WASHINGTON STATE DEPARTMENT OF HEALTH

2023 Washington State Cancer Registry Reporting Handbook

Washington State Department of HEALTH

DOH 342-127 Month 2023

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**DO NOT use email to send documents containing confidential information. Use the WSCR secure fax or WebPlus. **

General Information

Background

In 1990, the Revised Code of Washington (RCW 70.54.230) made cancer a reportable condition and mandated the Department of Health to establish a statewide cancer registry program. Under this mandate, the Department of Health established the Washington State Cancer Registry (WSCR) in 1991 with the collection of cancer data beginning January 1, 1992. The registry is dedicated to the fulfillment of the legislative intent "...to establish a system to accurately monitor the incidence of cancer in the state of Washington for the purposes of understanding, controlling and reducing the occurrence of cancer in this state." In 1995, WSCR received funding through the Centers for Disease Control and Prevention's National Program of Cancer Registries.

Mission

The mission of the Washington State Cancer Registry (WSCR) is to collect and disseminate high-quality statewide cancer data for use by public health agencies, health care providers, voluntary organizations, researchers, and academic institutions in their efforts to prevent and control cancer in Washington State.

Administration

The Washington State Cancer Registry is part of the Washington State Department of Health, Prevention and Community Health Division, Office of Healthy & Safe Communities, Community Based Prevention Section.

Cancer data for the state of Washington is collected primarily from hospital registries, private physicians, treatment centers, ambulatory surgery centers, and pathology laboratories. In addition, the Washington State Cancer Registry contracts with the Cancer Surveillance System (CSS) at the Fred Hutchinson Cancer Center to collect population-based data on cancer incidence and survival from 13 counties in western Washington. CSS is part of the Surveillance, Epidemiology and End Results (SEER) program at the National Cancer Institute.

As of July 1, 2022, the US Census Bureau showed the population of Washington State to be approximately 7.7 million, with an average of approximately 40,000 new cancer cases reported to the Washington State Cancer Registry each year.

Purpose

The purpose of WSCR is to identify and gather information from a variety of reporting sources throughout the state to monitor cancer trends over time, determine cancer patterns in various populations, plan and evaluate cancer prevention and control, help set priorities for allocating health resources, and to assist with the advancement of clinical, epidemiologic, and health services research.

Every year the state submits its data to the National Program of Cancer Registries (NPCR) and the North American Association of Central Cancer Registries (NAACCR).

Goals

- To collect data in a timely, accurate and efficient manner.
- Ensure the validity and reliability of the data through ongoing quality assurance activities.
- Utilize data from public health surveillance to support decision-making processes in cancer prevention and control.
- Make WSCR data and reports readily available to all parties or agencies interested or involved in accomplishing the registry's mission.
- Identify additional opportunities to promote WSCR data usage both within the state and beyond its borders.
- Assist all entities reporting to WSCR with updated data collection and reporting requirements.

Partnerships

Washington State Cancer Registry works closely with two other CDC funded Cancer Programs, Comprehensive Cancer Control and the Breast Cervical and Colon Health Program. The Breast Cervical and Colon Health Program provides free breast and cervical cancer screening to eligible people in Washington State. Eligibility for the BCCEDP is primarily based on health insurance status, income, and age. The Washington State Department of Health administers the program through grants from the CDC and state funding. The department contracts with six regional organizations throughout the state, known as Prime Contractors, who operate the programs within their local regions. The Comprehensive Cancer Control Program is dedicated to organizing partnerships and implementing evidence-based interventions that reduce the cancer burden in Washington State. The programs' main priorities include strategies to address primary prevention, early detection, and screening, supporting survivors, and addressing health equity. Some areas of work include increasing HPV vaccination rates, decreasing commercial tobacco use, increasing CRC screening rates, and strengthening provider skills in caring for survivors. Comprehensive Cancer Control is also working closely with diverse partners to relaunch a state-wide Cancer Coalition guided by a new 5-Year Cancer Plan.

Washington State Cancer Coalition and 5-year Cancer Plan

The Comprehensive Cancer Control has partnered with several organizations around the state to officially relaunch a state-wide Cancer Coalition guided by an updated 5-Year Cancer Plan. This coalition brings together any partners working to reduce the burden of cancer in Washington and those interested in engaging with activities related to goals outlined in the plan. Comprehensive Cancer Control worked closely with the Washington State Cancer Registry to produce a Cancer Burden Report that highlights the current cancer burden in WA and provides a framework for the drafting of a 5-Year Cancer Plan. This plan uses several data points from the Washington State Cancer Registry and each year the coalition will evaluate data points identified by the plan, report on progress, and make recommendations for future work. This plan will be implemented

by all partners associated with the coalition and can act as roadmap to help inform the work done by any health jurisdiction, community-based organization, provider, health care system, health insurer, policy maker, employer, or professional organization.

Washington State Cancer Registry Advisory Committee

The Washington State Cancer Registry (WSCR) Advisory Committee is a multidisciplinary committee that advises and advocates for the state central cancer registry. The committee will guide the registry to strengthen its policies, procedures, systems, data quality, partnerships, public visibility, and awareness of cancer registry data. Accomplishing this will improve the effectiveness of registry activities, increase understanding about the role of the registry, and ensure the registry is supported as a valuable cancer prevention and control resource for the Washington State Department of Health (DOH).

HIPPA Laws and Patient Privacy

HIPPA 1996 and the Washington State Cancer Registry

There is a public health surveillance exemption clause[i] to the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA) that applies to state cancer registries. This exemption clause allows disclosure of certain protected health information. State cancer registries are a Public Health Authority under HIPPA and according to federal law and state statutes, Washington State Cancer Registry staff may collect or receive individually identifiable health information as a Public Health Authority to "monitor the incidence of cancer in the state and report applicable limited data according to federal requirements." For more information, please visit: *HIPAA Resources for Cancer Registries - NAACCR*

Use and Disclosure

Case information received by the Washington State Cancer Registry is restricted and highly confidential. All research projects go through an extensive Washington State Institutional Review Board (WSIRB) process. The WSIRB protects the rights and welfare of individuals in accordance with state and federal law. Information on patient age, sex, county of residence, cancer type and treatment are generally accessible as aggregate statistical data to the public. Patient names, social security numbers, physicians, facility names and other personal identifiers are confidential.

For more information on the Washington State Institutional Review Board, please visit: *Human Research Review Section | DSHS (wa.gov)*.

Reportable Data Items

Item #	Item Name	NPCR	CoC	SEER & WSCR	CCCR	Source of Standard
10	Record Type	R	.	.	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	NAACCR
45	NPI--Registry ID	.	.	R*	.	CMS
50	NAACCR Record Version	R	.	R	.	NAACCR
60	Tumor Record Number	.	.	S	R*	NAACCR
70	Addr at DX--City	R	R	R	R*	CoC
80	Addr at DX--State	R	R	R	.	CoC
81	State at DX Geocode 1970/80/90	RH*	.	R	.	NAACCR
82	State at DX Geocode 2000	D	.	D	.	NAACCR
83	State at DX Geocode 2010	D	.	D	.	NAACCR
84	State at DX Geocode 2020	D	.	D	.	NAACCR
89	County at DX Analysis	D	.	D	.	NAACCR
90	County at DX Reported	R	R	R	.	FIPS/SEER
94	County at DX Geocode 1970/80/90	RH*	.	D	.	NAACCR
95	County at DX Geocode2000	D	.	D	.	NAACCR
96	County at DX Geocode2010	D	.	D	.	NAACCR
97	County at DX Geocode2020	D	.	D	.	NAACCR
100	Addr at DX--Postal Code	R	R	R	R*	CoC
102	Addr at DX--Country	.	R	R	.	NAACCR
110	Census Tract 1970/80/90	RH*	.	RH	.	SEER
120	Census Cod Sys 1970/80/90	RH*	.	RH	.	SEER
125	Census Tract 2020	D	.	D	.	NAACCR
130	Census Tract 2000	RH	.	RH	.	NAACCR
135	Census Tract 2010	R	.	R	.	NAACCR
145	Census Tr Poverty Indictr	D	.	D	.	NAACCR
150	Marital Status at DX	.	.	R	.	SEER
160	Race 1	R	R	R	.	SEER/CoC
161	Race 2	R	.	R	.	SEER
162	Race 3	R	.	R	.	SEER

163	Race 4	R	.	R	.	SEER
164	Race 5	R	.	R	.	SEER
170	Race Coding Sys--Current	.	.	.	.	NAACCR
180	Race Coding Sys--Original	.	.	.	.	NAACCR
190	Spanish/Hispanic Origin	R	R	R	.	SEER/CoC
191	NHIA Derived Hisp Origin	D	.	D	.	NAACCR
192	IHS Link	R*	.	R	.	NPCR
193	Race--NAPIIA(derived API)	R	.	.	.	NAACCR
194	IHS Purchased/Referred Care Delivery Area	D	.	D	.	NPCR
200	Computed Ethnicity	.	.	D	.	SEER
210	Computed Ethnicity Source	.	.	R	.	SEER
220	Sex	R	R	R	R	SEER/CoC
230	Age at Diagnosis	R	R	R	D	SEER/CoC
240	Date of Birth	R	R	R	R	SEER/CoC
250	Birthplace	RH*	.	.	.	SEER/CoC
252	Birthplace--State	R*	R	R	R	NAACCR
254	Birthplace--Country	R*	R	R	R	NAACCR
270	Census Occ Code 1970-2000	R*	.	.	.	Census/NPCR
272	Census Ind Code 2010 CDC	R*	.	.	.	Census/NPCR
280	Census Ind Code 1970-2000	R*	.	.	.	Census/NPCR
282	Census Occ Code 2010 CDC	R*	.	.	.	Census/NPCR
284	Urban Indian Health Organization (UIHO)	D	.	D	.	NPCR
285	UIHO City	D	.	D	.	NPCR
290	Occupation Source	R*	.	.	.	NPCR
300	Industry Source	R*	.	.	.	NPCR
310	Text--Usual Occupation	R*	.	.	.	NPCR
320	Text--Usual Industry	R*	.	.	.	NPCR
330	Census Occ/Ind Sys 70-00	R*	.	.	.	NPCR
339	RUCA 2000	D	.	D	.	NAACCR
341	RUCA 2010	D	.	D	.	NAACCR
344	Tobacco Use Smoking Status	R*	R	R*	R	NPCR
345	URIC 2000	D	.	D	.	NAACCR
346	URIC 2010	D	.	D	.	NAACCR
361	Census Block Group 2020	.	.	.	.	Census
362	Census Block Group 2000	.	.	S	.	Census
363	Census Block Group 2010	.	.	R	.	Census
364	Census Tr Cert 1970/80/90	RH*	.	RH	.	SEER

365	Census Tr Certainty 2000	RH	.	RH	.	NAACCR
366	GIS Coordinate Quality	R*	.	S	.	NAACCR
367	Census Tr Certainty 2010	R	.	R	.	NAACCR
368	Census Block Grp 1970/80/90	.	.	S	.	Census
369	Census Tract Certainty 2020	D	.	D	.	NAACCR
380	Sequence Number--Central	R	.	R	D	SEER
390	Date of Diagnosis	R	R	R	R	SEER/CoC
400	Primary Site	R	R	R	R	SEER/CoC
410	Laterality	R	R	R	R	SEER/CoC
420	Histology (92-00) ICD-0-2	RH	RH	RH	RH	SEER/CoC
430	Behavior (92-00) ICD-0-2	RH	RH	RH	RH	SEER/CoC
440	Grade	RH	RH	RH	RH	SEER/CoC
441	Grade Path Value	RH*	RH	RH	.	AJCC
442	Ambiguous Terminology DX	.	RH	RH	.	SEER
443	Date Conclusive DX	.	RH	RH	.	SEER
444	Mult Tum Rpt as One Prim	.	RH	RH	.	SEER
445	Date of Mult Tumors	.	RH	RH	.	SEER
446	Multiplicity Counter	.	RH	RH	.	SEER
449	Grade Path System	RH*	RH	RH	.	AJCC
450	Site Coding Sys--Current	R	.	.	.	NAACCR
460	Site Coding Sys--Original	.	.	.	R*	NAACCR
470	Morph Coding Sys--Current	R	.	.	.	NAACCR
480	Morph Coding Sys--Originl	.	.	.	R*	NAACCR
490	Diagnostic Confirmation	R	R	R	R	SEER/CoC
500	Type of Reporting Source	R	.	R	.	SEER
501	Casefinding Source	R*	.	.	.	NAACCR
522	Histologic Type ICD-0-3	R	R	R	R	SEER/CoC
523	Behavior Code ICD-0-3	R	R	R	R	SEER/CoC
530	EDP MDE Link Date	RS	.	.	.	NPCR
531	EDP MDE Link	RS	.	.	.	NPCR
540	Reporting Facility	R	R	R	.	CoC
545	NPI--Reporting Facility	R*	R	R*	.	CMS
550	Accession Number--Hosp	.	R	R	.	CoC
560	Sequence Number--Hospital	.	R	R	.	CoC
570	Abstracted By	.	R	R	.	CoC
580	Date of 1st Contact	R*	R	.	.	CoC
590	Date of Inpt Adm	.	.	.	.	NAACCR
600	Date of Inpt Disch	.	.	.	.	NAACCR

605	Inpatient Status	.	.	.	.	NAACCR
610	Class of Case	R	R	R	.	CoC
630	Primary Payer at DX	R*	R	R	.	CoC
668	RX Hosp--Surg App 2010	.	R	.	.	CoC
670	RX Hosp--Surg Prim Site 03-2022	.	R	RH	.	CoC
671	RX Hosp--Surg Prim Site 2023	.	R	R	.	CoC
672	RX Hosp--Scope Reg LN Sur	.	R	R	.	CoC
674	RX Hosp--Surg Oth Reg/Dis	.	R	R	.	CoC
676	RX Hosp--Reg LN Removed	.	RH	.	.	CoC
682	Date Regional Lymph Node Dissection	.	R	RC	.	NAACCR
690	RX Hosp--Radiation	.	.	RH	.	SEER
700	RX Hosp--Chemo	.	R	R	.	CoC
710	RX Hosp--Hormone	.	R	R	.	CoC
720	RX Hosp--BRM	.	R	R	.	CoC
730	RX Hosp--Other	.	R	R	.	CoC
740	RX Hosp--DX/Stg Proc	.	R	.	.	CoC
746	RX Hosp--Surg Site 98-02	.	RH	RH	.	CoC
747	RX Hosp--Scope Reg 98-02	.	RH	RH	.	CoC
748	RX Hosp--Surg Oth 98-02	.	RH	RH	.	CoC
752	Tumor Size Clinical	.	.	R	R*	SEER
754	Tumor Size Pathologic	.	.	R	R*	SEER
756	Tumor Size Summary	R	R	S	.	NPCR/CoC
759	SEER Summary Stage 2000	RH	RH	RH	.	SEER
760	SEER Summary Stage 1977	RH	RH	.	.	SEER
762	Derived Summary Stage 2018	.	.	D	.	SEER
764	Summary Stage 2018	R	.	R*	.	SEER
772	EOD Primary Tumor	.	.	R	.	SEER
774	EOD Regional Nodes	.	.	R	.	SEER
776	EOD Mets	.	.	R	.	SEER
780	EOD--Tumor Size	.	RH	RH	.	SEER/CoC
785	Derived EOD 2018 T	.	.	D	.	SEER
790	EOD--Extension	.	.	RH	.	SEER
795	Derived EOD 2018 M	.	.	D	.	SEER
800	EOD--Extension Prost Path	.	.	RH	.	SEER
810	EOD--Lymph Node Involv	.	.	RH	.	SEER
815	Derived EOD 2018 N	.	.	D	.	SEER
818	Derived EOD 2018 Stage Group	.	.	D	.	SEER
820	Regional Nodes Positive	R	R	R	R*	SEER/CoC

830	Regional Nodes Examined	R	R	R	R*	SEER/CoC
832	Date of Sentinel Lymph Node Biopsy	.	RS	R*	.	CoC
834	Sentinel Lymph Nodes Examined	.	RS	RS	.	CoC
835	Sentinel Lymph Nodes Positive	.	RS	RS	.	CoC
840	EOD--Old 13 Digit	.	.	RH	.	SEER
850	EOD--Old 2 Digit	.	.	RH	.	SEER
860	EOD--Old 4 Digit	.	.	RH	.	SEER
870	Coding System for EOD	.	.	RH	.	SEER
880	TNM Path T	.	RH	RH	.	AJCC
890	TNM Path N	.	RH	RH	.	AJCC
900	TNM Path M	.	RH	RH	.	AJCC
910	TNM Path Stage Group	.	RH	RH*	.	AJCC
920	TNM Path Descriptor	.	RH	RH	.	CoC
930	TNM Path Staged By	.	RH	RH	.	CoC
940	TNM Clin T	.	RH	RH	.	AJCC
950	TNM Clin N	.	RH	RH	.	AJCC
960	TNM Clin M	.	RH	RH	.	AJCC
970	TNM Clin Stage Group	.	RH	RH*	.	AJCC
980	TNM Clin Descriptor	.	RH	RH	.	CoC
990	TNM Clin Staged By	.	RH	RH	.	CoC
995	AJCC ID	D	D	D	R*	NAACCR
1001	AJCC TNM Clin T	.	R	RC	R*	AJCC
1002	AJCC TNM Clin N	.	R	RC	R*	AJCC
1003	AJCC TNM Clin M	.	R	RC	R*	AJCC
1004	AJCC TNM Clin Stage Group	.	R	RC	R*	AJCC
1011	AJCC TNM Path T	.	R	RC	R*	AJCC
1012	AJCC TNM Path N	.	R	RC	R*	AJCC
1013	AJCC TNM Path M	.	R	RC	R*	AJCC
1014	AJCC TNM Path Stage Group	.	R	RC	R*	AJCC
1021	AJCC TNM Post Therapy Path (yp) T	.	R	RC	R*	AJCC
1022	AJCC TNM Post Therapy Path (yp) N	.	R	RC	R*	AJCC
1023	AJCC TNM Post Therapy Path (yp) M	.	R	RC	R*	AJCC
1024	AJCC TNM Post Therapy Path (yp) Stage Group	.	R	RC	R*	AJCC
1031	AJCC TNM Clin T Suffix	.	R	RC	R*	AJCC
1032	AJCC TNM Path T Suffix	.	R	RC	R*	AJCC
1033	AJCC TNM Post Therapy Path (yp) T Suffix	.	R	RC	R*	AJCC

1034	AJCC TNM Clin N Suffix	.	R	RC	R*	AJCC
1035	AJCC TNM Path N Suffix	.	R	RC	R*	AJCC
1036	AJCC TNM Post Therapy Path (yp) N Suffix	.	R	RC	R*	AJCC
1060	TNM Edition Number	.	R	RH	R	CoC
1062	AJCC TNM Post Therapy Clin (yc) T	.	R	RC	.	AJCC
1063	AJCC TNM Post Therapy Clin (yc) T Suffix	.	R	RC	.	AJCC
1064	AJCC TNM Post Therapy Clin (yc) N	.	R	RC	.	AJCC
1065	AJCC TNM Post Therapy Clin (yc) N Suffix	.	R	RC	.	AJCC
1066	AJCC TNM Post Therapy Clin (yc) M	.	R	RC	.	AJCC
1067	AJCC TNM Post Therapy Clin (yc) Stage Group	.	.	.	.	AJCC
1068	Grade Post Therapy Clin (yc)	R*	R	RS	.	NAACCR
1112	Mets at DX-Bone	.	R	R	R	SEER
1113	Mets at DX-Brain	.	R	R	R	SEER
1114	Mets at Dx-Distant LN	.	R	R	R	SEER
1115	Mets at DX-Liver	.	R	R	R	SEER
1116	Mets at DX-Lung	.	R	R	R	SEER
1117	Mets at DX-Other	.	R	R	R	SEER
1120	Pediatric Stage	.	.	.	.	CoC
1130	Pediatric Staging System	.	.	.	.	CoC
1140	Pediatric Staged By	.	.	.	.	CoC
1150	Tumor Marker 1	.	RH	RH	.	SEER
1160	Tumor Marker 2	.	RH	RH	.	SEER
1170	Tumor Marker 3	.	RH	RH	.	SEER
1182	Lymphovascular Invasion	R*	R	RS	R*	AJCC
1200	RX Date Surgery	R*	R	R	.	CoC
1210	RX Date Radiation	R*	R	R	.	CoC
1220	RX Date Chemo	R*	R	R	.	CoC
1230	RX Date Hormone	R*	R	R	.	CoC
1240	RX Date BRM	R*	R	R	.	CoC
1250	RX Date Other	R*	R	R	.	CoC
1260	Date Initial RX SEER	R#*	.	R	.	SEER
1270	Date 1st Crs RX CoC	R#*	R	.	.	CoC
1280	RX Date DX/Stg Proc	.	R	.	.	CoC
1285	RX Summ--Treatment Status	R#	R	R	.	SEER/CoC
1290	RX Summ--Surg Prim Site 03-2022	R	R	RH	.	SEER/CoC
1291	RX Summ--Surg Prim Site 2023	RS	R	R	.	SEER/CoC

1292	RX Summ--Scope Reg LN Sur	R	R	R	.	SEER/CoC
1294	RX Summ--Surg Oth Reg/Dis	R	R	R	.	SEER/CoC
1296	RX Summ--Reg LN Examined	.	RH	RH	.	SEER/CoC
1310	RX Summ--Surgical Approch	.	RH	.	.	CoC
1320	RX Summ--Surgical Margins	.	R	R*	.	CoC
1330	RX Summ--Reconstruct 1st	.	RH	.	.	SEER
1340	Reason for No Surgery	R	R	R	.	SEER/CoC
1350	RX Summ--DX/Stg Proc	.	R	.	.	CoC
1360	RX Summ--Radiation	RH	.	RH	.	SEER
1370	RX Summ--Rad to CNS	.	.	RH	.	SEER/CoC
1380	RX Summ--Surg/Rad Seq	R	R	R	.	SEER/CoC
1390	RX Summ--Chemo	R	R	R	.	SEER/CoC
1400	RX Summ--Hormone	R	R	R	.	SEER/CoC
1410	RX Summ--BRM	R	R	R	.	SEER/CoC
1420	RX Summ--Other	R	R	R	.	SEER/CoC
1430	Reason for No Radiation	R	R	R	.	CoC
1460	RX Coding System--Current	R	.	.	.	NAACCR
1501	Phase I Dose per Fraction	.	R	R*	.	CoC
1502	Phase I Radiation External Beam Planning Tech	.	R	RC	.	CoC
1503	Phase I Number of Fractions	.	R	R*	.	CoC
1504	Phase I Radiation Primary Treatment Volume	.	R	R*	.	CoC
1505	Phase I Radiation to Draining Lymph Nodes	.	R	R*	.	CoC
1506	Phase I Radiation Treatment Modality	R	R	R	.	CoC
1507	Phase I Total Dose	.	R	R*	.	CoC
1510	Rad--Regional Dose: cGy	.	.	.	.	CoC
1511	Phase II Dose per Fraction	.	R	R*	.	CoC
1512	Phase II Radiation External Beam Planning Tech	.	R	RC	.	CoC
1513	Phase II Number of Fractions	.	R	R*	.	CoC
1514	Phase II Radiation Primary Treatment Volume	.	R	R*	.	CoC
1515	Phase II Radiation to Draining Lymph Nodes	.	R	R*	.	CoC
1516	Phase II Radiation Treatment Modality	.	R	R	.	CoC
1517	Phase II Total Dose	.	R	R*	.	CoC
1520	Rad--No of Treatment Vol	.	.	.	.	CoC

1521	Phase III Dose per Fraction	.	R	R*	.	CoC
1522	Phase III Radiation External Beam Planning Tech	.	R	RC	.	CoC
1523	Phase III Number of Fractions	.	R	R*	.	CoC
1524	Phase III Radiation Primary Treatment Volume	.	R	R*	.	CoC
1525	Phase III Radiation to Draining Lymph Nodes	.	R	R*	.	CoC
1526	Phase III Radiation Treatment Modality	.	R	R	.	CoC
1527	Phase III Total Dose	.	R	R*	.	CoC
1531	Radiation Treatment Discontinued Early	.	R	R*	.	CoC
1532	Number of Phases of Rad Treatment to this Volume	.	R	R*	.	CoC
1533	Total Dose	.	R	R*	.	CoC
1540	Rad--Treatment Volume	.	.	.	.	CoC
1550	Rad--Location of RX	.	R	.	.	CoC
1570	Rad--Regional RX Modality	RH	.	.	.	CoC
1632	Neoadjuvant Therapy	.	.	R	.	SEER
1633	Neoadjuvant Therapy-Clinical Response	.	.	R	.	SEER
1634	Neoadjuvant Therapy-Treatment Effect	.	.	R	.	SEER
1639	RX Summ--Systemic/Sur Seq	R	R	R	.	CoC
1640	RX Summ--Surgery Type	.	.	RH	.	SEER
1646	RX Summ--Surg Site 98-02	.	RH	.	.	SEER/CoC
1647	RX Summ--Scope Reg 98-02	.	RH	RH	.	SEER/CoC
1648	RX Summ--Surg Oth 98-02	.	RH	RH	.	SEER/CoC
1660	Subsq RX 2nd Course Date	.	.	.	.	CoC
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 SU	.	.	.	.	CoC
1678	Subsq RX 2nd--Surg Oth	.	.	.	.	CoC
1679	Subsq RX 2nd--Reg LN Rem	.	.	.	.	CoC
1680	Subsq RX 3rd Course Date	.	.	.	.	CoC
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
1700	Subsq RX 4th Course Date	.	.	.	.	CoC
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	.	SEER/CoC
1755	Date of Death--Canada	.	.	.	R*	CCCR
1760	Vital Status	R	R	R	D	SEER/CoC
1762	Vital Status Recode	D	.	D	.	NAACCR
1770	Cancer Status	.	R	R*	.	CoC
1772	Date of Last Cancer (tumor) Status	.	R	R*	.	CoC
1775	Record Number Recode	D	.	D	.	NAACCR
1780	Quality of Survival	.	.	.	.	CoC
1782	Surv-Date Active Followup	D	.	D	.	NAACCR
1783	Surv-Flag Active Followup	D	.	D	.	NAACCR
1784	Surv-Mos Active Followup	D	.	D	.	NAACCR
1785	Surv-Date Presumed Alive	D	.	D	.	NAACCR
1786	Surv-Flag Presumed Alive	D	.	D	.	NAACCR
1787	Surv-Mos Presumed Alive	D	.	D	.	NAACCR
1788	Surv-Date DX Recode	D	.	D	.	NAACCR
1790	Follow-Up Source	R*	R	.	.	CoC
1791	Follow-up Source Central	R	.	.	.	NAACCR
1800	Next Follow-Up Source	.	R	.	.	CoC
1810	Addr Current--City	.	.	R	.	SEER

1820	Addr Current--State	.	.	R	.	SEER
1830	Addr Current--Postal Code	.	.	R	.	SEER
1832	Addr Current--Country	.	.	R	.	NAACCR
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
1854	No Patient Contact Flag	.	.	R	.	NAACCR
1856	Reporting Facility Restriction Flag	.	.	R	.	NAACCR
1860	Recurrence Date--1st	.	R	RC	.	CoC
1880	Recurrence Type--1st	.	R	RC	.	CoC
1910	Cause of Death	R	.	R	R*	SEER
1914	SEER Cause Specific COD	D	.	D	.	SEER
1915	SEER Other COD	D	.	D	.	SEER
1920	ICD Revision Number	R	.	R	.	SEER
1930	Autopsy	.	.	.	.	NAACCR
1940	Place of Death	RH	.	.	R*	NPCR
1942	Place of Death--State	R	.	R	D	NAACCR
1944	Place of Death--Country	R*	.	R	D	NAACCR
1960	Site (73-91) ICD-O-1	.	.	RH	.	SEER
1971	Histology (73-91) ICD-O-1	.	.	RH	.	SEER
1972	Behavior (73-91) ICD-O-1	.	.	RH	.	SEER
1973	Grade (73-91) ICD-O-1	.	.	RH	.	SEER
1981	Over-ride SS/NodesPos	.	.	RH	.	NAACCR
1982	Over-ride SS/TNM-N	.	.	RH	.	NAACCR
1983	Over-ride SS/TNM-M	.	.	RH	.	NAACCR
1985	Over-ride Acsn/Class/Seq	.	.	.	.	NAACCR
1986	Over-ride HospSeq/DxConf	.	.	.	.	NAACCR
1987	Over-ride CoC-Site/Type	.	.	.	.	NAACCR
1988	Over-ride HospSeq/Site	.	.	.	.	NAACCR
1989	Over-ride Site/TNM-StgGrp	.	.	R	.	NAACCR
1990	Over-ride Age/Site/Morph	R	.	R	.	SEER
1992	Over-ride TNM Stage	.	.	.	.	NAACCR
1993	Over-ride TNM Tis	.	.	R	.	NAACCR
1994	Over-ride TNM 3	.	.	.	.	NAACCR
2000	Over-ride SeqNo/DxConf	R	.	R	.	SEER

2010	Over-ride Site/Lat/SeqNo	R	.	R	.	SEER
2020	Over-ride Surg/DxConf	R	.	R	.	SEER
2030	Over-ride Site/Type	R	.	R	.	SEER
2040	Over-ride Histology	R	.	R	.	SEER
2050	Over-ride Report Source	R	.	R	.	SEER
2060	Over-ride Ill-define Site	R	.	R	.	SEER
2070	Over-ride Leuk, Lymphoma	R	.	R	.	SEER
2071	Over-ride Site/Behavior	R	.	R	.	SEER
2072	Over-ride Site/EOD/DX Dt	.	.	R	.	SEER
2073	Over-ride Site/Lat/EOD	.	.	R	.	SEER
2074	Over-ride Site/Lat/Morph	R	.	R	.	SEER
2078	Over-ride Name/Sex	R	.	R	.	NAACCR
2081	CRC CHECKSUM	.	.	S	.	NAACCR
2085	Date Case Initiated	.	.	.	.	NAACCR
2090	Date Case Completed	.	.	.	.	NAACCR
2092	Date Case Completed--CoC	.	D	.	.	CoC
2100	Date Case Last Changed	.	D	.	.	NAACCR
2110	Date Case Report Exported	R	.	R	.	NPCR
2111	Date Case Report Received	R	.	R	.	NPCR
2112	Date Case Report Loaded	R	.	R	.	NPCR
2113	Date Tumor Record Availbl	R	.	D	.	NPCR
2116	ICD-O-3 Conversion Flag	R	.	R	.	SEER
2117	Schema ID Version Current	D	D	D	R*	SEER
2118	Schema ID Version Original	D	D	D	R*	SEER
2140	CoC Coding Sys–Current	.	.	.	.	CoC
2150	CoC Coding Sys–Original	.	.	.	.	CoC
2152	CoC Accredited Flag	R	.	R	.	NPCR
2155	RQRS NCDB Submission Flag	.	.	.	.	CoC
2156	AJCC API Version Current	.	D	D*	R*	AJCC
2157	AJCC API Version Original	.	D	D*	R*	AJCC
2158	AJCC Cancer Surveillance DLL Version Current	D	D	.	R*	AJCC
2159	AJCC Cancer Surveillance DLL Version Original	D	D	.	R*	AJCC
2170	Vendor Name	.	R	.	.	NAACCR
2200	Diagnostic Proc 73-87	.	.	.	.	SEER
2230	Name--Last	R	.	R	R	SEER
2232	Name--Birth Surname	R	.	R	R*	NAACCR
2240	Name--First	R	.	R	R*	SEER

