Tennessee Cancer Registry (TCR) Abstracting & Coding Manual

Mission Statement

Dedicated to the collection and use of quality data for the purpose of decreasing the incidence and mortality of cancer in Tennessee

ACKNOWLEDGEMENTS

We would like to thank the Collaborative Staging Task Force of the American Joint Committee on Cancer, the American College of Surgeons, Commission on Cancer (ACoS, COC), the National Cancer Institute, the Surveillance, Epidemiology, and End Results (SEER) program, and the North American Association of Central Cancer Registries (NAACCR) for allowing the reproduction and use of portions of the:

Collaborative Staging Manual and Coding Instructions, version 02.05

Facility Oncology Registry Data Standards (FORDS) Manual 2015

NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, 19th ed.

SEER Program Coding and Staging Manual 2015

SEER Training Materials

Multiple Primary and Histology Coding Rules

2015 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual

Citations:

Collaborative Stage Work Group of the American Joint Committee on Cancer. *Collaborative Stage Data Collection System User Documentation and Coding Instructions, version 02.05* Published by American Joint Committee on Cancer (Chicago, IL).

Facility Oncology Registry Data Standards (FORDS): Revised for 2015, Commission on Cancer of the American College of Surgeons; Chicago, IL. 2002.

Thornton ML, (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 15,* 19th ed. Springfield, Ill.: North American Association of Central Cancer Registries, October 2014; revised October 2014; revised February 2015.

Adamo M, Dickie, L, Ruhl J. (eds.) *2015 SEER Program Coding and Staging Manual*. National Cancer Institute, NIH Publication number 15-5581, Bethesda, MD

Johnson CH, Peace S, Adamo P, Fritz A, Percy-Laurry A, Edwards BK. *The 2007 Multiple Primary and Histology Coding Rules.* National Cancer Institute, Surveillance, Epidemiology and End Results Program. Bethesda, MD, 2007.

Ruhl J, Adamo M, Dickie L. (eds.), *2015 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*. National Cancer Institute, Bethesda, MD 20850-9765.

Dear Cancer Registrar:

The Tennessee Cancer Registry (TCR) is a non-profit professional organization that by law is required to collect, maintain and use cancer incidence data. Specific rules and regulations set forth by the Tennessee Department of Health (TDH) and the Centers for Disease Control and Prevention govern these processes.

For reference, copies of the Tennessee Cancer Reporting Act and the official Rules and Regulations associated with the law are included within this manual.

The success of the Tennessee Cancer Surveillance Program is dependent upon each individual registrar's dedication to the shared goals of identifying and accurately reporting every reportable case diagnosed and/or treated within the state.

This version of the Tennessee Cancer Registry (TCR) Abstracting and Coding Manual includes the latest guideline revisions and provides a more concise, user-friendly set of instructions for abstracting the cancer data required by the Tennessee Department of Health. Additional examples and clarifications have also been added to further assist in this process.

The role of a cancer registrar is an extremely important one in the fight against cancer.

Every abstract submitted to the Tennessee Cancer Registry is a valuable source of information used by epidemiologists, physicians, researchers, and state officials.

The data sent to TCR is used to calculate cancer incidence statistics for the state. This provides the necessary information to plan and implement cancer prevention and control measures. The information submitted directly impacts and improves the lives of the people of Tennessee.

Your dedication to the quality and completeness of cancer reporting is greatly valued.

Sincerely,

The TCR Staff

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STANDARDS FOR REPORTING

Guidelines for reporting cancer to the Tennessee Cancer Registry (TCR) are established by the North American Association of Central Cancer Registries (NAACCR). These guidelines are published in the *Data Standards and Data Dictionary* (Standards for Cancer Registries, Volume II). This document presents standards for which cases are to be included in the registry, which data items are to be collected, and the source of standard for the coding rules of those items.

The Tennessee Cancer Registry also uses guidelines for cancer reporting based on suggestions by the National Cancer Institute-Surveillance, Epidemiology, and End Results (SEER) Program, the American College of Surgeons (ACoS), the American Joint Committee on Cancer (AJCC), and the Collaborative Staging Task Force of the American Joint Committee on Cancer. The guidelines are published in the current versions of the *SEER Program Coding & Staging Manual, the Facility Oncology Registry Data Standards (FORDS), the American Joint Committee on Cancer- Cancer Staging Manual, the Collaborative Staging Manual and Coding Instructions, and the SEER Summary Stage 2000 Manual.*

The use of the *TCR Abstracting and Coding Manual* and each of the following manuals is REQUIRED when submitting data to the TCR.

1. *2007 Multiple Primary and Histology Coding Rules*
   (Available for downloading at http://seer.cancer.gov/tools/mphrules/download.html)

2. *2015 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding manual*
   (Available for downloading at http://seer.cancer.gov/seertools/hemelymph/)

4. *SEER Summary Staging Manual 2000* (Available for downloading at http://seer.cancer.gov/tools/ssm/)

5. *AJCC Cancer Staging Manual, Seventh Edition*

6. *Collaborative Staging Manual and Coding Instructions, Version 02.05*
   (Available for downloading at http://cancerstaging.org/cstage/coding/Pages/Version-02.05.aspx)

For additional information regarding the ACoS *FORDS Manual, SEER Program Coding and Staging Manual, Collaborative Staging Manual and Coding Instructions,* NAACCR *Data Standards and Data Dictionary,* please visit the following websites:

ACoS:	https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals
SEER:	http://seer.cancer.gov/tools/codingmanuals/
Collaborative Staging Manual and Coding Instructions:	https://cancerstaging.org/cstage/coding/Pages/Version-02.05.aspx
NAACCR:	http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx

TENNESSEE CODE
TITLE 68, CHAPTER 1, PART 10
CANCER REPORTING SYSTEM

68-1-1001. Short title.
This part shall be known and may be cited as the "Tennessee Cancer Reporting System Act of 1983."

[Acts 1983, ch. 124, § 1.]

68-1-1002. Definitions.
As used in this part, unless the context otherwise requires:

(1) "Cancer" means and includes, but is not limited to:
  (A) A large group of diseases characterized by uncontrolled growth and spread of abnormal cells;
  (B) Any condition of tumors having the properties of anaplasia, invasion, and metastasis;
  (C) A cellular tumor, the natural course of which is fatal;
  (D) Malignant neoplasm; and
  (E) In-situ cancer.

(2) "Commissioner" means the commissioner of health;

(3) "Committee" means the cancer reporting advisory committee;

(4) "Department" means the department of health;

(5) "Facility" means a health care facility in which diagnosis or treatment services are provided to patients with cancer, including, but not limited to, an ambulatory surgical treatment center, a freestanding cancer treatment center, a radiation therapy center, a chemotherapy treatment center, a nursing home, an oncology or dermatology clinic, a laboratory, or any other facility which provides screening, detection, diagnostic or therapeutic services to patients with cancer.

(6) "Health care practitioner" means a physician, surgeon, or other health care professional licensed under title 63 who is engaged in diagnosing and treating patients who have cancer;

(7) "Hospital" means an institution as defined by § 68-11-201;

(8) "In-situ cancer" means an abnormality of development and organization of cells. It is a condition of early cancer, without the invasion of neighboring tissue;

(9) "Laboratory" means a facility where tests are performed identifying anatomical and cytological changes, and where specimens are interpreted and pathological diagnoses are made; and

(10) "Medical, scientific and academic research communities" means those institutions which devote a substantial part of their activity to research and which have internal procedures providing for the collection, study and protection of data.

[Acts 1983, ch. 124, § 3; 1985, ch. 85 § 1; 2000, ch. 775, §§ 2-6.]

68-1-1003. Purpose of chapter - Reports to department – Format and contents of reports – Persons authorized to have access to patients medical records – Reimbursement – Failure to report or give access to records.

(a) The purpose of this act is to ensure an accurate and continuing source of data concerning cancer and to provide appropriate data to members of the medical, scientific, and academic research communities for purposes of authorized institutional research, approved by the appropriate research committee of the applying institution, into the causes, types and demography of such diseases, including, but not limited to, the occupation, family history, and personal habits of persons diagnosed with cancer.

(b) In order to accomplish the purpose described in (a), all hospitals, laboratories, facilities, and health care practitioners shall report to the department, within six (6) months after the date of diagnosis of cancer in a patient, information contained in the medical records of patients who have cancer; provided, however, health care practitioners are not required to report information on patients with cancer who are directly referred to or have been previously admitted to a hospital or a facility for cancer diagnosis or treatment.

(c) The reports required by this section shall be made in such format and shall contain such information as is required by the department. The department shall make available the necessary information regarding format and data to enable hospitals, laboratories, facilities, and health care practitioners to make accurate reports to the department.

(d) The commissioner or the commissioner's authorized representative may take such steps as are necessary to avoid duplicate reporting of information on the same patients, including, but not limited to, waiving the requirement for a health care practitioner to report information on cancer patients who are hospitalized or confined to a nursing home, where information on those patients has been reported by the hospital, nursing home, or other reporting source.

(e) The commissioner or the commissioner's authorized representative shall be permitted to have access to the medical records of cancer patients which are maintained by hospitals, laboratories, facilities, and health care practitioners where necessary to identify cases of cancer and to establish the characteristics of the cancer, the treatment of the cancer, or the medical status of an identified cancer patient.

(f) If a hospital, laboratory, facility, or health care practitioner fails to report the required information to the department in an acceptable format by the required deadline, the commissioner or the commissioner's authorized representative may obtain the information by a direct examination of those patients' medical records. In such cases, the hospital, laboratory, facility, or health care practitioner shall reimburse the department for the department's reasonable expenses incurred in obtaining the information in this manner. The commissioner shall establish in rules the maximum amount of reimbursement which may be sought, and a hospital, laboratory, facility, or health care practitioner from whom reimbursement is sought may appeal the assessment of expenses under the Tennessee Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(g) A hospital, laboratory, facility, or health care practitioner that fails to report information or allow access to records, as required by this section, shall be informed by the department that compliance with the requirements of this act is mandatory.

[Acts 1983, ch. 124, § 4; 1985, ch. 85 § 2; 2000, ch. 775, § 7.]

68-1-1004. Reports to department - Rules and regulations.

(a) The department shall require the reporting of cancer and the submission of such specified additional information on reported cases as the commissioner deems necessary and appropriate.

(b) The commissioner shall promulgate such rules and regulations, including public necessity rules, as are necessary for carrying out the duties and responsibilities of the department under this part. Such

promulgation shall be in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

[Acts 1983, ch. 124, § 5; 2000, ch. 775, § 8.]

68-1-1005. [Repealed.]

68-1-1006. Confidentiality of data.

(a) (1) All data obtained from the reports required by this part are for the confidential use of the department and persons that the commissioner determines are necessary to carry out the intent of this part.

(2) Information that could possibly identify individuals whose medical records have been used for collecting data may not be included in materials available to the public.

(b) In order to carry out the legislative intent set out elsewhere in this chapter that the data obtained from the reports required by this part are also to be made available for valid research projects, the commissioner, with the advice of the advisory committee established by this chapter, is authorized to make available to members of the research community set out elsewhere in this chapter specific and personally identifiable portions of the data collected; provided, that the following guidelines are observed:

(1) The researcher sets out clearly the uses for which the data are desired;

(2) The researcher clearly states the reasons for which confidential and personally identifiable portions of the data are necessary;

(3) The researcher assures that the data received from the department will be maintained by the researcher with the same level of confidentiality as that maintained by the department; and

(4) Upon completion of the research project, all data provided by the department and all copies of the data shall be destroyed.

(c) Guidelines for such research applications shall be set out by departmental regulations. For the purposes of this part, those approved to obtain data for research shall not be considered agents of the commissioner.

[Acts 1983, ch. 124, § 7; 1985, ch. 85, § 4.]

68-1-1007. Liability for release of information – Compliance not violative of confidentiality.

A hospital, laboratory, facility, or health care practitioner that reports information to the department or allows the commissioner or the commissioner's authorized representative access to the medical records of cancer patients, as required by this part, shall not be held liable to any person for the release of such information to the department, nor shall the release of such information to the department be construed as a violation of any requirement of law or professional obligation to maintain the confidentiality of patient information.

[Acts 1983, ch. 124, § 8; 2000, ch. 775, § 10.]

68-1-1008. Tests and supervision of patients prohibited.

No patient whose medical records are the subject of data collected in the reports required by this part shall be subjected to any medical examination or case supervision by the commissioner or the commissioner's agents for the purposes of this part.

[Acts 1983, ch. 124, § 9.]

68-1-1009. Violations - Penalties - Enforcement.

(a) Any person receiving information containing the personal identity of any patient, who willfully divulges that identity, except as lawfully provided for in this chapter, commits a Class C misdemeanor.

(b) It is the duty of the district attorney general to prosecute such suit when requested by the commissioner, the county health officer or local board of health.

[Acts 1985, ch. 85, § 5; 1989, ch. 591, § 113.]

68-1-1010. Interstate sharing of information – Confidentiality.

(a) In order to obtain complete information on Tennessee cancer patients who have been diagnosed or treated in other states and in order to provide information to other states regarding their residents who have been diagnosed or treated for cancer in Tennessee, the commissioner or the commissioner's authorized representative is hereby authorized to enter into appropriate written agreements with other states that maintain statewide cancer registries, allowing the exchange of information on cancer patients.

(b) Each state with which the commissioner agrees to exchange such information must agree in writing to keep all patient-specific information confidential and to require any research personnel to whom the information is made available to keep it confidential.

[Acts 2000, ch. 775, § 11.]

68-1011. Annual publishing of reports.

The Department shall annually compile and publish reports utilizing the data collected pursuant to this part and shall make these reports available to the governor, the general assembly, and the public.

[Acts 2000, ch. 775, § 12.]

HIPPAA PRIVACY RULE

SUBJECT: Disclosure of Protected Health Information to Cancer Registries under Federal Health Information Privacy Protections Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This memorandum is intended to site the regulations under which the reporting of protected health information, specifically cancer data to the Tennessee Cancer Registry (TCR), is permitted under both Tennessee law and the HIPAA Privacy Rule.

I hope this information is helpful to allay concerns regarding disclosure of confidential information to TCR in compliance with the law.

Reporting of Cancer Data to TCR:

As required by Tennessee law and as a public health authority, disclosure of confidential patient information to TCR is permitted. The specific provisions establishing this fact are specified below:

1. Under legislation, T.C.A. 68-1-1001, "Tennessee Cancer Reporting System Act of 1983":
   All hospitals, laboratories, facilities, and health care practitioners shall report to the department, within six (6) months after the date of diagnosis of cancer in a patient, information contained in the medical records of patients who have cancer….

2. According to the HIPAA Privacy Rule, 45 C.F.R, Section 164.512(a):
   Uses and disclosures required by law. (1) A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

3. According to the HIPAA Privacy Rule, 45 C.F.R, Section 164.512(b):
   A covered entity may disclose protected health information for public health activities…to a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including but not limited to, the reporting of disease, injury, vital events, such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions….

Disclosure without authorization of the individual:

1. According to HIPAA Privacy Rule, 45 C.F.R., Section 164.512:
   A covered entity may use or disclose protected health information without the written authorization of the individual or the opportunity for the individual to agree or object as described in the requirements of this section…(b) to a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability,…and the conduct of public health surveillance, public health investigations, and public heath interventions….

Liability for release of information – Compliance not violative of confidentiality:

1. Under legislation, T.C.A. 68-1-1007, "Tennessee Cancer Reporting System Act of 1983":
   A hospital, laboratory, facility, or health care practitioner that reports information to the department or allows the commissioner or the commissioner's authorized representative access to the medical records of cancer patients, as required by this part, shall not be held liable to any person for the release of such information to the department, nor shall the release of such information to the department be construed as a violation of any requirement of law or professional obligation to maintain the confidentiality of patient information.

Casefinding and Reabstracting Studies:

To assure completeness and accuracy of cancer reporting, casefinding and reabstracting studies must be performed. In order to complete these functions, confidential records of patients who have been diagnosed with cancer and those who have not been diagnosed with cancer must be reviewed (i.e.: disease index, master patient listing, pathology reports, etc.) Provisions covering these incidences are specified below:

1. According to Policies and Procedures 1200-7-2-. 05 (6a) (by authority of T.C.A. 68-1-1001):
   "Staff members of the TCR or their agents shall perform periodic quality assurance studies at all reporting facilities. These studies shall include casefinding and reabstracting."

2. The HIPAA Privacy Rule, under 45 C.F.R., Section 164.512 and 164.514 (d)(3)(iii), provides no barrier to a covered entity relying on a public official's determination of what information that official requires to accomplish its function.

During the course of conducting casefinding and reabstracting studies, the TCR may request access to documents containing information about patients who do not have cancer as a means to assure completeness and accuracy of reporting.

Section One:

General Guidelines

REPORTABILITY

Definition of Reportable: Reportable cases are cases that the registry is required to abstract and submit to the Tennessee Cancer Registry.

All reportable diseases diagnosed and/or treated at the reporting facility or one of its affiliates must be reported to the Tennessee Cancer Registry (TCR). Submissions must include inpatient cases and outpatient cases.

The TCR collects information on in situ tumors, invasive/malignant tumors, benign tumors of the brain and central nervous system, borderline tumors of the brain and central nervous system, various hematopoietic diseases, and various lymphoid neoplasms. Both clinically diagnosed and histologically diagnosed cases must be reported.

Use of the *International Classification of Diseases for Oncology, Third Edition* (ICD-O-3) is critical in identifying reportable cases. Many diagnoses that do not sound reportable must be abstracted and submitted to the TCR.

Examples:

VIN III - Vulvar Intraepithelial Neoplasia
VAIN III - Vaginal Intraepithelial Neoplasia
AIN III - Anal Intraepithelial Neoplasia

Refractory Anemia
Gamma Heavy Chain Disease

Reportable Diagnoses:

A. Report all histologies with a behavior code of /2 or /3 in the *International Classification of Diseases for Oncology*, Third Edition (ICD-O3) except those listed in the Exceptions area below.

B. Since the last publication of the ICD-O3, additional medical conditions have become reportable, new histology codes created, and histology and behavior code adjusted. These important additions that are not reflected in the ICD-O3 are listed below:

- Non-invasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP) is reportable (effective with diagnosis date 1/1/2017 onward). Use 8343/2 for the histology and behavior code.

  - ✓ Note: Additional coding clarifications for thyroid malignancies-

Description	**Histology/Behavior Code**
Non-invasive encapsulated follicular variant of papillary thyroid carcinoma (non-invasive EFVPTC)	8343/2
Invasive encapsulated follicular variant of papillary thyroid carcinoma (invasive EFVPTC)	8343/3
Encapsulated follicular variant of papillary thyroid carcinoma, NOS (EFVPTC, NOS). Synonym: Papillary carcinoma, encapsulated	8343/3

- Effective with diagnosis date 1/1/2015, Carcinoid, NOS (8240/3) of the appendix (C18.1) is reportable. (The ICD-O3 behavior code changed from /1 to /3.)

- Intraepithelial neoplasia, grade III is reportable:

  - Examples (not a complete list):
    - Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211)
    - Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)
    - Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509)
    - Penile intraepithelial neoplasia, grade III (PeIN III) (C600-C609)
    - Squamous intraepithelial neoplasia, grade III (SIN III) except cervix and skin.
    - Vaginal intraepithelial neoplasia, grade III (VAIN III) (C529)
    - Vulvar intraepithelial neoplasia III (VIN III) (C510-C519)

  ✓ Note: Intraepithelial neoplasia (8077/2 and 8148/2) must be unequivocally state as Grade III to be reportable.

- Additional reportable pancreatic conditions and coding clarifications:

Description	**Histology/Behavior Code**
Intraductal papillary mucinous neoplasm with high grade dysplasia (IPMN)	8453/2
Pancreatic neuroendocrine neoplasm (PanNet)	8240/3
Pancreatic endocrine neoplasm (PanNet)	8240/3
Pancreatic neoplasia III (PanIN III)	8500/2 for cases diagnosed prior to 2007. 8148/2 for cases diagnosed 2007 onward.
Pancreatic intraepithelial neoplasia, grade III (PanIN III) Note: PanIN-1A, PanIN-1B, and PanIn-2 are not reportable.	8500/2 for cases diagnosed prior to 2007. 8148/2 for cases diagnosed 2007 onward.
Glandular intraepithelial neoplasia III of the pancreas (PAIN III)	8148/2
Solid pseudopapillary neoplasm of pancreas (8452/3) is synonymous with solid pseudopapillary carcinoma.	8452/3

Cystic pancreatic endocrine neoplasm (CPEN)- Metastases have been reported in some cystic pancreatic endocrine neoplasm (CPEN) cases. With all other pancreatic endocrine tumors now considered malignant, CPEN will also be considered malignant, until proven otherwise.	Most CPEN cases are non-functioning and reportable using morphology code 8150/3, unless specified as neuroendocrine tumor, grade 1 (8240/3) or neuroendocrine tumor, grade 2 (8249/3).
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.	8470/2
Malignant enteroglucagonomas	Code 8157/3 became obsolete effective 1/1/2015. All pre- 2015 cases should be recoded as 8152/3 (malignant glucagonomas). All cases diagnosed 1/1/2015 onward should be assigned code 8152/3.

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- The following categories from C-RADS, PI-RADS, TI-RADS, and LI-RADS are reportable.

Colon- C-RADS	Category Description
Category C4	Colonic mass, likely malignant; surgical consultation recommended. Lesion compromises bowel lumen, demonstracts extracolonic invasion
Liver- LI-RADS	Category Description
Category LR-5	Definitely HCC. Observation with imaging features diagnostic of HCC or proven to be HCC at histology.
Category LR-5V	Definitely HCC with tumor in vein. Observation with imaging features diagnostic of HCC invading vein.
Prostate- PI-RADS	Category Description
Category 4	High (clinically significant cancer is likely to be present)
Category 5	Very high (clinically significant cancer is highly likely to be present)
Thyroid- TI-RADS	Category Description
Category TR5	High suspicion of malignancy
Thyroid- Bethesda	Category Description
Category VI	Thyroid FNAs evaluated using the Bethesda classification. Category VI = “Malignant”.

- ✓ Note: Breast BIRADS and Lung Lung-RADS are still NOT reportable.

- Pilocytic/Juvenile astrocytomas are reportable. Code the histology and behavior code as: 9421/3.

- Urine cytology positive for malignancy is reportable: Code the primary site to C689 in the absence of any other information. (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.)

    - Exception: When a subsequent biopsy of a urinary site is negative, do not report the case.

- Do not report bladder cancer based on UroVysion test results alone. Report the case if there is a physician statement of malignancy and/or the patient was treated for cancer.

- Ambiguous terminology should not be used when evaluating cytology for reportability. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the ambiguous cytology finding. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended. (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.)

- Mature teratoma of the testes in adults is malignant and reportable as 9080/3, but continues to be non-reportable in prepubescent children (9080/0). The following provides additional guidance:

    - Adult is defined as post puberty
    - Pubescence can take place over a number of years
    - Do not rely solely on age to indicate pre or post puberty status. Review all information for documentation of pubertal status. When testicular teratomas occur in adult males, pubescent status is likely to be stated in the medical record because it is an important factor of the diagnosis
    - Do not report if unknown whether patient is pre or post pubescence. When testicular teratoma occurs in a male and there is no mention of pubescence, it is likely the patient is a child, or pre-pubescent, and the tumor is benign.

- Gastro-intestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, they must be reported and assigned a *Behavior Code* of 3 if they are stated to be malignant, noted to have multiple foci, metastasis or positive lymph nodes.

- For cases diagnosed January 1, 2010 onward, all histologies in the *WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues (2008)* with a behavior code /3 are reportable. Instructions for determining reportability for hematopoietic and lymphoid neoplasms are located in the Reportability Instructions of the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual.* The manual is available online at: http://seer.cancer.gov/seertools/hemelymph/ (Use the 2015 version of the

manual for diagnosis dates 1/1/2010 onward). Use of the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* for hematopoietic and lymphoid neoplasms is REQUIRED.

- Effective with cases diagnosed 1/1/2004 onward, benign and borderline primary intracranial and CNS tumors with a behavior /0 or /1 in the ICD-O-3 are reportable for the sites listed in the table below:

  - ✓ Note: A brain or CNS neoplasm identified only by diagnostic imaging is reportable.

  - ✓ Note: **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.

  - ✓ Note: **Mass** and **lesion** are not reportable terms for brain and CNS because they are not listed in ICD-O3 with behavior codes of /0 or /1.

  - ✓ Note: Benign and borderline tumors of the cranial bones (C410) are not reportable.

Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors:

General Term	Specific Sites	ICD-O-3 Topography Code
Meninges	Cerebral meninges	C700
	Spinal meninges	C701
	Meninges, NOS	C709
Brain	Cerebrum	C710
	Frontal lobe	C711
	Temporal lobe	C712
	Parietal lobe	C713
	Occipital lobe	C714
	Ventricle, NOS	C715
	Cerebellum, NOS	C716
	Brain stem	C717
	Overlapping lesion of brain	C718
	Brain, NOS	C719
Spinal cord, cranial nerves, and other parts of the central nervous system	Spinal cord	C720
	Cauda equine	C721
	Olfactory nerve	C722
	Optic nerve	C723
	Acoustic nerve	C724
	Cranial nerve, NOS	C725
	Overlapping lesion of brain and central nervous system	C728
	Nervous system, NOS	C729
Pituitary, craniopharyngeal duct and pineal gland	Pituitary gland	C751
	Craniopharyngeal duct	C752

General Term	Specific Sites	ICD-O-3 Topography Code
	Pineal gland	C753

❖ **Exceptions:**

1. Prostatic intraepithelial neoplasia (PIN III) of the prostate (C619) is not reportable.

2. Carcinoma in situ of the cervix (/2), cervical intraepithelial neoplasia (CIN III), and SIN III of the cervix are not reportable by hospitals and surgery centers.

   ✓ Note: Collection of this data from hospitals and surgery centers **stopped** effective with cases diagnosed 1/1/1996 and later.

3. Malignant (In-Situ or Invasive) primary skin cancers with a primary site code C440-C449 and any of the following histology codes are **not reportable**:

   Malignant neoplasm (8000-8005)
   Epithelial carcinoma (8010-8046)
   Papillary and squamous cell carcinoma (8050-8084)
   Basal cell carcinoma (8090-8110)
   AIN III (8077) arising in perianal skin (C445)

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✓ Note: Squamous cell carcinoma originating in a mucoepidermoid site must be reported to the TCR. These sites are:

Lip	C00.1 – C00.9	Vagina	C52.9
Anus	C21.0	Prepuce	C60.0
Labia	C51.0 – C51.1	Penis	C60.1-C60.9
Clitoris	C51.2	Scrotum	C63.2
Vulva	C51.9		

Diagnosis Prior to Birth:

Diagnoses made in utero are reportable only when the pregnancy results in a live birth. In the absence of documentation of stillbirth, abortion, or fetal death, assume there was a live birth and report the case.

When a reportable diagnosis is confirmed prior to birth and disease is not evident at birth due to regression, report the case based on the pre-birth diagnosis.

Instructions for Determining Reportability for Solid (non-hematopoietic/non-lymphoid neoplasms) Tumors:

A. Cases Diagnosed Clinically:

a. When a recognized medical practitioner says the patient has a reportable disease, the case is reportable. Some reportable diseases are never histologically or cytologically confirmed. Cases diagnosed clinically are reportable. In the absence of a histologic or cytologic confirmation of a reportable disease, report the case based on the clinical diagnosis (when a recognized medical practitioner says the patient has a reportable disease). A clinical diagnosis may be recorded in the final diagnosis on the face sheet or other parts of the medical record.

- **Note:** A pathology report normally takes precedence over a clinical diagnosis. If the patient has a negative biopsy, the case would <u>not</u> be reported.

  - **Exception:** If the physician treats a patient for a reportable disease in spite of the negative biopsy, report the case.

  - **Exception:** It has been 6 months or longer since the negative pathology, and the physician continues to call this a reportable disease, report the case.

b. Brain or CNS Neoplasms Diagnosed Clinically**:** A brain or CNS 'neoplasm' identified by diagnostic imaging is reportable even when no other information is available (from biopsy, or resection, for example).

<u>Ambiguous Terminology:</u>

Often times, the medical record clearly indicates the patient has a reportable disease by using specific terms that are synonymous with a reportable disease (i.e., carcinoma, adenocarcinoma, etc.). However, a diagnosis is not always clearly stated and ambiguous terminology may be used. Ambiguous terminology may appear in any source document, such as pathology report, radiology report, or from a clinical report.

The terms listed below are reportable when they are used with a reportable term such as cancer, carcinoma, sarcoma, etc.

Ambiguous terms that <u>are reportable</u> (used to <u>determine reportability</u>)

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

- **Exception**: Cytology: Ambiguous terminology should not be used when evaluating cytology for reportability. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the ambiguous cytology finding. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended. (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.)

Do not substitute synonyms such as "supposed" for "presumed" or "equal" for "comparable". Do not substitute "likely" for "most likely".

If a word does not appear on the "Ambiguous Terms that are Reportable" list, the term is not diagnostic; unless, the word is a form of a word on the reportable list. Forms of a word are such as: "Favored" rather than Favor(s); "appeared to be" rather than appears.

How to Use Ambiguous Terminology for Case Ascertainment:

A. 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.), report the case.

- Example: The pathology report says: Prostate biopsy with markedly abnormal cells that are typical of adenocarcinoma." Report the case.

- Negative Example: The final diagnosis on the outpatient report reads: Rule out leukemia. Do not report the case.

b. Discrepancies:

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

i. Do not report a case when the original source document used a non-reportable ambiguous term and subsequent documents refer to history of cancer.

- Example: Report from the dermatologist is "possible melanoma". Patient later admitted for a broken arm (or other unrelated procedure) and physician listed history of melanoma. Give priority to the information from the dermatologist and do not report the case. "Possible" is not a reportable ambiguous term. The later information is less reliable in this case.

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

- 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." Report the case. "Consistent with" is a reportable ambiguous term. Accept "consistent with" over the non-reportable term "possibly".

- **Exception**: Cytology: Ambiguous terminology should not be used when evaluating cytology for reportability. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the ambiguous cytology finding. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended. (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.)

c. 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.

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

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

- Example: CT report states "mass in the right kidney, highly suspicious for renal cell carcinoma." CT-guided needle biopsy with final diagnosis "Neoplasm suggestive of oncocytoma. A malignant neoplasm cannot be excluded." Discharged back to nursing home and no other information is available. Do not report the case. The suspicious CT finding was biopsied and not proven to be malignant. "Suggestive of" is not a reportable ambiguous term.

- Example: Stereotactic biopsy of the left breast is "focally suspicious for DCIS" and is followed by a negative needle localization excisional biopsy was performed to further evaluate the suspicious stereotactic biopsy finding. The suspicious diagnosis was proven false.

- Example: 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 report the case. The esophagectomy proved that the suspicious biopsy result was false.

B. 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. If any of the reportable ambiguous terms precede either the word "tumor" or the word "neoplasm," the case is reportable.

c. **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.

d. **Mass** and **lesion** are not reportable terms for brain and CNS because they are not listed in ICD-O3 with behavior codes of /0 or /1.

- Example: The mass on the CT scan is consistent with pituitary tumor. Report the case.

e. Discrepancies:

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

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

2. When there is a single report, accept the reportable term and report the case when one section of a report uses a reportable term such as "apparently" and another section of the same report uses a term that is not on the reportable list.

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

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

<u>Reportability Examples</u>:

Reportable:

- Example: Path report says "Atypical fibroxanthoma (superficial malignant fibrous histiocytoma)." The case is reportable because the information in parentheses provides more detail and confirms a reportable malignancy.

- Example: Positive histology from needle biopsy followed by negative resection. This case is reportable based on positive needle biopsy.

- Example: Biopsy-proven squamous cell carcinoma of the nipple with a subsequent areolar resection showing foreign body granulomatous reaction to suture material and no evidence of residual malignancy in the nipple epidermis. This case is

reportable. The fact that no residual malignancy was found in the later specimen does not disprove the malignancy diagnosed by the biopsy.

- Example: Final diagnosis from dermatopathologist: “ulcerated histologically malignant spindle cell neoplasm, consistent with atypical fibroxanthoma. Note: An exhaustive immunohistochemical work-up shows no melanocytic, epithelial or vascular differentiation. Atypical fibroxanthoma is a superficial form of a malignant fibrous histiocytoma." This case is reportable. The pathologist has the final say on behavior for a particular case. In this case, the pathologist states that this tumor is malignant.

- Example: “Aggressive adult granulosa cell tumor with one of two lymph nodes positive for malignant metastatic granulosa cell tumor." This case is reportable because malignant granulosa cell tumor is reportable. The lymph node metastases prove malignancy.

- Example: Carcinoid of the appendix found on appendectomy. Carcinoid tumor, NOS of the appendix is reportable (8240/3) for cases diagnosed 1/1/2015 and forward.

- Example: Ovarian mucinous borderline tumor with foci of intraepithelial carcinoma. This case is reportable because there are foci of intraepithelial carcinoma (carcinoma in situ).

- Example: "Squamous cell carcinoma of the anus, NOS." Squamous cell carcinoma of the anus (C210) is reportable.

  Squamous cell carcinoma of the perianal skin (C445) is not reportable.

- Example: GIST with lymph nodes positive for malignancy. Report the case and code the behavior as malignant (/3).

- Dermoid cyst of the brain is reportable.

- Tectal plate lipoma is a reportable brain tumor. It is a benign neoplasm of the mid brain (brain stem).

- 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 (8470/2).

- Rathke pouch tumor (C751, 9350/1) is a reportable neoplasm for cases diagnosed 2004 onward. Rathke cleft cyst and Rathke pouch tumor are different conditions. Rathke cleft cyst is not reportable.

- Report as either 8240/3 or 8151/3 when the pathology diagnosis is a neuroendocrine tumor (/3) and the clinical diagnosis is an insulinoma (/0).

- Hemangioma, NOS (9120/0) and cavernous hemangioma (9121/0) arising in the dura

and parenchyma of the brain/CNS are reportable.

- Cystic pancreatic endocrine neoplasm (CPEN) is reportable. Assign 8150/3 unless specified as a neuroendocrine tumor, Grade I (8240/3) or neuroendocrine tumor, Grade 2 (8249/3).

- Solid pseudopapillary neoplasm of the pancreas is reportable as 8452/3.

- Report mature teratoma of the testis when diagnosed after puberty (malignant). For testis: Mature teratoma in adults is malignant. (Do not report mature teratoma of the testis when it is not known whether the patient is prepubescent or postpubescent. Pubescence can take place over a number of years; review physical history and do not rely only on age.)

- Report liver cases with a LI-RADS category LR-5 or LR-5V based on the 2014 American College of Radiology definitions, http://nrdr.acr.org/lirads. Use the date of the LR-5 or LR-5V scan as the date of diagnosis when it is the earliest confirmation of the malignancy. Do not report cases based only on a LI-RADS category of LR-4.

Not Reportable:

- Example: The terms “high grade dysplasia” (HGD) and “severe dysplasia” are not reportable. For the purposes of cancer reporting, they are not synonymous with in-situ for tumors in the gastrointestinal tract (such as colon, stomach, esophagus). These case are only reportable when the pathologist documents carcinoma in-situ, or intraepithelial neoplasia grade III, or when the reporting facility includes in their policies and procedures the pathologist’s statement that HGD is equivalent to carcinoma in-situ.

- Example: Left thyroid lobectomy shows microfollicular neoplasm with evidence of minimal invasion. Micro portion of path report states "The capsular contour is focally distorted by a finger of the microfollicular nodule which appears to penetrate into the adjacent capsular and thyroid tissue." Do not report this case based on the information provided. There is no definitive statement of malignancy. Search for additional information in the record. Contact the pathologist or the treating physician.

- Example: Sclerosing hemangioma of the lung with multiple regional lymph nodes involved with sclerosing hemangioma. This case is not reportable. The lymph node involvement is non-malignant. According to the WHO Classification of Lung Tumours, sclerosing hemangioma "behaves in a clinically benign fashion...Reported cases with hilar or mediastinal lymph node involvement do not have a worse prognosis."

- Example: Carcinoid tumorlets are not reportable.

- Example: “AIN II-III,” “AIN II/III,” “VAIN II-III,” “VAIN II/III,” “VIN II-III” and “VIN II/III” are not reportable. Intraepithelial neoplasia (8077/2 and 8148/2) must be unequivocally state as GRADE III to be reportable.

- Example: Squamous cell carcinoma of the perianal skin (C445) is not reportable. Squamous cell carcinoma of the anus (C210) is reportable.

- Example: Cases designated “BIRADS 4” or “BIRADS 5” without any additional information are not reportable. The American College of Radiology defines Category 4 as “Suspicious abnormality.” This is not reportable terminology-abnormality is **not** a reportable term. Category 5 is defined “Highly suggestive of malignancy.” “(Highly) suggestive” is **not** reportable ambiguous terminology (see the Ambiguous Terminology above).

- Example: Squamous cell Carcinoma of the canthus (C441) is not reportable.

- Example: Low-grade appendiceal mucinous neoplasm (LAMN) is not reportable. The WHO classification designates LAMN as /1 with uncertain malignant potential.

- Example: Diffuse idiopathic pulmonary neuroendocrine cell hyperplasia (DIPNECH) is not reportable. It is a generalized proliferation of scattered single cells, small nodules (neuroendocrine bodies), or linear proliferation of pulmonary neuroendocrine cells (PNCs), according to the WHO classification of lung tumors.

- Example: Lentiginous melanocytic lesion is not reportable.

- Example: Lobular intraepithelial neoplasia grade 1 and grade 2 are not reportable.

- Example: Intraductal papillary mucinous neoplasms with low or moderate grade dysplasia, also called IPMN adenomas, are not reportable.

- Example: Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with low or intermediate grade dysplasia is not reportable.

- Example: Subdural hygroma is not reportable—it is not a neoplasm. Subdural hygroma is a collection of cerebrospinal fluid in the subdural space. It may be related to a head injury.

- Example: Brain lesions associated with multiple sclerosis are not reportable. These brain lesions are not neoplastic; they are part of the disease process of multiple sclerosis.

- Example: High grade squamous intraepithelial lesion (HGSIL) of the vulva or vagina is not reportable.

- Example: HGSIL, HSIL, carcinoma in-situ (CIS), and AIN III (8077) arising in the perianal skin (C44.5) are not reportable.

- Example: Do not report liver cases based only on a LI-RADS category of LR-4.

- Example: For ovary: Mature teratoma is benign (9080/0); therefore, is not a reportable neoplasm.

- Example: Venous angiomas (9122/0) are not reportable wherever they arise. The primary site for venous hemangioma arising in the brain is blood vessel (C490). The combination of 9122/0 and C490 is not reportable. This is a venous abnormality. Previously called venous angiomas, there are currently referred to as development venous anomalies (DVA).

Reporting Deadlines:

See the TCR website (http://health.state.tn.us/TCR/index.htm) for the current reporting schedule.

CASEFINDING

Casefinding is one of the most important duties a cancer registrar performs. It is vital to the success of the program and adherence to the Tennessee reporting requirements.

Casefinding is a system designed to identify every patient, inpatient or outpatient, who is diagnosed and/or treated with a reportable diagnosis. Every registry must perform casefinding in order to assure that all reportable cases are located, abstracted, and submitted to the Tennessee Cancer Registry. The completeness of reporting at any facility is dependent on the quality and completeness of the casefinding at the facility.

The cancer registrar or a designated employee must review all documents that may contain information leading to the discovery of a patient who was diagnosed and/or treated with a reportable diagnosis. Review of multiple sources is necessary to ensure complete casefinding and reporting. Use of the disease index alone is not sufficient and will result in missed reportable cases.

Specimen Casefinding Sources:

The source documents may vary from one facility to another based on what specialty departments exist, but in general the source documents in a hospital can include, but are not limited to the following:

1. Pathology reports
2. Cytology reports
3. Bone Marrow
4. Autopsy reports
5. Disease indices
6. Radiology reports
7. Medical oncology logs
8. Nuclear medicine & Radiation oncology logs
9. Admission and discharge documents
10. Surgery schedule
11. Outpatient departments

The most effective casefinding system includes reviewing specimen reports (i.e., pathology, cytology, bone marrow, and autopsy) AND non-specimen reports (i.e., disease indices, radiology reports, oncology logs, etc).

Specimen Sources:

Pathology reports**:** Most cancers are histologically confirmed; therefore, pathology reports are a vital source of casefinding. The cancer registrar or designated personnel should review **ALL** pathology reports. This can be done manually in chronological order, or if the pathology department is computerized and using ICD-O histology codes and behavior codes, a computerized list of reportable diseases can be generated.

Cytology reports: Cytology reports are similar to pathology reports and can be reviewed in the same manner.

Bone marrow reports: A blood smear and/or a bone marrow specimen may be the sole basis of diagnosis for patients with leukemia/hematopoietic diseases. Bone marrow reports are similar to pathology reports and can be reviewed in the same manner.

Autopsy reports: Autopsy reports are usually filed separately from pathology reports in the pathology department or in the Health Information Management department. Review of autopsy reports is usually beneficial for casefinding and identifies cases of cancer that were not diagnosed prior to death.

Non-Specimen Sources:

Radiology reports: Some patients may be diagnosed on the basis of radiological findings alone and may never be histologically confirmed. Benign brain tumors are often initially diagnosed through scanning procedures. Review radiology reports where findings indicate the presence of neoplastic disease to prevent missed cases.

Surgery schedule/ medical oncology/ nuclear medicine/ radiation oncology logs: The surgery department, nuclear medicine department, radiation oncology department, and the medical oncology department logs should be reviewed to help ensure complete case ascertainment. These logs often identify cases that are diagnosed at another facility and then referred to a subsequent facility for treatment.

Admission and discharge documents: Routine review of all inpatient and outpatient admissions and discharges should be performed. Cases that are histologically confirmed at one facility and then referred to a subsequent facility for treatment are often identified within these documents.

Outpatient departments: Reviewing pathology reports from outpatient surgeries, radiation, and chemotherapy logs will often yield cases that might otherwise be missed.

Disease indices: The disease index is an excellent casefinding source, however, it is NOT accurate enough to use as the only source of casefinding. The disease index is a listing of cases by date of discharge and can be arranged in diagnostic groupings. A report can be generated by the health information management (HIM) department specifying a group of ICD-9-CM or ICD-10-CM codes to be reviewed. A list of codes published on the SEER website (http://seer.cancer.gov/tools/casefinding/) can be used to narrow the report to appropriate reportable codes. . For reference, the 10/1/2014 – 9/30/2016 ICD-9-CM and ICD-10-CM casefinding lists are included in this manual. The casefinding lists are updated as new codes and changes are made to the ICD-9-CM and ICD-10-CM. Facilities should review the casefinding lists annually to ensure the appropriate codes are used to create the disease index.

Establishing a Casefinding System:

All facilities should create a casefinding system to ensure all reportable cases are identified. The complexity of the casefinding system, as well as, the personnel involved depends upon the amount of data to be reviewed. In some facilities, the cancer registrar reviews all of the data. He/she reviews all of the pathology, cytology, bone marrow, and autopsy reports on a daily, weekly, biweekly, or monthly basis. He/she also analyzes the non-specimen reports (i.e., disease index, radiology reports, etc.) on a daily, weekly, biweekly, or monthly basis to ensure the identification of all reportable cases. In other

facilities, however, the cancer registrar enlists the assistance of individuals in various departments. In some cases, he/she might have someone in the HIM department, laboratory, radiology, and oncology department screen reports and record a list of potential cases.

It is important that all personnel involved in the casefinding be thoroughly familiar with the reportable diagnoses. It is also advisable to perform periodic internal audits to verify the casefinding system is functioning effectively.

ICD-10-CM Casefinding List, 2018

Based on the* International *Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2018

COMPREHENSIVE ICD-10-CM Casefinding Code List for Reportable Tumors (EFFECTIVE DATES: 10/1/2017-9/30/2018) Please refer to your standard setter(s) for specific reporting requirements before using the Casefinding List	
ICD-10 Code	**Explanation of Code**
C00.- - C43.-, C4A.-, C45.- - C48.-, C49.- - C96.-	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies ***NEW for FY2018:*** *C96.20 Malignant mast cell neoplasm, unspecified* *C96.21 Aggressive systemic mastocytosis* *C96.22 Mast cell sarcoma* *C96.29 Other malignant cell neoplasm*
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.10-, C44.19-	Unspecified/other malignant neoplasm of skin of eyelid
C44.20-, C44.29-	Unspecified/other malignant neoplasm skin of ear and external auricular canal
C44.30-, C44.39-	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.40, C44.49	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50-, C44.59-	Unspecified/other malignant neoplasm of skin of trunk
C44.60-, C44.69-	Unspecified/other malignant neoplasm of skin of upper limb, incl. shoulder
C44.70-, C44.79-	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin
C49.A-	Gastrointestinal Stromal Tumors Note: GIST is only reportable when it is malignant (/3). GIST, NOS (not stated whether malignant or benign) is a /1 and is not reportable.
D00.- - D09.-	In-situ neoplasms *Note: Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable*
D18.02	Hemangioma of intracranial structures and any site
D32.-	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.-	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3) *ICD-10-CM Coding instruction note: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)*
D46.-	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D47.02	Systemic mastocytosis *Note: Effective 10/1/2017*
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3) *ICD-10-CM Coding instruction note: Excludes the following:* *Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_)* *Chronic myeloid leukemia BCR/ABL-positive (C92.1_)*

ICD-10-CM Casefinding List, 2018

Based on the* International *Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2018

COMPREHENSIVE ICD-10-CM Casefinding Code List for Reportable Tumors (EFFECTIVE DATES: 10/1/2017-9/30/2018) Please refer to your standard setter(s) for specific reporting requirements before using the Casefinding List	
ICD-10 Code	**Explanation of Code**
	Myelofibrosis & Secondary myelofibrosis (D75.81) *Myelophthisic anemia & Myelophthisis (D61.82)*
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) *Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia*
D47.4	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis Myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.Z-	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3)
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina

1 *Note: Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. However, SEER registries will CONTINUE to report these cases and code behavior as /3 (malignant).*

NOTE: Cases with the codes listed below should be screened as registry time allows. Experience in the SEER registries has shown that using the supplemental list increases casefinding for benign brain and CNS, hematopoietic neoplasms, and other reportable diseases

SUPPLEMENTAL LIST ICD-10-CM (EFFECTIVE DATES: 10/1/2017-9/30/2018)	
ICD-10-CM Code	**Explanation of Code**
B20	Human immunodeficiency virus [HIV] disease with other diseases
B97.33, B97.34, B97.35	Human T-cell lymphotrophic virus, (type I [HTLV-1], type II [HTLV-II], type 2 [HIV 2]) as the cause of diseases classified elsewhere
B97.7	Papillomarvirus as the cause of diseases classified elsewhere
C44.01, C44.02	Basal/squamous cell carcinoma of skin of lip
C44.11-, C44.12-	Basal/squamous cell carcinoma of skin of eyelid
C44.21-, C44.22-	Basal/squamous cell carcinoma of skin of ear and external auricular canal
C44.31-, C44.32-	Basal/squamous cell carcinoma of skin of other and unspecified parts of face
C44.41, C44.42	Basal/squamous cell carcinoma of skin of scalp and neck
C44.51-, C44.52-	Basal/squamous cell carcinoma of skin of trunk
C44.61-, C44.62-	Basal/squamous cell carcinoma of skin of upper limb, including shoulder

SUPPLEMENTAL LIST ICD-10-CM (EFFECTIVE DATES: 10/1/2017-9/30/2018)	
ICD-10-CM Code	**Explanation of Code**
C44.71-, C44.72-	Basal/squamous cell carcinoma of skin of lower limb, including hip
C44.81, C44.82	Basal/squamous cell carcinoma of skin of overlapping sites of skin
C44.91, C44.92	Basal/squamous cell carcinoma of skin of unspecified sites of skin
D10.- - D31.-, D34, D35.0, D35.1, D35.5-D35.9, D36.-	Benign neoplasms (see "must collect" list for reportable benign neoplasms) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors* *Note: Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. SEER registries are not required to collect these cases for diagnoses made 1/1/2001 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted and reported to SEER.*
D3A._	Benign carcinoid tumors
D37. _ - D41. _	Neoplasms of uncertain or unknown behavior (see "must collect" list for reportable neoplasms of uncertain or unknown behavior) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors*
D44.0 - D44.2, D44.6-D44.9	Neoplasm of uncertain or unknown behavior of other endocrine glands (see "must collect" list for D44.3-D44.5) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors*
D47.01	Cutaneous mastocytosis (9740/1) *Note: Effective 10/1/2017*
D47.09	Other mast cell neoplasms of uncertain behavior *Note: Effective 10/1/2017*
D47.2	Monoclonal gammopathy *Note: Screen for incorrectly coded Waldenstrom's macroglobulinemia*
D47.Z2	Castleman disease
D48.-	Neoplasm of uncertain behavior of other and unspecified sites
D49.0 - D49.9	Neoplasm of unspecified behavior (except for D49.6 and D49.7)
D61.1	Drug-induced aplastic anemia (also known as *"aplastic anemia due to antineoplastic chemotherapy")* *ICD-10-CM Coding instruction note: Use additional code for adverse effect, if applicable, to identify drug*
D61.810	Antineoplastic chemotherapy induced pancytopenia
D61.82	Myelophthisis *ICD-10-CM Coding instruction: Code first the underlying disorder, such as: malignant neoplasm of breast (C50. _)*
D63.0	Anemia in neoplastic disease *ICD-10-CM Coding instruction: Code first neoplasm (C00-C49)*
D64.81	Anemia due to antineoplastic chemotherapy
D69.49, D69.59, D69.6	Other thrombocytopenia *Note: Screen for incorrectly coded thrombocythemia*

SUPPLEMENTAL LIST ICD-10-CM (EFFECTIVE DATES: 10/1/2017-9/30/2018)	
ICD-10-CM Code	**Explanation of Code**
D70.1	Agranulocytosis secondary to cancer chemotherapy *ICD-10-CM Coding instruction: code also underlying neoplasm*
D72.1	Eosinophilia (*Note: Code for eosinophilia (9964/3). Not every case of eosinophilia is a malignancy. Reportable Diagnosis is "Hypereosonophilic syndrome."*)
D75.81	Myelofibrosis (note: this is not primary myelofibrosis [9961/3] *ICD-10-CM Coding instruction note: Code first the underlying disorder, such as: malignant neoplasm of breast (C50. _)*
D76.-	Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue
D89.0, D89.1	Other disorders involving the immune mechanism, not elsewhere classified *Note: Review for miscodes*
D89.4-	Mast cell activation syndrome and related disorders *Note: Effective 10/1/2016*
E08	Diabetes mellitus due to underlying condition *ICD-10-CM Coding instruction note: Code first the underlying condition, such as: malignant neoplasm (C00-C96)*
E31.2-	Multiple endocrine neoplasia [MEN] syndromes *ICD-10-CM Coding instruction: Code also any associated malignancies and other conditions associated with the syndromes*
E34.0	Carcinoid syndrome *ICD-10-CM Coding instruction: May be used as an additional code to identify functional activity associated with a carcinoid tumor*
E83.52	Hypercalcemia
E88.09	Other disorders of plasma-protein metabolism, not elsewhere classified
E88.3	Tumor lysis syndrome (following antineoplastic chemotherapy)
G13.0	Paraneoplastic neuromyopathy and neuropathy *ICD-10-CM Coding instruction note: Code first underlying neoplasm (C00-D49)*
G13.1	Other systemic atrophy primarily affecting central nervous system in neoplastic disease *ICD-10-CM Coding instruction note: Code first underlying neoplasm (C00-D49)*
C32.8-	Other specified degenerative disorders of nervous system in diseases classified elsewhere *ICD-10-CM Coding instruction note: Code first underlying disease, such as: cerebral degeneration (due to) neoplasm (C00-D49)*
G53	Cranial nerve disorders in diseases classified elsewhere *Note: Code first underlying neoplasm (C00-D49)*
G55	Nerve root and plexus compressions in diseases classified elsewhere *ICD-10-CM Coding instruction note: code also underlying disease, such as neoplasm (C00-D49)*
G63	Polyneuropathy in diseases classified elsewhere *ICD-10-CM Coding instruction note: Code first underlying disease, such as: neoplasm (C00-D49)*

SUPPLEMENTAL LIST ICD-10-CM (EFFECTIVE DATES: 10/1/2017-9/30/2018)	
ICD-10-CM Code	**Explanation of Code**
G73.1	Lambert-Eaton syndrome in neoplastic disease *ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)*
G89.3	Neoplasm related pain (acute)(chronic)
G99.2	Myelopathy in diseases classified elsewhere *ICD-10-CM Coding instruction: Code first underlying disease, such as: neoplasm (C00-D49)*
H47.42	Disorders of optic chiasm in (due to) neoplasm *ICD-10-CM Coding instruction: Code also underlying condition*
H47.52-	Disorders of visual pathways in (due to) neoplasm *ICD-10-CM Coding instruction: Code also underlying condition*
H47.63-	Disorders of visual cortex in (due to) neoplasm *ICD-10-CM Coding instruction: Code also underlying condition*
J34.81	Nasal mucositis (ulcerative)
J91.0	Malignant pleural effusion *ICD-10-CM Coding instruction: Code first underlying neoplasm*
J93.12	Secondary spontaneous pneumothorax *ICD-10-CM Coding instruction: Code first underlying condition, such as:* *Malignant neoplasm of bronchus and lung (C34._)* *Secondary malignant neoplasm of lung (C78.0_)*
K12.31	Oral mucositis (ulcerative) due to antineoplastic therapy
K12.33	Oral mucositis (ulcerative) due to radiation
K22.711	Barrett's esophagus with high grade dysplasia
K62.7	Radiation proctitis
K62.82	Dysplasia of anus (AIN I and AIN II)
K92.81	Gastrointestinal mucositis (ulcerated) (due to antineoplastic therapy)
M36.0	Dermato(poly)myositis in neoplastic disease *ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)*
M36.1	Arthropathy in neoplastic disease *ICD-10-CM Coding instruction: Code first underlying neoplasm, such as:* Leukemia (C91-C95), malignant histiocytosis (C96.A), multiple myeloma (C90.0)
M84.5-	Pathologic fracture in neoplastic disease *ICD-10-CM Coding instruction: Code also underlying neoplasm (C00-D49)*
M90.6-	Osteitis deformans in neoplastic disease *ICD-10-CM Coding instruction: Code first the neoplasm (C40._, C41._)*
N42.3	Dysplasia of prostate (PIN I and PIN II)
N76.81	Mucositis (ulcerative) of vagina and vulva
N87.-	Dysplasia of cervix uteri (CIN I and CIN II)
N89.0, N89.1, N89.3	Vaginal dysplasia (VIN I and VIN II)
N90.0, N90.1, N90.3	Vulvar dysplasia (VAIN I and VAIN II)
O01.-	Hydatidiform mole

SUPPLEMENTAL LIST ICD-10-CM (EFFECTIVE DATES: 10/1/2017-9/30/2018)	
ICD-10-CM Code	**Explanation of Code**
	Note: Benign tumor that can become malignant. If malignant, report as Choriocarcinoma (9100/3,) malignancy code in the C00- C97 range
O9A.1-	Malignant neoplasm complicating pregnancy, childbirth and the puerperium (conditions in C00-C96) *ICD-10-CM Coding instruction: Use additional code to identify neoplasm*
Q85.0-	Neurofibromatosis (nonmalignant) (9540/1) *Note: Neurofibromatosis is not cancer. These tumors can be precursors to acoustic neuromas, which are reportable*
R18.0	Malignant ascites *ICD-10-CM Coding instruction: Code first malignancy, such as: Malignant neoplasm of ovary (C56._), secondary malignant neoplasm of retroperitoneum and peritoneum (C78.6)*
R53.0	Neoplastic (malignant) related fatigue *ICD-10-CM Coding instruction: Code first associated neoplasm*
R59.-	Enlarged lymph nodes
R85.6-	Abnormal findings on cytological and histological examination of digestive organs *Note: see "must collect" list for R85.614*
R87.61-, R87.62-	Abnormal findings on cytological/histological examination of female genital organs *Note: see "must collect" list for R87.614 and R87.624*
R92.-	Abnormal findings on diagnostic imaging of breast
R97.-	Abnormal tumor markers
T38.6-	Poisoning by antigonadotrophins, antiestrogens, antiandrogens, not elsewhere classified
T38.8-, T38.9-	Poisoning by hormones and their synthetic substitutes
T45.1-	Poisoning by, adverse effect of and under dosing of antineoplastic and immunosuppressive drugs
T45.8-, T45.9-	Poisoning by primary systemic and hematological agent, unspecified
T66	Unspecified effects of radiation
T80.1	Vascular complications following infusion, transfusion and therapeutic injection
T80.2-	Infections following infusion, transfusion and therapeutic injection
T80.810	Extravasation of vesicant antineoplastic chemotherapy
T80.818	Extravasation of other vesicant agent
T86.0	Complications of bone marrow transplant *ICD-10-CM Coding instruction: Use addition code to identify other transplant complications, such as: malignancy associated with organ transplant (C80.2) or post-transplant lymphoproliferative disorders (PTLD) (D47.Z1)*
Y63.2	Overdose of radiation given during therapy
Y84.2	Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out

SUPPLEMENTAL LIST ICD-10-CM (EFFECTIVE DATES: 10/1/2017-9/30/2018)	
ICD-10-CM Code	**Explanation of Code**
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm (medical surveillance following completed treatment) *ICD-10-CM Coding instruction: Use additional code to identify the personal history of malignant neoplasm (Z85._)*
Z12.-	Encounter for screening for malignant neoplasms
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z15.0	Genetic susceptibility to malignant neoplasm *ICD-10-CM Coding instruction: Code first, if applicable, any current malignant neoplasm (C00-C75, C81-C96); Use additional code, if applicable, for any personal history of malignant neoplasm (Z85._)*
Z17.0, Z17.1	Estrogen receptor positive and negative status *ICD-10-CM Coding instruction: Code first malignant neoplasm of breast (C50._)*
Z40.0-	Encounter for prophylactic surgery for risk factors related to malignant neoplasms
Z42.1	Encounter for breast reconstruction following mastectomy
Z48.3	Aftercare following surgery for neoplasm *ICD-10-CM Coding instruction: Use additional code to identify the neoplasm*
Z48.290	Encounter for aftercare following bone marrow transplant
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1-	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.5, Z51.89	Encounter for palliative care and other specified aftercare
Z79.81-	Long term (current) use of agents affecting estrogen receptors and estrogen levels *ICD-10-CM Coding instruction: Code first, if applicable, malignant neoplasm of breast (C50._), malignant neoplasm of prostate (C61)*
Z80.-	Family history of primary malignant neoplasm
Z85.-	Personal history of malignant neoplasm *ICD-10-CM Coding instruction: Code first any follow-up examination after treatment of malignant neoplasm (Z08)*
Z86.0-, Z86.01-, Z86.03	Personal history of in situ and benign neoplasms and neoplasms of uncertain behavior
Z92.21, Z92.23, Z92.25. Z92.3	Personal history of antineoplastic chemotherapy, estrogen therapy, immunosuppression therapy or irradiation (radiation)
Z94.81, Z94.84	Bone marrow and stem cell transplant status

Determining Multiple Primaries: Solid Tumors:

Apply the general instructions and instructions for determining multiple primaries in the *2007 Multiple Primary and Histology Coding Rules Manual*.

Apply the site-specific multiple primary rules in the *2007 Multiple Primary and Histology Coding Rules Manual*.

Site-specific multiple primary rules cover the following:

- Head and neck C000-C148, C300-C329
- Colon C180-C189
- Lung C340-C349
- Melanoma of the skin C440-C449 with Histology 8720-8780
- Breast C500-C509
- Kidney C649
- Ureter/Renal pelvis/Bladder C659, C669, C670-C679, C680-C689
- Benign brain C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
- Malignant brain C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
- Other sites Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain

Site-specific rules do **not** cover lymphoma and leukemia (9590-9992).

Determining Multiple Primaries: Hematopoietic and Lymphoid Neoplasms:

Apply the Multiple Primary Rules in the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual.* (Use the 2015 version of the manual for cases diagnosed 1/1/2010 onward.)

FIRST COURSE OF THERAPY

First Course Treatment for Solid Tumors

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

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

Concurrent therapy: A treatment that is given at the same time as another.

- 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. (Source: http://www.cancer.gov/dictionary?CdrID=667618)

Disease recurrence: For solid tumors, see the *Multiple Primary and Histology Coding Rules* manual and for hematopoietic and lymphoid neoplasms see the date appropriate *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. (Source: http://www.cancer.gov/dictionary?CdrID=616061)

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

Neoadjuvant therapy: Systemic therapy or radiation therapy given prior to surgery to shrink the tumor.

Palliative treatment: The World Health Organization describes palliative care as treatment that improves the quality of life by preventing or relieving suffering. Palliative therapy is part of the first course of therapy when it destroys or modifies cancer tissue.

- Example: The patient was diagnosed with stage IV cancer of the prostate with painful boney metastases. The patient starts radiation treatment intended to shrink the tumor in the bone and relieve the intense

pain. The radiation treatments are palliative because they relieve the bone pain; the radiation is also first course of therapy because it destroys proliferating cancer tissue.

Surgical Procedure: Any surgical procedure coded in the fields Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional or Distant Sites.

Treatment: Procedures that destroy or modify primary (primary site) or secondary (metastatic) cancer tissue.

Treatment failure: The treatment modalities did not destroy or modify the cancer cells. The tumor either became larger (disease progression) or stayed the same size after treatment.

Watchful waiting: Closely watching a patient's condition but not giving treatment unless symptoms appear or change. Watchful waiting is sometimes used in conditions that progress slowly. It is also used when the risks of treatment are greater than the possible benefits. During watchful waiting, patients may be given certain tests and exams. Watchful waiting is sometimes used in prostate cancer. It is a type of expectant management. (Source: http://www.cancer.gov/dictionary?CdrID=45942)

Treatment Timing:

Use the following instructions in hierarchical order.

1. Use the documented first course of therapy (treatment plan) from the medical record. First course of therapy ends when the treatment plan is completed. (No matter how long it takes to complete the plan).

- Example: The first course of therapy for a breast cancer patient is surgery, chemotherapy, and radiation. The patient completes surgery and chemotherapy. Bone metastases are diagnosed before the radiation was started. The physician says that the patient will start the radiation treatment as planned. Code the radiation as first course of therapy since it was given in agreement with the treatment plan and the treatment plan was not changed as a result of disease progression.

- Example: Hormonal therapy (e.g. Tamoxifen) after surgery, radiation, and chemotherapy. First course ends when hormonal therapy is completed, even if this takes years, unless there is documentation of disease progression, recurrence, or treatment failure (see # 2 below).

2. First course of therapy ends when there is documentation of disease progression, recurrence, or treatment failure.

- Example: The documented treatment plan for sarcoma is pre-operative (neoadjuvant) chemotherapy, followed by surgery, then radiation or chemotherapy depending upon the pathology from surgery. Scans show the tumor is not regressing after pre-operative chemotherapy. Plans for surgery are cancelled, radiation was not administered, and a different type of chemotherapy is started. Code only the first chemotherapy as first course. Do not code the second chemotherapy as first course because it is administered after documented treatment failure.

- Example: The documented treatment plan for a patient with locally advanced breast cancer includes mastectomy, chemotherapy, radiation to the chest wall and axilla, and hormone therapy. The patient has the mastectomy and completes chemotherapy. During the course of radiation therapy, the liver enzymes are rising. Workup proves liver metastases. The physician stops the radiation and does not continue with hormone therapy (the treatment plan is altered). The patient is placed on a clinical trial to

receive Herceptin for metastatic breast cancer. Code the mastectomy, chemotherapy, and radiation as first course of treatment. Do not code the Herceptin as first course of therapy because it is administered after documented disease progression.

3. When there is **no documentation** of a treatment plan or progression, recurrence or a treatment failure, first course of therapy ends one year after the date of diagnosis. Any treatment given after one year is second course of therapy in the **absence of a documented treatment plan or a standard of treatment**.

Coding Instructions:

A. Code all treatment fields to 0 or 00 (Not done) when physician opts for **active surveillance**. When the disease progresses or the patient becomes symptomatic, any prescribed treatment is second course.

- Code Treatment Status (RX Summ—Treatment Status) to 2

B. Code the treatment as first course of therapy if the patient refuses treatment but changes his/her mind and the prescribed treatment is implemented less than one year from the date of diagnosis, AND there is no evidence of disease progression.

C. The first course of therapy is no treatment when the patient refuses treatment. Code the treatment fields to Refused.

a. Keep the refused codes even if the patient later changes his/her mind and decides to have the prescribed treatment

1. more than one year after diagnosis **OR**

2. when there is evidence of disease progression before treatment is implemented

D. Code all treatment that was started and administered, whether completed or not.

- Example: The patient completed only the first dose of a planned 30-day chemotherapy regimen. Code chemotherapy as administered.

E. Code the treatment on both abstracts when a patient has multiple primaries and the treatment given for one primary also affects/treats the other primary.

- Example: The patient had prostate and bladder cancer. The bladder cancer was treated with a TURB. The prostate cancer was treated with radiation to the prostate and pelvis. The pelvic radiation includes the regional lymph nodes for the bladder. Code the radiation as treatment for both the bladder and prostate cases.

- Example: The patient had a hysterectomy for ovarian cancer. The pathology report reveals a previously unsuspected microinvasive cancer of the cervix. Code the hysterectomy as surgical treatment for both the ovarian and cervix primaries.

F. Code the treatments only for the site that is affected when a patient has multiple primaries and the treatment affects only one of the primaries.

- Example: The patient has colon and tonsil primaries. The colon cancer is treated with a hemicolectomy and the tonsil primary is treated with radiation to the tonsil and regional nodes. Do not code the radiation for the colon. Do not code the hemicolectomy for the tonsil.

G. Code the treatment given as first course even if the correct primary is identified later when a patient is diagnosed with an unknown primary.

- Example: The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Code the chemotherapy as first course of treatment.

    - Do not code treatment added to the plan when the primary site is discovered as first course. This is a change in the treatment plan.

- Example: The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Hormonal treatment is started. Code the chemotherapy as first course of treatment. The hormone therapy is second course because it was not part of the initial treatment plan.

H. Do not code proton pump inhibitors (PPI) as treatment for esophageal malignancies.

I. Do not code RFA for Barrett's esophagus as treatment. HALO 90 ultra radiofrequency ablation (RFA) of Barrett's esophagus is used to reduce progression of high-grade dysplasia to esophageal cancer. It is not used to treat esophageal cancer.

J. Do not code Lupron as treatment for a primary in the prostatic urethra.

First Course for Leukemia and Hematopoietic Diseases:

Lymphoma:

Do not code proton pump inhibitors as treatment. Proton pump inhibitors are used for gastric acid suppression; they treat symptoms, not the lymphoma itself.

Leukemia:

Leukemia is grouped or typed by how quickly the disease develops and worsens. Chronic leukemia gets worse slowly; acute leukemia, quickly.

Leukemias are also grouped by the type of white blood cell that is affected: lymphoid leukemia and myeloid leukemia.

Definitions:

Consolidation: Repetitive cycles of chemotherapy given immediately after the remission.

Induction: Initial intensive course of chemotherapy.

Maintenance: Chemotherapy given for a period of months or years to maintain remission.

Remission: The bone marrow shows normal cellular characteristics (is normocellular), with less than 5% blasts, no signs or symptoms of the disease, no signs or symptoms of central nervous system leukemia or other extramedullary infiltration, and all of the following laboratory values within normal limits: white blood cell count and differential, hematocrit/hemoglobin level, and platelet count.

Treatment for Leukemia is divided into three phases:

1. Remission induction (chemotherapy and/or biologic response modifiers)

2. CNS prophylaxis or consolidation (irradiation to brain, chemotherapy)

3. Remission continuation or maintenance (chemotherapy or bone marrow transplants)

Coding First Course of Therapy for Leukemia and Hematopoietic Diseases:

A. Use the SEER Hematopoietic and Lymphoid Neoplasm Database (http://seer.cancer.gov/seertools/hemelymph/) to identify usual treatment given for specific hematopoietic histologies.

B. When there is only one neoplasm (one primary), use the documented first course of therapy (treatment plan) from the medical record. First course of therapy ends when the treatment plan is completed, no matter how long it takes to complete the plan.

C. Chronic neoplasm followed by an acute neoplasm:

- The presence/absence of treatment **DOES NOT** affect the number of primaries when a chronic neoplasm transforms to an acute neoplasm.
  - Example: Patient diagnosed in 2000 with follicular lymphoma. Patient refused treatment. Patient returns in 2014 with DLBCL. Abstract the DLBCL as a second primary even though there was no treatment for the follicular lymphoma.
- First course of treatment for the chronic neoplasm may or may not be completed when the chronic neoplasm transforms to the acute neoplasm.

D. Acute neoplasm followed by a chronic neoplasm:

- The presence/absence of treatment **DOES** impact the determination of the number of primaries when the acute neoplasm reverts to a chronic neoplasm.
- The planned first course of therapy may not have been completed when a biopsy/pathologic specimen shows only chronic neoplasm after an initial diagnosis of an acute neoplasm.
- The patient may have completed the first course of treatment and have been cancer free (clinically, no evidence of the acute neoplasm) for an interim when diagnosed with the chronic neoplasm.

- The patient may not have been cancer free, but completed the first course of treatment and biopsy/pathology shows only chronic neoplasm.

E. Code the treatment on both abstracts when a patient has multiple primaries and the treatment given for one primary also affects/treats the other primary.

  - Example: Patient diagnosed in May 2014 with both multiple myeloma (9732/3) and mantle cell lymphoma (9673/3), which are separate primaries per rule M15. The oncologist states she began Velcade chemotherapy for the lymphoma. Velcade would affect both primaries, so it should be coded on both abstracts.

F. The following instructions apply to cases diagnosed 2010 onward:

- Do not collect **blood transfusions** (whole blood, platelets, etc.) as treatment. Blood transfusions are widely used to treat anemia and it is not possible to collect this procedure in a meaningful way.

- Collect **phlebotomy** for polycythemia vera (9950/3) only.

- Collect **blood-thinners** and/or **anti-clotting agents** for:

  i. 9740/3 Mast cell sarcoma

  ii. 9741/3 Systemic mastocytosis

  iii. 9742/3 Mast cell leukemia

  iv. 9875/3 Chronic myelogenous leukemia BCR-ABL1 positive

  v. 9950/3 Polycythemia vera

  vi. 9961/3 Primary myelofibrosis

  vii. 9962/3 Essential thrombocythemia

  viii. 9963/3 Chronic neutrophilic leukemia

  ix. 9975/3 Myelodysplastic/myeloproliferative neoplasm, unclassifiable

G. **Donor Leukocyte Infusions**- The use of donor leukocyte infusions for treatment of hematopoietic neoplasms, specifically leukemias, is increasing. Abstract as bone marrow transplant when a reportable hematopoietic neoplasm is treated with donor leukocyte infusion, even if it is not listed in the treatment section of the Heme DB for the specific neoplasm.

Introduction to TNM Staging

The information in this section is an overview and should not be used in place of the AJCC TNM Manual.

For cases diagnosed January 1, 2016 and forward, reportable diseases must be staged using the AJCC TNM Staging system. TNM is a staging classification that assigns a clinical stage (pretreatment stage) and a pathologic stage to each primary cancer. Each stage is composed of T (primary tumor information), N (regional lymph node information), and M (distant metastasis information). T, N, and M combinations are summarized as stage groups.

T is assigned based on the extension and/or size of the 'primary tumor', N is based on the involvement of regional lymph nodes, and M represents spread to distant lymph nodes or other generally discontiguous organs. The numbers, categories, and subcategories following the T, N, and M document the extent of disease. Definitions of TNM categories and stage grouping have been expanded into additional subcategories for clinical or research purposes, for example T1a and T1b.

- Example:

T0, T1, T2, T3, T4	N0, N1, N2, N3	M0, M1
T1a, T1b, T2a, T2b	N1a, N1b, N2a, N2b	M1a, M1

The factors that determine the extent of disease differ by primary site and histologic type. For example, when a patient has breast cancer, the size of the primary tumor is used when assigning the T value; however, for many other primary sites, the size of the primary tumor plays no part in determining the T value; instead the T value is determined by the extension of the primary tumor. The determining factors for each primary site/ histologic type are indicated in the site-specific chapters of the *AJCC TNM Manual, 7th Edition.*

The three TNM components (and additional information for selected cancer schemas) are combined into a single clinical or pathologic value that is used for analysis and prognosis. The stage group values range from I-IV with each higher number representing increasing severity of disease.

TNM staging:

- Aids the clinician in the planning of treatment
- Gives some indication of prognosis
- Assists in evaluation of the results of treatment
- Facilitates the exchange of information between treatment centers
- Contributes to the continuing investigation of human cancer
- Supports cancer control activities

In order to assign TNM, the registrar should:

A. Be knowledgeable of the general staging rules and when site-specific rules for sites/histologies take precedence, since some sites/histologies have site-specific rules that override the general rules.

   ✓ Note: The TCR highly recommends all abstractors view the AJCC and/or current NAACCR training modules on assigning AJCC TNM prior to attempting to complete the required TNM data elements. The free training modules are located:

      o AJCC training modules-
      https://cancerstaging.org/CSE/Registrar/Pages/AJCC-Curriculum.aspx
      https://cancerstaging.org/CSE/Registrar/Pages/Presentations.aspx
      https://cancerstaging.org/CSE/Registrar/Pages/Disease-Site-Webinars.aspx

         - Module I Introduction
         - Module II Beginning
         - Module III Intermediate
         - Module IV Advanced
         - Registrar's Guide to Chapter 1, AJCC Seventh Edition
         - Explaining Blanks and X, Ambiguous Terminology and Support for AJCC Staging
         - AJCC T, N, and M Category Options for Registry Data Items in 2016
         - Disease Site Webinar- Melanoma
         - Disease Site Webinar- Lung
         - Disease Site Webinar- Breast
         - Disease Site Webinar- Prostate
         - Disease Site Webinar- Colorectum

B. Review all available information in the medical record

C. Determine if the case meets the eligibility criteria (rules for classification) for clinical and/or pathologic staging

D. Detemine clinical versus pathologic timeframes

Reportability and TNM:

The *AJCC TNM 7th Edition* includes TNM definitions for some neoplasms that are not reportable to the Tennessee Cancer Registry (TCR). For example, high grade dysplasia of the colon and esophagus are not reportable to the TCR; however they do have a TNM staging schema. Registrars should use the rules in the Reportability section of this manual to determine if a disease is reportable. Do not use the AJCC TNM manual to determine if a disease is reportable.

AJCC Site-Specific Schemas:

Not all sites histologies combinations can be staged in AJCC TNM. For sites and histologies that do not have schemas in the *AJCC TNM Manual, 7th Edition,* the T, N, and M are assigned code '88' and the stage is assigned '99'.

- ✓ For lymphomas, the T, N, and M are assigned code '88', but a valid stage group must be assigned. See the Lymphoid Neoplasms chapter in the *AJCC TNM Manual, 7th Edition* for valid stage group codes.

Diagnostic Confirmation of Tumors:

Assign TNM whether the case is microscopically confirmed or not. Rare cases that do not have a biopsy or cytology of the tumor can be staged. A description of the type of diagnostic confirmation is collected in a separate data item. The diagnostic confirmation field can be used to exclude non-microscopically confirmed cases during analysis as necessary.

Timing:

Two TNM classifications (Clinical Staging and Pathologic Staging) must be recorded on each abstract. These classifications document what the physician(s) knew about the patient's disease at particular points in time.

A. **Timing for Clinical Staging:**

Clinical staging includes any information obtained about the extent of cancer **before** initiation of definitive treatment, including active surveillance, or within 4 months after the date of diagnosis whichever is **shorter** in absence of disease progression. In other words, it documents what the physician(s) knew about the patient's cancer prior to the start of treatment or within the first 4 months of diagnosis (whichever is shorter and in absence of disease progression.) The pretreatment clinical classification designated TNM is essential to select and evaluate therapy.

Included in Clinical Staging		**Not included in Clinical Staging**		
↓	↓			
Diagnosis	Workup-imaging, biopsies, lab tests, endoscopic procedures, fine needle aspirations, path/cytology report findings from the workup, etc. (See below for additional items included in the clinical workup.)	Neoadjuvant therapy (chemo., radiation, etc.)	Definitive surgery(ies) (include op. report findings, path/cytology report findings, etc.)	Post-surgical imaging or findings (done within 4 months of diagnosis and before adjuvant treatment begins)
----------4		months ----------		

The following are part of the clinical workup. (Note: It is **not** necessary to have access to all of the items below to assign the clinical stage. Use the information available to assign the stage.):

- Presenting symptoms
- Physical examination
- Imaging examination
- Endoscopic examination

- Biopsy of primary site
- Diagnostic biopsy
- Fine needle aspiration biopsy
- Resection of single lymph node/sentinel node(s) with clinical T
- Surgical observation without resection of the primary site/tumor
- Laboratory tests
- Other non-invasive clinical evidence
- All information obtained prior to neoadjuvant (preoperative) treatment (i.e. pre-op chemotherapy, pre-op radiation therapy, etc.)

B. **Timing for Pathologic Staging:**

Note: The dash (_) next to the T, N, or M in the examples below indicates a valid value (i.e., T1, T1a, N1, N2, etc.). The dash does not indicate the data field should be left blank.

Pathologic Staging is used to guide adjuvant therapy and provides additional data to estimate prognosis and calculate end results.

The timeframe for Pathologic Staging depends on whether or not the patient received neoadjuvant therapy prior to definitive surgery.

A. If the patient did NOT receive neoadjuvant therapy (chemotherapy, hormone therapy, immunotherapy or radiation therapy) prior to surgery, pathologic staging includes any information obtained about the extent of cancer through the completion of definitive surgery(ies) as part of first course of treatment or identified within four months of diagnosis, whichever is **longer**, in absence of disease progression. In other words, it documents what the physician(s) knew about the patient's cancer from the diagnosis through the completion of the first course definitive surgery(ies) or four months (whichever is longer and in absence of disease progression).

   ✓ Reminder: The information from the Clinical time period should be included in the Pathologic Staging when the patient did not have neoadjuvant therapy.

      ❖ Exception: If information identified during the Clinical Staging timeframe is disproven, it should not be included in the Pathologic Staging data fields.

      ➢ Example: Imaging done prior to definitive surgery indicates regional lymph nodes are suspicious for metastasis. (Clinical Staging: cT_ cN1 cM0). A lymph node resection is performed during the resection of the tumor. According to the pathology report, all of the regional lymph nodes are negative for malignancy.

      Because the regional lymph nodes were proven not to contain malignant cells, the information about the lymph nodes (suspicious for metastasis) would be excluded from the Pathologic Staging (pT_ pN0 cM0).

