7th Edition

Abstract Code Manual

MISSOURI CANCER REGISTRY
University of Missouri – Columbia

2006

University of Missouri Health Care

Missouri Cancer Registry

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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 is the seventh edition of the manual. This revision incorporates changes in coding structures and requirements from the National Program of Cancer Registries (NPCR), the North American Association of Central Cancer Registries (NAACCR) and the Commission on Cancer (CoC) Facility Oncology Required Data Standards (FORDS).

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 is certified for 1998-2003.

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. Usage of the data is regulated by DHSS policies and requests for data are forwarded to and approved by DHSS.

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/ to select the appropriate person to contact.

MISSOURI CANCER REPORTING REQUIREMENTS

Role of Hospitals, 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, efforts were launched to transform MCR into a true population-based central registry. Missouri statutes mandating cancer reporting were revised 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 by 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 beginning on page 1. Data items are based on fields required and/or recommended by NPCR for central registries collecting incidence data. Additional fields are required for quality assurance and two Missouri-specific fields, Tobacco Years and Patient History of Cancer, are included as well.

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 which provide only the minimum data required by state law.

Role of Missouri Cancer Registry

The role of MCR 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. 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 circuit-riding hospitals. Information from these facilities is accepted in chart

form and MCR staff complete the abstracts. The information collected is invaluable in determining 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.

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 ensure all reporting entities that neither their identity nor the confidential data they submit will be released.

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, procedures for handling requests for data and policies for handling breaches of confidentiality.

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.

Audits

MCR periodically conducts casefinding and re-abstracting audits as required by 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. Casefinding and re-abstracting audits are performed for electronic and Abstract Plus hospitals; casefinding audits are conducted at circuit-riding facilities. After completion of the audits detailed summary reports are prepared and shared with the hospital registrar and other interested parties.

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) based on MCR guidelines. Another method is to

note the reason a case is non-reportable on the registrar's casefinding source. The listing or notations will help registrars avoid duplication of efforts related to casefinding and identification of non-reportable cases.

Re-abstraction – The re-abstracting audit consists of auditors re-abstracting specific MCR required fields, and comparing results to the original abstracted data submission. Discrepancies are discussed with the hospital registrar and MCR abstracting and coding guidelines are reinforced. Attempts are always made during the resolution process to determine if registrars had additional information not available to the auditors.

Chapter 1

GENERAL INSTRUCTIONS

Basic Reporting Rules for State Reporting

The following information provides some basic rules regarding cancer reporting to the state central cancer registry. Hospital-based registries are required by Missouri statute (192.650-192.657 RSMo, 1999) to abstract inpatient *and* outpatient cancer cases. Increasing numbers of patients are being diagnosed and treated in outpatient settings. Reporting of outpatients was effective with cases diagnosed on or after January 1, 2000.

Important Items to Remember

- *Benign brain and CNS cases are reportable if diagnosed on or after January 1, 2004.*
- Completed cases should be submitted to the MCR within six months of date of initial contact for that facility.
- All cancer cases diagnosed and/or treated for cancer in your facility after August 28, 1984, must be abstracted and reported to MCR
- Electronic reporting is required for all facilities with an annual caseload greater than 75 cases. MCR will provide free software (Abstract Plus) to facilities that have 76-150 cases annually.
- Date is an eight-digit item (MMDDYYYY). Use two digits for the day, i.e., 01, 02 and four digits to complete the year, i.e., 2000, 2001, etc.

  Example: January 15, 2004 would be entered as 01152004.
- Incomplete abstracts (i.e., abstracts with required fields not completed) will be returned to the hospital.
- The *Collaborative Staging Manual* must be used to stage cases diagnosed on or after January 1, 2004. The *SEER Summary Staging Manual - 2000* is to be used for cases diagnosed between January 1, 2001 and December 31, 2003. The *SEER Summary Staging Guide,* 1986 reprint, is to be used for cases diagnosed prior to January 1, 2001.

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 send a ***change of information form*** to MCR and change the primary site code and, if necessary, the stages.

Hint: Changing the primary site will require review of and possible changes to site-specific fields, e.g., surgery codes, staging, laterality, etc.

Note: Change of Information (COI) forms and a list of fields requiring a COI form can be found on the MCR website.

Paper Abstracts

MCR no longer accepts paper abstracts. If your facility accessions 76-150 cases annually, please contact us at 1-800-392-2829 to inquire about Abstract Plus.

Data Transmissions

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.** Transmittal forms may be found on the MCR web page at http://mcr.umh.edu/hosprep.html.

Annual caseload >500	**Monthly**
Annual caseload <500	**Monthly or quarterly**

Electronic data can be transmitted via diskette or HyperSend. Instructions for the use of HyperSend can be found on the MCR website. If your facility has other required methods of data transmission, please contact MCR staff.

Chapter 2

DETERMINING REPORTABILITY

Casefinding Techniques, Cases that Must be Reported and How to Determine if a Case Does Not Need to be Reported

Casefinding Techniques

Cases to be included in the registry may come 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 radiographically or clinically only, without tissue confirmation would be missed during casefinding unless additional resources are employed. It is essential to include review of the 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.

Cases That Must Be Reported

- Refer to the Disease Index Codes list beginning on page 5 when casefinding. Depending on how casefinding is conducted, not all ICD-9-CM codes will be used by all facilities.

- Cases with diagnosis codes as specified on the ICD-9-CM reportable list that meet the reportable criteria as established by MCR.

- 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).

- 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 Table below.

Topography Codes for Benign Brain Tumors

Codes	Description
C70.0 – C70.9	Meninges
C71.0 – C71.9	Brain
C72.0 – C72.5, C72.8, C72.9	Spinal Cord, Cranial Nerves, Other parts of Central Nervous System
C75.1 – C75.3	Other Endocrine Glands and Related Structures

- 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. *)
- Patients diagnosed with a malignancy at your facility or elsewhere and/or receiving all or part of the first course of cancer directed therapy at your facility (Class 0, 1 or 2 cases). **Recurrence or metastatic disease is not required to be reported after the initial abstract has been submitted by your facility.**
- Patients with a previously diagnosed malignancy and first course of therapy at another facility (Class 3 cases), seen at your facility for diagnosis and/or treatment of recurrent or metastatic disease. Record all available information regarding the original diagnosis and treatment.

  Patient was originally diagnosed with prostate cancer in 1997 at another facility and is admitted to your facility in 2003 with questionable chest x-ray. A biopsy shows metastatic adenocarcinoma consistent with prostate primary. **THIS CASE IS REPORTABLE**.

  Patient with a history of breast cancer diagnosed elsewhere 5 years ago is admitted for a broken hip. Patient was not diagnosed with a recurrence or treated for her breast cancer during this admission. **THIS CASE IS NOT REPORTABLE**.
- Patients diagnosed at a staff physician's office and receiving any or their entire first course of treatment in your facility.
- **Patients who die at your facility with active cancer**, that was neither diagnosed or treated at your facility **may also be reported** (but are not required) to assist with the Death Clearance process. Cases not reported at 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.

- Basal cell carcinomas and squamous cell cancers that originate in mucoepidermoid sites:

Sites	Codes
Lip	C00.0-C00.9
Anus	C21.0
Vulva	C51.0 - C51.9
Vagina	C52.9
Penis	C60.0 - C60.9
Scrotum	C63.2

Note: Epithelial malignancies, basal and squamous cell carcinomas of skin (C44. *) **are not reportable**.

- Malignant tumors of the skin such as adnexal carcinoma/ adenocarcinoma (8390/3-8420/3), adenocarcinoma, lymphoma, melanoma, sarcoma, and Merkel cell tumor **must be reported**. Any carcinoma arising in a hemorrhoid is reportable, since hemorrhoids arise in mucosa, not in the skin.

- 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.

The following codes may be used as an aid in casefinding:

Disease Index Codes for Casefinding

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
042	AIDS (review cases for AIDS-related malignancies)
140.0 - 208.9	Malignant neoplasms
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
225.0 – 225.4	Benign neoplasm of brain, cranial nerves, cerebral meninges, cerebral meningioma, spinal cord, cauda equine, spinal meninges, spinal meningioma
225.8	Benign neoplasm of other specified sites of nervous system
225.9	Benign neoplasm of nervous system, part unspecified
227.3 – 227.4	Benign neoplasm of pituitary, craniopharyngeal duct, craniobuccal pouch, hypophysis, rathke's pouch, sella turcica, pineal gland,pineal body

Disease Index Codes for Casefinding (continued)

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
230.0 - 234.9	Carcinoma in situ
235.0 - 238.9	Neoplasms of uncertain behavior
238.4	Polycythemia vera (9950/3)
238.5	Mast cell disease (9741/3)
238.6	Solitary plasmacytoma (9731/3) Extramedullary plasmacytoma (9734/3)
238.7	Chronic myeloproliferative disease (9960/3) Myelosclerosis with myeloid metaplasia (9961/3) Essential thrombocythemia (9962/3) Refractory cytopenia with multilineage dysplasia (9985/3) Myelodysplastic syndrome with 5q- syndrome (9986/3) Therapy-related myelodysplastic syndrome (9987/3) Refractory anemia with ringed sideroblasts (9982/3) Refractory anemia with excel blasts (9983/3) Refractory anemia with excess blasts in transformation (9984/3)
239.0 - 239.9	Neoplasms of unspecified behavior (includes neoplasm of uncertain behavior of pituitary gland, craniopharyngeal duct, pineal gland, brain, spinal cord, meninges, nos, cerebral, spinal, neurofibromatosis (unspecified, Type one and Type two von Recklinghausen's disease), other and unspecified parts of nervous system, cranial nerves.
273.2	Gamma heavy chain disease; Franklin's disease
273.3	Waldenstrom's macroglobulinemia
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)
285.22	Anemia in neoplastic disease
288.3	Hypereosinophilic syndrome (9964/3)
289.89	Acute myelofibrosis (9932/3)
V07.3	Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
V07.8	Other specified prophylactic measure
V10.0 - V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries, and/or subsequent treatment)
V58.0	Admission for radiotherapy
V58.1	Admission for chemotherapy, has been deleted and replaced by subcategory V58.1 Encounter for antineoplastic chemotherapy and immunotherapy, and expanded to include two new codes. (changed/added 1/26/2006)
V58.11	Encounter for antineoplastic chemotherapy (changed/added 1/26/2006)
V58.12	Encounter for immunotherapy for neoplastic condition (changed/added 1/26/2006)
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow-up
V67.2	Chemotherapy follow-up
V71.1	Observation for suspected malignant neoplasm
V76.0 - V76.9	Special screening for malignant neoplasm
62.2 – 62.4	Orchiectomies
92.20– 92.29	Radioisotopes (I-131) (changed/added 1/26/2006)
92.3-92.39	Stereotactic radiosurgery

Cases Not Required To Be Reported

- Skin cancers (site = C44. * and histology = 8000-8110) (As of January 1, 2001).
- Class of Case 6 or Class of Case 7 cases. (May be voluntarily reported)
- Patients who have a history of cancer but no diagnosis or treatment at your facility.
- Patients who receive transient care to avoid interruption of therapy started elsewhere.
- Patients seen only in consultation to confirm a diagnosis.
- Pathology cases that are consultative readings of slides submitted from outside facilities.
- Patients with **carcinoma insitu 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. of a non-CNS site.

  Exception: Beginning with cases diagnosed **on or after** January 1, 2004, benign intracranial, brain and central nervous system tumors are reportable.
- Patients admitted to a hospice unit or home health care service.

  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 Diagnostic Terms

A patient has a reportable malignancy when stated by a recognized medical practitioner. The medical record usually presents the diagnosis clearly, however, physicians sometimes use vague or ambiguous terms to describe a tumor when its behavior is uncertain. This may occur in the absence of a cytologic/histologic diagnosis, as well as when there is a cytologic/histologic diagnosis.

Reporting requirements depend on the term used. Some malignancies may be first diagnosed radiographically with ambiguous terms. **Reportable terms must always include a reference to malignancy, cancer, etc. (Exception: non-malignant primary intracranial and central nervous system tumors)**.

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: Barium enema (BE) reveals a suspicious sigmoid mass. Colonoscopy reveals a sigmoid mass, "*questionable* 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.

Exception: Do not report cytology suspicious for malignancy, unless confirmed by biopsy or the physician states that the case supports a malignant diagnosis.

Physicians may use other ambiguous terms related to staging. Some indicate tumor involvement or extension, while others are not considered to be involvement. Refer to the following lists to determine reportable versus nonreportable cases, or to the Collaborative Staging Manual for a listing of ambiguous terms.

