2022 Cancer Reporting Handbook

Rules and Guidelines for Cancer Reporting in Texas

Texas Cancer Registry

Publication No. E10-10677

Released June 2022

TEXAS
Health and Human Services

Texas Department of State Health Services

CONTENTS

1 INTRODUCTION TO CANCER REPORTING

TEXAS CANCER REGISTRY

With original authorization from the *1979 Texas Cancer Control Act* and the *Texas Cancer Incidence Reporting Act,* Chapter 82, Health and Safety Code (amended April 2015), the Texas Cancer Registry (TCR) of the Texas Department of State Health Services (DSHS) collects information on each patient seeking diagnosis and/or treatment for cancer at health care facilities, clinical laboratories, as well as physician and other outpatient offices (in certain circumstances), within the State of Texas. Texas Administrative Code, Title 25, Part 1, Chapter 91, Subchapter A (amended April 2017) specifies the rules necessary to implement this act. The cancer reporting law and rules may be accessed on the TCR website at the following location: dshs.texas.gov/tcr/lawrules.aspx.

The mission of the TCR is to collect, maintain and disseminate high quality cancer data that contribute towards cancer prevention and control, research, improving diagnoses, treatment, survival, and quality of life for all cancer patients. It is estimated that there will be 131,601 new cancers and 46,353 cancer deaths in the Texas in 2021. A statewide cancer registry is the foundation for cancer prevention and control. The effectiveness of the Cancer Registry is dependent on complete, timely and accurate reporting.

The TCR is one of the largest cancer registries in the United States, and currently meets the National Program of Cancer Registries (NPCR), Centers for Disease Control and Prevention (CDC) high quality data standards, and is Gold Certified by the North American Association of Central Cancer Registries (NAACCR). In May 2021, the TCR became a Surveillance, Epidemiology, and End Results Program (SEER) Registry. Over 240,900 reports of cancer are received annually from over 550 hospitals, cancer treatment centers, ambulatory surgery centers, and pathology laboratories located throughout the state.

The Texas Cancer Registry Cancer Reporting Handbook serves an addendum to the *2022 SEER Program Coding and Staging Manual* for the consistent collection and coding of relevant cancer case information. **This edition should be used for reportable cases diagnosed January 1, 2022 and forward**. The contents of this manual are based on the guidelines and standards for cancer reporting established by the National Program of Cancer Registries (NPCR) at the Centers for Disease Control and Prevention (CDC), the North American Association of Central Cancer Registries (NAACCR), the Surveillance, Epidemiology, and End Results Program (SEER) at the National Cancer Institute (NCI), and the American College of Surgeons (ACoS).

The ***TCR Cancer Reporting Handbook*** can be accessed on the TCR website at 2022 Cancer Reporting Handbook | Texas DSHS

For any problems contact the TCR. Remember to check the TCR website for training opportunities. This information can be found at dshs.texas.gov/tcr/training.aspx.

CANCER CODING RESOURCES

- *SEER Program Coding and Staging Manual 2022* (Published September 2021). Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20892. seer.cancer.gov/tools/codingmanuals/.
- *STandards for Oncology Registry Entry (STORE 2022): Released 2021. Version 1.0* Commission on Cancer, American College of Surgeons, https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/store_manual_2022.ashx
- *Hematopoietic and Lymphoid Neoplasm Coding Manual* Ruhl J, Adamo M, Dickie L., Negoita, S. (August 2021). Hematopoietic and Lymphoid Neoplasm Coding Manual. National Cancer Institute, Bethesda, MD, 2020. https://seer.cancer.gov/tools/heme/
- *Solid Tumor Rules* (Published January 2019) seer.cancer.gov/tools/solidtumor/ Dickie L., Johnson, CH., Adams, S., Negoita, S. (September 2021). Solid Tumor Rules. National Cancer Institute, Rockville, MD 20850.
- *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 22.* Thornton ML, (ed). Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Version 22, 23rd ed. Springfield, Ill.: North American Association of Central Cancer Registries, July 2021, August, September, October 2021. naaccr.org/data-standards-data-dictionary/.
- *SEER Summary Stage 2018 V2.1 (September 2021)* Ruhl JL, Callaghan C, Schussler N (eds.) Summary Stage 2018: Codes and Coding Instructions, National Cancer Institute, Bethesda, MD, 2021 seer.cancer.gov/tools/ssm
- *Site-Specific Data Items (SSDI) /Grade* Last updated: August 24, 2021 *Version 2.1* https://apps.naaccr.org/ssdi/list/2.1
- *SEER*Rx Interactive Antineoplastic Drugs Database* (Web-based). Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20850-9765. seer.cancer.gov/seertools/seerrx/.
- *SEER Inquiry System (SINQ).* Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20850-9765. https://seer.cancer.gov/seer-inquiry/
- *Texas Cancer Incidence Reporting Act* (Amended April 2015), Texas Health and Safety Code, Chapter 82; and Rules, Title 25 Texas Administrative Code, Chapter 91, Subchapter A. Cancer Registry (Effective April 2017). dshs.texas.gov/tcr/lawrules.aspx.
- *Physician Data Query (PDQ).* National Cancer Institute, Bethesda, MD 20850-9765. cancer.gov/publications/pdq

Acknowledgment

We wish to acknowledge that some information presented in this handbook was taken verbatim from the *2022 SEER Program Coding and Staging Manual* (Published September 2021). Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20892.

HELPFUL WEBSITES

dshs.texas.gov/tcr/

seer.cancer.gov/registrars/

cancer.gov/

ncra-usa.org/

naaccr.org/

cancer.org/

iacr.com.fr/index.php

cancerbulletin.facs.org/forums/help

facs.org/quality-programs/cancer/ncdb/call-for-data

cancerstaging.org

tools.usps.com/go/ZipLookupAction_input

zip-codes.com/zip-code/78734/zip-code-78734.asp

melissa.com/lookups/addressverify.asp

bls.gov/soc/

nccn.org/

breastcancer.org/

nlm.nih.gov/

anatomyatlases.org/

oralcancerfoundation.org/

pathologyoutlines.com/

whonamedit.com/

docfinder.docboard.org/tx/df/txsearch.htm

https://www.txhima.org/

ACRONYMS

ACS	American Cancer Society
ACoS	American College of Surgeons
AJCC	American Joint Committee on Cancer
CDC	Centers for Disease Control and Prevention
CESB	Cancer Epidemiology and Surveillance Branch
CNS	Central Nervous System
CoC	Commission on Cancer
CRH	Cancer Reporting Handbook
CS	Collaborative Stage
DSHS	Department of State Health Services
FIPS	Federal Information Processing Standards
ICD-O-3	International Classification of Diseases for Oncology, 3rd Edition
ICD-O-2	International Classification of Diseases for Oncology, 2nd Edition
MP/H	Multiple Primary and Histology Coding Rules
NAACCR	North American Association of Central Cancer Registries
NPCR	National Program of Cancer Registries, CDC
HSR	Health Service Region
SEER	Surveillance, Epidemiology, and End Results Program, NCI
SINQ	SEER Inquiry System
SSDI	Site-Specific Data Items
STORE	**ST**andards for **O**ncology **R**egistry **E**ntry
TCR	Texas Cancer Registry
TNM	T=Tumor N=Lymph Nodes M=Metastases
WHO	World Health Organization
VSU	Vital Statistics Unit

TCR CODING AND STAGING REQUIREMENT SUMMARY

Coding Cancer Cases

SEER Program Coding and Staging Manual

The *2022 SEER Program Coding and Staging Manual* includes data item descriptions, codes, and coding instructions for cases diagnosed January 1, 2022 and forward as reported by SEER registries. For all cases diagnosed on or after January 1, 2022, the instructions and codes in this manual take precedence over all previous instructions and codes. Updates to this manual identified after publication will be found in SINQ under the category of 'Updates to current manual' until a subsequent revision of this manual is issued.

Note: See the American College of Surgeons Commission on Cancer CAnswer Forum for questions about **AJCC TNM staging**, the **Site-Specific Data Items**, and **data items not required by SEER**. SEER required data items are listed in the NAACCR Required Status Table.

The *2022 SEER Program Coding and Staging Manual* explains the format and the definitions of the data items required by SEER. Documentation and codes for historical data items can be found in earlier versions of the SEER Program Code Manual. Earlier versions are available on the SEER website.

This coding manual does not prevent SEER contract registries or other registries that follow SEER rules from collecting additional data items useful for those regions.

Data items that are not required for 2022 diagnoses but were collected in years prior to 2022 must be transmitted to SEER as blanks for cases diagnosed in 2022 and subsequent years. Descriptions of historic data items, allowable codes, and coding rules can be found in historic coding manuals on the SEER website.

ICD-O

For cancer coding**, the correct ICD-O version must be used for all cases according to the year in which the cancer case was diagnosed.** If the diagnosis year is unknown, use the year and month in which the case was accessioned. If this process is not applied the cancer case will fail required edits and will not be accepted by the TCR.

Effective for cases diagnosed January 1, 2022 forward, ICD-O-3.2 Coding Table Excel is the preferred reference for morphology codes.

The 2022 ICD-O-3.2 Update Guidelines includes comprehensive tables listing all changes to ICD-O-3.2 including new ICD-O codes, terminology and reportability changes effective for cases diagnosed 1/1/2022 forward. The 2022 update represents changes identified in recently published 5th Ed WHO Classification of Tumors books. Included in these guidelines are instructions for using the tables together with ICD-O-3.2. ***This update includes important information on reportable versus non-reportable high-grade dysplasia in gastrointestinal sites.***

The ICD-O-3 Implementation Work Group created this guide for users which provides important information on the background and issues for this update along with how to use the tables. The 2022 guidelines have been modified to include only two tables, numeric and alpha, listing new ICD-O codes,

terminology, behavior changes, and required status. The Work Group strongly recommends users read the guidelines in order to efficiently use ICD-O-3.2 and the 2022 Update tables.

Note: Use of these guidelines is required for determining reportability and accurate coding.

The 2022 ICD-O-3.2 Update Table 1 Numeric and 2022 ICD-O-3.2 Update Table 2 Alpha Table include changes identified during review of recently published World Health Organization's *International Histological Classification of Tumors 5th Edition* books (WHO "Blue Books"). This series covers all principal sites of cancer and includes ICD-O morphology codes for each neoplasm. Each new edition underwent thorough review to identify new histologies and ICD-O codes, behavior changes to existing ICD-O codes, and new terminology. The ICD-O-3 Implementation Work Group recommended adopting the changes for 2022 and implementation of the changes were approved by the standard setting agencies.

The 2022 ICD-O-3.2 update includes comprehensive tables listing all changes made after the 2021 update and is effective for cases diagnosed 1/1/2022 forward. New to the 2022 update tables are columns for each standard setter which will indicate if that particular code and/or term is required for data collection and submission.

***IMPORTANT REMINDERS:**

Please check the Solid Tumor Rules to determine if the histology is listed in the site-specific chapters. If the histology is not in the histology tables or there is no histology table for the site, review the 2022 ICD-O-3 Update Table 1 Numeric or 2022 ICD-O-3 Update Table 2 Alpha Table . If the histology is not included in the update, then review ICD-O-3.2 Coding Table Excel. When a histology code cannot be identified using the above recommendations, submit a question to Ask a SEER Registrar.

Note: ICD-O-3.2 Coding Table Excel includes changes from all 4th Ed WHO Classification of Tumors books. New editions released following the publication of 4th editions (the 5th Ed) are not included in 3.2. **A new ICD-O version will be released once all 5th Ed Blue Books have been published.**

Prior to 2021	1/1/2021 - 12/31/2021	1/1/2022 +
1. 2021 ICD-O-3.2 update tables	1. 2018 Solid Tumor Rules **(contains the 4th Edition WHO updates)** https://seer.cancer.gov/tools/solidtumor/STM_2018.pdf	1. Solid Tumor Rules **(contains the 5th Edition WHO updates)**
2. 2018 Solid Tumor Rules **(contains the 4th Edition WHO updates)** https://seer.cancer.gov/tools/solidtumor/STM_2018.pdf	2. 2021 ICD-O-3.2 Coding Table **(contains the 4th Edition WHO updates)**	2. 2022 ICD-O-3.2 Update Tables
3. 2021 ICD-O-3.2 Coding Table **(contains the 4th Edition WHO updates)**		3. ICD-O-3.2 Coding Table **(contains the 4th Edition WHO updates) (does NOT contain the 5th edition WHO updates)**

Solid Tumor Rules

Use the Solid Tumor Rules to determine the number of primaries to abstract and the histology to code for cases diagnosed 1/1/2018 and forward. The Solid Tumor Rules and the General Instructions replace the *2007 Multiple Primary & Histology (MP/H) Rules* for the following:

- Breast
- Colon (includes rectosigmoid and rectum for cases diagnosed 1/1/2018 forward)
- Head & Neck
- Kidney
- Lung
- Malignant CNS and Peripheral Nerves
- Non-malignant CNS
- Urinary Sites

Use the Solid Tumor Cutaneous Melanoma Rules to determine the number of primaries to abstract and the histology to code for cases diagnosed 1/1/2021 forward. The Solid Tumor Cutaneous Melanoma Rules and the General Instructions replace the *2007 Multiple Primary & Histology (MP/H) Rules* beginning 1/1/2021.

Revision Status for Remaining 2007 Multiple Primary and Histology Site Rules

SEER is currently working on revisions to the Other Sites MP/H module. Release date has not yet been determined. The *2007 MP/H* and *2007 General Instructions* are to be used, with a few exceptions, for cases for the following site groups until instructed to do otherwise:

- Other Sites

The *2017 Multiple Primary and Histology Rules* must be used for all the sites in the *Other Sites* **except for the following sites**:

- Rectosigmoid and rectum which are now included in *2018 Solid Tumor Rules* under Colon
- Peripheral nerves which are now included in the *2018 Solid Tumor Rules* under *Malignant CNS*

SEER has identified the need to separate select sites into individual modules. These site-specific rules may be individual sections within the *Other Sites* rules, or free-standing modules. The following sites have been determined to need additional rules: GYN, GI (excluding colorectal), Thyroid, Soft tissue/bone, and Male genital.

Hematopoietic & Lymphoid Neoplasm Database and Manual

The *Hematopoietic & Lymphoid Neoplasm Database* and the *Hematopoietic & Lymphoid Neoplasm Manual* consists of rules, guidelines and an interactive desktop Heme DB reference to assist registrars in determining case reportability, the number of primaries, as well as instructions for coding primary site, histology, grade, diagnostic confirmation and other therapy for a **hematopoietic and/or lymphoid neoplasms (9590/3-9992/3)**. *Hematopoietic & Lymphoid Neoplasm Database* is a tool to assist in

screening for reportable cases and determining reportability requirements. It contains abstracting and coding information such as definitions, synonyms, definitive diagnosis methods, and abstractor notes. The *Hematopoietic & Lymphoid Neoplasm Manual* has the rules and instructions for determining the number of primaries, the primary site and histology, and the cell lineage or phenotype.

Staging Cancer Cases

Below are the resources available for the staging-related data required to be collected by TCR for the following data items for cases diagnosed 2022 and forward.: Summary Stage 2018 (SS2018), Extent of Disease (EOD), Site-Specific Data Items, and the Grade data items.

Summary Stage 2018

Directly Coded SEER Summary Stage 2018 is required from all facilities for reporting year 2018 and forward. Summary Stage 2018 systems will continue to be used for cases diagnosed on or after January 1, 2022. A change log will be made available for the SS2018 revisions between versions 2.0 and 2.1.

Summary Stage is the most basic way of categorizing how far a cancer has spread from its point of origin. Historically, Summary Stage has also been called General Stage, California Stage, historic stage, and SEER Stage.

The 2018 version of Summary Stage applies to every site and/or histology combination, including lymphomas and leukemias. Summary Stage uses all information available in the medical record; in other words, it is a combination of the most precise clinical and pathological documentation of the extent of disease. Many central registries report their data by Summary Stage as the staging categories are broad enough to measure the success of cancer control efforts and other epidemiologic efforts.

See the SEER Summary Stage 2018 Manual for detailed coding instructions.

TCR Required Site-Specific Data Items (SSDI)

Collaborative Stage Site-Specific Factors (CS SSFs) have been discontinued and Site-Specific Data Items (SSDIs) are used for collection of site-specific information for cases diagnosed on or after January 1, 2018. See the Data Standards and Data Dictionary, Version 22, Chapter Volume II Required Status Table to determine which staging data items are required to be collected by the various standard setters for cases diagnosed on or after January 1, 2022.

Before using the Site-Specific Data Item Manual as an information resource for specific data items, it is important to review the introductory materials and general instructions carefully. Although the majority of data items that are collected as SSDIs were previously collected as SSFs, the format of the data items and allowable values have changed substantially, particularly for laboratory values.

An important new concept introduced in 2018 is the use of a **Schema ID** to define the applicable SSDIs and Grade table for a particular tumor, based on primary site, histology, and in some cases, additional information. The appropriate Schema ID will be defined by registry software and will not have to be assigned by the registrar. However, a Schema ID Table defining the Schema ID number, description and associated SSDIs is provided in the *SSDI Manual* for reference purposes. In addition to Schema IDs, the Schema ID Table provides the *AJCC 8th Edition* Chapter for which the SSDIs and Grade table defined

by the Schema ID apply, with a hyperlink to the page on which the description of the relevant SSDIs begins. A hyperlink at the end of the information on each SSDI can be used to return to the Schema ID Table.

For each SSDI, the SSDI Manual includes:

- NAACCR Data Item Name
- Item Length
- NAACCR Item #
- NAACCR Alternative Name
- AJCC 8th Edition Chapter(s)
- Description
    - The description is a brief summary used to define the data item in the NAACCR data dictionary.
    - The rationale describes the reason why the data item is collected, such as required for staging or recommended for registry data collection by AJCC. If the data item was collected in CSv2, the primary site and SSF# is included in the rationale.
- Definition
    - The definition provides additional background on the data item and its clinical importance. This information was previously included in the CSv2 Manual, Part I, Section II.
- Additional Information
    - This section may include source documents, other names, normal reference ranges and any other information deemed relevant for a particular SSDI. This information was previously included in the CSv2 Manual, Part I, Section II.
- Coding instructions and Codes
    - Coding instructions are provided as numbered notes. Codes are provided in a table.
    - Coding and coding instructions are usually provided in registry software.

Grade Manual

The *Grade Coding Instructions and Tables* (Grade Manual) is the primary resource for documentation and coding instructions for Grade for cases diagnosed on or after January 1, 2018. Before using the Grade Manual as a coding reference, it is important to review the introductory materials and general instructions of the manual carefully. These reflect several important changes in the collection of Grade data items, including use of AJCC-recommended grade tables where applicable and the introduction of Grade Clinical, Grade Pathological, and Grade Post Therapy Clin (yc) and Grade Post Therapy Path (yp) data items.

In addition to understanding the concept and structure of the Grade Tables, it is critically important to review all of the general information included in the Manual. Particular attention should be paid to understanding coding instructions for grade tables where both an AJCC-preferred grade system and the generic grade system are allowable codes, coding guidelines for Grade Clinical, Grade Pathological, Grade Post Therapy Clin (yc) and Grade Post Therapy Path (yp) data items and coding instructions for generic grade categories. Thorough understanding of this material will be necessary in order to code the new Grade Data Items accurately.

Extent of Disease (EOD) 2018

The TCR will begin collecting Extent of Disease (EOD) 2018 for cases diagnosed January 1, 2022 and forward. The three main data items are EOD Primary Tumor, EOD Regional Nodes and EOD Mets. Using these three data items, an EOD TNM T, EOD TNM N and EOD TNM M will be derived, along with an EOD TNM Stage Group based on the AJCC 8th edition. SEER developed a staging database referred to as the SEER*RSA that provides information about each cancer (primary site/histology/other factors defined).

AJCC TNM

AJCC TNM data items are required only from facilities accredited by the American College of Surgeons (ACoS) and only for analytical cases. For hospitals and cancer centers that are not ACoS accredited, these data items are required for analytical cases only as available (class of case 00-22).

The American Joint Committee on Cancer (AJCC) is making an important change to how it updates and releases Cancer Staging content beginning in 2021. The AJCC will be shifting from a Cancer Staging Manual to a Cancer Staging System and moving away from Editions, to Versions which better align with software development and how users are increasingly consuming AJCC content. The AJCC has started rolling updates with the release of Cervix 9th version. As warranted by medical practice, additional disease sites will be updated in the future as necessary, while the other disease sites will remain unchanged, and the 8th Edition will be used. There will no longer be a single edition or version number applicable to every disease site for the diagnosis year. While references will be made to the 9th version, the registry data item will continue to reference *TNM Edition Number* [1060]. Additional updates to the *AJCC Cancer Staging Manual* are always available at cancerstaging.org and available for software developers via the AJCC API. AJCC Cancer Staging questions should be directed to the CAnswer Forum at: cancerbulletin.facs.org/forums/help

For staging cancer cases, all cases must be staged, and the corresponding stage data fields must be completed according to the correct staging guidelines for the year the cancer was diagnosed. If the diagnosis year is unknown, the correct guidelines for the year in which the case is accessioned must be used. Otherwise, the cancer case will fail required edits and will not be accepted by the TCR.

Note: See the American College of Surgeons Commission on Cancer CAnswer Forum for questions about **AJCC TNM staging**, the **Site-Specific Data Items**, and **data items not required by SEER**. SEER required data items are listed in the NAACCR Required Status Table.

*Registrar Staging Assistant (SEER*RSA)*

The Registrar Staging Assistant (SEER*RSA) website is available for use by cancer registrars to help code the Summary Stage 2018(SS2018), Extent of Disease (EOD), Site-Specific Data Items, and Grade for case diagnosed 2018 and forward.

TCR Coding and Staging Manuals List

Table 1.1 TCR Coding and Staging By Date of Diagnosis

Coding and Staging Schema	Diagnosis Year
SEER Program Coding and Staging Manual 2020	2020 - forward
International Classification of Diseases for Oncology, 2nd Edition (ICD-O-2)	1995 – 2000*
International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3)	2001 - 2020
International Classification of Diseases for Oncology, 3rd Edition 2nd Revision (ICD-O-3.2)	2021- forward
Multiple Primary and Histology Rules	2007 - 2017
Solid Tumor Rules	2018 - forward
Hematopoietic and Lymphoid Neoplasm Manual and Database	2010 - forward
SEER April 1977 Summary Staging Guide	Prior to 2001
SEER Summary Staging Manual 2000 (SSSM2K)	2001 – 2003 2015 – 2017
SEER Summary Stage 2018	2018 - forward
Site-Specific Data Items (SSDI) Manual and Grade Manual	2018 - forward
Extent of Disease (EOD) 2018	2022 - forward
Collaborative Stage Data Collection System Coding Instructions, vs. 02.05	2004 - 2015
AJCC Cancer Staging Manual, Seventh Edition	2015 - 2017
AJCC Cancer Staging Manual, Eighth Edition	2018 - forward
AJCC Cancer Staging System, Version 9	2021 - forward

*The TCR no longer requires reporting of cases diagnosed prior to 1995

Note:

- Specific CS SSFs are required for 2017 diagnosis cases.
- SSDI's are replacing CS SSF for 2018 and forward diagnosis cases.
- Per SEER, the new coding and staging instructions/guidelines replaces the old for their respective time periods.

CDC NPCR & NCI SEER

Beginning with cases diagnosed January 1, 2022 and forward, CDC-NPCR and NCI SEER will adopt the new record format and data collection requirements as published in the Data Standards and Data Dictionary, Version 22.

Refer to the CDC-NPCR and NCI-SEER requirements listed in the NAACCR Data Standards and Data Dictionary, Version 22, Chapter VIII Required Status Table. Share these requirements with your software vendors and key stakeholders. For more information, see Appendix D Comparisons of Data Sets.).

SEER Coding and Staging Manual Contents

The *2022 SEER Program Coding and Staging Manual* includes data item descriptions, codes, and coding instructions for cases diagnosed January 1, 2022 and forward as reported by SEER registries. For all cases diagnosed on or after January 1, 2022, the instructions and codes in this manual take precedence over all previous instructions and codes. Updates to this manual identified after publication will be found in SINQ under the category of 'Updates to current manual' until a subsequent revision of this manual is issued.

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The *2022 SEER Program Coding and Staging Manual* explains the format and the definitions of the data items required by SEER. Documentation and codes for historical data items can be found in earlier versions of the SEER Program Code Manual. Earlier versions are available on the SEER website.

This coding manual does not prevent SEER contract registries or other registries that follow SEER rules from collecting additional data items useful for those regions.

Data items that are not required for 2022 diagnoses but were collected in years prior to 2022 must be transmitted to SEER as blanks for cases diagnosed in 2022 and subsequent years. Descriptions of historic data items, allowable codes, and coding rules can be found in historic coding manuals on the SEER website.

The *Texas Cancer Registry Cancer Reporting Handbook* serves an addendum to the 2022 *SEER Program Coding and Staging Manual* for the consistent collection and coding of relevant cancer case information.

COMPLIANCE

As the primary source of cancer case reporting to the Texas Cancer Registry (TCR), it is important that hospitals submit their cancer cases in a timely manner. To be compliant with the law, all records must be submitted **within 6 months of initial diagnosis, or admission with active disease, or treatment for cancer at your facility**.

Case Submission Requirements

Cancer reporting rules require monthly submissions from health care facilities with an annual caseload of greater than 400 and at least quarterly submissions for health care facilities with an annual caseload of 400 or fewer. **Weekly submissions from all facilities is strongly recommended.**

Note: Hospital Reporting instructions, as well as Reporting Laws and Rules can be found on the TCR website: dshs.texas.gov/tcr/

Table 1.2 Case Submission Requirements

Caseload	Submission
>400	Monthly
Equal to or <400	≥ Quarterly

To assure timely and complete cancer case reporting in Texas, TCR staff routinely monitor submissions of case reports from hospitals. If submissions are not received in a complete and timely manner according to state law and rules, the facility registrar or reporter will be contacted by TCR staff regarding the delinquent reporting status.

Further action, which may include cost recovery procedures, will be instituted if submissions continue to be delinquent. These actions are necessary to meet the state and national requirements for timely cancer data submissions.

Small Cancer Caseload Facilities (125 or fewer)

TCR developed the "Small Facility Casefinding and Data Collection Program" with the goal to increase and improve the reporting and data quality of cancer cases, as required by the *Texas Cancer Incidence Reporting Act (Chapter 82, Texas Health and Safety Code)*, from Texas facilities with 125 or fewer expected cancer cases. TCR staff will conduct the casefinding and data collection activities for these facilities. Facilities will be contacted regarding their facility's compliance and eligibility for participation in this program.

Timeliness of Data Submission

Timeliness of case reporting is important; however, data quality and completeness must be assured as well. Researchers, epidemiologists, health planners, clinicians, and laypersons benefit from access to the most current information. Due to reporting requirements of CDC, NCI and TCR, all **reports of cases shall be submitted to TCR within six months of initial diagnosis or admission at their facility with active disease and/or treatment of cancer.** This information is in *Section 91.5(a) (When to Report*) of the Cancer Registry Rules. Refer to the TCR's Cancer Reporting Law and Rules webpage for more information regarding reporting timeliness: dshs.texas.gov/tcr/lawrules.aspx

Timely Reporting Calendar

The TCR Reporting Calendar can be found online at dshs.texas.gov/tcr/reporting/hospitals.aspx.

TCR Timely Reporting Calendar

Cases admitted in:	Reported no later than:
January 2022	July 2022
February 2022	August 2022
March 2022	September 2022
April 2022	October 2022
May 2022	November 2022
June 2022	December 2022
July 2022	January 2023
August 2022	February 2023
September 2022	March 2023
October 2022	April 2023
November 2022	May 2023
December 2022	June 2023

REGIONAL CONTACTS

Table 1.3 Regional Contacts

REGISTRY OPERATIONS MANAGER **Miriam Robles, RHIT, CTR** 1100 W. 49th Street Austin, TX 78756 Phone: 512-776-3609 Cell: 512-413-4029 Email: Miriam.Robles@dshs.texas.gov	**REGISTRY OPERATIONS** **Allison Vasquez, BS, CTR** **Program Specialist (Data Acquisition)** 1100 W. 49th Street Austin, TX 78756 Phone: 512-776-2696 Email: Allison.Vasquez@dshs.texas.gov **PATHLAB/NON-HOSPITAL REPORTING** **Miriam Robles, RHIT, CTR** Email: Miriam.Robles@dshs.texas.gov
HEALTH SERVICE REGIONS 2, 3, 4 **Debra Anderson, BS, CTR** Regional Program Specialist (Team Lead) 1301 S. Bowen Rd., Ste. 200 Arlington, TX 76013 Phone: 817-264-4594 Email: Debra.Anderson@dshs.texas.gov	**HEALTH SERVICE REGIONS 1,7,9** **Jodi Vasquez, CTR, RHIT** Regional Program Specialist (Team Lead) 1100 W. 49th Street Austin, TX 78756 Phone: 512-776-3607 Fax: 512-776-7681 Email: Jodi.Vasquez@dshs.texas.gov
HEALTH SERVICE REGIONS 5, 6 **Marie Gallegos, CTR** Regional Program Specialist (Team Lead) 5425 Polk Ave. Houston, TX 77023-1497 Phone: 713-767-3183 Fax: 713-767-3284 Email: Marie.Gallegos@dshs.texas.gov	**HEALTH SERVICE REGIONS 8, 10, 11** **Kavitha Madishetty, PhD, CTR** Regional Program Specialist (Team Lead) 1100 W. 49th Street Austin, TX 78756 Phone: 512-776-3625 Fax: 512-776-7681 Email: Kavitha.Madishetty@dshs.texas.gov

Visit dshs.texas.gov/tcr/contact.aspx#regions to see a map of the Health Service Regions and to view the most current regional contact list.

2 STANDARDS FOR CONFIDENTIALITY, DISCLOSURE OF DATA, AND QUALITY ASSURANCE

CONFIDENTIALITY

Data obtained under the *Texas Cancer Incidence Reporting Act* are for the confidential use of the Texas Department of State Health Services, including persons, and public or private entities that are necessary to carry out the public health interests of the Act. The data are privileged and may not be divulged or made public in a manner that discloses the individual identity of any patient. All reporting entities that are performing in compliance with the Act are immune from civil and criminal liability for furnishing the required information.

DISCLOSURE OF DATA

All data reported to TCR are available for use in aggregate form for analysis by facility registry staff, physicians, health care workers, cancer researchers, and the public. Reports of cancer incidence are available on the TCR website under Cancer Statistics. A Web Query Tool which generates customized maps and tables of Texas cancer incidence and mortality rates is also available on the website at dshs.texas.gov/tcr/data.aspx. Public access to aggregate data is available through published reports, or through TCR, if in accordance with its data release policies and procedures.

TCR may exchange patient-specific data with the respective reporting facility, any other cancer-control agency, clinical facility, pathology laboratories, or physician's offices for the purpose of obtaining information necessary to complete the abstract or follow-up information, provided that these agencies and facilities comply with the TCR's confidentiality policies. However, no facility-specific patient information can be released unless authorized under law. TCR will not release information from one facility to a different facility under any circumstances. TCR can contact the facility where the patient was seen and obtain consent to release information other than that authorized by law under special circumstances.

To achieve complete case ascertainment, TCR may exchange patient-specific data with other state cancer registries if reciprocal data sharing agreements and confidentiality provisions are implemented.

TCR may grant researchers access to confidential information concerning individual cancer patients, provided that those researchers comply with the provisions and confidentiality policies mandated by the Texas Department of State Health Services Institutional Review Board.

QUALITY ASSURANCE

TCR implements an extensive series of quality assurance procedures that are based on the SEER Program, CDC recommendations, and NAACCR standards. These procedures, which consist of both internal and external processes, ensure the reliability, completeness, consistency, and comparability of TCR data.

INTERNAL PROCESS

Submission Review

The TCR's data upload system currently checks all submitted abstracts for errors. TCR uses CDC's Registry Plus Software Suite to upload submitted data. As abstracts are uploaded into the system, they are intensely scrutinized for:

- Possible duplicate submission of existing abstracts.
- Unacceptable codes for any field or inter-field inconsistencies.
- Invalid or unusual site/sex, age/site, age/morphology, or site/morphology combinations.
- Running data submissions through NAACCR and TCR edits

Currently, TCR is not rejecting cases at upload, but this could change, and you will be notified by TCR when this change is implemented.

Note: Facilities must run their data through the appropriate NAACCR and TCR edits and make necessary corrections before submitting a file to TCR.

EXTERNAL PROCESS

Facility Training

TCR staff provides technical assistance, training, and continuing education for cancer registrars and medical records personnel on standards and procedures for reporting. Requests for training and technical assistance should be directed to the Austin Central Office Training Specialist. To request training submit your training needs using the online training request forms found on the Education and Training section of the TCR website: dshs.texas.gov/tcr/training.aspx. You can also contact the TCR Training Team at TCR.Training@dshs.texas.gov.

Missed Cancer Casefinding (MCF) Q1 & Q2 & Death Clearance Missed Cancer Casefinding (DCCF) Q3 & Q4 Year

The Texas Cancer Registry (TCR) conducts data linkages twice a year with the Department of State Health Services Death Certificate File and Texas Inpatient and Outpatient Discharge Data to identify potentially missed cancer cases that have not been reported to TCR. Once the linkage is complete, each facility will be provided with a listing of potentially missed cases for your review, abstraction, and submission. This may include multiple primaries. This process combines the Death Clearance Only Audit performed in previous years as well as Casefinding Data Quality Audits. This process will help reporters and TCR staff identify possible missed resources to identify reportable cases (pathology, cytology, ambiguous terminology etc.).

All follow-back cases will be available for facilities on one report and will contain the casefinding source, for example: DCO or Inpatient/Outpatient. This will eliminate multiple listing requests for facilities, and it will be performed annually.

Your facility's assistance in reviewing, and if needed, reporting these potentially missed cases is critical for the TCR to meet the Centers for Disease Control and Prevention's National Program of Cancer Registries cooperative agreement requirements and high-quality data standards, as well as maintain North American Association of Central Cancer Registries (NAACCR) gold certification

Note: Small Casefinding and Data Collection (CFDC) facilities are not required to abstract missed cases. CFDC facilities must submit all medical records to TCR for review and abstraction.

Guidance

Refer to the email notification regarding the time sensitive completion dates for each project and submit the completed excel file via Web Plus.

Excel format contains 14 fields.

- Case Indicator

  I=inpatient

  I/O = inpatient and outpatient
- Last Name
- First Name
- Middle Initial
- SSN
- DOB
- Medical Record #
- ICD-10-CM
- Admission
- Discharge
- Cancer Codes (#)
- Visits (#)
- Reportable (Y/N)
- Reason Not Reportable

CANCER
CODES (#) Column
If there are two (2) or more codes, the probability of a Reportable is greater please re-review reportable cancer codes.

REPORTABLE
(Y/N)

If case is reportable, enter the Accession Number & Web Plus release date/submission date in the "Reportable" column.

If case is Non-Reportable, enter the reason in the "Reason Not Reportable" column.
Examples:

NR-02 Squamous cell carcinoma skin R temple
NR-03 HX CA Ovary. FU scans WNL.
NR-03 Hx of. Review of 5 inpatient admission during the year, only 1 mentioned hx of mesothelioma.
NR-07 No cancer mentioned for Primary site

NON-REPORTABLE CODES

01 – Benign
02 – Non-Reportable Skin Cancer (Site=C44.*, Morph=8000-8110)
03 – No Evidence of Disease (NED) (History of Cancer but No Evidence of Treatment Currently and No Evidence of Cancer Currently)
04 – Cancer Not Proven
05 – Duplicate Case (This Cancer has already been reported to TCR)
06 – In situ Cancer of Cervix, CIN III
07 – No Cancer Mentioned in Record
08 – Diagnosed prior to 1995
09 – Lab only
10 – Other (Include Explanation)

Data Quality Audits

A data quality audit is a systematic method of reviewing the facility's data quality. The audit is a tool to improve a facility's data quality and is not a punitive measure. There are several triggers for these audits such as a new reporter, a pattern of edit errors, changes in national guidelines, or inconsistencies identified during one of our various internal data quality processes. TCR staff or a TCR representative will request documents from a facility's medical records and compare the abstracting and coding to the submitted abstracts. The results are shared with the facility as a learning tool. Results from a specific facility's data quality audit are not shared with other entities without the facility's approval.

Reabstracting Data Quality Audits

TCR staff, or a TCR representative, performs complete re-abstracting of a sample of reported cases without reference to the original abstract. If discrepancies are identified, they are used to assess the facility's cancer case reporting and training needs.

Ambulatory Surgery Centers Guidelines

Texas ambulatory surgery centers (ASC) that diagnose and/or treat cancer patients provide valuable treatment information, that is otherwise not available to the Texas Cancer Registry.

If an ASC is affiliated with a health care system, cancer center, and/or hospital, that healthcare system, cancer center, and/or hospital is responsible for reporting cancer case(s) on the ASC's behalf.

If an ASC is a free-standing facility, TCR will conduct a linkage with the Texas Health Care Information Council Outpatient Data to identify reportable cases that are not otherwise reported to TCR, as well as missing surgical cancer treatment information. The linkage is done to minimize any additional reporting burden on the part of the ASC and TCR. The free-standing ASC is then required to provide the requested medical records to TCR for review and possible inclusion in the registry.

Pathology Laboratory Guidelines

Pathology Laboratories, both state and national, that diagnose cancer for Texas health care providers and residents provide valuable case-finding and diagnostic information that is not otherwise available to TCR. Receiving pathology reports from pathology laboratories is a critical source of information for comprehensive population-based cancer reporting.

The preferred electronic reporting formats are versions 2.3.1 or 2.5.1 HL7 standard protocols, in accordance with the North American Association of Central Cancer Registries, Pathology Laboratory Electronic Reporting, Volume 5 central registry standards.

In order to securely transmit pathology laboratory data to TCR, there are two strongly preferred options:

1. The Texas Department of State Health Services maintains the Public Health Information Network Messaging System (PHIN MS), a secure messaging platform provided by the Centers for Disease Control and Prevention (CDC) for receiving data from pathology laboratories. Information about the PHIN MS system can be found at: cdc.gov/phin/tools/PHINms/index.html.
2. Pathology reporting, either in HL7 formats, or as scanned pdf documents may also be securely uploaded to TCR using Web Plus, a web-based application also provided by the CDC. With this data submission method, you must obtain a Web Plus account by completing the Online Web Plus Account Registration and submitting the Web Plus Use and Confidentiality Statement via fax at 512-776-7681, or scan and email. More information on Web Plus can be found on our website: https://www.dshs.texas.gov/tcr/webplus.aspx

Required information in the pathology report includes not only information about the patient's cancer, but also patient identifiers and demographics, such as name, date of birth, sex, and patient address and social security number. Other fields which are encouraged if available are race/ethnicity and primary payer. If these data items are not on the pathology report, they can be included on a separate Excel spreadsheet that can be uploaded using Web Plus. For your convenience, a template is available on the TCR website: dshs.texas.gov/tcr/CancerReporting/Pathology-Lab-Reporting.aspx

Sending paper pathology reports via mail/FedEx or fax are strongly discouraged. These reporting methods result in significantly more manual processing by TCR and are not as secure as electronically submitting reports using either PHIN MS or Web Plus.

The accountability for any HIPAA breach using mail/FedEx or fax to submit reports to TCR falls on the pathology laboratory deviating from TCR recommended method of reporting. Any laboratory sending paper records to TCR should follow HIPAA guidance for securely sending patient records through U.S. mail and needs to ensure the guidance is followed correctly.

Current guidance provided to TCR includes instructions to double envelope the pathology reports and write “CONFIDENTIAL” on the outside envelope prior to sending the paper records. Before choosing this method, consider one of the more secure electronic methods discussed previously.

Refer to Who Do I Call list for the appropriate representative to call if you have additional questions: dshs.texas.gov/tcr/contact.aspx.

3

CASEFINDING FOR COMPLETENESS OF REPORTING

The *Texas Cancer Incidence Reporting Act (Chapter 82, Health and Safety Code)* requires every health care facility, clinical laboratory, and health care practitioner center to submit cancer information for each reportable diagnosis.

Casefinding (case ascertainment) is a process used to identify all eligible cases to be reported to TCR through a review of source documents and case listings. Casefinding covers a range of cases that need to be assessed to determine whether or not they are reportable. A casefinding list is **not** the same as a reportable list.

Casefinding sources include disease indices, pathology and laboratory reports, patient logs, and similar resources specific to each facility.

Refer to the Casefinding Sources list below for a more detailed list. Every inpatient and/or outpatient with active disease and/or receiving cancer-directed therapy must be reported to TCR regardless of the patient's state.

The requirements for reporting depend on the governing agencies of the registry. For example, hospitals participating in the Approvals Program of the Commissions on Cancer (CoC) of the American College of Surgeons follow the guidelines set forth by CoC; however, they must also adhere to the TCR reporting criteria.

Remember that cases diagnosed prior to 1995 and foreign residents are no longer required to be reported.

CASEFINDING METHODS

There are two types of casefinding methods—active and passive:

- Active casefinding—the personnel responsible for reporting obtain and review all sources for eligible cases. This method is more comprehensive and precise.
- Passive casefinding—the personnel responsible for reporting rely on others to notify the reporter of possible eligible cases. There is a greater potential for missed cases using this method.

A combination of active and passive casefinding is a more effective method and ensures fewer missed cases. It is strongly recommended that every facility have a Casefinding Policy and Procedure in place. The procedures should be evaluated from time to time and amended as facility procedures or services change.

CASEFINDING SOURCES

1. Medical Records Department

   a. Disease index
   b. Inpatient/Outpatient Admission and Discharge Reports
2. Pathology Department
   a. Histology reports
   b. Cytology reports
   c. Hematology reports
   d. Autopsy reports
   e. Bone Marrow reports
3. Surgery Department
4. Outpatient Departments
5. Medical and Diagnostic Imaging
6. Radiation Oncology
7. Medical Oncology\Hematology
8. Emergency Room reports
9. Lab reports
10. Nuclear Medicine
11. Pain Clinic Log

CASEFINDING PROCESS

Cooperation and a good working relationship between reporting personnel and other departments are essential for accurate case ascertainment. The reporter is responsible for identifying all casefinding sources under their facility licensure and arranging access to these sources. Examples include rural health clinics or surgery centers across town or off campus.

Disease indices should be obtained after medical records are completed and coded (monthly or quarterly). The indices must include both inpatient and outpatient admissions and must be based on year of admission. It must be sorted alphabetically by last name and include the following: last name, first name, medical record number, admission/discharge date, date of birth, social security number, all primary and secondary ICD-10-CM diagnosis codes and admission type.

Electronic Disease Indices in Excel format is preferred and should include a * *Non-Reportable* column. It should be obtained after medical records are completed and coded (monthly or quarterly).

The Excel format **Non-Reportable* column should be marked if it is deemed to be a non- reportable. Refer to the NR list page. Use the Non-Reportable codes found on page 51

The ICD-10 CM parameter codes to review at 100% are found on Table 3.1 (page 38). The ICD-10 CM 5% supplemental codes table found on Table 3.2 (page 43). Review at the end of your completed submission year.

Note: The Missed Casefinding/DCO linkage project stems from the facility's Casefinding processes.

Attachment A (page 57) is an example of a disease index that can be modified for individual facilities.

The following list includes some helpful hints for the casefinding process:

- Review the disease index for reportable cancer ICD-10-CM codes to ensure the facility has reported all of its reportable cases to TCR.
- Request a TCR Facility Data Report from your regional office when needed during the reporting year. A Facility Data Report is a complete listing of cases submitted by a facility.
- Compare the patients with reportable codes on the disease index to the TCR Facility Data Report.
- Review any patient charts with reportable codes that are missing from the TCR Facility Data Report for reportability.
- Prepare an abstract for each reportable case missing from the TCR Facility Data Report.
- If a previously reported patient is found to have a subsequent primary, assign the new primary the patient's original registry number. Change the sequence number to reflect the new primary and abstract the pertinent cancer information.

Note: If a facility uses an automated casefinding method (for example: the hospital's mainframe extracts possible reportable cases and places these into cancer registry software suspense file), a manual disease index should be run at the end of the reporting year. Ensure that the ICD-10-CM codes used are the most current for the reporting year. This disease index is then checked against the cancer registry database to ensure that all cases were either reported or clearly documented as non-reportable with the reason it is not reportable.

TCR now provides an avenue for following back to each facility for potentially missed cases. It is the facility's responsibility to maintain a reportable and non-reportable list to assist in the review process of the potentially missed cases list provided annually.

ICD-10-CM CASEFINDING LIST

The following comprehensive lists are intended to aid appropriate staff (e.g., Information Services, Data Management) in creating the disease index (DI) with the required reportable neoplasms and ICD-10-CM codes.

Two separate DI's must be requested:

1. A DI with reportable ICD-10-CM codes - 100% review required. This DI will include the Inpatient and Outpatient admissions based on ICD-10-CM primary and secondary diagnosis codes.

2. A DI with supplementary ICD-10-CM codes - 5% review: The purpose of this review is to guarantee complete case ascertainment and improve casefinding outcomes. This can assist in determining codes requiring additional review for the facility. The 5% review of this list will be based on number of patients and not number of diagnosis codes. If a patient on this DI also appears on the DI with a reportable code, they may be crossed off this list to avoid duplicate reviews. After removing duplicate patients, review 5% of the total number of remaining patients. If cases for a particular code were identified as reportable, this information should be documented, and the following year this code should be reviewed 100%. If no reportable cases are identified after reviewing the supplementary list for a year, then it may be acceptable to omit this process for the next 2 to 3 years. However, in the event that circumstances change (for example, new coders are hired, or new codes are added to the list), then the supplementary list should be reviewed sooner to ensure complete casefinding. Some facilities may find that it works best to review the supplementary codes every 3 or every 6 months.

All admissions (inpatient and outpatient) with the reportable diagnosis codes in the table below must be reviewed for reportability. Some of the codes contain conditions that are not reportable. The records need to be reviewed and evaluated separately to determine whether they are reportable to TCR.

Table 3.1 ICD-10-CM CASEFINDING LIST, 2022

ICD-10-CM Code (100% Review Required)	Description
C00.0 - C43.9 C4A.0 - C4A.9, C45._ - C96._	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies ***Note:*** The following neoplasm codes are new for FY2022 (10/1/2021) C56.3: Malignant neoplasm of bilateral ovaries C79.63: Secondary malignant neoplasm of bilateral ovaries C84.7A: Anaplastic large cell lymphoma, ALK-negative, breast
C44.13 - C44.1392	Sebaceous cell carcinoma of skin of eyelid, including canthus ***Note:*** Effective 10/1/2018
C49.A - C49.A9	Gastrointestinal Stromal Tumors (GIST) ***Note:*** All GIST tumors are now reportable starting in 2021 (per ICD-O-3.2), including GIST, NOS
D00.00 - D03.9 D05 - D05.92 D07.0 - D09.9	In-situ neoplasms ***Note:*** Carcinoma in situ of the cervix (D06._) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable.

ICD-10-CM Code (100% Review Required)	Description
D13.7	Benign neoplasm of endocrine pancreas ***Note:*** Effective 1/1/2021: Review this code to look for the following which were previously a benign tumor of the pancreas, but is now malignant per ICD-O-3.2 • Islet cell adenoma • Nesidioblastoma • Islet cell adenomatosis • Insulinoma • Beta cell adenoma
D18.02	Hemangioma of any site of intracranial structures
D18.1	Lymphangioma, any site ***Note:*** Includes Lymphangiomas of Brain, Other parts of nervous system and endocrine glands, which are reportable.
D21.4, D48.1	Benign neoplasm of connective and other soft tissue of abdomen ***Note:*** Effective 1/1/2021: Review this code to look for the following which were previously a benign tumor of the pancreas, but is now malignant per ICD-O-3.2 • Gastrointestinal stromal tumor, NOS/GIST, NOS/Gastrointestinal autonomic nerve tumor/GANT/Gastrointestinal pacemaker cell tumor (8936/1, now 8936/3)
D23.9	Other benign neoplasm of skin Benign carcinoid tumors of other sites **Note:** Effective 1/1/2021: Review these codes to look for the following which were previously benign and borderline tumors, but are now malignant per ICD-O-3.2 • Aggressive digital papillary adenoma (c44_) (8408/1, but now 8408/3)
D3A._	Benign carcinoid tumors of other sites ***Note:*** Effective 1/1/2021: Review these codes to look for the following which were previously benign and borderline tumors, but are now malignant per ICD-O-3.2 • Carcinoid tumor, argentaffinoma, NOS (8240/1, now 8241/3) • Enterochromaffin-like cell carcinoid, NOS (8242/1, now 8241/3)
D32.0 - D32.9	Benign neoplasm of meninges (cerebral, spinal, and unspecified)
D33.0 - D33.9	Benign neoplasm of brain and other parts of central nervous system

ICD-10-CM Code (100% Review Required)	Description
D35.00 - D35.02	Benign neoplasm of adrenal gland ***Note:*** Effective 1/1/2021: Review this code to look for the following which was previously a benign (8700/0) tumor of the adrenal gland, but is now malignant per ICD-O-3.2 (8700/3) • Pheochromocytoma • Adrenal medullary paraganglioma • Chromaffin paraganglioma • Chromaffin tumor . Chromaffinoma
D35.2 – D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D37.8	Neoplasm of uncertain behavior of other specified digestive organs (includes uncertain behavior of pancreas) ***Note:*** Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Pancreatic endocrine tumor, NOS (C259, 8150/1, now 8150/3) • Islet cell tumor, NOS (C259, 8150/1, now 8150/3) • Glucagonoma, NOS (C259, 8152/1, now 8152/3) • Alpha cell tumor, NOS (C259, 8152/1, now 8152/3) • Glucagon-like peptid-producing tumor (C259, 8152/1, now 8152/3) • Somastostatinoma, NOS (8156/1, now 8156/3) • Somatostatin cell tumor, NOS (8156/1, now 8156/3) • Endocrine tumor, functioning, NOS (8158/1, now 8158/3) • ACTH-producing tumor (8158/1, now 8158/3)
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D44.6	Neoplasm of uncertain behavior of carotid body ***Note:*** Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Carotid body tumor/Carotid body paraganglioma (8692/1, now 8692/3)

ICD-10-CM Code (100% Review Required)	Description
D44.7	Neoplasm of uncertain behavior of aortic body and other paraganglia ***Note:*** Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Paraganglioma, NOS (8680/1, now 8680/3) • Sympathetic paraganglioma (8681/1, now 8681/3) • Parasympathetic paraganglioma (8682/1, now 8682/3) • Glomulus jugulare tumor, NOS/jugular paraganglioma/juglotympanic paraganglioma (8690/1, now 8690/3) • Aortic body tumor/aortic body paraganglioma/aorticopulmonary paraganglioma (8691/1, now 8691/3) • Extra-adrenal paraganglioma, NOS/nonchromaffin paraganglioma, NOS/chemodectoma (8693/1, now 8693/3)
D45	Polycythemia vera (9950/3)
D46 - D46.9	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992, 9993)
D47.02	Systemic mastocytosis ***Note:*** Effective 10/1/2017
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3) ICD-10-CM Coding instruction note: Excludes the following: Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_) Chronic myeloid leukemia BCR/ABL-positive (C92.1_) Myelofibrosis & Secondary myelofibrosis (D75.81) Myelophthisic anemia & Myelophthisis (D61.82)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia
D47.4	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis Myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.Z1 - D47.Z9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9931/3) Note: Effective 1/1/2021, PTLD (9971/3) is no longer reportable (9971/1)
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)

ICD-10-CM Code (100% Review Required)	Description
D48.0	Neoplasm of uncertain behavior of bone and articular cartilage ***Note:*** Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Clear cell odontogenic tumor (9341/1, now 9341/3)
D49.2	Neoplasm of unspecified behavior of digestive organs (includes unspecified behavior of pancreas) ***Note:*** Review this code to look for the following which were previously unknown behavior tumors of the pancreas, but are now malignant tumors per ICD-O-3.2 (Histology 8150/3) • Pancreatic endocrine tumor, NOS • Islet cell tumor, NOS
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands, and other CNS
D72.110	Idiopathic hypereosinophilic syndrome [HES] Effective 10/1/2020 Note: Previous code (FY 2015- FY 2020): D72.1: Eosinophilia
D72.111	Lymphocytic Variant Hypereosinophilic Syndrome [LHES] Effective 10/1/2020 Note: Previous code (FY 2015- FY 2020): D72.1: Eosinophilia Syndrome [LHES]
D72.118	Other hypereosinophilic syndrome Effective 10/1/2020 Note: Previous code (FY 2015- FY 2020): D72.1: Eosinophilia
D72.119	Hypereosinophilic syndrome [HES], unspecified Effective 10/1/2020 Note: Previous code (FY 2015- FY 2020): D72.1: Eosinophilia
R87.624	Cytologic evidence of malignancy on smear of vagina

^ Based on the International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2022

Source: https://seer.cancer.gov/tools/casefinding/icd-10-cm-casefinding-list.20220105.pdf

SUPPLEMENTARY ICD-10-CM CODES

Table 3.2 Supplementary ICD-10-CM Code List

ICD-10-CM Code (5% Review Required)	Description
B20	Human immunodeficiency virus [HIV] disease with other diseases
B97.33, B97.34, B97.35	Human T-cell lymphotrophic virus, (type I [HTLV-1], type II [HTLV-II], type 2 [HIV 2]) as the cause of diseases classified elsewhere
B97.7	Papillomavirus as the cause of diseases classified elsewhere
D10.0 - D31.92, D34, D35.0, D35.1, D35.5_ D35.9, D36.0-D36.9	Benign neoplasms (see "must collect" list for reportable benign neoplasms) ***Note:*** Screen for incorrectly coded malignancies or reportable by agreement tumors ***Note:*** Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. SEER registries are not required to collect these cases for diagnoses made 1/1/2001 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted and reported to SEER.
D37.0 - D41.9	Neoplasms of uncertain or unknown behavior (see "must collect" list for reportable neoplasms of uncertain or unknown behavior) ***Note:*** Screen for incorrectly coded malignancies or reportable by agreement tumors
D44.0 - D44.2, D44.6-D44.9	Neoplasm of uncertain or unknown behavior of other endocrine glands (see "must collect" list for D44.3-D44.5) ***Note:*** Screen for incorrectly coded malignancies or reportable by agreement tumors
D47.01	Cutaneous mastocytosis (9740/1) ***Note:*** Effective 10/1/2017
D47.09	Other mast cell neoplasms of uncertain behavior ***Note:*** Effective 10/1/2017
D47.2	Monoclonalgammopathy ***Note:*** Screen for incorrectly coded Waldenstrom's macroglobulinemia
D47.Z2	Castleman disease
D48.0-D48.9	Neoplasm of uncertain behavior of other and unspecified sites
D49.0 - D49.9	Neoplasm of unspecified behavior (except for D49.6 and D49.7)
D61.1	Drug-induced aplastic anemia (also known as “aplastic anemia due to antineoplastic chemotherapy”) ICD-10-CM Coding instruction note: Use additional code for adverse effect, if applicable, to identify drug
D61.810	Antineoplastic chemotherapy induced pancytopenia

ICD-10-CM Code (5% Review Required)	Description
D61.82	Myelophthisis ICD-10-CM Coding instruction: Code first the underlying disorder, such as: malignant neoplasm of breast (C50. _)
D63.0	Anemia in neoplastic disease ICD-10-CM Coding instruction: Code first neoplasm (C00-C49)
D64.81	Anemia due to antineoplastic chemotherapy
D69.49, D69.59, D69.6	Other thrombocytopenia ***Note:*** Screen for incorrectly coded thrombocythemia
D70.1	Agranulocytosis secondary to cancer chemotherapy
D75.81	Myelofibrosis (note: this is not primary myelofibrosis [9961/3] ICD-10-CM Coding instruction note: Code first the underlying disorder, such as: malignant neoplasm of breast (C50. _)
D76.1-D76.3	Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue
D89.0, D89.1	Other disorders involving the immune mechanism, not elsewhere classified ***Note:*** Review for miscodes
D89.40-D89.49	Mast cell activation syndrome and related disorders ***Note:*** Effective 10/1/2016
E08	Diabetes mellitus due to underlying condition ICD-10-CM Coding instruction note: Code first the underlying condition, such as: malignant neoplasm (C00-C96)
E31.20-E31.9	Multiple endocrine neoplasia [MEN] syndromes ICD-10-CM Coding instruction: Code also any associated malignancies and other conditions associated with the syndromes
E34.0	Carcinoid syndrome ICD-10-CM Coding instruction: May be used as an additional code to identify functional activity associated with a carcinoid tumor
E83.52	Hypercalcemia
E88.09	Other disorders of plasma-protein metabolism, not elsewhere classified
E88.3	Tumor lysis syndrome (following antineoplastic chemotherapy)
G13.0	Paraneoplastic neuromyopathy and neuropathy ICD-10-CM Coding instruction note: Code first underlying neoplasm (C00-D49)
G13.1	Other systemic atrophy primarily affecting central nervous system in neoplastic disease ICD-10-CM Coding instruction note: Code first underlying neoplasm (C00-D49)
G32.8-G32.81	Other specified degenerative disorders of nervous system in diseases classified elsewhere ICD-10-CM Coding instruction note: Code first underlying disease, such as: cerebral degeneration (due to) neoplasm (C00-D49)

ICD-10-CM Code (5% Review Required)	Description
G53	Cranial nerve disorders in diseases classified elsewhere ***Note:*** Code first underlying neoplasm (C00-D49)
G55	Nerve root and plexus compressions in diseases classified elsewhere ICD-10-CM Coding instruction note: code also underlying disease, such as neoplasm (C00-D49)
G63	Polyneuropathy in diseases classified elsewhere ICD-10-CM Coding instruction note: Code first underlying disease, such as: neoplasm (C00-D49)
G73.1	Lambert-Eaton syndrome in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)
G89.3	Neoplasm related pain (acute)(chronic)
G99.2	Myelopathy in diseases classified elsewhere ICD-10-CM Coding instruction: Code first underlying disease, such as: neoplasm (C00-D49)
H47.42	Disorders of optic chiasm in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
H47.52-	Disorders of visual pathways in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
H47.63-	Disorders of visual cortex in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
J34.81	Nasal mucositis (ulcerative)
J91.0	Malignant pleural effusion ICD-10-CM Coding instruction: Code first underlying neoplasm
J93.12	Secondary spontaneous pneumothorax ICD-10-CM Coding instruction: Code first underlying condition, such as: Malignant neoplasm of bronchus and lung (C34._) Secondary malignant neoplasm of lung (C78.0_)
K12.31	Oral mucositis (ulcerative) due to antineoplastic therapy
K12.33	Oral mucositis (ulcerative) due to radiation
K22.711	Barrett's esophagus with high grade dysplasia
K62.7	Radiation proctitis
K62.82	Dysplasia of anus (AIN I and AIN II)
K92.81	Gastrointestinal mucositis (ulcerated) (due to antineoplastic therapy)
M31.11	Hematopoietic stem cell transplantation-associated thrombotic microangioplasty Note: Effective 10/1/2021
M36.0	Dermato(poly)myositis in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)
M36.1	Arthropathy in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm, such as: Leukemia (C91-C95), malignant histiocytosis (C96.A), multiple myeloma (C90.0)

ICD-10-CM Code (5% Review Required)	Description
M84.50-M84.576	Pathologic fracture in neoplastic disease ICD-10-CM Coding instruction: Code also underlying neoplasm (C00-D49)
M90.60-M90.69	Osteitis deformans in neoplastic disease ICD-10-CM Coding instruction: Code first the neoplasm (C40._, C41._)
N42.3	Dysplasia of prostate (PIN I and PIN II)
N52.35	Erectile dysfunction following radiation therapy
N52.36	Erectile dysfunction following interstitial seed therapy
N76.81	Mucositis (ulcerative) of vagina and vulva
N87._	Dysplasia of cervix uteri (CIN I and CIN II)
N89.0,N89.1, N89.3	Vaginal dysplasia (VIN I and VIN II)
N90.0,N90.1, N90.3	Vulvar dysplasia (VAIN I and VAIN II)
O01.-	Hydatidiform mole ***Note:*** Benign tumor that can become malignant. If malignant, report as Choriocarcinoma (9100/3,) malignancy code in the C00- C97 range
O9A.1-	Malignant neoplasm complicating pregnancy, childbirth and the puerperium (conditions in C00-C96) ICD-10-CM Coding instruction: Use additional code to identify neoplasm
P04.11	Newborn affected by maternal antineoplastic chemotherapy ***Note:*** Effective 10/1/2018
P04.12	Newborn affected by maternal cytotoxic drugs ***Note:*** Effective 10/1/2018
Q85.0-	Neurofibromatosis (nonmalignant) (9540/1) ***Note:*** Neurofibromatosis is not cancer. These tumors can be precursors to acoustic neuromas, which are reportable
R18.0	Malignant ascites ICD-10-CM Coding instruction: Code first malignancy, such as: Malignant neoplasm of ovary (C56._), secondary malignant neoplasm of retroperitoneum and peritoneum (C78.6)
R53.0	Neoplastic (malignant) related fatigue ICD-10-CM Coding instruction: Code first associated neoplasm
R59.-	Enlarged lymph nodes
R85.6-	Abnormal findings on cytological and histological examination of digestive organs. ***Note:*** See "must collect" list for R85.614
R87.61-, R87.62-	Abnormal findings on cytological/histological examination of female genital organs. ***Note:*** See "must collect" list for R87.614 and R87.624
R92.-	Abnormal findings on diagnostic imaging of breast
R97.-	Abnormal tumor markers

ICD-10-CM Code (5% Review Required)	Description
T38.6-	Poisoning by antigonadotrophins, antiestrogens, antiandrogens, not elsewhere classified
T38.8-, T38.996	Poisoning by hormones and their synthetic substitutes
T45.1-	Poisoning by, adverse effect of and under dosing of antineoplastic and immunosuppressive drugs
T45.8-, T45.96	Poisoning by primary systemic and hematological agent, unspecified
T66	Unspecified effects of radiation
T80.1	Vascular complications following infusion, transfusion and therapeutic injection
T80.2-	Infections following infusion, transfusion and therapeutic injection
T80.810	Extravasation of vesicant antineoplastic chemotherapy
T80.818	Extravasation of other vesicant agent
T86.0	Complications of bone marrow transplant ICD-10-CM Coding instruction: Use addition code to identify other transplant complications, such as: malignancy associated with organ transplant (C80.2) or post-transplant lymphoproliferative disorders (PTLD) (D47.Z1)
Y63.2	Overdose of radiation given during therapy
Y84.2	Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm (medical surveillance following completed treatment) ICD-10-CM Coding instruction: Use additional code to identify the personal history of malignant neoplasm (Z85._)
Z12.-_	Encounter for screening for malignant neoplasms
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z15.0	Genetic susceptibility to malignant neoplasm ICD-10-CM Coding instruction: Code first, if applicable, any current malignant neoplasm (C00-C75, C81-C96); Use additional code, if applicable, for any personal history of malignant neoplasm (Z85._)
Z17.0, Z17.1	Estrogen receptor positive and negative status ICD-10-CM Coding instruction: Code first malignant neoplasm of breast (C50._)
Z40.0_	Encounter for prophylactic surgery for risk factors related to malignant neoplasms
Z42.1	Encounter for breast reconstruction following mastectomy

ICD-10-CM Code (5% Review Required)	Description
Z48.290	Encounter for aftercare following bone marrow transplant
Z48.3	Aftercare following surgery for neoplasm ICD-10-CM Coding instruction: Use additional code to identify the neoplasm
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1-	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.5, Z51.89	Encounter for palliative care and other specified aftercare
Z79.81-	Long term (current) use of agents affecting estrogen receptors and estrogen levels ICD-10-CM Coding instruction: Code first, if applicable, malignant neoplasm of breast (C50._), malignant neoplasm of prostate (C61)
Z80.-	Family history of primary malignant neoplasm
Z85._	Personal history of malignant neoplasm ICD-10-CM Coding instruction: Code first any follow-up examination after treatment of malignant neoplasm (Z08)
Z86.0_, Z86.01_, Z86.03	Personal history of in situ and benign neoplasms and neoplasms of uncertain behavior
Z92.21, Z92.23, Z92.25. Z92.3	Personal history of antineoplastic chemotherapy, estrogen therapy, immunosuppression therapy or irradiation (radiation)
Z92.850	Personal history of Chimeric Antigen Receptor T-cell therapy- Personal history of CAR-T-cell therapy
Z94.81, Z94.84	Bone marrow and stem cell transplant status

^Based on the International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2022

OTHER CASEFINDING PROCESSES

Other methods for identifying reportable cancer cases should be developed to assure complete case reporting. Since the patient's medical record is the primary source of information, arrangements should be made so the appropriate charts can be routed to the personnel responsible for reporting.

