9th Edition

Abstract Code Manual

MISSOURI CANCER REGISTRY
University of Missouri – Columbia

2009
Revised

University of Missouri Health Care — Missouri Cancer Registry

Abstract Code Manual

9th Edition — 2009

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Preface

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 a 2009 revision of the eighth edition of the manual. This revision includes clarifications and any 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 1998-2005.

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, the statutes 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) in an effort to become a true population-based central registry. 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. Data items are based on fields required and/or recommended by NPCR for central registries collecting incidence data. Additional requirements include fields required for quality assurance and two Missouri-specific fields, Tobacco Years and Patient History of Cancer.

Role of Hospitals

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

Role of Missouri Cancer Registry

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 low-volume facilities. 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.

Edits

A Missouri-specific edit metafile was developed in 2008. This metafile was made available to all registry software vendors. A list of edits contained in the metafile is available on the MCR website. Questions regarding edits should be directed to MCR QA personnel.

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 low-volume 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 reviewed. In 2008, MCR initiated a pilot project to test the feasibility and viability of abstracting from text submitted . The pilot will continue in 2009.

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

- **Multiple primary & histology rules are applied to new solid malignant tumors diagnosed on or after January 1, 2007. *The Multiple Primary and Histology Coding Rules Manual* can be downloaded from:** http://seer.cancer.gov/tools/mphrules/download.html
- 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 reportable 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.
- Request forms are available for hospitals requiring special data reports from the central registry. Requests for studies, reports or information may be submitted to MCR staff by calling 1-800-392-2829.
- A list of Required Data Items can be found on the MCR web page (see http://mcr.umh.edu). This list is based on Missouri statutes, NPCR requirements, data quality requirements and projected needs of the citizens of the state of Missouri.
- The ICD-0-3 coding scheme must be used for site and histology of cases diagnosed on or after January 1, 2001. The ICD-0-2 coding scheme must be used for cases diagnosed prior to January 1, 2001.
- 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 (COI)*** 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:** 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

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

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

Confidential information on individual cases may be transmitted via fax. The MCR fax machine is in a locked office, not accessible to non-MCR personnel. The office is secure 24 hours a day.

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

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

Use Correct MCR Address to Maintain Secure Data Submissions

We still occasionally receive information that is incorrectly addressed. In order to protect and properly handle all packages, particularly those containing confidential patient information we encourage you to use Federal Express, UPS, Airborne Express or any other type of courier service. The MCR street address below must be used for courier packages:

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

You may wish to contact the addressee at MCR so that she/he knows they are expecting a package. Be sure to track the package to ensure that it has reached its destination. You may also want to explore the e-mail tracking and notification features that the courier of choice offers.

Our PO Box is still the same. If using the US Postal Service, which may include Express mail, Priority mail, and Certified mail, you must use the MCR PO Box address below:

Missouri Cancer Registry
PO BOX 718
Columbia, MO 65205

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.

Reportable List for Casefinding

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
140.0 - 208.9	Malignant neoplasms
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
228.02	Hemangioma of intracranial structures
229.9	Benign neoplasm of unspecified site (screen for potential 225-227 miscodes)
230.0 - 234.9	Carcinoma in situ
236.1	Neoplasm of uncertain behavior of placenta; Malignant hydatidiform mole

Reportable List for Casefinding (continued)