List of ambiguous terms

Terms that constitute a diagnosis	
Apparent(ly)	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect (ed)
Consistent with	Suspicious (for)
Favors	Typical of
Malignant appearing	
Neoplasm* or Tumor (beginning with 2004 diagnoses and only for C70.0-C72.9, C75.1-C75.3)	
Terms that DO NOT constitute a diagnosis**	
Cannot be ruled out	Questionable
Equivocal	Rule out
Possible	Suggests
Potentially malignant	Worrisome

*additional terms for non-malignant primary intracranial and central nervous system tumors only ** unless additional information is available

Chapter 3

DETERMINING PRIMARY TUMORS

Adapted from FORDS

The primary site of the cancer is always coded. The primary site is the organ or place in the body where the cancer first originated. The cancer may spread or be active in several areas of the body other than the primary site, but the original site is always coded.

Enter the case into the database as a single or multiple primaries **as documented by the physician**. If physician documentation is unavailable, then use the following guidelines: primary site, laterality, morphology, and timing are each considered.

- Use the instructions under "Site Differences" to decide whether the tumor(s) is one site or multiple sites.
- Follow the instructions under "Morphology" to decide whether tumors (other than lymphomas or leukemias) represent a single histology or mixed/multiple histologies.
- Follow the instructions under "Timing" to decide if one or more primaries are involved**.**
- For lymphomas, leukemias and other hematopoietic malignancies, primary site and timing are not applicable for determining single or multiple primaries – histology becomes the determining factor. Refer to the table in FORDS Appendix A: Single versus Subsequent Primaries or the SEER Multiple Primaries table to distinguish if a specific histology is considered to be a single or subsequent primary. Both tables can be located through links on the MCR website under Abstracting Resources. **NOTE: This table is a reference. Physician comments take precedence over the table.**

Site Differences

Primary Site and *Laterality* are used together to determine whether two lesions are considered one or two tumors based on anatomic location. The ICD-0-2 and ICD-O-3 topography code has four characters: the letter C followed by three digits (e.g., C61.9). The fourth character represents a subcategory. In general, the first three characters represent an individual organ and the fourth character is a subsite or a portion of that organ. However, in some instances two or more three-character ICD-O-3 topography codes apply to a single organ. The rules for distinguishing single from multiple sites address (1) whether organs or subsites of organs

represent unique tumors, (2) whether a unique organ is represented by one three-character ICD-O-3 topography code or more, and (3) whether a paired site is involved.

Note: Site organs are represented by a single three-character ICD-O-3 code. A difference in the **third** character of the ICD-O-3 topography code designates a separate site for all primary sites other than those listed below.

Subsites That Represent Unique Primaries

A difference in the fourth or final character of the ICD-O-3 topography code designates a separate site for the following site groups **only**, with the exception of NOS (C_ _.9) if there is a specific four-digit site code within the same category.

- Colon (C18.0–C18.9) except polyps involving multiple segments (see "Colon and Rectum Polyps" following)
- Anus/anal canal (C21.0–C21.8)
- Pleura (visceral, parietal, NOS) (C38.4)
- Bone (C40.0–C41.9)
- Melanoma of the skin (C44.0–C44.9)
- Peripheral nerves/autonomic nervous system (C47.0–C47.9)
- Connective tissue (C49.0–C49.9)
- **Non-malignant** meninges (C70.0–C70.9 with Behavior Code /0 or /1)
- **Non-malignant** brain (C71.0–C71.8 with Behavior Code /0 or /1)
- **Non-malignant** spinal cord, cranial nerves, and other parts of central nervous system (C72.0–C72.8 with Behavior Code /0 or /1)

Colon and Rectum Polyps

- Simultaneous lesions and polyps in the same segment of the colon are a single primary. Polyps may be present in more than one segment of the colon. If the diagnosis reads "adenocarcinoma in multiple polyps," it is one primary, colon, NOS (18.9).
- Familial polyposis is a genetic disease characterized by polyps that increase in numbers and may cover the mucosal surface of the colon. The benign disease usually develops into adenocarcinoma in adenomatous polyposis coli or adenocarcinoma in multiple adenomatous polyps.
- Patients with the histologies "adenocarcinoma in adenomatous polyposis coli" (8220/3) and "adenocarcinoma in multiple adenomatous polyps" (8221/3) have a different disease process

than those patients with typical adenocarcinomas of the colon or colon polyps. If multiple segments of the colon, or the colon and rectosigmoid, or the colon, rectosigmoid and rectum are involved with adenocarcinoma in adenomatous polyposis coli or adenocarcinoma in multiple adenomatous polyps, it is a single primary. Code the primary site to colon, NOS (C18.9).

Note: Site organs may be represented by more than one three-character ICD-O-3 topography code.

The following groups of three-character ICD-O-3 topography codes refer to single organs. Lesions within any combination of each group are considered to be the same primary site.

- C01 Base of tongue; C02 Other and unspecified parts of tongue
- C05 Palate; C06 Other and unspecified parts of mouth
- C07 Parotid gland; C08 Other and unspecified major salivary glands
- C09 Tonsil; C10 Oropharynx
- C12 Pyriform sinus; C13 Hypopharynx
- C23 Gallbladder; C24 Other and unspecified parts of biliary tract
- C30 Nasal cavity and middle ear; C31 Accessory sinuses
- C33 Trachea; C34 Bronchus and lung
- C37 Thymus; C38.0 Heart; C38.1–3 Mediastinum; C38.8 Overlapping lesion of heart, mediastinum, and pleura
- C51 Vulva; C52 Vagina; C57.7 Other specified female genital organs; C57.8–9 Unspecified female genital organs
- C56 Ovary; C57.0 Fallopian tube; C57.1 Broad ligament; C57.2 Round ligament; C57.3 Parametrium; C57.4 Uterine adnexa
- C60 Penis; C63 Other and unspecified male genital organs
- C64 Kidney; C65 Renal pelvis; C66 Ureter; C68 Other and unspecified urinary organs
- C74 Adrenal gland; C75 Other endocrine glands and related structures

Paired Organ Sites

Paired organ sites are listed along with the coding instructions for Field #53 – *Laterality*.

- Each side of a paired organ is a **separate** site **unless** a physician determines one side is metastatic from the other.

  Exception: The following are always single primaries—

- Simultaneous bilateral involvement of the ovaries with a single histology
- Simultaneous bilateral retinoblastomas

Exception: Disregard laterality for determination of single or multiple primaries for **malignant** (behavior of /2 or /3) tumors of the meninges (C70._), brain (C71._) and spinal cord, cranial nerves, and other parts of central nervous system (C72._).

- Both sides of a paired organ may be simultaneously involved with tumors. If the tumors are of the same histology, the patient may have one or two primaries. Consult the managing physician or the registry advisor.
- If there are two primaries, complete two abstracts. Code each primary to the appropriate laterality and stage.
- If there is one primary, prepare one abstract and code laterality to the side of origin.
- If there is a single primary and the side of origin cannot be identified, prepare a single abstract and code laterality as 4 - bilateral involvement, side of origin unknown; stated to be a single primary.

Morphology

The ICD-O-3 morphology code has five digits (e.g., 8500/3). The **fifth digit** of the ICD-O-3 morphology code is the behavior code. The behavior code is not used to determine multiple primaries.

Exception: Two primary intracranial and central nervous system tumors (C70.0–C72.9, C75.1–C75.3) in which one is malignant (behavior of /2 or /3) and one is non-malignant (behavior of /0 or /1) are always separate primaries regardless of timing.

Histology Differences

The first four characters are sometimes referred to as the "histology code." Multiple terms may describe a single histology. Refer to the ICD-O-3 histology code to determine whether two or more lesions represent the same tumor histologically.

- If the first three digits of the ICD-O-3 histology codes are identical, then the histology is the **same**.
- Lesion(s) may have a single histology (the first three digits of the morphology code are the same) with invasive and in situ components. This is a **single histology**. Code the behavior of the invasive component.

- A single lesion is **one** primary even if the lesion crosses site boundaries.
- A single lesion with mixed histologic types is **one** primary.
- A difference in the first three digits of the ICD-O-3 histology code indicates a **different** histologic type.

  Exception: If one malignancy is stated to be carcinoma, NOS, adenocarcinoma, NOS, or sarcoma, NOS, and the second lesion is a more specific term, such as large cell carcinoma, mucinous adenocarcinoma, or spindle cell sarcoma, consider this to be a **single** histology.

  Exception: For lymphatic and hematopoietic disease, use Appendix A in *FORDS* or 'Definitions of Single and Subsequent Primaries for Hematologic Malignancies' which can be found on the MCR Website under Abstracting Resources to determine which histologies represent single or multiple primaries. **NOTE: The 'Definitions of Single and Subsequent Primaries for Hematologic Malignancies' is only a guide. A physician diagnosis supersedes the guide.**

  Exception: Consider the following as a **single** histology, even though the first three digits of the ICD-O-3 morphology codes differ. Code its histology according to the rules for mixed histologies.

  - Transitional cell or papillary carcinoma (8120–8131) of the bladder (C67.–)
  - Ductal (8500) and lobular (8520) adenocarcinoma of the breast (C50.–)

  Use the following for the determination of single or multiple primaries of nonmalignant (behavior /0 or /1) primary intracranial and central nervous system tumors (C70.0-C72.9, C75.1-C75.3).

  - Two histologies appearing in the same grouping in the following table are the **same**; code the more specific histology.
  - Histology in the table and histology not in the table that has the same first three digits are the **same**; code its histology according to the rules for mixed histologies.
  - Two histologies not appearing in the table but having the same first three digits are the **same**; code its histology according to the rules for mixed histologies.
  - Multiple lesions with the **same** histology occurring in different sites are **separate** primaries **unless** a physician says they are metastatic.
  - Multiple lesions with **different** histologies occurring in different sites are **separate** primaries **unless** a physician states otherwise.

Histologic Group	ICD-O-3 Code
Choroid plexus neoplasms	9390/0, 9390/1
Ependymomas	9383, 9394, 9444
Neuronal & neuronal-glial neoplasm	9384,9412, 9413, 9442, 9505, 9506
Neurofibroma	9540/0,9540/1,9541,9550,9560
Neurinomatosis	9560
Neurothekeoma	9562
Neuroma	9570
Perineurioma, NOS	9571

Timing

Lesions occurring within two months of each other are "simultaneous."

- If two malignancies of the same histology (following the rules under "Histology Differences") occur in the same site (following the rules under "Site Differences", including those for laterality for paired sites) simultaneously (i.e., within two months of each other), there is only one primary.

  Exception: Each occurrence of melanoma of the skin is a new or separate primary unless a physician states otherwise.

- Multiple lesions with different histologies in a single site are **separate** primaries, whether they occur simultaneously or at different times.

- If two malignancies of the same histology (following the rules under "Histology Differences") and in the same site (following the rules under "Site Differences," including rules for laterality for paired sites) are identified **more** than two months apart, then there are **two** primaries. Complete a separate report for each one.

- If the tumor was originally diagnosed as in situ and the recurrence code is 16, 17, 26, 27, 36, or 46, then the "recurrence" must be reported as a new case. (See TYPE OF FIRST RECURRENCE section).

  Exception: The following are recurrences of the original disease without time limits-

  Exception: Non-malignant (behavior = /0 or /1) primary intracranial and central nervous system tumors (C70.0–C72.9, C75.1–C75.3) within a single site (following the rules under "Site Differences", including rules for laterality for paired sites) having the same histology (following the rules under "Histology Differences").

  Exception: Bladder primaries with morphology codes 8120–8130.

  Exception: Invasive adenocarcinoma of the prostate, site code C61.9.

Exception: Kaposi sarcoma (9140) of any site.

Note: Consider Kaposi sarcoma as one primary site. Refer to "Primary Site" for coding rules.

Histology Coding Rules for a Single Tumor

- The rules are in hierarchical order. Rule 1 has the highest priority.
- Use the rules in priority order.
- Use the first rule that applies to the case. (Do not apply any additional rules.)

1. Code the histology if only one type is mentioned in the pathology report.
2. Code the **invasive histology** when both invasive and in situ tumor are present

   Example: Pathology report reads infiltrating ductal carcinoma and cribriform ductal carcinoma in situ. Code the invasive histology 8500/3.

   Exception: If the histology of the invasive component is an 'NOS' term (e.g., carcinoma, adenocarcinoma, melanoma, sarcoma), then code the histology of the specific term associated with the in situ component and an invasive behavior code.