Casefinding Lists

Current and previous casefinding lists are available on the SEER website: seer.cancer.gov/tools/casefinding/. Use the casefinding lists to screen prospective cases and identify cancer cases for inclusion in the registry.

A casefinding list is **not** the same as a reportable list. Casefinding lists are intended for searching a variety of sources so as not to miss any reportable cases.

Pathology

The pathology department reports must be routinely checked. The best procedure is to have copies of **all** pathology reports routed to the personnel responsible for reporting. All pathology reports (both positive and negative) must be reviewed by the reporter to ensure all eligible cases are identified. The reporter should request that all cytology, hematology, bone marrow biopsies, and autopsies be included. Both computerized and manual methods of reviewing pathology reports must include a way to track reports to ensure that every report has been included in the review. Facilities that send all pathology specimens to outside labs should keep a log of all specimens, to include date sent out, date received, and the diagnosis. The reporter should be given a copy of all reports.

Note: If a hospital sends a specimen to another hospital to be read, and the patient is never seen at the reading facility, **only the hospital that performed diagnostic procedures or administered treatment for a cancer diagnosis is responsible for reporting the case.** The reading facility should document this process in their policy and procedure for consistency.

Exception: To ensure complete reporting, if the specimen is sent from a physician's office to a reading facility, the reading facility would be responsible for reporting the case.

Radiation Oncology

For facilities with radiation oncology departments, a procedure must be established to identify patients receiving radiation therapy. This should include all inpatient and outpatient treatments.

Different options, such as providing copies of the treatment summary, a treatment card, or even a daily appointment book may be available to identify these cases. Many cancer patients are seen in the outpatient department, hematology clinic, laboratory, emergency room, nuclear medicine, and diagnostic radiology and oncology departments. A method to identify reportable cases from these departments must also be established.

Oncology/Hematology

Many facilities now have a designated oncology/hematology unit where patients receive chemotherapy treatments as an inpatient. In some cases, patients receive chemotherapy in an ambulatory setting, a freestanding facility, or a physician's office. The registrar/reporter must establish a policy and procedure for identifying patients who receive chemotherapy in these settings if affiliated with their facility.

GUIDELINES FOR CASE REPORTING

In some instances, it is unclear whether cancer cases seen in a clinic are reportable through an associated facility. The cases should be included in the facility's caseload when:

- The clinic is owned by the facility.
- The facility is legally responsible for the medical charts in the clinic.
- The facility receives revenue from the medical charts at the clinic.
- The clinical charts are filed in the same location as the facility charts, or
- The facility pays the physicians to work in the clinic.

Cases diagnosed and/or treated for cancer prior to admission should be reported if there is evidence of active disease, whether or not diagnostic or therapeutic procedures were performed. Stable disease indicates active disease.

Cases diagnosed at autopsy are reportable.

Patients with active cancer coming into a facility for "consultation only" should be reported.

Abstract cases with a reportable diagnosis using the medical record from the first admission (inpatient or outpatient) to your facility. Use information from subsequent admissions to supplement documentation and to include all first course treatment information. Do not submit a report for each admission; submit one report per primary tumor.

Cases in which the disease is no longer active should only be reported if the patient is still receiving cancer-directed therapy.

Example: A patient diagnosed 6 months ago with acute myelocytic leukemia is now in remission and on a maintenance dose of chemotherapy. The patient was admitted for evaluation of neutropenia following the most recent course of chemotherapy. If this is the first admission to your facility, this patient should be reported because cancer-directed treatment (chemotherapy) is being administered.

Remember, physicians may refer to patients diagnosed with cancer prior to coming to a facility as having a "history of" cancer. These cases should be reviewed closely to determine if the patient has active disease and/or is receiving cancer-directed treatment.

If there is any indication within the medical record that the patient has evidence of disease, or is on cancer directed treatment, the case is reportable except for those morphologies listed under non-reportable neoplasms on page 45. This would include but not limited to radiology reports, pathology reports, consults, history and physicals, and clinic notes.

If you have any questions regarding the eligibility of a case, call your TCR health service region.

Every effort should be made to identify multiple primary tumors. Refer to the *Solid Tumor Rules* and to the *Hematopoietic and Lymphoid Neoplasm Coding Manual* to prevent reporting the same primary twice for a patient, compare the patient's name and primary cancer site from the registry database to the TCR facility data report. The TCR facility data report lists all the patients a facility has reported to TCR for multiple years.

Examples for Determining Case Reportability

Example 1: A patient comes to a facility for a bone scan. The face sheet has been coded to prostate cancer. The bone scan is negative and there is no other information to indicate that this patient has active disease or is receiving cancer directed treatment. **This case is not reportable because there is no information to indicate if this patient has active disease.**

Example 2: A patient comes to the emergency room. He tells the attending physician that he had cancer years ago. There is no other information documented to indicate that he has active disease or is on cancer-directed therapy. **This case is not reportable because there is no information confirming the patient has active disease.**

Example 3: A patient comes into the emergency room for a broken wrist. The history/physical states that the patient is currently undergoing chemotherapy for lung cancer, but the facility does not render any treatment for the cancer; the patient is only treated for the broken wrist. **This case is reportable because the patient is currently undergoing cancer directed treatment at another facility.**

Example 4: A patient is admitted to a facility with a breast lump. The H&P states that the patient was diagnosed elsewhere with breast cancer seven years ago and treated with a lumpectomy. There is now recurrence of the disease and the patient was referred for a mastectomy. **This case is reportable due to active disease.**

Example 5: A patient comes to your facility for lab work only. The face sheet states "cancer". The only other information available is the lab results. **This case is not reportable. A physician must state the patient has active disease, recurrence, or metastatic disease.**

SUSPENSE FILE

A reportable case should be abstracted after review of the patient's complete record, not just from the unit record for the admission in question. If reportable cases are identified at the time of discharge, the complete medical record may not be available at the time the case is abstracted. A suspense file should be compiled of all cases identified as eligible or potentially eligible for abstracting. The suspense file can be something as simple as a manila folder to hold the various casefinding source documents (monthly disease index, pathology reports and outpatient log sheets and so forth) in alphabetical order and/or by date of diagnosis to assess timeliness of the abstracting process.

NON-REPORTABLE LIST

Personnel responsible for reporting should review the list of terms that indicate a Reportable Neoplasm on page 6 of the 2022 SEER Program Coding and Staging Manual. Upon review of the disease index (DI), cases may be identified as TCR non-reportable cases. Examples of these would be basal and squamous cell carcinoma of the skin (C44.0 – C44.9) (excluding genital sites), and CIN of the cervix (D06.9). A list of these cases **must be kept each year**.

TCR will review the disease index and the non-reportable list when it conducts casefinding audits after facilities have completed reporting for a given year. The non-reportable list will answer any questions

TCR staff may have regarding the non-reporting of these cases. The list should include patient name, date of birth, social security number, medical record number, admission date, casefinding source, and the reason the case was not reportable.

Attachment B (page 58) is a sample form that can be used as a history file of the non-reportable cases. Non-reportable cases can also be documented on the disease index. Place the notation "NR" next to the patient information and include a justification if the case is determined not reportable. Another method would be to develop an electronic spreadsheet that can be sorted alphabetically, such as Excel or Word. An alphabetical index card file can also be used.

Note: There is no non-reportable log in the Web Plus system. Reporters using Web Plus may create and use a form such as the sample Attachment B or make a "not reportable" notation for each case on the disease index.

The following examples are resources to determine if a case is reportable to TCR. It is critical that these scenarios be applied appropriately. If a patient has active disease and/or is on cancer directed therapy, the case must be reported, unless it is a non-reportable condition.

Non-Reportable Examples

- The ICD-10-CM billing code indicates current disease. Reason for admission was radiology and laboratory testing. Radiology and laboratory findings do not indicate active disease. **This case is not reportable since there is no indication that the patient has current disease.**
- The discharge summary and face sheet states history of cancer and there is no other information within the chart to indicate active or stable disease. **This case is not reportable because the patient has a history of cancer with no evidence of active disease.**
- A patient is admitted for evaluation of congestive heart failure. The patient had a mastectomy for breast cancer 8 years ago and there is no evidence of recurrent or metastatic disease. **This case is not reportable because there is no indication that the patient has current disease.**
- A patient comes in for lab work. Face sheet states lung cancer. No other information or documentation indicating active disease is available. **This case is not reportable because there is no information regarding whether the patient has current lung cancer.**
- A patient comes in for a bone scan. The physician orders state prostate cancer, but the bone scan report states no evidence of disease. There is no other information in the chart. **Do not report this case since there is no evidence of disease and no mention of current treatment.**

Reportable List Examples

- Patient is admitted for staging procedures. Radiology reports no abnormal findings. The discharge summary states that the patient has recently been diagnosed with prostate cancer and is in the process of deciding treatment options. **This case is reportable because even though the radiology report shows no abnormal findings, the discharge summary states the patient has prostate cancer.**

- A patient was diagnosed with adenocarcinoma of the stomach in 1985 with no evidence of recurrent or metastatic disease. In 2022, the patient was admitted and diagnosed with small cell carcinoma of the lung. **The lung cancer is reportable for 2022 because the patient has active lung cancer.**
- Discharge summary diagnosis states cancer and the ICD-10-CM billing code indicates current disease. All laboratory findings are negative for active disease, but one radiology report indicates active disease compatible with malignancy. **This case is reportable because according to the radiology report the patient has active disease.**
- A patient is admitted to your facility with an acute cerebrovascular accident. The H&P states the patient was diagnosed with metastatic lung cancer four months prior to admission. He was treated with palliative care and referred to the Hospice program. All indications are that this patient still has active cancer**. This case is reportable because apparently the patient has active disease.**
- A patient was diagnosed with cervical cancer in 2000 and has had no recurrence. She is now admitted and diagnosed with a second primary in the lung. **The lung case is reportable because the patient has active lung cancer.**
- A patient comes to your facility for port-a-cath insertion to allow for chemotherapy for a malignancy. Documentation indicates the patient has active disease. **This case is reportable because the patient has active disease and is receiving cancer directed therapy, even though the therapy may be given at a different facility.**
- Patient with a recent excisional biopsy for melanoma of skin of arm is admitted to your facility for a wide excision. The pathology report shows no residual melanoma. **This case is reportable because the wide excision is considered treatment for the melanoma.**
- In 2022 a patient comes to your facility for a colonoscopy. The record states that the patient was diagnosed with breast cancer in 2018. She is still being treated with Tamoxifen which was part of the first course of treatment. It is unknown if the patient has evidence of disease at this time. **This case is reportable because the patient is still receiving hormone treatment.**

  Note: When Tamoxifen or other hormonal therapy, such as Arimidex, is used as adjuvant therapy for breast cancer it is generally prescribed for 5 years. It has been shown that when taken for 5 years it reduces the chance of the original breast cancer coming back in the same breast or metastasizing.

  - Therefore, if the patient has a history of breast cancer and is on hormonal treatment and it is known that the diagnosis was within the past 5 years, report the case.
  - It is unknown how long ago the breast cancer was diagnosed, report the case.
  - It is known that the diagnosis of breast cancer was greater than 5 years ago and there is no evidence of disease, and no evidence of other treatment being given at the time of admit, it is not necessary to report the case.
- A patient is admitted to the hospital after a heart attack. The chart states the patient has a history of prostate cancer and is on Lupron. There is no other information regarding the patient's history.

Report this case because the patient is on treatment that could be related to the history of prostate cancer.

- A patient comes to your facility for a bone scan. The physician orders state the patient was recently diagnosed with prostate cancer. **Regardless of the results, report this case since the patient was stated to be recently diagnosed; the bone scan is being done for staging purposes.**

HELPFUL HINTS TO CONDUCT CASEFINDING

All possible sources of cancer cases in a facility should be reviewed to achieve complete and accurate casefinding.

- Review pathology reports monthly.
- Review disease index monthly.
- Review radiation oncology logs weekly.
- Have coders route medical charts to the registrar/reporter on all identified cancer patients.
- Review outpatient and emergency room visits for reportability. Arrangements can be made to have these routed to the registrar/reporter, or the registrar/reporter can physically review them in the department.
- Maintain a list of non-reportable cases or document non-reportable cases on the disease index.

When reporting is complete for the year, it is the facility's responsibility to maintain a reportable and non-reportable list to assist in the review process of the potentially missed cases list provided annually.

Complete cancer reporting is an important element in a cancer registry quality assurance program. TCR performs casefinding audits to determine the completeness of case ascertainment and timeliness of reporting at facilities across the state. These audits are a part of TCR's data quality procedures and are necessary to assure complete and accurate cancer information and to meet the state's federal funding obligations. The results of a casefinding audit are reported back to the facility.

Note: For more information on cancer reporting visit the Cancer Reporting webpage on the TCR website at dshs.texas.gov/tcr/reporting.aspx.

Contact your regional representative for an assessment of your casefinding procedures. This will better prepare you for an audit.

CASEFINDING INSTRUCTIONS FOR HEMATOPOIETIC & LYMPHOID NEOPLASMS

Refer to Hematopoietic & Lymphoid Neoplasm Coding Manual Case Reportability Instructions for Hematopoietic and Lymphoid Neoplasms **(9590/3-9992/3)** (Reportability Instructions begin on page 18).

ATTACHMENT A: Sample Facility Disease Index

Mr#	Name	DOB	SSN	Sex	Pt Class/ Type	Admission Date	Discharge Date	Diagnosis/ Description
123123	Roberts, Jim	2/10/1959	455-66-9090	M	IN, MCR	05/02/22	05/03/1922	C7A.010 Mal Carcinoid Tumor Duodenum
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	04/05/22	04/07/22	Z51.11 Chemo Encounter
C5412	Smith, Bob	6/29/1938	422-23-2323	M	SCD, MCR	05/11/22	05/11/22	C64.9 Mal Neo Kidney
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	09/06/22	09/14/22	C79.1 Sec Mal Neo Brain
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	10/15/22	10/22/22	C64.9 Mal Neo of Unsp Kidney
MR421	Sun, Len	11/4/1980	566-66-6666	M	IN, OTH	10/16/22	10/20/22	D63.0 Anemia in Neoplastic Disease
MR311	Timms, Emma	6/15/1959	500-00-5000	F	CLL, MCR	03/22/22	03/22/22	D24.1 Benign Neo Breast
C1234	Timms, Emma	6/15/1959	500-00-5000	F	IN, MCR	05/29/22	06/02/22	C50.419 Mal Neo Breast UOQ
C1234	Timms, Emma	6/15/1959	500-00-5000	F	IN, MCR	05/29/22	06/02/22	C77.3 Mal Neo Lymph-Axilla
MR311	Timms, Emma	6/15/1959	500-00-5000	F	RCR, MCR	07/13/22	07/23/22	Z51.0 Encounter foro Antineoplastic Radiation Therapy
MR311	Timms, Emma	6/15/1959	500-00-5000	F	RCR, MCR	8/23/22	11/13/22	D49.9 GIST

ATTACHMENT B: Non-Reportable List

Facility Name: _____ Facility ID#___ Reviewed by: ___ Telephone: _____

Patient Name	Med Rec #	Admit Date	Date of Birth	SSN	Casefinding Source	N/R Code

KEEP A COPY FOR YOUR RECORDS

NON-REPORTABLE (N/R) CODES:

01 – Benign

02 – Non-Reportable Skin Cancer (Site=C44.*, Morph=8000-8110)

03 – No Evidence of Disease (NED) (History of Cancer but No Evidence of Treatment Currently and No Evidence of Cancer Currently)

04 – Cancer Not Proven

05 – Duplicate Case (This Cancer has already been reported to TCR)

06 – In situ Cancer of Cervix, CIN III

07 – No Cancer Mentioned in Record

08 – Diagnosed prior to 1995

09 – Lab only

10 – Other (Include Explanation)

4

REPORTABILITY

REPORTABLE NEOPLASMS

Definition of Reportable: Meets the criteria for inclusion in a registry. Reportable cases are cases that the registry is required to collect and report. Reporting requirements for SEER registries are established by NCI SEER.

Refer to "Reportability" beginning on page 6 of the 2022 SEER Program Coding and Staging Manual for Reportability List, instructions, acceptable ambiguous terminology, and examples.

.**Please note: TCR joined SEER in 2021 and has a different reporting start date than specified in the SEER manual. TCR no longer requires reporting of cases diagnosed prior to 1995.**

Refer to *Chapter III: Standards for Tumor Inclusion and Reportability*, in the 2022 NAACCR Data Standards and Data Dictionary, Vol II

Refer to Appendix E1 - 2022 SEER Program Coding And Staging Manual for reportable examples.

Refer to the ICD-O3.2 Updates for new/changed behaviors and terms.

A list of reportable neoplasms can also be found in Appendix E of the *2022 TCR Cancer Reporting Handbook.*

Examples

- Positive histology from needle biopsy followed by a negative resection is reportable. The fact that no residual malignancy was found in the later specimen does not disprove the malignancy diagnosed by the biopsy.
- Prostate cancer cases with an PI-RADS category of 4 or 5 is reportable. PI-RADS categories 4(high-clinically significant cancer is likely to be present) and 5(very high-clinically significant cancer is highly likely to be present) are reportable unless there is other information to the contrary.
- Early or evolving melanoma, in situ or invasive are reportable as of 1/1/2021.
- Microcarcinoid tumors of the stomach are reportable. The ICD-O-3.2 histology code is 8240/3. Microcarcinoid is a designation for neuroendocrine tumors of the stomach when they are less than 0.5 cm. in size. Neuroendocrine tumors of the stomach are designated carcinoid when they are 0.5cm or larger. The term microcarcinoid tumor is not equivalent to carcinoid tumorlet.
- Mature teratoma of the testis when diagnosed after puberty (malignant). For testis: Mature teratoma in adults is malignant (9080/3). Note: Do not report when diagnosed in a child (benign). Do not report mature teratoma of the testis when it is not known whether the patient is prepubescent or postpubescent. Pubescence can take place over a number of years; review physical history and do not rely only on age.
- Mammary analogue secretory carcinoma (MASC). MASC is a tumor that predominantly arises in the parotid gland. If the primary site is submandibular gland, assign C080. Assign 8502/3. Override any edits triggered by the combination of C080 and 8502/3.

- Ulcerated histologically malignant spindle cell neoplasm, consistent with atypical fibroxanthoma; an exhaustive immunohistochemical work-up shows no melanocytic, epithelial or vascular differentiation. Atypical fibroxanthoma is a superficial form of a malignant fibrous histiocytoma. This case is reportable. The pathologist has the final say on behavior for a particular case. In this case, the pathologist states that this tumor is malignant.
- Aggressive adult granulosa cell tumor with one of two lymph nodes positive for malignant metastatic granulosa cell tumor. This case is reportable because malignant granulosa cell tumor is reportable. The lymph node metastases prove malignancy.
- Ovarian mucinous borderline tumor with foci of intraepithelial carcinoma. This case is reportable because there are foci of intraepithelial carcinoma (carcinoma in situ).

NON-REPORTABLE NEOPLASMS

Reporting requirements for SEER registries are established by NCI SEER.

Refer to "Reportability" beginning on page 6 of the 2022 SEER Program Coding and Staging Manual for Reportability List, instructions, acceptable ambiguous terminology, and examples.

Refer to Appendix E2 - 2022 SEER Program Coding And Staging Manual for non-reportable examples.

Refer to the ICD-O3.2 Updates for new/changed behaviors and terms.

Refer to Appendix E - 2022 SEER Program Coding and Staging Manual for non-reportable examples.

Examples

- Left thyroid lobectomy shows microfollicular neoplasm with evidence of minimal invasion. Micro portion of path report states "The capsular contour is focally distorted by a finger of the microfollicular nodule which appears to penetrate into the adjacent capsular and thyroid tissue." Do not report this case based on the information provided. There is no definitive statement of malignancy. Search for additional information in the record. Contact the pathologist or the treating physician.
- Sclerosing hemangioma of the lung with multiple regional lymph nodes involved with sclerosing hemangioma. This case is not reportable. The lymph node involvement is non-malignant. According to the *WHO Classification of Lung Tumours*, sclerosing hemangioma "behaves in a clinically benign fashion. Reported cases with hilar or mediastinal lymph node involvement do not have a worse prognosis."
- Low grade appendiceal mucinous neoplasm (LAMN) is not reportable. The WHO classification designates LAMN as /1 with uncertain malignant potential.
- Diffuse idiopathic pulmonary neuroendocrine cell hyperplasia (DIPNECH) is not reportable. It is a generalized proliferation of scattered single cells, small nodules (neuroendocrine bodies), or linear proliferation of pulmonary neuroendocrine cells (PNCs), according to the WHO classification of lung tumors.

- Lentiginous melanocytic lesion is not reportable.
- Lobular intraepithelial neoplasia grade 1 and grade 2 are not reportable.
- Brain lesions associated with multiple sclerosis are not reportable. These brain lesions are not neoplastic; they are part of the disease process of multiple sclerosis.
- High grade squamous intraepithelial lesion (HGSIL or HSIL) of the vulva or vagina is not reportable. These are not the same as VIN III or VAIN III which are reportable.
- HGSIL, HSIL, carcinoma in situ (CIS), and AIN III (8077) arising in perianal skin (C445) are not reportable.

5

CHANGING INFORMATION ON THE ABSTRACT

Changing Information on the Abstract

There are some circumstances under which the information originally coded in the abstract should be updated. **For information and examples of circumstances, please refer to "Changing Information on the Abstract" beginning on page 15 of the 2022 SEER Program Coding and Staging Manual.**

Example 1: Patient has surgery for a benign argentaffin carcinoid (8240/1) of the sigmoid colon in May 2021. In January 2022, the patient is admitted with widespread metastasis consistent with malignant argentaffin carcinoid. The registrar accessions the malignant argentaffin carcinoid as a 2022 diagnosis. Two months later, the pathologist reviews the slides from the May 2021 surgery and concludes that the carcinoid diagnosed in 2021 was malignant. Change the date of diagnosis to May 2021 and histology to 8241 and the behavior code to malignant (/3).

Example 2: At the time of diagnosis, a patient is diagnosed with liver metastasis, but primary site cannot be determined, and the abstract is submitted as an unknown primary. At a later date the physician determines that the patient has a colon primary. Change the primary site from unknown to colon. Be sure to make any necessary changes in *Staging* and *Surgery Codes*. Document the new information in the appropriate text fields.

Example 3: A patient is diagnosed with lung cancer by CT exam alone. An abstract is submitted with the histology of cancer (8000/3) and diagnostic confirmation code 7. At a later admit the H&P states that the patient has squamous cell carcinoma of the lung diagnosed by fine needle aspiration. The *Histology* should be changed from cancer to squamous cell carcinoma (8070/3), and the *Diagnostic Confirmation* should be changed to 2, cytology. These findings should also be documented in the text fields.

Note: Contact the TCR health service regional office regarding the appropriate procedure to follow when there is updated information on an abstract already submitted to TCR. Do **NOT** resubmit the abstract. These cases will result in duplicate records and require manual resolution. TCR does not accept modified abstracts.

6

DETERMINING MULTIPLE PRIMARIES

The determination of how many primary cancers a patient has is, of course, a medical decision, but operational rules are needed in order to ensure consistency of reporting by cancer reporters.

When a patient has more than one tumor in the same or different organs, **multiple primaries** may be present, requiring more than one abstract. However, multiple tumors may also be considered a **single primary,** requiring only one abstract.

A **single primary** is a term used to describe the original, or first, tumor in the body. Cancer cells from a primary cancer may spread to other parts of the body and form new, or secondary, tumors.

A **single primary** can be:

- Single tumor
- Simultaneous multiple tumors abstracted as a **single primary**
- Subsequent tumor(s) which are a reappearance of disease, rather than a multiple primary

A **recurrence** is defined as either

- Reappearance of disease that was thought to be cured or inactive (in remission). It starts from cancer cells that were not removed or destroyed by the original therapy.
- A **new tumor** in the same primary site. It is a new occurrence of cancer that arise from cells that have nothing to do with the earlier (first) cancer. Another **single primary** to be abstracted.

SOLID TUMORS

To determine multiple primaries for solid tumors, refer to "Determining Multiple Primaries" beginning on page 16 of the SEER Program Coding and Staging Manual 2022 .

Refer to the Solid Tumor Rules for the general instructions and site-specific instructions for determining multiple primaries.

HEMATOPOIETIC AND LYMPHOID NEOPLASMS

To determine multiple primaries for hematopoietic and lymphoid neoplasms refer to "Determining Multiple Primaries" beginning on page 16 of the SEER Program Coding and Staging Manual 2022 .

Refer to the Hematopoietic & Lymphoid Neoplasm Coding Manual for the instructions and rules for determining multiple primaries for hematopoietic and lymphoid neoplasms (9590/3-9992/3).

TRANSPLANTS

To determine multiple primaries for transplanted sites or organs refer to "Determining Multiple Primaries" beginning on page 16 of the SEER Program Coding and Staging Manual 2022.

Example: Diagnosis of malignancy in transplanted section of colon serving as esophagus. Code the primary site as esophagus. Document the situation in a text field.

7

BASIC RECORD IDENTIFICATION

Reporting Facility

(NAACCR Item #540)

Description

Identifies the facility or institution reporting the case.

Rationale

This data item is used for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Coding Instructions

1. Enter the three-digit facility number assigned by TCR. This is a 10-digit code. The three-digit facility number should be coded with 7 leading zeros.
2. If you do not know your facility number, contact your Health Service Region office or the Central Office in Austin. See page 18 for contact information.

Medical Record Number

(NAACCR Item #2300)

Description

Records medical number used by facility to identify the patient.

Rationale

This number identifies the individual patients in a facility. It can be used by a central registry to point back to the patient record, and it helps identify multiple reports on the same patient.

Coding Instructions

1. Enter the eleven-digit medical record number used to identify the patient's first admission with active cancer and/or on cancer treatment. Medical record numbers with less than 11 digits and alpha characters are acceptable.
2. If a number is not available (outpatient clinic charts or ER visit reports), enter OP followed by nine 0's in this field. See **Table 7.1** for other optional medical record identifiers.

Table 7.1 Optional Medical Record Identifier Codes

Code	Description

ER	Emergency Room patient without a medical record number
OP	Outpatient without a medical record number
RT	Radiation Therapy department patient without HIM number
SU	One-day surgery clinic patient without HIM number
UNK	Medical record number unknown

Note: Other standard abbreviations may be used to indicate departments within the facility for patients without HIM numbers assigned.

Accession Number

(NAACCR Item #550) (STORE 2021 page 73)

Description

A registry or accession number is a unique number assigned to identify each patient regardless of the number of primary cancers.

Rationale

This data item serves as a reference number to protect the identity of the patient.

Coding Instructions

1. The first four digits identify the calendar year the patient was first seen at the facility with a reportable diagnosis. The following five digits identify the numerical order in which the case was entered into the registry. Each year's accession/registry number will start with 00001.

   Example: ---00001 would indicate the first case reported from a facility.

2. Do not assign a new registry number to a patient previously reported to TCR with a new primary cancer. Within a registry, all primaries for an individual must have the same accession number.

Note: Web Plus does not auto populate Accession Number.

Code	Definition
(fill spaces)	Nine-digit number used to identify the year in which the patient was first seen at the reporting facility for the diagnosis and/or treatment of cancer.

Examples

- Patient enters the hospital in 2022 and is diagnosed with breast cancer. The patient is the thirty-third patient accessioned in 2022. Code 202200033.

- A patient with the accession number 202100033 for a breast primary returns to the hospital with a subsequent colon primary in 2022. The accession number will remain the same.
- Patient diagnosed in November 2021 at another facility enters the reporting facility in January 2022 and is the tenth case accessioned in 2022. Code 202200010.
- Patient diagnosed in staff physician office in December 2021 enters the reporting facility in January 2022 and is the twelfth case accessioned in 2022. Code 202200012

8

INFORMATION SOURCE

Type of Reporting Source

(NAACCR Item #500) (SEER pages 25-27)

Description

This data item identifies the source documents that provided the most complete information when abstracting the case. This will not necessarily be the document that identified the case but the document that provided the best information.

Rationale

This field provides the source of the documents used to report the case, e.g., inpatient or outpatient charts, cases diagnosed in physician's offices, patients diagnosed at autopsy, pathology report only, or diagnosed by death certificate only.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Date of Admit/Date of First Contact

(NAACCR Item #580) (STORE 2022 pages 123-124)

Description

The date of first admission/contact with the reporting facility for diagnosis and/or treatment of this cancer. If previously diagnosed/treated elsewhere, the date of first admission to your facility with diagnoses of active cancer.

Rationale

This data item allows the facility to document the first contact with the patient. It can be used to measure the time between admission and when the case is abstracted and the length of time between the first contact and treatment.

Coding Instructions

1. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
2. Enter the date of the first admission to your facility for a diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with active cancer or receiving cancer treatment.
3. Date format is YYYYMMDD

Example: The patient is first seen at this facility on January 4, 2022 with a diagnosis of cancer. Record the date of admit: 20220104.

- A date must be entered in this field. If the patient was never an inpatient, enter the date of the first outpatient visit e.g., biopsy, x-ray, laboratory test, or emergency room visit at your facility with active cancer.
- For autopsy-only or death certificate-only cases, use the date of death as the date of first contact.
- For "read only" or "pathology only" cases, enter the date the specimen was collected. These are cases where a specimen is sent to be read by the pathology department and the patient is never seen or admitted at the reporting facility. These cases are reportable if the pathology department generates revenue for the reporting facility and is not a free-standing entity. The class of case should be coded to 43 and the reporting source would be 3.

Note: *STORE 2022* instructions on page 123 differ from TCR instructions. *STORE 2022* requires that for analytic cases Date of First Contact is the date the patient qualifies as an analytic case Class of Case 00-22. If the patient was admitted for non-cancer-related reasons, the Date of First Contact is the date the cancer was first suspected during the hospitalization. TCR will continue to instruct that the date be recorded as the admit date if the diagnosis is made at the reporting facility. It is understood that ACoS facilities will continue to follow the rules according to the *STORE 2022* Manual.

Example 1: A patient is admitted to the hospital on January 31, 2021, with chest pains. On February 2, 2022, a CT scan shows that the patient has a lung mass consistent with malignancy. Record the date of first contact as 20220131.

Example 2: A patient has a biopsy in a staff physician's office on March 17, 2022, and the specimen is sent to the reporting facility's pathology department on that same day. The pathologist reads the specimen as malignant melanoma. The patient enters the same reporting facility on March 22, 2021, for a wide re-excision. Record the date of first contact as 20220317.

Example 3: A patient has a lymph node biopsy at a small hospital on May 15, 2022. The specimen is sent to your hospital to be evaluated in your pathology department. The pathologist reports diffuse large b- cell lymphoma. The patient never enters your hospital. Record 20220515 as the date of first contact.

CoC Accredited Flag

(NAACCR Item #2152)

Description

CoC Accredited Flag is assigned at the point and time of data abstraction to label an abstract being prepared for an analytic cancer case at a facility accredited by the Commission on Cancer (CoC). The flag may be assigned manually or can be defaulted by the registry's software.

Rationale

CoC-accredited facilities are required to collect certain data items including TNM staging. It is burdensome for central registries to maintain a list of accredited facilities, and the list changes frequently. The flag is a means of incorporating the accredited status into abstracts at the time of abstraction by someone who has knowledge of the status. The flag thus simplifies validating that required items have been abstracted by CoC-accredited facilities. The flag also allows cases to be stratified during analyses to identify those never seen at a CoC-accredited facility, e.g., percentage of all cases seen in at least one CoC-accredited facility, evaluation of outcomes by facility status. NPCR will use this flag for facility status stratification.

Coding Instructions

Instructions for Hospital Cancer Registries

1. Assign at the time of data abstraction
2. Assign manually or automatically assign using registry software

CoC Accredited Flag Definitions

Code	Description
0	Abstract prepared at a facility WITHOUT CoC accreditation of its cancer program
1	ANALYTIC abstract prepared at facility WITH CoC accreditation of its cancer program (Includes Class of Case codes 10-22)
2	NON-ANALYTIC abstract prepared at facility WITH CoC accreditation of its cancer program (Includes Class of Case codes 30-43 and 99, plus code 00 which CoC considers analytic but does not require to be staged)
blank	Not applicable; DCO

Class of Case

(NAACCR Item #610) (STORE 2022 pages 1-120)

Description

Class of case identifies the role of the reporting facility in the patient's diagnosis and treatment.

Rationale

This data item divides case records into analytic and non-analytic categories. The class of case determines which cases should be included in the analysis of the facility's cancer experience.

Note: All reporting facilities must report their non-analytic cases to TCR, regardless of their approval status with the ACoS.

1. **Analytical cases (codes 00-22):** Diagnosed at the reporting facility or in a staff physician's office and/or received any of the first course treatment at the reporting facility. Abstracting for class of case 00 through 14 is to be completed within six months of diagnosis. This allows for treatment information to be documented in the patient's medical record. Abstracting for class of case 20 through 22 is to be completed within six months of first contact with the reporting facility. These cases are analyzed because the facility was involved in the diagnostic and therapeutic decision-making.

   Note: A facility network clinic or outpatient center belonging to the facility is part of the facility.

2. **Non-analytical cases (codes 30-49 and 99):** Diagnosed and received all of the first course of treatment at another facility, or cases which were diagnosed and/or received all or part of the first course of treatment at the reporting facility prior to the registry's reference date (reference date applies to ACoS facilities, facilities striving for ACoS certification, or facilities that follow ACoS standards and do not seek certification). Abstracting for non-analytical cases should be completed within six months of first contact with reporting facility. Non-analytical cases (classes 30-49 and 99) are usually excluded from a facility's routine treatment or survival statistics.

   Note:

   - **Per TCR reporting guidelines, non-analytical cases are reportable by all facilities for cases diagnosed January 1, 1995 and forward when there is documentation of active cancer or if the patient is receiving cancer directed therapy**.
   - **Non-analytical class of case codes 49 and 99 are to be used solely by the central registry.**
   - **Foreign residents are no longer required to be reported.**

Coding Instructions

1. Code the Class of Case that most precisely describes the patient's relationship to the facility.
2. Code 00 applies only when it is **known** the patient went elsewhere for treatment. If that information is not available, code Class of Case 10.
3. It is possible that information for coding Class of Case will change during the patient's first course of care. If that occurs, change the code accordingly.
4. Code 34 or 36 if the case is required by TCR but not required by CoC to be accessioned, and initial diagnosis and/or treatment was done at the reporting facility. Cases include Intraepithelial neoplasia grade III tumors (AIN III, VAIN III, VIN III) that are reportable to TCR.

   Note: TCR does not require benign or borderline cases diagnosed **before 2004** OR any site other than meninges, brain, spinal cord, cranial nerves, and other parts of central nervous system, pituitary gland, craniopharyngeal duct and pineal gland diagnosed in 2004 or later. Consult Appendix E of the *2022 TCR Cancer Reporting Handbook* for reportable neoplasms.

5. Physicians who are not employed by the hospital but are under contract with it or have routine admitting privileges there are described in codes 10-12 and 41 as physicians with admitting privileges. Treatment provided in the office of a physician with admitting privileges is provided "elsewhere". That is because care given in the physician's office is not within the hospital's realm of responsibility.
6. If the hospital purchases a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved have routine admitting privileges or not, as with any other physician.
7. "In-transit" care is care given to a patient who is temporarily away from the patient's usual practitioner for continuity of care. If these cases are abstracted, they are Class of Case 31. Monitoring of oral medication started elsewhere is coded Class of Case 31. If a patient begins first course radiation or chemotherapy infusion elsewhere and continues at the reporting facility, and the care is not in-transit, then the case is analytic (Class of Case 21).
8. First course maintenance treatment provided at the reporting facility prior to disease progression or recurrence is reportable IF the maintenance treatment is part of first course treatment plan and is provided by reported facility with documentation of prescription/administration. For example, if a patient is diagnosed and treated at another facility per the treatment plan was started on hormone therapy at the other facility then presents to your facility for continuation of hormone therapy the continuation of hormone therapy by your facility must be documented in medical record to assign class of case 21 (part of first course treatment elsewhere, part of first course of treatment at the reporting facility). This applies even if there is no longer active disease.

Table 8.1 Class of Case Definitions

Analytic Class of Case (Required by CoC to be abstracted by accredited program)	
Initial Diagnosis At Reporting Facility or in a staff physician's office	
Class 00*	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done ELSEWHERE. Cases include: • Patients who choose active surveillance. • Patients who choose to be treated elsewhere. • Patients referred elsewhere for treatment due to lack of special equipment; proximity of a patient's residence to the treatment center; financial, or rehabilitative considerations, etc. ***Note:*** Code 00 applies only when it is **known** the patient went elsewhere for treatment. If it is not known that the patient actually went somewhere else, code Class of Case 10.
Class 10*	Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND PART OR ALL of first course treatment or a decision not to treat was done at the reporting facility, NOS.

	Note: ACoS facilities should include cases in which patients are diagnosed at the reporting facility prior to the registry's reference date and all or part of the first course of treatment was received at the reporting facility after the registry's reference date. ***Note:*** If there is no information regarding **whether or where** the patient was treated, code Class of Case 10.
Class 11	Initial diagnosis in an office of a physician with admitting privileges AND PART of first course treatment was done at the reporting facility.
Class 12	Initial diagnosis in an office of a physician with admitting privileges AND ALL first course treatment or a decision not to treat was done at the reporting facility.
Class 13*	Initial diagnosis at the reporting facility AND PART of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.
Class 14*	Initial diagnosis at the reporting facility AND ALL first course treatment or a decision not to treat was done at the reporting facility.
Initial Diagnosis Elsewhere, Facility Involved In First Course Of Treatment Or A Decision Not To Treat	
Class 20*	Initial diagnosis elsewhere AND ALL OR PART of first course treatment was done at the reporting facility, NOS.
Class 21*	Initial diagnosis elsewhere AND PART of first course treatment was done at the reporting facility; part or first course treatment was done elsewhere.
Class 22*	Initial diagnosis elsewhere AND ALL first course of treatment or a decision not to treat was done at the reporting facility.

NON-ANALYTIC CASES Patient appears in person at reporting facility; both initial diagnosis and treatment elsewhere. Classes of Case not required by CoC to be abstracted. May be required by Cancer Committee, state or regional registry, or other entity.	
Class 30*	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in DIAGNOSTIC WORKUP (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere).
Class 31*	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent/port placement). ***Note:*** In-transit care is given when a patient is temporarily away from the patient's usual practitioner for continuity of care. Monitoring an oral medication started elsewhere is coded to this class of case. If the patient begins first course therapy (radiation or chemo) elsewhere and continues at the reporting facility and the care is not in-transit, then case is analytic (Class of case 21)
Class 32*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease RECURRENCE OR PERSISTENCE (active disease).
Class 33*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease HISTORY ONLY (***disease not active***).

Class 34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment done by reporting facility.
Class 35	Case diagnosed before program's Reference Date, AND initial diagnosis AND PART OR ALL of first course treatment by reporting facility.
Class 36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND part or all of first course treatment by reporting facility.
Class 37	Case diagnosed before program's Reference Date, AND initial diagnosis elsewhere AND all or part of first course treatment by facility.
Class 38*	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death.
Patient Does Not Appear In Person At Reporting Facility	
Class 40	Diagnosis AND all first course treatment given at the same staff physician's office.
Class 41	Diagnosis and all first course treatment given in two or more different staff physician offices with admitting privileges.
Class 42	Non-staff physician or non-CoC approved clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility).
Class 43*	Pathology or other lab specimens only.
Class 49*	Death certificate only. ***Note:*** Used by central registries only.
Unknown Relationship To Reporting Facility	
Class 99	Case not required by CoC to be abstracted; Of unknown relationship to facility (not for use by CoC approved cancer programs for analytic cases). ***Note:*** Used by central registries only.

*Indicates C*lass of Case* codes appropriate for abstracting cases from non-hospital sources such as physician offices, ambulatory surgery centers, freestanding pathology laboratories, radiation therapy centers. When applied to these types of facilities, the non-hospital source is the reporting facility. The codes are applied the same way as if the case were reported from a hospital.

By using *Class of Case* codes in this manner for non-hospital sources, the central cancer registry is able to retain information reflecting the facility's role in managing the cancer consistent with the way it is reported from hospitals. Using C*lass of Case* in conjunction with *Type of Reporting Source* (500) which identifies the source documents used to abstract the cancer being reported, the central cancer registry has two distinct types of information to use in making consolidation decisions.

Table 8.2 Class of Case Examples

Code	Reason
00	Leukemia was diagnosed at the facility, and all care was given in an office of a physician with practice privileges**.**

Code	Reason
10	Reporting facility found cancer in a biopsy but was unable to discover whether the homeless patient actually received any treatment elsewhere.
11	A patient is diagnosed with melanoma in a staff physician's office. He has a wide excision at the reporting facility, and then is treated with interferon at another facility.
12	A diagnosis of prostate cancer is made in a staff physician's office. The patient receives radiation therapy at the reporting facility, and no other treatment is given.
13	A patient is diagnosed with colon cancer at the reporting facility and undergoes a hemicolectomy there. She then receives chemotherapy at an outside clinic.
14	Reporting facility admits patient with hemoptysis. Workup reveals adenocarcinoma. The patient undergoes surgery followed by radiation therapy at the reporting facility. The patient did not receive any other treatment.
20	Patient presents to the reporting facility for thyroidectomy that was diagoned elsewhere. The physician notes state the treatment plan is for a thyroidectomy followed by hormone therapy. We don't know where or if the patient wnt for hormone therapy..
21	Patient diagnosed at another facility with breast cancer and received neo-adjuvant chemotherapy. She now presents to the reporting facility for modified radical mastectomy.
22	Patient had a biopsy at another facility and the diagnosis was breast cancer. She underwent a mastectomy at the reporting facility and did not receive any further treatment.
31	Patient receives chemotherapy while visiting relatives in the reporting facility city, then returned to the originating facility for subsequent treatments.
32	Patient was diagnosed and treated for primary bladder cancer prior to admission to reporting facility. Reporting facility admits patient for cystectomy for recurrent bladder cancer. After treatment failure, the patient was admitted to the facility for supported care.
38	Patient admitted to reporting facility with chest pain and expires. Autopsy performed at reporting facility identifies patient has pancreatic cancer.
43	A physician does a skin biopsy in his office and sends the biopsy specimen to a reading pathology/lab. The diagnosis is malignant melanoma. The pathology/lab facility is responsible for reporting the case.

9

DEMOGRAPHIC INFORMATION

First Name

(NAACCR Item #2240) (SEER page 30)

Description

Identifies the first name of the patient. First name may also be referred to as given name. First name is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Rationale

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

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Note: Document in *Text Remarks - Other Pertinent Information:* First name unknown.

Middle Name

(NAACCR Item #2250) (SEER page 31)

Description

Identifies the middle name or middle initial of the patient.

Rationale

This data item is used to differentiate between patients with identical first and last names.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Last Name

(NAACCR Item #2230) (SEER page 32)

Description

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

Rationale

This data item is used as a patient identifier.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Name Suffix

(NAACCR Item #2270)

Desciption

Title that follows a patient's last name, such as a generation order or credential status (e.g. "MD", "Jr.")

Note: This data item is no longer supported by CoC (as of January 1, 2003).

Birth Surname

(NAACCR Item #2232) (SEER page 33)

Description

Last name (surname) of patient at birth, regardless of gender or marital status.

Other alternate names should be recorded in the data item, *Name--Alias* [2280].

Rationale

This can be used to link reports on a person whose surname might be different on different documents. It is also useful when using a Spanish surname algorithm to categorize ethnicity.

Coding Instructions

Refer to the Reportability chapter beginning on page 9 of the SEER Program Coding and Staging Manual 2022

Alias Name

(NAACCR Item #2280)

Description

Records an alternate name or "AKA" (also known as) used by the patient, if known. Note that the birth surname (AKA maiden name) is entered in Name-Birth Surname not in this data item.

Rationale

A patient may use a different name or nickname. These different names are aliases. This item is useful for matching multiple records on the same patient.

Coding Instructions

1. If the patient does not use an alias leave blank. Do not record the patient's first and last name again.
2. Record the alias last name followed by a blank space and then the alias first name.
3. Mixed case, embedded spaces, hyphens and apostrophes are allowed.
4. No other special characters are allowed.

Examples

Example 1: Ralph Williams uses the name Bud Williams. **Record Williams Bud in the *NAME-ALIAS* field.**

Example 2: Samuel Clemens uses the name Mark Twain. **Record Twain Mark in the *NAME-ALIAS* field.**

Social Security Number

(NAACCR Item #2320) (SEER page 34)

Description

Identifies the patient by social security number.

Rationale

This item is used by TCR in internal processes such as linking for resolution of duplicate primaries and consolidation.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

- Every effort should be made to obtain the social security number. Research all resources from your facility for this information.
- Enter the patient's nine-digit social security number in this field.
- If the social security number is unavailable or unknown, enter all 9's in this field. Document in Text Remarks-Other Pertinent Information that the social security information is unavailable.

- If only the last 4 digits are available, enter it in the following format: enter leading 7's and the last 4 digits of the SS # provided in the 9-character field:
- ***Example:*** 777771234
- ***Note:*** All efforts must be made to obtain the complete social, but if only the last four digits are provided, they now can be used in the social security number field and not just documented in the *Other Pertinent Information* text box.
- A patient's Medicare number may not be identical to the person's social security number.
- Do not put dashes or slashes in this field.

Note: Social security numbers are used for Medicare benefits. Suffix A on a social security number indicates the number is the patient's Medicare number. Other suffixes identify another person's Medicare number under which the patient may be entitled to receive benefits. **Take caution to enter the patient's social security number and not the spouse's or guardian's number.**

The following are not allowed:

- First 3 digits= 000, 666, or 900-999
- Fourth and fifth digits= 00
- Last four digits= 0000
- First digit 9 (except for 999999999)

Place of Residence

SEER registries collect information on place of residence at diagnosis. Information relating to address is not transmitted to SEER. The SEER rules for determining residency at diagnosis are either identical or comparable to rules used by the U.S. Census Bureau, to ensure comparability of definitions of cases (numerator) and the population at risk (denominator).

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to page 35 of the SEER Program Coding and Staging Manual 2022

Address at Diagnosis - Number and Street

(NAACCR Item #2330) (SEER page 37)

Description

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

Rationale

Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes. A patient's physical address takes precedence over a post office box. If a

patient has multiple primary tumors the address may be different if diagnosed at different times. Do not update this field if the patient moves after diagnosis.

Note: ACoS facilities are required to provide information for this field regardless of class of case.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Address at Diagnosis - Supplemental

(NAACCR Item #2335) (SEER page 38)

Description

Provides the ability to store additional address information such as the name of a place or facility (a nursing home or name of an apartment complex).

Rationale

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

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Address at Diagnosis - City

(NAACCR Item #70) (STORE 2022 page 73) (SEER page 44)

Description

Identifies the name of the city or town in which the patient resides at the time of diagnosis. Do not update this field if the patient moves after being diagnosed.

Rationale

Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available, do not leave blank. The address data fields for these cases should be recorded Unknown in the street address, Unknown in the city, ZZ in the state, 99999 in the zip code and 999 in the FIPS data field. Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.

Address at Diagnosis - State

(NAACCR Item #80) (STORE 2022 page 74) (SEER page 45)

Description

Identifies the patient's state of residence at the time of diagnosis/admission. This field should not be updated if the patient moves after being diagnosed.

Rationale

It allows for analysis of geographic and environmental studies and inclusion in state and national cancer publications/studies.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available, do not leave blank. The address data fields for these cases should be recorded as Unknown in the street address, Unknown in the city, ZZ in the state, 99999 in the zip code and 999 in the FIPS data field. Do not record the reporting facility's city, state, zip and FIPS.

Examples:

- A patient's country of residence is documented as France; record XX in the state field. ***Note:*** **Residents of foreign countries are no longer reportable to TCR.**
- Documentation in the patient's medical record states the patient is a resident of a foreign country and no other address documentation provided; record YY in the state field. ***Note:*** **Residents of foreign countries are no longer reportable to TCR.**
- The patient's medical record states the patient lives in the United States or in a territory, commonwealth, or possession of the United States and no other address documentation is provided, **record US in the state field**.

- If every valid attempt has been made to obtain the address and it is still unknown, record ZZ in the state field. If there is not enough information to determine patient is a foreign resident the case must be reported to TCR.

Address at Diagnosis – Postal Code (ZIP Code)

(NAACCR Item #100) (STORE 2022 page 76) (SEER page 46)

Description

Identifies the postal code of the patient's address at the time of diagnosis/admission. If the patient has multiple tumors, the postal code may be different for each tumor.

Rationale

It allows for the analysis of cancer clusters, geographic or environmental studies and health services research.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

If the zip code is not available, refer to the *National Zip Code Directory* or to the USPS website: tools.usps.com/go/ZipLookupAction!input.action. This website is useful in obtaining missing address information in order to record a complete address.

If the patient is a resident of a foreign country at the time of diagnosis, record 88888 for the zip code.
Note: **Residents of foreign countries are no longer reportable to TCR.**

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available, do not leave blank. The address data fields for these cases should be recorded as Unknown in the street address, Unknown in the city, ZZ in the state, 99999 in the zip code and 999 in the FIPS data field. Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.

Examples:

- A patient's country of residence is documented as France; record 88888 in the zip code field. ***Note:*** Residents of foreign countries are no longer reportable to TCR.
- A patient's address is in Canada and the zip code cannot be verified; record 99999 in the zip code field.
- A patient's address is not documented in the medical record and remains unknown after researching all your facility's resources; record 99999 in the zip code field. If there is not enough information to determine patient is a foreign resident the case must be reported to TCR.

County

(NAACCR Item #90) (STORE 2022 page 78) (SEER page 39)

Description

Identifies the county of the patient's residence at the time of diagnosis. If the patient has multiple tumors, the county codes may be different for each tumor.

Rationale

This data item may be used for epidemiological purposes (for example: to measure the cancer burden in a particular geographical area).

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

- Enter the appropriate three-digit code for the county of residence. Use codes issued by the Federal Information Processing Standards (FIPS) publication, Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas. U.S. Census Bureau's online FIPS County Code Look-up Tool: nrcs.usda.gov/wps/portal/nrcs/detail/?cid=nrcs143_013697
- Refer to Appendix B for the list of Texas FIPS county codes.
- If the patient has multiple tumors, the FIPS county codes may be different for each tumor.
- Do not update this data item if the patient's county of residence changes after diagnosis.
- ACoS facilities following STORE guidelines must code **999** if patient is not a US resident. This case would no longer be reported to TCR.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available, do not leave blank. The address data fields for these cases should be recorded as Unknown in the street address, Unknown in the city, ZZ in the state, 99999 in the zip code and 999 in the FIPS data field. Do not record the reporting facility's city, state, zip and FIPS for unknown addresses. If there is not enough information to determine patient is a foreign resident the case must be reported to TCR.

Table 9.1 Fips County Code at Diagnosis

Code	Description	Definition
001–507	County at diagnosis	Valid Texas FIPS code
998	Outside state/country & code is unknown	Known town, city, state, or country of residence, but county code not known **AND** a resident outside the state of Texas (must meet all criteria)

999	Unknown county	The county is unknown and not documented in the patient's medical record

Address at Dx - Country

(NAACCR Item #102) (STORE 2022 page 77)

Description

Identifies the country of the patient's residence at the time of diagnosis. If the patient has multiple tumors, the country codes may be different for each tumor.

Rationale

This data item may be used for epidemiological purposes (for example: to measure the cancer burden in a particular geographical area).

Coding Instructions

1. Enter the appropriate alpha-3-digit code for the country of residence. Use codes issued by the United States Postal Services.
2. Do not change if the patient moves to another country. Patients with more than one tumor may have different countries at diagnosis, however.
3. **Residents of foreign countries are no longer reportable to TCR.**

Table 9.2 Country Code Examples:

Code	Country
USA	United States
CAN	Canada
MEX	Mexico
SLV	El Salvador
VNM	Viet Nam

Note: For other country codes refer to the International Standards Organization (ISO) 3166-1 Country Three Character Codes: iso.org/obp/ui/#search. ***Note:*** **Residents of foreign countries are no longer reportable to TCR.**

Current Address – Number and Street

(NAACCR Item #2350) (SEER page 53)

Description

The number and street address or the rural mailing address of the patient's current usual residence. This can be used to generate a follow-up inquiry and must correspond to other fields in the current address. If the patient has multiple tumors, the current address should be the same. Additional address information such as facility, nursing home, or name of apartment complex should be entered in item Addr Current--Supplemental [2335].

Rationale

This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Current Address – Supplemental

(NAACCR Item #2355) (SEER page 54)

Description

This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex. This can be used to generate a follow-up inquiry and must correspond to other fields in the current address. If the patient has multiple tumors, the current address should be the same.

Rationale

Sometimes the registry receives the name of a facility instead of a proper street address containing the street number, name, direction, and other elements necessary to locate an address on a street file for the purpose of geocoding. By having a second street address field to hold address information, the registry can look up and store the street address and not lose the facility name due to a shortage of space. The presence of a second street address field to hold additional address information also aids in follow-up.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Current Address – City

(NAACCR Item #1810) (SEER page 55)

Description

Name of city of the patient's current usual residence. If the patient has multiple tumors, the current city of residence should be the same for all tumors.

Rationale

"Current address" can be used to measure the regional "cancer burden" (cost, medical care needs), especially in major retirement regions. Sometimes central registries carry out follow-up by contacting the patients by a letter or telephone calls to ascertain their vital status. The most current reported address and telephone number are needed. This information is also useful for conducting interview studies.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Current Address – State

(NAACCR Item #1820) (SEER page 56)

Description

Captures the name of the state of the patient's current usual residence. It is often used for follow-up. This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Rationale

"Current address" can be used to measure the regional "cancer burden" (cost, medical care needs), especially in major retirement regions. Sometimes central registries carry out follow-up by contacting the patients by a letter or telephone calls to ascertain their vital status. The most current reported address and telephone number are needed. This information is also useful for conducting interview studies.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Current Address – Postal Code (ZIP Code)

(NAACCR Item #1830) (SEER page 57)

Description

Captures the postal code (ZIP code) of the patient's current usual residence. It is often used for follow-up. This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Rationale

"Current address" can be used to measure the regional "cancer burden" (cost, medical care needs), especially in major retirement regions. Sometimes central registries carry out follow-up by contacting the patients by a letter or telephone calls to ascertain their vital status. The most current reported address and telephone number are needed. This information is also useful for conducting interview studies.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Telephone

(NAACCR Item #2360) (SEER page 58)

Description

Current telephone number with area code for the patient. Number is entered without dashes.

Rationale

This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Birthplace - State

(NAACCR Item #252) (STORE 2022 page 79) (SEER page 59)

Description

Identifies the patient's state of birth. USPS abbreviation for the state, commonwealth, U.S. possession; or CanadaPost abbreviation for the Canadian province/territory in which the patient was born. If the patient has multiple primaries, the state of birth is the same for each tumor.

Rationale

Birthplace is used to ascertain ethnicity, identify special populations at risk for certain types of cancers, and for epidemiological analyses.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Table 9.3 Birthplace - State Examples

Code	Description
TX	If the patient is stated to have been born in Texas, then use the USPS code for the state of Texas.
US	If the patient is stated to have been born in the United States, NOS (state/commonwealth/territory/possession unknown)
CD	If the patient is stated to have been born in Canada, NOS; Use the specific abbreviation of Canadian Provinces/Territories if this information is provided.
	Born in another country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is known, refer to SEER Appendix B.
YY	Born in a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is unknown.
ZZ	Residence unknown.

Birthplace - Country

(NAACCR Item #254) (STORE 2022 page 80) (SEER page 60)

Description

Identifies the patient's country of birth.

Rationale

Birthplace is used to ascertain ethnicity, identify special populations at risk for certain types of cancers, and for epidemiological analyses.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Table 9.4 Birthplace Country Examples

Code	COUNTRY
USA	United States
CAN	Canada
MEX	Mexico
SLV	El Salvador
ZZC	Central America NOS
VNM	Viet Nam
ZZU	Place of birth is unknown, no mention in patient record

Note: For other country codes refer to the SEER 2018 Manual:
seer.cancer.gov/manuals/2021/SPCSM_2021_Appendix_B.pdf

Date of Birth

(NAACCR Item #240) (STORE 2022 page 81) (SEER pages 61-62)

Description

Identifies the patient's month, day, and year of birth.

Rationale

This item is used by TCR to match records, and to calculate age at diagnosis.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

- The patient's date of birth must be entered. Cases cannot be processed without the date of birth.

Note: If the complete date of birth is not available, documentation must be provided in *Other Pertinent Information.*

Example: Medical records indicate only month and year of date of birth.

- If only the age of the patient is known, calculate the year of birth from age and year of diagnosis and leave the day and month of birth unknown.

Example: A 50-year-old patient diagnosed in 2010 is calculated to have been born in 1960.

- The year of birth must be recorded. TCR will not accept unknown year of birth. Every effort must be made to obtain this information as it is critical for analysis.
- If the patient's age is 100 years or older, check the accuracy of the date of birth and date of diagnosis, and document both in a text field.

Place of Death - State

(NAACCR Item #1942) (SEER page 64)

Description

Identifies the state where the patient dies and where the certificate of death is filed. This field is left blank if the patient is still alive; not applicable.

Rationale

This field also helps carry out death clearance. When a reporting facility reports a place of death, the information can help in death certificate matching.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Place of Death - Country

(NAACCR Item #1944) (SEER page 65)

Description

Identifies the country where the patient died and where the certificate of death is filed. If the patient has multiple records, all records should contain the same code. This field is left blank if the patient is still alive; not applicable.

Rationale

Place of death is helpful for carrying out death clearance. When a reporting facility reports a place of death that is outside of the registry's country, the information can signal a death for which the death certificate will not be available from another state or through the NDI linkage.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Race 1, 2, 3, 4, 5

(NAACCR Item #160-#164) (STORE 2022 page 84-85) (SEER pages 67-71)

Description

Identifies the primary race of the person.

Rationale

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow accurate national comparisons. Race is defined by specific physical, hereditary, and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Refer to Appendix D of the SEER Manual, "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" when race is unknown or not stated in the medical record and birth place is recorded.

Table 9.5 Race Code 1 Examples

Code	Description
01	A patient was born in Mexico of Mexican parentage. A patient stated to be German-Irish. A person from Iran or Saudi Arabia. An immigrant from Sweden. A patient is described as Middle Eastern. A patient is described as Greek.
02	A black female patient. ***Note:*** A specific race code (other than blank or 99) must not occur more than once. For example, do not code Black in race 1 for one parent and Black in race 2 for the other parent.
04	A patient is of Chinese and Korean ancestry. Code 04, Chinese in Race 1. Code 08, Korean, in Race 2. Patient is stated to be Chinese and black. Code Race 1 as 04 (Chinese), code Race 2 as 02 (Black).
05	A patient has a Japanese father and a Caucasian mother. Code 05 Japanese in Race 1 and 01 White in Race 2.
07	A patient's race is a combination of Hawaiian and any other race(s). Code 07, Hawaiian, in Race 1 and Race 2–Race 5 as appropriate.
11	A patient is stated to be Asian. The place of birth is Laos. Code Race 1 as 11, Laotian, because it is more specific than 96, Asian, NOS.
25	Patient states she has a Polynesian mother and Tahitian father. Code race 1 as 25 (Polynesian), race 2 as 26 (Tahitian) and Race 3-5 as 88.

Code	Description
99	A patient's race is unknown. Code Race 1 as Unknown, code 99. Race 2–Race 5 must also be coded 99. If a patient has a Spanish last name and she is stated to be a native of Indiana, code to 99, Unknown, because nothing is known about her race. Exception is done when Race is noted as "other" on facesheet and there is not additional information; use code **99** for Race 1 and code 99 for Race 2-5.

Spanish Surname or Origin

(NAACCR Item #190) (STORE 2022 page 86) (SEER page 73-74)

Description

Identifies patients with Spanish/Hispanic surname or of Spanish origin. Persons of Spanish or Hispanic surname/origin may be of any race. The data item is requested for submission to NAACCR. If a patient has multiple tumors, all records should have the same code. Alternate name: Spanish/Hispanic Origin.

Rationale

This is used to identify whether or not the person should be classified as *Hispanic* for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the 01 (White) category of *race.*

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Refer to the list of Spanish/Hispanic surnames on the TCR website at:
dshs.texas.gov/tcr/training/handbook/Appendix-Spanish-Hispanic-Surnames.pdf

Note: Use code 0 if patient has a Spanish/Hispanic name and there is reason to believe he/she is not Hispanic. For example, patient is Filipino, or patient is a woman with a Hispanic married name, but she is known to be non-Hispanic.

- Use codes 1–5 if specific ethnicity is known.
- Use code 6 when you know the patient is Hispanic but cannot classify him/her to codes 1–5.
- Use code 9 when Spanish/Hispanic origin is not documented or is unknown.

Sex

(NAACCR Item #220) (STORE 2022 page 87) (SEER page 76)

Description

Identifies the sex of the patient.

Rationale

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

Definitions:

Intersex: A person born with ambiguous reproductive or sexual anatomy; chromosomal genotype and sexual phenotype other than XY male and XX female. An example is 45,X/46,XY mosaicism, also known as XO/XY mosaicism.

Transsexual: A person who was assigned to one gender at birth based in physical characteristics but who self-identifies psychologically and emotionally as the other gender.

Transgender: See Transsexual.

Transgendered person: A person who identifies with or expresses a gender identity that differs from the one which corresponds to the person's sex at birth.

Hermaphrodite: A person having both male and female reproductive organs.

Note: Hermaphrodite is an outdated term.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Marital Status at Diagnosis

(NAACCR Item #150) (SEER page 77)

Description

Code for the patient's marital status at the time of diagnosis for the reportable tumor. If the patient has multiple tumors, marital status may be different for each tumor.

Rationale

Incidence and survival with certain cancers vary by marital status. The item also helps in patient identification.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Primary Payer at Diagnosis

(NAACCR Item #630) (STORE 2022 pages 88-89) (SEER pages 78-79)

Description

Primary payer/insurance carrier at the time of initial diagnosis and/or treatment at the reporting facility.

Rationale

This item is used in financial analysis and as an indicator for quality and outcome analyses.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Medicare Beneficiary Identifier

(NAACCR Item #2315)

Description

Congress passed the Medicare Access and CHIP Reauthorization ACT to remove Social Security Number (SSN) from Medicare ID card and replace the existing Medicare Health Insurance Claim Numbers with a Medicare Beneficiary Identifier (MBI). The MBI will be a randomly generated identifier that will not include a SSN or any personal identifiable information.

