histology Coding Rules to assign primary site codes for solid tumors

- Primary site codes for lymphomas, leukemias and other hematopoietic neoplasms diagnosed **January 1, 2010 and after** are assigned according to instructions specified in the *2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual.* This manual may be downloaded from the SEER website at http://seer.cancer.gov/tools/heme/index.html. To determine primary site codes for cases diagnosed prior to 2010, follow instructions for coding in ICD-O-3, pages 20-40 and SEER's *Abstracting and Coding Guide for the Hematopoietic Diseases* (the "red book")

It is important to identify the exact location of the primary tumor whenever possible, and to enter the most specific ICD-O-3 topography code listed into Primary Site field. The registrar should use all documents available in the medical record to determine the most specific site code, including pathology reports, scans, x-rays, MRIs, etc. The following points are helpful to consider when coding this field:

- Enter the specific subsite code whenever applicable

  Example: A patient is diagnosed with breast cancer. The path report reads *a malignant neoplasm of the right breast, upper outer quadrant.* It is correct to code **C50.4**, rather than breast, NOS - **C50.9**

- When a primary lesion occupies contiguous overlapping subsites within an organ and the exact point of origin cannot be determined, use .8 to code the subsite

Example: Patient is diagnosed with colon cancer. The surgeon states that intraluminal tumor involved the colon from the cecum to the mid-ascending colon. Code **C18.8** - rather than coding the site to either the cecum or ascending colon

- When the primary tumor is multifocal throughout an organ, or when there is no information identifying the subsite from which the primary tumor arose, use the code .9 to indicate the site, NOS

  Example: The pathology from a mastectomy specimen shows diffuse, multifocal ductal carcinoma throughout the breast. Code C50.9

  Example: A patient with small cell lung cancer originally diagnosed and treated at an unknown facility is admitted for brain radiation for newly identified metastases. The only information available is a note stating, "Patient with 3-year history of SCLC here for XRT to brain mets." Code C34.9

- When multiple tumors arising in different subsites of the same anatomic site are reported as a single primary and point of origin cannot be determined, code the last digit of the primary site to 9.

  Example: Patient has an infiltrating duct tumor in the UOQ (C50.4) of the R breast, and another infiltrating duct tumor in the LIQ (C50.3) of the same breast. Code the primary site as C50.9.

- When the primary site is documented as an "unknown primary," use code C80.9
- Kaposi's Sarcoma is coded to the site in which it originates. Code to skin NOS **(C44.9)** if the disease arises simultaneously in the skin and another site, AND the primary site is not identified

Primary Site Coding—Lymphomas

- Rules for determining topography codes for lymphomas diagnosed in 2010 and after are specified in *2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*
- For cases diagnosed prior to 2010, use the guidelines found in Appendix A to determine the primary site codes for lymphomas

Histologic Type

The data item Histologic Type describes the microscopic composition of cells and/or tissue for a specific primary site. The tumor type or histology is a basis for staging and determination of treatment options. It affects the prognosis and course of the disease. Histology code is recorded in two fields: Histology (92-00) ICD-O-2 for cases diagnosed prior to 2001 and Histologic Type ICD-O-3, used for all cases.

Record histology using the 4-digit morphology codes found in the appropriate reference as shown in the table on the following page.

Instructions for Coding

- ICD-O-3 identifies the morphology codes with an "M" preceding the code number. Do not record the "M."
- Review all pathology reports related to the case.
- 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).
- Refer to Appendix A of this manual for cases diagnosed prior to January 1, 2007.

Malignant Solid Tumors	
Diagnosed January 1, 2007 and after	#1 *Multiple Primaries and Histology Coding Manual* #2 ICD-O-3
Diagnosed January 1, 2001 - December 31, 2006	ICD-O-3
Diagnosed prior to 2001	ICD-O-2 (enter into historic ICD-2 field) **AND** ICD-O-3 (enter into ICD-3 histologic type field)
Benign/borderline Intracranial and Other CNS Tumors	
Diagnosed January 1, 2007 and after	#1 *Multiple Primaries and Histology Coding Manual* #2 ICD-O-3
Diagnosed January 1, 2004 - December 31, 2006	ICD-O-3
Diagnosed prior to 2004	Not reportable
Lymphomas, Leukemias and other Hematopoietic Malignancies	
Diagnosed January 1, 2010 and after	*Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database*
Diagnosed January 1, 2001 – December 31, 2009	ICD-O-3
Diagnosed prior to 2001	ICD-O-2 (enter into historic ICD-2 field) **AND** ICD-O-3 (enter into ICD-3 histologic type field)

Information about the 2007 Histology Coding Rules

Note: Do not use these rules to determine case reportability

1. The 2007 multiple histology rules **replace all previous** multiple histology **rules**
2. The rules are **effective** for cases **diagnosed January 1, 2007** and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2007
3. The histology coding rules are available in **three formats**: flowchart, text, and matrix. The **rules are identical**, only the formats differ. Use the set of rules in the format that is easiest for you to follow

4. **Notes** and **examples** are included with some of the rules to **highlight key points** or to add **clarity** to the rules and do not necessarily represent all possible scenarios
5. Rules are in **hierarchical** order within each section (Single Tumor and Multiple Tumors Abstracted as a Single Primary)

How to Use the Rules
1. Read the **General Instructions**
2. Read the **site-specific Equivalent Terms and Definitions**
3. Use these rules to make a decision on coding the histology for all reportable solid malignant tumors
4. Use the multiple primary rules to determine whether the patient has single or multiple primaries before coding the histology
5. Code the histology for **each** primary in a **separate abstract**
6. Use the **site-specific rules** for the following primary sites:
   - Brain (intracranial and CNS)
   - Breast
   - Colon
   - Head and neck
   - Kidney
   - Lung
   - Malignant melanoma of the skin
   - Renal pelvis, ureter, bladder, and other urinary

7. Use the **Other Sites rules** for all solid malignant tumors that occur in primary sites **not included** in the site-specific rules
8. Determine whether the patient has a single tumor or multiple tumors that will be abstracted as a single primary
   a. Do not count metastatic tumors
   b. When the tumor is described as multifocal or multicentric, use the Multiple Tumors module
   c. When there is a tumor or tumors with separate foci of tumor do not count the Foci
   d. Only count the tumors that will be used to prepare that abstract. For example, when there are two tumors that will be abstracted as multiple primaries, you would use the Single Tumor modules to determine the histology code for each of the abstracts
9. **Each section** (Single Tumor and Multiple Tumors Abstracted as a Single Primary) is an independent, **complete set of coding rules**. For example, if the patient has multiple tumors that will be abstracted as a single primary, start with the first rule under the heading Multiple Tumors Abstracted as a Single Primary. Do not use any of the rules under the header Single Tumor
10. Use the first rule that applies and **STOP**

Priority Order for using Documents to Code Histology
Medical records frequently include multiple pathology reports and references to histologic diagnosis. Use the following instructions to identify which reports best represent the histology to be coded.
1. Pathology report:

a. From the **most representative** tumor specimen examined
b. From the **final diagnosis**

Note 1: Use information from **addenda** and **comments** associated with the final diagnosis to code the histology

Note 2: A **revised/amended diagnosis** replaces the original final diagnosis. Code the histology from the revised/amended diagnosis

Note 3: The new rules **limit** the information **to the final diagnosis**. The old rules allowed coding from information in the microscopic description

You will only use information from the microscopic portion of the pathology report when instructed to do so in one of the site-specific rules.

2. Cytology report
3. When you do not have either a pathology report or cytology report:
    a. Documentation in the medical record that references pathology or cytology findings
    b. From mention of type of cancer (histology) in the medical record

Ambiguous Terms Used to Code Histology

When any of the ambiguous terms below are used to describe a more specific histology, code the more specific histology.

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

Example: Non-small cell carcinoma, most likely adenocarcinoma. Adenocarcinoma is coded

General Instructions Histology Coding Rules

When using rule (see note) that states "Code the histology documented by the physician when the pathology/cytology report is not available" code the histology from the document with the highest priority. Make a second pass through the histology rules to determine which histology code should be recorded. Start with the appropriate module, Single Tumor or Multiple Tumors, and continue through the rules until you reach the rule that fits the case you are coding.

Note: For most sites this will be rule H1 and the first rule in the Multiple Tumors module

When using rule (see note) that states "When the only histology is from a metastatic site" make a second pass through the histology rules to determine which histology code should be recorded. Start with the appropriate module, Single Tumor or Multiple Tumors, and continue through the rules until you reach the rule that fits the case you are coding.