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
237.0-237.1	Neoplasm of uncertain behavior of pituitary gland, craniopharyngeal duct, pineal gland
237.5-237.72 237.9	Neoplasm of uncertain behavior of brain and spinal cord, meninges (NOS, cerebral, spinal) acoustic neurofibromatosis; Neoplasm of uncertain behavior of other and unspecified parts of [central] nervous system, cranial nerves
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3) Extramedullary plasmacytoma (9734/3)
238.71	Essential thrombocythemia (9962/3) Essential hemorrhagic thrombocythemia Essential thrombocytosis Idiopathic (hemorrhagic) thrombocythemia Primary thrombocytosis
238.72	Refractory anemia (RA) (9980/3) Refractory anemia with ringed sideroblasts (RARS) (9982/3) Refractory cytopenia with multilineage dysplasia (RCMD) (9985/3) Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS) (9985/3)
238.73	Refractory anemia with excess blasts-1 (RAEB-1) (9983/3) Refractory anemia with excess blasts in transformation (RAEB-2) (9984/3)
238.74	Myelodysplastic syndrome with 5q- syndrome (9986/3) 5q minus syndrome NOS Chronic myeloproliferative disease (9960/3) Myelosclerosis with myeloid metaplasia (9961/3) Refractory cytopenia with multilineage dysplasia (9985/3) Therapy-related myelodysplastic syndrome (9987/3)
238.75	Myelodysplastic syndrome, unspecified (9989/3)
238.76	Myelofibrosis with myeloid metaplasia (9961/3) Agnogenic myeloid metaplasia Idiopathic myelofibrosis (chronic) Myelosclerosis with myeloid metaplasia Primary myelofibrosis
238.79	Lymphoproliferative disease (chronic) NOS (9970/1) Megakaryocytic myelosclerosis (9961/3) Myeloproliferative disease (chronic) J551 NOS (9960/3) Panmyelosis (acute) (9931/3)
239.6-239.7	Neoplasm of unspecified nature of brain, meninges, cranial nerves
259.2	Carcinoid syndrome; Hormone secretion by carcinoid tumors
273.2	Gamma heavy chain disease; Franklin's disease (9762/3)
273.3	Waldenstrom's macroglobulinemia (9761/3)
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)
288.3	Hypereosinophilic Syndrome (9964/3)
289.83	Acute myelofibrosis (9931/3)
V07.3	Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
V10.0 - V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries, and/or subsequent treatment)
V58.0	Admission for radiotherapy
V58.11-V58.12	Admission for chemotherapy
62.3-62.42	Orchiectomies (Treatment for prostate malignancies)
92.20-92.29	Therapeutic radioscope administration
92.30-92.39	Stereotactic radiosurgery, NOS

The following table includes ICD-0 codes that CDC and NPCR or others suggest may be included in a reportable list. MCR does not include these codes in their reportable list. MCR feels that including these codes will result in significantly more cases to review but few cases that are reportable. Records with these codes can be screened if time allows.

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
042	AIDS (review cases for AIDS-related malignancies)
052.2	Postvaricella myelitis
053.14	Herpes zoster meylitis
054.74	Herpes simplex myelitis
277.30	Amyloidosis, unspecified
277.31	Familial Mediterranean fever
277.39	Other amyloidosis
284.01	Constitutional red blood cell aplasia
284.09	Other constitutional aplastic anemia
284.1	Pancytopenia
284.2	Myelophthisis
288.00	Neutropenia, unspecified
288.01	Congenital neutropenia
288.02	Cyclic neutropenia
288.03	Drug induced neutropenia
288.04	Neutropenia due to infection
288.09	Other neutropenia
288.4	Hemophagocytic syndromes
288.5	Leukocytopenia, unspecified
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

Cases That Must Be Reported

- Refer to the casefinding list when conducting casefinding. activities. 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. (Refer to *Multiple Primary & Histology Coding Rules Manual* for definition of recurrence.)**

- 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.

Example: Patient was originally diagnosed with prostate cancer in 2005 at another facility and is admitted to your facility in 2007 with questionable chest x-ray. A biopsy shows metastatic adenocarcinoma consistent with prostate primary. THIS CASE IS REPORTABLE.

Example: 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**, although not required, may be reported 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.

- 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.

- Adenocarcinoma insitu of the cervix is reportable.

- Pilocytic/juvenile astrocytoma (9421) will continue to be collected as a /3 even though the behavior code changed to /1 in the ICD-O-3.

Cases Not Required To Be Reported

- Skin cancers (site = C44. * and histology = 8000-8110) (As of January 1, 2001).
- Class of Case 6 or Class of Case 7 cases. (May be voluntarily reported)
- Patients who have a history of cancer but diagnosis or treatment were not performed 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..

  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)**. **Refer to the lists on the next page to determine reportable versus non-reportable cases. (Note: The terms used with the new multiple primary and histology coding rules are not to be used to determine reportability.)**

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.

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

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 above lists to determine reportable versus non-reportable cases. Refer to the Collaborative Staging Manual for a listing of ambiguous terms used for staging.