Rationale

The MBI is a step to minimize the risk of identity theft for Medicare beneficiaries and reduce opportunities for fraud. In early 2018, CMB plans to issue new Medicare cards with an MBI. A Health Insurance Claim Number will still be assigned to each Medicare beneficiary and will still be used for internal data exchanges between CMS and the states, but the new MBI must be used in all interactions with the beneficiary, the provider community, and all external partners. The collection of the MBI should not change how registries currently collect SSN.

Coding Instructions

1. The MBI has 11 characters. Each MBI is randomly generated. The MBI's characters are "non-intelligent" so they don't have any hidden or special meaning. MBIs are numbers and upper-case letters; 1-9 and all letters from A to Z, except for S, L, O, I, B, and Z.
2. Leave blank when MBI is not available, not applicable, unknown, or a non-Medicare patient

Note: The MBI format and information on understanding the MBI can be found at: https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI-with-Format.pdf

Text Usual Industry

(NAACCR Item #320)

Description

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

Rationale

Used to identify work-related health hazards; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

Definition

Type of business or industry where the patient worked in his or her usual occupation. Examples include manufacturing of tires, dry cleaning services, training of dogs, hospital.

Coding Instructions

1. Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that performs more than one of these components.
2. If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient for facility registrars to record the name of the company (with city or town) in which the patient performed his/her usual industry.

   Example:

   Inadequate: "ABC, Inc."
   Adequate: "ABC, Inc., Kyle, TX"
3. In those situations where the usual occupation is not available or is unknown, the patient's current or most recent occupation is recorded, if available.
4. Be descriptive and specific.

Examples:

Inadequate: "Automobile industry"
Adequate: "Automobile manufacturing"

Inadequate: "Mine"
Adequate: "Copper mine"

Inadequate: "Retail"
Adequate: "Retail bookstore"

5. When recording government agencies record the level (federal, state, county, municipal) and the division.

   Example:

   Inadequate: "Census"
   Adequate: "U.S. Census Bureau"

6. If no information is available regarding patient's industry, document "Unknown" in the text field. This should be used only as a last resort.

Text Usual Occupation

(NAACCR Item #310)

Description

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

Rationale

Used to identify work-related health hazards; identifies occupational groups in which cancer screening or prevention activities may be beneficial.

Definition

Type of job the patient was engaged in for the longest time. It is not necessarily the highest paid job, or the job considered the most prestigious, but the one that accounted for the greatest number of working years. Examples include police officer, bank teller, or nurse.

- ***Exception***

  If a patient has been a homemaker for most of her adult life, but has ever worked outside the home, report the occupation held outside the home.

Coding Instructions

1. Document the patient's usual occupation, the kind of work performed during most of the patient's working life before diagnosis of this tumor, to the extent that the information is available in the

medical record. Make sure the recorded usual occupation matches the recorded industry. **Do not record "retired."**

2. Be descriptive, specific, and complete: Record the word or words which most clearly describe the kind of work or type of duties performed by the patient.

   Examples:

   Inadequate: "Teacher"
   Adequate: "Preschool teacher," "high school teacher"

   Inadequate: "Laborer"
   Adequate: "Residential bricklayer"

   Inadequate: "worked in a warehouse," "worked in a shipping department"
   Adequate: "warehouse forklift operator"

   Inadequate: "Engineer"
   Adequate: "Chemical engineer," "Railroad engineer"

   Inadequate: "Self-employed"
   Adequate: "Self-employed auto mechanic"

3. If the patient's usual occupation is not known, record the patient's current or most recent occupation, or any available occupation.
4. If no information is available regarding patient's occupation document **"Unknown"** in the text field. This should be used only as a last resort.

Commonly confused occupations

Contractor vs. skilled worker—

a. A contractor mainly obtains contracts and supervises work.
b. A "skilled worker" works with his or her own tools as a carpenter, plasterer, plumber, or electrician.

Machine operator vs. machinist vs. mechanic—

a. A "machine operator" operates machines.
b. A "machinist" sets up and operates machines.
c. A "mechanic" repairs, installs, and adjusts machines.

Physician Follow Up

(NAACCR Item #2470)

Description

Identifies the physician currently responsible for the patient's medical care. TCR requires the physician's state license number.

Rationale

The follow-up (or "following") physician is the first contact for obtaining information on the patient's status. This information may be used for outcome studies.

Coding Instructions

1. Record the state license number of the physician currently responsible for the patient's care. Physician license numbers for Texas can be found at the following website: tmb.state.tx.us/page/look-up-a-license.
2. Cancer reporters using third party software must check with their vendor to ensure the physician's state license number transmits to TCR.
3. This field must be populated for cases diagnosed 2006 and forward. If the information is unknown code 99999999 and document in *Text Remarks - Other Pertinent Information* that the follow up physician is unknown.

Note: This item is not supported by CoC as of January 1, 2010, (the respective NPI item is required). TCR will continue to require this data item.

Tobacco Use Smoking Status

(NAACCR Item #344) (SEER page 80)

Description

Captures the patient's past or current use of tobacco (cigarette, cigar, and/or pipe). Tobaccos smoking history can be obtained from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats or Nursing Assessment section, or other available source from the patient's hospital medical record or physician office record.

Rationale

Cigarette smoking is the leading preventable cause of death in the US and a major risk factor for cancer. Reducing tobacco use is a focus of CDC's National Center for Chronic Disease Prevention and Health Promotion. Reliable registry-based tobacco use data will help public health planners and clinicians target populations of cancer survivors for tobacco cessation. In addition, individual states have reported smoking data on patients are a useful covariate risk factor for cancer cluster investigations. Some state central cancer registries collect tobacco use data, but these variables are not standardized among registries. In addition to describing tobacco use patterns and trends in patients diagnosed with cancer, the collection of cigarette smoking history can enable researchers to better understand the association of cigarette smoking to cancer outcomes. Cigarette use data at diagnosis may help health professionals better understand how tobacco use impacts cancer prognosis, including how smoking is related to effectiveness of treatment and survival. In addition, this information is important to target and assess tobacco control efforts to cancer survivors and their families.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Note: This is a new data item for 2022 collected by NPCR and SEER which captures the patient's past and prior use of tobacco for cigarette, cigar, and/or pipe in a combined data item.

Do not record the patient's past or current use of e-cigarette vaping devices.

10

DESCRIPTION OF THIS NEOPLASM

Pathology Reports

In general, SEER recommends that information from consult pathology reports be preferred over the original pathology report. This is because consults are usually requested from a more experienced or specialized pathologist/lab and are generally thought to be more accurate.

Date of Diagnosis

(NAACCR Item #390) (STORE 2022 page 123-124) (SEER pages 82-86)

Description

The date of initial diagnosis is the earliest date this primary reportable neoplasm is diagnosed clinically or microscopically by a recognized medical practitioner, regardless of whether the diagnosis was made at the reporting facility or elsewhere.

Rationale

The date of initial diagnosis is essential in the analysis of staging and treatment of the cancer, for epidemiology purposes, and for outcomes analysis. The timing for staging and treatment of cancer begins with the date of initial diagnosis for cancer.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Note: The Commission on Cancer does not recognize the BI-RADs schema for mammography as a case-finding source. However, if the radiologist states suspicious for malignancy (not neoplasm) in his/her impression, the case is reportable, and the date of the mammogram would be considered the date of initial diagnosis for breast cancer.

Note: For users of Web Plus always press the calculator icon in order to calculate age at diagnosis. If diagnosis date or date of birth are changed the calculator must be pressed to recalculate the age at diagnosis.

Age at Diagnosis

(NAACCR Item #230) (STORE 2022 page 83) (SEER page 66)

Description

Age of the patient at diagnosis in complete years. Different tumors for the same patient may have different values.

Rationale

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

Coding Instructions

Generally, registry software programs calculate the Age at Diagnosis using the Date of Birth and Date of Diagnosis.

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Sequence Number

(NAACCR Item #560) (STORE 2022 page 71-72)

Description

Indicates the chronological sequence of all reportable neoplasms (malignant and non-malignant) over the lifetime of the patient regardless of when or where the case was diagnosed. Each neoplasm is assigned a different number. Sequence number 00 indicates patient has only one reportable malignant neoplasm. Reportable neoplasms not included in the facility registry are also allotted a sequence number. For example, an ACoS registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the facility's reference date.

Rationale

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

Coding Instructions

1. Codes 00–59 and 99 indicate reportable cases of malignant or in situ behavior.
2. Code 00 if the patient has a single reportable primary. If the patient develops a subsequent invasive or in situ primary tumor, change the code for the first tumor from 00 to 01, and number the subsequent tumors sequentially.
3. If two or more reportable primaries are diagnosed simultaneously, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
    a. Base the prognosis decision on the primary site, histology, and extent of disease for each of the primaries.
    b. If there is no difference in prognosis, the sequence numbers may be assigned in any order.

4. Codes 60–88 indicate non-malignant neoplasms (benign and borderline) that are reportable by agreement cases (e.g., those cases required by state registries). All benign or borderline neoplasms diagnosed/admitted to your facility should be sequenced according to this guideline. This includes benign and borderline CNS neoplasms.
5. Code 60 if the patient has a single non-malignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first primary from 60 to 61, and number subsequent non-malignant primaries sequentially (62, 63…).
6. Sequence numbers should be reassigned in the database if the facility learns later of an unaccessioned tumor that would affect the sequence.
7. The *Sequence Number* refers to the number of malignant or non-malignant primaries in the patient's lifetime.
8. *Sequence Number* should not be changed if the patient develops metastasis.

Table 10.1 Sequence Number: Malignant Neoplasms

One Primary	More Than One Primary	Sequence Unknown
00 One primary only	01 First of two or more primaries	99 Unspecified
	02 Second of two or more primaries	
	03 Third of three or more primaries	

Table 10.2 Sequence Number: Non-Malignant Neoplasms

One Primary	More Than One Primary	Sequence Unknown
60 One primary only	61 First of two or more primaries	88 Unspecified
	62 Second of two or more primaries	
	63 Third of three or more primaries	

Note: Squamous and/or basal cell carcinoma of the skin (except genital sites) **are no longer** considered when assigning the appropriate sequence number.

Examples

- A person is diagnosed with one malignant primary. **Code the sequence number to 00.**
- A person was diagnosed with lung cancer in 2001. A colon cancer is diagnosed in 2022. **Code the sequence number of the colon cancer to 02 and change the sequence number of the lung cancer to 01.**
- A person was diagnosed with breast cancer in April 2010 and metastasis to the lungs in June 2022. Since the lung is a metastatic site and not a second primary, it would not be abstracted. **Code the sequence number of the breast cancer to 00.**

- A person was diagnosed with signet ring cell carcinoma of the bladder in 2017. In 2022, this person developed a benign meningioma in the temporal area of the brain**. Code the bladder to sequence number 00, and code the brain to sequence number 60.**
- A person was diagnosed with carcinoma of the stomach in 2016, squamous cell carcinoma of the left forearm (a non-reportable neoplasm) in 2017, and non-Hodgkin's lymphoma in 2022. **Code the sequence number of the stomach to 01. The sequence number of the left forearm would not be sequenced, abstracted, or reported. Code the sequence number of the lymphoma to 02.**
- A person was diagnosed with a benign meningioma in June 2016. MRI at your facility in 2022 shows no change. **Code the sequence number to 60 for the benign meningioma.**

Primary Site

(NAACCR Item #400) (STORE 2022 page 128-129) (SEER pages 92-96)

Description

Identifies the primary site of the cancer.

Rationale

The primary site helps to determine stage and treatment options and shapes disease course and prognosis.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Refer to the *Solid Tumor Rules* at seer.cancer.gov/tools/solidtumor for site-specific guidelines for primary sites, including Head and Neck, Breast, Lung, Brain, Urinary, and Cutaneous Melanoma.

Refer to the *SEER Program Coding and Staging Manual Appendix C* at https://seer.cancer.gov/tools/codingmanuals/2022manual.html for site-specific guidelines for primary sites, including Bladder, Breast, Colon, Esophagus, Kaposi Sarcoma of All Sites, Lung, and Rectosigmoid Junction.

Refer to the *Hematopoietic and Lymphoid Neoplasm Database and Coding Manual* at seer.cancer.gov/seertools/hemelymph/ for hematopoietic and lymphoid neoplasms (9590/3-9992/3) to determine primary site for hematopoietic and lymphoid neoplasms.

Adequate text documentation must be provided to support coding. Auto coding of the ICD-O-3 code description is not considered adequate text documentation. In general, when a primary site is preceded by carcinoma of…, or malignancy of…, code to that primary site.

Note: The exact location of the primary tumor is not always stated in the pathology report or discharge diagnosis. **Site of origin is not necessarily the site of a biopsy**. It is necessary to review the entire medical record in order to obtain the most precise description of the primary site.

Examples

- The pathology report states right breast resection specimen. The discharge diagnosis states carcinoma in the right breast. The History and Physical states examination of the right breast reveals a mass in the upper outer quadrant. **Code to the more detailed description from the History and Physical, upper outer quadrant of the right breast (C504).**
- Patient presents with headaches and seizures. CT of the brain demonstrates a meningioma in the frontal lobe. **Code the Primary Site field to C70.0 [cerebral meninges], the suggested site code for most meningiomas. Meningiomas arise from the meninges, not the brain (although they can invade brain).**
- Overlapping lesion of oropharynx. **Code C10.8 overlapping lesion when a large tumor involves both the lateral wall of the oropharynx (C10.2) and the posterior wall of the oropharynx (C10.3) and the point of origin is not stated.**
- Overlapping lesion of bladder. **Code C67.8 overlapping lesion of the bladder when a single lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated.**
- Colon, NOS. Familial polyposis with carcinoma and carcinoma in situ throughout the transverse (C18.4) and descending colon (C18.6) would be one primary and **coded to colon, NOS (C18.9). For a full explanation see the SEER 2007 Multiple Primary and Histology Coding Rules.**

Laterality

(NAACCR Item #410) (STORE 2022 page 130) (SEER pages 97-99)

Description

Identifies the side of a paired organ or the side of the body where the tumor originated.

Rationale

Aids in staging and extent of disease information and may indicate the number of primaries.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Table 10.3 Bilateral Site Codes in Alphabetic Order

Paired Organ Sites - Alphabetic Order	
Primary Site	**ICD-O-3 Code**
Acoustic nerve	C724
Adrenal gland [cortex, medulla]	C740–C749
Breast	C500–C509
Carotid body	C754
Cerebral meninges, NOS	C700
Cerebrum	C710
Conjunctiva, lacrimal gland, orbit, cornea, retina, choroid, ciliary body, iris, sclera, lens, eyeball	C690
Connective, subcutaneous and other soft tissues of lower limb & hip	C492
Connective, subcutaneous and other soft tissue of upper limb & shoulder	C491
Cranial nerve, NOS	C725
Epididymis	C630
Fallopian tube	C570
Frontal lobe	C711
Frontal sinus	C312
Kidney, NOS	C649
Long bones of upper limb, scapula and associated joints	C400
Long bones of lower limb and associated joints	C402
Lung	C341–C349
Main bronchus [excluding carina]	C340
Maxillary sinus [antrum]	C310
Middle ear [tympanic cavity]	C301
Nasal cavity [excluding nasal cartilage and nasal septum code 0]	C300
Occipital lobe	C714
Olfactory nerve	C722
Optic nerve	C723
Ovary	C569
Overlapping lesion of the eye and adnexa; Eye, NOS; Eye and lacrimal Gland	C690–C699
Parietal lobe	C713
Parotid gland	C079
Pelvic Bones and associated joints [excluding sacrum, coccyx and symphysis pubis - code 0]	C414

Paired Organ Sites - Alphabetic Order	
Primary Site	**ICD-O-3 Code**
Peripheral nerves and autonomic nervous system of lower limb and Hip	C472
Peripheral nerves and autonomic nervous system of upper limb and shoulder	C471
Pleura	C384
Renal pelvis	C659
Rib, clavicle, and associated joints [excluding sternum - code 0]	C413
Short bones of upper limb and associated joints	C401
Short bones of lower limb and associated joints	C403
Skin of external ear	C442
Skin of eyelid	C441
Skin of other and unspecified parts of face [IF midline tumor, code 5] *	C443
Skin of upper limb and shoulder	C446
Skin of lower limb and hip	C447
Skin of Scalp and Neck [IF midline tumor, code 5] *	C44.4
Skin of trunk [IF midline tumor, code 5] *	C445
Spermatic cord	C631
Sublingual gland	C081
Submandibular gland	C080
Temporal lobe	C712
Testis	C620–C629
Tonsil, NOS and Overlapping lesion of Tonsil	C098–C099
Tonsillar fossa	C090
Tonsillar pillar	C091

*Assign code 5 when the tumor originates in the midline of a site C700, C710-C714, C722-C725, C443, C445. Midline for code 5 refers to the point where the right and left sides of paired organs come into direct contact and a tumor forms at that point such as skin of trunk (C445).

Diagnostic Confirmation

(NAACCR Item #490) (STORE 2022 pages 136-138) (SEER pages 100-102)

Description

Records the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history. It is not limited to the confirmation at the time of initial diagnosis.

Rationale

This item is an indicator of the precision of diagnosis. The percentage of solid tumors that are clinically diagnosed only is an indication of whether casefinding includes sources beyond pathology reports. Complete casefinding must include both clinically and pathologically confirmed cases.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Refer to the *Hematopoietic and Lymphoid Neoplasm Database and Coding Manual* at seer.cancer.gov/seertools/hemelymph/ for coding instructions for diagnostic confirmation for hematopoietic and lymphoid neoplasms (9590/3-9992/3).

Note: The diagnostic code must be changed to the lower (more specific) code if a more definitive code confirms the diagnosis during the course of the disease, regardless of time frame.

Examples

- Mammography indicates a lesion suspicious for cancer. The diagnostic confirmation code is 7. Two weeks later a biopsy confirms infiltrating ductal carcinoma. **The correct diagnostic confirmation code is 1.**
- MRI originally diagnosed a patient with a glioblastoma. The diagnostic confirmation code is 7. A year later a surgical biopsy is obtained. **The diagnostic confirmation code would be changed to 1.**
- A thoracentesis is performed for a patient who is found to have a large pleural effusion. Cytology reveals malignant cells consistent with adenocarcinoma. **The diagnostic confirmation code is 2.**
- CAT scan of abdomen reveals metastatic deposits in the liver and a large lesion in the ascending colon. Biopsy and later resection of the colon lesion revealed mucin-producing adenocarcinoma. **The diagnostic confirmation code is 1**.
- Fine needle aspiration (FNA) is positive for malignant cells. **The diagnostic confirmation code is 2.**

Morphology ICD-O-3: Type and Behavior

(NAACCR Item #522, #523) (STORE 2022 pages 131-133) (SEER pages 104-108)

Description

Identifies the *Histologic Type ICD-O-3* [NAACCR Item #522] with *Behavior Code* [NAACCR Item #523] for cases diagnosed after 01/01/2001.

Rationale

The histological (morphologic) type helps to determine staging and treatment options. It also assists in determining the disease course and prognosis, and in identifying multiple primaries. The behavior code is used by pathologists to describe whether tissue samples are benign (0), borderline (1), in situ (2), or malignant (3).

The *Solid Tumor Rules*, the *ICD-O-3.2 Coding Table Excel*, the *2022 ICD-O-3.2 Table 1 Numeric or 2022 ICD-O-3.2 Table 2 Alpha Table*, the *Hematopoietic and Lymphoid Neoplasm Coding Manual*, and the *Hematopoietic and Lymphoid Neoplasm Database* are the standard references for histology codes for cases diagnosed 2022 and forward.

Note: Solid tumor histology can be coded only after the determination of single vs. multiple primaries has been made. Refer to Solid Tumor Rules to determine the number of primaries for solid tumors.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

- **Check the *Solid Tumor Rules* to determine if the histology is listed.**
- **If the ICD-O code is not in the site-specific histology table or there is no histology table for the site, refer to the *2022 ICD-O-3 Update Table 1 Numeric* or *2022 ICD-O-3 Update Table 2 Alpha Table* to determine if the histology is listed.**
- **If the histology is not included in the update tables, review the *ICD-O-3.2 Coding Table***

Histologic Type ICD-O-3

(NAACCR Item #522) (STORE 2022 page 131) (SEER pages 104-105)

The 2022 ICD-O-3 Update Guidelines includes comprehensive tables listing all changes to ICD-O-3.2 including new ICD-O codes, terminology and reportability changes effective for cases diagnosed 1/1/2022 forward. The 2022 update represents changes identified in recently published 5th Ed WHO Classification of Tumors books. Included in these guidelines are instructions for using the tables together with ICD-O-3.2. This update includes important information on reportable versus non-reportable high-grade dysplasia in gastrointestinal sites.

The ***2022 ICD-O-3.2 Table 1 Numeric or 2022 ICD-O-3.2 Table 2 Alpha Table*** includes comprehensive tables listing all changes made after the 2021 update and is effective for cases diagnosed 1/1/2022 forward. New to the 2022 update tables are columns for each standard setter which will indicate if that particular code and/or term is required for data collection and submission.

The ***ICD-O-3.2 Coding Table Excel*** is the official list of ICD-O-3.2 histology codes for cases diagnosed 1/1/2022 forward. Please check the Solid Tumor Rules to determine if the histology is listed in the site-specific chapters. If the histology is not in the histology tables or there is no histology table for the site, review the 2022 ICD-O-3 Update Table 1 Numeric or 2022 ICD-O-3 Update Table 2 Alpha Table . If the histology is not included in the update, then review ICD-O-3.2 Coding Table Excel. When a histology code cannot be identified using the above recommendations, submit a question to Ask a SEER

Registrar.

***ICD-O-3.2* included changes from all 4th Ed WHO Classification of Tumors books. New editions (5th edition) released following the publication of 4th editions are not included in 3.2. A new ICD-O version will be released once all 5th Ed Blue Books have been published. The following fifth editions were released after the 2021 ICD-O-3.2 update:**

- ***WHO Classification of Tumors of the Breast (2018)***
- ***WHO Classification of Tumors of Digestive System (2018)***
- ***WHO Classification of Tumors of the Female Reproductive Organs (2019)***
- ***WHO Classification of Tumors of Soft Tissue and Bone (2019)***

Behavior Code

(NAACCR Item #523) (STORE 2022 pages 132-133) (SEER pages 106-108)

Note: TCR does not accept cases coded with a metastatic (/6) behavior code. If the only pathology specimen is from a metastatic site, code the appropriate histology code and the malignant behavior code /3. The primary site and its metastatic site(s) have the same basic histology. See *ICD-O-3*, page 27.

Examples

- Final pathologic diagnosis is carcinoma, NOS (8010) of the prostate. Microscopic diagnosis specifies adenocarcinoma (8140) of the prostate. **Code 8140.**
- A patient is diagnosed with metastatic brain tumors and a fine needle aspiration biopsy shows that the tumor is metastatic small cell carcinoma (8041/6). The pathology report indicates that the tumor originated in the lung. **Code the primary site as lung and the morphology as small cell carcinoma (8041/3).**
- Intraductal carcinoma (8500/2) with focal areas of invasion. **Code behavior as /3.**
- Atypical meningioma (9539/1) invading bone of skull (the meninges, which line the skull, are capable of invading into the bone without being malignant; do not code as malignant unless it is specifically mentioned). **Code behavior as /1.**
- Adenocarcinoma in situ with lymph nodes positive for malignancy. **Code the behavior as malignant (/3).**

Grade Clinical

NAACCR Item # 3843 (STORE 2022 page 134) (SEER page 109)

Description

Grade Clinical, effective 1/1/2018, records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant). For some sites, grade is required to assign the clinical stage group.

For cases diagnosed January 1, 2018 and later, this data item, along with *Grade Pathological* and *Grade Post Therapy*, replaces the data item *Grade* [NAACCR Item #440] as well as site specific factors for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason].

Refer to the most recent version of the Grade Coding Instructions and Tables for additional site-specific instructions.

Rationale

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the clinical stage group.

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

Allowable values: 1-5, 8, 9, A, B, C, D, E, L, H, M, S

Coding Instructions

Refer to the most recent version of the Grade Coding Instructions and Tables.

Grade Post Therapy Clinical (yc)

NAACCR Item # 1068 (STORE 2022 page 195) (SEER page 110)

Description

This data item, implemented in 2021, records the grade of a solid primary tumor that has been microscopically sampled following neoadjuvant therapy or primary systemic/radiation therapy. If AJCC staging is being assigned, the tumor must have met the neoadjuvant therapy or primary systemic/radiation therapy requirements in the AJCC manual or according to national treatment guidelines. Record the highest grade documented from the microscopically sampled specimen of the primary site following neoadjuvant therapy or primary systemic/radiation therapy. For cases diagnosed January 1, 2021, and later, this data item, along with Grade Clinical, Grade Pathological, and Grade Post Therapy Path (yp), replaces all previous grade related data items, including NAACCR Data Item Grade [440] and Collaborative Stage Site-Specific Factors (SSF's) (2004-2017) for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason])

Refer to the most recent version of the Grade Coding Instructions and Tables for additional site-specific instructions.

Rationale

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the grade post therapy clin (yc)

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

Allowable values: 1-5, 8, 9, A, B, C, D, E, L, H, M, S

Coding Instructions

Refer to the most recent version of the Grade Coding Instructions and Tables.

Grade Pathological

NAACCR Item # 3844 (STORE 2022 page 135) (SEER page 111)

Description

Grade Pathological, effective 1/1/2018, records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. If AJCC staging is being assigned the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup.

For cases diagnosed January 1, 2018 and later, this data item, along with *Grade Clinical* and *Grade Post Therapy*, replaces the data item *Grade* [NAACCR Item #440] as well as site specific factors for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason].

Refer to the most recent version of the Grade Coding Instructions and Tables for additional site-specific instructions.

Rationale

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the pathological stage group.

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

Coding Instructions

Refer to the most recent version of the Grade Coding Instructions and Tables.

Grade Post Therapy Path (yp)

NAACCR Item # 3845 (STORE 2022 page 208) (SEER page 112)

Description

This data item records the grade of a solid primary tumor that has been resected following neoadjuvant therapy. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. Record the highest grade documented from the surgical treatment resection specimen of the primary site following neoadjuvant therapy. For cases diagnosed January 1, 2018 and later, this data item, along with Grade Clinical, Grade Pathological, and Grade Post Therapy Clin (yc), replaces all previous grade related data items, including NAACCR Data Item Grade (#440) and Collaborative Stage Site-Specific Factors (SSF's) (2004-2017) for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Refer to the most recent version of the Grade Coding Instructions and Tables for additional site-specific instructions.

Rationale

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the post neoadjuvant stage group. For those cases that are eligible for AJCC staging, the recommended grading system is specified in the AJCC Chapter. The AJCC Chapter-specific grading systems (codes 1-5, H, L, M, S and 9) take priority over the generic grade definitions (codes A-E). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions may apply.

Allowable values: 1-5, 8, 9, A, B, C, D, E, L, H, M, S

Coding Instructions

Refer to the most recent version of the Grade Coding Instructions and Tables.

Tumor Size-Clinical

(NAACCR Item #752) (SEER pages 113-118)

Description

This data item records the size of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant). Clinical classification is composed of diagnostic workup prior to first treatment, including physical examination, imaging, pathological findings (gross description and microscopic measurements most likely from a biopsy that did not remove the entire lesion), and surgical exploration without resection.

Rationale

Clinical tumor size (pre-treatment size) is essential for treatment decision making and prognosis determination for many types of cancer. Tumor size is required for all solid tumors.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Tumor Size-Pathologic

(NAACCR Item #754) (SEER pages 119-124)

Description

This data item records the size of a solid primary tumor that has been resected. Pathologic classification includes operative and pathological findings of the resected specimens before initiation of adjuvant treatment.

Rationale

Pathologic tumor size is an important prognostic indicator and valuable for clinical practice and research on surgically treated patients for most cancers. Tumor size is required for all solid tumors.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Tumor Size Summary

(NAACCR Item #756) (STORE 2022 pages 166-170)

Description

This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.

Rationale

Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Table 10.6 Tumor Size Summary

Code	Description
000	No mass/tumor found
001	1 mm or described as less than 1 mm (0.1 cm or less than 0.1 cm)

Code	Description
002-988	Exact size in millimeters (2 mm to 988 mm) (0.2 cm to 98.8cm)
989	989 millimeters or larger (98.9 cm or larger)
990	Microscopic focus or foci only and no size of focus is given
998	SITE-SPECIFIC CODES Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis • Rectosigmoid and rectum (C19.9, C20.9) • Colon (C18.0, C18.2-C18.9) **If no size is documented**: Circumferential: • Esophagus (C15.0-C15.5, C15.8-C15.9) Diffuse; widespread: 3/4s or more; linitis plastica: • Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9) Diffuse, entire lung or NOS: • Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9) Diffuse: • Breast (C50.0-C50.6, C50.8-C50.9)
999	Unknown; size not stated Not documented in patient record Size of tumor cannot be assessed No excisional biopsy or tumor resection done The only measurement(s) describes pieces or chips Not applicable

Coding Instructions

Note: *All measurements should be in millimeters (mm). Here is a link to one of the websites to convert cms to mms:* rapidtables.com/convert/length/cm-to-mm.htm

Record size in specified order:

1. Size measured on the surgical resection specimen, when surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered.
    a. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (also known as CAP protocol or pathology report (checklist). If only a text report is available, use: final diagnosis, microscopic, or gross examination, in that order.

Example 1: Chest X-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. Record tumor size as 028 (28 mm).

Example 2: Pathology report states lung carcinoma is 2.1 cm x3.2 cm x 1.4 cm. Record tumor size as 032 (32mm).

2. If neoadjuvant therapy followed by surgery, do not record the size of the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size 999.

   Example: Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size after total resection is 2.8 cm. Record tumor size as 022 (22mm).

3. If no surgical resection, then the largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures prior to any other form of treatment. (See the coding rules section below.)
4. If 1, 2, and 3 do not apply, the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

Coding Rules

1. Tumor size is the diameter of the tumor, not the depth or thickness of the tumor.
2. Recording 'less than'/ 'greater than' Tumor Size:
   a. If tumor size is reported as less than x mm or less than x cm, the reported tumor size should be 1 mm less; for example, if size is < 10 mm, code size as 009. Often these are given in cm such as < 1 cm, which is coded as 009; < 2 cm is coded as 019; < 3 cm is coded as 029; < 4 cm is coded as 039; < 5 cm is coded as 049. If stated as less than 1 mm, use code 001.
   b. If tumor size is reported as more than x mm or more than x cm, code size as 1 mm more; for example, if size is > 10 mm, size should be coded as 011. Often these are given in cm such as > 1 cm, which is coded as 011; > 2 cm is coded as 021; > 3 cm is coded as 031; > 4 cm is coded as 041; > 5 cm is coded as 051. If described as anything greater than 989 mm (98.9 cm), code as 989.
   c. If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two: i.e., add the two sizes together and then divide by two ("between 2 and 3 cm" is coded as 025).
3. Rounding: Round the tumor size only if it is described in fractions of millimeters. If the largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm), record size as 001 (do not round down to 000). If tumor size is greater than 1-millimeter, round tenths of millimeters in the 1- 4 range down to the nearest whole millimeter, and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. Do not round tumor size expressed in centimeters to the nearest whole centimeter (rather, move the decimal point one space to the right, converting

the measurement to millimeters).

Example 1: Breast cancer described as 6.5 millimeters in size. Round up Tumor Size as 007.

Example 2: Cancer in polyp described as 2.3 millimeters in size. Round down Tumor Size as 002.

Example 3: Focus of cancer described as 1.4 mm in size. Round down as 001.

Example 4: 5.2 mm breast cancer. Round down to 5 mm and code as 005.

4. Priority of imaging/radiographic techniques: Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but it should be taken as low priority, over a physical exam.
5. Tumor size discrepancies among imaging and radiographic reports: If there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies which imaging is most accurate, record the largest size in the record, regardless of which imaging technique reports it.
6. Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis. However, if the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.
7. Record the size of the invasive component, if given.
    a. If both an in situ and an invasive component are present and the invasive component is measured, record the size of the invasive component even if it is smaller.

        Example: Tumor is mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive. Record tumor size as 014 (14 mm)

    b. If the size of the invasive component is not given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

        Example 1: A breast tumor with infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023 (23 mm).

        Example 2: Duct carcinoma in situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (19 mm).
8. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

    Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).
9. Record the size as stated for purely in situ lesions.
10. Disregard microscopic residual or positive surgical margins when coding tumor size. Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data field.
11. Do not add the size of pieces or chips together to create a whole. They may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together

and measuring the total size), record that size. If the only measurement describes pieces or chips, record tumor size as 999.

12. Multifocal/multicentric tumors: If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor or if all of the tumors are in situ, code the size of the largest in situ tumor.
13. Tumor size code 999 is used when size is unknown or not applicable. Sites/morphologies where tumor size is not applicable are listed here.
    - Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms: (histology codes 9590- 9993)
    - Kaposi Sarcoma
    - Melanoma Choroid
    - Melanoma Ciliary Body
    - Melanoma Iris
    - Unknown Primary Site
14. Document the information to support coded tumor size in the appropriate text field of the abstract.

11

STAGE OF DISEASE AT DIAGNOSIS

Stage of Disease at Diagnosis data items contained within this manual fall under two categories

- Extent of Disease
- Summary Stage

Note: There are no specific instructions for pathology-only cases. Assign 9s or the appropriate "unknown" code when abstracting stage and related data items from pathology reports or HL-7 reports only and information is not provided.

For additional stage-related data items, refer to Stage-related Data Items section of the SEER Program Coding and Staging Manual 2022.

Extent of Disease Primary Tumor

(NAACCR Item #772) (SEER page 128)

Description

EOD Primary Tumor is part of the EOD 2018 data collection system and is used to classify contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. See also EOD Regional Nodes [774] and EOD Mets [776].

Rationale

EOD Primary Tumor is used to calculate *Derived EOD 2018 T* [785] (when applicable) and *Derived Summary Stage 2018* [762]. Derivation will occur at the level of the central registry.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Extent of Disease Regional Nodes

(NAACCR Item #774) (SEER page 129)

Description

EOD Regional Nodes is part of the EOD 2018 data collection system and is used to classify the regional lymph nodes involved with cancer at the time of diagnosis. See also EOD Primary Tumor [772] and EOD Mets [776].

Rationale

EOD Regional Nodes is used to calculate Derived EOD 2018 N [815] (when applicable) and Derived Summary Stage 2018 [762]. Derivation will occur at the level of the central registry.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Extent of Disease Metastases

(NAACCR Item #776) (SEER page 130)

Description

EOD Mets is part of the EOD 2018 data collection system and is used to classify the distant site(s) of metastatic involvement at time of diagnosis. See also EOD Primary Tumor [772] and EOD Regional Nodes [774].

Rationale

EOD Mets is used to calculate Derived EOD 2018 M [795] (when applicable) and Derived Summary Stage 2018 [762]. Derivation will occur at the level of the central registry.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Summary Stage 2018

(NAACCR Item #764) (SEER page 132)

Description

Summary Stage 2018 stores the directly assigned Summary Stage 2018. Effective for cases diagnosed January 1, 2018 and later. Refer to SEER*RSA for additional information.

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

Rationale

The SEER program has collected staging information on cases since its inception in 1973. Summary Stage groups cases into broad categories of in situ, local, regional, and distant. Summary Stage can be used to evaluate disease spread at diagnosis, treatment patterns and outcomes over time.

Coding Instructions

Refer to Summary Stage 2018 for guidelines, general instructions, and site-specific instructions.

12

STAGE-RELATED DATA ITEMS

Lymphovascular Invasion

(NAACCR Item #1182) (STORE 2022 page 146-150) (SEER page 136-138)

Description

Indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist.

Rationale

Lymphovascular invasion is an indicator of prognosis.

Note: **TCR collects this data item only for Penis (C60) and Testis (C62).**

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Macroscopic Evaluation of the Mesorectum

(NAACCR Item #3950) (STORE 2022 page 151) (SEER page 139)

Description

Records the results of a macroscopic evaluation of the mesorectum from a total mesorectal excision (TME).

Rationale

Numerous studies have demonstrated the total mesorectal excision (TME) improves local recurrence rates and the corresponding survival by as much as 20%. Macroscopic pathologic assessment of the completeness of the mesorectum, scored as complete, partially complete, or incomplete, accurately predicts both local recurrence and distant metastasis.

Coding Instructions

Note: TCR collects this data item from CoC accredited facilities when available.

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Mets at Diagnosis-Bone

(NAACCR Item #1112) (STORE 2022 pages 171-172) (SEER pages 140-141)

Description

This field identifies whether bone is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Mets at Diagnosis-Brain

(NAACCR Item #1113) (STORE 2022 pages 173-174) (SEER pages 142-143)

Description

This field identifies whether brain is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Mets at Diagnosis-Liver

(NAACCR Item #1115) (STORE 2022 pages 177-178) (SEER pages 144-145)

Description

This field identifies whether liver is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Mets at Diagnosis-Lung

(NAACCR Item #1116) (STORE 2022 pages 179-180) (SEER pages 146-147)

Description

This field identifies whether lung is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Mets at Diagnosis-Distant Lymph Node(s)

(NAACCR Item #1114) (STORE 2022 pages 175-176) (SEER pages 148-149)

Description

This field identifies whether distant lymph node(s) are an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions

(including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Mets at Diagnosis-Other

(NAACCR Item #1117) (STORE 2022 pages 181-182) (SEER pages 150-151)

Description

The six Mets at Dx-Metastatic Sites fields provide information on metastases for data analysis. This field identifies any type of distant involvement not captured in the Mets at Dx-Bone [1112], Mets at Dx-Brain [1113], Mets at Dx-Liver [1115], Mets at Dx-Lung [1116], and Mets at Dx-Distant LN [1114] fields. It includes involvement of other specific sites and more generalized metastases such as carcinomatosis. Some examples include but are not limited to the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum, and skin.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

SEER Site-specific Factor 1

(NAACCR Item #3700) (SEER pages 152-153)

Description

SEER Site-specific Factor 1, effective 01/01/2018, is reserved for human papilloma virus (HPV) status. This data item applies to the following sites:

• Buccal Mucosa: C060, C061 • Floor of Mouth: C040-C041, C048-C049 • Gum: C030, C031, C039, C062 • Hypopharynx: C129, C130-C132, C138-C139 • Lip: C003-C005, C008, C009 • Mouth Other: C058-C059, C068-C069 • Oropharynx (p16-): C019, C024, C051-C052, C090-C091, C098-C099, C100, C102-C104, C108- C109, C111 • Oropharynx HPV-Mediated (p16+): C019, C024, C051-C052,

C090-C091, C098-C099, C100, C102-C104, C108-C109, C111 • Palate Hard: C050 • Tongue Anterior: C020-C023, C028-C029

Rationale

There is evidence that human papilloma virus (HPV) plays a role in the pathogenesis of some cancers. HPV testing may be performed for prognostic purposes; testing may also be performed on metastatic sites to aid in determination of the primary site.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Site-specific Data Items (SSDIs)

(SEER page 154-156)

Description

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

SEER has developed a staging tool referred to as **SEER*RSA** that provides information (primary site/histology/other factors defined) about each cancer schema. Refer to **SEER*RSA** and the **SSDI Manual** for codes and coding instructions.

Before using the Manual as an information resource for specific data items, it is important to review the introductory materials and general instructions carefully. Although the majority of data items that are collected as SSDIs were previously collected as SSFs, the format of the data items and allowable values have changed substantially, particularly for laboratory values.

Note: See the American College of Surgeons Commission on Cancer CAnswer Forum for questions about **AJCC TNM staging**, the **Site-Specific Data Items**, and **data items not required by SEER**. SEER required data items are listed in the NAACCR Required Status Table.

For each SSDI, the SSDI Manual includes:

- NAACCR Data Item Name
- Item Length
- NAACCR Item #
- NAACCR Alternative Name
- AJCC 8th Edition Chapter(s)
- Description – a brief summary used to define the data item in the NAACCR data dictionary

- Rationale – describes the reason why the data item is collected, such as required for staging or recommended for registry data collection by AJCC. If the data item was collected in CSv2, the primary site and SSF# is included in the rationale.
- Definition – provides additional background on the data item and its clinical importance. This information was previously included in the CSv2 Manual, Part I, Section II.
- Additional Information – may include source documents, other names, normal reference ranges and any other information deemed relevant for a particular SSDI. This information was previously included in the CSv2 Manual, Part I, Section II.
- Coding instructions and codes
- Coding instructions are provided as numbered notes.
- Codes are provided in a table.
- Codes and coding instructions are usually provided in registry software.

Rationale

An important new concept introduced in 2018 is the use of a Schema ID to define the applicable SSDIs and grade table for a particular tumor, based on primary site, histology, and in some cases, additional information. The appropriate Schema ID will be defined by registry software and will not have to be assigned by the registrar. However, a Schema ID Table defining the Schema ID number, description and associated SSDIs is provided in the SSDI Manual for reference purposes.

For 2018, Schema ID [3800] is used to link all combinations of sites and histologies (using additional information from schema discriminators if needed) with the appropriate stage data collection systems and SSDIs. AJCC ID [995] is used to link AJCC staging eligible sites/histologies (using additional information from schema discriminators if needed) with the appropriate AJCC chapter and staging algorithm. Schema ID and AJCC ID will be derived by registry software based on site and histology codes entered by the registrar.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

For information about Schema IDs, and descriptions, codes, coding instructions for site-specific data items refer to the SSDI Manual

- **For coding SSDI for cases prior to 2022, please refer to the appropriate TCR Cancer Reporting Handbook for the list of SSDIs that are collected by TCR for the year of the diagnosis date of your case.**
- SSDIs have their own data item name and number and can be collected for as many sites/chapters/schemas as needed.
- Each Site-Specific Data Item (SSDI) applies only to selected schemas. SSDI fields should be blank for schemas where they do not apply.

AJCC TNM STAGING SYSTEM

From 2004 through 2015 AJCC TNM was derived based on Collaborative Staging. Effective January 1, 2018, the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries.

AJCC TNM data items is required only from facilities accredited by the American College of Surgeons (ACoS) and only for analytical cases. For hospitals and cancer centers that are not ACoS accredited, these data items are required for analytical cases only *as available* (class of case 00-22).

The American Joint Committee on Cancer (AJCC) is made an important change to how it updates and releases Cancer Staging content beginning in 2021. The AJCC will be shifting from a Cancer Staging Manual to a Cancer Staging System and moving away from Editions, to Versions which better align with software development and how users are increasingly consuming AJCC content. The AJCC has started rolling updates with the release of Cervix 9th version. As warranted by medical practice, additional disease sites will be updated in the future as necessary, while the other disease sites will remain unchanged, and the 8th Edition will be used. There will no longer be a single edition or version number applicable to every disease site for the diagnosis year. While references will be made to the 9th version, the registry data item will continue to reference TNM Edition Number [1060]. Additional updates to the AJCC Cancer Staging Manual are always available at cancerstaging.org and available for software developers via the AJCC API.

AJCC Cancer Staging questions should be directed to the CAnswer Forum at: cancerbulletin.facs.org/forums/help

AJCC TNM is a system to describe the amount and spread of cancer in a patient's body.

- **T** describes the size of the tumor and any spread of cancer into nearby tissue.
- **N** describes spread of cancer to nearby lymph nodes.
- **M** describes metastasis (spread of cancer to other parts of the body).

This system was created and is updated by the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC). The AJCC staging system is used to describe most types of cancer.

Staging forms are available online in the AJCC Cancer Staging Form Supplement. The 104 staging forms in this supplement are numbered according to their corresponding chapters in the AJCC Cancer Staging Manual, Eighth Edition. Some chapters have multiple staging forms as they describe distinct TNM, Prognostic Factors, and AJCC Prognostic Stage Groups for unique topographical sites, histologic types or a combination of the two. These forms may provide more data elements than required for collection by standard setters such as NCI SEER, CDC NPCR, and CoC NCDB.

TNM Edition Number

(NAACCR Item #1060) (STORE 2022 page 353)

Description

A code that indicates the edition of the AJCC manual used to stage the case. This applies to the manually coded TNM values for the patient. It does not apply to the Derived AJCC T, N, M and AJCC Stage Group fields.

Rationale

TNM codes have changed over time and conversion is not always simple. Therefore, a case-specific indicator is needed to allow grouping of cases for comparison.

Code	Description
00	Not staged (cases that have AJCC staging scheme and staging was not done)
01	First Edition
02	Second Edition (published 1983)
03	Third Edition (published 1988)
04	Fourth Edition (published 1992), for use for cases diagnosed 1993-1997
05	Fifth Edition (published 1997), for use for cases diagnosed 1998-2002
06	Sixth Edition (published 2002), for use for cases diagnosed 2003-2009
07	Seventh Edition (published 2009), for use with cases diagnosed 2010+
08	Eighth Edition (published 2016), for use with cases diagnosed 2018+
88	Not applicable (cases that do not have an AJCC staging scheme)
99	Edition unknown

Coding Instruction

Code based on the edition of the AJCC manual that was used to stage the case.

AJCC TNM Clin T

(NAACCR Item #1001) (STORE 2022 page 184)

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known prior to the start of any therapy. Detailed site-specific values for the clinical T category as defined by the current AJCC edition.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018, the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The clinical T category staging data item must be recorded for Class of Case 10-22.
2. It is strongly recommended that the clinical T category staging data item be recorded for Class of Case 00 cases if the patient's workup at the facility allows assigning of clinical T.
3. Assign clinical T category as documented by the first treating physician or the managing physician in the medical record.
4. If the managing physician has not recorded clinical T, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
5. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
6. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
7. Refer to the current AJCC Cancer Staging System for detailed staging rules.
8. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Clin T Suffix

(NAACCR Item #1031) (STORE 2022 page 185)

Description

Identifies the AJCC TNM clinical T category suffix for the tumor **prior** to the start of any therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Record the clinical T category suffix as documented by the first treating physician or the managing physician in the medical record.
2. If the managing physician has not recorded the suffix when applicable, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
3. If the tumor is not staged according to the AJCC manual, leave this data item blank.
4. Refer to the current AJCC Cancer Staging System for staging rules.

Code	Description
(blank)	No information available; not recorded
(m)	Multiple synchronous tumors OR Multifocal tumor (differentiated and anaplastic thyroid only)
(s)	Solitary tumor (differentiated and anaplastic thyroid only)

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Clin N

(NAACCR Item #1002) (STORE 2022 page 186)

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastases of the tumor known **prior** to the start of any therapy. Detailed site-specific values for the clinical tumor (N) as defined by the current AJCC edition. This field is manually coded.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The clinical N category staging data item must be assigned for Class of Case 10-22.
2. It is strongly recommended that the clinical N category staging data item be recorded for Class of Case 00 cases if the patient's workup at the facility allows assigned of clinical N category.
3. Record clinical N category as documented by the first treating physician or the managing physician in the medical record.
4. If the managing physician has not recorded clinical N, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
5. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
6. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
7. Refer to the current AJCC Cancer Staging System for staging rules.
8. The valid codes and labels for the AJCC Cancer Staging Manual, Eighth Edition have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Clin N Suffix

(NAACCR Item #1034) (STORE 2022 page 187)

Description

Identifies the AJCC TNM clinical N category suffix for the tumor **prior** to the start of any therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. To distinguish lymph nodes identified during diagnostic evaluation by sentinel node biopsy or FNA or core needle biopsy from those identified by physical examination and imaging, the following suffixes are used in assigning the clinical N (cN) category.
2. If SLN biopsy is performed as part of the diagnostic workup, the cN category should have the sn suffix: for example, cN1(sn).
3. If an FNA or a core biopsy is performed on lymph nodes as part of the diagnostic workup, the cN category should have the f suffix: for example, cN1(f).
4. If you do not know which procedure was done, leave it blank.
5. Record the clinical N category suffix as documented by the managing physician in the medical record.
6. If the managing physician has not recorded the suffix, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.
7. If the tumor is not staged according to the AJCC manual, leave this data item blank.
8. Refer to the current AJCC Cancer Staging System for staging rules.

Code	Description
(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only
(blank)	No suffix needed or appropriate, not recorded

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Clin M

(NAACCR Item #1003) (STORE 2022 page 188)

Description

Identifies the presence or absence of distant metastasis (M) of the tumor known **prior** to the start of any therapy. Detailed site-specific values for the clinical T category suffix as defined by the current AJCC edition.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The clinical M category staging data item must be assigned for Class of Case 10-22.
2. It is strongly recommended that the clinical M category staging data item be recorded for Class of Case 00 cases if the patient's workup at the facility allows assigning of clinical M.
3. Record clinical M category as documented by the first treating physician or managing physician in the medical record.
4. If the managing physician has not recorded clinical M category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
5. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
6. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
7. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Clinical Stage Group

(NAACCR Item #1004) (STORE 2022 page 189)

Description

Identifies the anatomic extent of disease based on the T,N,M category data items known **prior** to the start of any therapy. Detailed site-specific values for the clinical stage group is defined by the current AJCC edition.

Coding Instructions

1. Record the clinical stage group as documented by the first treating physician or the managing physician in the medical record.
2. If the managing physician has not recorded the clinical stage, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
3. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
4. Code 99 for clinical, pathological, post therapy clinical or post therapy pathological stage group if the TNM combination along with any required prognostic factors does not result in a valid stage group according to the current AJCC system.
5. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
6. Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
7. Refer to the current AJCC Cancer Staging System for staging rules. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Path T

(NAACCR Item #1011) (STORE 2022 page 196)

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known **following** the completion of surgical therapy. Detailed site-specific values for the pathological tumor (T) as defined by the current AJCC edition. This field is manually coded.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The pathological T category staging data item must be assigned for Class of Case 10-22.
2. Assign pathological T category as documented by the treating physician(s) or the managing physician in the medical record.
3. If the managing physician has not recorded pathological T category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC system and for in situ tumors that are not staged according to the current AJCC system. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
4. For lung, occult carcinoma is assigned TX according to the definition in the current AJCC system.
5. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
6. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Path T Suffix

(NAACCR Item #1032) (STORE 2022 page 197)

Description

Identifies the AJCC TMN pathological T category suffix for the tumor **following** the completion of surgical therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Record the pathological stage T category suffix as documented by the first treating physician or the managing physician in the medical record.
2. If the managing physician has not recorded the descriptor, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
3. If the tumor is not staged according to the AJCC system, leave this data item blank.
4. Refer to the current AJCC Cancer Staging System for staging rules.

Code	Description
(blank)	No information available; not recorded
(m)	Multiple synchronous tumors OR Multiple tumor (differentiated and anaplastic thyroid only)
(s)	Solitary tumor (differentiated and anaplastic thyroid only)

AJCC TNM Path N

(NAACCR Item #1012) (STORE 2022 page 198)

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known **following** the completion of surgical therapy.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer

registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The pathological N category staging data item must be assigned for Class of Case 10-22.
2. Assign pathological N category as documented by the treating physician(s) or managing physician in the medical record.
3. If the managing physician has not recorded pathological N category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
5. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
6. Refer to the current AJCC Cancer Staging System for staging rules.
7. The valid codes and labels for the AJCC Cancer Staging Manual, Eighth Edition have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Path N Suffix

(NAACCR Item #1035) (STORE 2022 page 199)

Description

Identifies the AJCC TNM pathological N suffix for the tumor **following** the completion of surgical therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed

this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. If SLN biopsy is performed in the absence of complete dissection of the nodal basin, the pN category should have the sn suffix: for example, pN0(sn).
2. If an FNA or a core biopsy is performed in the absence of a complete dissection of the nodal basin, the pN category should have the f suffix: for example, pN0(f).
3. If you do not know which procedure was done, leave it blank.
4. Record the pathological N category suffix as documented by the managing physician in the medical record.
5. If the managing physician has not recorded the suffix, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.
6. If the tumor is not staged according to the AJCC System, leave this data item blank.
7. Refer to the current AJCC Cancer Staging System for staging rules.

Code	Description
(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only
(blank)	No suffix needed or appropriate, not recorded

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Path M

(NAACCR Item #1013) (STORE 2022 page 200)

Description

Identifies the presence or absence of distant metastasis (M) of the tumor known following the completion of surgical therapy**.**

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The pathological M category staging data item must be assigned for Class of Case 10-22.
2. Assign pathological M category as documented by the treating physician(s) or the managing physician in the medical record.
3. If the managing physician has not recorded pathological M category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
4. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
5. Refer to the current AJCC Cancer Staging System for staging rules. The valid codes and labels for the AJCC Cancer Staging Manual, Eighth Edition have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Pathological Stage Group

(NAACCR Item #1014) (STORE 2202 page 201)

Description

Identifies the anatomic extent of disease based on the T, N, and M category data items known **following** the completion of surgical therapy**.**

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2015 the CoC requires that AJCC pathological TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Record the pathological stage group as documented by the treating physician(s) or the managing physician in the medical record.
2. If the managing physician has not recorded the pathological stage, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician(s). Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
3. Code 99 for clinical, pathological, post therapy clinical or post therapy pathological stage group if the TNM combination along with any required prognostic factors does not result in a valid stage group according to the current AJCC system.
4. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
5. Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
6. Refer to the current AJCC Cancer Staging System for staging rules. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Post Therapy Clin T

(NAACCR #1062) (STORE 2022 page 190)

Description

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

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to

estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The post therapy clin T category staging data item must be assigned for Class of Case 10-22.
2. Assign post therapy clin T category as documented by the treating physician(s) or the managing physician in the medical record.
3. If the managing physician has not recorded post therapy clin T category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC system and for in situ tumors that are not staged according to the current AJCC system. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
5. For lung, occult carcinoma is assigned TX according to the definition in the current AJCC system.
6. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
7. Refer to the current AJCC Cancer Staging System for staging rules.
8. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Post Therapy Clin T Suffix

(NAACCR #1063) (STORE 2022 page 191)

Description

Identifies the AJCC TNM post therapy clinical T category suffix for the tumor following the completion of **neoadjuvant** therapy (satisfying the definition for that disease site) and before planned **post neoadjuvant therapy surgical resection**. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Record the post therapy clin T category suffix as documented by the first treating physician or the managing physician in the medical record.
2. If the managing physician has not recorded the post therapy clin T category suffix, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
3. If the tumor is not staged according to the AJCC system, leave this data item blank.
4. Refer to the current AJCC Cancer Staging System for staging rules.

Code	Description
(blank)	No information available; not recorded
(m)	Multiple synchronous tumors OR Multiple tumor (differentiated and anaplastic thyroid only)
(s)	Solitary tumor (differentiated and anaplastic thyroid only)

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Post Therapy Clin N

(NAACCR #1064) (STORE 2022 page 192)

Description

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

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for

evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The post therapy clin N category staging data item must be assigned for Class of Case 10-22.
2. Assign post therapy clin N category as documented by the treating physician(s) or managing physician in the medical record.
3. If the managing physician has not recorded post therapy clin N category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
5. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
6. Refer to the current AJCC Cancer Staging System for staging rules.
7. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Post Therapy Clin N Suffix

(NAACCR #1065) (STORE 2022 page 193)

Description

Identifies the AJCC TNM post therapy clinical N suffix for the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and before planned post neoadjuvant therapy surgical resection. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. If SLN biopsy is performed in the absence of complete dissection of the nodal basin, the ypN category should have the sn suffix: for example, ypN0(sn).
2. If an FNA or a core biopsy is performed in the absence of a complete dissection of the nodal basin, the ypN category should have the f suffix: for example, ypN0(f).
3. If you do not know which procedure was done, leave it blank.
4. Record the post therapy clinical N category suffix as documented by the managing physician in the medical record.
5. If the managing physician has not recorded the suffix, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.
6. If the tumor is not staged according to the AJCC System, leave this data item blank.
7. Refer to the current AJCC Cancer Staging System for staging rules.

Code	Description
(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only
(blank)	No suffix needed or appropriate, not recorded

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Post Therapy Clin M

(NAACCR #1066) (STORE 2022 page 194)

Description

Identifies the presence or absence of distant metastasis (M) of the tumor as known in the clinical stage before initiation of neoadjuvant therapy and records this information following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and before planned post neoadjuvant therapy surgical resection.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The post therapy clin M category staging data item must be assigned for Class of Case 10-22.
2. Assign post therapy clin M category as documented by the treating physician(s) or the managing physician in the medical record.
3. If the managing physician has not recorded post therapy clin M category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
5. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
6. Refer to the current AJCC Cancer Staging System for staging rules.
7. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Post Therapy Clinical Stage Group

(NAACCR #1067)

Description

Detailed site-specific codes for the post therapy clinical stage group as defined by AJCC.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.
Identifies the remaining anatomic extent of disease based on the T and N following the completion of neoadjuvant therapy (satisfying the definition for that disease site) before planned surgical resection or primary treatment consisting of systemic and/or radiation therapy, and the M status defined during the diagnostic workup.

Coding Instructions

1. Refer to the current AJCC Staging System for staging rules.
2. Code 88 for not applicable, no code assigned for this case in the current AJCC Staging Manual
3. Code 99 for unknown, not staged

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Post Therapy Path T

(NAACCR #1021) (STORE 2022 page 202)

Description

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

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The post therapy path T category staging data item must be assigned for Class of Case 10-22.
2. Assign post therapy path T category as documented by the treating physician(s) or the managing physician in the medical record.

3. If the managing physician has not recorded post therapy path T category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC system and for in situ tumors that are not staged according to the current AJCC system. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
5. For lung, occult carcinoma is assigned TX according to the definition in the current AJCC system
6. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
7. Refer to the current AJCC Cancer Staging System for staging rules.
8. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Post Therapy Path T Suffix

(NAACCR #1033) (STORE 2022 page 203)

Description

Identifies the AJCC TNM post therapy pathological T category suffix for the tumor following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post neoadjuvant therapy surgical resection. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Record the post therapy path T category suffix as documented by the first treating physician or the managing physician in the medical record.
2. If the managing physician has not recorded the post therapy path T category suffix, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
3. If the tumor is not staged according to the AJCC System, leave this data item blank.
4. Refer to the current AJCC Cancer Staging System for staging rules.

Code	Description
(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only
(blank)	No suffix needed or appropriate, not recorded

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Post Therapy Path N

(NAACCR #1022) (STORE 2022 page 204)

Description

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

Coding Instructions

1. The post therapy path N category staging data item must be assigned for Class of Case 10-22.
2. Assign post therapy path N category as documented by the treating physician(s) or managing physician in the medical record.
3. If the managing physician has not recorded post therapy path N category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.

5. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
6. Refer to the current AJCC Cancer Staging System for staging rules.
7. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Post Therapy Path N Suffix

(NAACCR #1036) (STORE 2022 page 205)

Description

Identifies the AJCC TNM post therapy pathological N suffix for the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post neoadjuvant therapy surgical resection. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. If SLN biopsy is performed in the absence of complete dissection of the nodal basin, the ypN category should have the sn suffix: for example, ypN0(sn).
2. If an FNA or a core biopsy is performed in the absence of a complete dissection of the nodal basin, the ypN category should have the f suffix: for example, ypN0(f).
3. If you do not know which procedure was done, leave it blank.
4. Record the post therapy pathological N category suffix as documented by the managing physician in the medical record.
5. If the managing physician has not recorded the suffix, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.
6. If the tumor is not staged according to the AJCC System, leave this data item blank.

7. Refer to the current AJCC Cancer Staging System for staging rules

Code	Description
(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only
(blank)	No suffix needed or appropriate, not recorded

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Post Therapy Path M

(NAACCR #1023) (STORE 2022 page 206)

Description

Identifies the presence or absence of distant metastasis (M) of the tumor as known in the clinical stage before initiation of neoadjuvant therapy and records this information following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The post therapy path M category staging data item must be assigned for Class of Case 10-22.
2. Assign post therapy path M category as documented by the treating physician(s) or the managing physician in the medical record.
3. If the managing physician has not recorded post therapy path M category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.

5. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
6. Refer to the current AJCC Cancer Staging System for staging rules.
7. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

AJCC TNM Post Therapy Pathological Stage Group

(NAACCR #1024) (STORE 2022 page 207)

Description

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

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Record the post therapy path stage group as documented by the treating physician(s) or the managing physician in the medical record.
2. If the managing physician has not recorded the post therapy path stage, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician(s).
3. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.

4. Code 99 for clinical and pathological or post therapy clinical or post therapy pathological stage group if the TNM combination along with any required prognostic factors does not result in a valid stage group according to the current AJCC system.
5. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
6. Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
7. Refer to the current AJCC Cancer Staging System for staging rules.
8. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2022 manual for specifications for codes and data entry rules.

13

FIRST COURSE OF THERAPY

Definitions

First Course of Therapy

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

First Course of Treatment

First Course of Treatment includes **all methods of treatment** recorded in the treatment plan and administered to the patient before disease progression or recurrence.

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

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

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

Active Surveillance: A treatment plan that involves closely watching a patient's condition but not giving any treatment unless there are changes in test results that show the condition is getting worse. Active surveillance may be used to avoid or delay the need for treatments such as radiation therapy or surgery, which can cause side effects or other problems. During active surveillance, certain exams and tests are done on a regular schedule. It may be used in the treatment of certain types of cancer, such as prostate cancer, urethral cancer, and intraocular (eye) melanoma. It is a type of expectant management. (Source:cancer.gov/dictionary?CdrID=616060)

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

Concurrent therapy: A treatment that is given at the same time as another, such as chemotherapy and radiation therapy.

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

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

Hospice: A program that provides special care for people who are **near the end of life** and for their families, either at home, in freestanding facilities, or within hospitals. **Hospice care may include**

treatment that destroys or modifies cancer tissue. If performed as part of the first course, treatment that destroys or modifies cancer tissue is collected when given in a hospice setting. "Hospice, NOS" is not specific enough to be included as first course treatment.

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

Palliative treatment: The World Health Organization describes palliative care as treatment that **improves the quality of life by preventing or relieving suffering. Palliative therapy is also part of the first course of therapy when the treatment destroys or modifies cancer tissue**.

Example: The patient was diagnosed with stage IV cancer of the prostate with painful boney metastases. The patient starts radiation treatment intended to shrink the tumor in the bone and relieve the intense pain. The radiation treatments are palliative because they relieve the bone pain; the radiation is also first course of therapy because it destroys proliferating cancer tissue.

Surgical Procedure: Any surgical procedure coded in the fields *Surgery of Primary Site*, *Scope of Regional Lymph Node Surgery*, or **Surgery of Other Regional or Distant Sites**. See *Scope of Regional Lymph Node Surgery* data item for exceptions.

Treatment: Procedures that destroy or modify primary (primary site) or secondary (metastatic) cancer tissue.

Treatment failure: The treatment modalities did not destroy or modify the cancer cells. The tumor either became larger (disease progression) or stayed the same size after treatment.

Watchful waiting: Closely watching a patient's condition but not giving treatment unless symptoms appear or change. Watchful waiting is sometimes used in conditions that progress slowly. It is also used when the risks of treatment are greater than the possible benefits. During watchful waiting, patients may be given certain tests and exams. Watchful waiting is sometimes used in prostate cancer. It is a type of expectant management. (Source: cancer.gov/dictionary?CdrID=45942)

Treatment Timing

Note: Treatment is therapy (destroys or modifies cancer tissue) **or** active surveillance **or** decision for "no therapy".

Use the following instructions **in hierarchical order:**

1. Use the **documented** first course of therapy (treatment plan) from the medical record. First course of therapy ends when the treatment plan is **completed** no matter how long it takes to complete the plan unless there is documentation of disease progression, recurrence, or treatment failure (see #2 below).