Note: For most sites this will be rule H2 and the second rule in the Multiple Tumors module

When the patient has a previous or subsequent unknown primary site (C80.9) or an ill-defined primary site, check carefully to see if this abstract or document should be consolidated into the previous abstract rather than making it a new primary.

Further instructions and rules that clarify histology coding are found in the *Multiple Primary and Histology Coding Rules* manual.

ICD-O-3 Conversion Flag

This code specifies how the conversion of morphology codes from ICD-O-2 to ICD-O-3 was accomplished. This information is used for some data analysis and for further item conversions. New versions of the codes used for recording histology and behavior reflect advances in medical and pathologic knowledge, and converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Instructions for Coding

- Code 0 is used for newly abstracted cases and may be auto-coded by the software provider

Behavior Code

The behavior code occupies the fifth digit of the ICD-O morphology code and records the behavior of the tumor being reported. It is used by pathologists to describe whether tissue samples are benign (0), borderline (1), in situ (2), invasive (3), or metastatic (6). The cancer registry collects only **primary** sites. If the pathology report describes the cancer as metastatic, the registrar should be alerted that the primary site is not described on that report and must take steps to identify the primary site. In this situation, the behavior code is recorded **3** by the registry. Behavior codes 6 and 9 are not used by the hospital registry. Behavior code is recorded in two fields: Behavior (92-00) ICD-O-2 for cases diagnosed prior to 2001 and Behavior Code ICD-O-3 used for all cases.

Code	Label	Definition
0	Benign	Benign
1	Borderline	Uncertain whether benign or malignant Borderline malignancy Low malignant potential Uncertain malignant potential
2	In situ and/or carcinoma in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk Clark level 1 for melanoma (limited to epithelium) Comedocarcinoma, noninfiltrating (C50._)
3	Invasive	Invasive or microinvasive, no matter how limited

Example: Pathology report of breast biopsy reads: "ductal carcinoma in situ (8500/2) with areas of focal invasion (8500/3). This case should be coded to the invasive behavior **8500/3**

Example: Pathology report of bladder biopsies reads: "Papillary urothelial carcinoma, non-invasive (8130/2 and Papillary transitional cell (8130/3) with invasion of the lamina propria." This case should be coded to the invasive behavior

Colon and rectal sites with high grade or severe dysplasia are reportable as behavior code 2 cases only if the pathologist states they are equivalent to carcinoma in situ and the reporting facility's registry has a documented policy to this effect. Abstract text MUST document pathology as in situ carcinoma.

The following terms are synonymous with **behavior code 2** (in-situ) cancers:

- Adenocarcinoma in an adenomatous polyp with no invasion of stalk
- Bowen's disease (not reportable for C44._)
- Clark's level 1 for melanoma (limited to epithelium)
- Comedocarcinoma, non-infiltrating (C50._)
- Confined to epithelium
- Hutchinson melanotic freckle, NOS (C44._)
- Intracystic, non-infiltrating (carcinoma)
- Intraductal (carcinoma)
- Intraepidermal, NOS (carcinoma)
- Intraepithelial, NOS (carcinoma)
- Involvement up to but not including the basement membrane
- Lentigo maligna (C44._)
- Lobular neoplasia (C50._)
- Lobular, nonfiltrating (C50._) (carcinoma)
- Noninfiltrating (carcinoma)
- Noninvasive (carcinoma)
- No stromal invasion or involvement
- Papillary, noninfiltrating or intraductal (carcinoma)
- Pre-cancerous melanosis (C44._)
- Queyrat's erythoplasia (C60._)

Grade or Differentiation

Grade or differentiation describes the tumor's resemblance to normal tissue and conveys useful prognostic information. 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 lymphomas and leukemias. Grade is represented by a one-digit code number included at the sixth position of the histology code. In most cases, the histologic grade will be documented in the pathology report. Sometimes, it is possible to establish the tumor grade through MRI or PET imaging.

While FORDS 2012 allows coding special SSFs and systems in lieu of coding grade/differentiation, MCR does not require completion of all the SSFs for the 'special grades' listed in Section 1 p. 11 of FORDS. Therefore, in accordance with NPCR, MCR will require that you continue to use the Grade/Differentiation field as defined here. In Missouri, if Grade Path System and Value are coded, Grade/Differentiation should not be 9; an edit will still appear. CoC facilities will additionally code the applicable SSFs per FORDS.

Instructions for Coding

- Code grade according to ICD-O-3 pp. 30–31 and 67
- 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
- When the pathology report(s) lists more than one grade of tumor, code to the highest grade, even if the highest grade is only a focus

  Example: Pathology report reads, "infiltrating ductal carcinoma, moderately to poorly differentiated, Code 8500/3**3**. Grade 3 takes precedence over moderately differentiated Grade 2
- Do not use grading terms such as low grade or high grade for certain in situ malignancies when the term is a part of the classification system of the tumor. i.e.: diagnosis of high grade VIN III. For other in situ malignancies, the grade should be coded if stated
- Code the grade or differentiation from the pathologic examination of the primary tumor, not from metastatic sites
- Code the grade or differentiation from the pathology report prior to any neo-adjuvant treatment. If there is no pathology report prior to neo-adjuvant treatment, assign code 9
- When there is no tissue diagnosis, it may be possible to establish grade through magnetic resonance imaging (MRI) or positron emission tomography (PET). When available, code grade based on the recorded findings from these imaging reports
- If the primary site is unknown, code Grade as 9 (Unknown)
- 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
- Grade astrocytomas according to ICD-O-3 rules. Do not code glioblastoma multiforme as Grade IV; if no grade is indicated, code 9-unknown. For primary tumors of the brain and spinal cord (C71.0-C72.9) ***do not*** record the WHO grade as the tumor grade. The WHO grade is recorded in *CS Site-Specific Factor 1*

  Example: Pathology report reads, "anaplastic astrocytoma, WHO grade III. Grade code is 4 and CS SSF1 is 030

- **Do not** use "high grade," "low grade," or "intermediate grade" descriptions for lymphomas as a basis for differentiation. These terms are categories in the Working Formulation of Lymphoma Diagnoses and do not relate to *Grade/Differentiation*
- Codes 5–8 define T-cell or B-cell origin for leukemias and lymphomas. T-cell, B-cell, or null cell classifications have precedence over grading or differentiation. Do not use the WHO grade to code this data item
- If *Grade Path System* and *Grade Path Value* are coded, *Grade/Differentiation* must not be 9

Coding Two-grade Systems

Two-grade systems may apply to colon, rectosigmoid junction, rectum (C18.0-C20.9) and heart (C38.0). Code these sites as Low Grade or High Grade per table below. If the grade is stated as 1/2 or Low Grade , use code 2. If grade is stated as 2/2 or High Grade, use code 4.

Code	Terminology	Histologic Grade
2	Low Grade	1/2
4	High Grade	2/2

Coding Three-grade Systems

Three-grade systems may apply to peritoneum (C48.1, C48.2), breast (C50.0-C50.9), endometrium (C54.1), fallopian tube (C57.0), prostate (C61.9), kidney C64.9), bladder (C67.0-C67.9) and brain and spinal cord (C71.0-C72.9). For sites **other** than breast, prostate and kidney, code the tumor grade using the following priority order: 1) terminology; 2) histologic grade; and 3) nuclear grade per table below. For breast, prostate or kidney cancer, see the separate sections below.

Code	Terminology	Histologic Grade	Nuclear Grade
2	Low grade, well to moderately differentiated	I/III or 1/3	1/3, 1/2
3	Medium grade, moderately undifferentiated, relatively undifferentiated	II/III or 2/3	2/3
4	High grade, poorly differentiated to undifferentiated	III/III or 3/3	2/2, 3/3

Coding Bladder Cancers

When low or high grade terminology is stated on the path report for an ***invasive*** bladder cancer, use the three grade system conversion table above to assign Grade or Differentiation. For in situ and non-invasive bladder cancer, MCR prefers that the grade be coded 9.

Coding Breast Cancers

For breast sites, code grade using the following priority order:

1. Bloom-Richardson (Nottingham) scores 3-9 converted to grade (see conversion table below)

   Nuclear Grade

   Terminology

   Differentiation (well differentiated, moderately differentiated, etc)

   Histologic grade

   Grade I, grade II, grade III, grade IV

2. Bloom-Richardson (BR)

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

BR may be expressed in scores (range 3-9). The score is based on three morphologic features of "invasive no-special-type" breast cancers (degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism of tumor cells).