No Neoadjuvant Therapy Given			
Include in Pathologic Staging			
↓	↓	↓	↓
Diagnosis	Workup-imaging, biopsies, lab tests, endoscopic procedures, fine needle aspirations, path/cytology report findings from the workup, etc. (See previous page for additional items included in the clinical workup.)	Definitive surgery(ies) (include op. report findings, path/cytology report findings, etc.)	Post-surgical imaging or findings (done within 4 months of diagnosis and before adjuvant treatment begins)
----------4 months----------			

B. If the patient <u>received</u> pre-surgical neoadjuvant therapy (chemotherapy, hormone therapy, immunotherapy or radiation therapy), the pathologic staging timeframe begins at the end of neoadjuvant therapy and goes through the completion of the definitive surgery(ies) or 4 months, whichever is **longer** in absence of disease progression. In essence, when neoadjuvant therapy is given prior to definitive surgery, pathologic staging documents the effectiveness of the neoadjuvant therapy. The information obtained prior to neoadjuvant therapy is excluded.

- ✓ Reminder: The information from the Clinical time period should NOT be included in the Pathologic Staging when the patient received neoadjuvant therapy prior to definitive surgery.

Neoadjuvant therapy given prior to definitive surgery					
Do NOT include in Pathologic Staging			**Include in Pathologic Staging**		
			↓	↓	↓
Diagnosis	Workup-imaging, biopsies, lab tests, endoscopic procedures, fine needle aspirations, path/cytology report findings from the workup, etc. (See previous pages for additional items included in the clinical workup.)	Neoadjuvant therapy (chemo., radiation, hormone, immunotherapy)	Post-neoadjuvant workup (imaging, etc.)	Definitive surgery(ies) (include op. report findings, path/cytology report findings, etc.)	Post-surgical imaging and findings (done within 4 months of diagnosis and before adjuvant treatment begins)
----------4			months ----------		

Rules for Classification:

In addition to the specific timeframes for data collection, specific activities (i.e., physical evaluation, imaging, resection of tumor, etc.) must be done in order to assign the clinical and pathological stages.

These specific activities or requirements are called the 'Rules for Classification'. Depending on the primary site/histology of the disease and whether the clinical staging or pathologic staging is being assigned, the rules for classification can be as simple as the performance of a physical examination or as extensive as the removal of an entire anatomic organ or structure.

To ensure the submission of accurate data, it is imperative abstractors review the Clinical and Pathologic Rules for Classification located in the site-specific chapters of the *AJCC TNM Manual, 7th Edition* prior to assigning the Clinical or Pathologic T, N, and M.

A. **Rules for Classification-Clinical Staging:** The requirements (rules for classification) for clinical staging are minimal and can almost always be met; therefore, the clinical T, N, and M will rarely be blank.

   - ❖ Exception: An incidental finding of cancer found during surgery for a non-cancer related issue will result in blank Clinical T, N, and M.

   - ➢ Example: A patient undergoes an appendectomy for appendicitis. During the microscopic evaluation of the specimen, the pathologist identifies carcinoma in the attached adhesions that represent metastatic carcinoma from the colon. In this case, the clinical T, N, and M will be blank.

   Clinical evaluation includes: physical examination, imaging, or other non-invasive clinical evidence, endoscopic examination, diagnostic biopsy, fine needle aspiration biopsy, or other invasive techniques, including surgical observation without resection. (Note: It is **not** necessary to have access to all of the items listed to assign the clinical stage. Use the information available to assign the stage.)

   - ✓ Note: **If the rules for classification for the Clinical T (cT) have not been met,** the Clinical T (cT) and the Clinical N (cN) will be blank**.** If the cT and the cN are blank, the Clinical m (cM) will also be blank unless there is evidence of metastasis. The evidence of metastasis may be **microscopically confirmed or not** (for example, evidence from an imaging procedure). If there is evidence of metastasis, the Clinical m (cM) should be assigned to reflect the metastasis.

     - ➢ Example when there is evidence of metastasis that is not microscopically confirmed (i.e. evidence from imaging):
       cT cN cM1

     - ➢ Example when there is microscopic confirmation of distant metastasis:
       cT cN pM1

     - ➢ Example when there is no evidence of distant metastasis:
       cT cN cM

B. **Rules for Classification-Pathologic Staging:** The requirements (rules for classification) for pathologic staging vary by site. Sometimes a resection of the primary tumor is required, other times removal of the entire organ or structure is required. The specific surgical procedures that must be performed prior to assigning the pathologic stage are listed in the site-specific chapters of the *AJCC TNM Manual, 7th Edition.*

- ✓ Note: **If the rules for classification for the Pathologic T (pT) are not met**, the Pathologic T (pT) and Pathologic N (pN) will be blank. If the pT and the pN are blank, the Pathologic m (pM) will be blank unless there is **microscopic confirmation** of distant metastasis. If there is microscopic confirmation of distant metastasis, the Pathologic m (pM) should be assigned to reflect the metastasis.

    - ➢ Example when there is **microscopic confirmation** of distant metastasis:
      pT pN pM1a

    - ➢ Example when metastasis is NOT microscopically confirmed:
      pT pN pM

    - ❖ Exception: If the rules for classification are not met (i.e., no resection preformed), but there is microscopic confirmation of the highest T and highest N categories from a biopsy, the Pathologic Staging requirements have been satisfied and the pT and pN can be assigned.

Prefixes 'c' and 'p':

When entering data into the Clinical and Pathologic T, N, and M fields, the abstractor will include a prefix of either 'c' or 'p' for each of the T, N, and M elements. In general (although not always), the 'c' prefix indicates information from the Clinical timeframe and the 'p' prefix indicates information from the Pathologic timeframe.

- ➢ Example 1: Clinical elements: cT2 cN0 cM0
- ➢ Example 2: Pathologic elements: pT3 pN1 pM1a

Placement of the 'c' prefix with the Pathologic T, N, or M elements and placement of the 'p' prefix with the Clinical T, N, or M elements is allowed, but under a few very specific circumstances. (Refer to the site specific chapters in the *AJCC TNM Manual, 7th Edition* to determine when this is appropriate, as well as, the In Situ Tumors and Overview of the M Element sections of this chapter for details.)

- ➢ Example 1: Clinical elements: **pTis** cN0 cM0
- ➢ Example 2: Pathologic elements: pT1 pN2 **cM1a**

In situ Tumors:

An in situ tumor is a tumor that has not penetrated the basement membrane of the tissue in which it arose. Since the tumor has not penetrated the basement membrane, it has no access to the lymphatic or venous system and cannot metastasize. An in situ diagnosis can only be made microscopically, because a pathologist must identify the basement membrane and determine that it has not been penetrated. Because in situ tumors must be microscopically confirmed, the prefix for the T will always be 'p' (even when assigning the Clinical Staging elements). Depending on the schema, the T will either be pTis or pTa. Since there cannot be any metastasis, the M will always be assigned as cM0, but the N will be assigned as either cN0 or pN0 based on whether or not lymph nodes were microscopically examined.

- Examples for Clinical Staging:

  pTis cN0 cM0
  pTa cN0 cM0

- Examples for Pathologic Staging when the rules for classification have been met and lymph nodes were NOT microscopically examined:

  pTis cN0 cM0
  pTa cN0 cM0

- Examples for Pathologic Staging when the rules for classification have been met and lymph nodes were microscopically examined:

  pTis pN0 cM0
  pTa pN0 cM0

Overview of the M Element:

Note: The dash (_) next to the T, N, or M in the examples below indicates a value (i.e., T1, T1a, N1, N2, etc.). The dash does not indicate the data field should be left blank.

As previously mentioned, the criteria for assigning the Clinical and Pathologic T and N is generally governed by the time periods when knowledge was available, as well as, satisfying the rules for classification. In addition to these items, assignment of the Clinical and Pathologic M reflects whether the metastasis was microscopically confirmed versus based solely on clinical (i.e., from imaging) evidence. The prefix preceding the Clinical or Pathologic M reflects how the metastasis was confirmed (not the timeframe). For example, regardless of the timeframe (Clinical/Pathologic), a 'p' prefix is used when distant metastasis is microscopically confirmed and the 'c' prefix is used for clinically evident distant metastasis without microscopic confirmation.

A. Microscopic confirmation of distant metastasis only:

a. Any microscopically confirmed metastasis is assigned as pM1_ (pM1, pM1a, pM1b)

b. If the microscopically confirmed metastasis is identified during the Clinical time period, the pM1_ will be entered into <u>BOTH</u> the Clinical M field and the Pathologic M field.

c. If the microscopically confirmed metastasis is identified during the Pathologic time period, the pM1_ will be entered into the <u>Pathologic M field only</u>.

d. When distant metastasis is <u>microscopically confirmed</u>, the rules for classification for the T and N do not have to be met in order to assign the M. When distant metastasis is microscopically confirmed, the pM1_ should be assigned even if the T and N are blank.

   1. Example: The rules for classification for prostate cancer are a DRE

(digital rectal exam) for Clinical Staging and a prostatectomy for Pathologic Staging. If the DRE information is not in the medical chart and the patient did not have a prostatectomy, the rules for classification for the Clinical and Pathologic Staging have NOT been met and the cT, cN, pT, and pN must be left blank. Despite not meeting the rules for classification for the Clinical and Pathologic Staging, if there is microscopic confirmation of distant metastasis, the pM1_ would be assigned. In this case, the microscopic confirmation took place during the Clinical time period, so the pM1_ would be assigned in both the Clinical and Pathologic Staging.

Clinical Stage:	cT	cN	pM1_
Pathologic Stage:	pT	pN	pM1_

B. Clinical evidence of distant metastasis <u>without microscopic confirmation</u> only:

a. Clinical evidence of distant metastasis without microscopic confirmation is assigned cM1_ (cM1, cM1a, cM1b)

b. When clinically evident metastasis (not microscopically confirmed) is identified during the Clinical time period:

1. Enter the cM1_ into the Clinical M field even if the rules for classification for Clinical Staging have NOT been met and the cT and cN are blank.

   - Examples:

     cT1 cN0 cM1_ (rules for classification met)
     cT cN cM1_ (rules for classification not met)

2. If the rules for classification for Pathologic Staging have been met, enter the cM1_ into BOTH the Clinical and Pathologic M fields.

   - Example:

     cT1 cN0 cM1_
     pT1 pN0 cM1_

3. If the rules for classification for Pathologic Staging have NOT been met, enter the cM1_ into the Clinical M field only. The Pathologic M field will be blank.

4. If the clinically evident metastasis is identified during the Pathologic time period (and the rules for classification for Pathologic Staging have been met):

   i. Do NOT enter the cM1_ into the Clinical M field.

   ii. Enter the cM1_ into the Pathologic M field.

C. Both microscopically confirmed metastasis in one site and clinical evidence of distant metastasis in another site:

a. Combine the information to accurately reflect that multiple distant metastatic sites are involved. Use the prefix 'p' to indicate at least one of the metastatic sites was microscopically confirmed.

- Example: Imaging on a patient with colon cancer identifies metastatic lesions in the liver and lungs. Only the liver lesions are biopsied and microscopically proven to be malignant. Even though the metastatic lung lesions were not biopsied, the clinically evident metastasis is important and should be reflected. In this case, the M element would be assigned pM1b (metastasis to multiple sites/organs).

b. Assignment of the Clinical and Pathologic M will depend on what metastatic information and the type of confirmation was available during each time period. Both the Clinical M and Pathologic M should accurately reflect what was known about the metastasis and how it was confirmed.

- Example 1: Clinical evidence of metastasis identified in one site during the Clinical time period and microscopic confirmation of another site during the Pathologic time period would be assigned as:

  Clinical Staging: cT_ cN_ cM1_
  Pathologic Staging: pT_ pN_ pM1_

- Example 2: Microscopic evidence of metastasis identified in one site during the Clinical time period and clinical evidence of another site during the Pathologic time period would be assigned as:

  Clinical Staging: cT_ cN_ pM1_
  Pathologic Staging: pT_ pN_ pM1_

Use of Blanks in Coding the TNM Elements:

Each chapter within the *AJCC TNM 7th Edition* specifies the rules for classification that must be met in order to assign the clinical and pathologic T, N, and M. If the rules for classification have not been met, the T, N, and M data elements are left blank. The rules for classification vary by primary site. For example, the rules for classification for pathologic staging of breast cancer require the total removal of the tumor which can be accomplished during a lumpectomy, mastectomy, etc. In contrast, the rules for classification for pathologic staging for bladder cancer require a partial or total removal of the primary site (the bladder). In order to ensure accurate data, the registrar MUST review the rules of classification listed in the *AJCC Cancer Staging Manual, 7th Edition* prior to assigning the clinical or pathologic T, N, M and stage groups.

There are separate and distinct rules for classification for the clinical and pathologic T, N, and M. It is not unusual to meet the rules for classification for one, but not the other. When that occurs, the T, N,

and M elements would be coded for the T, N, and M that met the rules for classification, but the others would be left blank. For prostate cancer, for example, in order to assign the clinical T, N, and M elements you must have the results of the DRE (digital rectal exam); and, in order to assign the pathologic T, N, and M elements, the patient must have a total prostatectomy. If the registrar has the results of the DRE, but the patient did not undergo a total prostatectomy, the registrar would assign the clinical T, N, and M elements and leave the pathologic T, N, and M elements blank.

- Example: A patient with prostate cancer is seen by his physician. The physician performs a DRE and indicates there is a tumor involving both lobes of the prostate. Treatment options are discussed which include total prostatectomy, hormone therapy, or radioactive seed implants. The patient decides to have the radioactive seed implants.

  The rules for classification for clinical staging (results of the DRE) have been met, but the rules of classification for pathologic staging have not been met. The abstractor would report the clinical and pathologic T, N, and M elements as follows:

Clinical staging elements-	T2c	N0	M0	Stage Group IIB
Pathologic staging elements-	T	N	M	Stage Group 99

  - ✓ Reminder: **If the rules for classification for Clinical T (cT) have not been met,** the Clinical T (cT) and the Clinical N (cN) will be blank**.** If the cT and the cN are blank, the Clinical m (cM) will also be blank unless there is evidence of metastasis. The evidence of metastasis may be **microscopically confirmed or not** (for example, evidence from an imaging procedure). If there is evidence of metastasis, the Clinical m (cM) should be assigned to reflect the metastasis.

    - Example when there is evidence of metastasis that is not microscopically confirmed (i.e. evidence from imaging):
      cT cN cM1

    - Example when there is microscopic confirmation of distant metastasis:
      cT cN pM1

    - Example when there is no evidence of distant metastasis:
      cT cN cM

    If the rules for classification for Pathologic T (pT) are not met, the Pathologic T (pT) and Pathologic N (pN) will be blank. If the pT and the pN are blank, the Pathologic m (pM) will be blank unless there is **microscopic confirmation** of distant metastasis. If there is microscopic confirmation of distant metastasis, the Pathologic m (pM) should be assigned to reflect the metastasis.

    - Example when there is **microscopic confirmation** of distant metastasis:
      pT pN pM1a

    - Example when metastasis is NOT microscopically confirmed:
      pT pN pM

    - ❖ Exception: If the rules for classification are not met (i.e., no resection preformed), but there is microscopic confirmation of the highest T and

highest N categories from a biopsy, the Pathologic Staging requirements have been satisfied and the pT and pN can be assigned.

Ambiguous Terminology and the AJCC TNM System:

Most of the time, registrars will have definitive statements of tissue involvement; however, for those situations where involvement is described with ambiguous terminology, if possible, look at the physician documentation that he/she used to make informed decisions on how to treat the patient when you are unable to determine the extent of involvement. For example, assign the TNM based on involvement when the patient was treated as though adjacent organs or nodes were involved. The National Comprehensive Cancer Network (NCCN) website provides information on cancer treatment by stage of disease. This website may also be helpful in these situations (https://www.nccn.org/professionals/physician_gls/f_guidelines.asp#site).

Tumor size:

Tumor size and the size of lymph node metastasis is an important component when assigning the T and N for some schemas; however, some sizes are listed in centimeters (cm) while others are in millimeters (mm). Abstractors should verify the type of measurement used in each schema prior to assigning the T and N.

If the tumor size is stated in centimeters in the medical chart, but the AJCC schema lists the size in millimeters, convert the centimeter size to millimeters by multiplying the dimension by 10.

- Example: Tumor size listed in medical chart is 2.5 cm. To convert the size to millimeters, multiply by 10. Converted size is 25 mm.

Occult Lung Tumor:

Occult stage for lung cancer is assigned when a patient is diagnosed with lung cancer based on cancer cells found in the **sputum or bronchial washings**, but the **primary lung tumor cannot be identified on imaging or bronchoscopy** Many times, no other evidence of cancer is indicated. When that is the case, assign TX (malignant cells in the sputum or bronchial washings, but primary tumor not visualized), cN0, and cM0.

T0:

Assign T0 when a physician suspects a specific anatomic site is the primary site of the malignancy, but the primary tumor cannot be visualized.

- Example: A biopsy of a liver nodule is positive for carcinoma from a breast primary. Imaging of the both breasts performed, but no tumors are identified. Assign T0 (No evidence of primary tumor) since the breast is the suspected primary site, but the primary tumor is not visualized.

Use of Autopsy Information in TNM:

Use the designation of 'a' when autopsy information is used to assign the pathologic TNM. Autopsy classification is used when there was no evidence of cancer prior to the patient's death and should include all clinical and pathologic information collected at the time of death and autopsy. Record

information from an autopsy in the pathologic fields when it adheres to the Pathologic Staging rules.

Stage Grouping:

The TNM system is used to describe and record the anatomic extent of disease. For purposes of tabulation and analysis, it is useful to condense these categories into stage groups. The stage groups begin at stage 0 and go up to stage IV. For consistency, in most instances, carcinoma in situ is categorized as Stage 0. The grouping of stages is intended to ensure, as far as possible, that each group is more or less homogeneous in respect to survival, and that the survival rates of these groups for each cancer site are distinctive.

Although the anatomic extent of disease, as categorized by TNM, is a very powerful prognostic indicator in cancer, it is recognized that many factors have a significant impact on predicting outcomes. Some additional factors have been incorporated into stage grouping for certain sites; for example, grade in soft tissue sarcoma, age in thyroid cancer, and PSA and Gleason score for prostate cancer.

The TNM classification and stage groups, once established, should not be updated to reflect disease progression or success or failure of treatment.

TNM Descriptors:

TNM has additional Descriptors (or symbols) that identify special situations.

a. m Symbol: The suffix ‘m’, in parentheses (m), would be used to indicate the presence of multiple invasive primary tumors reported as a single primary. This information can be found in the Clinical Stage Descriptor and the Pathologic Stage Descriptor section of this manual.

b. y Symbol: A ‘y’ prefix indicates the pathologic TNM assignment is based on information available during or following multimodality therapy. This information can be found in the Pathologic Stage Descriptor section of this manual.

c. a Symbol: The prefix ‘a’ indicates that classification is first determined at autopsy. Autopsy information is being collected as appropriate but will not be indicated as ‘a’.

COLLABORATIVE STAGING

Use of the *Collaborative Stage (CS) Data Collection System Coding Instructions* manual is REQUIRED when abstracting and submitting data to the TCR. The current version of the *Collaborative Stage Data Collection System Coding Instructions* manual can be reviewed at https://cancerstaging.org/cstage/coding/Pages/Version-02.05.aspx

The *Collaborative Stage Data Collection System Coding Instructions* manual contains detailed rules and information concerning the best way to document the extension of disease and other pertinent disease information found in the medical chart.

Timing Rule:

The timing rule for CS coding was designed to make use of the most complete information possible to yield the "best stage" information for the tumor at the time of diagnosis– "use all information gathered through completion of surgery (ies) in first course of treatment or all information available within four months of the date of diagnosis in the absence of disease progression, whichever is longer." Disease progression is defined as further direct extension or distant metastasis known to have developed after the diagnosis was established. Information about tumor extension, lymph node involvement, or distant metastasis obtained after disease progression is documented should be excluded from the CS coding.

Disease Progression:

Disease progression is defined as further direct extension, regional node involvement, or distant metastasis known to have developed after the diagnosis was established. Information about tumor extension, lymph node involvement, or distant metastasis obtained after disease progression is documented should be excluded from the CS fields. CS represents the aggregate information obtained during the period of diagnosis and work-up, not just the initial contact with the patient. For example, within the limits of the timing rule, if further diagnostic tests show more precise extension or a more precise tumor size, this revised information is not considered disease progression. In other words, CS does not consider as disease progression a change from lack of evidence of disease (status unknown) to known status of disease (negative or positive). However, a change from known negative status to positive is disease progression. Take, for example, an asymptomatic patient who is treated surgically. She then develops bone pain and is found to have osseous metastases within a few weeks of surgery. This would be considered disease progression because she was asymptomatic at the time her treatment decisions were made. Furthermore, if the treatment plan is discontinued or changed due to a revised disease status, this is progression of disease and collection of CS information stops at this point. Other rule modifications have been made and are printed in the site/histology-specific chapters.

Documenting Negative Lymph Nodes and Distant Metastases:

In the process of bringing together the principles of Summary Stage, the TNM categories and stage groupings, and the SEER Extent of Disease coding structure, the Collaborative Stage Data Collection System has also attempted to update abstracting rules to deal with the contemporary health care environment, in which completeness of staging documentation in the medical record has become an issue. In many circumstances, a patient's insurance will not pay for an imaging study or lab test that is expected to be negative but may otherwise be considered part of an "ideal" cancer staging workup. Similarly, the content of clinician notes has changed over time to simply report any symptomatic, suspicious, or involved areas rather than chronicle every body part that is normal. Typically, the clinician

reports positive findings and tends to remain silent on some or all negative findings but proceeds with usual treatment of the primary site. This change in documentation is a source of frustration to data collectors who rely on statements of normalcy or negativity to establish the boundaries of how far the cancer has spread because in most cases the cancer cannot be completely staged if any of the T, N, or M elements is unknown.

When clinical practice changes and data collection guidelines do not, the completeness of the data is affected. The implementation of Version 1 of the Collaborative Stage Data Collection System introduced a paradigm shift in the collection of information documenting the extent of disease, particularly in the collection of information about regional lymph nodes not easily examined by palpation, observation, physical examination, or other clinical methods. The paradigm shift permits registrars to presume that there are no clinically apparent regional lymph nodes or distant metastases when the clinician proceeds with usual or standard treatment to the primary site, since knowledge of such metastases would change the treatment approach. By allowing registrars to code regional lymph nodes as "none" or clinically negative and/or coding distant metastasis as none rather than coding these fields as unknown, the Collaborative Stage Data Collection System computer algorithms are able to derive a stage group that includes the best information. The developers of the CS model believe that this change in the way extent of disease is documented improves the consistency and quality of data being collected by the cancer registry community. Uniform rules and standardized training make it easier for cancer registry personnel to complete staging tasks.

In Version 1, this concept was called the "Inaccessible Sites Rule;" however, it is not the primary site that is inaccessible but rather the lymph nodes themselves. In CS Version 2, this concept has been renamed the "Inaccessible Lymph Nodes Rule." The details of the Inaccessible Lymph Nodes Rule are discussed later in the General Rules and Instructions.

Elimination of MX:

Also in Version 1, if the status of distant metastasis is unknown, the case was mapped to MX. The seventh edition of the *AJCC Cancer Staging Manual* eliminates MX as an option for coding distant metastases for AJCC 7th edition. As a result, even if CS Mets at Dx is coded as 99, the output value will be M0 for AJCC 7th edition. In other words, as of AJCC seventh edition, unless there is evidence of distant metastases either clinically (physical exam, imaging, and so forth) or proven microscopically, the registrar should assume that there are no distant metastases and use code 00 for CS Mets at Dx.

Choosing the Correct Schema for a Case: The Schema Discriminator:

At the start of a cancer case, the abstractor codes the site of origin and general histology for the cancer from the medical record and enters them into the cancer abstracting software. A schema selection algorithm determines which schema is appropriate to each combination of primary site and histology, perhaps taking into account an additional schema discriminator variable, as well. For instance, if the primary site is a segment of the colon, the schema selection algorithm looks at the histology to determine whether the regular (in other words, carcinoma) Colon, GIST Colon, NET (carcinoid) Colon, or Lymphoma schema should be presented to the data collector.

Every site and histology combination plus, in some circumstances, the schema discriminator will go to one and only one schema. Therefore, every reportable case will go to some CS schema. However, not all combinations will have AJCC 7th edition stage. For some primary sites, it may be necessary for the abstractor to select a specific subsite of a topography code in one of the site-specific factors using a "schema discrimination factor". The primary sites where the schema discriminator is needed include

esophagus GE junction and stomach; extrahepatic bile ducts; nasopharynx and pharyngeal tonsil; female peritoneum; lacrimal gland and lacrimal sac; and melanomas of the iris and ciliary body of the eye.

As an example, all of the extrahepatic bile ducts have an ICD-O-3 topography code of C24.0. However, within this code, the right, left and common hepatic ducts use the perihilar duct schema, the cystic duct uses a separate cystic duct schema, and the common bile duct and Sphincter of Oddi use the distal bile duct schema. In this situation, in order for the schema selection algorithm to select the correct schema, the abstractor must indicate which of the extrahepatic bile ducts is involved. Using this information, the algorithm will select the correct schema to present on the screen to the abstractor. The abstractor should rely on the schema selection algorithm to select the correct schema based on the facts about the case and not try to force the software to present a particular schema.

- ✓ Note: The appropriate site or histology schema to use for coding surgical treatment(s) may be different from the site or histology schema used for coding the Collaborative Stage data set. For example, an extralymphatic lymphoma of the stomach treated surgically would use the lymphoma schema in these coding instructions to code CS, but surgery would be coded using the stomach codes for surgery of primary site. Refer to the treatment coding rules in the SEER Program coding manual or the FORDS manual for more details.

The data items specific to that cancer site/histology are then abstracted from the medical record and coded in the Collaborative Stage Data Collection System fields. When data collection and coding are complete, the data collector activates the computer algorithms to derive the output values for the items in the seventh and sixth editions of TNM and the Summary Stage (both 1977 and 2000). These algorithms are provided in portable platform-independent form. The classification or stage of each tumor is actually determined by the computer in a consistent and accurate manner (see Mapping and the Computer Algorithm, below).

Mapping and the Computer Algorithm:

Once the data collector has coded all of the Collaborative Stage data elements for a case (the input values), the coded values are passed to a computer program that generates the correct stage for the case in four systems: AJCC TNM seventh edition; TNM sixth edition; SEER Summary Stage 1977; and SEER Summary Stage 2000.

Obsolete Codes:

From time to time, it is necessary to revise CS coding tables by reassigning concepts from one code to another to maintain the underlying structure and rules for code assignment. This can occur when a single code needs to be split into more than one code, or when a structure needs to be moved from one table to another (for example, a lymph node moved from CS Lymph Nodes to CS Mets at Dx). Codes in CS tables are not deleted while users have data coded with those codes. Instead, the codes are marked as OBSOLETE in their descriptions, and instructions are provided for handling previously coded data.

The designation of OBSOLETE is an official part of the description of the code, and it should be displayed to users, for example, in pick lists or drop-down menus for coding new data so that the codes are not used into the future, and in translation of codes in displays or printouts of abstracts.

Note: Do not use codes marked with any of the notations beginning with the word 'OBSOLETE' for cases abstracted in CS version 0203, or CS version 0204.

Prior to coding any CS data items, abstractors must review all of the General Instruction/Guidelines, Coding Instructions for CS Data Elements, and the Site-Specific Notes.

COLLABORATIVE STAGING GENERAL GUIDELINES AND INSTRUCTIONS

- ✓ Note: These general instructions refer to schemas based on primary site when, in fact, some schemas, such as melanomas and lymphoma, are based on histologic type or combinations of topographic subsite and histology. Refer to the previous discussion of the schema discriminator for further explanation of the way the computer application selects the schema. In these general instructions, the schemas are referred to as site-specific for the sake of brevity.

1. **Collaborative Stage data is collected on all cases regardless of whether they are microscopically confirmed.** A description of the type of diagnostic confirmation is collected in a separate data item. The diagnostic confirmation field can be used to exclude non-microscopically confirmed cases during analysis as necessary, since the *AJCC Cancer Staging Manual* states that "all cases should be confirmed microscopically for classification by TNM (including clinical classification). Rare cases that do not have any biopsy or cytology of the tumor can be staged, but survival should be analyzed separately. These cases should not be included in overall disease survival analyses." The CS computer algorithm does not make these distinctions.

2. **Collaborative Stage data is collected on all sites/histologies.** Summary Stage 1977 and Summary Stage 2000 are generated for all sites and histologies. The TNM elements and stage group are only generated for cases that meet the TNM criteria. For example, there is no TNM staging for brain.

a. The Collaborative Stage Data Collection System consists of 152 schemas, most of which are site specific. Some malignancies that can develop in many parts of the body are coded according to the histology of the case. For example, all lymphomas (except ocular adnexal lymphoma) are coded according to the lymphoma schema, regardless of the organ in which the lymphoma develops.

b. The computer algorithm maps to sixth and seventh editions of the AJCC Cancer Staging Manual and to Summary Stage 1977 and Summary Stage 2000. All of these staging systems are intended primarily for adult cancers, although some schemas applicable to pediatric cases, such as retinoblastoma, are included in both TNM and CS. Regardless of the patient's age, the CS input values are collected, but the computer-derived TNM output values may not be valid for pediatric cases.

3. **All schemas apply to all histologies unless otherwise noted.** Summary Stage 1977 and Summary Stage 2000 are generated for all histologies. The computer algorithms for determining the final TNM stage group take into account any histologies that are excluded from TNM staging. For example, the TNM schema for prostate applies to all carcinomas. But, for histologies not on the inclusion list, the computer algorithm does not calculate a stage and returns values representing "Not Applicable," meaning that AJCC T, N, M, and Stage Group are not generated for that site-histology combination. For the purpose of TNM mapping, CS Version 1 used histology exclusion lists for each schema, and Version 2 uses histology inclusion lists, but the concept is the same and does not effect CS coding. Both lists are included as Appendices 6 and 7.

4. **Timing of Data Collection**. CS collects a combined clinical-pathologic or mixed stage. The data collected in the Collaborative Stage Data Collection System are limited to:

- information gathered through completion of surgery(ies) in first course of treatment, **OR**

- all information available within four months of the date of diagnosis in the absence of disease progression (metastasis known to have developed after the diagnosis was established should be excluded)

- whichever is **longer**.

✓ Note: Apply the same timing rule to collection of site-specific factor data items, except where the definition of the item and coding instructions specifically indicate that information is to be collected in a specific timeframe. Examples for specified timeframes: SSF4 for Retinoblastoma, which is defined as "Primary Globe-Sparing Treatment Failure"; SSF 1 for Colon, which records interpretation of a pre-operative CEA . If a specimen from the original diagnosis and treatment is preserved and used for later testing and the results are not used in the original treatment decisions, do not code this information in the relevant site-specific factor. Document all results of later testing in text fields.

5. **Site-specific and histology-specific guidelines take precedence** over general guidelines. Always read the notes pertaining to a specific site or histology schema.

6. For each field, **assign the highest applicable code number as specifically as possible.** (Exception: codes for Unknown, Not Applicable, and NOS categories such as Localized, NOS or “Stated as T1, NOS” do not take priority over more specific codes with lower numbers.)

a. The codes are ordered in a hierarchy so that increasing numbers generally indicate increasing degrees of tumor involvement. The hierarchies are not the same for the different staging systems, and Collaborative Stage generally follows the hierarchies of the TNM system.

➢ Example: The patient has a T1 colon carcinoma confined to the submucosa. Possible code choices are 160 Invades submucosa; 170 Stated as T1, NOS; and 300 Localized, NOS. All three of these codes map to T1, but the one that provides the most specific information about depth of invasion is code 160.

b. There will be a few situations where it is necessary to review the mapped values (the right-most columns in a table) to determine which code to record.

c. Combination codes (for example, code 350 for “250 plus 300”) have been assigned when using the higher of two individual code numbers does not result in the appropriate mapping for all staging systems. Combination codes have been omitted when use of a higher number results in correct mapping for all three staging systems.

7. **Collaborative Stage is a combined clinical-pathologic coding system.** In Versions 1.0x and 2.00, CS records the greatest extent of disease based on combined clinical and operative/pathologic assessment for the fields CS Tumor Size, CS Extension, CS Lymph Nodes, and CS Mets at DX. This is often referred to as “best” or “combined” stage.

a. In general, pathologic information about a specific organ or structure takes priority over clinical or imaging information about that structure.

- Example: Imaging suggests involvement of the visceral pleura for a lung cancer. When that area is resected, there is no involvement of the visceral pleura, only reactive changes. *Select the appropriate "confined to lung" extension code and a pathologic eval code rather than the code for pleural involvement and evaluation by imaging.*

b. Gross observations at surgery are particularly important when all malignant tissue is not removed. In the event of a discrepancy between pathology and operative reports concerning excised tissue, priority is given to the pathology report.

c. Clinical information, such as a description of skin involvement for breast cancer and size of the primary lesion and distant lymph nodes for any site, can change the stage. Clinical information should be reviewed carefully to assure accurate recording of the CS data set.

d. All information pertaining to the case being coded according to CS rules is collected. This means that extent of disease information may be clinical or pathologic, regardless of any limitations placed on data collection in other staging systems.

- Example: In the FIGO and TNM systems, staging of cervical cancer is almost entirely clinical. In CS, information from surgical procedures should be coded when there is no preoperative therapy and the Eval fields should accurately reflect how the information was obtained.

e. When the patient does not receive preoperative treatment and the operative/pathology information disproves the clinical information, code the operative/pathology information.

f. When the patient does receive preoperative treatment, the greatest extent of disease prior to the beginning of treatment should be recorded. Preoperative, or neoadjuvant, treatment is defined as systemic (chemotherapy, hormone therapy, or immunotherapy) treatment or radiation therapy that is administered as an attempt to shrink the tumor, improve resectability, or control symptoms before the patient undergoes surgery. In the infrequent situation where post-operative disease is more extensive despite neoadjuvant treatment, this can be coded in the method of evaluation field for extension, regional lymph nodes or metastases at diagnosis.

g. Reg LN Pos and Reg LN Exam fields are based on pathologic (microscopic) information only.

8. **Eval fields.** CS Tumor Size/Ext Eval, CS Reg Nodes Eval, and CS Mets Eval (referred to collectively as the Eval fields) document how the most extensive tumor was established as well as whether the patient received preoperative treatment. The Eval fields tag the extent of disease data as a staging basis of c (clinical), p (pathologic), y (intercurrent treatment) or a (autopsy) according to the rules of the TNM system. An understanding of the TNM system is essential when coding the Eval fields so that the CS computer algorithm will derive the correct mapping and staging basis.

a. Assign the Eval field code that describes the diagnostic procedure associated with the corresponding data field. The Eval field code may not be the numerically highest code.

- Example: Patient has a mammogram, core needle biopsy positive for cancer. The lumpectomy shows that the carcinoma is 2.3 cm in greatest dimension and within the margins of excision. *Code the CS Tumor Size/Ext field as 3 because the lumpectomy meets TNM criteria for pathological staging.*

b. The Eval field code should correspond to the highest T, N, or M category, not necessarily to the highest code selected in the Tumor Size, Extension, Regional Lymph Nodes or CS Mets at Dx field.

- Example: The workup of a patient with a tonsil lesion includes a positive biopsy of the nasopharynx (Extension code 710, equivalent to T4b) and a CT scan showing involvement of the skull base (Extension code 750, equivalent to T4b). *Code the CS Tumor Size/Ext field as 3 (pathologic) because the biopsy documented the highest T value.*

c. The rules of the TNM system say that if a positive biopsy of a structure documents the highest T, N, or M category, the case meets the criteria for pathologic staging. According to the AJCC, if there is no resection but the highest T or N category can be confirmed microscopically, the case may be classified by pT or pN without resection. Use the appropriate pathologic Eval code when positive biopsy or positive cytology is sufficient for pathologic staging.

d. Special codes 5 and 6 in the Eval fields indicate when the patient had pre-operative treatment that may have affected the tumor size or extension, involvement of lymph nodes, or the presence of distant metastases. Use these codes when the patient had neoadjuvant therapy followed by a surgical resection.

e. For further information about the individual Eval fields, refer to the coding rules for individual data fields.

9. **Site-Specific Factors (SSFs)** are included in every schema where they are needed. They are incorporated into the staging algorithms when additional information is necessary to derive tumor (T), lymph node (N), metastasis (M), or AJCC (or Summary) stage group, or where the factor is considered to be of clinical, prognostic, or predictive importance. For example, the number of positive axillary lymph nodes is a site-specific factor necessary for the calculation of the N output value for breast. Other site-specific factors for breast, such as the tumor markers estrogen receptor assay, progesterone receptor assay, and HER-2 status are useful for predicting the response to hormone therapy or the drug Herceptin. For sites/histologies where some or all site specific factors are not used, they are coded as Not Applicable.

10. **Metastasis** known to have developed after the initial extent of disease was established (in other words, disease progression) should be excluded when determining the farthest extent of disease at the time of diagnosis.

11. **Autopsy reports** are used in coding the Collaborative Stage Data Collection System in the same way as pathology reports, applying the same rules for inclusion and exclusion within the timing rules.

12. **Statement of T, N, or M only.** The extent of disease may be described by the clinician only in terms of T (tumor), N (node), and M (metastasis) categories. In CSv2, many codes have been added to allow coding of T, N, or M information when there is no additional information available in the medical record. Examples include "Stated as T1, NOS," "Stated as T1a, NOS." or "Stated as N2b, NOS."

a. When there is no information available to use a more specific code, assign the code in the appropriate field that corresponds to the TNM information. For example, if the clinician reports that the tumor is T3 with no more specific information, use the code for "Stated as T3, NOS." If there is a discrepancy between documentation in the medical record and the physician's assignment of TNM, the documentation takes precedence. Cases of this type should be discussed with the physician who assigned the TNM.

   - **Exception:** Where there is doubt that the documentation in the medical record is complete and the physician's assignment of the T, N, or M category differs from the stage assignment that the medical record would support, it is preferable to use a "Stated as" code for the T, N, or M value corresponding the physician's statement rather than a CS code mapping to a different T, N, or M value. The registrar is strongly encouraged to record in text the rationale for the selected code.

b. There will be occasions where there is no information in the medical record to code a specific subcategory of T, N, or M. In such cases, the registrar may use the "Stated as T1, NOS" code if there is not enough information to code T1a or T1b.

13. **Reportable-by-Agreement Cases**. The seventh edition of the AJCC Cancer Staging Manual is a working document for clinicians who treat more than just reportable cancers. Consequently, there are staging systems for a number of neoplasms that may not be reportable to population-based registries. These include terms for in situ cancers that are not included in current reporting regulations in most states, such as high grade dysplasia of the esophagus (the preferred term for in situ carcinoma according to GI pathologists) and pancreatic intraglandular neoplasia (PAIN) of the pancreas, which is also called severe ductal dysplasia. Carcinoid of the appendix is a borderline tumor (/1) in ICD-O- 3 but has its own staging schema. The same thing applies to squamous carcinoma of the skin.

a. **Follow the instructions of the population-based registry regarding reportability of cases using these terms.** Even though there is a TNM staging system and a CSv2 schema for a site histology combination, it may not be reportable to a central registry.

b. If a case is reportable to the state registry, code the CS data items as instructed in the site-specific schemas. For example, if benign and borderline tumors of the ovary are reportable to a state registry, they are coded as 999 in CS Extension but may be staged using the TNM system.

c. Coding of cases that are reportable-by-agreement to a hospital or other facility registry, such as familial adenomatous polyposis of the colon—in other words, cases that will not be reported to a population-based registry, should follow the policies and coding guidelines of the facility.

14. **No forward compatibility.** CS version 2 is not designed to take cases coded in CS version 1 and rerun the conversion algorithm to derive seventh edition TNM. However, in most schemas, a case coded in

CSv2 will map to both sixth and seventh edition TNM. Derivation of AJCC 7th edition T, N, M, or stage will not occur for cases diagnosed prior to 2010 even if they are collected under CSv2.

15. **Lymphomas and hematopoietic diseases generally excepted.** The staging rules for solid tumors are not the same as for lymphomas and systemic hematopoietic diseases. Follow the instructions included in the appropriate schema.

CODING "NONE" VS. "UNKNOWN" IN THE COLLABORATIVE STAGE DATA COLLECTION SYSTEM, TNM AND SUMMARY STAGE

Inaccessible Lymph Nodes Rule:

As noted in the introduction, regional lymph nodes for certain primary sites are not easily examined by palpation, observation, physical examination, or other clinical methods. These are lymph nodes within body cavities that in most situations cannot be palpated. In other words, these are "inaccessible" lymph nodes. As examples, these are the regional lymph nodes for such primary sites as bladder, colon, corpus uteri, esophagus, kidney, liver, lung, ovary, prostate, and stomach (**this is not an all-inclusive list**).

The Collaborative Stage Data Collection System allows data collectors to record regional lymph nodes as code 000 negative (based on clinical evaluation) rather than 999 unknown when **three conditions** are met:

- There is no mention of regional lymph node involvement in the physical examination, pretreatment diagnostic testing or surgical exploration.
- The patient has clinically low stage (T1, T2, or localized) disease.
- The patient receives what would be usual treatment to the primary site (treatment appropriate to the stage of disease as determined by the physician) (or patient is offered usual treatment but refuses it).

These guidelines apply primarily to localized or early (T1, T2) stage in the TNM system for inaccessible lymph nodes. When there is reasonable doubt that the tumor is no longer localized, the code(s) for unknown information can and should be used. For example, when there is clinical evidence that a prostate cancer has penetrated through the capsule into the surrounding tissues (T3a/regional direct extension) and regional lymph node involvement is not mentioned, it would be correct to code lymph node involvement as unknown in the absence of any specific information regarding regional nodes.

For "accessible" lymph nodes that can be observed, palpated or examined without instruments, such as the regional nodes for the breast, oral cavity, skin, salivary gland, thyroid, and other organs, the abstractor should look for some description of the regional lymph nodes. A statement such as "remainder of examination negative" is sufficient to code regional lymph nodes as clinically negative (code 000). If there is no documentation regarding accessible lymph nodes, code as 999.

Coding Distant Metastases:

This coding guideline also permits data collectors to record distant metastasis clinically as none rather than unknown (again, based on clinical evaluation) when the clinician proceeds with usual treatment of the primary site, since this action presumes that there are no distant metastasis that would otherwise change the treatment approach. Because there is no longer an MX category in the TNM system, any case where CS Mets at Dx is coded 99 (unknown) will map to clinical M0 in seventh edition, MX in sixth edition, and unknown in Summary Stage 1977 and Summary Stage 2000.

Coding Death Certificate Only Cases:

Death Certificate **only** (DCO) cases are coded as unknown (usually 9, 99, 999, etc.) or not applicable (usually 8, 98, 988, etc.) in all Collaborative Stage fields. Refer to the schema-specific lists of codes for DCO cases on the CS website for coding instructions for cases that are identified ***only*** by a diagnosis on a death certificate. True DCO cases are usually identified only at the central registry level. If a hospital finds a case identified through the DCO follow back process, it should be coded as completely as possible as an incident case, not using DCO coding rules.

Use of Autopsy Information in Collaborative Stage:

Information obtained from autopsy may be used in either of two ways in the Collaborative Stage Data Collection System. The evaluation fields must then be coded correctly to indicate how the autopsy information is to be interpreted. If a patient with a suspected diagnosis of cancer dies and an autopsy is performed, extent of disease information obtained from the autopsy may be included along with other clinical and pathologic information, if it meets the timing rules for inclusion. In such cases, the Eval code will be 2 and the computer algorithm will assign the T, N, or M to "p" (pathologic) classification. If cancer is not suspected at the time of autopsy (Eval code 8), the extent of disease information from the autopsy is included, but the algorithm will assign the T, N, and M to the autopsy (a) classification of the TNM system rather than to clinical or pathologic evaluation. Each of the evaluation field schemas has appropriate codes to allow this distinction.

Definitions of Adjacent Tissues, Structures, and Organs:

Adjacent connective tissue:

Some of the CS schemas for ill-defined or non-specific sites in this manual contain a code for adjacent connective tissue, which is defined here as the unnamed tissues that immediately surround an organ or structure containing a primary cancer. Use this code when a tumor has invaded past the outer border (capsule, serosa, or other edge) of the primary organ into the organ's surrounding supportive structures but has not invaded into larger structures or adjacent organs.

The structures identified in ICD-O-3 as connective tissue include the following: adipose tissue; aponeuroses; arteries; blood vessels; bursa; connective tissue, NOS; fascia; fatty tissue; fibrous tissue; ganglia; ligaments; lymphatic vessels or channels (not nodes); muscle; nerves (spinal, sympathetic and peripheral); skeletal muscle; subcutaneous tissue; synovia; tendons; tendon sheaths; veins; and vessels, NOS. In general, these tissues do not have specific names. These tissues form the framework of many organs, provide support to hold organs in place, bind tissues and organs together, and serve as storage sites for nutrients. Blood, cartilage and bone are sometimes considered connective tissues, but in this manual they would be listed separately.

Adjacent organs:
Organs are anatomic structures with specific physiologic functions other than (or in addition to) support and storage. Continuous tumor growth from one organ into an organ anatomically next to the primary would be coded to the appropriate code for "adjacent organs/structures" in the CS schemas for ill-defined and non-specific sites.

Adjacent structures:
Connective tissues large enough to be given a specific name would be described as adjacent structures. For example, the brachial artery has a name, as does the broad ligament. Continuous tumor growth from one organ into an adjacent named structure would be coded to the appropriate code for "adjacent organs/structures" in the CS schemas for ill-defined or non-specific sites.

Ambiguous Terminology:

Interpreting Ambiguous Terminology for Collaborative Stage:
Determination of the cancer stage is both a subjective and objective assessment of how far the cancer has spread. Sometimes the clinician is hesitant to commit to a definite statement that a particular organ or tissue is involved by the cancer and uses what data collectors refer to as "ambiguous terminology." The following lists can generally be used to interpret the intent of the clinician if there is no specific statement of involvement in the medical record. However, if individual clinicians use these terms differently, the clinician's definitions and choice of therapy should be recognized. If a term used in a diagnostic statement is not listed below, consult the clinician to determine the intent of the statement.

- ✓ Note: Some schemas interpret certain words as involvement, such as 'encasing' the carotid artery for a head and neck site. Terminology in the schema takes priority over this list.

- ✓ Note: This is not the same list published in the Reportability section of this manual. This is not the same list of ambiguous terminology provided for the Multiple Primary and Histology Coding Rules.

Consider as involvement:
adherent
apparent(ly)
appears to
comparable with
compatible with
consistent with
contiguous/continuous with
encroaching upon*
extension to, into, onto, out onto
features of
fixation to a structure other than primary**
fixed to another structure**
impending perforation of
impinging upon
impose/imposing on
incipient invasion

DO NOT Consider as Involvement:
abuts
approaching
approximates
attached
cannot be excluded/ruled out
efface/effacing/effacement
encased/encasing
encompass(ed)
entrapped
equivocal
extension to without invasion/involvement of
kiss/kissing
matted (except for lymph nodes)
possible
questionable
reaching

induration
infringe/infringing
into*
intrude
invasion to into, onto, out onto
most likely
onto*
overstep
presumed
Consider as involvement (Continued):
probable
protruding into (unless encapsulated)
suspected
suspicious
to*
up to
rule out
suggests
very close to
worrisome

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

** interpreted as involvement of other organ or tissue

Coding Involvement of Regional and Distant Lymph Nodes:

Clinicians describe the characteristics of regional and distant lymph nodes in a variety of ways. In general, for solid tumors, only the terms *fixed, matted,* or *mass in the hilum, mediastinum, retroperitoneum, and/or mesentery* (with no specific information as to tissue involved) are considered involvement for the purposes of TNM staging and CS coding. Other descriptions, such as *palpable*, *enlarged*, *visible swelling*, *shotty*, or *lymphadenopathy*, would be considered clinical involvement only when there is an additional comment by the physician that the nodes are, for example, suspicious for malignancy or involvement, or when the physician's TNM staging indicates cN1 or higher. The exceptions are regional lymph nodes of the lung where *mass*, *enlargement*, or *adenopathy* in the hilum or mediastinum is considered involvement of regional nodes; Kaposi sarcoma, and malignant lymphoma, where any mention of any of the terms above is considered lymph node involvement. For lymph nodes of the head and neck, the terms *fixed* and *matted* also imply extranodal extension of metastases in the lymph nodes.

How to Code the Collaborative Stage Data Collection System Data Elements:

- ✓ Note**:** This procedure focuses on only the Collaborative Stage data fields and assumes other registry operations such as case finding, completion of text fields and other data fields, edit checking and case submission are also being performed appropriately.

1. Before you begin to code using the Collaborative Stage Data Collection System, read completely the general rules in this manual.

2. Read the medical record carefully to determine the primary site and histology and identify the correct ICD-O-3 codes. While you are reviewing the record, make mental notes about the tissues, lymph nodes, and distant sites that are involved by tumor as well as pertinent lab test results and negative findings.

3. The first step is selecting the correct schema. This will usually be done automatically by the software, based on the primary site, histology, and schema discriminator code (if needed) you have entered.

4. Verify that you are in the correct schema by confirming that the primary site and, where relevant, the histology code, are in the list at the beginning of the schema.

5. Begin assigning codes for the fields in the Collaborative Stage Data Collection System according to the data item coding guidelines in this document. Read the notes and follow the schema-specific instructions at the beginning of each data field. Some schemas may have site-specific factors associated with extension, lymph nodes or metastasis; keep these in mind as you assign the codes.

a. Code the tumor size in the CS Tumor Size field.

b. Code how far the tumor has directly spread in the CS Extension field.

c. Code how the greatest tumor size and spread was determined in the CS Tumor Size/Ext Eval field.

d. Code whether regional lymph nodes are involved in the CS Lymph Nodes field.

e. Code how the farthest regional node spread was determined in the CS Reg Node Eval field.

f. Code the number of positive regional lymph nodes from the pathology report in the Reg Nodes Pos field.

g. Code the number of regional lymph nodes examined by the pathologist in the Reg Nodes Exam field.

h. Code the farthest distant metastasis (including distant lymph nodes) in the CS Mets at Dx field.

i. Code whether there are metastases in the bone, brain, lung and/or liver in the appropriate CS Mets at Dx-Metastatic Site fields.

j. Code how any distant metastasis was determined in the CS Mets Eval field.

k. Code the site-specific factors for the selected schema as required by your standard-setter(s). Code the specific information requested for each site specific factor. The software may provide default values for undefined or non-required site-specific factors.

Congratulations! You have collected all the facts about the case and the codes are ready for the computer to derive the T, N, M, and Stage Group for the AJCC seventh and sixth editions; Summary Stage 1977; and Summary Stage 2000. Depending on your software system, the final stage information may be derived now, when the case is saved, or prior to exiting the case. Finish the rest of the abstract, edit check it and save it.

When the computer derives the final stage information, the program will check the histology code and other coded information to determine whether T, N, M and AJCC Stage Group will be generated for the case. If the histology code is not in the computer's list of stageable morphology codes for that site, the T, N, M, and AJCC Stage Group will be reported as "Not Applicable." Summary Stage is generated for every case. The computer algorithm will also provide which version of the Collaborative Stage Data Collection System was used to derive the final stages. The registry software may display the derived values immediately or may display them when the case is saved; this is vendor-specific. Any error messages or edit warnings displayed by either the CS computer algorithm or the EDITS process must be resolved before the case is ready for transmission to the central registry.

TEXT WRITING

Text is required on all abstracts submitted to the TCR. To meet the minimum requirements, the text must justify the coding for the following data items:

Sex
Race
Dates (Diagnosis date, diagnostic procedure dates, and treatment dates)
Primary Site
Histology
Grade
Behavior
Extension of Disease (to support Summary Stage and TNM)
Treatment information
Overrides- All overrides must have a statement that documents the reason for the override.

- Example: Primary site/Histology conflict was overridden based on review by Dr. _ _ _ _.

The central registry is required to perform visual edits on a percentage of all abstracts submitted. Visual editing is a process that verifies the codes and text correlate. Without supporting text, visual editing can not be performed and the central registry is unable to determine the accuracy of the data.

The central registry also uses text to merge information submitted by different hospitals on the same case. On a daily basis, the central registry staff is faced with making decisions about how to handle multiple abstracts submitted for a single patient. Without text it is extremely difficult to decide whether the patient has a single malignancy or multiple primaries.

- Example: Hospital A: On Feb. 22, 2011 a patient has a scan that identifies a mass on the adrenal gland. On Feb 24, 2011 the patient undergoes a needle biopsy of the mass. The pathology report confirms an adenocarcinoma in the specimen. Hospital A submits an abstract with the primary site listed as adrenal gland (C74.9) and an unknown summary stage (9).

  Hospital B: On March 21, 2011, the patient goes to Hospital B for further workup and resection. A CT scan identifies a mass in the transverse colon that appears to extend into the adrenal gland. The surgeon performs a resection. The pathology report confirms the transverse colon mass to be adenocarcinoma with invasion into the adrenal gland. Hospital B submits an abstract with the primary site listed as transverse colon (C18.4) and the summary stage coded to distant.

  If neither hospital includes text on the abstracts, the Central Registry receives the following information:

Patient X:	Hospital A:	2/24/11	Primary site: C 74.9	Stage: 9	Hist: 8140/39
	Hospital B:	3/21/11	Primary site: C 18.4	Stage: 7	Hist: 8140/39

  Without text there is no way of knowing these abstracts represent the same malignancy; and, erroneously these abstracts would be entered into the database as two primaries and inflate the incidences of cancer in Tennessee.

What Text is Needed:

Text writing (abstracting) is the process of condensing a patient's medical chart into a few short lines of information that validate the coding of the data items. To save time and space, standard abbreviations should be used whenever possible (See a listing of common abbreviations included in this chapter.)
When justifying staging information it is very important to be specific regarding what tissues or organs are involved. (Example: into the serosa; 4 lymph nodes positive; mets to the liver; in-situ; into the submucosa.) General statements such as "localized", "regional", and "distant" are not specific and should not be used to justify the stage unless no specific information is available.

The text worksheet on the following page can be used as a guide for identifying valuable information located in a medical chart and what should be documented in the text fields.

Remember: Almost all reports can be reduced into a few words that justify the coding.

- Example: 4/7/01 Cystoscopy; bladder biopsies-The patient was placed in the lithotomy position. Under satisfactory general anesthesia, the cystoscope was passed into the bladder. At this point, a careful evaluation of the bladder revealed a relatively large, approximately 3cm, tumor on the dome of the bladder. This appeared sessile and it was obviously a malignancy. There was surrounding erythema. The rest of the bladder showed some inflammatory changes with erythema, but no overt lesions were noted.

  Example of text for the above report: 4/7/01 Cystoscopy: 3cm sessile tumor, bladder dome. Obvious malig.

Text/ Abstracting Worksheet

Physical Exam (PE): Record findings from the admit sheet and physical exam that support diagnosis, tumor size, palpable lymph nodes, age, race, cancer history, impression.

Admit sheet: Pt: MM DOB 8/1/1960 Race: Cauc
H&P: 6/1/11 5x3 cm mass in left upper outer quadrant of left breast found on exam by phys. No skin changes, no dimpling, palpable LN in r. axilla.

Text Example: 50 yr old WF 6/1/11 - 5x3 cm mass LUOQ breast, palpable LN R axilla, no skin changes

Path: Record the date and name of procedure, site of biopsy/resection, histology, grade, (identify grading scheme i.e., Gleason's), tumor size, lymph nodes involved/examined, extent of involvement If more than one procedure performed, list reports individually.

Case: Report S11-1258: 7/1/11 rad prostatectomy, mod diff. adenocarcinoma, neg. LN, gleason 3+3, involving both lobes, involved at apex, capsule/seminal vesicles free. **Text Example**: 7/1/11 (S11-1258)rad prost, mod diff adenoca, neg LN's, glea 3+3, involve both lobes and apex, caps /sem vesicle neg.

X-ray/Scans: Document date, location, laterality of mass (es), size, and enlarged lymph nodes,extent of disease from CT scans, chest x-rays, liver scans, etc.

Case: 9/2/11 CT chest-4.5 cm mass in right upper lobe of lung, no pleural effusion, enlarged hilar LN/CT abdomen normal
Text Example: 9/2/11 - CT chest/abd RUL-4.5 cm mass/neg. pleur. Eff/enlarge LN in mediastinum /abd. norm

Primary Site Title: Document information identifying the primary site and laterality.

Case: Ductal Carcinoma upper outer quadrant of left breast.

Text Example: UOQ L. Breast

Scopes: Document date of procedure, location of tumor, size, extent of disease, etc from endoscopic exam.

Case: 5/2/11 colonoscopy w/bx of mass found at 35 cm from anal verge, consistent w/adenocarcinoma
Text Example: 5/2/11 – colonspy/bx mass 35cm from anal verge/c/w adenoca

Histology Title: Document information information identifying the histologic type, behavior and grade.

Case: Papillary renal cell carcinoma in L. kidney, grade 2

Text Example: Papillary renal cell ca, grade 2

Lab Tests: Document findings from laboratory examinations, other than cytology or histopathology. Record date of test, positive and negative findings, tumor markers, special studies.

Text Examples: ERA/PRA positive, PSA 12.1/elevated, CEA within normal limits (WNL)

Surgery: Record the name(s) and date(s) of all surgical procedures.

Text Examples: 3/3/011 bronchoscopy w/RUL bx /Happytown Hospital 3/17/11 CT guided lung bx Happytown Hospital 4/1/11 Mediastinoscopy w/LN sampling, thorocotomy. RUL wedge resection American Cancer Center

OP: Document all surgical procedures that provide information for staging. Record dates, number of LN's removed, size of tumor, type of surgery, residual tumor, any invasion**. Case:** 9/10/11 partial gastrectomy, surgeon observed large, fixed mass in fundus of stomach, invading spleen. Small tumor nodules in liver.

Text Example: 9/10/06 – part. Gast, lg fixed mass, fundus of stom invading spleen/tumor nodules in liver

Remarks: Use this field as additional space for explanations, add'l information, history of previous cancer, override review documentation ,etc.
Case: 35 year old pt. with prostate cancer ***(primary site/age conflict***)

Text Example: reviewed age/histology conflict, correct age is 35.
Text Example: 3/8/11 pt. referred to hospice, expired 3/30/11.

RECOMMENDED ABBREVIATIONS FOR ABSTRACTORS

The use of abbreviations in cancer abstraction is becoming more commonplace as the demands on abstractors increase. Abbreviations often are used by cancer abstractors to shorten the written narratives entered into text fields to facilitate the electronic storage and transmission of the information. However, abbreviations can generate confusion, because abbreviations may vary among different institutions and even between different specialties within the same institution. To be useful, an abbreviation must be clearly understood by any individual who encounters it. Consequently, the use of abbreviations is a useful abstracting practice only if universally recognized and understood abbreviations are used.

The NAACCR Recommended Abbreviations Listings were developed for utilization by cancer report abstractors and the agencies to which they submit their data. These lists were compiled to reduce some of the confusion that can result from the use of common and not-so-common abbreviations when abstracting reports of cancer from the medical record. Although the lists may shed some light on abbreviations used in the medical record, please note that these lists are intended to be used as a primary reference by the cancer abstractor, to help abstract necessary information into a limited number of text fields for storage and transmission of cancer information.

The NAACCR Recommended Abbreviations Listings consist of two main lists of almost 500 word/terms and their recommended abbreviations/symbols, as well as a special table delineating context-sensitive abbreviations. The first main listing is ordered by word/term to enable the look-up of a recommended abbreviation for a particular word or term, and the second main listing is ordered by abbreviation/symbol to enable the look-up of the word or term for a particular abbreviation or symbol. The context-sensitive abbreviations list consists of a subset of the abbreviations from the main lists where a different context for the same abbreviation conveys a different meaning (for example, CA may mean calcium or carcinoma/ML may mean milliliter or middle lobe). For these context-sensitive abbreviations, the meaning of the abbreviation should be readily apparent from the context in which it is used.

The listings were compiled from abbreviation lists from SEER Book 3, the NAACCR Pathology Committee, the Veterans Administration, Dr. Jay Piccirillo's comorbid conditions training materials, the Florida Cancer Data System, and the California Cancer Registry. Terms included in the lists are limited to those that are commonly utilized when abstracting cancer information. The listings are not exhaustive, but many of the most commonly used terms were included. Abbreviations for chemotherapy drugs and/or regimens are not included. Please note that although abbreviations are presented in uppercase, either upper- or lowercase may be utilized when entering abbreviations within abstraction software. When abstracting into text fields, the use of abbreviations should be limited to those that appear on these lists whenever practical. Abbreviations and symbols should be used carefully. Any questions or suggestions for new/modified abbreviations may be emailed to either of the current Chairpersons of the NAACCR Registry Operations Committee.

NAACCR RECOMMENDED ABBREVIATION LIST
ORDERED BY WORD/TERM(S)

WORD/TERM(S)	ABBREVIATION/SYMBOL
Abdomen (abdominal)	ABD
Abdominal perineal	AP
Abnormal	ABN
Above	^
Above knee (amputation)	AK(A)
Absent/Absence	ABS
Abstract/Abstracted	ABST
Achilles tendon reflex	ATR
Acid phosphatase	ACID PHOS
Acquired Immune Deficiency Syndrome	AIDS
Activities of daily living	ADL
Acute granulocytic leukemia	AGL
Acute lymphocytic leukemia	ALL
Acute myelogenous leukemia	AML
Acute myocardial infarction	AMI
Acute Respiratory Distress (Disease) Syndrome	ARDS
Acute tubular necrosis	ATN
Acute renal failure	ARF
Adenocarcinoma	ADENOCA
Adenosine triphosphate	ATP
Adjacent	ADJ
Adult-onset Diabetes Mellitus	AODM
Admission/Admit	ADM
Adrenal cortical hormone	ACH
Adrenal cortex	AC
Adrenocorticotrophic hormone	ACTH
Affirmative	AFF
Against medical advice	AMA
AIDS-related condition (complex)	ARC
AIDS-related disease	ARD
Air contrast barium enema	ACBE
Albumin	ALB
Alcohol	ETOH
Alkaline phosphatase	ALK PHOS
Alpha-fetoprotein	AFP
Also known as	AKA
Ambulatory	AMB
Amount	AMT
Amputation	AMP
Amyotrophic lateral sclerosis	ALS
Anal intraepithelial neoplasia, grade III	AIN III
Anaplastic	ANAP

WORD/TERM(S)	ABBREVIATION/SYMBOL
And	&
Angiography/Angiogram	ANGIO
Anterior	ANT
Anteroposterior	AP
Antidiuretic hormone	ADH
Antigen	AG
Aortic stenosis	A-STEN
Appendix	APP
Apparently	APPL'Y
Approximately	APPROX
Arrhythmia	ARRHY
Arterial blood gases	ABG
Arteriosclerotic cardiovascular disease	ASCVD
Arteriosclerotic heart disease	ASHD
Arteriosclerotic Peripheral Vascular Disease	ASPVD
Arteriosclerosis/Arteriosclerotic	AS
Arteriovenous	AV
Arteriovenous malformation	AVM
Artery (ial)	ART
Ascending colon	A-COLON
Aspiration	ASP
Aspirin, Acetylsalicylic acid	ASA
As soon as possible	ASAP
At	@
Atrial fibrillation	A FIB
Atrial flutter	A FLUTTER
Atrial stenosis/insufficiency/incompetence	AI
Atrial premature complexes	APC
Auscultation & percussion	A&P
Autonomic nervous system	ANS
Autopsy	AUT
Autoimmune hemolytic anemia	AIHA
Average	AVG
Axilla(ry)	AX
Bacillus Calmette-Guerin	BCG
Barium	BA
Barium enema	BE
Bartholin's, Urethral & Skene's	BUS
Basal cell carcinoma	BCC
Before noon	AM
Below knee (amputation)	BK(A)
Benign prostatic hypertrophy/hyperplasia	BPH
Bilateral	BIL
Bilateral salpingo-oophorectomy	BSO
Bile duct	BD

WORD/TERM(S)	ABBREVIATION/SYMBOL
Biological response modifier	BRM
Biopsy	BX
Bipolar affective disorder	BAD
Black female	B/F
Black male	B/M
Bladder tumor	BT
Blood pressure	BP
Blood urea nitrogen	BUN
Blood volume	BV
Bone marrow	BM
Bone marrow transplant	BMT
Bowel movement	BM
Brother	BRO
Calcium	CA
Capsule (s)	CAP(S)
Carcinoembryonic antigen	CEA
Carcinoma	CA
Carcinoma *in situ*	CIS
Cardiovascular disease	CVD
CAT/CT scan/Computerized axial tomography	CT
Centimeter	CM
Central nervous system	CNS
Cerebrospinal fluid	CSF
Cerebrovascular accident	CVA
Cervical intraepithelial neoplasia	CIN
Cervical intraepithelial neoplasia, grade III	CIN III
Cervical vertebrae	C1-C7
Cervical spine	C-SPINE
Change	CHG
Chemotherapy	CHEMO
Chest X-ray	CXR
Chronic	CHR
Chronic granulocytic leukemia	CGL
Chronic lymphocytic leukemia	CLL
Chronic myeloid (myelocytic) leukemia	CML
Chronic obstructive lung disease	COLD
Chronic obstructive pulmonary disease	COPD
Chronic renal failure	CRF
Chronic ulcerative colitis	CUC
Cigarettes	CIG
Clear	CLR
Cobalt 60	CO60
Collaborative stage	CS
Colon, Ascending	A-COLON
Colon, Descending	D-COLON

WORD/TERM(S)	ABBREVIATION/SYMBOL
Colon, Sigmoid	SIG COLON
Colon, Transverse	TRANS-COLON
Colony-stimulating factor	C-SF
Complaint (-ning) of	C/O
Complete blood count	CBC
Congenital heart disease	CHD
Congestive heart failure	CHF
Consistent with	C/W
Continue/continuous	CONT
Contralateral	CONTRA
Coronary artery bypass graft	CABG
Coronary artery disease	CAD
Coronary care unit	CCU
Cubic centimeter	CC
Cystoscopy	CYSTO
Cytology	CYTO
Cystic fibrosis	CF
Date of birth	DOB
Date of death	DOD
Dead on arrival	DOA
Decrease(d)	DECR
Deep tendon reflex	DTR
Deep vein thrombosis	DVT
Deoxyribonucleic acid	DNA
Descending colon	D-COLON
Dermatology	DERM
Diabetes mellitus	DM
Diagnosis	DX
Diameter	DIAM
Diethylstilbestrol	DES
Differentiated/differential	DIFF
Digital rectal examination	DRE
Dilatation and curettage	D&C
Discharge	DISCH
Discontinue(d)	DC
Disease	DZ
Disseminated intravascular coagulopathy	DIC
Ductal carcinoma *in situ*	DCIS
Dyspnea on exertion	DOE
Ears, nose, and throat	ENT
Electrocardiogram	ECG/EKG
Electroencephalogram	EEG
Electromyogram	EMG
Emergency room	ER

WORD/TERM(S)	ABBREVIATION/SYMBOL
Endoscopic retrograde cholangiopancreatography	ERCP
End stage renal disease	ESRD
Enlarged	ENLGD
Equal(s)	=
Esophagogastro-duodenoscopy	EGD
Estrogen receptor (assay)	ER, ERA
Evaluation	EVAL
Every	Q
Every day	QD
Examination	EXAM
Excision/excised	EXC(D)
Expired	EXP
Exploratory	EXPL
Exploratory laparotomy	EXPL LAP
Extend/extension	EXT
Fever of unknown origin	FUO
Fine needle aspiration	FNA
Fine needle aspiration biopsy	FNAB
Floor of mouth	FOM
Fluid	FL
Fluoroscopy	FLURO
Follow-up	FU
For example	E.G.
Fracture	FX
Frequent/Frequency	FREQ
Frozen section	FS
Full thickness skin graft	FTSG
Gallbladder	GB
Gastroesophageal	GE
Gastroesophageal reflux disease	GERD
Gastrointestinal	GI
General/Generalized	GEN
Genitourinary	GU
Grade	GR
Greater/Greater than	>
Gynecology	GYN
Hematocrit	HCT
Hemoglobin	HGB
Hepatitis A (virus)	HAV
Hepatitis B (virus)	HBV
Hepatitis C (virus)	HCV
Hepatitis D (virus)	HDV
Hepatosplenomegaly	HSM

WORD/TERM(S)	ABBREVIATION/SYMBOL
History	HX
History and physical	H&P
History of	H/O
Hormone	HORM
Hospital	HOSP
Hour/Hours	HR(S)
Human chorionic gonadotropin	HCG
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymphotrophic Virus, (Type III)	HTLV
Hypertension	HTN
Hypertensive cardiovascular disease	HCVD
Hypertensive vascular disease	HVD
Hysterectomy	HYST
Idiopathic hypertrophic subaortic stenosis	IHSS
Idiopathic thrombocytopenia	ITP
Immunoglobulin	IG
Immunohistochemical	IHC
Impression	IMP
Incision & drainage	I&D
Includes/Including	INCL
Increase(d)	INCR
Inferior	INF
Inferior vena cava	IVC
Infiltrating	INFILT
Inflammatory bowel disease	IBD
Inpatient	IP
Insulin-dependent diabetes mellitus	IDDM
Intensive care unit	ICU
Intercostal margin	ICM
Intercostal space	ICS
Intermittent positive pressure breathing	IPPB
Internal	INT
Interstitial lung disease	ILD
Intramuscular	IM
Intrathecal	IT
Intravenous	IV
Intravenous cholangiogram	IVCA
Intravenous pyelogram	IVP
Invade(s)/invading/invasion	INV
Involve(s)/involvement/involving	INVL
Ipsilateral	IPSI
Irregular	IRREG

WORD/TERM(S)	ABBREVIATION/SYMBOL
Jugular venous distention	JVD
Juvenile rheumatic arthritis	JRA
Kaposi sarcoma	KS
Kidneys, ureters, bladder	KUB
Kilogram	KG
Kilovolt	KV
Laboratory	LAB
Lactic dehydrogenase	LDH
Laparotomy	LAP
Large	LRG
Last menstrual period	LMP
Lateral	LAT
Left	LT
Left bundle branch block	LBBB
Left costal margin	LCM
Left lower extremity	LLE
Left lower lobe	LLL
Left lower quadrant	LLQ
Left salpingo-oophorectomy	LSO
Left upper extremity	LUE
Left upper lobe	LUL
Left upper quadrant	LUQ
Left upper outer quadrant	LUOQ
Less/Less than	<
Licensed practical nurse	LPN
Linear accelerator	LINAC
Liver/spleen scan	LS SCAN
Lower extremity	LE
Lower inner quadrant	LIQ
Lower outer quadrant	LOQ
Lumbar vertebra	L1-L5
Lumbar spine	L-SPINE
Lumbosacral	LS
Lymphadenopathy-associated virus	LAV
Lymph node(s)	LN(S)
Lymph node dissection	LND
Lupus erythematosus	LUP ERYTH
Macrophage colony-stimulating factor	M-CSF
Magnetic resonance imaging	MRI
Magnetic resonance cholangiopancreatography	MRCP
Main stem bronchus	MSB
Malignant	MALIG
Mandible/mandibular	MAND

WORD/TERM(S)	ABBREVIATION/SYMBOL
Maximum	MAX
Medical center	MC
Medication	MED
Metastatic/Metastasis	METS
Methicillin Resistant Staphylococcus Aureus	MRSA
Microgram	MCG
Microscopic	MICRO
Middle lobe	ML
Millicurie (hours)	MC(H)
Milligram (hours)	MG(H)
Milliliter	ML
Millimeter	MM
Million electron volts	MEV
Minimum	MIN
Minus	-
Minute	MIN
Mitral valve prolapse	MVP
Mixed combined immunodeficiency	MCID
Mixed connective tissue disease	MCTD
Moderate (ly)	MOD
Moderately differentiated	MD, MOD DIFF
Modified radical mastectomy	MRM
More/More than	>
Multifocal arterial tachycardia	MAT
Multifocal premature ventricular contraction	MPVC
Multiple	MULT
Multiple sclerosis	MS
Multiple myeloma	MM
Myasthenia gravis	MG
Myocardial infarction	MI
Neck vein distention	NVD
Negative	NEG
Negative	-
Neoplasm	NEOPL
Neurology	NEURO
No evidence of disease	NED
No significant findings	NSF
Non-Hodgkins lymphoma	NHL
Normal	NL
Non small cell carcinoma	NSCCA
Not applicable	NA
Not otherwise specified	NOS
Not recorded	NR
Number	#
Nursing home	NH

WORD/TERM(S)	ABBREVIATION/SYMBOL
Obstetrics	OB
Obstructed (-ing, -ion)	OBST
Operating room	OR
Operative report	OP RPT
Organic brain syndrome	OBS
Orthopedics	ORTHO
Otology	OTO
Ounce	OZ
Outpatient	OP
Packs per day	PPD
Palpated (-able)	PALP
Papanicolaou smear	PAP
Papillary	PAP
Past/personal (medical) history	PMH
Pathology	PATH
Patient	PT
Pediatrics	PEDS
Pelvic inflammatory disease	PID
Peptic ulcer disease	PUD
Percutaneous	PERC
Percutaneous transhepatic cholecystogram	PTC
Peripheral vascular disease	PVD
Prescription	RX
Primary medical physician	PMP
Phosphorus 32	P32
Physical examination	PE
Physiotherapy/Physical therapy	PT
Platelets	PLT
Plus	+
Poorly differentiated	PD, POOR DIFF
Positive	POS
Positive	+
Positron emission tomography	PET
Possible	POSS
Posterior	POST
Postoperative (-ly)	POST OP
Pound(s)	LB(S)
Pound(s)	#
Premature atrial contraction	PAC
Preoperative (-ly)	PRE OP
Previous	PREV
Prior to admission	PTA
Probable (-ly)	PROB
Proctoscopy	PROCTO
Progesterone receptor (assay)	PR, PRA

WORD/TERM(S)	ABBREVIATION/SYMBOL
Prostatic intraepithelial neoplasia, grade III	PIN III
Prostatic specific antigen	PSA
Pulmonary	PULM
Quadrant	QUAD
Radiation absorbed dose	RAD
Radiation therapy	RT
Radioimmunoassay	RIA
Received	REC'D
Red blood cells (count)	RBC
Regarding	RE
Regional medical center	RMC
Regular	REG
Regular sinus rhythm	RSR
Resection (ed)	RESEC
Review of outside films	ROF
Review of outside slides	ROS
Rheumatoid arthritis	RA
Rheumatic heart disease	RHD
Right	RT
Right bundle branch block	RBBB
Right costal margin	RCM
Right inner quadrant	RIQ
Right lower extremity	RLE
Right lower lobe	RLL
Right lower quadrant	RLQ
Right middle lobe	RML
Right outer quadrant	ROQ
Right salpingo-oophorectomy	RSO
Right upper extremity	RUE
Right upper lobe	RUL
Right upper quadrant	RUQ
Rule out	R/O
Sacral spine	S-SPINE
Sacral vertebra	S1-S5
Salpingo-oophorectomy	SO
Satisfactory	SATIS
Serum glutamic oxaloacetic transaminase	SGOT
Serum glutamic pyruvic transaminase	SGPT
Severe combined immunodeficiency syndrome	SCID
Short(ness) of breath	SOB
Sick sinus syndrome	SSS
Sigmoid colon	SIG COLON
Small	SM

WORD/TERM(S)	ABBREVIATION/SYMBOL
Small bowel	SB
Specimen	SPEC
Spine, Cervical	C-SPINE
Spine, Lumbar	L-SPINE
Spine, Sacral	S-SPINE
Spine, Thoracic	T-SPINE
Split thickness skin graft	STSG
Squamous	SQ
Squamous cell carcinoma	SCC
Status post	S/P
Subcutaneous	SUBCU
Summary stage	SS
Superior vena cava	SVC
Surgery/Surgical	SURG
Suspicious/suspected	SUSP
Symptoms	SX
Syndrome of inappropriate ADH	SIADH
Systemic lupus erythematosus	SLE
Thoracic spine	T-SPINE
Thromboticthrombocytopenia purpura	TTP
Times	X
Total abdominal hysterectomy	TAH
Total abdominal hysterectomy- bilateral salpingo-oophorectomy	TAH-BSO
Total vaginal hysterectomy	TVH
Transient ischemic attack	TIA
Transitional cell carcinoma	TCC
Transurethral resection	TUR
Transurethral resection bladder	TURB
Transurethral resection prostate	TURP
Transverse colon	TRANS-COLON
Treatment	TX
True vocal cord	TVC
Tuberculosis	TB
Twice a day (daily)	BID
Ultrasound	US
Undifferentiated	UNDIFF
Unknown	UNK
Upper extremity	UE
Upper gastrointestinal (series)	UGI
Upper inner quadrant	UIQ
Upper outer quadrant	UOQ
Upper respiratory infection	URI
Urinary tract infection	UTI

WORD/TERM(S)	ABBREVIATION/SYMBOL
Vagina/Vaginal	VAG
Vaginal hysterectomy	VAG HYST
Vaginal intraepithelial neoplasia (grade III)	VAIN III
Vulvar intraepithelial neoplasia (grade III)	VIN III
Well differentiated	WD, WELL DIFF
White blood cells (count)	WBC
White female	W/F
White male	W/M
With	W/
Within normal limits	WNL
Without	W/O
Wolff-Parkinson-White syndrome	WPW
Work-up	W/U
Xray	XR
Year	YR

ABBREVIATIONS AND ACRONYMS USED

AACCR	American Association of Central Cancer Registries
AcoS	American College of Surgeons
ACS	American Cancer Society
AJCC	American Joint Committee on Cancer
BNA	Block Numbering Area
CCCR	Canadian Council of Cancer Registries
CDC	Centers for Disease Control and Prevention
CIN	Cervical intraepithelial neoplasia
CIS	Carcinoma *in situ*
CLIA	Clinical Laboratory Improvement Act
CoC	Commission on Cancer (of AcoS)
CPT	Current Procedural Terminology (codes)
CRC	Cyclic redundancy code
CS	Collaborative Staging
CTR	Certified Tumor Registrar
DAM	*Data Acquisition Manual* (of AcoS)
DCO	Death Certificate Only
EOD	Extent of Disease
FIPS	Federal Information Processing Standards
FORDS	*Facility Oncology Registry Data Standards* (manual of AcoS)
FTRO	*Fundamental Tumor Registry Operations Program* (of AcoS)
GenEDITS	Generic EDITS Driver Program
GIS	Geographic Information System
HCFA	Health Care Finance Administration
HIM	Health Information Management
IACR	International Association of Cancer Registries
IARC	International Agency for Research on Cancer
ICD	International Classification of Diseases
ICD-O	*International Classification of Diseases for Oncology*
ICD-O-1	*International Classification of Diseases for Oncology*, First Edition
ICD-O-2	*International Classification of Diseases for Oncology*, Second Edition
ICD-O-3	*International Classification of Diseases for Oncology*, Third Edition
NAACCR	North American Association of Central Cancer Registries
NAPIIA	NAACCR Asian/Pacific Islander Identification Algorithm
NCCCS	National Coordinating Council for Cancer Surveillance
NCDB	National Cancer Data Base
NCI	National Cancer Institute
NCRA	National Cancer Registrars Association
N.d.	No date (bibliographic term: no ascertainable place of publication)
NHIA	NAACCR Hispanic Identification Algorithm
NPCR	National Program of Cancer Registries
NPI	National Provider Identifier
PIN	Prostatic intraepithelial neoplasia
ROADS	*Registry Operations and Data Standards* (manual of AcoS)
SEER	Surveillance, Epidemiology, and End Results Program of NCI
SIL	Squamous intraepithelial lesion