   Example 1: The first course of therapy for a breast cancer patient is surgery, chemotherapy, and radiation. The patient completes surgery and chemotherapy. Bone metastases are diagnosed before the radiation was started. The physician says that the patient will start the radiation treatment as planned. **Code the radiation as first course of therapy since it was given in agreement with the treatment plan and the treatment plan was not changed as a result of disease progression.**

Example 2: Hormonal therapy (e.g., Tamoxifen) after surgery, radiation, and chemotherapy. First course ends when hormonal therapy is completed, even if this takes years, unless there is documentation of disease progression, recurrence, or treatment failure (see #2 below).

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

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

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

3. When there is **no documentation** of a treatment plan or progression, recurrence or a treatment failure, first course of therapy ends one year after the date of diagnosis. **Any treatment given after one year is second course of therapy in the absence of a documented treatment plan or a standard of treatment.**

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022 for all diseases (including benign and borderline malignancy intracranial & CNS tumors) except hematopoietic and lymphoid neoplasms (seer.cancer.gov/tools/heme/index.html)

First Course Treatment for Hematopoietic and Lymphoid Neoplasms

Refer to the Hematopoietic and Lymphoid Neoplasm Coding Manual to determine the correct coding of treatment for hematopoietic diseases.

Leukemia and Lymphomas

Treatment varies by the type of hematopoietic neoplasm.

Lymphomas can be treated with surgery (extranodal or nodal), chemotherapy, and radiation, while leukemias are often treated with chemotherapy and bone marrow transplants. In addition, immunotherapy (biologic response modifiers) and hormones are frequently used to treat hematopoietic neoplasms. Also, for many of these diseases, the principal treatment is either supportive care, observation, or another type of treatment that does not meet the usual definition of treatment that "modifies, controls, removes or destroys proliferating cancer tissue."

Starting in 2010, some neoplasms that have undergone a transformation are reported as new primaries (see rules M10-M13 for specific instructions), and treatment can affect this. For purposes of determining multiple primaries in the Hematopoietic diseases, "treatment" refers to the patient receiving at least one form of cancer-directed treatment such as surgery or systemic therapy, not passive treatment plans like supportive care or observation.

Coding Instructions

1. When there is only one neoplasm (one primary), use the documented first course of therapy (treatment plan) from the medical record. First course of therapy ends when the treatment plan is completed, no matter how long it takes to complete the plan.
2. Chronic neoplasm followed by an acute neoplasm.
    a. The presence/absence of treatment **does not** affect the number of primaries when a chronic neoplasm transforms to an acute neoplasm.

       Example: Patient diagnosed in 2000 with follicular lymphoma. Patient refused treatment. Patient returns in 2014 with DLBCL. Abstract the DLBCL as a second primary even though there was no treatment for the follicular lymphoma.

    b. First course of treatment for the chronic neoplasm may or may not be completed when the chronic neoplasm transforms to the acute neoplasm.
3. Acute neoplasm followed by a chronic neoplasm.
    a. The presence/absence of treatment **does** impact the determination of the number of primaries when the acute neoplasm reverts to a chronic neoplasm (see Rules M12 and M13).
    b. The planned first course of therapy may not have been completed when a biopsy/pathologic specimen shows only chronic neoplasm after an initial diagnosis of an acute neoplasm.
    c. The patient may have completed the first course of treatment and have been cancer free (clinically, no evidence of the acute neoplasm) for an interim when diagnosed with the chronic neoplasm.
    d. The patient may not have been cancer free but completed the first course of treatment and biopsy/pathology shows only chronic neoplasm.

Code the treatment on both abstracts when a patient has multiple primaries and the treatment given for one primary also affects/treats the other primary.

Example: Patient is diagnosed in May 2014 with both multiple myeloma (9732/3) and mantle cell lymphoma (9673/3), which are separate primaries per rule M15. The oncologist states she began Velcade chemotherapy for the lymphoma. Velcade would affect both primaries, so it should be coded on both abstracts.

Other Treatment for Hematopoietic Diseases

Record all treatment as described above. The following treatments are coded as "other" in Other Treatment even though they do not "modify, control, or destroy proliferating cancer tissue."

1. Collect **phlebotomy** for polycythemia vera only. Phlebotomy also may be referred to as blood removal, bloodletting or venesection.
2. Do **not** collect **blood transfusions** (whole blood, plasma, etc.) as treatment. Blood transfusions are widely used to treat anemia and it is not possible to collect this procedure in a meaningful way.
3. Collect **blood-thinners** and/or **anti-clotting agents** for essential thrombocythemia (9962/3) only.

Donor Leukocyte Infusions

The use of donor leukocyte infusions for treatment of hematopoietic neoplasms, specifically leukemias, is increasing. **Abstract as immunotherapy when a reportable hematopoietic neoplasm is treated with donor leukocyte infusion**, even if it is not listed in the treatment section of the Heme DB for the specific neoplasm.

Date Therapy Initiated

Date Therapy Initiated *(NAACCR Item #1260) (SEER page 162-164)*

Date of First Course of Treatment *(NAACCR Item #1270) (STORE 2022 page 212-212)*

Description

This is the start date of any type of treatment for this tumor, surgery, chemotherapy, radiation therapy, or other types of treatment. Treatment may be given in a hospital or non-hospital setting.

Rationale

This field is used to measure the delay between diagnosis and onset of treatment. A secondary use is as a starting point for survival statistics. This date cannot be calculated from the respective first course treatment dates if no treatment was given. Therefore, providing information about these instances is important when a physician decides not to treat a patient or the patient, patient's family or guardian declines treatment.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

- Code the **date of admission to the hospital for inpatient or outpatient treatment** when the exact date of the first treatment is unknown.
- Leave blank:
  - When no treatment is given during the first course
  - When Treatment Status is coded 2, Active surveillance (watchful waiting). If you are a CoC facility, follow CoC definition of First Course of Treatment.
  - When it is unknown whether the patient had treatment
  - For Death certificate-only (DCO) cases when the date is unknown and cannot be estimated
  - Autopsy only cases

Note: STORE 2022 (see STORE page 212) instructs for *Date of First Course of Treatment* to record the date when the decision of active surveillance or watchful waiting is selected as the *First Course of Treatment*. TCR will accept STORE 2022 guidelines for this field but will continue to follow SEER guideline for this data item. Facilities following STORE 2022 guidelines will not receive an edit on this data item.

Date of Initial RX Flag

(NAACCR Item #1261) (SEER page 165)

Description

This flag explains why there is no appropriate value in the corresponding date field, Date of Initial RX-SEER (1260).

Rationale

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

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Treatment Status

(NAACCR Item #1285) (STORE 2021 page 220-221; SEER page 159)

Description

This data item is a summary of the status for all treatment modalities. It is used in conjunction with *Date Initial RX SEER* [1260] and/or *Date 1st Crs RX CoC* [1270] and each modality of treatment with their respective date field to document whether treatment was given or not given, whether it is unknown if treatment was given, or whether treatment was given on an unknown date. Also indicates active surveillance (watchful waiting). This data item is effective for January 2010+ diagnoses.

Rationale

This item documents active surveillance (watchful waiting) and eliminates searching each treatment modality to determine whether treatment was given.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Examples

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

Date of First Surgical Procedure

(NAACCR ITEM #1200) (STORE 2022 page 216) (SEER page 167)

Description

The date of the first cancer-directed surgical procedure performed at any facility. Date of First Surgical Procedure is the date the first surgery was performed as part of first course of therapy. This is either the date of the *Surgery of Primary Site*, *Sentinel Lymph Node Biopsy*, *Scope of Regional Lymph Node Surgery* (**excluding cases coded to 1**), or *Surgical Procedure of Other Site,* whichever is earliest.

Rationale

Documents the date of the first cancer-directed surgical procedure. This date may or may not reflect the date of the most definitive surgical procedure.

This item can be used to sequence multiple treatment modalities and to evaluate the time intervals between treatments.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Examples

- A patient was found to have a large polyp during a colonoscopy on January 8, 2022. A polypectomy on that date confirmed adenocarcinoma of the descending colon. **The polypectomy is considered cancer directed surgery, so the date of first surgery should be coded 20220108.**
- Patient is seen for treatment recommendations following a mastectomy in March 2022. The exact day of surgery is unknown. **Code the date of surgery as 202203.**
- A patient had a radical prostatectomy in 2020 and is now seen with bone mets. The month and day of the surgery are unknown. **Code the date of surgery as 2020.**
- An incisional biopsy is performed on March 3, 2022 followed by a resection on March 17, 2022. **Record the date of the resection (20220317) as the date of the first surgical procedure. An incisional biopsy is a diagnostic procedure, not a cancer-directed surgery.**
- February 1, 2022 a patient had a fine needle aspiration of a right breast mass, consistent with infiltrating ductal carcinoma. On February 15, 2022, the patient underwent a right modified radical mastectomy. **The date of surgery would be recorded as 20220215**
- Patient had a lumpectomy as part of first course of treatment for breast cancer in 2022, but the date is unknown. On June 3, 2022 she comes to your facility to begin chemotherapy. **Record the date of surgery as 2022**.

Date of First Surgical Procedure Flag

(NAACCR Data Item #1201) (STORE 2022 page 217) (SEER page 168)

Description

This flag explains why there is no appropriate value in the corresponding date field, *RX Date Surgery*, NAACCR Item 1200.

Rationale

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

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Date of Most Definitive Surgical Resection of the Primary Site

(NAACCR Item #3170) (STORE 2022 page 218) (SEER page 169)

Description

Date of most definitive surgical resection of the primary site performed as part of the first course of treatment.

Rationale

This item is used to measure the lag time between diagnosis and the most definitive surgery of the primary site. This may or may not be the date of *the Date of First Surgical Procedure.* The most definitive surgery is the most extensive resection of the primary site done during the first course of treatment.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Examples

- The patient undergoes an excisional biopsy for right breast cancer on 1/2/2022, then undergoes a right modified radical mastectomy on 1/25/2022**. The *Date of First Surgical Procedure* is 1/2/2022 since this is the date of the first surgery done as first course of treatment. 1/25/2022 is the *Date of Most Definitive Surgical Resection of the Primary Site*, since the right modified mastectomy is more extensive than the excisional biopsy.**
- The patient undergoes a colonoscopy on 2/20/2022 and is found to have a suspicious polyp. A polypectomy is performed and is positive for adenocarcinoma. The patient proceeds to a segmental resection of the colon for margins done on 3/2/2022. The resection shows no residual disease. **The *Date of the First Surgical Procedure* is 2/20/2022. The *Date of Most Definitive Surgical Resection of the Primary Site* is 3/2/2022 even though no cancer is found in the specimen.**

Date of Most Definitive Surgical Resection of the Primary Site Flag

(NAACCR Item #3171) (SEER page 170)

Description

This flag explains why no appropriate value is in the field, *Date of Most Definitive Surgical Resection of the Primary Site.*

Rationale

As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date

information that had previously been transmitted in date fields.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Surgery of Primary Site

(NAACCR Item #1290) (STORE 2022 page 219-220) (SEER pages 171-172)

Description

Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of the primary site that is performed as part of the initial diagnostic and staging work-up or first course of therapy. Code the most definitive surgical procedure of the primary site performed at any facility as part of the first course of treatment. This field is for surgery of primary site only.

Rationale

Identifies the specific cancer-directed surgery of the primary site.

Use the entire operative report as the primary source document to determine the best surgery of primary site code. The body of the operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Use the site-specific coding scheme corresponding to the primary site or histology. **Refer to the Site-specific Surgery Codes in Appendix C of the SEER Manual or Appendix A of the STORE 2022 Manual**.

Note: For ACoS facilities, per STORE 2022 page 221:

> If a needle biopsy precedes an excisional biopsy or more extensive surgery, and upon the excisional biopsy or more extensive surgery the surgical margins are clear (i.e., no tumor remains), do not consider the needle biopsy to be an excisional biopsy. The needle biopsy should be recorded as such in the *Surgical Diagnostic and Staging Procedure at this Facility* [740] data item and the excisional biopsy or more extensive surgery in the *Surgical Procedure of the Primary Site at this Facility* data item [670].

Note: Per SEER page 171

> Code an excisional biopsy, even when documented as incisional, when

- All disease is removed (margins free), OR
- All gross disease is removed and there is only microscopic residual at the margin
- Example: Breast core needle biopsy with diagnosis of infiltrating duct carcinoma; subsequent re-excision with no residual tumor noted. Code as excisional biopsy

Do not code an incisional biopsy as an excisional biopsy when there is **macroscopic** residual disease.

Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins meet the criteria above.

- Example: Shave biopsy performed for a suspicious lesion on the skin of the right arm that has been changing in size and color. The shave biopsy pathology report showed malignant melanoma with only microscopically positive margins. Code the shave biopsy as an excisional biopsy.

Surgical Margins of the Primary Site

(NAACCR Item #1320) (STORE 2022 pages 235-236) (SEER page 173)

Description

Describes the final status of the surgical margins after resection of the primary tumor.

Rationale

This item serves as a quality measure for pathology reports, is used for staging, and may be a prognostic factor in recurrence. It applies to all cases that have a surgical procedure of the primary site.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Scope of Regional Lymph Node Surgery

(NAACCR Item #1292) (STORE 2022 page 237-243) (SEER pages 174-177)

Description

Indicates the removal, biopsy, or aspiration of **regional** lymph nodes at the time of surgery of the primary site or during a separate surgical procedure performed during the initial work-up of first course of therapy.

Rationale

This information is used to compare and evaluate the extent of surgical treatment.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

***Note*:** Use the entire **operative report** as the primary source document to determine whether the operative procedure was a SLNBx, or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The body of the operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. **The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.**

Note: When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. Code this as a SLNBx (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.

Note: Infrequently, a SLNBx is attempted, and the patient fails to map (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. Code these cases as 2 if no further dissection of regional lymph nodes was undertaken, or 6 when regional lymph nodes were dissected during the same operative event.

Examples

- Patient has a sentinel node biopsy of a single lymph node. **Assign code 2 (Sentinel lymph node biopsy [only]).**
- Local excision of breast cancer. Specimen includes an intra-mammary lymph node. **Assign code 4 (1 to 3 regional lymph nodes removed).**
- Patient has excision of a positive cervical node. The pathology report from a subsequent node dissection identifies three cervical nodes. **Assign code 5 (4 or more regional lymph nodes removed).**
- Patient has a Cystoprostatectomy and pelvic lymph node dissection for bladder cancer. Pathology identifies prostate cancer as well as the bladder cancer and 4/21 nodes positive for metastatic adenocarcinoma. **Code Scope of Regional Lymph Node Surgery to 5 (4 or more regional lymph nodes removed) for both primaries.**
- Patient has a radical neck dissection and the number of lymph nodes removed is not stated. **The appropriate code would be 3.**
- The patient has modified radical mastectomy with sentinel lymph node biopsy and axillary lymph node dissection. The final diagnosis is infiltrating ductal carcinoma with 2/12 axillary

lymph nodes positive. **The appropriate code would be 6, sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated.**

- Transverse colon: Adenocarcinoma with extension into subserosa, 3/10 pericolic lymph nodes are positive. **The appropriate code would be 5, four or more regional lymph nodes removed.**

Scope of Regional Lymph Node Surgery at this Facility

(NAACCR Item #672) (STORE 2022 page 243-249)

Description

Identifies the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at this facility.

Rationale

This item can be used to compare and evaluate the extent of surgical treatment.

Coding Instructions

The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.

- If a surgical procedure which aspirates, biopsies, or removes regional lymph nodes to diagnose or stage this cancer, record the scope of regional lymph nodes surgery in this data item. Record the date of this surgical procedure in data item Date of First Course of Treatment [1270] and/or Date of First Surgical Procedure [1200] as appropriate.
- Record the date of this procedure in Date of Sentinel Lymph Node Biopsy [832] and/or Date Regional Lymph Node Dissection [682], if applicable.
- Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
  If two or more surgical procedures of regional lymph nodes are performed, the codes entered in the registry for each subsequent procedure must include the cumulative effect of all preceding procedures. For example, a sentinel lymph node biopsy followed by a regional lymph node dissection at a later time is coded 7. Do not rely on registry software to determine the cumulative code.
- Code 9 for:
  - Any Schema ID with primary site: C420, C421, C423, C424, C700-C709, C710-C729, C751-C753, C761-C768, C770-C779, C809)
  - Lymphoma (excluding CLL/SLL, Schema ID 00790)
  - Lymphoma (CLL/SLL, Schema ID 00795)
  - Plasmacytoma, bone (9731/3)

Do not code distant lymph nodes removed during surgery to the primary site for this data item. They are coded in the data field Surgical Procedure/Other Site [1294].

- Refer to the current AJCC Cancer Staging Manual for site-specific identification of regional lymph nodes.
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item Palliative Care at This Facility [3280].

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

The following instructions should be applied to all surgically treated cases for all types of cancers. It is important to distinguish between sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes.

Table 13.1 Scope of Regional Surgery Codes

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
		Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.	Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), an axillary lymph node dissection (ALND), or a combination of both SLNBx and ALND. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and ALND, or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and an ALND.
0	None	No regional lymph node surgery.	
1	Biopsy or aspiration of regional lymph node(s), NOS	Review the operative report of to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed, and it did not include the use of dye or tracer for a SLNBx procedure (coded 2). If additional procedures were performed on the lymph nodes, use the appropriate code 2-7.	Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report of to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7.

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
2	Sentinel lymph node biopsy (only)	• The operative report states that a SLNBx was performed. • Code 2 SLNBx when the operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination. • When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes are palpably abnormal and selectively removed (or harvested) as part of the SLNBx procedure by the surgeon or may be discovered by the pathologist. Code this as a SLNBx (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.	• If a relatively large number of lymph nodes, more than 5, are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an axillary lymph node dissection (ALND). • Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. Review the operative report to confirm that an axillary incision was made, and a node exploration was conducted. Patients undergoing SLNBx who fail to map will often undergo ALND. Code these cases as 2 if no ALND was performed, or 6 when ALND was performed during the same operative event. Enter the appropriate number of nodes examined and positive in the data items Regional Lymph Nodes Examined [830] and Regional Lymph Nodes Positive [820].

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
Codes 3 – 5 are used for regional lymph node dissection/removal; there do NOT include sentinel lymph node biopsy (SLNBx).			
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	The operative report states that a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure). • Code 3 (Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS). Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a	Generally, ALND removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same procedure (code 6 or 7).
4	1–3 regional lymph nodes removed		

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
5	4 or more regional lymph nodes removed	regional lymph node dissection (code 6 or 7). • Code 4 (1-3 regional lymph nodes removed) should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only. • Code 5 (4 or more regional lymph nodes removed). If a relatively small number of nodes were examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes were examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7). Infrequently, a SNLBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. Code these cases as 2 if no further dissection of regional lymph nodes was undertaken, or 6 when regional lymph nodes were dissected during the same operative event.	

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated	• SNLBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known. • Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only. • Infrequently, a SNLBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection.) When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6.	• SLNBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known. Generally, look for a report to the Operating Room (OR) by the pathologist on the SLNBx results prior to the regional node dissection. If the SLNBx shows positive nodes, then a dissection may be done. If the nodes are negative, it is rare that a node dissection is performed. • Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed.

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
7	Sentinel node biopsy and code 3, 4, or 5 at different times	• SNLBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events. • Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.	• Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only, or whether a SLNBx plus an ALND was performed.
9	Unknown or not applicable	• The status of regional lymph node evaluation should be known for surgically-treated cases (i.e., cases coded 19-90 in the data item *Surgery of Primary Site* [NAACCR Item #1290]). Review surgically treated cases coded 9 in *Scope of Regional Lymph Node Surgery* to confirm the code.	

Date of Sentinel Lymph Node Biopsy

(NAACCR Item #832) (STORE 2022 page 153) (SEER page 178)

Description

Records the date of the sentinel lymph node biopsy procedure. **This data item is required for breast and cutaneous melanoma cases only.**

Rationale

It is a known fact that sentinel lymph node biopsies have been under-reported. Additionally, the timing and results of sentinel lymph node biopsy procedures are used in quality of care measures. This data item can be used to more accurately assess the date of the sentinel lymph node biopsy procedure separate from the date of a subsequent regional node dissection procedure, if performed.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Date of Sentinel Lymph Node Biopsy Flag

(NAACCR Item #833) (SEER page 179)

Description

Explains why there is no appropriate value in the corresponding data item, *Date of Sentinel Lymph Node Biopsy* [NAACCR Item #832**]. This data item is required for breast and cutaneous melanoma cases only.**

Rationale

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

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

This flag may be autogenerated depending on the software in use.

Sentinel Lymph Nodes Positive

(NAACCR Item #835) (STORE 2022 pages 156-157) (SEER page 181)

Description

Records the exact number of sentinel lymph nodes biopsied by the pathologist and found to contain metastases. This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later. **This data item is required for breast and melanoma cases only.**

Rationale

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Sentinel Lymph Nodes Examined

(NAACCR Item #834) (STORE pages 154-155) (SEER page 180)

Description

Records the total number of lymph nodes sampled during the sentinel node biopsy and examined by the pathologist. This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later. **This data item is required for breast and melanoma cases only.**

Rationale

It is a known fact that sentinel lymph node biopsies have been under-reported. Additionally, the timing and results of sentinel lymph node biopsy procedures are used in quality of care measures. This data item can be used to more accurately assess the number of lymph nodes biopsied during the sentinel node biopsy procedure separate from the number of lymph nodes dissected during additional subsequent regional node procedures.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Date of Regional Lymph Node Dissection

(NAACCR Item #682) (STORE 2022 page 158) (SEER page 183)

Description

Records the date non-sentinel regional node dissection was performed. **This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later when available**.

Rationale

It is a known fact that sentinel lymph node biopsies have been under-reported. Additionally, the timing and results of sentinel lymph node biopsy procedures are used in quality of care measures. This data item can be used to more accurately assess the date of regional node dissection separate from the date of sentinel lymph node biopsy if performed.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022. This data item is required for CoC-accredited facilities when available.

Date of Regional Lymph Node Dissection Flag

(NAACCR Item #683) (SEER page 184)

Description

This flag explains why there is no appropriate value in the corresponding date data item, *Date of Regional Lymph Node Dissection* [682]. **This data item is required for CoC-accredited facilities when available.**

Rationale

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

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Regional Lymph Nodes Positive

(NAACCR item # 820) (STORE 2022 page 162-164) (SEER page 185-187)

Description

Records the exact number of regional nodes examined by the pathologist and found to contain metastases. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system. For tumors diagnosed from 1988 through 2003, this item was part of the 10-digit EOD [779], detailed site-specific codes for anatomic EOD.

Rationale

This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Note: When definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual, use the AJCC definition.

Regional lymph nodes only. Record information only about regional lymph nodes in this field. Involved distant lymph nodes should be coded in the M (distant metastasis) field and not counted as positive regional nodes. Include lymph nodes that are regional in the current AJCC Staging Manual or EOD 2018.

Regional Lymph Nodes Examined

(NAACCR Item # 830) (STORE 2022 page 162-163) (SEER page 188-190)

Description

Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with cases diagnosed on or after January 1, 2014, this item became a component of the Collaborative Staging System (CS). In 2016 use of CS was discontinued, however this data item continued to be required.

Rationale

This data item serves as a quality measure of the pathologic and surgical evaluation and treatment of the patient.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Note: When definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual, use the AJCC definition.

Surgical Procedure of Other Site

(NAACCR Item #1294) (STORE 2021 pages 250-251) (SEER page 191-192)

Description

Indicates the surgical removal of other regional site(s), distant site(s), or distant lymph node(s) beyond the primary site. Code the surgical procedure of other sites the patient received, at any facility, as part of the first course of treatment.

Rationale

Documents the extent of surgical treatment and is useful in evaluating the extent of metastatic disease.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Examples

- The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon is **coded to 0**.
- Surgical biopsy of metastatic lesion from liver with an unknown primary is **coded to 1**.
- Surgical ablation of solitary liver metastasis with a hepatic flexure primary is **coded to 2 (Site regional by stage).**
- Excision of distant metastatic lymph nodes with a rectosigmoid primary is **coded to 3**.
- Removal of a solitary brain metastasis with a lung primary is **coded to 4** (site distant by stage).
- Excision of a solitary liver metastasis and hilar lymph node with a rectosigmoid primary is **coded to 5.**

Surgical Procedure/Other Site at this Facility

(NAACCR Item #674) (STORE 2022 page 252-253)

Description

Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site at this facility.

Rationale

The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Coding Instructions

- If other tissue or organs are removed during primary site surgery that are not specifically defined by the site-specific Surgical Procedure of the Primary Site [1290 or 670] code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- Assign the highest numbered code that describes the surgical resection of distant lymph node(s).
- Incidental removal of tissue or organs is not a "Surgical Procedure/Other Site."
- If multiple first course surgical procedures coded in this item are performed for a single primary, the code should represent the cumulative effect of those surgeries. Do not rely on registry software to perform this task for you.
- Surgical Procedure/Other Site is collected for each surgical event even if surgery of the primary site was not performed.
- Code 1 for:
    - Any case coded to primary site C420, C421, C423, C424 C760-C768, C770-C779, C809 Excluding cases coded to the Cervical Lymph Nodes and Unknown Primary 00060
    - When the involved contralateral breast is removed for a single primary breast cancer. Note: See also notes and codes in Appendix A, Breast surgery codes.
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item Palliative Care at This Facility [3280].

Reason for No Surgery of Primary Site

(NAACCR Item #1340) (STORE 2022 page 257-258) (SEER pages 193-195)

Description

Records the reason that no surgery was performed on the primary site. This field applies only to surgery of primary site. This data item records the reason that surgery of the **primary site** was not part of the first course of treatment.

Rationale

This data item provides information related to quality of care.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Examples

- A patient with primary tumor of the liver is not recommended for surgery due to advanced cirrhosis. **The reason for no primary site surgery is 2, not recommended due to comorbid conditions.**
- A patient is referred to another facility for recommended surgical resection of a non-small cell lung carcinoma. There is no further information from the facility to which the patient was referred. **The reason for no surgery of primary site is 8, recommended but unknown if performed.**

RX Text Surgery

(NAACCR Item #2610)

Description

Text area for information describing all surgical procedures performed as part of treatment.

Rationale

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information must be provided by all facilities.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Document all first course surgery regardless of where it was done, in chronological order.
5. Document date of each procedure.
6. Document name of facility where each procedure was performed.
7. Document type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites
8. If information is missing, state that it is missing.
9. Do not to enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.
10. Document Covid-19 information if available.
    a. Surgery delays or modifications due to COVID-19
    b. Examples
        i. SURG TX delayed D/T COVID-19

ii. SURG TX delayed D/T COVID-19 & given as subsequent TX after progression
iii. SURG TX delayed & CHG D/T COVID-19
iv. SURG TX CHG D/T COVID-19

11. SURG TX DC D/T COVID-19Refer to 2022 NAACCR Data Dictionary for list of data items to be verified by the text fields.

Note: See the Documentation of Cancer Diagnosis, Extent of Disease, And Treatment for further explanation and examples. Do not enter text in this fields when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

Date Radiation Started

(NAACCR Item #1210) (STORE 2022 page 260) (SEER page 196)

Description

The date the radiation therapy began at any facility as part of the first course of treatment.

Rationale

The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first course therapy and to reconstruct the sequence of first course treatment modes.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Note: If radiation therapy is given do not leave this field blank. If the date is not known record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the date of radiation therapy is unknown.

Date Radiation Started Flag

(NAACCR Item #1211) (SEER page 197)

Description

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

Rationale

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

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Note: If radiation was administered do not leave the date blank. **If the start date is not known, record the year of diagnosis as the start date and leave the month and day blank.** Document in the text field that the date of radiation treatment is unknown.

Radiation Primary Treatment Volume-Phase I, II, III

(NAACCR # 1504, 1514, 1524) (STORE 2022 pages 263-268)

Description

Identifies the primary treatment volume or primary anatomic target treated during phase I-II-III of radiation therapy during the first course of treatment.

Rationale

This data items provides information describing the anatomical structure targeted by radiation therapy during the phases of radiation treatment and can be used to determine whether the site of the primary disease was treated with radiation or if other regional or distant sites were targeted. This information is useful in evaluating the patterns of care within a facility and on a regional or national basis.

Coding Instructions

1. Phase I [1504] data item should be used to indicate the primary target volume, which is typically the primary tumor or tumor bed. If the primary tumor or primary tumor bed was not targeted, record the other regional or distant site that was targeted.
2. Phase II-III of radiation treatment also commonly includes draining lymph node regions that are associated with the primary tumor or tumor bed. The draining lymph nodes are recorded in the Phase II Radiation to Draining Lymph Nodes [1515, 1525].
3. Subsequent phase may be referred to as a boost or cone down and would be recorded in fields with subsequent phases recorded as Phase II [1514], Phase III [1524], etc. accordingly. If one or more discrete volumes are treated and one of those includes the primary site, record the Phase II -III treatment to the primary site in this data item.
4. Draining lymph nodes may also be concurrently targeted during the first phase. Whether draining lymph nodes were targeted, and which ones were targeted will be identified in a separate data item Phase I-II-III Radiation to Draining Lymph Nodes [1505, 1515, 1525].
5. When the primary volume is lymph nodes, draining lymph nodes are not targeted. Record code 88in the Phase I-II-III Radiation to Draining Lymph Nodes[1505, 1515, 1525]. Use codes 01 to 09 only when the lymph nodes are the primary target, for example, in lymphomas.
6. Note that for many of the treatment volumes, the same code should be used when the anatomic structure is targeted or when the surgical bed of the resected anatomical structure is targeted. For example, when prostate cancer is treated with radiation alone, code 64 will be the Primary

Treatment Volume. Similarly, when prostate cancer is treated with radiation after radical prostatectomy, code 64 will be the Primary Treatment Volume. There is an exception to the rule for breast cancer. In patients with breast cancer, code 41 (Breast- partial) in patients who have had a lumpectomy and were treated with partial breast irradiation (sometimes called accelerated partial breast irradiation (APBI)), code 40 (Breast – whole) in patients who had a lumpectomy and whole breast radiation, and code 42 (chest wall) in patients who had a mastectomy and post-mastectomy radiation.

7. A new paradigm of treatment called on-line adaptive (or on-table) adaptive radiation may be a source of confusion when coding the Primary Treatment Volume. New linear accelerators may now be attached to such high-quality imaging devices that they can function as both simulation scanners for planning and radiation delivery systems. If a new radiation plan is created while the patient is on the radiation delivery table to take into account that day's anatomy, this is referred to "on-line" (or "on-table") adaptive radiation. If a new radiation plan is created while the patient is not on the delivery table, then it is referred to as "off-line" (or "off-table") adaptive therapy. Off-line adaptive therapy treatments are relatively common, but MR-guided and CT-guided on-line adaptive therapy treatments are just emerging. In adaptive therapy, new radiation plans are created to account for changes in the position or shape of a target volume, but this does NOT mean that there has been a change in "phase". When the adaptive therapy paradigm is being used, a new phase should be documented only when there has been a change in the conceptual anatomic target volume (for example, a change from whole prostate to partial prostate) or if there has been a change in the draining lymph node target, dose per fraction, modality or planning technique.
8. Code 00 if the tumor was diagnosed at autopsy.
9. If the patient received just one phase of treatment, code the phase II Radiation Treatment Volume to "00" (No treatment). All other phase II and phase III data fields should be left blank.
10. If the patient received just two phases of treatment, code the phase III Radiation Treatment Volume to "00" and leave all other phase III data fields blank.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	Neck lymph node regions	The primary treatment is directed at lymph node regions of the neck. Example situations include treatment of lymphoma or lymph node recurrence (in the absence of primary site failure) following definitive surgery of the primary tumor. If radiation to the neck lymph nodes includes the supraclavicular region use code 03.
02	Thoracic lymph node regions	Radiation therapy is directed to some combination of hilar, mediastinal, and supraclavicular lymph nodes without

		concurrent treatment of a visceral organ site. Example situations include mantle or mini-mantle for lymphomas, and treatment of lymphatic recurrence after complete surgical excision of a thoracic primary. Note that the supraclavicular region may be part of a head and neck lymph node region. Use code 03 for treatments directed at neck nodes and supraclavicular nodes with a head and neck primary. Use code 04 if supraclavicular lymph nodes are part of breast treatment.
03	Neck and thoracic lymph node regions	Treatment is directed to lymph nodes in the neck and thoracic region without concurrent treatment of a primary visceral tumor. This code might apply to some mantle or mini-mantle fields used in lymphoma treatments or some treatments for lymphatic recurrences following definitive treatment for tumors of the head and neck or thoracic regions.
04	Breast/ Chest wall lymph node regions	Radiation is directed primarily to some combination of axillary, supraclavicular, and/or internal mammary lymph node sites WITHOUT concurrent treatment of the breast or chest wall. If the breast AND lymph nodes are being treated, then code the Primary Treatment Volume to Breast (codes 40 or 41) and Breast/chest wall lymph nodes (code 04) in Radiation to Draining Lymph Nodes.
05	Abdominal lymph nodes	Treatment is directed to some combination of the lymph nodes of the abdomen, including retro-crural, peri-gastric, peri-hepatic, portocaval and para-aortic nodes. Possible situations might include seminoma, lymphoma or lymph node recurrence following surgical resection of the prostate, bladder or uterus.
06	Pelvic lymph nodes	Treatment is directed to some combination of the lymph nodes of the pelvis, including the common, internal and external iliac, obturator, inguinal and peri-rectal lymph nodes. This might be done for lymphoma or

		lymph node recurrence following definitive surgery for a pelvic organ
07	Abdominal and pelvic lymph nodes	Treatment is directed to a combination of lymph nodes in both the abdomen and pelvis. This code includes extended fields ("hockey stick", "dog-leg", "inverted Y", etc.) utilized to treat seminomas and lymphomas or recurrence of a solid tumor.
09	Lymph node region, NOS	This category should be used to code treatments directed at lymph node regions that are not adequately described by codes 01-07.
10	Eye/orbit/optic nerve	Treatment is directed at all or a portion of the eye, orbit and/or optic nerve.
11	Pituitary	Treatment is directed at the pituitary gland.
12	Brain	Treatment is directed at all the brain and its meninges ("Whole brain").
13	Brain (limited)	Treatment is directed at one or more sub-sites of the brain but not the whole brain. Chart may describe "SRS", "Stereotactic Radiosurgery", "Gamma Knife®".
14	Spinal Cord	Treatment is directed at all or a portion of the spinal cord or its meninges
20	Nasopharynx	Treatment is directed at all or a portion of the nasopharynx.
21	Oral Cavity	Treatment is directed at all or a portion of the oral cavity, including the lips, gingiva, alveolus, buccal mucosa, retromolar trigone, hard palate, floor of mouth and oral tongue.
22	Oropharynx	Treatment is directed at all or a portion of the oropharynx, including the soft palate, tonsils, base of tongue and pharyngeal wall.
23	Larynx (glottis) or hypopharynx	Treatment is directed at all or a portion of the larynx and/or hypopharynx.

24	Sinuses/Nasal tract	Treatment is directed at all or a portion of the sinuses and nasal tract, including the frontal, ethmoid, sphenoid and maxillary sinuses.
25	Parotid or other salivary glands	Treatment is directed at the parotid or other salivary glands, including the submandibular, sublingual and minor salivary glands.
26	Thyroid	Treatment is directed at all or a portion of the thyroid. Code 98 when the thyroid is treated with I-131 radioisotope.
29	Head and neck (NOS)	The treatment volume is directed at a primary tumor of the head and neck, but the primary sub-site is not a head and neck organ identified by codes 20-26 or it is an "unknown primary".
30	Lung or bronchus	Treatment is directed at all or a portion of the lung or bronchus
31	Mesothelium	Treatment is directed to all or a portion of the mesothelium. This code should be used for mesothelioma primaries, even if a portion of the lung is included in the radiation field.
32	Thymus	Treatment is directed to all or a portion of the thymus.
39	Chest/lung (NOS)	The treatment is directed at a primary tumor of the chest, but the primary sub-site is unknown or not identified in codes 30-32. For example, this code should be used for sarcomas arising from the mediastinum.
40	Breast – whole	Treatment is directed at all the intact breast. Intact breast includes breast tissue that either was not surgically treated or received a lumpectomy or partial mastectomy
41	Breast – partial	Treatment is directed at a portion of the intact breast but not the whole breast. The chart may have terms such as "Mammosite", "interstitial (seed) implant)", or "(accelerated) partial breast irradiation". Consider the possibility of

		partial breast irradiation when "IMRT" is documented in the record.
42	Chest wall	Treatment encompasses the chest wall (following mastectomy).
50	Esophagus	Treatment is directed at all or a portion of the esophagus. Include tumors of the gastro-esophageal junction.
51	Stomach	Treatment is directed at all or a portion of the stomach.
52	Small bowel	Treatment is directed at all or a portion of the small bowel.
53	Colon	Treatment is directed at all or a portion of the colon.
54	Rectum	Treatment is directed at all or a portion of the rectum.
55	Anus	Treatment is directed at all or a portion of the anus
56	Liver	Treatment is directed at all or a portion of the liver.
57	Biliary tree or gallbladder	Treatment is directed at all or a portion of the biliary tree or gallbladder
58	Pancreas or hepatopancreatic ampulla	Treatment is directed at all or a portion of the pancreas or the hepatopancreatic ampulla. Hepatopancreatic ampulla tumors are sometimes referred to as periampullary tumors.
59	Abdomen (NOS)	The treatment volume is directed at a primary tumor of the abdomen, but the primary sub-site is not an abdominal organ defined by codes 50-58 or it is considered to be an "unknown primary". For example, this code should be used for sarcomas arising from the abdominal retroperitoneum

60	Bladder – whole	Treatment is directed at all the bladder
61	Bladder – partial	Treatment is directed at a portion of the bladder but not the whole bladder.
62	Kidney	Treatment is directed at all or a portion of the kidney.
63	Ureter	Treatment is directed at all or a portion of the ureter
64	Prostate – whole	Treatment is directed at all the prostate with/without seminal vesicles. Use this code even if seminal vesicles are not explicitly targeted.
65	Prostate – partial	Treatment is directed at a portion of the prostate but not the whole prostate.
66	Urethra	Treatment is directed at all or a portion of the urethra.
67	Penis	Treatment is directed at all or a portion of the penis. Treatments of urethral primaries should be coded as ‘urethra’ (code 66).
68	Testicle or scrotum	Treatment is directed at all or a portion of the testicle and/or scrotum
70	Ovaries or fallopian tubes	Treatment is directed at all or a portion of the ovaries or fallopian tubes
71	Uterus or Cervi	Treatment is directed at all or a portion of the uterus, endometrium or cervix
72	Vagina	Treatment is directed at all or a portion of the vagina. Treatments of urethral primaries should be coded as ‘urethra’ (code 66).
73	Vulva	Treatment is directed at all or a portion of the vulva. Treatments of urethral primaries should be coded as ‘urethra’ (code 66).

80	Skull	Treatment is directed at all or a portion of the bones of the skull. Any brain irradiation is a secondary consequence.
81	Spine/vertebral bodies	Treatment is directed at all or a portion of the bones of the spine/vertebral bodies, including the sacrum. Spinal cord malignancies should be coded using 'spinal cord' (code 14).
82	Shoulder	Treatment is directed to all or a portion of the proximal humerus, scapula, clavicle, or other components of the shoulder complex.
83	Ribs	Treatment is directed at all or a portion of one or more ribs.
84	Hip	Treatment is directed at all or a portion of the proximal femur or acetabulum.
85	Pelvic bones	Treatment is directed at all or a portion of the bones of the pelvis other than the hip or sacrum.
86	Pelvis (NOS, non-visceral)	The treatment volume is directed at a primary tumor of the pelvis, but the primary sub-site is not a pelvic organ or is not known or indicated. For example, this code should be used for sarcomas arising from the pelvis.
88	Extremity bone, NOS	Treatment is directed at all or a portion of the bones of the arms or legs. This excludes the proximal femur (Hip, code 84). This excludes the proximal humerus (Shoulder, code 82).
90	Skin	Treatment is directed at all or a portion of the skin. The primary malignancy originates in the skin and the skin is the primary target. So called skin metastases are usually subcutaneous and should be coded as a soft tissue site.
91	Soft tissue	This category should be used to code primary or metastatic soft tissue malignancies not fitting other categories.

92	Hemibody	A single treatment volume encompassing either all structures above the diaphragm, or all structures below the diaphragm. This is almost always administered for palliation of widespread bone metastasis in patients with prostate or breast cancer.
93	Whole body	Treatment is directed to the entire body included in a single treatment.
94	Mantle, mini-mantle (obsolete after 2017)	For conversion of historical data only
95	Lower extended field (obsolete after 2017)	For conversion of historical data only
96	Inverted Y (obsolete after 2017)	For conversion of historical data only
97	Invalid historical FORDS value	Conversion to new STORE data item could not take place due to an invalid FORDS Volume code
98	Other	Radiation therapy administered; treatment volume other than those previously categorized by codes 01-93.
99	Unknown	This category should be used to code treatments for which there is no information available about the treatment volume, or it is unknown if radiation treatment was administered.

Examples

- An elderly man with mild fatigue is found to have an elevated lymphocyte count on CBC. Bone marrow biopsy in your facility confirms a diagnosis of chronic lymphocytic leukemia. Physician and patient agree that no treatment is indicated at this time. Record Phase I Radiation Primary Treatment Volume as 00 (No radiation treatment).
- A man with a history of prostate cancer and prior radical prostatectomy is treated with SBRT to 3500cGy in five fractions to a recurrent tumor in a remnant right seminal vesicle. Record Phase I Radiation Primary Treatment Volume as 98 because there is no specific code for seminal vesicles.
- A woman with advanced multiple myeloma is referred for total body irradiation and is treated twice daily for three consecutive days in a total body stand at extended distance with open rectangular photon fields, 200cGy to mid-body per treatment. Record Phase I Radiation Primary Treatment Volume as 93 (Whole body).

Radiation to Draining Lymph Nodes Phase I, II, III

(NAACCR # 1505, 1515, 1525) (STORE 2022 pages 269-270)

Description

Identifies the draining lymph nodes treated (if any) during the phase I-II-III of radiation therapy delivered to the patient during the first course of treatment.

Rationale

The first phase of radiation treatment commonly targets both the primary tumor (or tumor bed) and draining lymph nodes as a secondary site. This data item should be used to indicate the draining regional lymph nodes, if any, that were irradiated during the first phase of radiation to the primary site. The second and third phase of radiation treatment commonly targets both the primary tumor (or tumor bed) and draining lymph nodes as a secondary site. This data item should be used to indicate the draining regional lymph nodes, if any, that were irradiated during the second and third phase of radiation to the primary site.

Coding Instructions

1. When the primary volume is lymph nodes, draining lymph nodes are not targeted. Record code 88in the Phase I-II-III Radiation to Draining Lymph Nodes [1505,1515,1525]. Use codes 01 to 09 only when the lymph nodes are the primary target, for example, in lymphomas.
2. Code 00 if the tumor was diagnosed at autopsy for all Phases Radiation to Draining Lymph Nodes.
3. Phase I data item, in conjunction with Phase I Radiation Primary Treatment Volume [1504], replaces the Radiation Treatment Volume [1540] and includes converted historical values. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.
4. Phase II and III radiation treatment includes primary tumor or tumor bed in addition to the draining lymph node regions that are associated with the primary tumor or tumor bed. The primary tumor or tumor bed is recorded in the Phase II-III Radiation Primary Treatment Volume [1514, 1524].
5. Note: When the Phase II Primary Treatment Volume is lymph nodes, draining lymph nodes are not targeted. Record code 88 in this data item.
6. Blanks allowed only for Phase II or III if no radiation treatment administered.

Code	Label
00	No radiation treatment to draining lymph nodes. Diagnosed at autopsy.
01	Neck lymph node regions
02	Thoracic lymph node regions

03	Neck and thoracic lymph node regions
04	Breast/chest wall lymph node regions
05	Abdominal lymph nodes
06	Pelvic lymph nodes
07	Abdominal and pelvic lymph nodes
08	Lymph node region, NOS
88	Not applicable; Radiation Primary Treatment Volume is lymph nodes
99	Unknown if any radiation treatment to draining lymph nodes; Unknown if radiation treatment administered

Examples

- A patient with breast cancer was treated with whole breast RT, 5040 cGy in 28 fractions. Axillary and supraclavicular (SC) nodes treated concurrently with an anterior field covering both regions and a posterior field (PAB) added to the axilla. The medial portion of the anterior field was blocked for the last three treatments to hold the SC region to a maximum of 4500cGy to minimize the risk of brachial plexus injury. Subsequently, the surgical bed received an electron boost of 1000cGy in 5 fractions using fields shaped to surround surgical bed with 1.5 cm margins. Record the Phase I Radiation to Draining Lymph Nodes as 04 (Breast/Chest wall lymph node regions).
- A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region. Record the Phase I Radiation to Draining Lymph Nodes as 88 because Phase I Radiation Primary Treatment Volume is lymph nodes.
- Prostate cancer patient declines surgery for management of his prostate cancer, and opts for EBRT. The treatment summary states that pelvis/prostate were targeted on phase 1 with 180 cGy X 25 fx= 45 Gy. Record Phase I Radiation to Draining Lymph Nodes as 06 because when the pelvis is specifically mentioned in the treatment summary, we can assume that regional lymph nodes were targeted.

Radiation Treatment Modality--Phase I, II, III

(NAACCR Item #1506, 1516, 1526) (STORE 2022 pages 271-272) (SEER pages 198)

Description

Identifies the radiation modality administered during phase I, II, III of radiation treatment delivered as part of the first course of treatment.

Rationale

Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities. This data item should be used to indicate the radiation modality administered during phase I, II, III of radiation.

Definitions

Chemoembolization: A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.

Radioembolization: Tumor embolization combined with injecting small radioactive beads or coils into an organ or tumor.

Tumor embolization: The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

- Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into Phases and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.

- The first phase may be commonly referred to as an initial plan and subsequent phase may be referred to as a boost or code down, and would be recorded as Phase II, Phase III, etc. accordingly. TCR does not collect Phase II or III.

- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (I.e., dose given during a session), modality or treatment technique. Any one of these changes will mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.

Coding Instructions

Refer to the current Standards for Oncology Registry Entry (STORE) Manual and the CTR Guide to Coding Radiation Therapy Treatment in the STORE

1. Radiation treatment modality will typically be found in the radiation oncologist's treatment summary for the first course of treatment. Segregation of treatment components into Phases and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
2. For purposes of this data item, photons, x-rays and gamma-rays are equivalent.
3. Use code 13 - Radioisotopes, NOS for radioembolization procedures, e.g., intravascular Yttrium-90 for cases diagnosed January 1, 2018 or later. For cases diagnosed prior January 1, 2018, use code 07- Brachytherapy, NOS.
4. This data item intentionally does not include reference to various MV energies because this is not a clinically important aspect of technique. A change in MV energy (e.g., 6MV to 12MV) is

not clinically relevant and does not represent a change in treatment technique. It is rare for change in MV energy to occur during any phase of radiation therapy.

5. If this data item is coded to any of the External beam codes (01-06 or 12), the planning technique must be recorded in the data item Phase I-II-III External Beam Radiation Planning Technique [1502, 1512, 1522].
6. If Radiation Treatment Modality is coded to any of the Brachytherapy or Radioisotopes codes (07-16) the code of 88 must be recorded in the data item Phase I-II-III External Beam Radiation Planning Technique [1502, 1512, 1522].
7. Note: Do not confuse a radioiodine scan with treatment. Only treatment is recorded in this item. STORE 2022 Phase I-II-III Radiation Treatment Modality
8. This data item, in conjunction with Phase I-II Radiation External Beam Planning Technique [1502, 1512], replaces the Rad--Regional RX Modality [1570], Rad--Boost RX Modality [3200] and includes converted historical values. Conversion took place upon upgrade to NAACCR v18-compliantsoftware; as of 2018 this data item is required for all cases regardless of diagnosis year.
9. Phase I must be coded however blanks allowed for Phase II-III if no treatment administered.

Table 13.2 Radiation Treatment Modality Phase I, II, III Codes

Code	Description
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-232
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
98	Radiation therapy administered, but treatment modality is not specified or unknown
99	Unknown if radiation treatment administered

Examples

- A patient with follicular carcinoma of the thyroid is treated with post-operative injection of radioiodine (I-131) for a total dose of 150 millicuries. **Record Phase I Radiation Treatment Modality as 13 (Radioisotopes, NOS).**
- A woman with multiple myeloma is treated using locally opposed conformal 15Mv photons to a total dose of 2000cGy in 5 fractions. **Record Phase I Radiation Treatment Modality as 13 (External beam, photons).**

Radiation External Beam Planning Technique-Phase I, II, III

(NAACCR Item #1502, 1512, 1522) (STORE 2022 pages 273-276) (SEER pages 199-201)

Description

Identifies the external beam radiation planning technique used to administer the first phase of radiation treatment during the first course of treatment. **This data item is required for CoC-accredited facilities when available.**

Rationale

External beam radiation is the most commonly-used radiation modality in North America. In this data item we specified the planning technique for external beam treatment. Identifying the radiation technique is of interest for patterns of care and comparative effectiveness studies.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022. This data item is required for CoC-accredited facilities when available.

Refer to the current Standards for Oncology Registry Entry (STORE) Manual and the CTR Guide to Coding Radiation Therapy Treatment in the STORE

Note: Blanks allowed if no Phase II, II radiation treatment administered.

Examples

- A man with prostate cancer is initially treated with whole pelvis RT using a four-field approach, all fields shaped conformally to pelvic anatomy. He then was treated with an IMRT boost. **Record the Phase I External Beam Radiation Planning Technique as 04 (Conformal or 3-D conformal therapy).**
- A woman with advanced multiple myeloma is referred for total body irradiation and is treated twice daily for three consecutive days in a total body stand at extended distance with open rectangular photon fields, 200cGy to mid-body per treatment. **Record the Phase I External Beam Radiation Planning Technique as 03 (2-D therapy).**

- **Record 88** as the Phase I External Beam Radiation Planning Technique for any phase uses radioisotopes or brachytherapy (e.g. I-131 radioiodine for thyroid cancer, brachytherapy for prostate cancer).

Number of Fractions-Phase I, II, III

(NAACCR # 1503, 1513, 1523) (STORE 2022 pages 279-280)

Description

Records the total number of fractions (treatment sessions) delivered to the patient in the first phase of radiation during the first course of treatment.

Rationale

Radiation therapy is delivered in one or more phases with each phase spread out over a number of fractions (treatment sessions). It is necessary to capture information describing the number of fraction(s) to evaluate patterns of radiation oncology care.

Coding Instructions

1. Although a fraction or treatment session may include several treatment beam positions delivered within a relatively confined period of time-usually a few minutes to a few hours-it is still considered one session. However, multiple fractions may be delivered in a single day. This may be documented as BID treatment or twice daily treatment. Usually multiple fractions in a single day are separated by at least 4 hours.
2. Count each separate administration of brachytherapy or implant as a single fraction or treatment.
3. Record the actual number of fractions delivered (NOT initially prescribed), as documented in the treatment summary.
4. Code 999 for Death Certificate Only (DCO) cases.
5. Phase I must be coded however blanks allowed for Phase II-III if no radiation treatment administered.

Code	Label
000	No radiation treatment
001-998	Number of fractions administered to the patient
999	Radiation therapy was administered, but the number of fractions is unknown; it is unknown whether radiation therapy was administered

Examples

- A patient with breast carcinoma had treatment sessions in which treatment was delivered to the chest wall and encompassing the ipsilateral supraclavicular region for a total of three fraction portals. Twenty-five treatment sessions were given. Record 25 fractions as 025.
- A patient with advanced head and neck cancer was treated using "hyperfractionation." Three fields were delivered in each session; two sessions were given each day, six hours apart, with each session delivering a total dose of 150 cGy. Treatment was given for a total of 25 days. The total course dose was 7500cGy. Record 50 fractions as 050.
- The patient was given Mammosite® brachytherapy, repeated in 10 separate sessions. Record 10 fractions as 010.
- Prostate cancer patient treated with a single administration of seeds. Record 1 fraction as 001.

Dose per Fraction-Phase I, II, III

(NAACCR Item #1501, 1511, 1521) (STORE 2022 pages 277-278)

Description

Records the dose per fraction (treatment session) delivered to the patient in the first phase of radiation during the first course of treatment. The unit of measure is centi-Gray (cGy).

Rationale

Radiation therapy is delivered in one or more phases with identified dose per fraction. It is necessary to capture information describing the dose per fraction to evaluate patterns of radiation oncology care.

Coding Instructions

1. In general, (Phase Dose per Fraction x Phase Number of Fractions = Phase Total Dose). But, there may be inconsistencies in rounding of dose or the way the dose is automatically measured in a treatment which will result in slight inconsistencies in the math. That is, in some radiation treatment summaries, Phase Dose per Fraction x Phase Number of Fractions ≈ Phase Total Dose.
2. For proton treatment, dosage may occasionally be specified as in CGe units (Cobalt Gray Equivalent) rather than Gy or cGy. 1 CGE = 1 Gy = 100 cGy. For a Phase Total Dose, you would need to multiply dose in CGE by 100 to get dose in cGy.).
3. Note that dose is still occasionally specified in "rads". 1 rad = 1cGy.
4. If dose is documented in the medical record includes a fraction of a cGy (e.g. 180.3), round to the nearest cGy. For example, 180.5 cGy should be rounded up to 181 cGy and 180.4 cGy should be rounded down to 180cGy.
5. Code 99998 when radioisotopes were administered to the patient (codes 13-16) for Phase I -I-III Radiation Treatment Modality [1506, 1516, 1526].
6. Code the actual cGy if available when brachytherapy was administered to the patient (codes 07-12 for Phase I-II-III Treatment Modality [1506, 1516, 1526]). If the dose is not available/provided in cGy for a brachytherapy procedure, code 99999.
7. Record the actual dose delivered (NOT the initially prescribed dose) as documented in the treatment summary.

Code	Label
00000	No radiation treatment
00001-99997	Record the actual Phase dose delivered in cGy
99998	Not applicable, radioisotopes administered to the patient
99999	Regional radiation therapy was administered but dose is unknown; Unknown whether radiation therapy was administered; Death Certificate only

Examples

- A patient with Stage III prostate carcinoma received pelvic irradiation to 5,000 cGy over 25 fractions followed by a Phase II (boost) prostate irradiation to 7,000 cGy. Record the Phase I dose per fraction as 00200 (5000/25).
- A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region over 40 fractions. The dose is calculated at the prescribed depth of 3cm. A secondary calculation shows a Dmax dose of 6,450 cGy. Record the Phase I dose per fraction as 00150 (6000/40).
- A patient with breast cancer was treated with whole breast RT, 5040 cGy in 28 fractions, but axillary and supraclavicular (SC) nodes treated concurrently with an anterior field covering both regions and a posterior field (PAB) added to the axilla. The medial portion of the anterior field was blocked for the last three treatments to hold the SC region to a maximum of 4500cGy to minimize the risk of brachial plexus injury. Subsequently, the surgical bed received an electron boost of 1000cGy in 5 fractions using fields shaped to surround surgical bed with 1.5 cm margins. Record phase I dose per fraction as 00180 (4500/25). See a detailed discussion of this example in the “CTR Guide to Coding Radiation Therapy Treatment in the STORE”

Total Dose Phase I, II, III

(NAACCR # 1507, 1517, 1527) (STORE 2022 pages 281-282)

Description

Identifies the total radiation dose delivered to the patient during phase I-II-III of radiation treatment during the first course of treatment. Each phase is meant to reflect the delivered radiation prescription. The unit of dose is centi-Gray (cGy).

Rationale

To evaluate the patterns of radiation care, it is necessary to capture information describing the prescribed dose of Phase I-II-III radiation to the patient during the first course of treatment.

Coding Instructions

1. Record the actual total dose delivered (NOT initially prescribed), as documented in the radiation treatment summary. The value recorded for this data item should NOT be auto-calculated within the registry abstraction software. In general, (Phase Dose per Fraction x Phase Number of Fractions = Phase Total Dose). But, there may be inconsistencies in rounding of dose or the way the dose is automatically measured in a treatment which will result in slight inconsistencies in the math. That is, in some radiation treatment summaries, Phase Dose per Fraction x Phase Number of Fractions ≈ Phase Total Dose.
2. For proton treatment, dosage may occasionally be specified as in CGe units (Cobalt Gray Equivalent) rather than Gy or cGy. 1 CGE = 1 Gy = 100 cGy. For a Phase Total Dose, you would need to multiply dose in CGE by 100 to get dose in cGy.).
3. Note that dose is still occasionally specified in "rads". 1 rad = 1cGy
4. If dose is documented in the medical record includes a fraction of a cGy (e.g. 180.3), round to the nearest cGy. For example, 180.5 cGy should be rounded up to 181 cGy and 180.4 cGy should be rounded down to 180cGy. A dose of Code 99998 when radioisotopes were administered to the patient (codes 13-16 for Phase I-II-III Treatment Modality [1506, 1516, 1526]).
5. Code 000000, radiation therapy not administered, when diagnosed at autopsy.
6. Code 999998 when radioisotopes are administered to the patient (codes 13-16 recorded in the Phase I-II-III Treatment Modality [1506, 1516, 1526]).
7. Code the actual cGy if available when brachytherapy was administered to the patient (codes 07-12 for Phase I-II-III Treatment Modality [1506, 1516, 1526]). If only one fraction of brachytherapy was delivered, then then the Phase I Dose per Fraction and the Phase I Total Dose will be the same.
8. Code 999999 for Death Certificate Only (DCO) cases.
9. Phase I must be coded however blanks are allowed for Phase II-III if no radiation treatment was administered.

Code	Label
000000	No radiation treatment. Diagnosed at autopsy.
000001-999997	Record the actual total dose delivered in cGy.
999998	Not applicable, radioisotopes administered to the patient
999999	Regional radiation therapy was administered but total dose is unknown; Unknown whether radiation therapy was administered; Death Certificate only

Examples

- A patient with Stage III prostate carcinoma received pelvic irradiation of 5,000 cGy in 25 fractions during Phase I Radiation Treatment. Record the Phase I Total Dose of 5,000 cGy as 005000.

- A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region. Record the Phase I Total Dose of 6,000 cGy as 006000.
- A patient with breast cancer was treated with whole breast RT, 5040 cGy in 28 fractions, but axillary and supraclavicular (SC) nodes treated concurrently with an anterior field covering both regions and a posterior field (PAB) added to the axilla. The medial portion of the anterior field was blocked for the last three treatments to hold the SC region to a maximum of 4500cGy to minimize the risk of brachial plexus injury. Subsequently, the surgical bed received an electron boost of 1000cGy in 5 fractions using fields shaped to surround surgical bed with 1.5 cm margins. Record the Phase I Total Dose of 4500 cGy as 004500. See a detailed discussion of this example in the "CTR Guide to Coding Radiation Therapy Treatment in the STORE".

Radiation Treatment Discontinued Early

(NAACCR # 1531) (STORE 2022 pages 284-285)

Description

This field is used to identify patients/tumors whose radiation treatment course was discontinued earlier than initially planned. That is, the patients/tumors received fewer treatment fractions (sessions) than originally intended by the treating physician.

Rationale

Currently, the total dose of radiation reflects what was actually delivered rather than what was intended. When a patient does not complete a radiation course as initially intended this is typically commented on within the radiation treatment summary. By flagging these patients within the cancer registry database, these patients can be excluded from analyses attempting to describe adherence to radiation treatment guidelines or patterns of care analyses.

Coding Instructions

1. Use code 01 when there is no indication in the record that radiation therapy was discontinued or completed early.
2. Use code 02-07 when there is an indication in the record that the radiation therapy discontinued or was completed early
3. Use code 99 when radiation therapy was administered, but it is not clear if the treatment course was discontinued early, or if it is unknown whether radiation therapy was administered, or it is a death certificate only case.

Code	Label
00	No radiation treatment
01	Radiation treatment completed as prescribed

02	Radiation treatment discontinued early-toxicity
03	Radiation treatment discontinued early - contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation etc.)
04	Radiation treatment discontinued early - patient decision
05	Radiation discontinued early – family decision
06	Radiation discontinued early – patient expired
07	Radiation discontinued early – reason not documented
99	Unknown if radiation treatment discontinued; Unknown whether radiation therapy administered. Death Certificate only

Examples

- A patient with Stage III prostate carcinoma received pelvic irradiation to 5,000 cGy over 25 fractions followed by a Phase II (boost) prostate irradiation to 7,000 cGy. Record Radiation Treatment Discontinued Early field as 01.
- A patient with a metastasis from a gastric carcinoma at the L1 vertebral body was planned to receive 3000 cGy over 10 fractions. However, after 5 fractions, the patient developed cord compression symptoms and imaging evidence of compression and was taken for urgent surgical resection of the mass at L1. He did not resume radiotherapy. Record Radiation Treatment Discontinued Early field as 03 because there was clear evidence of progression.
- A patient with muscle-invasive bladder cancer was being treated with radiation to the whole bladder. The initial plan was to treat the whole bladder to 6480cGy in 36 fractions but after 23 fractions he developed severe radiation enteritis and unrelenting diarrhea requiring a prolonged hospital admission. He discontinued treatment early after a total dose of 4140cGy. Record Radiation Treatment Discontinued Early field as 02 because treatment was stopped early due to treatment toxicity.

Number of Phases of Radiation Treatment

(NAACCR # 1532) (STORE 2022 page 283)

Description

A course of radiation is made up of one or more phases and each phase reflects a distinct delivered prescription. The STORE has fields for up to 3 phases of a radiation course to be documented. This field identifies the actual number of distinct radiation phases in a course so that it is clear when only a portion of the course is being captured in the phase summary sections.

Rationale

The number of phases of radiation treatment is used to flag cases where only a subset of phase data is being captured.

Code	Label
00	No radiation treatment
01-98	Record the actual number of phases in the radiation course
99	Unknown number of phases;

Examples

- A patient with advanced head and neck cancer was treated using "hyper-fractionation." Three fields were delivered in each session; two sessions were given each day, six hours apart, with each session delivering a total fractional dose of 150 cGy. Treatment was given for a total of 25 days. The total course dose was 7500cGy. Record the Number of Phases of Radiation Treatment as 01.
- A patient with breast cancer was treated with whole breast RT, 5040 cGy in 28 fractions, but axillary and supraclavicular (SC) nodes treated concurrently with an anterior field covering both regions and a posterior field (PAB) added to the axilla. The medial portion of the anterior field was blocked for the last three treatments to hold the SC region to a maximum of 4500cGy to minimize the risk of brachial plexus injury. Subsequently, the surgical bed received an electron boost of 1000cGy in 5 fractions using fields shaped to surround surgical bed with 1.5 cm margins. Record 03 as the Number of Phases of Radiation Treatment. See a detailed discussion of this example in the "CTR Guide to Coding Radiation Therapy Treatment in the STORE".

Radiation Total Dose

(NAACCR #1533) (STORE 2022 pages 286 – 287)

Description

Identifies the total cumulative radiation dose administered to the patient across all phases during the first course of treatment to the same body site. The unit of measure is centi-Gray (cGy).

Rationale

To evaluate the patterns of radiation care, it is necessary to capture information describing the total delivered prescribed total dose of radiation during the first course of treatment. Outcomes are strongly related to the dose delivered.