Use the following table to convert BR score:

BR Score	Differentiation	Grade	Code
3,4,5	Well differentiatiated	I	1
6,7	Moderately differentiated	II	2
8,9	Poorly differentiated	III	3

BR may be expressed as a grade (low, intermediate, high). BR grade is derived from the BR score. For cases diagnosed 1996 and later, use the following table to convert the BR grade into SEER code. Note that the conversion of low, intermediate, and high BR grade is different from the conversion used for all other tumors. Use the table below to convert BR grade to code.

BR Grade	Differentiation	Grade	Code
BR low grade	Well differentiated	I	1
BR intermedidate grade	Moderately differentiated	II	2
BR high grade	Poorly differentiated	III	3

Coding Prostate Cancers

For prostate cancers, code grade using the following priority order:

1. Gleason Score (sum of patterns, e.g. pattern 2+4 = score of 6)
2. Terminology
3. Histologic Grade

Code	Gleason Score (sum of primary and secondary patterns)	Terminology	Histologic Grade
1	2, 3, 4	Well differentiated	I
2	5, 6	Moderately differentiated	II
3	7, 8, 9, 10	Poorly differentiated	III

Gleason score 7 was previously coded to moderately differentiated grade 2. Effective with cases diagnosed 1/1/2003, Gleason score 7 is coded to poorly differentiated grade 3.

Grade Path Value

This field documents the numerator or first number of a tumor grade reported in a 2, 3, or 4 grade system. It supplements but does not replace the field Grade/Differentiation (NAACCR Item #440), which is part of the ICD-O-3 morphology code structure and may be converted from another grading system or coded by a different set of rules. Grade Path Value is paired with Grade Path System to describe the original grade of the tumor.

Instructions for Coding

Code	Definition
1	Recorded as Grade I or 1
2	Recorded as Grade II or 2
3	Recorded as Grade III or 3
4	Recorded as Grade IV or 4
Blank	No 2,3, or 4 grade system available, or unknown

Code the histologic grade or differentiation reported in the pathology report or a physician's statement in the medical record, in that order. **Do not convert** the grade described in the pathology report or medical record.

- Code this field from the same tissue used to code the sixth digit of the ICD-O-3 morphology code (Grade/Differentiation). This field identifies how the original grade of the tumor was described.
- **Do not convert** the terms *well*, *moderately,* or *poorly differentiated*, *low/high*, or *anaplastic* into codes in this field.
- Code the histologic grade/differentiation in priority over a nuclear or architectural grade.
- If grade is described in the medical record as a fraction (x/y), this data field is the numerator. In other words, this field is the first or upper number of a grade expressed in two parts.
- **Do not report grading systems such as Bloom-Richardson for breast or Fuhrman for kidney or Gleason for prostate or WHO grade as coded values in this field.**

- The code in this field cannot be greater than the corresponding code in Grade Path System.
- For lymphomas and hematopoietic malignancies, this field is blank.

Examples:

- Synoptic report states grade ii of iii. *Code Grade Path Value as 2.*
- Final pathologic diagnosis listed as grade 1/4. *Code Grade Path Value as 1.*
- Microscopic description reports high grade III of III. *Code Grade Path Value as 3.*

Grade Path System

This field documents the denominator or second number of a tumor grade reported in a 2, 3, or 4 grade system. It supplements but does not replace the field Grade/Differentiation (NAACCR Item #440), which is part of the ICD-O-3 morphology code structure and may be converted from another grading system or coded by a different set of rules. Grade Path System is paired with Grade Path Value to describe the original grade of the tumor.

Instructions for Coding

- **Code the grading system** reported in the medical record. **Do not convert** the grade described in the pathology report.
- Code this field from the same tissue used to code the sixth digit of the ICD-O-3 morphology code (Grade/Differentiation). This field identifies how the original grade of the tumor was described.
- If grade is described in the medical record as a fraction (x/y), this data field is the denominator. In other words, this field is the second or lower number of a grade expressed in two parts.
- Leave this field blank if another grading system is used in the pathology report. For example, do not report grading systems such as Bloom-Richardson for breast or Fuhrman for kidney or Gleason for prostate or WHO grade as coded values in this field.
- For lymphomas and hematopoietic malignancies, this field is blank.

Code	Definition
2	Recorded as Grade II or 2
3	Recorded as Grade III or 3
4	Recorded as Grade IV or 4
Blank	No 2,3,or 4 grade system available, or unknown

Examples:

- *Synoptic report states grade ii of iii. Code Grade Path System as 3.*
- *Final pathologic diagnosis listed as grade 1/4. Code Grade Path System as 4.*
- *Microscopic description reports high grade III of III. Code Grade Path System as 3.*

Note: A helpful video explaining these grade fields is at: http://youtube.com/watch?v=3PLVSLLay1E

Date of Diagnosis

Record the month, day, and year this cancer was originally diagnosed by a medical practitioner. This date should reflect the **first clinical** onset of disease and may not be histologically confirmed. This date should not be changed, even if the disease is histologically confirmed later.

> **Example:** Patient has a diagnostic ultrasound on June 6, 2010 that is highly suspicious for malignancy. On June 30, 2010 a biopsy is performed and results show invasive ductal carcinoma. CCYY = 2010, MM = 06, DD = 06

- Backdating - If a non-diagnostic workup was performed on a patient but at a later date malignancy is confirmed and the physician specifically states that in retrospect the patient had cancer earlier, backdate the date of diagnosis to reflect the earlier date. This also includes pathology that may not have been diagnostic but upon further review of the specimen it is now thought to have been malignant. Refer to the list of "Ambiguous Terms" in Chapter 2 for terminology that constitutes a diagnosis of cancer
- Record the date as completely as possible. Leave any unknown portions of the date blank
  Example: The patient was admitted to your facility in June of 2010 for seed implant radiation for prostate cancer diagnosed elsewhere approximately 4 months earlier, exact date unknown. CCYY = 2010, MM = 02 DD = blank
- Per FORDS, if the year of diagnosis can not be identified, it must be approximated. In that instance the month and day are unknown
- If the cancer was first diagnosed at autopsy, (class of case 38), the date of diagnosis is the date of death
- The date of the first cancer-directed treatment may be used for the date of diagnosis, if confirmation of disease occurs after therapy has begun, or if no other information is available
- If the month or day of diagnosis is not documented, an estimated date, based on available information is allowed. Please note in text if date was estimated
- If only the time of year, (spring, middle, fall, or winter) is documented, use April, July, October, and either December (if end of year) or January (if beginning of year) respectively

Ambiguous Terminology Field

This data item is included in the *Multiple Primary and Histology Coding Rules Manual*, and applies to cases diagnosed 1/1/2007 and after. It was created to identify all cases, including DCO and autopsy only, for which an ambiguous term is the most definitive word or phrase used to establish a cancer diagnosis. Ambiguous terminology may originate from any source document, such as pathology report, radiology report, or from a clinical report.

This data item is used only when ambiguous terminology is used to establish diagnosis. It is not used when ambiguous terminology is used to clarify a primary site, specific histology, histologic group, or stage of disease.

Ambiguous terms that are reportable:

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

- Refer to the *Multiple Primary and Histology Coding Rules* "New Data Items" and to the following table for more coding directions

Codes for Ambiguous Terminology

Code	Label	Definition	Time Frame	Examples
0	Conclusive term	There was a conclusive diagnosis within 60 days of the original diagnosis. Case was accessioned based on conclusive terminology. Includes all diagnostic methods such as clinical diagnosis, cytology, pathology, etc	Within 60 days of the date of initial diagnosis	1. Adenocarcinoma in TURP chips 2. Mammogram suspicious for DCIS. Excisional biopsy 1 week later positive for DCIS
1	Ambiguous term only	The case was accessioned based only on ambiguous terminology. There was no conclusive terminology during the first 60 days following the initial diagnosis. Includes all diagnostic methods except cytology ***Note:*** Cytology is excluded because registrars are not required to collect cases with ambiguous terms describing a cytology diagnosis	N/A	1. Chest MRI shows a malignant appearing lesion in the right upper lobe. Patient refused further workup or treatment 2. Pt with elevated PSA admitted for TRUS. Biopsy. Pathology: Prostatic chips: Consistent with adeno-carcinoma. No further information is available
2	Ambiguous term followed by conclusive term	The case was originally assigned a code 1 (was accessioned based only on ambiguous terminology). More than 60 days after the initial diagnosis, the information is being updated to show that a conclusive diagnosis was made by any diagnostic method including clinical diagnosis, cytology, pathology, autopsy, etc	61 days or more after the date of diagnosis	The biopsy of the thyroid reads: most likely thyroid cancer. Three months later a biopsy is positive for papillary follicular cancer. The case would have been coded 1 Ambiguous term only. Change the code to 2 Ambiguous term followed by conclusive term
9	Unknown term	There is no information about ambiguous terminology	N/A	

Diagnostic Confirmation

This item records the best method of diagnostic confirmation of the cancer being reported at any time during the course of disease. It is an indicator of the precision of diagnosis and marks whether or not the coded histologic type was microscopically confirmed.