2250	Name--Middle	R	.	R	R*	SEER
2260	Name--Prefix	.	.	.	.	NAACCR
2270	Name--Suffix	.	.	R	.	NAACCR
2280	Name--Alias	R	.	R	.	NAACCR
2290	Name--Spouse/Parent	.	.	.	.	NAACCR
2300	Medical Record Number	R	.	R	.	NAACCR
2310	Military Record No Suffix	.	.	.	.	CoC
2315	Medicare Beneficiary Identifier	R*	.	.	.	NAACCR
2320	Social Security Number	R	.	R	.	SEER
2330	Addr at DX--No & Street	R	.	R	.	SEER
2335	Addr at DX--Supplementl	R	.	R	.	SEER
2350	Addr Current--No & Street	.	.	R	.	SEER
2352	Latitude	R*	.	S	.	NAACCR
2354	Longitude	R*	.	S	.	NAACCR
2355	Addr Current--Supplementl	.	.	R*	.	SEER
2360	Telephone	.	.	R	.	SEER
2380	DC State File Number	R	.	R*	.	State
2390	Name--Maiden	.	.	.	R*	
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	.	CoC
2475	NPI--Physician--Follow-Up	.	.	R*	.	CMS
2480	Physician--Primary Surg	.	.	.	.	CoC
2485	NPI--Physician--Primary Surg	.	R	.	.	CMS
2490	Physician 3	.	.	.	.	CoC
2495	NPI--Physician 3	.	R	.	.	CMS
2500	Physician 4	.	.	.	.	CoC
2505	NPI--Physician 4	.	R	.	.	CMS
2508	EHR Reporting	.	.	.	.	NAACCR

2520	Text--DX Proc--PE	R^	.	R	.	NPCR
2530	Text--DX Proc--X-ray/Scan	R^	.	R	.	NPCR
2540	Text--DX Proc--Scopes	R^	.	R	.	NPCR
2550	Text--DX Proc--Lab Tests	R^	.	R	.	NPCR
2560	Text--DX Proc--Op	R^	.	R	.	NPCR
2570	Text--DX Proc--Path	R^	.	R	.	NPCR
2580	Text--Primary Site Title	R^	.	R	.	NPCR
2590	Text--Histology Title	R^	.	R	.	NPCR
2600	Text--Staging	R^	.	R	.	NPCR
2610	RX Text--Surgery	R^	.	R	.	NPCR
2620	RX Text--Radiation (Beam)	R^	.	R	.	NPCR
2630	RX Text--Radiation Other	R^	.	R	.	NPCR
2640	RX Text--Chemo	R^	.	R	.	NPCR
2650	RX Text--Hormone	R^	.	R	.	NPCR
2660	RX Text--BRM	R^	.	R	.	NPCR
2670	RX Text--Other	R^	.	R	.	NPCR
2680	Text--Remarks	.	.	R	.	NPCR
2690	Text--Place of Diagnosis	.	.	.	.	NPCR
2800	CS Tumor Size	RH*	RH	RH*	RH*	AJCC
2810	CS Extension	RH*	RH	RH*	RH*	AJCC
2820	CS Tumor Size/Ext Eval	RH*	RH	RH*	RH*	AJCC
2830	CS Lymph Nodes	RH*	RH	RH*	RH*	AJCC
2840	CS Lymph Nodes Eval	RH*	RH	RH*	RH*	AJCC
2850	CS Mets at DX	RH*	RH	RH*	RH*	AJCC
2851	CS Mets at Dx-Bone	.	RH	RH	RH*	AJCC
2852	CS Mets at Dx-Brain	.	RH	RH	RH*	AJCC
2853	CS Mets at Dx-Liver	.	RH	RH	RH*	AJCC
2854	CS Mets at Dx-Lung	.	RH	RH	RH*	AJCC
2860	CS Mets Eval	RH*	RH	RH*	RH*	AJCC
2861	CS Site-Specific Factor 7	RH*	RH	RH	RH*	AJCC
2862	CS Site-Specific Factor 8	RH*	RH	RH	RH*	AJCC
2863	CS Site-Specific Factor 9	RH*	RH	RH	RH*	AJCC
2864	CS Site-Specific Factor10	RH*	RH	RH	RH*	AJCC
2865	CS Site-Specific Factor11	RH*	RH	RH	RH*	AJCC
2866	CS Site-Specific Factor12	RH*	RH	RH	RH*	AJCC
2867	CS Site-Specific Factor13	RH*	RH	RH	RH*	AJCC
2868	CS Site-Specific Factor14	RH*	RH	RH	RH*	AJCC
2869	CS Site-Specific Factor15	RH*	RH	RH	RH*	AJCC

2870	CS Site-Specific Factor16	RH*	RH	RH	RH*	AJCC
2871	CS Site-Specific Factor17	RH*	RH	RH	RH*	AJCC
2872	CS Site-Specific Factor18	.	RH	RH	RH*	AJCC
2873	CS Site-Specific Factor19	.	RH	RH	RH*	AJCC
2874	CS Site-Specific Factor20	.	RH	RH	RH*	AJCC
2875	CS Site-Specific Factor21	.	RH	RH	RH*	AJCC
2876	CS Site-Specific Factor22	.	RH	RH	RH*	AJCC
2877	CS Site-Specific Factor23	.	RH	RH	RH*	AJCC
2878	CS Site-Specific Factor24	.	RH	RH	RH*	AJCC
2879	CS Site-Specific Factor25	RH*	RH	RH	RH*	AJCC
2880	CS Site-Specific Factor 1	RH*	RH	RH	RH*	AJCC
2890	CS Site-Specific Factor 2	RH*	RH	RH	RH*	AJCC
2900	CS Site-Specific Factor 3	RH*	RH	RH	RH*	AJCC
2910	CS Site-Specific Factor 4	RH*	RH	RH	RH*	AJCC
2920	CS Site-Specific Factor 5	RH*	RH	RH	RH*	AJCC
2930	CS Site-Specific Factor 6	RH*	RH	RH	RH*	AJCC
2935	CS Version Input Original	R*	RH	RH*	RH*	AJCC
2936	CS Version Derived	RH*	DH	D*	DH	AJCC
2937	CS Version Input Current	R*	RH	RH*	RH*	AJCC
2940	Derived AJCC-6 T	.	DH	DH	DH	AJCC
2950	Derived AJCC-6 T Descript	.	DH	DH	DH	AJCC
2960	Derived AJCC-6 N	.	DH	DH	DH	AJCC
2970	Derived AJCC-6 N Descript	.	DH	DH	DH	AJCC
2980	Derived AJCC-6 M	.	DH	DH	DH	AJCC
2990	Derived AJCC-6 M Descript	.	DH	DH	DH	AJCC
3000	Derived AJCC-6 Stage Grp	.	DH	DH	DH	AJCC
3010	Derived SS1977	.	DH	D*	DH	AJCC
3020	Derived SS2000	RH*	DH	DH	DH	AJCC
3030	Derived AJCC--Flag	.	DH	DH	.	AJCC
3040	Derived SS1977--Flag	.	DH	D*	.	AJCC
3050	Derived SS2000--Flag	RH*	DH	D*	.	AJCC
3100	Archive FIN	.	R	.	.	CoC
3105	NPI--Archive FIN	.	R	.	.	CMS
3110	Comorbid/Complication 1	.	RH	.	.	CoC
3120	Comorbid/Complication 2	.	RH	.	.	CoC
3130	Comorbid/Complication 3	.	RH	.	.	CoC
3140	Comorbid/Complication 4	.	RH	.	.	CoC
3150	Comorbid/Complication 5	.	RH	.	.	CoC

3160	Comorbid/Complication 6	.	RH	.	.	CoC
3161	Comorbid/Complication 7	.	RH	.	.	CoC
3162	Comorbid/Complication 8	.	RH	.	.	CoC
3163	Comorbid/Complication 9	.	RH	.	.	CoC
3164	Comorbid/Complication 10	.	RH	.	.	CoC
3165	ICD Revision Comorbid	.	.	.	.	CoC
3170	RX Date Mst Defn Srg	R*	R	RC	.	CoC
3180	RX Date Surg Disch	.	R	.	.	CoC
3190	Readm Same Hosp 30 Days	.	R	.	.	CoC
3200	Rad--Boost RX Modality	.	.	.	.	CoC
3210	Rad--Boost Dose cGy	.	.	.	.	CoC
3220	RX Date Rad Ended	.	R	.	.	CoC
3230	RX Date Systemic	.	R	RC	.	CoC
3250	RX Summ--TransplInt/Endocr	R	R	R	.	CoC
3270	RX Summ--Palliative Proc	.	R	.	.	CoC
3280	RX Hosp--Palliative Proc	.	R	.	.	CoC
3300	RuralUrban Continuum 1993	D	.	D	.	NAACCR
3310	RuralUrban Continuum 2003	D	.	D	.	NAACCR
3312	RuralUrban Continuum 2013	D	.	D	.	NAACCR
3400	Derived AJCC-7 T	RH*	DH	DH	DH	AJCC
3402	Derived AJCC-7 T Descript	RH*	DH	DH	DH	AJCC
3410	Derived AJCC-7 N	RH*	DH	DH	DH	AJCC
3412	Derived AJCC-7 N Descript	RH*	DH	DH	DH	AJCC
3420	Derived AJCC-7 M	RH*	DH	DH	DH	AJCC
3422	Derived AJCC-7 M Descript	RH*	DH	DH	DH	AJCC
3430	Derived AJCC-7 Stage Grp	RH*	DH	DH	DH	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 Grp	.	.	.	.	AJCC
3600	Derived Neoadjuv Rx Flag	.	.	.	.	AJCC

3605	Derived SEER Path Stg Grp	.	.	DH	.	SEER
3610	Derived SEER Clin Stg Grp	.	.	DH	.	SEER
3614	Derived SEER Cmb Stg Grp	.	.	DH	.	SEER
3616	Derived SEER Combined T	.	.	DH	.	SEER
3618	Derived SEER Combined N	.	.	DH	.	SEER
3620	Derived SEER Combined M	.	.	DH	.	SEER
3622	Derived SEER Cmb T Src	.	.	DH	.	SEER
3624	Derived SEER Cmb N Src	.	.	DH	.	SEER
3626	Derived SEER Cmb M Src	.	.	DH	.	SEER
3645	NPCR Derived AJCC 8 TNM Clin Stg Grp	.	.	.	R*	NPCR
3646	NPCR Derived AJCC 8 TNM Path Stg Grp	.	.	.	R*	NPCR
3647	NPCR Derived AJCC 8 TNM Post Therapy Stg Grp	.	.	.	R*	NPCR
3650	NPCR Derived Clin Stg Grp	.	.	.	.	NPCR
3655	NPCR Derived Path Stg Grp	.	.	.	.	NPCR
3700	SEER Site-Specific Fact 1	.	.	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	.	.	AJCC
3751	Over-ride CS 2	.	RH	.	.	AJCC
3752	Over-ride CS 3	.	RH	.	.	AJCC
3753	Over-ride CS 4	.	RH	.	.	AJCC
3754	Over-ride CS 5	.	RH	.	.	AJCC
3755	Over-ride CS 6	.	RH	.	.	AJCC
3756	Over-ride CS 7	.	RH	.	.	AJCC
3757	Over-ride CS 8	.	RH	.	.	AJCC
3758	Over-ride CS 9	.	RH	.	.	AJCC
3759	Over-ride CS 10	.	RH	.	.	AJCC
3760	Over-ride CS 11	.	RH	.	.	AJCC
3761	Over-ride CS 12	.	RH	.	.	AJCC
3762	Over-ride CS 13	.	RH	.	.	AJCC
3763	Over-ride CS 14	.	RH	.	.	AJCC
3764	Over-ride CS 15	.	RH	.	.	AJCC
3765	Over-ride CS 16	.	RH	.	.	AJCC

3766	Over-ride CS 17	.	RH	.	.	AJCC
3767	Over-ride CS 18	.	RH	.	.	AJCC
3768	Over-ride CS 19	.	RH	.	.	AJCC
3769	Over-ride CS 20	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	NAACCR
3801	Chromosome 1p: Loss of Heterozygosity (LOH)	.	RS	RS	.	NAACCR
3802	Chromosome 19q: Loss of Heterozygosity (LOH)	.	RS	RS	.	NAACCR
3803	Adenoid Cystic Basaloid Pattern	.	RS	RS	.	NAACCR
3804	Adenopathy	.	RS	RS	RS*	NAACCR
3805	AFP Post-Orchiectomy Lab Value	.	RS	RC	.	NAACCR
3806	AFP Post-Orchiectomy Range	.	RS	RS	.	NAACCR
3807	AFP Pre-Orchiectomy Lab Value	.	RS	RC	.	NAACCR
3808	AFP Pre-Orchiectomy Range	.	RS	RS	.	NAACCR
3809	AFP Pretreatment Interpretation	.	RS	RC	RS*	NAACCR
3810	AFP Pretreatment Lab Value	.	RS	RC	.	NAACCR
3811	Anemia	.	RS	RS	RS*	NAACCR
3812	B symptoms	.	RS	RS	RS*	NAACCR
3813	Bilirubin Pretreatment Total Lab Value	.	RS	RC	.	NAACCR
3814	Bilirubin Pretreatment Unit of Measure	.	RS	RC	.	NAACCR
3815	Bone Invasion	.	RS	RS	.	NAACCR
3816	Brain Molecular Markers	RS	.	RS	.	NAACCR
3817	Breslow Tumor Thickness	RS	RS	RS	RS*	NAACCR
3818	CA-125 Pretreatment Interpretation	.	RS	RS	RS*	NAACCR
3819	CEA Pretreatment Interpretation	.	RS	RS	RS*	NAACCR
3820	CEA Pretreatment Lab Value	.	RS	RS	.	NAACCR
3821	Chromosome 3 Status	.	RS	RC	.	NAACCR

3822	Chromosome 8q Status	.	RS	RC	.	NAACCR
3823	Circumferential Resection Margin (CRM)	.	RS	RS	RS*	NAACCR
3824	Creatinine Pretreatment Lab Value	.	RS	RC	.	NAACCR
3825	Creatinine Pretreatment Unit of Measure	.	RS	RC	.	NAACCR
3826	Estrogen Receptor Percent Positive or Range	.	RS	RC	.	NAACCR
3827	Estrogen Receptor Summary	RS	RS	RS	RS*	NAACCR
3828	Estrogen Receptor Total Allred Score	.	RS	.	.	NAACCR
3829	Esophagus and EGJ Tumor Epicenter	RS	RS	RS	RS*	NAACCR
3830	Extranodal Extension Clin (non-Head and Neck)	.	RS	RC	.	NAACCR
3831	Extranodal Extension Head and Neck Clinical	.	RS	RC	.	NAACCR
3832	Extranodal Extension Head and Neck Pathological	.	RS	RS	RS*	NAACCR
3833	Extranodal Extension Path (non-Head and Neck)	.	RS	RC	.	NAACCR
3834	Extravascular Matrix Patterns	.	RS	RC	.	NAACCR
3835	Fibrosis Score	RS	RS	RS	.	NAACCR
3836	FIGO Stage	.	RS	RS	.	NAACCR
3837	Gestational Trophoblastic Prognostic Scoring Index	.	RS	RS	RS*	NAACCR
3838	Gleason Patterns Clinical	RS	RS	RS	RS*	NAACCR
3839	Gleason Patterns Pathological	RS	RS	RS	RS*	NAACCR
3840	Gleason Score Clinical	RS	RS	RS	RS*	NAACCR
3841	Gleason Score Pathological	RS	RS	RS	RS*	NAACCR
3842	Gleason Tertiary Pattern	RS*	RS	RS*	RS*	NAACCR
3843	Grade Clinical	R	R	R	R	NAACCR
3844	Grade Pathological	R	R	R	R	NAACCR
3845	Grade Post Therapy Path (yp)	R*	R	RS	R	NAACCR
3846	hCG Post-Orchiectomy Lab Value	.	RS	RC	.	NAACCR
3847	hCG Post-Orchiectomy Range	.	RS	RS	.	NAACCR
3848	hCG Pre-Orchiectomy Lab Value	.	RS	RC	.	NAACCR
3849	hCG Pre-Orchiectomy Range	.	RS	RS	.	NAACCR
3850	HER2 IHC Summary	.	.	.	RH*	NAACCR
3851	HER2 ISH Dual Probe Copy Number	.	.	.	.	NAACCR
3852	HER2 ISH Dual Probe Ratio	.	.	.	.	NAACCR
3853	HER2 ISH Single Probe Copy	.	.	.	.	NAACCR

	Number					
3854	HER2 ISH Summary	.	.	.	RH*	NAACCR
3855	HER2 Overall Summary	RS	RS	RS	RS*	NAACCR
3856	Heritable Trait	.	RS	RS	RS*	NAACCR
3857	High Risk Cytogenetics	.	RS	RS	RS*	NAACCR
3858	High Risk Histologic Features	.	RS	RS	.	NAACCR
3859	HIV Status	.	.	RS	.	NAACCR
3860	International Normalized Ratio Prothrombin Time	.	RS	RC	.	NAACCR
3861	Ipsilateral Adrenal Gland Involvement	.	RS	RS	.	NAACCR
3862	JAK2	.	RS	RS	.	NAACCR
3863	Ki-67	.	RS	RC	.	NAACCR
3864	Invasion Beyond Capsule	.	RS	RS	.	NAACCR
3865	KIT Gene Immunohistochemistry	.	RS	RC	RS*	NAACCR
3866	KRAS	.	RS	RS	.	NAACCR
3867	LDH Post-Orchiectomy Range	.	RS	RS	.	NAACCR
3868	LDH Pre-Orchiectomy Range	.	RS	RS	.	NAACCR
3869	LDH Level	.	RS	RS	RS*	NAACCR
3870	LDH Upper Limits of Normal	.	RS	RC	.	NAACCR
3871	LN Assessment Method Femoral-Inguinal	.	RS	RC	.	NAACCR
3872	LN Assessment Method Para-Aortic	.	RS	RC	.	NAACCR
3873	LN Assessment Method Pelvic	.	RS	RC	.	NAACCR
3874	LN Distant Assessment Method	.	RS	RC	.	NAACCR
3875	LN Distant: Mediastinal, Scalene	.	RS	RC	.	NAACCR
3876	LN Head and Neck Levels I-III	.	RS	RS	.	NAACCR
3877	LN Head and Neck Levels IV-V	.	RS	RS	.	NAACCR
3878	LN Head and Neck Levels VI-VII	.	RS	RS	.	NAACCR
3879	LN Head and Neck Other	.	RS	RS	.	NAACCR
3880	LN Isolated Tumor Cells (ITC)	.	RS	RS	.	NAACCR
3881	LN Laterality	.	RS	RS	.	NAACCR
3882	LN Positive Axillary Level I-II	.	RS	RS	.	NAACCR
3883	LN Size	.	RS	RS	RS*	NAACCR
3884	LN Status Femoral-Inguinal, Para-Aortic, Pelvic	.	.	.	.	NAACCR
3885	Lymphocytosis	.	RS	RS	RS*	NAACCR
3886	Major Vein Involvement	.	RS	RS	.	NAACCR
3887	Measured Basal Diameter	.	RS	RS	.	NAACCR
3888	Measured Thickness	.	RS	RS	.	NAACCR

3889	Methylation of O6-Methylguanine-Methyltransferase	.	RS	RS	.	NAACCR
3890	Microsatellite Instability (MSI)	RS*	RS	RS	RS*	NAACCR
3891	Microvascular Density	.	RS	RC	.	NAACCR
3892	Mitotic Count Uveal Melanoma	.	RS	RC	.	NAACCR
3893	Mitotic Rate Melanoma	.	RS	RS	RS*	NAACCR
3894	Multigene Signature Method	.	RS	RS	.	NAACCR
3895	Multigene Signature Results	.	RS	RS	.	NAACCR
3896	NCCN International Prognostic Index (IPI)	.	RS	RS	.	NAACCR
3897	Number of Cores Examined	.	RS	RS	RS*	NAACCR
3898	Number of Cores Positive	.	RS	RS	RS*	NAACCR
3899	Number of Examined Para-Aortic Nodes	.	RS	RC	.	NAACCR
3900	Number of Examined Pelvic Nodes	.	RS	RC	.	NAACCR
3901	Number of Positive Para-Aortic Nodes	.	RS	RC	.	NAACCR
3902	Number of Positive Pelvic Nodes	.	RS	RC	.	NAACCR
3903	Oncotype Dx Recurrence Score-DCIS	.	RS	RC	.	NAACCR
3904	Oncotype Dx Recurrence Score-Invasive	.	RS	RS	RS*	NAACCR
3905	Oncotype Dx Risk Level-DCIS	.	RS	RC	.	NAACCR
3906	Oncotype Dx Risk Level-Invasive	.	RS	RC	.	NAACCR
3907	Organomegaly	.	RS	RS	RS*	NAACCR
3908	Percent Necrosis Post Neoadjuvant	.	RS	RC	RS*	NAACCR
3909	Perineural Invasion	.	RS	RS	.	NAACCR
3910	Peripheral Blood Involvement	.	RS	RS	RS*	NAACCR
3911	Peritoneal Cytology	.	RS	RS	.	NAACCR
3913	Pleural Effusion	.	RS	RS	.	NAACCR
3914	Progesterone Receptor Percent Positive or Range	.	RS	RC	.	NAACCR
3915	Progesterone Receptor Summary	RS	RS	RS	RS*	NAACCR
3916	Progesterone Receptor Total Allred Score	.	RS	.	.	NAACCR
3917	Primary Sclerosing Cholangitis	.	RS	.	.	NAACCR
3918	Profound Immune Suppression	.	RS	RS	.	NAACCR
3919	EOD Prostate Pathologic Extension	.	.	RS	.	SEER
3920	PSA (Prostatic Specific Antigen) Lab Value	RS	RS	RS	RS*	NAACCR
3921	Residual Tumor Volume Post Cytoreduction	.	RS	RS	.	NAACCR

3922	Response to Neoadjuvant Therapy	.	RS	RC	.	NAACCR
3923	S Category Clinical	.	RS	RS	RS*	NAACCR
3924	S Category Pathological	.	RS	RS	RS*	NAACCR
3925	Sarcomatoid Features	.	RS	RS	.	NAACCR
3926	Schema Discriminator 1	RS	RS	RS	RS*	NAACCR
3927	Schema Discriminator 2	RS	RS	RS	RS*	NAACCR
3928	Schema Discriminator 3	.	RS	RS	RS*	NAACCR
3929	Separate Tumor Nodules	.	RS	RS	.	NAACCR
3930	Serum Albumin Pretreatment Level	.	RS	RS	RS*	NAACCR
3931	Serum Beta-2 Microglobulin Pretreatment Level	.	RS	RS	RS*	NAACCR
3932	LDH Lab Value	RS	RS	RS	.	NAACCR
3933	Thrombocytopenia	.	RS	RS	RS*	NAACCR
3934	Tumor Deposits	.	RS	RS	.	NAACCR
3935	Tumor Growth Pattern	.	RS	.	.	NAACCR
3936	Ulceration	.	RS	RS	RS*	NAACCR
3937	Visceral and Parietal Pleural Invasion	.	RS	RS	.	NAACCR
3938	ALK Rearrangement	.	RS	R	.	NAACCR
3939	EGFR Mutational Analysis	.	RS	R	.	NAACCR
3940	BRAF Mutational Analysis	.	RS	R	.	NAACCR
3941	NRAS Mutational Analysis	.	RS	R	.	NAACCR
3942	CA 19-9 PreTX Lab Value	.	RS	R	.	NAACCR
3943	NCDB--SARSCoV2--Test	.	RH	RH*	.	CoC
3944	NCDB--SARSCoV2--Pos	.	RH	RH*	.	CoC
3945	NCDB--SARSCoV2--Pos Date	.	RH	RH*	.	CoC
3946	NCDB--COVID19--Tx Impact	.	RH	RH*	.	CoC
3950	Macroscopic Evaluation of Mesorectum	.	R	RC	.	CoC
3955	Derived Rai Stage	.	.	D	.	
3956	p16	RS	RS	RS	RS*	SEER
3957	LN Status Pelvic	.	RS	RC	RS*	SEER
3958	LN Status Para-Aortic	.	RS	RC	RS*	SEER
3959	LN Status Femoral-Inguinal	.	RS	RC	RS*	SEER
3960	Histologic Subtype	RS*	RS	RS	RS*	SEER
3961	Clinical Margin Width	.	RS	RS	.	CoC
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
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

Codes for Recommendations	
.	No recommendation
D	Derived
D*	Derived, 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
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
RS	Required, site specific
RS*	Required, site specific; when available
S	Supplementary/recommended

***Disclaimer**: It is important to note that reportable data items can be and will be changed and/or retired over time, our office will do our best to always keep you updated on those items when they occur, but it is vital that you continue to check with your standard setters. **

ICD-10-CM Casefinding List, 2023

https://seer.cancer.gov/tools/casefinding/icd-10-cm-casefinding-list.20230403.pdf

How to Use Ambiguous Terminology for Case Ascertainment

1. **In situ and Invasive** (Behavior codes /2 and /3)
    a. If any of the reportable ambiguous terms precede a word that is synonymous with an in situ or invasive tumor (e.g., cancer, carcinoma, malignant neoplasm, etc.), accession the case.
        i. ***Example:*** The pathology report says: Prostate biopsy with markedly abnormal cells that are typical of adenocarcinoma. Accession the case.
        ii. ***Negative Example:*** The final diagnosis on the outpatient report reads: Rule out pancreatic cancer. Do not accession the case.
    b. Discrepancies
        i. Accession the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record.
            1. **Do not** accession a case when the original source document used a non-reportable ambiguous term and subsequent documents refer to history of cancer.
                a. ***Example:*** Report from the dermatologist is "possible melanoma." Patient admitted later for unrelated procedure and physician listed history of melanoma. Give priority to the information from the dermatologist and do not report this case. "Possible" is not a reportable ambiguous term. The later information is less reliable in this case.
            2. Accept the reportable term and accession the case when there is a single report in which both reportable and non-reportable terms are used.
                a. ***Example:*** Abdominal CT reveals a 1 cm liver lesion. "The lesion is consistent with hepatocellular carcinoma" appears in the discussion section of the report. The final diagnosis is "1 cm liver lesion, possibly hepatocellular carcinoma." Accession the case. "Consistent with" is a reportable ambiguous term. Accept "consistent with" over the non-reportable term "possibly."
    c. **Do not** accession a case based ONLY on **suspicious** cytology.
        i. ***Note:*** "Suspicious cytology" means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable.

ii. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended.

iii. Cytology refers to the microscopic examination of cells in body fluids obtained from aspirations, washings, scrapings, and smears, usually a function of the pathology department.

iv. **Important:** Accession cases with cytology diagnoses that are positive for malignant cells.

d. Use the reportable ambiguous terms when **screening** diagnoses on pathology reports, operative reports, scans, mammograms, and other diagnostic testing with the exception of tumor markers.

i. Do not accession a case when resection, excision, biopsy, cytology, or physician's statement proves the ambiguous diagnosis is not reportable.

1. ***Example 1:*** Mammogram shows calcifications suspicious for intraductal carcinoma. The biopsy of the area surrounding the calcifications is negative for malignancy. Do not accession the case.

2. ***Example 2:*** Stereotactic biopsy of the left breast is "focally suspicious for DCIS" and is followed by a negative needle localization excisional biopsy. Do not accession the case. The needle localization excisional biopsy was performed to further evaluate the suspicious stereotactic biopsy finding. The suspicious diagnosis was proven to be false.

3. ***Example 3:*** Esophageal biopsy with diagnosis of "focal areas suspicious for adenocarcinoma in situ." Diagnosis on partial esophagectomy specimen "with foci of high-grade dysplasia; no invasive carcinoma identified." Do not accession the case. The esophagectomy proved that the suspicious biopsy result was false.

2. **Benign** and **borderline** primary **intracranial** and **CNS** tumors

a. Use the "Ambiguous terms that are reportable" list to identify benign and borderline primary intracranial and CNS tumors that are reportable.

b. **Neoplasm and tumor are reportable** terms for brain and CNS because they are listed in ICD-O-3 with behavior codes of /0 and /1.

c. Accession the case when any of the reportable **ambiguous terms precede** either the word **"tumor"** or the word **"neoplasm."**

i. ***Example:*** The mass on the CT scan is consistent with pituitary tumor. Accession the case.

d. **Mass and lesion are not reportable terms for brain and CNS because they are not listed in ICD-O-3 with behavior codes of /0 or /1.**

e. **Discrepancies**

i. Accession the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record.

1. Do not accession a case when subsequent documents refer to history of tumor and the original source document used a **non-reportable** ambiguous term.

ii. Accept the reportable term and accession the case when there is a single report, and one section of a report used a reportable term such as "apparently" and another section of the same report uses a term that is not on the reportable list.

1. ***Exception:*** Do not accession a case based ONLY on ambiguous **cytology** (the reportable term is preceded by an ambiguous term such as apparently, appears, compatible with, etc.).

f. Use these terms when **screening** diagnoses on pathology reports, scans, ultrasounds, and other diagnostic testing other than tumor markers.

i. Do not accession the case when resection, excision, biopsy, cytology, or physician's statement proves the ambiguous diagnosis is not reportable.