Coding Instructions

1. If the total dose for the course is not documented, then add the dose from each of the sequential phases (I, II, III, or IV or more) that target the same body site and document the total cumulative dose. Note when calculating the Radiation Course Total Dose, all of the phases should be used, not just the first three
2. Doses should ONLY be summed across phases to create a Total Dose when all of the phases were delivered sequentially to the same body site. If phases were delivered to multiple body sites (e.g. simultaneous treatment to multiple metastatic sites), then code the Radiation Course Total Dose as the dose to the body site that received the highest dose. Examples are provided in the "CTR Guide to Coding Radiation Therapy Treatment in the STORE"
3. Doses should ONLY be summed across phases to create a Total Dose when all of the phases were delivered using the same modality. If phases were delivered using two or more different modalities (e.g. external beam and brachytherapy to the same body site), then code 999998, Not applicable.
4. Doses can be summed across phases even if the fraction size of phases is different. That is, if phase I to the whole prostate and seminal vesicles is 180 cGy x 28 =5040 cGy, Phase II to a partial prostate volume is 200 cGy x 15 = 3000cGy, and these phases are delivered sequentially, then record 8040 cGy as the Radiation Course Total Dose.
5. For proton treatment, dosage may occasionally be specified as in CGe units (Cobalt Gray Equivalent) rather than Gy or cGy. 1 CGE = 1 Gy = 100 cGy. For a Phase Total Dose, you would need to multiply dose in CGE by 100 to get dose in cGy.).
6. Note that dose is still occasionally specified in "rads". 1 rad = 1cGy.
7. If dose is documented in the medical record includes a fraction of a cGy (e.g. 180.3), round to the nearest cGy. For example, 180.5 cGy should be rounded up to 181 cGy and 180.4 cGy should be rounded down to 180cGy. A dose of Code 99998 when radioisotopes were administered to the patient (codes 13-16 for Phase I Treatment Modality [1506]).
8. Code 999998 when radioisotopes are administered to the patient (codes 13-16 recorded in the Phase I, Phase II, or Phase III Treatment Modality [1506, 1516, 1526] data items).
9. Code the actual cGy if available when brachytherapy was administered to the patient (codes 07-12 for Phase I Treatment Modality [1506]).

Code	Label
000000	No radiation treatment. Diagnosed at autopsy
000001-999997	Record the actual total dose delivered in cGy
999998	Not applicable, radioisotopes administered to the patient, or the patient was treated with a mixed modalities (e.g. external beam and brachytherapy).
999999	Radiation therapy was administered, but the total dose is unknown; it is unknown whether radiation therapy was administered

Radiation Sequence with Surgery

(NAACCR Item #1380) (STORE 2022 page 288-289) (SEER page 202-203)

Description

This data item records the order in which surgery and radiation therapies were administered for those patients who had both surgery and radiation. For the purpose of coding the data item Radiation Sequence with Surgery, 'Surgery' is defined as a *Surgical Procedure of Primary Site* (codes 10-90) or *Scope of Regional Lymph Node Surgery* (codes 2-7) or *Surgical Procedure of Other Site* (codes 1-5).

Rationale

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

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Examples

- Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain. **Use code 0**.
- Patient received radiation therapy prior to resection of a lung lesion. **Use code 2**.
- A patient underwent excisional biopsy of a right breast mass followed by radiation therapy to breast. **Use code 3**.
- Preoperative radiation therapy was given to a large bulky vulvar lesion, followed by a lymph node dissection. Radiation therapy was then given to treat positive lymph nodes. **Use code 4.**
- A cone biopsy of the cervix was followed by intracavitary implant for IIIB cervical carcinoma. **Use code 5.**
- Stage IV vaginal carcinoma was treated with 5,000 cGy to the pelvis followed by a lymph node dissection and 2,500 cGy of intracavitary brachytherapy. **Use code 6.**
- A primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. **Use code 9.**
- Patient has an unknown primary. A radical neck dissection is done followed by radiation therapy. **Use code 3**.

Reason For No Radiation

(NAACCR Item #1430) (STORE 2022 page 291-292) (SEER page 204)

Description

Records the reason that no regional radiation therapy was administered to the patient as part of first course of therapy.

Rationale

When evaluating the quality of care, it is useful to know the reason that various methods of therapy were not used, and whether the failure to provide a given type of therapy was due to the physician's failure to recommend that treatment, or due to the refusal of the patient, a family member, or the patient's guardian.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

RX Text Radiation

(NAACCR Item #2620 and 2630)

Description

Text information regarding treatment of the tumor being reported with beam radiation and/or other radiation therapy.

Rationale

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions

1. Text information must be provided by **all** facilities.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.

4. Document all first course radiation treatment regardless of where it was done, in chronological order.
5. Document date(s) of radiation treatment.
6. Document name of facility where radiation treatment was administered.
7. Document type(s) of radiation (Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities, brachytherapy, seed implant, Radioisotopes).
8. If information is missing, state that it is missing.
9. Document other treatment information (ex. patient discontinued after 5 treatments)
10. Do not enter text in this field when treatment is either not done, unknown if done. This information is conveyed by the treatment flags.
11. Document Covid-19 information if available.
    a. Beam radiation delays, discontinuation, or modifications due to COVID-19
    b. Examples
        i. EBRT [XRT; RT] DC D/T COVID-19
        ii. EBRT [XRT; RT] CHG D/T COVID-19
        iii. EBRT [XRT; RT] delayed D/T COVID-19
        iv. EBRT [XRT] delayed D/T COVID-19 & given as subsequent TX after progression

12. Refer to 2022 NAACCR Data Dictionary for list of data items to be verified by the text fields.

Note: See Documentation of Cancer Diagnosis, Extent of Disease, and Treatment for further explanation and examples.

Date Systemic Therapy Started

(NAACCR Item #3230) (STORE 2022 page 294) (SEER page 205)

Description

Date of initiation of systemic therapy that is part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormone agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022. This data item is required for CoC-accredited facilities when available.

Note: Do not leave the date blank if systemic therapy was administered. If the date is unknown code the year of diagnosis as the start date and leave the day and month blank. Document in the text field that the complete first date of systemic therapy is not known.

Date Systemic Therapy Started Flag

(NAACCR Item #3231) (SEER page 206)

Description

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

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

This flag may be autogenerated depending on the software in use.

Examples

- A patient with breast cancer begins her regimen of chemotherapy on December 15, 2022 and is subsequently given Tamoxifen on January 20, 2004. **Record as 20221215.**
- A patient with Stage IV prostate cancer has an orchiectomy on June 2, 2022. He is then started on a regime of hormonal agents on June 9, 2022. **Record as 20220602**.

Date Chemotherapy Started

(NAACCR Item 1220) (STORE 2022 page 296) (SEER page 207)

Description

The date of initiation of chemotherapy that is part of the first course of treatment.

Explanation

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022

Note: If chemotherapy was administered do not leave the date blank. **If the start date is not known, record the year of diagnosis as the start date and leave the month and day blank**. Document in the text field that the date of hormone treatment is unknown.

Examples

- The patient had breast cancer diagnosed in April 2022. She has completed chemotherapy and now comes to your facility for radiation therapy. **Record the date of chemotherapy as 2022.**

Date Chemotherapy Started Flag

(NAACCR Item #1221) (STORE 2022 page 297) (SEER page 208)

Description

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

Rationale

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

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Chemotherapy

(NAACCR Item #1390) (STORE 2022 pages 295, 298-300) (SEER pages 209-214)

Description

Codes for chemotherapy given as part of the first course of treatment or the reason chemotherapy was not given. Includes treatment given at all facilities as part of the first course.

Rationale

This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Refer to the SEER*Rx Interactive Drug Database (https://seer.cancer.gov/tools/seerrx/) for a list of chemotherapeutic agents.

Examples

- A patient with primary liver cancer is known to have received chemotherapy. The type(s) of agent(s) delivered is not documented in the medical record. **Record code 01 and document the information in the treatment documentation text field.**
- A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the fluorouracil as a single agent and the levamisole as an immunotherapeutic agent. **Record code 02 and document the information in the treatment documentation data field**.
- A patient with early-stage breast cancer receives chemotherapy. The medical record indicated a combination regimen containing doxorubicin is to be administered. **Record code 03 and document the information in the treatment documentation data field.**
- Following surgical resection of an ovarian mass the physician recommends chemotherapy. The medical record states chemotherapy was not delivered, and the reason is not documented. **Record code 86 and document that the medical record states chemo not delivered but no reason given.**
- Patient has hepatocellular carcinoma. Under x-ray guidance, a small catheter is inserted into an artery in the groin. The catheter's tip is threaded into the artery in the liver that supplies blood flow to the tumor. A chemotherapy agent is injected through the catheter into the tumor and mixed with particles that embolize or block the flow of blood to the diseased tissue. **Record code 02 and document that chemoembolization was done.**

Chemotherapy at this Facility

(NAACCR Item #700) (STORE 2022 pages 301-303)

Desciption

Records the type of chemotherapy administered as first course treatment at this facility. If chemotherapy was not administered, then this item records the reason it was not administered to the patient. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if chemotherapy was not administered.

Coding Instructions

- Record only chemotherapy received at this facility. Do not record agents administered at other facilities.
- Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer. Diagnosed at autopsy.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include chemotherapy or if the option of "no treatment" was accepted by the patient.
- If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended the patient receive chemotherapy, but no further documentation is available yet to confirm its administration.
- Cases coded 88 must be followed to determine what kind of chemotherapy was administered or why it was not.
- Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered. Death Certificate only.
- Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved.
- If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy, and only the original agent or regimen is recorded as first course therapy.
- Refer to the SEER*Rx Interactive Drug Database (https://seer.cancer.gov/tools/seerrx/) for a list of chemotherapeutic agents.
- If chemotherapy was provided as a radiosensitizer or radioprotectant DO NOT code as chemotherapy treatment. When chemotherapy is given for radiosensitization or radioprotection it is given in low doses that do not affect the cancer.

- If chemotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy administered in the item Palliative Care at This Facility [3280].

Important information affecting classification of some systemic therapies. The six drugs listed in the table below were previously classified as Chemotherapy and are now classified as BRM/Immunotherapy. **This change is effective for cases diagnosed January 1, 2013, and forward.** For cases diagnosed prior to January 1, 2013, registrars have been instructed to continue coding these drugs as Chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs in SEER*Rx Interactive Drug Database.

Drug name/Brand name	Previous Category	New Category	Effective Date
Alemtuzumab/Campath	Chemotherapy	BRM/Immuno	01/01/2013
Bevacizumab/Avastin	Chemotherapy	BRM/Immuno	01/01/2013
Rituximab/Rituxan	Chemotherapy	BRM/Immuno	01/01/2013
Trastuzumab/Herceptin	Chemotherapy	BRM/Immuno	01/01/2013
Pertuzumab/Perjeta	Chemotherapy	BRM/Immuno	01/01/2013
Cetuximab/Erbitux	Chemotherapy	BRM/Immuno	01/01/2013

Table 13.3 Chemotherapy Codes

Code	Description
00	None; chemotherapy was not part of the first course of therapy.
01	Chemotherapy administered as first course of therapy, but the type and number of agents is not documented in the patient record.
02	Single-agent chemotherapy administered as first course of therapy.
03	Multi-agent chemotherapy was delivered as first course of therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors i.e., comorbid conditions, advanced age.
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

RX Text Chemo

(NAACCR Item # 2640)

Description

Text area for documentation of information regarding chemotherapy treatment of the reported tumor.

Rationale

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information to support chemotherapy treatment information **must be provided by all facilities**.
2. Document all first course treatment of chemotherapy information regardless of where it was done, in chronological order.
3. Text automatically generated from coded data is not acceptable.
4. NAACCR-approved abbreviations should be utilized.
5. Document date(s) of chemotherapy treatment.
6. Document name of facility where chemotherapy treatment was administered.
7. Document type(s) of chemotherapy (name of agent(s) or protocol)
8. If information is missing, state that it is missing.
9. Document other treatment information (ex. patient discontinued after 5 treatments)
10. Do not enter text in this field when treatment is either not done, unknown if done. This information is conveyed by the treatment flags.
11. Document Covid-19 information if available.
    a. Chemotherapy delays, discontinuation, or modifications due to COVID-19
    b. Examples
        i. CHEMO DC D/T COVID-19
        ii. CHEMO CHG D/T COVID-19
        iii. CHEMO delayed D/T COVID-19
        iv. CHEMO delayed D/T COVID-19 & given as subsequent TX after progression
12. Refer to 2022 NAACCR Data Dictionary for list of data items to be verified by the text fields.

Examples

- 3/15/17 Oncologist recommends 4 cycles adjuvant Taxol and carboplatin. PT wants treatment closer to home, referred to oncologist in his area. PT seen on 10/4/17 and physician notes patient has completed 4 cycles of Taxol and carboplatin.

Note: See Section 15: Documentation of Cancer Diagnosis, Extent of Disease, and Treatment for further explanation and examples.

Date Hormone Therapy Started

(NAACCR Item #1230) (STORE 2022 page 305) (SEER page 215)

Description

Records the date of initiation of hormone therapy that is part of the first course of treatment.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

Note: If hormone therapy was administered do not leave the date blank. **If the start date is not known, record the year of diagnosis as the start date and leave the month and day blank**. Document in the text field that the date of hormone treatment is unknown.

Date Hormone Therapy Started Flag

(NAACCR ITEM #1231) (STORE 2022 page 306) (SEER page 216)

Description

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

Rationale

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

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Hormone Therapy

(NAACCR Item #1400) (STORE 2022 pages 307-308) (SEER pages 217-219)

Description

Records the type of hormone therapy administered as first course treatment at this and all other facilities. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy.

Hormone therapy is a drug or group of drugs that is delivered to change the hormone balance. Hormone therapy may affect a long-term control of the cancer growth. It is not usually curative.

Note: Hormone therapy is administered to treat cancer tissue and is considered to achieve its effect through change of the hormone balance. Some cancers, such as prostate or breast, depend upon hormones to develop. When a malignancy arises in these tissues, it is usually hormone-responsive. Other primaries and histologic types may be hormone-responsive, such as melanoma and hypernephroma.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Note: Surgical removal of organs for hormone manipulation (such as orchiectomy for prostate cancer) is not coded in this data item. **Code these procedures in the data field Hematologic Transplant and Endocrine Procedures.**

- Some types of cancers are slowed or suppressed by hormones. These cancers are treated by administering hormones and should be coded in this data field.

  Example: Endometrial cancer may be treated with progesterone. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer and should be coded.

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

- If it is known that hormone therapy is usually delivered for this type and stage of cancer, but it was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Do not code as hormone replacement therapy when it is given because it is necessary to maintain normal metabolism and body function.
- If prednisone or other hormone is delivered for other reasons, do not code as hormone therapy.

  Example 1: A patient is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy. Code to 00.

  Example 2: A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormone therapy. Code to 00.

  Exception: Decadron is coded as hormonal treatment for lymphoid leukemias, lymphomas, and multiple myelomas only. It is delivered to achieve its effect on cancer tissue through change of the hormone balance.

STORE Note: If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy administered in the item Palliative Care [3270].

Examples

- A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. **Code to 00. Decadron is not coded as hormonal therapy.**
- A patient with breast cancer may be treated with aminoglutethimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. This patient must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (Florinef) as a replacement therapy. **Code to 00.**
- A patient diagnosed with metastatic prostate cancer is administered flutamide (an anti-androgenic agent) as part of the first course of therapy. **Code to 01 and document the information in the Treatment Documentation data field.**
- A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. **Prednisone is not coded as hormone therapy. Code to 00.**
- A patient with metastatic prostate cancer is administered flutamide (an antiestrogen). **Code to 01.**
- Patient with endometrial cancer is treated with progesterone. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer. **Code to 01 and document the information in the Treatment Documentation data field**.
- A patient with follicular or papillary cancers of the thyroid is treated with thyroid hormone to suppress/inhibits serum thyroid stimulating hormone (TSH). **If a patient with papillary and/or**

follicular cancer of this is given TSH, code the treatment in this field. Code to 01 and document the information in the Treatment Documentation data field.

- Lupron is a hormonal treatment for prostate cancer. **Code as hormonal treatment when Lupron is given for prostate cancer.**
- Bromocriptine suppresses the production of prolactin, which causes growth in pituitary adenoma. **Code bromocriptine as hormone treatment for pituitary adenoma.**
- A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) as part of the first course of therapy and the refusal is documented in the medical record. **Code to 87 and document the information.**

Hormone Therapy at this Facility

(NAACCR Item #710) (STORE 2022 pages. 309-310)

Description

Records the type of hormone therapy administered as first course treatment at this facility. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if hormone therapy was not administered.

Coding Instructions

- Record only hormone therapy received at this facility. Do not record procedures done at other facilities.
- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.
- Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer. Diagnosed at autopsy.

- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include hormone therapy or if the option of "no treatment" was accepted by the patient.
- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
- If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration.
- Cases coded 88 should be followed to determine whether they received hormone therapy or why not.
- Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered. Death certificate only.
- Refer to the SEER*Rx Interactive Drug Database (https://seer.cancer.gov/tools/seerrx/) for a list of hormonal agents.
- If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy administered in the item Palliative Care [3270].

Table 13.4 Hormone Therapy Codes

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

RX Text Hormone

(NAACCR Item #2650)

Description

Text area for information about hormonal treatment.

Rationale

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information to support hormone treatment information **must be provided by all facilities**.
2. Document all first course treatment of hormone treatment information regardless of where it was done, in chronological order.
3. Text automatically generated from coded data is not acceptable.
4. NAACCR-approved abbreviations should be utilized.

5. Document date(s) of hormone treatment.
6. Document name of facility where hormone treatment was administered.
7. **Document type(s) of hormone (ex. Tamoxifen)**
8. **Document type of endocrine surgery or radiation (ex. Orchiectomy)**
9. If information is missing, state that it is missing.
10. Document other treatment information (ex. patient discontinued after 5 treatments)
11. Do not enter text in this field when treatment is either not done, unknown if done. This information is conveyed by the treatment flags.
12. Document Covid-19 information if available.
    a. Hormone therapy delays, discontinuation, or modifications due to COVID-19
    b. Examples
        i. HORMONE DC D/T COVID-19
        ii. HORMONE CHG D/T COVID-19
        iii. HORMONE delayed D/T COVID-19
        iv. HORMONE delayed D/T COVID-19 & given as subsequent TX after progression
13. Refer to 2022 NAACCR Data Dictionary for list of data items to be verified by the text fields.

Example: After being diagnosed with adenocarcinoma of the prostate on 1/11/18, the patient opted for hormonal treatment and started Lupron on 2/1/18.

Note: See Section 15: Documentation of Cancer Diagnosis, Extent of Disease, and Treatment for further explanation and examples.

Do not enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

Date Immunotherapy Started

(NAACCR Item #1240) (STORE 2022 page 312) (SEER page 220)

Description

Records the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of treatment.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

If immunotherapy was administered do not leave the date blank. **If the start date is not known, record the year of diagnosis as the start date and leave the month and day blank.** Document in the text field that the start date is unknown.

> ***Example:*** A patient diagnosed with lung cancer with malignant pleural effusion earlier in 2021 has been treated with Picibanil, but the exact date is not known. **Record 2021 as the date immunotherapy started.**

Date Immunotherapy Started Flag

(NAACCR Item #1241) (STORE 2022 page 312) (SEER page 221)

Description

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

Rationale

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

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Immunotherapy

(NAACCR Item #1410) (STORE 2022 pages 314-315) (SEER pages 222-224)

Description

The data item Immunotherapy records immunotherapeutic (biological therapy, biotherapy, or biological response modifier (BRM)) agents administered as first course of therapy. See SEER*Rx for immunotherapy drug codes.

Rationale

This data item allows for the analysis of the administration of immunotherapeutic (biological therapy, biotherapy or biological response modifier) agents as part of the first course of therapy. Immunotherapy

uses the body's immune system, either directly or indirectly, to fight cancer or to reduce the side effects that may be caused by some cancer treatments. Record only those treatments that are administered to affect the cancer cells.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Refer to the SEER*Rx Interactive Drug Database (https://seer.cancer.gov/tools/seerrx/) for immunotherapeutic agents.

Examples

- A patient with malignant melanoma is treated with interferon. **Code 01.**
- Before recommended immunotherapy could be administered, the patient died from cancer. **Code 85.**
- **Abstract as immunotherapy** when a reportable hematopoietic neoplasm is treated with **donor leukocyte infusion**, even if it is not listed in the treatment section of the Heme DB for the specific neoplasm.

Immunotherapy at this Facility

(NAACCR Item #720) (STORE 2022 pages 316-317)

Description

Records the type of immunotherapy administered as first course treatment at this facility. If immunotherapy was not administered, then this item records the reason it was not administered to the patient. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of immunotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason immunotherapy was not administered.

Coding Instructions

- Record only immunotherapy received at this facility. Do not record agents administered at other facilities.
- Code 00 if immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.

- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include immunotherapy or if the option of "no treatment" was accepted by the patient.
- If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended the patient receive immunotherapy, but no further documentation is available yet to confirm its administration.
- Code 88 to indicate a referral was made to a medical oncologist about immunotherapy and the registry should follow the case to determine whether it was given or why not. If follow-up to the specialist or facility determines the patient was never there, code 00.
- Cases coded 88 should be followed to determine whether they received immunotherapy orwhy not.
- Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- Refer to the SEER*Rx Interactive Drug Database (https://seer.cancer.gov/tools/seerrx/) for a list of immunotherapeutic agents.
- If immunotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy administered in the item Palliative Care at This Facility [3280].

Important information affecting classification of some systemic therapies. The six drugs listed in the table below were previously classified as Chemotherapy and are now classified as BRM/Immunotherapy**. This change is effective for cases diagnosed January 1, 2013, and forward**. For cases diagnosed prior to January 1, 2013, registrars have been instructed to continue coding these drugs as Chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs in SEER*Rx Interactive Drug Database.

Drug name/Brand name	Previous Category	New Category	Effective Date
Alemtuzumab/Campath	Chemotherapy	BRM/Immuno	01/01/2013
Bevacizumab/Avastin	Chemotherapy	BRM/Immuno	01/01/2013
Rituximab/Rituxan	Chemotherapy	BRM/Immuno	01/01/2013
Trastuzumab/Herceptin	Chemotherapy	BRM/Immuno	01/01/2013
Pertuzumab/Perjeta	Chemotherapy	BRM/Immuno	01/01/2013
Cetuximab/Erbitux	Chemotherapy	BRM/Immuno	01/01/2013

Table13.5 Immunotherapy Codes

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

Hematologic Transplant/Endocrine Procedures

(NAACCR Item #3250) (STORE 2022 pages 318-319) (SEER pages 225-227)

Description

This data item records systemic therapeutic procedures administered as part of the first course of treatment. **These procedures include bone marrow transplants (BMT) and stem cell harvests with rescue (stem cell transplant), endocrine surgery and/or radiation performed for hormonal effect (when cancer originates at another site), and a combination of transplants and endocrine therapy.**

Rationale

This treatment involves the alteration of the immune system or changes the patient's response to tumor cells but does not involve the delivery of antineoplastic agents.

Note: Used for breast cancer, lymphoma, leukemia, aplastic anemia, myeloma, germ cell tumors, ovarian cancer, and small cell lung cancer.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

These procedures include bone marrow transplants (BMT) and stem cell harvests with rescue (stem cell transplant), endocrine surgery and/or radiation performed for hormonal effect (when cancer originates at another site), and a combination of transplants and endocrine therapy.

Note: Abstract as immunotherapy when a reportable hematopoietic neoplasm is treated with donor leukocyte infusion, even if it is not listed in the treatment section of the Heme DB for the specific neoplasm.

RX Text BRM

(NAACCR Item #2660)

Description

Text information describing all **immunotherapy or Biological Response Modifiers** given as part of first course of treatment.

Rationale

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information to support chemotherapy treatment information **must be provided by all facilities**.
2. Document all first course treatment of immunotherapy/BRM information regardless of where it was done, in chronological order.
3. Text automatically generated from coded data is not acceptable.
4. NAACCR-approved abbreviations should be utilized.
5. Document date(s) of immunotherapy/BRM treatment.
6. Document name of facility where immunotherapy/BRM treatment was administered.
7. **Document type(s) of agent (ex. Interferon, BCG)**
8. **Document BRM procedures (ex. Bone marrow transplant, stem cell transplant)**
9. If information is missing, state that it is missing.
10. Document other treatment information (ex. Treatment cycle incomplete)

11. Do not enter text in this field when treatment is either not done, unknown if done. This information is conveyed by the treatment flags.
12. Document Covid-19 information if available.
    a. BRM or immunotherapy delays, discontinuation, or modifications due to COVID-19
    b. Examples
        i. BRM DC D/T COVID-19
        ii. BMT DC D/T COVID-19
        iii. BRM CHG D/T COVID-19
        iv. BRM delayed D/T COVID-19
        v. BMT delayed D/T COVID-19
        vi. BRM delayed D/T COVID-19 & given as subsequent TX after progression
13. Refer to 2022 NAACCR Data Dictionary for list of data items to be verified by the text fields.

Note: See Documentation of Cancer Diagnosis, Extent of Disease, and Treatment for further explanation and examples.

Do not to enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

Systemic Treatment/Surgery Sequence

(NAACCR Item #1639) (STORE 2022 pages 320-321) (SEER page 228)

Description

This data item records the sequence of any systemic therapy and surgery given as first course of therapy for those patients who had both systemic therapy and surgery. For the purpose of coding systemic treatment sequence with surgery, 'Surgery' is defined as a Surgical Procedure of Primary Site (codes 10-90) or Scope of Regional Lymph Node Surgery (codes 2-7) or Surgical Procedure of Other Site (codes 1-5).

Rationale

The sequence of systemic therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Systemic therapy is defined as:

- Chemotherapy
- Hormone therapy
- Biological response therapy/immunotherapy
- Bone marrow transplant
- Stem cell harvests

- Surgical and/or radiation endocrine therapy

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

- Code the administration of systemic therapy in sequence with the first surgery performed, described in the item *Date of First Surgical Procedure* (NAACCR Item #1200).
- If none of the following surgical procedures were performed: *Surgical Procedure of Primary Site* (NAACCR Item #1290) (codes 10-90), S*cope of Regional Lymph Node Surgery* (NAACCR Item #1292) (codes 2-7), S*urgical Procedure/Other Site* (NAACCR Item #1294) (codes 1-5), then this item should be coded 0.
- If the patient received both systemic therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site* (NAACCR Item #1290), S*cope of Regional Lymph Node Surgery* (NAACCR Item #1292), *Surgical Procedure/Other Site* (NAACCR Item #1294), then code this item 2–9, as appropriate.
- If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

  Example: The sequence chemo, then surgery, then hormone therapy, then surgery is coded 4 for "chemo then surgery then hormone."

Examples

- Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain. **Record code 0 and document the information in the treatment documentation data field.**
- Patient with prostate cancer received hormone therapy prior to a radical prostatectomy. **Record code 2 and document the information in the treatment documentation data field.**
- Patient underwent a colon resection followed by a 5-FU based chemotherapy regimen. **Record code 3 and document the information in the treatment documentation data field.**
- Patient with breast cancer receives pre-operative chemotherapy followed by post-operative Tamoxifen. **Record code 4 and document the information in the treatment documentation data field.**
- Patient with intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity. **Record code 5 and document the information in the treatment documentation data field.**
- Patient with metastatic colon cancer receives intraoperative chemotherapy to the liver followed by 5-FU. **Record code 6 and document the information in the treatment documentation data field.**

- An unknown primary of the head and neck was treated with surgery and chemotherapy prior to admission, but the sequence is unknown. The patient enters for radiation therapy. **Record code 9 and document the information in the treatment documentation data field.**

Neoadjuvant Therapy

(NAACCR Item #1632) (SEER pages 229-233)

Description

This data item records whether the patient had neoadjuvant therapy prior to planned definitive surgical resection of the primary site.

Rationale

This data items provides information related to the quality of care and describes whether a patient had neoadjuvant therapy.
For the purposes of this data item, neoadjuvant therapy is defined as systemic treatment (chemotherapy, endocrine / hormone therapy, targeted therapy, immunotherapy, or biological therapy) and/or radiation therapy before intended or performed surgical resection to improve local therapy and long term outcomes.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Neoadjuvant Therapy-Clinical Response

(NAACCR Item #1633) (SEER pages 234-237)

Description

This data item records the clinical outcomes of neoadjuvant therapy prior to planned surgical resection.

Rationale

This data items provides information related to the quality of care and describes the clinical outcomes after neoadjuvant therapy. This data item provides prognostically relevant information by quantifying the extent of therapy-induced tumor regression. Therefore, this item can provide a better risk stratification for patients who received neoadjuvant therapy. In addition, this data item can contribute to assessments of cancer care quality.
This data item records the clinical outcomes of neoadjuvant therapy as determined by the managing physician (oncologic surgeon, radiation oncologist or medical oncologist).
For the purposes of this data item, neoadjuvant therapy is defined as systemic treatment (chemotherapy,

endocrine / hormone therapy, targeted therapy, immunotherapy, or biological therapy) and/or radiation therapy given to shrink a tumor before surgical resection.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Neoadjuvant Therapy-Treatment Effect

(NAACCR Item #1634) (SEER pages 238-239)

Description

This data item records the pathologist's statement of neoadjuvant treatment effect on the primary tumor from the surgical pathology report. Whenever treatment effect definitions are recommended by or available in CAP Cancer Protocols, this data item follows the CAP definitions indicating absent or present effect. When specific CAP definitions are not available, registrars should use treatment effect general use categories.

Rationale

This data item provides information related to the quality of care and describes the pathological outcomes after neoadjuvant therapy. This data item provides prognostically relevant information by quantifying the extent of therapy-induced tumor regression. Therefore, this item can provide a better risk stratification for patients who received neoadjuvant therapy. In addition, this data item can contribute to assessments of cancer care quality. **Code this data item based on the managing/treating physician's interpretation/statement of the response to neoadjuvant therapy, whenever this interpretation/statement is available.**

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Date Other Treatment Started

(NAACCR Item #1250) (STORE 2022 page 323) (SEER page 240)

Description

Date Other Treatment Started is the date when an alternative treatment other than surgery, radiation, chemotherapy, immunotherapy, and hematologic transplant and endocrine procedure is initiated/started as part of the first course of therapy.

Rationale

Collecting dates for each treatment modality allows for the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

If *Other Treatment* was administered do not leave the date blank. If the start date is not known, record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the date of *Other Treatment* is unknown.

Examples

- A patient with polycythemia vera was first treated with phlebotomy on February 20, 2022. **Record *Date of Other Treatment Started* as 20210220.**
- A patient with pancreatic cancer is enrolled in a double-blind clinical trial in May 2022, but the day is not known. **Record *Date of Other Treatment Started* as 202205.**
- A patient diagnosed with essential thrombocythemia in 2022 and has since been treated with aspirin, but the exact date is unknown. Record *Date of Other Treatment Started* as 2022.
- A patient with metastatic disease was started on an experimental therapy on March 16, 2022. **Record *Date of Other Treatment Started* as 20220316.**
- Alcohol was used as an embolizing agent for a patient on August 1, 2022. **Record *Date of Other Treatment Started* as 20220801.**
- A polycythemia vera patient was given several phlebotomies, the first being on September 17, 2020. **Record *Date of Other Treatment Started* as 20200917.**

Date Other Treatment Started Flag

(NAACCR Item #1251) (SEER page 241)

Description

This flag explains why there is no appropriated value in the corresponding date field, *Date Other Treatment Started,* NAACCR Item #1250.

Explanation

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

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Other Therapy

(NAACCR Item #1420) (STORE 2022 page 324-325) (SEER pages 234-236)

Description

Identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. This data item includes all complementary and alternative (CAM) used by the patient in conjunction with conventional therapy or in place of conventional therapy.

Rationale

Information on other therapy is used to describe and evaluate the quality of care and treatment practices.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Note: Do not code ancillary drugs in this field. There is no coding scheme for ancillary drugs such as Leucovorin.

Examples

- Lupron given for breast cancer. **Assign code 6.** Lupron is not an approved hormone treatment for breast cancer and should not be coded in the hormone field.
- A patient with polycythemia vera is treated with phlebotomies. **Use code 1 for polycythemia vera ONLY according to the *Hematopoietic and Lymphoid Neoplasm Coding Manual*** page 22 for cases diagnosed January 2010 and later. Phlebotomy may be called blood removal, bloodletting, or venesection.
- A patient with pancreatic cancer is enrolled in a double-blind clinical trial. The treatment agents are unknown. **Use code 3.**
- A patient was treated for melanoma with PUVA (psoralen and long-wave ultraviolet radiation). **Code this treatment as *Other Therapy,* code 1.**

Other Therapy at this Facility

(NAACCR Item #730) (STORE 2022 pages 326-327)

Description

Identifies other treatment given at this facility that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.

Rationale

Information on other therapy is used to describe and evaluate the quality of care and treatment practices.

Coding Instructions

- The principal treatment for certain reportable hematopoietic diseases could be supportive care that does not meet the usual definition of treatment that "modifies, controls, removes, or destroys' proliferating cancer tissue.
- Supportive care may include phlebotomy, transfusion, or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the Commission on Cancer have agreed to record treatments such as phlebotomy, transfusion, or aspirin as "Other Treatment" (Code 1) for certain hematopoietic diseases ONLY. Consult the most recent version of **the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** for instructions for coding care of specific hematopoietic neoplasms in this item.
- Code 1 for embolization using alcohol as an embolizing agent.
- Code 1 for embolization to a site other than the liver where the embolizing agent is unknown.
- Code 1 for PUVA (psoralen and long-wave ultraviolet radiation)
- Do not code presurgical embolization that given for a purpose to shrink the tumor.
- A complete description of the treatment plan should be recorded in the text field for "Other Treatment" on the abstract.
- If other treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item Palliative Care at This Facility [3280].
- Code 8 if it is known that a physician recommended the patient receive treatment coded as Other Treatment, but no further documentation is available yet to confirm its administration.
- Code 0 when diagnosed at autopsy.
- Code 9 for Death Certificate Only (DCO) cases.

Table13.6 Other Treatment Codes

Code	Type	Description
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment.
1	Other	Cancer treatment that cannot be appropriately assigned to specific treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases. *See **Examples**

Code	Type	Description
2	Other-Experimental	This code is not defined. It may be used to record participation in facility-based clinical trials.
3	Other-Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven	Cancer treatments administered by non-medical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Recommended; unknown if done	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment.

RX Text Other

(NAACCR Item #2670)

Description

Text area for manual documentation of information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field as first course of treatment.

Rationale

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information to support other treatment information **must be provided by all facilities**.
2. Document all first course information regardless of where it was done, in chronological order.
3. Text automatically generated from coded data is not acceptable.
4. NAACCR-approved abbreviations should be utilized.

5. Document date(s) of other treatment.
6. Document name of facility where other treatment was administered.
7. Document type(s) of other treatment (ex. Blinded clinical trial, hyperthermia)
8. If information is missing, state that it is missing.
9. Document other treatment information (ex. Treatment cycle incomplete)
10. Do not enter text in this field when treatment is either not done, unknown if done. This information is conveyed by the treatment flags.
11. Refer to 2022 NAACCR Data Dictionary for list of data items to be verified by the text fields.

Note: See Documentation of Cancer Diagnosis, Extent of Disease, and Treatment for further explanation and examples.

Do not enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

14

FOLLOW UP INFORMATION

Date of Last Cancer (Tumor) Status

(NAACCR Item #1772) (STORE 2022 page 336) (SEER page 246)

Description

Date of Last Cancer (Tumor) Status records the date of last known cancer status for this tumor. SEER requires the registries to update the follow up information on all cases on an annual basis.

Rationale

This information is used for patient follow-up and outcomes studies

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

- Record the last date on which the patient's cancer status (Cancer Status [1770)] was known to be updated.
- Cancer Status is based on information from the patient's physician or other official source such as a death certificate.
- The patient's Cancer Status should be changed only if new information is received from the patient's physician or other official source. If information is obtained from the patient, a family member, or other non-physician, then Cancer Status is not updated.
- Cancer Status changes if the patient has a recurrence or relapse.
- This data item differs from the Date of Last Contact or Death [1750] as it is a tumor-level data item. If a patient has multiple primaries, each primary could have a different Date of Last Cancer (tumor) Status [1772].

Date of Last Cancer (Tumor) Status Flag

(NAACCR Item #1773) (SEER page 247)

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Last Cancer (tumor) Status* [1772].

Rationale

This information is used for patient follow-up and outcomes studies. As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Cancer Status

(NAACCR Item #1770) (STORE 2022 page 337) (SEER page 248)

Description

Records the presence or absence of clinical evidence of the patient's malignant or non-malignant tumor as of the *Date of Last Cancer (tumor) Status* [1772]. If the patient has multiple primaries, the values may be different for each primary.

Rationale

This item can be used to compute disease-free survival. By maintaining this data item, central registries can assist hospital registries by sharing this information with other hospital registries that serve the same patients, if the state's privacy laws so permit.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

- Cancer Status is based on information from the patient's physician or other official source such as a death certificate.
- The patient's Cancer Status should be changed only if new information is received from the patient's physician or other official source. If information is obtained from the patient, a family member, or other non-physician, then cancer status is not updated.
- Cancer Status changes if the patient has a recurrence or relapse.
- If a patient has multiple primaries, each primary could have a different cancer status.

Recurrence Date-1st

(NAACCR Item #1860) (STORE 2022 page 332) (SEER page 249)

Description

Records the date the physician diagnoses the first progression, metastasis, or recurrence of disease after a disease-free period.

Rationale

This data item is used to measure the efficacy of the first course of treatment.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Recurrence Date-1st Flag

(NAACCR Item #1861) (SEER page 252)

Description

This flag explains why no appropriate value is in the field, *Recurrence Date--1st* [1860].

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Recurrence Type-1st

(NAACCR Item #1880) (STORE 2022 pages 332-335) (SEER pages 253-254)

Description

Identifies the type of first recurrence after a period of documented disease-free intermission or remission.

Rationale

This item is used to evaluate treatment efficacy and as a long-term prognostic factor.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Date of Last Follow-Up or Death

(NAACCR Item #1750) (STORE 2021 page 338; SEER page 239-241)

Description

Date of last contact with the patient, or date of death. If the patient has multiple tumors, Date of Last Contact should be the same for all tumors.

Rationale

Used for recording Date of Last Contact from active or passive follow-up. Used to record date of death and to calculate survival. This information is used for follow-up and patient outcome studies.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Note: If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the *Text Remarks-Other Pertinent Information* text area, document that the patient is deceased, and the date of death is not available.

Date of Last Follow-Up or Death Flag

(NAACCR Item #1751) (SEER page 259)

Description

This flag explains why no appropriate value is in the field, *Date of Last Follow-Up or of Death* [1750].

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Vital Status

(NAACCR Item #1760) (STORE 2022 page 339) (SEER page 260)

Description

Records the vital status of the patient as of the *Date of Last Contact or Death* known to the reporting facility through all available resources. If the patient has multiple tumors, vital status should be the same for all tumors.

Rationale

This information is used for outcome studies.

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2022 and forward refer to the SEER Program Coding and Staging Manual 2022.

Note: Failure to find a patient on a list of deceased individuals does not constitute evidence that the patient is alive. Vital Status is not changed, but neither is the *Date of Last Follow-Up or Death* changed. Unless more information is located, follow up of this patient has failed.

Date Abstracted

(NAACCR Item #2090)

Description

Record the date the registrar determined the tumor report was complete (all first course therapy administered, or treatment plan coded and documented) and the case has passed edits.

Rationale

This field is used for TCR data quality and timeliness evaluation.

Coding Instructions

1. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
2. Record the year, month, and day (YYYYMMDD) the form was completed.

Abstractor Initials

(NAACCR Item #570) (STORE 2022 page 343)

Description

Records the initials or assigned code of the individual abstracting the case.

Rationale

This data item is used for providing feedback for quality control.

Coding Instruction

Record the initials of the person abstracting the case.

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DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT

TEXT DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT

(NAACCR Text Item #s 2220, 2520, 2530, 2540, 2550, 2560, 2570, 2590, 2580, 2600, 2610, 2620, 2640, 2650, 2660, 2670, 2680)

Text documentation to support cancer diagnosis, stage, and treatment codes **must be provided by all facilities**.

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies.

High-quality and complete text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Text is used to support coded values and to provide supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor. Cancer Registry software generating text automatically from coded data cannot be utilized to check or support coded values. Information documenting the disease and treatment must be entered manually from the medical record. **TNM staging is not an acceptable substitute for stage documentation**.

Text documentation should explain where the cancer started, where it went (lymph nodes, other organs) and how it got there (direct extension, metastasis, implants). Clinical and pathological findings should be documented.

Document all types of the first course of definitive treatment administered, regardless of where the treatment was received, in chronological order. Documentation is necessary to verify all coded fields regarding types and timing of treatment.

NO treatment: Do not enter text in the treatment text fields when treatment is either not done or it's unknown if it was done. This information is conveyed by the treatment flags. Do not use words such as "none" or "unknown" or N/A. If a port is placed for chemotherapy, record this information but do not code that chemotherapy was given unless it is known that it was.

Note: As an NCI SEER registry, TCR will collect COVID-19 text field data items for cases diagnosed 1/1/2022 and forward if available.

Refer to the Covid-19 Abstraction Guidance for technical guidance regarding the implementation of COVID-19 data abstraction.

Always use text to document certain basic information:

- Specific subsite of primary site (Example*:* upper outer quadrant of left breast).
- The diagnostic impression, final diagnosis, or final conclusion if one is given (Example: Ductal carcinoma of left breast).
- Demographic information such as age at diagnosis, race and sex of the patient should also be recorded in text fields (Example: 76-year-old Caucasian male).

- The date of the examination or procedure (Example: 6/15/2021); keep dates in chronological order.
- The name of the examination or procedure (Example: excisional biopsy).
- The results of the examination or procedure-any pertinent positive or negative information (Examples: negative margins, chest X-ray negative, liver biopsy positive for metastasis).
- Specific number, chain of lymph nodes examined and results (Example: 3/16+ left axillary lymph nodes).
- Specific information about metastatic spread of disease to lymph nodes and/or other organs and tissues (Example: metastasis to 15 supraclavicular lymph nodes; brain metastasis).
- The planned treatment, whether or not it is known if treatment was given (Example: chemotherapy planned after left modified mastectomy).
- The date and type of treatment given, even if it was done at another institution (Example: 6/15/2021 5FU administered at ABC hospital).
- Documentation is used to verify all coded fields regarding the patient, disease, extent of disease and spread of disease. Text should be documented in the appropriate text fields.

Call your Health Service Region contact for technical assistance if additional direction is needed to determine the appropriate information to document. TCR staff may request copies of the necessary reports with your data submission in order to assist you.

Coding Instructions

1. Text automatically generated from coded data is not acceptable.
2. NAACCR-approved abbreviations should be utilized (see Appendix C).
3. Do not repeat information from other text fields.
4. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
5. If information is missing from the record, state that it is missing.
6. Do not include irrelevant information.
7. Do not include information that the registry is not authorized to collect.

Types of Reports to Review

- **Medical imaging** can provide key information for evaluating clinical extent of disease. For example, a CT of the lung can show the size and location of the tumor within the lung. It can demonstrate the presence of pleural effusion, or extension of the tumor to other tissues such as ribs, chest wall or pleura. Bone scans and MRI or CT of the brain are often used to evaluate for metastatic sites. History and Physical reports sometimes give the results from outside imaging

studies. Documentation of all positive and negative findings from imaging exams should be recorded in the Summary Stage Documentation field.

- **Physical exam** or **History and Physical (H&P)** can provide the size for palpable masses and information regarding palpable lymph nodes. For example, during a digital rectal exam (DRE) the prostate is palpated. The physician will note findings such as nodularity, induration, fixation of seminal vesicles, enlargement, firmness, etc. All positive and negative findings pertinent to the patient's cancer are an important aspect of Staging and must be noted in the Summary Stage Documentation field to support coding. Patient demographics can also be found in the H&P. Record age, race and sex when available. This information is useful in record consolidation.
- **Pathology reports provide** key information including cell type, grade, size and location of tumor, number of lesions or foci, depth of invasion, spread of tumor to other organs, and lymph node involvement. Record each of these items in the Summary Stage Documentation. Be sure to record the furthest extension that the pathologist mentions, for example: confined to mucosa; into subserosa; through full thickness of abdomen wall, etc.
- **Operative reports** will often contain the surgeon's observations regarding involvement or lack of involvement of lymph nodes or other organs. The operative report will also contain detailed information of the exact type of surgery performed, tissue or organ(s) excised, and tissue or organ(s) left intact. Record these findings in the Summary Stage Documentation.
- **Discharge summaries, clinical notes, or progress reports** are good sources for treatment information. Review all available reports and document all planned treatment, as well as the date and modalities of known treatment in the Treatment Documentation. Give specific information when available such as type and number of courses of chemotherapy. If no treatment is planned or the patient refuses recommended treatment, include this information in the text field.
- **Lab results** are used to code many of the Site-Specific Data Items (SSDI's). Source documents for many of the SSDI's can be found in the SSDI manual.

Tips for Text Documentation

- Review all the medical documents to get an understanding of the case.
- Highlight pertinent information regarding the diagnosis, work-up, extent of disease, and treatment plan.
- Enter the pertinent information in the text fields using phrases, not long sentences.
- Give a complete story of the patient in regards to their history, the diagnosis, the extent of spread (lymph nodes, other sites), and the treatment (what was done, at all facilities, whether completed or not).
- Use NAACCR Standard Abbreviations only.
- After entering all the coded data in their data item fields, review the text to assure the accuracy and consistency of your codes.
- Refer to *Using the Informational Abstracts in Your Registry* on the NCRA website for more information. http://www.cancerregistryeducation.org/rr

Final Diagnosis - Morphology/Behavior, Grade, Primary Site, and Laterality Documentation

(NAACCR Items #2580 [Text-Primary Site Title], #2590 [Text-Histology Title]

Description

Text area for manual documentation of information regarding the **primary site, laterality of the tumor, the histologic type, behavior,** and **grade** (differentiation) of the tumor being reported.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.
The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions

1. Document the specific location of the primary site, including subsite, and laterality.
2. Document the histologic type, behavior, and grade.
3. Do not use the generic ICD-10-CM code statement found on the face sheet.

   Example 1: Morphology: Moderately well differentiated mucin-producing adenocarcinoma
   Primary Site: Colon, ascending

   Example 2: Morphology: Grade 3, infiltrating ductal and lobular carcinoma
   Primary Site: Right breast, upper outer quadrant

   Example 3: Morphology: Anaplastic astrocytoma
   Primary Site: Brain, frontal-parietal lobe

   Example 4: Morphology: Intermediate grade large cell carcinoma
   Primary Site: Left lung lower lobe
4. NAACCR-approved abbreviations should be utilized (See Appendix C)
5. If information is missing, state that it is missing.
6. **Refer to 2022 NAACCR Data Dictionary for list of data items to be verified by the text fields.**

Text Remarks - Other Pertinent Information

(NAACCR Item #2680)

Description

Text area for information that is given only in coded form elsewhere or for which the abstract provides no other place. Overflow data can also be placed here. Problematic coding issues can also be discussed in this section.

Rationale

Information documenting the disease process should be entered manually from the medical record and not be generated from coded values. Such documentation should include additional staging information, additional treatment documentation, documentation of race and sex, history of disease, family history, place of birth, and comments regarding lack of information in the medical record. The name of the following (Follow Up) physicians should also be noted here. See the Text Documentation Section of 2021 TCR Cancer Reporting Handbook for detailed instructions.

Instructions

1. NAACCR-approved abbreviations should be utilized (see Appendix C).
2. Do not repeat information from other text fields.
3. Additional comments from other text fields can be continued in the Remarks field. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
4. If information is missing from the record, state that it is missing.
5. Do not include irrelevant information.
6. Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Age, sex and race of patient
- Spanish/Hispanic origin
- Place of birth
- Insurance/primary payer information
- Name of follow-up physician
- Family history of cancer
- **Personal history of cancer**
- Smoking history

- Comorbidities
- Unknown demographic information (ex. Unknown SS# or address at diagnosis)
- Information on sequence numbers if a person was diagnosed with another primary out-of-state or before the registry's reference date
- Justification of over-ride flags
- Information clarifying anything unusual such as reason for reporting a case seemingly not reportable for that facility or reason for coding numerous fields as "unknown
- Document Covid-19 information if available
    - ICD diagnosis code and date
    - U07.1 [COVID-19]
    - General cancer treatment delays, modifications
    - Change in first course of treatment
    - Z75.3 [unavailability or inaccessibility of health care facilities]
    - Examples
        - U07.1 05/09/2020
        - FCOT CHG D/T COVID-19
        - Z75.3 06/01/2020

Summary Stage Documentation

(NAACCR Item #2600) (Alternate Name: Text-Staging)

Description

Additional text area for staging information not already entered in other Text fields. However, in situations in which there is limited information, rather than putting a little information in all of the various text boxes, you can enter the small amount of information in this text field.

For example: a non-analytic case in which the patient appeared with active disease and was not treated by the reporting facility.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values and should not be generated electronically from coded values. Information documenting the disease process should be entered manually from the medical record. Staging should

include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.
5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.
9. **Refer to 2022 NAACCR Data Dictionary for list of data items to be verified by the text fields.**

Suggestions for Text

- Date(s) of procedure(s), including clinical procedures, which provided information for assigning stage; organs involved by direct extension
- Organs involved by direct extension
- Size of tumor
- Status of margins
- Number and sites of positive lymph nodes
- Site(s) of distant metastasis
- Physician‘s specialty and comments

Summary Stage Documentation – History & Physical Exam

(NAACCR Item #2520)

Description

Text area for manual documentation from the history and physical examination about the history of the current tumor and the clinical description of the tumor.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values and should not be generated electronically from coded values. Information documenting the disease process should be entered manually from the medical record. Staging should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.
5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.
9. **Refer to 2022 NAACCR Data Dictionary for list of data items to be verified by the text fields.**

Suggestions for Text

- Date of physical exam
- History that relates to cancer diagnosis
- Primary site
- Histology (if diagnosis prior to this admission)
- Tumor location
- Tumor size
- Palpable lymph nodes
- Record positive and negative clinical findings; record positive results first

- Impression (when stated and pertains to cancer diagnosis)
- Treatment plan

Summary Stage Documentation - Imaging

(NAACCR #2530)

Description

Text area for manual documentation from all X-rays, scans, and/or other imaging examinations that provide information about staging.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values and should not be generated electronically from coded values. Information documenting the disease process should be entered manually from the medical record. Staging should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.
5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.
9. **Refer to 2022 NAACCR Data Dictionary for list of data items to be verified by the text fields.**

Suggestions for text

- Date(s) and type(s) of X-ray/Scan(s)
- Facility name
- Primary site
- Histology (if given)
- Tumor location
- Tumor size
- Lymph nodes
- Record positive and negative clinical findings; record positive results first
- Distant disease or metastasis

Summary Stage Documentation - Scopes

(NAACCR Item #2540)

Description

Text area for manual documentation from endoscopic examinations that provide information for staging and treatment.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values and should not be generated electronically from coded values. Information documenting the disease process should be entered manually from the medical record. Staging should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.

5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.
9. **Refer to 2022 NAACCR Data Dictionary for list of data items to be verified by the text fields.**

Suggestions for Text

- Date(s) of endoscopic exam(s)
- Facility name
- Primary site
- Histology (if given)
- Tumor location
- Tumor size
- Record site and type of endoscopic biopsy
- Record positive and negative clinical findings; record positive results first

Summary Stage Documentation - Laboratory tests

(NAACCR Item # 2550)

Description

Text area for manual documentation of information from laboratory examinations **other than cytology or histopathology.**

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values and should not be generated electronically from coded values. Information documenting the disease process should be entered manually from the medical record. Staging should

include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.
5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.
9. **Refer to 2022 NAACCR Data Dictionary for list of data items to be verified by the text fields.**

Suggestions for Text

- Date of lab test(s)
- Type of lab test/tissue specimen(s)
- Record both positive and negative findings; record positive test results first
- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Tumor markers included, but are not limited to:
    - Breast Cancer – Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu
    - Prostate Cancer – Prostatic Specific Antigen (PSA)
    - Testicular Cancer – Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH)
- Covid-19
    - Interpretation of SARS-CoV-2 viral testing and antibody testing
    - Date of SARS-CoV-2 viral testing and antibody testing
    - Examples
        - COVID-19 viral POS 05/09/2020
        - COVID-19 viral NEG 03/09/2020 antibody POS 05/09/2020

Summary Stage Documentation – Operative Procedure

(NAACCR Item # 2560)

Description

Text area for manual documentation of all surgical procedures that provide information for staging.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values and should not be generated electronically from coded values. Information documenting the disease process should be entered manually from the medical record. Staging should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.
5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.
9. **Refer to 2022 NAACCR Data Dictionary for list of data items to be verified by the text fields.**

Suggestions for Text

- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived
- Number of lymph nodes removed

- Size of tumor removed
- Documentation of residual tumor
- Evidence of invasion of surrounding areas
- Reason primary site surgery could not be completed

Summary Stage Documentation - Pathology

(NAACCR Item # 2570)

Description

Text area for manual documentation of information from **cytology** and **histopathology** reports.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values and should not be generated electronically from coded values. Information documenting the disease process should be entered manually from the medical record. Staging should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.
5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.
9. **Refer to 2022 NAACCR Data Dictionary for list of data items to be verified by the text fields.**

Suggestions for Text

- Date(s) of procedure(s)
- Anatomic source of specimen
- Type of tissue specimen(s)
- Tumor type and grade (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.)
- Gross tumor size
- Extent of tumor spread
- Involvement of resection margins
- Number of lymph nodes involved and examined
- Record both positive and negative findings. Record positive test results first
- Note if pathology report is a slide review or a second opinion from an outside source, i.e., AFIP, Mayo, etc.
- Record any additional comments from the pathologist, including diagnoses considered and any ruled out or favored.

Text Field Documentation Suggestions

After manual entry of the text fields, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. Refer to NAACCR Data Standards and Data Dictionary, Volume II for the complete list of data items that can be verified with text.

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
Other Pertinent Information #2680	• Age, sex and race of patient • Spanish/Hispanic Origin • Place of birth • Country of Birth • Insurance/primary payer information • Name of Follow Up Physician • Family and personal history of cancer • Comorbidities • Smoking history • Unknown demographic information (unknown SS#, unknown address at diagnosis) • Overflow or problematic coding issues	Date of Diagnosis #390 Sex #220 Race 1-5 #160-164 Spanish/Hispanic Origin #190 Age at Diagnosis #230 Birthplace-State #252 Birthplace-Country #254 Primary Payer at Dx #630 Physician Follow Up #2470 Sequence Number #560 Tobacco Use #344

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
Summary Stage Documentation #2600	• Date(s) of procedure(s) including biopsies and clinical procedures that provide staging information such as x-rays • Organs involved by direct extension • Size of tumor • Status of margins • Number and sites of positive lymph nodes • Metastatic sites • Physician's specialty (Surgeon, Oncologist, etc.) • Physician's comments	Date of Diagnosis #390 Diagnostic Confirmation #490 Primary site #400 Laterality #410 Morphology/Behavior # 522, 523 Grade Clin #3843 Grade Path #3844 Grade Post Tx Clin #1068 Grade Post Tx Path #3845 Tumor Size #752, 754 Regional Nodes Positive #820 Regional Nodes Examined #830 SEER Summary Stage #764 EOD Data Items #772, 774, 776 AJCC TNM Data #1001-1036
Summary Stage Documentation –History and Physical Exam #2520	• Date of physical exam • History relating to cancer diagnosis • Primary site • Histology (if dx prior to this admission) • Tumor location • Tumor size • Impression pertaining to cancer diagnosis • Positive and negative clinical findings • Palpable lymph nodes • Treatment plan	Date of First Contact #580 Date of Diagnosis #390 Primary Site #400 Laterality #410 Histology ICD-O-3 #522 SEER Summary Stage 2018 #764 Reason for No Surgery #1340
Summary Stage Documentation-Imaging #2530	• Date and type of X-ray or Scan • Primary site • Histology (if given) • Tumor location • Tumor size • Lymph nodes • Record positive and negative findings • Distant disease or mets	Date of Diagnosis #390 Primary Site #400 Laterality #410 Histology ICD-O-3 #522 SEER Summary Stage 2018 #764 EOD Data Items #772, 774, 776 AJCC TNM Data #1001-1036

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
Summary Stage Documentation-Scopes #2540	• Dates of endoscopic exams • Primary site • Histology • Tumor location • Tumor size • Site and type of endoscopic biopsy • Positive and negative clinical findings	Date of Diagnosis #390 Diagnostic Confirmation #490 Primary Site #400 Laterality #410 Histology ICD-O-3 #522 SEER Summary Stage 2018 #764 EOD Data Items #772, 774, 776 AJCC TNM Data #1001-1036
Summary Stage Documentation-Laboratory #2550	• Type of lab test/tissue specimen • Both positive and negative findings • Tumor markers, special studies etc. Including: Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu, Human Chorionic Gonadotropin (hCG) • Date of lab tests	Primary Site #400 Diagnostic Confirmation #490 Date of Diagnosis #390 SSDIs #3803-3933
Summary Stage Documentation-Operative Report #2560	• Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived • Number of lymph nodes removed • Size of tumor removed • Documentation of residual tumor • Evidence of invasion of surrounding areas	Date of Diagnosis #390 Date Therapy Initiated #1260 Date of Surgical Procedure #1200 Date of Mst Defn Srg #3170 Diagnostic Confirmation #490 Primary Site #400 Laterality #410 Tumor Size-Path #754 Surgery of Primary Site #1290 Surg Procedure Other Site #1294 Scope of Reg Lymph Nodes #1292 SEER Summary Stage 2018 #764 EOD Data Items #772, 774, 776 AJCC TNM Data #1001-1036

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
Summary Stage Documentation Pathology #2570	• Dates of procedures • Anatomic source of specimen • Type of tissue specimen • Tumor type and grade (include all modifying adjectives: predominantly, with features of etc.) • Gross tumor size • Extent of tumor spread • Involvement of resection margin • Number of lymph nodes involved and examined • Both positive and negative findings • Record any additional comments from the pathologist, including differential diagnosis considered and any ruled out or favored	Date of Diagnosis #390 Date of Surgical Procedure #1200 Date of Mst Defn Srg #3170 Primary Site #400 Laterality #410 Histologic Type ICD-O-3 #522 Grade Clin #3843 Grade Path #3844 Grade Post Tx Clin #1068 Grade Post Tx Path #3845 Diagnostic Confirmation #490 Surgery of Primary Site #1290 Surgical Margins #1320 Scope Reg Lymph Nodes #1392 Surg Procedure Other Site #1294 SEER Summary Stage 2018 #764 SSDIs #3803-3933 Regional Nodes Positive #820 Regional Nodes Examined #830 Surg/Rad Seq #1380 Summ-Systemic/Sur Seq #1639
Final Diagnosis (Primary, Laterality) #2580	• Location of primary site of tumor • Information on laterality of tumor	Primary site #400 Laterality #410
Final Diagnosis (Morphology, Behavior, Grade) #2590	• Histologic Type/Behavior • Grade of tumor	Morphology/Behavior #522, #523 Grade Clin #3843 Grade Path #3844 Grade Post Tx Clin #1068 Grade Post Tx Path #3845
Rx Text Surgery #2610	• Date of each surgical procedure • Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites • Lymph nodes removed • Regional tissues removed • Facility where each procedure was performed • Other treatment information, e.g. planned procedure aborted.	Date of Initial Treatment #1360 Date Surgery #1300 Date Most Defn Surg #3170 Date Reg LN Dissection #682 Surgery of Primary Site #1290 Scope of Reg LN Surgery #1292 Surg Procedure Other Site #1294 Treatment Status #1285

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
Rx Text-Radiation #2620	• Date radiation treatment began and ended • Where treatment was given, e.g., at this facility, at another facility • Type(s) of radiation • Planned doses • Other treatment information (discontinued after 2 treatments.)	Date of Initial Treatment #1360 Date Radiation Started #1310 Radiation Treatment Modality I, II, III #1506, 1516, 1526 Radiation Ext Beam Planning Tech I, II, III #1502, 1512, 1522 Radiation Seq w/Surgery #1380 Treatment Status #1285
Rx Text-Chemo #2640	• Date when chemotherapy began and ended • Where chemotherapy was given, e.g., at this facility, at another facility • Type of chemotherapy (name of agent(s) and doses planned/received • Other treatment information (treatment cycle incomplete.)	Date of Initial Treatment #1360 Date Systemic Tx Started #3230 Date Chemo Started #1220 Chemotherapy #1390 Systemic/Surgery Sequence #1639 Treatment Status #1285
Rx Text-Hormone #2650	• Date treatment was started • Where treatment was given, e.g., at this facility, at another facility • Type of hormone or antihormone • Type of endocrine surgery or radiation • Other treatment Information, e.g. Treatment cycle incomplete.	Date of Initial Treatment #1360 Date Systemic Tx Started #3230 Date Hormone Tx Started #1230 Hormone Therapy #1400 Systemic/Surgery Sequence #1639 Treatment Status #1285
Rx Text-BRM Immunotherapy #2660	• Date treatment began • Where treatment was given e.g. at this facility, at another facility • BRM procedures, e.g. bone marrow transplant, stem cell transplant • Type of immunotherapy given • Type of BRM agent, e.g. Interferon, BCG • Other treatment information e.g. treatment cycle incomplete.	Date of Initial Treatment #1360 Date Systemic Tx Started # Date Immunotherapy Started #1240 Immunotherapy #1340 Hematologic Transplant/Endocrine Procedures #3250 Systemic/Surgery Sequence #1639 Treatment Status #1285
Rx Text-Other #2670	• Date treatment was started • Where treatment was given, e.g., at this facility, at another facility • Type of other treatment • Other treatment information (incomplete)	Date of Initial Treatment #1360 Date Other Tx Started #1250 RX Summ-Other #1420 Treatment Status #1285

Examples

Case #1 Lung

- Imaging Reports
    - 2/18/22 VA Clinic: CT Chest: Findings: Supraclavicular, axillary, and mediastinal structures unremarkable. No mediastinal or hilar adenopathy. There is a 2.8 x 2.4 x 4.8cm mass in the right lower lobe. The margins are well defined with minimal peripheral ground-glass opacity, probably some degree of obstructive pneumonitis. The remainder of the lungs is clear.
    - Impression: Lobulated soft tissue mass in the right lower lobe consistent with neoplasm. No evidence of adenopathy, mediastinal or hilar spread.
    - 2/28/22 CT Brain Your Hospital: Impression: No evident disease process.
- Pathology Reports
    - 2/28/22 Your Hospital: Final Diagnosis: Fine Needle Aspirate, right lower lobe lung: positive for malignant cells
    - 3/1/22 Your Hospital: Final Diagnosis: Superior segment right lower lobe, resection: moderately differentiated squamous cell carcinoma, maximum tumor diameter 5.0cm, 2nd nodule in right lower lobe measures 0.5cm, resection margin free of tumor, peribronchial lymph node negative for tumor, right lower paratracheal lymph node negative for tumor, right pretracheal lymph node negative for tumor.
- Clinic Reports
    - 3/15/22: Oncologist recommended 4 cycles of adjuvant Taxol and carboplatin. The patient would rather receive treatment closer to home and has been referred to an oncologist in that area.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

2/18/22 (VA Clinic) CT Chest: 4.8cm mass in RLL c/w neoplasm, supraclavicular, axillary, and mediastinal structures unremarkable, no mediastinal or hilar lymphadenopathy, probably some obstructive pneumonitis, remainder of lungs clear

2/28/22 (Your Hospital) Fine Needle Aspirate RLL lung: positive for malignant cells

2/28/22 (VA Clinic) Ct Brain: No evident dz process

3/1/22 (Your Hospital) RLL Resection: MD Squamous cell car, 2 nodules 5cm and 0.5cm, margin free, 0/3 peribronchial, paratracheal and pretracheal lns

Treatment Documentation (2610, 2620, 2640, 2650, 2660, 2670)

3/1/21 (Your hospital) RLL lobectomy with mediastinal ln dissection

3/15/21 Oncologist recommends 4 cycles adjuvant Taxol and carboplatin. PT wants treatment closer to home, referred to oncologist in his area, unknown if chemo done.