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

- 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 code (higher priority) if a more definitive method confirms the diagnosis *at any time during* the course of the disease

  Example: Patient is diagnosed on 2/10/2009, by CT scan with probable lung cancer with no further workup. Diagnostic confirmation is coded to radiology (7). Later in March of 2009, the patient undergoes a bronchoscopy in which biopsies confirm squamous cell carcinoma. The diagnostic confirmation code is changed to reflect the positive histology (1)
- Assign code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy or D&C or from aspiration or 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
- 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

Codes for Solid Tumors

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

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

- 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)* 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 that can not be coded as 5, 6 or 7. 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

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined)
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined)
3	Positive histology PLUS Positive immunophenotyping AND/OR Positive genetic studies	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results. For example, bone marrow examination is positive for acute myeloid leukemia (9861/3). Genetic testing shows AML with inv(16)(p13.1q22) (9871/3)
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only
8	Clinical diagnosis only, other than 5, 6 or 7	The malignancy was reported by the physician in the medical record
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic)

Laterality

Laterality 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. Laterality supplements staging and extent of disease information and defines the number of primaries involved. This item is required for the sites listed below, but can be used for sites not listed in the table.

Instructions for Coding

- Code laterality for all paired sites
- Do not code metastatic sites as bilateral involvement
- Where the right and left sides of paired sites are contiguous (come into contact) and the lesion is at the point of contact of the right and left sides, use code 5, midline. Most paired sites cannot develop midline tumors (such as the breast) because the right and left organs do not touch. Skin of the trunk is an example of a site where midline coding is possible. Note that "midline of the right breast" is coded 1, (right; "midline" in this usage indicates the primary site is C50.8 (overlapping sites)
- Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites 0

Laterality Codes

Code	Definition
0	Organ is not a paired site
1	Origin of primary is right
2	Origin of primary is left
3	Only one side involved, right or left origin not specified
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5	Paired site: midline tumor
9	Paired site, but no information concerning laterality

Paired Organ Sites

ICD-O-3	Site	ICD-O-3	Site
C07.9	Parotid gland	C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C08.0	Submandibular gland	C47.2	Peripheral nerves and autonomic nervous system of lower limb and shoulder
C08.1	Sublingual gland	C49.1	Connective, subcutaneous and other soft tissues of upper limb and shoulder
C09.0	Tonsillar fossa	C49.2	Connective, subcutaneous and other soft tissues of lower limb and hip
C09.1	Tonsillar pillar	C50.0-C50.9	Breast
C09.8	Overlapping lesion of tonsil	C56.9	Ovary
C09.9	Tonsil, NOS	C57.9	Fallopian tube
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)	C62.0-C62.9	Testis
C30.1	Middle ear	C63.0	Epididymis
C31.0	Maxillary sinus	C63.1	Spermatic cord
C31.2	Frontal sinus	C64.9	Kidney, NOS
C34.0	Main bronchus (excluding carina)	C65.9	Renal pelvis
C34.1-C34.9	Lung	C66.9	Ureter
C38.4	Pleura	C69.0-C69.9	Eye and lacrimal gland
C40.0	Long bones of upper limb and scapula	C70.0	Cerebral meninges. NOS*
C40.1	Short bones of upper limb	C71.0	Cerebrum*
C40.2	Long bones of lower limb	C71.1	Frontal lobe*
C40.3	Short bones of lower limb	C71.2	Temporal lobe*
C41.3	Rib and clavicle (excluding sternum)	C71.3	Parietal lobe*
C41.4	Pelvic bones (excluding sacrum, coccyx and symphysis pubis)	C71.4	Occipital lobe*
C44.1	Skin of eyelid	C72.2	Olfactory nerve*
C44.2	Skin of external ear	C72.3	Optic nerve*
C44.3	Skin of other/unspecified parts of face	C72.4	Acoustic nerve*
C44.5	Skin of trunk	C72.5	Cranial nerve*
C44.6	Skin of upper limb and shoulder	C74.0-C74.9	Adrenal gland
C44.7	Skin of lower limb and hip	C75.4	Carotid body

Chapter 8

STAGING SCHEMES

Collaborative Stage

The Collaborative Stage (CS) data collection system is a set of data items that describe how far a cancer has spread from its primary site at the time of diagnosis and how the extent of disease was evaluated. The data items were selected by a task force convened to address the issue of discrepancies in staging guidelines among the three major staging systems used in the U.S. Cancer registries have traditionally collected most of the data items incorporated into the CS system, the use of which should provide a higher degree of compatibility among staging schemes that will expand data-sharing opportunities. Site-specific Factors (SSFs) are incorporated into the staging algorithms when additional information is necessary to derive the SEER Summary Stage, TNM Stage Group, or where the SSF is considered to be of clinical or prognostic importance. Information formerly coded as Tumor Markers and certain supplemental data required for obtaining the derived AJCC stage are coded in SSF fields. (For more complete details, refer to the introduction of the *Collaborative Stage Data Collection System Coding Instructions*, Part I, Section 1: General Instructions at: http://cancerstaging.org/cstage/manuals/pt1sec1v0204.pdf).

The Collaborative Stage Data Collection System Version 02.04 (CSv2) is required for use with cases diagnosed on or after January 1, 2012. It also applies to older cases entered after conversion to NAACCR version 12.2.

The CS Version 01 series applies to cases diagnosed January 1, 2004 through December 31, 2009 and abstracted before NAACCR version 12 was implemented. Complete directions are in the *Collaborative Stage Manual and Coding Instructions, Version 01.04.01*. Collaborative stage fields are not to be used for cases diagnosed before January 1, 2004.

Lymph-Vascular Invasion

This data item 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. Lymph-vascular Invasion (LVI) is an indicator of prognosis. This field is used by the CS algorithm to map AJCC T for some primary sites.

Instructions for Coding

- This item may be left blank for cases diagnosed before 2010.
- The primary source of this information is the College of American Pathologists (CAP) synoptic report or checklist. If that is not available, code from the pathology report or a physician's statement, in that order of priority.
- Use code 1 if lymph-vascular invasion is identified anywhere in a primary tumor specimen.
- Use code 0 if the pathology report indicates no lymph-vascular invasion was found or if tumor is purely *in situ* carcinoma.
- Use code 8 for histologies 9590-9992.
- Use code 9 if primary site tissue was sent to pathology, but no report based on it is available (the report cannot be found or surgery was at a different facility and the information was not provided to the reporting facility).
- Use code 9 if the pathology report indicates that the presence of lymph-vascular invasion could not be determined (no microscopic examination of primary tissue, cytology only, insufficient tissue sample) or is not mentioned.

Code	Definition
0	Lymph-vascular invasion is not present (absent) or is not identified
1	Lymph-vascular invasion is present or identified
8	Not applicable
9	Unknown or indeterminate

CS Tumor Size

Record the largest dimension or diameter of the primary tumor in millimeters. Refer to ***CSv2 Coding Instructions Part I, Section 1: General Instructions*** for complete directions.

CS Extension

CS extension identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontiguous metastasis is coded in the CS Extension field. See ***CSv2 Coding Instructions Part I, Section 1: General Instructions*** and site-specific schemas for detailed codes and coding instructions.

CS Tumor Size/Ext-Eval

Identifies how the farthest tumor spread coded in the CS Tumor Size/Ext field was determined. This field is used primarily to derive the staging basis for the T category in the TNM system. It records how the codes for the two items "CS Tumor Size" and "CS Extension" were determined, based on the diagnostic methods employed. See ***CSv2 Coding Instructions Part I, Section 1: General Instructions*** and site-specific schemas for detailed codes and coding instructions.