Ambiguous Terms at Diagnosis

As part of the registry casefinding activities, all diagnostic reports should be reviewed to confirm whether a case is required. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included. Words or phrases that appear to be synonyms of these terms do not constitute a diagnosis. For example, "likely" alone does not constitute a diagnosis. Words in parenthesis are optional.

Ambiguous Terms that Constitute a Diagnosis	
Apparent(ly)	Presumed
Appears	Probable
Comparable with	Suspect(ed)
Compatible with	Suspicious (for)
Consistent with	Tumor* (beginning with 2004 diagnoses and only for C70.0 – C72.9, C75.1 – C75.3)
Favors	Typical of
Malignant appearing	
Most likely	
Neoplasm* (beginning with 2004 diagnoses and only for C70.0 – C72.9, C75.1 – C75.3_	

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

Exception: If cytology is identified with an ambiguous term, do not interpret it as a diagnosis of cancer.

- Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Examples of Diagnostic Terms:

- The inpatient discharge summary documents a chest x-ray *consistent with carcinoma* of the right upper lobe. The patient refused further work-up or treatment. *Consistent with carcinoma* is indicative of cancer.
- The pathology report states *suspicious for malignancy*. *Suspicious for malignancy* is indicative of cancer.

Ambiguous Terms That Do Not Constitute a Diagnosis Without Additional Information	
Cannot be ruled out	Questionable
Equivocal	Rule out
Possible	Suggests
Potentially malignant	Worrisome

Examples of Nondiagnostic Terms:

- The inpatient discharge summary documents a chest x-ray consistent with neoplasm of the right upper lobe. The patient refused further work-up or treatment. Consistent with neoplasm is not indicative of cancer. While "consistent with" can indicate involvement, "neoplasm" without specification of malignancy is not diagnostic except for non-malignant primary intracranial and central nervous system tumors.
- Final diagnosis is reported as possible carcinoma of the breast. Possible is not a diagnostic term for cancer.

Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only and do not constitute a diagnosis.

Class of Case

All accessioned cases are assigned a Class of Case [610] based on the nature of involvement of the facility in the care of the patient.

Analytic Cases

Cases diagnosed and/or administered any of the first course of treatment at the accessioning facility are analytic (Class of Case 00-22). A network clinic or outpatient center belonging to the facility is part of the facility. The CoC is aligned with the Joint Commission accreditation status for your hospital/facility. Any services or facility covered under your Join Commission accreditation would then be covered under your CoC accreditation and you would be responsible for reporting the associated data that is reportable as defined in the STORE.

Analytic cases Class of Case 10-22 are included in treatment and survival analysis.

Analytic cases Class of Case 00 are not required to be staged or followed, regardless of the year of diagnosis. Class of Case 00 is reserved for patients who are originally diagnosed by the reporting facility and receive all of their treatment elsewhere or a decision not to treat is made elsewhere. If the patient receives no treatment, either because the patient refuses recommended treatment or a decision is made not to treat, the Class of Case is 14. If there is no information about whether or where the patient was treated, the Class of Case is 10.

Nonanalytic Cases

Nonanalytic cases {Class of Case 30-99) are not usually included in routine treatment or survival statistics. The CoC does not require registries in accredited programs to accession, abstract, or follow these cases, but the program or central registry may require them.

Class of Case
(NAACCR Item #610)

Description

Class of Case divides cases into two groups. Analytic cases (codes 00-22) are those that are required by CoC to be abstracted because of the program's primary responsibility in managing the cancer. Analytic cases are grouped according to the location of diagnosis and first course treatment. Nonanalytic cases (codes 30-49 and 99) may be abstracted by the facility to meet central registry requirements or in response to a request by the facility's cancer program. Nonanalytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.

Explanation

Class of Case reflects the facility's role in managing the cancer and whether the cancer is required to be reported by CoC.

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 it is not known that the patient actually went somewhere else, 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. Document NPI-Institution Referred To [2425] or the applicable physician NPI (NAACCR #s 2585, 2495, 2505) for patients coded 00 to establish that the patient went elsewhere for treatment.
5. Code 34 or 36 if the diagnosis benign or borderline (Behavior 0 or 1) for any site is diagnosed before 2004 or for any site other than meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of central nervous system (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3) that was diagnosed in 2004 or later.
6. Code 34 or 36 for carcinoma in situ of the cervix (CIS) and intraepithelial neoplasia grade III (8077/2 or 8148/2) or the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III).
7. Physicians who are not employed by the hospital but are under contract with it or have routine admitting privileges there are described in coded 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.

8. 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.

9. "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).

10. 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 or 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.

Code	Label
Analytic Classes of Case (Required by CoC to be abstracted by accredited programs)	
Initial diagnosis at reporting facility or in a staff physician's office	
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
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 at the reporting facility, NOS
11	Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility
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
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
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	
20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility

Classes of Case not required by CoC to be abstracted (May be required by Cancer Committee, state or regional registry, or other entity)	
Patient appears in person at reporting facility	
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)
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 placement)
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease)
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active)
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 by reporting facility
35	Case diagnosed before the program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility
36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37	Case diagnosed before the program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
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	
40	Diagnosis AND all first course treatment given at the same staff physician's office
41	Diagnosis and all first course treatment given in two or more difference offices of physicians with admitting privileges
42	Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility or diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43	Pathology or other lab specimens only
49	Death certificate only
99	Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).

Examples

Code	Reason
00	Leukemia was diagnosed at the facility, and all care was given in an office of a physician with practice privileges. The treatment may be abstracted if the cancer committee desires, but the case if Class of Case 00.
13	Breast cancer was diagnosed at the reporting hospital and surgery performed there. Radiation was given at the hospital across the street with which the reporting hospital has an agreement.
10	Reporting hospital found cancer in a biopsy but was unable to discover whether the homeless patient actually received any treatment elsewhere.
32	After treatment failure, the patient was admitted to the facility for supportive care.
11	Patient was diagnosed by a physician with practice privileges, received neoadjuvant radiation at another facility, then underwent surgical resection at the reporting facility.
42	Patients from an unaffiliated, free-standing clinic across the street that hospital voluntarily abstracts with its cases because many physicians work both at the clinic and the hospital.
31	Patient received chemotherapy while attending daughter's wedding in the reporting hospital's city, then returned to the originating hospital for subsequent treatments.

Laterality

Laterality [410] must be recorded for the following paired organs as 1-5 or 9. Organs that are not paired, unless they are recorded "right" or "left" laterality, are coded 0. When the primary site is unknown (C80.9), code 0. Midline origins are coded 5. "Midline" in this context refers to the point where the "right" and "left" sides of paired organs come into direct contact and a tumor form at that point. Most paired sites cannot develop midline tumors. For example, skin of the trunk can have a midline tumor, but the breasts cannot.

Paired Organ Sites	
ICD-O-3	Site
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1-C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bones of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum)
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face

C44.4	Skin of Scalp and Neck
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C50.0-C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0-C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges, NOS (excluding diagnoses prior to 2004)
C71.0	Cerebrum (excluding diagnoses prior to 2004)
C71.1	Frontal lobe (excluding diagnoses prior to 2004)
C71.2	Temporal lobe (excluding diagnoses prior to 2004)
C71.3	Parietal lobe (excluding diagnoses prior to 2004)
C71.4	Occipital lobe (excluding diagnoses prior to 2004)
C72.2	Olfactory nerve (excluding diagnoses prior to 2004)
C72.3	Optic nerve (excluding diagnoses prior to 2004)
C72.4	Acoustic nerve (excluding diagnoses prior to 2004)
C72.5	Cranial nerve, NOS (excluding diagnoses prior to 2004)
C74.0-C74.9	Adrenal gland
C75.4	Carotid body

Laterality
(NAACCR Item #410)

Description

Identifies the side of a paired organ or the side of the body on which the reportable tumor originated. This applies to the primary site only.

Explanation

Laterality supplements stating and extent of disease information and defines the number of primaries involved.

Coding Instructions

1. Code laterality for all paired sites.
2. Do not code metastatic sites as bilateral involvement.
3. If both lungs have nodules or tumors and the lung of origin is not known, assign code 4.
4. Where the right and left sides of paired sites are contiguous (come into contact) and the lesion is at the point of contact of the right and left sides, use code 5, midline. Note that "midline of the right breast" is coded 1, right; midline in this usage indicates the primary site is C50.8 (overlapping sites).
5. Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites 0.

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

First Course of Therapy

This section applies to all neoplasms (including benign and borderline intracranial and CNS tumors) except hematopoietic and lymphoid neoplasms. For information regarding first course of therapy for hematopoietic and lymphoid neoplasms, refer to the NCI SEER Hematopoietic and Lymphoid Neoplasm Coding Manual.

http://www.cancer.gov/dictionary?CdrID=616060

http://seer.cancer.gov/tools/heme/index.html

Definitions

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.

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.

> ***Example:*** Chemotherapy and radiation therapy

Deferred therapy: Closely watching a patient's condition but not giving treatment unless symptoms appear or change, or there are changes in test results. Deferred therapy avoids problems that may be caused by treatments such as radiation or surgery. It is used to find early signs that the condition is getting worse. During deferred therapy, patients may be given certain exams and tests. It is sometimes used in prostate cancer. Also called expectant management.

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 Database to determine disease recurrence.

Expectant management: Closely watching a patient's condition but not giving treatment unless symptoms appear or change, or there are changes in test results. Expectant management avoids problems that may be caused by treatments such as radiation or surgery. It is used to find early signs that the condition is getting worse. During expectant management, patients may be given certain exams and tests. It is sometimes used in prostate cancer. Also called deferred therapy.

First course of therapy: All treatments administered to the patient after the original diagnosis of cancer 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 treatment (chemotherapy, endocrine/hormone therapy, targeted therapy, immune therapy, or biological therapy) and/or radiation therapy before intended or performed surgical resection to improve local therapy and long-term outcomes. Neoadjuvant therapy is administered to reduce disease burden, eradicate, or control undiscovered metastases, and improve outcomes of overall survival and disease-free survival.

> ***Example:*** Pt diagnosed with 3cm Lt. breast nodule and core bx c/w High Grade DCIS w/apocrine features and Lt. axillary LN core bx c/w mets invasive ductal ca. Pt. had neoadjuvant treatment f/w w/Lt. skin sparing mastectomy w/SLN bx with no residual ds on pathology report.

Bridge Therapy: Limited systemic exposure when the intent was not neoadjuvant; treatment did not meet the definition of neoadjuvant therapy.

> ***Example:*** Patients receive some type of therapy prior to surgical resection, but not enough to qualify for a full course of neoadjuvant therapy.

Palliative treatment: The World Health Organization describes palliative care as treatment that improves the quality of life by preventing or relieving suffering.

> ***Note:*** Palliative therapy is part of the first course of therapy only when it destroys or modifies cancer tissue.
>
> > ***Example:*** The patient was diagnosed with stage IV cancer of the prostate with painful bone 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.

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.

Maintenance Therapy: Treatment that is given to help keep cancer from coming back after it has disappeared following the initial therapy. It may include treatment with drugs, vaccines, or antibodies that kill cancer cells, and it may be given for a long time.

Death Certificate Clearance Overview

The Washington State Cancer Registry conducts Death Clearance on an annual basis. We follow the North American Association of Central Cancer Registries guidelines for conducting death clearance. You can find a complete overview, explanation, and minimum guidelines for conducting death clearance in the Death Clearance Manual on the NAACCR website: https://www.naaccr.org/wp-content/uploads/2023/05/NAACCR_Death-Clearance_Manual-4-23-FINAL.pdf.

Explained in this section are specific practices and procedures that may be unique to our registry.

We perform a manual review of all vital statistics records and use the information to update matching cases in our database. To ensure accurate incidence reporting, we perform follow back on death file records that indicate cancer as a cause of death for the individuals listed in the master death file who are not in our database. We also perform follow-back on record matches that list a type of cancer not previously captured in our database to ensure the individual did not develop additional reportable cancers. Our registry only performs follow-back on cases that are not part of the 13-county western Washington SEER region.

Follow-Back Procedures

The registry will send a letter to the certifying MD indicated in the death file requesting information on patients that died of cancer but were not captured in our database.

We use the information received from the certifying MD to determine whether the case is reportable and requires additional follow-up with other physicians and treatment centers. Based on the information received from the facilities, cases are either abstracted as DCO cases, (if no further information can be provided) MD cases, or full incidence cases. If we do not receive follow-back information before the completion of death clearance, we update and enter the case information into our database as soon as the data becomes available.

Patient Address and Residency Rules

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

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

Normally a residence is the home named by the patient. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with the rules of the Census Bureau's definition, "the place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home." State Vital Statistics rules may differ from Census rules. Do not record residence from the death certificate. Review each case carefully.

Rules for Persons with Ambiguous Residences

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

Persons with No Usual Residence **(transients, homeless):** Use the address of the place the patient was staying when the cancer was diagnosed. This location may be a shelter or the diagnosing facility.

Persons Away at School: College students are residents of the school area. Boarding school students below the college level are residents of their parents' homes.

Persons in Institutions: The Census Bureau states, "Persons under formally authorized, supervised care or custody" are residents of the institution. This classification includes the following:

- Incarcerated persons
- Persons in nursing, convalescent, and rest homes
- Persons in home, schools, hospitals, or wards for the physically disabled, mentally retarded, or mentally ill.
- Long-term residents of other hospitals, such as Veterans Affairs (VA) hospitals.

Person in the Armed Forces and on Maritime Ships: Members of the armed forces are residents of the installation area. Use the stated address for military personnel and their families. Military personnel may use installation address or the surrounding community's address. The Census Bureau has detailed residency rules for Navy personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for the detailed rules.

Address at Diagnosis—Number and Street
(NAACCR Item #2330)

Description

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

Explanation

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

1. Record the number and street address or the rural mailing address of the patient's usual residence when the tumor was diagnosed.
2. Record the physical number and street address of the patient at diagnosis. If the patient also has a Post Office (PO) Box address, record the PO Box address in *Address at Diagnosis—Supplemental*.
3. Spell out the address fully with standardized use of abbreviations and punctuation per U.S. Postal Service (USPS) postal addressing standards. The USPS Postal Addressing Standards, Publication 28, May 2015, can be found on the Internet at http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf.
4. The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations. Do not use punctuation unless absolutely necessary to clarify an address; leave space between numbers and words.

   Example: 103 FIRST AVE SW APT 102

5. Limit abbreviations to those recognized by the Postal Service standard abbreviations. A complete list of recognized street abbreviations is provided in Appendix C of USPS Publication 28.

Street Address Abbreviations

ABBREV.	DESCRIPTION	ABBREV.	DESCRIPTION	ABBREV.	DESCRIPTION
APT	Apartment	FL	Floor	S	South
AVE	Avenue	N	North	SE	Southeast
BLDG	Building	NE	Northeast	SQ	Square
BLVD	Boulevard	NW	Northwest	ST	Street

CIR	Circle	PLZ	Plaza	STE	Suite
CT	Court	PK	Park	SW	Southwest
DEPT	Department	PKWY	Parkway	UNIT	Unit
DR	Drive	RD	Road	W	West
E	East	RM	Room		

6. Punctuation is normally limited to periods (for example, 39.2 RD), slashes for fractional addresses (101 ½ MAIN ST), and hyphens when a hyphen carries meaning (289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (425 FLOWER BLVD # 72).
7. If the patient has multiple tumors, the address may be different for different primaries.
8. Do not update this data item if the patient's address changes.
9. Enter UNKNOWN when the patient's street address is unknown.

Patients with an Unknown Address:

If the patient's address is not available in the medical record, record **UNKNOWN. Do not** leave blank. These cases should be rare, and every effort should be made to obtain a valid address. The address data fields for these cases should be recorded as the city **Unknown**, the state as **ZZ,** the zip code should be **99999** and the FIPS as **999**. **Do not record the reporting facility's city, state, zip and FIPS.**

Note: Document in Text Remarks/Other Pertinent Information: Patient address is unknown. An excessive number of unknown addresses will result in additional efforts by WSCR staff to obtain a valid address which may include contacting the reporting facility or managing/following physician.

Use the USPS Zip Code Look Up tool for help in completing address information at https://www.usps.com/.

Persons with More than One Residence:

These include snowbirds who live in the south for the winter months, sunbirds who live in the north during the summer months. This also includes persons with vacation residences which they occupy for a portion of the year.

Code the residence where the patient spends the majority of time (usual residence).

If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.

Persons with No Usual Residence:

Homeless people and transients are examples of persons with no usual residence.

Code the patient's residence at the time of diagnosis as unknown.

Note: Under pertinent information document that patient is homeless. An unknown address is not the same as homeless.

Temporary Residents:

Code the place of usual residence rather than the temporary address for:

a. Migrant workers
b. Persons temporarily residing with family during cancer treatment.
c. Military personnel on temporary duty assignment
d. Boarding school students below the college level (code the parent's residence)

Code the residence where the student is living while attending **college.**

Code the address of the institution for **Persons in Institutions**.

e. Persons who are incarcerated
f. Persons who are physically or mentally handicapped or mentally ill who are residents of homes, schools, hospitals, or wards.
g. Residents of nursing and rest homes
h. Long-term residents of other hospitals such as Veteran's Administration (VA) hospitals

Persons in the Armed Forces and on Maritime Ships (Merchant Marine):

Armed Forces-For military personnel and their family members, code the address of the military installation or surrounding community as stated by the patient.

Personnel Assigned to Navy, Coast Guard, and Maritime Ships-The US Census Bureau has detailed rules for determining residency for personnel assigned to these ships. The rules refer to the ship's deployment, port of departure, destination, and its homeport. Refer to US Census Bureau Publications for detailed rules www.census.gov.

Use residency information from a **death certificate** only when the residency from other sources is coded as unknown. Review each case carefully and apply the U.S. Census Bureau Publications for determining residence. For example, the death certificate may give the person's previous home address rather than the nursing home address as the place of residence. If the person was a resident of a nursing home at diagnosis, use the nursing home address as the place of residence.

Address at Dx - Supplemental
(NAACCR Item #2335)

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).

Explanation

Address at Diagnosis—Supplemental allows for additional address information such as the name of a place or facility (for example, a nursing home, apartment complex, or other mailing address) at the time of diagnosis. The data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

Record the name of the place or facility where the patient resided when the tumor was diagnosed.

For example, the name of an apartment complex or a nursing home.

If the patient has multiple tumors, the address may be different for different primaries.

1. Do **not** use this data item to record the number and street address of the patient. Record number and street in *Address at Diagnosis—Number and Street*.
2. Do **not** update this data item if the patient's address changes.
3. Leave blank if this data item is not needed.

Address at Diagnosis--City
(NAACCR Item #70)

Description

Identifies the name of the city or town in which the patient resides at the time the tumor is diagnosed and treated.

Explanation

Address at Diagnosis—City captures the name of the city or town of the patient's residence at the time of diagnosis. This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

1. Record the city of the physical number and street address of the patient at diagnosis. If the patient also has a Post Office (PO) Box address, record the PO Box address in *Address at Diagnosis-Supplemental*.
2. Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the United States Postal Service (USPS), use abbreviations when necessary.
3. If the patient has multiple malignancies/tumors, the city or town of residence at diagnosis may be different for different primaries.
4. Do not update city/town if the patient's city/town of residence changes.
5. Enter UNKNOWN if the patient's city or town is unknown.
6. See Residency Rules for further instructions.

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.

Code	Reason
CITY NAME	Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting. Abbreviate where necessary.
UNKNOWN	If the patient's city or town is unknown.

Address at Diagnosis-- (State)

(NAACCR Item #80)

Description

Identifies the patient's state of residence at the time of diagnosis.

Explanation

The state of residence is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Coding Instructions

1. Use U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province or territory in which the patient resides at the time the tumor is diagnosed and treated.
2. If the patient has multiple tumors, the state of residence may be different for subsequent primaries.
3. If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
4. Do not update this data item if the patient's state of residence changes.
5. Assign the most specific code possible from Appendix B.

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.

State Codes

CODE	DESCRIPTION
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
CD	Resident of Canada, NOS; Use the specific abbreviation of Canadian Provinces/Territories if this information is provided.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is known.
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is unknown.
ZZ	Residence unknown.

Examples:

- A patient's country of residence is documented as France; record XX in the state field.
- 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.
- The patient's medical record states the patient lives 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.

Canadian Provinces/Territories

PROVINCE/TERRITORY	ABBREVIATION	PROVINCE/TERRITORY	ABBREVIATION
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NF	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NA		

State and Territory Abbreviations (Refer to the ZIP Code directory for further listings).

STATE		STATE		STATE	
Alabama	AL	Kentucky	KY	North Dakota	ND
Alaska	AK	Louisiana	LA	Ohio	OH
Arizona	AZ	Maine	ME	Oklahoma	OK
Arkansas	AR	Maryland	MD	Oregon	OR
California	CA	Massachusetts	MA	Pennsylvania	PA
Colorado	CO	Michigan	MI	Rhode Island	RI
Connecticut	CT	Minnesota	MN	South Carolina	SC
Delaware	DE	Mississippi	MS	South Dakota	SD
District of Columbia	DC	Missouri	MO	Tennessee	TN
Florida	FL	Montana	MT	Texas	TX
Georgia	GA	Nebraska	NE	Utah	UT
Hawaii	HI	Nevada	NV	Vermont	VT
Idaho	ID	New Hampshire	NH	Virginia	VA
Illinois	IL	New Jersey	NJ	Washington	WA
Indiana	IN	New Mexico	NM	West Virginia	WV
Iowa	IA	New York	NY	Wisconsin	WI
Kansas	KS	North Carolina	NC	Wyoming	WY

Other U.S. Territories

OTHER U.S. TERRITORIES	
American Samoa	AS
Guam	GU
Puerto Rico	PR
Virgin Islands	VI
Outlying Islands	UM

Address at Diagnosis—Postal Code (ZIP Code) *(NAACCR Item #100)*

Description

Identifies the postal code of the patient's address at the time of diagnosis.

Explanation

Address at Diagnosis—Postal Code (ZIP Code) captures the postal code (ZIP Code) of the patient's residence at diagnosis. This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

1. For U.S. residents, record the patient's nine-digit extended postal code of the patient's residence at the time of diagnosis.
2. For Canadian residents, record the six-character postal code.
3. When available, record the postal code for other countries.
4. If the patient has multiple malignancies/tumors, the postal code may be different for all primaries.
5. Do not update this data item if the patient's postal code changes.

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.

Zip Code

CODE	DESCRIPTION
(actual ZIP Code)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
60611_ _ _ _	When the nine-digit extended US Zip Code is not available, record the five-digit zip code followed by four blanks
M6G2S8 _ _ _	The patient's six-character Canadian postal code left justified, followed by three blanks.
88888 _ _ _ _ or 888888888	Permanent address in a country other than Canada, United States, or U.S. possessions and zip code is unknown.
99999 _ _ _ _ or 999999999	Resident of the United States (including its possessions, etc.) or Canada and the zip code is unknown.

Examples:

a. A patient's country of residence is documented as France; record 88888 in the zip code field.

b. A patient's address is in Canada and the zip code cannot be verified; record 99999 in the zip code field.

c. 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.

County
(NAACCR Item #90)

Description

Identifies the county of the patient's residence at the time the reportable tumor is diagnosed.

Explanation

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

Coding Instructions

1. For U.S. residents, use codes issued by the Federal Information Processing Standards (FIPS) publication Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas. This publication is available in a reference library or can be accessed on the internet through the U.S. EPA's Envirofacts Data Warehouse and Applications Web site at https://www.epa.gov/.
2. If the patient has multiple tumors, the county codes may be different for each tumor.
3. If the patient is a non-US resident, use code 999.
4. Do not update this data item if the patient's county of residence changes.
5. See Appendix A

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.

CODE	DESCRIPTION	DEFINITION
001–997	County at diagnosis	Valid 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 the reporting institution (must meet all criteria).
999	County unknown	The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.

Address at Dx - Country
(NAACCR Item #102)

Description

Identifies the country of the patient's residence at the time of diagnosis. The codes are based on International Organization for Standardization (ISO) 3166-1 alpha-3 country codes, with some custom codes.

Explanation

The country code is part of the patient's demographic data and has multiple uses. If may be useful for understanding risk factors, assessment of patient prognosis, and chances for survival.

Coding Instructions

1. This item corresponds to the other Addr at DX items (state, postal code).
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. See Appendix A for a list of country codes and their respective state codes.
4. This item was first defined for use in 2013; cases diagnosed before that date should be converted automatically by the registry's software.

Country Code Examples

CODE	COUNTRY
USA	United States
CAN	Canada
MEX	Mexico
SLV	El Salvador
VNM	Viet Nam

Industry and Occupation

Industry: Business activity of a person's employer. This should be 1-3 words and abbreviations should be avoided.

Occupation: What a person does for work or their job. This should be 1-3 words and may be a person's job title.

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.

Explanation

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. Document the patient's usual (longest held) industry to the extent that the information is available in the medical record.
2. Be descriptive and specific.

   Examples:

   Inadequate: "Automobile industry"

   Adequate: "Automobile manufacturing"

   Inadequate: "Mine"

   Adequate: "Copper mine"

   Inadequate: "Retail"

   Adequate: "Retail bookstore"

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

   Example:

   Inadequate: "Census"

   Adequate: "U.S. Census Bureau"

4. Be complete. If the primary activity of the industry is unknown, record the name of the company (with city or town) in which the patient worked the greatest number of years before diagnosis.

   Example:

   Inadequate: "ABC, Inc."

   Adequate: "ABC, Inc., Tumwater, WA"

5. If the patient's usual industry is not available or is unknown, but the patient's current or most recent occupation is recorded, the information for industry should be based upon the information in occupation. Therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient's current or most recent business/industry. If 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.

Explanation

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

Definition

The 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.

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. 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.

Lymph Node/Lymph Node Chain Reference Table

Use this table with the Primary Site and Histology Rules to determine whether involved lymph nodes are in a single ICD-O-3 lymph node region or in multiple ICD-O-3 lymph node regions.

This table contains the names of lymph nodes that have the capsule and sinus structure of true lymph nodes. Lymphoid tissue such as that in the GI tract, tonsils, etc., is not represented in this table.

Note: Pathology reports may identify lymph nodes within most organs, the most common being breast, parotid gland, lung, and pancreas. The lymph nodes in these organs are call intra- (organ name) lymph nodes such as intramammary lymph nodes. We have included the most common intra-organ lymph nodes on this table. For an intra-organ lymph node not listed on the table, code to the ICD-O-3 topography code for that organ's regional lymph node chain(s).