Chapter 3

DETERMINING PRIMARY TUMORS

The 2007 Multiple Primary and Histology (MP/H) Coding Rules include site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, and malignant brain. A separate set of rules addresses the specific and general rules for malignant solid tumors originating in all other sites. The multiple primary rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions. For example, there are instructions and guidance for identifying histologic lineages, differentiating between general (NOS) terms and specific histologic types, and correctly assigning mixed and combination codes.

The rules are available in three formats: flowchart, matrix and text. The different formats were developed to meet the needs of registrars who have different learning styles. The manual can be downloaded at http://seer.cancer.gov/tools/mphrules/download.html.

Note: **The MP/H rules do not apply to hematopoietic primaries (lymphoma and leukemia). Use the tables in Appendix A of *FORDS* to determine whether hematopoietic primaries are single or multiple. Primary site and timing are not applicable to determine number or primaries for these sites.**

Determining Multiple Primaries for Solid Malignant Tumors—General Instructions

General Information

1. Use these rules to determine the number of reportable primaries. Do **not** use these rules to determine case reportability, stage, or grade.

2. The 2007 multiple primary and histology coding rules **replace all previous** multiple primary and histology coding **rules**.

3. The rules are **effective** for cases **diagnosed January 1, 2007** and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.

4. Read the **General Instructions** and the **site-specific Equivalent Terms and Definitions** before using the multiple primary rules.

6. **Notes** and **examples** are included with some of the rules to **highlight key points** or to add **clarity** to the rules.

7. **Do not use** a physician's statement to decide whether the patient has a recurrence of a previous cancer or a new primary. Use the multiple primary rules as written **unless** a **pathologist compares** the present tumor to the "original" tumor and states that this tumor is a recurrence of cancer from the previous primary.

8. Use the Determining Multiple Primaries: Hematopoietic Primaries (Lymphoma and Leukemia) rules and table "Definitions of Single and Subsequent Primaries for Hematologic Malignancies" to determine single versus multiple primaries for lymphoma and leukemia cases.

How to Use the Multiple Primary Rules

1. **Use** the **Multiple Primary** rules to **determine the number of primary malignancies** to be abstracted for reportable solid malignant tumors.

2. Use the **site-specific rules** for the following primary sites:

- Benign brain
- Brain, malignant (intracranial and CNS)
- Breast
- CNS tumors
- Head and neck
- Kidney
- Lung
- Malignant melanoma of the skin
- Renal pelvis, ureter, bladder, and other urinary

3. Use the **Other Sites rules** for solid malignant tumors that occur in primary sites not covered by the site-specific rules.

4. Each module within the site-specific rules (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors) is an independent, complete set of coding rules.

To determine which set of primary site rules to use:

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

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

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

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

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

II. Determine the number of tumors

i. Do not count metastatic lesions

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

if Single or Multiple Tumors" module

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

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

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

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

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

5. If a **single primary**, prepare **one abstract**..

6. If there are **multiple primaries**, prepare **two or more abstracts**.

7. Rules are in hierarchical order within each module (Unknown if Single or Multiple Tumors, Single Tumor, and Multiple Tumors). Use the first rule that applies. **Priority order for using Documents to Code Histology**.

Medical records frequently include multiple pathology reports and references to histologic diagnosis. Use the following instructions to identify which reports best represent the histology to be coded.

1. Pathology report:

a. From the **most representative** tumor specimen examined.

b. From the **final diagnosis**.

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

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

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

You will only use information from the microscopic portion of the pathology report when

instructed to do so in one of the site-specific rules.

2. Cytology report.

3. When you do not have either a pathology report or cytology report:

a. Documentation in the medical record that references pathology or cytology findings.

b. From mention of type of cancer (histology) in the medical record.

Ambiguous Terms Used to Code Histology

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

Ambiguous terms that are characteristic (used to code histology):

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

Example: Non-small cell carcinoma, most likely adenocarcinoma. Code adenocarcinoma.

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: The following table is a reference. Physician comments take precedence over the table.**

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

Exceptions: The following are recurrences of the original disease without time limits.

-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. (Refer to the *Multiple Primary and Histology Coding Rules* for additional information)

-Kaposi sarcoma (9140) of any site.

Example: Consider Kaposi sarcoma as one primary site no matter what the site. Refer to "Primary Site" for coding rules.

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/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/.