3. Use a **mixed** histology code if one exists

   Examples of mixed codes: (This is not a complete list, these are examples only)

   8490 Mixed tumor, NOS

   9085 Mixed germ cell tumor

   8855 Mixed liposarcoma

   8990 Mixed mesenchymal sarcoma

   8951 Mixed mesodermal tumor

   8950 Mixed Mullerian tumor

   9362 Mixed pineal tumor

   8940 Mixed salivary gland tumor, NOS

   9081 Teratocarcinoma, mixed embryonal carcinoma and teratoma

4. Use a **combination** histology code if one exists

   Examples of combination codes: (This is not a complete list; these are examples only)

   8255 Renal cell carcinoma, mixed clear cell and chromophobe types

8523 Infiltrating duct carcinoma mixed with other types of carcinoma

8524 Infiltrating lobular carcinoma mixed with other types of carcinoma

8560 Adenosquamous carcinoma

8045 Combined small cell carcinoma, combined small cell-large cell

5. Code the **more specific term** when one of the terms is 'NOS' and the other is a more specific description of the same histology.

   Example 1: Pathology report reads poorly differentiated carcinoma, probably squamous in origin. Code the histology as squamous cell carcinoma rather than the non-specific term "carcinoma."

   Example 2: The pathology report from a nephrectomy reads renal cell carcinoma (8312) (renal cell identifies the affected organ system rather than the histologic cell type) in one portion of the report and clear cell carcinoma (8310) (a histologic cell type) in another section of the report. Code clear cell carcinoma (8310); renal cell carcinoma (8312) refers to the renal system rather than the cell type, so renal cell is the less specific code.

6. Code the **majority** of tumor.

   a. Based on the pathology report description of the tumor.

   b. Based on the use of majority terms. See definition for majority terms.

7. Code the **numerically higher** ICD-O-3 code. This is the rule with the lowest priority and should be used infrequently.

Examples of single or multiple primary coding

Example: A patient has separate, independent tumors on the lower gum (C03.1) and the anterior floor of the mouth (C04.0). The third characters of the ICD-O-3 topography code are different, so the patient has multiple tumors in multiple primary sites.

Example: The patient has multiple, separate, simultaneous tumors in the trigone of the bladder (C67.0) and the lateral wall of the bladder (C67.2) of the same histologic type. Code one primary site, bladder, NOS (C67.9).

Example: The patient has separate, independent tumors in the sigmoid colon (C18.7) and the transverse colon (C18.4). Abstract two primaries.

Example: A physician detects two lesions in the **same segment** of the colon. The pathology report identifies the lesions as an adenocarcinoma (8140/3) and an adenocarcinoma in an adenomatous polyp (8210/3). This is one primary; code the histology to adenocarcinoma (8140/3). Adenocarcinoma in an adenomatous polyp is an earlier stage of disease than an invasive adenocarcinoma.

Example: A patient has a colectomy, and the pathology identifies two lesions in the sigmoid colon. The first lesion is an invasive adenocarcinoma (8140/3) and the second is an adenocarcinoma in situ (8140/2). This is a single histology. Code the histology and behavior as adenocarcinoma, NOS (8140/3).

Example: A stomach biopsy is interpreted as adenocarcinoma, NOS (8140/3). The pathology from the resection identifies the tumor as linitis plastica (8142/3). Record the morphology code for linitis plastica (8142/3).

Example: The pathology of a breast cancer describes mixed ductal (8500/3) and lobular carcinoma (8520/3). Record the combination code "ductal carcinoma and lobular carcinoma" (8522/3).

Example: A lung lesion is predominantly squamous cell carcinoma (8070/3) with focal areas of bronchiolalveolar adenocarcinoma (8250/3). A combination code does not exist. Record the predominant histology, squamous cell carcinoma (8070/3).

Example: A patient with bladder cancer is diagnosed with a mixed transitional cell carcinoma (8120/3) and epidermoid carcinoma (8070/3). There is no combination code for these histologies, and the pathology report does not identify a predominant histology. Record the higher-numbered morphology code, transitional cell carcinoma (8120/3).

Example: A patient had a desmoplastic infantile astrocytoma (9412/1) in the right lateral ventricle (C71.5) diagnosed and treated thirteen years ago. Last week, a ganglioma (9505/1) of the right lateral ventricle was diagnosed. The two tumors have the same subsite and laterality. They are both non-malignant and both histologies are in the same group in the table for non-malignant primary intracranial and central nervous system tumor. They represent a single tumor with the morphology, 9505/1.

Coding Mixed or Multiple Morphologies

Refer to the following when coding mixed or multiple morphologies in a single lesion:

COMBINATION - Always select a **combination** histology code first, if available.

MORE SPECIFIC TERM – Code a more specific morphology versus a non-specific. Non-specific includes: carcinoma, adenocarcinoma, melanoma, and sarcoma. **Example:** Poorly differentiated carcinoma, probably squamous in origin. Code to **8070** – squamous cell carcinoma.

MAJORITY – If no combination code is listed, code to the histology that reflects the **majority** of the tumor mass. Terms that identify the principal tumor type are *predominantly… with features of…major, type*, and *with …differentiation.* Terms that do not reflect the majority of the tumor mass such as *focal, with foci/focus of… areas of… elements of… …component* only describe minor areas or patterns, and do not depict the bulk of the tumor.

HIGHEST - If more than one histology is identified, there is no combination code, and the pathology report does **not** distinguish one to be more prevalent than the other(s),

code to the histology that generates the **highest** code.

Exception: Adenocarcinoma in a Polyp

By definition, adenocarcinoma in an adenomatous polyp (8210/3) is an earlier stage of disease than adenocarcinoma (8140/3). When both an adenocarcinoma and an adenocarcinoma in a polyp are found in the same segment of the colon or rectum, within two months of each other, code as adenocarcinoma (8140/3). **The rule, in this case, is to code the cancer, NOT the polyp.**

Note: A breast lesion that contains both ductal (8500/3) and lobular (8520/3) carcinomas. The ICD-0-3 manual lists a **combination** code - **8522/3**. This is the proper histology code. **Review carefully and frequently.**

Note: Patient with a single colon tumor that pathologically describes adenocarcinoma (8140/3) and with foci of mucinous adenocarcinoma (8480/3). Code to **8140/3** because adenocarcinoma represents the **majority** of the tumor.

Note: Pathology states squamous cell carcinoma NOS (8070/3) and large cell carcinoma NOS (8012/3) of the lung. No combination code is listed and the histological majority of the tumor is not specified. Code to **8070/3** because it reflects the **higher** of the two codes.

Chapter 4

FIRST COURSE OF THERAPY

DEFINITIONS

Treatment or therapy for cancer should 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 of 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.

Reportable hematopoietic diseases: Some treatments for reportable hematopoietic diseases, such as transfusions, phlebotomy, aspirin administration, do not meet the usual standard criteria for and definition of definitive treatment. Please refer to the SEER "Abstracting and Coding Guide for the Hematopoietic Diseases" to become familiar with the reportable diagnoses and appropriate treatments. (To obtain a copy visit the SEER website at: http://www.seer.cancer.gov)

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 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 no physician counsel is available, use the principle: *initial treatment must begin within four months of the date of initial diagnosis.*

Leukemias: For patients with a diagnosis of leukemia, the first course of therapy includes all cancer-directed treatments and planned therapies during or after the initial diagnosis of leukemia. All remission-inducing or maintenance cancer-directed therapy is recorded as the first course, including radiation to the central nervous system. The multiple modalities of

therapy for the treatment of leukemia may involve a year or more.

Example: If the patient has an adverse reaction, the regimen may be changed and a new drug introduced. 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. Additionally, 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/.

Note: Physician plans a combination regimen of chemotherapy. Velban is one of the drugs but, due to adverse reactions, it is replaced with Oncovin after several cycles. 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.

Note: Physician plans a regimen of Adriamycin/Cytoxan. The patient does not respond and disease progresses so the treatment plan is changed to Methotrexate/5FU. The treatment becomes subsequent because the planned first course of treatment failed.

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.

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

Reporting Hospital/Facility Number

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 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. If a facility does not have an ID number, go to the ACoS website at http://www.facs.org/dept/cancer/coc/fin.html to request a number. A list of Missouri hospital ID numbers is located on the MCR website at http://mcr.umh.edu/

Accession Number + Sequence Number

The accession number is assigned by the reporting facility and used to identify cancer patients accessioned into that institution's cancer registry. The accession number represents an exclusive nine-digit number for each cancer patient registered.

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 **case number** for that 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 - 200500034-00 signifies that the patient was diagnosed or treated at the reporting hospital in calendar year 2005 and that this patient is the **34th** patient entered into that hospital's registry for the year 2005. The **00** (sequence number) denotes that this cancer is the first and only primary malignant or in situ cancer for this patient.

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.

Note: Patient is diagnosed and treated for breast cancer in 2005. The patient has a documented history of cervical cancer in 1997. The sequence number for the breast cancer should be **02.**

Note: A patient is first diagnosed in 1999 with breast cancer. The accession number assigned is 1999-00032-00. In 2004, the patient is diagnosed with colon cancer. The accession number remains 1999-00032, 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 Sequence Numbers

The decision on 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 facilities cancer committee, follow these same guidelines.

- Codes 00-35 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.
- 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 00-35 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.

Type of Neoplasm/Sequence Number Series	
Neoplasm	**SeqNum-Central (Numeric Series)**
Series 1: In situ/Malignant as Federally Required based on Diagnosis year	**00-35, 99**
All in Situ (behavior code = 2) Cervix CIS, CIN II (diagnosis before year before 1996) all other in situ including VIN II, VAIN III, AIN III ; malignant (behavior code = 3); Juvenile astrocytoma (diagnosis year 2001 and later);* Invasive following in situ—new primary defined by SEER	00-35
Unspecified Federally required sequence number or unknown	99
Series 2: Non-malignant Tumor as Federally Required based on Diagnosis Year or State or Regional Registry Defined**	60-87, 88
Examples: Non-malignant tumor/benign brain; Borderline ovarian (diagnosis year 2001+); Other borderline/benign; Skin SCC/BCC; PIN III (diagnosis year 2001+); Cervix CIS/CIN III (diagnosis year 2003+)	60-87
Unspecified non-malignant tumor or central registry defined sequence number	88
Cervix CIS/CIN iii (diagnosis year 1996-2002)	98

*Juvenile astrocytomas should be reported as 9421/3

**Series 2 - only tmors in Series 2 that SEER requires are benign/borderline intracranial and central nervous system (CNS) tumors.

Note: Conversion Guidance—The sequence numbers for neoplasms whose histologies were associated with behavior codes that changed from in situ/malignant to benign/borderline or vice versa during the conversion from ICD-O-2 to ICD-O-3 should not be re-sequenced

Personal History (1 & 2)

Record ICD-0-3 code of previous primary (primaries) and 4-digit year of diagnosis. **If more than 2 previous primaries, record any additional primaries in Remarks text field.**

Last Name

Record the patient's last name. Hyphenated names and names with spaces in them are acceptable. For male patients who have a Sr., Jr., III, etc., place those symbols after the last name. If it is known that the patient has a graduate professional degree (M.D., D.D.S., D.D.), indicate -- for example, Smith, III MD, Robert Quintin. Sr.

First Name

Record first name. No spaces or punctuation are allowed. For example, MARY JANE should be entered as MARYJANE.

Middle Name

Record middle name. Middle initial may be used if full middle name is not available. Leave blank if no middle name/initial is given.

Maiden Name

Record the maiden name of married female patients. If the patient has no maiden name or the information is not available, leave blank.

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.

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. Standard abbreviations may be used. If no street address is available, record "UNKNOWN." **DO NOT LEAVE BLANK**.
- 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 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:

Province	Code	Province	Code
Alberta	AB	Nova Scotia	NS
British Columbia	BC	Ontario	ON
Labrador	LB	Prince Edward Island	PE
Manitoba	MB	Quebec	PQ
New Brunswick	NB	Saskatchewan	SK
Newfoundland	NF	Yukon	YT
Northwest Territories	NT		

- XX = Resident of country other than U.S. or Canada and the country is known
- YY = Resident of country other than U.S. (including its territories, commonwealths, or possessions) or Canada & country unknown.
- ZZ = Resident of the U.S., NOS; Canada, NOS; residence unknown.

Zip Code at Diagnosis

Record the 5-digit zip code and the 4-digit extension (if known) for the patient's address at diagnosis, in the boxes provided; 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 zip code is not known, record 999999999 if the patient is a resident of Canada, United States or U.S. possessions but the zip code is unknown or residence is unknown.