Case #2 Lung

- Imaging Reports
    - 6/25/22 River Ranch Radiology CT Chest: I see no pneumothorax or pleural effusion. There is an 11.7 x 8.5cm soft tissue mass in the right apex. There is associated marked mediastinal lymphadenopathy with enlarged nodes in the anterior mediastinum, enlarged nodes lying lateral to the main pulmonary artery, and enlarged nodes in the pretracheal and precarinal region. There are enlarged nodes around the right hilum. The left lung appears normal.
    - Conclusion: Right upper lobe mass with associated marked mediastinal lymphadenopathy. The findings are highly suspicious for a primary carcinoma of the lung.
    - 7/1/22 Oncology Associates Bone scan: Non-specific increased uptake at L3 and L5, no obvious metastasis.
    - 7/1/22 Oncology Associates MRI brain: Diffuse cerebral atrophy
- Bronchoscopy Report
    - 6/26/22 Bronchoscopy: The vocal cords were visualized and appeared to move normally. The bronchoscope was passed to the trachea, which was widely patent. No endobronchial lesions were noted. There was a small amount of bleeding from the right upper orifice. No lesions were noted at the right lower lobe or right middle lobe. Endobronchial biopsy was performed times six at the right upper lobe. Bleeding was minimal.
- Pathology Report
    - 6/26/22 Right upper lobe mass biopsy Final Diagnosis: non-small cell carcinoma
- Clinical Reports
    - 7/5/22 Oncology Clinic Consultation: This patient has at least Stage 3b disease. This condition can best be treated with a combination of chemotherapy and radiation therapy concurrently. We want to start treatment as soon as possible.
    - 7/15/22 Discharge Summary: The patient has been treated with VP-16 times three days along with daily radiation therapy for a diagnosis of non-small cell carcinoma. He was hospitalized because of shortness of breath and iron deficiency anemia. At this time his condition has stabilized.

Summary Stage Documentation ((2520, 2530, 2540, 2550, 2560, 2570, 2600)

6/25/22 (RRR) CT chest: no pneumothorax or pleural effusion, 11.7cm mass in rt apex, highly suspicious for lung carcinoma, marked mediastinal lymphadenopathy, enlarged nodes in anterior mediastinum, enlarged nodes lateral to main pulmonary artery, in pretracheal and precarinal region and in rt hilum, lft lung appears normal

6/26/22 (Your hospital) Bronchoscopy: vocal cords appear to move normally, no endobronchial, rll or rml lesions

6/26/22 (Your hospital) RUL mass bx: Non-small cell carcinoma

7/1/22 (Onc Assoc) Bone Scan: no mets

7/1/22 (Onc Assoc) MRI brain: diffuse cerebral atrophy

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

7/5/21 (Onc Clinic) concurrent chemo/radiation therapy recommended

7/15/21 Discharge Summary: PT has been treated with VP-16 x 3 days along with daily radiation therapy

Case #3 Breast

- Imaging Reports
    - 1/2/22 Mammogram: Left breast: No dominant masses, or suspicious calcifications, or architectural disturbances are present. In the right breast there is a 3.5 x 4.6cm irregular spiculated mass in the lower-outer quadrant.
    - Impression: Large mass in the lower-outer quadrant of the right breast, biopsy is recommended.
    - 1/13/22 CT Chest: COPD with mild parenchymal scarring. No evidence of cardiomegaly. There is bone destruction of posterior ribs/spine. CT Abdomen and Pelvis no abnormal findings.
    - Impression: Bone destruction of posterior ribs/spine, probably mets from known breast cancer.
- Pathology Reports
    - 1/10/22 Core biopsy right breast lower outer quadrant: Final Diagnosis: Infiltrating ductal carcinoma, poorly differentiated, ER and PR positive, HER2 ICH 0, negative.
- Clinical Reports

- 1/15/22 Surgery consult: Patient noted a mass in the lower-outer quadrant of her right breast. There is marked lymphadenopathy in the right axilla. The left breast is within normal limits.
- HEENT: Clear conjunctivae, pupils equal, round and reactive to light. Nasal passages clear without drainage.
- Neck: Supple, full range of motion. No thyromegaly, trachea is midline.
- Lungs: No wheezing or crackles. There are no bronchial breath sounds or pleural rub.
- Abdomen: Soft, non-tender, non-distended without hepatosplenomegaly or masses. Normal bowel sounds.
- Patient will be referred to Radiation Oncology for consideration of radiation therapy to known bony mets.
- 2/1/22 Oncology note: Patient has decided to try alternative therapy and has declined radiation therapy and chemotherapy.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

1/2/22 Mammogram: Lt breast no masses, Rt breast 4.6cm mass in LOQ, biopsy recommended.

1/10/22 Bx rt breast LOQ Infil ductal car, PD, ER and PR positive, HER2 IHC 0-Negative

1/13/22 CT Chest: Bone destruction posterior ribs/spine, probably mets from breast ca, CT Abdomen/Pelvis: no abnormal findings

1/15/22 Surg consult: marked lymphadenopathy in rt axilla

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

1/15/22 Surg Consult: Patient referred to radiation oncology for consideration of radiation therapy to bony mets.

2/1/22 Oncology note: Pt has decided to try alternative therapy, declined radiation therapy and chemotherapy.

Case #4 Breast

- Imaging Reports
  - 6/1/22 Mammogram: In the right breast there is a 1.2 x 1.5cm mass in the upper-outer quadrant. There is no evidence of axillary lymphadenopathy. The left breast appears normal.
  - 6/14/22 Chest Xray: Within normal limits
  - 6/14/22 Bone Scan: Impression: No evidence of skeletal disease. Thoracic and lumbar spine negative for metastases.

- Pathology Reports
    - 6/8/22 Right breast fine needle aspiration cytology: Adenocarcinoma
    - 6/15/22 Right breast modified radical mastectomy: Final Diagnosis: Infiltrating ductal carcinoma, tubular type, 1.4cm, margins clear, Bloom Richardson score 3, no dermal or lymphatic invasion, no evidence of tumor in 32 regional lymph nodes, Estrogen and Progesterone Receptors negative, HER2 IHC 3+, positive.
- Clinical Reports
    - 6/1/22 History and Physical: Family physician noted 2cm mass in right breast on physical exam. No pain or tenderness; no nipple discharge; no skin changes. Slight nipple retraction. Freely movable mass. Left breast: no masses palpated. No enlarged lymph nodes.
    - 10/13/22 Oncology Clinic Follow-up ***Note:*** Patient started 3 cycles of adjuvant Adriamycin and Cytoxan on 7/20/22, recently completed and now has begun Tamoxifen.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

6/1/22 Mammogram: 1.5cm mass rt breast UOQ, no lymphadenopathy, lt breast appears normal

6/1/22 H&P 2cm mass in right breast, no masses palpated in lt breast, no enlarged lymph nodes

6/14/22 CXR: WNL; Bone Scan: no evident mets

6/8/22 Rt Breast fine needle aspiration = adenoca

6/15/22 Rt breast mastectomy: infiltrating duct carcinoma, tubular type, 1.4cm, margin clear, Bloom Richardson score 3, 0/32 LNS positive, ER/PR negative, HER2 IHC 3+ positive.

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

6/15/22 Rt breast modified radical mastectomy

10/13/22 Oncology note: pt had 3 cycles Adriamycin and Cytoxan begun on 7/20/22, recently completed and has begun Tamoxifen.

Case #5 Colon/Rectum

- Imaging Reports
    - 4/20/22 CT Abdomen and Pelvis
        - Two areas of circumferential colonic wall thickening affecting the distal sigmoid colon and a loop of colon in the right lower quadrant/right pelvic region with multiple low-density lesions being noted in the liver. Although these could represent incidental benign hepatic cysts, metastatic liver disease cannot be excluded at this time as colonic carcinoma is one of the causes of cystic liver

metastasis. It should be noted although there are shotty lymph nodes present, there is no definite lymphadenopathy demonstrated.

- History of uterine cancer in 2003 with evidence of prior hysterectomy. This is not usually a cause of cystic liver metastasis.
- Otherwise, unremarkable CT scan of the abdomen and pelvis with other incidental findings as noted above.

- 4/25/22 Whole Body PET Scan
  - Conclusion: Radionuclide uptake in the left abdomen, representing a nonspecific finding.
  - No focal areas of increased uptake are seen in the liver to suggest hepatic metastasis.

- Pathology Reports
  - 4/15/2022 Final Diagnosis: Colon biopsy at 135cm moderately differentiated adenocarcinoma, mucin producing signet ring cell, high grade.
  - 5/1/2022 Final Diagnosis right hemicolectomy
    - High-grade mucin-producing signet ring cell carcinoma, 4 cm in size and located in colon near ileocolic junction, tumor invades pericolonic adipose tissue, (PT3)
    - No evidence of lymph node metastasis among seven lymph nodes. (PNO)
    - Excision margin is negative.
    - KRAS mutated
    - Normal heterozygous state (Normal LOH)
- Operative Report
  - Date of Procedure: 5/1/22
  - Preoperative Diagnosis: Right colon cancer
  - Postoperative Diagnosis: Right colon cancer, with adhesive bowel disease.
  - Procedures Performed: Exploratory laparotomy, lysis of adhesions, right hemicolectomy.
  - Findings: On exploration of the abdomen, the liver was palpated found to be unremarkable. There were no lesions in the colon other than in the right colon. In the small bowel, there were adhesions, especially in the terminal ileum, adherent to the cecum.
- Oncology Consult: 5/15/22
  - History Of Present Illness: Patient is a 56-year-old female who had a diagnosis of endometrial cancer, status post-surgery followed by radiation therapy fifteen years ago. A few weeks ago, the patient had a routine colonoscopic examination and the patient was

found to have lesions in the right side of the colon. The patient underwent surgery on May 1, 2022.

- Assessment: The patient has a new diagnosis of high-grade mucin producing signet ring cell adenocarcinoma of colon. This is about 4 cm in size with pericolonic tissue invasion. Based on these reports and findings, the patient may benefit from adjuvant chemotherapy.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

4/15/22 Colon biopsy at 135cm: Moderately differentiated adenoca, mucin producing signet ring cell, high grade.

4/20/22 Ct Abdomen and Pelvis: 2 areas circumferential colonic wall thickening affecting the distal sigmoid colon and a loop of colon in the rt lower quadrant/rt pelvic region. Multiple liver lesions could represent benign hepatic cysts, mets liver dz cannot be excluded; snotty lymph nodes present, no definitive lymphadenopathy, otherwise unremarkable CT abdomen and pelvis; pt has a history of uterine cancer in 2003 with evidence of hysterectomy

4/25/22 Whole body PET scan: no focal areas of increased uptake in liver to suggest hepatic mets

5/1/22 Operative report: Liver palpated, found to be unremarkable, no lesion in colon other than rt colon

5/1/22 Right hemicolectomy: High-grade mucin producing signet ring cell carcinoma, 4cm, located near ileocolic junction, invades pericolonic adipose tissue, 0/7LNS positive, excision margin is negative; MSI-stable, KRAS mutated, normal LOH

5/15/22 Oncology consult: The patient may benefit from adjuvant chemotherapy; unknown if chemotherapy given.

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

5/1/22 Right Hemicolectomy

Case #6 Melanoma

- Imaging Reports
    - 5/10/22 CT Chest: Impression: Probably malignant involvement of left axillary lymph nodes. Several lymph nodes seen in supraclavicular region too small to characterize. The remainder of the exam is normal.
- Pathology Reports
    - 5/3/22 Final Diagnosis: Shave biopsy skin of left forearm, Malignant melanoma
    - 5/11/22 Final Diagnosis: Wide excision of skin of left forearm, Malignant melanoma, nodular type, Clark's Level III, Breslow's depth 1.0mm, papillary dermis invaded, no

ulceration present no mitosis present. Margins of resection free, but within less than 2mm. LDH Less than 1.5 x upper limit of normal for lactate dehydrogenase (LDH) assay

- Oncology Report
    - 6/15/22 The patient was started on an interferon regimen today.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

5/3/22 Shave bx skin of lt forearm: Malignant melanoma

5/10/22 CT chest: Probably malignant involvement of lt axillary lymph nodes, remainder of exam normal

5/11/22 Wide exc skin of lt forearm: Malignant melanoma, nodular type, Clark's Level 3, Breslow's depth 1.0mm, papillary dermis invaded, no ulceration, no mitosis, margin free but within less than 2mm, LDH Range 1: Less than 1.5 x upper limit of normal for lactate dehydrogenase (LDH) assay

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

5/11/22 Wide excision of skin of lt forearm

6/15/22 started interferon regimen

Case #7 Melanoma

- Imaging Reports
    - 11/18/22 Chest Xray: Within normal limits
    - 11/24/22 CT Chest, Abdomen and Pelvis: Impression: Nonspecific soft tissue nodule in the right upper lobe. This is nonspecific but would be consistent with benign parenchymal scar or granuloma. The remainder of the lungs is clear.
    - There is no evidence of metastatic disease in the chest, abdomen or pelvis.
- Pathology Reports
    - Outside Facility:
        - 11/13/22 Final Diagnosis: Excision of lesion on right side of neck, 1.5 x .0.8 x 0.5 cm specimen contains a pigmented, 0.4 x 0.3cm area consistent with malignant melanoma in situ, extending to margins of excision.
    - Your Facility:
        - 11/25/22 Final Diagnosis: Wide re-excision skin of right neck, Inflammation and organizing granulation tissue, negative for any residual melanoma, margins of resection negative.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

11/18/22 CXR: Within normal limits

11/24/22 CT Chest/abdomen/pelvis: No evidence of mets in chest, abdomen or pelvis

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

11/13/22 Exc of lesion rt side of neck: 0.4x0.3cm malignant melanoma in situ, Ext to margin

11/25/22 Wide re-excision of skin rt neck, negative for residual melanoma, margins negative

Case #8 Lymphoma

- Imaging Reports
    - 2/2/22 CT Chest Impression: Extensive right and left hilar lymphadenopathy, enlarged lymph nodes in the mediastinum.
    - 2/2/22 CT Abdomen Impression: Splenomegaly, otherwise within normal limits.
    - 2/4/22 PET scan: Intense focus of tracer uptake seen in peri-portal region consistent with lymphoma.
- Pathology Reports
    - 2/3/22 Biopsy of left axillary lymph nodes, Follicular Lymphoma, Gr 1
    - H&P
    - 2/2/22 Patient presents with bilateral cervical and axillary lymphadenopathy, night sweats, and fevers for last couple of months.
- Oncology Consult
    - 2/13/22 The patient was started on combination chemotherapy including Rituxan on February 5 and has done well with the exception of nausea. We will start him on a trial of antiemetics.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

2/2/22 H&P Pt has bilateral cervical and axillary lymphadenopathy, hx of night sweats, fevers

2/2/22 CT Chest: rt and lt hilar lymphadenopathy, enlarged lymph nodes in the mediastinum

2/2/22 CT Abdomen: Splenomegaly, otherwise within normal limits

2/3/22 Biopsy lt axillary lns: Follicular Lymphoma, Gr 1

2/4/22 PET scan: focus of tracer uptake in peri-portal region consistent with lymphoma

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

2/5/22 Combination chemotherapy including Rituxan, other types of chemo not mentioned

Case #9 Prostate

- Imaging Reports
  - 4/14/22 CT Abdomen/Pelvis Impression:
  - Tiny cyst in the liver.
  - No lymphadenopathy in abdomen or pelvis
  - 4/14/22 Bone scan Impression: Evidence of previous fracture in right 13th rib, otherwise negative bone scan
- Pathology Reports
  - 4/1/22 Final Diagnosis: Prostate core needle biopsy, adenocarcinoma present in 8 of 13 cores, Gleason Score 3+3=6
- Clinical Reports
  - 3/27/22 Surgical consult: Patient is seen in consultation because PSA elevated at 6. DRE shows slightly enlarged prostate with no nodularity or induration. The abdomen and pelvis are examined and show no palpable abnormalities.
  - 7/1/22 Patient was counseled regarding various treatment options including radiation therapy, surgery and hormonal treatment. He decided to proceed with external beam radiation therapy, and this was completed on 6/15/18.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

3/27/22 PE: DRE shows slightly enlarged prostate with no nodularity or induration, abdomen and pelvis with no palpable abnormalities, PSA 6

4/1/22 Prostate core needle biopsy: adenocarcinoma in 8/13 cores, Gleason Score 3+3=6

4/14/22 CT Abdomen/Pelvis: no lymphadenopathy in abdomen or pelvis

4/14/22 Bone scan: negative

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

External beam radiation therapy completed on 6/15/22, start date not given; estimate start date 5/2021

A

APPENDIX A: REPORTING LAW AND RULES

THE LAW

HEALTH AND SAFETY Code

TITLE 2. HEALTH

SUBTITLE D. PREVENTION, CONTROL, AND REPORTS OF DISEASES

CHAPTER 82. CANCER REGISTRY

Sec. 82.001. SHORT TITLE. This chapter may be cited as the Texas Cancer Incidence Reporting Act.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 33, eff. Sept. 1, 1991.

Sec. 82.002. DEFINITIONS. In this chapter:

(1) "Cancer" includes:

(A) a large group of diseases characterized by uncontrolled growth and spread of abnormal cells;

(B) any condition of tumors having the properties of anaplasia, invasion, and metastasis;

(C) a cellular tumor the natural course of which is fatal, including malignant and benign tumors of the central nervous system; and

(D) malignant neoplasm, other than nonmelanoma skin cancers such as basal and squamous cell carcinomas.

(2) "Clinical laboratory" means an accredited facility in which:

(A) tests are performed identifying findings of anatomical changes; and

(B) specimens are interpreted, and pathological diagnoses are made.

(3) "Health care facility " means:

(A) a general or special hospital as defined by Chapter 241 (Texas Hospital Licensing Law);

(B) an ambulatory surgical center licensed under Chapter 243;

(C) an institution licensed under Chapter 242; or

(D) any other facility, including an outpatient clinic, that provides diagnosis or treatment services to patients with cancer.

(4) "Health care practitioner" means:

(A) a physician as defined by Section 151.002, Occupations Code; or

(B) a person who practices dentistry as described by Section 251.003, Occupations Code.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 1, eff. Sept. 1, 2001.

Sec. 82.003. APPLICABILITY OF CHAPTER. This chapter applies to records of cases of cancer, diagnosed on or after January 1, 1979, and to records of all ongoing cancer cases diagnosed before January 1, 1979.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 2, eff. Sept. 1, 2001.

Sec. 82.004. REGISTRY REQUIRED. The department shall maintain a cancer registry for the state.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0252, eff. April 2, 2015.

Sec. 82.005. CONTENT OF REGISTRY. (a) The cancer registry must be a central data bank of accurate, precise, and current information that medical authorities agree serves as an invaluable tool in the early recognition, prevention, cure, and control of cancer.

(b) The cancer registry must include:

(1) a record of the cases of cancer that occur in the state; and

(2) information concerning cancer cases as the executive commissioner considers necessary and appropriate for the recognition, prevention, cure, or control of cancer.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 3, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0253, eff. April 2, 2015.

Sec. 82.006. EXECUTIVE COMMISSIONER AND DEPARTMENT POWERS. (a) To implement this chapter, the executive commissioner may adopt rules that the executive commissioner considers necessary.

(b) To implement this chapter, the department may:

(1) execute contracts considered necessary;

(2) receive the data from medical records of cases of cancer that are in the custody or under the control of clinical laboratories, health care facilities, and health care practitioners to record and analyze the data directly related to those diseases;

(3) compile and publish statistical and other studies derived from the patient data obtained under this chapter to provide, in an accessible form, information that is useful to physicians, other medical personnel, and the general public;

(4) comply with requirements as necessary to obtain federal funds in the maximum amounts and most advantageous proportions possible;

(5) receive and use gifts made for the purpose of this chapter; and

(6) limit cancer reporting activities under this chapter to specified geographic areas of the state to ensure optimal use of funds available for obtaining the data.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 4, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0254, eff. April 2, 2015.

Sec. 82.007. REPORTS. (a) The department shall publish an annual report to the legislature of the information obtained under this chapter.

(b) The department, in cooperation with other cancer reporting organizations and research institutions, may publish reports the department determines are necessary or desirable to carry out the purpose of this chapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 34, eff. Sept. 1, 1991.

Sec. 82.008. DATA FROM MEDICAL RECORDS. (a) To ensure an accurate and continuing source of data concerning cancer, each health care facility, clinical laboratory, and health care practitioner shall furnish to the department, on request, data the executive commissioner considers necessary and appropriate that is derived from each medical record pertaining to a case of cancer that is in the custody or under the control of the health care facility, clinical laboratory, or health care practitioner. The department may not request data that is more than three years old unless the department is investigating a possible cancer cluster. At the request and with the authorization of the applicable health care facility, clinical laboratory, or health care practitioner, data may be furnished to the department through a health information exchange as defined by Section 182.151.

(b) A health care facility, clinical laboratory, or health care practitioner shall furnish the data requested under Subsection (a) in a reasonable format prescribed by department rule and within six months of the patient's admission, diagnosis, or treatment for cancer unless a different period is prescribed by the United States Department of Health and Human Services.

(c) The data required to be furnished under this section must include patient identification and diagnosis.

(d) The department may access medical records that would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified patient from the following sources:

(1) a health care facility or clinical laboratory providing screening, diagnostic, or therapeutic services to a patient with respect to cancer; or

(2) a health care practitioner diagnosing or providing treatment to a patient with cancer, except as described by Subsection (g).

(e) The executive commissioner shall adopt procedures that ensure adequate notice is given to the health care facility, clinical laboratory, or health care practitioner before the department accesses data under Subsection (d).

(f) A health care facility, clinical laboratory, or health care practitioner that knowingly or in bad faith fails to furnish data as required by this chapter shall reimburse the department or its authorized representative for the costs of accessing and reporting the data. The costs reimbursed under this subsection must be reasonable, based on the actual costs incurred by the department or by its authorized representative in the collection of data under Subsection (d), and may include salary and travel expenses. The department may assess a late fee on an account that is 60 days or more overdue. The late fee may not exceed one and one-half percent of the total amount due on the late account for each month or portion of a month the account is not paid in full. A health care facility, clinical laboratory, or health care practitioner may request that the department conduct a hearing to determine whether reimbursement to the department under this subsection is appropriate.

(g) The department may not require a health care practitioner to furnish data or provide access to records if:

(1) the data or records pertain to cases reported by a health care facility providing screening, diagnostic, or therapeutic services to cancer patients that involve patients referred directly to or previously admitted to the facility; and

(2) the facility reported the same data the practitioner would be required to report.

(h) The data required to be furnished under this section may be shared with cancer registries of health care facilities subject to the confidentiality provisions in Section 82.009.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 35, eff. Sept. 1, 1991; Acts 1997, 75th Leg., ch. 343, Sec. 1, eff. May 27, 1997; Acts 1999, 76th Leg., ch. 1411, Sec. 23.01, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 589, Sec. 5, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0255, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1085 (H.B. 2641), Sec. 5, eff. September 1, 2015.

Sec. 82.009. CONFIDENTIALITY. (a) Reports, records, and information obtained under this chapter are confidential and are not subject to disclosure under Chapter 552, Government Code, are not subject to subpoena, and may not otherwise be released or made public except as provided by this section or Section 82.008(h). The reports, records, and information obtained under this chapter are for the confidential use of the department and the persons or public or private entities that the department determines are necessary to carry out the intent of this chapter.

(b) Medical or epidemiological information may be released:

(1) for statistical purposes in a manner that prevents identification of individuals, health care facilities, clinical laboratories, or health care practitioners;

(2) with the consent of each person identified in the information; or

(3) to promote cancer research, including release of information to other cancer registries and appropriate state and federal agencies, under rules adopted by the executive commissioner to ensure confidentiality as required by state and federal laws.

(c) A state employee may not testify in a civil, criminal, special, or other proceeding as to the existence or contents of records, reports, or information concerning an individual whose medical records have been used in submitting data required under this chapter unless the individual consents in advance.

(d) Data furnished to a cancer registry or a cancer researcher under Subsection (b) or Section 82.008(h) is for the confidential use of the cancer registry or the cancer researcher, as applicable, and is subject to Subsection (a).

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 5.95(90), eff. Sept. 1, 1995; Acts 1997, 75th Leg., ch. 343, Sec. 2, eff. May 27, 1997; Acts 1999, 76th Leg., ch. 1411, Sec. 23.02, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 589, Sec. 6, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0256, eff. April 2, 2015.

Sec. 82.010. IMMUNITY FROM LIABILITY. The following persons subject to this chapter that act in compliance with this chapter are not civilly or criminally liable for furnishing the information required under this chapter:

(1) a health care facility or clinical laboratory;

(2) an administrator, officer, or employee of a health care facility or clinical laboratory;

(3) a health care practitioner or employee of a health care practitioner; and

(4) an employee of the department.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 7, eff. Sept. 1, 2001.

Sec. 82.011. EXAMINATION AND SUPERVISION NOT REQUIRED. This chapter does not require an individual to submit to any medical examination or supervision or to examination or supervision by the department.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0257, eff. April 2, 2015.

THE RULES

Texas Administrative Code

Title 25. Health Services

Part 1. Department of State Health Services

Chapter 91. Cancer

Subchapter A. Cancer Registry

Effective Date: April 2, 2017

§91.1. Purpose.

This subchapter implements the Texas Cancer Incidence Reporting Act, Health and Safety Code, Chapter 82. This legislation concerns the reporting of cases of cancer for the recognition, prevention, cure or control of those diseases, and to facilitate participation in the national program of cancer registries established by 42 United States Code, §§280e - 280e-4. Nothing in this subchapter shall preempt the authority of facilities or individuals providing diagnostic or treatment services to patients with cancer to maintain their own cancer registries.

§91.2. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Act--The Texas Cancer Incidence Reporting Act, Texas Health and Safety Code, Chapter 82.

(2) Cancer--Includes a large group of diseases characterized by uncontrolled growth and spread of abnormal cells; any condition of tumors having the properties of anaplasia, invasion, and metastasis; a cellular tumor the natural course of which is fatal, including intracranial and central nervous system malignant, borderline, and benign tumors as required by the national program of cancer registries; and malignant neoplasm, other than non-melanoma skin cancers such as basal and squamous cell carcinomas.

(3) Cancer Reporting Handbook--The Texas Cancer Registry's manual for reporting entities that documents reporting procedures and format.

(4) Clinical laboratory--An accredited facility in which tests are performed identifying findings of anatomical changes; specimens are interpreted, and pathological diagnoses are made.

(5) Confidential cancer data--Information that includes items that may identify an individual, and is subject to Health and Safety Code, §82.009.

(6) Department--Department of State Health Services.

(7) Health care facility--A general or special hospital as defined by the Health and Safety Code, Chapter 241; an ambulatory surgical center licensed under the Health and Safety Code, Chapter 243; an institution licensed under the Health and Safety Code, Chapter 242; or any other facility, including an outpatient clinic, that provides diagnostic or treatment services to patients with cancer.

(8) Health care practitioner--A physician as defined by Occupations Code, §151.002 or a person who practices dentistry as described by the Occupations Code, §251.003.

(9) Quality assurance--Operational procedures by which the accuracy, completeness, and timeliness of the information reported to the department can be determined and verified.

(10) Report--Information provided to the department that notifies the appropriate authority of the occupancy of a specific cancer in a person, including all information required to be provided to the department.

(11) Reporting Entity--A reporting entity may include a health care facility, clinical laboratory, health care practitioner, or a health information exchange as defined by Health and Safety Code, §182.151.

(12) Research--A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

(13) Statistical cancer data--Aggregate presentation of individual records on cancer cases excluding patient identifying information.

(14) Texas Cancer Registry--The cancer incidence reporting system administered by the Department of State Health Services.

§91.3. Who Reports and Access to Records.

(a) Each health care facility, clinical laboratory or health care practitioner shall report to the department, by methods specified in §§91.4 - 91.7 of this title (relating to Cancer Registry), required data from each medical record pertaining to a case of cancer in its custody or under its control except for cases to which subsection (d) of this section would apply.

(b) A health care facility or clinical laboratory providing screening, diagnostic or therapeutic services to patients with cancer shall grant the department or its authorized representative access to but not removal of all medical records which would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified cancer patient.

(c) A health care practitioner providing diagnostic or treatment services to patients with cancer shall grant the department or its authorized representative access to but not removal of all medical records which would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified cancer patient except for cases to which subsection (d) of this section would apply.

(d) The department may not require a health care practitioner to furnish data or provide access to records if:

(1) the data or records pertain to cases reported by a health care facility providing screening, diagnostic, or therapeutic services to cancer patients that involve patients referred directly to or previously admitted to the facility; and

(2) the facility reported the same data the practitioner would be required to report.

(e) Health care facilities, clinical laboratories, and health care practitioners are subject to federal law known as the Health Insurance Portability and Accountability Act of 1996 found at Title 42 United States Code §1320d et seq.; the federal privacy rules adopted in Title 45 Code of Federal Regulations (C.F.R.) Parts 160 and 164; and applicable state medical records privacy laws. Because state law requires reporting of cancer data, persons subject to this chapter are permitted to provide the data to the department without patient consent or authorization under 45 C.F.R. §164.512(a) relating to uses and disclosures required by law and §164.512(b)(1) relating to disclosures for public health activities. Both of these exceptions to patient consent or authorization are recognized in the state law.

§91.4. What to Report.

(a) Reportable conditions.

(1) The cases of cancer to be reported to the Texas Cancer Registry are as follows:

(A) all neoplasms with a behavior code of two or three in the most current edition of the International Classification on Diseases for Oncology (ICD-O) of the World Health Organization with the exception of those designated by the Texas Cancer Registry as non-reportable in the Cancer Reporting Handbook; and

(B) all benign and borderline intracranial and central nervous system neoplasms as required by the national program of cancer registries.

(2) Codes and taxa of the most current edition of the International Classification of Diseases, Clinical Modification of the World Health Organization which correspond to the Texas Cancer Registry's reportable list are specified in the Cancer Reporting Handbook.

(b) Reportable information.

(1) Except as provided in paragraph (2) of this subsection and health care practitioners in §91.5(c) of this title (relating to When to Report), those data required to be reported for each cancer case shall include:

(A) name, address, zip code, and county of residence;

(B) social security number, date of birth, gender, race and ethnicity, marital status, birthplace, and primary payer at time of diagnosis, to the extent such information is available from the medical record;

(C) information on industrial and occupational history, smoking status, height and weight to the extent such information is available from the medical record;

(D) diagnostic information including the cancer site and laterality, cell type, tumor behavior, markers, grade and size, stage of disease, date of diagnosis, diagnostic confirmation method, sequence number, and other primary tumors;

(E) first course of cancer-related treatment, including dates and types of procedures;

(F) text information to support cancer diagnosis, stage and treatment codes;

(G) health care facility or practitioner related information including reporting institution number, casefinding source, type of reporting source, medical record number, registry number, tumor record number, class of case, date of first contact, date of last contact, vital status, facility referred from, facility referred to, managing physician, follow-up physician, date abstracted, abstractor, and electronic record version; and

(H) clinical laboratory related information including laboratory name and address, pathology case number, pathology report date, pathologist, and referring physician name and address.

(2) The department or its authorized representative may exempt a reporting entity from providing specific reportable data items delineated in paragraph (1) of this subsection to the extent that those data to be exempted are not collected by the reporting entity.

(3) Except as provided in §91.6(b) of this title (relating to How to Report), each report shall:

(A) be electronically readable and contain all data items required in paragraph (1) of this subsection;

(B) be fully coded and in a format prescribed by the Texas Cancer Registry;

(C) meet all quality assurance standards utilized by the Texas Cancer Registry;

(D) in the case of individuals who have more than one form of cancer, be submitted separately for each primary cancer diagnosed;

(E) be submitted to the Texas Cancer Registry electronically; and

(F) be transmitted by secure means at all times to protect the confidentiality of the data.

§91.5. When to Report.

(a) All reports shall be submitted to the department within six months of the patient's admission, initial diagnosis, or treatment for cancer.

(b) Data shall be submitted no less than quarterly by health care facilities with annual caseloads of 400 or less. Monthly submissions are required for all other health care facilities.

(c) Data shall be submitted no less than quarterly by health care practitioners initially diagnosing a patient with cancer and performing the in-house pathological tests for that patient. Otherwise, data shall be submitted within 2 months of the request to a health care practitioner by the department or its authorized representative for a report or subset of a report on a patient diagnosed or treated elsewhere and for whom the same cancer data has not been reported.

(d) Data shall be submitted no less than quarterly by clinical laboratories.

§91.6. How to Report.

(a) Reports of cancer from health care facilities, clinical laboratories and health care practitioners shall be submitted to the Texas Cancer Registry electronically using a secure electronic process as defined by the department. At the request and with the authorization of the applicable health care facility, clinical laboratory, or health care practitioner, data may be furnished to the Texas Cancer Registry through a health information exchange.

(b) The Texas Cancer Registry may accept the submission of paper copies of medical records from a health care facility, pathology reports from a clinical laboratory and reports or subsets of reports from a health care practitioner under the following conditions.

(1) The department, or its authorized representative, shall determine that such paper submissions are more expedient than electronic reporting.

(2) The acceptance of paper submissions from a health care facility, clinical laboratory or health care practitioner shall be approved by the department or its authorized representative.

(3) The department, or its authorized representative, may approve acceptance of paper submissions from defined groups or types of health care facilities, clinical laboratories or health care practitioners.

(4) All records and reports provided to the Texas Cancer Registry pursuant to this subsection must be transmitted by secure means at all times to protect the confidentiality of the data.

§91.7. Where to Report.

Data reports should be submitted to the Texas Cancer Registry as specified in the Cancer Reporting Handbook.

§91.8. Compliance.

(a) Each health care facility, clinical laboratory, or health care practitioner that reports to the department, by methods specified in §§91.4 - 91.7 of this title (relating to Cancer Registry), is considered compliant.

(b) A person will be notified in writing if the person has not reported in compliance with this chapter within 30 days following the end of the required monthly or quarterly reporting timeframe and will be given an opportunity to take corrective action within 60 days from the date of the notification letter. A second notification letter will be sent 30 days after the date of the original notification letter if no corrective action has been taken.

(c) If a person is non-compliant and takes no corrective action within 60 days of the original notification letter, the department or its authorized representative may access the information from the health care facility, clinical laboratory or health care practitioner as provided in §91.3 of this title (relating to Who Reports, Access to Records) and report it in the appropriate format.

(1) The health care facility, clinical laboratory or health care practitioner shall be notified at least two weeks in advance before a scheduled arrival for collection of the information.

(2) A health care facility, clinical laboratory or health care practitioner that knowingly or in bad faith fails to furnish data as required by this chapter shall reimburse the department or its authorized representative for its cost to access and report the information. The costs must be reasonable, based on the actual costs incurred by the department or by its authorized representative in the collection of the data and may include salary and travel expenses. It is presumed that a health care facility, clinical laboratory or health care practitioner acted knowingly or in bad faith if it failed to take corrective action within 60 days of the date of the original notification letter.

(3) A health care facility, clinical laboratory or health care practitioner may request the department to conduct a hearing under the department's fair hearing rules to determine whether reimbursement to the department is appropriate.

(d) Any health care facility, clinical laboratory or health care practitioner which is required to reimburse the department or its authorized representative for the cost to access and report the information pursuant to subsection (c)(2) of this section shall provide payment to the department or its authorized representative within 60 days of the day this payment is demanded. In the event any health care facility, clinical laboratory or health care practitioner fails to make payment to the department or its authorized representative within 60 days of the day the payment is demanded, the department or its authorized representative may, at its discretion, assess a late fee not to exceed 1-1/2 % per month of the outstanding balance.

§91.9. Confidentiality and Disclosure.

(a) Pursuant to the Act, Chapter 82, §82.009, all data obtained is for the confidential use of the department and the persons or entities, public or private, that the department determines are necessary to carry out the intent of the Act.

(b) Limited release of the data is allowed by the Act, §82.008(h) and §82.009(b).

(c) Any requests for confidential or statistical cancer data shall be made in accordance with §91.11 or §91.12 of this title (relating to Cancer Registry).

(d) The Texas Cancer Registry is subject to state law that requires compliance with portions of the federal law and regulations cited in §91.3(e) of this title (relating to Who Reports, Access to Records). The department is authorized to use and disclose, for purposes described in the Act, cancer data without patient consent or authorization under 45 C.F.R §164.512(a) relating to uses and disclosures required by law, §164.512(b)(1) and (2) relating to uses and disclosures for public health activities, and §164.512(i) relating to uses and disclosures for research purposes.

§91.10. Quality Assurance.

The department shall cooperate and consult with persons required to comply with this chapter so that such persons may provide timely, complete, and accurate data. The department will provide:

(1) reporting training, technical assistance, on-site case-finding studies, and reabstracting studies;

(2) quality assessment reports to ascertain that the computerized data utilized for statistical information and data compilation is accurate; and

(3) educational information on cancer morbidity and mortality statistics available from the Texas Cancer Registry and the department.

§91.11. Requests for Statistical Cancer Data.

(a) Statistical cancer data previously analyzed are available upon written or oral request to the Texas Cancer Registry. All other requests for statistical cancer data shall be in writing and directed to: Texas Cancer Registry, Mail Code 1928, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347 or CancerData@dshs.state.tx.us.

(b) To ensure that the proper data are provided, the request shall include, but not be limited to, the following information:

(1) name, address, and telephone number of the person requesting the information;

(2) type of data needed and for what years (e.g. lung cancer incidence rates, Brewster County, 1998 - 2002); and

(3) name and address of person(s) to whom data and billings are to be submitted (if applicable).

§91.12. Requests and Release of Confidential Cancer Data.

(a) Data requests for research.

(1) Requests for confidential cancer data shall be in writing and directed to: Texas Cancer Registry, Mail Code 1928, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347 or CancerData@dshs.state.tx.us.

(2) Written requests for confidential cancer data shall meet the submission requirements of the department's Institutional Review Board (IRB) before release.

(3) The Texas Cancer Registry may release confidential cancer data to state, federal, local, and other public agencies and organizations if approved by the IRB.

(4) The Texas Cancer Registry may release confidential cancer data to private agencies, organizations, and associations if approved by the IRB.

(5) The Texas Cancer Registry may release confidential cancer data to any other individual or entities for reasons deemed necessary by the department to carry out the intent of the Act if approved by the IRB.

(b) Data requests for non-research purposes.

(1) The Texas Cancer Registry may provide reports containing confidential cancer data back to the respective reporting entity from records previously submitted to the Texas Cancer Registry from each respective reporting entity for the purposes of case management and administrative studies. These reports will not be released to any other entity.

(2) The Texas Cancer Registry may release confidential cancer data to other areas of the department, provided that the disclosure is required or authorized by law. All communications of this nature shall be clearly labeled "Confidential" and will follow established departmental internal protocols and procedures.

(3) The Texas Cancer Registry may release confidential cancer data to state, federal, local, and other public agencies and organizations in accordance with subsection (a) of this section.

(4) The Texas Cancer Registry may release confidential cancer data to any other individual or entities for reasons deemed necessary to carry out the intent of the Act and in accordance with subsection (a) of this section.

(5) An individual who submits a valid authorization for release of an individual cancer record shall have access to review or obtain copies of the information described in the authorization for release.

- Texas Cancer Incidence Reporting Act and Reporting Rules also available on the web at dshs.texas.gov/tcr/lawrules.aspx.
- The Texas Cancer Registry Rule can be found at the Texas Administrative Code webpage texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=91&rl=4.

B

APPENDIX B:
FIPS COUNTY CODES

Texas County	FIPS Code
Anderson	001
Andrews	003
Angelina	005
Aransas	007
Archer	009
Armstrong	011
Atascosa	013
Austin	015
Bailey	017
Bandera	019
Bastrop	021
Baylor	023
Bee	025
Bell	027
Bexar	029
Blanco	031
Borden	033
Bosque	035
Bowie	037
Brazoria	039
Brazos	041
Brewster	043
Briscoe	045
Brooks	047
Brown	049
Burleson	051
Burnet	053
Caldwell	055
Calhoun	057
Callahan	059
Cameron	061
Camp	063
Carson	065

Texas County	FIPS Code
Cass	067
Castro	069
Chambers	071
Cherokee	073
Childress	075
Clay	077
Cochran	079
Coke	081
Coleman	083
Collin	085
Collingsworth	087
Colorado	089
Comal	091
Comanche	093
Concho	095
Cooke	097
Coryell	099
Cottle	101
Crane	103
Crockett	105
Crosby	107
Culberson	109
Dallam	111
Dallas	113
Dawson	115
Deaf Smith	117
Delta	119
Denton	121
DeWitt	123
Dickens	125
Dimmit	127
Donley	129
Duval	131

Texas County	FIPS Code
Eastland	133
Ector	135
Edwards	137
Ellis	139
El Paso	141
Erath	143
Falls	145
Fannin	147
Fayette	149
Fisher	151
Floyd	153
Foard	155
Fort Bend	157
Franklin	159
Freestone	161
Frio	163
Gaines	165
Galveston	167
Garza	169
Gillespie	171
Glasscock	173
Goliad	175
Gonzales	177
Gray	179
Grayson	181
Gregg	183
Grimes	185
Guadalupe	187
Hale	189
Hall	191
Hamilton	193
Hansford	195
Hardeman	197

Texas County	FIPS Code
Hardin	199
Harris	201
Harrison	203
Hartley	205
Haskell	207
Hays	209
Hemphill	211
Henderson	213
Hidalgo	215
Hill	217
Hockley	219
Hood	221
Hopkins	223
Houston	225
Howard	227
Hudspeth	229
Hunt	231
Hutchinson	233
Irion	235
Jack	237
Jackson	239
Jasper	241
Jeff Davis	243
Jefferson	245
Jim Hogg	247
Jim Wells	249
Johnson	251
Jones	253
Karnes	255
Kaufman	257
Kendall	259
Kenedy	261
Kent	263

Texas County	FIPS Code
Kerr	265
Kimble	267
King	269
Kinney	271
Kleberg	273
Knox	275
Lamar	277
Lamb	279
Lampasas	281
La Salle	283
Lavaca	285
Lee	287
Leon	289
Liberty	291
Limestone	293
Lipscomb	295
Live Oak	297
Llano	299
Loving	301
Lubbock	303
Lynn	305
McCulloch	307
McLennan	309
McMullen	311
Madison	313
Marion	315
Martin	317
Mason	319
Matagorda	321
Maverick	323
Medina	325
Menard	327
Midland	329

Texas County	FIPS Code
Milam	331
Mills	333
Mitchell	335
Montague	337
Montgomery	339
Moore	341
Morris	343
Motley	345
Nacogdoches	347
Navarro	349
Newton	351
Nolan	353
Nueces	355
Ochiltree	357
Oldham	359
Orange	361
Palo Pinto	363
Panola	365
Parker	367
Parmer	369
Pecos	371
Polk	373
Potter	375
Presidio	377
Rains	379
Randall	381
Reagan	383
Real	385
Red River	387
Reeves	389
Refugio	391
Roberts	393
Robertson	395

Texas County	FIPS Code
Rockwall	397
Runnels	399
Rusk	401
Sabine	403
San Augustine	405
San Jacinto	407
San Patricio	409
San Saba	411
Schleicher	413
Scurry	415
Shackelford	417
Shelby	419
Sherman	421
Smith	423
Somervell	425
Starr	427
Stephens	429
Sterling	431
Stonewall	433
Sutton	435

Texas County	FIPS Code
Swisher	437
Tarrant	439
Taylor	441
Terrell	443
Terry	445
Throckmorton	447
Titus	449
Tom Green	451
Travis	453
Trinity	455
Tyler	457
Upshur	459
Upton	461
Uvalde	463
Val Verde	465
Van Zandt	467
Victoria	469
Walker	471
Waller	473
Ward	475

Texas County	FIPS Code
Washington	477
Webb	479
Wharton	481
Wheeler	483
Wichita	485
Wilbarger	487
Willacy	489
Williamson	491
Wilson	493
Winkler	495
Wise	497
Wood	499
Yoakum	501
Young	503
Zapata	505
Zavala	507

Unknown County and Non-Texas Resident	998
Unknown	999

C

APPENDIX C: COMMON ACCEPTABLE ABBREVIATIONS

Common Acceptable Abbreviations

(In order of Abbreviation)

In writing this text, registrars rely on abbreviations, especially in response to time and record space constraints. Abbreviations can generate confusion, however, as they may vary among different institutions and different specialties. Because abbreviations should be understood by any reader, only those that are clear and precise should be used. The NAACCR Recommended Abbreviations Lists, below, were compiled for cancer abstractors and the agencies to which they submit their data.

datadictionary.naaccr.org/default.aspx?c=17&Version=21

When abbreviating words in an address, refer to the Address Abbreviations section of the National Zip Code and Post Office Directory, published by the U.S. Postal Service. For short names of antineoplastic drugs, consult SEER*RX Interactive Antineoplastic Drugs Database: seer.cancer.gov/seertools/seerrx/.

Abbreviation/Symbol	Term
^	Above or elevated
&	And
≈	Approximately
@	At
=	Equals
>	Greater than, more, or more than
<	Less or less than
-	Negative or minus
#	Number or pound(s)
+	Plus or positive
X	Times
A FIB	Atrial fibrillation
A FLUTTER	Atrial flutter
A&P	Auscultation & percussion
A/P	Abdomen/Pelvis
AA	African American
AB	Antibody
ABD	Abdomen (abdominal)
ABG	Arterial blood gases
ABN	Abnormal
ABNL	Abnormal
ABS	Absent/Absence

Abbreviation/Symbol	Term
ABST	Abstract/Abstracted
ABX	Antibiotics
AC	Adrenal cortex
ACBE	Air contrast barium enema
ACH	Adrenal cortical hormone
ACID PHOS	Acid phosphatase
A-COLON	Ascending Colon
ACTH	Adrenocorticotrophic hormone
ADENOCA	Adenocarcinoma
ADENOP	Adenopathy
ADH	Antidiuretic hormone
ADJ	Adjacent
ADL	Activities of daily living
ADM	Admission/Admit
ADR	Adverse drug reaction
AFF	Affirmative
AFP	Alpha-fetoprotein
AG	Antigen
AGL	Acute granulocytic leukemia
AI	Aromatase inhibitor
AI	Atrial stenosis/insufficiency/incompetence
AIDS	Acquired Immune Deficiency Syndrome
AIHA	Autoimmune hemolytic anemia
AIN III or AIN 3	Anal intraepithelial neoplasia, grade III
AK(A)	Above knee (amputation)
AKA	Also known as
ALB	Albumin
ALK PHOS	Alkaline phosphatase
ALL	Acute lymphocytic leukemia
ALND	Axillary Lymph node dissection
ALS	Amyotrophic lateral sclerosis
AM	Before noon
AMA	Against medical advice
AMB	Ambulatory
AMI	Acute myocardial infarction

Abbreviation/Symbol	Term
AML	Acute myelogenous leukemia
AMP	Amputation
AMT	Amount
ANAP	Anaplastic
ANGIO	Angiography/Angiogram
ANS	Autonomic nervous system
ANT	Anterior
AODM	Adult-onset Diabetes Mellitus
AP	Abdominal perineal
A-P	Anteroposterior
APC	Atrial premature complexes
APP	Appendix
APPL'Y	Apparently
ARC	AIDS-related condition (complex)
ARD	AIDS-related disease
ARDS	Acute Respiratory Distress (Disease) Syndrome
ARF	Acute renal failure
ARRHY	Arrhythmia
ART	Artery (ial)
AS	Arteriosclerosis/Arteriosclerotic
ASA	Aspirin, Acetylsalicylic acid
ASAP	As soon as possible
ASCVD	Arteriosclerotic cardiovascular disease
ASHD	Arteriosclerotic heart disease
ASP	Aspiration
ASPVD	Arteriosclerotic Peripheral Vascular Disease
ASSOC	Associated
A-STEN	Aortic stenosis
ATN	Acute tubular necrosis
ATP	Adenosine triphosphate
ATR	Achilles tendon reflex
AUT	Autopsy
AV	Arteriovenous
AVG	Average
AVM	Arteriovenous malformation

Abbreviation/Symbol	Term
AX	Axilla(ry)
AXLND	Axillary Lymph node dissection
B/F	Black female
B/L	Bilateral
B/M	Black male
BA	Barium
BAD	Bipolar affective disorder
BCC	Basal cell carcinoma
BCG	Bacillus Calmette-Guerin
BD	Bile duct
BE	Barium enema
BF	Black female
BID	Twice a day (daily)
BIL	Bilateral
BK(A)	Below knee (amputation)
B/L	Bilateral
BM	Black Male
BM	Bone marrow
BM	Bowel movement
BMBX	Bone marrow biopsy
BMI	Body mass index
BMT	Bone marrow transplant
BOT	Base of tongue
BP	Blood pressure
BPH	Benign prostatic hypertrophy/hyperplasia
BR	Bloom-Richardson
BRACHY	Brachytherapy
BRBPR	Bright red blood per rectum
BRCA 1 and BRCA 2	Breast cancer susceptibility gene
BRM	Biological response modifier
BRO	Brother
BSA	Body surface area
BSC	Bone scan
BSO	Bilateral salpingo-oophorectomy
BT	Bladder tumor or Brain tumor

Abbreviation/Symbol	Term
BUN	Blood urea nitrogen
BUS	Bartholin's, Urethral & Skene's
BV	Blood volume
BX	Biopsy
C/A/P	Chest, abdomen, pelvis
C/O	Complaint (-ning) of
C/W	Consistent with
C1-C7	Cervical vertebrae
CA	Calcium
CA	Carcinoma
CA 125	Cancer antigen 125
CA 19-9	Carbohydrate antigen 19-9
CA++	Calcification(s)
CABG	Coronary artery bypass graft
CAD	Coronary artery disease
CALC(S)	Calcification(s)
CAP(S)	Capsule(s)
CBC	Complete blood count
CC	Chief complaint or Cubic centimeter
CCU	Coronary care unit
CEA	Carcinoembryonic antigen
CF	Cystic fibrosis
CFN	Centimeters from nipple
CGA	Serum chromogranin A
CGL	Chronic granulocytic leukemia
CGY	Centigray
CHD	Congenital heart disease
CHEMO	Chemotherapy
CHF	Congestive heart failure
CHG	Change
CHR	Chronic
CIG	Cigarettes
CIN	Cervical intraepithelial neoplasia
CIN III or CIN 3	Cervical intraepithelial neoplasia, grade III
CIS	Carcinomain situ

Abbreviation/Symbol	Term
CISH	Chromogenic in situ hybridization
CLL	Chronic lymphocytic leukemia
CLR	Clear
CM	Centimeter
CML	Chronic myeloid (myelocytic) leukemia
CNS	Central nervous system
CO60	Cobalt 60
COLD	Chronic obstructive lung disease
CONT	Continue/continuous
CONTRA	Contralateral
COPD	Chronic obstructive pulmonary disease
CRF	Chronic renal failure
CRM	Circumferential resection margin
CS	Collaborative stage
CSF	Cerebrospinal fluid
C-SF	Colony stimulating factor
C-SPINE	Cervical spine
CT	CAT/CT scan/Computerized axial tomography
CTC	Circulating tumor cells
CUC	Chronic ulcerative colitis
CVA	Cerebrovascular accident
CVD	Cardiovascular disease
CXR	Chest X-ray
CYSTO	Cystoscopy
CYTO	Cytology
D&C	Dilatation and curettage
D/C	Discharge
D/T	Due to
DC	Discontinue(d)
DCIS	Ductal carcinoma in situ
D-COLON	Descending colon
DDX	Differential diagnosis
DECR	Decrease(d)
DERM	Dermatology
DES	Diethylstilbestrol

Abbreviation/Symbol	Term
DIAM	Diameter
DIC	Disseminated intravascular coagulopathy
DIFF	Differentiated/differential
DISCH	Discharge
DJD	Degenerative joint disease
DK	Don't/Doesn't know
DM	Diabetes mellitus
DNA	Deoxyribonucleic acid
DOA	Dead on arrival
DOB	Date of birth
DOD	Date of death
DOE	Dyspnea on exertion
DRE	Digital rectal examination
DTC	Disseminated tumor cells
DTR	Deep tendon reflex
DVT	Deep vein thrombosis
DX	Diagnosis
DZ	Disease
E.G.	For example
E/O	Evidence of
EBRT	External beam radiotherapy
ECG/EKG	Electrocardiogram
ED	Emergency department
EEG	Electroencephalogram
EENT	Eye, ear, nose, throat
EGD	Esophagogastro-duodenoscopy
EGFR	Epidermal growth factor receptor
ELEV	Elevated
EMG	Electromyogram
ENL	Enlarged
ENLGD	Enlarged
ENT	Ears, nose, and throat
ER	Emergency room
ER(A)	Estrogen receptor (assay)
ERCP	Endoscopic retrograde cholangiopancreatography

Abbreviation/Symbol	Term
ESRD	End stage renal disease
ETOH	Alcohol
EUA	Exam under anesthesia
EV	Electron volt
EVAL	Evaluation
EXAM	Examination
EXC(D)	Excision/excised
EXP	Expired
EXP LAP	Exploratory laparotomy
EXPL	Exploratory
EXPL LAP	Exploratory laparotomy
EXT	Extend/extension
FAP	Familial adeomatous polyposis
FCOT	First course of treatment
FHX	Family History
FISH	Fluorescence in situ hybridization
FL	Fluid
FLIPI	Follicular lymphoma international prognostic index
FLOW CYTO	Flow cytometry
FLURO	Fluoroscopy
FNA	Fine needle aspiration
FNAB	Fine needle aspiration biopsy
FOM	Floor of mouth
FREQ	Frequent/Frequency
FS	Frozen section
FTSG	Full thickness skin graft
FU	Follow-up
FUO	Fever of unknown origin
FX	Fracture
FX(S)	Fractions(s)
GB	Gallbladder
GE	Gastroesophageal
GEN	General/Generalized
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal

Abbreviation/Symbol	Term
GIST	Gastrointestinal stromal tumors
GR	Grade
GU	Genitourinary
GY	Gray
GYN	Gynecology
H&E	Hematoxylin and Eosin
H&P	History and physical
H/H	Hemoglobin and hematrocrit
H/O	History of
HAV	Hepatitis A (virus)
HBV	Hepatitis B (virus)
HCG	Human chorionic gonadotropin
HCT	Hematocrit
HCV	Hepatitis C (virus)
HCVD	Hypertensive cardiovascular disease
HDR	High dose rate
HDV	Hepatitis D (virus)
HEM/ONC	Hematology/Oncology (ist)
HEP A	Hepatitis A (virus)
HEP B	Hepatitis B (virus)
HEP C	Hepatitis C (virus)
HEP D	Hepatitis D (virus)
HER2	Human epidermal growth factor receptor 2
HF	Hispanic female
HGB	Hemoglobin
HGSIL	High grade squamous intraepithelial lesion
HIV	Human Immunodeficiency Virus
HM	Hispanic male
HORM	Hormone
HOSP	Hospital
HPI	History of present illness
HPV	Human Papilloma Virus
HR(S)	Hour/Hours
HRT	Hormone replacement therapy
HSM	Hepatosplenomegaly

Abbreviation/Symbol	Term
HTLV	Human T-Lymphotrophic Virus, (Type III)
HTN	Hypertension
HVD	Hypertensive vascular disease
HX	History
HYST	Hysterectomy
I&D	Incision & drainage
I-131	Iodine 131
IBD	Inflammatory bowel disease
ICB	Intracavitary brachytherapy
ICM	Intercostal margin
ICS	Intercostal space
ICU	Intensive care unit
IDC	Infiltrating/invasive ductal carcinoma
IDDM	Insulin-dependent diabetes mellitus
IG	Immunoglobulin
IHC	Immunohistochemical
IHSS	Idiopathic hypertrophic subaortic stenosis
ILD	Interstitial lung disease
IM	Intramuscular
IMP	Impression
IMRT	Intensity modulated radiation therapy
INCL	Includes/Including
INCR	Increase(d)
INF	Inferior
INFIL	Infiltrating
INFILT	Infiltrating
INPT	Inpatient
INT	Internal
INV	Invade(s)/invading/invasion
INVL	Involve(s)/involvement/involving
IP	Inpatient
IPI	International prognostic index (for lymphoma)
IPPB	Intermittent positive pressure breathing
IPS	International prognostic score
IPSI	Ipsilateral

Abbreviation/Symbol	Term
IRREG	Irregular
IT	Intrathecal
ITC	Isolated tumor cells
ITP	Idiopathic thrombocytopenia
IV	Intravenous
IVC	Inferior vena cava
IVCA	Intravenous cholangiogram
IVP	Intravenous pyelogram
JAK2	Janus kinase 2
JRA	Juvenile rheumatic arthritis
JVD	Jugular venous distention
KG	Kilogram
KS	Kaposi sarcoma
KUB	Kidneys, ureters, bladder
KV	Kilovolt
L1-L5	Lumbar vertebra
LAB	Laboratory
LAD	Lymphadenopathy
LAN	Lymphadenopathy
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-associated virus
LB(S)	Pound(s)
LBBB	Left bundle branch block
LCIS	Lobular carcinoma in situ
LCM	Left costal margin
LDH	Lactic dehydrogenase
LDR	Low dose rate
LE	Lower extremity
LFT	Liver function test
LIN	Laryngeal intraepithelial neoplasia
LINAC	Linear accelerator
LIQ	Lower inner quadrant
LLE	Left lower extremity
LLL	Left lower lobe

Abbreviation/Symbol	Term
LLQ	Left lower quadrant
LMP	Last menstrual period
LN(S)	Lymph node(s)
LND	Lymph node dissection
LOQ	Lower outer quadrant
LPN	Licensed practical nurse
LRG	Large
LS	Lumbosacral
LSO	Left salpingo-oophorectomy
L-SPINE	Lumbar spine
LS SCAN	Liver/spleen scan
LT	Left
LUE	Left upper extremity
LUL	Left upper lobe
LUOQ	Left upper outer quadrant
LUQ	Left upper quadrant
LVI	Lymph/vascular invasion / Lymphovascular invasion
M/DIFF	Moderately differentiated
MAL	Malignant
MALIG	Malignant
MAMMO	Mammogram
MAND	Mandible/mandibular
MAT	Multifocal atrial tachycardia
MAX	Maximum
MC	Medical center
MC(H)	Millicurie (hours)
MCG	Microgram
MCID	Mixed combined immunodeficiency
M-CSF	Macrophage colony-stimulating factor
MCN	Mucinous cystic neoplasm
MCTD	Mixed connective tissue disease
MD	Moderately differentiated
MDS	Myelodysplastic syndrome
MED	Medication
MED ONC	Medical oncology (ist)

Abbreviation/Symbol	Term
METS	Metastatic/Metastasis
MEV	Million electron volts
MG	Myasthenia gravis
MG(H)	Milligram (hours)
MGF	Maternal grandfather
MGM	Maternal grandmother
MGUS	Monoclonal gammaopathy of uncertain significance
MI	Myocardial infarction
MIBB	Minimally invasive breast biopsy
MICRO	Microscopic
MIN	Minimum
MIN	Minute
MIS	Melanoma in situ
ML	Middle lobe
ML	Milliliter
MM	Millimeter
MMG	Mammogram
MO(S)	Months
MOD	Moderate(ly)
MOD DIFF	Moderately differentiated
MPVC	Multifocal premature ventricular contraction
MRCP	Magnetic resonance cholangiopancreatography
MRI	Magnetic resonance imaging
MRM	Modified radical mastectomy
MRSA	Methicillin Resistant Staphylococcus Aureus
MS	Multiple sclerosis
MSB	Main stem bronchus
MSI	Microsatellite instability
MULT	Multiple
MV	Megavolt
MVP	Mitral valve prolapse
N&V	Nausea and vomiting
N/A	Not applicable
N/V	Nausea and vomiting
NA	Not applicable

Abbreviation/Symbol	Term
NE	No evidence
NEC	Not elsewhere classified
NED	No evidence of disease
NEG	Negative
NEOPL	Neoplasm
NET	Neuroendocrine tumor
NEURO	Neurology
NH	Nursing home
NHL	Non-Hodgkin lymphoma
NIDDM	Non insulin dependent diabetes mellitus
NL	Normal
NML	Normal
NORM	Normal
NOS	Not otherwise specified
NR	Not recorded
NR	Not reportable
NSCCA	Non small cell carcinoma
NSCLC	Non small cell lung carcinoma
NSF	No significant findings
NVD	Neck vein distention
OB	Obstetrics
OBS	Organic brain syndrome
OBST	Obstructed (-ing, -ion)
ONC	Oncology (ist)
OP	Outpatient
OP RPT	Operative report
OR	Operating room
ORTHO	Orthopedics
OTO	Otology
OUTPT	Outpatient
OZ	Ounce
P/DIFF	Poorly differentiated
P32	Phosphorus 32
PAC	Premature atrial contraction
PALP	Palpated (-able)

Abbreviation/Symbol	Term
PAP	Papanicolaou smear
PAP	Papillary
PATH	Pathology
PBSCT	Peripheral blood stem cell transplant
PCP	Primary care physician
PCV	Polycythemia vera
PD	Poorly differentiated
PE	Physical examination
PEDS	Pediatrics
PERC	Percutaneous
PET	Positron emission tomography
PGF	Paternal grandfather
PGM	Paternal grandmother
PID	Pelvic inflammatory disease
PIN III or PIN 3	Prostatic intraepithelial neoplasia, grade III
PLT	Platelets
PMH	Past/personal (medical) history
PMP	Primary medical physician
PNS	Peripheral nervous sytem
POOR DIFF	Poorly differentiated
POS	Positive
POSS	Possible
POST	Posterior
POST OP	Postoperative(-ly)
PPD	Packs per day
PR	Per rectum
PR(A)	Progesterone receptor (assay)
PRE OP	Preoperative(-ly)
PREV	Previous
PROB	Probable (-ly)
PROCTO	Proctoscopy
PS	Performance status
PSA	Prostatic specific antigen
PT	Patient
PT	Physiotherapy/Physical therapy

Abbreviation/Symbol	Term
PTA	Prior to admission
PTC	Percutaneous transhepatic cholecystogram
PTCC	Papillary transitional cell carcinoma
PUD	Peptic ulcer disease
PULM	Pulmonary
PVD	Peripheral vascular disease
P VERA	Polycythemia vera
PY	Pack years
Q	Every
QD	Every day
QUAD	Quadrant
R/O	Rule out
RA	Rheumatoid arthritis
RAD	Radiation absorbed dose
RAD ONC	Radiation Oncology
RAEB	Refractory anemia with excess blasts
RAI	Radioactive iodine
RAIU	Radioactive iodine uptake
RAL	Robotic assisted laparoscopy
RARP	Robotic assisted radical prostatectomy
RBBB	Right bundle branch block
RBC	Red blood cells (count)
RCC	Renal cell carcinoma
RCM	Right costal margin
RCS	Reticulum cell sarcoma
RE	Regarding
REC	Recommend
REC'D	Received
REFRACT ANEM	Refractory anemia
REG	Regional
REG	Regular
RESEC	Resection (ed)
RHD	Rheumatic heart disease
RIA	Radioimmunoassay
RIQ	Right inner quadrant

Abbreviation/Symbol	Term
RLE	Right lower extremity
RLL	Right lower lobe
RLQ	Right lower quadrant
RMC	Regional medical center
RML	Right middle lobe
ROF	Review of outside films
RONC	Radiation Oncology
ROQ	Right outer quadrant
ROS	Review of outside slides
RRP	Radical retropubic prostatectomy
RSO	Right salpingo-oophorectomy
RSR	Regular sinus rhythm
RT	Radiation therapy
RT	Right
RUE	Right upper extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
RX	Prescription
RXT	Radiation therapy
S/P	Status post
S1-S5	Sacral vertebra
SATIS	Satisfactory
SB	Small bowel
SCC	Squamous cell carcinoma
SCF	Supraclavicular fossa
SCID	Severe combined immunodeficiency syndrome
S-COLON	Sigmoid colon
SCT	Stem cell transplant
SCV	Supraclavicular
SGOT	Serum glutamic oxaloacetic transaminase
SGPT	Serum glutamic pyruvic transaminase
SH	Social history
SHX	Social history
SIADH	Syndrome of inappropriate ADH
SIG COLON	Sigmoid colon

Abbreviation/Symbol	Term
SIN III or SIN 3	Squamous intraepithelial neoplasia
SLE	Systemic lupus erythematosus
SLL	Small lymphocytic lymphoma
SLN	Sentinel lymph node
SLNBX	Sentinel lymph node biopsy
SM	Small
SmCC	Small cell carcinoma
SO	Salpingo-oophorectomy
SOB	Short(ness) of breath
SPEC	Specimen
SPEP	Serum protein electrophoresis
SQ	Squamous
SS	Summary stage
S-SPINE	Sacral spine
SSS	Sick sinus syndrome
STSG	Split thickness skin graft
SQCC	Squamous cell carcinoma
SUBCU	Subcutaneous
SUBQ	Subcutaneous
SUGG	Suggestive
SURG	Surgery/Surgical
SUSP	Suspicious/suspected
SVC	Superior vena cava
SX	Symptoms
T1-T12	Thoracic vertebra
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy- bilateral salpingo-oophorectomy
TB	Tuberculosis
TB	Tumor board
TCC	Transitional cell carcinoma
T-COLON	Transverse colon
TIA	Transient ischemic attack
TNM	Tumor, node, metastatis
TOB	Tobacco
TRANS-COLON	Transverse colon

Abbreviation/Symbol	Term
TRUS	Transrectal ultrasound
TS	Tumor size
T-SPINE	Thoracic spine
TTP	Thromboticthrombocytopenia purpura
TUR	Transurethral resection
TURB	Transurethral resection bladder
TURP	Transurethral resection prostate
TVC	True vocal cord
TVH	Total vaginal hysterectomy
TX	Treatment
UE	Upper extremity
UGI	Upper gastrointestinal (series)
UIQ	Upper inner quadrant
UNDIFF	Undifferentiated
UNK	Unknown
UOQ	Upper outer quadrant
URI	Upper respiratory infection
US	Ultrasound
UTI	Urinary tract infection
VAG	Vagina/Vaginal
VAG HYST	Vaginal hysterectomy
VAIN III or VAIN 3	Vaginal intraepithelial neoplasia (grade III)
VIN III or VIN 3	Vulvar intraepithelial neoplasia (grade III)
VGP	Vertical growth phase
VGR	Vertical growth rate
VS	Vital signs
W/	With
W/DIFF	Well differentiated
W/F	White female
W/M	White male
W/O	Without
W/U	Work-up
WBC	White blood cells (count)
WD	Well differentiated
WELL DIFF	Well differentiated

Abbreviation/Symbol	Term
WF	White female
WK(S)	Week(s)
WL	Weight loss
WM	White male
WNL	Within normal limits
WPW	Wolff-Parkinson-White syndrome
WT	Weight
XR	Xray
XRT	External radiation therapy
Y/O	Year old
YO	Year old
YR(S)	Year(s)

Symbols

@ At

/ Comparison

< Decrease, Less than

= Equals

> Increase, More than

- Negative

Number*

+ Positive

Pounds**

x Times

*If it appears before a numeral.