NPI—Reporting Facility

The National Provider Identifier (NPI) code represents the data transmission source. The NPI is a unique identification number for health care providers by the Centers for Medicare & Medicaid Services (CMS) as part of HIPAA. The NPI Registry can be found at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

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 199900032-00. In 2004, the patient is diagnosed with colon cancer. The accession number remains 199900032, 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 regarding which sequence number to assign a neoplasm depends upon its' behavior code at the time of diagnosis. Codes 00-35 and 99 indicate the sequence of neoplasms of *in situ* or malignant behavior (2 or 3) at the time of diagnosis. Codes 60-88 indicate the sequence of non-malignant tumors. Neoplasms which are reportable by agreement, either by MCR or your 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..

Neoplasm	SeqNum-Hospital
Malignant and in situ	
One in situ (behavior code = 2) or malignant (behavior code =3) primary tumor only in the patient's lifetime	00
First of multiple in situ or malignant primary tumors in the patient's lifetime	01
Actual sequence of two or more in situ or malignant primary tumors	02 - 35
Unspecified malignant sequence number or unknown	99
Non-Malignant	
One benign (behavior code = 0) or borderline (behavior code = 1) primary tumor only in the patient's lifetime	60
First of two or more benign or borderline primary tumors in the patient's lifetime	61
Actual sequence of two or more non-malignant primary tumors	62 - 87
Unspecified non-malignant sequence number or unknown	88

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 are acceptable.

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**.
- It may be necessary to use "UNKNOWN" for Class of Case 3 cases if the correct Address at Diagnosis is not known.
- 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		

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

Zip Code at Diagnosis

For U.S. residents record the 5-digit zip code and the 4-digit extension (if known) for the patient's address at diagnosis, in the boxes provided; left justify the field. For Canadian residents, use the 6-character alphanumeric postal code; left justify the field. Record 888888888 if the patient is a resident of a country other than Canada, United States or U.S. possessions and 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/mcr-absresources.html.

- Code 998 If 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 must 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.

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 and using 16 years old as the starting age (e.g., the patient is 76 y.o. and has smoked his entire life, then 60 years would be a conservative estimate). If no information is available, enter 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

- **Race should be documented in text.**
- 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
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (Not Brazil)
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 comes 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/.

NPI—Institution Referred From

The NPI that identifies the facility that referred the patient to the reporting facility. Enter only valid NPI assigned 10-digit numbers. If unknown, leave blank. The NPI Registry can be found at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

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).

NPI—Institution Referred To

The NPI that identifies the facility to which the patient was transferred for additional care.. Enter only valid NPI assigned 10-digit numbers. If unknown, leave blank. The NPI Registry can be found at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

Primary Payer at Diagnosis

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

Code	Description
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

(Primary Payer at Diagnosis table continued from previous page)

Code	Description
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.

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

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 including palliative in lieu of 1st course.

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.

Type of Reporting Source

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

1 Hospital inpatient, hospital outpatient, hospital clinic
2 Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
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

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 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 histology coding are found in the *Multiple Primary and Histology Coding Rules* 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

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

Code	Grade/Cell	Description
1	Grade I, 1, i	Well differentiated, differentiated, NOS
2	Grade II, 2, ii/I/III or 1/3	Moderately differentiated, moderately well; intermediate differentiated
3	Grade III, 3, iii, II/III or 2/3	Poorly differentiated
4	Grade IV, 4, iv, III/III or 3/3	Undifferentiated, anaplastic
For Lymphomas and Leukemias		
5	T-cell, T-Precursor, lymphomas & leukemias	
6	B-cell, Pre-B, B-precursor, lymphomas, & leukemias	
7	Luekemias only, Null cell, Non T-Non B	
8	Natural Killer cell, lymphomas & leukemias	
For all histologies		
9	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, relatively undifferentiated	II/III or 2/3	2/3
4	High grade, poorly differentiated to undifferentiated	III/III or 3/3	2/2, 3/3

Coding Breast Cancers

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

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

Nuclear Grade

Terminology

Differentiation (well differentiated, moderately differentiated, etc)

Histologic grade

Grade I, grade ii, grade iii, grade iv

2. Bloom-Richardson (BR)

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

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

Use the following table to convert BR score

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

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

Use the table below to convert BR grade to code.

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

Coding Prostate Cancers

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

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

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

Gleason'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.
- 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.