Lymph Node/Lymph Node Chain	ICD-O-3 Code	ICD-O-3 Lymph Node Region(S)	TNM Staging
Abdominal	C772	Intra-abdominal	Mesenteric
Anorectal (pararectal)	C775	Pelvic	Pelvic, right and left*
Anterior axillary (pectoral)	C773	Axilla or arm	Axillary, right and left*
Anterior cecal (prececal)	C772	Intra-abdominal	Mesenteric
Anterior deep cervical (laterotracheal, recurrent laryngeal, recurrent pharyngeal)	C770	Head, face, and neck	Cervical, right and left*
Anterior jugular	C770	Head, face, and neck	Cervical, right and left*
Anterior mediastinal	C771	Intrathoracic	Mediastinal
Aortic (ascending, lateral, lumbar, subaortic, NOS)	C772	Intra-abdominal	Para-aortic
Aortico-pulmonary window (subaortic)	C772	Intra-abdominal	Para-aortic
Apical (subclavian)	C770	Head, face, and neck	Cervical, right and left*
Appendiceal	C772	Intra-abdominal	Mesenteric
Apical axillary (deep axillary, Level III axillary)	C773	Axilla or arm	Axillary, right and left*
Aselli's glands (nodes near pancreas)	C772	Intra-abdominal	Para-aortic
Auricular (infraauricular, postauricular, preauricular, retroauricular, NOS)	C770	Head, face, and neck	Cervical, right and left*
Axillary (anterior, brachial, deep, lateral, superficial, NOS)	C773	Axilla or arm	Axillary, right and left*
Axillary (Level 1 [low axillary, superficial axillary], Level II, Level III [apical, deep])	C773	Axillar or arm	Infraclavicular, right and left*
Azygos (lower paratracheal)	C771	Intrathoracic	Mediastinal

Lymph Node/Lymph Node Chain	ICD-O-3 Code	ICD-O-3 Lymph Node Region(S)	TNM Staging
Brachial (lateral axillary)	C773	Axilla or arm	Axillary, right and left*
Brachiocephalic	C773	Axilla or arm	Axillary, right and left*
Bronchial	C771	Intrathoracic	Hilar
Bronchopulmonary (hilar) (proximal lobar) (pulmonary root)	C771	Intrathoracic	Hilar
Buccal (buccinator)	C770	Head, face, and neck	Cervical, right and left*
Calot's node (cystic, cysto-hepatic triangle or hepato-biliary triangle)	C772	Intra-abdominal	Para-aortic
Cardiac (cardial)	C771	Intrathoracic	Mediastinal
Cardioesophageal (tracheobronchial, tracheal bifurcation)	C771	Intrathoracic	Mediastinal
Carinal (tracheal bifurcation, tracheobronchial)	C771	Intrathoracic	Mediastinal
Caval (para-)	C772	Intra-abdominal	Para-aortic
Cecal (anterior, posterior, prececal, retrocecal, NOS)	C772	Intra-abdominal	Mesenteric
Celiac	C772	Intra-abdominal	Para-aortic
Central compartment (paralaryngeal, prelaryngeal, [Delphian]) adjacent to thyroid gland	C770	Head, face, and neck	Cervical, right and left*
Cervical, NOS	C770	Head, face, and neck	Cervical, right and left*
Cervical paratracheal	C770	Head, face, and neck	Cervical, right and left*
Cervical periesophageal	C770	Head, face, and neck	Cervical, right and left*
Cloquet's node (inguinal)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Colic (ileocolic, left, mesocolic, middle, right, NOS)	C772	Intra-abdominal	Mesenteric
Common bile duct (pericholedochal)	C772	Intra-abdominal	Para-aortic
Common hepatic	C771	Intrathoracic	Mediastinal
Common iliac	C775	Pelvic	Pelvic, right and left*
Cubital	C773	Axilla or arm	Axillary, right and left*
Cystic (Calot's node, cysto-hepatic triangle, or hepato-biliary triangle)	C772	Intra-abdominal	Para-aortic
Cystic duct	C772	Intra-abdominal	Para-aortic
Deep axillary	C773	Axilla or arm	Axillary, right and left*

Lymph Node/Lymph Node Chain	ICD-O-3 Code	ICD-O-3 Lymph Node Region(S)	TNM Staging
Deep cervical (lower, middle, upper, NOS)	C771	Intrathoracic	Cervical, right and left*
Delphian node (precricoid)	C770	Head, face, and neck	Cervical, right and left*
Deltopectoral	C773	Axilla or arm	Axillary, right and left*
Diaphragmatic, sub	C771	Intrathoracic	Mediastinal
Duodenal	C772	Intra-abdominal	Para-aortic
Epicolic (Foramen or Winslow, omental)	C772	Intra-abdominal	Mesenteric
Epitrochlear	C773	Axilla or arm	Axillary, right and left*
Esophageal (para-, peri-)	C771	Intrathoracic	Mediastinal
Esophageal groove	C770	Head, face, and neck	Cervical, right and left*
External iliac	C775	Pelvic	Pelvic, right and left*
Facial (buccal, buccinator, nasolabial)	C770	Head, face, and neck	Cervical, right and left*
Femoral (superficial inguinal)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Foramen of Winslow (epicolic, omental)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Gastric (inferior, left, right, superior, NOS)	C772	Intra-abdominal	Mesenteric
Gastrocolic	C772	Intra-abdominal	Mesenteric
Gastroduodenal	C772	Intra-abdominal	Mesenteric
Gastroepiploic (gastro-omental)	C772	Intra-abdominal	Mesenteric
Gastrohepatic	C772	Intra-abdominal	Mesenteric
Gastropancreatic	C772	Intra-abdominal	Mesenteric
Gerota'a node (promontorial, middle sacral)	C775	Pelvic	Para-aortic
Greater curvature	C772	Intra-abdominal	Mesenteric
Greater omentum (greater omental)	C772	Intra-abdominal	Mesenteric
Hemorrhoidal (inferior, middle, superior, NOS)	C775	Pelvic	Pelvic, right and left*
Hepatic artery	C772	Intra-abdominal	Para-aortic
Hepatic pedicle	C772	Intra-abdominal	Para-aortic
Hepatoduodenal ligament (hilar)	C772	Intra-abdominal	Para-aortic
Highest deep inguinal (Rosenmuller or Node of Cloquet)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Hilar ([in hilus of liver], hepatoduodenal ligament, porta hepatis, portal, splenic, NOS)	C772	Intra-abdominal	Mesenteric

Lymph Node/Lymph Node Chain	ICD-O-3 Code	ICD-O-3 Lymph Node Region(S)	TNM Staging
Hilar (bronchial, bronchopulmonary, proximal lobar, pulmonary root)	C771	Intrathoracic	Hilar, right and left*
Hypogastric (internal iliac)	C775	Pelvic	Pelvic, right and left*
Ileocolic	C772	Intra-abdominal	Mesenteric
Iliac (common, external, internal [hypogastric, obturator])	C775	Pelvic	Pelvic, right and left*
Inferior deep cervical (scalene)	C770	Head, face, and neck	Cervical, right and left*
Inferior gastric (right, NOS)	C772	Intra-abdominal	Mesenteric
Inferior hemorrhoidal	C775	Pelvic	Pelvic, right and left*
Inferior (deep) jugular	C770	Head, face, and neck	Cervical, right and left*
Inferior mesenteric	C772	Intra-abdominal	Mesenteric
Inferior rectal (hemorrhoidal)	C775	Pelvic	Pelvic, right and left*
Inferior phrenic vein	C771	Intra-thoracic	Mediastinal
Inferior vena cava	C772	Intra-abdominal	Para-aortic
Infraauricular	C770	Head, face, and neck	Cervical, right and left*
Infraclavicular (subclavicular)	C773	Axilla or arm	Infraclavicular, right and left*
Infrapyloric	C772	Intra-abdominal	Para-aortic
Infundibulopelvic (utero-ovarian)	C775	Pelvic	Pelvic, right and left*
Inguinal (deep, sublingual, superficial, NOS)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Interaortocaval	C772	Intra-abdominal	Para-aortic
Intercostal	C771	Intrathoracic	Mediastinal
Interlobar (within the lung) (intrapulmonary)	C771	Intrathoracic	Mediastinal
Internal iliac (hypogastric, obturator)	C775	Pelvic	Pelvic, right and left*
Internal jugular (upper deep cervical)	C770	Head, face, and neck	Cervical, right and left*
Internal mammary (parasternal)	C771	Intrathoracic	Mediastinal
Interpectoral (Rotter's node)	C773	Axilla or arm	Axillary, right and left*
Intestinal	C772	Intra-abdominal	Mesenteric
Intra-abdominal	C772	Intra-abdominal	Mesenteric
Intrabronchial, NOS	C771	Intrathoracic	Hilar
Intramammary	C773	Axilla or arm	Axillary, right and left*
Intrapancreatic	C772	Intra-abdominal	Para-aortic

Lymph Node/Lymph Node Chain	ICD-O-3 Code	ICD-O-3 Lymph Node Region(S)	TNM Staging
Intraparotid	C770	Head, face, and neck	Cervical, right and left*
Intrapelvic	C775	Pelvic	Pelvic, right and left*
Intrapulmonary (segmental, subsegmental)	C771	Intrathoracic	Mediastinal
Jugular (anterior, inferior [deep], internal, lateral, lower, mid, superior, NOS)	C770	Head, face, and neck	Cervical, right and left*
Jugulodigastric (subdigastric)	C770	Head, face, and neck	Cervical, right and left*
Jugulo-omohyoid (supraomohyoid)	C770	Head, face, and neck	Cervical, right and left*
Lateral aortic (ascending, lumbar, subaortic)	C772	Intra-abdominal	Para-aortic
Lateral axillary (brachial)	C773	Axilla or arm	Axillary, right and left*
Lateral compartment (jugular, mid and lower; supraclavicular; upper deep jugular; spinal accessory; retropharyngeal; submandibular; submental)	C770	Head, face, and neck	Cervical, right and left*
Lateral jugular	C770	Head, face, and neck	Cervical, right and left*
Laterosacral (lateral sacral)	C775	Pelvic	Pelvic, right and left*
Laterotracheal (anterior deep cervical)	C771	Intrathoracic	Cervical, right and left*
Left colic	C772	Intra-abdominal	Mesenteric
Left gastric (superior gastric)	C772	Intra-abdominal	Mesenteric
Left gastrocolic (superior gastrocolic)	C772	Intra-abdominal	Mesenteric
Left supraclavicular (Virchow's node, Trosier's node)	C770	Head, face, and neck	Cervical, right and left*
Leg/Lower limb	C774	Inguinal region or leg	Inguino-femoral, right and left*
Lesser curvature	C772	Intra-abdominal	Mesenteric
Lesser omentum (lesser omental)	C772	Intra-abdominal	Mesenteric
Level I axillary (low axillary) (superficial axillary)	C773	Axilla or arm	Infraclavicular, right and left*
Level II axillary	C773	Axillar or arm	Infraclavicular, right and left*
Level III axillary (deep axillary, high axillary)	C773	Axillar or arm	Infraclavicular, right and left*
Lineal (splenic)	C772	Intra-abdominal	Mesenteric
Lobar (intrapulmonary)	C771	Intrathoracic	Hilar

Lymph Node/Lymph Node Chain	ICD-O-3 Code	ICD-O-3 Lymph Node Region(S)	TNM Staging
Lobar (proximal, pulmonary)	C771	Intrathoracic	Hilar
Low axillary (Level I axillary)	C773	Axilla or arm	Infraclavicular, right and left*
Lower deep cervical	C771	Intrathoracic	Cervical, right and left*
Lower jugular	C770	Head, face, and neck	Cervical, right and left*
Lower paratracheal (azygos)	C771	Intrathoracic	Mediastinal
Lower periesophageal (intrathoracic esophagus)	C771	Intrathoracic	Mediastinal
Lower peritracheal	C771	Intrathoracic	Mediastinal
Lower thoracic paraesophageal	C771	Intrathoracic	Mediastinal
Lumbar aortic (ascending, lateral, subaortic)	C772	Intra-abdominal	Para-aortic
Mandibular	C770	Head, face, and neck	Cervical, right and left*
Mastoid (postauricular, retroauricular, NOS)	C770	Head, face, and neck	Cervical, right and left*
Mediastinal (anterior, posterior, superior, NOS)	C771	Intrathoracic	Mediastinal
Mesenteric (inferior, sigmoid [sigmoidal], superior, NOS)	C772	Intra-abdominal	Mesenteric
Mesocolic	C772	Intra-abdominal	Mesenteric
Mid jugular	C770	Head, face, and neck	Cervical, right and left*
Midcolic	C772	Intra-abdominal	Pelvic, right and let*
Middle deep cervical	C771	Intrathoracic	Cervical, right and left*
Middle (right) colic	C772	Intra-abdominal	Mesenteric
Middle hemorrhoidal	C775	Pelvic	Pelvic, right and left*
Middle sacral (Gerota's node, promontorial)	C775	Pelvic	Pelvic, right and left*
Middle thoracic paraesophageal	C771	Intrathoracic	Mediastinal
Nasolabial (facial)	C770	Head, face, and neck	Cervical, right and left*
Node of Cloquet's or Rosenmuller (highest deep inguinal)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Obturator (internal iliac)	C775	Pelvic	Pelvic, right and left*
Pancreatic (Aselli's glands [nodes near pancreas], parapancreatic; peripancreatic, NOS)	C772	Intra-abdominal	Para-aortic

Lymph Node/Lymph Node Chain	ICD-O-3 Code	ICD-O-3 Lymph Node Region(S)	TNM Staging
Pancreaticoduodenal (anterior, posterior, NOS)	C772	Intra-abdominal	Para-aortic
Pancreaticosplenic (pancreaticolineal)	C772	Intra-abdominal	Mesenteric
Para-aortic	C772	Intra-abdominal	Para-aortic
Parabronchial (peribronchial)	C771	Intrathoracic	Mediastinal
Paracardial	C772	Intra-abdominal	Mesenteric
Paracaval	C772	Intra-abdominal	Para-aortic
Paracervical	C775	Pelvic	Pelvic, right and left*
Paracolic (pericolic)	C772	Intra-abdominal	Para-aortic
Paraesophageal	C771	Intrathoracic	Mediastinal
Paralaryngeal	C770	Head, face, and neck	Cervical, right and left*
Parametrial	C775	Pelvic	Pelvic, right and left*
Parapancreatic	C772	Intra-abdominal	Para-aortic
Parapharyngeal	C770	Head, face, and neck	Cervical, right and left*
Pararectal (anorectal)	C775	Pelvic	Pelvic, right and left*
Parasternal (internal mammary)	C771	Intrathoracic	Mediastinal
Paratracheal (lower, NOS)	C771	Intrathoracic	Mediastinal
Parotid (peri-, NOS)	C770	Head, face, and neck	Cervical, right and left*
Pectoral (anterior axillary)	C773	Axilla or arm	Axillary, right and left*
Pelvic, NOS	C775	Pelvic	Pelvic, right and left*
Peri-aortic	C772	Intra-abdominal	Para-aortic
Peri-parotid	C770	Head, face, and neck	Cervical, right and left*
Peri-thymic	C770	Head, face, and neck	Cervical, right and left*
Peribronchial (parabronchial)	C771	Intrathoracic	Mediastinal
Pericardial (pericardiac)	C771	Intrathoracic	Mediastinal
Pericaval	C772	Intra-abdominal	Para-aortic
Pericholedochal (common bile duct)	C772	Intra-abdominal	Para-aortic
Pericolic (paracolic)	C772	Intra-abdominal	Mesenteric
Periduodenal	C772	Intra-abdominal	Para-aortic
Periesophageal	C771	Intrathoracic	Mediastinal
Perigastric (except cardiac)	C772	Intra-abdominal	Mesenteric
Peripancreatic	C772	Intra-abdominal	Para-aortic

Lymph Node/Lymph Node Chain	ICD-O-3 Code	ICD-O-3 Lymph Node Region(S)	TNM Staging
Periportal	C772	Intra-abdominal	Pelvic, right and left*
Periprostatic	C775	Pelvic	Pelvic, right and left*
Perirectal	C775	Pelvic	Pelvic, right and left*
Periparotid	C770	Head, face, and neck	Cervical, right and left*
Perithyroidal	C771	Intrathoracic	Mediastinal
Peritracheal (lower)	C771	Intrathoracic	Mediastinal
Periureteral	C772	Intra-abdominal	Para-aortic
Perivesical	C775	Pelvic	Pelvic, right and left*
Pharyngeal (Delphian node, prepharyngeal, retropharyngeal, NOS)	C770	Head, face, and neck	Cervical right and left*
Phrenic vein (inferior, superior, NOS)	C771	Intra-thoracic	Mediastinal
Popliteal	C774	Inguinal region or leg	Inguino-femoral, right and left*
Porta hepatis (in hilus of liver)	C772	Intra-abdominal	Para-aortic
Portal (portal vein)	C772	Intra-abdominal	Para-aortic
Postauricular (mastoid, retroauricular)	C770	Head, face, and neck	Cervical, right and left*
Posterior axillary (subscapular)	C773	Axilla or arm	Axillary, right and left*
Posterior cecal (retrocecal)	C772	Intra-abdominal	Para-aortic
Posterior cervical (spinal accessory)	C770	Head, face, and neck	Cervical, right and left*
Posterior mediastinal (tracheoesophageal)	C771	Intrathoracic	Mediastinal
Postglandular	C770	Head, face, and neck	Cervical, right and left*
Posterior triangle	C770	Head, face, and neck	Cervical, right and left*
Postvascular	C770	Head, face, and neck	Cervical, right and left*
Preaortic	C772	Intra-abdominal	Para-aortic
Preauricular	C770	Head, face, and neck	Cervical, right and left*
Precarinal	C771	Intrathoracic	Mediastinal
Prececal (anterior cecal)	C772	Intra-abdominal	Mesenteric
Precricoid (Delphian node)	C770	Head, face, and neck	Cervical, right and left*
Preglandular	C770	Head, face, and neck	Cervical, right and left*

Lymph Node/Lymph Node Chain	ICD-O-3 Code	ICD-O-3 Lymph Node Region(S)	TNM Staging
Prepharyngeal (Delphian node), adjacent to thyroid gland; anterior to thyroid isthmus	C770	Head, face, and neck	Cervical, right and left*
Presacral	C775	Pelvic	Pelvic, right and left*
Presymphseal	C775	Pelvic	Pelvic, right and left*
Pretracheal	C770	Head, face, and neck	Cervical, right and left*
Prevascular	C770	Head, face, and neck	Cervical, right and left*
Promontorial (Gerota's node, middle sacral)	C775	Pelvic	Para-aortic
Proximal lobar (bronchopulmonary, hilar, pulmonary root)	C771	Intrathoracic	Hilar
Proximal mesentery	C772	Intra-abdominal	Mesenteric
Pulmonary ligament	C771	Intrathoracic	Mediastinal
Pulmonary (pulmonary root, NOS)	C771	Intrathoracic	Hilar
Pyloric (infrapyloric, subpyloric, suprapyloric)	C772	Intra-abdominal	Para-aortic
Rectal (superior, NOS)	C775	Pelvic	Pelvic, right and left*
Recurrent laryngeal (anterior deep cervical, laterotracheal)	C770	Head, face, and neck	Cervical, right and left*
Recurrent pharyngeal (anterior deep cervical)	C770	Head, face, and neck	Cervical, right and left*
Renal artery	C772	Intra-abdominal	Para-aortic
Renal hilar	C772	Intra-abdominal	Para-aortic
Retroaortic	C772	Intra-abdominal	Para-aortic
Retro-auricular (mastoid, postauricular)	C770	Head, face, and neck	Cervical, right and left*
Retrocaval	C772	Intra-abdominal	Para-aortic
Retrocecal (posterior cecal)	C772	Intra-abdominal	Para-aortic
Retrocrural	C771	Intra-thoracic	Mediastinal
Retropancreatic	C772	Intra-abdominal	Para-aortic
Retroperitoneal	C772	Intra-abdominal	Para-aortic
Retropharyngeal	C770	Head, face, and neck	Cervical, right and left*
Retrotracheal (tracheal)	C771	Intrathoracic	Mediastinal
Right colic	C772	Intra-abdominal	Mesenteric
Right gastric	C772	Intra-abdominal	Mesenteric
Rosenmuller or Node of Cloquet (highest deep inguinal)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Rotter's nodes (interpectoral between major and minor pectoralis)	C773	Axilla or arm	Axillary, right and left*

Lymph Node/Lymph Node Chain	ICD-O-3 Code	ICD-O-3 Lymph Node Region(S)	TNM Staging
Rouviere's node (retropharyngeal)	C770	Head, face, and neck	Cervical, right and left*
Sacral (lateral sacral, laterosacral, middle sacral, presacral, NOS)	C775	Pelvic	Pelvic, right and left*
Sacral (uterosacral)	C774	Pelvic	Pelvic, right and left*
Scalene (inferior deep cervical)	C770	Head, face, and neck	Cervical, right and left*
Segmental (intrapulmonary, subsegmental)	C771	Intrathoracic	Mediastinal
Sigmoid (sigmoidal mesenteric, NOS)	C772	Intra-abdominal	Mesenteric
Sister Mary Joseph	C772	Intra-abdominal	Mesenteric
Spermatic vein	C774	Inguinal region or leg	Inguino-femoral, right and left*
Spinal accessory (posterior cervical)	C770	Head, face, and neck	Cervical, right and left*
Splenic (hilar, lineal)	C772	Intra-abdominal	Mesenteric
Subaortic (ascending, lateral, lumbar)	C772	Intra-abdominal	Para-aortic
Subcapsular (posterior axillary)	C773	Axilla or arm	Infraclavicular, right and left*
Subcarinal	C771	Intrathoracic	Mediastinal
Subclavian (apical)	C770	Head, face, and neck	Cervical, right and left*
Subclavicular (infraclavicular)	C773	Axilla or arm	Axillary, right and left*
Subdigastric (jugulodigastric)	C770	Head, face, and neck	Cervical, right and left*
Subinguinal (superficial inguinal)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Sublingual	C770	Head, face, and neck	Cervical, right and left*
Submandibular (submaxillary)	C770	Head, face, and neck	Cervical, right and left*
Submaxillary (submandibular)	C770	Head, face, and neck	Cervical, right and left*
Submental	C770	Head, face, and neck	Cervical, right and left*
Suboccipital (occipital)	C770	Head, face, and neck	Cervical, right and left*
Subpleural (in the periphery of the lung)	C771	Intrathoracic	Mediastinal
Subpyloric	C772	Intra-abdominal	Para-aortic
Subsegmental (intrapulmonary, segmental)	C771	Intrathoracic	Mediastinal
Substernal	C771	Intrathoracic	Mediastinal

Lymph Node/Lymph Node Chain	ICD-O-3 Code	ICD-O-3 Lymph Node Region(S)	TNM Staging
Superficial axillary (Level I axillary)	C773	Axilla or arm	Infraclavicular, right and left*
Superficial inguinal (femoral, subinguinal)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Superior gastric (left gastric)	C772	Intra-abdominal	Mesenteric
Superior gastrocolic (left gastrocolic)	C772	Intra-abdominal	Mesenteric
Superior hemorrhoidal	C775	Pelvic	Pelvic, right and left*
Superior hilum	C772	Intra-abdominal	Pelvic, right and left*
Superior jugular	C770	Head, face, and neck	Cervical, right and left*
Superior mediastinal	C771	Intrathoracic	Mediastinal
Superior mesenteric	C772	Intra-abdominal	Pelvic, right and left*
Superior phrenic vein	C771	Intra-thoracic	Mediastinal
Superior rectal (hemorrhoidal)	C775	Pelvic	Pelvic, right and left*
Supraclavicular (transverse cervical)	C770	Head, face, and neck	Cervical, right and left*
Supraomohyoid (jugulo-omohyoid)	C770	Head, face, and neck	Cervical, right and left*
Suprapancreatic	C772	Intra-abdominal	Para-aortic
Suprapyloric	C772	Intra-abdominal	Para-aortic
Thoracic	C771	Intrathoracic	Mediastinal
Thyroid	C770	Head, face, and neck	Cervical, right and left*
Tibial	C774	Inguinal region or leg	Inguino-femoral, right and left*
Tracheal (retrotracheal, NOS)	C771	Intrathoracic	Mediastinal
Tracheal bifurcation (carinal, tracheobronchial)	C771	Intrathoracic	Mediastinal
Tracheobronchial (carinal, tracheal bifurcation)	C771	Intrathoracic	Mediastinal
Tracheoesophageal (posterior mediastinal)	C771	Intrathoracic	Mediastinal
Transverse cervical (supraclavicular)	C770	Head, face, and neck	Cervical, right and left*
Trosier's node (left supraclavicular)	C770	Head, face, and neck	Cervical, right and left*
Upper deep cervical (internal jugular)	C770	Head, face, and neck	Cervical, right and left*
Upper thoracic paraesophageal	C771	Intrathoracic	Mediastinal
Utero-ovarian (infundibulopelvic)	C775	Pelvic	Pelvic, right and left*

Lymph Node/Lymph Node Chain	ICD-O-3 Code	ICD-O-3 Lymph Node Region(S)	TNM Staging
Uterosacral	C774	Pelvic	Pelvic, right and left*
Virchow's node (left supraclavicular)	C770	Head, face, and neck	Cervical, right and left*

*The right and left are separate regions per AJCC.

2018 CHANGES

Reportable Diagnosis List

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. A "Reportable List" includes all diagnoses to be reported by the registry to NCI SEER.

1. **Malignant Histologies (In Situ and Invasive)**

    a. Report all histologies with a **behavior code of /2 or /3** in the *International Classification of Diseases for Oncology*, Third Edition (ICD-O-3) and in approved ICD-O-3 updates, except as noted in below.

        i. Carcinoid, NOS of the appendix is reportable. As of 1/1/2015, the ICD-O-3 behavior code changed from /1 to /3.

        ii. The following diagnoses are reportable. Please note this is not a complete list.

            1. Lobular carcinoma in situ (LCIS) of the breast

            2. Intraepithelial neoplasia, grade III

                a. ***Examples:*** (not a complete list)

                    i. Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211)

                    ii. High grade biliary intraepithelial neoplasia (BiIN III) of the gallbladder (C239)

                    iii. Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)

                    iv. Lobular neoplasia III (LN III)/Lobular intraepithelial neoplasia grade III (LN III) breast (C500-C509)

                    v. Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259)

                    vi. Penile intraepithelial neoplasia, grade III (PeIN III) (C600-C609)

                    vii. Squamous intraepithelial neoplasia III (SIN III) excluding cervix and skin sites coded to C44_

                    viii. Vaginal intraepithelial neoplasia III (VAIN III) (C529)

                    ix. Vulvar intraepithelial neoplasia III (VIN III) (C510-C519)

        iii. Report Pilocytic/Juvenile astrocytoma; code the histology and behavior as 9421/3

        iv. Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. For neoplasm of the pancreas, the term MCN with high grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive.

v. Mature teratoma of the testes in adults is malignant and reportable as 9080/3

vi. **Urine** cytology positive for malignancy is reportable for diagnoses in 2013 and forward.

1. ***Exception:*** When a subsequent biopsy of a urinary site is negative, do not report

2. Code the primary site to C689 in the absence of any other information

3. Do not implement new/additional casefinding methods to capture these cases.

4. Do not report cytology cases with ambiguous terminology (see ---- for a list of ambiguous terms)

vii. GIST tumors and thymomas are reportable when there is evidence of multiple foci, lymph node involvement or metastasis

b. Do not report (Exceptions to reporting requirements)

i. **Skin** primary (C440-C449) with any of the following histologies

1. Malignant neoplasm (800-8005)

2. Epithelial carcinoma (8010-8046)

3. Papillary and squamous cell carcinoma (8050-8084)

4. Squamous intraepithelial neoplasia III (8077) arising in perianal skin (C445)

5. Basal cell carcinoma (8090-8110)

a. ***Note:*** If the registry collects basal or squamous cell carcinoma of the skin sites (C440-C449), sequence them in the 60-99 range and do not report to SEER

ii. Carcinoma in situ of cervix (/2), cervical intraepithelial neoplasia (CIN III) or SIN III of the cervix (C530-C539)

1. ***Note:*** Collection stopped effective with cases diagnosed 01/01/1996 and later. As of the 2018 data submission, cervical in situ carcinoma is no longer required for any diagnosis year. Sequence all cervix in situ cases in the 60-88 range regardless of diagnosis year.

iii. Prostatic intraepithelial neoplasia (PIN III) (C619)

1. ***Note:*** Collection **stopped** effective with cases diagnosed 01/01/2001 and later.

2. **Benign/Non-Malignant Histologies**

a. Reference the Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors table

i. ***Note 1:*** Benign and borderline tumors of the cranial bones (C410) are **not reportable**.

ii. ***Note 2:*** Benign and borderline tumors of the peripheral nerves (C47_) are **not reportable.**

b. Report **Pilocytic/Juvenile astrocytoma**; code the histology and behavior as 9421/3

c. Report **benign and borderline primary intracranial and central nervous system (CNS)** tumors with a behavior code of /0 or /1 in ICD-O-3, **effective with cases diagnosed 01/01/2004** and later.

d. **Neoplasm and tumor** are reportable terms for brain and CNS because they are listed in ICD-O-3 and approved ICD-O-3 updates with behavior codes of /0 and /1.

Site-specific Data Items (SSDI's)

Each Site-specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDI's 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. The following table lists the site-specific schema discriminators and site-specific data items (SSDIs) that are new and are required for collection in 2018. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.

Table 1 lists Schema Discriminators with the corresponding NAACCR item number and description implemented in 2018. **Schema Discriminators are required for staging.** Table 2 lists SSDIs required for staging.

Table 1: Schema Discriminators Implemented in 2018

Schema Discriminator	NAACCR Item #	Schema Discriminator Description
Schema Discriminator 1	3926	Occult Head and Neck Lymph Nodes
Schema Discriminator 1	3926	Nasopharynx/Pharyngeal Tonsil
Schema Discriminator 2	3927	Oropharyngeal p16
Schema Discriminator 1	3926	EsophagusGEJunction (EGJ)/Stomach
Schema Discriminator 2	3927	Histology Discriminator for 8020/3
Schema Discriminator 1	3926	BileDuctsDista/BileDuctsPerihlilar/Cystic Duct
Schema Discriminator 1	3926	Primary Peritoneum Tumor
Schema Discriminator 1	3926	Urethra/Prostatic Urethra
Schema Discriminator 1	3926	Melanoma Ciliary Body/Melanoma Iris
Schema Discriminator 1	3926	Lacrimal Gland/Sac
Schema Discriminator 1	3926	Thyroid Gland/Thyroglossal Duct
Schema Discriminator 1	3926	Plasma Cell Myeloma Terminology
Schema Discriminator 1	3926	Histology Discriminator for 9591/3

Table 2: Site-specific Data Items Required for Staging*

Schema	NAACCR Item #	SSDI
Breast	3882	LN Positive Axillary Level I-II
Breast	3827	Estrogen Receptor Summary
Breast	3855	HER2 Overall Summary
Breast	3904	Oncotype DX Recurrence Score-Invasive
Breast	3915	Progesterone Receptor Summary
Corpus Adenosarcoma	3911	Peritoneal Cytology
Corpus Carcinoma and Carcinosarcoma	3911	Peritoneal Cytology
Corpus Sarcoma	3911	Peritoneal Cytology
Esophagus and Esophagus GE Junction (Squamous)	3829	Esophagus and EGJ Tumor Epicenter
Melanoma Choroid and Ciliary Body	3887	Measured Basal Diameter
Melanoma Choroid and Ciliary Body	3888	Measured Thickness
Melanoma Iris	3887	Measured Basal Diameter
Melanoma Iris	3888	Measured Thickness
Melanoma Skin	3869	LDH Level
Mycosis Fungoides	3910	Peripheral Blood Involvement
Oropharynx HPV-Mediated (p16+)	3883	LN Size
Placenta	3837	Gestational Trophoblasitic Prognostic Score Index
Prostate	3920	PSA (Prostatic Specific Antigen) Lab Value
Testis	3923	S Category Clinical
Testis	3924	S Category Pathological

*Schema Discriminators are required for staging

Summary Stage 2018
(NAACCR Item #764)

Summary Stage 2018 is new for 2018 and stores the directly assigned Summary Stage 2018. This data item is effective for cases diagnosed January 1, 2018, and later. Refer to SEER*RSA for additional information.

Code	Description
0	In situ
1	Localized only
2	Regional by direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension AND regional lymph nodes
7	Distant site(s)/node(s) involved
8	Benign, borderline*
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death certificate only case

*Applicable for the following Summary Stage 2018 chapters: Brain, CNS Other, Intracranial Gland.

CoC Accredited Flag
(NAACCR Item #2152)

The CoC Accredited Flag, effective 01/01/2018, identifies abstracts from CoC-accredited hospitals. Further, for those abstracts, the flag will designate analytic versus non-analytic abstracts.

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 is analytic for CoC but not required to be staged)
Blank	Not applicable; DCO

Coding Instructions

1. **Instructions for Hospital Cancer Registries**
    a. Assign at the time of data abstraction.
    b. Assign manually or automatically assign using registry software.
2. **Instructions for Central Cancer Registries**
    a. Set the flag to **1** when **any** of the facilities who contributed to the consolidated data for a cancer record set the CoC Accredited Flag to 1.
    b. Set the flag to **2** when **all** incoming records for the consolidated case have the CoC Accredited Flag set to 2.
    c. Set the flag to **0** when **all** incoming records for the consolidated case have the CoC Accredited Flag set to 0.
    d. Set the flag to **2** when incoming records for the consolidated case have the CoC Accredited Flag set to 0 and 2.
    e. Flag remains **blank** for
        i. DCO cases

Derived Summary Stage 2018
(NAACCR Item #762)

Derived Summary Stage 2018 is new for 2018. Derived Summary Stage 2018 is derived using the EOD data collection system (EOD Primary Tumor, EOD Regional Nodes, and EOD Metastases) algorithm. Other data items may be included in the derivation process. This data item is effective for cases diagnosed January 1, 2018, and later.

Code	Description
0	In situ
1	Localized only
2	Regional by direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension AND regional lymph nodes
7	Distant site(s)/node(s) involved
8	Benign, borderline
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death certificate only case

Lymphovascular Invasion

(NAACCR Item #1182)

Lymphovascular Invasion indicates whether lymphatic duct or blood vessel is identified in the pathology report.