**If it appears after a numeral.

D

APPENDIX D: COMPARISON OF DATA SETS

Definitions

- **Required Data Set (R):** Commission-approved programs must record the required data set items using the codes and definitions specified in the STORE manual.
- **Supplementary Data Set (S):** The supplementary data set contains additional data items that are important for the efficient operation of a cancer registry.
- **Surveillance, Epidemiology, and End Results Program (SEER):** Required data elements for a central registry affiliated with the National Cancer Institute's SEER Program.
- **National Program of Cancer Registries (NPCR):** Refers to requirements and recommendations of the NPCR regarding data items that should be collected or computed by NPCR state registries.
- **Commission on Cancer (CoC):** Refers to requirements and recommendations of the Commission on Cancer of ACoS.
- **Texas Cancer Registry (TCR):** Refers to the requirements and recommendations of the Texas Cancer Registry.
- **Exchange Elements for Hospital to Central and Central to Central:** Items required for facilities reporting to central registries (labeled Hosp>Central), and items that central registries should use when sending cases to other central registries (labeled Central>Central).

Codes for Recommendations

(If left blank, the data field is not currently collected by TCR and other entities.)

• No recommendations

C Collect

D Derived

D* Derived, when available

D+ Derived; central registries may collect either SEER Summary Stage 2000 or Collaborative Stage

DH Historically derived and currently transmitted

DH* Historically derived and currently transmitted when available

R Required

R# Required; central registries may code available data using either SEER or CoC data items and associated rules

R#* Required, when available; central registries may code available data using SEER or CoC data items and associated rules

R$ Requirements differ by year

R* Required, when available

R^ Required, these text requirements may be met with one or several text block fields

RC Collected by SEER from CoC-accredited hospitals

RH Historically collected and currently transmitted

RH* Historically collected and currently transmitted when available

RN Collect according to NPCR stage transition schedule

RS Required, site specific

RS# Required, site specific; central registries may code available data using either SEER or CoC data items and associated rules

RS* Required, site specific; when available

Ret. Retired

Rev. Revised

S Supplementary/recommended

T Data is vital to complete exchange record

T* Transmit data if available for any case in exchange record

TH Only certain historical cases may require these fields

TH* Only certain historical cases may require these fields; transmit data if available for any case in exchange record

√ Populated by TCR

Table F.1 is derived from Chapter VIII: Required Status Table of the NAACCR *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary*

Table D.1 Comparison of Data Sets:

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	10	Record Type	√	R	•	•	•	•			NAACCR
	20	Patient ID Number	√	R	•	•	R	R			Reporting Registry
	21	Patient System ID-Hosp	•	•	•	•	•	•			NAACCR
	30	Registry Type	•	•	•	•	•	•			NAACCR
	40	Registry ID	R	R	•	•	R	R			NAACCR
	45	NPI--Registry ID	•	•	•	•	R*	•			CMS
	50	NAACCR Record Version	R	R	•	•	R	R			NAACCR
	60	Tumor Record Number	•	•	•	•	S	S			NAACCR
	70	Addr at DX--City	R	R	R	R	R	•			CoC
	80	Addr at DX--State	R	R	R	R	R	R			CoC
Rev.	81	State at DX Geocode 1970/80/90	D	RH*	•	•	R	R			NAACCR
	82	State at DX Geocode 2000	D	D	•	•	R	R			NAACCR
	83	State at DX Geocode 2010	D	D	•	•	R*	R*			NAACCR
	84	State at DX Geocode 2020	D	D	•	•	•	•			NAACCR
	89	County at DX Analysis	D	D	•	•	R	R			NAACCR
	90	County at DX Reported	R	R	R	R	R	R			FIPS/SEER
Rev.	94	County at DX Geocode 1970/80/90	D	RH*	•	•	D	R			NAACCR
	95	County at DX	D	D	•	•	D	R			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
		Geocode2000									
	96	County at DX Geocode2010	D	D	•	•	D	R			NAACCR
	97	County at DX Geocode2020	D	D	•	•	•	•			NAACCR
	100	Addr at DX--Postal Code	R	R	R	R	R	•			CoC
	102	Addr at DX--Country	R	•	R	R	R	•			NAACCR
	110	Census Tract 1970/80/90	DH*	RH*	•	•	RH	RH			SEER
	120	Census Cod Sys 1970/80/90	DH*	RH*	•	•	RH	RH			SEER
	125	Census Tract 2020	D	D	•	•	R*	R*			NAACCR
	130	Census Tract 2000	DH	RH	•	•	RH	RH			NAACCR
	135	Census Tract 2010	D	R	•	•	R	R			NAACCR
	145	Census Tr Poverty Indictr	D	D	•	•	D	R			NAACCR
	150	Marital Status at DX	R	•	•	•	R	R			SEER
	160	Race 1	R	R	R	R	R	R			SEER/CoC
.	161	Race 2	R	R	R	R	R	R			SEER/CoC
	162	Race 3	R	R	R	R	R	R			SEER/CoC
	163	Race 4	R	R	R	R	R	R			SEER/CoC
	164	Race 5	R	R	R	R	R	R			SEER/CoC
	170	Race Coding Sys--Current	•	•	•	•	•	•			NAACCR
	180	Race Coding Sys--Original	•	•	•	•	•	•			NAACCR
	190	Spanish/Hispanic Origin	R	R	R	R	•	R			SEER/CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp >	Central > Central	
	191	NHIA Derived Hisp Origin	D	D	•	•	D	R			NAACCR
	192	IHS Link	√	R*	•	•	•	R			NPCR
.	193	Race--NAPIIA(derived API)	D	R	•	•	•	R			NAACCR
New	194	IHS Purchased/Referred Care Delivery Area	D	D	•	•	D	R			NPCR
Rev.	200	Computed Ethnicity	D	•	•	•	D	R			SEER
Rev.	210	Computed Ethnicity Source	R	•	•	•	R	R			SEER
	220	Sex	R	R	R	R	R	R			SEER/CoC
	230	Age at Diagnosis	√	R	R	R	R	R			SEER/CoC
	240	Date of Birth	R	R	R	R	R	R			SEER/CoC
	241	Date of Birth Flag	D	R	R	R	R	R			NAACCR
	250	Birthplace	RH*	RH*	•	•	•	•			SEER/CoC
	252	Birthplace--State	R	R*	R	R	R	R			NAACCR
	254	Birthplace--Country	R	R*	R	R	R	R			NAACCR
	270	Census Occ Code 1970-2000	√	R*	•	•	•	•			Census/NPCR
	272	Census Ind Code 2010 CDC	R*	R*	•	•	•	•			Census/NPCR
	280	Census Ind Code 1970-2000	√	R*	•	•	•	•			Census/NPCR
	282	Census Occ Code 2010 CDC	R*	R*	•	•	•	•			Census/NPCR
New	284	Urban Indian Health	D	D	•	•	D	R			NPCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp >	Central > Central	
		Organization (UIHO)									
New	285	UIHO City	D	D	•	•	D	R			NPCR
	290	Occupation Source	√	R*	•	•	•	•			NPCR
	300	Industry Source	√	R*	•	•	•	•			NPCR
	310	Text--Usual Occupation	R	R*	•	•	•	•			NPCR
	320	Text--Usual Industry	R	R*	•	•	•	•			NPCR
	330	Census Occ/Ind Sys 70-00	√	R*	•	•	•	•			NPCR
	339	RUCA 2000	D	D	•	•	D	R			NAACCR
	341	RUCA 2010	D	D	•	•	D	R			NAACCR
New	344	Tobacco Use Smoking Status	R	R*			R*	R*			NPCR
	345	URIC 2000	D	D	•	•	D	R			NAACCR
	346	URIC 2010	D	D	•	•	D	R			NAACCR
Rev.	351	GeoLocationID - 1970/80/90	•	RH*	•	•	•	•			NAACCR
	352	GeoLocationID - 2000	D	D	•	•	•	•			NAACCR
	353	GeoLocationID - 2010	D	D	•	•	•	•			NAACCR
	354	GeoLocationID - 2020	D	D	•	•	•	•			NAACCR
	361	Census Block Group 2020	•	•	•	•	•	•			Census
	362	Census Block Group 2000	D	•	•	•	S	S			Census
	363	Census Block Group 2010	D	•	•	•	R	•			Census

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	364	Census Tr Cert 1970/80/90	D	RH*	•	•	RH	RH			SEER
	365	Census Tr Certainty 2000	D	RH	•	•	RH	RH			NAACCR
	366	GIS Coordinate Quality	D	R*	•	•	S	S			NAACCR
	367	Census Tr Certainty 2010	D	R	•	•	R	R			NAACCR
	368	Census Block Grp 1970/80/90	•	•	•	•	S	S			Census
	369	Census Tract Certainty 2020	D	D	•	•	•	•			NAACCR
	380	Sequence Number--Central	R	R	•	•	R	R			SEER
	390	Date of Diagnosis	R	R	R	R	R	R			SEER/CoC
	391	Date of Diagnosis Flag	D	R	•	•	R	R			NAACCR
	400	Primary Site	R	R	R	R	R	R			SEER/CoC
	410	Laterality	R	R	R	R	R	R			SEER/CoC
	419	Morph--Type&Behav ICD-O-2	•	•	•	•	•	•			
	420	Histology (92-00) ICD-O-2	RH	RH	RH	RH	RH	RH			SEER/CoC
	430	Behavior (92-00) ICD-O-2	RH	RH	RH	RH	RH	RH			SEER/CoC
	439	Date of Mult Tumors Flag	•	•	RH	RH	RH	RH			NAACCR
	440	Grade	RH	RH	RH	RH	RH	RH			SEER/CoC
	441	Grade Path Value	•	RH*	RH	RH	RH	RH			AJCC
	442	Ambiguous Terminology DX	•	•	RH	RH	RH	RH			SEER

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	443	Date Conclusive DX	•	•	RH	RH	RH	RH			SEER
	444	Mult Tum Rpt as One Prim	•	•	RH	RH	RH	RH			SEER
	445	Date of Mult Tumors	•	•	RH	RH	RH	RH			SEER
	446	Multiplicity Counter	•	•	RH	RH	RH	RH			SEER
	448	Date Conclusive DX Flag	•	•	RH	RH	RH	RH			NAACCR
	449	Grade Path System	•	RH*	RH	RH	RH	RH			AJCC
	450	Site Coding Sys--Current	R	R	•	•	•	•			NAACCR
	460	Site Coding Sys--Original	•	•	•	•	•	•			NAACCR
	470	Morph Coding Sys--Current	R	R	•	•	•	•			NAACCR
	480	Morph Coding Sys--Original	•	•	•	•	•	•			NAACCR
	490	Diagnostic Confirmation	R	R	R	R	R	R			SEER/CoC
	500	Type of Reporting Source	R	R	•	•	R	R			SEER
	501	Casefinding Source	R*	R*	•	•	•	•			NAACCR
	521	Morph--Type&Behav ICD-O-3	•	•	•	•	•	•			
	522	Histologic Type ICD-O-3	R	R	R	R	R	R			SEER/CoC
	523	Behavior Code ICD-O-3	R	R	R	R	R	R			SEER/CoC
New	530	EDP MDE Link Date	RS	RS	•	•	•	•			
New	531	EDP MDE Link	RS	RS	•	•	•	•			
	540	Reporting Facility	R	R	R	R	R	•			CoC
	545	NPI--Reporting Facility	D	R*	R	R	R*	•			CMS
	550	Accession Number--Hosp	R	•	R	R	R	•			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp >	Central >	
	560	Sequence Number--Hospital	R	•	R	R	R	•			CoC
	570	Abstracted By	R	•	R	R	R	•			CoC
	580	Date of 1st Contact	R	R	R	R	•	•			CoC
	581	Date of 1st Contact Flag	D	R	R	R	•	•			NAACCR
	590	Date of Inpt Adm	•	•	•	•	•	•			NAACCR
	591	Date of Inpt Adm Flag	•	•	•	•	•	•			NAACCR
	600	Date of Inpt Disch	•	•	•	•	•	•			NAACCR
	601	Date of Inpt Disch Flag	•	•	•	•	•	•			NAACCR
	605	Inpatient Status	•	•	•	•	•	•			NAACCR
	610	Class of Case	R	R	R	R	RC	•			CoC
	630	Primary Payer at DX	R	R*	R	R	R	R			CoC
	668	RX Hosp--Surg App 2010	•	•	R	R	•	•			CoC
	670	RX Hosp--Surg Prim Site	•	•	R	R	R	•			CoC
	672	RX Hosp--Scope Reg LN Sur	R	•	R	R	R	R			CoC
	674	RX Hosp--Surg Oth Reg/Dis	R	•	R	R	R	R			CoC
	676	RX Hosp--Reg LN Removed	•	•	RH	RH	•	R			CoC
	682	Date Regional Lymph Node Dissection	RC	•	R	R	RC	RC			NAACCR
	683	Date Regional Lymph Node Dissection Flag	R*	•	•	•	R*	R*			NAACCR
	690	RX Hosp--Radiation	•	•	•	•	RH	RH			SEER

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	700	RX Hosp--Chemo	•	•	R	R	R	R			CoC
	710	RX Hosp--Hormone	•	•	R	R	R	R			CoC
	720	RX Hosp--BRM	•	•	R	R	R	R			CoC
	730	RX Hosp--Other	•	•	R	R	R	R			CoC
	740	RX Hosp--DX/Stg Proc	•	•	R	R	•	•			CoC
	746	RX Hosp--Surg Site 98-02	•	•	RH	RH	RH	RH			CoC
	747	RX Hosp--Scope Reg 98-02	•	•	RH	RH	RH	RH			CoC
	748	RX Hosp--Surg Oth 98-02	•	•	RH	RH	RH	RH			CoC
	752	Tumor Size Clinical	R	•	•	•	R	R			SEER
	754	Tumor Size Pathologic	R	•	•	•	R	R			SEER
	756	Tumor Size Summary	R	R	R	R	S	S			NPCR/CoC
	759	SEER Summary Stage 2000	RH	RH	RH	RH	RH	RH			SEER
	760	SEER Summary Stage 1977	•	RH	RH	RH	•	•			SEER
	762	Derived Summary Stage 2018	D	•	•	•	D	R			SEER
	764	Summary Stage 2018	R	R	•	•	R*	R*			SEER
	772	EOD Primary Tumor	R	•	•	•	R	R			SEER
	774	EOD Regional Nodes	R	•	•	•	R	R			SEER
	776	EOD Mets	R	•	•	•	R	R			SEER
	779	Extent of Disease 10-Dig	•	•	•	•	•	•			

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	780	EOD--Tumor Size	•	•	RH	RH	RH	RH			SEER/CoC
	785	Derived EOD 2018 T	D	•	•	•	D	R			SEER
	790	EOD--Extension	•	•	•	•	RH	RH			SEER
	795	Derived EOD 2018 M	D	•	•	•	D	R			SEER
	800	EOD--Extension Prost Path	•	•	•	•	RH	RH			SEER
	810	EOD--Lymph Node Involv	•	•	•	•	RH	RH			SEER
	815	Derived EOD 2018 N	D	•	•	•	D	R			SEER
	818	Derived EOD 2018 Stage Group	D	•	•	•	D	R			SEER
	820	Regional Nodes Positive	R	R	R	R	R	R	R		SEER/CoC
	830	Regional Nodes Examined	R	R	R	R	R	R	R		SEER/CoC
	832	Date of Sentinel Lymph Node Biopsy	RS	•	RS	RS	R*	R*	R*		CoC
	833	Date Sentinel Lymph Node Biopsy Flag	RS	•	RS	RS	R*	R*	R*		CoC
	834	Sentinel Lymph Nodes Examined	RS	•	RS	RS	R*	R*	R*		CoC
	835	Sentinel Lymph Nodes Positive	RS	•	RS	RS	R*	R*	R*		CoC
	840	EOD--Old 13 Digit	•	•	•	•	RH	RH	RH		SEER
	850	EOD--Old 2 Digit	•	•	•	•	RH	RH	RH		SEER
	860	EOD--Old 4 Digit	•	•	•	•	RH	RH	RH		SEER
	870	Coding System for EOD	•	•	•	•	RH	RH	RH		SEER

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp >	Central >	
	880	TNM Path T	RH	•	RH	RH	RH	RH	RH		AJCC
	890	TNM Path N	RH	•	RH	RH	RH	RH	RH		AJCC
	900	TNM Path M	RH	•	RH	RH	RH	RH	RH		AJCC
	910	TNM Path Stage Group	RH	•	RH	RH	RH*	RH*	RH*		AJCC
	920	TNM Path Descriptor	RH	•	RH	RH	RH	RH	RH		CoC
	930	TNM Path Staged By	•	•	RH	RH	RH	RH	RH		CoC
	940	TNM Clin T	RH	•	RH	RH	RH	RH	RH		AJCC
	950	TNM Clin N	RH	•	RH	RH	RH	RH	RH		AJCC
	960	TNM Clin M	RH	•	RH	RH	RH	RH	RH		AJCC
	970	TNM Clin Stage Group	RH	•	RH	RH	RH*	RH*	RH*		AJCC
	980	TNM Clin Descriptor	RH	•	RH	RH	RH	RH	RH		CoC
	990	TNM Clin Staged By	•	•	•	RH	RH	RH	RH		CoC
	995	AJCC ID	D	D	D	R	RC	RC	RC		NAACCR
	1001	AJCC TNM Clin T	RC	•	R	R	RC	RC	RC		AJCC
	1002	AJCC TNM Clin N	RC	•	R	R	RC	RC	RC		AJCC
	1003	AJCC TNM Clin M	RC	•	R	R	RC	RC	RC		AJCC
	1004	AJCC TNM Clin Stage Group	RC	•	R	R	RC	RC	RC		AJCC
	1011	AJCC TNM Path T	RC	•	R	R	RC	RC	RC		AJCC
	1012	AJCC TNM Path N	RC	•	R	R	RC	RC	RC		AJCC
	1013	AJCC TNM Path M	RC	•	R	R	RC	RC	RC		AJCC
	1014	AJCC TNM Path Stage Group	RC	•	R	R	RC	RC	RC		AJCC
	1021	AJCC TNM Post Therapy T	RC	•	R	R	RC	RC			AJCC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	1022	AJCC TNM Post Therapy N	RC	•	R	R	RC	RC			AJCC
	1023	AJCC TNM Post Therapy M	RC	•	R	R	RC	RC			AJCC
	1024	AJCC TNM Post Therapy Stage Group	RC	•	R	R	RC	RC			AJCC
	1031	AJCC TNM Clin T Suffix	RC	•	R	R	RC	RC			AJCC
	1032	AJCC TNM Path T Suffix	RC	•	R	R	RC	RC			AJCC
	1033	AJCC TNM Post Therapy T Suffix	RC	•	R	R	RC	RC			AJCC
	1034	AJCC TNM Clin N Suffix	RC	•	R	R	RC	RC			AJCC
	1035	AJCC TNM Path N Suffix	RC	•	R	R	RC	RC			AJCC
	1036	AJCC TNM Post Therapy N Suffix	RC	•	R	R	RC	RC			AJCC
	1060	TNM Edition Number	RH	•	R	R	RH	RH			CoC
	1062	AJCC TNM Post Therapy Clin (yc) T	RC	•	R	R	RC	RC			AJCC
	1063	AJCC TNM Post Therapy Clin (yc) T Suffix	RC	•	R	R	RC	RC			AJCC
	1064	AJCC TNM Post Therapy Clin (yc) N	RC	•	R	R	RC	RC			AJCC
	1065	AJCC TNM Post Therapy Clin (yc) N Suffix	RC	•	R	R	RC	RC			AJCC
	1066	AJCC TNM Post Therapy	RC	•	R	R	RC	RC			AJCC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
		Clin (yc) M									
	1067	AJCC TNM Post Therapy Stage Group	•	•	•	•	•	•			AJCC
	1068	Grade Post Therapy Clin (yc)	R	R*	R	R	RS	RS			NAACCR
	1112	Mets at DX-Bone	R	•	R	R	R	R			SEER
	1113	Mets at DX-Brain	R	•	R	R	R	R			SEER
	1114	Mets at Dx-Distant LN	R	•	R	R	R	R			SEER
	1115	Mets at DX-Liver	R	•	R	R	R	R			SEER
	1116	Mets at DX-Lung	R	•	R	R	R	R			SEER
	1117	Mets at DX-Other	R	•	R	R	R	R			SEER
	1120	Pediatric Stage	•	•	•	•	•	•			CoC
	1130	Pediatric Staging System	•	•	•	•	•	•			CoC
	1140	Pediatric Staged By	•	•	•	•	•	•			CoC
	1150	Tumor Marker 1	•	•	RH	RH	RH	RH			SEER
	1160	Tumor Marker 2	•	•	RH	RH	RH	RH			SEER
	1170	Tumor Marker 3	•	•	RH	RH	RH	RH			SEER
	1182	Lymphovascular Invasion	RS	R*	R	R	RS	RS			AJCC
	1200	RX Date Surgery	R	R	R	R	RC	RC			CoC
	1201	RX Date Surgery Flag	R	R	•	•	RC	RC			NAACCR
	1210	RX Date Radiation	R	R	R	R	RC	RC			CoC
	1211	RX Date Radiation Flag	R	R	•	•	R*	R*			NAACCR
	1220	RX Date Chemo	R	R	R	R	RC	RC			CoC
	1221	RX Date Chemo Flag	R	R	•	•	RC	RC			NAACCR
	1230	RX Date Hormone	R	R	R	R	RC	RC			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	1231	RX Date Hormone Flag	R	R	R	R	RC	RC			NAACCR
	1240	RX Date BRM	R	R	R	R	RC	RC			CoC
	1241	RX Date BRM Flag	R	R	R	R	RC	RC			NAACCR
	1250	RX Date Other	R	R	R	R	RC	RC			CoC
	1251	RX Date Other Flag	R	R	•	•	R*	R*			NAACCR
	1260	Date Initial RX SEER	R	R#	•	•	R	R			SEER
	1261	Date Initial RX SEER Flag	R	R#	•	•	R	R			NAACCR
	1270	Date 1st Crs RX CoC	R#	R#	R	R	•	•			CoC
	1271	Date 1st Crs RX CoC Flag	R#	R#	•	•	•	•			NAACCR
	1280	RX Date DX/Stg Proc	•	•	R	R	•	•			CoC
	1281	RX Date DX/Stg Proc Flag	•	•	R	R	•	•			NAACCR
	1285	RX Summ--Treatment Status	R	R#	R	R	R	R			SEER/CoC
	1290	RX Summ--Surg Prim Site	R	R	R	R	R	R			SEER/CoC
	1292	RX Summ--Scope Reg LN Sur	R	R	R	R	R	R			SEER/CoC
	1294	RX Summ--Surg Oth Reg/Dis	R	R	R	R	R	R			SEER/CoC
	1296	RX Summ--Reg LN Examined	•	•	RH	RH	RH	RH			SEER/CoC
	1310	RX Summ--Surgical Approach	•	•	RH	RH	•	•			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	1320	RX Summ--Surgical Margins	R*	•	R	R	R*	R*			CoC
	1330	RX Summ--Reconstruct 1st	•	•	RH	RH	•	•			SEER
	1340	Reason for No Surgery	R	R	R	R	R	R			SEER/CoC
	1350	RX Summ--DX/Stg Proc	•	•	R	R	•	•			CoC
	1360	RX Summ--Radiation	RH	RH	•	•	RH	RH			SEER
	1370	RX Summ--Rad to CNS	•	•	•	•	RH	RH			SEER/CoC
	1380	RX Summ--Surg/Rad Seq	R	R	R	R	R	R			SEER/CoC
	1390	RX Summ--Chemo	R	R	R	R	R	R			SEER/CoC
	1400	RX Summ--Hormone	R	R	R	R	R	R			SEER/CoC
	1410	RX Summ--BRM	R	R	R	R	R	R			SEER/CoC
	1420	RX Summ--Other	R	R	R	R	R	R			SEER/CoC
	1430	Reason for No Radiation	R	R	R	R	R	R			CoC
	1460	RX Coding System--Current	R	R	•	•	•	•			NAACCR
	1501	Phase I Dose per Fraction	R*	•	R	R	R*	R*			CoC
	1502	Phase I Radiation External Beam Planning Tech	RC	•	R	R	RC	RC			CoC
	1503	Phase I Number of Fractions	R*	•	R	R*	R*	R*			CoC
	1504	Phase I Radiation Primary Treatment Volume	R*	•	R	R*	R*	R*			CoC
	1505	Phase I Radiation to Draining Lymph Nodes	R*	•	R	R*	R*	R*			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	1506	Phase I Radiation Treatment Modality	R	R	R	R	R	R			CoC
	1507	Phase I Total Dose	R*	•	R	R	R*	R*			CoC
	1510	Rad--Regional Dose: cGy	•	•	•	•	•	•			CoC
	1511	Phase II Dose per Fraction	R*	•	R	R	R*	R*			CoC
	1512	Phase II Radiation External Beam Planning Tech	RC	•	R	R	RC	RC			CoC
	1513	Phase II Number of Fractions	R*	•	R	R	R*	R*			CoC
	1514	Phase II Radiation Primary Treatment Volume	R*	•	R	R	R*	R*			CoC
	1515	Phase II Radiation to Draining Lymph Nodes	R*	•	R	R	R*	R*			CoC
	1516	Phase II Radiation Treatment Modality	R	•	R	R	R	R			CoC
	1517	Phase II Total Dose	R*	•	R	R	R*	R*			CoC
	1520	Rad--No of Treatment Vol	•	•	•	•	•	•			CoC
	1521	Phase III Dose per Fraction	R*	•	R	R	R*	R*			CoC
	1522	Phase III Radiation External Beam Planning Tech	RC	•	R	R	RC	RC			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	1523	Phase III Number of Fractions	R*	•	R	R	R*	R*			CoC
	1524	Phase III Radiation Primary Treatment Volume	R*	•	R	R	R*	R*			CoC
	1525	Phase III Radiation to Draining Lymph Nodes	R*	•	R	R	R*	R*			CoC
	1526	Phase III Radiation Treatment Modality	R	•	R	R	R	R			CoC
	1527	Phase III Total Dose	R*	•	R	R	R*	R*			CoC
	1531	Radiation Treatment Discontinued Early	R*	•	R	R	R*	R*			CoC
	1532	Number of Phases of Rad Treatment to this Volume	R*	•	R	R	R*	R*			CoC
	1533	Total Dose	R*	•	R	R	R*	R*			CoC
	1540	Rad--Treatment Volume	•	•	R	R	•	•			CoC
	1550	Rad--Location of RX	•	•	RH	RH	•	•			CoC
	1570	Rad--Regional RX Modality	RH	RH	•	•	•	•			CoC
	1632	Neoadjuvant Therapy	R	•	•	•	R	R			SEER
	1633	Neoadjuvant Therapy-Clinical Response	R	•	•	•	R	R			SEER
	1634	Neoadjuvant Therapy-Treatment Effect	R	•	•	•	R	R			SEER
	1639	RX Summ--Systemic/Sur Seq	R	R	R	R	R	R			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	1640	RX Summ--Surgery Type	•	•	•	•	RH	RH			SEER
	1646	RX Summ--Surg Site 98-02	•	•	RH	RH	•	•			SEER/CoC
	1647	RX Summ--Scope Reg 98-02	•	•	RH	RH	RH	RH			SEER/CoC
	1648	RX Summ--Surg Oth 98-02	•	•	RH	RH	RH	RH			SEER/CoC
	1660	Subsq RX 2nd Course Date	•	•	•	•	•	•			CoC
	1661	Subsq RX 2ndCrs Date Flag	•	•	•	•	•	•			NAACCR
	1670	Subsq RX 2nd Course Codes	•	•	•	•	•	•			
	1671	Subsq RX 2nd Course Surg	•	•	•	•	•	•			CoC
	1672	Subsq RX 2nd Course Rad	•	•	•	•	•	•			CoC
	1673	Subsq RX 2nd Course Chemo	•	•	•	•	•	•			CoC
	1674	Subsq RX 2nd Course Horm	•	•	•	•	•	•			CoC
	1675	Subsq RX 2nd Course BRM	•	•	•	•	•	•			CoC
	1676	Subsq RX 2nd Course Oth	•	•	•	•	•	•			CoC
	1677	Subsq RX 2nd--Scope LN	•	•	•	•	•	•			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
		SU									
	1678	Subsq RX 2nd--Surg Oth	•	•	•	•	•	•			CoC
	1679	Subsq RX 2nd--Reg LN Rem	•	•	•	•	•	•			CoC
	1680	Subsq RX 3rd Course Date	•	•	•	•	•	•			CoC
	1681	Subsq RX 3rdCrs Date Flag	•	•	•	•	•	•			NAACCR
	1690	Subsq RX 3rd Course Codes	•	•	•	•	•	•			
	1691	Subsq RX 3rd Course Surg	•	•	•	•	•	•			CoC
	1692	Subsq RX 3rd Course Rad	•	•	•	•	•	•			CoC
	1693	Subsq RX 3rd Course Chemo	•	•	•	•	•	•			CoC
	1694	Subsq RX 3rd Course Horm	•	•	•	•	•	•			CoC
	1695	Subsq RX 3rd Course BRM	•	•	•	•	•	•			CoC
	1696	Subsq RX 3rd Course Oth	•	•	•	•	•	•			CoC
	1697	Subsq RX 3rd--Scope LN Su	•	•	•	•	•	•			CoC
	1698	Subsq RX 3rd--Surg Oth	•	•	•	•	•	•			CoC
	1699	Subsq RX 3rd--Reg LN Rem	•	•	•	•	•	•			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	1700	Subsq RX 4th Course Date	•	•	•	•	•	•			CoC
	1701	Subsq RX 4thCrs Date Flag	•	•	•	•	•	•			NAACCR
	1710	Subsq RX 4th Course Codes	•	•	•	•	•	•			
	1711	Subsq RX 4th Course Surg	•	•	•	•	•	•			CoC
	1712	Subsq RX 4th Course Rad	•	•	•	•	•	•			CoC
	1713	Subsq RX 4th Course Chemo	•	•	•	•	•	•			CoC
	1714	Subsq RX 4th Course Horm	•	•	•	•	•	•			CoC
	1715	Subsq RX 4th Course BRM	•	•	•	•	•	•			CoC
	1716	Subsq RX 4th Course Oth	•	•	•	•	•	•			CoC
	1717	Subsq RX 4th--Scope LN Su	•	•	•	•	•	•			CoC
	1718	Subsq RX 4th--Surg Oth	•	•	•	•	•	•			CoC
	1719	Subsq RX 4th--Reg LN Rem	•	•	•	•	•	•			CoC
	1741	Subsq RX--Reconstruct Del	•	•	•	•	•	•			CoC
	1750	Date of Last Contact	R	R	R	R	R	R			SEER/CoC
	1751	Date of Last Contact Flag	R	R	•	R	R	R			NAACCR
	1760	Vital Status	R	R	R	R	R	R			SEER/CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	1762	Vital Status Recode	D	D	•	•	D	R			NAACCR
Rev.	1770	Cancer Status	R*	•	R	R	R*	R*			CoC
Rev.	1772	Date of Last Cancer (tumor) Status	R*	•	R	R	R*	R*			CoC
Rev.	1773	Date of Last Cancer (tumor) Status Flag	R*	•	•	•	R*	R*			CoC
	1775	Record Number Recode	D	D	•	•	D	R			NAACCR
	1780	Quality of Survival	•	•	•	•	•	•			CoC
	1782	Surv-Date Active Followup	D	D	•	•	D	R			NAACCR
	1783	Surv-Flag Active Followup	D	D	•	•	D	R			NAACCR
	1784	Surv-Mos Active Followup	D	D	•	•	D	R			NAACCR
	1785	Surv-Date Presumed Alive	D	D	•	•	D	R			NAACCR
	1786	Surv-Flag Presumed Alive	D	D	•	•	D	R			NAACCR
	1787	Surv-Mos Presumed Alive	D	D	•	•	D	R			NAACCR
	1788	Surv-Date DX Recode	D	D	•	•	D	R			NAACCR
	1790	Follow-Up Source	R*	R*	R	•	•	•			CoC
	1791	Follow-up Source Central	D	R	•	•	•	•			NAACCR
	1800	Next Follow-Up Source	•	•	R	•	•	•			CoC
	1810	Addr Current--City	R	•	•	•	R	•			CoC
	1820	Addr Current--State	R	•	•	•	R	•			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	1830	Addr Current--Postal Code	R	•	•	•	R	•			CoC
	1832	Addr Current--Country	•	•	•	•	R	•			NAACCR
	1835	Reserved 10									
	1840	County--Current	•	•	•	•	•	•			NAACCR
	1842	Follow-Up Contact--City	•	•	•	•	•	•			SEER
	1844	Follow-Up Contact--State	•	•	•	•	•	•			SEER
	1846	Follow-Up Contact--Postal	•	•	•	•	•	•			SEER
	1847	FollowUp Contact--Country	•	•	•	•	•	•			NAACCR
	1850	Unusual Follow-Up Method	•	•	•	•	•	•			NAACCR
	1860	Recurrence Date--1st	RC	•	R	R	RC	•			CoC
	1861	Recurrence Date--1st Flag	R*	•	•	•	R*	•			NAACCR
	1880	Recurrence Type--1st	RC	•	R	R	RC	•			CoC
	1910	Cause of Death	√	R	•	•	R	R			SEER
	1914	SEER Cause Specific COD	D	D	•	•	D	R			SEER
	1915	SEER Other COD	D	D	•	•	D	R			SEER
	1920	ICD Revision Number	√	R	•	•	R	R			SEER
	1930	Autopsy	•	•	•	•	•	•			NAACCR
	1940	Place of Death	•	RH	•	•	•	•			NPCR
	1942	Place of Death--State	R	R	•	•	R	R			NAACCR
	1944	Place of Death--Country	R	R*	•	•	R	R			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	1960	Site (73-91) ICD-O-1	•	•	•	•	RH	RH			SEER
	1970	Morph (73-91) ICD-O-1	•	•	•	•	•	•			
	1971	Histology (73-91) ICD-O-1	•	•	•	•	RH	RH			SEER
	1972	Behavior (73-91) ICD-O-1	•	•	•	•	RH	RH			SEER
	1973	Grade (73-91) ICD-O-1	•	•	•	•	RH	RH			SEER
	1980	ICD-O-2 Conversion Flag	R	•	•	•	R	R			SEER
	1981	Over-ride SS/NodesPos	•	•	•	•	RH	RH			NAACCR
	1982	Over-ride SS/TNM-N	•	•	•	•	RH	RH			NAACCR
	1983	Over-ride SS/TNM-M	•	•	•	•	RH	RH			NAACCR
	1985	Over-ride Acsn/Class/Seq	•	•	•	•	•	•			CoC
	1986	Over-ride HospSeq/DxConf	•	•	•	•	•	•			CoC
	1987	Over-ride CoC-Site/Type	•	•	•	•	•	•			CoC
	1988	Over-ride HospSeq/Site	•	•	•	•	•	•			CoC
	1989	Over-ride Site/TNM-StgGrp	D	•	•	•	R	R			CoC
	1990	Over-ride Age/Site/Morph	D	R	•	•	R	R			SEER
	1992	Over-ride TNM Stage	•	•	•	•	•	•			NAACCR
	1993	Over-ride TNM Tis	D	•	•	•	R	•			NAACCR
	1994	Over-ride TNM 3	•	•	•	•	•	•			NAACCR
	2000	Over-ride SeqNo/DxConf	D	R	•	•	R	R			SEER
	2010	Over-ride Site/Lat/SeqNo	D	R	•	•	R	R			SEER

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	2020	Over-ride Surg/DxConf	D	R	•	•	R	R			SEER
	2030	Over-ride Site/Type	D	R	•	•	R	R			SEER
	2040	Over-ride Histology	D	R	•	•	R	R			SEER
	2050	Over-ride Report Source	D	R	•	•	R	R			SEER
	2060	Over-ride Ill-define Site	D	R	•	•	R	R			SEER
	2070	Over-ride Leuk, Lymphoma	D	R	•	•	R	R			SEER
	2071	Over-ride Site/Behavior	D	R	•	•	R	R			SEER
	2072	Over-ride Site/EOD/DX Dt	D	•	•	•	R	R			SEER
	2073	Over-ride Site/Lat/EOD	D	•	•	•	R	R			SEER
	2074	Over-ride Site/Lat/Morph	D	R	•	•	R	R			SEER
	2078	Over-ride Name/Sex	D	R	•	•	R	R			NAACCR
	2081	CRC CHECKSUM	•	•	•	•	S	S			NAACCR
	2085	Date Case Initiated	•	•	•	•	•	•			NAACCR
	2090	Date Case Completed	•	•	•	•	•	•			NAACCR
	2092	Date Case Completed--CoC	•	•	D	D	•	•			CoC
	2100	Date Case Last Changed	√	•	D	D	•	•			NAACCR
	2110	Date Case Report Exported	√	R	•	•	•	•			NPCR
	2111	Date Case Report Received	√	R	•	•	•	•			NPCR
	2112	Date Case Report Loaded	√	R	•	•	•	•			NPCR
	2113	Date Tumor Record	R	R	•	•	•	•			NPCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
		Availbl									
	2116	ICD-O-3 Conversion Flag	R	R	•	•	R	R			SEER/CoC
	2117	Schema ID Version Current	D	D	D	D	D	R			SEER
	2118	Schema ID Version Original	D	D	D	D	D	R			SEER
	2120	SEER Coding Sys--Current	•	•	•	•	•	•			NAACCR
	2130	SEER Coding Sys--Original	•	•	•	•	•	•			NAACCR
	2140	CoC Coding Sys--Current	•	•	•	•	•	•			CoC
	2150	CoC Coding Sys--Original	•	•	•	•	•	•			CoC
	2152	CoC Accredited Flag	√	R	•	•	R	R			NPCR
	2155	RQRS NCDB Submission Flag	•	•	•	•	•	•			CoC
	2156	AJCC API Version Current	D*	•	D	D	D*	R*			AJCC
	2157	AJCC API Version Original	D*	•	D	D	D*	R*			AJCC
Rev.	2158	AJCC Cancer Surveillance API Version Current	D	D	D	D	D*	R*			AJCC
Rev.	2159	AJCC Cancer Surveillance API Version Original	D	D	D	D	D*	R*			AJCC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	2170	Vendor Name	√	•	R	R	•	•			NAACCR
	2180	SEER Type of Follow-Up	•	•	•	•	•	•			SEER
	2190	SEER Record Number	•	•	•	•	•	•			SEER
	2200	Diagnostic Proc 73-87	•	•	•	•	•	•			SEER
	2210	Reserved 14	•								
	2220	State/Requestor Items	•	•	•	•	•	•			Varies
	2230	Name--Last	R	R	•	•	R	•			CoC
	2232	Name-Birth Surname	R	R	•	•	R	•			NAACCR
	2240	Name--First	R	R	•	•	R	•			CoC
	2250	Name--Middle	R	R	R	•	R	•			CoC
	2260	Name--Prefix	•	•	•	•	•	•			NAACCR
	2270	Name--Suffix	R	•	•	•	R	•			NAACCR
	2280	Name--Alias	R	R	•	•	R	•			NAACCR
	2290	Name--Spouse/Parent	•	•	•	•	•	•			NAACCR
	2300	Medical Record Number	R	R	•	•	R	•			CoC
	2310	Military Record No Suffix	•	•	•	•	•	•			CoC
	2315	Medicare Beneficiary Identifier	R*	R*	•	•	•	•			NAACCR
	2320	Social Security Number	R	R	•	•	R	•			CoC
	2330	Addr at DX--No & Street	R	R	•	•	R	•			CoC
	2335	Addr at DX--Supplementl	R	R	•	•	R	•			CoC
	2350	Addr Current--No & Street	R	•	•	•	R	•			CoC
	2352	Latitude	D	R*	•	•	S	S			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	2354	Longitude	D	R*	•	•	S	S			NAACCR
	2355	Addr Current--Supplementl	R*	•	•	•	R*	•			CoC
	2360	Telephone	R	•	•	•	R	•			CoC
	2380	DC State File Number	R	R	•	•	R*	•			State
	2390	Name-Maiden	•	•	•	•	•	•			
	2392	Follow-Up Contact--No&St	•	•	•	•	•	•			SEER
	2393	Follow-Up Contact--Suppl	•	•	•	•	•	•			SEER
	2394	Follow-Up Contact--Name	•	•	•	•	•	•			SEER
	2410	Institution Referred From	•	•	•	•	•	•			CoC
	2415	NPI--Inst Referred From	•	•	R	•	•	•			CMS
	2420	Institution Referred To	•	•	•	•	•	•			CoC
	2425	NPI--Inst Referred To	•	•	R	•	•	•			CMS
	2440	Following Registry	•	•	•	•	RH	•			CoC
	2445	NPI--Following Registry	•	•	•	•	RH*	•			CMS
	2460	Physician--Managing	•	•	•	•	•	•			NAACCR
	2465	NPI--Physician--Managing	•	•	•	•	•	•			CMS
	2470	Physician--Follow-Up	R	•	•	•	R	•			CoC
	2475	NPI--Physician--Follow-Up	R*	•	•	•	R*	•			CMS
	2480	Physician--Primary Surg	•	•	•	•	•	•			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp >	Central > Central	
	2485	NPI--Physician--Primary Surg	•	•	R	R	•	•			CMS
	2490	Physician 3		•	•	•	•	•			CoC
	2495	NPI--Physician 3	•	•	R	R	•	•			CMS
	2500	Physician 4	•	•	•	•	•	•			CoC
	2505	NPI--Physician 4	•	•	R	R	•	•			CMS
	2508	EHR Reporting	•	•	•	•	•	•			NAACCR
	2520	Text--DX Proc--PE	R^	R^	•	•	R	•			NPCR
	2530	Text--DX Proc--X-ray/Scan	R^	R^	•	•	R	•			NPCR
	2540	Text--DX Proc--Scopes	R^	R^	•	•	R	•			NPCR
	2550	Text--DX Proc--Lab Tests	R^	R^	•	•	R	•			NPCR
	2560	Text--DX Proc--Op	R^	R^	•	•	R	•			NPCR
	2570	Text--DX Proc--Path	R^	R^	•	•	R	•			NPCR
	2580	Text--Primary Site Title	R	R^	•	•	R	•			NPCR
	2590	Text--Histology Title	R	R^	•	•	R	•			NPCR
	2600	Text--Staging	R	R^	•	•	R	•			NPCR
	2610	RX Text--Surgery	R	R^	•	•	R	•			NPCR
	2620	RX Text Radiation (Beam)	R	R^	•	•	R	•			NPCR
	2630	RX Text Radiation Other	R	R^	•	•	R	•			NPCR
	2640	RX Text Chemo	R	R^	•	•	R	•			NPCR
	2650	RX Text Hormone	R	R^	•	•	R	•			NPCR
	2660	RX Text--BRM	R	R^	•	•	R	•			NPCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp >	Central > Central	
	2670	RX Text--Other	R	R^	•	•	R	•			NPCR
	2680	Text--Remarks	R	•	•	•	R	•			NPCR
	2690	Text--Place of Diagnosis	•	•	•	•	•	•			NPCR
	2800	CS Tumor Size	RH*	RH*	RH	RH	RH*	RH*			AJCC
	2810	CS Extension	RH*	RH*	RH	RH	RH*	RH*			AJCC
	2820	CS Tumor Size/Ext Eval	RH*	RH*	RH	RH	RH*	RH*			AJCC
	2830	CS Lymph Nodes	RH*	RH*	RH	RH	RH*	RH*			AJCC
	2840	CS Lymph Nodes Eval	RH*	RH*	RH	RH	RH*	RH*			AJCC
	2850	CS Mets at DX	RH*	RH*	RH	RH	RH*	RH*			AJCC
	2851	CS Mets at Dx-Bone	•	•	RH	RH	RH	RH			AJCC
	2852	CS Mets at Dx-Brain	•	•	RH	RH	RH	RH			AJCC
	2853	CS Mets at Dx-Liver	•	•	RH	RH	RH	RH			AJCC
	2854	CS Mets at Dx-Lung	•	•	RH	RH	RH	RH			AJCC
	2860	CS Mets Eval	RH*	RH*	RH	RH	RH*	RH*			AJCC
	2861	CS Site-Specific Factor 7	RH*	RH*	RH	RH	RH	RH			AJCC
	2862	CS Site-Specific Factor 8	RH*	RH*	RH	RH	RH	RH			AJCC
	2863	CS Site-Specific Factor 9	RH*	RH*	RH	RH	RH	RH			AJCC
	2864	CS Site-Specific Factor10	RH*	RH*	RH	RH	RH	RH			AJCC
	2865	CS Site-Specific Factor11	RH*	RH*	RH	RH	RH	RH			AJCC
	2866	CS Site-Specific Factor12	RH*	RH*	RH	RH	RH	RH			AJCC
	2867	CS Site-Specific Factor13	RH*	RH*	RH	RH	RH	RH			AJCC
	2868	CS Site-Specific Factor14	RH*	RH*	RH	RH	RH	RH			AJCC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	2869	CS Site-Specific Factor15	RH*	RH*	RH	RH	RH	RH			AJCC
	2870	CS Site-Specific Factor16	RH*	RH*	RH	RH	RH	RH			AJCC
	2871	CS Site-Specific Factor17	RH*	RH*	RH	RH	RH	RH			AJCC
	2872	CS Site-Specific Factor18	•	•	RH	RH	RH	RH*			AJCC
	2873	CS Site-Specific Factor19	•	•	RH	RH	RH	RH*			AJCC
	2874	CS Site-Specific Factor20	•	•	RH	RH	RH	RH*			AJCC
	2875	CS Site-Specific Factor21	•	•	RH	RH	RH	RH*			AJCC
	2876	CS Site-Specific Factor22	•	•	RH	RH	RH	RH*			AJCC
	2877	CS Site-Specific Factor23	•	•	RH	RH	RH	RH*			AJCC
	2878	CS Site-Specific Factor24	•	•	RH	RH	RH	RH*			AJCC
	2879	CS Site-Specific Factor25	RH	RH*	RH	RH	RH	RH			AJCC
	2880	CS Site-Specific Factor 1	RH*	RH*	RH	RH	RH	RH			AJCC
	2890	CS Site-Specific Factor 2	RH*	RH*	RH	RH	RH	RH			AJCC
	2900	CS Site-Specific Factor 3	RH*	RH*	RH	RH	RH	RH			AJCC
	2910	CS Site-Specific Factor 4	RH*	RH*	RH	RH	RH	RH			AJCC
	2920	CS Site-Specific Factor 5	RH*	RH*	RH	RH	RH	RH			AJCC
	2930	CS Site-Specific Factor 6	RH*	RH*	RH	RH	RH	RH			AJCC
	2935	CS Version Input Original	D	R*	RH	RH	RH*	RH*			AJCC
	2936	CS Version Derived	RH*	RH*	DH	DH	D*	RH*			AJCC
	2937	CS Version Input Current	D*	R*	RH	RH	RH*	RH*			AJCC
	2940	Derived AJCC-6 T	•	•	DH	DH	DH	RH			AJCC
	2950	Derived AJCC-6 T Descript	•	•	DH	DH	DH	RH			AJCC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp >	Central > Central	
	2960	Derived AJCC-6 N	•	•	DH	DH	DH	RH			AJCC
	2970	Derived AJCC-6 N Descript	•	•	DH	DH	DH	RH			AJCC
	2980	Derived AJCC-6 M	•	•	DH	DH	DH	RH			AJCC
	2990	Derived AJCC-6 M Descript	•	•	DH	DH	DH	RH			AJCC
	3000	Derived AJCC-6 Stage Grp	•	•	DH	DH	DH	RH			AJCC
	3010	Derived SS1977	•	•	DH	DH	D*	S			AJCC
	3020	Derived SS2000	D+	RH*	DH	DH	D+	R+			AJCC
	3030	Derived AJCC--Flag	•	•	DH	DH	DH	RH			AJCC
	3040	Derived SS1977--Flag	^	•	DH	DH	D*	S			AJCC
	3050	Derived SS2000--Flag	^	RH*	DH	DH	D*	S			AJCC
	3100	Archive FIN	•	•	R	R	•	•			CoC
	3105	NPI--Archive FIN	•	•	R	R	•	•			CMS
	3110	Comorbid/Complication 1	•	•	RH	RH	•	•			CoC
	3120	Comorbid/Complication 2	•	•	RH	RH	•	•			CoC
	3130	Comorbid/Complication 3	•	•	RH	RH	•	•			CoC
	3140	Comorbid/Complication 4	•	•	RH	RH	•	•			CoC
	3150	Comorbid/Complication 5	•	•	RH	RH	•	•			CoC
	3160	Comorbid/Complication 6	•	•	RH	RH	•	•			CoC
	3161	Comorbid/Complication 7	•	•	RH	RH	•	•			CoC
	3162	Comorbid/Complication 8	•	•	RH	RH	•	•			CoC
	3163	Comorbid/Complication 9	•	•	RH	RH	•	•			CoC
	3164	Comorbid/Complication	•	•	RH	RH	•	•			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
		10									
	3165	ICD Revision Comorbid	•	•	•	•	•	•			CoC
	3170	RX Date Mst Defn Srg	R	R	R	R	RC	RC			CoC
	3171	RX Date Mst Defn Srg Flag	R	R	R	R	R*	R*			NAACCR
	3180	RX Date Surg Disch	•	•	R	R	•	•			CoC
	3181	RX Date Surg Disch Flag	•	•	R	R	•	•			NAACCR
	3190	Readm Same Hosp 30 Days	•	•	R	R	•	•			CoC
	3200	Rad--Boost RX Modality	•	•	•	•	•	•			CoC
	3210	Rad--Boost Dose cGy	•	•	•	•	•	•			CoC
	3220	RX Date Rad Ended	•	•	R	R	•	•			CoC
	3221	RX Date Rad Ended Flag	•	•	R	R	•	•			NAACCR
	3230	RX Date Systemic	RC	•	R	R	RC	RC			CoC
	3231	RX Date Systemic Flag	R*	•	R	R	R*	R*			NAACCR
	3250	RX Summ--Transplnt/Endocr	R	R	R	R	R	R			CoC
	3270	RX Summ--Palliative Proc	•	•	R	R	•	•			CoC
	3280	RX Hosp--Palliative Proc	•	•	R	R	•	•			CoC
	3300	RuralUrban Continuum 1993	D	D	•	•	•	•			NAACCR
	3310	RuralUrban Continuum 2003	D	D	•	•	•	•			NAACCR
	3312	RuralUrban Continuum 2013	D	D	•	•	D	R			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	3400	Derived AJCC-7 T	DH*	RH*	DH	DH	DH	RH			AJCC
	3402	Derived AJCC-7 T Descript	DH*	RH*	DH	DH	DH	RH			AJCC
	3410	Derived AJCC-7 N	DH*	RH*	DH	DH	DH	RH			AJCC
	3412	Derived AJCC-7 N Descript	DH*	RH*	DH	DH	DH	RH			AJCC
	3420	Derived AJCC-7 M	DH*	RH*	DH	DH	DH	RH			AJCC
	3422	Derived AJCC-7 M Descript	DH*	RH*	DH	DH	DH	RH			AJCC
	3430	Derived AJCC-7 Stage Grp	DH*	RH*	DH	DH	DH	RH			AJCC
	3440	Derived PreRx-7 T	•	•	•	•	•	•			AJCC
	3442	Derived PreRx-7 T Descrip	•	•	•	•	•	•			AJCC
	3450	Derived PreRx-7 N	•	•	•	•	•	•			AJCC
	3452	Derived PreRx-7 N Descrip	•	•	•	•	•	•			AJCC
	3460	Derived PreRx-7 M	•	•	•	•	•	•			AJCC
	3462	Derived PreRx-7 M Descrip	•	•	•	•	•	•			AJCC
	3470	Derived PreRx-7 Stage Grp	•	•	•	•	•	•			AJCC
	3480	Derived PostRx-7 T	•	•	•	•	•	•			AJCC
	3482	Derived PostRx-7 N	•	•	•	•	•	•			AJCC
	3490	Derived PostRx-7 M	•	•	•	•	•	•			AJCC
	3492	Derived PostRx-7 Stge	•	•	•	•	•	•			AJCC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
		Grp									
	3600	Derived Neoadjuv Rx Flag	•	•	•	•	•	•			AJCC
	3605	Derived SEER Path Stg Grp	•	•	•	•	DH	RH			SEER
	3610	Derived SEER Clin Stg Grp	•	•	•	•	DH	RH			SEER
	3614	Derived SEER Cmb Stg Grp	•	•	•	•	DH	RH			SEER
	3616	Derived SEER Combined T	•	•	•	•	DH	RH			SEER
	3618	Derived SEER Combined N	•	•	•	•	DH	RH			SEER
	3620	Derived SEER Combined M	•	•	•	•	DH	RH			SEER
	3622	Derived SEER Cmb T Src	•	•	•	•	DH	RH			SEER
	3624	Derived SEER Cmb N Src	•	•	•	•	DH	RH			SEER
	3626	Derived SEER Cmb M Src	•	•	•	•	DH	RH			SEER
	3645	NPCR Derived AJCC 8 TNM Clin Stg Grp	•	•	•	•	•	•			NPCR
	3646	NPCR Derived AJCC 8 TNM Path Stg Grp	•	•	•	•	•	•			NPCR
	3647	NPCR Derived AJCC 8 TNM Post Therapy Stg	•	•	•	•	•	•			NPCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
		Grp									
	3650	NPCR Derived Clin Stg Grp	•	•	•	•	•	•			NPCR
	3655	NPCR Derived Path Stg Grp	•	•	•	•	•	•			NPCR
	3700	SEER Site-Specific Fact 1	R	•	•	•	R	R			SEER
	3702	SEER Site-Specific Fact 2	•	•	•	•	•	•			SEER
	3704	SEER Site-Specific Fact 3	•	•	•	•	•	•			SEER
	3706	SEER Site-Specific Fact 4	•	•	•	•	•	•			SEER
	3708	SEER Site-Specific Fact 5	•	•	•	•	•	•			SEER
	3710	SEER Site-Specific Fact 6	•	•	•	•	•	•			SEER
	3750	Over-ride CS 1	•	•	RH	RH	•	•			AJCC
	3751	Over-ride CS 2	•	•	RH	RH	•	•			AJCC
	3752	Over-ride CS 3	•	•	RH	RH	•	•			AJCC
	3753	Over-ride CS 4	•	•	RH	RH	•	•			AJCC
	3754	Over-ride CS 5	•	•	RH	RH	•	•			AJCC
	3755	Over-ride CS 6	•	•	RH	RH	•	•			AJCC
	3756	Over-ride CS 7	•	•	RH	RH	•	•			AJCC
	3757	Over-ride CS 8	•	•	RH	RH	•	•			AJCC
	3758	Over-ride CS 9	•	•	RH	RH	•	•			AJCC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	3759	Over-ride CS 10	•	•	RH	RH	•	•			AJCC
	3760	Over-ride CS 11	•	•	RH	RH	•	•			AJCC
	3761	Over-ride CS 12	•	•	RH	RH	•	•			AJCC
	3762	Over-ride CS 13	•	•	RH	RH	•	•			AJCC
	3763	Over-ride CS 14	•	•	RH	RH	•	•			AJCC
	3764	Over-ride CS 15	•	•	RH	RH	•	•			AJCC
	3765	Over-ride CS 16	•	•	RH	RH	•	•			AJCC
	3766	Over-ride CS 17	•	•	RH	RH	•	•			AJCC
	3767	Over-ride CS 18	•	•	RH	RH	•	•			AJCC
	3768	Over-ride CS 19	•	•	RH	RH	•	•			AJCC
	3769	Over-ride CS 20	RH	RH	RH	RH	RH	RH			AJCC/NPCR
	3780	Secondary Diagnosis 1	•	•	R	R	•	•			CoC
	3782	Secondary Diagnosis 2	•	•	R	R	•	•			CoC
	3784	Secondary Diagnosis 3	•	•	R	R	•	•			CoC
	3786	Secondary Diagnosis 4	•	•	R	R	•	•			CoC
	3788	Secondary Diagnosis 5	•	•	R	R	•	•			CoC
	3790	Secondary Diagnosis 6	•	•	R	R	•	•			CoC
	3792	Secondary Diagnosis 7	•	•	R	R	•	•			CoC
	3794	Secondary Diagnosis 8	•	•	R	R	•	•			CoC
	3796	Secondary Diagnosis 9	•	•	R	R	•	•			CoC
	3798	Secondary Diagnosis 10	•	•	R	R	•	•			CoC
	3800	Schema ID	D	D	D	D	D	R			NAACCR
	3801	Chromosome 1p: Loss of Heterozygosity (LOH)	RS	•	RS	RS	RS	RS			NAACCR
	3802	Chromosome 19q: Loss	RS	•	RS	RS	RS	RS			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp >	Central > Central	
		of Heterozygosity (LOH)									
	3803	Adenoid Cystic Basaloid Pattern	RS	•	RS	RS	RS	RS			NAACCR
	3804	Adenopathy	RS	•	RS	RS	RS	RS			NAACCR
	3805	AFP Post-Orchiectomy Lab Value	RC	•	RS	RS	RC	RC			NAACCR
	3806	AFP Post-Orchiectomy Range	RS	•	RS	RS	RS	RS			NAACCR
	3807	AFP Pre-Orchiectomy Lab Value	RC	•	RS	RS	RC	RC			NAACCR
Rev.	3808	AFP Pre-Orchiectomy Range	RS	•	RS	RS	RS	RS			NAACCR
	3809	AFP Pretreatment Interpretation	RC	•	RS	RS	RC	RC			NAACCR
	3810	AFP Pretreatment Lab Value	RC	•	RS	RS	RC	RC			NAACCR
	3811	Anemia	RS	•	RS	RS	RS	RS			NAACCR
	3812	B symptoms	RS	•	RS	RS	RS	RS			NAACCR
	3813	Bilirubin Pretreatment Total Lab Value	RC	•	RS	RS	RC	RC			NAACCR
	3814	Bilirubin Pretreatment Unit of Measure	RC	•	RS	RS	RC	RC			NAACCR
	3815	Bone Invasion	RS	•	RS	RS	RS	RS			NAACCR
Rev.	3816	Brain Molecular Markers	RS	RS	•	•	RS	RS			NAACCR
Rev.	3817	Breslow Tumor Thickness	RS	RS	RS	RS	RS	RS			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	3818	CA-125 Pretreatment Interpretation	RS	•	RS	RS	RS	RS			NAACCR
	3819	CEA Pretreatment Interpretation	RS	•	RS	RS	RS	RS			NAACCR
	3820	CEA Pretreatment Lab Value	RS	•	RS	RS	RS	RS			NAACCR
	3821	Chromosome 3 Status	RC	•	RS	RS	RC	RC			NAACCR
	3822	Chromosome 8q Status	RC	•	RS	RS	RC	RC			NAACCR
	3823	Circumferential Resection Margin (CRM)	RS	•	RS	RS	RS	RS			NAACCR
	3824	Creatinine Pretreatment Lab Value	RC	•	RS	RS	RC	RC			NAACCR
	3825	Creatinine Pretreatment Unit of Measure	RC	•	RS	RS	RC	RC			NAACCR
	3826	Estrogen Receptor Percent Positive or Range	RC	•	•	•	RC	RC			NAACCR
Rev.	3827	Estrogen Receptor Summary	RS	RS	RS	RS	RS	RS			NAACCR
	3828	Estrogen Receptor Total Allred Score	RC	•	RS	RS	RC	RC			NAACCR
Rev.	3829	Esophagus and EGJ Tumor Epicenter	RS	RS	RS	RS	RS	RS			NAACCR
	3830	Extranodal Extension Clin (non-Head and Neck)	RC	•	RS	RS	RC	RC			NAACCR
	3831	Extranodal Extension	RC	•	RS	RS	RC	RC			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp >	Central > Central	
		Head and Neck Clinical									
	3832	Extranodal Extension Head and Neck Pathological	RS	•	RS	RS	RS	RS			NAACCR
	3833	Extranodal Extension Path (non-Head and Neck)	RC	•	RS	RS	RC	RC			NAACCR
	3834	Extravascular Matrix Patterns	RC	•	RS	RS	RC	RC			NAACCR
Rev.	3835	Fibrosis Score	RS	RS	RS	RS	RC	RC			NAACCR
	3836	FIGO Stage	RS	•	RS	RS	RS	RS			NAACCR
	3837	Gestational Trophoblastic Prognostic Scoring Index	RS	•	RS	RS	RS	RS			NAACCR
Rev.	3838	Gleason Patterns Clinical	RS	RS	RS	RS	RS	RS			NAACCR
Rev.	3839	Gleason Patterns Pathological	RS	RS	RS	RS	RS	RS			NAACCR
Rev.	3840	Gleason Score Clinical	RS	RS	RS	RS	RC	RC			NAACCR
Rev.	3841	Gleason Score Pathological	RS	RS	RS	RS	RC	RC			NAACCR
	3842	Gleason Tertiary Pattern	RS*	RS*	RS	RS	RC	RC			NAACCR
	3843	Grade Clinical	R	R	R	R	R	R			NAACCR
	3844	Grade Pathological	R	R	R	R	R	R			NAACCR
	3845	Grade Post Therapy	R	R*	R	R	RS	RS			NAACCR
	3846	hCG Post-Orchiectomy Lab Value	RC	•	RS	RS	RC	RC			NAACCR
	3847	hCG Post-Orchiectomy	RS	•	RS	RS	RS	RS			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
		Range									
	3848	hCG Pre-Orchiectomy Lab Value	RC	•	RS	RS	RC	RC			NAACCR
	3849	hCG Pre-Orchiectomy Range	RS	•	RS	RS	RS	RS			NAACCR
	3850	HER2 IHC Summary	•	•	•	•	•	•			NAACCR
	3851	HER2 ISH Dual Probe Copy Number	•	•	•	•	•	•			NAACCR
	3852	HER2 ISH Dual Probe Ratio	•	•	•	•	•	•			NAACCR
	3853	HER2 ISH Single Probe Copy Number	•	•	•	•	•	•			NAACCR
	3854	HER2 ISH Summary	•	•	•	•	•	•			NAACCR
	3855	HER2 Overall Summary	RS	RS	RS	RS	RS	RS			NAACCR
	3856	Heritable Trait	RS	•	RS	RS	RS	RS			NAACCR
	3857	High Risk Cytogenetics	RS	•	RS	RS	RS	RS			NAACCR
	3858	High Risk Histologic Features	RS	•	RS	RS	RS	RS			NAACCR
	3859	HIV Status	RS	•	•	•	RS	RS			NAACCR
	3860	International Normalized Ratio Prothrombin Time	RC	•	RS	RS	RC	RC			NAACCR
	3861	Ipsilateral Adrenal Gland Involvement	RS	•	RS	RS	RS	RS			NAACCR
	3862	JAK2	RS	•	RS	RS	RS	RS			NAACCR
	3863	Ki-67	RC	•	RS	RS	RC	RC			NAACCR
	3864	Invasion Beyond Capsule	RS	•	RS	RS	RS	RS			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp >	Central > Central	
	3865	KIT Gene Immunohistochemistry	RC	•	RS	RS	RC	RC			NAACCR
	3866	KRAS	RS	•	RS	RS	RS	RS			NAACCR
	3867	LDH Post-Orchiectomy Range	RS	•	RS	RS	RS	RS			NAACCR
	3868	LDH Pre-Orchiectomy Range	RS	•	RS	RS	RS	RS			NAACCR
	3869	LDH Pretreatment Level	RS	•	RS	RS	RS	RS			NAACCR
	3870	LDH Upper Limits of Normal	RC	•	RS	RS	RC	RC			NAACCR
	3871	LN Assessment Method Femoral-Inguinal	RC	•	RS	RS	RC	RC			NAACCR
	3872	LN Assessment Method Para-Aortic	RC	•	RS	RS	RC	RC			NAACCR
	3873	LN Assessment Method Pelvic	RC	•	RS	RS	RC	RC			NAACCR
	3874	LN Distant Assessment Method	RC	•	RS	RS	RC	RC			NAACCR
	3875	LN Distant: Mediastinal, Scalene	RC	•	RS	RS	RC	RC			NAACCR
	3876	LN Head and Neck Levels I-III	RS	•	RS	RS	RS	RS			NAACCR
	3877	LN Head and Neck Levels IV-V	RS	•	RS	RS	RS	RS			NAACCR
	3878	LN Head and Neck Levels VI-VII	RS	•	RS	RS	RS	RS			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	3879	LN Head and Neck Other	RS	•	RS	RS	RS	RS			NAACCR
	3880	LN Isolated Tumor Cells (ITC)	RS	•	RS	RS	RS	RS			NAACCR
	3881	LN Laterality	RS	•	RS	RS	RS	RS			NAACCR
	3882	LN Positive Axillary Level I-II	RS	•	RS	RS	RS	RS			NAACCR
	3883	LN Size	RS	•	RS	RS	RS	RS			NAACCR
	3884	LN Status Femoral-Inguinal, Para-Aortic, Pelvic	RS	•	RS	RS	RS	RS			NAACCR
	3885	Lymphocytosis	RS	•	RS	RS	RS	RS			NAACCR
	3886	Major Vein Involvement	RS	•	RS	RS	RS	RS			NAACCR
	3887	Measured Basal Diameter	RS	•	RS	RS	RS	RS			NAACCR
	3888	Measured Thickness	RS	•	RS	RS	RS	RS			NAACCR
	3889	Methylation of O6-Methylguanine-Methyltransferase	RS	•	RS	RS	RS	RS			NAACCR
	3890	Microsatellite Instability (MSI)	RS	RS*	RS	RS	RS	RS			NAACCR
	3891	Microvascular Density	RC	•	RS	RS	RC	RC			NAACCR
	3892	Mitotic Count Uveal Melanoma	RC	•	RS	RS	RC	RC			NAACCR
	3893	Mitotic Rate Melanoma	RS	•	RS	RS	RS	RS			NAACCR
	3894	Multigene Signature Method	RS	•	RS	RS	RS	RS			NAACCR
	3895	Multigene Signature	RS	•	RS	RS	RS	RS			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
		Results									
	3896	NCCN International Prognostic Index (IPI)	RS	•	RS	RS	RS	RS			NAACCR
	3897	Number of Cores Examined	RS	•	RS	RS	RS	RS			NAACCR
	3898	Number of Cores Positive	RS	•	RS	RS	RS	RS			NAACCR
	3899	Number of Examined Para-Aortic Nodes	RC	•	RS	RS	RC	RC			NAACCR
	3900	Number of Examined Pelvic Nodes	RC	•	RS	RS	RC	RC			NAACCR
	3901	Number of Positive Para-Aortic Nodes	RC	•	RS	RS	RC	RC			NAACCR
	3902	Number of Positive Pelvic Nodes	RC	•	RS	RS	RC	RC			NAACCR
	3903	Oncotype Dx Recurrence Score-DCIS	RC	•	RS	RS	RC	RC			NAACCR
	3904	Oncotype Dx Recurrence Score-Invasive	RS	•	RS	RS	RS	RS			NAACCR
	3905	Oncotype Dx Risk Level-DCIS	RC	•	RS	RS	RC	RC			NAACCR
	3906	Oncotype Dx Risk Level-Invasive	RC	•	RS	RS	RC	RC			NAACCR
	3907	Organomegaly	RS	•	RS	RS	RS	RS			NAACCR
	3908	Percent Necrosis Post Neoadjuvant	RC	•	RS	RS	RC	RC			NAACCR
	3909	Perineural Invasion	RS	•	RS	RS	RS	RS			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	3910	Peripheral Blood Involvement	RS	•	RS	RS	RS	RS			NAACCR
	3911	Peritoneal Cytology	RS	•	RS	RS	RS	RS			NAACCR
	3913	Pleural Effusion	RS	•	RS	RS	RS	RS			NAACCR
	3914	Progesterone Receptor Percent Positive or Range	RC	•	RS	RS	RC	RC			NAACCR
Rev.	3915	Progesterone Receptor Summary	RS	RS	RS	RS	RS	RS			NAACCR
	3916	Progesterone Receptor Total Allred Score	RC	•	RS	RS	RC	RC			NAACCR
	3917	Primary Sclerosing Cholangitis	•	•	RS	RS	•	•			NAACCR
	3918	Profound Immune Suppression	RS	•	RS	RS	RS	RS			NAACCR
	3919	Prostate Pathological Extension	RS	•	•	•	RS	RS			NAACCR
	3920	PSA (Prostatic Specific Antigen) Lab Value	RS	RS	RS	RS	RS	RS			NAACCR
	3921	Residual Tumor Volume Post Cytoreduction	RS	•	RS	RS	RS	RS			NAACCR
	3922	Response to Neoadjuvant Therapy	RC	•	RS	RS	RC	RC			NAACCR
	3923	S Category Clinical	RS	•	RS	RS	RS	RS			NAACCR
	3924	S Category Pathological	RS	•	RS	RS	RS	RS			NAACCR
	3925	Sarcomatoid Features	RS	•	RS	RS	RS	RS			NAACCR
Rev.	3926	Schema Discriminator 1	RS	RS	RS	RS	RS	RS			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
Rev.	3927	Schema Discriminator 2	RS	RS	RS	RS	RS	RS			NAACCR
	3928	Schema Discriminator 3	RS	•	RS	RS	RS	RS			NAACCR
	3929	Separate Tumor Nodules	RS	•	RS	RS	RS	RS			NAACCR
	3930	Serum Albumin Pretreatment Level	RS	•	RS	RS	RS	RS			NAACCR
	3931	Serum Beta-2 Macroglobulin Pretreatment Level	RS	•	RS	RS	RS	RS			NAACCR
Rev.	3932	LDH Pretreatment Lab Value	RS	RS	RS	RS	RS	RS			NAACCR
	3933	Thrombocytopenia	RS	•	RS	RS	RS	RS			NAACCR
	3934	Tumor Deposits	RS	•	RS	RS	RS	RS			NAACCR
Rev.	3935	Tumor Growth Pattern	•	•	RS	RS	•	•			NAACCR
	3936	Ulceration	RS	•	RS	RS	RS	RS			NAACCR
	3937	Visceral and Parietal Pleural Invasion	RS	•	RS	RS	RS	RS			NAACCR
	3938	ALK Rearrangement	RS	•	RS	RS	R	R			NAACCR
	3939	EGFR Mutational Analysis	RS	•	RS	RS	R	R			NAACCR
	3940	BRAF Mutational Analysis	RS	•	RS	RS	R	R			NAACCR
	3941	NRAS Mutational Analysis	RS	•	RS	RS	R	R			NAACCR
	3942	CA 19-9 PreTX Lab Value	RS	•	RS	RS	R	R			NAACCR
	3943	NCDB—SARSCoV2--	•	•	R*	R*	R*	R*			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
		Test									
	3944	NCDB—SARSCoV2--Pos	•	•	R*	R*	R*	R*			NAACCR
	3945	NCDB—SARSCoV2—Pos Date	•	•	R*	R*	R*	R*			NAACCR
	3946	NCDB—COVID19—Tx Impact	•	•	R*	R*	R*	R*			NAACCR
New	3950	Macroscopic Evaluation of Mesorectum	RC	•	R	R	RC	RC			AJCC
New	3955	Derived Rai Stage	D*	•	•	•	D	R			
New	3956	p16	RS	RS	RS	RS	RC	RC			SEER
New	3957	LN Status Pelvic	RC	•	RS	RS	RC	RC			SEER
New	3958	LN Status Para-Aortic	RC	•	RS	RS	RC	RC			SEER
New	3959	LN Status Femoral-Inguinal	RC	•	RS	RS	RC	RC			SEER
	7010	Path Reporting Fac ID 1	•	•	•	•	•	•			HL7
	7011	Path Reporting Fac ID 2	•	•	•	•	•	•			HL7
	7012	Path Reporting Fac ID 3	•	•	•	•	•	•			HL7
	7013	Path Reporting Fac ID 4	•	•	•	•	•	•			HL7
	7014	Path Reporting Fac ID 5	•	•	•	•	•	•			HL7
	7090	Path Report Number 1	•	•	•	•	•	•			HL7
	7091	Path Report Number 2	•	•	•	•	•	•			HL7
	7092	Path Report Number 3	•	•	•	•	•	•			HL7
	7093	Path Report Number 4	•	•	•	•	•	•			HL7
	7094	Path Report Number 5	•	•	•	•	•	•			HL7