Ambiguous Terminology

Identifies all cases, including DCO and autopsy only, for which an ambiguous term is the most definitive word or phrase used to establish a cancer diagnosis. Ambiguous terminology may originate from any source document, such as pathology report, radiology report, or from a clinical report. This data item is used only when ambiguous terminology is used to establish diagnosis. It is not used when ambiguous terminology is used to clarify a primary site, specific histology, histologic group, or stage of disease.

Cases with a code 1 in this data item should be excluded from case selection in research studies and from annual contract (i.e., follow-up) by registrars. Direct patient contact is not recommended for these cases.

Ambiguous terms that are reportable:

Apparent(ly)
Appears (effective with cases diagnosed 1/1/1998 and later)
Comparable with (effective with cases diagnosed 1/1/1998 and later)
Compatible with (effective with cases diagnosed 1/1/1998 and later)
Consistent with
Favor(s)
Malignant appearing (effective with cases diagnosed 1/1/1998 and later)
Most likely
Presumed
Probable
Suspect(ed)
Suspicious (for)
Typical (of)

Follow-back to a physician or subsequent readmission (following the initial two month diagnosis period) may eventually confirm a cancer diagnosis (conclusive cancer diagnosis greater than two months after date of initial diagnosis that was based on ambiguous terminology).

Rationale

Cases with a reportable cancer diagnosis that has been established based only on reports that contain ambiguous terminology to describe final diagnostic findings cannot currently be identified. Multiple surveys have identified a lack of consensus in the interpretation and use of ambiguous terms across physician specialties. These cases may or may not have an actual cancer diagnosis based on clinician, radiologist, and pathologist review. Furthermore, the historical interpretation and use of ambiguous terms by cancer registrars and registries has not been consistent or compatible with physician use of these terms.

This data item will identify specific primary sites where the ambiguous terminology is commonly used to describe or establish a cancer diagnosis. Data collected will be used as the basis for modifications to case inclusion and reportable rules following complete analysis and impact assessment. This data item will allow cases to be identified within an analysis file. It will also allow these cases to be identified and excluded from patient contact studies.

Codes

0 Diagnosis based on unambiguous terminology (definite statement of malignancy) within two months of initial diagnosis

1 Diagnosis based on ambiguous terminology within two months of initial diagnosis (diagnosis may be from a pathology report, cytology report, or radiology report or on the medical record)

2 Diagnosis previously based on ambiguous terminology, with unambiguous confirmation two months or more after initial diagnosis (conclusive cancer diagnosis, by any method, more than two months following an initial diagnosis based on ambiguous terminology)

9 Unknown if diagnosis based on ambiguous terminology

Date of Conclusive DX

Description

Documents the date when a conclusive cancer diagnosis (definite statement of malignancy) is made following an initial diagnosis that was based only on ambiguous terminology. The date of the conclusive diagnosis must be greater than two months following the initial (ambiguous terminology only) diagnosis.

If the date of conclusive diagnosis is within two months following the initial (ambiguous terminology only) diagnosis, the case does not meet the criteria for ambiguous terminology only.

Rationale

This date will allow analysis of the primary site locations and frequency of cases that were originally diagnosed by ambiguous terminology and later confirmed by other conclusive method.

This date will also allow for analysis of the time interval between cancer diagnosis based on ambiguous terminology and confirmation of the cancer diagnosis by conclusive means.

The date must be greater than two months from the original/initial diagnosis date.

Codes

00000000	No conclusive diagnosis made
88888888	Not applicable, initial diagnosis made by unambiguous terminology
99999999	Unknown date, unknown if diagnosis based on ambiguous terminology

Multiple Tumors Reported as One Primary

Description

This data item is used to identify cases with multiple tumors that are abstracted and reported as a single primary using the SEER, IARC, or Canadian Cancer Registry multiple primary rules. Multiple tumors may individually exhibit in situ, invasive, or any combination of in situ and invasive behaviors. Multiple intracranial and central nervous system tumors may individually exhibit benign, borderline, malignant, or any combination of these behaviors. Multiple tumors found in the same organ or in a single primary site may occur at the time of initial diagnosis or within one year of the initial diagnosis.