REQUIRED REPORTING STATUS

TENNESSEE CANCER REGISTRY

NAACCR Record Version 21

January 1, 2021

Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
Abstracted By	x			
Accession Number-Hosp	x			
Addr at DX--City	x			
Addr at Dx-Country	x			
Addr at DX--No & Street	x			
Addr at DX--Postal Code	x			
Addr at DX--State	x			
Addr at DX—Supplementl	x		Required when applicable	
Age at Diagnosis	x			
AJCC API Version Current	D		Derived data item	New data item
AJCC API Version Original	D		Derived data item	New data item
AJCC ID	D		Derived data item	
Ambiguous Terminology Dx	RH		Required for cases diagnosed 1/1/2007-12/31/2012	
Behavior (92-00) ICD-O-2	RH		Required for cases diagnosed prior to 01/01/2001	
Behavior Code ICD-O-3	x		Required for cases diagnosed on or after 01/01/2001	
Birthplace-Country	x		Required when available	
Birthplace-State	x		Required when available	
Brain Molecular Markers	x		Primary site specific	
Breslow Tumor Thickness	x		Primary site specific	
Casefinding Source	x		Required when available	
Cause of Death	x			
Class of Case	x			
CoC Accredited Flag	x			

DH-Derived Historically

RH-Required Historically

ACoS-American College of Surgeons

x*-Required from ACoS accredited facilities only

Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
COC Coding Sys--Current	x			
COC Coding Sys--Original	x			
County at DX Reported	x		FIPS, 998 (non Tennessee resident)	
CS Extension	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
CS Lymph Nodes	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
CS Lymph Node Eval	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
CS Mets at DX	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
CS Mets at DX-Bone	RH		Required for cases diagnosed 1/1/2010 - 12/31/2015	
CS Mets at DX-Brain	RH		Required for cases diagnosed 1/1/2010 - 12/31/2015	
CS Mets at DX-Liver	RH		Required for cases diagnosed 1/1/2010 - 12/31/2015	
CS Mets at DX-Lung	RH		Required for cases diagnosed 1/1/2010 - 12/31/2015	
CS Mets Eval	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
CS Site-Specific Factor 1	RH		Required for cases diagnosed 1/1/2004 - 12/31/2017	
CS Site-Specific Factor 2	RH		Required for cases diagnosed 1/1/2004 - 12/31/2017	
CS Site-Specific Factor 3	RH		Required for cases diagnosed 1/1/2004 - 12/31/2017	
CS Site-Specific Factor 4	RH		Required for cases diagnosed 1/1/2004 - 12/31/2017	
CS Site-Specific Factor 5	RH		Required for cases diagnosed 1/1/2004 - 12/31/2017	

DH-Derived Historically
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ACoS-American College of Surgeons
x*-Required from ACoS accredited facilities only

Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
CS Site-Specific Factor 6	RH		Required for cases diagnosed 1/1/2004 - 12/31/2017	
CS Site-Specific Factor 7	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 8	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 9	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 10	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 11	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 12	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 13	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 14	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 15	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 16	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 17	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 18	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 19	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 20	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	

DH-Derived Historically
RH-Required Historically

ACoS-American College of Surgeons
x*-Required from ACoS accredited facilities only

Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
CS Site-Specific Factor 21	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 22	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 23	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 24	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Site-Specific Factor 25	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
CS Tumor Size	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
CS Tumor Size/Ext Eval	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
CS Version Derived	RH			
CS Version Input Current	R		Required when available	Status change
CS Version Input Original	R		Required when available	Status change
Date Case Report Exported	x			
Date of 1st Contact	x			
Date of 1st Contact Flag	x			
Date of 1st Crs RX--COC	x			
Date of 1st Crs RX--COC Flag	x			
Date of Birth	x			
Date of Birth Flag	x			
Date of Conclusive Dx	RH		Required for cases diagnosed 1/1/2007 - 12/31/2012	
Date of Conclusive Dx Flag	RH		Required for cases diagnosed 1/1/2007 - 12/31/2012	
Date of Diagnosis	x			
Date of Diagnosis Flag	x			
Date of Last Contact	x			

DH-Derived Historically
RH-Required Historically

ACoS-American College of Surgeons
x*-Required from ACoS accredited facilities only

Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
Date of Last Contact Flag	x			
Date of Multiple Tumors	RH		Required for cases diagnosed 1/1/2007 - 12/31/2012	
Date of Multiple Tumors Flag	RH		Required for cases diagnosed 1/1/2007 - 12/31/2012	
Death Certificate File Number	x		Required when available	
Derived AJCC-+89:107-Flag	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived AJCC-6 M	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived AJCC-6 M Descriptor	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived AJCC-6 N	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived AJCC-6 N Descriptor	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived AJCC-6 Stage Group	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived AJCC-6 T	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived AJCC-6 T Descriptor	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived AJCC-7 M	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived AJCC-7 M Descriptor	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived AJCC-7 N	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived AJCC-7 N Descriptor	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	

DH-Derived Historically
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Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
Derived AJCC-7 Stage Group	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived AJCC-7 T	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived AJCC-7 T Descriptor	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived SS1977	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived SS1977--Flag	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived SS2000	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Derived SS2000--Flag	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Diagnostic Confirmation	x			
Estrogen Receptor Summary	x		Primary site specific	
Fibrosis Score	x		Primary site specific	
Follow-Up Source	x		Required when available	
GIS Coordinate Quality			**Coded by Central Registry Staff ONLY**	
Gleason Patterns Clinical	x		Primary site specific	New data item
Gleason Patterns Pathological	x		Primary site specific	New data item
Gleason Score Clinical	x		Primary site specific	New data item
Gleason Score Pathological	x		Primary site specific	New data item
Gleason Tertiary Pattern	x		Primary site specific. Required when available	New data item
Grade	RH		Required for cases diagnosed prior to 1/1/2018	
Grade Clinical	x			
Grade Path System	RH		Required, when available, for cases diagnosed 1/1/2010 - 12/31/2013	

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Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
Grade Path Value	RH		Required, when available, for cases diagnosed 1/1/2010 - 12/31/2013	
Grade Pathological	x			
Grade Post Therapy Clin (yc)	x		Required when available	New data item
Grade Post Therapy Path (yp)	x		Required when available	Name change (formerly Grade Post Therapy)
HER2 Overall Summary	x		Primary site-specific	
Histology (92-00) ICD-O-2	RH		Required for cases diagnosed prior to 01/01/2001	
Histologic Type ICD-O-3	x		Required for cases diagnosed on or after 01/01/2001	
ICD Revision Number	x		Must be code 1 if death occurred on or after 01/01/1999	
ICD-O-3 Conversion Flag	x			
Institution Referred From	x			
Institution Referred To	x			
Laterality	x			
LDH Lab Value	x		Primary site specific	
Lymphovascular Invasion	x		Required when available	
Medical Record Number	x			
Medicare Beneficiary Identifier	x		Required when available	New data item
Mets at Dx-Bone	x			
Mets at Dx-Brain	x			
Mets at Dx-Distant LN	x			
Mets at Dx-Liver	x			
Mets at Dx-Lung	x			
Mets at Dx-Other	x			
Microsatellite Instability (MSI)	x		Required site-specifically when available	
Morphology Coding Sys--Current	x			
Morphology Coding Sys--Original	x			

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Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
Multiple Tumors Reported As One Primary	RH		Required for cases diagnosed 1/1/2007 - 12/31/2012	
Multiplicity Counter	RH		Required for cases diagnosed 1/1/2007 - 12/31/2012	
NAACCR Record Version	x			
Name--Alias	x			
Name--First	x			
Name--Last	x			
Name--Birth Surname	x			Use this data item to document the last name of the patient at birth regardless of gender or marital status.
Name--Middle	x			
Name--Suffix	x		Required when applicable	
NPI--Managing Physician	**x**		**If the managing physician NPI number is not available, use the NPI number for any physician involved in the patient's cancer care. This field cannot be blank.**	
NPI--Reporting Facility	x		Required when available	
Over-ride Acsn/Class/Seq	x		When coded, text must support code	
Over-ride Age/Site/Morph	x		When coded, text must support code	
Over-ride COC-Site/Type	x		When coded, text must support code	
Over-ride CS 1	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Over-ride CS 2	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	

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Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
Over-ride CS 3	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Over-ride CS 4	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Over-ride CS 5	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Over-ride CS 6	RH		Required for cases diagnosed 1/1/2004 - 12/31/2015	
Over-ride CS 7	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
Over-ride CS 8	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
Over-ride CS 9	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
Over-ride CS 10	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
Over-ride CS 11	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
Over-ride CS 12	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
Over-ride CS 13	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
Over-ride CS 14	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
Over-ride CS 15	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
Over-ride CS 16	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
Over-ride CS 17	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	

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Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
Over-ride CS 18	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
Over-ride CS 19	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
Over-ride CS 20	RH		Required for cases diagnosed 1/1/2010 - 12/31/2017	
Over-ride Histology	x		When coded, text must support code	
Over-ride HospSeq/DxConf	x		When coded, text must support code	
Over-ride HospSeq/Site	x		When coded, text must support code	
Over-ride III define Site	x		When coded, text must support code	
Over-ride Leuk, Lymphoma	x		When coded, text must support code	
Over-ride Name/Sex	x		When coded, text must support code	
Over-ride Report Source	x		When coded, text must support code	
Over-ride SeqNo/DXConf	x		When coded, text must support code	
Over-ride Site/Behavior	x		When coded, text must support code	
Over-ride Site/EOD/Dx Dt	x		When coded, text must support code	
Over-ride Site/Lat/EOD	x		When coded, text must support code	
Over-ride Site/Lat/Morph	x		When coded, text must support code	

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Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
Over-ride Site/Lat/SeqNo	x		When coded, text must support code	
Over-ride Site/TNM Stg Grp	x		When coded, text must support code	
Over-ride Site/Type	x		When coded, text must support code	
Over-ride SS/DisMet1	x		When coded, text must support code	
Over-ride SS/Nodes Pos	x		When coded, text must support code	
Over-ride SS/TNM_M	x		When coded, text must support code	
Over-ride SS/TNM_N	x		When coded, text must support code	
Over-ride Surg/DXConf	x		When coded, text must support code	
Over-ride TNM Stage	x			
Over-ride TNM Tis	x			
Over-ride TNM 3	x			
Phase I Radiation Treatment Modality	x			
Place of Death	RH		Required when available for cases diagnosed prior to 1/1/2013	
Place of Death-Country	x			
Place of Death-State	x			
Place of Diagnosis	x		Required when applicable and available	
Primary Payer at DX	x		Required when available	
Primary Site	x			
Progesterone Receptor Summary	x		Primary site specific	
PSA (Prostatic Specific Antigen) Lab Value	x		Primary site specific	
Race 1	x			

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Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
Race 2	x			
Race 3	x			
Race 4	x			
Race 5	x			
Race Coding Sys--Current	x			
Race Coding Sys--Original	x			
Rad—Regional RX Modality	RH		Required for cases 1/1/2006 - 12/31/2017	
Reason for No Radiation	x			
Reason for No Surgery	x			
Record Type	x		Must be A- Full case Abstract record type (incidence and confidential data plus text summaries; used for reporting to central registries).	
Recurrence Date—1st		x		
Recurrence Type—1st		x		
Regional Nodes Examined	x		Regional lymph nodes as defined by AJCC	
Regional Nodes Positive	x		Regional lymph nodes as defined by AJCC	
Registry Type	x			
Reporting Facility	x		Must use Tennessee assigned facility ID code	
RX Coding Sys--Current	x			
RX Date- BRM	x			
RX Date--BRM Flag	x			
RX Date-Chemo	x			
RX Date--Chemo Flag	x			
RX Date-Hormone	x			
RX Date--Hormone Flag	x			

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Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
RX Date—Most Defin Surg	x			
Rx Date--Most Defin Surg Flag	x			
RX Date--Other	x			
RX Date--Other Flag	x			
RX Date--Radiation	x			
RX Date--Radiation Flag	x			
RX Date--Surgery	x			
RX Date--Surgery Flag	x			
Rx Date--Systemic	RH		Required for cases diagnosed 1/1/2009 - 12/31/2015	
Rx Date--Systemic Flag	RH		Required for cases diagnosed 1/1/2009 - 12/31/2015	
RX Hosp—BRM	x*		Required from ACoS accredited facilities only	
RX Hosp—Chemo	x*		Required from ACoS accredited facilities only	
RX Hosp—DX/Stg Proc	x*		Required from ACoS accredited facilities only	
RX Hosp—Hormone	x*		Required from ACoS accredited facilities only	
RX Hosp—Other	x*		Required from ACoS accredited facilities only	
Rx Hosp--Palliative Proc	x*		Required from ACoS accredited facilities only	
Rx Hosp—Scope Reg Ln Sur	x*		Required from ACoS accredited facilities only	
RX Hosp—Surg Oth Reg/Dis	x*		Required from ACoS accredited facilities only	
RX Hosp—Surg Prim Site	x*		Required from ACoS accredited facilities only	
RX Summ--BRM	x			

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Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
RX Summ--Chemo	x			
RX Summ--Hormone	x			
RX Summ--Other	x			
RX Summ—Palliative Proc	x*		Required from ACoS accredited facilities only	
RX Summ--Radiation	RH		Derived for cases 1/1/2008 - 12/31/2011	
RX Summ--Scope Reg LN Surg	x			
RX Summ--Surg Other Reg/Dis	x			
RX Summ--Surg Primary Site	x			
RX Summ--Surg/Rad Seq	x			
Rx Summ--Systemic/Sur Seq	x			
RX Summ—Transplnt/ Endocr	x			
RX Summ--Treatment Status	x			
RX Text--BRM	x		Required when corresponding treatment fields are coded	
RX Text--Chemo	x		Required when corresponding treatment fields are coded	
RX Text--Hormone	x		Required when corresponding treatment fields are coded	
RX Text--Other	x		Required when corresponding treatment fields are coded	
RX Text--Radiation (Beam)	x		Required when corresponding treatment fields are coded	
RX Text--Radiation Other	x		Required when corresponding treatment fields are coded	
RX Text--Surgery	x		Required when corresponding treatment fields are coded	
Schema Discriminator I	x			
Schema Discriminator 2	x			
Schema ID	D			

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Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
Schema ID Version Current	D		Derived data item	New data item
Schema ID Version Original	D		Derived data item	New data item
SEER Coding Sys--Current	x			
SEER Coding Sys--Original	x			
SEER Summary Stage 1977	RH		Required for cases diagnosed before 01/01/2001	
SEER Summary Stage 2000	RH		Required for cases diagnosed 1/1/2001 - 12/31/2003 and 1/1/2015 - 12/31/2017	
Sequence Number-Hospital	x			
Sex	x			
Site Coding Sys--Current	x			
Site Coding Sys--Original	x			
Social Security Number	x			
Spanish/Hispanic Origin	x			
Summary Stage 2018	x		Required for cases diagnosed 1/1/2018 onward	
Telephone		x		
Text--Dx Proc--Lab Tests	x		Required to support coding	
Text--DX Proc--Op	x		Required to support coding	
Text--DX Proc--Path	x		Required to support coding	
Text--DX Proc--PE	x		Required to support coding	
Text--Dx Proc--Scopes	x		Required to support coding	
Text--Dx Proc--X-ray/scan	x		Required to support coding	
Text--Histology Title	x		Required to support coding	
Text--Primary Site Title	x		Required to support coding	
Text--Staging	x		Required to support coding	
Text--Usual Industry	x		Required when available	
Text--Usual Occupation	x		Required when available	
TNM Clinical Descriptor	RH		See Staging System Requirements For 2015-2018 below for details	

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Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
TNM Clinical M	RH		See Staging System Requirements For 2015-2018 below for details	
TNM Clinical N	RH		See Staging System Requirements For 2015-2018 below for details	
TNM Clinical Stage Group	RH		See Staging System Requirements For 2015-2018 below for details	
TNM Clinical Staged By	RH		See Staging System Requirements For 2015-2018 below for details	
TNM Clinical T	RH		See Staging System Requirements For 2015-2018 below for details	
TNM Edition Number	RH		See Staging System Requirements For 2015-2018 below for details	
TNM Path Descriptor	RH		See Staging System Requirements For 2015-2018 below for details	
TNM Path M	RH		See Staging System Requirements For 2015-2018 below for details	
TNM Path N	RH		See Staging System Requirements For 2015-2018 below for details	
TNM Path Stage Group	RH		See Staging System Requirements For 2015-2018 below for details	
TNM Path Staged By	RH		See Staging System Requirements For 2015-2018 below for details	
TNM Path T	RH		See Staging System Requirements For 2015-2018 below for details	
Tumor Size Summary	x			
Type of Reporting Source	x			
Vendor Name	x			
Vital Status	x			

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Data Fields	Required	Supplementary/ Recommended	Comments/Special Codes	Note
Staging System Requirements For 2015 - 2018				
Dx Year 2015- Collaborative Staging (CS) System and SEER Summary 2000 Staging System required from all facilities. TNM required from ACoS facilities. (AJCC TNM required when available for non-ACoS facilities.)				
Dx Year 2016- SEER Summary 2000 Staging System and TNM required from all facilities.				
Dx Year 2017- SEER Summary 2000 Staging System and TNM required from all facilities.				
Dx Year 2018- SEER Summary 2018 Staging System required from all facilities.				

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CHANGING INFORMATION ON THE ABSTRACT

The information originally collected on the abstract should be changed or modified under the following circumstances.

A. To correct coding or abstracting errors whenever identified (for example, during quality control activities).

B. When clarifications or rule changes retroactively affect data item codes.

- Example: Codes are added to a data item and asks the registries to review a set of cases and update using the new codes.

C. When better information is available later.

- Example: Consults from specialty labs, pathology report addendums or comments or other information have been added to the chart. Reports done during the diagnostic workup and placed on the chart after the registrar abstracted the information may contain valuable information. Whenever these later reports give better information about the histology, grade of tumor, primary site, etc., change the codes to reflect the better information.

- Example: The primary site was recorded as unknown at the time of diagnosis. At a later date, the physician determines that the cancer is primary to the testis. Change the primary site from unknown to testis.

- Example: The original diagnosis was in situ. Metastases are diagnosed at a later date. Change the behavior code for the original diagnosis from in situ to invasive when no new primary has been diagnosed in the interim.

- Example: Patient seen in Hospital A. The pathologic diagnosis was negative for malignancy. Patient goes to Hospital B and the slides from Hospital A are re-read. The diagnosis at Hospital B is reportable. Hospital B sends their slide report back to Hospital A. Hospital A reports the case based on the info from Hospital B. Enter supporting documentation in a text field.

D. When the date of diagnosis is confirmed in retrospect to be earlier than the original date abstracted.

- Example: Patient has surgery for a benign argentaffin carcinoid (8240/1) of the sigmoid colon in May 2009. In January 2010 the patient is admitted with widespread metastasis consistent with malignant argentaffin carcinoid. The registrar accessions the malignant argentaffin carcinoid as a 2010 diagnosis. Two months later, the pathologist reviews the slides from the May 2009 surgery and concludes that the carcinoid diagnosed in 2009 was malignant. Change the date of diagnosis to May 2009 and histology to 8241 and the behavior code to malignant (/3).

CORRECTIONS

On occasion, circumstances arise that lead to the discovery of additional or more accurate information about a case after it has been submitted to the central registry.

- Example: Consults from specialty labs, pathology report addendums or comments, or other information have been added to the chart. Reports done during the diagnostic workup and placed on the chart after the registrar abstracted the information may contain valuable information. Whenever these late reports give more specific information about the histology, grade of tumor, primary site, etc., change the affected codes to reflect the better information and notify the TCR of the correction.

- Example: The primary site was recorded as unknown at the time of diagnosis. At a later date, the physician determines that the cancer is primary to the testis. Change the primary site from unknown to testis and notify the TCR of the correction.

When a correction to a completed abstract must be made, it is not necessary to re-abstract the case. In fact, submitting a second abstract creates confusion and a backlog at the TCR. Corrections should be made either by telephone, electronically via Web Plus or in writing.

- ✓ Note: Often a change to one data item will impact other data items (i.e., laterality, CS tumor size, CS lymph nodes, etc.). Please review all data items and note any corrections necessary on the correction form.

When submitting corrections, the following information must be submitted to allow your Regional Coordinator to locate and correct your abstract:

1. Patient identifiers: Name, date of birth and Social Security number
2. Abstract Information: Primary site, date of diagnosis, laterality, accession number, sequence number, and histology.
3. Data Item(s) to be corrected
4. Corrected code(s)
5. Text to document the change(s)

To submit a correction via the telephone, please call your Regional Coordinator or the TCR front desk at 800-547-3558 or 615-253-5937.

To submit a correction electronically, please upload the corrected information using your Web Plus account. Upon receipt, it will be forwarded to your Regional Coordinator.

To submit a correction via the Tennessee Cancer Registry Correction Form, please complete the form and mail it to:

Tennessee Cancer Registry
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, TN 37243

Section Two:

Data Items

Medical Record Number

Field Length: 11

Source of Standard: CoC

Description:

Documents the medical record number used by the facility to identify the patient.

Coding Instructions:

1. Other standard abbreviations may be used to indicate departments that do not use the HIM medical record numbers.

Codes (in addition to the medical record number):

Code Number	Code Description
UNK	Medical record number unknown
RT	Radiation therapy department patient without medical record number
SU	1-day surgery clinic patient without medical record number

Social Security Number

Field Length: 9

Source of Standard: CoC

Description:

Records patient's Social Security Number.

General Guidance:

- A patient's Medicare claim number may not always be identical to the person's Social Security Number.

- If the Social Security Number ends with "B" or "D", the patient is receiving benefits under the spouse's Social Security Number and this is the spouse's number. Attempt to identify the patient's Social Security Number. If the person's Social Security Number cannot be determined, enter 999999999 into this field.

Coding Instructions:

1. Enter the number without dashes.

Code

Code Number	Code Description
(fill spaces)	Record the patient's Social Security number without dashes.
999999999	Unknown; Patient does not have a SSN; SSN is not available.

Name--Last

Field Length: 40

Source of Standard: CoC

Description:

Records the last name of the patient.

Coding Instructions:

1. Capitalize all letters.

2. May include embedded spaces, hyphens, and apostrophes, but no other special characters may be entered into this field.

3. Update this field if the last name changes.

Name--First

Field Length: 40

Source of Standard: CoC

Description:

Records the first name of the patient.

Coding Instructions:

1. Capitalize all letters.

2. May include embedded spaces, hyphens, and apostrophes, but no other special characters may be entered into this field.

3. Update this field if the first name changes.

Name--Middle

Field Length: 40

Source of Standard: CoC

Description:

Records the middle name or, if middle name is unavailable, middle initial of the patient.

Coding Instructions:

1. Capitalize all letters.

2. May include embedded spaces, hyphens, and apostrophes, but no other special characters may be entered into this field.

3. If patient's name is not known or there is none, leave this field blank.

Name--Suffix

Field Length: 3

Source of Standard: CoC

Description:

Records the title that follows a patient's last name, such as a generation order or credential status (e.g., "MD," "JR").

Coding Instructions:

1. Capitalize all letters.

2. May include embedded spaces, hyphens, and apostrophes, but no other special characters may be entered into this field.

Name--Maiden

Field Length: 40

Source of Standard: CoC

Description:

Records the maiden name of female patients who are or have been married.

Coding Instructions:

1. Capitalize all letters.

2. May include embedded spaces, hyphens, and apostrophes, but no other special characters may be entered into this field.

3. The field should be left blank if the maiden name is not known or not applicable. Since a value in this field may be used by linkage software or other computer algorithms, only legitimate surnames are allowable, and any variation of “unknown” or “not applicable” is not allowable.

Name--Alias

Field Length: 40

Source of Standard: CoC

Description:

Records an alternate name or “AKA” (also known as) used by the patient.

Coding Instructions:

1. Capitalize all letters.

2. May include embedded spaces, hyphens, and apostrophes, but no other special characters may be entered into this field.

3. Do not record the maiden name in this field.

Addr at DX--No & Street

Field Length: 60

Source of Standard: CoC

Description:

The number and street address or the rural mailing address of the patient's residence at the time the reportable tumor was diagnosed.

General Guidance:

- Indicate the patient's street address at the time the tumor was diagnosed.
- Normally, a residence is the home named by the patient. Use the Census Bureau's definition, "the place where he or she lives and sleeps most of the time or the place the person says is his or her usual home" to resolve residency questions. Additional address information such as facility, nursing home, or name of apartment complex should be entered in Addr At DX-Supplemental field.
- A post office box is not a reliable source to identify the residency at diagnosis. Use the post office box address only if no street address information is available.
- Patients with More than One Residence:
    - Code the residence where the patient spends the majority of his/her time (usual residence).
    - If the usual residence is not known, code the residence the patient specifies at the time of diagnosis.
- Patients with No Usual Residence:
    - Homeless people and transients are examples of persons with no usual residence.
    - Record the patient's residence at the time of diagnosis such as the shelter or the hospital where diagnosis was confirmed.
- Patient in an Institution:

Incarcerated persons and persons in nursing, convalescent, and rest homes are examples of patients in an institution. Code the address of the institution. Do not code the post office box.

- Patients Away at School:
    - If the patient is a college student living away at school, code the residence where he/she resides while attending college.
    - If the patient is a student below college level, code the parent's residence.
- For Patients with a Temporary Residence:
    - Migrant workers, educators temporarily assigned to a university, temporary duty assignment personnel are examples of patients with a temporary residence.
    - Code the place of usual residence, not the temporary address.
- For Armed Forces Personnel and Their Family Members:
    - Members of the armed forces are residents of the installation area. Military personnel may use the installation address or the surrounding community's address.
    - Code the address of the military installation or surrounding community as stated by the patient.
- For Personnel Assigned to Navy, Coast Guard, and Maritime ships:
    - Refer to the US Census Bureau Publications for rules on determining the usual residence.
- Do not use legal status or citizenship to code residence.
- Do not update this field if the patient's address changes.
- If the patient's address is unknown, enter UNKNOWN.
- Only use standard Postal Service abbreviations recognized by USPS standard abbreviations. A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub. 28

(http://pe.usps.gov/text/pub28/28apc_002.htm) Use of special characters is limited to periods, hyphens, and pound signs.

- 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 rules above or U.S. Census Bureau rules 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.

Addr at DX--City

Field Length: 50

Source of Standard: CoC

Description:

Name of the city in which the patient resides at the time the reportable tumor was diagnosed.

General Guidance:

- Use the rules indicated under the Addr at DX -- No. & Street data item in this manual to determine residency.
- If patient resides in a rural area, record the name of the city or town used in his or her mailing address.
- Do not use punctuation or special characters.
- Do not update this field if the patient's address changes.
- If the patient has multiple tumors, the city may be different for each primary.
- If the city is not known, record UNKNOWN.

Addr at DX--State

Field Length: 2

Source of Standard: CoC

Description:

The state, territory, commonwealth, U.S. possession, or the Canadian province/territory in which the patient resides at the time the reportable tumor is diagnosed.

General Guidance:

- Use the rules indicated under the Addr at DX -- No. & Street data item in this manual to determine residency.
- Use the U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province of the patient's residence at the time the tumor was diagnosed.
- Do not update this field if the patient's address changes.
- If the patient has multiple primaries, the state of residence may be different for each primary.
- If the patient is a foreign resident, use either code XX or YY depending on the circumstances.
- Some States, territories, commonwealths, provinces, etc. have custom codes. These codes can be found in Appendix A.
- See Appendix A for listing of U.S. Postal Service abbreviations.

Codes (in addition to USPS abbreviations):

Code Number	Code Description
CD	Resident of Canada, NOS (province/territory unknown)
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
XX	Resident of country other than the United States (including its territories,

Addr at DX--State

Code Number	Code Description
	commonwealths, or possessions) or Canada, and country is known
YY	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown
ZZ	Residence unknown

Addr at DX-- Country

Field Length: 3

Source of Standard: NAACCR

Description:

This data item 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.

General Guidance:

- This field supplements the Address at Diagnosis-- State.
- Do no change if the patient moves to another country.
- Patients with more than one tumor may have different countries at diagnosis.
- See Appendix A for a list of country codes and their respective state codes.

Addr at DX--Supplementl

Field Length: 60

Source of Standard: CoC

Description:

This data item provides the ability to store additional address information such as the name of a place or facility.

General Guidance:

- Use the rules indicated under the Addr at DX -- No. & Street data item in this manual to determine residency.
- Record the place or facility (for example, a nursing home or name of an apartment complex) of the patient's usual residence when the tumor was diagnosed.
- Do not update this field if the patient’s address changes.
- If the patient has more than one tumor, the address may be different for each primary.
- This field may be left blank.

Addr at DX--Postal Code

Field Length: 9

Source of Standard: CoC

Description:

Postal code for the address of the patient's residence at the time the reportable tumor is diagnosed.

General Guidance:

- Use the rules indicated under the Addr at DX -- No. & Street data item in this manual to determine residency.
- Indicate the postal code for the address of the patient's residence at the time the tumor was diagnosed.
- Do not use punctuation or special characters.
- Do not update this field if the patient's address changes.
- If the patient has multiple tumors, the postal code may be different for each tumor.
- When available, enter the postal code for other countries.

Coding Instructions:

1. For U.S. zip codes, use either the 5-digit or 9-digit extended zip code. (Blanks follow the 5-digit code.)
2. For Canadian residents, use the 6-character alphanumeric postal code. (Blanks follow the 6-character code.)

Addr at DX--Postal Code

Codes (in addition to US, Canadian, or other postal codes):

Code Number	Code Description
88888 or 888888888	Resident of a country other than Canada, United States, or U.S. possessions and postal code is unknown.
99999 or 999999999	Resident of Canada, United States, or U.S. possession and postal code is unknown.

County at DX

Field Length: 3

Source of Standard: FIPS/SEER

Description:

Code for the county of the patient's residence at the time the tumor was diagnosed.

General Guidance:

- Use the rules indicated under the Addr at DX -- No. & Street data item in this manual to determine residency.
- For U.S. residents, standard codes used in this field are those issued by the Federal Information Processing Standards (FIPS) publication, *Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas*. The codes are listed in Appendix B of this manual.
- If the patient has more than one tumor, the county codes may be different for each tumor.
- Do not update this data item if the patient's county of residence changes.

Coding Instructions:

1. Use code 998 for Canadian residents.
2. Code 999 should not be used for Tennessee residents. If unable to locate the FIPS code for a Tennessee resident, please call the Tennessee Cancer Registry for assistance.
3. If your software supports coding FIPS for non-Tennessee residents, please use the correct FIPS code vs. 998.

County at DX

Codes (in addition to FIPS and geocodes):

Code Number	Code Description
998	Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria)
999	County unknown

Telephone

Field Length: 10

Source of Standard: CoC

Description:

Records the patient's current telephone number with area code.

General Guidance:

- Do not use special characters (e.g., dashes, or parenthesis).
- This field should be updated when the patient’s phone number changes.

Codes (in addition to valid telephone number):

Code Number	Code Description
0000000000	Patient does not have a telephone
9999999999	Telephone number unavailable or unknown

Date of Birth

Field Length: 8

Source of Standard: SEER/CoC

Description:

Identifies the patient's date of birth.

General Guidance:

- The birth date is recorded in the year, month, and day (YYYYMMDD) format.
- A zero must precede single-digit months and days.
    - **Example:** September 5, 1970 would be transmitted as 19700905.
- If the date of birth is unknown, but the date of diagnosis and the patient's age at diagnosis are known, calculate the year of birth by subtracting the patient's age at diagnosis from the year of diagnosis (leave the month and day blank).
- For in-utero diagnosis and/or treatment, use the patient's actual date of birth.
- If the date of birth is not known at all, record the reason in the Date of Birth Flag field.

Date of Birth Flag

Field Length: 2

Source of Standard: NAACCR

Description:

This flag explains why no appropriate value is in the Date of Birth field.

Coding Instructions:

1. Leave this data field blank if a full or partial date is recorded in the Date of Birth field.

2. Assign code 12 if the Date of Birth cannot be determined at all.

Codes:

Code Number	Code Description
12	A proper value is applicable but not known (i.e., birth date is unknown)
Blank	A valid date value is provided in item Date of Birth, or the date was not expected to have been transmitted

Age at Diagnosis

Field Length: 3

Source of Standard: SEER/CoC

Description:

Records the age of the patient at diagnosis for each reportable disease.

General Guidance:

- If the patient has multiple primaries, the age at diagnosis may be different for subsequent primaries.
- Measure the patient's age in completed years of life.
- If the patient's age is 100 years or older, check the accuracy of the date of birth and date of diagnosis, and document both in a text field.
- Document the Age at Diagnosis of the patient in text to support the Date of Birth coded.

Coding Instructions:

1. For cases diagnosed in-utero, use code 000.
2. For all diagnoses within the 1st year of life, use code 000.

Codes:

Code Number	Code Description
000	Less than 1 year old; diagnosed in utero
001	1 year old, but less than 2 years
…	(show actual age in complete years)
999	Unknown age

Birthplace--State

Field Length: 2

Source of Standard: NAACCR

Description:

Records the patient's state of birth.

General Guidance:

- USPS abbreviation for the state, commonwealth, U.S. possession; or CanadaPost abbreviation for the Canadian province/territory in which the patient was born.
- If the patient has multiple primaries, the state of birth is the same for each tumor.
- This field supplements *Birthplace--Country*.
- *Birthplace--State and Birthplace--Country* replace the item **BIRTHPLACE**.

Coding Instructions:

1. Use the most specific code possible.
2. This item corresponds to *Birthplace--Country*.
3. See Appendix A for a list of state codes and their respective country codes.

Examples:

Code	Reason
IL	If the state in which the patient was born is Illinois, then use the USPS code for the state of Illinois.
XX	Born in a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and they country is *known* (code the country in *Birthplace--Country*).
YY	Born in a country other than the U.S. (including its territories, commonwealths, or

Birthplace--State

	possessions) or Canada and the country is *unknown.*
US	Born in the U.S. (including its territories, commonwealths, or possessions) and the state is *unknown.*
CD	Born in Canada and the province is *unknown.*
ZZ	Place of birth is unknown, not mentioned in patient record

Birthplace--Country

Field Length: 3

Source of Standard: NAACCR

Description:

Records the country in which the patient was born.

General Guidance:

- The codes are based on International Organization for Standardization (ISO) 3166-1 alpha-3 country codes, with some custom codes.
- If the patient has multiple primaries, the country of birth is the same for each tumor.
- This field supplements *Birthplace--State*.
- *Birthplace--State* and *Birthplace--Country* replace the field **BIRTHPLACE**.

Coding Instructions:

1. Use the most specific code possible.
2. This item corresponds to *Birthplace--State*.
3. See Appendix A for a list of state codes and their respective country codes.

Examples:

Code	Reason
USA	United States
CAN	Canada
ZZU	Place of birth is unknown, not mentioned in medical record.
MEX	Mexico
ZZC	Central American, NOS
ZZE	Europe, NOS

Sex

Field Length: 1

Source of Standard: SEER/CoC

Description:

Records the sex (gender) of the patient.

General Guidance:

- Document the Sex of the patient in text to support the code used in this data field.

Definitions:

- **Intersex:** A person born with ambiguous reproductive or sexual anatomy, chromosomal genotype and sexual phenotype other than XY-male and XX-female.
- **Transsexual**: A person who was assigned to one gender at birth based on physical characteristics but who self-identifies psychologically and emotionally as the other gender.
- **Transgender**: See Transsexual.
- **Transgendered person**: A person who identifies with or expresses a gender identity that differs from the person's sex at birth.

Coding Instructions:

1. Assign code **3** for:
    a. Intersexed (persons with sex chromosome abnormalities)
    b. Hermaphrodite
2. Assign code **5** for transsexuals who are natally male or transsexuals with primary site of C600-C639.

Sex

3. Assign code **6** for transsexuals who are natally female or transsexuals with primary site of C510-C589.

4. Assign code **4** for transsexuals with unknown natal sex primary site is not C510-C589 or C600-C639.

5. When gender is not known:

    a. Assign code **1** when the primary site is C600-C639.
    b. Assign code **2** when the primary site is C510-C589.
    c. Assign code **9** for primary sites not included above.

6. Codes 5 and 6 (natality for transsexuals) were added for use in 2015, but may be applied for earlier diagnoses.

Codes:

Code Number	Code Description
1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not stated/Unknown

Race 1, Race 2, Race 3, Race 4, and Race 5

Field Length: 2

Source of Standard: SEER/CoC

Description:

Records the patient's race.

General Guidance:

- Race is coded separately from Spanish/Hispanic ethnicity.
- All resources in the facility, including medical record, face sheet, physician and nursing notes, and other sources, must be used to determine race.
- Document the Race of the patient in text to support the codes used in these data fields.

Coding Instructions:

1. If the patient's race is stated to be a combination of Hawaiian and any other race(s), code the Race 1 field as Hawaiian and code the other races in the Race 2-Race 5 fields.
2. If the patient's race is stated to be a combination of white and any other race, code the other race in the Race 1 field and code white in the next race field.
3. If the patient is a combination of white and several other races, white would be the last race coded.
    - Example: The medical chart indicates the patient is black, white, and Japanese. Black and Japanese would be coded in the Race 1 and the Race 2 fields. White would be coded in the Race 3 field.
4. If the patient is multiracial, code all of the race(s) using fields Race 1, Race 2, Race 3, Race 4, and Race 5. (Do not use 96, 97, or 98 for "multi-racial".)

Race 1, Race 2, Race 3, Race 4, and Race 5

5. Assign code 03 for any person stated to be native American (western hemisphere) or Indian, whether from North, Central, South, or Latin America.

6. When race is reported differently by two or more sources, code race using the highest priority source available according to the list below:

   Sources Listed in Priority Order:

   A. The patient's self-declared identification

   B. Documentation in the medical record

   C. Death certificate

7. Do not use the patient's name solely as the basis for coding race.

8. After coding the patient's race(s), any remaining race fields would be coded 88.

   - Example: Patient states she has a Polynesian mother and Tahitian father. Code Race 1 as 25 (Polynesian), Race 2 as 26 (Tahitian) and Race 3 through Race 5 as 88.

   - Example: Physician notes indicate patient is Arabian (01). Code Race 1 to 01 (White) and Race 2 through Race 5 to 88.

9. Code only the specific race when both a specific race code and a non-specific race code apply.

   - Example: The patient is described as Asian-American with Korean parents. Code race as 08 (Korean) because it is more specific than 96 (Asian) [-American].

10. Assign a specific code when a specific Asian race is stated. Code 96 is not applicable when a specific race is known.

    - Example: Patient is described as Asian in a consult note and as second generation Korean-American in the history. Code Race 1 as 08 (Korean) and Race 2 through Race 5 as 88.

    - ✓ Note: Do not code 96 (Other Asian including Asian, NOS and Oriental, NOS) in a subsequent race field when a specific Asian race has been coded.

Race 1, Race 2, Race 3, Race 4, and Race 5

11. Code the race based on birthplace information when the race is recorded as Oriental, Mongolian, or Asian and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation.

    - Example: Race is recorded as Asian and the place of birth is recorded as Japan. Code race as 05 (Japanese) because it is more specific than 96.

    - Example: The person describes himself as an Asian-American born in Laos. Code race as 11 (Laotian) because it is more specific than 96.

12. Use the appropriate non-specific code 96 (Other Asian including Asian, NOS and Oriental, NOS), 97 (Pacific Islander, NOS) or 98 (Other) when there is no race code for a specific race.

13. Code 07 takes priority over all other race codes.

    a. Example: Patient is described as Japanese and Hawaiian. Code Race 1 as 07 (Hawaiian) and Race 2 as 05 (Japanese).

14. Codes 02-32, 96-98 take priority over code 01.

15. Code only the specific race when both a specific race code and a non-specific race code apply.

    a. Codes 04-17 take priority over code 96.
    b. Codes 16-17 take priority over code 15.
    c. Codes 20-32 take priority over code 97.
    d. Codes 02-32 and 96-97 take priority over code 98.
    e. Code 98 takes priority over code 99.

16. According to SEER: When there is a statement the patient is Hispanic or Latino(a) and no further race information is available, code the Race 1 field to 01. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white.

    - ✓ Note: Do not use code 98 (Other) in this situation.

17. In some cases, race may be inferred from the nationality. Use **Appendix D** to identify nationalities from which race codes may be inferred.

    - Example: Medical record states patient is a native of Portugal. Code race as 01 (White) per Appendix D.

- Example: Medical record states the patient is Nigerian. Code race as 02 (Black) per Appendix D.

- Exception: Code Race 1 - Race 5 as 99 (Unknown) when the patient's name is incongruous with the race inferred on the basis of nationality.

- Example: The patient's name is Siddhartha Rao and his birthplace is listed as England. Code Race 1- Race 5 as 99 (Unknown).

18. All tumors for the same patient should have the same race code(s).

19. When Race 1 is coded 99 (Unknown), all race fields must be coded 99.

20. Code 88 for the remaining race fields (Race 2- Race 5) when at least one race, but fewer than 5 races, are reported.

Coding Examples:

Example 1: Patient is stated to be Japanese. Code as 05 (Japanese).

Example 2: Patient is stated to be German-Irish. Code as 01 (White). See Appendix D.

Example 3: Patient is described as Arabian. Code as 01 (White).

Example 4: Patient described as a black female. Code as 02 (Black).

Example 5: Patient states she has a Polynesian mother and Tahitian father. Code Race 1 as 25 (Polynesian), Race 2 as 26 (Tahitian) and Race 3 – Race 5 as 88 (No additional races).

Example 6: Patient describes herself as multi-racial (nothing more specific) and nursing notes say "African-American." Code Race 1 as 02 (Black) and Race 2 through Race 5 as 88.

Example 7: The patient is described as Asian-American with Korean parents. Code race as 08 (Korean) because it is more specific than 96 (Asian) [-American].

Example 8: Patient is stated to be Chinese and black. Code Race 1 as 04 (Chinese), code Race 2 as 02 (Black). Code in the order stated when no other priority applies.

Codes:

Race 1, Race 2, Race 3, Race 4, and Race 5

Code Number	Code Description
01	White
02	Black
03	American Indian, Aleutian, Alaskan Native or Eskimo (includes all indigenous populations of the Western hemisphere)
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (code effective with 1/1/2010 dx)
16	Asian Indian (code effective with 1/1/2010 dx)
17	Pakistani (code effective with 1/1/2010 dx)
20	Micronesian, NOS
21	Chamorro/Chamoru
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
96	Other Asian, including Asian, NOS and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown
88	No further race documented (Race2-5 only)

Spanish/Hispanic Origin

Field Length: 1

Source of Standard: SEER/CoC

Description:

Code identifying persons of Spanish or Hispanic origin.

General Guidance:

- Persons of Spanish or Hispanic origin may be of any race.
- Some individuals may have Spanish maiden or surnames (Native American, Filipinos, etc), but the persons are not necessarily of Hispanic origin.
- Brazilian, Portuguese, and Filipinos are not presumed to be Spanish or non-Spanish.
- All information resources should be used to determine the correct code:
    - Stated ethnicity in the medical record
    - Stated Hispanic origin on the death certificate
    - Birthplace
    - Information about life history and/or language spoken found during the abstracting process
    - Patient's last name or maiden name found on a list of Hispanic names
- If the patient has multiple tumors, all records should have the same code.

Coding Instructions:

1. Assign code 0 when the patient is Portuguese, Brazilian, or Filipino and there is no indication the patient is of Spanish or Hispanic origin.

Spanish/Hispanic Origin

Codes:

Code Number	Code Description
0	Non-Spanish; non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS Hispanic, NOS Latino, NOS There is evidence, other than surname or maiden name, that the person is Hispanic, but he/she cannot be assigned to any of the categories 1-5
7	Spanish surname only The only evidence of the person's Hispanic origin is the surname or maiden name and there is no contrary evidence that the patient is not Hispanic (Code 7 is ordinarily for central registry use only, hospital registrars may use code 7 if using a list of Hispanic surnames provided by their central registry; otherwise, code 9 'unknown whether Spanish or not' should be used.)
8	Dominican Republic (code effective with 1/1/2005 dx.)
9	Unknown whether Spanish or not

Primary Payer at DX

Field Length: 2

Source of Standard: CoC

Description:

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

Coding Instructions:

1. Code the type of insurance reported on the patient's admission page.
2. If more than one insurance carrier or payer is listed on the patient's admission page, code the first one listed.
3. When there are multiple admissions and/or multiple physician's encounters and multiple insurance carriers listed, code the type of insurance reported closest to the date of diagnosis.
4. Code the patient's insurance at the time of diagnosis and/or treatment. Do not change the insurance information based on subsequent information.
5. If the insurance changes, do not change the initially recorded code.

Codes:

Code Number	Code Description	Code Note
01	Not insured	Patient has no insurance and is declared a charity write-off
02	Not insured, self-pay	Patient has no insurance and is declared responsible for charges
10	Insurance, NOS	Type of insurance unknown or other than types listed in codes 20, 21, 31, 35, 60-68
20	Private Insurance: Managed care, HMO, or PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network, or a staff model. "Gate-keeper model" is another term for describing this type of insurance.

Primary Payer at DX

Code Number	Code Description	Code Note
21	Private Insurance: Fee-for-Service	An insurance plan that does not have negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs. Medicaid other than described in code 35
35	Medicaid - Administered through a Managed Care plan	Patient is enrolled in Medicaid through a Managed Care program (e.g. HMO or PPO). The managed care plan pays for all incurred costs.
60	Medicare/Medicare, NOS	Federal government funded insurance for persons who are 62 years of age or older, or are chronically disabled (social security insurance eligible). Includes Medicare without supplement. Not described in codes 61, 62, or 63.
61	Medicare with supplement, NOS	Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare. (See also, codes 63 and 64.)
62	Medicare - Administered through a Managed Care plan	Patient is enrolled in Medicare through a Managed Care plan (e.g. HMO or PPO). The Managed Care plan pays for all incurred costs.
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with state-administered Medicaid supplement.
65	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents. Formerly CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).
66	Military	Military personnel or their dependents treated at a military facility
67	Veterans Affairs	Veterans treated in Department of Veterans Affairs facilities
68	Indian/Public Health Service	Patient receives care at an Indian Health Service facility or at another facility and medical costs are reimbursed by the Indian Health Service Patient receives care at a Public Health Service facility or at another facility, and medical costs are reimbursed by the Public Health Service.
99	Insurance status unknown	Patient's medical record does not indicate whether or not the patient is insured.

Text--Usual Industry

Field Length: 100

Source of Standard: NPCR

Description:

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

General Guidance:

- Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among "manufacturing", "wholesale", "retail", and "service" components of an industry that performs more than one of these components.

- If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient for facility registrars to record the name of the company (with city or town) in which the patient performed his/her usual occupation. In these situations, if resources permit, a central or regional registry may be able to use the employer name and city/town to determine the type of activity conducted at that location.

- In those situations where the usual occupation is not available or is unknown, the patient's current or most recent occupation is recorded. The information for industry should follow suit; and, if the patient's current or most recent occupation rather than usual occupation is recorded, record the patient's current or most recent business/ industry.

- If later documentation in the patient's record provides an industry that is more likely to be the usual industry than what was originally recorded, facility registrars are encouraged to update the abstract with the new information.

- If the patient was not a student or housewife and had never worked, record "Never Worked" as the usual occupation.

- If no information is available regarding the industry in which the reported occupation was carried out, record "Unknown".

Text--Usual Occupation

Field Length: 100

Source of Standard: NPCR

Description:

Text area provided for information about the patient's usual occupation, also known as usual type of job or work (i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor).

General Guidance:

- Do not record "Retired".
- If the usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation. If later documentation in the patient's record provides an occupation that is more likely to be the usual occupation than what was originally recorded, update the abstract.
- If the patient was a housewife/househusband and also worked outside the home during most of his/her adult life, record the usual occupation outside the home. If the housewife/househusband did not work outside the home for most of his/her adult life, record "Housewife" or "Househusband".
- If the patient was not a student or housewife/househusband and had never worked, record "Never Worked" as the usual occupation.
- If no information is available, record "Unknown".

Vital Status

Field Length: 1

Source of Standard: SEER/CoC

Description:

Vital status of the patient as of the date entered in Date of Last Contact field.

General Guidance:

- This field is associated with the patient, not the cancer, so if the patient has multiple primary tumors, the vital status should be the same for all tumors.

Codes:

Code Number	Code Description
0	Dead
1	Alive

Cause of Death

Field Length: 4

Source of Standard: SEER

Description:

Official cause of death as coded from the death certificate in valid ICD-7, ICD-8, ICD-9, and ICD-10 codes.

General Guidance:

- Do not record decimal points.
- The cause of death code is commonly four characters. Do not code a fifth character if present.
- Left justify the codes; if less than four characters, left justify and add a 9 to the right.
- If the underlying cause of death code is not available, do not attempt to code the underlying cause of death unless you have a trained ICD-10 nosologist on staff or on consult.
- Beginning with deaths in 1999, the United States agreed to code all deaths using the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10).*

Coding Instructions:

Priority Order for use of source documents to assign codes, with 1 having the highest priority:

1. Use the underlying cause of death as coded by a state health department even if the code seems to be in error.
2. Report the coded underlying cause of death code from another source such as NDI Plus or state data exchange.

3. Code the underlying cause of death if a trained ICD-10 nosologist is on staff or under contract

4. Code the underlying cause of death 7797 when the death certificate is available but the underlying cause of death code is not coded and cause of death is not available from another source such as NDI Plus or state data exchange.

5. Code 7777 when the death certificate is not available AND the coded underlying cause of death is not available from other sources such as NDI or state data exchange.

- Example: Medical doctor states patient died, but death certificate not available (not on state death file, not available through federal or state agencies); code 7777.

Special codes in addition to ICD-7, ICD-8, ICD-9, and ICD-10:

Code Number	Code Description
0000	Patient alive at last contact
7777	State death certificate not available
7797	State death certificate available but underlying cause of death is not coded

Place of Death--State

Field Length: 2

Source of Standard: NAACCR

Description:

State or Province where the patient died and where certificate of death is filed.

General Guidance:

- USPS abbreviation for the state, commonwealth, U.S. possession; or CanadaPost abbreviation for the Canadian province/territory in which the patient expired.
- If the patient has multiple primaries, the state of death is the same for each tumor.
- This field supplements *Place of Death--Country*.
- *Place of Death--State* and *Place of Death--Country* replace the item **Place of Death**.

Coding Instructions:

1. This item corresponds to *Place of Death--Country*.
2. See Appendix A for a list of state codes and their respective country codes.

Examples:

Code Number	Code Description
Blank	Not applicable, patient alive.
ZZ	Unknown if U.S., Canada, or other country.
TN	Patient expired in Tennessee.
US	United States, NOS (state, etc., unknown)

Place of Death--Country

Field Length: 3

Source of Standard: NAACCR

Description:

Code for the country in which the patient died and where the certificate of death is filed.

General Guidance:

- The codes are based on International Organization for Standardization (ISO) 3166-1 alpha-3 country codes, with some custom codes.
- If the patient has multiple primaries, the state of death is the same for each tumor.
- This field supplements *Place of Death--State*.
- *Place of Death--State* and *Place of Death--Country* replace the item **Place of Death**.

Coding Instructions:

1. This item corresponds to *Place of Death--State*.
2. See Appendix A for a list of state codes and their respective country codes.

Examples:

Code Number	Code Description
Blank	Not applicable, patient alive.
USA	United States
CAN	Canada
ZZU	Place of Death is unknown.
MEX	Mexico
ZZN	North America, NOS

DC State File Number

Field Length: 6

Source of Standard: State

Description:

Death certificate identification number as assigned by the vital statistics office in the place recorded in the place recorded *Place of Death*.

General Guidance:

- Record the death certificate number if it's available in the medical record.
- If the death certificate number is not on file, leave blank.
- If the patient is alive, leave blank.

Date of Diagnosis

Field Length: 8

Source of Standard: SEER/CoC

Description:

Records the date of diagnosis (year, month, and day) the reportable neoplasm was first diagnosed, clinically or microscopically, by a recognized medical practitioner.

General Guidance:

- Use the first date of diagnosis whether clinically or histologically established.
- Refer to the instructions in the Ambiguous Terminology segment of the Reportability section of this manual for terms that represent a diagnosis of cancer.
- If the year of diagnosis cannot be identified, it must be approximated. In that instance, the month and day are unknown and may be left blank.
- The date must be in the year, month, and day (YYYYMMDD) format.
- Document the Date of Diagnosis in text to support the date coded.

Coding Instructions:

1. Code the month, day and year the reportable neoplasm was first diagnosed, clinically or microscopically, by a recognized medical practitioner.
    a. When the first diagnosis includes reportable ambiguous terminology, record the date of that diagnosis.

        - Example: Area of microcalcifications in breast suspicious for malignancy on 2/13/2014. Biopsy positive for ductal carcinoma on 2/28/2014. The date of diagnosis is 2/13/2014.

Date of Diagnosis

2. When the only information available is a positive pathology or cytology report, code the date the biopsy was done, not the date the report was dictated or transcribed.

3. The first diagnosis of cancer may be **clinical** (i.e. based on clinical findings or physician's documentation).

    - ✓ Note: Do not change the date of diagnosis when a clinical diagnosis is subsequently confirmed by positive histology or cytology.

    - ➢ Example: On May 15, 2012, physician states that patient has lung cancer based on clinical findings. The patient has a positive biopsy of the lung in June 3, 2012. The date of diagnosis remains May 15, 2012.

4. If **no information** about the date of diagnosis is available:

    A. Use the date of admission as the date of diagnosis

    B. In the absence of an admission date, code the date of first treatment as the date of diagnosis

5. Use the date treatment was started as the date of diagnosis if the patient receives a first course of treatment before a diagnosis is documented.

6. Positive **tumor markers** alone are **not** diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.

    - ➢ Example: The patient has an elevated PSA and the physical examination is negative. The physician documents only that the patient is referred for a needle biopsy of the prostate. The biopsy is positive for adenocarcinoma. The date of diagnosis is the date of the biopsy (do not code the date the procedure was dictated or transcribed).

    - ➢ Example: The patient has an elevated PSA and the physical examination is negative. The physician documents that he/she suspects that the patient has prostatic cancer and is referring the patient for a needle biopsy. The needle biopsy is positive, confirming the physician's suspicion of cancer. The date of diagnosis is the date the physician documented that he/she **suspects** that the patient has prostatic cancer.

    - ✓ Note: Positive tumor markers alone are never used for case ascertainment.

Date of Diagnosis

7. Do **not** use cytology as a basis for diagnosis when **ambiguous terms** are used. **Ambiguous cytology** alone is **not** diagnostic of cancer. Use the date of clinical, histologic, or **positive** cytologic confirmation as the date of diagnosis.

    - ✓ Note: "Ambiguous" cytology means that the diagnosis is preceded by an ambiguous term (such as apparently, appears, compatible with, etc.).

    - ✓ Note: Do not use ambiguous cytology alone for case ascertainment.

    - ➢ Example: Cytology suspicious for malignancy 1/12/2015. Diagnosis of carcinoma per biopsy on 2/6/2015. Record 2/6/2015 as the date of diagnosis.

8. Code the **earlier date** as the date of diagnosis when:

    A. A recognized medical practitioner says that, in **retrospect**, the patient had cancer at an earlier date or

    B. The original slides are reviewed and the pathologist documents that cancer was present. Code the date of the original procedure as the diagnosis date.

    - ➢ Example: The patient had an excision of a benign fibrous histiocytoma in January 2012. Six months later, a wide re-excision was positive for malignant fibrous histiocytoma. The physician documents in the chart that the previous tumor must have been malignant. Code the diagnosis date as January 2012.

    - ✓ Note: Do not back-date the diagnosis when:

        a. The information on the previous tumor is unclear **AND/OR**

        b. There is no review of previous slides **AND/OR**

        c. There is **no physician's statement** that, in retrospect, the previous tumor was malignant

    - ➢ Example: The patient had a total hysterectomy and a bilateral salpingo-oophorectomy (BSO) in June 2012 with pathology diagnosis of papillary cystadenoma of the ovaries. In December 2012 the patient is diagnosed with widespread metastatic papillary cystadenocarcinoma. The slides from June 2010 are not reviewed and there is no physician statement saying the previous tumor was malignant. The date of diagnosis is December 2012.

9. Code the **date of death** as the date of diagnosis for autopsy-only cases.

Date of Diagnosis

10. **Estimate the date of diagnosis** if an exact date is not available. Use all information available to calculate the month and year of diagnosis.

11. When estimating the **month**:

    Code "spring" to April
    Code "summer" or "middle of the year" to July
    Code "fall" or "autumn" as October
    For "winter" try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month of diagnosis.
    Code "early in year" to January
    Code "late in year" to December
    Code the month of admission when there is no basis for estimation

12. Use whatever information is available to calculate the month of diagnosis

    - Example: Admitted October 2012. History states that the patient was diagnosed 7 months ago. Subtract 7 from the month of admission and code date of diagnosis to March 2012.

    - Example: Outpatient bone scan done January 2012 that states history of prostate cancer. The physician says the patient was diagnosed in 2012. Assume bone scan was part of initial work-up and code date of diagnosis to January 2012.

13. Leave month blank (or convert 99 to blank) if there is no basis for approximation.

14. When estimating the **year**:

    Code "a couple of years" to two years earlier
    Code "a few years" to three years earlier
    Use whatever information is available to calculate the year of diagnosis
    Code the year of admission when there is no basis for estimation

<u>Nursing Home and Hospice Residents (Not hospitalized for their cancer; no information other than nursing home or hospice records and/or death certificate):</u>

1. Use the **best approximation** for the date of diagnosis when the only information available is that the patient **had cancer while in the nursing home** and it is unknown whether the patient had cancer when admitted.

2. Code the date of admission to the nursing home as the date of diagnosis when:

    A. The only information available is that the patient had cancer when admitted to the nursing home.

    B. The only information available is that the patient had cancer while in the nursing home, it is unknown whether the patient had cancer when admitted, and there is no basis for approximation.

Cases Diagnosed Before Birth:

1. Effective for cases diagnosed 1/1/2009 onward- Record the actual date of diagnosis for diagnoses made in-utero even though this date will precede the date of birth. For cases diagnosed prior to 1/1/2009- Record the date of birth for diagnoses made in-utero.

    - Example: Fetal intrahepatic mass consistent with hepatoblastoma diagnosed via ultrasound at 39 weeks gestation (1/30/2015). Live birth by C-section 2/4/2015. Code the date of diagnosis as 01/30/2015.

Date of Diagnosis Flag

Field Length: 2

Source of Standard: NAACCR

Description:

Date flag fields were created as part of an initiative to standardize date fields. The purpose of the flags is to explain why a date was not entered into a particular field. The Date of Diagnosis must always be entered; therefore, the Date of Diagnosis Flag field must always be blank.

Primary Site

Field Length: 4

Source of Standard: SEER/CoC

Description:

Identifies the primary site.

General Guidance:

- Code the primary site using the topography codes listed in the *International Classification of Diseases for Oncology, Third Edition (ICD-O-3)*, the *Multiple Primary and Histology Coding Manual*, the *Hematopoietic and Lymphoid Neoplasm Reportability and Coding Manual*, and the Hematopoietic Database.

- Document the Primary Site in text to support the code used in this data field.

Coding Instructions:

For Hematopoietic and Lymphoid Neoplasms (9590/3-9992/3):

1. Follow the instructions in the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and Hematopoietic Database for assigning site for lymphomas, leukemia, and other hematopoietic neoplasms (Use the 2015 version of the manual and database for cases diagnosed 1/1/2010 and forward*).

For Solid Tumors:

1. Use the coding instructions listed in both the *Multiple Primary and Histology Coding Manual* and the *ICD-O-3* to code the primary site.

Primary Site

2. Unless otherwise instructed, use all available information in the medical chart to code the site.

3. Code the site in which the **primary tumor originated, even if it extends onto/into an adjacent subsite**.

    - Example: Final diagnosis is adenocarcinoma of the upper lobe of the right lung. Code the topography to lung, upper lobe (C341).

    - Example: The patient has a 4 cm tumor in the right breast. The tumor originated in the upper inner quadrant and extends into the lower inner quadrant. Code the primary site to upper inner quadrant of breast (C502).

    - Example: Patient has a right branchial cleft cyst; the pathology report identifies an adenocarcinoma arising in an ectopic focus of thyroid tissue within the branchial cleft cyst. Thyroidectomy pathology is negative. Code the primary site to branchial cleft (C104).

    - Example: The patient had a total hysterectomy with a bilateral salpingo-oophorectomy ten years ago for non-cancer reasons. She now has widespread cystadenocarcinoma in the peritoneum. Code the primary site to peritoneum, NOS (C482). (The chart may or may not state that the patient has extra-ovarian carcinoma.)

    - Example: Pathology report shows adenocarcinoma arising in a patch of endometriosis on the sigmoid colon. Code the primary site to sigmoid colon (C187), the site in which the cancer originated.

4. Code the last digit of the primary site code to '8' when a **single tumor overlaps** an adjacent **subsite(s)** of an organ and the point of origin cannot be determined.

    - Example: The patient has a primary tumor of the cervicothoracic esophagus and the point of origin of an organ and the point of origin cannot be determined.

5. Code the site of the **invasive** tumor when there is an invasive tumor and in situ tumor in different subsites of the same anatomic site.

    - Example: Patient has an invasive breast tumor in the upper-outer quadrant of the left breast and in situ tumor in multiple quadrants of the left breast. Code the primary site to C504 (upper outer quadrant of breast).

- Example: Patient has in situ Paget disease of the right nipple and invasive duct carcinoma of the lower inner quadrant of the right breast. Code the primary site to C503 (lower inner quadrant).

6. Code the last digit of the primary site code to '9' for **single primaries**, when **multiple tumors arise** in **different subsites** of the same anatomic site and the point of origin cannot be determined.

   - Example: During a TURB, the physician describes multiple papillary tumors in the bladder neck (C675) and the lateral wall of the bladder (C672). Code the primary site as bladder, NOS (C679).

   - Example: Patient has an infiltrating duct tumor in the upper outer quadrant (C504) of the right breast and another infiltrating duct carcinoma in the lower inner (C503) quadrant of the right breast. Code the primary site as breast, NOS (C509).

7. Some histology/behavior terms in ICD-O-3 have a related site code in parentheses; for example: Hepatoma (C220).

   A. Code the site as documented in the medical record and ignore the suggested ICD-O-3 code when a primary site is specified in the medical record.

   - Example: The pathology report says "infiltrating duct carcinoma of the head of the pancreas." The listing in ICD-O-3 is infiltrating duct carcinoma 8500/3 (C50_). Code the primary site to head of pancreas (C250), NOT to breast (C50_) as suggested by the ICD-O-3.

   B. Use the site code suggested by ICD-O-3 when the primary site is the same as the site code suggested or the primary site is unknown.

   - Example: The biopsy is positive for hepatoma, and no information is available about the primary site. Code the primary site to liver (C220) as suggested by ICD-O-3.

   - Example: An excision of the right axillary nodes reveals metastatic infiltrating duct carcinoma. The right breast is negative. The ICD-O-3 shows infiltrating duct carcinoma (8500) with a suggested site of breast (C50_). Code the primary site as breast, NOS (C509).

C. Use the site code suggested by ICD-O-3 when there is no information available indicating a different primary site.

- Example: Biopsy of lymph node diagnosed as metastatic non-small cell carcinoma. Patient expired and there is no information available about the primary site. Assign C349 based on the site code suggested in ICD-O-3.

8. Code the primary site, not the metastatic site. If a tumor is metastatic and the primary site is unknown, code the primary site as unknown (C809).

9. Code C422 (Spleen) as the primary site for **angiosarcoma** of spleen with mets to bone marrow.

10. Per SEER, code C50_ (breast) for **angiosarcoma** of breast. Although angiosarcoma actually originates in the lining of the blood vessels, an angiosarcoma originating in the breast has a poorer prognosis than many other breast tumors.

11. Gastrointestinal Stromal Tumors (GIST): Code the primary site to the location where the malignant GIST originated.

12. Transplants: Transplanted organs or tissue may originate from organs or tissue from the patient's own body (called autograft) or another human donor (homograft or allograft).

    A. Code the primary site to the location of the transplanted organ when a malignancy arises in a transplanted organ, i.e., code the primary site to where the malignancy resides or lies.

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

    B. For additional information about hematopoietic-related transplants, refer to the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database.

13. In the **absence of any additional information about the primary site**, assign the codes listed for these primary sites

Primary Site	Code
Anal margin	C445
Angle of the stomach	C162
Book-leaf lesion (mouth)	C068
Colored / lipstick portion of upper lip	C000
Cutaneous leiomyosarcoma	C44_
Distal conus	C720

Edge of tongue	C021
Frontoparietal (brain)	C718
Gastric angular notch	C163
Glossotonsillar sulcus	C109
Infrahilar area of lung	C349
Leptomeninges	C709
Masticatory space	C069
Melanoma, NOS	C449
Nail bed, thumb	C446
Pancreatobiliary	C269
Parapharyngeal space	C490
Perihilar bile duct	C240

14. When the medical record does not contain enough information to assign a primary site:

    A. Consult a physician advisor to assign the site code.

    B. Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site.

    C. Code Unknown Primary Site (C809) if there is not enough information to assign an NOS or Ill-Defined Site category.

    D. Code unknown primary in the absence of any information when the physician documents an unknown primary.

    - Example: Two possible sites are documented in the GI System such as colon and small intestine; code to the GI tract, NOS (C269). Document the possible primary sites in a text field.

    E. Assign the NOS code for the body system when there are two or more possible primary sites documented and all are within the same system.

    F. Assign C148 when there is an unknown head and neck primary.

    - Example: Lymph node biopsy with diagnosis of squamous cell carcinoma deemed to be a head and neck primary and no specific head and neck primary site identified. Assignment of C148 is based on a note in ICD-O-3 indicating it should be used when a code between C000 and C142 cannot be assigned. This code is more specific than C760.

Primary Site

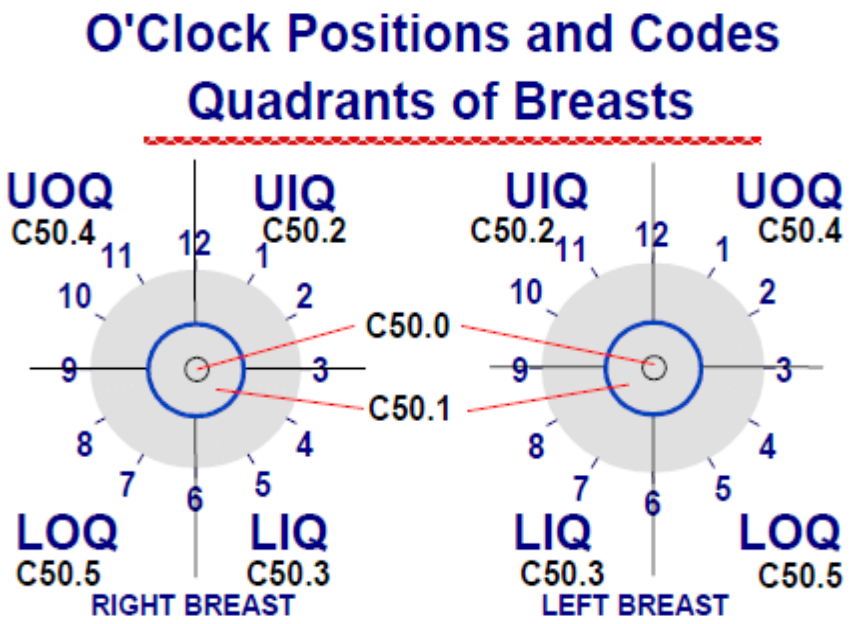
Breast:

Coding Subsites:

C500	Nipple (areolar) Paget disease without underlying tumor
C501	Central portion of breast (subareolar) area extending 1 cm around areolar complex Retroareolar Infraareolar Next to areola, NOS Behind, beneath, under, underneath, next to, above, cephalad to, or below nipple Paget disease with underlying tumor Lower central
C502	Upper inner quadrant (UIQ) of breast Superior medial Upper medial Superior inner
C503	Lower inner quadrant (LIQ) of breast Inferior medial Lower medial Inferior inner
C504	Upper outer quadrant (UOQ) of breast Superior lateral Superior outer Upper lateral
C505	Lower outer quadrant (LOQ) of breast Inferior lateral Inferior outer Lower lateral
C506	Axillary tail of breast Tail of breast, NOS Tail of Spence
C508	Overlapping lesion of breast Inferior breast, NOS Inner breast, NOS Lateral breast, NOS Lower breast, NOS Medial breast, NOS Midline breast, NOS Outer breast, NOS Superior breast, NOS Upper breast, NOS 3:00, 6:00, 9:00, 12:00 o'clock
C509	Breast, NOS Entire breast Multiple tumors in different subsites within breast Inflammatory without palpable mass ¾ or more of breast involved with tumor

	Diffuse (tumor size 998)

A. The position of the tumor in the breast may be described as the positions on a clock



B. Use the information from reports in the following priority order to code a subsite when there is conflicting information:

1. Pathology report
2. Operative report
3. Physical examination
4. Mammogram, ultrasound

C. Code the subsite with the invasive tumor when the pathology report identifies invasive tumor in one subsite and in situ tumor in a different subsite or subsites.

D. Code the specific quadrant for multifocal tumors all within one quadrant. **Do not** code C509 in this situation.

E. Code the primary site to C508 when:

a. there is a single tumor in two or more subsites AND the subsite in which the tumor originated is unknown

b. there is a single tumor located at the 12, 3, 6, 9 o'clock position on the breast

F. Code the primary site to C509 when there are multiple tumors (two or more) in at least two quadrants of the breast.

Colon:

A. Priority Order for Coding Primary Site:

a. Use the information from reports in the following priority order to code the primary site when there is conflicting information:

Resected Cases:
Operative report with surgeon's description
Pathology report
Imaging

Polypectomy or excision without resection:
Endoscopy report
Pathology report

B. Coding Subsites:

a. Code the subsite with the most tumor when the tumor overlaps two subsites.

b. Code C188 when both subsites are equally involved.

Rectosigmoid Junction:

A. Definitions:

a. Anal verge: The lower (distal) end of the anal canal, junction between the skin of the anal canal and the perianal skin

b. Anorectal ring: Top (proximal end) of the anal canal

c. Dentate line: An anatomic landmark located between the anal verge and the anorectal ring indicating where the rectum changes to the anal canal. Also called the pectinate line.

d. Tenia coli: (Plural teniae coli) Any one of three longitudinal bands of smooth muscle in the colon. They extend from the cecum to the sigmoid colon. Each band is approximately 8 mm wide throughout most of the colon. The widths of the teniae increase in the sigmoid colon and eventually fuse into a covering of longitudinal muscle in the rectum.

B. A tumor is classified as rectosigmoid when differentiation between rectum and sigmoid is not possible.

C. A tumor is classified as rectal if:

a. Lower margin lies less than 16 cm from the anal verge OR

b. Any part of the tumor is located at least partly within the supply of the superior rectal artery

D. Anatomic Transition from Sigmoid to Rectum: In the sigmoid colon, approximately 12 to 15 cm from the dentate line, the tenia coli fuse to form the circumferential longitudinal muscle of the rectal wall.

E. The rectum is defined clinically as the distal large intestine commencing opposite the sacral promontory and ending at the anorectal ring, which corresponds to the proximal border of the puborectalis muscle palpable on digital rectal examination. It extends 16 cm from the anal verge.*

*Wittenkind C, Henson DE, Hutter RVP, Sobin LH, eds. TNM Supplement: A Commentary on Uniform Use. 2nd ed. New York, NY: Wiley-Liss; 2001.

Bladder:

Coding subsites:

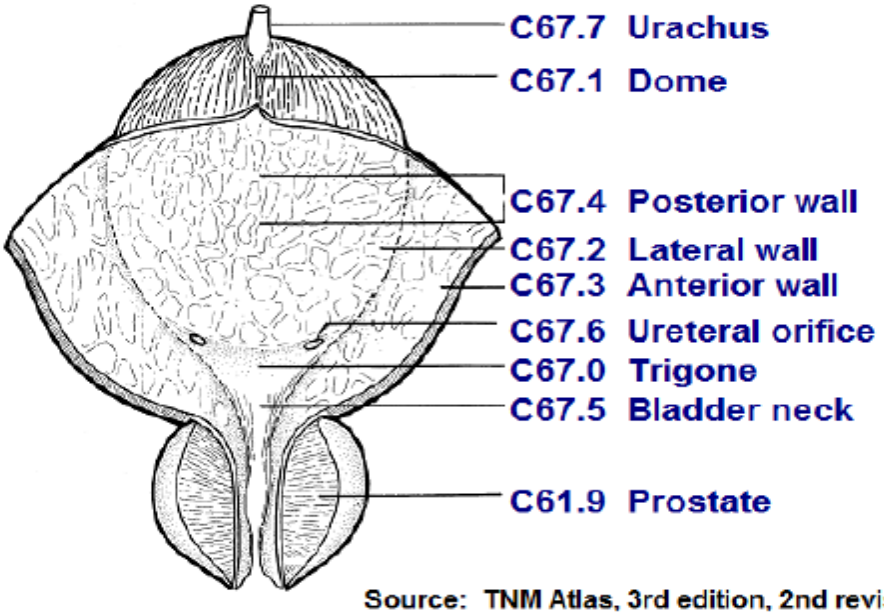
C670	Trigone of bladder Base of bladder Floor Below interureteric ridge* (interureteric crest, or interureteric fold)
C671	Dome of bladder

Primary Site

	Vertex Roof Vault
C672	Lateral wall of bladder Right wall Left wall Lateral to ureteral orifice Sidewall
C673	Anterior wall of bladder
C674	Posterior wall of bladder
C675	Bladder neck Vesical neck Internal urethral orifice Internal urethral/uretero orifice
C676	Ureteric orifice Just above ureteric orifice
C677	Urachus Mid umbilical ligament Urachal remnant
C678	Overlapping lesion of bladder Lateral-posterior wall (hyphen) Fundus
C679	Bladder, NOS Lateral posterior wall (no hyphen)

- The interureteric ridge is a fold of mucous membrane extending across the bladder between the ureteric orifices and forms one of the boundaries for the trigone of the bladder.

Bladder Anatomy and ICD-O-3



Source: TNM Atlas, 3rd edition, 2nd revision

A. Priority Order for Coding Subsite:

   a. Use the information from reports in the following priority order to code a subsite when the medical record contains conflicting information:

      1. Operative report (TURB)
      2. Pathology report

B. Multifocal Tumors:

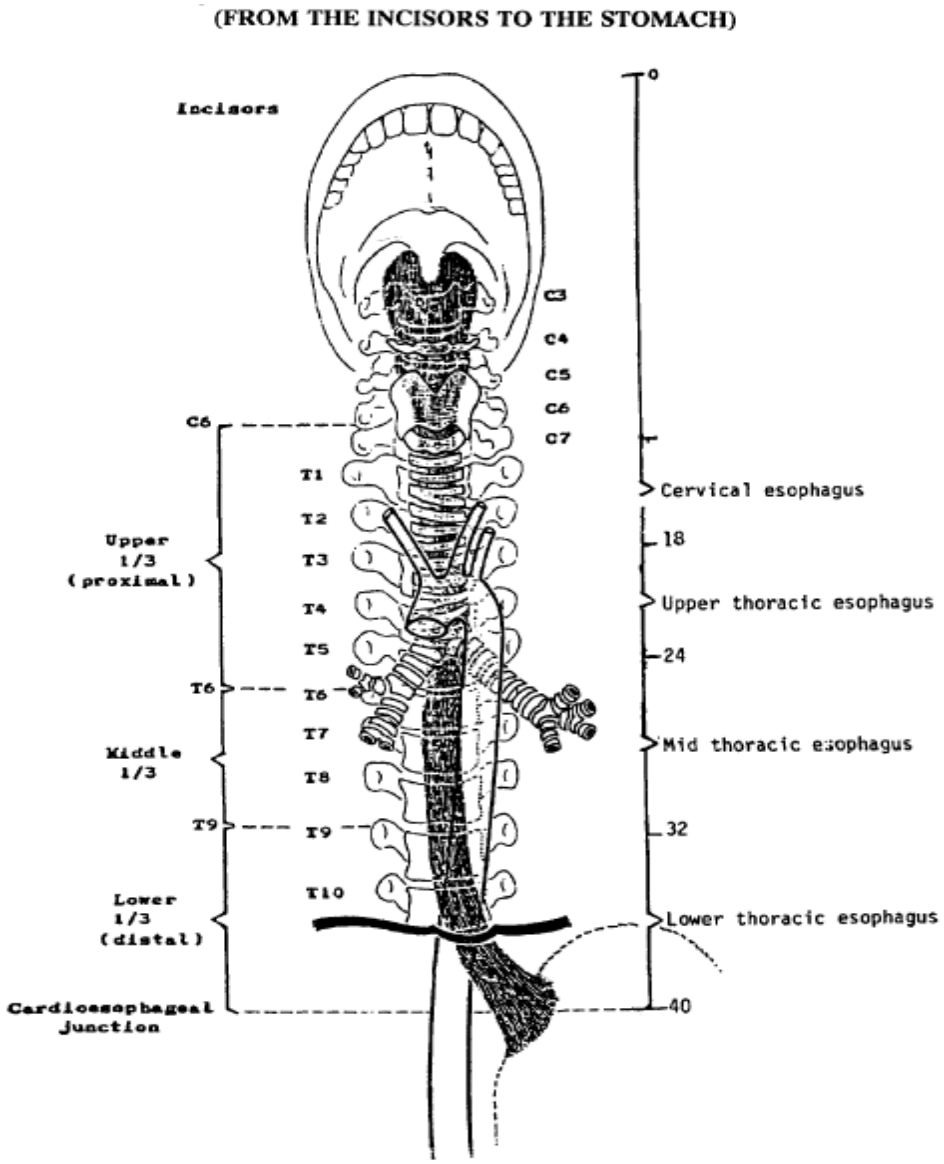
   a. Invasive tumor in more than one subsite: Assign site code C679 when the tumor is multifocal (separate tumors in more than one subsite of the bladder.)

   b. If the TURB or pathology proves invasive tumor in one subsite and in situ tumor in all other involved subsites, code the subsite involved with the invasive tumor.

<u>Esophagus:</u>

Primary Site

A. Two independent systems divide the esophagus into three subsites. The first system divides the esophagus into the upper third, middle third, and lower third. The second system describes the subsites as the cervical esophagus, upper thoracic esophagus, mid thoracic esophagus, lower thoracic (abdominal) esophagus. The subsites for these two different systems are not identical. Assign the ICD-O-3 topography code that describes the primary site documented in the medical record.