Note: **SEER requires Lymphovascular Invasion (LVI) recorded for penis and testis cases only.** SEER registries may submit LVI for other sites when available. Record 8 for sites other than penis and testis when LVI is not available or when not applicable. LVI is always coded 8 for certain sites (see Coding Instruction #6).

Code	Description
0	Lymphovascular Invasion stated as Not Present
1	Lymphovascular Invasion Present/Identified
2	Lymphatic and small vessel invasion only (L)
3	Venous (large vessel invasion only (V)
4	Both lymphatic and small vessel AND venous (large vessel) invasion
8	Not applicable
9	Unknown/Indeterminate/not mentioned in path report

Coding Instructions

1. **Code from pathology report(s).** If not available, code the absence or presence of lymphovascular invasion as described in the medical record.
    a. The primary sources of information about lymphovascular invasion are pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from other sections of the pathology report or a physician's statement, in that order.
    b. Do not code perineural invasion in this field.
    c. Information to code this field can be taken from any specimen from the primary tumor (biopsy or resection).
    d. If lymphovascular invasion is identified in any primary tumor specimen, code as present/identified.
    e. Assign **Code 8 Not applicable** for benign/borderline brain and CNS tumors.
    f. For cases treated with neoadjuvant (preoperative) therapy, refer to table below to code this field. However, if documentation in the medical record conflicts with this table, code lymphovascular invasion based on the documentation in the medical record.

LVI on pathology report Prior to neoadjuvant (preoperative) therapy	LVI on pathology report AFTER neoadjuvant (preoperative) therapy	Code LVI to
0 – Not present/Not identified	0 – Not present/Not identified	0 – Not present/Not identified
0 – Not present/Not identified	1 – Present/Identified	1 – Present/Identified
0 – Not present/Not identified	9 – Unknown/Indeterminate	9 – Unknown/Indeterminate
1 – Present/Identified	0 – Not present/Not identified	1 – Present/Identified
1 – Present/Identified	1 – Present/Identified	1 – Present/Identified
1 – Present/Identified	9 – Unknown/Indeterminate	1 – Present/Identified
9 – Unknown/Indeterminate	0 – Not present/Not identified	9 – Unknown/Indeterminate
9 – Unknown/Indeterminate	1 – Present/Identified	1 – Present/Identified
9 – Unknown/Indeterminate	9 – Unknown/Indeterminate	9 – Unknown/Indeterminate

2. Use **code 0** when the pathology report indicates that there is no lymphovascular invasion. Assign code 0 for in situ cases.
3. Use **code 1** when the pathology report or a physician's statement indicates that lymphovascular invasion (or one of its synonyms) is present in the specimen.
    a. **Synonyms** include, but are not limited to
        i. Angiolymphatic invasion
        ii. Blood vessel invasion
        iii. Lymph vascular emboli
        iv. Lymphatic invasion
        v. Lymph-vascular invasion
        vi. Vascular invasion
4. Lymphovascular invasion must be coded 0, 1, 2, 3, 4 or 9 for the following Schemas/Schema IDs

    Ampulla of Vater 00270

    Appendix 00190

    Bile Ducts Distal 00260

    Bile Ducts Intrahepatic 00230

Bile Ducts Perihilar 00250

Bladder 00620

Buccal Mucosa 00076

Cervix 00520

Colon and Rectum 00200

Corpus Adenosarcoma 00542

Corpus Carcinoma 00530

Corpus Sarcoma 00541

Esophagus (including GE Junction) (excluding Squamous) 00169

Esophagus (including GE Junction Squamous 00161

Floor of Mouth 00074

Gum 00073

Hypopharynx 00112

Larynx Glottic 00132

Larynx Other 00130

Larynx Subglottic 00133

Larynx Supraglottic 00131

Lip 00071

Lung 00360

Major Salivary Glands 00080

Maxillary Sinus 00121

Melanoma Skin 00470

Merkel Cell Skin 00460

Mouth Other 00077

Nasal Cavity and Ethmoid Sinus 00122

NET Ampulla of Vater 00302

NET Appendix 00320

NET Colon and Rectum 00330

NET Duodenum 00301

NET Pancreas 00340

NET Stomach 00290

Oropharynx (p16-) 00111

Oropharynx (p16+) 00100

Palate Hard 00075

Pancreas 00280

Penis 00570

Placenta 00560

Small Intestine 00180

Stomach 00170

Testis 00590

Thymus 00350

Thyroid 00730

Thyroid Medullary 00740

Tongue Anterior 00072

Vagina 00510

Vulva 00500

5. Lymphovascular invasion must be coded 0, 1, 2, 3, 4, 8, or 9 for the following Schemas/IDs

Anus 00210

Breast (Invasive) 00480

Bone Appendicular Skeleton 00381

Bone Pelvis 00383

Bone Spine 00382

Cystic Duct 00242

Gallbladder 00241

Heart, Mediastinum, and Pleura 00422

Kidney Parenchyma 00600

Kidney Renal Pelvis 00610

Liver 00220

Melanoma Choroid and Ciliary Body 00672

Melanoma Conjunctiva 00660

Melanoma Iris 00671

Orbital Sarcoma 00700

Parathyroid 00750

Prostate 00580

Retroperitoneum 00440

Skin Eyelid 00640

Soft Tissue Abdomen and Thorax 00421

Soft Tissue Head and Neck 00400

Soft Tissue Other 00450

Soft Tissue Trunk and Extremities 00410

Urethra 00631

Urethra-Prostatic 00632

6. Use **code 8** for the following Schemas/IDs

Adnexa Uterine Other 00558

Biliary Other 00278

Brain 00721

Cervical Lymph Nodes, Occult Head and Neck 00060

CNS Other 00722

Conjunctiva 00650

Cutaneous Carcinoma Head and Neck 00150

Digestive Other 00288

Endocrine Other 00778

Eye Other 00718

Fallopian Tube 00553

Genital Female Other 00559

Genital Male Other 00598

HemeRetic 00830

Ill-Defined Other 99999

Intracranial Gland 00723

Kaposi Sarcoma 00458

Lacrimal Gland 00690

Lacrimal Sac 00698

Lymphoma 00790

Lymphoma (CLL/SLL) 00795

Lymphoma Ocular Adnexa 00710

Melanoma Head and Neck 00140

Middle Ear 00119

Mycosis Fungoides (MF) 00811

NET Adrenal Gland 00770

Ovary 00551

Pharynx Other 00118

Plasma Cell Disorder 00822

Plasma Cell Myeloma 00821

Pleural Mesothelioma 00370

Primary Cutaneous Lymphoma (excluding MF and SS) 00812

Primary Peritoneal Carcinoma 00552

Respiratory Other 00378

Retinoblastoma 00680

Sinus Other 00128

Skin Other 00478

Trachea 00358\

Urinary Other 00638

a. Schemas other than Penis 00570 and Testis 00590 if the registry has opted not to collect.

b. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.

7. Use **code 9** when

   a. There is no microscopic examination of a primary tissue specimen.

   b. The primary site specimen is cytology only or a fine needle aspiration.

   c. The biopsy is only a very small tissue sample.

d. It is not possible to determine whether lymphovascular invasion is present.

e. The pathologist indicates the specimen is insufficient to determine lymphovascular invasion.

f. Lymphovascular invasion is not mentioned in the pathology report.

g. Primary site is unknown.

8. Clarification between codes 8 and 9

    a. Use code 8 in the following situations

        i. Standard-setter does not require this item and registry is not collecting it.

        ii. Schemas listed above in instructions for code 8 for which LVI is always not applicable.

    b. Use code 9 when there is no information/documentation from the pathology report of other sources.

SEER Site-specific Factor 1
(NAACCR Item #3700)

SEER Site-specific Factor 1 is new for 2018. This data item is reserved for human papilloma virus (HPV) status. This data item applies to the following schemas.

Oropharynx (p16+): C019, C024, C051-C052, C090-C091, C098-C099, C100, C102-C103, C108-C109, C111

Oropharynx (p16-) and Hypopharynx: C019, C024, C051-C052, C090-C091, C098-C099, C100, C102-C103, C108-C109, C111, C129, C130-C132, C138-C139

Lip and Oral Cavity: C000-C009, C020-C023, C028-C029, C030-C031, C039, C040-C041, C048-C049, C050, C058-C059, C060-C062, C068-C069

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 per performed on metastatic sites to aid in determination of the primary site.

Code	Description
0	HPV negative for viral DNA by ISH test
1	HPV positive for viral DNA by ISH test
2	HPV negative for viral DNA by PCR test
3	HPV positive for viral DNA by PCR test
4	HPV negative by ISH E6/E7 RNA test
5	HPV positive by ISH E6/E7 RNA test
6	HPV negative by RT-PCR E6/E7 RNA test
7	HPV positive by RT-PCR E6/E7 RNA test
8	HPV status reported in medical records as positive or negative, but test type is unknown
9	Unknown if HPV test detecting viral DNA or RNA was performed

Coding Instructions

1. Codes 0-7 are hierarchical; use the highest code that applies (0 is highest, 7 is lowest)
2. **This data item is only for HPV status determined by tests designed to detect viral DNA or RNA**. Tests based on ISH, PCR, RT-PCR technologies detect the viral DNA or RNA.
3. **Do not record the results of IHC p16 expression in this field.**
    a. There are several methods for determining HPV status. The most frequently used test is IHC for p16 expression which is a surrogate marker for HPV infection and is not to be recorded in this field.

b. HPV-type 16 refers to **virus type** and is different from p16 overexpression (p16+)

4. Record the results of HPV testing performed on pathologic specimens including surgical and cytological (from cell blocks) tissue from the primary tumor or a metastatic site, including lymph nodes.
5. Do not record the results of blood tests or serology.
6. Leave blank when no applicable test is performed.

Grade Clinical
(NAACCR Item #3843)

Description

Grade Clinical is new for 2018. This data item records the grade of a solid primary tumor before any treatment (surgical resection of 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]0.

Explanation

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.

Coding Instructions

Please see the following URL for detailed coding instructions and site-specific coding rules.
Grade Coding Instructions and Tables (naaccr.org)

Additional Coding Instructions

If there are multiple pathology consults, ask the pathologist or physician advisor to determine which information should be used.

FIGO (International Federation of Obstetrics and Gynecology) grades are not coded. For a diagnosis that includes a commonly used differentiation term with a FIGO grade, such as moderately differentiated FIGO grade II, disregard the FIGO grade and code according to the term moderately differentiated.

For cases without pathology or cytology confirmation, code the grade of tumor stated on a Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) report if there is no tissue diagnosis (pathology or cytology report).

WHEN CODING GRADE FOR HEMATOPOIETIC AND LYMPHOID NEOPLASMS REMEMBER TO FOLLOW THE INSTRUCTIONS GIVEN AT THE CURRENT HEMATOPOIETIC AND LYMPHOID NEOPLASM MANUAL https://seer.cancer.gov/tools/heme/

Grade Pathological
(NAACCR Item #3844)

Description

Grade Pathological is new for 2018. This data item records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup. For some sites, grade is required to assign the pathological stage group.

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]).

Explanation

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

Please see the following URL for detailed coding instructions and site-specific coding rules.
Grade Coding Instructions and Tables (naaccr.org)

Additional Coding Instructions

If there are multiple pathology consults, ask the pathologist or physician advisor to determine which information should be used.

FIGO (International Federation of Obstetrics and Gynecology) grades are not coded. For a diagnosis that includes a commonly used differentiation term with a FIGO grade, such as moderately differentiated FIGO grade II, disregard the FIGO grade and code according to the term moderately differentiated.

For cases without pathology or cytology confirmation, code the grade of tumor stated on a Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) report if there is no tissue diagnosis (pathology or cytology report).

WHEN CODING GRADE FOR HEMATOPOIETIC AND LYMPHOID NEOPLASMS REMEMBER TO FOLLOW THE INSTRUCTIONS GIVEN AT THE CURRENT HEMATOPOIETIC AND LYMPHOID NEOPLASM MANUAL https://seer.cancer.gov/tools/heme/

Grade Post Therapy
(NAACCR Item #3845)

Description

Grade, Post Therapy is new for 2018. This data item records the grade of a solid primary tumor that has been resected following the neoadjuvant therapy. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. For some sites, grade is required to assign the post-neoadjuvant stage group.

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

For cases diagnosed January1, 2018 and later, this data item, along with Grade Clinical and Grade Pathological, replaces the data item Grade [NAACCR #440] as well as site specific factors for cancer sites with alternative grading systems 9e.g., breast [Bloom-Richardson], prostate [Gleason]).

Explanation

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 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

Please see the following URL for detailed coding instructions and site-specific coding rules.
Grade Coding Instructions and Tables (naaccr.org)

Additional Coding Instructions

If there are multiple pathology consults, ask the pathologist or physician advisor to determine which information should be used.

FIGO (International Federation of Obstetrics and Gynecology) grades are not coded. For a diagnosis that includes a commonly used differentiation term with a FIGO grade, such as moderately differentiated FIGO grade II, disregard the FIGO grade and code according to the term moderately differentiated.

For cases without pathology or cytology confirmation, code the grade of tumor stated on a Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) report if there is no tissue diagnosis (pathology or cytology report).

WHEN CODING GRADE FOR HEMATOPOIETIC AND LYMPHOID NEOPLASMS REMEMBER TO FOLLOW THE INSTRUCTIONS GIVEN AT THE CURRENT HEMATOPOIETIC AND LYMPHOID NEOPLASM MANUAL https://seer.cancer.gov/tools/heme/

Extent of Disease Primary Tumor
(NAACCR Item #772)

Description

Extent of Disease Primary Tumor is new for 2018. 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 at the time of diagnosis. See also EOD Regional Nodes and EOD Metastases. Effective for cases diagnosed January 1, 2018, and later.

See the most current version of EOD for rules and site-specific coded and coding structures: EOD Data SEER*RSA (cancer.gov).

Codes (In addition to schema-specific codes where needed)

Special Codes

Code	Description
000	In situ, intraepithelial, noninvasive
800	No evidence of primary tumor
999	Unknown; primary tumor not stated. Primary tumor cannot be assessed. Not documented in patient record Death certificate only (DCO)

Explanation

Extent of Disease (EOD) is a set of three data items that describe how far a cancer has spread at the time of diagnosis. EOD 2018 is effective for cases diagnosed in 2018 or later.

Extent of Disease Regional Nodes
(NAACCR Item #774)

Description

Extent of Disease Regional Nodes is new for 2018. 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 and EOD Metastases. Effective for cases diagnosed January 1, 2018, and later.

See the most current version of EOD for rules and site-specific coded and coding structures: EOD Data SEER*RSA (cancer.gov).

Codes (In addition to schema-specific codes)

Special Codes

Code	Description
000	None
800	Regional lymph node(s), NOS Lymph node(s), NOS
888	Not applicable – e.g., CNS, hematopoietic
999	Unknown

Explanation

Extent of Disease (EOD) is a set of three data items that describe how far a cancer has spread at the time of diagnosis. EOD 2018 is effective for cases diagnosed in 2018 or later.

Extent of Disease Metastases
(NAACCR Item #776)

Description

Extent of Disease Metastases is new for 2018. EOD Metastases is part of the EOD 2018 data collection system and is used to classify the distant site(s) of metastatic involvement at the time of diagnosis. See also EOD Primary Tumor and EOD Regional Nodes. Effective for cases diagnosed January 1, 2018, and later.

See the most current version of EOD for rules and site-specific coded and coding structures: EOD Data SEER*RSA (cancer.gov).

Codes (In addition to schema-specific codes)

Special Codes

Code	Description
00	None No distant metastasis Unknown if distant metastasis
88	Not applicable; Information not collected for this schema. Use for these sites only: HemeRetic. Ill Defined Other (includes unknown primary site). Kaposi Sarcoma. Lymphoma. Lymphoma – CLL/SLL. Myeloma Plasma Cell Disorder
99	Death certificate only (DCO)

Explanation

Extent of Disease (EOD) is a set of three data items that describe how far a cancer has spread at the time of diagnosis. EOD 2018 is effective for cases diagnosed in 2018 or later.

Date of Most Definitive Surgical Resection of the Primary Site *(NAACCR Item #3170)*

Description

Date of Most Definitive Surgical Resection of the Primary Site is new for 2018. This data item captures the date of the most definitive surgical procedure of the primary site performed as part of the first course of therapy.

Explanation

Date of Most Definitive Surgical Resection of the Primary Site must be transmitted in the YYYYMMDD format. Date of Most Definitive Surgical Resection of the Primary Site may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

SEER Central Registries: Collect when available from CoC reporting facilities.

Coding Instructions

1. Record the date of the most invasive, extensive, or definitive surgery when Surgery of Primary Site was recorded as part of the first course of therapy.
    a. This is the date of the procedure coded in Surgery of Primary Site
2. Transmit date fields in the year, month, day format (YYYYMMDD)

Date of Most Definitive Surgical Resection of the Primary Site Flag
(NAACCR Item #3171)

Description

Date of Most Definitive Surgical Resection of the Primary Site Flag is new for 2018 and explains why there is no appropriate value in the corresponding date data item, Date of Most Definitive Surgical Resection of the Primary Site Flag [NAACCR Item #3170].

Explanation

Date flag fields were added beginning with the diagnoses on or after 01/01/2010 as part of an initiative to standardize date fields. Date flags replace non-date information that had previously been transmitted in date fields. Coding 99999999 to indicate "unknown" is an example of non-date information that was previously transmitted in date fields.

SEER Central Registries: Collect when available from CoC reporting facilities.

Code	Label	Definition
	Blank	A valid date value is provided in Date of Most Definitive Surgical Resection of the Primary Site
10	No information	No information whatsoever can be inferred
11	Not applicable	No proper value is applicable in this context
12	Unknown	A proper value is applicable but not known

Coding Instructions

1. Leave this item blank of Date of Most Definitive Surgical Resection of the Primary Site has a full or partial date recorded.
2. Assign code 10
    a. When it is unknown whether the patient had any surgery
    b. For death certificate only (DCO) cases
3. Assign code 11 when no surgical procedure was performed as part of the first course of therapy, or the initial diagnosis was at autopsy.
4. Assign code 12 when the Date of Most Definitive Surgical Resection of the Primary Site cannot be determined, and first course surgery was performed.

Date of Sentinel Lymph Node Biopsy
(NAACCR Item #832)

Description

Date of Sentinel Lymph Node Biopsy is new for 2018 and records the date of the sentinel lymph node biopsy procedure. **This data item is required for breast and melanoma cases only**.

Explanation

Date of Sentinel Lymph Node Biopsy must be transmitted in the YYYYMMDD format. Date of Sentinel Lymph Node Biopsy may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

SEER Central Registries: Collect when available.

Coding Instructions

1. Record the date of the sentinel lymph node biopsy procedure documented in the Sentinel Lymph Node Examined data item [NAACCR Item #834]
2. This data item documents the date of sentinel node biopsy. Do not record the date of lymph node aspiration, fine needle aspiration, fine needle aspiration biopsy, core needle biopsy, or core biopsy.
3. Record the date documented in this data item in the Date of First Surgical Procedure data item [NAACCR Item #1200] when the sentinel lymph node biopsy is the first or only surgical procedure performed.
4. Record the date of the sentinel lymph node biopsy in this data item and record the date the subsequent regional node dissection was performed in the Date of Regional Lymph Node Dissection data item [NAACCR Item #682] when both a sentinel node biopsy procedure and a subsequent regional node dissection procedure are performed.
5. Record the date of the procedure in both this data item and in the Date of Regional Lymph Node Dissection [NAACCR Item #632] when a sentinel lymph node biopsy is performed is the same procedure as the regional node dissection. The dates should be the same.

Date of Sentinel Lymph Node Biopsy Flag
(NAACCR Item #833)

Description

Date of Sentinel Lymph Node Biopsy Flag is new for 2018 and explains why there is no appropriate value in the corresponding date data item, Date of Sentinel Lymph Node Biopsy [NAACCR Item #832]. **This data item is required for breast and melanoma cases only.**

Explanation

Date flag fields were added beginning with diagnoses on or after 01/01/2010 as part of an initiative to standardize date fields. Date flags replace non-date information that had previously been transmitted in date fields. Coding 99999999 to indicate "unknown" is an example of non-date information that was previously transmitted in date fields.

SEER Central Registries: Collect when available from CoC reporting facilities.

Code	Label	Definition
	Blank	A valid date value is provided in item Date of Sentinel Lymph Node Biopsy [NAACCR Item #832]. Case was diagnosed prior to January 1, 2018.
10	No information	No information whatsoever can be inferred from this exceptional value (that is, unknown if any sentinel lymph node biopsy was performed)
11	Not applicable	No proper value is applicable in this context (for example, no sentinel lymph node biopsy performed; autopsy only cases)
12	Unknown	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, sentinel lymph node biopsy performed but date is unknown)

Coding Instructions

1. Leave this item blank if Date of Sentinel Lymph Node Biopsy [NAACCR Item #832] has a full or partial date recorded.
2. Code 10 if it is unknown whether sentinel lymph nodes were biopsied.
3. Code 11 if no sentinel lymph node biopsy was performed.
4. Code 12 if the Date of Sentinel Lymph Node Biopsy [NAACCR Item #832] cannot be determined, but a sentinel lymph node biopsy was performed.

Sentinel Lymph Nodes Examined
(NAACCR Item #834)

Description

Sentinel Lymph Nodes Examined is new for 2018 and records the total number of lymph nodes sampled during the sentinel node biopsy and examined by the pathologist.

SEER Central Registries: Collect when available.

Code	Description
00	No sentinel nodes were examined
01-90	Sentinel nodes were examined (code the exact number of sentinel lymph nodes examined)
95	No sentinel lymph nodes were removed, but aspiration of sentinel nodes(s) was performed
98	Sentinel lymph nodes were biopsied, but the number is unknown
99	It is unknown whether sentinel nodes were examined; not stated in patient record

Explanation

This data item is required for breast and cutaneous melanoma cases only.

Coding Instructions

1. Document the **total number of nodes sampled during the sentinel node procedure** in this data item when both sentinel and non-sentinel nodes are sampled during the sentinel node biopsy procedure, i.e., record the total number of nodes from the procedure regardless of sentinel node status.
2. Record the total number of nodes biopsied during the sentinel node biopsy procedure in this data item and record the total number of regional lymph nodes biopsied/dissected **(which includes the number of nodes documented in this data item)** in Regional Lymph Nodes Examined [NAACCR Item #830] when
    (a) Both a sentinel node biopsy procedure and a subsequent dissection procedure are performed OR
    (b) A sentinel node biopsy procedure is performed during the same procedure as the regional node dissection.
3. Record the results for the sentinel node biopsy in this data item when an aspiration of sentinel lymph node(s) AND a sentinel node biopsy procedure were performed for the same patient.

4. The number of sentinel lymph nodes biopsied will typically be found in the pathology report, radiology reports, or documented by the physician. Determination of the exact number of sentinel lymph nodes examined may require assistance from the managing physician for consistent coding.
5. The number of sentinel nodes should be equal to or less than the number of regional nodes examined recorded in the Regional Lymph Nodes Examined [NAACCR Item #830} data item.

Sentinel Lymph Nodes Positive
(NAACCR Item #835)

Description

Sentinel Lymph Nodes Positive is new for 2018 and records the exact number of sentinel lymph nodes found to contain metastases.

SEER Central Registries: Collect when available.

Explanation

This data item is required for breast and cutaneous melanoma cases only.

Code	Description
00	All sentinel nodes examined are negative
01-90	Sentinel nodes are positive (code exact number of nodes positive)
95	Positive aspiration of sentinel lymph node(s) was performed
97	Positive sentinel nodes are documented, but the number is unspecified. For breast ONLY: SLN and RLND occurred during the same procedure
98	No sentinel nodes were biopsied
99	It is unknown whether sentinel nodes are positive; not applicable; not stated in patient record

Coding Instructions

1. Document the total number of positive nodes identified during the sentinel node procedure in this data item when, during a sentinel node biopsy procedure a few non-sentinel nodes happen to be sampled and are positive, i.e., record the total number of positive nodes from the sentinel node biopsy procedure regardless of whether the nodes contain dye or colloidal material (tracer or radiotracer)
2. Record the number of **positive sentinel nodes** biopsies in the data item and record the total number of positive regional **(which includes sentinel)** lymph nodes biopsied/dissected in Regional Lymph Nodes Positive [NAACCR Item #820] when both sentinel and additional regional nodes are examined via sentinel node biopsy and subsequent regional node dissection.
3. Record the results from the positive sentinel node biopsy procedure when a positive aspiration of sentinel lymph node(s) AND a positive sentinel node biopsy procedure were performed for the same patient.

4. FOR BREAST ONLY

    a. Use code 97 in this data item and record the total number of positive regional lymph nodes biopsies/dissected (both sentinel and regional) in Regional Lymph Nodes Positive [NAACCR Item #820] when a sentinel lymph node biopsy is performed **during the same procedure** as the regional node dissection.

    b. Sentinel lymph nodes are **negative** when only positive Isolated Tumor Cells (ITCs) are identified.

5. FOR CUTANEOUS MELANOMA ONLY

    a. Record the total number of positive sentinel nodes identified in this data item and record the total number of positive regional lymph nodes identified **(which includes the number of positive sentinel nodes documented in this data item)** in Regional Lymph Nodes Positive [NAACCR Item #820] when a sentinel lymph node biopsy is performed **during the same procedure** as the regional node dissection.

        i. The CAP Protocol for melanoma captures both the number of positive sentinel nodes as well as the number of positive regional nodes (i.e., the number of positive sentinel nodes is captured) when the sentinel lymph node biopsy is performed during the same procedure as the regional node dissection.

    b. Sentinel lymph nodes are **positive** when only positive Isolated Tumor Cells (ITCs) are identified.

6. The number of sentinel lymph nodes biopsied and found positive will typically be found in the pathology report, radiology reports, or documented by the physician. Determination of the exact number of sentinel lymph nodes positive may require assistance from the managing physician for consistent coding.

7. The number of sentinel nodes positive should be less than or equal to the total number of Regional Nodes Positive [NAACCR Item #820]

8. mi (microscopic or micro mets) sentinel lymph nodes are positive.

Date of Regional Lymph Node Dissection
(NAACCR Item #682)

Description

Date of Regional Lymph Node Dissection is new for 2018 and records the date non-sentinel regional node dissection was performed.

SEER Central Registries: Collect when available from CoC reporting facilities.

Explanation

Date of Regional Lymph Node Dissection must be transmitted in the YYYYMMDD format. Date of Regional Lymph Node Dissection may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

Coding Instructions

1. Record the date of regional lymph node dissection documented in the Regional Lymph Nodes Examined data item [NAACCR Item #830]
2. Record the date of the regional lymph node dissection in this data item and record the date of the sentinel node biopsy procedure in the Date of Sentinel Lymph Node Biopsy data item [NAACCR Item #832] for breast and melanoma cases when
    a. Both a sentinel node biopsy procedure and a subsequent regional node dissection procedure are performed OR
    b. A sentinel lymph node biopsy is performed in the same procedure as the regional node dissection. The dates should be the same.
3. Record the date of the regional lymph node dissection in this data item for all cases other than breast and melanoma.

Date of Regional Lymph Node Dissection Flag
(NAACCR Item #683)

Description

Date of Regional Lymph Node Dissection Flag is new for 2018 and explains why there is no appropriate value in the corresponding date data item, Date of Regional Lymph Node Dissection [NAACCR Item #682].

SEER Central Registries: Collect when available from CoC reporting facilities.

Explanation

Date flag fields were added beginning with diagnoses on or after 01/01/2010 as part of an initiative to standardize date fields. Date flags replace non-date information that had previously been transmitted in date fields. Coding 99999999 to indicate "unknown" is an example of non-date information that was previously transmitted in date fields.

Code	Label	Definition
	Blank	A valid date value is provided in item Date of Regional Lymph Node Dissection [NAACCR Item #682]. Case was diagnosed prior to January 1, 2018.
10	No information	No information whatsoever can be inferred from this exceptional value (that is, unknown if any regional lymph node dissection was performed)
11	Not applicable	No proper value is applicable in this context (for example, no regional lymph node dissection was performed; autopsy only cases)
12	Unknown	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, regional lymph node dissection was performed but date is unknown)

Coding Instructions

1. Leave this item blank if Date of Regional Lymph Node Dissection [NAACCR Item #682] has a full or partial date recorded.
2. Code 10 if it is unknown whether regional lymph nodes were dissected.
3. Code 11 if no regional lymph nodes were dissected.
4. Code 12 if the Date of Regional Lymph Node Dissection [NAACCR Item #682] cannot be determined, but regional lymph nodes were dissected.

Radiation Treatment Modality – Phase I, II, III
(NAACCR Item #1506, #1516, #1526)

Description

Radiation Treatment Modality – Phases I, II, and III are new for 2018. These data items identify the radiation modality administered during the first, second, and third phase, respectively, of radiation treatment delivered during the first course of treatment.

Explanation

Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities.

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
99	Treatment radiation modality unknown; Unknown if radiation treatment administered

Coding Instructions

1. Assign code **13**, Radioisotopes, NOS, for Radioembolization procedures, e.g., intravascular Yttrium-90.

Radiation External Beam Planning Technique -- Phase I, II, III
(NAACCR Item #1502, #1512, #1522)

Description

Radiation External Beam Planning Technique – Phases I, II, and III are new for 2018. These data items identify the external beam radiation planning technique used to administer the first, second, and third phase respectively, of radiation treatment during the first course of treatment.

SEER Central Registries: Collect when available from CoC reporting facilities.

Code	Label	Description
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific planning technique
02	Low energy x-ray/photon therapy	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Energies are typically expressed in units of kilovolts (kV). These types of treatments are sometimes referred to as electronic brachytherapy or orthovoltage or superficial therapy. Clinical notes may refer to the brand names of low energy x-ray delivery devices, e.g., Axxent®, INTRABEAM®, or Esteya®.
03	2-D therapy	An external beam planning technique using 2-D imaging, such as plain film x-rays or fluoroscopic images, to define the location and size of the treatment beams. Should be clearly described as 2-D therapy. This planning modality is typically used only for palliative treatments.
04	Conformal or 3-D conformal therapy	An external beam planning technique using multiple, fixed beams shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
05	Intensity modulated therapy	An external beam planning technique where the shape or energy of beams is optimized using software algorithms. Any external beam modality can be modulated but these generally refer to photon or proton beams. Intensity modulated therapy can be described as intensity modulated radiation therapy (IMRT), intensity modulated x-ray or proton therapy (IMXT/IMPT), volumetric arc therapy (VMAT) and other ways. If a treatment is described as IMRT with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.