- The data item does not apply to metastatic tumors.
- Data will be collected at the time of initial case abstract or within one year of the initial diagnosis.
- This data item is also used when a physician states that there are two or more primaries, but for surveillance purposes, the case is reported as a single primary.
- Leave blank for cases diagnosed on or before December 31, 2006

Rationale

Patients with multiple tumors that are currently reported as a single primary for surveillance purposes may have a worse prognosis or more extensive treatment than patients with a single tumor. This data item will make it possible to identify important information about these cases for data analysis.

Data collected under this item will be used to assess the number, type, and anatomic location of multiple tumors currently abstracted as a single primary using the SEER, IARC, or Canadian Cancer Registry rules for determining multiple primary cancers and the impact of these cases on cancer case counts and incidence rates.

Data will also serve as a basis for measuring the impact and feasibility of future modifications to the multiple primary rules.

This data item will make it possible to compare individually reported cancer cases with historical data if the rules are changed.

Codes

00	Single tumor
10	At least two benign tumors in same organ/primary site (Intracranial and CNS sites only)
11	At least two borderline tumors in the same organ/primary site (Intracranial and CNS sites only)
12	Benign and borderline tumors in the same organ/primary site (Intracranial and CNS sites only)
20	At least two in situ tumors in the same organ/primary site
30	One or more in situ and one or more invasive tumors in the same organ/primary site
31	One or more in situ/invasive adenocarcinoma in a polyp and one or more frank adenocarcinoma in one segment of colon
32	Familial polyposis with one or more in situ/invasive carcinoma
40	At least two invasive tumors in the same organ (Includes one or more invasive tumor with histology "NOS" and one or more separate invasive tumor with a more specific histology)
80	Multiple tumors present in the same organ/primary site, unknown if in situ or invasive
88	Information on multiple tumors not collected/not applicable for this site
99	Unknown

Multiplicity Counter

Description

This data item is used to count the number of individual reportable tumors (multiplicity) that are present at the time of diagnosis or the number of reportable tumors that occur within one year of the original diagnosis reported as a single primary using the SEER, IARC, or Canadian Cancer Registry multiple primary rules.

Rationale

Patients with multiple tumors currently reported as a single primary for surveillance purposes may have a worse prognosis or more extensive treatment than patients with a single tumor. This data item will make it possible to identify important information about these cases for data analysis.

Data collected under this item will be used to assess the number, type, and anatomic location of multiple reportable tumors currently abstracted as a single primary using the SEER, IARC, or Canadian Cancer Registry rules for determining multiple primary cancers and the impact of these cases on cancer case counts and incidence rates.

Data will also serve as a basis for measuring the impact and feasibility of future modifications to the multiple primary rules.

This data item will also make it possible to compare individually reported cancer cases with historical data if the rules are changed.

Codes

01	One tumor only
02	Two tumors present
03	Three tumors present
..	
..	
88	Information on multiple tumors not collected/not applicable for this site
99	Multiple tumors present, unknown how many

Date of Multiple Tumors

Description

This data item is used to identify the month, day and year the patient is diagnosed with multiple or subsequent reportable tumor(s) reported as a single primary using the SEER, IARC, or Canadian Cancer Registry multiple primary rules. Multiple tumors must have the same histology as the original tumor and must be located in the same organ or primary site as the original tumor, using primary site and histology coding rules. See page 91 for date format.

Record the Date of Diagnosis as the Date of Multiple Tumors when multiple reportable tumors are abstracted and reported as a single primary at the time of initial diagnosis.

Record the date the first subsequent reportable tumor was diagnosed (same histology and same site as the original tumor, using the primary site and histology coding rules).

The Date of Multiple Tumors must occur within one year following the initial/first diagnosis of the reported tumor.

Rationale

Patients with multiple tumors currently reported as a single primary for surveillance purposes may have a worse prognosis or more extensive treatment than patients with a single tumor. This data item will make it possible to identify important information about these cases for data analysis.

The Date of Multiple Tumors will allow separation of cases with multiple reportable tumors present at the time of initial diagnosis from cases with subsequent reportable tumors. The date will allow tracking of the time interval between the date of original diagnosis and the first date of subsequent tumor(s) for specific primary sites and tumor histologies.