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	7100	Path Order Phys Lic No 1	•	•	•	•	•	•			HL7
	7101	Path Order Phys Lic No 2	•	•	•	•	•	•			HL7
	7102	Path Order Phys Lic No 3	•	•	•	•	•	•			HL7
	7103	Path Order Phys Lic No 4	•	•	•	•	•	•			HL7
	7104	Path Order Phys Lic No 5	•	•	•	•	•	•			HL7
	7190	Path Ordering Fac No 1	•	•	•	•	•	•			HL7
	7191	Path Ordering Fac No 2	•	•	•	•	•	•			HL7
	7192	Path Ordering Fac No 3	•	•	•	•	•	•			HL7
	7193	Path Ordering Fac No 4	•	•	•	•	•	•			HL7
	7194	Path Ordering Fac No 5	•	•	•	•	•	•			HL7
	7320	Path Date Spec Collect 1	•	•	•	•	•	•			HL7
	7321	Path Date Spec Collect 2	•	•	•	•	•	•			HL7
	7322	Path Date Spec Collect 3	•	•	•	•	•	•			HL7
	7323	Path Date Spec Collect 4	•	•	•	•	•	•			HL7
	7324	Path Date Spec Collect 5	•	•	•	•	•	•			HL7
	7480	Path Report Type 1	•	•	•	•	•	•			HL7
	7481	Path Report Type 2	•	•	•	•	•	•			HL7
	7482	Path Report Type 3	•	•	•	•	•	•			HL7
	7483	Path Report Type 4	•	•	•	•	•	•			HL7
	7484	Path Report Type 5	•	•	•	•	•	•			HL7

E

APPENDIX E: REPORTABLE LIST

This list provides documentation of all conditions TCR considers reportable for cases **diagnosed 1/1/2022 and forward**.

Effective for cases diagnosed January 1, 2022 forward, ICD-O-3.2 Coding Table Excel is the preferred reference for morphology codes.

The 2022 ICD-O-3.2 Update Table 1 Numeric and 2022 ICD-O-3.2 Update Table 2 Alpha Table include changes identified during review of recently published World Health Organization's *International Histological Classification of Tumors 5th Edition* books (WHO "Blue Books"). This series covers all principal sites of cancer and includes ICD-O morphology codes for each neoplasm. Each new edition underwent thorough review to identify new histologies and ICD-O codes, behavior changes to existing ICD-O codes, and new terminology. The ICD-O-3 Implementation Work Group recommended adopting the changes for 2022 and implementation of the changes were approved by the standard setting agencies.

2022 ICD-O-3.2 Table 1 and 2022 ICD-O-3.2 Table 2 are comprehensive tables listing all changes made after the 2021 update and is effective for cases diagnosed 1/1/2022 forward. New to the 2022 update tables are columns for each standard setter which will indicate if that particular code and/or term is required for data collection and submission.

***IMPORTANT REMINDERS:**

Note: ICD-O-3.2 Coding Table Excel includes changes from all 4th Ed WHO Classification of Tumors books. New editions released following the publication of 4th editions (the 5th Ed) are not included in the ICD-O-3.2. The 2022 ICD-O-3.2 Tables 1 and 2 contain the new changes made after the 2021 update. **A new ICD-O version will be released once all 5th Ed Blue Books have been published.**

For this list:

- New terms and synonyms for existing ICD-O codes were added.
- Terms **bolded** indicate new terms in ICD-O-3 effective for January 1, 2022.
- Terms followed by asterisks (**) indicate that the terms are reportable for benign and borderline behaviors (0 and 1) only when the primary site is listed in the table Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors on page 59 in the Casefinding Section of the Cancer Reporting Handbook 2021. If the behavior is malignant (2 or 3) the terms are reportable for any site.

Reportable List

- ACTH-producing tumor
- Acute myeloid leukemia with mutated NPM1
- Acute myeloid leukemia with biallelic mutation of CEBPA
- Acute myeloid leukemia with mutated RUNX1
- Acute myeloid leukemia with BCR-ABL1 Adamantinoma (long bones, malignant, tibial only)
- Adenoacanthoma
- Adenocarcinofibroma

- Adenocarcinoma
- Adenocarcinoma, pancreatobilliary-type
- Adenofibroma (malignant endometrioid only)
- Adenoma**
- Adenoma (carcinoid bronchial and cylindroid bronchial and islet cell)
- Adenoma, Beta cell
- **Adenomatous polyp, high grade dysplasia (C160-C166, C168-C169, C170-C173, C178-C179)**
- Adenomyoepithelioma with carcinoma
- Adenosarcoma
- Adrenal medullary paraganglioma (C74.1)
- Aggressive digital papillary adenoma (C44._)
- AIN III (anal intraepithelial neoplasia, grade III)
- ALK positive large B-cell lymphoma
- Ameloblastoma (malignant only)
- Anaplastic large cell lymphoma, ALK-negative/ Breast implant-associated anaplastic large cell lymphoma
- Anaplastic oligodendroglioma, IDH-mutant and 1p/19q-codeleted
- Anaplastic pleomorphic xanthroastrocytoma
- Androblastoma (malignant only)
- Anemia, refractory
- Angioendotheliomatosis
- Angiolipoma**
- Angiomyosarcoma
- Angiosarcoma
- Aortic body tumor (C75.5)
- Aortic body paraganglioma (C75.5)
- Aorticopulmonary paraganglioma (C75.5)
- Argentaffinoma (malignant only)
- Arrhenoblastoma (malignant only)
- Astroblastoma
- Astrocytoma**

- Astroglioma
- B lymphoblastic leukemia/lymphoma
- B-lymphocytic leukemia/lymphoma, BCR-ABL1-like
- Beta cell adenoma (C25.4)
- Biliary intraepithelial neoplasia (BiIN III) (c23.9)
- Blastoma
- Breast implant-associated anaplastic large cell lymphoma
- Bronchus associated lymphoid tissue lymphoma
- Cancer
- Carcinoid, malignant (stromal, argentaffin tumor NOS, enterochromaffin-like cell NOS, and tubular)
- Carcinoid, NOS (C18.1)
- Carcinofibroma
- Carcinoma
- Carcinomatosis
- Carcinosarcoma
- Carotid body paranganglioma (C75.4)
- Carotid body tumor (C75.4)
- CASTLE (Carcinoma showing thymus-like element)
- Chemodectoma
- Chloroma
- Cholangiocarcinoma
- Chondroblastoma
- Chondrosarcoma
- **Chondrosarcoma, grade 1 (C40._, C41._)**
- Chordoma
- Choriocarcinoma
- Chorioepithelioma
- Chorionepithelioma
- Chromaffin paraganglioma (C74.1)
- Chromaffin tumor
- Chronic lymphoproliferative disorder of NK-cells

- **CIC-rearranged sarcoma**
- Class IV cytology
- Class V cytology
- **Clear cell neuroendocrine tumor, non-functioning pancreatic (C25._)**
- CNS Embryonal tumor with rhabdoid features
- Combined large cell neuroendocrine carcinoma
- Comedocarcinoma
- Composite paraganglioma (C74.1)
- CPNET (central primitive neuroectodermal, NOS)
- Craniopharyngioma**
- Cylindroma (exclude eccrine dermal, and skin)
- Cyst (dermoid with malignant transformation only or dermoid with secondary tumor)
- Cystadenocarcinofibroma
- Cystadenocarcinoma
- Cystadenofibroma (malignant endometrioid only)
- Cystic pancreatic endocrine neoplasm (CPEN)
- **Cystic neuroendocrine tumor, non-functioning pancreatic (C25._)**
- Cystosarcoma phyllodes (malignant only)
- Cytopenia, refractory of childhood
- Cytopenia, refractory with multilineage dysplasia
- Dermatofibrosarcoma, protuberans, fibrosarcomatous
- Dermatofibrosarcoma, sarcomatous
- Differentiated penile intraepithelial neoplasia
- Differentiated-type vulvar intraepithelial neoplasia
- Diffuse leptomeningeal glioneuronal tumor**
- Diktyoma (exclude benign)
- DIN III (ductal intraepithelial neoplasia, grade III)
- Disease (include only):
    - alpha heavy chain
    - Bowen
    - Chronic myeloproliferative
    - Di Guglielmo

  - Franklin
  - Gamma heavy chain
  - Heavy chain NOS
  - Hodgkin
  - immunoproliferative [NOS and small
  - intestinal only]
  - Letterer-Siwe
  - Mast cell, systemic tissue
  - Mu heavy chain
  - Myeloproliferative, chronic, NOS
  - Paget [exclude of bone]
  - Sezary
- Disorder, myeloproliferative, chronic
- Disorder, primary cutaneous CD30+ T-cell lymphoproliferative
- **Ductal carcinoma in situ, papillary**
- Dysgerminoma
- Ectomesenchymoma
- Embryoma
- Embryonal tumor with multilayered rosettes C19MC-altered
- Embryonal tumor with multilayered rosettes, NOS
- Embryonal tumor with rhabdoid features
- Endocrine tumor, functioning, NOS
- Endometriod intraepithelial neoplasia (C54.1)
- Endometriosis, stromal
- Ependymoblastoma
- Ependymoma**
- Epithelioid malignant peripheral nerve sheath tumor
- Epithelioma (NOS, basal cell, malignant, and squamous cell only)
- Erdheim-Chester Disease
- Erythremia (acute and chronic only)
- Erythroleukemia
- Erythroplasia, Queyrat

- Esthesioneuroblastoma
- Esthesioneurocytoma
- Esthesioneuroepithelioma
- Extra-adrenal paraganglioma, NOS
- Fibroblastic reticular cell tumor
- Fibrochondrosarcoma
- Fibrodentinosarcoma
- Fibroepithelioma, of Pinkus type or NOS
- Fibrolipoma**
- Fibroliposarcoma
- Fibroma, NOS**
- Fibromyxosarcoma
- Fibro-odontosarcoma
- Fibrosarcoma
- Fibrosarcomatous dermatofibrosarcoma protuberans
- Fibroxanthoma (malignant only)
- Gangliocytoma**
- Ganglioglioma**
- Ganglioneuroblastoma
- Ganglioneuroma**
- Gastrinoma
- **Gastroblastoma (C16._)**
- Gemistocytoma
- Germ cell tumors with associated hematological malignancy
- Germinoma
- GIST-Gastrointestinal stromal tumor (malignant)
- Gastrointesitnal autonomic nerve tumor (GANT)
- Gastrointestinal pacemaker cell tumor
- Gastrointestinal stomal tumor (GIST)
- Glioblastoma
- Gliofibroma**
- Glioma**

- Gliomatosis cerebri
- Gliosarcoma
- Glomangiosarcoma
- Glomus jugulare tumor, NOS (C75.5)
- **Goblet cell adenocarcinoma**
- Glucagonoma
- Granuloma (Hodgkin only)
- Granulosa cell tumor, adult type (C56.9)
- Hemangioblastoma**
- Hemangioendothelioma**
- Hemangioma**
- Hemangiopericytoma**
- Hemangiosarcoma
- Hepatoblastoma
- Hepatocarcinoma
- Hepatocholangiocarcinoma
- Hepatoma (exclude benign)
- Hidradenocarcinoma
- Hidradenoma (malignant only)
- **High grade appendiceal mucinous neoplasm (HAMN) (C181)**
- Histiocytoma (malignant fibrous only)
- Histiocytosis (malignant, and acute progressive X only)
- Histiocytosis, Langerhans cell, disseminated or generalized
- Hutchinson melanotic freckle (melanoma in situ only)
- HypernephromaImmunocytoma
- **HPV-associated adenocarcinoma (C530-C531, C538-C539)**
- **HPV-independent adenocarcinoma, mesonephric type**
- Insulinoma, NOS (C25.4)
- **Intestinal-type adenoma, high grade (C160-C166, C168-C169, C170-C173, C178, C179)**
- **Intraductal oncocytic papillary neoplasm, NOS (C25._)**
- **Indraductal oncocytic papillary neoplasm with associated invasive carcinoma (C250-C254, C257-C259)**

- Intrapulmonary thymoma (C34._)
- Intravascular large B-cell lymphoma
- Islet cell adenoma (C25.4)tu
- Islet cell adenomatosis (C25.4)
- Islet cell tumor, NOS (C25.4)
- Jugular paraganglioma (C75.5)
- Jugulotympanic paraganglioma (C75.5)
- Keratoacanthoma
- Langerhans cell histiocytosis, multifocal**
- Langerhans cell histiocytosis, unifocal**
- Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease
- Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)
- Laryngeal paraganglioma
- LCIS, NOS (lobular carcinoma in situ)
- Leiomyoma (NOS)**
- Leiomyomatosis (NOS)**
- Leiomyosarcoma
- Lentigo maligna
- Leukemia
- LIN III
- Linitis plastica
- Lipoma (atypical or NOS)**
- Liposarcoma (exclude well differentiated liposarcoma, superficial)
- LN2 (of breast also called lobular neoplasia, grade 2 only)
- Lobular carcinoma in situ (LCIS) (C50._)
- Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) (C50._)
- **Low-grade appendiceal mucinous neoplasm (LAMN) (C181)**
- Lymphangioendothelioma (malignant only)
- Lymphangioma **
- Lymphangiosarcoma
- Lymphoblastoma
- Lymphoepithelioma

- Lymphoma
- Lymphomatoid granulomatosis grade 3
- Lymphosarcoma
- Macroglobulinemia, Waldenstrom
- Malignancy
- Malignant
- Malignant Poorly Differentiated neuroendocrine tumors
- Mastocytoma (malignant only)
- Mastocytosis (malignant only)
- Medulloblastoma
- Medulloepithelioma
- Medullomyoblastoma
- Melanocytoma, meningeal
- Melanoma, early/evolving in situ
- Melanoma, early/evolving invasive
- Melanoma (exclude juvenile)
- Melanocytoma, meningial**
- Melanocytosis, diffuse**
- Melanomatosis, meningeal
- Melanosis (precancerous only)
- Meningioma**
- Meningiomatosis**
- Mesenchymoma (malignant only)
- Mesonephroma (exclude benign)
- **Mesonephric-like adenocarcinoma**
- Mesothelioma (exclude benign and cystic)
- Metaplasia, agnogenic myeloid
- Metaplastic thymoma (C37.9)
- Microglioma
- Micropapillary carcinoma, NOS
- Middle ear paraganglioma (C30.1, C755.5)
- Midline carcinoma of children and young adults with NUT rearrangement

- Mixed acinar ductal carcinoma
- Mixed phenotype acute leukemia
- MPNST, NOS (malignant peripheral nerve sheath tumor)
- Multinodular and vascolating neuronal tumor (MVNT)(C71.2)
- Mycosis Fungoides
- Myeloid and lymphoid neoplasms
- Myelodysplastic/Myeloproliferative neoplasm
- Myelofibrosis (acute, chronic idiopathic, with myeloid metaplasia or as a result of myeloproliferative disease only)
- Myeloma
- Myelomatosis
- Myelosclerosis (megakaryocytic, acute, malignant or with myeloid metaplasia)
- Myelosis
- Myoblastoma (malignant granular cell only)
- Myoepithelioma (malignant only)
- Myosarcoma
- Myosis, stromal NOS or endolymphatic stromal
- **Myxoid pleomorphic liposarcoma**
- Myxofibrosarcoma
- Myxoliposarcoma
- Myxosarcoma
- Neoplasia, ductal intraepithelial, grade 3 (of breast, also called DIN III)
- Neoplasia, intratubular germ cell
- Neoplasia, lobular, grade 2 of breast only (also called LN2)
- Neoplasia, squamous intraepithelial, grade 3 (of anus, vulva and vagina only- also called, AIN III, VIN III and VAIN III)
- Neoplasm (malignant only)
- Neoplasm**
- Nephroblastoma
- Nephroma (exclude mesoblastic)
- Nesidioblastoma (C25.4)
- Neurilemmoma**

- Neurilemmosarcoma
- Neuroblastoma
- Neurocytoma**, olfactory
- **Neuroendocrine tumor, non-functioning pancreatic (C25._)**
- Neuroendocrine tumor, well differentiated
- Neuroepithelioma
- Neurofibroma**
- Neurofibromatosis (NOS)**
- Neurofibrosarcoma
- Neuroma (NOS)**
- Neurosarcoma
- Neurothekeoma**
- Nevus (malignant blue only)
- Non-invasive EFVPTC
- Non-invasive mucinous cystic neoplasm (MCN) of the páncreas with high-grade displasia
- Nonchromaffin paraganglioma, NOS
- NUT carcinoma
- **Oncocytic neuroendocrine tumor, non-functioning pancreatic (C25._)**
- Odontosarcoma
- Oligoastrocytoma, mixed
- Oligoastrocytoma, Anaplastic
- Oligodendroblastoma
- Oligodendroglioma
- Orchioblastoma
- Osteochondrosarcoma
- Osteoclastoma (malignant only)
- Osteofibrosarcoma
- Osteosarcoma
- Pancreatic endocrine tumor, NOS (C25.4)
- Pancreatic intraepitelial neoplasia (PanIN III) (C25._)
- Pancreatoblastoma
- Pancreatobilliary-type carcinoma

- Panmyelosis, acute only
- Papillary tumor of the pineal region
- **Papillary neoplasm, Pancreatobiliary type, with high grade intraepitelial neoplasia (C24.1)**
- Papilloma**
- Paraganglioma
- Paragranuloma, Hodgkin
- PEComa, malignant
- Penile intraepithelial neoplasia, grade III (PeIN III) (C60._)
- Perineural MPNST
- Perineurioma**
- Pheochromoblastoma (C74.1)
- Pheochromocytoma
- Pheochromocytoma, NOS (C74.1)
- Pilocytic/Juvenile astrocytomas (code the histology and behavior as 9421/3
  Exception: behavior is non-malignant when primary site is optic nerve (C72.3)
- Pilomatrixoma (malignant only)
- Pilomyxoid astrocytoma
- Pinealoma (NOS)**
- Pineoblastoma
- Pineocytoma**
- Pituicytoma**
- Pituitary Adenoma
- Plasmacytoma
- Plasmablastic lymphoma
- PNET (primitive neuroectodermal tumor)
- Pneumoblastoma
- Polycythemia (proliferative, rubra vera, or vera)
- Polyembryoma
- Polymorphic PTLD
- Polyposis (malignant lymphomatous only)
- Porocarcinoma
- Poroma, eccrine (malignant only)

- PPNET (peripheral primitive neuroectodermal tumor)
- Preleukemia
- Primary cutaneous follicle centre lymphoma
- Primary cutaneous gamma-delta T-cell lymphoma
- Prolactinoma**
- Pseudomyxoma peritonei
- Queyrat erythroplasia
- Rathke Pouch Tumor
- Refractory neutropenia
- Refractory thrombocytopenia
- Reticuloendotheliosis
- Reticulosarcoma
- Reticulosis (histiocytic medullary, malignant, pagetoid, and polymorphic only)
- Retinoblastoma
- Rhabdomyoma (NOS)**
- Rhabdomyosarcoma
- Rhabdosarcoma
- Sarcoma (exclude well differentiated liposarcoma, superficial)
- Sarcomatosis (meningeal only)
- Schwannoma**
- Sclerosing thymoma (C34._)
- Secondary Neuroendocrine tumors
- Seminoma
- Serrated adenocarcinoma
- **Serrated dysplasia, high grade (C160-C166, C168-C169, C170-C173, C178-C179)**
- SETTLE (spindle epithelial tumor with thymus-like element)
- Solid pseudopapillary neoplasm of the pancreas
- Somatostatinoma
- Spermatocytoma
- Spiradenoma (malignant only)
- Spongioblastoma
- Spongioneuroblastoma

- Squamous intraepithelial neoplasia, grade III (excludes cervix and skin sites coded to C44._)
- Stromatosis, endometrial
- Struma (malignant ovarii and Wuchernde Langhans only)
- Subependymoma**
- Subependymoma-ependymoma, mixed
- Sympathicoblastoma
- Syndrome
    - 5q deletion with Myelodysplastic (5q-) syndrome
    - Hypereosinophilic
    - Myelodysplastic
        - NOS
        - with 5q deletion syndrome
        - with multilineage dysplasia
        - with isolated del (5q)
        - with ring sideroblasts and multilineage dysplasia
        - with ring sideroblasts and single lineage dysplasia
        - with single lineage dysplasia
        - therapy-related, NOS
        - therapy-related, alkylating agent related
        - therapy-related, epidopophyllotoxin related
    - Preleukemic
    - Sezary
- Synovioma (NOS and malignant only)
- **Syringocystadenocarcioma papilliferum**
- Syringoma chondroid, (malignant only)
- Systemic EBV positive T-cell Lymphoproliferative disease of childhood
- T-cell/histiocyte rich large B-cell lymphoma
- T-cell large granular lymphocytic leukemia
- T lymphoblastic leukemia/lymphoma
- **Tall cell carcinoma with reversed polarity**
- Teratoblastoma, malignant
- Teratocarcinoma

- Teratoma**
- Teratoma, immature (except for lung, thyroid, and thymus)
- Teratoma, mature (C62._) code the histology and behavior as 9080/3
- Thecoma (malignant only)
- Thrombocythemia (essential, essential hemorrhagic, idiopathic, or idiopathic hemorrhagic)
- Thymoma, NOS (C37.9)
    - Type A thymoma including atypical variant (C37.9)
    - Type AB thymoma (C37.9)
    - Type B1 thymoma (C37.9)
    - Type B2 thymoma (C37.9)
    - Type B3 thymoma (C37.9)
    - Thymoma, atypical (C37.9)
    - Thymoma, epithelial (C37.9)
- Tumor (include only):
    - ACTH-producing
    - adenocarcinoid
    - adrenal cortical (malignant only)
    - alpha cell (malignant only)
    - Aortic body
    - Askin
    - beta cell (malignant only)
    - Brenner (malignant only)
    - Burkitt
    - carcinoid, NOS (except of appendix)
    - carcinoid (malignant only)
    - Carotid body
    - cells**
    - Chromaffin
    - desmoplastic small round cell
    - dysembryoplastic neuroepithelial**
    - embolus
    - endocrine, functioning, NOS

- endodermal sinus
- endolymphatic sac
- epithelial**
- Ewing
- fibrous, solitary**
- follicular dendritic cell
- fusiform cell type (malignant only)
- G cell (malignant only)
- gastrin cell (malignant only)
- gastrointestinal stromal (malignant only)
- germ cell
- giant cell (malignant only)
- glomus (malignant only)
- Glomus jugulare tumor, NOS (C75.5)
- granular cell**
- granulosa cell (malignant or sarcomatoid or adult type)
- Grawitz
- interstitial cell (malignant only)
- intravascular bronchial alveolar
- islet
- Klatskin
- Krukenberg
- Leydig cell (malignant only)
- malignant (any type)
- mast cell (malignant only)
- Merkel cell
- mesenchymal (malignant only)
- mesodermal, mixed
- metastatic
- mixed pineal
- mixed salivary gland type (malignant only)
- mucinous, of low malignant potential

- mucocarcinoid
- Mullerian mixed
- neuroectodermal (exclude melanotic)
- neuroendocrine, (grade 2, grade 3)
- nonencapsulating sclerosing
- odontogenic (malignant only)
- olfactory, neurogenic
- Pancoast
- Pancreatic endocrine, nonfunctioning
- Pancreatic endocrine, NOS
- Pancreatic neuroendocrine, nonfunctioning
- Papillary glioneuronal tumor
- papillary mucinous, of low malignant potential
- papillary serous, of low malignant potential
- Parathyroid
- peripheral neuroectodermal or peripheral primitive neuroectodermal, NOS
- peripheral nerve sheath (malignant only)
- phyllodes (malignant only)
- pineal parenchymal of intermediate differentiation
- Pinkus
- plasma cell
- polyvesicular vitelline
- primitive neuroectodermal
- rhabdoid, NOS
- rhabdoid/teratoid, atypical,
- round cell, desmoplastic, small
- Rosette-forming glioneuronal tumor
- Schminke
- Secondary
- serous, NOS, of low malignant potential serous, papillary, of low malignant potential
- Sellar region granular cell tumor

  - Sertoli-Leydig cell (poorly differentiated, with heterologous elements, sarcomatoid (malignant only)
  - sinus, endodermal
  - small cell type (malignant only)
  - smooth muscle (NOS)**
  - soft tissue**
  - spindle cell type (malignant only)
  - spindle epithelial with thymus-like element or thymus-like differentiation
  - steroid cell (malignant only)
  - sweat gland (malignant only)
  - teratoid/rhabdoid, atypical
  - transitional pineal
  - Triton, malignant
  - trophoblastic, epithelioid
  - vitelline, polyvesicular
  - Wilms
  - yolk sac or yolk sac, hepatoid
- Type A thymoma including atypical variant (C37.9)
- Type AB thymoma (C37.9)
- Type B1 thymoma (C37.9)
- Type B2 thymoma (C37.9)
- Type B3 thymoma (C37.9)
- Thymoma, atypical (C37.9)
- Thymoma, epithelial (C37.9)
- Ulcer, rodent
- Urachal carcinoma
- Urine cytology (positive for malignancy)

  Exception: when subsequent biopsy of urinary site if negative
- Vagal paraganglioma
- VAIN III (vaginal intraepithelial neoplasia, grade 3)
- VIN III (vulvar intraepithelial neoplasia, grade 3)
- VipomaXanthoastrocytoma, pleomorphic

F

APPENDIX F: DATA ITEMS CURRENTLY OR PREVIOUSLY COLLECTED

DATA ITEMS CURRENTLY OR PREVIOUSLY COLLECTED

The Texas Cancer Registry adheres to reporting requirements mandated by the National Program of Cancer Registries. Additional data items are required to meet requests from our data users.

Table F.1 Data Items Currently or Previously Collected

Data Item	NAACCR Item Number	Collection Dates
Date of Admission/First Contact	580	1995 - present
Date of Admission/First Contact Flag *	581	2010 – present
Registry/Accession Number	550	1995 - present
Reporting Facility	540	1995 - present
NPI Reporting Facility (Derived)	545	2009 - present
Types of Reporting Source	500	1995 - present
Medical Record #	2300	1995 - present
Class of Case	610	1998 - present
Last Name	2230	1995 - present
First Name	2240	1995 - present
Middle Name	2250	1995 - present
Maiden Name	2390	1995 - 2020
Birth Surname	2232	2021
Alias	2280	1995 - 2002 2006 - present
Address at Dx Street Address	2330	1995 - present
Address at Dx Supplemental	2335	2006 - present
Address at Dx City	70	1995 - present
Address at Dx State	80	1995 - present
Address at Dx Zip Code	100	1995 - present
FIPS County Code at DX	90	1995 - present
Address at Dx-Country	102	2013 - present
Current Address Number and Street	2350	2022
Cuurent Address Supplemental	2355	2022
Current Address City	1810	2022
Current Address – State	1820	2022
Cuurent Address -Zip Code	1830	2022
Telephone	2360	2022

Data Item	NAACCR Item Number	Collection Dates
Social Security Number	2320	1995 - present
Date of Birth	240	1995 - present
Date of Birth Flag *	241	2010 - present
Place of Birth	250	1998 - 2013
Birthplace-State	252	2013 - present
Birthplace-Country	254	2013 -present
Race 1	160	1995 - present
Race 2	161	2001 - present
Race 3	162	2001 - present
Race 4	163	2001 - present
Race 5	164	2001 - present
Spanish/Hispanic Origin	190	1995 - present
Sex	220	1995 - present
Marital Status at Dx	150	2022
Text Usual Occupation	310	2010 - present
Text Usual Industry	320	2010 - present
Other Pertinent Information	2680	1995 - present
Physician Managing	2460	2006 - 2010
Physician Follow Up	2470	2006 - present
Tobacco Use Smoking Status	344	2022
Facility Referred From	2410	2001 - 2010
Facility Referred To	2420	2001 - 2010
Sequence Number Hospital	560	1995 - present
Sequence Number Central	380	1995 - present
Other Primary Tumors	2200	1995 - 2020
Primary Payer at DX	630	2007 - present
Medicare Beneficiary Identifier	2315	2021 - present
Comorbidity/Secondary Diagnosis #1	3110	2011 - 2017
Comorbidity/Secondary Diagnosis #2	3120	2011 - 2017
Comorbidity/Secondary Diagnosis #3	3130	2011 - 2017
Comorbidity/Secondary Diagnosis #4	3140	2011 - 2017
Comorbidity/Secondary Diagnosis #5	3150	2011 - 2017
Comorbidity/Secondary Diagnosis #6	3160	2011 - 2017

Data Item	NAACCR Item Number	Collection Dates
Comorbidity/Secondary Diagnosis #7	3161	2011 - 2017
Comorbidity/Secondary Diagnosis #8	3162	2011 - 2017
Comorbidity/Secondary Diagnosis #9	3163	2011 - 2017
Comorbidity/Secondary Diagnosis #10	3164	2011 - 2017
Source Comorbidity/Secondary Diagnosis	Non-NAACCR 9970	2011 - 2017
Date of Initial Diagnosis	390	1995 - present
Date of Diagnosis Flag	391	2010 - present
ICD-O-2 Morph Prior to 2001	420	1995 - 2000
Behavior prior to 2001	430	1995 - 2000
Histologic Type ICD-O-3 2001 and forward	522	2001 - present
Behavior 2001 and forward	523	2001 - present
Primary Site	400	1995 - present
Grade of Tumor	440	1995 - 2017
Grade Path Value	441	2011 - 2013
Grade Path System	449	2011 - 2013
Grade Clinical	3843	2018 – present
Grade Pathological	3844	2018 - present
Grade Post Therapy Clinical (yc)	1068	2021
Grade Post Therapy Path (yp)	3845	2021
Laterality	410	1995 - present
Final DX Morph/Beh/Grade	2590	1995 - present
Final DX Primary Site and Laterality	2580	1995 - present
Diagnostic Confirmation	490	1995 - present
Tumor Size Clinical	752	2022
Tumor Size Pathologic	754	2022
Tumor Size Summary	756	2016 - present
Tumor Size Prior to 2004	780	1998 – 2003
Summary Stage 1977 for appropriate years	760	1995 - 2000
Summary Stage 2000 for appropriate years	759	2001 – 2004, 2014-present
EOD Primary Tumor	772	2022
EOD Regional Nodes	774	2022
EOD Metastases	776	2022

Data Item	NAACCR Item Number	Collection Dates
Summary Stage 2018	764	2018 - present
Lymphovascular Invasion (testis and penis only)	1182	2011 - present
Macroscopic Evaluation of the Mesorectum	3950	2022
Mets at Diagnosis-Bone	1112	2022
Mets at Diagnosis-Brain	1113	2022
Mets at Diagnosis – Liver	1115	2022
Mets at Diagnosis-Lung	1116	2022
Mets at Diagnosis – Distant LNs	1114	2022
Mets at Diagnosis-Other	1117	2022
SEER Site Specific Factor 1	3700	2022
CS Tumor Size 2004 and forward	2800	2004 - 2015
CS Extension	2810	2004 - 2015
CS Tumor Size/EXT Eval	2820	2008 - 2015
CS Lymph Nodes	2830	2004 - 2015
CS Lymph Nodes Eval	2840	2011 - 2015
CS Mets at DX	2850	2004 - 2015
CS Mets Eval	2860	2011 - 2015
CS Site Specific Factor 1 NPCR required only	2880	2004 - 2017
CS Site Specific Factor 2 NPCR required only	2890	2010 - 2017
CS Site Specific Factor 3 NPCR required only	2900	2004 - 2015
CS Site Specific Factor 4 NPCR required only	2910	2011 - 2015
CS Site Specific Factor 5 NPCR required only	2920	2011 - 2017
CS Site Specific Factor 6 NPCR required only	2930	2011 - 2017
CS Site Specific Factor 7 NPCR required only	2861	2011 - 2015
CS Site Specific Factor 8 NPCR required only	2862	2010 - 2017
CS Site Specific Factor 9 NPCR required only	2863	2010 - 2017
CS Site Specific Factor 10 NPCR required only	2864	2010 - 2017
CS Site Specific Factor 11 NPCR required only	2865	2010 - 2017
CS Site Specific Factor 12 NPCR required only	2866	2010 - 2015
CS Site Specific Factor 13 NPCR required only	2867	2010 - 2017
CS Site Specific Factor 14 NPCR required only	2868	2010 - 2017
CS Site Specific Factor 15 NPCR required only	2869	2011 - 2017
CS Site Specific Factor 16 NPCR required only	2870	2011 - 2017

Data Item	NAACCR Item Number	Collection Dates
CS Site Specific Factor 17 NPCR required only	2871	2011 - 2015
CS Site Specific Factor 25 NPCR required only	2879	2010 - 2017
Chromosome 1p: Loss of Heterozygosity (LOH)	3801	2022
Chromosome 19q: Loss of Heterozygosity (LOH)	3802	2022
Adenoid Cystic Basaloid Pattern	3803	2022
Adenopathy	3804	2022
AFP Post-Orchiectomy Lab Value	3805	2022
AFP Post-Orchiectomy Range	3806	2022
AFP Pre-Orchiectomy Lab Value	3807	2022
AFP Pre-Orchiectomy Range	3808	2022
AFP Pretreatment Interpretation	3809	2022
AFP Pretreatment Lab Value	3810	2022
Anemia	3811	2022
B symptoms	3812	2022
Bilirubin Pretreatment Total Lab Value	3813	2022
Bilirubin Pretreatment Unit of Measure	3814	2022
Bone Invasion	3815	2022
CA-125 Pretreatment Interpretation	3818	2022
CEA Pretreatment Interpretation	3819	2022
CEA Pretreatment Lab Value	3820	2022
Chromosome 3 Status	3821	2022
Chromosome 8q Status	3822	2022
Circumferential Resection Margin (CRM)	3823	2022
Creatinine Pretreatment Lab Value	3824	2022
Creatinine Pretreatment Unit of Measure	3825	2022
Esophagus and EGJ Tumor Epicenter	3829	2022
Estrogen Receptor Percent Positive or Range	3826	2022
Estrogen Receptor Total Allred Score	3828	2022
Extranodal Extension Clin (non-Head and Neck)	3830	2022
Extranodal Extension Head and Neck Clinical	3831	2022
Extranodal Extension Head and Neck Pathological	3832	2022
Extranodal Extension Path (non-Head and Neck)	3833	2022

Data Item	NAACCR Item Number	Collection Dates
Extravascular Matrix Patterns	3834	2022
FIGO Stage	3836	2022
Gestational Trophoblastic Prognostic Scoring Index	3837	2022
hCG Post-Orchiectomy Lab Value	3846	2022
hCG Post-Orchiectomy Range	3847	2022
hCG Pre-Orchiectomy Lab Value	3848	2022
hCG Pre-Orchiectomy Range	3849	2022
Heritable Trait	3856	2022
High Risk Cytogenetics	3857	2022
High Risk Histologic Features	3858	2022
HIV Status	3859	2022
International Normalized Ratio Prothrombin Time	3860	2022
Ipsilateral Adrenal Gland Involvement	3861	2022
JAK2	3862	2022
Ki-67	3863	2022
Invasion Beyond Capsule	3864	2022
KIT Gene Immunohistochemistry	3865	2022
KRAS	3866	2022
LDH Post-Orchiectomy Range	3867	2022
LDH Pre-Orchiectomy Range	3868	2022
LDH Level	3869	2022
LDH Upper Limits of Normal	3870	2022
LN Assessment Method Femoral-Inguinal	3871	2022
LN Assessment Method Para-Aortic	3872	2022
LN Assessment Method Pelvic	3873	2022
LN Distant Assessment Method	3874	2022
LN Distant: Mediastinal, Scalene	3875	2022
LN Head and Neck Levels I-III	3876	2022
LN Head and Neck Levels IV-V	3877	2022
LN Head and Neck Levels VI-VII	3878	2022
LN Head and Neck Other	3879	2022
LN Isolated Tumor Cells (ITC)	3880	2022

Data Item	NAACCR Item Number	Collection Dates
LN Laterality	3881	2022
LN Positive Axillary Level I-II	3882	2022
LN Size	3883	2022
LN Status Femoral-Inguinal, Para-Aortic, Pelvic	3884	2022
Lymphocytosis	3885	2022
Major Vein Involvement	3886	2022
Measured Basal Diameter	3887	2022
Measured Thickness	3888	2022
Methylation of O6-Methylguanine-Methyltransferase	3889	2022
Microsatellite Instability (MSI)	3890	2022
Microvascular Density	3891	2022
Mitotic Count Uveal Melanoma	3892	2022
Mitotic Rate Melanoma	3893	2022
Multigene Signature Method	3894	2022
Multigene Signature Results	3895	2022
NCCN International Prognostic Index (IPI)	3896	2022
Number of Cores Examined	3897	2022
Number of Cores Positive	3898	2022
Number of Examined Para-Aortic Node	3899	2022
Number of Examined Pelvic Nodes	3900	2022
Number of Positive Para-Aortic Nodes	3901	2022
Number of Positive Pelvic Nodes	3902	2022
Oncotype Dx Recurrence Score-DCIS	3903	2022
Oncotype Dx Recurrence Score-Invasive	3904	2022
Oncotype Dx Risk Level-DCIS	3905	2022
Oncotype Dx Risk Level-Invasive	3906	2022
Organomegaly	3907	2022
Percent Necrosis Post Neoadjuvant	3908	2022
Perineural Invasion	3909	2022
Peripheral Blood Involvement	3910	2022
Peritoneal Cytology	3911	2022
Pleural Effusion	3913	2022

Data Item	NAACCR Item Number	Collection Dates
Progesterone Receptor Percent Positive or Range	3914	2022
Progesterone Receptor Total Allred Score	3916	2022
Profound Immune Suppression	3918	2022
EOD Prostate Pathologic Extension	3919	2022
Residual Tumor Volume Post Cytoreduction	3921	2022
Response to Neoadjuvant Therapy	3922	2022
S Category Clinical	3923	2022
S Category Pathological	3924	2022
Sarcomatoid Features	3925	2022
Schema Discriminator 3	3928	2022
Separate Tumor Nodules	3929	2022
Serum Albumin Pretreatment Level	3930	2022
Serum Beta-2 Microglobulin Pretreatment Level	3931	2022
Tumor Deposits	3934	2022
Ulceration	3936	2022
Visceral and Parietal Pleural Invasion	3937	2022
ALK Rearrangement	3938	2022
EGFR Mutational Analysis	3939	2022
BRAF Mutational Analysis	3940	2022
NRAS Mutational Analysis	3941	2022
CA 19-9 PreTX Lab Value	3942	2022
NCDB--SARSCoV2--Pos	3944	2022
Macroscopic Evaluation of Mesorectum	3950	2022
p16	3956	2022
LN Status Pelvic	3957	2022
LN Status Para-Aortic	3958	2022
LN Status Femoral-Inguinal	3959	2022
Brain Molecular Markers	3816	2018 – present
Breslow Tumor Thickness	3817	2018 – present
Estrogen Receptor Summary	3827	2018 – present
Fibrosis Score	3835	2018 – present
HER2 Overall Summary	3855	2018 – present
LDH Lab Value	3932	2018 – present

Data Item	NAACCR Item Number	Collection Dates
Gleason Patterns Clinical	3838	2021 - present
Gleason Patterns Pathological	3839	2021 - present
Gleason Score Clinical	3840	2021 - present
Gleason Score Pathological	3841	2021 - present
Gleason Tertiary Pattern	3842	2021 - present
Microsatellite Instability (MSI)	3890	2021 - present
Progesterone Receptor Summary	3915	2018 – present
PSA (Prostatic Specific Antigen) Lab Value	3920	2018 – present
Schema Discriminator 1	3926	2018 - present
Schema Discriminator 2	3927	2018 - present
Summary Stage Documentation	2600	1995 - present
TNM Clinical T	940	2015 – 2017
AJCC TNM Clin T	1001	2018 - present
AJCC TNM Clin T Suffix	1031	2021 - present
TNM Clinical N	950	2015 – 2017
AJCC TNM Clin N	1002	2018 – present
AJCC TNM Clin N Suffix	1034	2021- present
TNM Clinical M	960	2015 – 2017
AJCC TNM Clin M	1003	2018- present
TNM Clinical Stage (Prefix/Suffix) Descriptor	980	2015 - 2017
TNM Clinical Stage Group	970	2015 - 2017
AJCC TNM Clin Stage Group	1004	2018 – present
TNM Pathologic T	880	2015 – 2017
AJCC TNM Path T	1011	2018 – present
AJCC TNM Path T Suffix	1032	2021- present
TNM Pathologic N	890	2015 - 2017
AJCC TNM Path N	1012	2018- present
AJCC TNM Path N Suffix	1035	2021- present
TNM Pathologic M	900	2015 - 2017
AJCC TNM Path M	1013	2018 – present
TNM Pathologic Stage (Prefix/Suffix) Descriptor	920	2015 – 2017
TNM Pathologic Stage Group	910	2015 - 2017
AJCC TNM Path Stage Group	1014	2018- present

Data Item	NAACCR Item Number	Collection Dates
AJCC TNM Post Therapy Clin (yc) T	1062	2021- present
AJCC TNM Post Therapy Clin (yc) T Suffix	1063	2021- present
AJCC TNM Post Therapy Clin (yc) N	1064	2021- present
AJCC TNM Post Therapy Clin (yc) N Suffix	1065	2021- present
AJCC TNM Post Therapy Clin (yc) M	1066	2021- present
AJCC TNM Post Therapy Clin (yc) Stage Group	1067	2021 - present
AJCC TNM Post Therapy Path (yc) T	1021	2021 - present
AJCC TNM Post Therapy Path (yc) T Suffix	1033	2021 - present
AJCC TNM Post Therapy Path (yc) N	1022	2021 - present
AJCC TNM Post Therapy Path (yc) N Suffix	1036	2021 –present
AJCC TNM Post Therapy Path (yc) M	1023	2021 - present
AJCC TNM Post Therapy Path Stage Group	1024	2021 - present
Regional Nodes Positive	820	1998 - present
Regional Nodes Examined	830	1998 - present
Date of Reg LN Dissection	682	2022
Date of Reg LN Dissection Flag	683	2022
Date of Sentinal Lymph Node Biopsy	832	2022
Date of Sentinal Lymph Node Biopsy Flag	833	2022
Sentinal Lymph Nodes Examined	834	2022
Sentinal Lymph Nodes Positive	835	2022
RX Summary - Reg LN Examined	1296	2001 - 2005
RX Summary - Scope of Reg LN Surgery	1292	2001 - present
Date of Initial Treatment	1260	2010 - present
Date of Initial Treatment Flag	1261	2010 - present
RX Date Surgery	1200	1995 - present
RX Date Surgery Flag	1201	2010 - present
Rx Summ-Surg Primary Site	1290	1995 - present
Surgical Margins of Primary Site	1320	2022
RX Date Mst Defn Srg	3170	2015 - present
RX Date Mst Defn Srg Flag	3171	2015 - present
Reason for No Surgery	1340	1998 - 2002 2006 - present
RX Summary - Surgery Other/Dist RX Code	1294	1998 - present

Data Item	NAACCR Item Number	Collection Dates
RX Text Surgery	2610	2004 - present
Rx Date Radiation	1210	1995 - present
RX Date Radiation Flag	1211	2010 - present
Phase I Dose per Fraction	1501	2022
Phase I Radiation External Beam Planning Tech	1502	2022
Phase I Number of Fractions	1503	2022
Phase I Radiation Primary Treatment Volume	1504	2022
Phase I Radiation to Draining Lymph Nodes	1505	2022
Phase I Radiation Treatment Modality	1506	2022
Phase I Total Dose	1507	2022
Phase II Dose per Fraction	1511	2022
Phase II Radiation External Beam Planning Tech	1512	2022
Phase II Number of Fractions	1513	2022
Phase II Radiation Primary Treatment Volume	1514	2022
Phase II Radiation to Draining Lymph Nodes	1515	2022
Phase II Radiation Treatment Modality	1516	2022
Phase II Total Dose	1517	2022
Phase III Dose per Fraction	1521	2022
Phase III Radiation External Beam Planning Tech	1522	2022
Phase III Number of Fractions	1523	2022
Phase III Radiation Primary Treatment Volume	1524	2022
Phase III Radiation to Draining Lymph Nodes	1525	2022
Phase III Radiation Treatment Modality	1526	2022
Phase III Total Dose	1527	2022
RX Summary - Radiation	1360	1998 - 2002 2012 - 2017
Radiation Regional RX Modality Code	1570	2003 - 2017
Reason for no Radiation	1430	1998 - 2002 2011 - present
RX Text - Radiation	2620, 2630	2004 - present
RX Summary - Surgery/Radiation Sequence	1380	2004 - present
RX Date - Systemic	3230	2004 - 2010
Date Chemotherapy Started	1220	2010 - present
RX Date Chemotherapy Flag	1221	2010 - present

Data Item	NAACCR Item Number	Collection Dates
Chemotherapy Code	1390	1995 - present
Reason for no Chemotherapy	1440	1998 - 2002
RX Text - Chemotherapy	2640	2004 - present
Date Hormone Therapy Started	1230	2010 - present
RX Date Hormone Flag	1231	2010 - present
Hormone Code	1400	1995 - present
Reason for no Hormone	1450	1998 - 2002
RX Text - Hormone	2650	2004 - present
Date Immunotherapy Started	1240	2010 - present
RX Date Immunotherapy Flag	1241	2010 - present
Immunotherapy Code	1410	1995 - present
RX Summary Transplant/Endocrine	3250	2003 - present
RX Text - Immunotherapy	2660	2004 - present
RX Summary - Systemic/Surgery Sequence	1639	2006 - present
Date other Treatment Started	1250	1995 - present
RX Date Other Flag	1251	2010 - present
Other Treatment Code	1420	1995 - present
RX Text - Other	2670	2004 - present
Neoadjuvant Therapy	1632	2022
Neoadjuvant Therapy-Clinical Response	1633	2022
Neoadjuvant Therapy-Treatment Effect	1634	2022
RX - Summary Treatment Status	1285	2010 - present
Date of Last Cancer(Tumor) Status	1772	2022
Date of Last Cancer(Tumor) Status Flag	1773	2022
Cancer Status	1770	2022
Recurrence Date--1st	1860	2022
Recurrence Date--1st Flag	1861	2022
Recurrence Type--1s	1880	2022
Date of Last Followup or Death	1750	1995 - present
Date of Last Followup or Death Flag	1751	2010 - present
Vital Status	1760	1998 - present
Underlying Cause of Death	1910	2022
Place of Death-State	1942	2013 - present

Data Item	NAACCR Item Number	Collection Dates
Place of Death-Country	1944	2013 - present
Follow Up Source (Derived)	1790	2009 - present
Date Abstracted	2090	1995 - present
Abstractor Initials	570	1995 - present
NAACCR Record Version	50	2003 - present
AJCC Edition Number	1060	2015 - present
Height	Non - NAACCR 9960	2011 - 2020
Weight	Non - NAACCR 9961	2011 - 2020
Tobacco Use	Non - NAACCR 9965 - 9968	2011- 2020
CoC Accredited Flag	2152	2018

TCR does not allow blanks for the following items:

*Date of Admission/First Contact, NAACCR #580

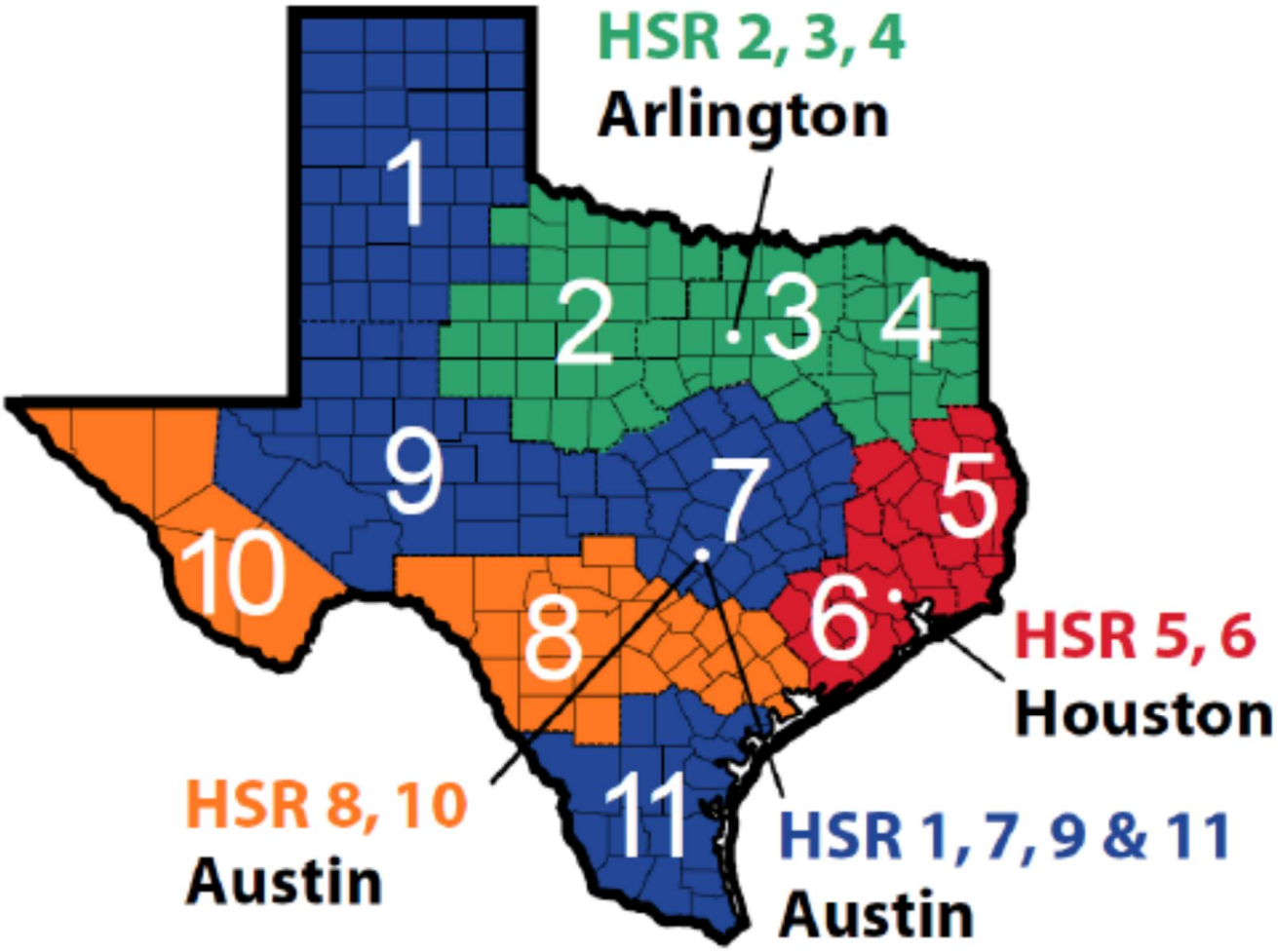
*Date of Date of Birth, NAACCR #240

G

APPENDIX G: HEALTH SERVICES REGIONS

Health Service Region Map

dshs.texas.gov/tcr/training/handbook/Appendix-Health-Service-Regions.pdf



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APPENDIX H: SPANISH/HISPANIC SURNAMES

Available on the TCR website at

dshs.texas.gov/tcr/training/handbook/Appendix-Spanish-Hispanic-Surnames.pdf

2022 Cancer Reporting Handbook

Texas Cancer Registry

Publication No. E10-10677

Released June 2022