CS Lymph Nodes

This field identifies the regional lymph nodes involved with cancer at the time of diagnosis. Criteria for involvement are site-specific and may include the location, laterality, size and/or number of involved regional lymph nodes. In general, involved distant lymph nodes are coded in CS Mets at Dx. See ***CSv2 Coding Instructions Part I, Section 1: General Instructions*** and site-specific schemas for detailed codes and coding instructions.

CS Regional Nodes Evaluation (CS Lymph Nodes Eval)

This field is used primarily to derive the staging basis for the N category in the TNM system. It records how the code for the item "CS Lymph Nodes" was determined, based on the diagnostic methods employed and their intent. See ***CSv2 Coding Instructions Part I, Section 1: General Instructions*** and site-specific schemas for detailed codes and coding instructions.

CS Mets at Diagnosis

This field identifies the distant site(s) of metastatic involvement at time of diagnosis. See ***CSv2 Coding Instructions Part I, Section 1: General Instructions*** and site-specific schemas for detailed codes and coding instructions.

CS Mets at DX - Bone

CS Mets at Dx - Brain

CS Mets at Dx - Liver

CS Mets at Dx - Lung

These data items identify the presence of distant metastatic involvement at the time of diagnosis. The presence of specific metastatic site disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Stage to derive AJCC M codes and SEER Summary Stage codes for some sites.

Instructions for Coding

- See the current *CS Manual* for coding instructions

CS Mets Evaluation

This field is used primarily to derive the staging basis for the M category in the TNM system. It records how the code for the item "CS Mets at Dx" was determined based on the diagnostic methods employed. See ***CSv2 Coding Instructions Part I, Section 1: General Instructions*** and site-specific schemas for detailed codes and coding instructions.

CS Version Original (Formerly CS Version Input Original)

This item indicates the number of the version initially used to code Collaborative Stage (CS) fields. The CS version number is returned as part of the output of the CS algorithm. Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items. This item is auto-coded by the software provider.

Codes
CS Version Input Original is a 6-digit code. The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results (e.g.,010100).

CS Version Derived (Formerly CS Version Latest)

This data item is recorded the first time the CS output fields are derived and should be updated each time the CS Derived items are recomputed. The CS version number is returned as part of the output of the CS algorithm. The CS algorithm may be re-applied to compute the CS Derived items; for example, when the data are to be used for a special study, transmitted, or when an updated CS algorithm is produced. This item identifies the specific algorithm used to obtain the CS Derived values in the data record. This item is auto-coded by the software provider.

Codes
CS Version Derived is a 6-digit code. The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results (e.g., 010100).

CS Version Input Current (Formerly CS Version 1st)

This item indicates the version of CS input fields after they have been updated or recoded. This data item is recorded the first time the CS input fields are entered and should be updated each time the CS input fields are modified. Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items. This item is auto-coded by the software provider.

Codes
CS Version Input Current is a 6-digit code. The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results (e.g., 010100).

Regional Nodes Positive

Record the exact number of regional lymph nodes examined by the pathologist and found to contain metastases. **Note: distant lymph nodes are coded in the "CS Mets at Dx" field**

Regional Lymph Node Positive Codes

Code	Description
00	All nodes examined are negative
01 – 89	1 to 89 nodes are positive (Code exact number of nodes positive)
90	90 or more nodes are positive
95	Positive aspiration or core biopsy of lymph node(s) was performed. *See Rule 6 in CS General Instructions*
97	Positive nodes are documented, but the number is unspecified. *See Rule 7 in CS General Instructions*
98	No nodes were examined. *See Rule 8 in CS General Instructions*
99	It is unknown whether nodes are positive; not applicable; not stated in patient record

Regional Nodes Examined

Record the total number of regional lymph nodes that were removed and examined by the pathologist. Refer to ***CSv2 Coding Instructions Part I, Section 1: General Instructions*** for complete directions.

Regional Lymph Nodes Examined Codes

Code	Description
00	No nodes were examined
01 – 89	1 to 89 nodes were examined (Code the exact number of regional lymph nodes examined)
90	90 or more nodes were examined
95	No regional nodes were removed, but aspiration or core biopsy of regional nodes was performed. *See Rule 5 in CS General Instructions*
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated. *See Rule 7 in CS General Instructions*
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated. *See Rule 8 in CS General Instructions*
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown. *See Rule 4e in CS General Instructions*
99	It is unknown whether nodes were examined; not applicable or negative; not stated in patient record

CS Site-Specific Factors

Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival. See Collaborative Stage Manual and Coding Instructions for more information. Refer to MCR Required Data Elements List (http://mcr.umh.edu/mcr-cancer-reporting-hospital.html) for the particular primary sites and factors that are to be sent to MCR. Note that since 2011 there is an additional tab on the spreadsheet that lists factors which are required "as available".

General Summary Stage at Diagnosis

For cases diagnosed prior to January 1, 2004 only, General Summary Stage is to be entered in the individual Summary Stage fields (i.e., Summary Stage 2000, Summary Stage 1977). See Appendix A of this manual. **For cases diagnosed after this date, these fields are to be left blank. If you have internal needs to collect this field, your software vendor must assure that it is not sent to MCR.** For cases diagnosed on or after January 1, 2004, Collaborative Stage fields are to be completed. Some software may auto-calculate a separate derived summary stage field from Collaborative Stage entries.

AJCC Stage

AJCC staging is not required to be reported to MCR but may be included at the discretion of the reporting facility. Please refer to FORDS 2011 for complete instructions for coding AJCC coding items.

Surgical Diagnostic and Staging Procedure (RX Summ-DX/Stg Proc)

Identifies the positive surgical procedure(s) performed in an effort to diagnose and/or stage disease. 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 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* 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* 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*. See instructions for *Scope of Regional Lymph Node Surgery*
- Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation*. 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* to code these procedures

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

- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure* to code these procedures

Date of Surgical, Diagnostic and Staging Procedure (Rx Date—Dx/Stg/Proc)

This data item records the date on which the surgical diagnostic and/or staging procedure was performed and 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* was performed at this or any facility
- Record the date as completely as possible. Leave any unknown portions of the date blank
- **Example:** The patient came to your facility for chemotherapy in March of 2010 after having had exploratory lap with biopsy in February of 2010, exact day unknown. CCYY = 2010, MM = 02, DD = blank
- If information for this item is entirely unknown or not applicable, leave the field blank and complete the *Rx Date—Dx/Stg Proc Flag* field

Rx Date – Dx/Stg Proc Flag

This flag explains why there is no appropriate value in the corresponding date field, *Date of Surgical Diagnostic and Staging Procedure*. Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any diagnostic or staging procedure performed)
11	No proper value is applicable in this context (for example, no diagnostic or staging procedure performed; autopsy only case)
12	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)
(blank)	A valid date value is provided in item *Date of Surgical Diagnostic and Staging Procedure*. Case was diagnosed prior to January 1, 2007

Chapter 9

TUMOR-DIRECTED TREATMENT

Record all cancer-directed therapy information available whether administered at the reporting hospital or at another facility. If the patient receives part of the first course of therapy at the reporting hospital and is transferred to another facility to continue treatment, also record the treatment given at the other hospital, if it is known. Documenting all treatments in the given Rx Summ fields provides a complete "picture" of the patient's cancer experience and is meaningful in calculating survival statistics and assessing treatment success. Subsequent courses of treatment should be mentioned in text fields.

Date of 1st Course of Treatment (Date of 1st Crs Rx-CoC)

Record the earliest date on which treatment for the reported cancer began, including active surveillance only, or the date the decision was made not to treat (watchful waiting or refusal by patient).

Instructions for Coding

- Record the date as completely as possible. Leave any unknown portions of the date blank
  Example: The patient came to your facility for chemotherapy in March of 2010 after having had surgery in February of 2010, exact day unknown. CCYY = 2010, MM = 02, DD = blank
- Leave this item blank if the cancer was diagnosed at autopsy and not suspected prior to that
- If the patient expired before planned treatment could begin, enter the date of death

Date of 1st Course RX Flag

This flag explains why there is no appropriate value in the corresponding date field, *Date of First Course of Treatment*. 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* has a full or partial date recorded
- Code 12 if the *Date of First Course of Treatment* can not be determined, but the patient did receive first course treatment

- 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

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any treatment was given)
11	No proper value is applicable in this context (for example, autopsy only)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, treatment was given but date is unknown)
(blank)	A valid date value is provided in item

First Course Calc Method

This data item designates whether the time interval for defining the *First Course of Treatment* is entered according to CoC coding rules or whether SEER definitions are used. MCR requires facilities to follow CoC definitions when reporting *First Course of Treatment*.