Consult the zip code list at: http://www.dhss.mo.gov/Geocodes/

County at Diagnosis

The source of standard for current county address is the most current issue of Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas, Federal Information Processing Standards (FIPS) (see Missouri Geocodes at http://www.dhss.mo.gov/Geocodes/GeocodeList.html.) FIPS codes are also available at http://mcr.umh.edu/abs_resources.html

- Code 998 Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution. (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)

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 9"s. 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

Address Current

Current address fields only need to be completed if the current address is different than the Address at Diagnosis.

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.

Abstracted By

This is a three-digit data field used to identify the hospital registrar that abstracted the cancer case. **Do not leave blank or use 'XXX' or other indications for Unknown.**

Social Security Number

Record the patient's Social Security number, if known. Use **9's** if unknown and **0's** if none.

Telephone Number

Record the telephone number, including the area code. Use **9's** if the number is unknown and **zeros** (0) if the patient has no phone.

Alcohol History

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

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

Tobacco History

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

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 (e.g., the patient is 75 y.o. and has smoked his entire life, then 50 years would be a conservative estimate). If no information is available, enter 9's and if the patient has never smoked, enter 0's.

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:

1 Single (never married)
2 Married (includes common law)
3 Separated
4 Divorced
5 Widowed
9 Unknown

Sex

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

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

Race 1 – 5

For multi-racial patients, code all races. Listed race codes correlate closely to categories used by the U.S. Census Bureau to allow calculation of race specific incidence rates.

Use the following codes to record race:

01	White		20	Micronesian, NOS
02	Afro/American		21	Chamorran
03	American Indian, Aleutian, Eskimo (includes South and Central American Indians		22	Guamanian, NOS
04	Chinese		25	Polynesian, NOS
05	Japanese		26	Tahitian
06	Filipino		27	Samoan
07	Hawaiian		28	Tongan
08	Korean		30	Melanesian, NOS
09	Asian Indian, Pakistani		31	Fiji Islander
10	Vietnamese		32	New Guinean
11	Laotian		96	Other Asian-Asian, NOS, Oriental, NOS
12	Hmong		97	Pacific Islander, NOS
13	Kampuchean (Cambodian)		98	Other
14	Thai		99	Unknown

- If only one race is reported for the person, use code 88 for the remaining race fields (Race 2-Race 5).
- **If Race 1 is '99,' Unknown, Race 2 through Race 5 must be '99."**
- This field is used to code the primary race of the person and is to be used in conjunction with "Spanish/Hispanic Origin." Additional races reported by the person should be coded in Race 2, Race 3, Race 4, and Race 5.
- Persons of Mexican, Puerto Rican, or Cuban origin are usually white.
- Race 1 identifies the primary race of the person and will be the field used to compare with race data on cases diagnosed **prior to** 1/1/2000.
- If a person's race is recorded as a combination of white and any other race, code to the appropriate other race in this 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 race is recorded as "Negro" or African-American," code race 02.
- When the race is recorded as "Oriental," "Mongolian," 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.

Spanish/Hispanic Origin

Code the patient's Spanish/Hispanic origin. The following codes are used to identify persons of Spanish/Hispanic surname or ethnicity:

0	Non-Spanish; Non-Hispanic (including Brazil)
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (not including Brazil—code to '0' for Non-Spanish/Hispanic)

5 Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)

6 Spanish, Hispanic, Latino, NOS; Evidence other than surname or maiden name that person is Hispanic, but person cannot be assigned to categories 1-5)

7 Spanish surname only: Only evidence of the person's Hispanic origin is surname or maiden name - no evidence verifying that the person is not Hispanic **(Central registry use only)**

8 Dominican Republic

9 Unknown whether Spanish/Hispanic or not

Date of Birth

Complete the patient's birth date, recording the month in the first two spaces, the day in the next two spaces, and the four-digit birth-year in the last four spaces. If the month or the day is a single digit, precede it with a zero **(0)**.

Example: A Patient born: June 06, 1916 would be recorded as 06-06-1916.

- If the month and day of birth are unknown, but year is known, record as '99-99-1937'.
- Please document age at diagnosis in text.
- If the year of birth is unknown, estimate the year.

Example: The medical record states the patient is 60 years old at the time he is admitted to the hospital, June 15, 2000; there is no birth date documented; record the date of birth as 99-99-1940.

Place of Birth

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

- Use **998** for unknown birthplace outside the United States.
- Use **999** for unknown birthplace.

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.

- Record the patient's usual 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."
- If the patient was NOT a student or homemaker, and never worked, record "never worked," or "never employed."
- Record "unknown" if no information is available. **DO NOT LEAVE BLANK**.

The central registry office will code the usual occupation according to the U.S. Department of Commerce publication ***Index of Industries and Occupations.***

Type of Industry

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

- 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.
- 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**.

The central registry staff will assign the appropriate number code for industry, using the US Department of Commerce publication ***Index of Industries and Occupations.***

Date of 1st Contact

Record the date (month, day, and four-digit year) of the first inpatient or outpatient encounter at this facility for diagnostic procedure; review or administration of treatment; or palliative care. This may be the date of an outpatient visit for a biopsy, x-ray, scan or lab. If autopsy only, record the date of death.

Example: Patient **c**omes into your facility for a mammogram on 7/1/2003 that is suspicious

for malignancy. Patient returns for excisional biopsy revealing ductal carcinoma followed by re-excision. Date of 1st Contact will be 7/1/2003 (date of mammogram).

Hospital Referred From

The hospital referred from is used to record the institution from which the patient was referred for further care. If the patient was not diagnosed or no treatment was provided at any other facility, leave blank. If the hospital referred from is unknown, record **0000999998** for unspecified in state hospital or record **0000999994** for unspecified out of state hospital. Number must be right justified with leading zeroes (i.e., 0006630999). For a complete list of Hospital ID numbers, refer to the MCR web site at http://mcr.umh.edu/.

Hospital Referred To

The hospital referred to is used to record the institution to which the patient was transferred for additional care after discharge from the reporting facility. If the patient was not transferred or referred elsewhere, leave blank. If the patient was referred to an unknown facility, record **0000999998** for unspecified in state hospital or record **0000999994** for unspecified out of state hospital. The number must be right justified with leading zeroes (i.e., 0006630999).

Primary Payer at Diagnosis

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

Codes:

01	Not insured
02	Not insured, self-pay
10	Insurance, NOS
20	Private Insurance: Managed care, HMO, or PPO
21	Private Insurance: Fee-for-Service
31	Medicaid
35	Medicaid Administered through a Managed Care Plan
60	Medicare/Medicare, NOS
61	Medicare with supplement, NOS
62	Medicare, Administered through a Managed Care plan

63 Medicare with private supplement

64 Medicare with Medicaid eligibility

65 TRICARE

66 Military

67 Veterans Affairs

68 Indian/Public Health Service

99 Insurance status unknown

Class of Case

This data element is designed to separate the reporting registry's cancer cases into ***analytic*** and ***nonanalytic*** categories. MCR requires Class of Case 0, 1,2,3,4 and 5.

Definitions

Analytic cases (classes 0, 1, 2)

0 Patients first diagnosed at reporting facility after that facility's reference date and all the first course of treatment given elsewhere or decision not to treat was made at another facility

1 Patients who were first diagnosed and received all or part of the first course of treatment at the reporting facility, since that facility's reference date.

2 Patients diagnosed elsewhere who received all or part of first course of treatment at the reporting facility, since that facility's reference date.

Non-analytic cases (classes 3, 4, 5, 6, 7, 8, and 9)

3 Patients first diagnosed and received all first course of treatment elsewhere.

4 Patients first diagnosed and/or treated at the reporting facility before the reference date.

5 Patients first diagnosed at autopsy.

6* Patient diagnosed and treated in a staff physician's office only. **(Not required by MCR but will be accepted if submitted.)**

7* Pathology report only. Patient did not enter the reporting facility at any time for diagnosis or treatment. Excludes cases diagnosed at autopsy. **(Not required by**

MCR but will be accepted if submitted.)

8* Patients diagnosed by death certificate only (**used by central registry only**).

9* Unknown class of case (**used by central registry only**).

MCR does not require Class of Case 6,7,8,9

The term "***elsewhere***" refers to any facility or practitioner **not** affiliated with your hospital, including freestanding cancer clinics and detection centers.

Class of case definitions:

0 Patients first diagnosed at your institution, after your reference date, and **the entire** first course of therapy administered elsewhere or decision not to treat was made elsewhere. Cases include patients referred and transferred elsewhere for treatment.

1 Patients who were first diagnosed and received all or part of the first course of treatment at the reporting facility since that facility's reference date.

Patients first diagnosed at the reporting facility and the decision was made for no treatment or patient/family refused treatment.

2 Patients diagnosed elsewhere who received all or part of the first course of the treatment at the reporting facility since that facility's reference date.

Patients diagnosed elsewhere who had palliative care in lieu of first course of treatment at the reporting facility.

3 Patients initially diagnosed and all of the planned first course of therapy performed elsewhere and presents at your facility with recurrent or persistent or metastatic disease. MCR NOTE: This includes patients now receiving subsequent treatment at your hospital for active disease; patients who were diagnosed and treated (first course of therapy) at another facility now requiring subsequent treatment for a recurrent malignancy or disease progression, or patients diagnosed at your facility with a recurrence or metastatic disease. **Patients who die at your facility with cancer may also be reported but are not required.**

4 Patients who were diagnosed or received the planned first course of therapy at your hospital **before your reference date.** Class 4 patients would have to return to your facility, ***after the reference date, with either a recurrence or to receive additional treatment.*** These cases include: patients who were diagnosed at your hospital prior to your reference date but it is unknown if the first course of therapy was given at your hospital; patients who were diagnosed at your hospital prior to the reference date and who received all the first course of therapy elsewhere; patients who were diagnosed elsewhere, but received any or all of the first course of therapy at your hospital, prior to the reference date.

5 Patients first diagnosed at autopsy. These cases include incidental findings of cancer at the time of autopsy. There was no suspicion of cancer before the autopsy.

6 Patients diagnosed and receiving their entire first course of treatment in a staff physician's office.

7 A hospital pathology department received a tissue sample for evaluation. The patient never visited the hospital.

8 Used by the **central registry only** and includes death certificate only cases.

9 Used by the **central registry only**: Unknown if insufficient detail for determining class of case.

Reporting Source

The Type of Reporting Source identifies the source documents used to abstract the case. This is not necessarily the original document that identified the case; rather it is the source that provided the best information.

1 Hospital inpatient, hospital outpatient, hospital clinic
2 Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent) - NEW
3 Laboratory only (hospital or private)
4 Physician office/private medical practitioner (LMD)
5 Nursing/convalescent home/hospice
6 Autopsy only
7 Death certificate only
8 Other hospital outpatient units/surgery centers - NEW

Primary Surgeon

- The reporting registry uses this data item to identify the surgeon who performed the most definitive surgical procedure. The reporting facility will assign a unique number to the primary surgeon.
- The identification number assigned by the reporting facility may include letters and numbers; many registries use the physician's state medical license number.
- Code **9's** if the primary surgeon is unknown or when an identification number is not assigned.

Attending Physician (Managing Physician)

- The managing physician is the doctor responsible for the overall management and care of the patient during the diagnosis or treatment of this primary.
- The identification number assigned by the reporting facility may include letters and numbers; many registries use the physician's state medical license number.

- Code **9's** if the managing/attending physician is unknown or when an identification number is not assigned.

Following Physician (Follow-Up Physician)

- The following physician assumes responsibility for the patient's current medical care. Follow-up letters requesting information about the patient's cancer and cancer status will be directed to this physician.

- The identification number assigned by the reporting facility may include letters and numbers; many registries use the physician's state medical license number.

- Code **9's** if the following physician is unknown or when an identification number is not assigned

Chapter 6

CANCER IDENTIFICATION

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-0-3 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.

It is preferable to identify the exact location of the primary (originating) tumor, whenever possible. The most specific location of a tumor should be coded. If the specific sub-site of an organ cannot be determined, use the NOS (not otherwise specified) category for that organ or region. 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.

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

- When a primary lesion has overlapped into one or more subsites, the **.8** (overlapping lesion code) is applied. Overlapping applies to sites that are contiguous (adjacent) to one another.

  > **Example:** Patient diagnosed with lung cancer.. The surgeon states that the tumor involved the middle and upper lobes. of the right lung - Code **C34.8** - rather than coding the site to either the upper or lower lobe of the lung.