Codes

00000000	Single tumor
88888888	Information on multiple tumors not collected/not applicable for this site
99999999	Unknown date

Place of Diagnosis

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

Diagnostic Confirmation

Information in this field records the most definitive method of diagnosis 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 required for following major heading sites and sub-sites: (see table on following pages), but can be used for sites not listed in the table.

Laterality	
Site	**Code**
Parotid	C07.9
Submandibular gland	C08.0
Sublingual gland	C08.1
Tonsillar fossa	C09.0
Tonsillar pillar	C09.1
Overlapping lesion of tonsil	C09.8
Tonsil, Nos	C09.9
Nasal cavity-excludes nasal cartilage & nasal septum	C30.0
Middle ear	C30.1
Maxillary sinus	C31.0
Frontal sinus	C31.2
Main bronchus-excluding carina	C34.0
Lung	C34.*
Pleura, Nos	C38.4
Long bone-upper limb & scapula	C40.0
Short bone, upper limb	C40.1
Long bone, lower limb	C40.2
Short bone, lower limb	C40.3
Rib & clavicle - excludes sternum	C41.3
Pelvic bones - excludes sacrum, coccyx, & symphysis pubis	C41.4
Skin of eyelid	C44.1
Skin of external ear	C44.2
Skin-other-unspecified parts of face-if midline use 9	C44.3
Skin of trunk - code 9 if midline	C44.5
Skin of upper limb & shoulder	C44.6
Skin of lower limb & hip	C44.7
Peripheral nerves & autonomic nervous system, upper limb & shoulder	C47.1
Peripheral nerves & autonomic nervous system of lower limb & hip	C47.2
Connective, subcutaneous, & other soft tissues-upper limb & shoulder	C49.1
Connective, subcutaneous, & other soft tissues, lower limb & hip	C49.2

Laterality (continued)

Site	Code
Breast	C50.*
Ovary	C56.9
Fallopian tube	C57.0
Testis, undescended, descended, nos	C62.0-C62.9
Epididymis	C63.0
Spermatic cord	C63.1
Kidney, nos	C64.9
Renal pelvis	C65.9
Ureter	C66.9
Eye & adnexa	C69.*
Cerebral meninges, NOS (exc diagnoses prior to 2004)	C70.0
Cerebrum (excluding diagnoses prior to 2004)	C71.0
Frontal Lobe (excluding diagnoses prior to 2004)	C71.1
Temporal lobe (excluding diagnoses prior to 2004)	C71.2
Parietal lobe (excluding diagnoses prior to 2004)	C71.3
Occipital lobe (excluding diagnoses prior to 2004)	C71.4
Olfactory nerve (excluding diagnoses prior to 2004)	C72.2
Optic nerve (excluding diagnoses prior to 2004)	C72.3
Acoustic nerve (excluding diagnoses prior to 2004)	C72.4
Cranial nerve (excluding diagnoses prior to 2004)	C72.5
Adrenal gland	C74.*
Carotid body	C75.4

Chapter 7

STAGING SCHEMES

Collaborative, General Summary

Two staging schemes are available on the abstract:

1. Collaborative Staging System
2. General Summary Stage at diagnosis - SEER summary stage

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 01.04.01*.
- 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):

Collaborative Staging	
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:

** 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 TX/Ext-Evaluation

Identifies how the farthest tumor spread coded in the CS Tumor Size/Ext field was determined.

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 Regional Nodes Evaluation

Identifies how the farthest regional node spread coded in the CS Lymph Node field was determined.

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 Mets Evaluation

Identifies how the distant metastasis coded in the CS Mets Diagnosis field was determined.

CS Version 1st/CS Version Latest

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. CS Version Latest identifies the current version number (i.e., 010300).

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.

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

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.

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.

Surgical Dx/Staging/ Procedure Date

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 done.
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 was done.
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.

Date of 1st Course of Treatment (First RX Date CoC)

Date of initiation of the first therapy for this cancer. MCR uses the CoC definition of first course. If no treatment is given, use the date a decision not to treat was made.

Codes (in addition to valid dates)

00000000	Diagnosed at autopsy
999999999	Unknown if any treatment was administered, date is unknown, death certificate only

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 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

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

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

Codes

0	No systemic therapy and/or surgical procedures
2	Systemic therapy before surgery
3	Systemic therapy after surgery
4	Systemic therapy both before and after surgery
5	Intraoperative systemic therapy
6	Intraoperative systemic therapy with other therapy administered before or after surgery
9	Sequence unknown (both systemic therapy and surgery treatment given)

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.