- Enter 1 for First Course Calc Method
- Many software products allow facilities to set 1 as a default value for this field

Rx Summ – Treatment Status

This data item summarizes whether the patient received any treatment, including watchful waiting. This item was added to document active surveillance and eliminate searching each treatment modality in order to determine whether any treatment was given. It is used in conjunction with *Date of First Course of Treatment* to document whether treatment was or was not given, whether it is unknown if treatment was given, or whether 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, including co-morbidities

Code	Definition
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment was given

Examples:

Code	Reason
0	An elderly patient with pancreatic cancer requested no treatment
0	Patient is expected to receive radiation, but it has not occurred yet (*Reason for No Radiation* [NAACCR Item #1430] = 8)
2	Treatment plan for a lymphoma patient is active surveillance

Surgery of Primary Site (RX Summ—Surg Prim Site)

This data item records the surgical procedure(s) performed to the primary site and can be used to compare the efficacy of treatment options.

Instructions for Coding

- Site-specific codes for this data item are found in *FORDS 2011 Appendix B*, and they are posted on the MCR web site at http://mcr.umh.edu/mcr-absresources.php
- The pathology and operative reports may conflict concerning excised tissue; use all available information to accurately determine what tissue was removed. It may be necessary to contact the surgeon and/or pathologist for a final determination
- If registry software allows multiple procedures to be recorded, this item refers to the most invasive surgical procedure of the primary site
- For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is not available
- Surgery for extra-nodal lymphoma sites should be coded using the coding scheme for that site. For example, a lymphoma of the stomach is coded using the surgery codes for stomach, not lymph nodes
- Excisional biopsies (those that remove the entire tumor and/or leave only microscopic margins) are to be coded in this item
- 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 *FORDS Appendix B*
- Code 00 if no primary site surgical procedure was performed, except when code 98 takes precedence
- 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. Do not rely on registry software to perform this task for you

- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care*
- Code 98 for unknown or ill-defined primary (site = C76.0 – C76.8, C80.9), hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease (C42.0 - C42.4) (except for M9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)
- Code 98 in this field for all unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment. Surgical procedures done for unknown and ill-defined primaries are to be recorded using the data item *Surgical Procedure/Other Site* and entering "1"

Surgical Procedure of Primary Site—General Codes

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

Date of First Surgical Procedure (Rx Date-Surgery)

This data item records the earliest date on which any first course surgical procedure was performed and 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, Scope of Regional Lymph Node Surgery or Surgical Procedure/Other Site performed for this cancer
- If a biopsy of the primary site (including core needle biopsy) is the initial surgical procedure and leaves only microscopic residual tumor, code the date of the biopsy in this field

Example:
An excisional biopsy of a right forearm lesion done on 4/15/10 showed a Clark II melanoma extending to the deep margin. Re-excision on 4/22/10 did not show any residual tumor. Code the *Date of First Surgical Procedure* as 4/15/10

Rx Date – Surgery Flag

This flag explains why there is no appropriate value in the corresponding date field, *Date of First SurgicalProcedure*. Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Rx Date-Surgery Flag codes

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed)
11	No proper value is applicable in this context (for example, no surgery performed)
12	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)
(blank)	A valid date value is provided in item

Reason for No Surgery of Primary Site (Reason for No Surgery)

This field records the reason that no surgery was performed on the primary site. 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* is coded 00, then record the reason based on documentation in the patient record

- Code 1 if the treatment plan offered multiple 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* 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 can 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 treatment, if any was provided

Reason No Surgery Codes

Code	Definition
0	Surgery of the primary site was performed
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned surgery etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in patient record
7	Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended
9	It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only

Examples:

Code	Reason
2	A patient with a primary tumor of the liver is not recommended for surgery due to advanced cirrhosis
8	A patient is referred to another facility for recommended surgical resection of a gastric carcinoma, but further information from the facility to which the patient was referred is not available

Surgical Margins of the Primary Site (RX Summ – Surgical Margins)

This data item records the final status of the surgical margins after resection of the primary tumor. It serves as a quality measure for pathology reports, is used for staging, and may be a prognostic factor in recurrence.

Instructions for Coding

- Record the margin status as it appears in the pathology report
- Codes 0–3 are hierarchical; if two codes describe the margin status, use the numerically higher code
- Code 7 if the pathology report indicates the margins could not be determined. If no surgery of the primary site was performed, code 8
- Code 9 if the pathology report makes no mention of margins
- For 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), code 9
- For an 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), code 9

Code	Label	Definition
0	No residual tumor	All margins are grossly and microscopically negative
1	Residual tumor, NOS	Involvement is indicated, but not otherwise specified
2	Microscopic residual tumor	Cannot be seen by the naked eye
3	Macroscopic residual tumor	Gross tumor of the primary site which is visible to the naked eye
7	Margins not evaluable	Cannot be assessed (indeterminate)
8	No primary site surgery	No surgical procedure of the primary site. Diagnosed at autopsy
9	Unknown or not applicable	It is unknown whether a surgical procedure to the primary site was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease

Example:

Code	Reason
3	**C18-Colon** The pathology report from a colon resection describes the proximal margin as grossly involved with tumor (code 3) and the distal margin as microscopically involved (code 2). Code macroscopic involvement (code 3)

Systemic/Surgery Sequence (RX Summ-System/Sur Seq)

Record the sequence of systemic therapy (Chemotherapy, Hormone, BRM and Transplant/Endocrine) and surgical procedures given as part of the first course of treatment. Use the following codes in addition to valid dates.

Code	Definition
0	No systemic therapy and/or surgical procedures
2	Systemic therapy before surgery
3	Systemic therapy after surgery
4	Systemic therapy both before and after surgery (at least 1 course before and at least one after surgery)
5	Intraoperative systemic therapy
6	Intraoperative systemic therapy with other therapy administered before and/or after surgery
7	Systemic therapy both before and after surgery (administered between two separate surgical procedures)
9	Sequence unknown (both systemic therapy and surgery treatment given)

Note: 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.

Scope of Regional Lymph Node Surgery (Rx Summ—Scope Reg LN Surg)

This field 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. 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* and/or *Date of First Surgical Procedure* as appropriate
- Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher and records the cumulative effect of all procedures
- For intracranial and central nervous system primaries (C70.0–C70.9, C71.0–C71.9, C72.0–C72.9, C75.1–C75.3), code 9
- For 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), code 9

- For an 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), code 9
- 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*
- Refer to the current *AJCC Cancer Staging Manual* or Collaborative Stage Schema Instructions for site-specific identification of regional lymph nodes
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care*

Code	MCR status*
0	None
1	Biopsy or aspiration of regional lymph node, NOS
2	Sentinel lymph node biopsy
3	Number of regional nodes removed unknown or not stated; regional lymph nodes removed, NOS
4	1–3 regional lymph nodes removed
5	4 or more regional lymph nodes removed
6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

For specific definitions and examples, see FORDS 2012 pages 206-208

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.*

Examples

Code	Reason
0	There was an attempt at regional lymph node dissection or sentinel lymph node dissection, but no lymph nodes were found in the pathological specimen
1	**(C14.0-Pharynx)** Aspiration of regional lymph node to confirm histology of widely metastatic disease
2	**(C44.5-Skin of Back)** Patient has melanoma of the back. A sentinel lymph node dissection was done with the removal of one lymph node. This node was negative for disease
3	**(C61.9-Prostate**) Bilateral pelvic lymph node dissection for prostate cancer
6	**(C50.3-Breast)** Sentinel lymph node biopsy of right axilla, followed by right axillary lymph node dissection during the same surgical event
9	**(C34.9-Lung)** Patient was admitted for radiation therapy following surgery for lung cancer. There is no documentation on the extent of surgery in patient record

Surgical Procedure/Other Site (RX Summ – Surg Oth Reg/Dis)

Records the surgical removal of *distant lymph nodes* or other tissue(s) or organ(s) removed beyond the primary site. The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Instructions for Coding

- 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* 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 other tissue or organs beyond the primary site surgical code, including the cumulative effect if there are multiple such surgeries
- Assign the highest numbered code that describes the surgical resection of *distant lymph node(s).*
- Incidental removal of tissue or organs is not a "Surgical Procedure/Other Site"
- Code the removal of non-primary tissue removed because the surgeon considered it suspicious even if the pathology is negative
- *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)
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care*

Code	Label	Definition
0	None	No surgical procedure of nonprimary site was performed. Diagnosed at autopsy
1	Nonprimary surgical procedure performed	Nonprimary surgical resection to other site(s), unknown whether the site(s) is regional or distant
2	Nonprimary surgical procedure to other regional sites	Resection of regional site
3	Nonprimary surgical procedure to *distant lymph node(s)*	Resection of *distant lymph node(s)*
4	Nonprimary surgical procedure to distant site	Resection of distant site
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4
9	Unknown	It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only

Date Radiation Started (RX Date - Radiation)

This field records the date on which radiation therapy began at any facility that is part of the first course of treatment. 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*
- The date when treatment started will typically be found in the radiation oncologist's summary letter for the first course of treatment
- Record the date as completely as possible. Leave any unknown portions of the date blank.