Lung:

C340	Main bronchus Carina

	Hilum Bronchus intermedius
C341	Upper lobe, lung Lingula Apex Pancoast tumor
C342	Middle lobe, lung (right lung only)
C343	Lower lobe, lung Base
C348	Overlapping lesion of lung
C349	Lung, NOS Bronchus, NOS

Kaposi Sarcoma:

A. Kaposi sarcoma that is not AIDS-related is a rare condition. It usually presents as localized disease with an easily recognized primary site.

B. AIDS-related Kaposi sarcoma usually presents as a disseminated disease with involvement of mucosal surfaces, visceral surfaces of organs, and skin. It is important to review consecutive records carefully to determine the extent of involvement at diagnosis. Review of a single record may reveal only the site being treated during that admission.

C. Code the Kaposi sarcoma to the **primary site in which it arises**.

D. If the Kaposi sarcoma is present in the **skin and another site** simultaneously, code to the specified skin site, (C44_).

E. If the **primary site is unknown** or cannot be determined, code skin, NOS (C449).

Sarcoma:

The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system, which includes the fat, muscles, blood vessels, deep skin tissues, nerves, bone, and cartilage. The default code for sarcomas of unknown primary site is **C499 rather than C809.**

Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. Code the primary site to the organ of origin.

- Example: The pathologist identifies a carcinosarcoma of the uterine corpus. Code the primary site to corpus uteri (C549).

- Example: Rhabdomyosarcoma of ethmoid sinus. Code primary site to C311.

Melanoma (8720-8790):

A. Code to Skin, NOS (C449) if a patient is diagnosed with metastatic melanoma and the primary site is not identified.

Specific Tissues with Ill-Defined Sites:

If any of the following histologies appears only with an ill-defined site description (e.g., "abdominal" or "arm", code it to the tissue in which such tumors arise rather than the ill-defined region (C76_) of the body, which contains multiple tissues. Use the alphabetic index in the *ICD-O3* to assign the most specific site if only a general location is specified in the record.

Histology	Description	Code to This Site
8720-8790	Melanoma	C44_ Skin
8800-8811, 8813-8830, 9940-8921, 9040-9044	Sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	C49_ Connective, Subcutaneous and Other Soft Tissues
8990-8991	Mesenchymoma	C49_ Connective, Subcutaneous and Other Soft Tissues
9120-9170	Blood vessel tumors, lymphatic vessel tumors	C49_ Connective, Subcutaneous and Other Soft Tissues
9580-9582	Granular cell tumor and alveolar soft part sarcoma	C49_ Connective, Subcutaneous and Other Soft Tissues
9240-9252	Mesenchymal chondrosarcoma and giant cell tumors	C40_, C41_ for Bone and Cartilage C49_ Connective, Subcutaneous and Other Soft Tissues
8940-8941	Mixed tumor, salivary gland type	C07._ for Parotid Gland C08._ for Other and Unspecified Major Salivary Glands

Laterality

Field Length: 1

Source of Standard: SEER/CoC

Description:

Code for 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.

General Guidance:

- Document the Laterality in text to support the code used in this data field.

Coding Instructions:

1. Code laterality using codes 1-9 for all of the sites listed in the following Paired Sites list.

2. Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites to 0.

3. Do not code metastatic sites as bilateral involvement.

4. Code the side where the primary tumor originated.

    A. Assign code 3 if the laterality is not known but the tumor is confined to a single side of the paired organ.

    - Example: Pathology report: Patient has a 2 cm carcinoma in the upper pole of the kidney. Code laterality as 3 because there is documentation that the disease exists in only one kidney, but it is unknown if the disease originated in the right or left kidney.

5. Code 4 is seldom used EXCEPT for the following:

    A. Both ovaries involved simultaneously with a single histology, or epithelial histologies (8000-8799).

B. Diffuse bilateral lung nodules

C. Bilateral retinoblastomas

D. Bilateral Wilms tumors

E. Per FORDs- If both lungs have nodules or tumors and the lung of origin is not known.

6. Assign code 5 when the tumor originates in the midline of a site listed in 6.a:

   a. C700, C710-C714, C722-C725, C443, C445
      i. Do not assign code 5 to sites not listed in 6.a

   Example 1: Patient has an excision of a melanoma located just above the umbilicus (C445, laterality 5).

   Example 2: Patient has a midline meningioma of the cerebral meninges (C700, laterality 5).

   ✓ Note: a statement such as "midline of the right breast" is coded 1, right. Midline in this example indicates the location of the tumor in the primary site not laterality.

7. Assign code 9 when the disease originated in a paired site, but the laterality is unknown **and** there is no statement that only one side of the paired organ is involved.

   ➢ Example: Admitting history says patient was diagnosed with lung cancer based on positive sputum cytology. Patient is treated for painful bony metastases. There is no information about laterality in the diagnosis of this lung cancer.

   ➢ Example: Widely metastatic ovarian carcinoma surgically debulked. Ovaries could not be identified in the specimen.

8. Assign code 0 when the primary site is unknown (C809).

<u>Paired Sites:</u>

C079	Parotid gland
C080	Submandibular gland
C081	Sublingual gland
C090	Tonsillar fossa
C091	Tonsillar pillar
C098	Overlapping lesion of tonsil

Laterality

C099	Tonsil, NOS
C300	Nasal cavity (excluding nasal cartilage, nasal septum)
C301	Middle ear
C310	Maxillary sinus
C312	Frontal sinus
C340	Main bronchus (excluding carina)
C341-C349	Lung
C384	Pleura
C400	Long bones of upper limb, scapula, and associated joints
C401	Short bones of upper limb and associated joints
C402	Long bones of lower limb and associated joints
C403	Short bones of lower limb and associated joints
C413	Rib, clavicle (excluding sternum)
C414	Pelvic bones (excluding sacrum, coccyx, symphysis pubis)
C441	Skin of the eyelid
C442	Skin of the external ear
C443	Skin of other and unspecific parts of the face
C445	Skin of the trunk
C446	Skin of upper limb and shoulder
C447	Skin of the lower limb and hip
C471	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C472	Peripheral nerves and autonomic nervous system of the lower limb and hip
C491	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C492	Connective, subcutaneous, and other soft tissues of the lower limb and hip
C500-C509	Breast
C569	Ovary
C570	Fallopian tube
C620-C629	Testis
C630	Epididymis
C631	Spermatic cord
C649	Kidney, NOS
C659	Renal pelvis
C669	Ureter
C690-C699	Eye and adnexa
C700	Cerebral meninges, NOS (Effective with cases diagnosed 1/1/2004)
C710	Cerebrum (Effective with cases diagnosed 1/1/2004)
C711	Frontal lobe (Effective with cases diagnosed 1/1/2004)
C712	Temporal lobe (Effective with cases diagnosed 1/1/2004)
C713	Parietal lobe (Effective with cases diagnosed 1/1/2004)
C714	Occipital lobe (Effective with cases diagnosed 1/1/2004)
C722	Olfactory nerve (Effective with cases diagnosed 1/1/2004)

Laterality

C723	Optic nerve (Effective with cases diagnosed 1/1/2004)
C724	Acoustic nerve (Effective with cases diagnosed 1/1/2004)
C725	Cranial nerve, NOS (Effective with cases diagnosed 1/1/2004)
C740-C749	Adrenal gland
C754	Carotid body

Note: A laterality code other than 0 must be assigned for the sites listed above. Note that there is an effective date for assigning laterality for some of the sites. If the site is not listed above, code 0 may be assigned for laterality. Laterality may be coded for sites other than those required above. For example: Code 2 may be assigned for a tumor originating in the left lobe of the thyroid.

Codes:

Code Number	Code Description
0	Not a paired site
1	Right: origin of primary
2	Left: origin of primary
3	Only one side involved, right or left origin unspecified
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms' tumors
5	Paired site: midline tumor (effective with 1/1/2010 dx)
9	Paired site, but no information concerning laterality

Diagnostic Confirmation for Solid Tumors (Histology Coded to M8000-9589)

Field Length: 1

Source of Standard: SEER/CoC

Description:

Records the best method used to confirm the presence of the cancer being reported. The best method may occur at any time throughout the entire course of the disease. It is not limited to the confirmation at the time of initial diagnosis.

General Guidance:

- There are two sets of rules governing how the Diagnostic Confirmation field is coded. The rules listed below are for diseases with a histology code of 8000-9589. If the histology of the cancer being reported is 9590- 9992, refer to the Diagnostic Confirmation rules for Hematopoietic and Lymphoid Tumors portion of this manual.

Coding Instructions:

1. The codes are in **priority order**; code 1 has the highest priority. Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods.

2. Change the diagnostic confirmation code to a lower code if at any time during the course of the disease the patient has a diagnostic confirmation with a higher priority.

   Example: Benign brain tumor diagnosed on MRI. Assign diagnostic confirmation code 7. Patient later becomes symptomatic and the tumor is surgically removed. Change diagnostic confirmation code to 1.

3. Assign code 1 when the microscopic diagnosis is based on:

   A. Tissue specimens from biopsy, frozen section, surgery, autopsy, or D&C

   B. Bone marrow specimens (aspiration and biopsy).

Diagnostic Confirmation for Solid Tumors (Histology Coded to M8000-9589)

4. Assign code 2 when the microscopic diagnosis is based on:

    A. Examination of cells (rather than tissue) including but not limited to: sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears, or vaginal smears.

    B. Paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.

5. Assign code 4 when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.

6. Assign code 5 when the diagnosis of cancer is based on laboratory tests or marker studies that are clinically diagnostic for that specific cancer.

    - Example: If the workup for a prostate cancer patient is limited to a highly elevated PSA and the physician diagnoses and/or treats the patient based only on that PSA, code the diagnostic confirmation to 5.

        - ✓ Note: For tests and tumor markers that may be used to help diagnose cancer, see http://www.cancer.gov/cancertopics/factsheet/detection http://www.cancer.gov/cancertopics/factsheet/detection/tumor-markers

7. Assign code 6 when the diagnosis is based only on:

    A. The surgeon's operative report from a surgical exploration or endoscopy such as colonoscopy, mediastinoscopy, or peritoneoscopy and no tissue was examined

    B. Gross autopsy findings (no tissue or cytologic confirmation).

8. Assign code 7 when the only confirmation of malignancy was diagnostic imaging such as computerized axial tomography (CT scans), magnetic resonance imaging (MRI scans), or ultrasounds/sonography.

9. Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes. The diagnostic confirmation is coded 8 when the only confirmation of disease is a physician's clinical diagnosis.

    - Example: CT diagnosis possible lung cancer. Patient returns to the nursing home with a DNR order. Physician enters a diagnosis of lung cancer in the medical record. Code the

diagnostic confirmation to 8: there is a physician's clinical diagnosis- clinical diagnosis made by the physician using the information available for the case.

10. Assign code 9:

    A. When it is unknown if the diagnosis was confirmed microscopically

    B. For death certificate only cases.

Codes:

Confirmation Type	Code Number	Code Description
Microscopically Confirmed	1	Positive histology
Microscopically Confirmed	2	Positive cytology
Microscopically Confirmed	4	Positive microscopic confirmation, method not specified
Not Microscopically Confirmed	5	Positive laboratory test/marker study
Not Microscopically Confirmed	6	Direct visualization without microscopic confirmation
Not Microscopically Confirmed	7	Radiography and/or other imaging techniques without microscopic confirmation
Not Microscopically Confirmed	8	Clinical diagnosis only (other than 5, 6, or 7)
Unknown	9	Unknown whether or not microscopically confirmed; death certificate only

Diagnostic Confirmation for Hematopoietic or Lymphoid Neoplasms (Histology Coded to M9590-9992)

Field Length: 1

Source of Standard: SEER/CoC

Description:

Records the best method used to confirm the presence of the hematopoietic or lymphoid neoplasm being reported.

General Guidance:

- There are two sets of rules governing how the Diagnostic Confirmation field is coded. The rules listed below are for diseases with a histology code of 9590-9992. If the histology of the cancer being reported is 8000-9589, refer to the Diagnostic Confirmation rules for Solid Tumors portion of this manual.

Coding Instructions:

1. There is no priority order or hierarchy for coding the Diagnostic Confirmation for hematopoietic or lymphoid neoplasms. Most commonly the bone marrow provides several provisional diagnoses and the specific histological type is determined through immunophenotyping or genetic testing.

    ✓ Note: See the glossary in the *Hempatopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* for definitions of immunophemotyping and genetic testing.

2. See the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and Hematopoietic Database for information on the definitive diagnostic confirmation method(s) for the specific neoplasm being abstracted. (Use the 2015 version of the manual and database for cases diagnosed 1/1/2010 and forward*).

3. Assign code 1 when the microscopic diagnosis is based on:

    A. Tissue from lymph node(s), organ(s) or other tissue specimens from biopsy, frozen section, surgery, or autopsy.

B. Bone marrow specimens (aspiration and biopsy).

C. Peripheral blood smear
   - Can be used as a histological diagnosis for any of the hematopoietic histologies (9590/3-9992/3).

D. For leukemias only (9800/3-9948/3), complete blood count (CBC) and white blood count (WBC).

E. Neoplasm microscopically positive **and** Immunophenotyping, genetic testing, or JAK2 **not** done **OR** Immunophenotyping, genetic testing, or JAK2 done but negative for the neoplasm being abstracted.

   Example: Acute myelomonocytic leukemia (9867/3) CD10+. CD10+ is not listed under immunophenotyping in the Hem. DB for this histology, so diagnostic confirmation should be 1.

- ✓ Note: Use code 1 when ONLY the tissue, bone marrow, or blood was used to diagnose the specific histology. Do not use code 1 if the provisional diagnosis was based on tissue, bone marrow, or blood, and the immunophenotyping or genetic testing on the same specimen identified the specific disease.

4. Code 2 would rarely be used for hematopoietic or lymphoid neoplasms. Use code 2 when the microscopic diagnosis is based on:

   A. Examination of cells (other than tissue) including but not limited to: spinal fluid, peritoneal fluid, or pleural fluid, urinary sediment, cervical smears, or vaginal smears

   B. Paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.

5. Assign code 3 when:

   A. Cases positive for neoplasm being abstracted (including acceptable ambiguous terminology and provisional diagnosis) **And** Immunophenotyping, genetic testing, or JAK2 is listed in the Definite Diagnosis in the Hem DB **And**
      a. Confirms the neoplasm **OR**
      b. Identifies a more specific histology (not preceded by ambiguous terminology).

- Example (**Identifying a more specific histology**): Bone marrow examination is positive for acute myeloid leukemia (9861/3). Genetic testing shows AML with inv(16)(p13.1q22)(9871/3). Code the Diagnostic Confirmation 3, positive histology and positive genetic testing.

- Example (**Confirming the histologic diagnosis**): Bone Marrow biopsy diagnosis is plasma cell dyscrasia (9765/1). Peripheral blood smear is compatible with plasma cell leukemia. FISH and chromosome analysis revealed plasma cell myeloma. Both plasma cell leukemia and plasma cell myeloma are coded ICD-O-3 code, 9732/3, so there is only one disease process. The peripheral blood smear is histologic diagnosis for the plasma cell leukemia and FISH confirmed the diagnosis of multiple Myeloma. Code Diagnostic Confirmation 3.

- Example (**Histologic confirmation plus genetic and immunophenotyping confirmation**): Patient diagnosed with CLL by CBC and flow cytometry that was positive for both the genetic and CD antigens (immunophenotyping) for CLL. A bone marrow biopsy not performed. Since this is leukemia, the CBC is histologic confirmation, so this patient had histologic confirmation, genetic, and immunophenotyping positive for CLL. Code Diagnostic Confirmation 3.

- Example (**Identifying a more specific histology**): Peripheral blood smear with lymphoblastic lymphoma (9671/3). Bone marrow biopsy with immunophenotyping showing CD5 negative and IgM positive, diagnosis Waldenstrom Macroglobulinemia (9761/3). Code diagnostic Confirmation code 3.

- Example (**Ambiguous terminology plus genetic and immunophenotyping**): Bone marrow biopsy shows B lymphoblastic leukemia. Abnormal FISH results most likely represent a hyperdiploid clone. Code the histology to 9811 (B-ALL, NOS) and assign a diagnostic confirmation code of 1. Neither Diagnostic Confirmation 3 nor the more specific hyperdiploidy histology is coded because the associated FISH result is preceded by ambiguous terminology.

6. Assign code 4 when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.

7. Assign code 5 when the diagnosis of a hematopoietic or lympoid neoplsm is based ONLY on laboratory tests or marker studies.

   - ✓ Note: Code 5 would rarely, if ever, be used for hematopoietic neoplasms. Testing, immunophenotyping or genetic, is performed on tissue, bone marrow, and/or blood.

The tissue, bone marrow, and/or blood that was used for testing must establish a provisional diagnosis or suspicion of cancer. If there was no provisional diagnosis or suspicion of cancer, the immunophenotyping or genetic testing would not have been done. When there is a provisional diagnosis or suspicion of cancer based on tissue, bone marrow, and/or blood, code diagnostic confirmation as 3, not 5.

- Example: The only information available is that the patient had a positive JAK2 done on a blood sample and is diagnosed with polycythemia vera. Code 5 for diagnosis based on a marker study that is diagnostic for polycythemia vera.

8. Assign code 6 when the diagnosis is based only on:

   A. The surgeon's operative report from a surgical exploration or endoscopy and no tissue was examined

   B. Gross autopsy findings (no tissue or cytologic confirmation).

9. Assign code 7 when the only confirmation of malignancy was diagnostic imaging such as computerized axial tomography (CT scans), magnetic resonance imaging (MRI scans), or ultrasounds/sonography.

10. Assign code 8 when the case was diagnosed by any clinical method not mentioned in the preceding codes. A number of hematopoietic and lymphoid neoplasms are diagnosed clinically; these are called "diagnoses of exclusion" (the tests for the disease are equivocal and the physician does a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation).

    - ✓ Note: The Hematopoietic DB will identify clinical diagnosis as the definitive diagnostic method.

    Example: Bone marrow biopsy shows anemia, NOS; physician notes states the patient's overall clinical presentation of hypercalcemia, fever, and anemia is consistent with Myelodysplastic Syndrome, NOS (9989/3). Code diagnostic confirmation 8, clinical diagnosis only.

11. Assign code 9:

    A. When it is unknown if the diagnosis was confirmed microscopically

    B. For death-certificate-only cases.

Diagnostic Confirmation for Hematopoietic or Lymphoid Neoplasms (Histology Coded to M9590-9992)

Codes:

Confirmation Type	Code Number	Code Description
Microscopically Confirmed	1	Positive histology
Microscopically Confirmed	2	Positive cytology
Microscopically Confirmed	3	Positive histology PLUS – positive immunophenotyping AND/OR positive genetic studies (Effective with cases diagnosed 1/1/2010 onward)
Microscopically Confirmed	4	Positive microscopic confirmation, method not specified
Not Microscopically Confirmed	5	Positive laboratory test/marker study
Not Microscopically Confirmed	6	Direct visualization without microscopic confirmation
Not Microscopically Confirmed	7	Radiography and/or other imaging techniques without microscopic confirmation
Not Microscopically Confirmed	8	Clinical diagnosis only (other than 5, 6, or 7)
Unknown	9	Unknown whether or not microscopically confirmed; death certificate only

Histologic Type ICD-O-3

Field Length: 4

Source of Standard: SEER/CoC

Description:

Describes the microscopic composition of cells and/or tissue for a specific primary.

General Guidance:

- The *2007 Multiple Primary and Histology Coding Rules*, the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual,* the Hematopoietic Database (Hematopoietic DB), and *the International Classification of Diseases for Oncology, Third Edition (ICD-O-3)* are the standard references for histology codes.

- Document the Histology of the tumor in text to support the code used in this data field.

- **There have been several updates, errata, and clarifications released for the *ICD-O-3* since its original publication date. They are included at the end of this section of the manual. Before using the *ICD-O-3,* make certain to update it accordingly.**

Coding Instructions:

For Solid Tumors:

1. Use the current *Multiple Primary and Histology Coding Rules* when coding the histology for all reportable solid tumors. These rules are effective for cases diagnosed January 1, 2007 onward. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.

2. Apply the site-specific histology coding rules in the *Multiple Primary and Histology Coding Rules* manual.

3. Site-specific histology coding rules cover the following:

    - Head and neck- C000-C148, C300-C329
    - Colon- C180-C189
    - Lung- C340-C349
    - Melanoma- C440-C449 with Histology 8720-8780
    - Breast- C500-C509
    - Kidney- C649
    - Ureter/Renal pelvis/Bladder- C659, C669, C670-C679, C680-C689
    - Benign brain- C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
    - Malignant brain- C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
    - Other sites- Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain

4. Code low grade neuroepithelial neoplasm to 9505/1 (ganglioglioma, NOS)

5. Effective with diagnosis date 1/1/2015, code 8240/1 for Carcinoid Tumor, NOS of the appendix (C181) is obsolete. Report Carcinoid Tumor, NOS of the appendix as 8240/3.

6. Effective with diagnosis date 1/1/2015, codes 8157/1 Enteroglucagonoma, NOS and 8157/3 Malignant Enteroglucagonoma are obsolete. Use 8152/1 for Enteroglucagonoma, NOS and 8152/3 for Malignant Enteroglucagonoma. Enteroglucagonoma is now a related term for glucagonoma.

7. Additional new histology terms and codes for the ICD-O-3 were recently released. See the *NAACCR Guidelines for ICD-O-3 Update Implementation* document at the end of this section for guidance on the use of these codes and terms.

8. If any of the reportable terms listed below are used on a path report or in the medical chart and the diagnosis date is 1/1/2015 – 12/31/2017, report the case using the code listed in the Current Code to Use When Abstracting column.

ICD-O-3 Change	New Code in ICD-O-3 (Do not use these codes until further notice.)	Description	Comment	Current Code to Use When Abstracting
New term and code	8158/1	Endocrine tumor, functioning, NOS	FYI only- this disease is not	Do not report this case.

Histologic Type ICD-O-3

			reportable.	
New related term	8158/1	ACTH-producing tumor	FYI only- this disease is not reportable.	Do not report this case.
New term and code	8163/3	Pancreatobiliary-type carcinoma (C24.1)	DO NOT use new code	8255/3
New synonym	8163/3	Adenocarcinoma, pancreatobiliary-type (C24.1)	DO NOT use new code	8255/3
New term	8213/3	Serrated adenocarcinoma		8213/3*
New code and term	8265/3	Micropapillary carcinoma, NOS (C18._, C19.9, C20.9)	DO NOT use new code	8507/3*
New code and term	8480/1	Low grade appendiceal mucinous neoplasm (C18.1)	FYI only- this disease is not reportable.	Do not report this case.
New term and code	8552/3	Mixed acinar ductal carcinoma	DO NOT use new code	8523/3
New term and code	8975/1	Calcifying nested epithelial stromal tumor (C22.0)	FYI only- this disease is not reportable.	Do not report this case.
New term and code	9395/3	Papillary tumor of the pineal region	DO NOT use new code	9361/3*

Histologic Type ICD-O-3

New term and code	9425/3	Pilomyxoid astrocytoma	DO NOT use new code	9421/3
New term and code	9431/1	Angiocentric glioma	DO NOT use new code	9380/1*
New term and code	9432/1	Pituicytoma	DO NOT use new code	9380/1*
New term and code	9509/1	Papillary glioneuronal tumor	DO NOT use new code	9505/1
New related term	9509/1	Rosette-forming glioneuronal tumor	DO NOT use new code	9505/1
New term and code	9741/1	Indolent systemic mastocytosis	FYI only- this disease is not reportable.	Do not report this case.

** ICD-O-3 rule F applies (code the behavior stated by the pathologist). If necessary, over-ride any advisory messages.*

For Hematopoietic and Lymphatic Primaries

1. For lymphomas, leukemias, and other hematopoietic tumors, follow the instructions in the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic DB. (Use the 2015 version of the manual and database for cases diagnosed 1/1/2010 onward.)

Behavior Code ICD-O-3

Field Length: 1

Source of Standard: SEER/CoC

Description:

Describes the malignant potential of the tumor, ranging from /0 benign to /3 malignant (invasive)

General Guidance:

- Tumors arise because of uncontrolled growth or multiplication of cells. The behavior of a tumor is the way the tumor acts. Malignant tumors are composed of cells that will invade or spread to other parts of the body, either by direct extension to regional organs or tissues, or by metastasizing to distant sites by means of the blood stream, the lymphatic system, or by implantation of cancer cells.

- All malignancies with in situ (/2) and malignant (/3) behavior codes as described in the *ICD-O-3* must be reported. In addition, benign (/0) and borderline (/1) intracranial and CNS tumors for cases diagnosed on or after 1/1/2004 must be reported.

Coding Instructions:

Metastatic or Non-Primary Sites:

1. If the only pathology specimen is from a metastatic site, code the appropriate histology code and use the malignant behavior code (/3). The primary site and its metastatic site(s) have the same histology.

2. Code the behavior as malignant (/3) when malignant metastasis is present.

    - Example: GIST with lymph nodes positive for malignancy. Code the behavior as malignant (/3).

Behavior Code ICD-O-3

Bladder:

1. Code the behavior as malignant /3, NOT in situ /2, when:

    - the only surgery performed is a transurethral resection of the bladder (TURB) documenting that depth of invasion cannot be measured because there is no muscle in the specimen
        AND
    - the physician's TNM designation is not available
        OR
    - the pathology report says the submucosa is invaded with tumor
        OR
    - the pathology report does not mention whether the submucosa is free of tumor or has been invaded by tumor

2. Code the behavior as in situ /2 when the TNM designation is Ta for TURB with no muscle in the specimen

In Situ and Invasive:

1. Code the behavior as malignant (/3) if any portion of the primary tumor is invasive no matter how limited (i.e., microinvasion).

    - Example: Pathology from mastectomy: Large mass composed of intraductal carcinoma with a single focus of invasion. Code the behavior as malignant (/3).

2. Re-code the behavior as malignant (/3) when metastases are attributed to a tumor originally thought to be in situ.

    - Example: Right colon biopsy reveals tubulovillous adenoma with microfocal carcinoma in situ; right hemicolectomy is negative for residual disease. Later core liver biopsy consistent with adenocarcinoma of gastrointestinal origin. Oncologist states most likely colon primary. Change the behavior code for the colon primary from /2 to /3. There were no other colon primaries in this case.

In Situ:

1. Clinical evidence alone cannot identify the behavior as in situ; a behavior code of /2 (in situ) must be based on pathologic examination.

2. Synonyms for in situ:

AIN III (C211)
Behavior code '2'
Bowen disease (not reportable for C440-C449)
Clark level I for melanoma (limited to epithelium)
Confined to epithelium
Hutchinson melanotic freckle, NOS (C44_)
Intracystic, non-infiltrating
Intraductal
Intraepidermal, NOS
Intraepithelial, NOS
Intraepithelial neoplasia, Grade III (e.g. AIN III, LIN III, VAIN III, VIN III)
Involvement up to, but not including the basement membrane
Lentigo maligna (C44_)
LIN III (C320-C329)
Lobular, noninfiltrating (C50_)
Noninfiltrating
Noninvasive
No stromal invasion/involvement
Papillary, noninfiltrating or intraductal
Precancerous melanosis (C44_)
Queyrat erythroplasia (C60_)
SIN III
Stage 0 (except Paget's disease (8540/3) of breast, colon, or rectal tumors confined to the lamina propria)
VAIN III (C529)
VIN III (C51_)

ICD-O-3 Histology/Behavior Code Listing:

1. The behavior code associated with each histology code listed in the *International Classification of Diseases for Oncology, Third Edition (ICD-O-3)* is the "typical" behavior for that histology; however the pathologist has the final say on the behavior of the tumor. The *ICD-O-3* may have only one behavior code, in situ (/2) or malignant (/3), listed for a specific histology. If the pathology report describes the histology as:

    A. In situ (/2) and the *ICD-O-3* lists the histology only with a malignant behavior code (/3), assign the in situ behavior code (/2) as indicated on the pathology report.

B. Malignant (/3) and the *ICD-O-3* lists the histology only with an in situ behavior code (/2), assign the malignant behavior code (/3) as indicated on the pathology report.

- Example: The pathology report says large cell carcinoma in situ. The *ICD-O-3* lists large cell carcinoma only with a malignant behavior code (8012/3). Code the histology and behavior as specified by the pathologist on the pathology report (8012/2).

2. The behavior code for juvenile astrocytoma (9421) was changed from (/1), in the *International Classification of Diseases for Oncology, Second Edition (ICD-O-2)*, to (/3), in the *ICD-O-3*. However, juvenile astrocytoma (9421/1) is still reportable. When submitting these cases, code the behavior code as malignant (9421/3).

Intracranial and CNS Tumors:

1. Intracranial and CNS tumors with behavior code /0 (benign) or /1 (borderline malignancy) are reportable beginning with cases diagnosed January 1, 2004 onward. These reportable sites include benign and borderline tumors of the following primary sites:

C710	Cerebrum
C711	Frontal lobe
C712	Temporal lobe
C713	Parietal lobe
C714	Occipital lobe
C715	Ventricle
C716	Cerebellum
C717	Brain stem
C718	Overlapping lesion of the brain
C719	Brain, NOS
C700	Cerebral meninges
C701	Spinal meninges
C709	Meninges, NOS
C720	Spinal cord
C721	Cauda equine
C722	Olfactory nerve
C723	Optic nerve
C724	Acoustic nerve
C725	Cranial nerve, NOS
C728-C729	Other CNS
C751	Pituitary gland
C752	Craniopharyngeal duct

C753 Pineal gland

2. Code the behavior from CT scan, Magnetic Resonance Imaging (MRI), or Positron Emission Tomography (PET) report when there is no tissue diagnosis (pathology or cytology report). Code the behavior listed on the scan. Do not use the WHO grade to code the behavior data field.

Codes:

Code Number	Code Description
0	Benign (Reportable for intracranial and CNS sites only)
1	Borderline, Uncertain whether benign or malignant, Borderline malignancy, Low malignant potential, Uncertain malignant potential (Reportable for intracranial and CNS sites only)
2	In Situ, noninvasive (carcinoma), noninfiltrating, intraepithelial
3	Invasive, malignant

Histology (92-00) ICD-O-2

Field Length: 4

Source of Standard: SEER/COC

Description:

Describes the microscopic composition of cells and/or tissue for a specific primary for cases diagnosed from January 1, 1992 – December 31, 2000.

General Guidance:

- This data item is required for cancer cases diagnosed from January 1, 1992, through December 31, 2000, and recommended for cases diagnosed prior to 1992.
- The *International Classification of Diseases for Oncology, Second Edition (ICD-O-2)* is the standard reference for these histology codes.

Coding Instructions:

1. For coding guidance, refer to the Histologic Type ICD-O-3 section of this manual.

Codes:

See *ICD-O-2* manual, Morphology Section for applicable codes.

Behavior (92-00) ICD-O-2

Field Length: 1

Source of Standard: SEER/CoC

Description:

Describes the behavior of the tumor being reported for cases diagnosed from January 1, 1992 – December 31, 2000.

General Guidance:

- This data item is required for cancer cases diagnosed from January 1, 1992, through December 31, 2000, and recommended for cases diagnosed prior to 1992. For cases diagnosed after 12/31/2000, refer to the Behavior Code ICD-O-3 section of this manual.

- The *International Classification of Diseases for Oncology, Second Edition (ICD-O-2)* is the standard reference for these behavior codes.

Coding Instructions:

1. For coding guidance, refer to the Behavior Code ICD-O-3 section of this manual.

Codes:

Code Number	Code Description
0	Benign
1	Borderline
2	In Situ
3	Invasive

Grade

Field Length: 1

Source of Standard: SEER/CoC

Description:

For solid tumors, this field describes the tumor's resemblance to normal tissue. For hematopoietic and lymphoid neoplasms, this field describes the cell lineage or phenotype.

- Codes 1, 2, 3, and 4:
    - Pathologic examination determines the grade, or degree of differentiation, of the tumor. For these cancers, the grade is a measurement of how closely the tumor cells resemble the parent tissue (organ of origin). Well differentiated tumor cells closely resemble the tissue from the organ of origin. Poorly differentiated and undifferentiated tumor cells are disorganized and abnormal looking; they bear little or no resemblance to the tissue from the organ of origin. These similarities/differences may be based on pattern (architecture), cytology, nuclear (or nucleolar) features, or a combination of these elements depending upon the grading system that is used. Some grading systems use only pattern, for example Gleason grading in prostate. Others use only a nuclear grade (usually size, amount of chromatin, degree of irregularity, and mitotic activity). Fuhrman's grade for kidney is based only on nuclear features. Most systems use a combination of pattern and cytologic and nuclear features; for example Nottingham's for breast combines numbers for pattern, nuclear size and shape, and mitotic activity. The information from this data item is useful for determining prognosis and treatment.
    - Pathologists describe the tumor grade using three systems or formats:
        - Two levels of similarity; also called a two-grade system
        - Three levels of similarity; also called a three-grade system
            - Grade I, well
            - Grade II, moderately
            - Grade III, poorly (undifferentiated carcinoma is usually separated from this system, since "poorly" bears some, albeit little, similarity to the host tissue, while "undifferentiated" has none, e.g. Undifferentiated carcinoma)
        - Four levels of similarity; also called a four-grade system. The four-grade system describes the tumor as:
            - Grade I; also called well differentiated

- Grade II; also called moderately differentiated
- Grade III; also called poorly differentiated
- Grade IV; also called undifferentiated or anaplastic

- Codes 5, 6, 7, and 8:
  - Cell Indicator (Codes 5, 6, 7, and 8) describes the lineage or phenotype of the cell. The codes are used only for hematopoietic and lymphoid neoplasms.

- Code 9:
  - Code 9 may be used for solid tumors, hematopoietic neoplasms, and lymphoid neoplasms when the grade is unknown or not specified by the pathologist.

General Guidance:

- Grades 1-4 are used to code the grade or differentiation of solid tumors. Grades 5-8 define particular cell lines for hematopoietic and lymphoid neoplasms.

Coding Instructions for Solid Tumors:

- ✓ **Note: The following Grade rules are effective with diagnosis date 1/1/2014 onward. For cases diagnosed prior to 1/1/2014, refer to the Grade rules in the previous TCR Abstracting and Coding Manual or the SEER Manual.**

- ✓ **Note: Do not use the guidelines specified in *the American Joint Committee on Cancer (AJCC) Cancer Staging Manual* to code this field. In some cases, the grade coding instructions in the *AJCC Cancer Staging Manual* differ from the instructions specified in this manual.**

1. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code grade based on information prior to neoadjuvant therapy even if the grade is unknown.

2. Code the grade from the primary tumor only.

   a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site.

   b. If the primary site is unknown (C809), code the grade to 9.

3. Code the grade shown below for specific histologic terms that imply a grade.
   - Carcinoma, undifferentiated (8020/3<u>4</u>)
   - Carcinoma, anaplastic (8021/3<u>4</u>)

- Follicular adenocarcinoma, well differentiated (8331/31)
- Thymic carcinoma, well differentiated (8585/31)
- Sertoli-Leydig cell tumor, poorly differentiated (8631/33)
- Sertoli-Leydig cell tumor, poorly differentiated with heterologous elements (8634/33)
- Undifferentiated sarcoma (8805/34)
- Liposarcoma, well differentiated (8851/31)
- Seminoma, anaplastic (9062/34)
- Malignant teratoma, undifferentiated (9082/34)
- Malignant teratoma, intermediate type (9083/32)
- Intraosseous osteosarcoma, well differentiated (9187/31)
- Astrocytoma, anaplastic (9401/34)
- Oligodendroglioma, anaplastic (9451/34)
- Retinoblastoma, differentiated (9511/31)
- Retinoblastoma, undifferentiated (9512/34)

4. In situ and/or combined in situ/invasive components:

   a. If a grade is given for an in situ tumor, code it. **Do NOT code grade for dysplasia such as high grade dysplasia.**

   b. If there are both in situ and invasive components, code only the grade for the invasive portion even if it is unknown.

5. If there is more than one grade, code the highest grade within the applicable system. Code the highest grade even if it is only a focus. Code grade in the following priority order using the first applicable system:

   a. Special grade systems for breast, prostate, heart, mediastinum, peritoneum, retroperitoneum, soft tissue, and kidney parenchyma. See instruction # 6 below for details.

CS Schema	Special Grade System
Breast	Nottingham or Bloom-Richardson (BR) Score/Grade (SSF7)
Prostate	Gleason's Score on Needle Core Biopsy/Tranuretheral Resection of Prostate (TURP) (SSF8)
Prostate	Gleason's Score on Prostatectomy/Autopsy (SSF 10)
Heart, Mediastinum	Grade for Sarcomas (SSF 1)
Peritoneum	Grade for Sarcomas (SSF 1)
Retroperitoneum	Grade for Sarcomas (SSF 1)
Soft Tissue	Grade for Sarcomas (SSF 1)
Kidney	Fuhrman Nuclear Grade (SSF 6)

b. Differentiation: Determine the type of grade system used (the 2-, 3-, or 4-grade system) and then use the appropriate grade system table located below in instruction # 7 to identify the grade code.
c. Nuclear grade: Determine the type of grade system used (the 2-, 3-, or 4-grade system) and then use the appropriate grade system table located below in instruction # 7 to identify the grade code.
d. If it isn't clear whether it is a differentiation or nuclear grade and a 2-, 3-, or 4- grade system was used, code it (see the tables in instruction # 7).
e. Terminology: See instruction # 8 below for details.

6. For breast, prostate, heart, mediastinum, peritoneum, retroperitoneum, soft tissue, and kidney parenchyma primaries, use the information from the special grade systems first to code the grade. See the Special Grade System Rules section below for details on how to code grade using the special grade systems.

   If no special grade can be coded, use the priority list (see instruction # 5 above) to determine the most appropriate method of coding the grade field.

✓ Note: Breast and prostate grades may convert differently than other primary sites. These exceptions are noted in the tables below.

DO NOT USE THESE TABLES TO CODE GRADE FOR ANY OTHER GROUPS INCLUDING THE WHO (CNS TUMORS), WHO/ISUP (BLADDER/RENAL PELVIS), or FIGO (FEMALE GYNECOLOGIC SITES) GRADES.

7. Determine the type of grade system used (the 2-, 3-, or 4-grade system) and then use the appropriate grade system table located below to identify the grade code.

a. Two-grade system:

Grade	Differentiation/ Description	Grade code for primary sites **other than breast and prostate primaries**	Grade code for **breast and prostate primaries-**
1/2 , I/II	Low grade	2	1
2/2, II/II	High grade	4	3

In transitional cell carcinoma for bladder, the terminology high grade TCC and low grade TCC are coded in the two-grade system.

b. Three-grade system:

Grade	Differentiation/ Description	Grade code for primary sites **other than breast and**	Grade code for **breast and prostate**

Grade

		prostate primaries	**primaries-**
1/3, I/III	Low grade	2	1
2/3, II/III	Intermediate grade	3	2
3/3, III/III	High grade	4	3

c. Four-grade system: Any four-grade system including Edmondson and Steiner grade for liver.

Term	Description	Grade code
1/4, I/IV	Grade I; Well-differentiated	1
2/4, II/IV	Grade II; Moderately differentiated	2
3/4, III/IV	Grade III; Poorly differentiated	3
4/4, IV/IV	Grade IV; Undifferentiated	4

8. Terminology: Use the 'Description' column or the Grade column below to code the grade. Breast & Prostate use the same grade code with a few noted exceptions.

Description	Grade	Code to be entered into Grade field	Exception for **breast and prostate Grade code**
Differentiated, NOS	I	1	
Well differentiated	I	1	
Only stated as 'Grade 1'	I	1	
Fairly well differentiated	II	2	
Intermediate differentiation	II	2	
Low grade	I-II	2	1
Mid differentiated	II	2	
Moderately differentiated	II	2	
Moderately well differentiated	II	2	
Partially differentiated	II	2	
Partially well differentiated	I-II	2	1
Relatively or generally well differentiated	II	2	
Only stated as 'Grade II'	II	2	
Medium grade, intermediate grade	II-III	3	2
Moderately poorly differentiated	III	3	

Moderately undifferentiated	III	3	
Poorly differentiated	III	3	
Relatively poorly differentiated	III	3	
Relatively undifferentiated	III	3	
Slightly differentiated	III	3	
Dedifferentiated	III	3	
Only stated as 'Grade III'	III	3	
High grade	III-IV	4	3
Undifferentiated, anaplastic, not differentiated	IV	4	
Only stated as 'Grade IV'	IV	4	
Non-high grade		9	

9. If no description fits or grade is unknown prior to neoadjuvant therapy, code as a 9 (unknown).

10. Per SEER- code grade from the time of the initial diagnosis. Do not code grade from recurrence or progression.

    - Example: Prostate carcinoma Gleason 2+3 per biopsies. Watchful waiting for one year. One year later, score of 4+3 per second biopsies. Surgery performed and Gleason score is 7. Code the grade based on the original Gleason score of 2+3.

Special Grade System Rules:

Breast (excluding lymphomas):

Use Bloom Richardson (BR) or Nottingham score/grade to code grade based on CSv2 site-specific factor (SSF) 7.

BR could also be referred to as: Bloom-Richardson, modified Bloom-Richardson, BR, BR grading, Scarff-Bloom-Richardson, SBR grading, Elston-Ellis modification of Bloom-Richardson score, Nottingham modification of Bloom-Richardson score, Nottingham modification of Scarff-Bloom-Richardson, Nottingham-Tenovus grade, or Nottingham grade.

Priority Order: Code the tumor grade using the following priority order:

a. BR scores 3-9

b. BR grade (low, intermediate, high)

BR Score may be expressed as a range, 3-9. The score is based on three morphologic features; degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism/nuclear grade of tumor cells. If a report uses words such as low, intermediate, or high rather than numbers, use the table below to code the grade.

If only a grade of 1 through 4 is given with no information on the score and it is unclear if it is a Nottingham or BR Grade, do not use the table below. Use the priority list (see instruction # 5 above) to determine the most appropriate method of coding the grade field.

Code the highest score if multiple scores are reported (exclude scores from tests after neoadjuvant therapy begins). Examples: different scores may be reported on multiple pathology reports for the same primary cancer; different scores may be reported for multiple tumors assigned to the same primary cancer.

Codes 030-130 in CS SSF 7 (Nottingham or Bloom-Richardson (BR) Score/Grade) can be converted and used in the grade field (see the conversion table below).

CS Site-Specific Factor (CS SSF) 7 conversion table:

Description	CS Code	Grade Code
Score of 3	030	1
Score of 4	040	1
Score of 5	050	1
Score of 6	060	2
Score of 7	070	2
Score of 8	080	3
Score of 9	090	3
Low Grade, Bloom-Richardson (BR) grade 1, score not given	110	1
Medium (Intermediate) Grade, BR grade 2, score not given	120	2
High Grade, BR grade 3, score not given	130	3

Kidney Parenchyma (excluding lymphomas):

Fuhrman Nuclear Grade: The Fuhrman Nuclear Grade should be used to code grade for kidney parenchyma only. **Do not use for kidney renal pelvis.** Fuhrman nuclear grade is a four-grade system based on nuclear diameter and shape, the prominence of nucleoli, and the presence of chromatin clumping in the highest grade. Coding grade for kidney parenchyma primaries is based on the CSv2 SSF 6.

Codes 010-040 in CS SSF 6 (Fuhrman Nuclear Grade) can be converted and used in the grade field (see the conversion table below).

CS Site-Specific Factor (CS SSF) 6 conversion table:

Grade

Description	CS Code	Grade Code
Grade 1	010	1
Grade 2	020	2
Grade 3	030	3
Grade 4	040	4

Grade for Sarcomas of the Soft Tissue, Heart, Mediastinum, Peritoneum, and Retroperitoneum:

Coding grade for sarcomas should be based on CSv2 SSF 1.

The French Federation of Cancer Centers Sarcoma Group (FNCLCC) is the preferred system; however, if the FNCLCC system is not used, record the grade from any three-grade sarcoma grading system the pathologist uses. For terms such as "well differentiated" or "poorly differentiated", use the table in instruction #8 to code the grade field.

In some cases, especially for needle biopsies, grade may be specified only as "low grade" or "high grade". The numeric grade takes precedence over "low grade" or "high grade".

Codes 010-200 in CS SSF 1 can be converted and used in the grade field (see the conversion table below).

CS Site-Specific Factor (CS SSF) 1 conversion table:

Description	CS Code	Grade Code
Specified as Grade 1 (of 3)	010	2
Specified as Grade 2 (of 3)	020	3
Specified as Grade 3 (of 3)	030	4
Grade stated as low grade, NOS	100	2
Grade stated as high grade, NOS	200	4

Prostate (excluding lymphomas):

Use the highest Gleason score from the biopsy/TURP or prostatectomy/autopsy.

Use a known value over an unknown value.

Exclude results from tests performed after neoadjuvant therapy began.

This information is collected in CSv2 SSF 8 (Gleason score from biopsy/TURP) and SSF 10 (Gleason score from prostatectomy/autopsy). The SSFs codes can be converted and used in the grade field (see the conversion table below).

Usually prostate cancers are graded using Gleason score or pattern. Gleason grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows

two main histologic patterns. The primary pattern, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason's grade, and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10. If there are two numbers, assume that they refer to two patterns (the first number being the primary pattern and the second number the second pattern), and sum them to obtain the score. If only one number is given on a particular test and it is less than or equal to 5 and not specified as a score, do not use the information because it could refer to either a score or a grade. If only one number is given and it is greater than 5, assume that it is a score and use it. If the pathology report specifies a specific number out of a total of 10, the first number given is the score. Example: The pathology report says Gleason 3/10. The Gleason score would be 3.

CS Site-Specific Factor (CS SSF) 8 and 10 conversion table:

Gleason Score	CS Code	Grade Code
2	002	1
3	003	1
4	004	1
5	005	1
6	006	1
7	007	2
8	008	3
9	009	3
10	010	3

Historical perspective on long term trends in prostate grade: The relationship of Gleason score to grade changed for 1/1/2014 + diagnoses in order to have the grade field in sync with AJCC 7th ed. Analysis of prostate grade before 2014 based solely on the grade field is not recommended. In Collaborative Stage (CS), Gleason score was originally coded in CSv1 in one field (SSF 6) and then it was split into two fields in CSv2 based on the tissue used for the test: needle biopsy/ TURP (SSF 8) and prostatectomy/autopsy (SSF 10). For trends using data back to 2004, if one collected the various CS Gleason scores, one could design a recode to have the same criteria as the data collected 2014+. The original grade field would NOT be changed, but for analyses this recode could be based on the CS SSFs and the original grade code.

Hematopoietic and Lymphoid Neoplasm Grade Coding Instructions:

Description:

For Hematopoietic and Lymphoid Neoplasms, the grade field is used to report the cell lineage or phenotype. Applicable codes for the grade field for hematopoietic and lymphoid neoplasms are: 5, 6, 7, 8, and 9.

Terminology	Grade Code
T-cell; T-precursor; T-cell origin; T-cell phenotype; Pre-T; Gamma-Delta-T; null cell and T-cell	5
B-cell; Pre-B; B-precursor; B-cell phenotype; null-cell and B-cell	6
Null cell; Non T-non B; common cell	7
NK cell; natural killer cell, nasal NK/T–cell lymphoma; null-cell and NK cell	8
Grade unknown; not stated; combined T and B cell; combined B and NK cell; not applicable	9

Coding Instructions:

- Step 1: Determine the histology of the hematopoietic or lymphoid disease
    - Use the rules in the *Hematopoietic and Lymphoid Neoplasm Manual* to determine the most appropriate histology. The manual is locate on the following website: *http://www.seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules*
- Step 2: Determine the cell lineage or phenotype
    - ✓ Note 1: Instructions for coding grade can be found in *the Hematopoietic and Lymphoid Neoplasm Database* and the *Hematopoietic and Lymphoid Neoplasm Manual*. Both rules are the same. Use whichever method you prefer (see below for instructions). The *Hematopoietic and Lymphoid Neoplasm Database* is located on the following website: http://www.seer.cancer.gov/seertools/hemelymph/.

      If the pathology report indicates a different grade for a disease than the one in the Hematopoietic and Lymphoid Neoplasm Database or the Hematopoietic and Lymphoid Neoplasm Manual, use the rules from the Hematopoietic manual to code the grade.

    - ✓ Note 2: Do NOT use Table 13 on pages 16-17 of the ICD-O-3 to determine the grade. The table is outdated.

Hematopoietic and Lymphoid Neoplasm Grade Coding Instructions:

- ✓ Note 3: Use a physician's statement to code the phenotype in the grade field. Use statements from any part of the medical record including but not limited to:
  - Pathology report
  - History and physical
  - Consultation
  - Final diagnosis
  - Face sheet

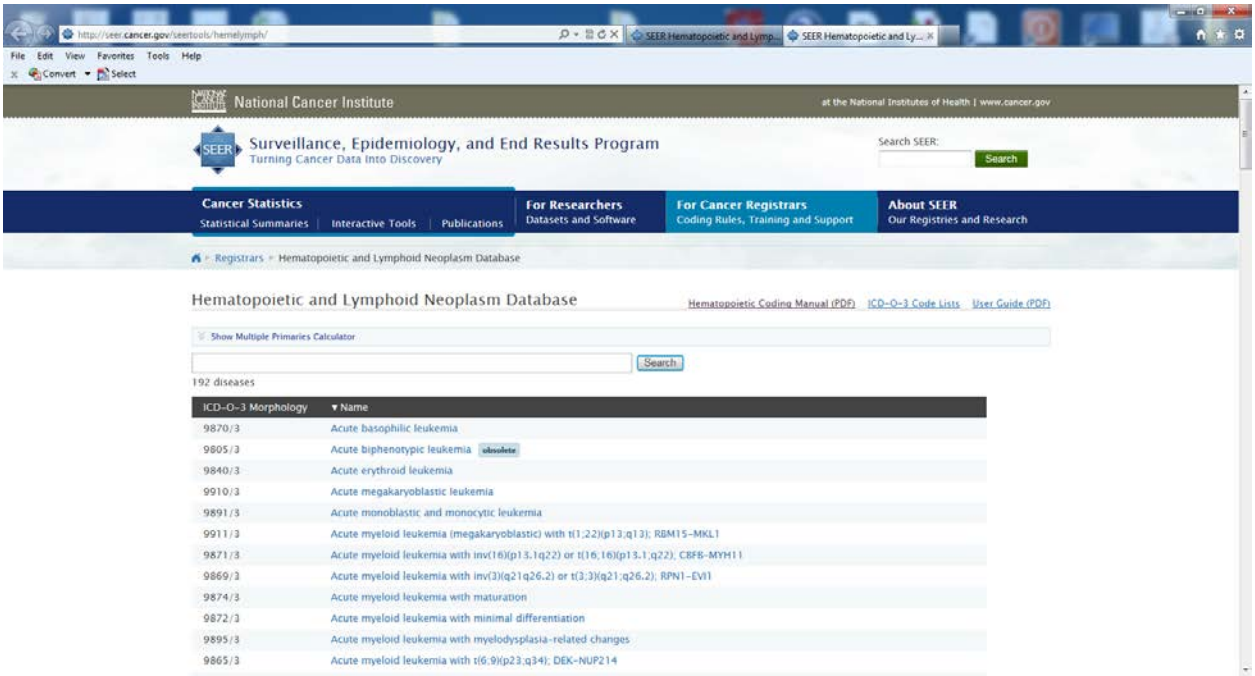
- ✓ Note 4: When there is no physician statement, code the Grade/Phenotype as 9 (Unknown)

- ✓ Note 5: The only valid grade codes for hematopoietic neoplasms are 5, 6, 7, 8, and 9.

- ✓ Note 6: Do not code descriptions "low grade", "intermediate grade", or "high grade" in the grade field. These terms refer to the Working Formulation categories of lymphoma diagnosis. Do not code grade 1, 2, or 3 describing follicular lymphomas.

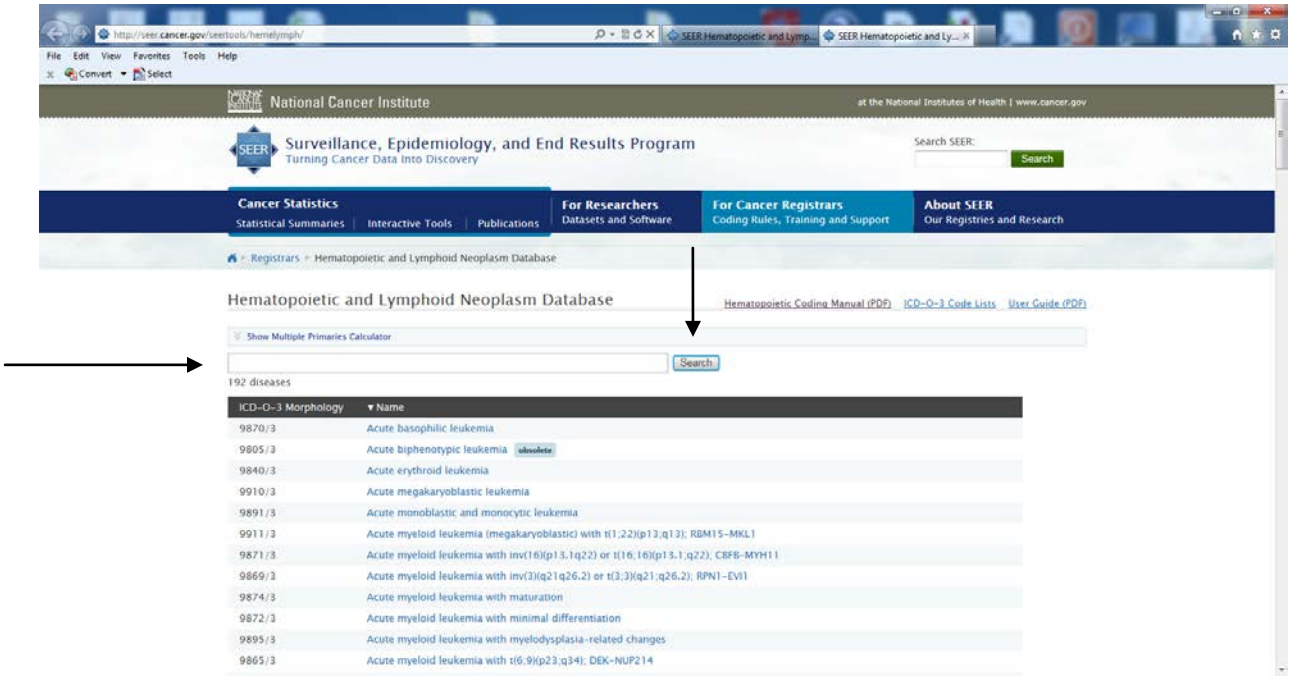
- ***Instructions for using the Hematopoietic and Lymphoid Neoplasm Database to code grade:***

  1. Open the *Hematopoietic and Lymphoid Neoplasm Database*
     http://www.seer.cancer.gov/seertools/hemelymph/

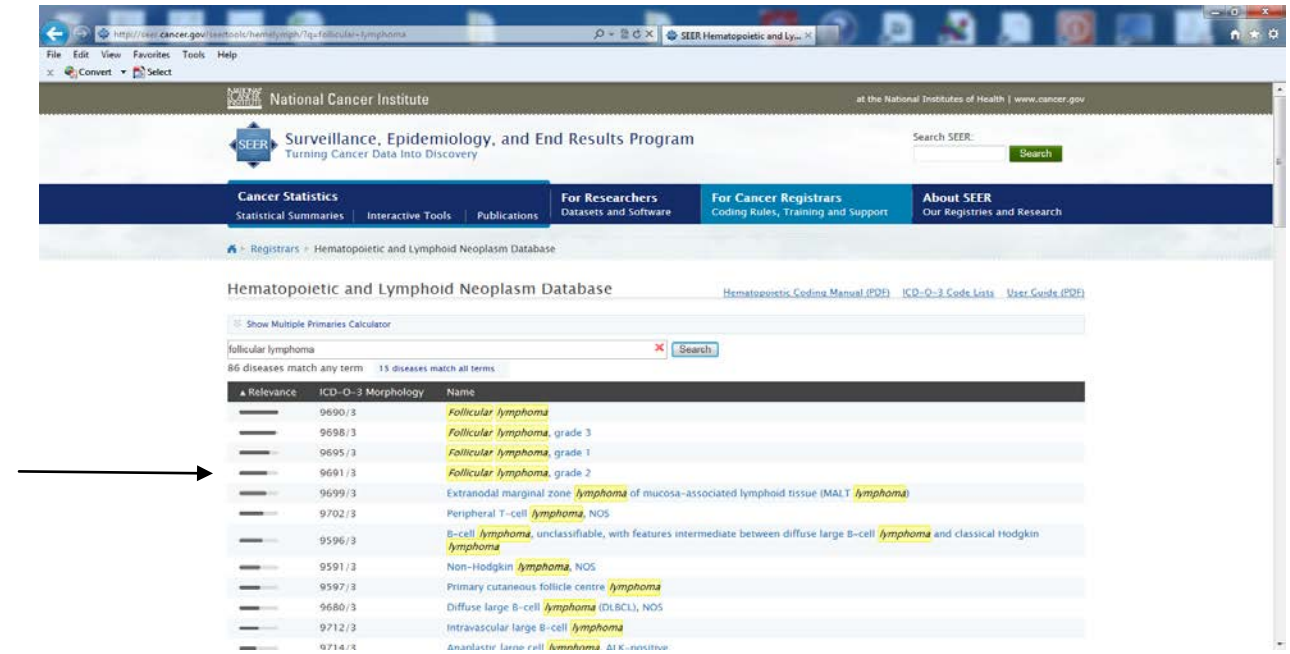


Hematopoietic and Lymphoid Neoplasm Grade Coding Instructions:

2. Enter the name or histology code of the disease in the search bar and click on the Search button.

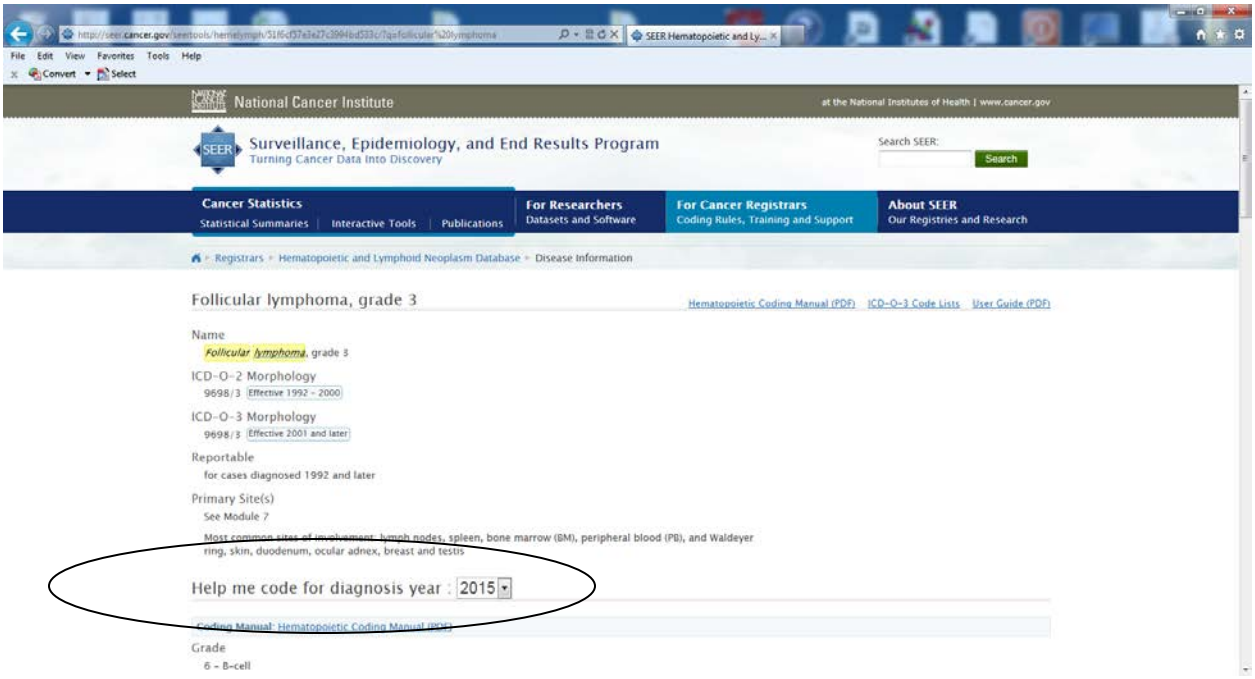


3. Select the diagnosis from the list of search results.

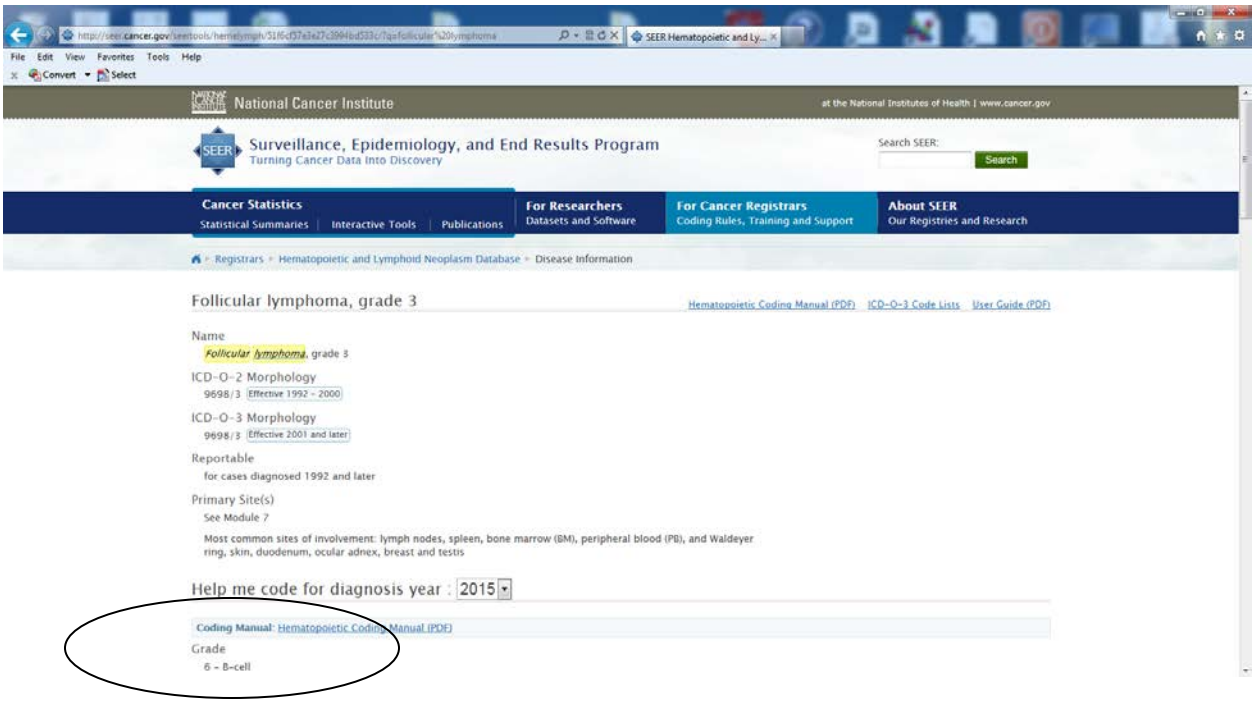


Hematopoietic and Lymphoid Neoplasm Grade Coding Instructions:

4. Select the appropriate diagnosis year from the drop-down menu in the *Help me code for dx year* area.



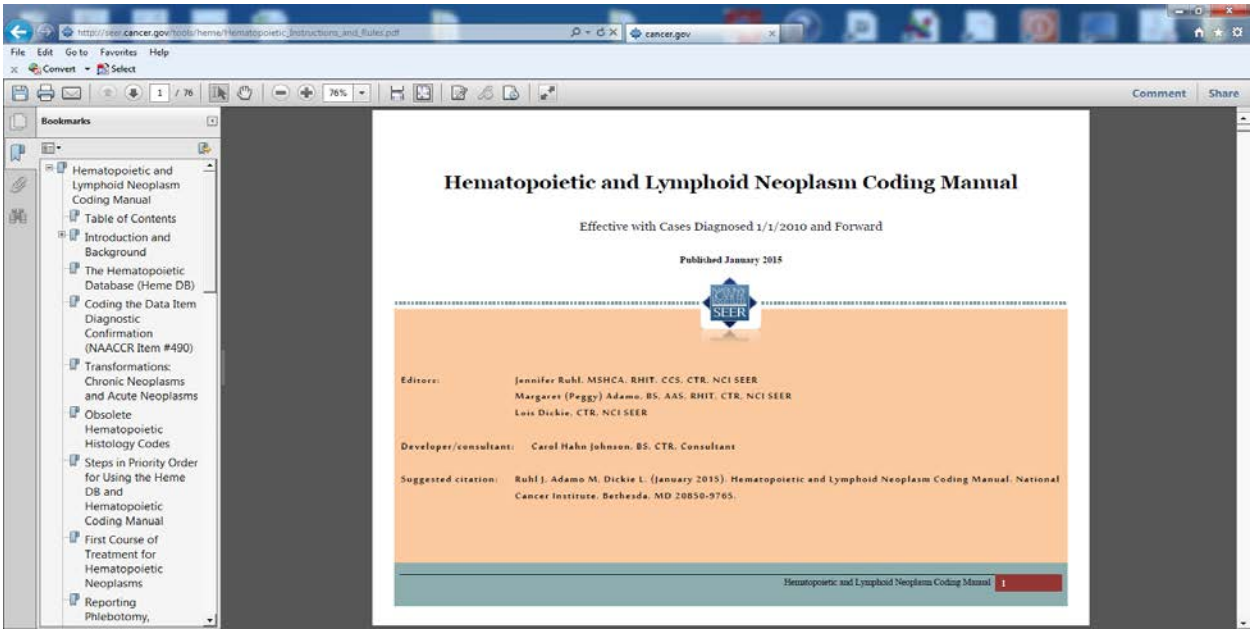
5. Information about coding grade for the disease is listed under the *Grade* area



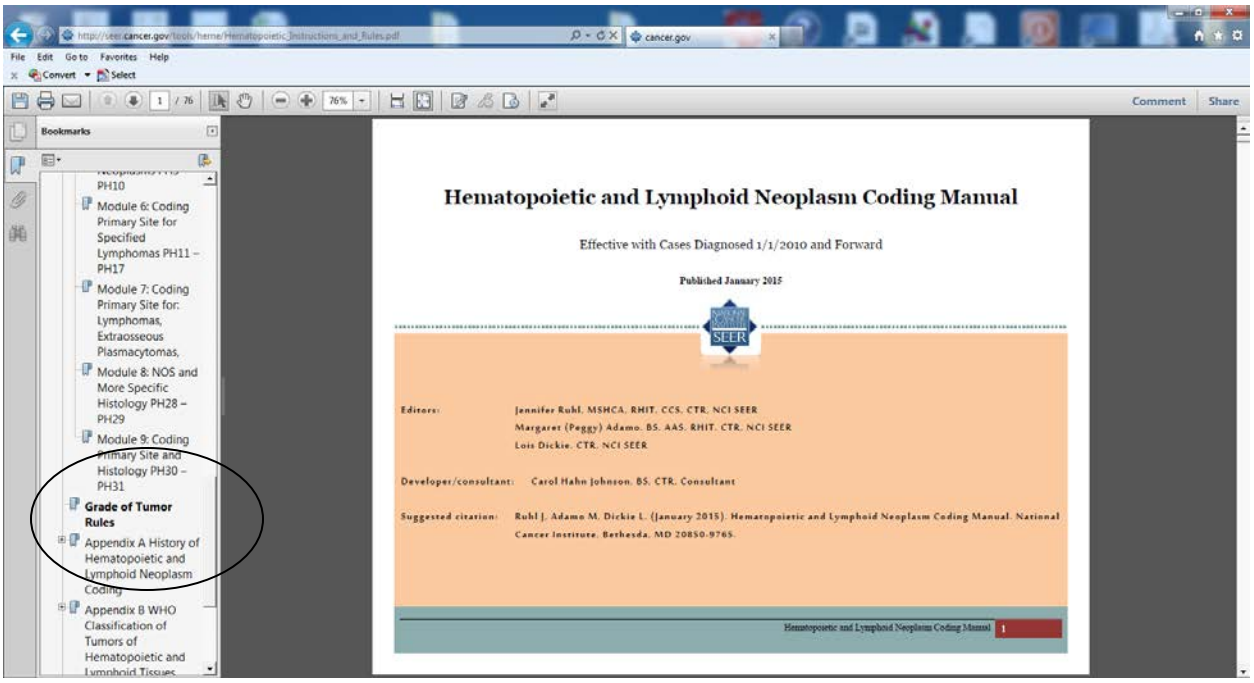
Hematopoietic and Lymphoid Neoplasm Grade Coding Instructions:

- ***Instructions for using the Hematopoietic and Lymphoid Neoplasm Manual to code grade:***

1. Open the *Hematopoietic and Lymphoid Neoplasm Manual* http://www.seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules

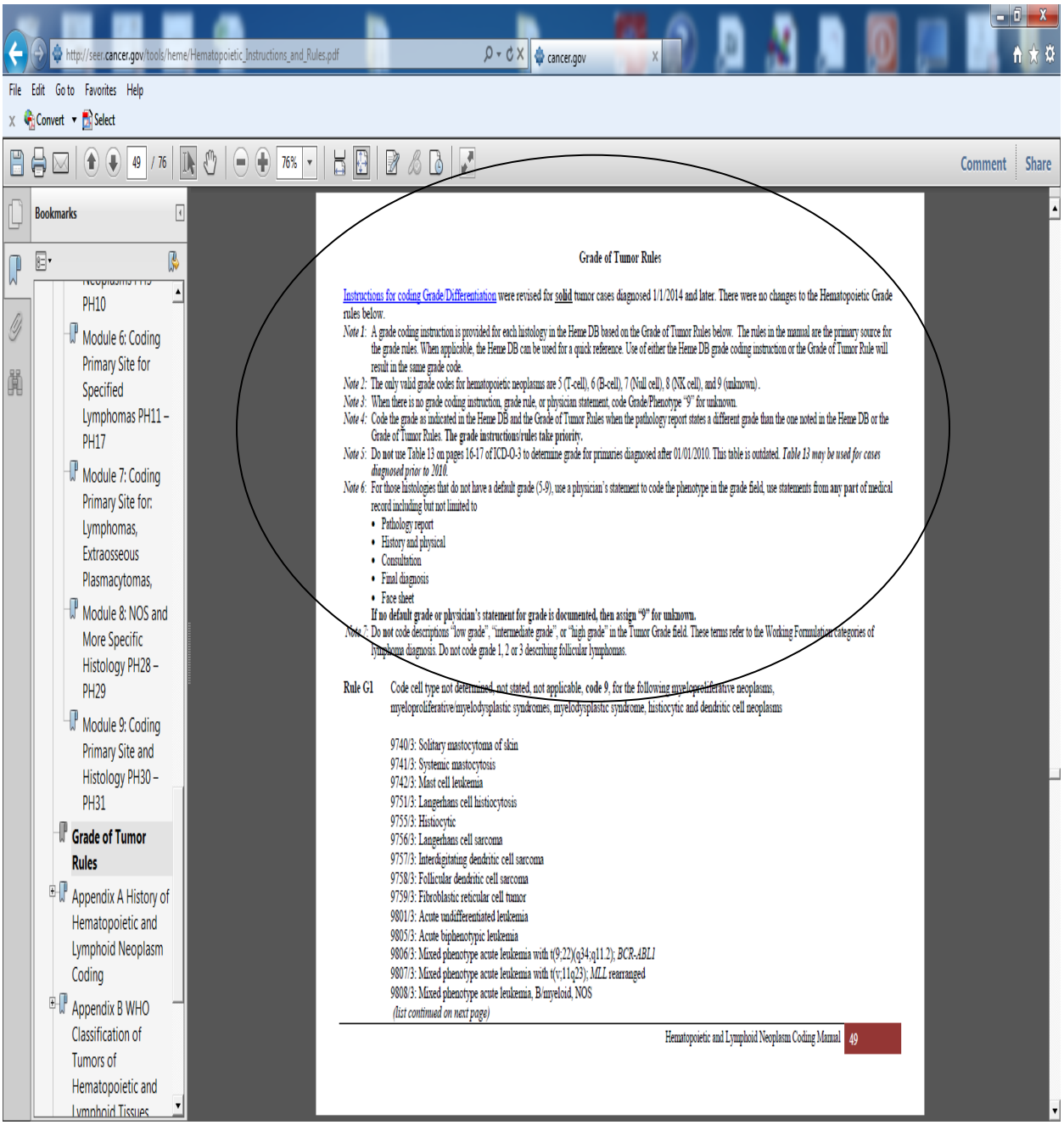


2. Locate *the Grade of Tumor Rules* section of the manual using the bookmark or by advancing through the manual.



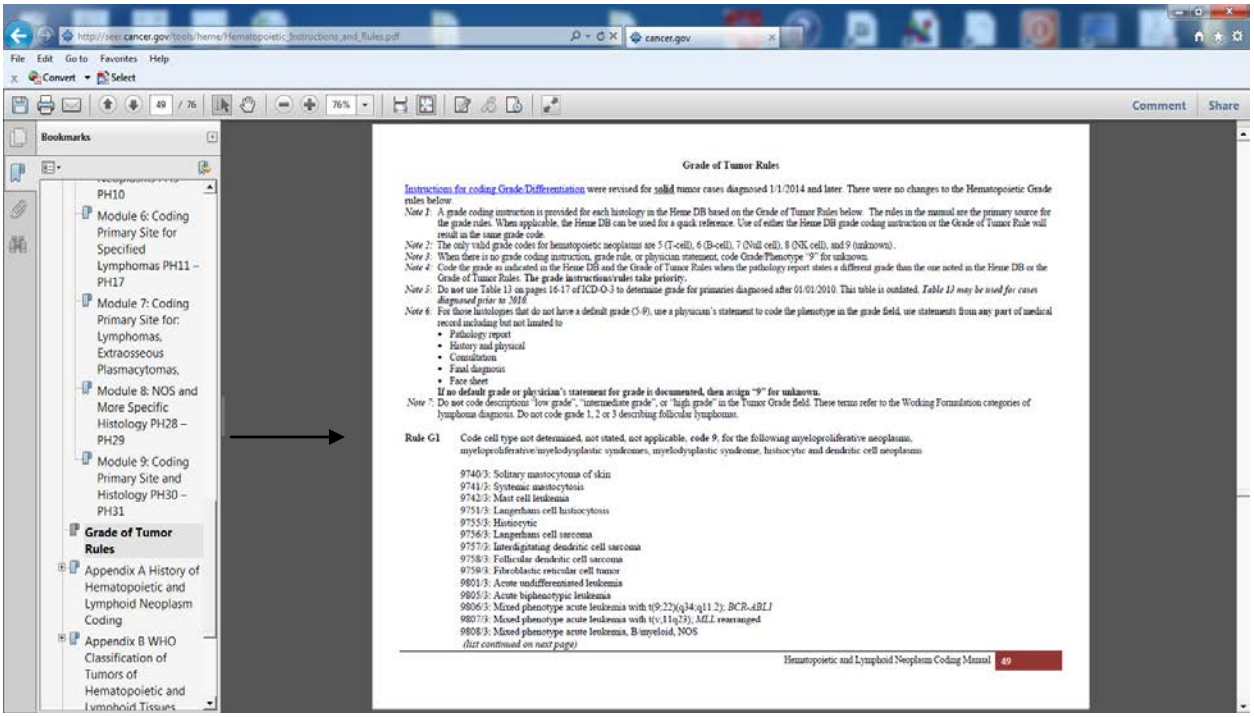
Hematopoietic and Lymphoid Neoplasm Grade Coding Instructions:

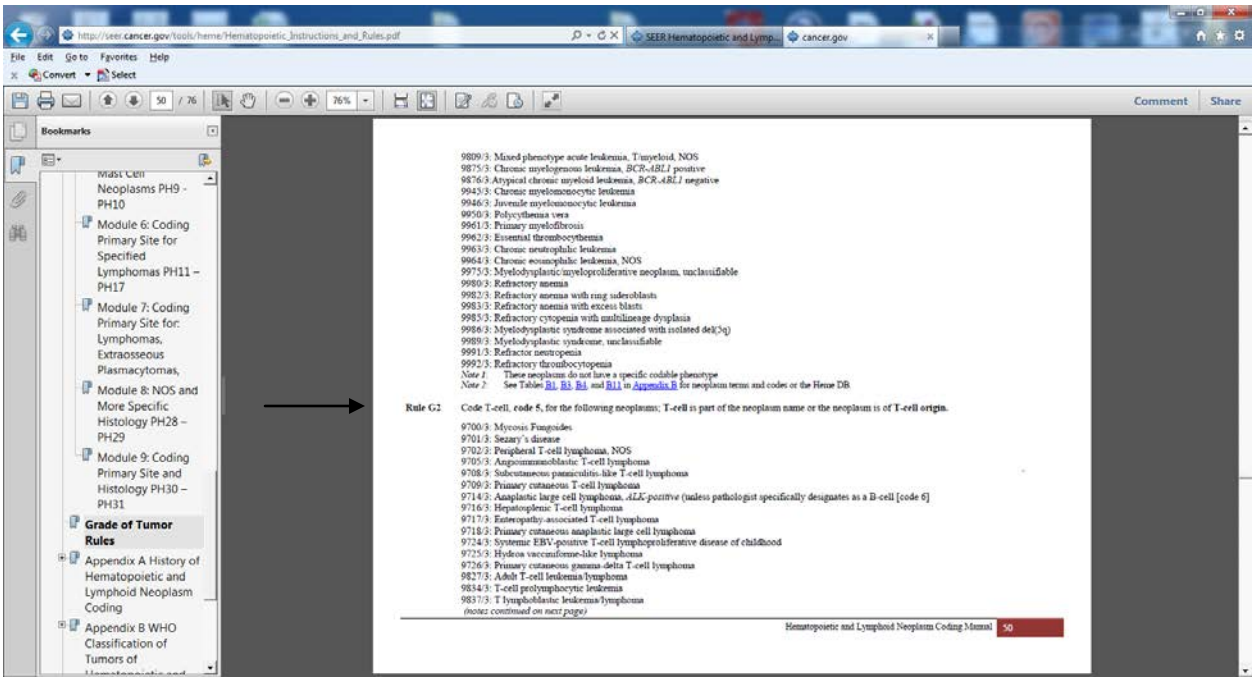
3. Read the rules for coding grade



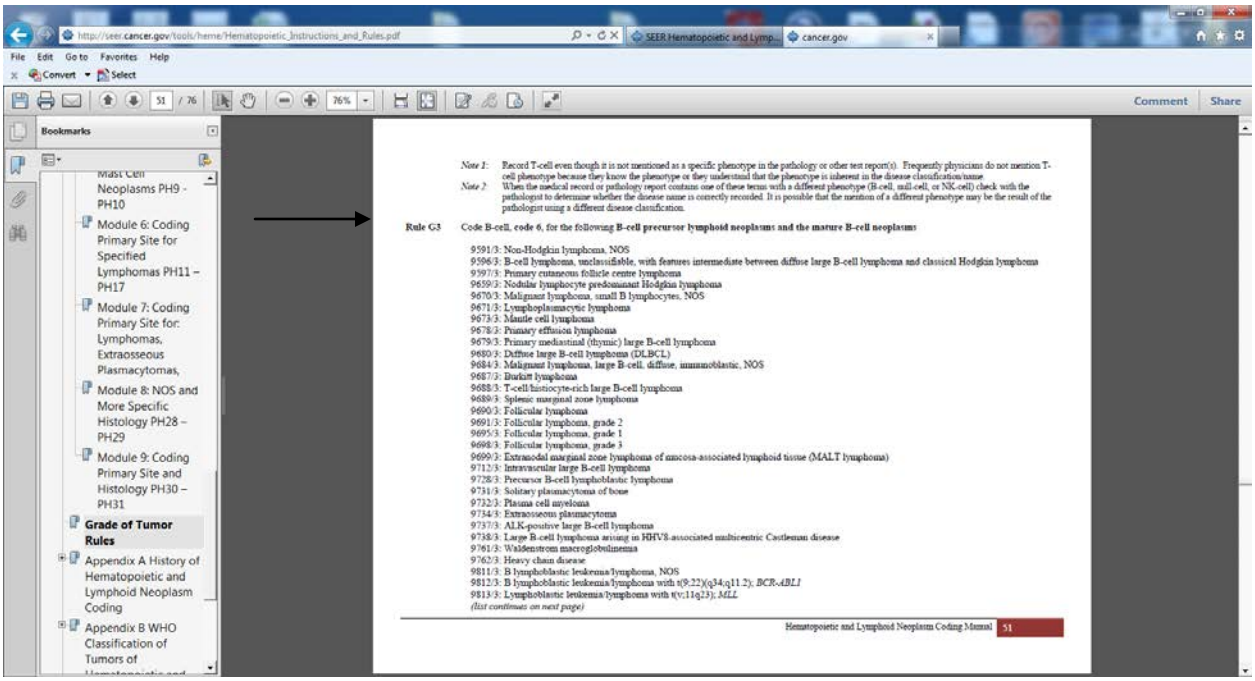
Hematopoietic and Lymphoid Neoplasm Grade Coding Instructions:

4. Start at Rule G1. Review each rule until you find the one that applies to your case then follow the instructions given to code the grade.