- If the primary site is documented as an "unknown primary", use code **C80.9.**

- Code all leukemias except myeloid sarcoma (9930/3) to the bone marrow - **C42.1.** Myeloid sarcoma is coded to the site of origin.

- Complete primary site coding rules are described in the ICD-O-3 manual under *Coding Guidelines for Topography and Morphology*.

  > **Example:** 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

Use the following guidelines to determine the primary site(s) for malignant lymphomas:

- Lymphomas originating in the lymph nodes are coded C77._
- If a lymphoma originates in a single organ, code the primary site to that organ.

  Example: Patient diagnosed with lymphoma of the stomach. Primary site code would be **stomach** (**C16.9**).

- If disease is prevalent in a single organ and the lymph nodes, but the physician states the cancer originated in the extra-nodal site, code the primary site to the **organ.**
- If there is disease in a single organ and nodes, but the physician does not state extra-nodal site, **code to the site of lymph nodes involved.**
- If no site is specified, use **code C77.9**, lymph nodes NOS.
- If origin of a lymphoma is unknown but is suggested by the histology code in ICD-0-3, code to the suggested site. Example: 9689/3 Splenic marginal zone B-cell lymphoma (**C42.2**).
- If an extranodal site is suspected but is unknown, code to **C80.9**.
- When there are multiple lymph node sites involved, **code C77.8**.
- Do not code the site of the biopsy when multiple sites are involved.
- When coding a disseminated lymphoma and the originating site is unknown, **code to unknown primary site - C80.9**.

  Example: Malignant pleural effusion positive for malignant lymphoma and no tissue masses identified.

- **Code C77.9** when a mass is identified as "retroperitoneal," inguinal," "mediastinal," or "mesentery" and there is no definitive information to indicate tissue(s) involved.
- ICD-O-3 Rule D provides additional information on coding the primary site for lymphomas.

Primary Site Title

After recording the appropriate primary site code, record the text from the pathology report that describes the primary site.

Example: Stomach cancer - code: C16.9 *description* = stomach, NOS

Example: Malignant brain tumor/frontal lobe code: C71.1 *description* = ***brain***, frontal lobe

Histologic Type

Behavior ICD-O-3 (Cases diagnosed on or after January 1, 2001)

Histologic type refers to the ***classification*** of malignancy described in the pathology or cytology report. Refer to the ICD-0-3 manual to select the correct histologic code. If diagnosed **before** January 1, 2001 a corresponding code from ICD-O-2 will also need to be entered into the appropriate field. The first three digits of the histology code will indicate the cancer cell type and usually the FINAL pathological diagnosis is used to make the code determination. However, if the **microscopic** description indicates a more specific histological diagnosis, use the most definitive code available.

> **Example:** The final pathologic diagnosis is **carcinoma** (8010) of the prostate. Microscopic diagnosis states **adenocarcinoma** (8140) of the prostate. Adenocarcinoma (8140) should be coded because it provides a more specific description of the **type** of cancer..

The World Health Organization diagnosis "B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma" is coded as 9823/3 and cross-referenced to 9670/3, malignant lymphoma, small b-cell lymphocytic. If diagnosed in blood or bone marrow, code 9823/3; if diagnosed in tissue, lymph nodes or any organ in combination with blood or bone marrow, code 9670/3.

Further instructions and rules that clarify coding rules for histology are found under *Coding Guidelines for Topography and Morphology* in the ICD-O-3 manual.

Behavior Code

The behavior code occupies the 5th space (digit) of the histologic code. This component of the histologic code indicates the way in which the neoplasm will act or *behave* - malignant or not malignant. 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 this report and must take steps to identify the primary site with a behavior code of **3**. In this situation, the behavior code is recorded **3** by the registry. Behavior codes 6 or 9 are not utilized by the hospital registry.

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
- Clark's level 1 for melanoma (limited to epithelium)
- Comedocarcinoma, non-infiltrating (C50.*)
- Confined to epithelium

- Hutchinson's melanotic freckle, NOS (C44.*)
- Intracystic, non-infiltrating
- Intraductal
- Intraepidermal, NOS
- Intraepithelial, NOS
- Involvement up to but not including the basement membrane
- Lentigo maligna (C44.*)
- Lobular neoplasia
- Lobular, nonfiltrating (C50.*)
- Noninfiltrating
- Noninvasive
- No stromal involvement
- Pre-cancerous melanosis (C44.*)
- Queyrat's erythoplasia (C60.*)

Behavior is coded as **malignant (3)** if there is documentation of any invasion present.

> **Example:** Pathology report of prostate biopsy reads: "adenocarcinoma in situ (8140/2) with focal area of adenocarcinoma (8140/3). This case should be coded to the invasive behavior **8140/3**.
>
> **Example:** Pathology report of bladder biopsies reads: "Papillary Transitional cell, 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.

Grade or Differentiation

(Parts of the following instructions are adapted from FORDS. Please check with you pathologist(s) regarding their interpretation of the grading instructions.)

A one-digit code number is included at the sixth position of the histologic code. This number describes the grade or differentiation characteristics of the cancer at the primary site. In most cases, the pathology report is the source for this description. The grade of a tumor, including brain, can also be established through MRI or PET if there is no tissue diagnosis available.

- Code the grade as stated in the **FINAL** pathologic diagnosis. If the grade is **NOT** stated in the final pathologic diagnosis, but is stated in the microscopic description, then code the grade based on the most specific information.

- Code the higher grade even if it is just a "focus."

- 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*.

- If the pathology report describes a neoplasm with two different grades, code to the highest grade reported.

  Example: Pathology report reads, "infiltrating ductal carcinoma, moderately to poorly differentiated, Code 8500/3**3**. Grade 3 takes precedence over moderately differentiated Grade 2.

- Code the grade/differentiation from the primary tumor not from metastatic sites.

- Code grade/differentiation as '9 – unknown' when primary site is unknown.

- 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.

- T-cell, B-cell, null-cell, and NK cell descriptors are used for leukemias and lymphomas only. Information documented about T-cell, B-cell, null-cell, or NK cell descriptions has priority over grade information. Code any statement of T-cell, B-cell, null-cell or NK cell involvement whether or not marker studies are documented in the chart.

Note: Do not use "high grade," "low grade" or "intermediate grade" description for lymphomas as a basis for grade. These terms are categories used in the Working Formulation and do not relate to grade.

GRADING SYSTEMS - SOLID TUMORS, LYMPHOMAS/ LEUKEMIAS

Refer to the following table when coding differentiation/grade from a four-grade system as specified in the pathology report or elsewhere in the medical record, i.e.: grade II/IV (code 2). Breast, prostate and kidney cases and some sites using a two- grade or three- grade system are excluded (refer to their respective tables). For solid tumors code the tumor grade using the following priority order: 1. terminology 2. histologic grade 3. nuclear grade. *Refer to general guidelines listed above when assigning codes for lymphomas and leukemias.

Code	Grade/Cell	Description
1	Grade I	Well Differentiated, differentiated, NOS
2	Grade II	Moderately differentiated, moderately well; intermediate differentiated
3	Grade III	Poorly differentiated
4	Grade IV	Undifferentiated, anaplastic
For Lymphomas and Leukemias		
5	T-cell	T-cell, T-Precursor, lymphomas & leukemias
6	B-cell	B-cell, Pre-B, B-precursor, lymphomas & leukemias
7	Null cell	Leukemias only, Null cell, Non T - Non B
8	NK cell	Natural Killer cell, lymphomas & leukemias
For all histologies		
9	Grade/diff unknown	Grade/cell type not determined, not stated, not applicable

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 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), 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.

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,	II/III or 2/3	2/3
4	High grade, poorly differentiated to undiffer-	III/III or 3/3	2/2, 3/3

Coding Breast Cancers

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

1. Bloom-Richardson (Nottingham) scores
2. Bloom-Richardson Grade
3. Nuclear Grade
4. Terminology
5. Histologic grade as shown in table below:

Code	Bloom-Richardson Scores	Bloom-Richardson Grade	Nuclear Grade	Terminology	Histologic grade
1	3-5 points	Low grade	1/3, 1/2	Well differentiated	II/III or 1/3
2	6, 7 points	Intermediate Grade	2/3	Moderately differentiated	II/III or 2/3
3	8, 9 points	High grade	2/2, 3/3	Poorly differentiated	III/III or 3/3

Coding Kidney Cancers

For kidney cancer, code grade using the following priority order:

1. Fuhrman Grade
2. Nuclear Grade

3. Terminology (Well diff, mod. Diff.)

4. Histologic Grade

Exception: These prioritization rules do not apply to Wilm's tumor .

The most widely used and most predictive grading system for renal cell cancer is the "Fuhrman Nuclear Grade". Fuhrman grade is on a scale of I-IV, where grade I carries the best prognosis and grade IV the worst. Nuclear grade means that the system is based on just the appearance of the nuclei of the cancer cells, rather than the appearance or structure of the cells as a whole. Nuclear characteristics used in the Fuhrman Grade particularly indicate how actively the cells are making protein. Nuclear Characteristics Used in the Fuhrman System are:

- Size and shape of the nucleus as a whole.
- Number and size of nucleoli (Nucleoli are organelles found in the cell nucleus which make ribosomes which in turn are protein making factories. More nucleoli imply more active protein synthesis).
- Chromatin clumping (Chromatin is the substance of chromosomes and contains DNA and associated proteins.)

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

Gleason's score 7 was previously coded to moderately differentiated (2). Effective with case diagnosed 1/1/2003, Gleason's score 7 is coded to poorly differentiated (3).

Histology Title

After recording the appropriate ICD-0-3 histologic code, enter the text that describes the histologic code in the space provided.

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

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.

- 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. Backdating is rarely used for most initial cancer work-up/diagnosis scenarios in which the clinical or imaging studies or biopsies may be non-diagnostic but malignancy is confirmed by surgery or other methods. It is most commonly seen in cases where complete cancer work-up failed to reveal a malignancy but sometime later the patient has further work-up, is subsequently diagnosed with a malignancy and the physician states in retrospect it was present at an earlier date.

- Record the month in the first two spaces, the day in the second two spaces, and the year in the last four spaces.

  Example: Patient has a diagnostic ultrasound on June 6, 2003, that supports a malignancy. On June 30, 2003 a biopsy is performed. Record the diagnosis date as 06-06-2003.

- If the cancer was first diagnosed at autopsy, **(class of case 5)**, 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 year of diagnosis is not documented, an estimated date, if based on documentation, is preferable over recording **9s**.

- If only the time of year, spring, middle, fall, or winter of the year is documented, use April, July, October, and either December (if end of year) or January (if beginning of year) respectively.

Place of Diagnosis

Indicate where patient was diagnosed; i.e., name of hospital, physician's office, clinic, etc.

Diagnostic Confirmation

Information in this field reports **how** the cancer was diagnosed and whether or not the malignancy was confirmed microscopically **any time during the disease process**.

The data item represents a hierarchical coding scheme with **code 1** taking precedence.

- If at any time during the patient's cancer experience, a more definitive diagnostic method is performed and confirms the malignancy; this data item should be changed to reflect that confirmation.

  Example: Patient is diagnosed on 2/10/2002, by CT scan with probable lung cancer with no further workup. Diagnostic confirmation is coded to radiology **(7)**. Later in March of 2002, the patient undergoes a bronchoscopy in which biopsies confirm squamous cell carcinoma. The diagnostic confirmation code is changed to reflect the positive histology **(1)**.

Explanation of diagnostic confirmation codes:

Code	Label	Definitions
1	*Positive Histology*	Tissue specimens from biopsy, frozen section, surgery, autopsy, or dilation and curettage. Bone marrow biopsy and bone marrow aspiration; Hematologic confirmation of leukemia and myelodysplastic disorders (peripheral blood smear)
2	Positive Cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined). Includes positive brushings, washings, cell aspiration and Hematologic findings (except for leukemia and myelodysplastic disorders)
4	Positive microscopic confirmation, method not specified	Case is reported as microscopically confirmed, but no information is available about the method (histology, cytology)
5	Positive laboratory test/ marker study	Diagnosis based on certain laboratory tests or marker studies clinically diagnostic (electrophoretic spike for multiple myeloma or Waldenstrom's macro-globulinemia, alpha – fetoprotein for liver cancer). Elevated PSA is nondiagnostic 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 w/o microscopic confirmation	Diagnosis made at surgical exploration or by endoscopy - no positive histology or cytology - Autopsy only case (information from gross autopsy report)
7	Radiography & other imaging techniques w/o microscopic confirmation	Diagnosed by radiology, includes ultrasound, computerized (axial) tomography (CT or CAT) and magnetic resonance imaging (MRI) - no positive histology or cytology
8	Clinical diagnosis only (other than 5, 6, or 7)	Reported by the physician in the medical record
9	Unknown whether or not microscopically confirmed	Death-certificate-cases only - method of confirmation is unknown

Laterality

Laterality refers to a **paired (right or left)** organ.