  Example: The patient came to your facility for chemotherapy in March of 2010 after having had surgery in February of 2010, exact day unknown. CCYY = 2010, MM = 02 DD = blank

Rx Date – Radiation Flag

This flag explains why there is no appropriate value in the corresponding date field, *Date Radiation Started*. Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Codes for Radiation Flag

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any radiation was given)
11	No proper value is applicable in this context (for example, no radiation given)
12	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)
15	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)
(blank)	A valid date value is provided in item *Date Radiation Started*

Regional Treatment Modality (Rad - Regional RX Modality)

Records the dominant modality of radiation therapy used to deliver the most clinically significant regional dose to the primary volume of interest during the first course of treatment. Radiation treatment is frequently delivered in two or more phases which can be summarized as "regional" and "boost" treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

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 regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding
- In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality
- Note that in some circumstances the boost treatment may precede the regional treatment
- For purposes of this data item, photons and x-rays are equivalent
- Code IMRT or conformal 3D whenever either is explicitly mentioned
- Code radioembolization as brachytherapy

Codes found on following two pages

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV)
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt- 60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51
23	Photons (2–5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2–5 MV
24	Photons (6–10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6–10 MV
25	Photons (11–19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11–19 MV
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment
28	Electrons	Treatment delivered by electron beam
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record
40	Protons	Treatment delivered using proton therapy
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, radioembolization, or intracavitary applicators of radioactive materials not otherwise specified
51	Brachytherapy, Intracavitary, LDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator)
52	Brachytherapy, Intracavitary, HDR	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases
62	Strontium-90	

Table continued on next page

Code	Label	Definition
80	Combination modality, specified	Combination of external beam radiation and either radioactive implants or radioisotopes (converted pre-2003 dx only)
85	Combination modality, NOS	Combination of radiation treatment modalities not specified in code 80 (converted pre-2003 dx only)
98	Other, NOS	Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown
99	Unknown	It is unknown whether radiation therapy was administered

Reason for No Radiation

This data item records the reason that no regional radiation therapy was administered to the patient. 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 *Regional Treatment Modality* is coded 00, then record the reason based on documentation in patient record
- Code 1 if the treatment plan offered multiple 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 can 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 options, but it is unknown which treatment, if any, was provided

Code	Definition
0	Radiation therapy was administered
1	Radiation therapy was not administered because it was not part of the planned first course treatment
2	Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation, etc.)
5	Radiation therapy was not administered because the patient died prior to planned or recommended therapy
6	Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record
7	Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record
8	Radiation therapy was recommended, but it is unknown whether it was administered
9	It is unknown if radiation therapy was recommended or administered. Death certificate and autopsy cases only

Example

Code	Reason
1	A patient with Stage I prostate cancer is offered either surgery or brachytherapy to treat his disease. The patient elects to be surgically treated

Radiation/Surgery Sequence (Rx Summ—Surg/Rad Sequence)

This data item records the sequencing of radiation and surgical procedures given as part of the first course of treatment. The sequence of radiation and surgical procedures cannot always be determined using the date on which each modality was started or performed, so this field can be used to more precisely evaluate the timing of treatment delivery by modality.

Instructions for Coding

- Surgical procedures include *Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, Surgical Procedure/Other Site*. 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

Code	Label	Definition
0	No radiation therapy and/or surgical procedures	No radiation therapy given or unknown if radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s) or it is unknown whether any surgery given
2	Radiation therapy before surgery	Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s)
3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s)
4	Radiation therapy both before and after surgery	At least two courses of radiation therapy are given; at least one before, and at least one 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)
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s)
6	Intraoperative radiation therapy with other radiation administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site (s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s)

(table continued on next page)

(Codes for Radiation/Surgery Sequence continued from previous page)

Code	Label	Definition
7	Surgery both before and after radiation	Radiation was administered between two separate surgical procedures to the primary site; regional lymph nodes, surgery to other regional site(s), distant site(s) or distant lymph node(s)
9	Sequence unknown	Administration of radiation therapy and surgery to primary site, scope of regional lymph node surgery, surgery to other regional site (s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record

Chemotherapy (Rx Summ—Chemo)

This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis. Systemic therapy may involve the administration of one or a combination of agents. If chemotherapy was not administered, then this item also records the reason it was not given. When evaluating the quality of care, it is useful to know whether chemotherapy was given and, if not, the reason it was not.

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 options, and the patient selected treatment that did not include chemotherapy
- 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 to a medical oncologist. The registry can follow-up to determine whether it was given. If follow-up with the specified specialist or facility indicates the patient was never there, code 00
- 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 the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group 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/tools/seerrx/) for a

list of chemotherapeutic agents and groups

- If chemotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy administered in the item Palliative Care

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 in patient record
02	Single-agent chemotherapy administered as first course therapy
03	Multi-agent chemotherapy administered as first course therapy
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, 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 the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record
88	Chemotherapy was recommended, but it is unknown if it was administered
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only

Examples

Code	Reason
01	A patient with primary liver cancer is known to have received chemotherapy; however, the name(s) of agent(s) administered is not stated in patient record
02	A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the administration of fluorouracil as single agent chemotherapy, and levamisole as an immunotherapeutic agent
02	A patient with non-Hodgkin lymphoma is treated with fludarabine
03	A patient with early stage breast cancer receives chemotherapy. The patient chart indicates that a regimen containing doxorubicin is to be administered
86	After surgical resection of an ovarian mass the following physician recommends chemotherapy. The patient record states that chemotherapy was not subsequently administered to the patient, but the reason why chemotherapy was not administered is not given

Date Chemotherapy Started (Rx Date—Chemo)

This field records the date of initiation of chemotherapy that is part of the first course of treatment. 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*
- Record the date as completely as possible. Leave any unknown portions of the date blank

  Example: The patient came to your facility for surgery in March of 2010 after having had chemotherapy in February of 2010, exact day unknown. CCYY = 2010, MM = 02, DD = blank

Rx Date – Chemo Flag

This flag explains why there is no appropriate value in the corresponding date field, *Date Chemotherapy Started*. Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any chemotherapy was given)
11	No proper value is applicable in this context (for example, no chemotherapy given)
12	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)
15	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)

Hormone (Hormone/Steroid) Therapy (Rx Summ-Hormone)

This data item records the type of hormone therapy administered as first course treatment, or the reason it was not given. 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. When evaluating quality of care, this data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy. In addition, it is sometimes useful to know the reason 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 options, and the patient selected treatment that did not include hormone therapy
- 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. The registry can follow the case for hormone therapy. If follow-up with the specified specialist or facility indicates the patient was never there, code 00
- 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/tools/seerrx/) for a list of hormonal agents
- If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy administered in the item *Palliative Care*

Code	Definition
00	None. Hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy
01	Hormone therapy administered as first course therapy
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.)
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record
88	Hormone therapy was recommended, but it is unknown if it was administered
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only

Examples

Code	Reason
00	A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormonal therapy
00	A patient with breast cancer may be treated with aminoglutethimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. This patient must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (Florinef)
00	A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy in this example
01	A patient with metastatic prostate cancer is administered flutamide (an antiestrogen)
87	A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) and the refusal is noted in the patient record

Date Hormone Therapy Started (RX Date -Hormone)

This field records the date of initiation of hormone therapy that is part of the first course of treatment. 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*
- Record the date as completely as possible. Leave any unknown portions of the date blank

  Example: The patient came to your facility for prostatectomy in May of 2010 after having begun Lupron in February of 2010, exact day unknown. CCYY = 2010, MM= 02, DD = blank

Rx Date – Hormone Flag

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

Coding Instructions

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any hormone therapy was given)
11	No proper value is applicable in this context (for example, no hormone therapy given)
12	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)
15	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)