Hematopoietic and Lymphoid Neoplasm Grade Coding Instructions:

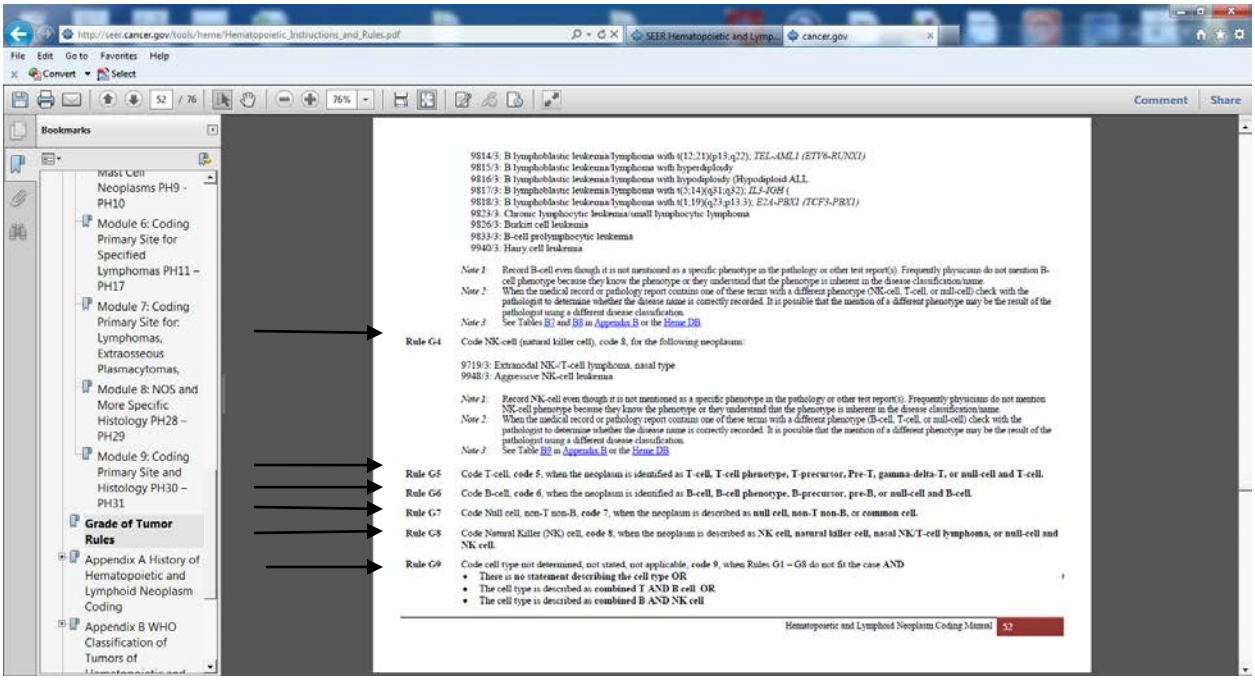


Note 1: Record T-cell even though it is not mentioned as a specific phenotype in the pathology or other test report(s). Frequently physicians do not mention T-cell phenotype because they know the phenotype or they understand that the phenotype is inherent in the disease classification/name.
Note 2: When the medical record or pathology report contains one of these terms with a different phenotype (B-cell, null-cell, or NK-cell) check with the pathologist to determine whether the disease name is correctly recorded. It is possible that the mention of a different phenotype may be the result of the pathologist using a different disease classification.

Rule G3 Code **B-cell**, **code 6**, for the following **B-cell precursor lymphoid neoplasms and the mature B-cell neoplasms**:

9591/3: Non-Hodgkin lymphoma, NOS
9596/3: B-cell lymphoma, unclassifiable, with features intermediate between diffuse large B-cell lymphoma and classical Hodgkin lymphoma
9597/3: Primary cutaneous follicle centre lymphoma
9659/3: Nodular lymphocyte predominant Hodgkin lymphoma
9670/3: Malignant lymphoma, small B lymphocytes, NOS
9671/3: Lymphoplasmacytic lymphoma
9673/3: Mantle cell lymphoma
9678/3: Primary effusion lymphoma
9679/3: Primary mediastinal (thymic) large B-cell lymphoma
9680/3: Diffuse large B-cell lymphoma (DLBCL)
9684/3: Malignant lymphoma, large B-cell, diffuse, immunoblastic, NOS
9687/3: Burkitt lymphoma
9688/3: T-cell/histiocyte-rich large B-cell lymphoma
9689/3: Splenic marginal zone lymphoma
9690/3: Follicular lymphoma
9691/3: Follicular lymphoma, grade 2
9695/3: Follicular lymphoma, grade 1
9698/3: Follicular lymphoma, grade 3
9699/3: Extranodal marginal zone lymphoma of mucosa-associated lymphoid tissue (MALT lymphoma)
9712/3: Intravascular large B-cell lymphoma
9728/3: Precursor B-cell lymphoblastic lymphoma
9731/3: Solitary plasmacytoma of bone
9732/3: Plasma cell myeloma
9734/3: Extraosseous plasmacytoma
9737/3: ALK-positive large B-cell lymphoma
9738/3: Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease
9761/3: Waldenstrom macroglobulinemia
9762/3: Heavy chain disease
9811/3: B lymphoblastic leukemia/lymphoma, NOS
9812/3: B lymphoblastic leukemia/lymphoma with t(9;22)(q34;q11.2); *BCR-ABL1*
9813/3: Lymphoblastic leukemia/lymphoma with t(v;11q23); *MLL*

(list continues on next page)



9814/3: B lymphoblastic leukemia/lymphoma with t(12;21)(p13;q22); *TEL-AML1 (ETV6-RUNX1)*
9815/3: B lymphoblastic leukemia/lymphoma with hyperdiploidy
9816/3: B lymphoblastic leukemia/lymphoma with hypodiploidy (Hypodiploid ALL
9817/3: B lymphoblastic leukemia/lymphoma with t(5;14)(q31;q32); *IL3-IGH (*
9818/3: B lymphoblastic leukemia/lymphoma with t(1;19)(q23;p13.3); *E2A-PBX1 (TCF3-PBX1)*
9823/3: Chronic lymphocytic leukemia/small lymphocytic lymphoma
9826/3: Burkitt cell leukemia
9833/3: B-cell prolymphocytic leukemia
9940/3: Hairy cell leukemia

Note 1: Record B-cell even though it is not mentioned as a specific phenotype in the pathology or other test report(s). Frequently physicians do not mention B-cell phenotype because they know the phenotype or they understand that the phenotype is inherent in the disease classification/name.
Note 2: When the medical record or pathology report contains one of these terms with a different phenotype (NK-cell, T-cell, or null-cell) check with the pathologist to determine whether the disease name is correctly recorded. It is possible that the mention of a different phenotype may be the result of the pathologist using a different disease classification.
Note 3: See Tables B7 and B8 in Appendix B or the Heme DB.

Rule G4 Code **NK-cell (natural killer cell)**, **code 8**, for the following neoplasms:

9719/3: Extranodal NK-/T-cell lymphoma, nasal type
9948/3: Aggressive NK-cell leukemia

Note 1: Record NK-cell even though it is not mentioned as a specific phenotype in the pathology or other test report(s). Frequently physicians do not mention NK-cell phenotype because they know the phenotype or they understand that the phenotype is inherent in the disease classification/name.
Note 2: When the medical record or pathology report contains one of these terms with a different phenotype (B-cell, T-cell, or null-cell) check with the pathologist to determine whether the disease name is correctly recorded. It is possible that the mention of a different phenotype may be the result of the pathologist using a different disease classification.
Note 3: See Table B9 in Appendix B or the Heme DB.

Rule G5 Code **T-cell**, **code 5**, when the neoplasm is identified as **T-cell, T-cell phenotype, T-precursor, Pre-T, gamma-delta-T, or null-cell and T-cell.**

Rule G6 Code **B-cell**, **code 6**, when the neoplasm is identified as **B-cell, B-cell phenotype, B-precursor, pre-B, or null-cell and B-cell.**

Rule G7 Code **Null cell, non-T non-B**, **code 7**, when the neoplasm is described as **null cell, non-T non-B, or common cell.**

Rule G8 Code **Natural Killer (NK) cell**, **code 8**, when the neoplasm is described as **NK cell, natural killer cell, nasal NK/T-cell lymphoma, or null-cell and NK cell.**

Rule G9 Code **cell type not determined, not stated, not applicable**, **code 9**, when Rules G1 – G8 do not fit the case **AND**

- There is **no statement describing the cell type OR**
- The cell type is described as **combined T AND B cell OR**
- The cell type is described as **combined B AND NK cell**

Regional Nodes Examined

Field Length: 2

Source of Standard: SEER/CoC

Description:

Records the total number of regional lymph nodes that were removed and examined by the pathologist.

Coding Instructions:

1. **Regional lymph nodes only**: Record information about only regional lymph nodes in this field. Do not record information about distant lymph nodes in this field.

2. This field is **based on pathologic information only**: This field is to be recorded regardless of whether the patient received preoperative treatment.

3. Use the *AJCC Cancer Staging Manual* to identify regional lymph nodes for each primary site.

4. **Use code 00**:

    A. When the assessment of lymph nodes is clinical.

    B. When no lymph nodes are removed and examined.

    C. When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.

    D. If Regional Nodes Examined is coded 00, Regional Nodes Positive is coded as 98.

5. **Cumulative nodes removed and examined**: Record the total number of regional lymph nodes removed and examined by the pathologist.

    A. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment with the exception of aspiration or core biopsies coded to 95.

B. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Examined.

   - Example: Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. *Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.*

C. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Examined.

   - Example: Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. *Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain*.

D. If the location of the lymph node that is aspirated or core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Examined.

   - Example: Patient record states that core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. *Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14*.

E. When neither the type of lymph node removal procedure nor the number of lymph nodes examined is known, use code 98.

6. **Priority of lymph node counts**: If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.

7. **Use of code 95**: Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

   - Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. *Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.*

8. **Lymph node biopsy**: If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, use code 96.

Regional Nodes Examined

9. **Definition of "sampling" (code 96)**: A lymph node "sampling" is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.

10. **Definition of "dissection" (code 97)**: A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed and the number is unknown.

11. **Multiple lymph node procedures**: If both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown, use code 97.

12. **Use code 99** if it is unknown whether nodes were removed or examined.

13. For the following schemas, the Regional Nodes Examined field is always coded as 99:

    Placenta
    Brain and Cerebral Meninges
    Other Parts of Central Nervous System
    Intracranial Gland
    Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
    Hodgkin and non-Hodgkin Lymphoma
    Myeloma and Plasma Cell Disorders
    Other and Ill-Defined Primary Sites
    Unknown Primary Site

Codes:

Code Number	Code Description
00	No nodes were examined
01-89	1-89 nodes were examined (code the exact number of regional lymph nodes examined)
90	90 or more nodes were examined
95	No regional nodes were removed, but aspiration or core biopsy of regional nodes was performed (See rule 6)
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated (See rule 8)
97	Regional lymph node removal was documented as a dissection, and the number of

Regional Nodes Examined

Code Number	Code Description
	nodes is unknown/not stated (See rule 9)
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown (See rule 4E)
99	It is unknown whether nodes were examined; not applicable or negative; not stated in patient record

Regional Nodes Positive

Field Length: 2

Source of Standard: SEER/CoC

Description:

Records the exact number of regional nodes examined by the pathologist and found to contain metastases.

Coding Instructions:

1. **Regional lymph nodes only**: Record information about only regional lymph nodes in this field. Do not record information about distant lymph nodes in this field.

    A. Although all lymph node involvement (regional and distant) is coded in CS Lymph Nodes for Kaposi sarcoma, retinoblastoma and lymphoma ocular adnexa, only count positive regional lymph nodes in this field. Do not include distant nodes coded in CS Lymph Nodes. If CS Lymph Nodes is coded 300 (for KaposiSarcoma) or 800 (for Retinoblastoma or LymphomaOcularAdnexa), assume the involved nodes are regional and code the number positive in this field.

2. This field is **based on pathologic information only**. This field is to be recorded regardless of whether the patient received preoperative treatment.

3. Use the *AJCC Cancer Staging Manual* to identify regional lymph nodes for each primary site.

4. True in situ cases cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined). Codes 01-97 and 99 are not allowed.

5. **Cumulative nodes positive**: Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.

    A. The number of regional lymph nodes positive is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.

B. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection. In other words, if there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also Definition of Code 95 below.

   - Example: Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. *Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.*

   - Example: Positive right cervical lymph node aspiration followed by right cervical lymph node dissection showing 1 of 6 nodes positive. *Code Regional Nodes Positive as 01 and Regional Nodes Examined as 06.*

C. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Positive.

   - Example: Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. *Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.*

D. If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Positive.

   - Example: Patient record states that core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. *Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.*

6. **Priority of lymph node counts**: If there is a discrepancy regarding the number of positive lymph nodes, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.

7. **Positive Nodes in Multiple Primaries in Same Organ.** If there are multiple primary cancers with different histologic types in the same organ and the pathology report just states the number of nodes positive, the registrar should first try to determine the histology of the metastases in the nodes and code the nodes as positive for the primary with that histology. If no further information is available, code the nodes as positive for all primaries.

- Example: A breast cancer has two separate primaries as determined by the SEER multiple primary rules. The pathology report states "3 of 11 lymph nodes positive for metastasis" with no further information available. *Code Regional Nodes Positive as 03 and Regional Nodes Examined as 11 for both primaries.*

8. **Isolated tumor cells (ITCs) in lymph nodes**: For all primary sites except cutaneous melanoma and Merkel cell carcinoma of skin, count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size). Do not include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs). If the path report indicates that nodes are positive but the size of metastasis is not stated, assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive.

    a. **For cutaneous melanoma and Merkel cell carcinoma,** count nodes with ITCs as positive lymph nodes.

9. **Use of Code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

    A. Use code 95 when a positive lymph node is aspirated and there are no surgically resected lymph nodes.

    - Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. *Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.*

    B. Use code 95 when a positive lymph node is aspirated and surgically resected lymph nodes are negative.

    - Example: Lung cancer patient has aspiration of suspicious hilar mass, which shows metastatic squamous carcinoma in lymph node tissue. Patient undergoes preoperative radiation therapy followed by lobectomy showing 6 negative hilar lymph nodes. *Code Regional Nodes Positive as 95 and Regional Nodes Examined as the 06 nodes surgically resected. (Code Reg Nodes Eval as 5.)*

10. **Definition of code 97**: Use code 97 for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.

Regional Nodes Positive

- Example: Patient with carcinoma of the pyriform sinus has a mass in the mid neck. Fine needle aspiration (FNA) of one node is positive. The patient has neoadjuvant chemotherapy, then resection of the primary tumor and a radical neck dissection. In the radical neck dissection "several" of 10 nodes are positive; the remainder of the nodes show chemotherapy effect. *Code Regional Nodes Positive as 97 because the total number of positive nodes biopsied and removed is unknown, and code Regional Nodes Examined as 10.*

  - ✓ Note: For primary sites where the number of involved nodes must be known in order to map to N1, N2, etc., code 97 maps to N1 and therefore should be avoided.

  - ✓ Note: If the aspirated node is the only one that is microscopically positive, use code 95.

  - ✓ Note: Avoid using Regional Nodes Positive code 97 if possible, even if this means slightly undercounting the number of nodes positive.

11. **Use code 98**:

    A. When the assessment of lymph nodes is clinical only.

    B. When no lymph nodes are removed and examined.

    C. When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.

    D. If Regional Nodes Positive is coded as 98, Regional Nodes Examined is usually coded 00.

12. Use code 99 if it is unknown whether regional lymph nodes are positive.

13. For the following primary sites and histologies, the Regional Nodes Positive field is always coded as 99:

    Placenta
    Brain and Cerebral Meninges
    Other Parts of Central Nervous System
    Intracranial Gland
    Hodgkin and non-Hodgkin Lymphoma
    Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
    Myeloma and PlasmaCell Disorders

Regional Nodes Positive

Other and Ill-Defined Primary Sites
Unknown Primary Site

Codes:

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

Lymph-vascular Invasion

Field Length: 1

Source of Standard: AJCC

Description:

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

General Guidance:

- Lymph-vascular invasion is defined as the presence of tumor cells found inside small blood vessels or lymphatic channels within the tumor and surrounding tissues in the primary site. The tumor cells have broken free of the primary tumor and now have the capability to float throughout the body.

- Other names for lymph-vascular invasion are LVI, lymphovascular invasion, vascular invasion, blood vessel invasion, and lymphatic invasion.

- Lymphatic invasion is not the same as involvement of regional lymph nodes.

- Vascular invasion is not the same as direct tumor extension from the primary tumor into adjacent blood vessels; LVI cells are not attached to or growing into the wall of the blood vessel.

- Lymph-vascular invasion does not include perineural invasion.

Coding Instructions:

1. **Code from pathology report(s).** Code the absence or presence of lymph-vascular invasion as described in the medical record.

    A. The primary sources of information about lymph-vascular invasion are the 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 the pathology report or a physician's statement, in that order.

Lymph-vascular Invasion

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 lymph-vascular invasion is identified in any specimen, it should be coded as present/identified.

E. For cases with benign or borderline behavior, code the lymph-vascular invasion documented (negative or positive) and, if not documented, code unknown.

F. For cases treated with neoadjuvant therapy, refer to the table below in order to code this field. However, if documentation in the medical record indicates information that conflicts with this table, code lymph-vascular invasion with the documentation in the medical record.

LVI on pathology report PRIOR to neoadjuvant therapy	**LVI on pathology report AFTER neoadjuvant 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. A**ssign code 0 when the pathology report indicates that there is no lymph-vascular invasion**. This includes cases of **purely in situ** carcinoma, which biologically have no access to lymphatic or vascular channels below the basement membrane.

3. Assign code 1 when the pathology report or a physician's statement indicates that lymph-vascular invasion (or one of its synonyms) is present in the specimen.

4. **Assign code 8 for the following primary sites**:

Hodgkin and Non-Hodgkin lymphoma
Leukemias
Hematopoietic and reticuloendothelial disorders
Myelodysplastic syndromes including refractory anemias and refractory cytopenias
Myeloproliferative disorders

5. **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 lymph-vascular invasion is present.

   E. The pathologist indicates the specimen is insufficient to determine lymph-vascular invasion.

   F. Lymph-vascular invasion is not mentioned in the pathology report.

   G. Primary site is unknown.

6. **Clarification between codes 8 and 9**:

   A. Code 8 should only be used in the following situations:

      a. Standard-setter does not require this item and you are not collecting it.

      b. Those histologies noted above described in code 8 for which LVI is always not applicable.

   B. For those cases where there is no information/documentation from the pathology report or other sources, use code 9.

Codes:

Code Number	Code Description
0	Lymph-vascular Invasion stated as Not Present
1	Lymph-vascular Invasion Present/Identified
8	Not Applicable

Lymph-vascular Invasion

Code Number	Code Description
9	Unknown/Indeterminate/not mentioned in path report

Tumor Size Summary

Field Length: 3

Source of Standard: NPCR/CoC

Description:

Records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.

General Guidance:

- Tumor size should always be recorded in millimeters (mm).
- If the tumor size is stated in centimeters, convert the centimeter size to millimeters by multiplying the dimension by 10.
    - Examples:
      Mammogram shows 2.5 cm breast malignancy. Code as 025 (2.5 cm = 25 millimeters)
      CT of chest shows 4 cm mass in RUL. Code as 040 (4 cm = 40 mm)
      Thyroidectomy specimen yields 8 mm carcinoma. Code as 008
      Lumpectomy shows multiple microscopic foci, no size stated. Code as 990

Coding Instructions:

1. Record size in specified order:

    A. Size measured on the surgical resection specimen, when surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered.

        a. If there is a discrepancy among tumor size measurements in the various section of the pathology report, code the size from the synoptic report (also known as the CAP protocol or pathology report checklist). If the synoptic report is not available, use the: final diagnosis section of the report, microscopic section, or gross examination, in that order.

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

- Example: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. Record tumor size as 032 (32 mm).

2. If the patient had neoadjuvant therapy prior to surgery, do not record the size of the tumor from the pathologic specimen taken after the neoadjuvant therapy. Code the largest size of tumor prior to neoadjuvant treatment; if the size is unknown prior to the neoadjuvant therapy, code the size as 999 (unknown).

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

   - Example: Patient has a 5 cm mass in the right breast per mammogram. Core needle biopsy of the mass shows ductal carcinoma. Patient receives a course of neoadjuvant chemotherapy followed by a radical mastectomy. The tumor size from the mastectomy is 1.5 cm. Record the tumor size as 050 (50 mm).

3. If no surgical resection, record the largest measurement of the tumor from the physical exam, imaging, or other diagnostic procedures prior to any other form of treatment (See additional guidance below).

4. If 1, 2, and 3 above do not apply, record the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

5. Tumor size is the diameter of the tumor, not the depth or thickness of the tumor.

6. Recording tumor size from less than/greater than statements:

   A. If tumor size is reported as less than X mm or less than X cm, the reported tumor size should be 1 mm less: for example if size is < 10 mm, code size as 009. Often these are given in cm such as < 1 cm which is coded as 009, <2 cm is coded 019, <3 cm is coded as 029, <4 cm is coded as 039, <5 cm is coded as 049. If stated as less than 1 mm, use code 001.

   B. If tumor size is reported as more than X mm or more than X cm, code size as 1 mm more; for example if size is > 10 mm, size should be coded as 011. Often these are given in cm such as >1 cm, which is coded as 011, >2 cm is coded as 021, >3 cm is coded as

031, >4 cm is coded as 041, >5 cm is coded as 051. If described as anything greater than 989 mm (98.9 cm) code as 989.

C. If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two: i.e., add the two sizes together and then divide by two ("between 2 and 3 cm" is coded as 025).

7. Rounding: Round the tumor size only if it is described in fractions of millimeters. If the largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm), record size as 001 (do not round down to 000). If tumor size is greater than 1 millimeter, round tenths of millimeters in the 1-4 range down to the nearest whole millimeter, and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. Do not round tumor size expressed in centimeters to the nearest whole centimeter (rather, move the decimal point one space to the right, converting the measurement to millimeters.)

   - Examples:

     Breast cancer described as 6.5 millimeters in size. Round up to 007.
     Cancer in polyp described as 2.3 millimeters in size. Round down to 002.
     Focus of cancer described as 1.4 mm in size.
     Round down to 001.5.2 mm breast cancer. Round down to 005.

8. Priority of imaging/radiographic techniques: Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, it should be taken as low priority, but over a physical exam.

9. Tumor size discrepancies among imaging and radiographic reports: If there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies which imaging is most accurate, record the largest size in the record, regardless of which imaging technique reports it.

10. Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis. However, if the tumor is described as a "cystic mass", and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

11. Record the size of the invasive component, if given.

    A. If both an in-situ and an invasive component are present and the invasive component is measured, record the size of the invasive component even if it is smaller.

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

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

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

- Example: Duct carcinoma in-situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (19 mm).

12. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

    - Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).

13. Record the size as stated for purely in-situ lesions.

14. Disregard microscopic residual or positive surgical margins when coding tumor size. Microscopic residual tumor does not affect overall tumor size.

15. Do not add the size of pieces or chips together to create a whole; they may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size. If the only measurement describes pieces or chips, record tumor size as 999.

16. Multifocal/multicentric tumors: If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor or if all of the tumors are in-situ, code size of the largest in-situ tumor.

17. Tumor size code 999 is used when size is unknown or not applicable. Site/morphologies where tumor size is not applicable are listed below.

    - Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms: histology codes 9590-9992
    - Kaposi Sarcoma
    - Melanoma Choroid
    - Melanoma Ciliary Body
    - Melanoma Iris
    - Unknown primary site

Tumor Size Summary

18. The TCR requires documentation in the text fields supporting the code selected for the tumor size and the source used to identify the size.

    - Example: 5/2/2012 Mammogram: 5.1 cm tumor upper outer quadrant rt. breast.

Codes:

Code Number	Description
000	No mass/tumor found
001	1 mm or described as less than 1 mm (0.1 cm or less than 0.1 cm)
002-988	Exact size in millimeters (2 mm to 988 mm) (0.2 cm to 98.8 cm)
989	989 millimeters or larger (98.9 cm or larger)
990	Microscopic focus or foci only and no size of focus is given
998	Alternate descriptions of tumor size for specific sites: • Familial/multiple polyposis: ∗ Rectosigmoid and rectum (C19.9, C20.9) ∗ Colon (C18.0, C18.2-C18.9) If no size is documented: • Circumferential: ∗ Esophagus (C15.0-C15.5, C15.8-C15.9) • Diffuse; widespread: 3/4s or more; linitis plastica: ∗ Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9) • Diffuse, entire lung or NOS: ∗ Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9) • Diffuse: ∗ Breast (C50.0-C50.6, C50.8-C50.9)
999	Unknown; size not stated Not documented in patient record Size of tumor cannot be assessed Not applicable

SEER Summary Stage 2000

Field Length: 1

Source of Standard: SEER

Description:

Code for summary stage at the initial diagnosis or treatment of the reportable tumor.

General Guidance:

- **Summary Staging** is the most basic way of categorizing how far a cancer has spread from its point of origin. Summary staging has also been called General Staging, California Staging, and SEER Staging. The 2000 version of Summary Stage applies to every anatomic site, including lymphomas and leukemias. Summary staging uses all information available in the medical record; in other words, it is a combination of the most precise clinical and pathological documentation of the extent of disease.

- For each site, summary stage is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are particularly important when all malignant tissue is not removed. In the event of a discrepancy between pathology and operative reports concerning excised tissue, priority is given to the pathology report.

- Summary stage should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

- Summary stage information obtained after treatment with radiotherapy, chemotherapy, hormonal therapy, or immunotherapy has begun may be included unless it is beyond the time frame given in the note above.

- Exclude any metastasis known to have developed after the diagnosis was established.

- Clinical information, such as description of skin involvement for breast cancer and distant lymph nodes for any site, can change the stage. Be sure to review the clinical information carefully to assure accurate summary stage. If the operative/pathology information disproves the clinical information, code the operative/pathology information.

- All schemes apply to all histologies unless otherwise noted. Exceptions to this, for example, include all lymphomas and Kaposi sarcoma which should be staged using the histology schemes regardless of the primary site.

SEER Summary Stage 2000

- Autopsy reports are used in coding summary stage just as are pathology reports, applying the same rules for inclusion and exclusion.

- DCO cases and unknown primaries are coded '9' for summary stage.

- The summary stage may be described only in terms of T (tumor), N (node) and M (metastasis) characteristics. In such cases, record the summary stage code that corresponds to the TNM information. If there is a discrepancy between documentation in the medical record and the physician's assignment of TNM, the documentation takes precedence. Cases of this type should be discussed with the physician who assigned TNM.

    - ✓ Note: The *SEER Summary Stage 2000 Manual* was published when the 5th Edition of the *AJCC Staging Manual* was in use. Currently, the 7th Edition of the *AJCC Staging Manual* is being used. Some of the values have changed between the versions. Abstractors should determine the current meaning of the TNM values and select the appropriate summary stage based on that information. Some schema, such as bladder and prostate, list TNM values within the stage descriptions. These values were based on the 5th Edition of the *AJCC Staging Manual* and may NOT be the same as the 7th Edition *AJCC Staging Manual* values. The National Program of Cancer Registries advises abstractors to ignore the TNM values listed in the *SEER Summary Stage 2000 Manual* and base the selection of the stage on the meaning of the current TNM values. These issues will be resolved with the upcoming revision of the SEER Summary Stage Manual.

- The FIGO stages listed in the *SEER Summary Stage 2000 Manual* are not current and may not be used. The National Program of Cancer Registries advises abstractors to ignore the FIGO values listed in the *SEER Summary Stage 2000 Manual* and base the selection of the stage on the meaning of the current FIGO values. These issues will be resolved with the upcoming revision of the SEER Summary Stage Manual.

- **Site-specific guidelines take precedence over general guidelines. Always consider information pertaining to a specific site.**

- Use this data field to code the SEER Summary Staging on cases diagnosed 01/01/2001 – 12/31/2003 & 1/1/2015 onward. This data field **cannot** be left blank if the diagnosis date falls within these date ranges.

- Use code 8 for benign and borderline brain/CNS tumors.

- The TCR requires documentation in the text fields supporting the code used in this data field.

- ***<u>There are five main categories in summary stage, each of which is discussed in detail at the end of this section. In addition, the regional stage is subcategorized by the method of spread. The code structure & guidelines by stage are:</u>***

<u>Definitions of Adjacent Tissues, Structures, and Organs:</u>

Adjacent connective tissue:
Some of the summary staging schemas for ill-defined or non-specific sites in the *SEER Summary Staging Manual 2000* contain a code for adjacent connective tissue, which is defined here as the unnamed tissues that immediately surround an organ or structure containing a primary cancer. Use this code when a tumor has invaded past the outer border (capsule, serosa, or other edge) of the primary organ into the organ's surrounding supportive structures but has not invaded into larger structures or adjacent organs.

The structures identified in ICD-O-3 as connective tissue include the following: adipose tissue; aponeuroses; arteries; blood vessels; bursa; connective tissue, NOS; fascia; fatty tissue; fibrous tissue; ganglia; ligaments; lymphatic vessels or channels (not nodes); muscle; nerves (spinal, sympathetic and peripheral); skeletal muscle; subcutaneous tissue; synovia; tendons; tendon sheaths; veins; and vessels, NOS. In general, these tissues do not have specific names. These tissues form the framework of many organs, provide support to hold organs in place, bind tissues and organs together, and serve as storage sites for nutrients. Blood, cartilage and bone are sometimes considered connective tissues, but in this manual they would be listed separately.

Adjacent organs:
Organs are anatomic structures with specific physiologic functions other than (or in addition to) support and storage. In general, continuous tumor growth from one organ into an organ lying next to the primary site would be coded as '2-Regional by direct extension only' (unless regional lymph nodes are also involved).

Adjacent structures:
Connective tissues large enough to be given a specific name would be considered adjacent structures. For example, the brachial artery has a name, as does the broad ligament. In general, continuous tumor growth from one organ into an adjacent named structure would be coded to '2-Regional by direct extension only' (unless regional lymph nodes were also involved).

Cortex (adjective: cortical):
The external or outer surface layer of an organ, as distinguished from the core, or medulla, of the organ. In some organs, such as the adrenal glands, the cortex has a different function than the medulla.

Medulla (adjective: medullary):
The central portion of an organ, in contrast to the outer layer or cortex. Sometimes call marrow. In some organs, such as bone, the medulla or marrow has a different physiologic role than the cortex.

Parenchyma:

The parenchyma is the functional portion of an organ, in contrast to its framework or stroma. For example, the parenchyma of the kidney contains all of the structures which filter and remove waste products from the blood. In general, malignancies tend to arise in the parenchyma of an organ.

Stroma:

The stroma is the cells and tissues that support, store nutrients, and maintain viability within an organ. Stroma consists of connective tissue, vessels and nerves, and provides the framework of an organ. In general, spread of tumor to the stroma of an organ is still considered localized or confined to the organ of origin.

Ambiguous Terminology:

Interpreting Ambiguous Terminology for Summary Stage:

- ✓ Note: This is not the same list published in the Reportability section of this manual.

Consider as involvement:	***DO NOT Consider as Involvement:***
adherent	abuts
apparent(ly)	approaching
appears to	approximates
comparable with	attached
compatible with	cannot be excluded/ruled out
consistent with	efface/effacing/effacement
contiguous/continuous with	encased/encasing
encroaching upon*	encompass(ed)
extension to, into, onto, out onto	entrapped
features of	equivocal
fixation to a structure other than primary**	extension to without invasion/involvement of
fixed to another structure**	kiss/kissing
impending perforation of	matted (except for lymph nodes)
impinging upon	possible
impose/imposing on	questionable
incipient invasion	reaching
induration	rule out
infringe/infringing	suggests
into*	very close to
intrude	worrisome
invasion to into, onto, out onto	
most likely	
onto*	
overstep	
presumed	
probable	
protruding into (unless encapsulated)	
suspected	
suspicious	
to*	
up to	

SEER Summary Stage 2000

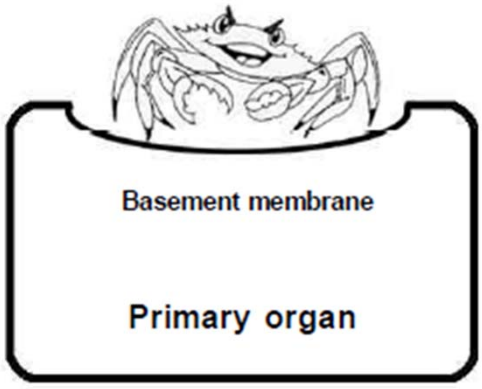
* interpreted as involvement whether the description is clinical or operative/pathological

** interpreted as involvement of other organ or tissue

In situ (code = 0)

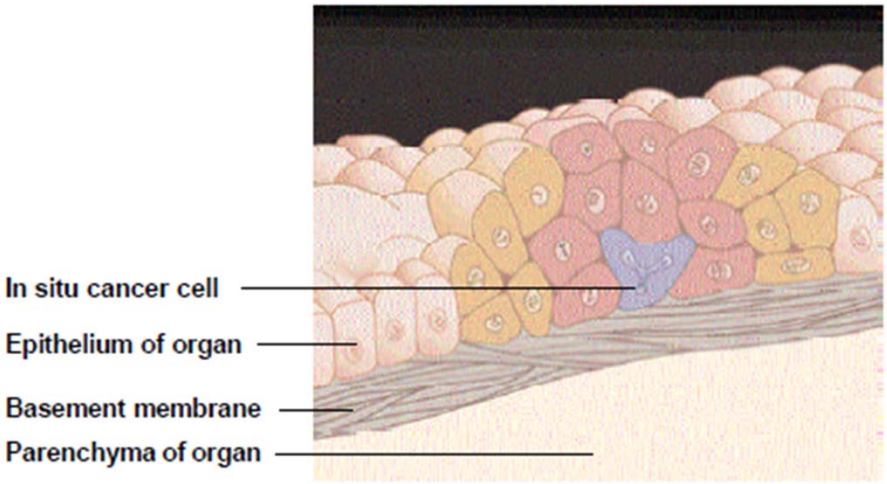
In situ means “in place.” The technical definition of in situ is the presence of malignant cells within the cell group from which they arose. There is no penetration of the basement membrane of the tissue and no stromal invasion. Generally, a cancer begins in the rapidly dividing cells of the epithelium or lining of an organ and grows from the inside to the outside of the organ. An in situ cancer fulfills all pathologic criteria for malignancy except that it has not invaded the supporting structure of organ on which it arose.

An in situ diagnosis can only be made microscopically, because a pathologist must identify the basement membrane and determine that it has not been penetrated. If the basement membrane has been disrupted (in other words, the pathologist describes the tumor as microinvasive), the case is no longer in situ and is at least localized. Pathologists have many ways of describing in situ cancer, such as non-invasive, pre-invasive, non-infiltrating, intra-epithelial, Stage 0, intraductal, intracystic, no stromal invasion, and no penetration below the basement membrane. Organs and tissues that have no epithelial layer cannot be staged as in situ, since they do not have a basement membrane. Therefore, there cannot be a diagnosis of “sarcoma in situ.”



In situ Stage

A more scientific illustration of an in situ tumor is shown here.



In situ tumor

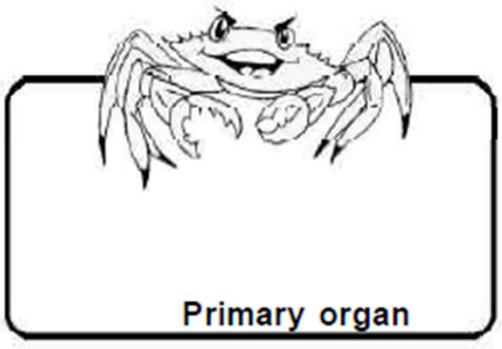
Source: Adapted from an illustration by Brian Shellito of *Scientific American*, as printed in *Cancer in Michigan, The Detroit News*, Nov. 1-2, 1998.

Localized (code = 1)

A localized cancer is a malignancy limited to the organ of origin; it has spread no farther than the organ in which it started. There is infiltration past the basement membrane of the epithelium into the functional part of the organ, but there is no spread beyond the boundaries of the organ. A tumor can be widely invasive or even show metastases within the organ itself and still be considered "confined to organ of origin" or localized in summary stage.

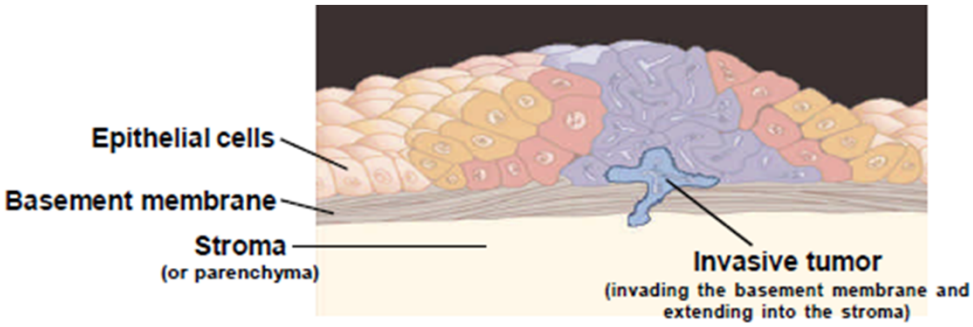
For organs that have definite boundaries (such as prostate, testis, or stomach) or sites where there is a clear line between the organ of origin and the surrounding region (such as breast or bladder), it is usually straightforward to determine whether the cancer is localized. An exception is skin, because it is sometimes difficult to determine where the dermis ends and subcutaneous tissue begins. For most internal organs, it is not possible to determine whether tumor is localized without exploratory surgery. However, the increasing sophistication of many imaging techniques is predicted to eventually make exploratory surgery obsolete.

It is important to know and recognize the names of different structures within the organ (such as lamina propria, myometrium, muscularis) so that a description of invasion or involvement of these structures will not be interpreted as regional spread.



Localized Stage

Because summary stage uses both clinical and pathologic information, it is important to read the pathology and operative report(s) for comments on gross evidence of spread, microscopic extension and metastases, as well as diagnostic imaging reports for mention of distant disease. If any of these reports provides evidence that the cancer has spread beyond the boundaries of the organ of origin, the case is not localized. On the other hand, if the pathology report, operative report and other investigations show no evidence of spread, the tumor may be assumed to be localized. The following illustration shows a tumor that has invaded past the basement membrane below the surface epithelium of the organ into the parenchyma or stroma.



Localized tumor

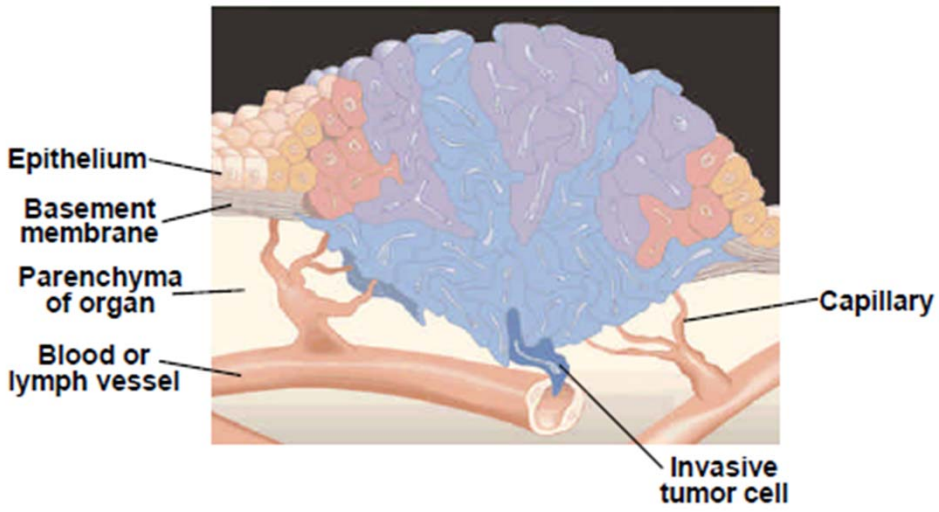
Source: Adapted from an illustration by Brian Shellito of *Scientific American*, as printed in *Cancer in Michigan, The Detroit News*, Nov. 1-2, 1998.

Regional (code = 2-5)

Regional stage is perhaps the broadest category as well as the most difficult to properly identify. The brief definition of regional stage is tumor extension beyond the limits of the organ of origin. Although the boundary between localized and regional tumor extension is usually well-identified, the boundary between regional and distant spread is not always clear and can be defined differently by physicians in various specialities.

Cancer becomes regional when there is the potential for spread by more than one lymphatic or vascular supply route. For example, the tumor in the hepatic flexure of the colon with extension along the lumen to the ascending colon is staged as localized because both areas drain to same lymph nodes. On the other hand, a sigmoid tumor extending into the rectum is staged as regional because the tumor now has potential for the tumor cell drainage to both iliac and mesenteric nodes.

The formal (scientific) definition used by surgeons is that area extending from the periphery of an involved organ that lends itself to removal en bloc with a portion of— or an entire— organ with outer limits to include at least the first level nodal basin. However, en bloc resection (removal of multiple organs or tissues in one piece at the same time) is not always feasible or may have been shown not to be necessary. For example, a number of clinical trials have shown that lumpectomy or modified radical mastectomy has equivalent survival to the very disfiguring radical mastectomy for treatment of breast cancer. In contrast, radiation oncologists define the term regional as including any organs or tissues encompassed in the radiation field used to treat the primary site and regional lymph nodes.



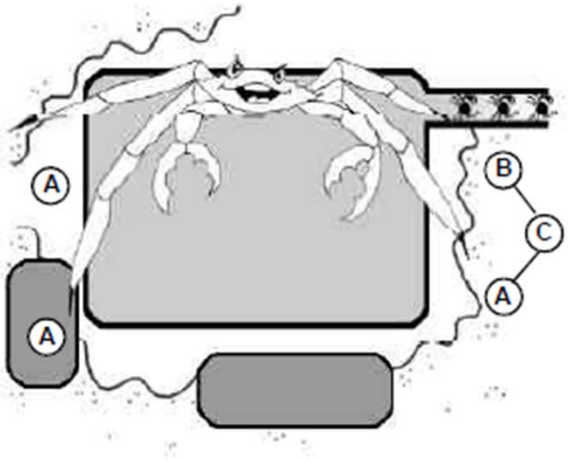
Invasive tumor

Source: Adapted from an illustration by Brian Shellito of *Scientific American*, as printed in *Cancer in Michigan, The Detroit News*, Nov. 1-2, 1998.

Regional stage has several subcategories, each of which is described in detail below.

Code Definition

2 Regional by direct extension only
3 Regional lymph nodes involved only
4 Regional by BOTH direct extension AND lymph node involvement
5 Regional, NOS (Not Otherwise Specified)



Regional Stages
A. Direct extension
B. To regional lymph nodes
C. Combination of A and B

These codes and subcategories describe different methods of regional spread of tumor:

A. Invasion through entire wall of organ into surrounding organs and/or adjacent tissues (code 2, regional by direct extension or contiguous spread)
B. Tumor invasion of walls of lymphatics where cells can travel through lymphatic vessels to nearby lymph nodes where they are "filtered" out and begin to grow in the nodes (code 3, regional to lymph nodes)
C. A combination of direct extension and lymph node involvement (code 4, regional by direct extension and to regional nodes)

A fourth category of regional stage is code 5, regional not otherwise specified. This category may be used when it is unclear whether the tissues are involved by direct extension or lymph nodes, or when the other categories are not applicable, such as for staging Non-Hodgkin and Hodgkin lymphoma of more than one lymph node chain.

Clinicians may use some terms differently than cancer registrars. Therefore, it is important to understand the words used to describe the spread of the cancer and how they are used in staging. For example:

1) "Local" as in "carcinoma of the stomach with involvement of the local lymph nodes." Local nodes are the first group of nodes to drain the primary. Unless evidence of distant spread is present, such a case should be staged as regional, not local.

2) "Metastases" as in "carcinoma of lung with peribronchial lymph node metastases." Metastases in this sense means involvement by tumor. Such a case would still be regional. Learn the names of regional nodes for each primary site.

Regional Lymph Node Involvement

Regional lymph nodes are listed for each site.

1. Consider the farthest specific lymph node chain that is involved by tumor.

2. For lymphomas, any mention of lymph nodes is indicative of involvement and is used to determine the number and location of lymph node chains involved (see lymphoma scheme).

3. For solid tumors, the terms “fixed” or “matted” and “mass in the mediastinum, retroperitoneum, and/or mesentery” (with no specific information as to tissue involved) are considered involvement of lymph nodes.

4. Terms such as “palpable”, “visible swelling”, and “shotty” should be ignored. Look for a statement of involvement, either clinical or pathological. The terms “enlarged” and “lymphadenopathy” should be ignored for all sites except lung. For lung primaries, these terms are interpreted as regional lymph node involvement.

5. The terms “homolateral” and “ipsilateral” are used interchangeably. Any unidentified nodes included with the resected primary site specimen are to be considered as “Regional Lymph Nodes, NOS.”

6. If the only indication of lymph node involvement in the record is the physician’s statement of an N category from the TNM staging system or a stage from a site-specific staging system, such as Dukes’ C, consider that information in considering regional lymph node involvement.

7. If there is a discrepancy between documentation in the medical record and the physician’s assignment of TNM, the documentation takes precedence. Cases of this type should be discussed with the physician who assigned the TNM.

8. If a specific chain of lymph nodes is named, but not listed as regional, first determine if the name is synonymous with a listed lymph node. Otherwise, assume distant lymph node(s) are involved.

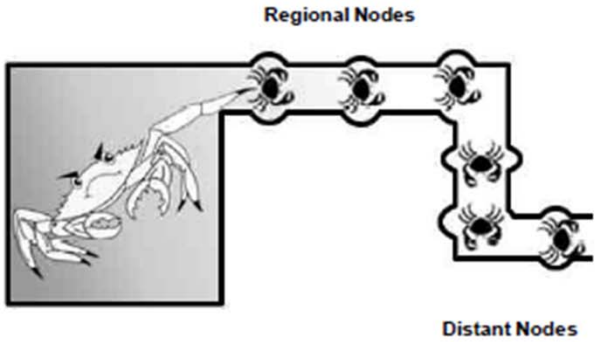
Note: Regional lymph nodes are not palpable for inaccessible sites such as bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri and ovary. The best description concerning regional lymph nodes will be the surgeon’s evaluation at the time of exploratory surgery or definitive surgery.

Distant (code = 7)

Distant metastases are tumor cells that have broken away from the primary tumor, have travelled to other parts of the body, and have begun to grow at the new location. Distant stage is also called remote, diffuse, disseminated, metastatic, or secondary disease. The point is that in most cases there is no continuous trail of tumor cells between the primary site and the distant site. Cancer cells can travel from the primary site in any of four ways:

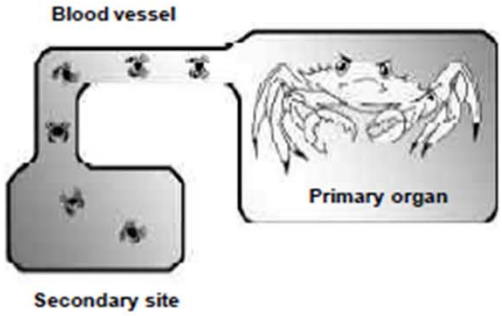
1) Extension from primary organ beyond adjacent tissue into next organ; for example, from the lung through the pleura into bone or nerve.

2) Travel in lymph channels beyond the first (regional) drainage area. Tumor cells can be filtered, trapped and begin to grow in any lymph nodes in the body.



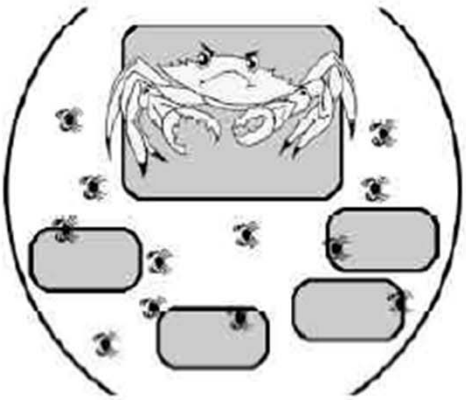
Distant lymph node involvement

3) Hematogenous or blood-borne metastases. Invasion of blood vessels within the primary tumor (veins are more susceptible to invasion than thicker-walled arteries) allows escape of tumor cells or tumor emboli which are transported through the blood stream to another part of the body where it lodges in a capillary or arteriole. At that point the tumor penetrates the vessel wall and grows back into the surrounding tissue. (Please see the scientific illustration on the next page.)



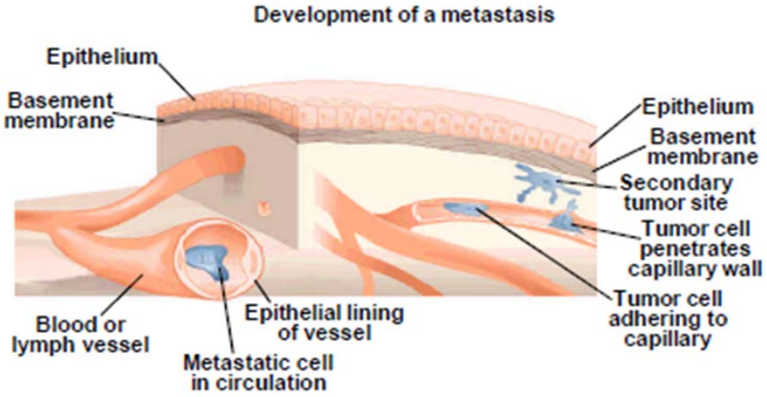
Blood-borne metastases

4) Spread through fluids in a body cavity. Example: malignant cells rupture the surface of the primary tumor and are released into the thoracic or peritoneal cavity. They float in the fluid and can land on and begin to grow on any tissue reached by the fluid. This type of spread is also called implantation or seeding metastases. Some tumors form large quantities of fluid called ascites that can be removed, but the fluid rapidly re-accumulates. However, the presence of fluid or ascites does not automatically indicate dissemination. There must be cytologic evidence of malignant cells.


Implantation metastases

Common sites of distant spread are liver, lung, brain, and bones, but they are not listed specifically for each scheme. These organs receive blood flow from all parts of body and thus are a target for distant metastases. However, if the primary site is adjacent to the liver, lung, brain or bone, it is important to review the summary staging scheme for the primary site to assure that the stage is not regional by direct extension. An example would be liver involvement from a primary in the gallbladder. It is likely that this is regional by direct extension rather than distant stage, since the gallbladder is adjacent to liver. Read the diagnostic imaging reports to determine whether the cancer involves the surface of the secondary organ, which would be regional by direct extension, or whether the cancer is inside the secondary organ. If the latter is the case, the only way it could have developed in the secondary organ is if the tumor cells arrived there via the blood stream (distant hematogenous metastases). Another way to remember the difference between regional direct extension and distant metastases is whether the secondary site has tumor ***on*** the surface (most likely direct extension) or ***in*** the organ (blood-borne metastases). Hematopoietic, reticuloendothelial, immunoproliferative, and myeloproliferative neoplasms are considered distant except as noted in the staging scheme.

In the last of the series of scientific drawings, the cancer cell that invaded the blood vessel has floated to a new organ. As the blood vessels in the secondary site get smaller, the cancer cell has the ability to penetrate the capillary wall and settle in the new organ. The growth of tumor in the new organ is called a metastasis.



Source: Adapted from an illustration by Brian Shellito of *Scientific American*, as printed in *Cancer in Michigan, The Detroit News*, Nov. 1-2, 1998.

Unknown if Extension or Metastasis (code = 9)

If the primary site is unknown (C80.9), then the summary stage must be unknown.

There will be cases for which sufficient evidence is not available to adequately assign a stage. Examples include occasions when the patient expires before workup is completed, when a patient refuses a diagnostic or treatment procedure, and when there is limited workup due to the patient's age or a simultaneous contraindicating condition. If sufficient information does not exist, the case is unstageable.

This code should be assigned very sparingly. If at all possible, contact the physician to see if there is more information about the case which is not in the record, such as diagnostic studies performed prior to admission or documentation in the physician's office record.

Death certificate only cases are coded to '9', unknown.

SEER Summary Stage 2000

Codes:

Code Number	Code Description
0	In situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant
8	Not applicable
9	Unstaged

Mets at Dx-Bone

Field Length: 1

Source of Standard: SEER

Description:

Identifies whether bone is an involved metastatic site.

Coding Instructions:

1. Code information about bone metastases only (discontinuous or distant metastases to bone) identified at the time of diagnosis. Do not code bone marrow involvement in this data field.

✓ Note: Bone marrow involvement is coded in the Mets at Dx-Other field.

   A. Bone involvement may be single or multiple

   B. Information about bone involvement may be clinical or pathologic

   C. Code this field whether or not the patient had any neoadjuvant (preoperative) systemic therapy.

   D. Code this field for all solid tumors, Kaposi sarcoma, Lymphomas, Unknown Primary Site, and Other and Ill-Defined Primary Sites

      a. Code this field for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837) (All sites)

2. Assign the code that best describes whether the case has bone metastases at diagnosis.

   A. Use code 0 when the medical record:

      a. Indicates that there are no distant (discontinuous) metastases at all

      b. Includes a clinical or pathologic statement that there are no bone metastases

c. Includes imaging reports that are negative for bone metastases

d. Indicates that the patient has distant (discontinuous) metastases but bone is not mentioned as an involved site

- Example: Use code 0 when the patient has lung and liver metastases but not bone.

B. Use code 1 when the medical record:

a. Indicates that the patient has distant (discontinuous) metastases and bone is mentioned as an involved site

b. Indicates that bone is the primary site and there are metastases in a different bone or bones

✓ Note: Do not assign code 1 for a bone primary with multifocal bone involvement of the same bone.

c. Indicates that the patient is diagnosed as an unknown primary (C80.9) and bone is mentioned as a distant metastatic site

C. Use code 8 (Not applicable) for the following site/histology combination for which distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

D. Use code 9 when it cannot be determined whether the patient specifically has bone metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include bone.

E. The TCR requires documentation in the text field supporting the code selected for this field and the source used to identify metastatic involvement (or lack of involvement) of the bone.

Mets at Dx-Bone

- 09/02/2016 Bilateral hip scan- Positive for metastatic disease.
- 07/05/2016 Bone scan- No metastatic lesions noted.

Codes:

Code	Description
0	None; No bone metastases
1	Yes; Distant bone metastases
8	Not applicable
9	Unknown whether bone is an involved metastatic site Not documented in patient record

Mets at Dx-Brain

Field Length: 1

Source of Standard: SEER

Description:

Identifies whether brain is an involved metastatic site.

Coding Instructions:

1. Code information about brain metastases only (discontinuous or distant metastases to brain) identified at the time of diagnosis. Do not code involvement of spinal cord or other parts of the central nervous system in this data field.

✓ Note: Spinal cord or other parts of the central nervous system metastases is coded in the Mets at Dx-Other field.

   A. Brain involvement may be single or multiple

   B. Information about brain involvement may be clinical or pathologic

   C. Code this field whether or not the patient had any neoadjuvant (preoperative) systemic therapy

   D. This field should be coded for all solid tumors, Kaposi sarcoma, Lymphomas, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

      a. Code this field for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837) (All sites)

2. Assign the code that best describes whether the case has brain metastases at diagnosis.

   A. Use code 0 when the medical record:

      a. Indicates that there are no distant (discontinuous) metastases at all

      b. Includes a clinical or pathologic statement that there are no brain metastases

c. Includes imaging reports that are negative for brain metastases

d. Indicates that the patient has distant (discontinuous) metastases but brain is not mentioned as an involved site.

- Example: Use code 0 when the patient has lung and liver metastases but not brain.

B. Use code 1 when the medical record:

a. Indicates that the patient has distant (discontinuous) metastases and brain is mentioned as an involved site

b. Indicates the patient is diagnosed as an unknown primary (C80.9) and brain is mentioned as a distant metastatic site

C. Use code 8 (Not applicable) for the following site/histology combination for which distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

D. Use code 9 when it cannot be determined whether the patient specifically has brain metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include brain.

3. The TCR requires documentation in the text field supporting the code selected for this field and the source used to identify metastatic involvement (or lack of involvement) of the brain.

- Example: 11/03/2016 CT of brain- Multiple metastatic lesions in the temporal lobe.

- Example: 07/05/2016 Brain scan negative.

Mets at Dx-Brain

Codes:

Code	Description
0	None; No brain metastases
1	Yes; Distant brain metastases
8	Not applicable
9	Unknown whether brain is an involved metastatic site Not documented in patient record

Mets at Dx-Liver

Field Length: 1

Source of Standard: SEER

Description:

Identifies whether liver is an involved metastatic site.

Coding Instructions:

1. Code information about liver metastases only (discontinuous or distant metastases to liver) identified at the time of diagnosis.
    A. Liver involvement may be single or multiple
    B. Information about liver involvement may be clinical or pathologic
    C. Code this field whether or not the patient had any neoadjuvant (preoperative) systemic therapy
    D. This field should be coded for all solid tumors, Kaposi sarcoma, Lymphomas, Unknown Primary Site, and Other and Ill-Defined Primary Sites
        a. Code this field for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837) (All sites)
2. Assign the code that best describes whether the case has liver metastases at diagnosis.
    A. Use code 0 when the medical record:
        a. Indicates that there are no distant (discontinuous) metastases at all
        b. Includes a clinical or pathologic statement that there are no liver metastases
        c. Includes imaging reports that are negative for liver metastases

d. Indicates that the patient has distant (discontinuous) metastases but liver is not mentioned as an involved site

- Example: Use code 0 when the patient has lung and brain metastases but not liver.

B. Use code 1 when the medical record:

a. Indicates that the patient has distant (discontinuous) metastases and liver is mentioned as an involved site

b. Indicates that the patient is diagnosed as an unknown primary (C80.9) and liver is mentioned as a distant metastatic site

C. Use code 8 (Not applicable) for the following site/histology combination for which distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

D. Use code 9 when it cannot be determined whether the patient specifically has liver metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include liver.

3. The TCR requires documentation in the text field supporting the code selected for this field and the source used to identify metastatic involvement (or lack of involvement) of the liver.

- Example: 2/5/2016- Abdominal xray findings- Multiple metastatic liver lesions.

- Example: 07/05/2016 Abdominal MRI- normal

Codes:

Code	Description
0	None; No liver metastases
1	Yes; Distant liver metastases
8	Not applicable

Mets at Dx-Liver

9	Unknown whether liver is an involved metastatic site Not documented in patient record

Mets at Dx-Lung

Field Length: 1

Source of Standard: SEER

Description:

Identifies whether lung is an involved metastatic site.

Coding Instructions:

1. Code information about lung metastases only (discontinuous or distant metastases to lung) identified at the time of diagnosis. Do not code pleural or pleural fluid involvement in this data field.

✓ Note: Pleural nodules, malignant pleural or pericardial effusion are coded in the Mets at Dx-Other field.

   A. Lung involvement may be single or multiple

   B. Information about lung involvement may be clinical or pathologic

   C. Code this field whether or not the patient had any neoadjuvant (preoperative) systemic therapy.

   D. This field should be coded for all solid tumors, Kaposi sarcoma, Lymphomas, Unknown Primary Site, and Other and Ill-Defined Primary Sites

      a. Code this field for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837) (All sites)

2. Assign the code that best describes whether the case has lung metastases at diagnosis.

   A. Use code 0 when the medical record:

      a. Indicates that there are no distant (discontinuous) metastases at all

      b. Includes a clinical or pathologic statement that there are no lung metastases

c. Includes imaging reports that are negative for lung metastases

d. Indicates that the patient has distant (discontinuous) metastases but lung is not mentioned as an involved site

- Example: Use code 0 when the patient has liver and brain metastases but not lung.

B. Use code 1 when the medical record:

a. Indicates that the patient has distant (discontinuous) metastases and lung is mentioned as an involved site

b. Indicates that lung is the primary site and there are metastases in the contralateral lung

- ✓ Note: Do not assign code 1 for a lung primary with multifocal involvement of the same lung

c. Indicates that the patient is diagnosed as an unknown primary (C80.9) and lung is mentioned as a distant metastatic site

C. Use code 8 (Not applicable) for the following site/histology combination for which distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

D. Use code 9 when it cannot be determined whether the patient specifically has lung metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include lung.

Mets at Dx-Lung

3. The TCR requires documentation in the text field supporting the code selected for this field and the source used to identify metastatic involvement (or lack of involvement) of the lung.

    - Example: 7/4/2016- Chest xray- Multiple tumors right lung consistent with mets.

    - Example: 11/5/2016- Chest xray- No mets

Codes:

Code	Description
0	None; No lung metastases
1	Yes; Distant lung metastases
8	Not applicable
9	Unknown whether lung is an involved metastatic site Not documented in patient record

Mets at Dx-Other

Field Length: 1

Source of Standard: SEER

Description:

Identifies any type of distant involvement not captured in the Mets at Dx-Bone, Mets at Dx-Brain, Mets at Dx-Liver, Mets at Dx-Lung, and Mets at Dx-Distant Lymph Nodes fields. It includes involvement of other specific sites and more generalized metastases such as carcinomatosis. Some examples include but are not limited to the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum, and skin.

Coding Instructions:

1. Code information about other metastases only (discontinuous or distant metastases) identified at the time of diagnosis. This field should not be coded for bone, brain, liver, lung or distant lymph node metastases.

    A. Other involvement may be single or multiple

    B. Information about other involvement may be clinical or pathologic

    C. Code this field whether or not the patient had any neoadjuvant (preoperative) systemic therapy.

    D. Code this field for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Site

        a. Code this field for Lymphomas (9590-9699, 9702-9727, 9735, 9737- 9738, 9811-9818, 9823, 9827, 9837) (All sites)

2. Assign the code that best describes whether the case has other metastases at diagnosis.

    A. Use code 0 when the medical record:

        a. Indicates that there are no distant (discontinuous) metastases at all

b. Includes a clinical or pathologic statement that there are no other metastases

c. Includes imaging reports that are negative for other metastases

d. Indicates that the patient has distant (discontinuous) metastases but other sites are not mentioned as involved

- Example: Use code 0 when the patient has lung and liver metastases only

B. Use code 1 when the medical record indicates:

a. The patient has distant (discontinuous) metastases in any site(s) other than bone, brain, liver, lung or distant lymph node(s)

i. Includes, but not limited to, the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum and skin

b. Lymphomas with bone marrow involvement (Stage IV disease)

- ✓ Note: Does not include lymphomas/leukemias where primary site is C421 (bone marrow)

C. Use code 2 when the medical record indicates

a. The patient has carcinomatosis

i. Carcinomatosis is a condition in which cancer is spread widely throughout the body, or, in some cases, to a relatively large region of the body.

- ✓ Note: It is possible to have metastatic disease to a specific organ AND also have carcinomatosis. If a patient has metastatic disease to bone, brain, liver, lung or distant nodes AND carcinomatosis, use code 1 for the appropriate field (bone, brain, liver, lung, or distant nodes) and use code 2 for carcinomatosis. If a patient has metastatic disease to a site other than bone, brain, liver, lung, or distant nodes AND carcinomatosis, assign code 2 for carcinomatosis. Code 2 for carcinomatosis takes priority.

- Example 1: Patient with colon cancer noted to have mets to the stomach and carcinomatosis. Code “Mets at Dx-Other” as 2 for carcinomatosis.

Mets at Dx-Other

- Example 2: Patient with breast cancer noted to have mets to the liver and carcinomatosis. Code " Mets at Dx-Liver" as 1 and "Mets at Dx-Other" as 2.

D. Use code 8 (Not applicable) for the following site/histology combination for which distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

E. Use code 9 when it cannot be determined whether the patient has metastases other than bone, brain, liver, lung and distant lymph node(s).

F. The TCR requires documentation in the text field supporting the code selected for this field and the source used to identify metastatic involvement (or lack of involvement) of the other sites.

- 09/02/2016 Hemicolectomy op report- mets seeding on surface of the gallbladder

- 07/05/2016 Abdominal CT- within normal limits

Codes:

Code	Description
0	None; No other metastases
1	Yes; Distant metastases in known site(s) other than bone, brain, liver, lung or distant lymph nodes Note: Includes bone marrow involvement for lymphomas
2	Generalized metastasis such as carcinomatosis
8	Not applicable
9	Unknown whether any other metastatic site or generalized metastases Not documented in patient record

Mets at Dx-Distant Lymph Node(s)

Field Length: 1

Source of Standard: SEER

Description:

Identifies whether distant lymph node(s) are an involved metastatic site.

Coding Instructions:

- ✓ Note 1: Use AJCC TNM to determine regional versus distant lymph nodes.
- ✓ Note 2: For unknown primaries, unless involved lymph nodes are stated to be distant lymph nodes, assign code 9 for unknown.
- ✓ Note 3: Placental lymph node involvement for placental primaries is classified as distant lymph involvement and recorded in this field.

1. Code information about distant lymph node(s) metastases only (metastases to distant lymph nodes) identified at the time of diagnosis.

    A. Distant lymph node involvement may be single or multiple

    B. Information about distant lymph node involvement may be clinical or pathologic

    C. Code this field whether or not the patient had any neoadjuvant (preoperative) systemic therapy

    D. Do not code this field for regional lymph node involvement

    E. Code this field for all solid tumors, Kaposi sarcoma, Lymphomas, Unknown Primary Site, and Other and Ill-Defined Primary Sites

    - ✓ Note: Code 0 for all lymphomas. Lymph node involvement is recorded in stage group and is based on involvement above and below the diaphragm. The distinction between regional and distant lymph nodes is not relevant.

Mets at Dx-Distant Lymph Node(s)

a. Code this field for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837) (All sites)

2. Assign the code that best describes whether the case has distant lymph node metastases at diagnosis.

A. Use code 0 when the medical record:

a. Indicates that there are no distant (discontinuous) metastases at all

b. Includes a clinical or pathologic statement that there are no distant lymph node metastases

c. Includes imaging reports that are negative for distant lymph node metastases

d. Indicates lymph nodes are involved, but there is no indication whether they are regional or distant

e. Indicates that the patient has distant (discontinuous) metastases but distant lymph node(s) are not mentioned as an involved site

- Example: Use code 0 when the patient has lung and liver metastases but not distant lymph node(s).

B. Use code 1 when the medical record:

a. Indicates that the patient has distant (discontinuous) metastases and distant lymph node(s) are mentioned as an involved site

b. Indicates that the patient is diagnosed as an unknown primary (C80.9) and distant lymph node(s) are mentioned as a metastatic site

C. Use code 8 (Not applicable) for the following site/histology combination for which distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

Mets at Dx-Distant Lymph Node(s)

D. Use code 9 when it cannot be determined whether the patient specifically has distant lymph node metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include distant lymph node(s).

3. The TCR requires documentation in the text field supporting the code selected for this field and the source used to identify metastatic involvement (or lack of involvement) of the distant lymph node(s).

   - Example for a prostate primary: 7/4/2016- Chest xray- Supraclavicular adenopathy consistent with mets.

Codes:

Code	Description
0	None; No distant lymph node metastases
1	Yes; Distant lymph node metastases
8	Not applicable
9	Unknown whether distant lymph node(s) are an involved metastatic site Not documented in patient record

TNM Clin T

Field Length: 4

Source of Standard: AJCC

Description:

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known **prior** to the start of any therapy as defined by AJCC.

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

Transition from the Collaborative Staging system to the AJCC TNM Staging System is being implemented in stages. For this data field, report according to the following timeline:

Non-CoC Accredited Facilities	CoC-Accredited Facilities
1/1/2014 – 12/31/2014: Required when available in medical chart.	1/1/2014 – 12/31/2014: Required when available in medical chart.
1/1/2015 – 12/31/2015: Required when available in medical chart.	1/1/2015 onward: Required
1/1/2016 onward: Required	

General Guidance:

- Code clinical T as documented by the first treating physician or the managing physician in the medical record. If the managing physician has not recorded clinical T, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.
- For lung, occult carcinoma is coded TX.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules and site-specific guidelines.

TNM Clin T

- This field is left blank if no information at all is available to code this item.
- The TCR requires documentation in the text fields supporting the code used in this data field.

Code	Definition
(leave blank)	Not recorded.
X	TX
0	T0
A	Ta
IS	Tis
ISPU	Tispu
ISPD	Tispd
1MI	T1mi, T1 mic
1	T1
1A	T1a
1A1	T1a1
1A2	T1a2
1B	T1b
1B1	T1b1
1b2	T1b2
1C	T1c
1D	T1d
2	T2
2A	T2a
2A1	T2a1
2A2	T2a2
2B	T2b
2C	T2c
2D	T2d
3	T3
3A	T3a
3B	T3b
3C	T3c
3D	T3d
4	T4
4A	T4a
4B	T4b
4C	T4c
4D	T4d
4E	T4e
88	Not applicable

TNM Clin N

Field Length: 4

Source of Standard: AJCC

Description:

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known **prior** to the start of any therapy as defined by AJCC.

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

Transition from the Collaborative Staging system to the AJCC TNM Staging System is being implemented in stages. For this data field, report according to the following timeline:

Non-CoC Accredited Facilities	CoC-Accredited Facilities
1/1/2014 – 12/31/2014: Required when available in medical chart.	1/1/2014 – 12/31/2014: Required when available in medical chart.
1/1/2015 – 12/31/2015: Required when available in medical chart.	1/1/2015 onward: Required
1/1/2016 onward: Required	

General Guidance:

- Code clinical N as documented by the first treating physician or the managing physician in the medical record. If the managing physician has not recorded clinical N, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- This field is left blank if no information at all is available to code this item.

TNM Clin N

- The TCR requires documentation in the text fields supporting the code used in this data field.

Code	Definition
(leave blank)	Not recorded.
X	NX
0	N0
0I-	N0i-
0I+	N0i+
0M-	N0m-
0M+	N0m+
1MI	N1mi
0A	N0a
0B	N0b
1	N1
1A	N1a
1B	N1b
1C	N1c
2	N2
2A	N2a
2B	N2b
2C	N2c
3	N3
3A	N3a
3B	N3b
3C	N3c
4	N4
88	Not applicable

TNM Clin M

Field Length: 4

Source of Standard: AJCC

Description:

Identifies the presence or absence of distant metastasis (M) of the tumor known **prior** to the start of any therapy as defined by AJCC.

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

Transition from the Collaborative Staging system to the AJCC TNM Staging System is being implemented in stages. For this data field, report according to the following timeline:

Non-CoC Accredited Facilities	CoC-Accredited Facilities
1/1/2014 – 12/31/2014: Required when available in medical chart.	1/1/2014 – 12/31/2014: Required when available in medical chart.
1/1/2015 – 12/31/2015: Required when available in medical chart.	1/1/2015 onward: Required
1/1/2016 onward: Required	

General Guidance:

- Code clinical M as documented by the first treating physician or the managing physician in the medical record. If the managing physician has not recorded clinical M, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- This field is left blank if no information at all is available to code this item.

TNM Clin M

- The TCR requires documentation in the text fields supporting the code used in this data field.

Code	Definition
(leave blank)	Not recorded.
0	M0
0I+	M0(i+)
1	M1
1A	M1a
1B	M1b
1C	M1c
1D	M1d
1E	M1e
88	Not applicable

TNM Clin Stage Group

Field Length: 4

Source of Standard: AJCC

Description:

Clinical Stage Group is the detailed site-specific field used to code the clinical stage group as defined by AJCC. Clinical Stage Group identifies the extent of disease based on the clinical T, N, and M values prior to the start of treatment.

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

Transition from the Collaborative Staging system to the AJCC TNM Staging System is being implemented in stages. For this data field, report according to the following timeline:

Non-CoC Accredited Facilities	CoC-Accredited Facilities
1/1/2014 – 12/31/2014: Required when available in medical chart.	1/1/2014 – 12/31/2014: Required when available in medical chart.
1/1/2015 – 12/31/2015: Required when available in medical chart.	1/1/2015 onward: Required
1/1/2016 onward: Required	

General Guidance:

- Record the clinical stage group as documented by the first treating physician or the managing physician in the medical record. If the managing physician has not recorded the clinical stage group, registrars will code this item based on the best available information without necessarily requiring additional contact with the physician.

- To assign the clinical stage group when some, but not all, T, N and/or M components can be determined, interpret missing components as “X”.

- If the value does not fill all 4 characters, then record the value to the left and leave the remaining spaces blank.

TNM Clin Stage Group

- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The TCR requires documentation in the text fields supporting the code used in this data field.

Code	Definition
0	Stage 0
0A	Stage 0A
0IS	Stage 0is
1	Stage I
1A	Stage IA
1A1	Stage IA1
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1B2	Stage IB2
1C	Stage IC
IS	Stage IS
2	Stage II
2A	Stage IIA
2A1	Stage IIA1
2A2	Stage IIA2
2B	Stage IIB
2C	Stage IIC
3	Stage III
3A	Stage IIIA
3B	Stage IIIB
3C	Stage IIIC
3C1	Stage IIIC1
3C2	Stage IIIC2
4	Stage IV
4A	Stage IVA
4A1	Stage IVA1
4A2	Stage IVA2
4B	Stage IVB
4C	Stage IVC
OC	Occult
88	Not applicable
99	unknown

TNM Clin Descriptor

Field Length: 1

Source of Standard: CoC

Description:

Identifies the AJCC clinical stage (prefix/suffix) descriptor of the tumor **prior** to the start of any therapy. Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group.

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

Transition from the Collaborative Staging system to the AJCC TNM Staging System is being implemented in stages. For this data field, report according to the following timeline:

Non-CoC Accredited Facilities	CoC-Accredited Facilities
1/1/2014 – 12/31/2014: Required when available in medical chart.	1/1/2014 – 12/31/2014: Required when available in medical chart.
1/1/2015 – 12/31/2015: Required when available in medical chart.	1/1/2015 onward: Required
1/1/2016 onward: Required	

General Guidance:

- Record the clinical stage (prefix/suffix) descriptor as documented by the first treating physician or the managing physician in the medical record. If the managing physician has not recorded the clinical stage group, registrars will code this item based on the best available information without necessarily requiring additional contact with the physician.

- Previous editions of FORDS included a code 4 for y-classification, and a note that it was not applicable for clinical stage. Code 4 has been removed from the list of valid codes.

- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

TNM Clin Descriptor

- The TCR requires documentation in the text fields supporting the code used in this data field.

Code	Label	Description
0	None	There are no prefix or suffix descriptors that would be used for this case.
1	E- Extranodal, lymphomas only	A lymphoma case involving an extranodal site.
2	S- Spleen, lymphomas only	A lymphoma case involving the spleen.
3	M- Multiple primary tumors in a single site	This is one primary with multiple tumors in the primary site at the time of diagnosis.
5	E&S- Extranodal and spleen, lymphomas only	A lymphoma case with involvement of both an extranodal site and the spleen.
9	Unknown; not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct.

TNM Path T

Field Length: 4

Source of Standard: AJCC

Description:

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known **following** the completion of surgical therapy as defined by AJCC.

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

Transition from the Collaborative Staging system to the AJCC TNM Staging System is being implemented in stages. For this data field, report according to the following timeline:

Non-CoC Accredited Facilities	CoC-Accredited Facilities
1/1/2014 – 12/31/2014: Required when available in medical chart.	1/1/2014 – 12/31/2014: Required when available in medical chart.
1/1/2015 – 12/31/2015: Required when available in medical chart.	1/1/2015 onward: Required
1/1/2016 onward: Required	

General Guidance:

- Code pathologic T as documented by the first treating physician or the managing physician in the medical record. If the managing physician has not recorded pathologic T, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Truncate the least significant subdivision of the category from the right as needed.
- For lung, occult carcinoma is coded TX.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.

TNM Path T

- Refer to the current *AJCC Cancer Staging Manual* for staging rules and site-specific guidelines.
- This field is left blank if no information at all is available to code this item.
- The TCR requires documentation in the text fields supporting the code used in this data field.

Code	Definition
(leave blank)	Not recorded.
X	TX
0	T0
A	Ta
IS	Tis
ISPU	Tispu
ISPD	Tispd
1MI	T1mi, T1 mic
1	T1
1A	T1a
1A1	T1a1
1A2	T1a2
1B	T1b
1B1	T1b1
1b2	T1b2
1C	T1c
1D	T1d
2	T2
2A	T2a
2A1	T2a1
2A2	T2a2
2B	T2b
2C	T2c
2D	T2d
3	T3
3A	T3a
3B	T3b
3C	T3c
3D	T3d
4	T4
4A	T4a
4B	T4b
4C	T4c
4D	T4d
4E	T4e

TNM Path T

88	Not applicable

TNM Path N

Field Length: 4

Source of Standard: AJCC

Description:

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

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

Transition from the Collaborative Staging system to the AJCC TNM Staging System is being implemented in stages. For this data field, report according to the following timeline:

Non-CoC Accredited Facilities	CoC-Accredited Facilities
1/1/2014 – 12/31/2014: Required when available in medical chart.	1/1/2014 – 12/31/2014: Required when available in medical chart.
1/1/2015 – 12/31/2015: Required when available in medical chart.	1/1/2015 onward: Required
1/1/2016 onward: Required	

General Guidance:

- Code pathologic N as documented by the first treating physician or the managing physician in the medical record. If the managing physician has not recorded pathologic N, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.

- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.

- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

- This field is left blank if no information at all is available to code this item.

TNM Path N

- The TCR requires documentation in the text fields supporting the code used in this data field.

Code	Definition
(leave blank)	Not recorded.
X	NX
0	N0
0I-	N0i-
0I+	N0i+
0M-	N0m-
0M+	N0m+
1MI	N1mi
0A	N0a
0B	N0b
1	N1
1A	N1a
1B	N1b
1C	N1c
2	N2
2A	N2a
2B	N2b
2C	N2c
3	N3
3A	N3a
3B	N3b
3C	N3c
4	N4
88	Not applicable

TNM Path M

Field Length: 4

Source of Standard: AJCC

Description:

Identifies the presence or absence of distant metastasis (M) of the tumor known from **any** positive biopsy or resection of a distant site.

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

Transition from the Collaborative Staging system to the AJCC TNM Staging System is being implemented in stages. For this data field, report according to the following timeline:

Non-CoC Accredited Facilities	CoC-Accredited Facilities
1/1/2014 – 12/31/2014: Required when available in medical chart.	1/1/2014 – 12/31/2014: Required when available in medical chart.
1/1/2015 – 12/31/2015: Required when available in medical chart.	1/1/2015 onward: Required
1/1/2016 onward: Required	

General Guidance:

- Code pathologic M as documented by the first treating physician or the managing physician in the medical record. If the managing physician has not recorded pathologic M, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- This field is left blank if no information at all is available to code this item.

TNM Path M

- The TCR requires documentation in the text fields supporting the code used in this data field.

Code	Definition
(leave blank)	Not recorded.
0 (AJCC editions 1-6_only)	M0 (AJCC editions 1-6_only)
1	M1
1A	M1a
1B	M1b
1C	M1c
1D	M1d
1E	M1e
88	Not applicable

TNM Path Stage Group

Field Length: 4

Source of Standard: AJCC

Description:

Pathologic Stage Group is the detailed site-specific field used to code the pathologic stage group as defined by AJCC. Pathologic Stage Group identifies the extent of disease based on the pathologic T, N, and M values **following** the completion of surgical therapy.

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

Transition from the Collaborative Staging system to the AJCC TNM Staging System is being implemented in stages. For this data field, report according to the following timeline:

Non-CoC Accredited Facilities	CoC-Accredited Facilities
1/1/2014 – 12/31/2014: Required when available in medical chart.	1/1/2014 – 12/31/2014: Required when available in medical chart.
1/1/2015 – 12/31/2015: Required when available in medical chart.	1/1/2015 onward: Required
1/1/2016 onward: Required	

General Guidance:

- Record the pathologic stage group as documented by the first treating physician or the managing physician in the medical record. If the managing physician has not recorded the pathologic stage group, registrars will code this item based on the best available information without necessarily requiring additional contact with the physician.

- To assign the pathologic stage group when some, but not all, T, N and/or M components can be determined, interpret missing components as “X”, except for M which should be interpreted as blank.

- If pathologic M is coded as blank and clinical M is coded as 0, 1, 1A, 1B, or 1C, then the combination of staging elements pT, pN, and cM may be used to complete the pathologic stage group.

TNM Path Stage Group

- If the value does not fill all 4 characters, then record the value to the left and leave the remaining spaces blank.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The TCR requires documentation in the text fields supporting the code used in this data field.

Code	Definition
0	Stage 0
0A	Stage 0A
0IS	Stage 0is
1	Stage I
1A	Stage IA
1A1	Stage IA1
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1B2	Stage IB2
1C	Stage IC
1S	Stage IS
2	Stage II
2A	Stage IIA
2A1	Stage IIA1
2A2	Stage IIA2
2B	Stage IIB
2C	Stage IIC
3	Stage III
3A	Stage IIIA
3B	Stage IIIB
3C	Stage IIIC
3C1	Stage IIIC1
3C2	Stage IIIC2
4	Stage IV
4A	Stage IVA
4A1	Stage IVA1
4A2	Stage IVA2
4B	Stage IVB
4C	Stage IVC
OC	Occult
88	Not applicable

TNM Path Stage Group

99	unknown

TNM Path Descriptor

Field Length: 1

Source of Standard: CoC

Description:

Identifies the AJCC pathologic stage (prefix/suffix) descriptor known **following** the completion of surgical therapy. Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group.

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

Transition from the Collaborative Staging system to the AJCC TNM Staging System is being implemented in stages. For this data field, report according to the following timeline:

Non-CoC Accredited Facilities	CoC-Accredited Facilities
1/1/2014 – 12/31/2014: Required when available in medical chart.	1/1/2014 – 12/31/2014: Required when available in medical chart.
1/1/2015 – 12/31/2015: Required when available in medical chart.	1/1/2015 onward: Required
1/1/2016 onward: Required	

General Guidance:

- Record the pathologic stage (prefix/suffix) descriptor as documented by the first treating physician or the managing physician in the medical record. If the managing physician has not recorded the clinical stage group, registrars will code this item based on the best available information without necessarily requiring additional contact with the physician.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The TCR requires documentation in the text fields supporting the code used in this data field.

TNM Path Descriptor

Code	Label	Description
0	None	There are no prefix or suffix descriptors that would be used for this case.
1	E- Extranodal, lymphomas only	A lymphoma case involving an extranodal site.
2	S- Spleen, lymphomas only	A lymphoma case involving the spleen.
3	M- Multiple primary tumors in a single site	This is one primary with multiple tumors in the primary site **at the time of diagnosis**.
4	Y- Classification during or after initial multimodality therapy	Neoadjuvant treatment given before staging.
5	E&S- Extranodal and spleen, lymphomas only	A lymphoma case with involvement of both an extranodal site and the spleen.
6	M&Y- Multiple primary tumors and initial multimodality therapy	A case meeting the parameters of both codes 3 (multiple primary tumors in a single site) and 4 (classification during or after initial multimodality therapy).
9	Unknown; not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct.

CS Tumor Size

Field Length: 3

Source of Standard: AJCC

Description:

Records the largest dimension or diameter of the primary tumor in millimeters. If the tumor size is stated in centimeters, convert the centimeter size to millimeters.

General Guidance:

- This data item is only required on cases diagnosed 1/1/2004 – 12/31/2015. For cases diagnosed 1/1/2016 onward, see the Tumor Size Summary section of this manual for the new rules for coding tumor size.

- Tumor size should always be recorded in millimeters.

- If the tumor size is stated in centimeters, convert the centimeter size to millimeters by multiplying the dimension by 10.

    - Examples:
      Mammogram shows 2.5 cm breast malignancy. Code as 025 (2.5 cm = 25 millimeters)
      CT of chest shows 4 cm mass in RUL. Code as 040 (4 cm = 40 mm)
      Thyroidectomy specimen yields 8 mm carcinoma. Code as 008
      Lumpectomy shows multiple microscopic foci, no size stated. Code as 990
      Clinician reports T1 tongue tumor removed at another facility. Code as 992 (Stated as T1 with no other information on size).

- Round the tumor size only if it is described in fractions of millimeters. If tumor size is less than 1 millimeter, record size as 001 if largest dimension or diameter of tumor is between 0.1 and 0.9 mm (do not round down to 000). If tumor size is greater than 1 millimeter, round tenths of millimeters in the 1-4 range down to the nearest whole millimeter, and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. Do not round tumor size expressed in centimeters to the nearest whole centimeter.

    - Examples:
      Breast cancer described as 6.5 millimeters in size. Code CS Tumor Size as 007.

Cancer in polyp described as 2.3 millimeters in size. Code CS Tumor Size as 002.
Focus of cancer described as 0.5 mm in size. Code as 001.
Focus of cancer described as 1.4 mm in size. Code as 001.
5.2 mm breast cancer. Round down to 5 mm and report as 005; will map to T1a rather than T1b.

Coding Instructions:

1. **Timing rule**: Refer to the General Guidelines for Collaborative Stage for timing rules for data collection.

2. **Schema-specific instructions**: Refer to site/histology-specific instructions (notes before the table) for additional information. Schema-specific instructions take priority over general instructions. Where there are no site/histology-specific instructions, the general instructions apply.

3. **Record the largest tumor diameter from reports in the following order:**

   A. Record tumor size **from the pathology report**, if it is available, when the patient receives no radiation or systemic treatment prior to surgery. Tumor size is the diameter of the tumor, not the depth or thickness of the tumor. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the final diagnosis, synoptic report, (also known as CAP protocol or pathology report checklist), microscopic, then gross examination, in that order.

   - Example: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. Record tumor size as 032.

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

   B. If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the largest size of tumor prior to neoadjuvant treatment unless the size of tumor is larger at surgery (see 3.E below).

      - **Exception**: If extension or size information from the post-neoadjuvant therapy time frame increases the T category, then tumor size and extension should be coded from the post-neoadjuvant time frame. Information for both CS Tumor Size and CS Extension must be taken from either the pre-neoadjuvant treatment

time frame or from the post-neoadjuvant treatment time frame but not from a mix of information from different time frames.

- Example: Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size of tumor after total resection is 0.8 cm. Record tumor size as 022.

C. **Priority of imaging/radiographic techniques:** Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but it should be taken as low priority, just above a physical exam.

D. **Tumor size discrepancies among reports:** If there is a difference in reported tumor size among imaging and radiographic techniques, record the largest size of tumor reported in the record, regardless of which imaging technique reports it.

E. **If no response to neoadjuvant treatment:** In the infrequent event that the tumor does not respond to neoadjuvant treatment and the extension and/or size information from the post-neoadjuvant therapy time frame **increases the T category**, then code the largest tumor size and the furtherest extension from the post-neoadjuvant time frame and code CS Tumor Size/Ext Eval as '6'. Information for both CS Tumor Size and CS Extension must be taken from either the pre-neoadjuvant treatment time frame or from the post-neoadjuvant treatment time frame but not from a mix of information from different time frames.

    - If extension or size information from the post-neoadjuvant therapy time frame **increases the T category** compared to the pre-neoadjuvant T, then CS Tumor Size and CS Extension must be coded from the post neoadjuvant time frame and CS Tumor Size/Ext Eval coded as 6.

    - If the clinician states there was a response to neoadjuvant therapy, code CS Extension and CS Tumor Size based on the pre-neoadjuvant information even if unknown and code CS Tumor Size/Ext as 5.

    - If the clinician states there was no response to treatment and the pre-neoadjuvant information on CS Extension and CS Tumor Size yield a T category TX, but information based on post-neoadjuvant pathologic extension and tumor size yield a T category other than TX, code CS Extension and CS Tumor Size from the post-neoadjuvant information and code CS Tumor Size/Ext Eval as 6.

CS Tumor Size

4. **Record the exact size of the primary tumor** for all sites/histologies except those for which it is stated to be not applicable. Code the exact size in preference to a statement of a T category or a size range (see special codes below). If there is no reference at all about tumor size in the record, code as 999.

    A. Always **code the size of the primary tumor**, not the size of the polyp, ulcer, cyst, or distant metastasis. However, if the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

    B. **Record the largest dimension** or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

    - Example: A 3.3 cm tumor would be 33 millimeters and would be coded as 033.

    - Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051

    C. **Record the size of the invasive component,** if given.

    D. **If both an in situ and an invasive component are present** and the invasive component is measured, **record the size of the invasive component** even if it is smaller.

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

    E. Additional rule for **breast primaries**: If the size of the invasive component is not given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

        - Example: Infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023.

        - Example: Duct carcinoma in situ covering a 1.9 cm area with focal areas of invasive ductal carcinoma. Record tumor size as 019.

        - ✓ Note: For breast cancer, document how the size of the tumor was determined in Site Specific Factor 6. Information from the pathology report can be used to identify in situ versus invasive tumor even if exact size is not given. If tumor size is a clinical measurement only in the range 001-989, Site Specific Factor 6 must be coded as 987.

    F. For **purely in situ lesions**, code the size as stated.

G. **Disregard microscopic residual or positive surgical margins when coding tumor size**. Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data field.

H. **Do not add pieces or chips together to create a whole; they may not be from the same location**, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size. If the clinician gives a size not in agreement with the pathologist or pathology report, the clinician statement must be confirmed with pathology prior to reporting/coding.

I. **When residual tumor is larger than excisional biopsy**: If an excisional biopsy is performed and residual tumor at time of resection of the primary is found to be larger than the excisional biopsy, code the size of the residual tumor.

J. **No clinical size but incisional needle biopsy**: Code the size from an incisional needle biopsy only when no residual tumor is found on further resection or on the rare occasion when the size of the tumor on incisional needle biopsy is larger than the size of the tumor on resection. If there is no further resection, do not code the size from the incisional needle biopsy; code 999 in the absence of a clinical size.

K. **Malignant melanoma of skin, mucosal membrane, mucosa of head and neck sites, or eye**: Record tumor size (diameter or lateral dimension) for malignant melanoma. Depth of invasion (tumor thickness) is coded in a site-specific factor.

L. **Multifocal/multicentric tumors**: If the tumor is multi-focal or there are multiple tumors being reported as a single primary, code the size of the largest tumor.

M. Size **stated as T_:** If both a T category and exact tumor size are given, code the exact size. If the only information about tumor size given in the medical record is a physician statement of a T category, determine whether the T category is based on tumor size or extension.

- If the T category is based solely on tumor size, use the appropriate “Stated as T_, NOS” code in CS TumorSize or select the appropriate code from the 99_series (see below for special codes).

- If the T category is based on extension, use the appropriate “Stated as T_” code in CS Extension.

- If the T category is based on both tumor size and extension, use the appropriate "Stated as T_, NOS" code in CS Extension. Code a specific tumor size as stated in the medical record. If an explicit tumor size is not given but there is a "Stated as T __ value based on size, code the tumor size in the 99__ series in CS Tumor Size. Otherwise, use code 999.

5. **Special codes:**

A. Use field for tumor dimension only: Tumor dimension is to be recorded for all schemas, except as noted below. Other information collected in this field in previous staging systems, such as depth of invasion for melanoma, has been moved to Site-Specific Factors for those sites/histologies.

B. **No size reported**: If size is not reported, code as 999, which means unknown size or not documented in the patient record.

C. **Use of Code 000**: Code 000 indicates no mass or no tumor was found at the primary site; for example, when a tumor has metastasized but no tumor can be found at the primary site.

D. **Use of code 990:** Code 990, Microscopic focus or foci only and no size is given, should be used when no gross tumor is seen and tumor is only identified microscopically.

- ✓ Note: A macroscopic focus or foci indicates a very small or isolated area, pinpoint, or spot of tumor that may be visible grossly. Only tumor identified microscopically should be coded to 990. If the tumor is described as both a microscopic focus and a specific size, code the specific size.

- ➢ Example: Ovary specimen: extensive cystic disease with focal areas of tumor seeding. Disregard "focal" and code tumor size to 999 unknown.

- ➢ Example: Cervix conization: severe dysplasia with focal areas of microinvasion. Code tumor size as 990 microscopic focus, no size given.

- ➢ Example: Multicentric microscopic foci in breast, largest is 0.5 millimeters. Code tumor size as 001.

E. **Non-specific size descriptions**: Codes 991 through 995 are non-specific size descriptions that, for some sites, could still be used to determine a T category. However, if a specific size is given, code the more precise size in the range 001-989. If the tumor is described as "greater than 5 cm" and there is not an applicable code in the site-specific schema, record as 051.

F. Site-specific special codes: Other special codes in the range 996 to 997 are used on a site specific basis. See the individual site/histology schemas for further information and definitions.

G. Use of code 998: The descriptions in code 998 take precedence over any mention of size. Code 998 is used only for the following schemas sites:

Esophagus (C15.0-C15.5, C15.8-C15.9): Circumferential
EsophagusGEJunction (C16.0-C16.2): Diffuse; widespread: 3/4s or more; linitis plastica
Stomach (C16.0-C16.6, C16.8-C16.9): Diffuse; widespread; 3/4s or more; linitis plastica
Appendix (C18.1): Familial/multiple polyposis
Carcinoid of appendix (C18.1): Familial/multiple polyposis
Colon (C18.0, C18.2-C18.9): Familial/multiple polyposis
Rectosigmoid and rectum (C19.9, C20.9): Familial/multiple polyposis
Lung and main stem bronchus (C34.0-C34.3, C34.8 C34.9): Diffuse, entire lung or NOS
Breast (C50.0-C50.6, C50.8-C50.9): Diffuse

H. Size not applicable: For the following diagnoses and/or primary sites, size is not applicable. Code as 988:

Disseminated Langerhans cell histiocytosis (Letterer Siwe disease)
Hematopoietic neoplasms
Immunoproliferative diseases
Kaposi sarcoma
Leukemia
Malignant lymphoma (Hodgkin lymphoma and non- Hodgkin lymphoma) other than ocular adnexal lymphoma
Mast cell tumors
Multiple myeloma and other plasma cell tumors
Myelodysplastic syndromes
Myeloproliferative diseases
Polycythemia vera
Polymorphic Post-Transplant Lymphoproliferative Disorder (PTLD)
Refractory anemias
Other Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms (see HemeRetic schema for a complete list of codes and diagnoses)
MelanomaChoroid

MelanomaCiliaryBody
MelanomaIris

I. Use of CS Tumor Size/Ext Eval field with CS Tumor Size: The source of the tumor size (radiographs, endoscopy, pathology specimen, etc.) is documented in the CS Tumor Size/Ext Eval field when tumor size is the determining factor for the T category.

6. The TCR requires documentation in the text field supporting the code selected for the tumor size and the source used to identify the size.

   - Example: 5/2/2012 Mammogram: 5.1 cm tumor upper outer quadrant rt. breast.

Determining Size Based on Description:

(Millimeter Equivalents for Descriptive Terms)

B. **Fruits** **mm**

Apple	070
Apricot	040
Cherry	020

C. Fruits (continued) **mm**

Date	040
Fig (dried)	040
Grape	020
Grapefruit	100
Kumquat	050
Lemon	080
Olive	020
Orange	090
Peach	060
Pear	090
Plum	030
Tangerine	060

D. **Nuts** **mm**

Almond	030
Chestnut	040
Chestnut, horse	040
Hazel	020
Hickory	030
Peanut	010
Pecan	030
Walnut	030

CS Tumor Size

E. **Vegetables**	**mm**
Bean	010
Bean, lima	020
Pea	991
Pea, split	991

F. **Miscellaneous Food**	**mm**
Doughnut	090
Egg	050
Bantam	040
Goose	070
Hen	030
Pigeon	030
Robin	020
Lentil	991
Millet	991

G. **Money**	**mm**
Dime	010
Dollar, half	030
Dollar, silver	040
Nickel	020

H. **Money (Continued)**	**mm**
Penny	010
Quarter	020

I. **Other**	**mm**
Ball, golf	040
Ball, ping-pong	030
Ball, tennis	060
Baseball	070
Eraser on Pencil	991
Fist	090
Marble	010
Matchhead	991
Microscopic Focus	990

Codes:

See the most current version of the *Collaborative Stage Data Collection System* for applicable codes.

CS Tumor Size

https://cancerstaging.org/cstage/schema/Pages/version0205.aspx

CS Extension

Field Length: 3

Source of Standard: AJCC

Description:

Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites, such as ovary, discontinuous metastasis is coded in CS Extension. See site-specific schemas for detailed codes and coding instructions.

Coding Instructions:

1. This data item is only required on cases diagnosed 1/1/2004 – 12/31/2015.

2. **Timing rule:** Refer to General Guidelines for Collaborative Stage for timing rules for data collection.

3. **Code the farthest documented extension of the primary tumor.** Do not include discontinuous metastases to distant sites (these are coded in CS Mets at Dx) except for corpus uteri, ovary, fallopian tube, and female peritoneum (see 2F below).

    - Example: In the CS Extension table for colon, Note 2 states that codes 600-800 are used for contiguous extension from the site of origin, and discontinuous involvement is coded in CS Mets at Dx. Thus direct tumor extension from the transverse colon onto the surface of the liver would be coded as CS Extension 600, while hematogenous metastases within the liver would be coded as CS Mets at Dx 26.

    - ✓ Note: For a few schemas such as breast, lung, and kidney, some codes in CS Mets at Dx are distant direct (contiguous) extension either in the summary staging system or in TNM. If the structure involved by direct extension is not listed in CS Extension, look for a code in CS Mets at Dx. Code the involved structure wherever it is listed—the CS computer algorithm will derive the correct stage in both TNM and summary stage. If the specific structure involved by direct extension is not listed in either CS Extension or CS Mets at Dx, code as CS Extension 800, further contiguous extension.

4. Record extension information in the following priority order:

CS Extension

A. No neoadjuvant treatment planned or administered: Record extension from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.

B. Neoadjuvant treatment planned and administered: If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the farthest extension identified prior to treatment (clinically).

- **Exception**: If extension or size information from the post-neoadjuvant therapy time frame **increases the T category**, then tumor size and extension must be coded from the post-neoadjuvant time frame. Information for both CS Tumor Size and CS Extension must be taken from either the pre-neoadjuvant treatment time frame or from the post-neoadjuvant treatment time frame but not from a mix of information from different time frames.

- Example: Patient has rectal mass firmly fixed to pelvic wall (clinically T4, extension code 610). Patient undergoes preoperative radiation therapy. The pathology report from the low anterior resection shows residual tumor outside the rectum in perimuscular tissue (pathologically T3, extension code 400). Code extension as 610, because the preoperative treatment apparently "shrank" the tumor away from the pelvic wall.

C. **No response to neoadjuvant treatment**: In the infrequent event that the tumor does not respond to neoadjuvant treatment and is, in fact, more extensive after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code CS Tumor Size/Ext Eval as 6, based on pathology/operative report after treatment. If response to treatment is unknown, code the farthest clinical extension and code CS Tumor Size/Ext Eval as 5.

- Example: Patient found to have an obstructing central lung tumor very close to the main stem bronchus (clinically T2, extension code 200). Patient undergoes six weeks of intensive chemotherapy. At resection, tumor was observed directly extending into trachea and no size was recorded (pathologically T4, extension code 700). *Code CS Extension as 700 and CS Tumor Size as 999, because the tumor was noted to be more extensive after the preoperative treatment.*

- Example: Patient has a 5.5 cm hard, moveable mass in the right breast (clinically T3, extension code 100 & CS Tumor Size 055) and receives preoperative chemotherapy. The pathology report from the modified radical mastectomy shows residual 2.8 cm mass with infiltration of the deep subcutaneous tissues over the mass (pathologically T2, extension code 200 and size code 028). Code the pre-neoadjuvant information on size and extension, because the pathologic information post-neoadjuvant did not produce a higher T category. Both the size and extension must be coded from the same pre-

neoadjuvant time frame. (Code Tumor Size as 055 because derived T3 pre-neoadjuvant treatment is greater than the post-treatment T2. Code CS Tumor Size as 055 and CS Extension as 100 based on information from pre-neoadjuvant treatment and code CS Tumor Size/Ext Eval as 5 (clinical information prior to neoadjuvant treatment). Note Tumor Size determines the T classification for CS Extension codes 100, 200, and 300 for breast.)

- If extension or size information from the post-neoadjuvant therapy time frame increases the T category compared to the pre-neoadjuvant T, then CS Tumor Size and CS Extension must be coded from the post-neoadjuvant time frame and CS Tumor Size/Ext Eval coded as 6

- If clinical extension is unknown but a pathologic extension is given after treatment and clinician states there was a response to neoadjuvant, code CS Extension as 999 and TS/Ext Eval as 5.

- If clinical extension is unknown but a pathologic extension is given and clinician states no response to treatment, code CS Extension from path report and TS/Ext Eval as 6.

D. **Priority of imaging/radiographic techniques:** Information on extent of disease from imaging/radiographic techniques can be used to code extension when there is no more specific extension information from a pathology or operative report, but it should be taken as low priority, just above a physical exam.

E. **Involved organ not listed in schema**: If an involved organ or tissue is not mentioned in the schema, approximate the location and code it with listed organs or tissues in the same anatomic area.

F. **Contiguous (direct) extension only**: With the exception of mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, all codes represent contiguous (direct) extension of tumor from the site of origin to the organ/structure/tissue represented in the code.

➢ Example: Carcinoma of the prostate with extension to pubic bone is coded 600. Carcinoma of the prostate with metastases to thoracic spine is coded in CS Extension to the appropriate code for tumor extension and the metastases to the thoracic spine are coded in the CS Mets at Dx field.

5. **Ambiguous terminology:** Refer to the Collaborative Staging section for ambiguous terms that constitute tumor involvement or extension.

6. **Code the highest applicable <u>specific</u> number:** Codes for Unknown, Not Applicable, and NOS categories such as Localized, NOS or "Stated as T1, NOS" do not take priority over more specific codes with lower numbers.

    - Example: The patient has a T1 colon carcinoma confined to the submucosa. Possible code choices are 160 Invades submucosa; 170 Stated as T1, NOS; and 300 Localized, NOS. All three of these codes map to T1, but the one that provides the most specific information about depth of invasion is code 160.

7. **Inferring extension code from stated T category or site-specific staging**: If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the T category or alternative staging system stated by the physician.

    A. If the only indication of extension in the record is the physician's statement of a T category from the TNM staging system or a stage from a site-specific staging system, such as Dukes C, code the appropriate "Stated as T_, NOS" category or record the numerically lowest equivalent extension code for the site-specific staging system.

    B. Where there is doubt that the documentation in the medical record is complete and the physician's assignment of the T, N, or M category differs from the stage assignment that the medical record would support, it is preferable to use a "Stated as" code for the T, N or M value corresponding to the physician's statement rather than a CS code mapping to a different T, N or M value. The registrar is strongly encouraged to record in text the rationale for the selected code.

8. **Use of NOS categories**: Some schemas include designations such as T1, NOS; T2, NOS; Localized, NOS; and other non-specific categories. The NOS is added when there is further breakdown of the category into subsets (such as T1a, T1b, T1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as T1 NOS" when the appropriate subset (e.g., T1a or T1b) cannot be determined.

9. **Discontinuous or distant metastases:** Distant metastases must be coded in the CS Mets at Dx field. The only exceptions are mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, where discontinuous metastases in the pelvis or abdomen are coded in the CS Extension field.

CS Extension

10. **In situ pathology with nodal or metastatic tumor**: Do not code CS Extension as in situ if there is any evidence of nodal or metastatic involvement; use the code for Localized, NOS, if there is no better information.

    - Example: Excisional biopsy of breast tumor shows extensive DCIS. Sentinel node biopsy reveals one positive axillary node. *Code CS Extension as 100, localized, NOS, because an in situ tumor theoretically cannot metastasize and apparently an area of invasion was missed by the pathologist.*

11. **Microscopic residual or positive tumor margins**: The presence of microscopic residual disease or positive tumor margins does not increase the extension code.

12. The **TCR requires documentation in the text** fields supporting the extension code and the source used to identify the extension code.

    - Example: 8/1/2012 Polypectomy- Adenocarcinoma in ascending colon polyp. Tumor cells confined to head of the polyp. No tumor involvement of the polyp stalk.

Codes:

See the most current version of the *Collaborative Stage Data Collection System* for applicable codes.

https://cancerstaging.org/cstage/schema/Pages/version0205.aspx

CS Tumor Size/Ext Eval

Field Length: 1

Source of Standard: AJCC

Description:

Records how the codes for the two items CS Tumor Size and CS Extension were determined, based on the diagnostic methods employed.

Coding Instructions:

1. This data item is only required on cases diagnosed 1/1/2004 – 12/31/2015.

2. **Document the staging basis for the farthest extension and/or greatest tumor size**: The underlying purpose of this field is to capture the staging basis for the highest T category assigned to the case. In most circumstances, this will be the staging basis for the highest Tumor Size code or Extension code as appropriate to the site. See also instructions 2, 3, and 4.

    A. Select the CS Tumor Size/Ext Eval code that documents the report or procedure from which the information about the farthest extension or largest size of the primary tumor (where applicable) was obtained; this may not be the numerically highest Eval code.

        - Example: Fine needle aspiration biopsy (Eval code 1) confirms adenocarcinoma of prostate. CT scan of pelvis (Eval code 0) shows tumor extension through the prostatic capsule into adjacent connective tissues. *Code CS Tumor Size/Ext Eval as 0 because the CT scan showed more extensive tumor than the biopsy*.

        - Example: Patient has elevated PSA, negative digital rectal exam, and clinically inapparent prostate tumor. Needle biopsy identifies adenocarcinoma in right lobe only. *Code CS Tumor Size/Ext Eval as 1 because the needle biopsy, not the clinical examination, established the extent of disease.*

        - Example: Patient has bronchoscopic biopsy (Eval code 1) confirming squamous cell carcinoma of the right upper lobe bronchus. CT scan of chest (Eval code 0) shows that RUL mass extends into mediastinum (Lung Extension code 700). *Code CS Tumor Size/Ext Eval as 0 because the CT scan showed the farthest extension of tumor.*

- Example: Imaging shows 3.0 cm mass in right upper lobe of lung. Fine needle aspiration biopsy shows adenocarcinoma. *Code CS Tumor Size/Ext Eval as 0 because the imaging documents what is known about the tumor and drives the classification of T, and the FNA simply confirms that the mass is cancer.*

- Example: Patient has 6 cm mass in left breast with overlying erythema and edema. Core needle biopsy confirms duct carcinoma and the patient receives neoadjuvant chemotherapy followed by a modified radical mastectomy. The pathology report from the surgery shows a 2.5 cm residual carcinoma. *Code the Tumor Size/Ext Eval as 5 (surgical resection after neoadjuvant therapy – size/extension based on clinical information prior to treatment), which maps to clinical staging. (Tumor size would be coded 060.)*

B. In the infrequent situation where there is both clinical and pathologic documentation of the same category, **pathologic information takes priority**.

- Example: Lung cancer patient has biopsy-proven extension to adjacent trachea (Extension code 700) and radiographic evidence of extension to neural foramina (Extension code 750). *Code CS Extension as 750 and TS/Ext Eval as 3. When both codes map to T4, pathologic staging basis takes priority.*

C. **Mapping of T subcategories:** Select the CS TS/Ext Eval code that describes how the most advanced subcategory of the derived T was determined.

a. If a specific subcategory of T will be derived (such as T2a, etc.), determine if there was any pathological evidence for the specific subcategory. If so, select a CS Tumor Size/Ext Eval code that will derive a “p” staging basis.

b. If there was only clinical evidence of the subcategory disease, select a CS Tumor Size/Ext Eval code that will derive a “c” staging basis. In the latter case there may have been pathological evidence of a lower T subcategory, but this is not considered in assigning the Eval code.

- Example: Cervical carcinoma with bullous edema of bladder (CS Extension code 605, maps to T3a) demonstrated on cystoscopy (CS Tumor Size/Eval code 1). KUB radiography (CS Tumor Size/Eval code 0) shows non-functioning kidney (CS Extension code 635, maps to T3b). *Code CS Tumor Size/Ext Eval as 0 because the imaging documented a higher subcategory of T3 than the cystoscopy.*

D. When the only procedure is a polypectomy: In some situations, an endoscopic procedure may remove the entire tumor, and the TS/Ext Eval must be coded to reflect the correct staging basis for tumor extension.
   a. If there is no tumor at the margin of resection after the polypectomy, code TS/Ext Eval as 3 (pathologic).

   b. If there is tumor at the margin of resection after the polypectomy, code TS/Ext Eval as 1 (endoscopic/diagnostic biopsy).

   When the patient has further surgery:

   c. If there is no primary tumor in resection, use extension information from polypectomy and code TS/Ext Eval as 3 (pathologic).

   d. If more tumor is found at resection, code farthest extension from polypectomy or resection and code Eval as 3 (pathologic).

3. **When tumor size <u>is</u> the primary factor:** For primary sites where tumor size is the primary factor in determining the T category in TNM, code CS Tumor Size/Ext Eval on the basis of how the tumor size was determined.

   ✓ Note: In the CS Extension field, an asterisk (*) in the TNM 6 Map column or a caret (^) in the TNM 7 Map column usually indicates that tumor size is the determining factor in the mapping.

A. If the tumor size is taken from physical exam or imaging and there was also a needle biopsy or incisional biopsy, code CS Tumor Size/Ext Eval according to which gave the better information about tumor size.

   ➢ Example: On physical examination, patient has a 1.5 cm (T1) lesion in the floor of mouth with mucosal extension onto the gingiva. A biopsy confirms the malignancy and the patient is treated with radiation therapy. *Code the CS Tumor Size/Ext Eval as 0 since the tumor size was determined on physical exam and the biopsy simply confirmed the malignant diagnosis. (Mucosal extension to another structure does not alter the T classification).*

   ➢ Example: Bronchoscopy (Eval code 1) shows blockage in right middle bronchus with no parenchymal extension (Extension code 100). CT scan (Eval code 0) shows tumor size as 2.5 cm (maps to T1b). *Code CS Tumor Size/Ext Eval as 0 because the tumor size determines the difference between T1a, T1b and T2.*

B. In circumstances where it is not possible to obtain accurate measurements of the surgically excised primary specimen (e.g, a sarcoma removed piecemeal) that qualifies as pT, it is acceptable to use radiologic assessment of the tumor size to assign a pT category (usually CS Tumor Size/Ext Eval code 3) using radiologic dimensions of the tumor.

4. **When tumor size is <u>not</u> a factor**: For primary sites/histologies where tumor size is not a factor in determining the T category in TNM, code CS Tumor Size/Ext Eval on the basis of the CS extension field only.

   - ✓ **Note**: For most primary sites, if the tumor is classified as T4 or sometimes even T3, tumor size is no longer a factor.

   - ➢ Example: CT scan of head and neck (Eval code 0) shows tumor confined to supraglottic larynx (Extension code 100). Panendoscopy (Eval code 1) demonstrates that there is impaired vocal cord mobility (Extension code 250). *Code CS Tumor Size/Ext Eval as 1 because the endoscopy documented a higher Extension code than the CT scan.*

   - ➢ Example: Sigmoidoscopy and biopsy (Eval code 1) show a 4 cm adenocarcinoma in the upper rectum. Ultrasound (Eval code 0) shows that the carcinoma invades into the perirectal fat. Patient opts for radiation therapy. *Code the CS Tumor Size/Ext Eval field as 0 because the ultrasound showed the depth of invasion, which is the primary factor in classifying the T category for colorectal cancers.*

   - ✓ **Note**: For colon, rectosigmoid and rectum carcinomas, always assign the Tumor Size/Ext Eval code based on extension (depth of invasion). Tumor size is not a factor in classifying colorectal cancers.

5. **When both <u>tumor size</u> and <u>extension</u> determine T category**: For primary sites where both tumor size and extension determine the T category in TNM, select the code that best explains how the information in the CS Tumor Size and CS Extension fields were determined.

   A. If there is a difference between the derived category for the tumor size and the CS extension, select the evaluation code that reflects how the worse or higher category was determined.

      - ➢ Example: Tumor size for a breast cancer biopsy is 020 (maps to T1). On physical exam, there is ulceration of the skin (extension code 512, maps to T4). *Code CS Tumor Size/Ext Eval field as 0, physical examination, because the ulceration information from the physical examination results in a higher T category.*

- ✓ Note: For breast, unless there is skin or chest wall involvement, always assign the Tumor Size/Ext Eval code based on size. If there is skin or chest wall involvement or a statement of inflammatory carcinoma (T4 disease), assign Eval code based on extension.

- ➢ Example: Panendoscopy and biopsy (Eval code 1) confirm a 3.5 cm lesion on the lateral border of the anterior tongue involving the intrinsic musculature (Extension code 200 with tumor size 035, equivalent to a T2). CT scan of the head and neck (Eval code 0) indicates that the lesion actually involves the extrinsic or deep muscles of the tongue (Extension code 750, equivalent to T4a). *Code CS Tumor Size/Ext Eval as 0 because the CT scan documented a higher stage than the tumor size.*

B. If the patient had no surgery, use code 0, 1, or 9.

- ➢ Example: Patient has a chest x-ray showing an isolated 4 cm tumor in the right upper lobe. Patient opts for radiation therapy. *Code this field as 0. Staging algorithm will identify information as clinical (c).*

- ➢ Example: Colon cancer with colonoscopy and biopsy confirming adenocarcinoma in the submucosa. *Code this field as 1. Staging algorithm will identify information as clinical (c). The biopsy does not meet the criteria for pathologic staging.*

- ➢ Example: Information obtained from endoscopies for cervix or bladder showing size or extent of the tumor is coded as 1 in this field and the staging algorithm will identify the information as clinical (c).

- ❖ Exception: Lung cancer with mediastinoscopy showing direct extension into mediastinum. Code this field as 1. The staging algorithm will identify information as pathologic (p) in the sixth edition mapping and clinical (c) in the seventh edition mapping.

C. If the patient had surgery followed by other treatment(s), use code 3.

D. If the size or extension of the tumor determined prior to treatment was the basis for neoadjuvantctherapy, use code 5. Cases coded to Tumor Size/Ext Eval code 5 can be analyzed or compared with other cases with a clinical staging basis.

E. If the size or extension of the tumor was greater after presurgical treatment than before treatment, use code 6. This code is likely to be used infrequently and maps to the “y” intercurrent treatment staging basis. Cases coded to Tumor Size/Ext Eval code 6 cannot

be analyzed with or compared to any other cases that did not receive neoadjuvant treatment and surgery.

F. If the patient had an autopsy and the autopsy information meets the timing rules for determining extension, use code 2 if the diagnosis was known or suspected prior to death. Use code 8 if the malignancy was not known or suspected prior to death.

5. **When there is no TNM mapping**: For sites and histologies for which no TNM schema has been defined, such as brain or Kaposi sarcoma, this field is always coded 9, Not Applicable. For any sites and histologies that have no TNM mapping, code to the value that best reflects the diagnostic methods used, whether or not a stage is actually calculated for an individual case. In other words, do not use code 9 when a case has a histology that is excluded from staging but the site does have a TNM schema defined, for example, a sarcoma of the breast. In those cases, use code 9 only when the nature of the diagnostic methods is actually unknown.

6. **Examples of imaging studies included in Code 0**: Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography (US), angiography, scintigraphy (nuclear scans), magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

7. **Explanation of Code 1**: Codes 0 – 3 are oriented to the AJCC staging basis. In general, Code 1 includes microscopic analysis of tissue that does not meet the requirements for pathologic staging in the TNM system. Code 1 also includes observations at surgery, such as an exploratory laparotomy in which unresectable pancreatic cancer is identified and further tumor extension is not biopsied. However, pathologic staging requirements vary by site; for some site schemas, code 1 may be classified as pathologic. For specific classification rules, refer to the *AJCC Cancer Staging Manual, Seventh Edition.*

- Example: A total cystectomy is required to pathologically stage a bladder cancer. Any tissue removed during another procedure, such as a transurethral resection of a bladder tumor, does not meet the requirements for pathologic staging and should be coded to 1 in this field. This also applies to transurethral resection of the prostate.

A. If there is a choice between Eval code 0 (physical exam and imaging) and Eval code 1 (needle biopsy), use the Eval code that provides the best information about the tumor size and/or extent of disease. In most situations, the needle biopsy simply confirms the malignancy and the physical exam or imaging provides more information about tumor extension.

- Example: Colposcopic examination and biopsy (Eval code 1) of the cervix shows extensive involvement of the endocervix. Bimanual examination of the pelvis (Eval code 0) indicates that the tumor is fixed to the pelvic sidewall ("frozen pelvis"). Code CS Tumor Size/Ext Eval as 0 (clinical) because the bimanual examination indicates farther extension than the endoscopy.

- Example: Patient has nonspecific abdominal symptoms. An Upper GI exam (Eval code 0) shows localized thickening of the stomach wall. Esophagogastroscopy and biopsy (Eval code 1) confirm diffuse involvement of the upper part of the stomach with extension into the lower esophagus. *Code CS Tumor Size/Ext Eval as 1 because the endoscopy documents more involvement than the imaging.*

8. **Explanation of Code 3**: For most schemas, Code 3 meets the criteria for pathologic staging. For most schemas, use code 3 for a biopsy of tumor extension that meets the requirements for pathologic staging basis. The definition of code 3 includes the statement "Evaluation based on evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery". Therefore, information from an operative report is considered pathologic evidence provided there is a resection but only clinical evidence if there is no resection.

- Example: Operative report for a hemicolectomy indicates sigmoid colon mass that extends transmurally into the retroperitoneum. Hemicoloectomy specimen submitted to a pathologist. Pathology indicates tumor invades through the muscularis propria into the pericolic fat with a positive radial margin. *Code CS Tumor Size/Ext Eval as 3 (pathologic) with CS Extension coded to 675 (retroperitoneum) using the operative findings to supplement the pathologic findings. However, if the radial margin has been negative on the pathology report, the operative findings would have been disproven and CS Extension would be coded 450 (pericolic fat).*

  - ✓ **Note:** In CSv2, the definition of code 3 has been reworded to include not only surgical resection but also a positive biopsy that confirms the highest T classification. In other words, according to TNM rules, if the highest T category can be confirmed microscopically (positive cytology or tissue), this meets the requirements for pathologic staging basis and the CS Tumor Size/Ext Eval field should be coded to 3.

- Example: Patient visits doctor complaining of urinary frequency and pain. Pelvic examination shows extensive cervical carcinoma (Eval code 0). Cystoscopic biopsy of bladder shows squamous carcinoma compatible with cervical origin (cervix extension code 700 equivalent to T4). *Code CS Tumor Size/Ext Eval as 3 (pathologic) because biopsy documents highest T category.*

9. **Neoadjuvant therapy and 2nd primaries**: When an incidental 2nd primary is discovered at the time of surgery following neoadjuvant therapy (systemic/radiation therapy followed by surgery), this 2nd primary should be coded to Eval code 3, and **NOT** be coded to eval codes 5 or 6. This would also be true for a 2nd (or higher number) primary diagnosed and treated with a surgical resection as the first course of therapy, when the previous primary was treated with systemic or radiation therapy at any time (adjuvant or neoadjuvant or for a recurrence). To include these cases with those purposefully treated with neoadjuvant therapy would skew the data. The effect of the prior treatment for the previous primary on the new primary is unknown.

10. **Different code structure for prostate**: The CS Tumor Size/Ext Eval field for prostate is unique. An extra category was inserted between codes 1 and 2 in the common (standard table used for other sites) Tumor Size/Ext Eval table to provide a code for situations where no prostatectomy was performed, but there was a positive biopsy of extraprostatic tissue. This allows assignment of codes in the T3-T4 range (Extension 410-700). Common table code 2 (autopsy of suspected/known cancer) becomes code 3 for prostate, and common table code 3 (pathologic) becomes code 4.

- Example: A prostate cancer patient has a biopsy of the rectum that shows microscopic involvement of the rectal wall (Extension code 500, equivalent to T4). *Code Tumor Size/Ext Eval as 2 (positive biopsy of extraprostatic tissue, which maps to pathologic) because according to the AJCC Cancer Staging Manual, seventh edition, the case meets the requirements for pathologic staging in the T category.*

- Example: Patient presents with urinary symptoms and undergoes transurethral resection to improve urinary flow. Adenocarcinoma is found in the chips of tissue removed from the prostate. *Code Tumor Size/Ext Eval as 1 because there was no clinical evidence of cancer and the transurethral resection is an endoscopic procedure that does not meet the criteria for pathologic staging of prostate.*

- Example: Needle biopsies of the prostate confirm adenocarcinoma. The patient undergoes a radical prostatectomy that shows extensive involvement of the prostate. *Code Tumor Size/Ext Eval as 4 because the prostatectomy meets the criteria for pathologic staging.*

  Note: Cryoprostatectomy does not meet pathologic staging criteria because there is no tissue available for the pathologist to examine.

11. **Coding Eval field when tumor size or extension is unknown**: The Eval fields should be coded based on how the information was obtained, even if the information in the related field (Tumor Size, Regional Nodes, or CS Mets at Dx) is unknown. For example, even if it is not possible to determine the tumor size or extension and the Extension field is coded as 999, the registrar still

knows what procedures were used to try to determine those fields. In other words, just because the tumor size or extension is coded 999, the Eval field does not have to be coded 9.

12. **Schemas for which CS Tumor Size/Ext Eval is always coded 9:**
    AdnexaUterineOther
    Brain
    CNSOther
    DigestiveOther
    EndocrineOther
    EyeOther
    GenitalFemaleOther
    GenitalMaleOther
    HemeRetic
    IllDefinedOther
    IntracranialGland
    KaposiSarcoma
    MelanomaSinusOther
    MiddleEar
    MyelomaPlasmaCellDisorder
    PharynxOther
    RespiratoryOther
    SinusOther
    Trachea
    UrinaryOther

13. The TCR requires documentation in the text field supporting the code selected for this field. Documentation must indicate what source was used to determine the CS Tumor Size and CS Ext fields.

Codes:

See the most current version of the Collaborative Stage Data Collection System for applicable codes.

https://cancerstaging.org/cstage/schema/Pages/version0205.aspx

CS Lymph Nodes

Field Length: 3

Source of Standard: AJCC

Description:

Identifies the regional lymph nodes involved with cancer at the time of diagnosis.

Coding Instructions:

1. This data item is only required on cases diagnosed 1/1/2004 – 12/31/2015.

2. Timing rule: Refer to General Guidelines for Collaborative Stage for timing rules for data collection.

3. **Record the specific involved regional lymph node chain(s) farthest from the primary site**. The lymph nodes may be involved by tumor either clinically or pathologically. Regional lymph nodes are listed for each schema. In general, the regional lymph nodes in the chain(s) closest to the primary site have the lower codes. Nodes farther away from the primary or in farther lymph node chains have higher codes. If a lymph node chain is not listed, check an anatomy book or medical dictionary for a synonym. If the lymph node chain and its synonym are not listed in CS Lymph Nodes, code the involved node in CS Mets at DX. **Record the highest applicable code in the following order: pathology report, imaging, physical exam.**

    - ❖ Exception: The higher codes for "Regional lymph nodes, NOS;" "Lymph nodes, NOS;" "Stated as N1, no other information;" "Stated as N2a, no other information;" and so forth, should be used only when there is no available information regarding the specific regional nodes involved.

    - ➢ Example: Patient has a right upper lobe lung cancer, and right hilar lymph nodes are positive on fine needle aspiration biopsy. CT scan shows matted left paratracheal (contralateral mediastinal) nodes, but they are not biopsied. Patient chooses radiation therapy as primary treatment. *Use the code for contralateral mediastinal lymph node involvement as it is higher than the code for peribronchial lymph nodes.*

CS Lymph Nodes

A. **If there is no neoadjuvant therapy:** Record involved regional lymph nodes **from the pathology report**, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.

B. **Pathologic information takes precedence**: If there is a discrepancy between clinical information and pathologic information about the same lymph nodes, pathologic information takes precedence if no preoperative treatment was administered. It is not necessary to biopsy every lymph node in the suspicious area to disprove involvement.

- Example: Axillary lymphadenopathy stated as "suspicious for involvement" noted on physical exam. After axillary dissection, all lymph nodes are negative. *Code CS Lymph Nodes as 000, no regional lymph node involvement.*

C. **Inaccessible lymph nodes rule for regional lymph nodes**: (See pg. 57 for additional information on inaccessible lymph nodes). For inaccessible lymph nodes, record CS Lymph Nodes as Code 000 (None) rather than Code 999 (Unknown) when the following three conditions are met:

   a. There is no mention of regional lymph node involvement in the physical examination, pretreatment diagnostic testing or surgical exploration.

   b. The patient has clinically low stage (T1, T2, or localized) disease.

   c. The patient receives what would be usual treatment to the primary site (treatment appropriate to the stage of disease as determined by the physician) or is offered usual treatment but refuses it, since this presumes that there are no involved regional lymph nodes that would otherwise alter the treatment approach.

   - ✓ **Note:** Code 999 can and should be used in situations where there is reasonable doubt that the tumor is no longer localized and there is no documentation of involved regional lymph nodes. Code 999 should also be used when there is no documentation in the medical record about the status of accessible regional lymph nodes.

   - ✓ **Note:** If the inaccessible nodes rule applies and the case is coded 000, use code 0 in CS Reg Nodes Eval, as this code documents that criteria were met for a clinical N0.

D. **Direct tumor extension into lymph node:** If there is direct extension of the primary tumor into a regional lymph node, code the involved node in this field.

E. **Multiple nodes involved for head and neck primary:** The code structure for CS Lymph

Nodes for head and neck cancers varies by primary site, but in general, the following code ranges apply:

000 None
100-190 Single positive ipsilateral node involved
200-290 Multiple positive ipsilateral nodes
300-320 Positive ipsilateral nodes, unknown if 1 or > 1
400-490 Bilateral or contralateral positive nodes
500-520 Regional nodes, NOS, unk. number and laterality
800 mph nodes, NOS

If even one involved node is in a higher category, use the appropriate code in the higher category.

- Example: Patient with hypopharyngeal cancer has two positive ipsilateral level IV nodes and one positive ipsilateral level V node. Level IV nodes are listed in CS Lymph Nodes code 100; level V nodes are listed in CS Lymph Nodes code 120. Because more than one node is involved, the correct code range is 200-290. *Code as 220 because there are multiple lymph nodes involved and at least one of them is in code 120.*

- Example: Patient with base of tongue cancer has regional lymph nodes involved on both sides of neck. "Regional nodes, NOS" is in code 100, but bilateral nodes are involved. *Code as 400, bilateral lymph nodes listed in 100.*

F. **Neoadjuvant treatment planned or administered**: If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the farthest involved regional lymph nodes based on information prior to surgery.

- Example: Patient has a hard matted mass in the axilla (code 510) and a needle biopsy of the breast that confirms ductal carcinoma. Patient receives three months of chemotherapy. The pathology report from the modified radical mastectomy shows only scar tissue in the axilla with no involvement of axillary lymph nodes (Negative, code 000). *Code CS Lymph Nodes as 510 because prior to treatment they appeared to be clinically involved and the chemotherapy apparently "sterilized" the lymph nodes.*

G. **Partial or no response to neoadjuvant treatment**: In the infrequent event that clinically involved regional lymph nodes do not respond to neoadjuvant treatment and are, in fact, more extensively involved after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code CS Reg Nodes Eval as 6, based on pathology/ operative report after treatment. In the infrequent event that the nodes do not respond to neoadjuvant treatment and there is no evidence of more extensive involvement after preoperative treatment as determined by the operative or pathology report, code the farthest extension from the clinical prior to neoadjuvant therapy and code CS Lymph Nodes Eval as 5. If response to treatment is not documented, code the clinical status of the lymph nodes and code CS Reg Nodes Eval as 5.

- Example: Patient has needle biopsy-proven prostate cancer with no mention of involved lymph nodes on CT scan (Negative, code 000). He receives Lupron while deciding whether to undergo a radical prostatectomy. At the time of surgery, a laparoscopic pelvic node biopsy is reported to show metastases (Regional nodes involved, code 100) to lymph nodes and the prostatectomy is canceled. *Code CS Lymph Nodes as 100 because the preoperative treatment (Lupron) had no effect on the lymph nodes.*

    a. If clinical involvement of regional lymph nodes is unknown but pathologic involvement is stated after treatment and clinician states there was a response to neoadjuvant, code CS Lymph Nodes as 999 and CS Reg Nodes Eval as 5.

    b. If clinical involvement of regional lymph nodes is unknown but pathologic involvement is stated and clinician states no response to treatment, code CS Lymph Nodes from path report and CS Reg Nodes Eval as 6.

H. **Use of Code 800**: The CS Lymph Nodes table for nearly every schema contains a code 800, defined as Lymph nodes, NOS. This code is to be used only when it is not possible to determine whether the involved lymph nodes are regional or distant. Each schema also includes a separate code for “Regional lymph nodes, NOS”. In general, lymph nodes removed during a resection of the primary site are regional and should be coded as such. Occasionally a distant lymph node will be removed separately from the primary site. In the infrequent situation where the involved lymph node is not identified as either regional or distant, use code 800, which will map to N1 category using the TNM downstaging rule applied in the CS computer algorithm.

4. **When CS Extension is coded as in situ/noninvasive**: Use code 000 for lymph node involvement when the CS Extension is coded in situ, even if no lymph nodes are removed, since “in situ” by definition means noninvasive. If there is evidence of nodal involvement associated with a tumor described as in situ, it would indicate that an area of invasion was missed and the primary tumor

is not an in situ lesion, so involved lymph nodes can be coded as appropriate for the case. Code the CS Extension field and the behavior code to reflect that the tumor is invasive.

5. **Terms meaning lymph node involvement**: For solid tumors, the terms "fixed" or "matted" and "mass in the hilum, mediastinum, retroperitoneum, and/or mesentery" (with no specific information as to tissue involved) are considered involvement of lymph nodes.

    A. Any other terms, such as "palpable," "enlarged," "visible swelling," "shotty," or "lymphadenopathy" should be ignored, unless there is a statement of involvement by the clinician.

    ❖ Exception: The terms adenopathy, enlargement, and mass in the hilum or mediastinum should be coded as involvement for lung primaries only.

    ➢ Example: Peribronchial lymph nodes are positive on fine needle aspiration biopsy. Contralateral mediastinal mass noted on CT scan but not biopsied. Patient chooses radiation therapy as primary treatment. *Use the code for contralateral mediastinal lymph node involvement as it is higher than the code for peribronchial lymph nodes.*

    B. **For lymphomas**, any positive mention of lymph nodes indicates involvement of those lymph nodes. Keep in mind, however, that involved lymph nodes are coded in CS Extension for lymphomas.

    C. Regional lymph nodes are not palpable for inaccessible lymph nodes sites such as bladder, colon, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri and ovary. The best description concerning regional lymph nodes will be on imaging studies or in the surgeon's evaluation at the time of exploratory surgery or definitive surgery. If regional lymph nodes for these sites are not mentioned on imaging or exploratory surgery, they are presumed to be clinically negative (code 000) based on the inaccessible lymph nodes rule.

    D. The terms "homolateral," "ipsilateral," and "same side" are used interchangeably.

    E. Any unidentified nodes included with the resected primary site specimen are to be coded as regional lymph nodes, NOS.

6. **Coding size of lymph node**: When size of involved regional lymph nodes is required, code from pathology report, if available:

    A. Code the size of the metastasis, not the entire node, unless otherwise stated in the site-specific schema. The size of the metastasis within the lymph node can be inferred if the

size for the entire node falls within one of the codes; for example, a single involved node 1.5 cm in size can be coded to "single lymph node < = 2 cm" because the metastasis cannot be larger than 1.5 cm.

- Example: Patient has radical nephroureterectomy for urothelial carcinoma of the renal pelvis. Synoptic pathology list shows three involved nodes, the largest of which is 2 cm in greatest diameter. *Code CS Lymph Nodes as 200 because multiple lymph nodes are involved and no single lymph node or its metastasis is larger than 5 cm in size.*

B. If the size of the metastasis in the node is unknown, code the size of the involved node(s) if given.

C. Code the clinical size of the involved node(s) in the absence of a pathologic size.

D. If the size given is described as a mass, code the size of the mass.

- Example: Patient presents with 6 cm hard upper jugular (Level II) neck mass. Needle biopsy of mass shows metastatic squamous carcinoma. Panendoscopy finds lesion on soft palate. *Code CS Lymph Nodes as 300 (regional lymph nodes listed in 100 {regional lymph node, NOS}, not stated if single or multiple).*
  Code Lymph Nodes Eval as 0 (physical exam).
  Code Site-specific Factor 1 (size of lymph node) as 060.
  Code Site-specific Factor 2 as 988 (not applicable in CSv2).
  Code Site-specific Factor 3 as 010 (level II node involved).
  Code Site-specific Factors 4-6 as 000 (no nodes involved).
  Code Site-specific Factor 7 as 010 (upper level nodes involved).
  Code Site-specific Factor 8 as 010 (nodes involved clinically, no extracapsular extension clinically).
  Code Site-specific Factor 9 as 050 (lymph nodes involved pathologically, unknown if extracapsular extension).
  The computer algorithm will combine the codes from CS Lymph Nodes, SSF1, and Lymph Nodes Eval and derive a cN2a.

E. Information about location, number and size of lymph nodes may be split among the CS Lymph Nodes field and one or more site-specific factors. Code the fields as completely as possible and the computer algorithm will derive the correct N category. Refer to the discussion of head and neck lymph nodes and breast lymph nodes in *Collaborative Stage Data Collection System Coding Instructions Manual,* Part 1-Section 2 for further information.

7. **Inferring lymph node involvement from stated N category or site-specific staging**: If the only indication of lymph node involvement in the record is the physician's statement of an N

category from the TNM staging system or a stage from a site-specific staging system, such as Dukes C, code the appropriate "Stated as N_, NOS" category or record the numerically lowest equivalent CS Lymph Nodes code for the site-specific staging system. CS Version 2 includes many code choices to accommodate physician statements of N1, N2 NOS, N2a, and so forth.

A. If there is a discrepancy between documentation in the medical record and the physician's assignment of TNM, the documentation takes precedence. Cases of this type should be discussed with the physician who assigned the TNM.

B. If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, lymph node involvement may be inferred from the N category stated by the physician.

C. Where there is doubt that the documentation in the medical record is complete and the physician's assignment of the T, N or M category differs from the stage assignment that the medical record would support, it is preferable to use a "Stated as" code for the T, N or M value corresponding to the physician's statement rather than a CS code mapping to a different T, N or M value. The registrar is strongly encouraged to record in text the rationale for the selected code.

8. **Isolated Tumor Cells (ITCs) in lymph nodes**: Several chapters in the TNM seventh edition refer to isolated tumor cells or ITCs. ITCs are single cells or small clusters of epithelial cells in regional lymph nodes whose metastatic potential is unknown. ITCs are coded according to site-specific guidelines.

   A. For breast, ITCs are coded as negative lymph nodes (CS Lymph Nodes code 000 or 050, which maps to pN0(i+) or pN0(mol+).

   B. For cutaneous melanoma, ITCs are coded as positive lymph nodes.

   C. For Merkel cell carcinoma, ITCs are coded as positive lymph nodes.

9. **Use of NOS categories**: Some schemas include designations such as N1, NOS; N2, NOS, and other non-specific categories. The NOS is added when there is further breakdown of the category into subsets (such as N1a, N1b, N1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as N1 NOS" when the appropriate subset (e.g., N1a or N1b) cannot be determined.

10. **Discontinuous (satellite) tumor deposits (peritumoral nodules) for colon, appendix, rectosigmoid and rectum:** Tumor nodules in pericolic or perirectal fat without evidence of

residual lymph node structures can be one of several aspects of the primary cancer: discontinuous spread, venous invasion with extravascular spread, or a totally replaced lymph node. These various aspects are handled in different ways in CS. Furthermore, there are different definitions in the sixth and seventh editions of the AJCC Cancer Staging Manual for discontinuous tumor nodules found near the primary site.

A. In the seventh edition and CSv2, if the primary tumor is localized or maps to T1 or T2, code CS Lymph Nodes as 050 if the only information available is the presence of tumor nodules in pericolic fat. In addition, code the total number of tumor deposits in the appropriate Site-specific Factor for Tumor Deposits. If there are tumor deposits and involved regional lymph nodes, code the information on regional lymph nodes in CS Lymph Nodes, the number of positive nodes in Lymph Nodes Positive, and the number of tumor deposits in the appropriate Site-specific Factor for Tumor Deposits.

B. In the sixth edition of TNM and CS Version 1, tumor nodule(s) present in pericolic or perirectal fat should be coded using the following guidelines:

    a. Code as regional lymph node involvement if the nodule has a smooth contour.

    b. Code as tumor extension if the nodule has an irregular contour.

11. **Lymph Node Maps for Esophageal Cancer.** AJCC has provided maps of regional lymph nodes to aid in CS coding. See illustrations in Part II of the *Collaborative Stage Data Collection System Coding Instructions Manual,* Part 1-Section 2.

12. **Sentinel lymph nodes:** Involved nodes found during sentinel lymph node procedures are classified as positive nodes and coded in CS Lymph Nodes. However, whether the involved sentinel lymph nodes are clinical or pathologic will depend on whether the primary tumor meets the criteria for clinical or pathologic staging. In other words, involved sentinel nodes may be classified as clinical if there is no resection of the primary tumor. For further information, see the coding guidelines for CS Reg Nodes Eval.

13. **For the following primary sites, CS Lymph Nodes is always coded 988, Not applicable:**

    Placenta
    Brain and Cerebral Meninges
    Other Parts of Central Nervous System
    Intracranial Gland
    Hodgkin and Non-Hodgkin Lymphoma
    Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
    Other and Ill-Defined Primary Sites
    Unknown Primary Site

14. The TCR requires documentation in the text field supporting the code selected for this field and the source used to identify the lymph node involvement (or lack of involvement) information.

    - Example: 7/15/2012 Sentinel lymph node biopsy, left breast- 1 lymph node positive for ductal carcinoma.

Codes:

See the most current version of the *Collaborative Stage Data Collection System* for applicable codes.

https://cancerstaging.org/cstage/schema/Pages/version0205.aspx

CS Lymph Nodes Eval

Field Length: 1

Source of Standard: AJCC

Description:

Records how the code for CS Lymph Nodes was determined, based on the diagnostic methods employed.

General Guidance:

- A major change reflecting current medical practice occurred in the rules for clinical and pathologic classification of regional lymph nodes effective with the *Seventh Edition of the AJCC Cancer Staging Manual*. In CSv2, CS Lymph Nodes Eval is coded as clinical or pathologic based on the intent of the procedure and matching the assessment of the T classification (coded in CS TS/Ext Eval). The intent can be either clinical/diagnostic or therapeutic.

- When the lymph node procedure is part of the workup, the staging basis is clinical (CS Lymph Nodes Eval codes 0, 1, 5, 9). If the microscopic assessment (workup) of lymph nodes, such as a regional node biopsy or sentinel lymph node procedure, is intended to help choose the treatment plan, the information obtained is part of clinical staging. In these circumstances, the tumor size and/or extension (T-category) information is also clinical and any resection of the primary site does not meet the criteria for pathologic T classification. If a subsequent resection of primary is performed that meets the criteria for pathologic T classification or biopsy assessment of the highest T category occurs, the regional node biopsy or sentinel lymph node procedure, performed originally as part of workup, can then be used for the pathologic N classification.

- When the intent of the lymph node procedure is therapeutic (treatment), the staging basis is pathologic (CS Reg Nodes Eval codes 2, 3, 6). In these circumstances, there is often a resection of the primary site that meets the criteria for pathologic T classification (also part of the treatment) or there is microscopic confirmation of the highest T category without a surgical resection of the primary site. However, having a resection or pathologic assessment of the highest T category is not mandatory, and when the lymph node procedure is therapeutic (treatment), the staging basis is pathologic.

CS Lymph Nodes Eval

- Example: Breast cancer patient diagnosed by mammography and core needle biopsy; axilla clinically negative. Patient opts for lumpectomy and sentinel node biopsy, which is negative for lymph node metastases. *Code CS Lymph Nodes Eval as 3 because the sentinel node biopsy was part of the treatment.*

- Example: Large breast mass found to be cancerous on core needle biopsy. Fullness in axilla on physical examination. Sentinel node biopsy shows micrometastasis in one of three nodes. Patient received neoadjuvant chemotherapy followed by modified radical mastectomy. On the mastectomy pathology report, no positive lymph nodes were found. *Code CS Lymph Nodes Eval as 5 because the sentinel node biopsy was performed as part of the workup and the patient received surgical treatment to primary site following neoadjuvant treatment.*

- Example: Patient has hard lump in low neck and an endoscopic paratracheal node biopsy confirms metastatic lung cancer. Patient treated with chemoradiation. *Code CS Lymph Nodes Eval as 1 because the endoscopic biopsy was part of the workup and patient did not have resection of the primary site.*

- Example: Sigmoid colon cancer diagnosed by colonoscopy. At the time of resection, 3/15 pericolic lymph nodes were found to contain metastatic cancer. *Code CS Lymph Nodes Eval as 3 because positive nodes were found as part of surgical resection of primary site*.

- Example: Needle core biopsy confirms ductal carcinoma right breast. Subsequent sentinel node biopsy is negative for lymph node metastases. Simple skin sparing mastectomy)no lymph node dissection) performed one week later. *Code CS Lymph Nodes Eval as 3 because, although the sentinel node biopsy was part of workup, the patient received surgical treatment of the primary that meets criteria for pathologic T classification.*

- Example: Patient has malignant melanoma on the forearm confirmed by shave biopsy. Patient has an FNA of an enlarged axillary lymph node that shows no involvement of the axillary lymph node by melanoma. Patient's treatment consists of wide excision of primary site. *Code CS Lymph Nodes Eval as 1 because the lymph node aspiration was done to determine what type of treatment the patient should have,* and a lymph node aspiration does not meet the AJCC rule that "at least one node documented by pathologic examination is required for pathologic staging N."

- Example: Patient has squamous cell carcinoma of glottis confirmed by biopsy. Patient is experiencing pain due to lymphadenopathy. Subsequent lymph node dissection indicates 9/31 nodes on right consistent with metastatic squamous cell carcinoma. After lymph node dissection, patient agrees to concurrent chemotherapy and radiotherapy.

Code CS Lymph Nodes Eval as 3 because the lymph node dissection was part of treatment.

Coding Instructions:

1. This data item is only required on cases diagnosed 1/1/2004 – 12/31/2015.

2. Timing rule: Refer to General Guidelines for Collaborative Stage for timing rules for data collection.

3. **Document the farthest involved regional nodes**.

   A. Select the CS Lymph Nodes Eval code that identifies the type of report or procedure from which the information about the farthest involved regional lymph nodes was obtained. This may not be the numerically highest eval code.

      - Example: Modified radical neck dissection for hypopharyngeal cancer shows one lower jugular node involved (CS LN code 100, Eval code 3). Physical exam shows hard, matted scalene (transverse cervical) node presumed to contain metastasis (CS LN code 320, Eval code 0). *Code CS Lymph Nodes Eval as 0 because the scalene node involvement was determined clinically rather than by examination of tissue.*

   B. If there is a discrepancy between clinical and pathologic information about the same lymph node chain(s), **pathologic information takes priority**. It is not necessary to biopsy every node in the chain to prove that they are negative.

      - Example: Lung cancer patient has a CT scan showing a mass of lymph nodes in the ipsilateral mediastinum. Biopsies at mediastinoscopy report that two ipsilateral mediastinal lymph nodes are negative for tumor. *Code CS Lymph Nodes as 000 and CS Lymph Nodes Eval as 1 because the mediastinoscopy disproved the clinically suspicious mediastinal nodes.*

   C. **Mapping of N subcategories**: Select the CS Lymph Node Eval code that describes how the most advanced subcategory of the derived N was determined.

      a. If a specific subcategory of N will be derived (such as N2b), determine if there was any pathological evidence for the specific subcategory. If so, select a CS Lymph Node Eval code that will derive a “p” staging basis if the patient also has surgical resection of the primary site.

b. If there was only clinical evidence of the subcategory disease, select a CS Lymph Node Eval code that will derive a "c" staging basis. In the latter case there may have been pathological evidence of a lower N subcategory, but this is not considered in assigning the Eval code.

- Example: Breast cancer patient with 10 of 14 axillary nodes positive at time of modified radical mastectomy (CS Lymph Nodes code 600, Site-specific Factor 3 code 010, maps to pN3a). Patient also has palpable hard supraclavicular node presumed to be involved by the clinician (CS Lymph Nodes code 800, maps to N3c). *Code CS Lymph Node Eval as 0 because the physical examination documented a higher N subcategory than the axillary dissection.*

4. **When there is no TNM mapping:** For sites and histologies for which no TNM schema has been defined , such as brain or Kaposi sarcoma, this field is always coded 9, Not Applicable. For any sites that have no TNM mapping, code to the value that best identifies the diagnostic methods used, whether or not a stage group is actually calculated for an individual case. In other words, do not use code 9 when a case has a histology that is excluded from staging but the site does have a TNM schema defined, for example, for sarcoma of the breast. In those cases, use code 9 only when the nature of the diagnostic method is actually unknown.

5. Select the code that best explains how the information in the CS Lymph Nodes field was determined.

A. **If no lymph nodes are removed**. If the patient had no removal of lymph node(s), use code 0, 1, or 9.

- Example: Prostate cancer with laparoscopic lymph node biopsy showing microscopically involved nodes; radical prostatectomy canceled*. Code CS Lymph Node Eval as 3. Staging algorithm will identify information as pathologic (p). According to AJCC, a positive biopsy of one or more regional lymph nodes is sufficient to meet the pathologic staging basis for prostate cancer.*

- Example: Lung cancer with CT scan or MRI showing involved contralateral mediastinal nodes. *Code CS Lymph Node Eval as 0. Staging algorithm will identify information as clinical (c).*

B. **Lymph nodes removed followed by other treatment(s):** If the patient had removal of lymph node(s) surgery together with removal of the primary site that meets the criteria for a pathologic T and these procedures are followed by other treatment(s), use code 3.

C. **When there is pre-operative treatment:** If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or

radiation therapy, the clinical status of lymph nodes takes precedence (code 5). If lymph node dissection is not performed after neoadjuvant therapy, use code 0 or 1.

D. **When there is more extensive lymph node involvement after preoperative treatment**: Use only code 5 or 6 if the node assessment is performed after neoadjuvant therapy. If the size, number or extension of regional lymph node involvement determined prior to treatment was the basis for neoadjuvant therapy, use code 5. However, if more extensive tumor is found during lymph node examination after neoadjuvant therapy, use code 6.

E. **Use of autopsy codes 2 and 8.** If the patient had an autopsy and the autopsy information meets the timing rules for determining regional lymph node involvement, use code 2 if the diagnosis was known or suspected prior to death. Use code 8 if the malignancy was not known or suspected prior to death.

6. **Definition of code 0**: Code 0 is the lowest common denominator for evaluation methods and includes physical examination, imaging examination, and/or other non-invasive clinical evidence. If CS Lymph Nodes is coded 000 based on the clinician's impression that there are no involved regional nodes (inaccessible nodes rule), use code 0 to document that met the criteria for a clinical M0.

   - ***Examples of imaging studies included in Code 0***: Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography (US), lymphography, angiography, scintigraphy (nuclear scans), magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non invasive methods of examining tissues. According to the AJCC Cancer Staging Manual seventh edition, extensive imaging is not necessary to assign a clinical staging basis.

7. **Use of code 1:** Codes 0-3 are oriented to the AJCC staging basis. Code 1 includes microscopic analysis of tissue insufficient to meet the requirements for pathologic staging in the TNM system. For example, a needle biopsy of an axillary lymph node will document that a lymph node contains metastases from a breast cancer, but does not meet the requirement for removal of a sufficient number of lymph nodes so that the highest N stage can be assessed. For specific classification rules, refer to the *AJCC Cancer Staging Manual, Seventh Edition*. Code 1 also includes observations at surgery, such as abdominal exploration at the time of a colon resection, where regional lymph nodes are not biopsied. Code 1 is used when the lymph node procedure is part of the patient's workup to determine the course of treatment and the patient does not undergo resection of the primary site sufficient to meet the criteria for a pathologic T category.

8. **Use of code 3**: Code 3 maps to pathologic staging across all sites. Use code 3 when the lymph node procedure meets the requirements for pathologic staging basis of regional lymph nodes. The requirements vary among sites as to the location and number of lymph nodes involved, the size of the involved nodes, and other characteristics. For example, for prostate cancer, a positive fine needle aspiration biopsy of a single lymph node is sufficient to code CS Lymph Nodes Eval as code 3, because only one positive node is needed to classify the case as pN1 and there is only one positive N category (N1). In contrast, a fine needle aspiration of a hilar mass (N1) associated with a lung cancer should be coded in CS Lymph Nodes Eval as 1 because by itself it is not sufficient to document the highest N since there are three positive N categories. However, microscopic assessment of the highest N category, for example a supraclavicular node containing metastatic lung cancer, is always pathologic (code 3).

9. **Sentinel nodes**: The coding guidelines for positive sentinel lymph nodes in CS Lymph Nodes Eval are site-specific. In general, however, whether the involved sentinel lymph nodes are clinical or pathologic will depend on whether the primary tumor meets the criteria for clinical or pathologic staging. In other words, involved sentinel nodes may be classified as clinical if there is no resection of the primary tumor or if the resection of the primary tumor is not adequate for pathologic T.

    A. When the tumor size and/or extension of the primary tumor meets the criteria for pathologic staging and lymph nodes are biopsied or removed for examination, information on lymph nodes is considered pathologic and it is not necessary to document the highest N category.

    - Example: Patient has a lumpectomy and sentinel lymph node procedure for breast cancer. The margins around the primary tumor are clear, and there is one of three sentinel nodes positive for metastatic duct carcinoma. *Code CS Lymph Nodes Eval as 3 because when the primary tumor procedure meets the criteria for pathologic T and sentinel nodes meet the criteria for pathologic N.*

    B. When the tumor size and/or extension of the primary tumor does not meet the criteria for pathologic staging, examination of a single lymph node or sentinel nodes is considered clinical.

    - Example: Patient presents with large ulcerated mass in the breast and clinically positive axillary nodes. Core needle biopsies of the breast mass and the axillary node confirm carcinoma. Patient undergoes pre-operative chemotherapy followed by a modified radical mastectomy. *Code CS Lymph Nodes Eval as 5 because when the primary tumor procedure does not meet the criteria for pathologic T, and a core needle biopsy of level I lymph nodes performed prior to neoadjuvant treatment is clinical.*

C. If there is a positive biopsy of a lymph node in the highest N category, CS Lymph Nodes Eval should be coded as 3 regardless of whether the primary tumor is clinical or pathologic.

- Example: Patient presents with a hard supraclavicular mass, which is excised and shows metastatic squamous carcinoma. Further diagnostic workup shows a mass in the left upper lobe of the lung with several satellite nodules. *Code CS Lymph Nodes Eval as 3 because supraclavicular nodes are in the highest N category (N3).*

10. **Neoadjuvant therapy and 2nd primaries:** When an incidental 2nd primary is discovered at the time of surgery following neoadjuvant therapy (systemic/radiation therapy followed by surgery), this 2nd primary should be coded to Eval code 3, and **NOT** be coded to eval codes 5 or 6. This would also be true for a 2nd (or higher number) primary diagnosed and treated with a surgical resection as the first course of therapy, when the previous primary was treated with systemic or radiation therapy at any time (adjuvant or neoadjuvant or for a recurrence). To include these cases with those purposefully treated with neoadjuvant therapy would skew the data. The effect of the prior treatment for the previous primary on the new primary is unknown.

11. **Coding CS Lymph Nodes Eval when lymph node status is unknown**: The Eval fields should be coded based on how the information was obtained, even if the information in the related field (Tumor Size, Regional Nodes, or Mets at Dx) is unknown. For example, even if it is not possible to determine lymph node involvement and the CS Lymph Nodes field is coded as 999, the registrar still knows what procedures were used to try to determine that field. In other words, just because the lymph nodes are coded 999, the Eval field does not have to be coded 9.

12. **The following schemas are always coded 9 Not Applicable or Does Not Apply:**

AdnexaUterineOther
Brain
CNSOther
DigestiveOther
EndocrineOther
EyeOther
GenitalFemaleOther
GenitalMaleOther
HemeRetic
IllDefinedOther
IntracranialGland
KaposiSarcoma
Lymphoma
MelanomaSinusOther
MiddleEar
MyelomaPlasmaCellDisorder

PharynxOther
Placenta
RespiratoryOther
SinusOther
Trachea
UrinaryOther

13. The TCR requires documentation in the text field supporting the code selected for this field. Documentation must indicate what source was used to determine the CS Lymph Nodes field. Example: 05/03/2012 Sentinel lymph node bx: 1 LN +.

Codes:

See the most current version of the *Collaborative Stage Data Collection System* for applicable codes.

https://cancerstaging.org/cstage/schema/Pages/version0205.aspx

CS Mets at DX

Field Length: 2

Source of Standard: AJCC

Description:

Identifies the distant site(s) of metastatic involvement at time of diagnosis.

Coding Instructions:

1. This data item is only required on cases diagnosed 1/1/2004 – 12/31/2015.

2. Timing rule: Refer to General Guidelines for Collaborative Stage for timing rules for data collection.

3. **Discontinuous or hematogenous metastases**: This field represents distant metastases (the TNM M component or distant stage in Summary Staging) that are known at the time of diagnosis. In other words, when the patient was diagnosed, tumor had already spread indirectly (through vascular or lymph channels) to lymph nodes beyond those defined as regional or to a site remote from the primary tumor.

    - ✓ Note: The structure of the CS Mets at Dx field is based on the M category of TNM. In some schemas, there may be additional items in CS Extension or CS Lymph Nodes that map to distant stage in Summary Staging (1977 and/or 2000) and there may be some items in CS Mets at Dx that map to regional stage in Summary Staging. Regardless of where such items are recorded, the staging algorithms will properly account for the information.

    - ✓ Note: For a few schemas such as breast, lung, and kidney, some codes in CS Mets at Dx are distant direct (contiguous) extension either in the summary staging system or in TNM. If the structure involved by direct extension is not listed in CS Extension, look for a code in CS Mets at Dx. Code the involved structure wherever it is listed—the CS computer algorithm will derive the correct stage in both TNM and summary stage. If the specific structure is not listed in either CS Extension or CS Mets at Dx, code as CS Extension 800, further contiguous extension.

4. **Use highest applicable code**: Assign the highest applicable code for metastasis at diagnosis, whether the determination was clinical or pathological and whether or not the patient had any preoperative systemic therapy. Code 40 includes statements of metastases to specific named structures or "carcinomatosis." Code 60 is nonspecific distant metastases or a statement of M1 with no further information about metastases; code 60 does not take priority over lower codes.

5. **Progression of disease**: Metastasis known to have developed after the extent of disease was established (also referred to as progression of disease) should not be recorded in the CS Mets at Dx field.

6. **Coding 00 versus 99**:

    A. Record CS Mets at Dx as Code 00 (None) if there is no clinical or pathologic evidence of distant metastases and the patient is not treated as if metastases are present or suspected. This presumes that there are no distant metastasis that would otherwise alter the treatment approach.

    B. Code 99 may be used in situations where there is reasonable doubt that the tumor is no longer localized and there is no documentation of distant metastases. Note that code 99 maps to MX in sixth edition and cM0 in seventh edition.

    C. Based on the *AJCC Cancer Staging Manual, Seventh Edition*, determination of the clinical M classification (CS Mets at Dx code 00) only requires history and physical examination. Imaging of distant organ sites is not required to assign cM0 or CS Mets at Dx code 00. In other words, the data collector can infer that there are no distant metastases and code CS Mets at Dx as 00 (cM0) unless distant metastases are identified and classified as cM1 or pM1 (or its equivalents in CS Mets at Dx). Use code 0 in CS Mets Eval as this documents minimal physical examination to support the inference of clinical M0.

7. **No MX classification for AJCC seventh edition**: The category MX has been eliminated from the seventh edition of the TNM staging system. As noted above, if there are no symptoms or other indication of distant metastases, the mapping algorithm takes CS Mets at Dx codes 00 and 99 and maps both to cM0.