0 Not a paired site – (includes unknown primary site (C80.9)
1 Right organ origin of primary only
2 Left organ origin of primary only
3 Only one side involved; right **or** left, unspecified which
4 Bilateral involvement, lateralty unknown, single primary
INCLUDES:
Both ovaries simultaneously involved with ONE histology
Bilateral retinoblastomas
Bilateral Wilm's' tumors
9 Paired site, no laterality information

Laterality is applicable for following major heading sites and sub-sites:

Site	Code	Site	Code
Parotid	C07.9	Peripheral nerves & autonomic nervous system, upper limb & shoulder	C47.1
Submandibular gland	C08.0	Peripheral nerves & autonomic nervous system of lower limb & hip	C47.2
Sublingual gland	C08.1	Connective, subcutaneous, & other soft tissues-upper limb & shoulder	C49.1
Tonsillar fossa	C09.0	Connective, subcutaneous, & other soft tissues, lower limb & hip	C49.2
Tonsillar pillar	C09.1	Breast	C50.*
Overlapping lesion of tonsil	C09.8	Ovary	C56.9
Tonsil, Nos	C09.9	Fallopian tube	C57.0
Nasal cavity-excludes nasal cartilage & nasal septum	C30.0	Testis, undescended, descended, nos	C62.0-C62.9
Middle ear	C30.1	Epididymis	C63.0
Maxillary sinus	C31.0	Spermatic cord	C63.1
Frontal sinus	C31.2	Kidney, nos	C64.9
Main bronchus-excluding carina	C34.0	Renal pelvis	C65.9
Lung	C34.*	Ureter	C66.9
Pleura, Nos	C38.4	Eye & adnexa	C69.*
Long bone-upper limb & scapula	C40.0	Cerebral meninges, NOS (exc diagnoses prior to 2004)	C70.0
Short bone, upper limb	C40.1	Cerebrum (excluding diagnoses prior to 2004)	C71.0
Long bone, lower limb	C40.2	Frontal Lobe (excluding diagnoses prior to 2004)	C71.1
Short bone, lower limb	C40.3	Temporal lobe (excluding diagnoses prior to 2004)	C71.2
Rib & clavicle - excludes sternum	C41.3	Parietal lobe (excluding diagnoses prior to 2004)	C71.3
Pelvic bones - excludes sacrum, coccyx, & symphysis pubis	C41.4	Occipital lobe (excluding diagnoses prior to 2004)	C71.4
Skin of eyelid	C44.1	Olfactory nerve (excluding diagnoses prior to 2004)	C72.2

Site	Code	Site	Code
Skin of external ear	C44.2	Optic nerve (excluding diagnoses prior to 2004)	C72.3
Skin-other-unspecified parts of face-if midline use 9	C44.3	Acoustic nerve (excluding diagnoses prior to 2004)	C72.4
Skin of trunk - code 9 if midline	C44.5	Cranial nerve (excluding diagnoses prior to 2004)	C72.5
Skin of upper limb & shoulder	C44.6	Adrenal gland	C74.*
Skin of lower limb & hip	C44.7	Carotid body	C75.4

Chapter 7

STAGING SCHEMES

Collaborative, General Summary and TNM Schemes

Three staging schemes are available on the abstract:

1. Collaborative Staging System
2. General Summary Stage at diagnosis - SEER summary stage
3. TNM staging schemes - clinical, pathological, other, and pediatric

Collaborative Staging

The Collaborative Staging (CS) system is a set of data items that describe how far a cancer has spread from its' primary site at the time of diagnosis. 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. Use of the CS system should provide a higher degree of compatibility between the staging systems 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 is coded in SSFs. For sites/histologies where some or all SSFs are not used, they are coded 888 (not applicable). (For more complete details, refer to the introduction of the *Collaborative Staging Manual*.)

- The CS system applies to cases diagnosed January 1, 2004 and later. Complete directions are in the *Collaborative Staging Manual and Coding Instructions, Version 01.02.00*
- Cases diagnosed prior to that date should be coded to whatever coding system was in effect at the time of diagnosis (i.e. SEER Summary Stage 1977, SEER Summary Stage 2000, etc.).

The following fields are required to derive Summary Stage 1977 and Summary Stage 2000 (cases diagnosed on or after January 1, 2004):

Item Name	NAACCR Item Number
CS Extension	2810
CS Lymph Nodes	2830
CS Mets at DX	2850
CS Site Specific Factor 1*	2880
CS Site Specific Factor 2*	2900
CS Site Specific Factor 3*	2900
CS Site Specific Factor 4*	2910
CS Site Specific Factor 5*	2920
CS Site Specific Factor 6*	2930
Derived SS1977 Flag**	3040
Derived SS2000 Flag**	3050
CS Version 1st ***	2935
CS Version Latest****	2936

* Identifies additional information needed to generate stage for following sites:

** Required for electronically submitted data only. This field is not on the abstract form.

*** This item indicates the number of the version used to initially code CS fields.

****This item indicates the number of the version of the CS used most recently to derive the CS output fields.

CS Tumor Size

Record the largest dimension or diameter of the primary tumor in millimeters. See Collaborative Staging Manual and Coding Instructions for more information.

CS Extension

Identifies contiguous growth (extension) of the primary tumor within the organ or direct extension into neighboring organs. See Collaborative Staging Manual and Coding Instructions for more information.

CS Lymph Nodes

Identifies the regional lymph nodes involved with cancer at the time of diagnosis. See Collaborative Staging Manual and Coding Instructions for more information.

CS Mets at Diagnosis

Identifies the distant site(s) of metastatic involvement at time of diagnosis. See Collaborative Staging Manual and Coding Instructions for more information.

CS Version 1st

Identifies version used to code collaborative staging fields. CS Version 1st 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.

Example: First version was 1.0., record 010000.

CS Version Latest

The current version is 01.02.00

Regional Nodes Positive

Record the exact number of regional lymph nodes examined by the pathologist and found to contain metastases. See Collaborative Staging Manual and Coding Instructions for more information.

Regional Nodes Examined

Records the total number of regional lymph nodes that were removed and examined by the pathologist. See Collaborative Staging Manual and Coding Instructions for more information.

CS Site-Specific Factor 1

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. See Collaborative Staging Manual and Coding Instructions for more information.

CS Site-Specific Factor 2

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. See Collaborative Staging Manual and Coding Instructions for more information.

CS Site-Specific Factor 3

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. See Collaborative Staging Manual and Coding Instructions for more information.

CS Site-Specific Factor 4

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. See Collaborative Staging Manual and Coding Instructions for more information.

CS Site-Specific Factor 5

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. See Collaborative Staging Manual and Coding Instructions for more information.

CS Site-Specific Factor 6

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. See Collaborative Staging Manual and Coding Instructions for more information.

General Summary Stage at Diagnosis

For cases diagnosed prior to January 1, 2004, General Summary Stage is to be entered in the individual Summary Stage fields (i.e., Summary Stage 2000, Summary Stage 1977). For cases diagnosed on or after January 1, 2004, Collaborative Stage fields are to be completed. MCR will derive the Summary Stage from this information.

SEER Summary Stage 2000

For cases diagnosed January 1, 2001 through December 31, 2003, use Summary Staging Manual 2000.

> **Note:** Pay particular attention to the site-specific schemes for primaries with subsites and the notes on the last page of many schemes. Do not rely on memory.
>
> **Note:** A comparison of cases diagnosed before January 1, 2001 and cases diagnosed on or after January 1, 2001, may not be possible due to changes in staging guidelines. (See Abstracting Resources and article on NAACCR website at http://www.naaccr.org/filesystem/pdf/Summary%20Stage%20Report%201-21-04b.pdf).

Example: For lung, a separate tumor nodule in a different lobe is considered **1-Localized** in the SEER Staging Guide, 1986 Reprint, and **7-Distant** in the SEER Summary Staging Manual 2000.

SEER Summary Stage 1977

For cases diagnosed prior to January 1, 2001, use the *Summary Staging Guide*, 1986 reprint. Please refer to SEER Summary Staging Manual 2000 or Summary Staging Guide, 1986 reprint for specific coding instructions for ALL sites.

The following codes and descriptions apply to both Summary Stage 1977 and Summary Stage 2000.

Stage	Descripton
0	In-situ; non-invasive; intraepithelial; non-infiltrating; limited to the epithelium; intraepidermal (skin). Other parts CNS
1	Localized; tumor confined to organ of origin; microinvasion; no evidence of metastasis **(Stage I – lymphoma)**. Localized brain, cerebral meniges, CNS
2	Regional by direct extension; tumor extends directly beyond the primary site into surrounding (regional) organs or tissues
3	Regional to lymph nodes; tumor extends beyond the organ of origin (primary site) into the regional lymph nodes
4	Regional to both **2 & 3**; tumor extends beyond primary site by direct extension, into regional lymph nodes AND adjacent tissues
5	Regional, NOS; tumor documented as regional and no other information is available **(Stage II – lymphoma)**. Regional brain, CM, CNS
7	Distant metastasis; widely disseminated; systemic disease; tumor has spread from primary site to remote areas of the body, through the blood stream or lymph system **(Stage III or IV – lymphoma)**. Brain, CM, CNS
9	Unstaged; unknown; unspecified - use for unknown primaries and those cases where adequate staging information is NOT available

Describe Extent (Text Justifying Stage at Dx)

Record, in text, an adequate description to justify extent of disease. Possible sources of information include path report, operative report, x-rays, scan, scopes and physician documentation.

Surgical Dx/Staging/ Procedure Code

Record the surgical procedures performed to diagnosis or stage the cancer. Codes 01-07 have priority over 09; codes 01-06 have priority over 07; and within the range of 01-06, the higher code has priority. Identifies the surgical procedures(s) performed in an effort to diagnose and/or stage disease. Removal of gross tumor is considered surgery of primary site.

Code	Definition
00	No surgical diagnostic or staging procedure was performed
01	A biopsy (incisional/needle/aspiration) of other than primary site. No exploratory procedure was
02	A biopsy (incisional/needle/aspiration) of primary site
03	Surgical exploration only. (No biopsy)
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
06	A bypass procedure was performed and a biopsy of primary or other sites was done.
07	A procedure was done but the type of procedure was unknown
09	No information of whether a diagnostic or staging procedure was performed.

Surgical Dx/Staging/ Procedure Date (non-cancer directed surgery date)

Record the date that Diagnostic or Staging were performed. (Record the month in the first two boxes, the day in the next two spaces, followed by the four-digit year, in which the positive specimen was obtained.)

Chapter 8

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 known provides a complete "picture" of the patient's cancer experience and is meaningful in calculating survival statistics and assessing treatment success.

Surgery of Primary Site

- Use the operative and pathology reports to determine the proper code(s) for surgical procedure(s). Refer to the site-specific surgery codes on the MCR web site under Abstracting Resources to select the correct code for the procedure performed.

- 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 a part of an organ was removed previously for other reasons and the remaining portion is now removed as cancer-directed treatment, code as a total removal of the organ, (i.e., if one ovary was removed previously for a cyst, removal of remaining ovary would equal a bilateral oophorectomy).

- 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.

- Code surgery to remove regional tissue or organs only if removed with the primary site in an **en bloc** (removal of organs in one piece at one time) resection. Non en bloc resections of secondary or metastatic sites are to be recorded in Field 48C - "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)"

- Codes from 00-79 are hierarchical. If more than one code describes the procedure, use the higher code. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more specific information is not available.

- Code 00 if no primary site surgical procedure was performed.

- **Code 98** for unknown or ill-defined primary (site = C76.0 – C76.8, C80.9), hematopoietic, reticuloendothelial, immuniproliferative or myeloproliferative disease (C42.0 - C42.4), or M-9750, 9760-9764, 9800-9820, 9831-9920, 9931-9964,9980-9989.

- Biopsies that remove all gross tumors or leave only microscopic margins should be coded to surgery of the primary site.

Date of First Surgical Procedure

Record the earliest date that a first course surgical procedure was performed. This date was formerly "Date of Cancer-Directed Surgery".