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.
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.

- 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*.

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.

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.
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.
9	Unknown	Unknown whether any surgical procedure of non-primary site performed. Death certificate only.

- 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*.

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.

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.
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.

- 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.

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 (see table below).

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
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

Regional Treatment Modality *(continued)*	
Code	**Reason**
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 (see table below).

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. Intra-cavitary 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.
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
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 the date radiation therapy began at any facility that is part of the first course of treatment. Use the following codes **(in addition to valid dates**).

00000000 - No radiation therapy administered; autopsy-only case.

88888888 - When radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up. The date should be revised at the next follow-up.

99999999 - When it is unknown whether any radiation therapy was administered; the date is unknown, or the case was identified by death certificate-only.

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. (**table below continued on next page**)

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).

(Radiation table continued from previous page)

Code	Label	Definition
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
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.)

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.

- 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**.

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 the date of initiation of chemotherapy that is part of the first course treatment. Use the following codes (**in addition to valid dates**).

00000000 - No chemotherapy administered; autopsy-only case

99999999 - Unknown if any chemotherapy administered; date unknown, or death certificate only-case.

NOTE: '88888888' is NOT a valid date code for chemotherapy.

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

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

Edition contains a comprehensive list of hormonal agents. http://seer.cancer.gov/tools/seerrx/

- 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://seer.cancer.gov/training/manuals)

- 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 the date of initiaton for hormone therapy that is part of the first course of treatment. Use the following codes **(in addition to valid dates)**.

00000000 - No hormone therapy administered; autopsy-only case

99999999 - Unknown if any hormone therapy administered; date unknown, or death certificate- only case

NOTE: '**88888888**' is NOT a valid date code for Hormone treatment

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/.

TX Date—Immunotherapy

Enter the date of initiation for immunotherapy that is part of the first course of treatment. Use the following codes (**in addition to valid dates**).

00000000 - No immunotherapy administered; autopsy-only case

99999999 - Unknown if any immunotherapy administered; date unknown, or death certificate-only case

NOTE: '**88888888**' is NOT a valid date code for Immunotherapy.

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 family/guardian and refusal documented in record
88	Immunotherapy recommended – unknown if administered
99	Unknown whether Immunotherapy was recommended or administered because it is not documented in record. Death certificate only

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 (**table below continued on next page**).

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

(Hematologic table continued from previous page)

Code	Definition
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. (**table below continued on following page**)

Code	Label	Definition
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.

(Other Treatment table continued from previous page)

Code	Label	Definition
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 the date of initiation for other treatment that is part of the first course of treatment at any facility. Use the following codes **(in addition to valid dates**).

00000000 - No other treatment administered; autopsy-only case

99999999 - Unknown if any other treatment administered; date unknown, or death certificate-only case

NOTE: '**88888888**' is NOT a valid date code for Other treatment

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.

- 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

(Palliative Care table continued from previous page)

Code	Definition
0	No palliative care provided.
1	Surgery (may involve a bypass) to alleviate symptoms but no attempt is made to diagnose, stage, or treat the primary is made.
2	Radiation to alleviate symptoms but no attempt is made to diagnose, stage, or treat the primary.
3	Chemo, hormone therapy, or other systemic therapy to alleviate symptoms but no attempt is made to diagnose, stage or treat the primary.
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 record.
9	Unknown if palliative care performed or referred; not stated in patient record.

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. MCR does not require recurrence information unless it is available at the time the initial abstract is completed.**

DISCLAIMER: MCR staff have reviewed the Types of First Recurrence and believe some changes need to be made based on the new Multiple Primary & Histology rules. Notes relating to this issue have been added to the definitions below.

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 table below (and on the following pages) to record the correct numeric code for the type of **first recurrence:**

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.

Recurrence (continued)

Code	Definition
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).
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_i10tabular.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	Description
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.

NOTE: Reabstracting Audits: MCR is conducting a pilot study using text submitted by the reporting facility to review data quality. Depending on results, this method could replace the usual process of reabstracting actual charts

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 that pertain to the disease should be included.

X-rays/Scans: Written descriptions of information and dates 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.