8. **Inferring distant metastases from stated M category or site-specific staging**: If the only indication of distant metastases in the record is the physician's statement of an M category from the TNM staging system or a stage from a site-specific staging system, such as Dukes D, code the appropriate "Stated as M_, NOS" category or record the numerically lowest equivalent CS Mets at Dx code for the site-specific staging system. In most cases, this will be 60, Distant metastasis, NOS.

A. If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the M category stated by the physician.

B. Where there is doubt that the documentation in the medical record is complete and the physician's assignment of the T, N or M category differs from the stage assignment that the medical record would support, it is preferable to use a "Stated as" code for the T, N or M value corresponding to the physician's statement rather than a CS code mapping to a different T, N or M value. The registrar is strongly encouraged to record in text the rationale for the selected code.

9. **Use of NOS categories**: Some schemas include a designation of M1, NOS. The NOS is added when there is further breakdown of the category into subsets (such as M1a, M1b, M1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as M1 NOS" when the appropriate subset (such as M1a or M1b) cannot be determined.

10. **Circulating Tumor Cells (CTCs) and Disseminated Tumor Cells (DTCs)**: CTCs and DTCs are small clusters of tumor cells found in distant sites such as bone, circulating blood, or bone marrow having uncertain prognostic significance.

    A. For breast, code CS Mets at Dx as 05 when a biopsy of a possible metastatic site shows isolated tumor cells or bone marrow micrometastases detected by IHC or molecular techniques. CS Mets at Dx code 05 maps to cM0(i+).

    B. For other sites, CTCs and DTCs are coded in CS Mets at Dx as 00 and map to cM0.

11. **Primary sites always coded 98**: For the following primary sites and histologies, CS Mets at Dx is always coded as 98:

    Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
    Hodgkin and non-Hodgkin Lymphoma
    Kaposi Sarcoma
    Myeloma and Plasma Cell Disorders
    Other and Ill-Defined Primary Sites
    Unknown Primary Site

12. The TCR requires documentation in the text field supporting the code selected for this field and the source used to identify the metastases (or lack of metastatic disease).

- Example: 10/19/2012 Abdominal xray- Multiple metastatic liver lesions from newly diagnosed colon cancer.

Codes:

See the most current version of the *Collaborative Stage Data Collection System* for the applicable codes.

https://cancerstaging.org/cstage/schema/Pages/version0205.aspx

CS Mets at Dx-Bone

Field Length: 1

Source of Standard: AJCC

Description:

Identifies the presence of distant metastatic involvement of bone at time of diagnosis.

General Guidance:

- This data item is only required on cases diagnosed 1/1/2010 – 12/31/2015.
- If CS Mets at Dx is coded to 00, this field must be coded 0. If CS Mets at Dx is not coded to 00, this field may still be coded to 0 if bone is not a site of metastasis.

Coding Instructions:

1. Timing rule: Refer to General Guidelines for Collaborative Stage for timing rules for data collection.
2. **Code information about bone metastases only (discontinuous or distant metastases to bone) identified at the time of diagnosis**. This field should not be coded for bone marrow involvement.
    A. Bone involvement may be single or multiple.
    B. Information about bone involvement may be clinical or pathologic.
    C. Code this field whether or not the patient had any preoperative systemic therapy.
    D. This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.
3. **Use of codes**: Assign the code that best describes whether the case has bone metastases.
    A. Use code 0 when the medical record:

a. Indicates that there are no distant (discontinuous) metastases at all

b. Includes a clinical or pathologic statement that there are no bone metastases

c. Includes imaging reports that are negative for bone metastases

d. Indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) but bone is not mentioned as an involved site. For example, use code 0 when the patient has lung and liver metastases but not bone.

B. Use code 1 when the medical record:

a. Indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) and bone is mentioned as an involved site

b. Indicates that bone is the primary site and there are metastases in a different bone or bones

C. Use code 8 when CS Mets at Dx is coded as 98 (not applicable for this site) **except** for unknown and ill-defined primary site (IllDefinedOther schema) and the exceptions below. CS Mets at Dx is coded 98 for most hematopoietic, reticuloendothelial, immunoproliferative, and myeloproliferative neoplasms and Hodgkin and non-Hodgkin lymphoma.

❖ **Exception**: The following lymphoma schemas have CS Mets at DX codes other than 98. Code 8 is not allowed for the four CS Mets at DX Bone, Brain, Liver, and Lung fields. Codes 0, 1 or 9 should be used:

a. Mycosis Fungoides: Histologies 9700 (Mycosis Fungoides) and 9701 (Sezary Syndrome).

b. LymphomaOcular Adnexa: M-9590-9699, 9702-9738, 9811-9818, 9820-9837 with primary sites: C44.1- Skin of Eyelid, C69.0- Conjunctiva, C69.5- Lacrimal Gland and C69.6- Orbit.

D. Use code 9 when:

a. It cannot be determined from the medical record whether the patient specifically has bone metastases; for example, when CS Mets at Dx is coded as carcinomatosis but bone is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include bone.

b. CS Mets at Dx is coded 99 (unknown).

4. The TCR requires documentation in the text field supporting the code selected for this field and the source used to identify metastatic involvement (or lack of involvement) of the bone.

   - 09/02/2012 Bilateral hip xray- Negative for metastatic disease.

Codes:

See the most current version of the *Collaborative Stage Data Collection System* for applicable codes.

https://cancerstaging.org/cstage/schema/Pages/version0205.aspx

CS Mets at Dx-Brain

Field Length: 1

Source of Standard: AJCC

Description:

Identifies the presence of metastatic involvement of the brain at the time of diagnosis.

General Guidance:

- This data item is only required on cases diagnosed 1/1/2010 – 12/31/2015.
- If CS Mets at Dx is coded to 00, this field must be coded 0. If CS Mets at Dx is not coded to 00, this field may still be coded to 0 if brain is not a site of metastasis.

Coding Instructions:

1. Timing rule: Refer to General Guidelines for Collaborative Stage for timing rules for data collection.
2. **Code information about brain metastases only** (discontinuous or distant metastases to brain) known at the time of diagnosis. This field should not be coded for involvement of spinal cord or other parts of the central nervous system.
    A. Brain involvement may be single or multiple.
    B. Information about brain involvement may be clinical or pathologic.
    C. Code this field whether or not the patient had any preoperative systemic therapy.
    D. This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
3. **Use of codes**: Assign the code that best describes whether the case has brain metastases.
    A. Use code 0 when the medical record:

a. Indicates that there are no distant (discontinuous) metastases at all

b. Includes a clinical or pathologic statement that there are no brain metastases

c. Includes imaging reports that are negative for brain metastases

d. Indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) but brain is not mentioned as an involved site. For example, use code 0 when the patient has lung and liver metastases but not brain.

B. Use code 1 when the medical record:

a. Indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) and brain is mentioned as an involved site

b. Indicates that brain is the primary site and there are metastases within the brain

C. Use code 8 when CS Mets at Dx is coded as 98 (not applicable for this site) **except** for unknown and ill-defined primary site (IllDefinedOther schema) and the exceptions below. CS Mets at Dx is coded 98 for most hematopoietic, reticuloendothelial, immunoproliferative, and myeloproliferative neoplasms and Hodgkin and non-Hodgkin lymphoma.

❖ **Exception**: The following lymphoma schemas have CS Mets at DX codes other than 98. Code 8 is not allowed for the four CS Mets at DX Bone, Brain, Liver, and Lung fields. Codes 0, 1 or 9 should be used:

a. Mycosis Fungoides: Histologies 9700 (Mycosis Fungoides) and 9701 (Sezary Syndrome).

b. LymphomaOcular Adnexa: M-9590-9699, 9702-9738, 9811-9818, 9820-9837 with primary sites: C44.1- Skin of Eyelid, C69.0- Conjunctiva, C69.5- Lacrimal Gland and C69.6- Orbit.

D. Use code 9 when:

a. It cannot be determined from the medical record whether the patient specifically has brain metastases; for example, when CS Mets at Dx is coded as

carcinomatosis but brain is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include brain.

b. CS Mets at Dx is coded 99 (unknown).

4. The TCR requires documentation in the text field supporting the code selected for this field and the source used to identify metastatic involvement (or lack of involvement) of the brain.

   - Example: 11/03/2012 CT of brain- Multiple metastatic lesions in the temporal lobe.

Codes:

See the most current version of the *Collaborative Stage Data Collection System* for the applicable codes.

https://cancerstaging.org/cstage/schema/Pages/version0205.aspx

CS Mets at Dx-Liver

Field Length: 1

Source of Standard: AJCC

Description:

Identifies the presence of distant metastatic involvement of the liver at time of diagnosis.

General Guidance:

- This data item is only required on cases diagnosed 1/1/2010 – 12/31/2015.
- If CS Mets at Dx is coded to 00, this field must be coded 0. If CS Mets at Dx is not coded to 00, this field may still be coded to 0 if liver is not a site of metastasis.

Coding Instructions:

1. Timing rule: Refer to General Guidelines for Collaborative Stage for timing rules for data collection.
2. **Code information about liver metastases only** (discontinuous or distant metastases to liver) known at the time of diagnosis.
    A. Liver involvement may be single or multiple.
    B. Information about liver involvement may be clinical or pathologic.
    C. Code this field whether or not the patient had any preoperative systemic therapy.
    D. This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.
3. **Use of codes**: Assign the code that best describes whether the case has liver metastases.
    A. Use code 0 when the medical record:

a. Indicates that there are no distant (discontinuous) metastases at all

b. Includes a clinical or pathologic statement that there are no liver metastases

c. Includes imaging reports that are negative for liver metastases

d. Indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) but liver is not mentioned as an involved site. For example, use code 0 when the patient has lung and brain metastases but not liver.

B. Use code 1 when the medical record:

a. Indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) and liver is mentioned as an involved site

b. Indicates that liver is the primary site and there are metastases within the liver

C. Use code 8 when CS Mets at Dx is coded as 98 (not applicable for this site) **except** for unknown and ill-defined primary site (IllDefinedOther schema) and the exceptions below. CS Mets at Dx is coded 98 for most hematopoietic, reticuloendothelial, immunoproliferative, and myeloproliferative neoplasms and Hodgkin and non-Hodgkin lymphoma.

❖ **Exception**: The following lymphoma schemas have CS Mets at DX codes other than 98. Code 8 is not allowed for the four CS Mets at DX Bone, Brain, Liver, and Lung fields. Codes 0, 1 or 9 should be used:

a. Mycosis Fungoides: Histologies 9700 (Mycosis Fungoides) and 9701 (Sezary Syndrome).

b. LymphomaOcular Adnexa: M-9590-9699, 9702-9738, 9811-9818, 9820-9837 with primary sites: C44.1- Skin of Eyelid, C69.0- Conjunctiva, C69.5- Lacrimal Gland and C69.6- Orbit.

D. Use code 9 when:

a. It cannot be determined from the medical record whether the patient specifically has liver metastases; for example, when CS Mets at Dx is coded as carcinomatosis but liver is not specifically mentioned as a metastatic site. In

other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include liver.

b. CS Mets at Dx is coded 99 (unknown).

4. The TCR requires documentation in the text field supporting the code selected for this field and the source used to identify metastatic involvement (or lack of involvement) of the liver.

   - Example: 2/5/2012- Abdominal xray findings- Multiple metastatic liver lesions.

Codes:

See the most current version of the *Collaborative Stage Data Collection System* for applicable codes.

https://cancerstaging.org/cstage/schema/Pages/version0205.aspx

CS Mets at Dx-Lung

Field Length: 1

Source of Standard: AJCC

Description:

Identifies the presence of distant metastatic involvement of the lung at time of diagnosis.

General Guidance:

- This data item is only required on cases diagnosed 1/1/2010 – 12/31/2015.
- If CS Mets at Dx is coded to 00, this field must be coded 0. If CS Mets at Dx is not coded to 00, this field may still be coded to 0 if lung is not a site of metastasis.

Coding Instructions:

1. Timing rule: Refer to General Guidelines for Collaborative Stage for timing rules for data collection.
2. **Code information about lung metastases only** (discontinuous or distant metastases to lung) known at the time of diagnosis. This field should not be coded for pleural or pleural fluid involvement.
    A. Lung involvement may be single or multiple.
    B. Information about lung involvement may be clinical or pathologic.
    C. Code this field whether or not the patient had any preoperative systemic therapy.
    D. This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.
3. **Use of codes**: Assign the code that best describes whether the case has lung metastases.
    A. Use code 0 when the medical record:

a. Indicates that there are no distant (discontinuous) metastases at all

b. Includes a clinical or pathologic statement that there are no lung metastases

c. Includes imaging reports that are negative for lung metastases

d. Indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) but lung is not mentioned as an involved site. For example, use code 0 when the patient has brain and liver metastases but not lung.

B. Use code 1 when the medical record:

a. Indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) and lung is mentioned as an involved site

b. Indicates that lung is the primary site and that there are metastases within the lung

C. Use code 8 when CS Mets at Dx is coded as 98 (not applicable for this site) **except** for unknown and ill-defined primary site (IllDefinedOther schema) and the exceptions below. CS Mets at Dx is coded 98 for most hematopoietic, reticuloendothelial, immunoproliferative, and myeloproliferative neoplasms and Hodgkin and non-Hodgkin lymphoma.

❖ **Exception**: The following lymphoma schemas have CS Mets at DX codes other than 98. Code 8 is not allowed for the four CS Mets at DX Bone, Brain, Liver, and Lung fields. Codes 0, 1 or 9 should be used:

a. Mycosis Fungoides: Histologies 9700 (Mycosis Fungoides) and 9701 (Sezary Syndrome).

b. LymphomaOcular Adnexa: M-9590-9699, 9702-9738, 9811-9818, 9820-9837 with primary sites: C44.1- Skin of Eyelid, C69.0- Conjunctiva, C69.5- Lacrimal Gland and C69.6- Orbit.

D. Use code 9 when:

a. It cannot be determined from the medical record whether the patient specifically has lung metastases; for example, when CS Mets at Dx is coded as

carcinomatosis but lung is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include lung.

b. CS Mets at Dx is coded 99 (unknown).

4. The TCR requires documentation in the text field supporting the code selected for this field and the source used to identify metastatic involvement (or lack of involvement) of the lung.

   - Example: 7/4/2012- Chest xray- Multiple tumors right lung consistent with mets.

Codes:

See the most current version of the *Collaborative Stage Data Collection System* for applicable code.

https://cancerstaging.org/cstage/schema/Pages/version0205.aspx

CS Mets Eval

Field Length: 1

Source of Standard: AJCC

Description:

Records how the code for CS Mets at Dx was determined based on the diagnostic methods employed.

Coding Instructions:

1. This data item is only required on cases diagnosed 1/1/2004 – 12/31/2015.

2. **Document the highest code in CS Mets at Dx**. The primary use of the CS Mets Eval field is to assign a "c" or "p" to the M category derived from the CS Mets at Dx field. Since both clinical and pathologic evidence might be available for assessing distant metastasis, the coding of the Eval field can be confusing. The goal is to assign the Eval code that indicates the best evidence used to determine the M category. In other words, the concept of the Mets Eval field is slightly different from the other Eval fields in that results of the procedure are coded, rather than the type of procedure that provided the information about distant metastasis. Coding of the Eval field therefore requires that the abstractor take note of the M category that will be derived from the code in the CS Mets at Dx field and then use the following guidelines to determine the best Eval code to assign.

    A. **Deriving M0**: If M0 will be derived (i.e., no distant metastasis are present), select an Eval code that will derive a "c" staging basis. There is no category of pM0, because it is impossible to disprove all possible sites of metastasis pathologically. Therefore, do not assign CS Mets Eval code 2, 3, or 6 when CS Mets at DX is coded 00.

        - Example: Pancreatic carcinoma with negative chest X-ray and negative liver biopsy. Code CS Mets at Dx as 00 (None), which maps to M0. *Code CS Mets Eval as 1 to document the liver biopsy, which maps to the "c" staging basis.*

        - Example: Chest x-ray negative and surgical observation during hemicolectomy shows no liver metastasis. *Code CS Mets Eval as 1, because there was an invasive technique (surgery observation) that yielded a negative result.*

- Example: CT scan indicates thickened stomach wall with normal liver, spleen, lung bases and impression states presumed gastric malignancy. Patient dies 2 days later from chronic renal failure. Autopsy confirms primary gastric adenocarcinoma with all other body systems normal. *Code CS Mets Eval as 0 (imaging prior to death) as there is no category of pM0.*

B. **Mapping of CS Mets at Dx code 99**: If the status of distant metastases is unknown (CS Mets at Dx code 99), choose an Eval code that will derive a "c" staging basis, because code 99 maps to M0 in TNM7, and this category can only be clinical. The appropriate code might be 9 (Unknown) in rare situations or might be another code if workup was done but the results were not definitively positive or negative.

- Example: Cecum carcinoma abstracted from a pathology report of biopsy only, no clinical data or surgical observations available. Code CS Mets at Dx as 99 (Unknown), which will map to M0 in the seventh edition*. Code CS Mets Eval as 9 (Unknown), which maps to the "c" staging basis.*

- Example: Lung cancer diagnosed by imaging. Patient has behavior changes, and brain imaging cannot rule out metastases. Patient is not a surgical candidate. *Code CS Mets at Dx as 99 (Unknown), which maps to M0 in the seventh edition. Code CS Mets Eval as 0 (imaging), which maps to the "c" staging basis.*

C. **Pathologic M1 takes priority**: If M1 will be derived (i.e., there is metastatic disease present and coded in the CS Mets at Dx field) and there are no subcategories of M1, such as M1a and M1b, then determine if there was any pathological evidence for the M1 category.

a. If there is microscopic confirmation of distant metastases, select an Eval code that will derive a "p" staging basis. ***In other words, any microscopic confirmation of a distant metastasis meets the criteria for pathologic M1.***

- Example: Patient with perforated stomach cancer. At surgery, peritoneal cytology is positive. CT scan shows multiple liver metastases. Code CS Mets at Dx as 40 for both the liver and peritoneal metastases, which maps to M1. (There are no subcategories of M1 for stomach). *Code CS Mets Eval as 3 because any positive microscopic confirmation of distant metastases meets the criteria for pathologic staging of distant metastases.*

b. If there was only clinical evidence of the M1 disease, select an Eval code that will derive a "c" staging basis.

- Example: Patient diagnosed with kidney cancer and discharged to nursing home where she expired within two weeks of diagnosis. Discharge summary states bone metastases from kidney cancer as final diagnosis. There is no supporting documentation for the bone metastases in either the original hospital record or the nursing home record. *Code CS Mets Eval as 0 because the physicians' statement of bone metastases is part of "other non-invasive clinical evidence" in code 0 and maps to a clinical staging basis. Do not use code 9, because the presence of distant metastases was assessed by the clinician.*

D. **Mapping of M1 subcategories.** If a specific subcategory of M1 will be derived (such as M1a), determine if there was any pathological evidence for the specific subcategory. If so, select an Eval code that will derive a "p" staging basis. If there was only clinical evidence of the subcategory disease, select an Eval code that will derive a "c" staging basis. In the latter case, there may have been pathological evidence of a lower M subcategory, but this is not considered in assigning the Eval code.

- Example: Prostate carcinoma with one or more of the following:

Involvement	CS Mets at Dx Code	TNM Map
Positive biopsy of aortic lymph node (distant node)-	Code 12	pM1a
Positive bone imaging	Code 30	cM1b
Positive brain imaging	Code 40	cM1c
All of the above	Code 55 (= codes 12+30+40)	cM1c

To code CS Mets at Dx, follow the general rule to code the highest applicable code, even though there is pathological evidence of metastases. Code CS Mets at Dx as 55, *which combines the codes for the lymph node, bone, and brain involvement. Code 55 maps to M1c. There is no pathologic evidence for the subcategory M1c (the only pathological evidence is for subcategory M1a). Code CS Mets Eval as 0 (imaging), which maps to the "c" staging basis*. The positive lymph node would map to M1a, a lower M subcategory. Do not base the Eval code on positive microscopic findings for a lower subcategory.

- Example: Prostate carcinoma with positive biopsy of aortic lymph node (distant node), negative bone scan, and negative brain scan. Code CS Mets at Dx as 12 (distant lymph node), which maps to M1a*. Code CS Mets Eval as 3, which maps to the "p" staging basis.*

- Example: Testicular carcinoma patient has a positive pelvic lymph nodes on FNA (CS Mets at Dx code 11, maps to M1a). Patient has CT of brain showing distant

metastases (CS Mets at Dx code 40, maps to M1b). *Code CS Mets Eval as 0 because the higher M subcategory was established by imaging.*

- Example: Cecum carcinoma with lung metastases on chest X-ray and positive liver biopsy. CS Mets at Dx is coded 36 (Metastases to more than one distant organ), which maps to M1b. *Code CS Mets Eval as 0, which maps to the "c" staging basis because only one organ/site was microscopically proven.*

- Example: Sigmoid adenocarcinoma with liver metastases on ultrasound and positive peritoneal nodule biopsy. CS Mets at Dx is coded 36 (Metastasis to peritoneum). *Code CS Mets Eval as 3, which maps to the "p" staging basis because although only one organ/site is microscopically confirmed, that one organ/site is the peritoneum (M1b).*

3. **When there is no TNM mapping**: For sites and histologies for which no TNM schema has been defined, such as brain or Kaposi sarcoma, this field is always coded 9, Not Applicable. (See Rule 10.) For any sites and histologies that have no TNM mapping, code to the value that best reflects the diagnostic methods used, whether or not a stage is actually calculated for an individual case. In other words, do not use code 9 when a case has a histology that is excluded from staging but the site does have a TNM schema defined, for example, a sarcoma of the breast. In those cases, use code 9 only when the nature of the diagnostic methods is actually unknown.

4. **When there is neoadjuvant treatment**: If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, the clinical status of metastases at diagnosis takes precedence (code 5), unless the pathologic evidence is more extensive (code 6).

5. **Definition of code 0**: Code 0 is the lowest common denominator for evaluation methods and includes physical examination, imaging examination, and/or other non-invasive clinical evidence. If CS Mets at Dx is coded 00 based on the clinician's impression that there are no distant metastases, use code 0 to document that met the criteria for a clinical M0.

    - **Examples of imaging studies included in Code 0:** Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography (US), lymphography, angiography, scintigraphy (nuclear scans), magnetic resonance imaging (MRI), positron emission tomography (PET), spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

6. **Definition of Code 1**: Code 1 includes endoscopy and observations at surgery, such as abdominal exploration at the time of a colon resection, where distant metastasis is not biopsied as well as biopsies of distant sites that are negative.

7. **Definition of Code 3**: In general, **<u>any positive microscopic confirmation of a metastasis</u>** meets the criteria for pathologic staging. Therefore, a positive needle biopsy of a metastatic site is Eval Code 3. Complete removal of a metastatic site is not required for pathologic staging.

8. **No pathologic M0**: AJCC does not recognize a pM0 category since it is not possible to microscopically rule out all possible metastatic sites. According to the *AJCC Cancer Staging Manual, seventh edition*, "A case where there are no symptoms or signs of metastases is classified as clinically M0. The only evaluation necessary to classify a case as clinically M0 is history and physical examination. It is not necessary to do extensive imaging studies to classify a case as clinically M0."

    A. If there is no mention in the medical record of distant metastases, code CS Mets at Dx as 00 and CS Mets Eval as 0, which maps to cM0.

    B. If there is evidence of metastases on physical examination, imaging, or exploratory surgery and there is no biopsy of the suspected metastatic site, code CS Mets at Dx appropriately (not 00 or 99) and CS Mets Eval with a code that maps to "c" staging basis. In general, such cases will map to cM1_.

    C. If the patient has a biopsy or removal of a distant site and the pathology report is negative, generally use Eval code 1, because this does not meet the criteria for pathologic staging.

9. **Circulating Tumor Cells (CTCs) and Disseminated Tumor Cells (DTCs) in metastatic sites**: CTCs and DTCs, including bone marrow micrometastases, are clinical findings if detected by immunohistochemistry or molecular methods. The significance of these small clusters of tumor cells in distant sites is indeterminate. When identified, CTCs and DTCs are coded in CS Mets at Dx as 00 and CS Mets Eval should be assigned a code that maps to "c" staging basis. In general, such cases will map to cM0 or cM0(i+).

10. **Neoadjuvant therapy and 2nd primaries**: When an incidental 2nd primary is discovered at the time of surgery following neoadjuvant therapy (systemic/radiation therapy followed by surgery), this 2nd primary should be coded to Eval code 3, and NOT be coded to eval codes 5 or 6. This would also be true for a 2nd (or higher number) primary diagnosed and treated with a surgical resection as the first course of therapy, when the previous primary was treated with systemic or radiation therapy at any time (adjuvant or neoadjuvant or for a recurrence). To include these cases with those purposefully treated with neoadjuvant therapy would skew the data. The effect of the prior treatment for the previous primary on the new primary is unknown.

11. **Schemas always coded 9 Not Applicable**:
    AdnexaUterineOther
    Brain

CNSOther
DigestiveOther
EndocrineOther
EyeOther
GenitalFemaleOther
GenitalMaleOther
HemeRetic
IllDefinedOther
IntracranialGland
KaposiSarcoma
Lymphoma
MelanomaSinusOther
MiddleEar
MyelomaPlasmaCellDisorder
PharynxOther
RespiratoryOther
SinusOther
Trachea
UrinaryOther

Codes:

See the most current version of the *Collaborative Stage Data Collection System* for the applicable codes.

https://cancerstaging.org/cstage/schema/Pages/version0205.aspx

CS Site-Specific Factor 1- 25

Field Length: 3

Source of Standard: AJCC

Description:

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

General Guidance:

- Site-specific factors (SSFs) serve a variety of purposes in CS:

    - **Required to support TNM mapping**: Some SSFs provide additional information beyond the 9 core CS fields and are necessary for mapping to T, N, M, or stage group. Examples are the number of positive axillary lymph nodes for breast, extracapsular extension for head and neck sites, and the thickness of a malignant melanoma of the skin or mucous membrane.

    - **Tumor Markers and Lab Values**: Some SSFs are tumor markers or lab values of prognostic significance for various sites, such as CA-125 for ovary, CA 19-9 for GI sites, alpha fetoprotein and hCG for testis, KRAS for colon and rectum, and Ki-67 for CNS and various eye sites.

    - **Prognostic/Predictive Items**: A number of SSFs are included because of their prognostic or predictive value, such as the Gleason tertiary pattern for prostate, and the various international prognostic indices for lymphoma, such as the IPI for aggressive lymphomas, FLIPI for follicular lymphomas, and the IPS for Hodgkin lymphoma.

    - **Special Interest/Future Research**: As part of the effort to be clinically relevant, the seventh edition chapter authors included items of special interest for future research, such as the presence of microsatellite instability for GI cancers and tumor infiltrating lymphocytes (TIL) for Merkel cell carcinoma of the skin.

    - **Other Clinically Significant Information**: Some data items pertain to the patient's history of other diseases, such as Sjogren's syndrome for ocular lymphoma, a history of

asbestos exposure for pleural mesothelioma, and a particular gene mutation present in many retinoblastoma cases.

Coding Instructions:

1. The code structure is the same for each site-specific factor (SSF), although the meaning of the codes for each SSF varies on the type of test or measurement being collected. Select the best code that applies to the case.

2. **Number of SSFs used**: The number of SSFs used varies by schema.

3. **Use of code for Not Applicable**: If the site-specific factor is not defined for a schema, code as 988, not applicable. Site-specific factors are coded 988 when they are not defined, i.e., not set up to collect a specific data item. Defined site-specific factors may be coded 988 when they are not required by a standard setter and the registry has established a policy of not collecting the site-specific factor information for any case. The definitions for site-specific factors vary by CS Version Input Original, and standard setter requirements vary by CS Version Original and year of diagnosis. Code 988 may be a valid code choice for a site-specific factor when the case was originally coded in CSv1 (CS Version Input Original = 01XXXX) and diagnosed in a year before CSv2 was required. Code 988 may not be a valid code choice for that same site-specific factor when the case was originally coded using CSv2 (CS Version Input Original = 020200) and diagnosed in 2010. Code 988 in defined site specific factors includes the notation, "If this information is required by your standard setter, use of code 988 may result in an edit error."

    - Example: SSF 1 for Lung was undefined in CSv1, but was defined for separate tumor nodules in CSv2 and required by standard setters for CS V0202 and all 2010 diagnoses. For all lung cases with a CS Version Input Original code of 01XXXX, diagnosed 2004-2009, 988 is a valid code. For all lung cases with a CS Version Input Original code of 02XXXX or diagnosis year 2010 or later, where the registry reports to a standard setter that requires SSF 1 for lung, 988 is not an accepted code choice and will generate an edit error if used.

    - Example: SSF 15 for Breast was undefined in CSv1, but was defined in CSv2 for a summary of HER2 testing results. However, SSF 15 was not required by a standard setter for CS V0202, but was required for CS V0203 and all 2011 diagnoses. For all breast cases with a CS Version Input Original code of 01XXXX or 020202, diagnosed 2004-2010, 988 is a valid code choice. For all breast cases with a CS Version Input Original code of 020302 or higher or diagnosis year 2011 or later, where the registry reports to a standard setter

that requires SSF 15 for breast, 988 is not an accepted code choice and will generate an edit error if used.

For some schemas there may be undefined site-specific factors between defined site-specific factors to align items for consistency across schemas to make it easier for data analysis. For example, there are three schemas for colon: Colon, GISTColon, and NETColon. SSF1 is defined for Colon but not for GISTColon or NETColon. SSF2 is the same for Colon and NETColon but is no longer used for GISTColon. SSFs 3-10 are defined only for Colon. SSF11 is defined for GISTColon and NETColon but not Colon. SSFs 12-15 are defined for GISTColon only, and SSFs 16-17 for NETColon only. Any site-specific factor not defined for a schema, such as SSFs 3-10 for GISTColon and SSFs 18-25 for all three schemas, is coded 988.

4. **Test not done**: Depending on the format of the site-specific factor template, code 000 or some other code may be used when there is a statement in the record that a test was not performed, when the SSF instructions say to code "Not done" when there is nothing in the record, or when the test is negative or normal. The SSF may also provide coding guidelines for situations where the information is not available in the medical record. Follow the instructions provided for the site-specific factor.

   - Example: For malignant melanoma of skin SSF2, note 2 says "If there is no documentation or no mention of ulceration in the pathology report, assume ulceration is not present *and code 000*."

5. **Coding lab tests**: Each site-specific factor includes instructions how it is to be coded.

   A. Follow the instructions for the SSF to record the correct lab value, such as highest, lowest, pretreatment, immediately post-operative, closest to diagnosis, and so forth.

   B. If there is an indication that the lab test was completed but the results are not in the record, code as Ordered, results not in chart. For most types of SSFs, this is *code 997.*

   C. **Rounding:** Follow the instructions for the SSF in coding the lab value, as units of measurements vary. If there is an implied decimal point, round values of 1-4 down to the nearest number and round values of 5-9 up to the next number.

   - Example: Prostate SSF 1 PSA Value. Physician reports PSA of 4.35. *Round the .35 up to .4 and code as 044.*

6. P**riority for Coding Lab Test Interpretation Information**: The results of many tumor markers and laboratory tests vary according to the laboratory conducting the test. The normal reference range and notes are included in the tumor marker comments as background information only.

CS Site-Specific Factor 1- 25

The following instructions provide the priority order for coding information about the interpretation of the lab test. These instructions are stated at the beginning of the *Collaborative Stage section Part I Section 2* with extensive examples.

A. Whenever possible, code the clinician's/pathologist's interpretation of the lab test. This would include statements of "abnormal", "elevated", "normal", "equivocal", "present", "absent", and so forth. In addition, the physician's statement of a T, N, or M value or stage group for the case would constitute an implied interpretation of any lab value used to determine the TNM classification.

   ✓ Note: If the pathologist uses the term "indeterminate," code as 030 (borderline; undetermined if positive or negative) if that code exists in the site-specific factor. If code 030 does not exist, code as 999.

B. In the absence of a physician's interpretation of the test, if the reference range for the lab is listed on the test report, the registrar may use that information to assign the appropriate code.

C. When there is no clinician/pathologist interpretation of the lab test and no description of the reference range in the medical record the registrar should code 999 (not documented, unknown) to code the SSF. Do not code the lab value interpretation based on background information provided in Part 1- Section 2 of the *Collaborative Stage Data Collection System Coding Instructions Manual* for the SSF.

   ✓ **Note:** There will be some cases where an interpretation may be inferred from the background information in the CS User Documentation because the lab result is extremely abnormal. In such cases, common sense would dictate that the case should be coded as 010 (elevated) rather than 999.

7. **Use of 999**: Use code 999 if the tumor marker, prognostic score, predictive value or other SSF is not in the medical record. Use code 999 in the following circumstances, unless different instructions are provided in the SSF:

   A. The facility does not offer the test.

      ✓ Note: The data collector should determine whether the facility offers the test, perhaps under a different name. For example, not every hospital will test for chromosome 18q loss of heterozygosity for appendiceal carcinoma.

   B. The facility does not offer the test but sends it out and there is no report in the patient record.

C. The facility does offer the test and there is no information in the medical record.

D. There is no report of the lab test in the patient record**. It is not the responsibility of the data collector to track down test results if they are not in the patient record.**

E. For Kaposi sarcoma SSF1, if AIDS status is not documented, code as 999 rather than 002, Not Present.

F. For lymphoma SSF3, if the IPI score is not stated in the record. It is not necessary to calculate the IPI score from other information in the record.

8. **Lymph Node Involvement for In-Situ Cases.** When CS Extension is coded as in situ/noninvasive, use the appropriate code for "no lymph node involvement" when coding the relevant site-specific factors even if no lymph nodes are removed, since "in situ" by definition means noninvasive. If there is evidence of nodal involvement associated with a tumor described as in situ, it would indicate that an area of invasion was missed and the primary tumor is not an in situ lesion, so involved lymph nodes can be coded as appropriate for the case. Code the CS Extension field and the behavior code to reflect that the tumor is invasive.

Codes:

See the most current version of the *Collaborative Stage Data Collection System* for applicable codes.

https://cancerstaging.org/cstage/schema/Pages/version0205.aspx

CS Version Input Original

Field Length: 6

Source of Standard: AJCC

Description:

This item indicates the number of the version initially used to code Collaborative Staging (CS) fields. The CS version number is returned as part of the output of the CS algorithm.

General Guidance:

- Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items.

- This field is generated by the software.

CS Version Input Current

Field Length: 6

Source of Standard: AJCC

Description:

This item indicates the version of CS input fields after they have been updated or recoded. This data item is recorded the first time the CS input fields are entered and should be updated each time the CS input fields are modified.

General Guidance:

- Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items.

- This field is generated by the software.

CS Version Derived

Field Length: 6

Source of Standard: AJCC

Description:

This data item is recorded the first time the CS output fields are derived and should be updated each time the CS Derived items are recomputed. The CS version number is returned as part of the output of the CS algorithm.

General Guidance:

- The CS algorithm may be re-applied to compute the CS Derived items; for example, when the data are to be used for a special study, transmitted, or when an updated CS algorithm is produced. This item identifies the specific algorithm used to obtain the CS Derived values in the data record.

- This field is generated by the software.

Derived Data Items

Field Length: Varies per data item

Source of Standard: AJCC

Description:

Data Items:

Derived SS1977, Derived SS1977—Flag, Derived SS2000, Derived SS2000—Flag, Derived AJCC-6 M, Derived AJCC-6 M Descript, Derived AJCC-6 N, Derived AJCC-6 N Descript, Derived AJCC-6 Stage Grp, Derived AJCC-6 T, Derived AJCC-6 T Descript, Derived AJCC-7 M, Derived AJCC-7 M Descript, Derived AJCC-7 N, Derived AJCC-7 N Descript, Derived AJCC-7 Stage Grp, Derived AJCC-7 T, Derived AJCC-7 T Descript, Derived AJCC—Flag.

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on *AJCC Cancer Staging Manual 6th & 7th Editions*, *SEER Summary Stage 1977*, and *SEER Summary Stage 2000*. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

General Guidance:

- The values in these data fields are generated based on a computer algorithm.

Date of 1st Crs RX--CoC

Field Length: 8

Source of Standard: CoC

Description:

- Records the date on which treatment (surgery, radiation, systemic, or other therapy) of the patient began at any facility or non-hospital setting.

- This field also records the date:

    - Watchful waiting/ Active surveillance was selected as the treatment.
    - A decision was made not to treat the patient.
    - The patient refused all treatment.

General Guidance:

- Prior to coding any treatment field, review the rules in the First Course of Treatment section of this manual.

- The TCR requires documentation in the text fields supporting the date used in this data field.

Coding Instructions:

1. Record the earliest of the following dates in this field:
    Rx Date- Surgery
    Rx Date- Systemic
    Rx Date- Radiation
    Rx Date- Other

2. Code the date of excisional biopsy as the date therapy initiated when it is the first treatment. Code the date of a biopsy documented as incisional if further surgery reveals no residual or only microscopic residual.

    - Example: Breast biopsy with diagnosis of infiltrating duct carcinoma; subsequent re-excision with no residual noted. Code the date of the biopsy as the Date of 1st Crs Rx-CoC.

Date of 1st Crs RX--CoC

3. Record the actual date of treatment when treatment is performed prior to birth. Record the type of treatment in appropriate data item, for example, Surgery of Primary Site, or Radiation.

    - Example: On 01/03/2015, fetus is diagnosed with malignant teratoma. The teratoma is resected in utero on 01/10/2015. Live birth on 04/18/2015. Code the date therapy initiated as January 10, 2015 (20150110).

4. If active surveillance or watchful waiting is selected as the first course of treatment, record the date that decision was made (Rx Summ Treatment Status = 2).

5. If the patient refuses all treatment, record the date of the refusal (Rx Summ Treatment Status = 0).

6. If the physician decides not to treat the cancer, record the date of that decision (Rx Summ Treatment Status = 0).

7. If the patient's family or guardian declines all treatment for the patient, record the date of that decision (Rx Summ Treatment Status = 0).

8. If the cancer was diagnosed at autopsy, leave this data field blank.

9. Record the date in the year, month, and day (YYYYMMDD) format.

Date of 1st Crs Rx--COC Flag

Field Length: 2

Source of Standard: NAACCR

Description:

This flag explains why no appropriate value is in the Date of 1st Course of Treatment field.

Coding Instructions:

1. Leave this data field blank if a full or partial date is recorded in the Date of 1st Course of Treatment field.

2. Assign code 12 if the Date of 1st Course of Treatment cannot be determined at all, but the patient did receive first course treatment.

3. Assign code 12 if a decision not to treat was made, but the date is totally unknown.

4. Assign code 12 if a decision to use active surveillance was made, but the date is totally unknown.

5. Assign code 10 if it is unknown whether any treatment was administered.

6. Assign code 11 if the initial diagnosis was at autopsy.

7. Registrars should enter this data item directly (when appropriate). It should not be automatically coded by the software.

Codes:

Code Number	Code Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown whether treatment was administered)
11	No proper value is applicable in this context (e.g., autopsy only case)

Date of 1st Crs Rx--COC Flag

Code Number	Code Description
12	A proper value is applicable but not known (e.g., treatment administered but date is unknown)
Blank	A valid date value is provided in item Date of 1st Course Treatment, or the date was not expected to have been transmitted

RX Summ--Treatment Status

Field Length: 1

Source of Standard: SEER/CoC

Description:

This data item summarizes whether the patient received any treatment or the tumor was under active surveillance.

General Guidance:

- This data field is used in conjunction with the Date of 1st Crs RX field, the treatment fields, and the treatment date fields to document:
    - Whether treatment was given or not given
    - Whether it is unknown if treatment was given
    - Whether treatment was given on an unknown date
    - Whether the plan of treatment was active surveillance (watchful waiting)

Coding Instructions:

1. Treatment given after a period of active surveillance (watchful waiting) is considered subsequent treatment and is not coded in this data field.

2. Assign code 1 when the patient receives treatment coded in any of the following fields:
    - Rad Regional Modality
    - Rx Summ-BRM
    - Rx Summ-Chemo
    - Rx Summ-Hormone
    - Rx Summ-Other
    - Rx Summ-Scope Reg LN Surg
    - Rx Summ-Surg Other Reg/Dis
    - Rx Summ-Surg Primary Site
    - Rx Summ-Transplant/Endocr

RX Summ--Treatment Status

3. Assign code 0 when treatment is refused or the physician decides not to treat for any reason (i.e., presence of comorbid conditions).

    - Example: A patient is diagnosed with pancreatic cancer and requests no treatment. Code this data field to 0.

    - Example: A patient is expected to receive radiation treatment, but it has not occurred yet. Code this data field to 0.

    - Example: A patient is diagnosed with prostate cancer and the treatment plan is watchful waiting. Code this data field to 2.

Codes:

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

RX Date--Surgery

Field Length: 8

Source of Standard: CoC

Description:

The earliest date on which **any first course cancer directed surgery** was performed. This is either the date of the Surgery of the Primary Site, Scope of Regional Lymph Node Surgery, or Surgical Procedure of Other Reg/Distant Site, whichever is earliest.

General Guidance:

- Prior to coding any treatment field, review the rules in the First Course of Treatment section of this manual.
- The TCR requires documentation in the text fields supporting the date used in this data field.

Coding Instructions:

1. Record the date of the **first surgical procedure** of the types coded as Rx Summ Surg Prim Site, Rx Summ Scope Reg LN Sur, or Rx Summ Surg Oth Reg/Dis performed at this or any facility.
2. Enter the date of the first cancer directed surgery, even if your facility did not perform the procedure.
3. The date in this item may be the same as that in *Rx Date Mst Defn Srg* of primary site, if the patient received only one surgical procedure and it was a resection of the **primary site.**
4. Not all procedures performed are coded as surgery (e.g., incisional biopsies). To determine which procedures are coded as surgery, refer to the site-specific surgery codes in Appendix C.
5. Record date of the first cancer directed surgery in the year, month, day format (YYYYMMDD).
6. If surgery is the first or only treatment administered to the patient, then the date of surgery should be the same as the date entered into the item Date of First Course Treatment field.

RX Date--Surgery Flag

Field Length: 2

Source of Standard: NAACCR

Description:

This flag explains why no appropriate value is in the RX Date--Surgery field.

Coding Instructions:

1. Leave this data field blank if a full or partial date is recorded in the RX Date-- Surgery field.
2. Assign code 12 if the RX Date--Surgery cannot be determined, but the patient did receive first course surgery.
3. Assign code 10 if it is unknown whether any surgery was performed.
4. Assign code 11 if no surgical procedure was performed as part of first course of therapy or the initial diagnosis was at autopsy.
5. Registrars should enter this data item directly (when appropriate). It should not be automatically coded by the software.

Codes:

Code Number	Code Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any surgical procedure site was performed).
11	No proper value is applicable in this context (e.g., no surgical procedure was performed; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., surgery was performed but the date is unknown).
Blank	A valid date value is provided in item RX Date--Surgery, or the date was not expected to have been transmitted.

RX Date--Mst Defn Srg

Field Length: 8

Source of Standard: CoC

Description:

Records the date of the **most definitive** surgical procedure of the **primary site** performed as part of the first course treatment.

- This is a new data item required by the Tennessee Cancer Registry.

General Guidance:

- Prior to coding any treatment field, review the rules in the First Course of Treatment section of this manual.
- The TCR requires documentation in the text fields supporting the date used in this data field.

Coding Instructions:

1. Record the date on which the surgery described by *RX Summ-- Surg Prim Site* was performed at this or any facility.
2. Enter the date of the most extensive surgery done to the **primary site.**
3. Record date of the first cancer directed surgery to the **primary site** in the year, month, day format (YYYYMMDD).

RX Date—Mst Defn Srg Flag

Field Length: 2

Source of Standard: NAACCR

Description:

This flag explains why no appropriate value is in the *RX Date—Mst Defn Srg* field.

Coding Instructions:

1. Leave this item blank if *Date of Most Definitive Surgical Resection of the Primary Site* has a full or partial date recorded.

2. Assign code 12 if the *RX Date—Mst Defn Srg* of the Primary Site cannot be determined, but the patient did receive first course surgery to the **Primary Site.**

3. Assign code 10 if it is unknown whether any surgery was performed to the **Primary Site**.

4. Assign code 11 if no surgical procedure was performed to the **Primary Site**.

5. Registrars should enter this data item directly (when appropriate). It should not be automatically coded by the software.

Codes:

Code Number	Code Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any surgical procedure to the primary site was performed).
11	No proper value is applicable in this context (e.g., no surgical resection of the primary site was performed; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., surgical procedure of the primary site was performed but the date is unknown).
Blank	A valid date value is provided in item RX Date-- Mst Defn Srg, or the date was not expected to have been transmitted.

RX Summ--Surg Prim Site

Field Length: 2

Source of Standard: SEER/CoC

Description:

Surgery of the Primary Site describes a surgical procedure that removes 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.

General Guidance:

- Prior to coding any treatment field, review the rules in the First Course of Treatment section of this manual.
- Use the site-specific coding scheme corresponding to the coded primary site and histology.
- Site-specific surgery codes for this data item are included in Appendix C of this manual.
- The TCR requires documentation in the text fields supporting the code used in this data field.

Coding Instructions:

1. Code 00 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

➢ (Note: Code 00 excludes all sites and histologies that would be coded as 98. See Coding Instruction # 11 below.)

2. 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 for the most extensive surgery.

- 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*.

3. Code an 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.

   ✓ Note: Do not code an excisional biopsy when there is macroscopic residual disease.

   ✓ Note: Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins are clear.

4. 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. Do not rely on registry software to perform this task for you.

5. 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 codes. Specimens from an en bloc resection may be submitted to pathology separately.

   - Example: Code an en bloc removal when the patient has a hysterectomy and an omentectomy.

6. Code surgery for extra-lymphatic lymphoma using the site-specific surgery coding scheme for the primary site. (Do not use the lymph node scheme.)

7. 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 00.

8. If a needle biopsy precedes an excisional biopsy or more extensive surgery, and upon the excisional biopsy or more extensive surgery no tumor remains, DO NOT consider the needle biopsy to be an excisional biopsy.

9. Bladder malignancies- Code Bacillus Calmette-Guerin (BCG) as both surgery and immunotherapy. Also code the introduction of immunotherapy in the immunotherapy items. If immunotherapy is followed by surgery of the type coded as 20-80, code that surgery instead and code the immunotherapy only as immunotherapy.

RX Summ--Surg Prim Site

10. For codes 00 through 79, the codes are hierarchical. The last-listed codes take precedence over codes written above.

11. Code 98 takes precedence over code 00.

12. Use codes 80 and 90 only if more precise information about the surgery is not available.

13. Excisional biopsies (those that remove the entire tumor and/or leave only microscopic margins) are to be coded in this field.

14. Use code 98 for the following sites:

    A. Hematopoietic neoplasms

        a. Primary sites: C421 (all histologies)

        b. Histologies: 9740, 9751, 9754-9759, 9762, 9930

    B. Unknown or ill-defined sites (C760-768, C809)(all histologies)

Codes (in addition to the site-specific codes) :

Code Number	Code Description	Definition
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10-19	Site-specific code; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to Appendix C for the correct site specific code for the procedure.
20-80	Site-specific codes; resection	Refer to Appendix C for the correct site-specific code for the procedure.
90	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Site specific codes; special	Special code for hematopoietic neoplasms; ill-defined sites; and unknown primaries. (Refer to Appendix C for the correct site-specific code for the procedure.)
99	Unknown	Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death Certificate only.

RX Summ--Scope Reg LN Sur

Field Length: 1

Source of Standard: SEER/CoC

Description:

Describes the procedure of removal, biopsy, or aspiration of regional lymph nodes performed during the initial work-up or first course of therapy.

General Guidance:

- ✓ Note: The instructions for coding sentinel lymph node biopsies (SLNBx) have been clarified for 2012 and later diagnoses (see below).
- Additional instructions for breast primaries (C500-C509) follow the general coding instructions.
- Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data field.
- The TCR requires documentation in the text fields supporting the code used in this data field.

Coding Instructions:

1. Use the **operative report** as the primary source document to determine whether the operative procedure was a SLNBx, or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the **operative report takes precedence** when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.

2. Code regional lymph node procedures in this data item. Record distant lymph node removal in Surgical Procedure of Other Site.

A. Include lymph nodes that are regional in the current AJCC Staging Manual.

- Example: Melanoma with no primary skin site identified. One axillary lymph node removed revealing melanoma. No other tumors found. The axillary lymph node is coded as regional for CS lymph node coding. Include this lymph node in Scope of Regional LN Surgery

3. Record all surgical procedures that remove, biopsy, or aspirate regional lymph node(s) whether or not there were any surgical procedures of the primary site. The regional lymph node surgical procedure(s) may be done to diagnose cancer, stage the disease, or as a part of the initial treatment.

    - Example: Patient has a sentinel node biopsy of a single lymph node. *Assign code 2 (Sentinel lymph node biopsy [only]).*

4. Include lymph nodes obtained or biopsied during any procedure within the first course of treatment. A separate lymph node surgery is not required.

    A. Code the removal of intra-organ lymph nodes in Scope of Regional LN Surgery.

    - Example: Local excision of breast cancer. Specimen includes an intra-mammary lymph node. Assign code 4 (1 to 3 regional lymph nodes removed).

5. Add the number of all of the lymph nodes removed during each surgical procedure performed as part of the first course of treatment. The Scope of Regional Lymph Node field is cumulative.

    - Example: Patient has excision of a positive cervical node. The pathology report from a subsequent node dissection identifies three cervical nodes. Assign code 5 (4 or more regional lymph nodes removed).

    A. Lymph node aspirations:

    a. Do not double-count when a regional lymph node is aspirated and that node is in the resection field. Do not add the aspirated node to the total number.

    b. Count as an additional node when a regional lymph node is aspirated and that node is NOT in the resection field. Add it to the total number.

6. Code the removal of regional nodes for both primaries when the patient has **two primaries with common regional lymph nodes.**

- Example: Patient has a cystoprostatectomy and pelvic lymph node dissection for bladder cancer. Pathology identifies prostate cancer as well as the bladder cancer and 4/21 nodes positive for metastatic adenocarcinoma. Code Scope of Regional Lymph Node Surgery to 5 (4 or more regional lymph nodes removed) for both primaries.

7. Assign code 0 when:

   A. Regional lymph node removal procedure was not performed (excludes all sites and histologies that would be coded 9 [See Below]) **OR**

   B. The operative report lists a lymph node dissection, but no nodes were found by the pathologist **OR**

   C. First Course of treatment was active surveillance/watchful waiting

8. Assign code 1 when:

   A. The operative report states that a biopsy or aspiration or a regional lymph node, NOS was performed.

   B. Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed.

9. Assign code 2 when:

   A. The operative report states that a SLNBx was performed **OR**

   B. The operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination.

✓ Note: When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. Code this as a SLNBx (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.

10. Codes 3, 4, and 5: The operative report states that a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure).

A. **Code 3**: Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7).

B. **Code 4** should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only.

C. **Code 5**: If a relatively small number of nodes was examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes was examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7).

✓ Note: Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. Code these cases as 2 if no further dissection of regional lymph nodes was undertaken, or 6 when regional lymph nodes were dissected during the same operative event.

11. Code 6: SLNBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known

A. Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However it is possible for these procedures to harvest only a few nodes.

B. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.

C. Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection.) When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. **Code these cases as 6.**

12. Code 7: SLNBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events.

A. Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes.

B. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.

13. Code 9: The status of regional lymph node evaluation should be known for surgically treated cases (i.e., cases coded 19-90 in the data item Surgery of Primary Site [NAACCR Item #1290]). Review surgically treated cases coded 9 in Scope of Regional Lymph Node Surgery to confirm the code.

    A. Assign code 9 for:

        a. Primary sites:
            i. Brain (C700-C709) OR
            ii. Spinal cord (C710-C719) OR
            iii. Cranial nerves and other parts of the central nervous system (C720-C729, C75.1-C75.3)
            iv. Unknown or ill-defined sites (C760-C768, C809) (all histologies) (including cases diagnosed at autopsy).

        b. Lymphoma with primary site in lymph nodes (C770-C779) AND histology code
            i. 9590, 9726, 9735-9738, OR
            ii. 9727, 9811-9818, 9823, 9827, 9837 (leukemia/lymphoma histologies)

        c. Hematopoietic neoplasms
            i. Primary sites: C421 (all histologies)
            ii. Histologies: 9740, 9751, 9754-9759, 9762, 9930

<u>Coding Instructions - Sentinel lymph node biopsy (SLNBx), breast primary C500-C509:</u>

1. Use the **operative report** as the primary source document to determine whether the operative procedure was a SLNBx, an axillary node dissection (ALND), or a combination of both SLNBx and ALND. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and ALND, or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and an ALND.

2. Code 1:

    A. Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is

a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7.

3. Code 2:

    A. If a relatively large number of lymph nodes, more than 5, are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an axillary lymph node dissection (ALND).

    B. Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. Review the operative report to confirm that an axillary incision was made and a node exploration was conducted. Patients undergoing SLNBx who fail to map will often undergo ALND. Use code 2 if no ALND was performed, or 6 when ALND was performed during the same operative event. Enter the appropriate number of nodes examined and positive in the data items Regional Lymph Nodes Examined (NAACCR Item #830) and Regional Lymph Nodes Positive (NAACCR Item #820).

4. Codes 3, 4, and 5: Generally, ALND removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same procedure (code 6 or 7).

5. Code 6:

    A. Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However it is possible for these procedures to harvest fewer (or more) nodes.

    B. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed.

6. Code 7:

    A. Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes.

    B. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only, or whether a SLNBx plus an ALND was performed.

RX Summ--Scope Reg LN Sur

Codes:

Code Number	Code Description
0	None regional lymph nodes removed or aspirated: diagnosed at autopsy
1	Biopsy or aspiration of regional lymph node, NOS
2	Sentinel lymph node biopsy
3	Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS
4	1 to 3 regional lymph nodes removed
5	4 or more regional lymph nodes removed
6	Sentinel node biopsy and code 3, 4, or 5 at same time or timing not noted
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

RX Summ--Surg Oth Reg/Dis

Field Length: 1

Source of Standard: SEER/CoC

Description:

Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

General Guidance:

- Code the removal of non-primary site tissue that was removed because the surgeon suspected it was involved with malignancy even if the pathology is negative.

- DO NOT CODE the incidental removal of tissue. Incidental is defined as tissue removed for reasons other than suspected malignancy. Incidental removal of organs means the tissue was removed for reasons other than removing cancer or preventing the spread of cancer. Examples of incidental removal of organ(s) would be removal of the uninvolved appendix, gallbladder, etc. during abdominal surgery.

- Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.

    - If other tissue or organs are removed during primary site surgery that are not specifically defined by the site-specific *RX Summ-- Surg Prim Site* code (Appendix C), assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.

- If multiple first course surgical procedures coded in this item are performed for a single primary, the code should represent the cumulative effect of those surgeries. **Do not** rely on registry software to perform this task for you.

- Assign the highest numbered code that describes the surgical resection of distant lymph node(s).

- Surgical Procedure/Other Site should be coded even if surgery of the primary site was not performed.

RX Summ--Surg Oth Reg/Dis

- The TCR requires documentation in the text fields supporting the code used in this data field.

Coding Instructions:

1. Assign code 0 when:

   A. No surgical procedures were performed that removed distant lymph node(s) or other tissue(s) or organ(s) beyond the primary site **OR**

   B. First course of treatment was active surveillance/watchful waiting.

2. The codes are hierarchical.

   A. Codes 1-5 have priority over codes 0 and 9.

3. Assign code 1:

   A. When the **involved contralateral breast** is removed for a **single primary** breast cancer.

      - Note: See also notes and codes in Appendix C, Breast surgery codes.

   B. When any surgery is performed to remove tumors and the primary site is unknown or ill-defined (C76.0-76.8, C80.9).

   C. When any surgery is performed for hematopoietic neoplasms (C42.1 or M-9740, 9751, 9754-9759, 9762, 9930).

4. Assign code 2 for sites that are regional.

5. Assign code 4 for sites that are distant.

Codes:

Code Number	Code Description
0	None; diagnosed at autopsy
1	Non-primary surgical procedure performed
2	Non-primary surgical procedure to other regional sites
3	Non-primary surgical procedure to distant lymph node(s)
4	Non-primary surgical procedure to distant site

RX Summ--Surg Oth Reg/Dis

Code Number	Code Description
5	Any combination of codes 2, 3, or 4
9	Unknown

RX Text--Surgery

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for manual documentation of information describing all surgical procedures performed as part of first course treatment for the tumor being reported.

General Guidance:

- If cancer directed surgical procedures were performed, text detailing the procedures MUST be entered into this field. Text is needed to justify the codes entered into the abstract and to allow recording pertinent information that is not coded at all. The text is used for consolidation of records, quality control, and special studies.

- The supporting text must include:
  Date of each procedure
  Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites.
  Lymph nodes removed.
  Regional tissue removed.
  Metastatic sites.
  Positive findings and negative findings.
  Where the treatment was given (e.g., at this facility, at hospital ____)
  Any additional pertinent information (e.g., planned procedure aborted; treatment recommended, unknown if performed, etc.)

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviations to conserve space.

- If necessary, text can be continued in other empty text fields.

  - Example of text for this field: 5/18/01 Rt lumpectomy (or abbreviate as Rt lump) at Oakdale Med Center. 6/12/01 Rt Modified radical mastectomy (or abbreviate as Rt MRM) at this hosp.

Reason for No Surgery

Field Length: 1

Source of Standard: SEER/CoC

Description:

Records the reason no first course surgery was performed on the primary site.

Coding Instructions:

1. Assign code 0 when Surgery of Primary Site is coded in the range of 10-90 (the patient did have surgery of primary site).

2. Assign a code in the range of 1-8 if Surgery of Primary Site is coded 00 or 98.

    A. Referral to a surgeon is equivalent to a recommendation for surgery.

    B. Assign code 1 when:

        a. There is no information in the patient's medical record about surgery AND

            i. It is known that surgery is not usually performed for this type and/or stage of cancer OR

            ii. There is no reason to suspect that the patient would have had surgery of primary site.

        b. The treatment plan offered multiple treatment options and the patient selected treatment that did not include surgery of the primary site.

        - Example: Prostate cancer patient is offered three treatment options: a. Radical prostatectomy, b. Radiation therapy, or c. Hormone therapy. The patient chose to have radiation therapy. Assign code 1. Surgery of the primary site was not performed because it was not part of the planned first-course treatment. The treatment plan was for the patient to receive ONE of three treatment modality options: surgery OR radiation OR hormone therapy. At no time did the physician recommend that the patient have surgery AND radiation therapy AND hormone

therapy. The patient chose radiation. This does not mean he refused surgery because at no time did the treatment plan include both radiation AND surgery. Recording that a patient refused the treatment modality means that the patient refused recommended therapy. This is a quality control check explaining why the patient did not receive the expected treatment for their cancer (patient's choice versus physician's choice, or facility's lack of providing quality care).

C. Patient elected to pursue no treatment following the discussion of surgery. Discussion does not equal a recommendation.

D. Watchful waiting/active surveillance (prostate)

E. Surgery is not normally performed for the site/histology.

3. Assign code 6 when:

It is KNOWN that surgery was recommended **AND**
It is KNOWN that surgery was not performed **AND**
There is no documentation explaining why surgery was not done

- Example: The medical record has a recommendation that the patient have surgery. No further admissions or documentation of surgery found; the primary care physician replies that the patient did NOT have surgery. No further information is given; it is unknown if the patient refused surgery or if there were co-morbid conditions that prevented the surgical procedure.

4. Assign code 7 when the patient:

A. Refuses recommended surgery **OR**

B. Makes a blanket statement that he/she refused all treatment when surgery is a customary option for the primary site/histology

  - Note: Assign code 1 when surgery is not normally performed for the site/histology.

- ✓ Note: Coding Reason for No Surgery of Primary Site as "refused" does not affect the coding of the other treatment fields (e.g. Radiation, Chemotherapy, Hormone Therapy, etc.). Code 7 means surgery is exactly what was recommended by the physician and the patient refused. If two treatment alternatives were offered and surgery was not chosen, code Reason no surgery

of primary site as 1 [Surgery of the primary site was not performed because it was not part of the planned first-course treatment].

5. Assign code 8 when surgery is recommended, but it is unknown if the patient actually had the surgery.
   - ➢ Example: There is documentation in the medical record that the primary care physician referred the patient to a surgical oncologist. Follow-back to the surgical oncologist and primary care physician yields no further information. Assign code 8, it is known that surgery was recommended but there is no information on whether or not the patient actually had the surgical procedure.

6. Assign code 9:

   A. When there is no documentation that surgery was recommended or performed

   B. If the treatment plan offered multiple choices, but is unknown which treatment, if any was provided.

   C. Autopsy only

   - ✓ Note: Review cases coded 8 periodically for later confirmation of surgery

Codes:

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

Reason for No Surgery

Code Number	Code Description
9	It is unknown if surgery of the primary site was recommended or performed. Autopsy-only cases.

RX Date--Radiation

Field Length: 8

Source of Standard: CoC

Description:

Records the date on which first course treatment radiation therapy began at any facility.

General Guidance:

- Prior to coding any treatment field, review the rules in the First Course of Treatment section of this manual.
- Enter the date first course of treatment radiation therapy began, even if your facility did not provide the treatment.
- Record date radiation therapy began in the year, month, day format (YYYYMMDD).
- If radiation therapy is the first or only treatment administered to the patient, then the date radiation therapy began should be the same as the date entered into the Date of 1st Crs Rx CoC.
- The TCR requires documentation in the text fields supporting the date used in this data field.

RX Date--Radiation Flag

Field Length: 2

Source of Standard: NAACCR

Description:

This flag explains why no appropriate value is in the RX Date--Radiation field.

Coding Instructions:

1. Leave this data field blank if a full or partial date is recorded in the RX Date-- Radiation field.

2. Assign code 12 if the RX Date--Radiation cannot be determined, but the patient did receive first course radiation.

3. Assign code 10 if it is unknown whether any radiation was given.

4. Assign code 11 if no radiation is planned or given.

5. Assign code 15 if radiation is planned, but not yet started and the start data is not yet available. Cases coded 15 should be reviewed periodically to determine if radiation was administered. Any status change should be reported to the Tennessee Cancer Registry.

6. Registrars should enter this data item directly (when appropriate). It should not be automatically coded by the software.

Codes:

Code Number	Code Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown whether any radiation therapy administered).
11	No proper value is applicable in this context (e.g., no radiation therapy administered; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., radiation therapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).

RX Date--Radiation Flag

Code Number	Code Description
Blank	A valid date value is provided in item RX Date--Radiation, or the date was not expected to have been transmitted.

Rad--Regional RX Modality

Field Length: 2

Source of Standard: CoC

Description:

Records the dominant modality of radiation therapy used to deliver the clinically most significant regional dose to the primary volume of interest during the first course of treatment.

General Guidance:

- Radiation treatment is frequently delivered in two or more phases which can be summarized as "regional" and "boost" treatments. In this data field, only report the modality used to deliver the regional treatment. The modality used to deliver the radiation boost is coded in another data field which is not required by the TCR.
- In some circumstances, the boost treatment may be given before the regional treatment.
- If multiple radiation therapy modalities were used in the treatment of the patient, record only the dominant modality.
- Code IMRT or conformal 3D whenever either is explicitly mentioned.
- When coding this data field, consider photons and x-rays as equivalent.
- Code radioembolization as brachytherapy. (Radioembolization is embolization combined with injecting small radioactive beads or coils into an organ or tumor.)
- Do not confuse **radioiodine scan** with treatment. Only treatment is recorded in this item.
- *For cases diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation administered to the patient as part or all of the first course of therapy. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to Vol. II, ROADS, and DAM rules and should not be used to record regional radiation for cases diagnosed on or later than January 1, 2003.

Rad--Regional RX Modality

- The TCR requires documentation in the text fields supporting the code used in this data field.

Codes:

Code Number	Code Description	Code Note
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt- 60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.
23	Photons (2-5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2–5 MV.
24	Photons (6-10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6–10 MV.
25	Photons (11-19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11–19 MV.
26	Photons (> 19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered

Rad--Regional RX Modality

Code Number	Code Description	Code Note
		with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, radioembolization, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, Intracavitary, Low Dose Rate (LDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavitary, High Dose Rate (HDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, Low Dose Rate (LDR)	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, High Dose Rate (HDR)	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radio-isotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium - 89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium - 90	
80*	Combination modality, specified	Combination of external beam radiation and either radioactive implants or radioisotopes
85*	Combination modality, NOS	Combination of radiation treatment modalities not specified in code 80.
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.

RX Summ--Surg/Rad Seq

Field Length: 1

Source of Standard: SEER/CoC

Description:

This field records the order in which surgery and radiation therapies were administered for those patients who had both surgery and radiation.

- ✓ Note: Surgical procedures include *Surgical Procedure of Primary Site; Scope of Regional Lymph Node Surgery; Surgical Procedure/Oth Site.*

General Guidance:

- When completing this data field, include all known information concerning the patient's first course surgical and radiation treatment regardless of where the procedures/treatments were performed.
- The TCR requires documentation in the text fields supporting the code used in this data field.

Coding Instructions:

1. Assign code 0 when:
    A. The patient did not have either surgery or radiation.
    B. The patient had surgery, but did not have radiation.
    C. The patient had radiation, but did not have surgery.
    D. It is unknown whether or not the patient had surgery and/or radiation.
2. If the patient received both radiation therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site, Regional Lymph Node Surgery, or Surgical Procedure/Other Site,* then code this item 2-9, as appropriate.

RX Summ--Surg/Rad Seq

3. Assign code 4 when there are at least two episodes of fractions of radiation therapy.

   - Example: Pt had-
     1. Preoperative radiation therapy was administered to shrink large, bulky lesion
     2. A resection was performed
     3. Postoperative radiation therapy

4. Assign code 7 when there are at least two surgeries; radiation was administered between one surgical procedure and a subsequent surgical procedure.

   - Example 1: Pt had-
     1. Sentinel lymph node biopsy
     2. Radiation therapy
     3. Surgery of the primary site

   - Example 2: Pt had-
     1. Lymph node aspiration
     2. Radiation
     3. Surgery of the primary site

5. If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

Codes:

Code Number	Code Description	Definition
0	No radiation and/or no surgery; unknown if surgery and/or radiation given	No radiation therapy given or unknown if radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s) or it is unknown whether any surgery is given.
2	Radiation before surgery	Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
3	Radiation after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
4	Radiation both before and after surgery	At least two courses of radiation therapy are given before and at least two more after surgery to the primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).

RX Summ--Surg/Rad Seq

Code Number	Code Description	Definition
5	Intraoperative radiation	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative radiation with other radiation given before or after surgery	Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown, but both surgery and radiation were given	Administration of radiation therapy and surgery to primary site, scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record.
7	Surgery both before and after radiation (effective with cases diagnosed 1/1/2012 onward)	Radiation was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).

Example(s):

Code	Reason
0	Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate bone.
2	A large lung lesion received radiation therapy prior to resection.
3	A patient received a wedge resection of a right breast mass with axillary lymph node dissection followed by radiation to right breast.
4	Preoperative radiation therapy was given to a large, bulky vulvar lesion and was followed by a lymph node dissection. This was then followed by radiation therapy to treat positive lymph nodes.
5	A cone biopsy of the cervix followed by intracavitary implant for IIIB cervical carcinoma
6	Stage IV vaginal carcinoma was treated with 5,000 cGy to the pelvis followed by a lymph node dissection and 2,500 cGy of intracavitary brachytherapy.
9	An unknown primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. The patient enters for chemotherapy.

Reason for No Radiation

Field Length: 1

Source of Standard: CoC

Description:

Records the reason the patient did not receive radiation treatment as part of first course of therapy.

Coding Instructions:

1. Assign code 1 when several treatment options were offered and the patient selected a treatment plan that did not include radiation therapy.

2. If the patient is offered radiation therapy as a treatment option, but refuses it, assign code 7. If the patient refuses all recommended treatment or refuses all treatment before it is recommended, assign code 7.

3. Assign code 8 if it is known a physician recommended radiation treatment, but no further documentation is available to confirm if the treatment took place.

4. Assign code 8 to indicate referral to a radiation oncologist was made. If follow-up with the radiation oncologist or facility determines the patient was never there or no other documentation can be found, use code 1.

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

6. Assign code 9 if several treatment plans were offered, but it is unknown which, if any treatment was provided.

7. If data item, Regional Treatment Modality, is coded 00, review the patient's records to determine why radiation was not performed. Select the code based on the documentation in the records.

Reason for No Radiation

Codes:

Code Number	Code Description
0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first-course treatment.
2	Radiation therapy was not administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, 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. Death-certificate-only and autopsy-only cases.

RX Text--Radiation (Beam)

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for manual documentation of information about beam radiation treatment given to the patient for the tumor being reported.

General Guidance:

- If the patient is treated with beam radiation, text detailing the treatment MUST be entered into this field. Text is needed to justify the codes entered into the abstract and to allow recording pertinent information that is not coded at all. The text is used for consolidation of records, quality control, and special studies.

- The supporting text must include:
  Date treatment began and ended (approximated dates are acceptable)
  Type(s) of beam radiation (e.g., Cobalt 60, Electrons, mixed modalities)
  Anatomical site treated (e.g., breast, brain)
  Where the treatment was given (e.g., at this facility, at hospital ____)
  Any additional pertinent information

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviations to conserve space.

- If necessary, text can be continued in other empty text fields.

  - Example of text for this field: 7/9/11 – 8/20/11 5000cGY to breast & 1500 cGY boost at this hosp.

RX Text--Radiation Other

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for manual documentation of information about radiation treatment (other than beam) given to the patient for the tumor being reported. This includes brachytherapy and systemic radiation therapy.

General Guidance:

- If the patient is treated with radiation (other than beam radiation), text detailing the treatment MUST be entered into this field. Text is needed to justify the codes entered into the abstract and to allow recording pertinent information that is not coded at all. The text is used for consolidation of records, quality control, and special studies.

- The supporting text must include:
  Date treatment began and ended (approximated dates are acceptable)
  Type(s) of radiation (e.g., seed implant, radioisotopes, high dose rate brachytherapy)
  Anatomical site treated (e.g., breast, brain)
  Where the treatment was given (e.g., at this facility, at hospital ____)
  Any additional pertinent information

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviations to conserve space.

- If necessary, text can be continued in other empty text fields.

  - Example of text for this field: 11/15/11 I-125 seeds in prostate at this hosp.

RX Date--Chemo

Field Length: 8

Source of Standard: CoC

Description:

Records the date on which first course treatment chemotherapy began at any facility.

General Guidance:

- Enter the date first course of treatment chemotherapy began, even if your facility did not provide the treatment.

  a. Code the date that the prescription was written if date administered unknown.

- Record date chemotherapy began in the year, month, day format (YYYYMMDD).

- The TCR requires documentation in the text fields supporting the date used in this data field.

RX Date--Chemo Flag

Field Length: 2

Source of Standard: NAACCR

Description:

This flag explains why no appropriate value is in the RX Date--Chemo field.

Coding Instructions:

1. Leave this data field blank if a full or partial date is recorded in the RX Date-- Chemo field.

2. Assign code 12 if the RX Date—Chemo cannot be determined, but the patient did receive first course chemotherapy.

3. Assign code 10 if it is unknown whether any chemotherapy was given.

4. Assign code 11 if no chemotherapy is planned or given.

5. Assign code 15 if chemotherapy is planned, but not yet started. Cases coded 15 should be reviewed periodically to determine if chemotherapy was administered. Any status change should be reported to the Tennessee Cancer Registry.

6. Registrars should enter this data item directly (when appropriate). It should not be automatically coded by the software.

Codes:

Code Number	Code Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if chemotherapy administered).
11	No proper value is applicable in this context (e.g., no chemotherapy administered; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).

RX Date--Chemo Flag

Code Number	Code Description
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date--Chemo, or the date was not expected to have been transmitted.

RX Summ--Chemo

Field Length: 2

Source of Standard: SEER/CoC

Description:

Records whether chemotherapy was administered as first-course treatment at any facility or the reason chemotherapy was not given.

General Guidance:

- Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.
- Systemic therapy may involve the administration of one or a combination of agents.
- Refer to the *SEER RX Interactive Drug Database* (http://seer.cancer.gov/tools/seerrx/) for a list of chemotherapy drugs.
- When chemotherapeutic agents are used as radiosensitizers or radioprotectants, they are given at a much lower dosage and do not affect the cancer. Radiosensitizers and radioprotectants are classified as ancillary drugs. Do not code as chemotherapy.
- Do not assume that a chemo agent given with radiation therapy is a radiosensitizer. Seek additional information. Compare the dose given to the dose normally given for treatment. For additional information, see the National Cancer Institute's Physician Data Query (PDQ), Health Professional Version http://www.cancer.gov/cancertopics/pdq or the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology http://www.nccn.org/professionals/physician_gls/f_guidelines.asp
- The TCR requires documentation in the text fields supporting the code used in this data field.

RX Summ--Chemo

Important update effective for diagnosis date January 1, 2013 forward

The six drugs listed in the table below were previously classified as Chemotherapy and are **now classified** as BRM/Immunotherapy. **This change is effective for cases diagnosed January 1, 2013, and forward.** For cases diagnosed prior to January 1, 2013, registrars have been instructed to continue coding these drugs as Chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs in *SEER*Rx Interactive Drug Database.*

Drug Name(s)	Category Prior to 2013 Diagnosis	Category 2013 Diagnosis and Forward
Alemtuzumab/Campath	Chemotherapy	BRM/Immunotherapy
Bevacizumab/Avastin	Chemotherapy	BRM/Immunotherapy
Rituximab/Rituxan	Chemotherapy	BRM/Immunotherapy
Trastuzumab/Herceptin	Chemotherapy	BRM/Immunotherapy
Pertuzumab/Perjeta	Chemotherapy	BRM/Immunotherapy
Cetuxumab/Erbitux	Chemotherapy	BRM/Immunotherapy

- ✓ **Note:** Use the **date of diagnosis,** not the date of treatment, to determine whether to code these drugs as chemotherapy or BRM/Immunotherapy.

- ➢ Example: Patient diagnoses with breast cancer November 1, 2012, and begins receiving Rituximab January 30, 2013, as part of first course therapy. Code the Rituximab in the chemotherapy data field.

Definitions:

- **Chemotherapy recommended**: There was a consult recommending chemotherapy or the attending physician documented that chemotherapy was recommended. A referral to a clinical oncologist is equivalent to a recommendation.

- **Multiple agent chemotherapy**: Planned first course of therapy included two or more chemotherapeutic agents and those agents were administered. The planned first course of treatment may or may not have included other agents such as hormone therapy, immunotherapy, or other treatment in addition to the chemotherapeutic agents.

- **Single agent chemotherapy**: Only one chemotherapeutic agent was administered to destroy cancer tissue during the first course of therapy. The chemotherapeutic agent may or may not have been administered with other drugs classified as immunotherapy, hormone therapy, ancillary, or other treatment.

- **Chemotherapeutic agents** are chemicals that affect cancer tissue by means other than hormonal manipulation. Chemotherapeutic agents may be divided into five groups:

Alkylating agents
Antimetabolites
Natural Products
Targeted therapy
Miscellaneous

Alkylating agents:

- Alkylating agents are not cell-cycle-specific. Although they are toxic to all cells, they are most active in the resting phase of the cell. Alkylating agents directly damage DNA to prevent the cancer cell from reproducing. Alkylating agents are used to treat many different cancers including acute and chronic leukemia, lymphoma, Hodgkin disease, multiple myeloma, sarcoma, and cancers of the lung, breast and ovary. Because the drugs damage DNA they can cause long-term damage to the bone marrow and can, in rare cases, lead to acute leukemia. The risk of leukemia from alkylating agents is "dose-dependent." Types of alkylating agents include:

  Mustard gas derivatives/nitrogen mustards: Mechlorethamine, Cyclophosphamide, Chlorambucil, Melphalan, and Isosfmide
  Ethylemines: Thiotepa and Hexamethylmelamine
  Aklysulfonates: Busulfan
  Hydrazines and Trizines: Alkretamine, Procarbazine, Decarbazine, and Temozolomide
  Nitrusureas: Camustine, Lomustine and Streptozcin. Nitrosureas are unique because they can cross the blood-brain barrier and can be used in treating brain tumors
  Metal salts: Carboplatin, Cisplatin, and Oxaliplating

Antimetabolites:

- Antimetabolites are cell-cycle specific. Antimetabolites are very similar to normal substances within the cell. When the cells incorporate these substances into the cellular metabolism, they are unable to divide. Antimetabolites are classified according to the substances with which they interfere.

  Folic acid antagonist: Methotrexate
  Pyrimidine antagonist: 5-Florouracil, Foxuridine, Cytarabine, Capecitabine, and Gemcitabine
  Purine antagonist: 6-Mercaptopurine and 6-Thioguanine
  Adenosine deaminase inhibitor: Cladribine, Fludarabine, Nelarabine, and Pentostatin

RX Summ--Chemo

Natural Products:

- Plant Alkaloids are cell-cycle specific which means they attack the cells during various phases of division. They block cell division by preventing microtubule function. Microtubules are vital for cell division. Without them, division cannot occur. Plant alkaloids, as the name implies, are derived from certain types of plants.

  Vinca alkaloids: Vincristine, Vinblastine, and Vinorelbine
  Taxanes: Paclitaxel and Docetaxel
  Podphyllotoxins: Etoposide and Tenisopide
  Camptothecan analogs: Innotecan and Topotecan

- Antitumor antibiotics are also cell-cycle specific and act during multiple phases of the cell cycle. They are made from natural products and were first produced by the soil fungus Streptomyces. Antitumor antibiotics form free radicals that break DNA strands, stopping the multiplication of cancer cells.

  Anthracyclines: Doxorubicin, Danorubicin, Epirubicin, Mitoxantone, and Idabicin
  Chromomycins: Dactinomycin and Plicamycin
  Miscellaneous: Mitomycin and Bleomycin

- Topoisomerase inhibitors interfere with the action of topoisomerase enzymes (topoisomerase I and II). They control the manipulation of the structure of DNA necessary for replication.

  Topoisomerase I inhibitors: Ironotecan, topotecan
  Topoisomerase II inhibitors: Amasrine, etoposide, etoposide phosphate, teniposide

Targeted therapy:

- Targeted cancer therapies are drugs or other substances that block the growth and spreads of cancer by interfering with specific molecules ("molecular targets") that are involved in the growth, progression, and spread of cancer. Targeted cancer therapies are sometimes called "molecularly targeted drugs", "molecularly targeted therapies," "precision medicines," or similar names. Examples of molecularly targeted therapy are inatinib (Gleevec), Lapatinib (Tykerb), erlotinib (Tavceva), sunitinib (Sutent).

Miscellaneous:

Miscellaneous Antineoplastics that are unique

- Ribonuclotide reductase inhibitor: Hydroxyurea

- Adrenocortical steroid inhibiotor: Mitotane
- Enzymes: Asparaginase and Pegaspargse
- Antimicrotubule agent: Estramustine
- Retinoids: Bexatene, Isotretinoin, Tretinoin (ATRA)

Coding Instructions:

1. Code as treatment for both primaries when the patient receives chemotherapy for invasive carcinoma in one breast and also has in situ carcinoma in one breast. Chemotherapy would likely affect both primaries.