Text – Surgery of Primary Site

Enter text describing and justifying surgical procedure coded in Field For example, Modified Radical Mastectomy, Retropubic Radical Prostatectomy or list organs removed.

Reason for No Surgery of Primary Site

Select the reason code that best describes why no surgery was not performed on the primary site.

Code	Definition
0	Surgery of primary site was performed
1	Surgery of the primary site was not performed because it was not part of the planned first course of treatment
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, 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 if the first course. 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

Scope of Regional Lymph Node Surgery

This field defines the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgery.

- No minimum number of nodes must be removed. If at least one regional lymph node was removed, the entry must be in the range of 1-5.
- A regional lymph node aspiration or biopsy is coded as 1 - regional lymph node(s) removed, NOS.
- Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes to diagnose or stage disease. Record the date of this procedure in *Date of First Course of Treatment* and/or *Date of First Surgical Procedure* as appropriate.
- Codes 0-7 are hierarchical so the numerically higher code is to be recorded.
- **Code 9** for primaries of the meninges, brain, spinal cord, cranial nerves and other parts of the central nervous system (C70.0-C70.9, C71.0-C71.9, C72.0-C72.9).
- **Code 9** for unknown or ill-defined primary (site = C76.0 – C76.8, C80.9), hematopoietic, reticuloendothelial, immuniproliferative or myeloproliferative disease (C42.0 - C42.4), or M-9750, 9760-9764, 9800-9820, 9831-9920, 9931-9964,9980-9989.0
- **Code 9** for lymphomas (M-9890-9596, 9650-9719, 9727-9729) with a lymph node primary site (C77.0-C77.9)
- Do not code removal of distant lymph nodes in this field. Distant nodes are coded to *Surgical Procedure/Other Site.*
- 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 Procedure.*

Code	Label	Definition
0	None	No regional lymph node surgery or no nodes found in pathological specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph node, NOS	Biopsy or aspiration of regional lymph node (s).
2	Sentinel lymph node biopsy	Biopsy of first lymph node(s) that are identified by the injection of dye or a radio label at the site of the primary tumor.
3	Number of regional nodes removed unknown or not stated; regional lymph nodes removed, NOS	Sampling or dissection and number of regional lymph nodes removed unknown or not stated and not specified as sentinel node biopsy.
4	1-3 regional lymph nodes removed	Sampling or dissection with fewer than 4 regional lymph nodes found in specimen and not specified as sentinel node biopsy.

Code	Label	Definition
5	4 or more regional lymph nodes removed	Sampling or dissection with at least 4 regional lymph nodes found in specimen and not specified as sentinel node biopsy.
6	Sentinel node biopsy and code 3, 4 or 5 at same time, or timing not stated	Code 2 was performed during same surgical event as code 3, 4, or 5. Or, codes 2, 3, 4 or 5 were performed but timing not stated.
7	Sentinel node biopsy and code 3, 4 or 5 at different times	Code 2 was followed in a subsequent surgery by procedures coded as 3, 4 or 5.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery was performed; death-certificate only; unknown or ill-defined primary (site = C76.0 – C76.8, C80.9), hematopoietic, reticuloendothelial, immuniproliferative or myeloproliferative disease, lymphoma (Site = C77.0-C77.9) and brain (site = C70.0-C70.9, C71.0 – C71.9, C72.0 – C72.9) primaries.

Sx – Reg/Distant Sites (Surgical Procedure/Other Site)

This field describes the removal of distant lymph nodes or tissue(s) or organ(s) other than the primary tumor or organ of origin.

- An **en bloc** (removal of organs in continuity with the primary tumor) resection is excluded.
- Assign the highest code that accurately describes the surgical resection.
- Code the removal of non-primary tissue removed because the surgeon considered it suspicious even if the pathology is negative.
- **DO NOT CODE** removal of tissue removed for reasons other than the malignancy. For example: During a colon resection, the surgeon removes the gall bladder because of cholelithiasis. Do not code removal of the gall bladder.
- 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, C42.2 or M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)
- If the procedure coded in this item was provided to prolong a patient's live by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Procedure*.

Code	Label	Definition
0	None	No surgical procedure of non-primary site was performed. Diagnosed at autopsy.
1	Non-primary surgical procedure performed	Non-primary surgical resection of other site(s), unknown if regional or distant.
2	Non-primary surgical procedure to other regional sites	Resection of regional site.

Code	Label	Definition
3	Non-primary surgical procedure to distant lymph node(s)	Resection of distant lymph node(s).
4	Non-primary surgical procedure to distant site	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3 or 4.
	Unknown	Unknown whether any surgical procedure of non-primary site performed. Death certificate only.

Surgical Margins

Code the status of the surgical margins after resection of the PRIMARY tumor. Do not code status of margins from regional lymph node surgery or secondary/metastatic site surgery.

- Microscopic involvement is not visible to the naked eye and is usually documented in the final diagnosis or microscopic portion of the pathology report.
- Macroscopic involvement is visible to the naked eye and may be documented in the operative report or the gross portion of the pathology report.
- The code is hierarchical; if two codes describe the margin status, use the numerically higher code.

  Example: 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). Use the higher code (code 3 - macroscopic involvement).

- If the patient has multiple cancer-directed surgeries of the primary site, code the status of the surgical margins after the final or last surgery.

  Example: Patient has an excisional biopsy of a breast lesion with margins microscopically involved. Later, the patient has a modified radical mastectomy with all margins free. Code the margin status after the mastectomy, 0 - All margins grossly and microscopically negative.

- If no cancer-directed surgery of primary site is performed ("Surgery of Primary Site" is 00), "Surgical Margins" must be coded 8 - No Cancer-Directed Surgery of Primary Site.

Code	Label	Definition
0	No residual tumor	All margins grossly & microscopically negative.
1	Residual tumor, NOS	Involvement indicated but no further information is known.
2	Microscopic residual tumor	Residual tumor identified by microscopic means.
3	Macroscopic residual tumor	Gross tumor of the primary site visible to the naked eye.
7	Margins not evaluable	Margins cannot be assessed.

Code	Label	Definition
8	No primary site surgery	No surgical procedure of primary site. Diagnosed at autopsy.
9	Unknown or not applicable	Unknown whether surgical procedure to primary site performed; death-certificate only; for lymphomas with lymph node primary site; unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immuniproliferative or myeloproliferative disease.

Radiation Therapy

Select the most appropriate code which describes the dominant modality of radiation therapy used to deliver the most clinically significant regional dose during the first course of treatment. Radiation therapy is frequently delivered in two or more stages which can be summarized as "regional" and "boost" treatments.

Regional Treatment Modality

Code	Reason
00	No radiation treatment. Radiation therapy was not administered to the patient. Diagnosed at autopsy.
20	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). O rthovoltage 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 beam.
30	Neutrons, with or without Neutrons, with or without photons/electrons Treatment delivered using neutron beam

Regional Treatment Modality (continued)

Code	Reason
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, 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
80	Combination modality, specified Combination of external beam radiation and either radioactive implants or radioisotopes
85	Combination modality, NOS Combination of radiation treatment modalities no t specified in code 80.
98	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown Radiation therapy administered, treatment volume unknown or not stated in the patient record; it is unknown whether radiation therapy was administered. Death certificate only.

Boost Treatment Modality

Select the most appropriate code which describes the most clinically significant boost dose during the first course of treatment. This is usually done with external beam fields of redud size (relative to the regional treatment fields), implants, stereotactic radiosurgery, conformal therapy, or IMRT. External beam boosts may consist of two or more successive stages with progressively smaller fields usually coded as a single entity.

Code	Reason
00	No radiation treatment. Radiation therapy was not administered to the patient. Diagnosed at autopsy.
20	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). O rthovoltage 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 beam energy in the range of 2–5 MV.
24	Photons (6–10 MV) External beam therapy using a photon producing machine with beam energy in the range of 6–10 MV.
25	Photons (11–19 MV) External beam therapy using a photon producing machine with 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 beam
30	Neutrons, with or without 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.

Code	Reason
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, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, Intracavitary, LDR Intracavitary (no direct insertion into tissues) radioisotope 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
98	Other, NOS. Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown Radiation therapy administered, treatment volume unknown or not stated in the patient record; it is unknown whether radiation therapy was administered. Death certificate only.

Treatment Date – Radiation

Enter date radiation started.

Text - Radiation

Enter text describing radiation performed.

Example: XRT: 3000cgy/10fx

Reason for No Radiation

Select the reason that most closely describes why no radiation therapy was administered to the patient.

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, 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.

Radiation/Surgery Sequence

Select the reason code which describes the sequencing of radiation and surgical procedures given as a part of the first course of treatment.

Code	Label	Definition
0	No radiation therapy and/pr surgical procedures	No 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 no reconstructive surgery. Diagnosed at autopsy.
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	Radiation therapy given before and after any 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).

Code	Label	Definition
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
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. It is unknown is radiation therapy was administered and/or it is unknown if 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. Death certificate only.

Chemotherapy

Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis. For a complete list of chemotherapy drugs, refer to the SEER Rx - Interactive Antineoplastic Drug Database, which can be downloaded from the Seer website at http://seer.cancer.gov/tools/seerrx or through the link provided on the MCR website. (**Note:** Please do not rely on memory alone. Some drugs may have changed treatment categories.)

- One planned course of chemotherapy may be given in several segments; these segments are recorded as **one** course.
- If two or more single chemotherapy agents are given at separate times during the first course of therapy, code these as a combination regimen - **03**.

Code	Definition
00	None
01	Chemotherapy, NOS
02	Chemotherapy, single agent (one drug)
03	Chemotherapy, multiple agents (several drugs, combination regimens)
82	Chemotherapy not recommended/administered – contraindicated due to patient risk factors
85	Chemotherapy not administered – patient died prior to planned or recommended therapy
86	Chemotherapy recommended by physician but not administered. No reason stated in patient's record.
87	Chemotherapy recommended by physician by not administered. Refused by patient, patient's family/ guardian and refusal documented in record.
88	Chemotherapy recommended but unknown if administered
99	Unknown if chemotherapy recommended or administered because it is not documented in patient record. Death certificate only cases.

Note: Per CoC, arterial embolization is coded depending on type of chemo used. If not done in conjunction with chemo, it would be coded to "Other Treatment."

Tx Date—Chemotherapy

Enter date chemotherapy started.

Text – Chemotherapy

Enter text describing type of chemotherapy.

Hormone (Hormone/Steroid) Therapy

Endocrine therapy is defined as any agent (drug) that affects cancer tissue by changing the hormonal balance of the patient. Included are hormones, antihormones and steroids. The SEER Program *Self-Instructional Manual for Tumor Registrars, Book 8, Antineoplastic Drugs,* Third Edition contains a comprehensive list of hormonal agents. http://www.seer.cancer.gov/tools/seerrx/

Code	Definition
00	None, not part of planned first course of therapy
01	Hormone therapy administered as part of first course therapy
82	Hormone therapy not recommended/administered – contradicted due to patient risk factors
85	Hormone therapy not administered – patient died prior to planned or recommended therapy
86	Hormone therapy recommended but not administered – no reason stated in record
87	Hormone therapy recommended by not administered – treatment refused by patient, patient's family/guardian and refusal documented in record
88	Hormone therapy recommended – unknown if administered
99	Unknown whether a hormonal agent(s) was recommended or administered because it is not documented in record. Death certificate only

- When steroids such as prednisone/decadron are given in combination with chemotherapy agents for treatment of lymphoid leukemias, lymphomas or multiple myeloma code as hormonal therapy. (i.e.: MOPP therapy - methrotrexate, oncovin, procarbazine code as chemotherapy and prednisone as hormonal. In the general cancer population, however, corticosteroids are more often used for symptom control and are not considered definitive treatment. For example, decadron for brain metastases or prednisone to stimulate the appetite. (SEER Rx - Interactive Antineoplastic Drug Database, can be downloaded from the Seer website at http://seer.cancer.gov/tools/seerrx or through the link provided on the MCR website. Seer Book 8 – Antineoplastic Drugs, Third Edition is still available and can be located on the Seer website at http://www.seer.cancer.gov/training/manual)

- Tumor involvement may destroy hormone-producing tissue. Do not code hormone replacement therapy as treatment.

- Code 00 if hormone therapy was not administered and it is known that it is usually not administered for this type and stage of cancer.

- Code 01 for thyroid replacement therapy that inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.

- If it is known that hormone therapy is usually administered for this type and stage of cancer but was not administered, use code 82, 85, 86, or 87 to record the reason why it was not administered.

- Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no documentation whether it was recommended or administered.