06	Stereotactic radiotherapy or radiosurgery, NOS	Treatment planning using stereotactic radiotherapy/radiosurgery techniques, but the treatment is not described as CyberKnife® or Gamma Knife®. These approaches are sometimes described as SBRT (stereotactic body radiation), SABR (stereotactic ablative radiation), SRS (stereotactic radiosurgery), or SRT (stereotactic radiotherapy). If the treatment is described as robotic radiotherapy (e.g., CyberKnife®) or Gamma Knife ®, use stereotactic radiotherapy subcodes below. If a treatment is described as stereotactic radiotherapy or radiosurgery with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.
07	Stereotactic radiotherapy or radiosurgery, robotic	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which is specifically described as robotic (e.g., CyberKnife®)
08	Stereotactic radiotherapy or radiosurgery, Gamma Knife®	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which uses a Cobalt-60 gamma ray source and is specifically described as Gamma Knife®. This is most commonly used for treatments in the brain.
09	CT-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using a CT scan obtained at the treatment machine (online). These approaches are sometimes described as CT-guided online re-optimization or online re-planning. If a treatment technique is described as both CT-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as CT-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online," this code should not be used.
10	MR-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using an MRI scan obtained at the treatment machine (online). These approaches are sometimes described as MR-guided online re-optimization or online re-planning. If a treatment technique is described as both MR-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as MR-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online," this code should not be used.

88	Not Applicable	Treatment not by external beam
98	Other, NOS	Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown
99	Unknown	It is unknown whether radiation therapy was administered

Explanation

- Radiation external beam treatment planning technique will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the external beam planning technique may require assistance from the radiation oncologists to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality, or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.
- Note: "Online adaptive therapy" refers to treatment where radiation treatment plans are adapted or updated while a patient is on the treatment table. When treatment plans are adapted, the shape of the target volume may change from day to day but, for registry purposes, the volume that is being targeted will not change. An adapted plan should not be coded as though a new phase of treatment has been initiated unless, as above, the radiation oncologist documents it as a new phase in the radiation treatment summary. Two new technique codes have been added to capture when online adaptive therapy is occurring: CT-guided and MR-guided adaptive therapy.

Coding Instructions

1. Assign code **00** when
    a. The patient did not have radiation.
    b. Diagnosed at autopsy (for death certificate only (DC) cases)
2. Assign code **04** for Conformal or 3-D Conformal Therapy whenever either is explicitly mentioned.
3. Assign code **05** for Intensity Modulated Therapy (IMT) or Intensity Modulated Radiation Therapy (IMRT)
4. Document the planning technique in the appropriate text data item when assigning code **98**.

Reason for No Radiation
(NAACCR Item #1430)

Description

Reason for No Radiation has been added in 2018. This data item captures the reason the patient did not receive radiation treatment as part of first course of therapy.

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

Coding Instructions

1. Assign Code **0** if the patient received regional radiation as part of first course of therapy.
2. Assign Code **1** if the treatment plan offered multiple alternative treatment options but the patient selected treatment that did not include radiation therapy.
3. Assign Code **7** if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
4. Assign Code **8**

    (b) If it is known that a physician recommended radiation treatment, but no further documentation is available to confirm it was given.

    (c) To indicate referral to a radiation oncologist was made and the registry should follow to determine whether radiation was administered.

(d) If follow-up to the specialist or facility determines the patient was never there and no other documentation can be found, assign Code 1

Note: Cases coded 8 should be followed and updated to a more definitive code as appropriate.

5. Assign Code 9

   (a) If the treatment plan offered multiple alternative treatment options, but it is unknown which treatment, if any, was provided.

   (b) If a DCO case

2021 CHANGES

Reportable Diagnosis List

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. A "Reportable List" includes all diagnoses to be reported by the registry to NCI SEER.

1. **Malignant Histologies (In Situ and Invasive)**
    a. Report all histologies with a **behavior code** of **/2 or /3** in the ICD-O-Third Edition, Second Revision Morphology **(ICD-O-3.2)**, except as noted below
        i. Early or evolving melanoma, in situ and invasive: As of 01/01/2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable.
        ii. **All** GIST tumors are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2.
        iii. Nearly all thymomas are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2. The exceptions are
            1. Microscopic thymoma or thymoma benign (8580/0)
            2. Micronodular thymoma with lymphoid stroma (8580/1)
            3. Ectopic hamartomatous thymoma (8587/0)
        iv. Carcinoid, NOS of the appendix is reportable. As of 01/01/2015, the ICD-O-3 behavior code changed from /1 to /3.
        v. The following diagnoses **are reportable** (not a complete list)
            1. Lobular carcinoma in situ (LCIS) of breast
            2. Intraepithelial neoplasia, grade III
                a. ***Examples*** (Not a complete list)
                    1. Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211)
                    2. High grade biliary intraepithelial neoplasia (BilN III) of the gallbladder (C239)
                    3. Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)
                    4. Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509)
                    5. Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259)
                    6. Penile intraepithelial neoplasia, grade III (PeIN III) (C600-C609)

7. Squamous intraepithelial neoplasia III (SIN III) excluding cervix (C53_) and skin sites coded to C44_

8. Vaginal intraepithelial neoplasia III (VAIN III) (C529)

9. Vulvar intraepithelial neoplasia III (VIN III) (C510-C519)

vi. Report Pilocytic/Juvenile astrocytoma; code the histology and behavior as 9421/3

1. ***Exception:*** The behavior is non-malignant when the primary site is optic nerve (C723)

vii. Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive.

viii. Mature teratoma of the testes in adults is malignant and reportable as 9080/3

ix. **Urine** cytology positive for malignancy is reportable for diagnoses in 2013 and forward.

1. ***Exception:*** When subsequent biopsy of a urinary site is negative, do not report.

2. Code the primary site to C689 in the absence of any other information

3. Do not implement new/additional casefinding methods to capture these cases.

4. Do **not** report cytology cases with ambiguous terminology.

b. Do **not** report (Exceptions to reporting requirements)

i. **Skin** primary (C440-C449) with any of the following histologies

1. Malignant neoplasm (8000-8005)

2. Epithelial carcinoma (8010-8046)

3. Papillary and squamous cell carcinoma (8050-8084)

4. Squamous intraepithelial neoplasia III (SIN III) (8077) of skin sites coded to C44_

5. Basal cell carcinoma (8090-8110)

a. ***Note:*** If the registry collects basal or squamous cell carcinoma of skin sites (C440-C449), sequence them in the 60-87 range and do not report to SEER.

ii. **In situ** carcinoma of **cervix** (/2), any histology, cervical intraepithelial neoplasia (**CIN III**), or SIN III of the cervix (C530-C539)

1. ***Note:*** Collection stopped effective with cases diagnosed 01/01/1996 and later. As of the 2018 data submission, cervical in situ cancer is no longer

required for any diagnosis year. Sequence all cervix in situ cases in the 60-87 range regardless of diagnosis year.

iii. Prostatic intraepithelial neoplasia (PIN III) (C619)

1. ***Note:*** Collection stopped effective with cases diagnosed 01/01/2001 and later.

2. **Benign/Non-Malignant Histologies**

a. Report **benign** and **borderline** primary **intracranial** and **central nervous system (CNS)** tumors with a behavior code of /0 or /1 in ICD-O-3 (effective with cases diagnosed 01/01/2004 to 12/31/2020) or ICD-O-3.2 (effective with cases diagnosed 01/01/2021 and later).

i. ***Note 1:*** Benign and borderline tumors of the cranial bones (C410) are not reportable.

ii. ***Note 2:*** Benign and borderline tumors of the peripheral nerves (C47_) are not reportable.

b. Report **Pilocytic/Juvenile astrocytoma**; code the histology and behavior as 9421/3 when the primary site is C71_.

i. ***Exception:*** The behavior is non-malignant when the primary site is optic nerve (C723).

c. **Neoplasm and tumor** are reportable terms for intracranial and CNS because they are listed in ICD-O-3.2 with behavior codes of /0 and /1.

i. **"Mass"** and **"lesion"** are not reportable terms for intracranial and CNS because they are not listed in ICD-O-3.2 with behavior codes of /0 or /1.

Site-specific Data Items (SSDI's)

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. The following tables list the site-specific schema discriminators and site-specific data items (SSDIs) that are new and required for collection in 2021. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.

Table 1 lists Schema Discriminators Modified for 2021. Table 2 lists Site-specific Data Items implemented in 2021. Table 3 lists Site-specific Data Items Required for Staging*. Schema Discriminators are required for staging.

Table 1: Schema Discriminators Modified for 2021

Schema Discriminator	NAACCR Item #	New Schema Discriminator Description
Schema Discriminator 2*	3927	Soft Tissue Abdomen and Thoracic Soft Tissue Trunk and Extremities Soft Tissue Other

Schema Discriminator 2 [3927] was implemented in 2018. As of 2021, it is also required for C473, C475, C493-C495 applicable to Soft Tissue schemas.

Table 2: Site-specific Data Items Implemented in 2021

Schema	NAACCR Item #	SSDI
Colon and Rectum	3940	BRAF Mutational Analysis
Colon and Rectum	3941	NRAS Mutational Analysis
Esophagus Squamous Esophagus Stomach	3855	HER2 Overall Summary
Lung	3938	ALK Rearrangement
Lung	3939	EGFR Mutational Analysis
Neuroendocrine Tumors NET Ampulla of Vater NET Appendix NET Colon and Rectum NET Duodenum 00301	3863	Ki-67

NET Jejunum and Illeum NET Stomach		
Pancreas 00280	3942	CA 19-9 Pre Tx Lab Value

Table 3: Site-specific Data Items Required for Staging*

Schema	NAACCR Item #	SSDI
Breast	3882	LN Positive Axillary Level I-II
Breast	3827	Estrogen Receptor Summary
Breast	3855	HER2 Overall Summary
Breast	3904	Oncotype DX Recurrence Score-Invasive
Breast	3915	Progesterone Receptor Summary
Corpus Adenosarcoma	3911	Peritoneal Cytology
Corpus Carcinoma and Carcinosarcoma	3911	Peritoneal Cytology
Corpus Sarcoma	3911	Peritoneal Cytology
Esophagus and Esophagus GE Junction (Squamous)	3829	Esophagus and EGJ Tumor Epicenter
Melanoma Choroid and Ciliary Body	3887	Measured Basal Diameter
Melanoma Choroid and Ciliary Body	3888	Measured Thickness
Melanoma Iris	3887	Measured Basal Diameter
Melanoma Iris	3888	Measured Thickness
Melanoma Skin	3869	LDH Level
Mycosis Fungoides	3910	Peripheral Blood Involvement
Oropharynx HPV-Mediated (p16+)	3883	LN Size
Placenta	3837	Gestational Trophoblastic Prognostic Score Index
Prostate	3920	PSA (Prostatic Specific Antigen) Lab Value
Testis	3923	S Category Clinical
Testis	3924	S Category Pathological

*Schema Discriminators are required for staging

Birth Surname
(NAACCR Item #2232)

Description

Birth Surname, effective 01/01/2021, is a gender-neutral replacement for the NAACCR data item Name-Maiden [2390]. Birth Surname reflects the last name of the patient at birth regardless of gender or marital status. Allowable values for Birth Surname are identical to those used for Name-Maiden.

Explanation

Birth surname is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

1. Truncate name if longer than 40 characters
2. Record when known regardless of value in the Sex data item.
3. Leave blank if the birth surname is not known or applicable.
4. Blank spaces, hyphens, and apostrophes are allowed; do not use other punctuation.

Examples:

Mc Donald: Recorded with space as Mc Donald

O'Hara: Recorded with apostrophe as O'Hara.

Grade Post Therapy Clin (yc)
(NAACCR Item #1068)

Description

Grade, Post Therapy Clin (yc), effective 01/01/2021, records the grade of a solid primary tumor that has been microscopically sampled following neoadjuvant therapy or primary systemic/radiation therapy.

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

Neoadjuvant Therapy—Clinical Response
(NAACCR Item #1633)

Description

Neoadjuvant Therapy—Clinical Response, effective for cases diagnosed 01/01/2021 and later, record the clinical outcomes of neoadjuvant therapy prior to planned surgical resection.

Explanation

This data item provides information related to the quality of care and describes the clinical outcomes after neoadjuvant therapy. Prognostically relevant information is captured by quantifying the extent of therapy-induced tumor regression. 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.

Code	Description
0	Neoadjuvant therapy not given
1	Complete clinical response (CR) (per managing/treating physician statement)
2	Partial clinical response (PR) (per managing/treating physician statement)
3	Progressive disease (PD) (per managing/treating physician statement)
4	Stable disease (SD) (per managing/treating physician statement)
5	No response (NR) (per managing/treating physician statement) Not stated as progressive disease (PD) or stable disease (SD)
6	Neoadjuvant therapy done, managing/treating physician interpretation not available, treatment response inferred from imaging, biomarkers, or yc stage
7	Complete clinical response based on biopsy results from a pathology report (per pathologist assessment)
8	Neoadjuvant therapy done, response not documented or unknown
9	Unknown if neoadjuvant therapy performed. Death certificate only (DCO)

Coding Guidelines

Use this data item to record the clinical response (outcomes) to neoadjuvant therapy.

Neoadjuvant Therapy-Clinical Response is evaluated after primary systemic and/or radiation therapy is completed and prior to surgical resection. It is based on clinical history, physical examination, biopsies, imaging studies, and other diagnostic work up. Do not use information from the surgical pathology report to code this data item.

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.

This data item is related to Neoadjuvant Therapy [NAACCR #1632]

Coding Instructions

1. Assign code **0**
    a. When neoadjuvant therapy is not administered
        i. Neoadjuvant Therapy data item [NAACCR #1632] coded to 0 or 3.
    b. When therapy administered does not qualify as neoadjuvant therapy (pre-surgical treatment) because surgical resection not planned

        Example: Patient with unresectable lung cancer (no surgical resection planned), chemotherapy and radiation planned. Chemotherapy and radiation do not qualify as neoadjuvant therapy because surgical resection not planned.
    c. When the patient did **not** have neoadjuvant therapy based on the sequence of diagnosis and treatment

        Example: Patient diagnosed with breast cancer via needle core biopsy, had surgical resection followed by chemotherapy and radiation
    d. For autopsy only cases
    e. For the following cases for which neoadjuvant therapy is not a part of standard treatment
        i. Primary site: C420, C421, C423, C424, C809
        ii. One of the following schemas
            1. HemeRetic 00830
            2. Ill-Defined Other 99999
            3. Lymphoma 00790
            4. Lymphoma (CLL/SLL) 00795
            5. Mycosis Fungoides 00811
            6. Plasma Cell Disorders 00822

7. Plasma Cell Myeloma 00821
8. Primary Cutaneous Lymphomas (excluding MF and SS) 00812

2. A managing/treating physician statement is required to assign coded 1 – 5.
3. Assign code **1**
    a. When the managing/treating physician documents complete (or total) response (CR) based on clinical findings

        Note 1: CR is defined as the disappearance of all known tumors/lesions and lymph nodes.

        Note 2: Neoadjuvant Therapy data item [NAACCR #1632] coded to 1 or 2.
4. Assign code **2**
    a. The managing/treating physician documents partial response (PR) based on clinical findings of

        Note: PR is defined as a decrease in the size/extent of the tumor and/or presence of lymph nodes or metastatic disease.

    b. Documented as **not** being either complete response (CR) or progressive disease (PD)

        Note: Neoadjuvant Therapy data item [NAACCR #1632] coded to 1 or 2.
5. Assign code **3**
    a. When the managing/treating physician documents
        i. **Progressive disease (PD)** based on clinical findings or
        ii. "Progression" or that the size/extent of the tumor and/or the presence of lymph nodes or metastatic disease has increased or
        iii. There is evidence of new metastasis.

            Note 1: PD is defined as an increase in the size/extent of the tumor and/or presence of lymph nodes or metastatic disease.

            Note 2: Neoadjuvant Therapy data item [NAACCR #1632] coded to 1 or 2
6. Assign code **4**
    a. When the managing/treating physician
        i. Documents **no clinical response based on clinical findings due to stable disease (SD)** or
        ii. States that there is no change in the size/extent of the tumor and/or the presence of lymph nodes or metastatic disease.
            1. ***Note 1:*** SD is defined as no changed in the size/extent of the tumor

and/or presence of lymph nodes or metastatic disease.

2. ***Note 2:*** Neoadjuvant Therapy data item [NAACCR #1632] coded to 1 or 2.

7. Assign code **5**

   a. When clinical evaluation after neoadjuvant therapy is done and the managing/treating physician documents no response (NR); **and does not indicate:**

      i. If the tumor progressed (code 3) or

      ii. If there was change in the tumor size/extent or

      iii. If the tumor was stable (see code 4)

      Note 1: No response (NR), NOS is documented by the managing/treating physician based on clinical findings.

      Note 2: Neoadjuvant Therapy data item [NAACCR #1632] coded to 1 or 2.

8. Assign code **6**

   a. When neoadjuvant therapy was completed, there is **no** statement from the managing/treating physician based on clinical evaluation documented or available, and clinical response is inferred from imaging impression, changes in biomarkers or yc stage.

      Note: Neoadjuvant Therapy data item [NAACCR #1632] coded to 1.

      Example: Patient completes neoadjuvant therapy and presents to radiology for follow up scan. Per the radiology report, there is a significant decrease in the size of the tumor. No documentation can be found from the managing/treating physician regarding the response.

9. Assign code **7**

   a. When a biopsy is done of the primary site, the pathology report states complete response, and there is **no** statement regarding clinical response from the managing physician.

      Note: Neoadjuvant Therapy data item [NAACCR #1632] coded as 1.

      Example: Patient completes neoadjuvant therapy for a rectal cancer. Imaging does not identify definitive residual tumor. On endoscopic biopsy, the biopsy of the treated rectal tumor is negative for malignancy.

10. Assign code **8**

    a. When neoadjuvant therapy done, and clinical response is not documented or is unknown

       Note: Neoadjuvant Therapy data item [NAACCR #1632] to 1.

Example: Patient completes neoadjuvant therapy; however, there is no information available regarding the status of the cancer.

11. Assign code **9**

    a. When it is unknown whether neoadjuvant therapy was administered

        i. Planned, but unknown if given.

        ii. Death certificate only (DCO)

            Note 1: Neoadjuvant Therapy data item [NAACCR #1632] coded to 9

        Note 1: Code 9 (unknown) should be used rarely.

        Note 2: Use code 0 when it is clear that the patient did not have neoadjuvant therapy based on the sequence of diagnosis and treatment or on standard of care for the diagnosis.

Neoadjuvant Therapy—Treatment Effect
(NAACCR Item #1634)

Description

Neoadjuvant Therapy—Treatment Effect, effective for cases diagnosed 01/01/2021 or later, records the pathologist's statement of neoadjuvant treatment effect on the primary tumor site, with or without lymph nodes and/or distant metastasis, from the surgical pathology report. Whenever treatment effect definitions are recommended by, or available in, the College of American Pathologists (CAP) Cancer Protocols, this data item follows the CAP definitions indicating absent or present effect. When site-specific CAP definitions are not available, use treatment effect codes for All Other Schemas.

Explanation

This data item provides information related to the quality of care and describes the pathological outcomes after neoadjuvant therapy. Prognostically relevant information is captured by quantifying the extent of therapy-induced tumor regression. 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.

Coding Structure

Code	Description
0	Neoadjuvant therapy not given/no known presurgical therapy
1 - 4	Site-specific code; type of response
6	Neoadjuvant therapy completed and surgical resection performed, response not documented or unknown. Cannot be determined
7	Neoadjuvant therapy completed and planned surgical resection not performed
9	Unknown if neoadjuvant therapy performed. Unknown if planned surgical procedure performed after completion of neoadjuvant therapy. Death certificate only (DCO)

For 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.

Surgical resection: For purposes of this data item, surgical resection is defined as the most definitive surgical procedure that removes some or all of the primary tumor or site, with or without lymph nodes and/or distant metastasis. For many sites, this would be Surgical Codes 30-80; however, there are some sites where surgical codes less than 30 could be used (for example, code 22 for Breast (excisional biopsy or lumpectomy)).

Note: This data item is not the same as AJCC's Post Therapy Path (yp) Pathological Response, which is based on the managing/treating physician's evaluation from the surgical pathology report and clinical evaluation after neoadjuvant therapy. This data item only addresses the response based on the surgical pathology report.

- Assign code 9 when the only information available is the managing/treating physician's evaluation.

2022 CHANGES

Reportable Diagnosis List

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. A "Reportable List" includes all diagnoses to be reported by the registry to NCI SEER.

1. **Malignant Histologies (In Situ and Invasive)**
    a. Report all histologies with a **behavior code** of **/2** or **/3** in the ICD-O-Third Edition, Second Revision Morphology **(ICD-O-3.2)**, except as noted below
        i. Clear cell papillary renal cell carcinoma (8323/3) is reportable.
        ii. Low-grade appendiceal mucinous neoplasm (LAMN) is reportable.
        iii. Early or evolving melanoma, in situ and invasive: As of 01/01/2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable.
        iv. **All** GIST tumors, ***except*** for those stated to be benign, are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2.
        v. Nearly all thymomas are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2. The exceptions are
            1. Microscopic thymoma or thymoma benign (8580/0)
            2. Micronodular thymoma with lymphoid stroma (8580/1)
            3. Ectopic hamartomatous thymoma (8587/0)
        vi. Carcinoid, NOS of the appendix is reportable. As of 01/01/2015, the ICD-O-3 behavior code changed from /1 to /3.
        vii. The following diagnoses **are reportable** (not a complete list)
            1. Lobular carcinoma in situ (LCIS) of breast
            2. Intraepithelial neoplasia, grade III
                a. ***Examples*** (Not a complete list)
                    i. Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211)
                    ii. High grade biliary intraepithelial neoplasia (BiIN III) of the gallbladder (C239)
                    iii. Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)
                    iv. Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509)

v. Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259)

vi. Penile intraepithelial neoplasia, grade III (PeIN III) (C600-C609)

vii. Squamous intraepithelial neoplasia III (SIN III) excluding cervix (C53_) and skin sites coded to C44_

viii. Vaginal intraepithelial neoplasia III (VAIN III) (C529)

ix. Vulvar intraepithelial neoplasia III (VIN III) (C510-C519)

viii. Report Pilocytic/Juvenile astrocytoma; code the histology and behavior as 9421/3

1. ***Exception:*** The behavior is non-malignant when the primary site is optic nerve (C723)

ix. Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive.

x. Mature teratoma of the testes in adults is malignant and reportable as 9080/3

xi. **Urine** cytology positive for malignancy is reportable for diagnoses in 2013 and forward.

1. ***Exception:*** When subsequent biopsy of a urinary site is negative, do not report.
2. Code the primary site to C689 in the absence of any other information
3. Do not implement new/additional casefinding methods to capture these cases.
4. Do **not** report cytology cases with ambiguous terminology.

b. Do **not** report (Exceptions to reporting requirements)

i. **Skin** primary (C440-C449) with any of the following histologies

1. Malignant neoplasm (8000-8005)
2. Epithelial carcinoma (8010-8046)
3. Papillary and squamous cell carcinoma (8050-8084)
4. Squamous intraepithelial neoplasia III (SIN III) (8077) of skin sites coded to C44_
5. Basal cell carcinoma (8090-8110)

a. ***Note:*** If the registry collects basal or squamous cell carcinoma of skin sites (C440-C449), sequence them in the 60-87 range and do not report to SEER.

ii. **In situ** carcinoma of **cervix** (/2), any histology, cervical intraepithelial neoplasia (**CIN III**), or SIN III of the cervix (C530-C53

1. ***Note:*** Collection stopped effective with cases diagnosed 01/01/1996 and later. As of the 2018 data submission, cervical in situ cancer is no longer required for any diagnosis year. Sequence all cervix in situ cases in the 60-87 range regardless of diagnosis year.

iii. Prostatic intraepithelial neoplasia (PIN III) (C619)

1. ***Note:*** Collection stopped effective with cases diagnosed 01/01/2001 and later.

iv. Colon atypical hyperplasia

v. High-grade dysplasia in colorectal and esophageal primary sites

vi. Adenocarcinoma in situ, HPV associated (8483/2) (C53)

2. **Benign/Non-Malignant Histologies**

a. Report **benign** and **borderline** primary **intracranial** and **central nervous system (CNS)** tumors with a behavior code of /0 or /1 in ICD-O-3 (effective with cases diagnosed 01/01/2004 to 12/31/2020) or ICD-O-3.2 (effective with cases diagnosed 01/01/2021 and later).

i. ***Note 1:*** Benign and borderline tumors of the cranial bones (C410) are **not reportable**.

ii. ***Note 2:*** Benign and borderline tumors of the peripheral nerves (C47_) are **not reportable**.

b. Report **Pilocytic/Juvenile astrocytoma**; code the histology and behavior as 9421/3 when the primary site is C71_.

i. ***Exception:*** The behavior is non-malignant when the primary site is optic nerve (C723).

c. **Neoplasm and tumor** are reportable terms for intracranial and CNS because they are listed in ICD-O-3.2 with behavior codes of /0 and /1.

i. "**Mass**" and "**lesion**" are not reportable terms for intracranial and CNS because they are not listed in ICD-O-3.2 with behavior codes of /0 or /1.

Site-specific Data Items (SSDIs)

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. The following tables list the site-specific schema discriminators and site-specific data items (SSDIs) that are new and required for collection in 2022. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.

Table 1 lists Site-specific Data Items Implemented in 2022. Table 2 lists Additional Site-specific Data Items Required for Transmission.

Table 1: Site-specific Data Items Implemented in 2022

Schema	NAACCR Item #	SSDI
Cervix (9th)	3956	p16
Lymphoma-CLL/SLL	3955	Derived Rai Stage
Cervix (8th); Cervix (9th), Vagina, Vulva	3957	LN Status: Pelvic
Cervix (8th); Cervix (9th), Vagina	3958	LN Status: Para-Aortic
Vagina, Vulva	3959	LN Status: Femoral-Inguinal

Note: The new data items are collected by SEER from CoC-accredited hospitals except Derived Rai Stage.

Table 2: Additional Site-specific Data Items Required for Transmission (See NAACCR Vol II Required Status Table for more information).

NAACCR Item #	SSDI	NAACCR Item #	SSDI
3800	Schema ID*	3874	LN Distant Assessment Method
3801	Chromosome 1p: Loss of Heterozygosity (LOH)	3875	LN Distant: Mediastinal, Scalene
3802	Chromosome 19q: Loss of Heterozygosity (LOH)	3876	LN Head and Neck Levels I-III
3803	Adenoid Cystic Basaloid Pattern	3877	LN Head and Neck Levels IV-V
3804	Adenopathy	3878	LN Head and Neck Levels VI-VII

NAACCR Item #	SSDI	NAACCR Item #	SSDI
3805	AFP Post-Orchiectomy Lab Value	3879	LN Head and Neck Other
3806	AFP Post-Orchiectomy Range	3880	LN Isolated Tumor Cells (ITC)
3807	AFP Pre-Orchiectomy Lab Value	3881	LN Laterality
3808	AFP Pre-Orchiectomy Range	3882	LN Positive Axillary Level I-II
3809	AFP Pretreatment Interpretation	3883	LN Size
3810	AFP Pretreatment Lab Value	3884	LN Status Femoral-Inguinal, Para-Aortic, Pelvic
3811	Anemia	3885	Lymphocytosis
3812	B Symptoms	3886	Major Vein Involvement
3813	Bilirubin Pretreatment Total Lab Value	3887	Measured Basal Diameter
3814	Bilirubin Pretreatment Unit of Measure	3889	Methylation of o6-Methylguanine-Methyltransferase
3815	Bone Invasion	3890	Microsatellite Instability (MSI)
3940	BRAF Mutational Analysis	3891	Microvascular Density
3816	Brain Molecular Markers	3892	Mitotic Count Uveal Melanoma
3817	Breslow Tumor Thickness	3893	Mitotic Rate Melanoma
3818	CA-125 Pretreatment Interpretation	3894	Multigene Signature Method
3819	CEA Pretreatment Interpretation	3895	Multigene Signature Results
3820	CEA Pretreatment Lab Value	3896	NCCN International Prognostic Index (IPI)
3821	Chromosome 3 Status	3897	Number of Cores Examined
3822	Chromosome 8q Status	3898	Number of Cores Positive
3823	Circumferential Resection Margin (CRM)	3899	Number of Examined Para-Aortic Nodes
3824	Creatinine Pretreatment Labe Value	3900	Number of Examined Pelvic Nodes
3825	Creatinine Pretreatment Unit of Measure	3901	Number of Positive Para-Aortic Nodes
3826	Estrogen Receptor Percent Positive or Range	3902	Number of Positive Pelvic Nodes
3827	Estrogen Receptor Summary	3903	OncotyPe Dx Recurrence Score-DCIS
3828	Estrogen Receptor Total Allred Score	3904	OncotyPe Dx Recurrence Score-Invasive
3829	Esophagus and EGJ Tumor Epicenter	3905	OncotyPe Dx Risk Level-DCIS

NAACCR Item #	SSDI	NAACCR Item #	SSDI
3830	Extranodal Extension Clin (non-Head and Neck)	3906	OncotyPe Dx Risk Level-Invasive
3831	Extranodal Extension Head and Neck Clinical	3907	Organomegaly
3832	Extranodal Extension Head and Neck Pathological	3908	Percent Necrosis Post Neoadjuvant
3833	Extranodal Extension Path (non-Head and Neck)	3909	Perineural Invasion
3834	Extravascular Matrix Patterns	3910	Peripheral Blood Involvement
3835	Fibrosis Score	3911	Peritoneal Cytology
3836	FIGO Stage	3913	Pleural Effusion
3837	Gestational Trophoblastic Prognostic Scoring Index	3914	Progesterone Receptor Percent Positive or Range
3838	Gleason Patterns Clinical	3915	Progesterone Receptor Summary
3839	Gleason Patterns Pathological	3916	Progesterone Receptor Total Allred Score
3840	Gleason Score Clinical	3918	Profound Immune Suppression
3841	Gleason Score Pathological	3919	EOD Prostate Pathologic Extension
3842	Gleason Tertiary Pattern	3920	PSA (Prostatic Specific Antigen) Lab Value
3846	hCG Post-Orchiectomy Lab Value	3921	Residual Tumor Volume Post Cytoreduction
3847	hCG Post-Orchiectomy Range	3922	Response to Neoadjuvant Therapy
3848	hCG Pre-Orchiectomy Lab Value	3923	S Category Clinical
3849	hCG Pre-Orchiectomy Range	3924	S Category Pathological
3855	HER2 Overall Summary	3925	Sarcomatoid Features
3856	Heritable Trait	3926	Schema Discriminator 1
3857	High Risk Cytogenetics	3927	Schema Discriminator 2
3858	High Risk Histologic Features	3928	Schema Discriminator 3
3859	HIV Status	3929	Separate Tumor Nodules
3860	International Normalized Ratio Prothrombin Time	3930	Serum Albumin Pretreatment Level

NAACCR Item #	SSDI	NAACCR Item #	SSDI
3861	Ipsilateral Adrenal Gland Involvement	3931	Serum Beta-2 Microglobulin Pretreatment Level
3862	JAK2	3932	LDH Lab Value
3863	Ki-67	3933	Thrombocytopenia
3864	Invasion Beyond Capsule	3934	Tumor Deposits
3865	KIT Gene Immunohistochemistry	3936	Ulceration
3866	KRAS	3937	Visceral and Parietal Pleural Invasion
3867	LDH Post-Orchiectomy Range	3938	ALK Rearrangement
3868	LDH Pre-Orchiectomy Range	3939	EGFR Mutational Analysis
3869	LDH Level	3940	BRAF Mutational Analysis
3870	LDH Upper Limits of Normal	3941	NRAS Mutational Analysis
3871	LN Assessment Method Femoral-Inguinal	3942	CA-19-9 PreTx Lab Value
3872	LN Assessment Method Para-Aortic		
3873	LN Assessment Method Pelvic		

*Derived

Tobacco Use Smoking Status
(NAACCR Item #344)

Description

Tobacco Use, effective 01/01/2022, captures the patient's past or current use of tobacco (cigarette, cigar and/or pipe).