Immunotherapy (BRM) (Rx Summ—BRM)

Records the type of immunotherapy administered as first course treatment, or the reason it was not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells. This data item allows for the evaluation 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 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 options, and the patient selected treatment that did not include immunotherapy
- If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered
- Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended
- Code 88 if it is known that a physician recommended immunotherapy but no further documentation is available yet to confirm its administration
- Code 88 to indicate a referral was made to a medical oncologist about immunotherapy. The registry can 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
- 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

- Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/tools/seerrx/) for a list of immunotherapeutic agents
- If immunotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy administered in the item *Palliative Care*

Code	Definition
00	None, immunotherapy was not part of the planned first course of therapy. Diagnosed at autopsy
01	Immunotherapy administered as first course therapy
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age, progression of tumor prior to administration, etc.)
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record
88	Immunotherapy was recommended, but it is unknown if it was administered
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only

Examples

Code	Reason
01	A patient with malignant melanoma is treated with interferon
85	Before recommended immunotherapy could be administered, the patient died from cancer

Date Immunotherapy Started (Rx Date—BRM)

This field records the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of treatment. 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
- Record the date as completely as possible. Leave any unknown portions of the date blank

Example: The patient came to your facility for cystectomy in May of 2010 after having undergone a series of BCG treatments beginning in March of 2010, exact day unknown. CCYY = 2010, MM = 03 DD = blank

RX Date – BRM Flag

This flag explains why there is no appropriate value in the corresponding date field, *Date Immunotherapy Started*. Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any immunotherapy was given)
11	No proper value is applicable in this context (for example, no immunotherapy given)
12	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)
15	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)

Hematologic Transplant and Endocrine Procedures (Rx Summ—TransplInt/Endocr)

This data item identifies systemic therapeutic *procedures* administered as part of the first course of treatment, or the reason none of the procedures was performed. Procedures coded in this field include bone marrow transplants, stem cell harvests, and endocrine surgery and/or radiation. Evaluation of this data item allows analysis of patterns of care involving alteration of the immune system or changes to the patient's tumor response that does not involve administration of antineoplastic agents. In addition, when evaluating quality of care, it is useful to know the reason these *procedures* were not performed.

Instructions for Coding

- Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow 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 qualifies 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 treatment plan offered multiple options, and the patient selected treatment that did not include a transplant or endocrine procedure
- 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. The registry can 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
- Code 99 if it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered
- If the hematologic transplant or endocrine procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hematologic transplant or endocrine procedure provided in the items *Palliative Care*, as appropriate

Code	Definition
00	No transplant procedure or endocrine therapy was administered as part of first course therapy. Diagnosed at autopsy
10	A bone marrow transplant procedure was administered, but the type was not specified
11	Bone marrow transplant–autologous
12	Bone marrow transplant–allogeneic
20	Stem cell harvest and infusion. Umbilical cord stem cell transplant
30	Endocrine surgery and/or endocrine radiation therapy
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20)
82	Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age, progression of disease prior to administration, etc)
85	Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record
87	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record
88	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record. Death certificate only

Other Treatment (Rx Summ—Other)

This field identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. 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. 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 Manual and database for instructions to code other treatments for a specific disease.
- Code 1 for embolization using alcohol as an embolizing agent and for embolization to a site other than the liver where the embolizing agent is unknown. Do not code presurgical embolization that is given only to shrink the tumor.
- Code 1 for PUVA (psoralen and long-wave ultraviolet radiation.)
- A complete description of the treatment plan should be recorded in the text field for "Other Treatment" on the abstract.
- If other treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item *Palliative Care*.
- 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. The registry can follow. If follow-up with the specialist or facility determines the patient was never there, code 0.

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

Date Other Treatment Started (Rx Date—Other)

Records the start dates for other treatments which cannot be coded as surgery, radiation, or systemic therapy according to the defined data items in this manual. 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* 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*
- Record the date as completely as possible. Leave any unknown portions of the date blank

  Example: The patient came to your facility for nephrectomy in March of 2010 after having undergone a renal embolization at an outside facility in late February, exact day unknown. CCYY = 2010, MM = 02, DD = blank

Rx Date—Other Flag

This flag explains why there is no appropriate value in the corresponding date field, *Date Other Treatment Started*. Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any Other Treatment was given)
11	No proper value is applicable in this context (for example, no Other Treatment given)
12	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)
(blank)	A valid date value is provided in item *Date Other Treatment Started*

Palliative Procedure (Rx Summ—Palliative Proc)

The purpose of this data item is to identify any care provided in an effort to palliate or alleviate symptoms. Palliative care is performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or other pain management therapy. This data item allows reporting facilities to track care that is considered palliative rather than diagnostic or curative in intent.

Instructions for Coding

- Record the type of palliative care provided
- Surgical procedures, radiation therapy, or systemic therapy provided to prolong the patient's life by controlling symptoms, to alleviate pain, or to make the patient comfortable should be coded palliative care and as first course therapy if that procedure removes or modifies either primary or metastatic malignant tissue
- Palliative care is not used to diagnose or stage the primary tumor
- Do not code routine pain management following surgery or other treatment; do code first course pain management for persistent pain

Code	Definition
0	No palliative care provided. Diagnosed at autopsy
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made
4	Patient received or was referred for pain management therapy with no other palliative care
5	Any combination of codes 1, 2, and/or 3 without code 4
6	Any combination of codes 1, 2, and/or 3 with code 4
7	Palliative care was performed or referred, but no information on the type of procedure is available in the patient record. Palliative care was provided that does not fit the descriptions for codes 1–6
9	It is unknown if palliative care was performed or referred; not stated in patient record

Chapter 10

OUTCOME INFORMATION

Date of Last Contact or Death (Date of Last Contact)

This field records the date of last contact with the patient or the date of death. This information is used for patient follow-up and outcome studies.

Instructions for Coding

- Record the last date on which the patient was known to be alive or the date of death
- If a patient has multiple primaries, all records should have the same date of last contact
- Record the date as completely as possible. Leave any unknown portions of the date blank
  Example: It is known that the patient was last seen in February of 2010, but the exact day is unknown. CCYY = 2010, MM = 02, DD = blank. If the date is completely unknown, leave this field blank and use the *Date of Last Contact Flag* to code the reason

Date of Last Contact Flag

This data item explains why there is no appropriate value in the corresponding date field, *Date of Last Contact or Death*.

Instructions for Coding

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

Code	Definition
12	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)
(blank)	A valid date value is provided in item *Date of Last Contact or Death*

Vital Status

Record the patient's vital status at the date of the last contact.

If a patient has multiple primaries, all records should have the same vital status code.

0 - Dead
1 - Alive

Cancer Status

Records the presence or absence of clinical evidence of the reported primary at the date the patient was last known to be alive, or at the date of death.

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

Code	Label
1	No evidence of this cancer
2	Evidence of this cancer
9	Unknown, indeterminate whether this cancer is present; not stated in patient record

Example

Code	Reason
1	Patient with hematopoietic disease who is in remission
1	A patient is seen by the physician on February 2, 2009 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, 2009. The *Date of Last Contact or Death* is updated, but the cancer status is not
2	A patient with prostate cancer is diagnosed with bone metastasis in April 2010. The registrar finds an obituary documenting the patient's death in a nursing home in June 2010

Underlying Cause of Death (Cause of Death)

Underlying cause of death may be found on the death certificate or in the medical record. If the *Date of Last Contact/Death* is on or after **1/1/2000**, the Cause of Death must be coded in the abstract using the ICD-10-CM. If the death certificate/death information is not available or the field is not applicable use the following codes:

0000 - Patient alive at last contact

7777 - State death certificate or listing not available

7797 - State death certificate or listing available, underlying cause of death not coded

Note: Death certificates from the Missouri Bureau of Vital Statistics are coded using ICD-10-CM. A complete listing of ICD-10-CM codes may also be found on the MCR web site at http://mcr..umh.edu/

ICD Revision Number

Enter the ICD-Edition that applies for the date of death:

Code	Definition
0	Patient alive at last contact
1	ICD-10 (date of death on or after 1/1/2000)
9	ICD-9 (date of death before 1/1/2000)

Place of Death

Code the appropriate three-digit SEER Geo code for the **state** or country (not county) of death. A listing is available at: http://seer.cancer.gov/tools/codingmanuals/.

997 Not applicable, patient alive

999 Place of death unknown

Follow-up Source

Use the code corresponding to the source from which your date of last contact was obtained, if available.