Note: Endocrine surgery and/or endocrine radiation therapy are now recorded in the hematologic transplant and endocrine procedures section.

Tx Date – Hormone

Enter date hormone therapy started.

Text – Hormone

Enter type of hormone therapy.

Immunotherapy

Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells. The SEER Program *Self-Instructional Manual for Tumor Registrars, Book 8, Antineoplastic Drugs,* Third Edition contains a comprehensive list of

immunotherapy agents. This manual can be found on the SEER website at http://www.seer.cancer.gov/tools/seerrx/

Code	Definition
00	None
01	Immunotherapy administered as first course therapy
82	Immunotherapy not recommended/administered – contraindicated due to patient risk factors
85	Immunotherapy not administered – patient died prior to planned or recommended therapy
86	Immunotherapy recommended but not administered – no reason stated in record
87	Immunotherapy recommended by not administered – treatment refused by patient, patient's
88	Immunotherapy recommended – unknown if administered
99	Unknown whether Immunotherapy was recommended or administered because it is not

Tx Date – Immunotherapy

Enter date BRM started.

Text – Immunotherapy

Enter type of BRM.

Hematologic Transplant and Endocrine Procedures

This data item allows for the coding of treatment that involve the alteration of the immune system or change the patient's response to tumor cells but does not involve the administration of antineoplastic agents.

Code	Definition
00	None
10	Bone marrow transplant procedure administered but type not specified
11	Autologous bone marrow transplant

Code	Definition
12	Allogeneic bone marrow transplant
20	Stem cell harvest
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 not recommended/administered – contraindicated due to patient risk factors
85	Hematologic transplant and/or endocrine surgery/radiation not administered – patient died prior to planned or recommended therapy
86	Hematologic transplant and/or endocrine surgery/radiation recommended but not administered – no reason stated in record
87	Hematologic transplant and/or endocrine surgery/radiation recommended by not administered – treatment refused by patient, patient's family/guardian and refusal documented in record
88	Hematologic transplant and/or endocrine surgery/radiation recommended – unknown if administered
99	Unknown whether Hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not documented in record. Death certificate only

- Bone marrow transplants should be coded as autologous (bone marrow from patient) or allogeneic (bone marrow donated). Syngeneic transplants (marrow from identical twin) are coded as allogeneic.

- Endocrine irradiation and/or endocrine surgery procedures suppress the naturally occurring hormonal activity to alter or affect the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or radiation.

- Code 00 if transplant or endocrine procedures not administered and it is known that these procedures are not usually administered for this type and stage of cancer.

- If it is known that a transplant or endocrine procedure is usually administered for this type and stage of cancer, use code 82, 85, 86, or 87 to record the reason why procedures not administered.

- Code 99 if unknown if transplant or endocrine procedure usually administered for this type and stage of cancer and there is no documentation whether it was recommended or administered.

Other Cancer-Directed Therapy

Identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy.

0	None	All treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no treatment
1	Other	Treatment that cannot be assigned to specified treatment data items. Use this code for treatment unique to hematopoietic diseases, e.g., phlebotomy, transfusions and aspirin.
2	Other - experimental	Not defined – may be used to record participation in institution-based clinical trials.
3	Other – Double Blind	Double blind study, code not yet broken – code treatment actually administered when code is broken.
6	Other - Unproven therapy	Treatments administered by non-medical personnel.
7	Refusal	Treatment recommended but not administered - patient or patient's family/guardian refused therapy which would have been coded 1,2, or 3 above.
8	Recommended; unknown if administered	Other treatment recommended but unknown if administered
9	Unknown	Unknown if other cancer directed therapy recommended or administered – no documentation in medical records.

Tx Date – Other

Enter date other treatment started.

Text – Other Treatment

Enter type of other treatment.

Palliative Procedure

This data item allows reporting facilities to code procedures that are considered palliative along with therapeutic, diagnostic or staging.

Code	Definition
0	No palliative care provided.
1	Surgery (may involve a bypass) to alleviate symptoms but no attempt is made to diagnose,
2	Radiation to alleviate symptoms but no attempt is made to diagnose, stage, or treat the
3	Chemo, hormone therapy, or other systemic therapy to alleviate symptoms but no attempt
4	Patient received or was referred for pain management with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without 4.
6	Any combination of codes 1,2, and/or 3 with 4.
7	Palliative care was performed or referred but information on type is available in patient re-
9	Unknown if palliative care performed or referred; not stated in patient record.

- Record the type of palliative procedure administered during the first course of treatment or in lieu of treatment.
- If palliative procedures/treatment are given during the first course of treatment they must also be recorded in the appropriate treatment/procedure section.
- Palliative procedures are not used in diagnosing, staging or treating the primary tumor.

  Example: A patient with unresectable pancreatic cancer receives bypass surgery to alleviate jaundice and pain. Patient received radiation for painful bone metastases or chemotherapy for advanced cancer.

Chapter 9

RECURRENCE INFORMATION

The term "recurrence" indicates the return of a malignancy after remission or after the patient has experienced a period of time without disease. Use this field for the **first recurrence only.**

Type of First Recurrence

- Codes 00 through 70 are hierarchical. Record the highest-numbered applicable response.
- If the tumor was originally diagnosed as in situ and the recurrence code is 16, 17, 26, 27, 36, or 46 then the recurrence must be reported as a new case.
- Codes 00, 88 or 99 may apply to any tumor.
- Codes 51-59 apply only if all first occurrences were in a single category. There may be multiple metastases (or "seeding") within the distant location.
- Code leukemias that are in remission 00. If the patient relapses, code recurrence status as 59.
- If patient has multiple primary tumors and the physician does not document the site that has recurred, code recurrence for each tumor. Codes can be revised at a later date.

Use the following table to record the correct numeric code for the type of **first recurrence:**

Code	Definition
00	Patient became disease-free after treatment and has not had a recurrence.
04	In situ recurrence of an invasive tumor.
06	In situ recurrence of an in situ tumor.
10	Local recurrence, and there is insufficient information available to code to 13-17. Local recurrence includes recurrence confined to the remnant of the organ of origin, to the organ of origin, to the anastomosis, or to scar tissue where the organ previously existed.
13	Local recurrence of an invasive tumor.
14	Trocar recurrence of an invasive tumor. Includes recurrence in the trocar path or entrance site following prior surgery
15	Both local and trocar recurrence of an invasive tumor (both 13 and 14).

Code	Definition
16	Local recurrence of an in situ tumor, NOS
17	Both local and trocar recurrence of an in situ tumor.
20	Regional recurrence, and there is insufficient information available to code to 21.27.
21	Recurrence of an invasive tumor in adjacent tissue or organ(s) only.
22	Recurrence of an invasive tumor in regional lymph nodes only.
25	Recurrence of an invasive tumor in adjacent tissue or organ(s) and in regional lymph nodes (both 21 and 22 at the same time
26	Regional recurrence of an in situ tumor, NOS
27	Recurrence of an in situ tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time.
30	Both regional recurrence of an invasive tumor in adjacent tissue or organ(s) and/or regional lymph nodes (20-25) **and** local and/or trocar recurrence (10,13,14, or 15)
36	Both regional recurrence of an in situ tumor in adjacent tissue or organ(s) and/or regional lymph nodes (26-27) **and** local and/or trocar recurrence (16 or 17)
40	Distant recurrence, and there is insufficient information available to code to 46.62.
46	Distant recurrence of an in situ tumor.
51	Distant recurrence of an invasive tumor in the peritoneum only. Peritoneum includes peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
52	Distant recurrence of an invasive tumor in the lung only. Lung includes the visceral pleura.
53	Distant recurrence of an invasive tumor in the pleura only. Pleura includes the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
54	Distant recurrence of an invasive tumor in the liver only.
55	Distant recurrence of an invasive tumor in bone only. This includes bones other than the primary site.
56	Distant recurrence of an invasive tumor in the CNS only. This includes the brain and spinal cord, but **not** the external eye.
57	Distant recurrence of an invasive tumor in the skin only. This includes skin other than the primary site.
58	Distant recurrence of an invasive tumor in lymph node only. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site.
59	Distant systemic recurrence of an invasive tumor only. This includes leukemia, bone marrow metastasis, carcinomatosis, generalized disease.
60	Distant recurrence of an invasive tumor in a single distant site (51-58) **and** local, trocar and/or regional recurrence (10-15, 20-25, or 30).
62	Distant recurrence of an invasive tumor in multiple sites (recurrences that can be coded to more than one category 51-59).
70	Since diagnosis, patient has never been disease-free. This includes cases with distant metastasis at diagnosis, systemic disease, unknown primary or minimal disease that was not treated.
88	Disease has recurred, but the type of recurrence is unknown.
99	It is unknown whether the disease has recurred or if the patient was ever disease-free.

Date of First Recurrence

Code the month in the first two spaces, the day in the next two, and the four-digit year in the last four spaces.

> **Example:** Patient is diagnosed in April of 1990 with lung cancer. He has a first recurrence on June 15, 1991 - code: 06 15 1991.

- If the exact date of the first recurrence is not known, estimate, at least the year of recurrence, using documented information. Estimation is preferable to recording an unknown date.
- If only the time of year, spring, middle, fall, or winter is referenced, estimate these months as April, July, or October, and December or January respectively.

Last Contact Date/Date of Death

Record month, day, and four-digit year on which the patient was last known to be alive or the date of death.

Vital Status

Record the patient's vital status using:

0 - Dead
1 - Alive

Tumor Status

Use the following codes:

1 No evidence of this cancer
2 Evidence of this cancer
9 Unknown whether this cancer is present

Chapter 10

DEATH INFORMATION

Underlying causes, ICD revisions and place of death

Underlying Cause of Death

Code the underlying cause of death that is listed on the death certificate or in the medical record using the International Classification of Diseases 10th revision (ICD-10-CM). If the DATE OF LAST CONTACT/DEATH is prior to 1/1/1999, code the Cause of Death using the ICD-9-CM. If the DATE OF LAST CONTACT/DEATH is 1999, the Cause of Death may be coded using the ICD-9-CM or the ICD-10-CM. If the DATE OF LAST CONTACT/ DEATH is on or after 1/1/2000, code the Cause of Death 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

Underlying Cause of Death	ICD - 9 Code	Registry Code	ICD-10 Code	Registry Code
Cancer of the thyroid	193	1939	C739	C739
Adenocarcinoma of the stomach	151.9	1519	C169	C169
Pneumonia	486	4869	J189	J189
Acute appendicitis with peritonitis	540.0	5400	K350	K350
Myocardial infarction, nos	410.90	4109	I228	I228

Note: Beginning in 1999, death certificates from the Bureau of Vital Statistics are coded using ICD-10. A list of ICD-10 codes is available at http://www.cdc.gov/nchs/data/icd9/draft_icdtneo.pdf. A complete listing of ICD-10-CM codes may also be found on the MCR web site at http://mcr.umh.edu/

ICD Revision No.

Code the ICD-Edition used when the cause of death was coded:

Code	
0	Patient alive at last contact
1	ICD-10 (on or after 1/1/2000)
9	ICD-9

Place of Death

Code the appropriate three-digit SEER Geo code for the **state** or country of death (http://seer.cancer.gov).

Chapter 11

TEXT FIELDS

Procedures and Treatments

Text fields provide MCR with written documentation and descriptions of abstracted data necessary to perform accurate quality control and case evaluation. Text also strengthens the case consolidation procedure when more than one facility submits data on the same patient. Record pertinent information and tests that substantiate the abstracted data.

Dx Procedures and Treatments

Physical Exam: Findings at the time of initial physical examination are recorded in this text field. Information from the history and physical should be included.

X-rays/Scans: Written descriptions of information obtained from diagnostic imaging reports are entered in this field. Information should include chest x-rays, MRIs, CT scans, or PETs and the dates they were performed.

Scopes: The date and description of any endoscopic examination performed is included in the "scopes" section. Some examples are: cystoscopy, EGD, colonoscopy, sigmoidoscopy, and proctoscopy.

Lab Tests: This text area should include information from laboratory examinations and dates they were performed other than cytology or histology, such as CA-125, or PSA values.

OP: The text should include a description and date(s) of all surgical procedure (s) performed that are related to the first course of treatment

PATH: Pathological findings which should be recorded include histology present and degree of differentiation, size of neoplasm, extent of disease, number and type of lymph nodes sampled/ found positive.. The date the pathological tissue was obtained should also be noted.

STAGING/REMARKS: Recorded text should justify stage assigned. Other pertinent information should be recorded here as well.