Explanation

Tobacco smoking history can be obtained from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats, or Nursing Assessment section, or other available sources from the patient's hospital medical record or physician office record. The information recorded in this data item is not comparable to the information previously collected under the CDC Comparative Effectiveness Research (CER) and Patient Centered Outcomes Research (PCOR) projects.

Code	Description
0	Never smoker
1	Current some day smoker
2	Former smoker
3	Smoker, current status unknown
9	Unknown if ever smoked

Coding Instructions

1. Record the past of current use of tobacco.
    a. Tobacco use includes cigarettes, cigar, and/or pipe.
2. Do not record the patient's past or current use of e-cigarette vaping devices.
3. Assign code 2 when the medical record indicates patient has smoked tobacco in the past but do not smoke now.
    a. If there is evidence in the medical record that the patient quit recently (within 30 days prior to diagnosis), assign code 1, current smoker. The 30 days prior information, if available, is intended to differentiate patients who may have quit recently due to symptoms that lead to a cancer diagnosis.
4. Assign code 9 when the medical record only indicates "No"

Macroscopic Evaluation of the Mesorectum
(NAACCR Item #3950)

Description

Macroscopic Evaluation of the Mesorectum, effective January 1, 2022, records whether a total mesorectal excision (TME) was performed and the macroscopic evaluation of the completeness of the excision. This applies to rectal cases only.

Explanation

Numerous studies have demonstrated that TME improves local recurrence rates and the corresponding survival by as much as 20%. Macroscopic pathologic assessment of the completeness of the mesorectum excision is scored as complete, nearly complete, or incomplete, and accurately predicts both local recurrence and distant recurrence. SEER Central Registries: Collect when available from CoC reporting facilities.

Code	Description
00	Patient did not receive TME
10	Incomplete
20	Nearly complete
30	Complete
40	TME performed not specified on pathology report as incomplete, nearly complete, or complete. TME performed but pathology report not available. Physician statement that TME performed, no mention of incomplete, nearly complete, or complete status.
99	Unknown if TME performed
Blank	Site not rectum (C209)

Coding Instructions

1. Use information from the pathology report and/or the CAP protocol for this data item.
2. Leave this field blank when the primary site is other than rectum (C20.9)
3. Neoadjuvant therapy does not alter coding of this data item.
4. Assign code **00** when a total mesorectal excision is not performed.
5. Assign codes **10, 20**, and **30** based on pathology report and/or CAP protocol.
    a. Do not attempt to apply the pathologist's criteria to assess completeness status in order to assign codes 10, 20, or 30.

6. Assign code **40** when the pathologist does not indicate incomplete, nearly complete, or complete for a TME specimen.

2023 CHANGES

Reportable Diagnosis List

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. A "Reportable List" includes all diagnoses to be reported by the registry to NCI SEER.

1. **Malignant Histologies (In Situ and Invasive)**
    a. Report all histologies with a **behavior code** of **/2** or **/3** in the ICD-O-Third Edition, Second Revision Morphology (**ICD-O-3.2**), except as noted below.
        i. High-grade astrocytoma with piloid features (HGAP) (9421/3) as of 01/01/2023
        ii. Lymphangioleiomyomatosis (9174/3) is reportable as of 01/01/2023; behavior changed from /1 to /3.
        iii. Mesothelioma in situ (9050/2) is reportable as of 01/01/2023.
        iv. Diffuse leptomeningeal glioneuronal tumor (9509/3) is reportable as of 01/01/2023.
        v. Low-grade appendiceal mucinous neoplasm (LAMN) is reportable.
        vi. Early or evolving melanoma, in situ and invasive: As of 01/01/2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable.
        vii. **All** GIST tumors, ***except*** for those stated to be benign, are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2.
        viii. Nearly all thymomas are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2. The exceptions are
            1. Microscopic thymoma or thymoma benign (8580/0)
            2. Micronodular thymoma with lymphoid stroma (8580/1)
            3. Ectopic hamartomatous thymoma (8587/0)
        ix. Carcinoid, NOS of the appendix is reportable. As of 01/01/2015, the ICD-O-3 behavior code changed from /1 to /3.
        x. The following diagnoses **are reportable** (not a complete list)
            1. Lobular carcinoma in situ (LCIS) of breast
            2. Intraepithelial neoplasia, high grade, grade II, grade III
                a. ***Examples*** (Not a complete list)
                    i. Anal intraepithelial neoplasia II (AIN II) of the anus or anal canal (C210-C211)

ii. Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211)

iii. Biliary intraepithelial neoplasia, high grade

iv. Differentiated vulvar intraepithelial neoplasia (VIN)

v. Endometrioid intraepithelial neoplasia

vi. Esophageal intraepithelial neoplasia (dysplasia), high grade

vii. Intraductal papillary neoplasm with high grade intraepithelial neoplasia

viii. Intraepithelial neoplasia, grade III

ix. Laryngeal intraepithelial neoplasia II (LIN II) (C320-C329)

x. Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)

xi. Lobular neoplasia grade II (LN II)/lobular intraepithelial neoplasia grade II (LIN II) breast (C500-C509)

xii. Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509)

xiii. Pancreatic intraepithelial neoplasia (PanIN II) (C250-C259)

xiv. Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259)

xv. Penile intraepithelial neoplasia, grade II (PeIN II) (C600-C609)

xvi. Penile intraepithelial neoplasia, grade III (PeIN III) (C600-C609)

xvii. Squamous intraepithelial neoplasia, grade II excluding cervix (C53_) and skin sites coded to C44_

xviii. Squamous intraepithelial neoplasia III (SIN III) excluding cervix (C53_) and skin sites coded to C44_

xix. Vaginal intraepithelial neoplasia II (VAIN II) (C529)

xx. Vaginal intraepithelial neoplasia III (VAIN III) (C529)

xxi. Vulvar intraepithelial neoplasia II (VIN II) (C510-C519)

xxii. Vulvar intraepithelial neoplasia III (VIN III) (C510-C519)

xi. Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive.

xii. Mature teratoma of the testes in adults is malignant and reportable as 9080/3

xiii. **Urine** cytology positive for malignancy is reportable for diagnoses in 2013, and forward.

1. ***Exception:*** When subsequent biopsy of a urinary site is negative, do not report.
2. Code the primary site to C689 in the absence of any other information
3. Do not implement new/additional casefinding methods to capture these cases.

b. Do **not** report (Exceptions to reporting requirements)

i. **Skin** primary (C440-C449) with any of the following histologies

1. Malignant neoplasm (8000-8005)
2. Epithelial carcinoma (8010-8046)
3. Papillary and squamous cell carcinoma (8050-8084)
4. Squamous intraepithelial neoplasia III (SIN III) (8077) of skin sites coded to C44_
5. Basal cell carcinoma (8090-8110)

a. ***Note:*** If the registry collects basal or squamous cell carcinoma of skin sites (C440-C449), sequence them in the 60-87 range and do not report to SEER.

ii. **In situ** carcinoma of **cervix** (/2), any histology, cervical intraepithelial neoplasia (**CIN III**), or SIN III of the cervix (C530-C539)

1***. Note:*** Collection stopped effective with cases diagnosed 01/01/1996 and later. As of the 2018 data submission, cervical in situ cancer is no longer required for any diagnosis year. Sequence all cervix in situ cases in the 60-87 range regardless of diagnosis year.

iii. Prostatic intraepithelial neoplasia (PIN III) (C619)

1***. Note:*** Collection stopped effective with cases diagnosed 01/01/2001 and later.

iv. Colon atypical hyperplasia

v. High-grade dysplasia in colorectal and esophageal primary sites

vi. Adenocarcinoma in situ, HPV associated (8483/2) (C53)

c. "Carcinomatosis" (8010/9) and "metastatic" tumor or neoplasm (8000/6) indicate malignancy and could be indicative of a reportable neoplasm. Review all of the available information to determine the origin of the carcinomatosis or the origin of the metastases.

2. Benign/Non-Malignant Histologies

a. Report **benign** and **borderline** primary **intracranial** and **central nervous system (CNS)** tumors with a behavior code of /0 or /1 in ICD-O-3 (effective with cases diagnosed 01/01/2004 to 12/31/2020) or ICD-O-3.2 (effective with cases diagnosed 01/01/2021 and later).

i. ***Note 1:*** Benign and borderline tumors of the cranial bones (C410) are **not reportable**.

ii. ***Note 2:*** Benign and borderline tumors of the peripheral nerves (C47_) are **not reportable**.

b. Report pilocytic astrocytoma/juvenile pilocytic astrocytoma as 9421/1 for ***all*** CNS sites as of 01/01/2023.

c. Report diffuse astrocytoma, MYB or MYBK1-altered and diffuse low-grade glioma, MAPK pathway-altered (9421/1) as of 01/01/2023.

d. Report multinodular and vacuolating neuronal tumor (9509/0) as of 01/01/2023.

e. Report juvenile xanthogranuloma (9749/1) as of 01/01/2023 (C715 is the most common site)

f. **Neoplasm and tumor** are reportable terms for intracranial and CNS because they are listed in ICD-O-3.2 with behavior codes of /0 and /1.

i. "**Mass**" and "**lesion**" are not reportable terms for intracranial and CNS because they are not listed in ICD-O-3.2 with behavior codes of /0 or /1.

Site-specific Data Items (SSDIs)

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. The following tables list the site-specific schema discriminators and site-specific data items (SSDIs) that are new and required for collection in 2023. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.

Table 1 lists Site-specific Data Items Implemented in 2023. Table 2 lists Additional Site-specific Data Items Required for Transmission.

Table 1: Site-specific Data Items Implemented in 2023

Schema	NAACCR Item #	SSDI
Appendix	3960	Histologic Subtype (Appendix 8480)
Melanoma Skin	3961	Clinical Margin Width
Anus V9 (existing SSDI added to schema)	3957	p16

Table 2: Additional Site-specific Data Items Required for Transmission (See NAACCR Vol II Required Status Table for more information).

NAACCR Item #	SSDI	NAACCR Item #	SSDI
3800	Schema ID*	3873	LN Assessment Method Pelvic
3801	Chromosome 1p: Loss of Heterozygosity (LOH)	3874	LN Distant Assessment Method
3802	Chromosome 19q: Loss of Heterozygosity (LOH)	3875	LN Distant: Mediastinal, Scalene
3803	Adenoid Cystic Basaloid Pattern	3876	LN Head and Neck Levels I-III
3804	Adenopathy	3877	LN Head and Neck Levels IV-V
3805	AFP Post-Orchiectomy Lab Value	3878	LN Head and Neck Levels VI-VII
3806	AFP Post-Orchiectomy Range	3879	LN Head and Neck Other
3807	AFP Pre-Orchiectomy Lab Value	3880	LN Isolated Tumor Cells (ITC)
3808	AFP Pre-Orchiectomy Range	3881	LN Laterality

NAACCR Item #	SSDI	NAACCR Item #	SSDI
3809	AFP Pretreatment Interpretation	3882	LN Positive Axillary Level I-II
3810	AFP Pretreatment Lab Value	3883	LN Size
3811	Anemia	3885	Lymphocytosis
3812	B Symptoms	3886	Major Vein Involvement
3813	Bilirubin Pretreatment Total Lab Value	3887	Measured Basal Diameter
3814	Bilirubin Pretreatment Unit of Measure	3888	Measured Thickness
3815	Bone Invasion	3889	Methylation of o6-Methylguanine-Methyltransferase
3940	BRAF Mutational Analysis	3890	Microsatellite Instability (MSI)
3816	Brain Molecular Markers	3891	Microvascular Density
3817	Breslow Tumor Thickness	3892	Mitotic Count Uveal Melanoma
3818	CA-125 Pretreatment Interpretation	3893	Mitotic Rate Melanoma
3819	CEA Pretreatment Interpretation	3894	Multigene Signature Method
3820	CEA Pretreatment Lab Value	3895	Multigene Signature Results
3821	Chromosome 3 Status	3896	NCCN International Prognostic Index (IPI)
3822	Chromosome 8q Status	3897	Number of Cores Examined
3823	Circumferential Resection Margin (CRM)	3898	Number of Cores Positive
3824	Creatinine Pretreatment Labe Value	3899	Number of Examined Para-Aortic Nodes
3825	Creatinine Pretreatment Unit of Measure	3900	Number of Examined Pelvic Nodes
3826	Estrogen Receptor Percent Positive or Range	3901	Number of Positive Para-Aortic Nodes
3827	Estrogen Receptor Summary	3902	Number of Positive Pelvic Nodes
3828	Estrogen Receptor Total Allred Score	3903	OncotyPe Dx Recurrence Score-DCIS

NAACCR Item #	SSDI	NAACCR Item #	SSDI
3829	Esophagus and EGJ Tumor Epicenter	3904	OncotyPe Dx Recurrence Score-Invasive
3830	Extranodal Extension Clin (non-Head and Neck)	3905	OncotyPe Dx Risk Level-DCIS
3831	Extranodal Extension Head and Neck Clinical	3906	OncotyPe Dx Risk Level-Invasive
3832	Extranodal Extension Head and Neck Pathological	3907	Organomegaly
3833	Extranodal Extension Path (non-Head and Neck)	3908	Percent Necrosis Post Neoadjuvant
3834	Extravascular Matrix Patterns	3909	Perineural Invasion
3835	Fibrosis Score	3910	Peripheral Blood Involvement
3836	FIGO Stage	3911	Peritoneal Cytology
3837	Gestational Trophoblastic Prognostic Scoring Index	3913	Pleural Effusion
3838	Gleason Patterns Clinical	3914	Progesterone Receptor Percent Positive or Range
3839	Gleason Patterns Pathological	3915	Progesterone Receptor Summary
3840	Gleason Score Clinical	3918	Profound Immune Suppression
3841	Gleason Score Pathological	3919	EOD Prostate Pathologic Extension
3842	Gleason Tertiary Pattern	3920	PSA (Prostatic Specific Antigen) Lab Value
3846	hCG Post-Orchiectomy Lab Value	3921	Residual Tumor Volume Post Cytoreduction
3847	hCG Post-Orchiectomy Range	3922	Response to Neoadjuvant Therapy
3848	hCG Pre-Orchiectomy Lab Value	3923	S Category Clinical
3849	hCG Pre-Orchiectomy Range	3924	S Category Pathological
3855	HER2 Overall Summary	3925	Sarcomatoid Features
3856	Heritable Trait	3926	Schema Discriminator 1
3857	High Risk Cytogenetics	3927	Schema Discriminator 2
3858	High Risk Histologic Features	3928	Schema Discriminator 3

NAACCR Item #	SSDI	NAACCR Item #	SSDI
3859	HIV Status	3929	Separate Tumor Nodules
3860	International Normalized Ratio Prothrombin Time	3930	Serum Albumin Pretreatment Level
3861	Ipsilateral Adrenal Gland Involvement	3931	Serum Beta-2 Microglobulin Pretreatment Level
3862	JAK2	3932	LDH Lab Value
3863	Ki-67	3933	Thrombocytopenia
3864	Invasion Beyond Capsule	3934	Tumor Deposits
3865	KIT Gene Immunohistochemistry	3936	Ulceration
3866	KRAS	3937	Visceral and Parietal Pleural Invasion
3867	LDH Post-Orchiectomy Range	3938	ALK Rearrangement
3868	LDH Pre-Orchiectomy Range	3939	EGFR Mutational Analysis
3869	LDH Level	3940	BRAF Mutational Analysis
3870	LDH Upper Limits of Normal	3941	NRAS Mutational Analysis
3871	LN Assessment Method Femoral-Inguinal	3942	CA-19-9 PreTx Lab Value
3872	LN Assessment Method Para-Aortic		

*Derived

Surgery of Primary Site 2023
(NAACCR Item #1291)

Description

Surgery of Primary Site 2023, effective 01/01/2023, describes a surgical procedure that removed and/or destroys tissue of the primary site that is performed as part of the initial diagnostic and staging work-up or first course of therapy. Site-specific surgery codes can be found Appendix C: Site Specific Coding Modules - 2023 SEER Coding and Staging Manual (cancer.gov).

General Coding Structure

Code	Description
A000	None; no surgical procedure of primary site; diagnosed at autopsy only
A100-A190	Site-specific codes. Tumor destruction; no pathologic specimen or unknown where there is a pathologic specimen
A200-A800	Site-specific codes. Resection; pathologic specimen
A900	Surgery, NOS. A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided
A980	Special codes for hematopoietic neoplasms; ill-defined sites; and unknown primaries (See site-specific codes for the sites and histologies), except death certificate only
A990	Unknown if surgery performed

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

1. Code A000 or B000 when
    a. No surgery was performed on the primary site, OR
    b. First course of treatment was active surveillance/watchful waiting, OR
    c. Case was diagnosed at autopsy.
        i. *Note:* Codes A000 and B000 exclude all sites and histologies that would be coded as A980. (See Coding Instruction 10 below.)
2. Use the site-specific coding scheme corresponding to the primary site or histology.
3. Code the most **invasive, extensive, or definitive** surgery if the patient has multiple surgical procedures of the primary site even if there is no residual tumor found in the

pathologic specimen from the more extensive surgery.

a. ***Example:*** Patient has a needle biopsy of prostate that is positive for adenocarcinoma. The patient chooses to have a radical prostatectomy. The pathologic examination of the prostatectomy specimen shows no residual tumor. Code the radical prostatectomy.

4. Code and **excisional biopsy**, even when documented as **incisional**, when
    a. All disease is removed (**margins free**), OR
    b. All gross disease is removed and there is only microscopic residual at the margin.
        i. ***Note 1:*** Do **not** code an incisional biopsy as an excisional biopsy when there is macroscopic residual disease.
        ii. ***Note 2:*** 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 in either 4.a or 4.b above.
            1. ***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.
5. Code total **removal of the primary site** when a previous procedure resected a portion of the site, and the current surgery removed the rest of the organ. The previous procedure may have been cancer directed or non-cancer directed surgery.
    a. ***Example:*** Left thyroidectomy for suspicious nodules. Path showed papillary carcinoma. Completion thyroidectomy was performed. Code surgery of primary site as total thyroidectomy (A500).
6. Assign the code that reflects the **cumulative effect** of all surgeries to the primary site.
    a. When a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, code the total or final results. Do not rely on registry software to perform this task.
        i. ***Example:*** The patient underwent a partial mastectomy and sentinel lymph node biopsy, followed by an axillary lymph node dissection for the first right breast primary in 2011. The separate 2020 right breast primary was treated with a total mastectomy and removal of one involved axillary lymph node. The operative report only refers to this as a non-sentinel lymph node, with no mention of other axillary findings. Cumulatively, this patient has undergone a modified radical mastectomy since there were likely no remaining axillary lymph nodes. For the 2020 primary, code the cumulative effect of the surgery done in 2011 plus the surgery performed in 2020. Use text fields on both abstracts to record the details.

7. Code the removal of regional or distant **tissue/organs** when they are resected in continuity with the primary site (**en bloc**) and that regional organ/tissue is listed in the *Surgery of Primary Site 2023* codes. Specimens from an en bloc resection may be submitted to pathology separately.
    a. **Example:** Code and en bloc removal when the patient has a hysterectomy and an omentectomy.
8. Code surgery for extra-lymphatic lymphoma using **site-specific** surgery coding scheme for the primary site. Do **not** use the lymph node scheme.
9. Assign the surgery code(s) that best represents the extent of the surgical procedure that was actually carried out when surgery is aborted. If the procedure was aborted before anything took place, assign code A000. See 1.a. above.
10. Code **A800**, **B800**, **A900**, or **B900** only when there is no specific information.
11. Code **A980** for the following primary sites unless the case is death certificate only (see #13 below)
    a. Any case coded to C420, C421, C423, C424, C760-C768, or C809
12. When *Surgery of Primary Site 2023* is coded **A980**
    a. Code *Surgical Margins of the Primary Site* (#1320) to 9
    b. Code *Reason for No Surgery of Primary Site* (#1340) to 1
13. Code **A990** or **B990** for death certificate only (DCO) cases or if patient record does not state whether a surgical procedure of the primary site was performed (i.e., is unknown)
14. Leave blank for diagnosis years 2003-2022

No Patient Contact Flag
(NAACCR Item #1854)

Description

No Patient Contact Flag, effective 01/01/2023, flags a record when a patient, family member, or provider informs the physician, hospital, or central registry that they do not want to be contacted for research purposes. This data item is populated by the central registry.

Explanation

Restrictions on release do not apply to routine surveillance reporting to NCI, CDC, and NAACCR, for which all reportable tumor records are to be submitted. It also does not apply to release for studies where no patient contact is planned. This data item is applied at the patient level and used to exclude all tumor records of the patient. It is used in combination with the data item *Reporting Facility Restriction Flag* (NAACCR Item #1856) to identify data at the patient and tumor level that the registry may not be allowed to release.

Code	Description
0	Patient may be contacted for research purposes
1	Patient may NOT be contacted for research purposes, per notification from patient, family member, or provider

Coding Instructions

1. Code this data item as either 0 or 1. Blanks are not allowed regardless of diagnosis year.
    a. This data item should always have a value for all diagnosis years. If there is not a known restriction, then code 0 (e.g., the person can be contacted unless known otherwise).
2. Assign the code that best describes whether the patient should or should not be contacted for research purposes.
3. Assign this flag at the patient-level so that it can be used to flag release of all associated tumors.
4. Code 1 takes precedence over code 0 when consolidating records.

Reporting Facility Restriction Flag
(NAACCR Item #1856)

Description

Reporting Facility Restriction Flag, effective 01/01/2023, flags cases that the central cancer registry may not be allowed to release for research and certain other types of uses due to the restrictions of the reporting facility. This data item is populated by the central registry.

Explanation

Case data, regardless of the reporting facility, can be released for routine surveillance reporting to NCI, CDC, and NAACCR, for which all reportable tumor records are to be submitted. This item is used in combination with the data item No Patient Contact Flag (NAACCR Item #1854) to identify data that the registry may not be allowed to release.

Code	Description
00	No restrictions on release based on reporting facility. This code is assigned if the tumor record is only reported by a facility without potential restrictions on release of data (e.g., in-state hospital, physician offices, pathology lab). The code is also assigned id the tumor record is reported by both a facility without restrictions and a facility listed below that potentially has restrictions. For example, if an in-state hospital and a VHA facility report the same tumor, code 00 would be assigned upon consolidation.
01	OOS: Tumor records received only from Out of State (OOS) data exchange with another central registry
02	VHA: Tumor records received only from Veterans Health Administration (VHA)
03	DoD: Tumor records received only from Department of Defense (DoD)
04	VHA and OOS
05	DoD and OOS
06	DoD and VHA
07	DoD, VHA and OOS

Coding Instructions

1. Code this data item using the most appropriate code. Blanks are not allowed regardless of diagnosis year.
    a. This data item should always have a value for all diagnosis years. If there is no known restriction, assign code 00.
2. Assign code 00 when codes 01-07 do not apply.
3. Record the flag that best describes the reporting facility(ies) that have contributed to the case.

4. Update the flag when additional reporting facilities contribute to the case.
5. Work with software vendors to populate this data item for information previously captured in other fields and/or based on the reporting facilities contributing to the case.

Documenting Text

TEXT DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT

Text information to support cancer diagnosis, stage, and treatment codes **MUST BE PROVIDED BY ALL FACILITIES**.

Text documentation is an important element of a complete abstract. It is critical for quality assurance and special studies and is used to support coded values and to provide supplemental information not transmitted within coded values. Complete text documentation facilitates consolidation of information from multiple reporting sources.

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 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**. Document all types of the **first course** of definitive treatment administered, regardless of where the treatment was received, in chronological order. 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.

Always use text to document certain basic information:

1. The date of the examination or procedure; **keep dates in chronological order.**

2. The name of the examination or procedure.

3. The results of the examination or procedure and any pertinent **positive or negative** information.

4. The diagnostic impression, final diagnosis, or conclusion if one is given.

5. The planned treatment, whether or not it is known if the treatment was given.

6. The date and type of treatment given, even if it was done at another institution.

7. Specific subsite of primary site.

8. Specific number, chain of lymph nodes examined and results.

9. Specific information about metastatic spread of disease to lymph nodes and/or other organs and tissues.

10. Demographic information such as age at diagnosis, race and sex of the patient should also be recorded in text fields.

Unknown should only be used when there is insufficient information to determine the stage or extent of disease. If the primary site is unknown (C809) then the Summary Stage must be unknown. Document where the cancer was found if the primary site is unidentified.

Documentation is necessary to verify all coded fields regarding types and timing of treatment. 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.

Call WSCR for technical assistance if additional direction is needed to determine the appropriate information to document. WSCR staff may request copies of the necessary reports with your data submission to assist you.

Types of Reports to Review

Medical imaging: Medical imaging can provide key information for evaluating the 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 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.

Physical exam (PE) or History and Physical (H&P): The PE or 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 Collaborative Staging and must be noted 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: 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. 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: 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.

Discharge summaries, treatment summaries, clinical notes, or progress reports: These 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 the 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: These can be and are used to code many of the Site-Specific Data Items (SSDI)

SPECIFIC INSTRUCTION ON INVOLVEMENT

Venous Invasion: An assessment of blood vessels within the primary organ. This does not constitute regional or distant spread of malignancy.

Lymphatic Invasion: A microscopic assessment of involvement of the lymphatic channels within the primary organ and at the margins of resection. This is an assessment of the potential, from the primary tumor, to metastasize to lymph nodes, even though the tumor has extended no further than the lymph channels and is still confined to the primary site.

Residual Tumor: Refers to the status of the margins after a surgical procedure of the primary site. It is important to document this information if it is available in the pathology and/or operative report. ***Microscopic residual tumor*** is identified by the pathologist through the microscope but is not grossly visualized. An example would be a positive margin of resection when the surgeon stated that the tumor was completely removed. ***Macroscopic residual tumor*** is identified during the procedure by the surgeon and is a tumor that is grossly visualized. An example of this would be a tumor adhering to another structure that the surgeon could not remove.

Determination of the cancer stage is both a subjective and objective assessment of how far the cancer has spread. The following list of terms may be used to determine involvement for **SEER Summary Staging only**.

Note: Do not use these lists for case finding or to determine multiple primaries or histology.

Consider as Involvement

adherent	Incipient invasion
apparent(ly)	induration
appears to	infringe/infringing
comparable with	into*
compatible with	intrude
consistent with	most likely
contiguous/continuous with	onto*
encroaching upon*	overstep
extension to, into, onto, out onto	presumed
features of	probable
fixation to a structure other than primary**	protruding into (unless encapsulated)
fixed to another structure**	suspected
impending perforation of	suspicious

impinging upon	to*
impose/imposing on	up to

*Interpreted as involvement whether the description is clinical or operative/pathological

**Interpreted as involvement of other organ or tissue

Do Not Consider as Involvement

abuts	extension to without invasion/involvement of
approaching	kiss/kissing
approximates	matted (except for lymph nodes)
attached	possible
cannot be excluded/ruled out	questionable
efface/effacing/effacement	reaching
encased/encasing	rule out
encompass(ed)	suggests
entrapped	very close to
equivocal	worrisome

Text Field Examples

The following table lists suggestions for the type of text to include for each text field.

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 Unknown demographic information (unknown SS#, unknown address at diagnosis) Overflow or problematic coding issues	Date of Birth #240 Age at Diagnosis #230 Sex #220 Race 1-5 #160-164 Spanish/Hispanic Origin #190 Birthplace - State #252 Birthplace – Country #254 Primary Payer at Dx #630
Other Primary Tumors #2220	Site of Other Primary Morphology of Other Primary DX Date of Other Primary	Sequence Number #560
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 Initial Diagnosis #390 Diagnostic Confirmation #490 Primary site #400 Histology # 522 Regional Nodes Positive #820 Regional Nodes Examined #830 Laterality #410

Summary Stage Documentation – PE #2520	Date of diagnosis History relating to cancer diagnosis. Impression pertaining to cancer diagnosis. Positive and negative clinical findings Palpable lymph nodes Treatment plan	Date of First Contact #580 Date of Diagnosis #390 Race 1-5 #160-164 Span/Hispanic Origin #190 Sex #220 Primary Site #400 Laterality #410 Histology ICD-0-3 #522 Sequence # Hospital #560 Collaborative Stage variables #2800-2930 SEER Summary Stage 2000 #759
Summary Stage Documentation-Xray/Scan #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-0-2 #420 Histology ICD-0-3 #522 Collaborative Stage variables #2800-2930 SEER Summary Stage 2000 #759
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-0-2 #420 Histology ICD-0-3 #522 Collaborative Stage variables #2800-2930 SEER Summary Stage 2000 #759 RX Date-Surgery #1300

Summary Stage Documentation-Lab Tests #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 Grade #440 Diagnostic Confirmation #490 Collaborative Stage variables #2800-2930 Date of Diagnosis #390
Summary Stage Documentation-Op #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 Reason primary site surgery could not be completed	Date of Diagnosis #390 Diagnostic Confirmation #490 Primary Site #400 Collaborative Stage variables #2800-2930 SEER Summary Stage 2000 #759 Reason for No Surgery #1340
Summary Stage Documentation Path #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 Primary Site #400 Laterality #410 Histologic Type ICD-0-3 #522 Grade #440 Collaborative Stage variables #2800-2930 Diagnostic Confirmation #490 RX Summ-Surg Prim Site #670 RX Sum-Scope Reg LN Sur #1392 RX Summ-Surg Oth Reg/Dis # 1394 SEER Summary Stage 2000 #759 Regional Nodes Positive #820 Regional Nodes Examined

		#830 RX Date-Surgery #1300 Reason for No Surgery #1340 RX Summ-Surg/Rad Seq #1380 RX 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	Morphology/Behavior Grade of tumor	Morphology/Behavior #522, #523 Grade #440
Rx Text Surgery #2610	Date of each surgical procedure Type(s) of surgical procedure(s), including surgery to other and distant sites. Lymph nodes removed. Regional tissues removed. Metastatic Sites Facility and date for each procedure Record positive and negative findings. Record Positive findings first. Reason for no surgery Other treatment information, e.g., planned procedure aborted.	DX confirmation #490 RX Date Surgery #1300 Surgery Rx Code #1390 RX Summ Scope of Reg LN Surgery #1392 RX Summ-Surg Other/Dist RX Code #1394 Reason for No Surgery #1340 RX-Summ-Radiation # 1360
Rx Text-Radiation #2620	Date radiation treatment began and ended. Where treatment given Type(s) of radiation Planned doses. Other treatment information (discontinued after 2 treatments.)	Date Radiation Started #1310 Rad-Regional RX Modality Code #1570 RX Summ-Surg/Rad Sequence #1380

Rx Text-Chemo #2640	Date when chemotherapy began and ended. Where chemotherapy was given Type of chemotherapy (name of agent(s) and doses planned/received. Other treatment information (treatment cycle incomplete.)	Chemotherapy Code #1390 RX Date-Systemic #3230 Systemic/Surgery Sequence #1639 RX Date Chemo #1220
Rx Text-Hormone #2650	Planned hormone treatment. Date treatment was started. Where treatment was given Type of hormone or antihormone Type of endocrine surgery or radiation Other treatment Information, e.g., Treatment cycle incomplete.	Hormone Code #1400 RX Date-Systemic #3230 Systemic/Surgery Sequence #1639
Rx Text-BRM Immunotherapy #2660	Date treatment began. Where treatment was given e.g., at this facility, at another facility. Planned immunotherapy treatment. 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.	Immunotherapy Code #1340
Rx Text-Other #2670	Date treatment was started. Where treatment was given Type of other treatment Other treatment information (incomplete)	Date of Initial Treatment #1360 RX Summ-Other #1420 RX Date-Other #1350

Text Documentation Examples

The pertinent information in the following examples has been documented in bold lettering for easier identification of required text.

CASE #1 LUNG

Imaging Reports

2/18/18 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.

2/28/18 CT Brain Your Hospital: **Impression**: No evident disease process.

Pathology Reports

2/28/18 Your Hospital: **Final Diagnosis:** Fine Needle Aspirate, right lower lobe lung: positive for malignant cells

3/1/18 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.

Clinical Reports

3/15/18: 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

2/18/18 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

2/28/18 Ct Brain: No evident dz process

2/28/18 Fine Needle Aspirate RLL lung: positive for malignant cells

3/1/18 RLL Resection: MD SCC, 2 nodules 5cm and 0.5cm, margin free, 0/3 peribronchial, paratracheal and pretracheal lns

Treatment Documentation

3/1/17 RLL lobectomy with mediastinal ln dissection

3/15/18 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 BREAST

Imaging Reports

6/1/18 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.

6/14/18 Chest Xray: Within normal limits

6/14/18 Bone Scan: **Impression**: No evidence of skeletal disease. Thoracic and lumbar spine negative for metastases.

Pathology Reports

6/8/18 Right breast fine needle aspiration cytology: Adenocarcinoma

6/15/18 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

6/1/18 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.

10/13/18 Oncology Clinic Follow-up Note: Patient started 3 cycles of adjuvant Adriamycin and Cytoxan on

7/20/18, recently completed and now has begun Tamoxifen.

Summary Stage Documentation

6/1/18 H&P 2cm mass in Rt breast, no masses palpated in Lt breast, no enlarged lymph nodes.

6/1/18 Mammogram: 1.5cm mass Rt breast UOQ, no lymphadenopathy, Lt breast appears normal.

6/14/18 CXR: WNL; Bone Scan: No evident mets

6/8/18 Rt Breast fine needle aspiration - AdenoCa

6/15/18 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

6/15/18 Rt breast modified radical mastectomy.

10/13/18 Oncology note: Pt had 3 cycles Adriamycin and Cytoxan begun on 7/20/18, recently completed and has begun Tamoxifen.

CASE #3 COLON/RECTUM

Imaging Reports

4/20/2017 CT Abdomen and Pelvis: **Conclusion**: 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 that 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.

4/25/17 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

4/15/2017 **Final Diagnosis:** Colon biopsy at 135cm moderately differentiated adenocarcinoma, mucin producing signet ring cell, high-grade.

5/1/2017 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.

Microsatellite Instability-Stable

KRAS mutated.

Normal heterozygous state (Normal LOH)

Operative **Report**

Date of Procedure: 5/1/17

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 and 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: 5/15/17

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 colonoscopy and was found to have lesions in the right side of the colon. The patient underwent surgery on May 1, 2017.

ASSESSMENT

The patient has a new diagnosis of high-grade mucin producing signet ring cell adenocarcinoma of the 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

4/15/17 Colon biopsy at 135cm: Moderately differentiated AdenoCa, mucin producing signet ring cell, high-grade.

4/20/17 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; shotty 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.

4/25/17 Whole body PET scan: No focal areas of increased uptake in liver to suggest hepatic mets.

5/1/17 Operative report: Liver palpated, found to be unremarkable, no lesion in colon other than Rt colon.

5/1/17 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.

5/15/17 Oncology consult: The patient may benefit from adjuvant chemotherapy; unknown if chemotherapy given.

Treatment Documentation

5/1/17 Right Hemicolectomy

CASE #4 MELANOMA

Imaging Reports

5/10/17 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

5/3/17 Final Diagnosis: Shave biopsy skin of left forearm, malignant melanoma

5/11/17 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

6/15/17 The patient started on an interferon regimen today.

Summary Stage Documentation

5/3/17 Shave bx skin of lt. forearm: Malignant melanoma

5/10/17 CT chest: Probably malignant involvement of lt. axillary lymph nodes, remainder of exam normal

5/11/17 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: Less than 1.5 x upper limit of normal for lactate dehydrogenase (LDH) assay.

Treatment Documentation

5/11/17 Wide excision of skin of lt. forearm

6/15/17 started interferon regimen

CASE #5 LYMPHOMA

Imaging Reports

2/2/17 CT Chest Impression: Extensive right and left hilar lymphadenopathy, enlarged lymph nodes in the mediastinum.

2/2/17 CT Abdomen Impression: Splenomegaly, otherwise within normal limits.

2/4/17 PET Scan: Intense focus of tracer uptake seen in peri-portal region consistent with lymphoma.

Pathology Reports

2/3/17 Biopsy of left axillary lymph nodes, Follicular Lymphoma, Gr 1

H&P

2/2/17 Patient presents with bilateral cervical and axillary lymphadenopathy, night sweats, and fevers for last couple of months.

Oncology Consult

2/13/17 The patient started combination chemotherapy including Rituxan on February 5 and has done well except for nausea. We will start him on a trial of antiemetics.

Summary Stage Documentation

2/2/17 H&P Pt has bilateral cervical and axillary lymphadenopathy, hx of night sweats, fevers.

2/2/17 CT Chest: rt. and lt. hilar lymphadenopathy, enlarged lymph nodes in the mediastinum.

2/2/17 CT Abdomen: Splenomegaly, otherwise within normal limits

2/3/17 Biopsy lt. axillary lns: Follicular Lymphoma, Gr 1

2/4/17 PET scan: focus of tracer uptake in peri-portal region consistent with lymphoma

Treatment Documentation

2/5/17 Combination chemotherapy including Rituxan, other types of chemo not mentioned.

CASE #6 PROSTATE

Imaging Reports

4/14/17 CT Abdomen/Pelvis Impression: Tiny cyst in the liver. No lymphadenopathy in abdomen or pelvis.

4/14/17 Bone scan Impression: Evidence of previous fracture in right 13th rib, otherwise negative bone scan.

Pathology Reports

4/1/17 Final Diagnosis: Prostate core needle biopsy, adenocarcinoma present in 8 of 13 cores, Gleason Score 3+3=6.

Clinical Reports

3/27/17 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.

7/1/17 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 6/15/17.

Summary Stage Documentation

3/27/17 PE: DRE shows slightly enlarged prostate with no nodularity or induration, abdomen and pelvis with no palpable abnormalities, PSA 6.

4/1/17 Prostate core needle biopsy: adenocarcinoma in 8/13 cores, Gleason Score 3+3=6.

4/14/17 CT Abdomen/Pelvis: no lymphadenopathy in abdomen or pelvis.

4/14/17 Bone scan: negative.

Treatment Documentation

External beam radiation therapy completed on 6/15/17, start date not given; estimate start date 5/2017.

Additional Resources

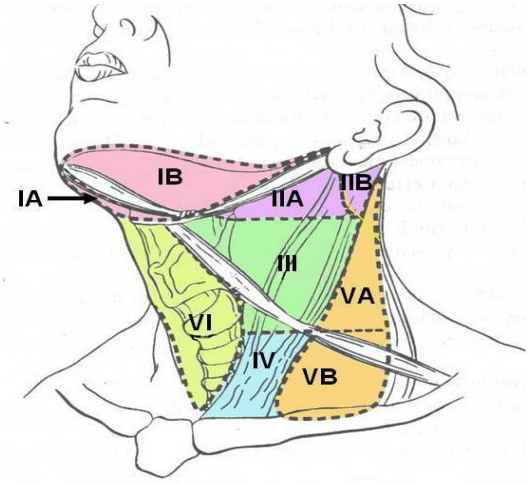


Table 5.1 Anatomical structures defining the boundaries of the neck levels and sublevels.

Boundary Level	Superior	Inferior	Anterior (medial)	Posterior (lateral)
IA	Symphysis of the mandible	Body of the hyoid	Anterior belly of the contralateral digastric muscle	Anterior belly of the ipsilateral digastric muscle
IB	Body of the mandible	Posterior belly of the digastric muscle	Anterior belly of the digastric muscle	Stylohyoid muscle
IIA	Skull base	Horizontal plane defined by the inferior border of the hyoid bone	Stylohyoid muscle	Vertical plane defined by the spinal accessory nerve
IIB	Skull base	Horizontal plane defined by the inferior body of the hyoid bone	Vertical plane defined by the spinal accessory nerve	Lateral border of the sternocleidomastoid muscle
III	Horizontal plane defined by the inferior body of the hyoid	Horizontal plane defined by the inferior border of the cricoid cartilage	Lateral border of the sternohyoid muscle	Lateral border of the sternocleidomastoid or sensory branches of the cervical plexus
IV	Horizontal plane defined by the inferior border of the cricoid cartilage	Clavicle	Lateral border of the sternohyoid muscle	Lateral border of the sternocleidomastoid or sensory branches of the cervical plexus
VA	Apex of the convergence of the sternocleidomastoid and trapezius muscles	Horizontal plane defined by the lower border of the cricoid cartilage	Posterior border of the sternocleidomastoid muscle or sensory	Anterior border of the trapezius muscle

			branches of the cervical plexus	
VB	Horizontal plane defined by the lower border of the cricoid cartilage	Clavicle	Posterior border of the sternocleidomastoid muscle	Anterior border of the trapezius muscle
VI	Hyoid bone	Suprasternal notch	Common carotid artery	Common carotid artery
VII	Suprasternal notch	Innominate artery	Sternum	Trachea, esophagus, and prevertebral fascia

Modified from Robbins KT. Glayman G, Levine PA, et al., with permission from the American Medical Association

UNIT ABBREVIATIONS

NUMBER	PREFIX	WRITTEN
1,000,000	Mega-	M
1,000	Kilo-	K
1 (baseline)	Deka-	Da
1/10	Deci-	d
1/100	Centi-	c
1/1000	Milli-	m
One millionth	Micro-	µ
One billionth	Nano-	n
One trillionth	Pico-	p
One quadrillionth	Femto	f

MEASUREMENT PREFIXES

UNIT	ABBREVIATION
Liter	l
Unit	U
Meter	m
Unit of substance	mole, mol
Gram	g, gr
milli Equivalent	mEq, meq

COMMON CODES IN SITE-SPECIFIC FACTORS

CODE	DESCRIPTION
000	0 ng/ml
001	0.1 or less ng/ml
002-979	0.2-97.9 ng/ml
980	98.0 or greater ng/ml
988	Not applicable. Information not collected for this case. May include cases converted from code 888 used in CSv1 for “Not Applicable” or when the item was not collected. If this item is required to derive T, N, M, or any stage, use of code 988 may result in an error.
997	Test ordered, results not in chart
998	Test not done (test was not ordered and was not performed)
999	Unknown or no information; Not documented in patient record

COMMON ACCEPTABLE ABBREVIATIONS

RECOMMENDED ABBREVIATIONS FOR ABSTRACTORS

Even in the age of computerized abstracts with coded fields, text is still required to supplement and support coded information. 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.

These consist of two main lists of over 600 words/terms and their recommended abbreviations/symbols, as well as a special table of context-sensitive abbreviations. The first list is ordered by the words/terms for which an abstractor seeks an abbreviation, and the second is ordered by abbreviation/symbol, paired with the complete word or term. The context-sensitive abbreviations table consists of a subset of the abbreviations, for which a different context for the same abbreviation conveys a different meaning (for example, CA may mean calcium or carcinoma, and ML may mean milliliter or middle lobe). For these context-sensitive abbreviations, the meaning of the abbreviation should be readily apparent from its context.

NAACCR RECOMMENDED ABBREVIATION LIST
ORDERED BY ABBREVIATION/SYMBOL

ABBREVIATION/SYMBOL	WORD/TERM(S)
^	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	
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
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
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
AX	Axilla(ry)
AXLND	Axillary Lymph node dissection
B	
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
BNA	Block Numbering Area
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
BUN	Blood urea nitrogen
BUS	Bartholin's, Urethral & Skene's
BV	Blood volume
BX	Biopsy
C	
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	Carcinoma in situ
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
CPT	Current Procedural Terminology (codes)
CRC	Cyclic redundancy code
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	
D&C	Dilatation and curettage
D/C	Discharge
D/T	Due to
DC	Discontinue(d)
DCIS	Ductal carcinoma in situ
DCO	Death Certificate Only
D-COLON	Descending colon
DDX	Differential diagnosis
DECR	Decrease(d)
DERM	Dermatology
DES	Diethylstilbestrol
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	
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
EOD	Extent of Disease
ER	Emergency room
ER(A)	Estrogen receptor (assay)
ERCP	Endoscopic retrograde cholangiopancreatography
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
F	
FAP	Familial adenomatous 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)
G	
GB	Gallbladder
GE	Gastroesophageal
GEN	General/Generalized
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GIST	Gastrointestinal stromal tumors
GR	Grade
GU	Genitourinary
GY	Gray
GYN	Gynecology
H	
H&E	Hematoxylin and Eosin
H&P	History and physical
H/H	Hemoglobin and hematocrit
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
HTLV	Human T-Lymphotropic Virus, (Type III)
HTN	Hypertension
HVD	Hypertensive vascular disease
HX	History
HYST	Hysterectomy
I	
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
IRREG	Irregular
IT	Intrathecal
ITC	Isolated tumor cells
ITP	Idiopathic thrombocytopenia
IV	Intravenous
IVC	Inferior vena cava
IVCA	Intravenous cholangiogram
IVP	Intravenous pyelogram
J	
JAK2	Janus kinase 2
JRA	Juvenile rheumatic arthritis
JVD	Jugular venous distention
K	
KG	Kilogram

KS	Kaposi sarcoma
KUB	Kidneys, ureters, bladder
KV	Kilovolt
L	
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
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	
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)
METS	Metastatic/Metastasis
MEV	Million electron volts
MG	Myasthenia gravis
MG(H)	Milligram (hours)
MGF	Maternal grandfather
MGM	Maternal grandmother
MGUS	Monoclonal gammopathy 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	
N&V	Nausea and vomiting
N/A	Not applicable
N/V	Nausea and vomiting
NA	Not applicable
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
O	
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	
P/DIFF	Poorly differentiated
P32	Phosphorus 32
PAC	Premature atrial contraction
PALP	Palpated (-able)
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 system
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
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	
Q	Every
QD	Every day
QUAD	Quadrant
R	
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
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	
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
SIL	Squamous intraepithelial lesion
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
SSF	Site Specific Factor
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
T	
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, metastasis
TOB	Tobacco
TRANS-COLON	Transverse colon

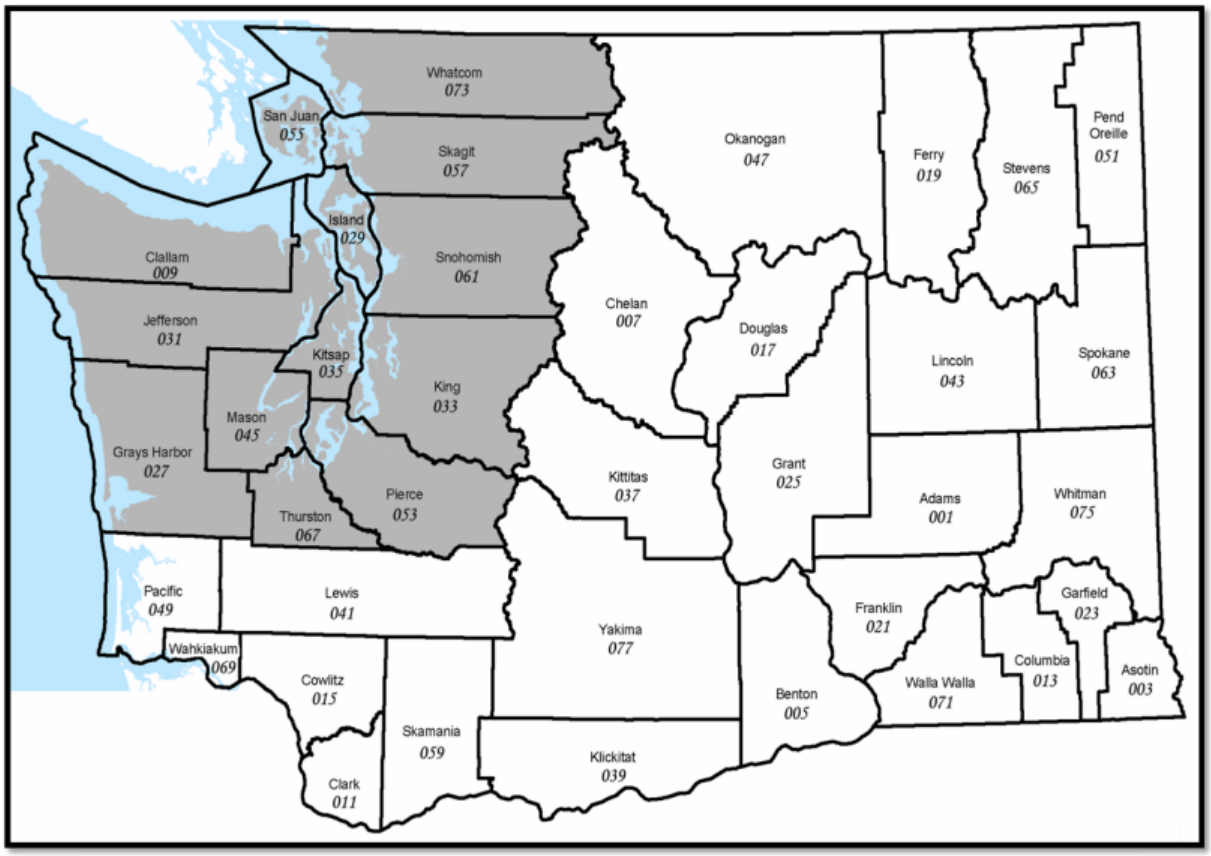
TRUS	Transrectal ultrasound
TS	Tumor size
T-SPINE	Thoracic spine
TTP	Thrombotic thrombocytopenic purpura
TUR	Transurethral resection
TURB	Transurethral resection bladder
TURP	Transurethral resection prostate
TVC	True vocal cord
TVH	Total vaginal hysterectomy
TX	Treatment
U	
UE	Upper extremity
UGI	Upper gastrointestinal (series)
UIQ	Upper inner quadrant
UNDIFF	Undifferentiated
UNK	Unknown
UOQ	Upper outer quadrant
URI	Upper respiratory infection
US	Ultrasound
UTI	Urinary tract infection
V	
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	
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
WF	White female
WK(S)	Week(s)
WL	Weight loss
WM	White male
WNL	Within normal limits
WPW	Wolff-Parkinson-White syndrome
WT	Weight
X	
XR	Xray
XRT	External radiation therapy
Y	
Y/O	Year old
YO	Year old
YR(S)	Year(s)

FIPS COUNTY CODES

County Code	County
001	Adams County
003	Asotin County
005	Benton County
007	Chelan County
009	Clallam County
011	Clark County
013	Columbia County
015	Cowlitz County
017	Douglas County
019	Ferry County
021	Franklin County
023	Garfield County
025	Grant County
027	Grays Harbor County
029	Island County
031	Jefferson County
033	King County
035	Kitsap County
037	Kittitas County
039	Klickitat County
041	Lewis County
043	Lincoln County
045	Mason County
047	Okanogan County
049	Pacific County
051	Pend Oreille County
053	Pierce County
055	San Juan County
057	Skagit County
059	Skamania County
061	Snohomish County
063	Spokane County
065	Steven County
067	Thurston County
071	Walla Walla County
073	Whatcom County
075	Whitman County
077	Yakima County

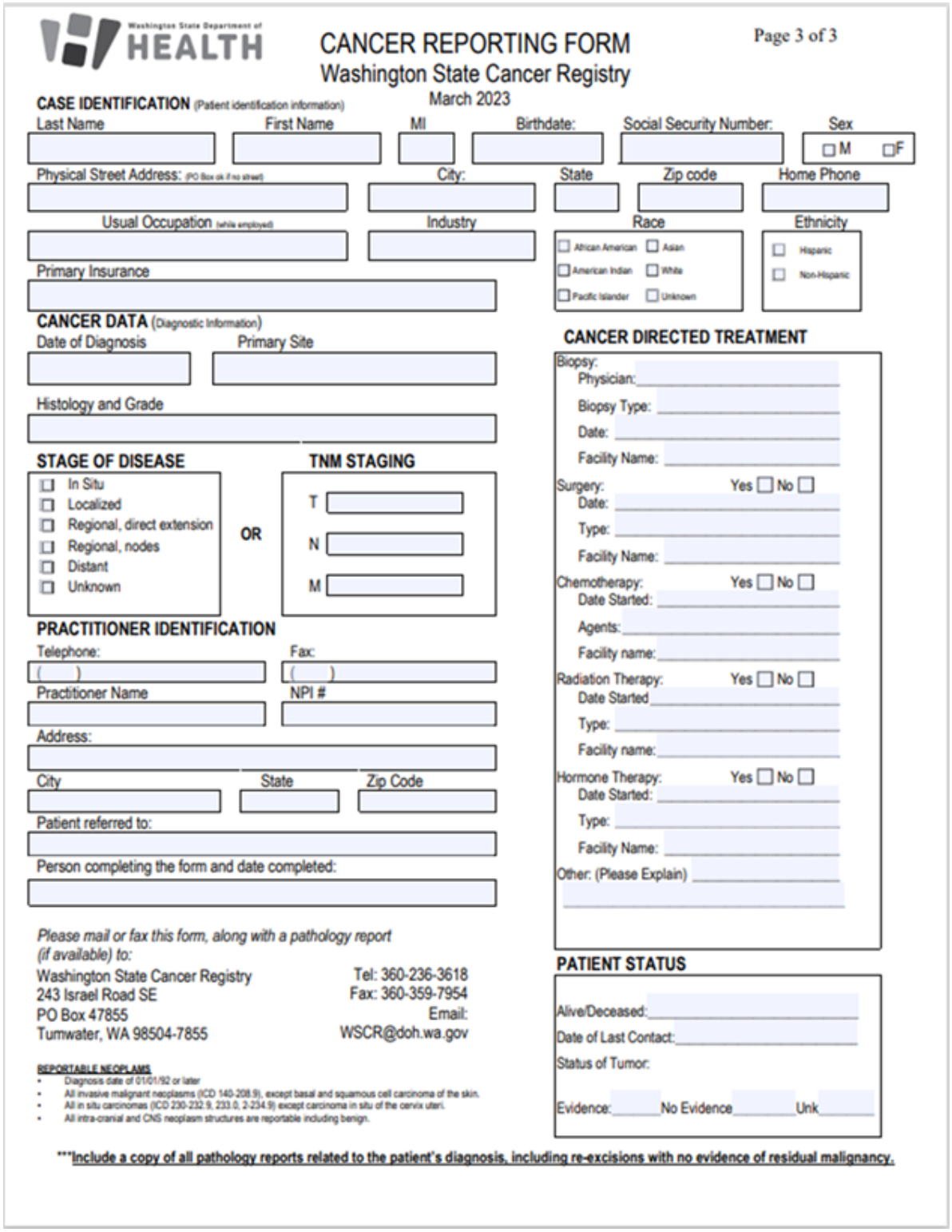
WASHINGTON STATE CANCER REGISTRY



Washington State County FIPS Codes and Western Washington SEER Reporting Area.

= SEER Reporting Area

WSCR CANCER REPORTING FORM



Washington State Department of HEALTH

CANCER REPORTING FORM
Washington State Cancer Registry
March 2023

Page 3 of 3

CASE IDENTIFICATION (Patient identification information)

Last Name | First Name | MI | Birthdate: | Social Security Number: | Sex ☐M ☐F

Physical Street Address: (PO Box ok if no street) | City: | State | Zip code | Home Phone

Usual Occupation (while employed) | Industry

Race: ☐ African American ☐ Asian ☐ American Indian ☐ White ☐ Pacific Islander ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Primary Insurance

CANCER DATA (Diagnostic Information)

Date of Diagnosis | Primary Site

Histology and Grade

STAGE OF DISEASE

☐ In Situ
☐ Localized
☐ Regional, direct extension
☐ Regional, nodes
☐ Distant
☐ Unknown

OR

TNM STAGING

T
N
M

PRACTITIONER IDENTIFICATION

Telephone: ( ) | Fax: ( )

Practitioner Name | NPI #

Address:

City | State | Zip Code

Patient referred to:

Person completing the form and date completed:

Please mail or fax this form, along with a pathology report (if available) to:

Washington State Cancer Registry
243 Israel Road SE
PO Box 47855
Tumwater, WA 98504-7855

Tel: 360-236-3618
Fax: 360-359-7954
Email:
WSCR@doh.wa.gov

REPORTABLE NEOPLASMS

- Diagnosis date of 01/01/92 or later
- All invasive malignant neoplasms (ICD 140-208.9), except basal and squamous cell carcinoma of the skin.
- All in situ carcinomas (ICD 230-232.9, 233.0, 2-234.9) except carcinoma in situ of the cervix uteri.
- All intra-cranial and CNS neoplasm structures are reportable including benign.

CANCER DIRECTED TREATMENT

Biopsy:
Physician:
Biopsy Type:
Date:
Facility Name:

Surgery: Yes ☐ No ☐
Date:
Type:
Facility Name:

Chemotherapy: Yes ☐ No ☐
Date Started:
Agents:
Facility name:

Radiation Therapy: Yes ☐ No ☐
Date Started
Type:
Facility name:

Hormone Therapy: Yes ☐ No ☐
Date Started:
Type:
Facility Name:

Other: (Please Explain)

PATIENT STATUS

Alive/Deceased:
Date of Last Contact:
Status of Tumor:

Evidence: No Evidence Unk

***Include a copy of all pathology reports related to the patient's diagnosis, including re-excisions with no evidence of residual malignancy.

References & Resources

National Cancer Institute – Surveillance, Epidemiology, and End Results Program (SEER)
Surveillance, Epidemiology, and End Results Program (cancer.gov)

North American Association of Central Cancer Registries (NAACCR)
Home (naaccr.org)

National Cancer Registrars Association (NCRA)
National Cancer Registrars Association > Home (ncra-usa.org)

American College of Surgeons (ACOS)
American Joint Committee on Cancer
American Joint Committee on Cancer | ACS (facs.org)

Cancer Program
Cancer Programs | ACS (facs.org)

Commission on Cancer
Commission on Cancer | ACS (facs.org)

National Accreditation for Breast Cancer Programs
National Accreditation Program for Breast Centers (NAPBC) | ACS (facs.org)

National Accreditation Program for Rectal Cancer
National Accreditation Program for Rectal Cancer | ACS (facs.org)

National Cancer Database
National Cancer Database (NCDB) | ACS (facs.org)

Cancer Surgery Standards Program
Cancer Surgery Standards Program | ACS (facs.org)

College of American Pathologists
Cancer Protocol Templates | College of American Pathologists (cap.org)

Washington State Cancer Registry
Cancer Data | Washington State Department of Health

Washington State Comprehensive Cancer Control Program
About Comprehensive Cancer Control | Washington State Department of Health

Washington State Breast, Cervical, and Colon Health Program
Breast, Cervical and Colon Health Program | Washington State Department of Health

Revised Code of Washington
Revised Code of Washington (RCW)

Cancer Surveillance System (Fred Hutch Cancer Center)
Cancer Surveillance System (CSS) (fredhutch.org)

Resources for Registrars and Vendors | Washington State Department of Health
Resources for Registrars and Vendors | Washington State Department of Health

***Note: All information found in this handbook can be found by using the above-mentioned resources. While our office will always try to give you the most updated information available, it is possible that updated will occur in between the dates we have updated this document and you have received it. We encourage everyone to be diligent and always double check with standard setters and your own facility for additional information and updates. ***