2. Code the chemotherapeutic agents whose actions are chemotherapeutic only; do not code the method of administration.

3. The physician may change a drug during the first course of therapy because the patient cannot tolerate the original agent.

    a. **This is continuation of the first course of therapy** when the chemotherapeutic agent that is substituted **belongs to the same group** (alkylating, antimetabolites, natural products, or other miscellaneous).

    b. Do **not** code the new agent as first course therapy when the original chemotherapeutic agent is changed to one that is NOT in the same group. **Code** only the original agent as first course.

    c. Use the *SEER RX Interactive Drug Database* and compare the subcategory of each chemotherapy agent to determine whether or not they belong to the same group (subcategory). See "Chemotherapeutic Agents" below for the groups and their definitions.

4. Assign code 00 when:

    A. The medical record documents chemotherapy was not given, was not recommended, or was not indicated

    B. There is no information in the patient's medical record about chemotherapy, AND

        a. It is known that chemotherapy is not usually performed for this type and/or stage of cancer **OR**

b. There is no reason to suspect that the patient would have had chemotherapy.

c. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include chemotherapy.

d. Patient elects to pursue no treatment following the discussion of chemotherapy. Discussion does not equal a recommendation.

e. Active surveillance/watchful waiting is the first course of treatment (e.g., CLL)

f. Patient diagnosed at autopsy

- Example: Patient is diagnosed with plasma cell myeloma. There is no mention of treatment or treatment plans in the medical record. Follow-back finds that the patient died three months after diagnosis. There are no additional medical records or other pertinent information available. Assign code 00 since there is no reason to suspect that the patient had been treated.

C. The treatment plan offered multiple options and the patient selected treatment that did not include chemotherapy.

D. The patient elects to pursue no treatment following the discussion of chemotherapy. Discussion does not equal a recommendation.

E. The treatment plan is Active Surveillance/Watchful Waiting (e.g., CLL)

F. If the patient was diagnosed at autopsy.

5. Do not code combination of ancillary drugs administered with single agent chemotherapeutic agents as multiple chemotherapy. For example the administration of 5-FU (antimetabolite) and Leucovorin (ancillary drug) is coded to single agent (Code 02).

6. Assign code 82 when chemotherapy is a customary option for the primary site/histology but it was not administered due to patient risk factors, such as: advanced age or comorbid conditions(s) (heart disease, kidney failure, other cancer, etc.)

7. Assign code 87 if the patient refused recommended chemotherapy, or made a blanket refusal of all treatment, or refused all treatment before any was recommended.

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

9. Assign code 88 when the only information available is that:

    A. A port-a-cath was inserted

    B. A physician recommended chemotherapy, but no further documentation is available to determine if chemotherapy was administered

    C. A referral was made to a medical oncologist about chemotherapy

        ✓ Note: Cases coded 88 should be reviewed periodically to determine if chemotherapy was administered. Any status changes should be reported to the Tennessee Cancer Registry.

10. Assign code 99 when it is not known whether chemotherapy is usually administered for this type and/or stage of cancer, and there is no documentation that chemotherapy was recommended or performed.

Coding for Tumor Embolization: The American College of Surgeons Commission on Cancer CoC), the Centers for Disease Control and Prevention National Program of Cancer Registries (NPCR), and the SEER Program have collaborated to clarify and refine coding directives for tumor embolization and are jointly issuing the following instructions.

Definitions:

- **Chemoembolization**: A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.

    - Code Chemoembolization as chemotherapy administered in the Rx *Summ-- Chemo* data item.

- **Radioembolization**: Embolization combined with the injection of small radioactive beads or coils into an organ or tumor.

    - Code Radioembolization in the *Rad--Regional RX Modality* data item as Brachytherapy.

- **Tumor embolization**: The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

    - If specified as any other tumor embolization or tumor embolization, NOS, see the RxSumm--Other section of this manual for direct coding instructions.

Coding Instructions:

1. Code as Chemotherapy when the embolizing agent(s) is a chemotherapeutic drug(s). Use SEER*Rx (http://seer.cancer.gov/tools/seerrx/) to determine whether the drugs used are classified as chemotherapeutic agents. Use codes 01, 02, 03 as specific information regarding the agent(s) is documented.

➢ Example: The patient has hepatocellular carcinoma (primary liver cancer). From a procedure report: Under x-ray guidance, a small catheter is inserted into an artery in the groin. The catheter's tip is threaded into the artery in the liver that supplies blood flow to the tumor. Chemotherapy is injected through the catheter into the tumor and mixed with particles that embolize or block the flow of blood to the tumor.

2. Do not code pre-surgical (pre-operative) embolization of hypervascular tumors with agents such as particles, coils or alcohol as treatment. Pre-surgical embolization is typically performed to prevent excess bleeding during the resection of the primary tumor. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

Codes:

Code Number	Code Description
00	None, chemotherapy was not part of the planned first course of therapy.
01	Chemotherapy, NOS.
02	Chemotherapy, single agent.
03	Chemotherapy, multiple agents.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Chemotherapy was not administered because the patient died prior to planned or

RX Summ--Chemo

Code Number	Code Description
	recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Chemotherapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record; death certificate-only cases.

RX Text--Chemo

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for manual documentation of information about the chemotherapy treatment given to the patient for the tumor being reported.

General Guidance:

- If the patient is treated with chemotherapy, text detailing the therapy MUST be entered into this field. Text is needed to justify the codes entered into the abstract and to allow recording pertinent information that is not coded at all. The text is used for consolidation of records, quality control, and special studies.

- The supporting text must include:
  Date treatment began and ended (approximated dates are acceptable)
  Type and dosage of chemotherapy given (e.g., name of agent(s) or protocol)
  Where the treatment was given (e.g., at this facility, at hospital ____)
  Any additional pertinent information

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviations to conserve space.

- If necessary, text can be continued in other empty text fields.

  - Example of chemotherapy text: 7/6/11 – 10/30/11 45mg Adriamycin, 500 mg Cytoxan, 400 mg 5-FU in Onc. office.

RX Date--Hormone

Field Length: 8

Source of Standard: CoC

Description:

Records the date on which first course treatment hormone therapy began at any facility.

General Guidance:

- Enter the date first course of treatment hormone therapy began, even if your facility did not provide the treatment.

    a. Code the date that the prescription was written if date administered unknown.

- Record date hormone therapy began in the year, month, day format (YYYYMMDD).

- The TCR requires documentation in the text fields supporting the date used in this data field.

RX Date--Hormone Flag

Field Length: 8

Source of Standard: NAACCR

Description:

This flag explains why no appropriate value is in the RX Date--Hormone field.

Coding Instructions:

1. Leave this data field blank if a full or partial date is recorded in the RX Date-- Hormone field.

2. Assign code 12 if the RX Date--Hormone cannot be determined, but the patient did receive first course hormone therapy.

3. Assign code 10 if it is unknown whether any hormone therapy was given.

4. Assign code 11 if no hormone therapy is planned or given.

5. Assign code 15 if hormone therapy is planned, but not yet started. Cases coded 15 should be reviewed periodically to determine if hormone therapy was administered. Any status change should be reported to the Tennessee Cancer Registry.

6. Registrars should enter this data item directly (when appropriate). It should not be automatically coded by the software.

Codes:

Code Number	Code Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any hormone therapy administered).
11	No proper value is applicable in this context (e.g., no hormone therapy administered; autopsy only cases).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., hormone therapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later

RX Date--Hormone Flag

Code Number	Code Description
	(e.g., hormone therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date--Hormone, or the date was not expected to have been transmitted.

RX Summ--Hormone

Field Length: 2

Source of Standard: SEER/CoC

Description:

Records whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given.

General Guidance:

- Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.
- Systemic therapy may involve the administration of one or a combination of agents.
- Refer to the SEER RX Interactive Drug Database (http://seer.cancer.gov/tools/seerrx/) for a list of hormone drugs.
- The TCR requires documentation in the text fields supporting the code used in this data field.

Definitions:

- Hormones may be divided into several categories:

  Androgens: Fluoxymesterone
  Anti-androgens: Bicalutamide (Casodex), flutamide (Eulexin), and nilutamde (Nilandron)
  Corticosteroids: Adrenocorticotrophic agents
  Estrogens
  Progestins
  Estrogen antagonists, Anti-estrogens: Fulvestrant (Faslodex), tamoxifen, and toremifene (Fareston).
  Aromatase inhibitors, Antiaromatase: Anastrozole (Arimidex), exemestane (Aromasin), and letrozole (Femara)
  GnRH or LH-RH: Lupron, Zoladex

RX Summ--Hormone

Polypeptide hormone release suppression: Octreotide
Somatostatin analog: Octreotide
Thyroid hormones: Levothyroxine, liothyronine, Synthroid

Important update effective for diagnosis date January 1, 2013 forward

The six drugs listed in the table below were previously classified as Chemotherapy and are **now classified** as BRM/Immunotherapy. **This change is effective for cases diagnosed January 1, 2013, and forward.** For cases diagnosed prior to January 1, 2013, registrars have been instructed to continue coding these drugs as Chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs in *SEER*Rx Interactive Drug Database.*

Drug Name(s)	Category Prior to 2013 Diagnosis	Category 2013 Diagnosis and Forward
Alemtuzumab/Campath	Chemotherapy	BRM/Immunotherapy
Bevacizumab/Avastin	Chemotherapy	BRM/Immunotherapy
Rituximab	Chemotherapy	BRM/Immunotherapy
Trastuzumab/Herceptin	Chemotherapy	BRM/Immunotherapy
Pertuzumab/Perjeta	Chemotherapy	BRM/Immunotherapy
Cetuxumab/Erbitux	Chemotherapy	BRM/Immunotherapy

- ✓ **Note:** Use the **date of diagnosis,** not the date of treatment, to determine whether to code these drugs as chemotherapy or BRM/Immunotherapy.

- ➢ Example: Patient diagnoses with breast cancer November 1, 2012, and begins receiving Rituximab January 30, 2013, as part of first course therapy. Code the Rituximab in the chemotherapy data field.

Coding Instructions:

1. Surgical removal of organs for hormone manipulation is not coded in this data field. Code these procedures in the data field Rx Summ-Transplant/Endocrine.

2. Code the hormonal agent given as part of combination chemotherapy (e.g. MOPP or COPP) whether it affects the cancer cells or not.

3. Prednisone:

A. Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

B. Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.

4. Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.

5. Assign code 00:

A. The medical record states that hormone therapy was not given, was not recommended, or was not indicated

B. There is no information in the patient's medical record about hormone therapy AND

a. It is known that hormone therapy is not usually performed for this type and/or stage of cancer OR

b. There is no reason to suspect that the patient would have had hormone therapy

C. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include hormone therapy

D. Patient elected to pursue no treatment following the discussion of hormone therapy treatment. Discussion does not equal a recommendation.

E. Active surveillance/watchful waiting (e.g., prostate)

F. Patient diagnosed at autopsy

G. Hormone treatment was given for a non-reportable condition or as chemoprevention prior to diagnosis of a reportable condition.

- Example 1: Tamoxifen given for hyperplasia of breast four years prior to breast cancer diagnosis. Code 00 in Hormone Therapy. Do not code tamoxifen given for hyperplasia as treatment for breast cancer.

- Example 2: Patient with a genetic predisposition to breast cancer is on preventative hormone therapy. Do not code hormone therapy given before cancer is diagnosed.

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

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

8. Assign code 87 if the patient refused recommended hormone therapy, or made a blanket refusal of all treatment, or refused all treatment before any was recommended.

9. Assign code 88:

   A. If it is known a physician recommended hormone therapy, but no further documentation is available to determine if hormone therapy was administered.

   B. Assign code 88 to indicate a referral was made to a medical oncologist about hormone therapy.

✓ Note: Cases coded 88 should be reviewed periodically to determine if hormone therapy was administered. Any status changes should be reported to the Tennessee Cancer Registry.

10. Assign code 99 when it is not known whether hormone therapy is usually administered for this type and/or stage of cancer, and there is no documentation that hormone therapy was recommended or performed.

11. Coding Examples:

    - Example: Endometrial cancer may be treated with progesterone. Code all administration of progesterone to patients with endometrial cancer in this field. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer.

    - Example: Follicular and papillary cancers of the thyroid are often treated with thyroid hormone to suppress serum thyroid-stimulating hormone (TSH). If a patient with papillary and/or follicular cancer of the thyroid is given a thyroid hormone, code the treatment in this field.

    - Example: Bromocriptine suppresses the production of prolactin, which causes growth in pituitary adenoma. Code Bromocriptine as hormone treatment for pituitary adenoma.

RX Summ--Hormone

- Example: Lupron is a hormonal treatment for prostate cancer. Code as hormonal treatment when Lupron is given for prostate cancer.

Codes:

Code Number	Code Description
00	None, hormone therapy was not part of the planned first course of therapy; not usually administered for this type/stage of cancer; diagnosed at autopsy
01	Hormone therapy administered as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Hormone 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.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in the patient record. Death certificate-only cases.

RX Text--Hormone

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for manual documentation of information about hormonal treatment given to the patient for the tumor being reported.

General Guidance:

- If the patient is treated with hormonal therapy, text detailing the therapy MUST be entered into this field. Text is needed to justify the codes entered into the abstract and to allow recording pertinent information that is not coded at all. The text is used for consolidation of records, quality control, and special studies.

- The supporting text must include:
  Date treatment began (approximated dates are acceptable)
  Type of hormone or antihormone given (e.g., Tamoxifen)
  Type of endocrine surgery or radiation (e.g., orchiectomy)
  Where the treatment was given (e.g., at this facility, at hospital ____)
  Any additional pertinent information

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviations to conserve space.

- If necessary, text can be continued in other empty text fields.

  - Example of hormone text: 2/16/11 20 mg Tamoxifen- MD office

RX Date--BRM

Field Length: 8

Source of Standard: CoC

Description:

Records the date on which first course immunotherapy (a.k.a. biological response modifier) began at any facility.

General Guidance:

- Enter the date first course of treatment immunotherapy or biological response modifier was given, even if your facility did not provide the treatment.

  a. Code the date that the prescription was written if date administered unknown.

- Record date immunotherapy or biological response modifier began in the year, month, day format (YYYYMMDD).

- The TCR requires documentation in the text fields supporting the date used in this data field.

RX Date--BRM Flag

Field Length: 2

Source of Standard: NAACCR

Description:

This flag explains why no appropriate value is in the RX Date--BRM field.

Coding Instructions:

1. Leave this data field blank if a full or partial date is recorded in the RX Date-- BRM field.

2. Assign code 12 if the RX Date--BRM cannot be determined, but the patient did receive first course immunotherapy or a biological response modifier.

3. Assign code 10 if it is unknown whether any immunotherapy or a biological response modifier was given.

4. Assign code 11 if no immunotherapy or biological response modifier is planned or given.

5. Assign code 15 if immunotherapy or a biological response modifier is planned, but not yet started. Cases coded 15 should be reviewed periodically to determine if immunotherapy or a biological response modifier was administered. Any status change should be reported to the Tennessee Cancer Registry.

6. Registrars should enter this data item directly (when appropriate). It should not be automatically coded by the software.

Codes:

Code Number	Code Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if immunotherapy administered).
11	No proper value is applicable in this context (e.g., no immunotherapy administered; autopsy only case).

RX Date--BRM Flag

Code Number	Code Description
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., immunotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., immune therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date BRM, or the date was not expected to have been transmitted.

RX Summ--BRM

Field Length: 2

Source of Standard: SEER/CoC

Description:

Records whether immunotherapeutic (biologic response modifiers) agents were administered as first-course treatment at any facility or the reason immunotherapy was not given.

General Guidance:

- Immunotherapy uses the body's immune system, either directly or indirectly, to fight cancer or to reduce the side effects that may be caused by some cancer treatments. Record only those treatments that are administered to affect the cancer cells.
- Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.
- Systemic therapy may involve the administration of one or a combination of agents.
- Refer to the *SEER RX Interactive Drug Database* (http://seer.cancer.gov/seertools/seerrx) for a list of immunotherapy drugs.
- The TCR requires documentation in the text fields supporting the code used in this data field.

Important update effective for diagnosis date January 1, 2013 forward

The six drugs listed in the table below were previously classified as Chemotherapy and are **now classified** as BRM/Immunotherapy. **This change is effective for cases diagnosed January 1, 2013, and forward.** For cases diagnosed prior to January 1, 2013, registrars have been instructed to continue coding these drugs as Chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs in *SEER*Rx Interactive Drug Database.*

Drug Name(s)	Category Prior to 2013 Diagnosis	Category 2013 Diagnosis and Forward
Alemtuzumab/Campath	Chemotherapy	BRM/Immunotherapy

Bevacizumab/Avastin	Chemotherapy	BRM/Immunotherapy
Rituximab/Rituxan	Chemotherapy	BRM/Immunotherapy
Trastuzumab/Herceptin	Chemotherapy	BRM/Immunotherapy
Pertuzumab/Perjeta	Chemotherapy	BRM/Immunotherapy
Cetuxumab/Erbitux	Chemotherapy	BRM/Immunotherapy

- ✓ **Note:** Use the **date of diagnosis,** not the date of treatment, to determine whether to code these drugs as chemotherapy or BRM/Immunotherapy.

  Example: Patient diagnoses with breast cancer November 1, 2012, and begins receiving Rituximab January 30, 2013, as part of first course therapy. Code the Rituximab in the chemotherapy data field.

Definitions:

- Immunotherapy is designed to:

  A. Make cancer cells more recognizable; and therefore, more susceptible to destruction by the immune system.

  B. Boost the killing power of immune system cells such as T-cells, NK-cells, and macrophages.

  C. Alter the growth patterns of cancer cells to promote behavior like that of healthy cells.

  D. Block or reverse the process that changes a normal cell or a pre-cancerous cell into a cancerous cell.

  E. Enhance the body's ability to repair or replace normal cells damaged or destroyed by other forms of cancer treatment, such as chemotherapy or radiation.

  F. Prevent cancer cells from spreading to other parts of the body.

Types of immunotherapy:

- **Cancer Treatment Vaccines**: Also called therapeutic vaccines, are a type of immunotherapy. The vaccines work to boost the body's natural defenses to fight a cancer. Doctors give treatment vaccines to people already diagnosed with cancer. The vaccines may:
  - Prevent cancer from returning
  - Destroy any cancer cells still in the body after other treatment

- Stop a tumor from growing or spreading
- Please refer to SEER*RX (https://seer.cancer.gov/tools/seerrx/index.html) to determine how to code non-FDA approved vaccines.

- **Interferons**: Interferons belong to a group of proteins called cytokines. They are produced naturally by the white blood cells in the body. Interferon-alpha is able to slow tumor growth directly as well as activate the immune system. It is used for a number of cancers including multiple myeloma, chronic myelogenous leukemia (CML), hairy cell leukemia, and malignant melanoma.

- **Interleukins** (IL-2) are often used to treat kidney cancer and melanoma.

- **Monoclonal Antibodies**: Monoclonal antibodies (Mab) are produced in a laboratory. The artificial antibodies are used in a variety of ways in systemic therapy and can be chemotherapy, immunotherapy, or ancillary drugs. Some are injected into the patient to seek out and disrupt cancer cell activities. When the monoclonal antibody disrupts tumor growth, it is coded as chemotherapy. Other Mabs are linked to radioisotopes (conjugated monoclonal antibodies). The Mab finds and attaches to the target tumor cells and brings with it the radioisotope that actually kills the tumor cell. The monoclonal antibody itself does nothing to enhance the immune system. Conjugated monoclonal antibodies such as tositumomab (Bexxar) or ibritumomab (Zevalin) are coded to the part of the drug that actually kills the cells, usually radioisotopes. A third function of Mabs is to enhance the immune response against the cancer, either by identifying tumor cells that are mimicking normal cells, or by boosting the body's natural defenses that destroy foreign cells. Consult the *SEER RX Interactive Drug Database* for the treatment category in which monoclonal antibody should be coded.

Coding Instructions:

1. Assign code 00 when:
   A. The medical record states that immunotherapy was not given, not recommended, or not indicated

   B. There is no information in the patient's medical record about immunotherapy **AND**

      a. It is known that immunotherapy is not usually performed for this type and/or stage of cancer **OR**
      b. There is no reason to suspect that the patient would have had immunotherapy.

   C. When the treatment plan offered multiple options and the patient selected treatment that did not include immunotherapy.

D. When the treatment plan is Active Surveillance/watchful waiting is the first course of treatment (e.g., prostate).

E. When the patient elects to pursue no treatment following the discussion of immunotherapy. Discussion does not equal a recommendation.

F. If the patient was diagnosed at autopsy.

G. Anti-thymocyte globulin treatment is given. Anti-thymocyte globulin is used to treat transplant rejection. Do not code as immunotherapy.

2. Bladder malignancies- Code Bacillus Calmette-Guerin (BCG) as both surgery and immunotherapy. Also code the introduction of immunotherapy in the immunotherapy items. If immunotherapy is followed by surgery of the type coded as 20-80, code that surgery instead and code the immunotherapy only as immunotherapy.

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

4. Assign code 87 if the patient refused recommended immunotherapy, or made a blanket refusal of all treatment, or refused all treatment before any was recommended.

5. Assign code 88:

   A. If it is known a physician recommended immunotherapy, but no further documentation is available to determine immunotherapy was administered.

   B. To indicate a referral was made to a medical oncologist about immunotherapy.

✓ Note: Cases coded 88 should be reviewed periodically to determine if immunotherapy was performed. If follow-up to the specialist or facility determines the patient was never there, code 00. Any status changes should be reported to the Tennessee Cancer Registry.

6. Assign code 99 when it is not known whether immunotherapy is usually administered for this type and/or stage of cancer, and there is no documentation that immunotherapy was recommended or performed.

RX Summ--BRM

Codes:

Code Number	Code Description
00	None, immunotherapy was not part of the planned first course of therapy; not customary therapy for this cancer, diagnosed at autopsy
01	Immunotherapy administered as first course therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Immunotherapy 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.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record; death certificate-only cases.

RX Text--BRM

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for manual documentation of information about the biological response modifier or immunotherapy treatment given to the patient for the tumor being reported.

General Guidance:

- If the patient is treated with biological response modifier/immunotherapy, text detailing the therapy MUST be entered into this field. Text is needed to justify the codes entered into the abstract and to allow recording pertinent information that is not coded at all. The text is used for consolidation of records, quality control, and special studies.

- The supporting text must include:
  Date treatment began and ended (approximated dates are acceptable)
  Type of biological response modifier given (e.g., BCG, Interferon)
  Biological response modifier procedures (e.g., bone marrow transplant, stem cell transplant)
  Where the treatment was given (e.g., at this facility, at hospital ____)
  Any additional pertinent information

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviations to conserve space.

- If necessary, text can be continued in other empty text fields.

  - Example of BRM text: 5/12/11 - 7/5/11 10 mg Interferon at Oakdale Med. Center

RX Summ--Transplnt/Endocr

Field Length: 2

Source of Standard: CoC

Description:

Records whether systemic therapeutic procedures were performed as first-course treatment at any facility or the reason systemic therapeutic procedures was not performed. These procedures include bone marrow transplants (BMT) and stem cell harvest with rescue (stem cell transplant), endocrine surgery and/or radiation performed for hormonal effect (when cancer originates at another site), and a combination of transplants and endocrine therapy.

General Guidance:

- Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.

- Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.

- Endocrine irradiation and/or endocrine surgery are procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or affect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.

- The TCR requires documentation in the text fields supporting the code used in this data field.

RX Summ--Transplnt/Endocr

Definitions:

- **Bone marrow transplant (BMT):** Procedure where bone marrow is used to restore stem cells that were destroyed by chemotherapy and/or radiation. Replacing the stem cells allows the patient to undergo higher doses of chemotherapy.

- **BMT Allogeneic:** Receives bone marrow from a donor. This includes haploidentical (or half-matched) transplants.

- **BMT Autologous:** Uses the patient's own bone marrow. The tumor cells are filtered out and the purified blood and stem cells are returned to the patient.

- **BMT Syngeneic:** Bone marrow received from an identical twin.

- **Conditioning:** High-dose chemotherapy with or without radiation administered prior to transplants such as BMT and stem cells to kill cancer cells. This conditioning also destroys normal bone marrow cells so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the Chemotherapy field and the radiation is coded in the Radiation field.

- **Hematopoietic Growth Factors:** A group of substances that support hematopoietic (blood cell) colony formation. The group includes erythropoietin, interleukin-3, and colony-stimulating factors (CSFs). The growth-stimulating substances are ancillary drugs and not coded.

- **Non-Myeloablative Therapy:** Uses immunosuppressive drugs pre- and post-transplant to ablate (destroy) the bone marrow. These are not recorded as therapeutic agents.

- **Peripheral Blood Stem Cell Transplantation (PBSCT):** Rescue that uses peripheral blood stem cells to replace stem cells after conditioning.

- **Rescue:** Rescue is the actual BMT or PBSCT done after conditioning.

- **Stem Cells:** Immature cells found in bone marrow, blood stream and umbilical cords. The stem cells mature into blood cells.

- **Stem Cell Transplant**: Procedure to replenish supply of healthy blood-forming cells. Also known as bone marrow transplant, PBSCT, or umbilical cord blood transplant, depending on the source of the stem cells.

- **Umbilical Cord Stem Cell Transplant:** Treatment with stem cells harvested from umbilical cord.

Coding Instructions:

RX Summ--Transplnt/Endocr

1. Assign code 00 when:

    A. The medical record states there was no hematologic transplant or endocrine therapy or these were not recommended, or not indicated

    B. There is no information in the patient's medical record about a transplant or endocrine procedure **AND**

        a. It is known that a transplant or endocrine procedure is not usually performed for this type and/or stage of cancer **OR**

        b. There is no reason to suspect that the patient would have had transplant procedure or endocrine therapy.

    C. The treatment plan offered multiple options and the patient selected treatment that did not include a transplant or endocrine procedure.

    D. Active surveillance/watchful waiting is the first course of treatment (e.g., CLL)

    E. When the patient elects to pursue no treatment following the discussion of transplant procedure or endocrine therapy. Discussion does not equal a recommendation.

    F. Patient was diagnosed at autopsy.

2. Assign code 10 if the patient has "mixed chimera transplant (mini-transplant or non-myeloablative transplant). These transplants are a mixture of the patient's cells and donor cells.

3. Codes 11 and 12 have priority over code 10 (BMT, NOS).

4. Assign code 12 (allogeneic) for a syngeneic bone marrow transplant (from an identical twin) or for a transplant from any person other than the patient.

5. If the patient does not have a rescue, code the stem cell harvest as 88, recommended, unknown if administred.

6. Assign code 20 for umbilical cord stem cell transplant (single or double).

    ✓ Note: If the patient does not have a rescue, code the stem cell harvest as 88, (recommended, unknown if administered).

RX Summ--Transplnt/Endocr

7. Assign code 30 for endocrine radiation and/or surgery. Endocrine organs are testes and ovaries. Endocrine radiation and/or surgical procedures must be bilateral, or must remove the remaining paired organ for hormonal effect.

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

9. Assign code 87 if the patient refused a recommended transplant or endocrine procedure, or made a blanket refusal of all treatment, or refused all treatment before any was recommended.

10. Assign code 88 when the only information available is that the patient was referred to an oncologist for consideration of hematologic transplant or endocrine procedure.

    - ✓ Note: Cases coded 88 should be reviewed periodically to determine if a transplant or endocrine procedure was administered. Any status changes should be reported to the Tennessee Cancer Registry.

11. Assign code 99 when it is not known whether a transplant or endocrine procedure is usually administered for this type and/or stage of cancer, and there is no documentation that a transplant or endocrine procedure was recommended or performed.

Codes:

Code Number	Code Description
00	No transplant procedure or endocrine therapy was administered as part of first course therapy; not customary therapy for this cancer; diagnosed at autopsy
10	Bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant—autologous
12	Bone marrow transplant—allogeneic
20	Stem cell harvest (stem cell transplant) and infusion
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of transplant procedure with endocrine surgery and/or endocrine radiation. (Combination of codes 30 and 10, 11, 12 or 20).
82	Transplant procedure and/or endocrine therapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
85	Transplant procedure and/or endocrine therapy was not administered because the patient died prior to planned or recommended therapy.
86	Transplant procedure and/or endocrine therapy was not administered; it was recommended by the patient's physician but was not administered as part of first

RX Summ--Transplnt/Endocr

Code Number	Code Description
	course therapy. No reason was noted in the patient record.
87	Transplant procedure and/or endocrine 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; refusal noted in patient record
88	Transplant procedure and/or endocrine therapy was recommended, but it is unknown if it was administered
99	It is unknown if a transplant procedure or endocrine therapy was recommended or administered because it is not stated in patient record; death certificate-only cases

RX Date--Systemic

Field Length: 8

Source of Standard: CoC

Description:

Identifies the date on which systemic therapy began during first course of treatment.

General Guidance:

- Systemic therapy includes the administration of chemotherapy agents, hormone agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy.
- Enter the date first course of treatment systemic therapy began.
- Record date systemic therapy began in the year, month, day format (YYYYMMDD).
- The TCR requires documentation in the text fields supporting the date used in this data field.

RX Date Systemic Flag

Field Length: 2

Source of Standard: NAACCR

Description:

This flag explains why no appropriate value is in the RX Date--Systemic field.

Coding Instructions:

1. Leave this data field blank if a full or partial date is recorded in the RX Date-- Systemic field.
2. Assign code 12 if the RX Date--Systemic cannot be determined, but the patient did receive first course systemic therapy.
3. Assign code 10 if it is unknown whether any systemic therapy was given.
4. Assign code 11 if no systemic therapy was given during the first course of therapy or initial diagnosis was at autopsy.
5. Assign code 15 if systemic therapy is planned, but not yet started. Cases coded 15 should be reviewed periodically to determine if systemic therapy was administered. Any status change should be reported to the Tennessee Cancer Registry.
6. Registrars should enter this data item directly (when appropriate). It should not be automatically coded by the software.

Codes:

Code Number	Code Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if systemic therapy was administered).
11	No proper value is applicable in this context (e.g., no systemic therapy was administered; autopsy only case).

RX Date Systemic Flag

Code Number	Code Description
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., systemic therapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., systemic therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date--Systemic, or the date was not expected to have been transmitted.

RX Summ--Systemic/Sur Seq

Field Length: 1

Source of Standard: CoC

Description:

This field records the sequence of any systemic therapy and surgery given as first course of treatment for those patients who had both systemic therapy and surgery.

General Guidance:

- When completing this data field, include all known information concerning the patient's first course surgical and systemic treatment regardless of where the procedures/treatments were performed.
- The TCR requires documentation in the text fields supporting the code used in this data field.
- Systemic therapy is defined as:

  Chemotherapy
  Hormone therapy
  Biological response therapy/immunotherapy
  Bone marrow transplant
  Stem cell harvests
  Surgical and/or radiation endocrine therapy

Coding Instructions:

1. Assign code 0 when:

   A. The patient did not have either surgery or some type of systemic therapy.

   B. The patient had surgery, but did not have systemic therapy.

   C. The patient had systemic therapy, but did not have surgery.

D. It is unknown whether or not the patient had surgery and/or systemic therapy.

2. Assign codes 2-9 when first course of therapy consists of both cancer-directed surgery and systemic therapy.

3. For code 6, the systemic therapy administered before or after surgery does not have to be the same type as the intraoperative systemic therapy.

4. Assign code 4 when there are at least two episodes or courses of systemic therapy.

   - Example: Treatment consisted of-

     1. Preoperative systemic therapy
     2. A resection was performed
     3. Postoperative systemic therapy

5. Assign code 7 when there are at least two surgeries; systemic therapy was administered between one surgical procedure and a subsequent surgical procedure.

   - Example: Treatment consisted of-

     1. Sentinel lymph node biopsy
     2. Systemic therapy
     3. Surgery of the primary site

   - Example: Treatment consisted of-

     1. Lymph node aspiration
     2. Systemic therapy
     3. Surgery of the primary site

6. If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

Codes:

Code Number	Code Description	Definition
0	No systemic therapy and/or surgical procedures; unknown if surgery and/or systemic	No systemic therapy was given; and/or no surgical procedure of primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant

RX Summ--Systemic/Sur Seq

Code Number	Code Description	Definition
	therapy given	lymph node(s); or no reconstructive surgery was performed. It is unknown whether both surgery and systemic treatment were provided.
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
4	Systemic therapy both before and after surgery	At least two courses of systemic therapy were given before and at least two more after a surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
5	Intraoperative systemic therapy	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
6	Intraoperative systemic therapy with other therapy administered before or after surgery	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) with other systemic therapy administered before or after one of surgeries listed above.
9	Sequence unknown, but both surgery and systemic therapy given	Both surgery and systemic therapy were provided, but the sequence is unknown.
7	Surgery both before and after systemic therapy	Systemic therapy was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).

RX Date--Other

Field Length: 8

Source of Standard: CoC

Description:

Records the date on which first course "other treatment" began at any facility.

General Guidance:

1. Enter the date first course other therapy began, even if your facility did not provide the treatment.

2. Record date other treatment began in the year, month, day format (YYYYMMDD).

3. The TCR requires documentation in the text fields supporting the date used in this data field.

Definitions:

- “Other treatment” includes any and all complementary and alternative medicine used by the patient in conjunction with conventional therapy or in place of conventional therapy.

RX Date--Other Flag

Field Length: 2

Source of Standard: NAACCR

Description:

This flag explains why no appropriate value is in the RX Date--Other field.

Coding Instructions:

1. Leave this data field blank if a full or partial date is recorded in the RX Date-- Other field.
2. Assign code 12 if the RX Date—Other cannot be determined, but the patient did receive first course other therapy.
3. Assign code 10 if it is unknown whether any other therapy was given.
4. Assign code 11 if no other therapy is planned or given.
5. Registrars should enter this data item directly (when appropriate). It should not be automatically coded by the software.

Codes:

Code Number	Code Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if other therapy administered).
11	No proper value is applicable in this context (e.g., no other treatment administered; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., other therapy administered but the date is unknown).
15	Other therapy is planned as part of the first course of treatment, but had not been started at the time of the most recent follow-up.
Blank	A valid date value is provided in item RX Date--Other, or the date was not expected to have been transmitted.

RX Summ--Other

Field Length: 1

Source of Standard: SEER/CoC

Description:

Other Therapy identifies treatment given that cannot be classified as surgery, radiation, systemic therapy, or ancillary treatment according to the defined data items in this manual. This data item includes all complementary and alternative medicine used by the patient in conjunction with conventional therapy or in place of conventional therapy.

General Guidance:

- The TCR requires documentation in the text fields supporting the code used in this data field.

Definitions:

- **Chemoembolization** is a procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.
    - Code Chemoembolization as chemotherapy administered in the Rx *Summ-- Chemo* data item.
- **Radioembolization** is embolization combined with injecting small radioactive beads or coils into an organ or tumor.
    - Code Radioembolization in the *Rad--Regional RX Modality* data item as Brachytherapy.
- **Tumor embolization** is the intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.
    - See instructions below for coding Tumor Embolization in the Rx Summ--Other data item.
- A quote from the website for the National Cancer Institute (NCI), Office of Cancer complementary and Alternative Medicine (OCCAM) defines Complementary and Alternative Medicine (CAM) as any medical system, practice, or product that is not thought of as "western medicine" or standard medical care.

A. Complementary medicine means it is used along with standard medicine, also called conventional medicine.

B. Alternative medicine is used in place of standard treatments.

- CAM treatments may include dietary supplements, megadose vitamins, herbal preparations, acupuncture, massage therapy, magnet therapy, spiritual healing, and meditation.

- The OCCAM was established to coordinate and enhance activities of the NCI in complementary

- See complete information on types of complementary and alternative medicine specific to cancer at: http://www.cancer.gov/cam/. For additional information on cancer and other diseases, please visit http://nccam.nih.gov/health/whatiscam/.

Coding Instructions:

1. Assign code 0:

   A. When the treatment plan offered multiple options and the patient selected treatment that did not include Other therapy **And**

      a. It is known that other therapy is not usually performed for this type and/or stage of cancer **OR**

      b. There is no reason to suspect that the patient would have had other therapy.

   B. When the patient elects to pursue no treatment following the discussion of Other therapy. Discussion does not equal a recommendation.

   C. If the patient was diagnosed at autopsy.

   D. First course of treatment was active surveillance/watchful waiting.

   E. The treatment plan offered multiple treatment options and the patient selected treatment that did not include other therapy.

2. Assign code 1 for:

   A. Supportive care may include phlebotomy, transfusion, or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the

Commission on Cancer have agreed to record treatments such as phlebotomy, transfusion, or aspirin as "Other Treatment" (Code 1) for certain hematopoietic diseases ONLY. **Consult** the ***Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*** for instructions for coding care of specific hematopoietic neoplasms in this item.

- ✓ Note: Do not code blood transfusion as treatment. Blood transfusions may be used for any medical condition that causes anemia. It would be virtually impossible for the registrar to differentiate between blood transfusions used for a co-morbid condition from those given as prophylactic treatment of a hematopoietic neoplasm.

B. PUVA (Psoralen (P) and long-wave ultraviolet radiation (UVA)) in the RARE event that it is used as treatment for extremely thin melanomas or cutaneous T-cell lymphomas (e.g. mycosis fungoides).

C. Cancer treatment that could not be assigned to the previous treatment fields (surgery, radiation, chemotherapy, immunotherapy, or systemic therapy)

D. Photophoresis. This treatment is used ONLY for thin melanoma or cutaneous T-cell lymphoma (mycosis fungoides).

E. When tumor embolization is performed using alcohol as the embolizing agent

- ➢ Example: For head and neck primaries: Ideally, an embolic agent is chosen that will block the very small vessels within the tumor but spare the adjacent normal tissue. Liquid embolic agents, such as ethanol or acrylic, and powdered particulate materials can penetrate into the smallest blood vessels of the tumor.

F. Embolization of a tumor in a site other than the liver when the embolizing agent is unknown.

- ✓ Note: Do not code pre-surgical embolization of hypervascular tumors with particles, coils or alcohol. Pre-surgical embolization is typically performed to prevent excess bleeding during the resection of the primary tumor. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

3. Assign code 2 for any experimental or newly developed treatment, such as a clinical trial, that differs greatly from proven types of cancer therapy.

- ✓ Note: Hyperbaric oxygen has been used to treat cancer in clinical trials, but it is also used to promote tissue healing following head and neck surgeries. Do not code the administration of hyperbaric oxygen to promote healing as an experimental treatment.

4. Assign code 3 when the patient is enrolled in a double blind clinical trial. When the trial is complete and the code is broken, review and recode the therapy.

5. Assign code 6 for:

   A. Cancer treatment administered by nonmedical personnel

   B. Unconventional methods whether they are the only therapy or are given in combination with conventional therapy

   C. Alternative therapy ONLY if the patient receives no other type of treatment

      - Example: Lupron given for breast cancer. Assign code 6. Lupron is not an approved hormone treatment for breast cancer and should not be coded in the hormone field.

6. Assign code 8 When other therapy was recommended by the physician but there is no information that the treatment was given.

7. Assign code 9 when there is no documentation that other therapy was recommended or performed

Codes:

Code Number	Code Description
0	None
1	Other
2	Other Experimental
3	Other-Double Blind
6	Other-Unproven
7	Refusal
8	Recommended, unknown if administered
9	Unknown; unknown if administered

RX Text--Other

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for manual documentation of information about the treatment given to the patient for the tumor being reported that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical trials.

General Guidance:

- If the patient undergoes a cancer directed treatment that cannot be defined as surgery, radiation, or systemic therapy, text detailing the treatment MUST be entered into this field. Text is needed to justify the codes entered into the abstract and to allow recording pertinent information that is not coded at all. The text is used for consolidation of records, quality control, and special studies.

- The supporting text must include:
  Date treatment began and ended (approximated dates are acceptable)
  Type of treatment (e.g., hyperthermia, blinded clinical trial)
  Where the treatment was given (e.g., at this facility, at hospital ____)
  Any additional pertinent information

  Text automatically generated from coded data is not acceptable.

  Use standard abbreviations to conserve space.

  If necessary, text can be continued in other empty text fields.

  - Example of text for this field: 4/28/11-7/5/11 Hyperthermia 2x weekly at this hosp.

Reporting Facility

Field Length: 10

Source of Standard: CoC

Description:

Facility ID code for the facility reporting the case.

General Guidance:

- Use the 4-digit facility ID number assigned by the Tennessee Cancer Registry (TCR) preceded by 0's for a total length of 10 characters (e.g. 0000002225).

Codes in addition to the TCR assigned codes:

Code Number	Code Description
0000000000	Case not reported by a facility
0099999999	Case reported, but facility number is unknown

NPI--Reporting Facility

Field Length: 10

Source of Standard: CMS

Description:

The NPI (National Provider Identifier) code for the facility submitting the data in the record.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

General Guidance:

- Enter valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit).

Coding Instructions:

1. NPI- Reporting Facility may be automatically coded by the software vendor.

2. The facility's NPI can be obtained from the billing or accounting department, or searched at http://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do

3. If the facility has more than one NPI number assigned, use the "umbrella" number that applies to the entire facility.

Abstracted By

Field Length: 3

Source of Standard: CoC

Description:

An alphanumeric code assigned by the reporting facility that identifies the individual abstracting the case.

General Guidance:

- Allowable Values and Format: Letters and numbers, no special characters, cannot be all blank.

Type of Reporting Source

Field Length: 1

Source of Standard: SEER

Description:

Identifies the source documents that provided the best information when abstracting the case. This is not necessarily the original document that identified the case; rather, it is the source that provided the best information.

General Guidance:

- Code the source that provides the best information used to abstract the case.
- When multiple source documents are used to abstract a case, use the following priority order to assign a code for Type of Reporting Source: Codes: 1, 2, 8, 4, 3, 5, 6, 7.
- ✓ Note: Beginning with cases diagnosed 1/1/2006, the definitions for this field have been expanded. Codes 2 and 8 were added to identify outpatient sources that were previously grouped under code 1. Laboratory reports now have priority over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.

Definitions:

- **Comprehensive, unified medical record**: A hospital or managed health care system that maintains a single record for each patient. That record includes all encounters in affiliated locations.
- **Stand-alone medical record**:
    A. An independent facility; a facility that is not a part of a hospital or managed care system.
    B. An independent medical record containing only information from encounters with that specific facility
- **Managed health plan**:

Type of Reporting Source

A. Any facility where all of the diagnostic and treatment information is maintained in one unit record

B. The abstractor is able to use the unit record when abstracting the case.

- Examples of such facilities: HMOs or other health plan such as Kaiser, Veterans Administration, or military facilities.

- **Physician office**:

A. A physician office performs examinations and tests. Some physician offices may perform limited surgical procedures.

✓ Note: The category "physician's office" also includes facilities called surgery centers when those facilities cannot perform surgical procedures under general anesthesia.

- **Surgery center**:

A. Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia.

B. The patient usually does not stay overnight.

✓ Note: If the facility cannot perform surgical procedures under general anesthesia, code as physician's office.

Codes:

Code Number	Code Description
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
3	Laboratory only (hospital-affiliated or independent)
4	Physician's office/private medical practitioner (LMD)
5	Nursing/convalescent home/hospice
6	Autopsy only
7	Death certificate only
8	Other hospital outpatient units/surgery centers

Accession Number--Hosp

Field Length: 9

Source of Standard: CoC

Description:

Provides a unique identifier for the patient consisting of the year in which the patient was first seen at the reporting facility and the consecutive order in which the patient was abstracted.

General Guidance:

- The first 4 digits identify the year (in the format CCYY) the patient was first seen at the institution for the diagnosis or treatment of cancer. The first 4 digits must be greater than or equal to 1944.

- The last five numbers are the numeric order in which the registry entered the case into the database.

    - Example: The 33rd patient to be accessioned in 2001 will be assigned accession number 200100033.

Coding Instructions:

1. When a patient is deleted from the database, **do not** reuse the accession number for another patient.

2. Numeric gaps are allowed in accession numbers.

3. A patient's accession number is never reassigned.

4. If a patient is first accessioned into the registry, then the registry later changes its reference date and the patient is subsequently accessioned into the registry with a new primary, use the original accession number associated with the patient and code the Sequence Number data item appropriately.

Accession Number--Hosp

Examples:

Code Number	Code Description
200300033	Patient enters the hospital in 2003, and is diagnosed with breast cancer. The patient is the 33rd patient accessioned in 2003.
200300033	A patient with the accession number 200300033 for a breast primary returns to the hospital with a subsequent colon primary in 2004. The accession number will remain the same. Sequence Number (NAACCR Item #560) will reflect this primary.
200300010	Patient is diagnosed in November 2002 at another facility; enters the reporting facility in January 2003, and is the tenth case accessioned in 2003.
200300012	Patient is diagnosed in staff physician office in December 2002; enters the reporting facility in January 2003, and is the 12th case accessioned in 2003.
199100067	Patient enters the hospital in 1991 and is diagnosed with prostate cancer. The registry later sets a new reference date of January 1, 1997. The same patient presents with a diagnosis of lymphoma in 2005. (The Sequence Number (NAACCR Item # 560) will distinguish this primary.
200300001	First patient diagnosed/treated and entered into the registry database for 2003
200300999	999th patient diagnosed/treated and entered into the registry database for 2003.
200401504	One thousand five hundred fourth patient diagnosed and/or treated and entered into the registry database for 2004.

Sequence Number--Hospital

Field Length: 2

Source of Standard: CoC

Description:

Indicates the sequence of all malignant and non-malignant neoplasms over the lifetime of the patient.

General Guidance:

- Each neoplasm is assigned a different number.
- The Sequence Number refers to the chronological order of the diagnoses of independent reportable neoplasms over the lifetime of the patient.
- Codes 00–59 and 99 indicate neoplasms of in situ or malignant behavior (Behavior equals 2 or 3).
- Codes 60–88 indicate neoplasms of non-malignant behavior (Behavior equals 0 or 1).
- Sequence Number 00 indicates the person has only one malignant primary (in situ or invasive) in his lifetime (regardless of hospital registry reference date).
- Sequence Number 01 indicates the first of two or more malignant neoplasms, while 02 indicates the second of two or more malignant neoplasms, and so on.
- Sequence Number 60 indicates the patient has only one non-malignant neoplasm, and Sequence Number 61 represents the first of multiple non-malignant neoplasms.
- Because the time period of Sequence Number is a person's lifetime, reportable neoplasms not included in the hospital registry are also allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred years before the patient was seen at the facility.

Sequence Number--Hospital

Coding Instructions:

In situ/Malignant Coding Instructions:

1. Count all previous and current in situ/malignant reportable primaries which occur (red) over the lifetime of the patient, regardless of where he/she lived at diagnosis.

2. Assign code 00 only if the patient has a single malignant primary.

3. If the patient develops a subsequent malignant or in situ primary tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially (02 for the second primary, 03 for the third primary, etc.).

    - Example: The patient has a history of breast cancer in 1999. She has colon cancer in 2010. Assign sequence number 02 to the colon cancer and change the sequence number on the breast cancer from 00 to 01.

4. If two or more malignant or in situ neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis.

    a. Base the prognosis decision on the primary site, histology, and extent of disease of each of the primaries.

    b. If no difference in prognosis is evident, the decision is arbitrary.

5. Any tumor in the patient's past which is reportable or reportable-by-agreement at the time the current tumor is diagnosed must be taken into account when sequencing subsequently accessioned tumors. However, do not reassign sequence numbers if one of those tumors becomes nonreportable later.

6. Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence.

Sequence Number--Hospital

Non-Malignant and "Report-by-Agreement" Coding Instructions:

1. Include all non-malignant primary tumors of the brain/CNS diagnosed in 2004 and forward regardless of where the patient lived at diagnosis.

2. Assign code 60 only if the patient has a single nonmalignant primary.

3. If the patient develops a subsequent non-malignant primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent nonmalignant primaries sequentially (62 for the second primary, 63 for the third primary, etc.).

4. If a facility chooses to collect tumors not required by the Tennessee Cancer Registry, a Sequence Number in the 60-87 range should be assigned. These cases are referred to as "Reportable by agreement."

    - Example: Prostatic intraepithelial neoplasia, Grade III is not currently required by the Tennessee Cancer Registry. If a facility collected them, the Sequence Number assigned would be 60.

5. Any tumor in the patient's past which is reportable or reportable-by-agreement at the time the current tumor is diagnosed must be taken into account when sequencing subsequently accessioned tumors. However, do not reassign sequence numbers if one of those tumors becomes nonreportable later.

6. Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence.

Codes:

Code Number	Code Description
00	One malignant or in situ primary only in the patient's lifetime
01	First of two or more independent malignant or in situ primaries
02	Second of two or more independent malignant or in situ primaries
..	(Actual number of this malignant or in situ primary)
59	Fifty-ninth or higher of fifty-nine or more independent malignant or in situ primaries
99	Unknown number of malignant or in situ primaries.
60	Only one non-malignant tumor in the patient's lifetime
61	First of two or more independent non-malignant tumors

Sequence Number--Hospital

Code Number	Code Description
62	Second of two or more independent non-malignant tumors
..	(Actual number of this non-malignant primary)
88	Unspecified number of independent non-malignant tumors

Examples:

Code	Reason
00	Patient with no previous history of cancer diagnosed with in situ breast carcinoma on June 13, 2003.
01	The sequence number is changed when the patient with an in situ breast carcinoma diagnosed June 13, 2003, is diagnosed with a subsequent melanoma on August 30, 2003.
02	Sequence number assigned to the melanoma diagnosed on August 30, 2003, following a breast cancer in situ diagnosed on June 13, 2003.
04	A nursing home patient is admitted to the hospital for first course surgery of a colon adenocarcinoma. The patient has a prior history of three malignant cancers of the type the registry is required to accession, though the patient was not seen for these cancers at the hospital. No sequence numbers 01, 02 or 03 are accessioned for the patient.
60	The sequence number assigned to a benign brain tumor diagnosed on November 1, 2005, following a breast carcinoma diagnosed on June 13, 2003, and a melanoma on August 30, 2003.
63	Myeloproliferative disease (9975/1) is diagnosed by the facility in 2003 and accessioned as Sequence 60. A benign brain tumor was diagnosed and treated elsewhere in 2002; the patient comes to the facility with a second independent benign brain tumor in 2004. Unaccessioned earlier brain tumor is counted as Sequence 61, myeloproliferative disease is resequenced to 62, and second benign brain tumor is Sequence 63.

Class of Case

Field Length: 2

Source of Standard: CoC

Description:

Identifies the reporting facility's role in managing the patient's disease. Also, divides cases into two groups, analytic and nonanalytic.

General Guidance:

- Tennessee Cancer Registry (TCR) requirements for reporting:
    - If a facility clinically or pathologically diagnoses a reportable disease, the case must be abstracted and submitted to the TCR.
    - If a facility treats a reportable disease (first course treatment, subsequent course treatment, or treatment of the metastasis), the case must be abstracted and submitted to the TCR.
    - The following Class of Case codes are to be reported: 00, 10, 11, 12, 13, 14, 20, 21, 22, 31*, 32*, 34^, 35, 36^, 37, and 38.

*Class of case 31 and 32 are only required if the reporting facility provides cancer directed treatment.

^Class of case 34 and 36 are required for report-by-agreement diagnoses such as: VIN III, VAIN III, and AIN III.

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.

Class of Case

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. A staff physician (codes 10-12, 41) is a physician who is employed by the reporting facility, under contract with it, or a physician who has routine practice privileges there. Treatment provided in a staff physician's office is provided "elsewhere".

5. If the hospital has purchased a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved are staff physicians or not, as with any other physician.

6. "In-transit" care is care given to a patient who is temporarily away from the patient's usual practitioner for continuity of care.

Codes:

Code Number	Code Description
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 a staff physician's office AND PART OR ALL of first course treatment or a decision not to treat was at the reporting facility, NOS
11	Initial diagnosis in staff physician's office AND PART of first course treatment was done at the reporting facility
12	Initial diagnosis in staff physician's office AND ALL first course treatment or a decision not to treat was done at the reporting facility
13	Initial diagnosis at the reporting facility AND PART of first course treatment was done at the reporting facility; part of the 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
20	Initial diagnosis elsewhere AND PART OR ALL 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 the first course treatment was done elsewhere.
22	Initial diagnosis elsewhere AND ALL first course treatment or decision not to treat was done at the reporting facility
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in DIAGNOSTIC WORKUP (for example, consult 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)

Class of Case

Code Number	Code Description
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 program's Reference Date AND initial diagnosis AND PART OR ALL 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 program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
38	Initial diagnosis established by AUTOPSY at the reporting facility, cancer not suspected prior to death
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 different staff physician offices
42	Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43	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.); UNKNOWN

Casefinding Source

Field Length: 2

Source of Standard: NAACCR

Description:

Documents the type of source through which the tumor was first identified.

Coding Instructions:

1. Determine where the case was first identified and enter the appropriate code.

Codes:

Code Number	Code Description
10	Reporting Hospital, NOS
20	Pathology Department Review (surgical pathology reports, autopsies, or cytology reports)
21	Daily Discharge Review (daily screening of charts of discharged patients in the medical records department)
22	Disease Index Review (review of disease index in the medical records department)
23	Radiation Therapy Department/Center
24	Laboratory Reports (other than pathology reports, code 20)
25	Outpatient Chemotherapy
26	Diagnostic Imaging/Radiology (other than radiation therapy, codes 23; includes nuclear medicine)
27	Tumor Board
28	Hospital Rehabilitation Service or Clinic
29	Other Hospital Source (including clinic, NOS or outpatient department, NOS)
30	Physician-Initiated Case
40	Consultation-only or Pathology-only Report (not abstracted by reporting hospital)
50	Independent (non-hospital) Pathology-Laboratory Report
60	Nursing Home-Initiated Case
70	Coroner's Office Records Review
75	Managed Care Organization (MCO) or Insurance Records
80	Death Certificate (case identified through death clearance)

Casefinding Source

Code Number	Code Description
85	Out-of-State Case Sharing
90	Other Non-Reporting Hospital Source
95	Quality Control Review (case initially identified through quality control activities such as casefinding audit of a regional or central registry)
99	Unknown

Date of 1st Contact

Field Length: 8

Source of Standard: CoC

Description:

Date of first patient contact with the reporting facility for the diagnosis and/or treatment of the reportable disease.

General Guidance:

- The date may be the date of an outpatient visit for a biopsy, x-ray, scan, laboratory test, or the date a pathology specimen was collected at the facility.
- When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility.
- The format for all dates is the year, month, and day (YYYYMMDD) format.
- If this is an autopsy-only or death certificate-only case, Date of 1st Contact is the Date of Death.
- The date of first contact is the date of the service that causes the case to be abstracted.

Examples:

Scenario	Date 1st Contact
Patient undergoes a biopsy in a staff physician's office on September 8, 2009. The pathology specimen was sent to the reporting facility and was read as Malignant Melanoma. The patient enters that same reporting facility on September 14, 2009 for wide re-excision.	September 14, 2009
Patient has an MRI of the brain on December 7, 2010, for symptoms including severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery on December 19 removes all gross tumor.	December 7, 2010

Date of 1st Contact Flag

Field Length: 2

Source of Standard: NAACCR

Description:

This flag explains why no appropriate value is in the Date of 1st Contact field.

Coding Instructions:

1. Leave this data field blank if a full or partial date is recorded in the Date of First Contact field.

2. Assign code 12 if the Date of First Contact cannot be determined. Code 12 should only be used under extremely rare circumstances.

3. Registrars should enter this data item directly (when appropriate). It should not be automatically coded by the software.

Codes:

Code Number	Code Description
12	A proper value is applicable but not known (e.g., date of 1st contact is unknown). This code is only used under extremely rare circumstances.
Blank	A valid date value is provided in item Date of 1st Contact, or the date was not expected to have been transmitted

Physician--Managing

Field Length: 8

Source of Standard: NAACCR

Description:

Code for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.

General Guidance:

- Must use Tennessee assigned physician code.
- The code in this field will differ from the code in the CoC required NPI-Managing Physician field.
- Once the registry has designated a managing physician for the patient, the information should not be changed or updated even if a different managing physician is assigned.

Code (in addition to the Tennessee assigned physician code):

Code Number	Code Description
99999999	Managing physician unknown or ID number not assigned

Physician--Primary Surg

Field Length: 8

Source of Standard: CoC

Description:

Code for physician who performed the most definitive surgical procedure.

General Guidance:

- Must use Tennessee assigned physician code.
- The code in this field will differ from the code in the CoC required NPI-Primary Surgeon field.
- Once the registry has designated a primary surgeon for the patient, the information should not be changed or updated even if the patient receives care from another surgeon.

Codes (in addition to the Tennessee assigned physician code):

Code Number	Code Description
00000000	Patient had no surgery and no surgical consultation
88888888	Physician who performed a surgical procedure was not a surgeon (i.e., radiation oncologist, diagnostic radiologist, or general practitioner)
99999999	Primary Surgeon unknown or ID number not assigned

Physician--Follow-Up

Field Length: 8

Source of Standard: CoC

Description:

Code for the physician currently responsible for the patient's medical care.

General Guidance:

- Must use Tennessee assigned physician code.
- The code in this field will differ from the code in the CoC required NPI-Following Physician field.
- Change this data item when patient follow-up becomes the responsibility of another physician.

Code (in addition to the Tennessee assigned physician code):

Code Number	Code Description
99999999	Follow-up physician unknown or ID number not assigned

Physician 3

Field Length: 8

Source of Standard: CoC

Description:

Code for another physician involved in the care of the patient. The preferred use of this field is to document the primary radiation oncologist involved in the patient's medical care.

General Guidance:

- Must use Tennessee assigned physician code.
- The code in this field will differ from the code in the CoC required NPI-Physician #3 field.
- Once the registry has designated a primary radiation oncologist for the patient, the information should not be changed or updated even if the patient receives care from another radiation oncologist.

Codes (in addition to the Tennessee assigned physician code):

Code Number	Code Description
00000000	None, no additional physician
99999999	Physician is unknown or an identification number is not assigned

Physician 4

Field Length: 8

Source of Standard: CoC

Description:

Code for another physician involved in the care of the patient. The preferred use of this field is to document the primary medical oncologist involved in the patient's medical care.

General Guidance:

- Must use Tennessee assigned physician code.
- The code in this field will differ from the code in the CoC required NPI-Physician #4 field.
- Once the registry has designated a medical oncologist for the patient, the information should not be changed or updated even if a different medical oncologist is assigned.

Codes (in addition to the Tennessee assigned physician code):

Code Number	Code Description
00000000	None, no additional physician
99999999	Physician is unknown or an identification number is not assigned

Institution Referred From

Field Length: 10

Source of Standard: CoC

Description:

Identifies the facility that referred the patient to the reporting facility.

General Guidance:

- Use the 4-digit facility ID number assigned by the Tennessee Cancer Registry preceded by 0's for a total length of 10 characters (e.g., 0000007894).

- The code in this field will differ from the code in the CoC required NPI-Institution Referred From field.

Codes (in addition to the facility ID number assigned by the Tennessee Cancer Registry):

Code Number	Code Description
0000000000	Patient not referred from a facility
0099999999	Patient referred from a facility, but facility number is unknown

Institution Referred To

Field Length: 10

Source of Standard: CoC

Description:

Identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

General Guidance:

- Use the 4-digit facility ID number assigned by the Tennessee Cancer Registry preceded by 0's for a total length of 10 characters (e.g., 0000007894).

- The code in this field will differ from the code in the CoC required NPI-Institution Referred To field.

Codes (in addition to the facility ID number assigned by the Tennessee Cancer Registry):

Code Number	Code Description
0000000000	Patient not referred to a facility
0099999999	Patient referred to a facility, but facility number is unknown

Date of Last Contact or Death

Field Length: 8

Source of Standard: SEER/CoC

Description:

Date of last contact with the patient, or date of the patient's death.

General Guidance:

- Record the last date on which the patient was known to be alive or the patient's date of death.
- The date must be in the year, month, and day (YYYYMMDD) format.
- This field pertains to the patient and not to the cancer. A patient with more than one malignancy should have the same date of last contact for all records.
- This field may be updated with new follow-up information, as necessary.

Date of Last Contact Flag

Field Length: 2

Source of Standard: NAACCR

Description:

This flag explains why no appropriate value is in the Date of Last Contact field.

Coding Instructions:

1. Leave this data field blank if a full or partial date is recorded in the Date of Last Contact field.

2. Assign code 12 if the Date of Last Contact cannot be determined. Code 12 should only be used under extremely rare circumstances.

3. Registrars should enter this data item directly (when appropriate). It should not be automatically coded by the software.

Codes:

Code Number	Code Description
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., date of last contact is unknown). This code is only used under extremely rare circumstances.
Blank	A valid date value is provided in item Date of Last Contact, or the date was not expected to have been transmitted.

Follow-Up Source

Field Length: 1

Source of Standard: CoC

Description:

Records the source from which the latest follow-up information was obtained.

Codes:

Code Number	Code Description	Code Note
0	Reported hospitalization	Hospitalization at another institution/hospital or the first admission to the reporting facility.
1	Readmission	Hospitalization or outpatient visit at the reporting facility.
2	Physician	Information from a physician.
3	Patient	Direct contact with the patient.
4	Department of Motor Vehicles	The Department of Motor Vehicles confirmed the patient has a current license.
5	Medicare/Medicaid file	The Medicare or Medicaid office confirmed the patient is alive.
7	Death certificate	Information from the death certificate only.
8	Other	Friends, relatives, employers, other registries, or any sources not covered by the other codes.
9	Unknown, not stated in patient record	The follow-up source is unknown or not stated in the patient record.

Text--DX Proc--PE

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for manual documentation of information from the history and physical examination/hospital admission.

General Guidance:

- Text detailing the patient's symptoms leading to the diagnosis of the malignancy and clinical findings from medical examination MUST be entered into this field. Text is needed to justify the codes entered into the abstract and to allow recording pertinent information that is not coded at all. The text is used for consolidation of records, quality control, and special studies.

- The supporting text must include:
  Date of physical exam
  Age, race, and sex of patient
  Symptoms and history relating to the diagnosis
  Tumor location
  Tumor size
  Palpable lymph nodes
  Positive and pertinent negative clinical findings.
  Impression (relating to the cancer diagnosis)
  Treatment plan (if applicable)

- If necessary, text can be continued in other empty text fields.

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviation to conserve space.

  - Example of text for this field: 7/6/11 WM, 45 yrs., weight loss, diarrhea, rectal bleeding, mass RLQ abd.

Text--DX Proc--X-ray/Scan

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for manual documentation from all X-rays, scan, and/or other imaging examinations that provide information about staging.

General Guidance:

- Text from radiological reports is especially valuable in determining the stage of the cancer, especially when surgery is not performed. Detailed information is found in the body of the report and may or may not be listed as part of the final diagnosis. If the patient had radiological scans, the findings from the procedures MUST be documented in this field. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

- Suggested text for this field:
  Date(s) and type(s) of X-ray/Scan(s)
  Primary site
  Histology (if given)
  Tumor location
  Tumor size
  Lymph nodes
  Record positive and negative clinical findings, if pertinent.
  Distant disease or metastasis

- If necessary, text can be continued in other empty text fields.

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviation to conserve space.

  - Example of text for this field: 5/20/2011 Mammogram: 5X5cm upper outer quadrant right breast mass consistent with malignancy.

Text--DX Proc--Lab Tests

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for manual documentation of information from laboratory tests (other than cytology or histopathology).

General Guidance:

- Text detailing the pertinent results of laboratory tests MUST be entered into this field. Text is needed to justify the codes entered into the abstract and to allow recording pertinent information that is not coded at all. The text is used for consolidation of records, quality control, and special studies.

- The supporting text must include:
  Date(s) of lab tests
  Type of lab test/tissue specimen(s)
  Record positive findings and pertinent negative findings.
  Include tumor markers, serum and urine electrophoresis, special studies, etc.

  - Examples of tumor makers:
    Estrogen Receptor Assay (ERA) for breast cancer
    Progesterone Receptor Assay (PRA) for breast cancer
    Her2/neu for breast cancer
    Prostatic Specific Antigen (PSA) for prostate cancer
    Human Chorionic Gonadotropin (hCG) for testicular cancer
    Alpha Fetoprotein (AFP) for testicular cancer
    Lactate Dehydrogenase (LDH) for testicular cancer

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviations to conserve space.

- If necessary, text can be continued in other empty text fields.

Text--DX Proc--Lab Tests

- Example of text for this field: 11/5/11 PSA: 104 (elevated)

Text--DX Proc--Scopes

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for manual documentation from endoscopic examinations that provide information for staging and treatment.

General Guidance:

- Endoscopic examinations often lead to the earliest diagnosis date of a malignancy and provide valuable information regarding location and summary stage of the cancer. If the patient underwent an endoscopic procedure, the findings MUST be entered into this field. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

- The supporting text must include:
  Date(s) of endoscopic exam(s)
  Primary site
  Histology (if given)
  Tumor location
  Site and type of endoscopic biopsy.
  Positive and negative findings, if pertinent.

- If necessary, text can be continued in other empty text fields.

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviation to conserve space.

  - Example of text for this field: 4/4/11 Bronchoscopy: Circumferential CA of esophagus, at 21 cm, with involvement of the trachea.

Text--DX Proc--Op

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for manual documentation of information about all surgical procedures that provide information for staging.

General Guidance:

- Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

- Text documenting the surgical procedures performed on the patient MUST be entered into this field. Frequently, the surgeon will visually examine various organs and make a notation in the operative report regarding the spread of disease. The surgeon may or may not find it necessary to biopsy or resect a metastatic site when he visually confirms the spread of disease. Text from operative reports is especially valuable in determining the stage of the cancer.

- Supporting text must include:
  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

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviations to conserve space.

Text--DX Proc--Op

- If necessary, text can be continued in other empty text fields.

    - Example of text for this field: 9/20/2011 Partial gast: Lg fixed mass fundus, invades spleen. Tumor studdings lt. lobe liver. 3/15 LNs +

Text--DX Proc--Path

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for manual documentation of information from cytology and histopathology reports.

General Guidance:

- Text detailing the information from pathology, cytology, and bone marrow reports MUST be entered into this field. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

- The supporting text must include:
  - Date(s) of procedure(s)
  - Path report number
  - Anatomic source of specimen
  - Type of tissue specimen(s)
  - Tumor type and grade (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.)
  - Tumor size
  - Extent of tumor spread
  - Involvement of resection margins
  - Number of lymph nodes involved and examined
  - Record both positive and negative findings, if pertinent.
  - Indicate if pathology report is a slide review or a second opinion from an outside source, i.e., AFIP, Mayo, etc.
  - Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored.

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviations to conserve space.

- If necessary, text can be continued in other empty text fields.

Text--DX Proc--Path

- Example of text for this field: 8/5/11 (S11-501)3cm Rt ant. wall- Bladder: P-d TCCA, invasion of lamina propria/subserosa into serosa. 1/19 LNs+

Text--Histology Title

Field Length: 100

Source of Standard: NPCR

Description:

Text area provided for manual documentation of information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.

General Guidance:

- Text detailing the histologic type, behavior, and grade of the tumor MUST be entered into this field. Text is needed to justify the codes entered into the abstract and to allow recording pertinent information that is not coded at all. The text is used for consolidation of records, quality control, and special studies.

- The supporting text must include: Histology, behavior, and grade in natural language (not codes).

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviations to conserve space.

- If necessary, text can be continued in other empty text fields.

    - Example of text for this field: Papillary renal cell carcinoma, grade 2

Text--Primary Site Title

Field Length: 100

Source of Standard: NPCR

Description:

Text area provided for manual documentation of information regarding the primary site and laterality of the tumor being reported.

General Guidance:

- Text detailing the primary site and laterality of the tumor MUST be entered into this field. Text is needed to justify the codes entered into the abstract and to allow recording pertinent information that is not coded at all. The text is used for consolidation of records, quality control, and special studies.

- The supporting text must include:

- Specific location of the primary site, including the subsite.
- Laterality (when applicable)

- Text automatically generated from coded data is not acceptable.

- If necessary, text can be continued in other empty text fields.

    - Example of text for this field: Lt breast, UOQ

Text--Staging

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for staging information not already entered in other text fields.

General Guidance:

- Text documenting the stage of the cancer MUST be reported in this field, unless it is included in another text field. Text is needed to justify the codes entered into the abstract. The text is used for consolidation of records, quality control, and special studies.

- Suggested text for this field:
  TNM staging
  Organs involved by direct extension
  Size of tumor
  Status of margins
  Number and location of positive lymph nodes
  Site(s) of distant metastasis
  Physician comments

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviation to conserve space.

- If necessary, text can be continued in other empty text fields.

  - Example of text for this field: 1 cm tumor, reticular dermis invaded, Clarks level IV, margins clear.

Text--Place of Diagnosis

Field Length: 60

Source of Standard: NPCR

Description:

Text area provided for manual documentation of the facility, physician office, city, state, or county where the diagnosis was made.

General Guidance:

- Text documenting where the patient was diagnosed MUST be entered into this field. Text is needed to justify the codes entered into the abstract and to allow recording pertinent information that is not coded at all. The text is used for consolidation of records, quality control, and special studies.
- Enter the name of the facility or physician's office where the diagnosis occurred.
- Using only initials for the facility leads to confusion and should be avoided.
- For out of state residents and facilities, include the city and the state.
- If necessary, text can be continued in other empty text fields.
    - Example of text for this field: Oakdale Med. Center

Text--Remarks

Field Length: 1000

Source of Standard: NPCR

Description:

Text area provided for information that is given only in coded form elsewhere or for which the abstract provides no other place. Overflow data can also be placed here. Problematic coding issues can also be discussed in this section.

General Guidance:

- Text is needed to justify the codes entered into the abstract and to allow recording of pertinent information that is not coded at all. The text is used for consolidation of records, quality control, and special studies.

- Suggested text for this field:

  Justification for overriding an edit
  List the patient's previous malignancies
  Place of birth
  Treatment plan
  Clarification about missing or unusual information (e.g., referral for additional treatment)
  Smoking history
  Comorbidities
  Family history of cancer

- Text automatically generated from coded data is not acceptable.

- Use standard abbreviation to conserve space.

- If necessary, text can be continued in other empty text fields.

  - Example of justification for an override: Site and histology verified as correct per Dr. James Smith

ICD Revision Number

Field Length: 1

Source of Standard: SEER

Description:

Indicator for the coding scheme used to code the cause of death.

General Guidance:

- If the patient has multiple records, the ICD Revision Number must be identical on each record.

Coding Instructions:

1. Beginning with deaths occurring January 1, 1999, use code 1 (ICD-10).

Codes:

Code Number	Code Description
0	Patient alive at last follow-up
1	ICD-10
7	ICD-7
8	ICDA-8
9	ICD-9

Over-ride Acsn/Class/Seq

Field Length: 1

Source of Standard: CoC

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software:

Accession Number, Class of Case, Seq Number (CoC).

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- The edit, Accession Number, Class of Case, Seq Number (CoC), checks the following:

    A. If the case is the only case or the first of multiple cases diagnosed at the facility (Sequence Number--Hospital = 00, 01, 60, or 61, and Class of Case = 00, 10, 12, 13, or 14), then the first 4 characters of the Accession Number--Hosp must equal the year of the Date of 1st Contact.

    B. If the case is first diagnosed at autopsy (Class of Case = 38) and the case is the only case or the first of multiple cases for a patient (Sequence Number--Hospital = 00, 01, 60, or 61), then the first 4 characters of the Accession Number--Hosp must equal the year of the Date of Last Contact or Death AND must equal the year of the Date of 1st Contact.

    C. If the case is first diagnosed at autopsy (Class of Case = 38) and the case is not the first case for a patient (Sequence Number--Hospital) greater than 01 or greater than 61), then the year of the Date of 1st Contact must equal the year of Date of Last Contact or Death.

Over-ride Acsn/Class/Seq

- There are some exceptions to the above rules. Over-ride Acsn/Class/Seq may be used to override the edit when the circumstances fit the following situation or one similar to it:

  The case may be the only or the first of multiple malignant cases for a patient (Sequence Number--Hospital = 00 or 01), but there is an earlier benign case (with an earlier year of the Date of 1st Contact) to which the Accession Number--Hosp applies.

Coding Instructions:

1. If an edit error is generated, verify that the Accession Number--Hosp, Sequence Number--Hospital, and Class of Case are correct. If an item is discovered to be incorrectly coded, correct the error and leave this field blank. If the information is determined to be accurate, enter code 1 in this field.

2. If this field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

3. If the case does not generate an error for the edit Accession Number, Class of Case, Seq Number (CoC), leave this field blank.

Codes:

Code Number	Code Description
1	Reviewed and confirmed- Data coded accurately
Blank	Not reviewed

Over-ride Age/Site/Morph

Field Length: 1

Source of Standard: SEER

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Age, Primary Site, Morphology

Age, Primary Site, Morph ICDO3--Adult (SEER)

Age, Primary Site, Morph ICDO3--Pediatric (NPCR)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- Edits of this type require review if a site-morphology combination occurs in an age group for which it is extremely rare or if the cancer is diagnosed in utero.

- If the edit generates an error or warning message, check that the primary site and histologic type are coded correctly and that the age, date of birth, and date of diagnosis are correct.

Coding Instructions:

1. Leave blank if the program does not generate an error message.

2. If an item is discovered to be incorrectly coded, correct the error and leave this field blank.

Over-ride Age/Site/Morph

3. Code 1 for an unusual occurrence of a particular age/site/histology for a given age has been reviewed and confirmed to be correct.

4. Code 2 if the case was diagnosed in utero.

5. Code 3 if both conditions apply.

6. If this field is coded 1, 2, or 3, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed that age/site/histology combination is coded accurately
2	Reviewed and confirmed that case was diagnosed in utero
3	Reviewed and confirmed that conditions 1 and 2 both apply
Blank	Not reviewed

Over-ride CoC-Site/Type

Field Length: 1

Source of Standard: CoC

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, Morphology-Type ICDO2 (CoC)

Primary Site, Morphology-Type ICDO3 (CoC)

Primary Site, Morphology-Type, Behavior ICDO3 (CoC)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- Edits of this type, check for "usual" combinations of site and histology.

- The Site/Histology validation list (available on the SEER web site) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not included. These edits require review of all combinations not listed.

- Review of these cases requires investigating whether the combination is biologically implausible or there are cancer registry coding conventions that would dictate different codes for the diagnosis. Review of these rare combinations often results in a change to either the site or histology.

Over-ride CoC-Site/Type

Coding Instructions:

1. Leave blank if the program does not generate an error message.

2. If an item is discovered to be incorrectly coded, correct the error and leave this field blank.

3. If review of the primary site and morphology confirms the data are correct and coded in conformance with coding rules, enter code 1 in this field.

4. If this field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed- Data coded correctly
Blank	Not reviewed

Over-ride CS 1- CS 20

Field Length: 1

Source of Standard: AJCC

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Coding Instructions:

1. Leave blank if the program does not generate an error.
2. If an item is discovered to be incorrectly coded, correct the error and leave this field blank.
3. Review the case. If the information is determined to be accurate, use code 1 in this field.
4. If this field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed-Data coded accurately
Blank	Not reviewed or reviewed and corrected

Over-ride Histology

Field Length: 1

Source of Standard: SEER

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Diagnostic Confirmation, Behavior ICDO2 (SEER IF31)

Diagnostic Confirmation, Behavior ICDO3 (SEER IF31)

Morph (1973-91) ICD-O-1 (SEER MORPH)

Morphology--Type/Behavior ICDO2 (SEER MORPH)

Morphology--Type/Behavior ICDO3 (SEER MORPH)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- Edits of the type, Diagnostic Confirmation, Behavior, differ in the use of ICD-O-2 or ICD-O-3 and check that, for in situ cases (Behavior = 2), Diagnostic Confirmation specifies microscopic confirmation (1, 2, or 4).

- The distinction between in situ and invasive is very important to a registry, since prognosis is so different. Since the determination that a neoplasm has not invaded surrounding tissues, i.e., in situ, made microscopically, cases coded in situ in behavior should have a microscopic confirmation code. However, very rarely, a physician will designate a case noninvasive or in situ without microscopic evidence.

Over-ride Histology

- If an edit of the type, Diagnostic Confirmation, Behavior, gives an error message or warning, check that Behavior and Diagnostic Confirmation have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding.

- Edits of the type, Morphology--Type/Behavior, perform the following check:

    A. Codes listed in ICD-O-2 or ICD-O-3 with behavior codes of only 0 or 1 are considered valid, since the behavior matrix of ICD-O-2 and ICD-O-3 allows for the elevation of the behavior of such histologies when the tumor is in situ or malignant. This edit forces review of these rare cases to verify that they are indeed in situ or malignant.

    B. The following histologies are generally not accepted as *in situ*: ICD-O-2 histologies 8000-8004, 8020, 8021, 8331, 8332, 8800-9054, 9062, 9082, 9083, 9110-9491, 9501-9989, ICD-O-3 histologies 8000-8005, 8020, 8021, 8331, 8332, 8800-9055, 9062, 9082, 9083, 9110-9493, 9501-9989. This edit forces review of these cases

    C. If a Morphology-Type/Behavior edit produces an error or warning message and the case is one in which the 4-digit morphology code is one that appears in ICD-O-2 or ICD-O-3 only with behavior codes of 0 or 1, verify the coding of morphology and that the behavior should be coded malignant or in situ. The registrar may need to consult a pathologist or medical advisor in problem cases.

        ❖ Exceptions:

        If year of Date of Diagnosis > 2000, then a behavior code of 1 is valid for the following ICD-O-2 histologies and no over-ride flag is needed: 8931, 9393, 9538, 9950, 9960-9962, 9980-9984, and 9989. Similarly, the following ICD-O-3 histologies are valid with a behavior code of 1: 8442, 8451, 8462, 8472, and 8473.

        If year of Date of Diagnosis > 2003, the following ICD-O-3 benign histologies will pass without review: 8146, 8271, 8861, 8897, 9121, 9122, 9131, 9161, 9350, 9351, 9352, 9360, 9361, 9383, 9384, 9394, 9412, 9413, 9444, 9492, 9493, 9506, 9531, 9532, 9533, 9534, 9537, 9541, 9550, 9562, and 9570.

    D. Grade 5-8 with histologies not in the range of 9590-9948 is impossible.

    E. Some terms in ICD-O-2 and ICD-O-3 carry an implied statement of grade. These histologies must be reported with the correct grade as stated below. An error of this type cannot be over-riden.

        ICD-O-2:
        8020/34 Carcinoma, undifferentiated

Over-ride Histology

8021/34 Carcinoma, anaplastic
8331/31 Follicular Adenocarcinoma, well differentiated
8851/31 Liposarcoma, well differentiated
9062/34 Seminoma, anaplastic
9082/34 Malignant teratoma, undifferentiated
9083/32 Malignant teratoma, intermediate type
9401/34 Astrocytoma, anaplastic
9451/34 Oligodendroglioma, anaplastic
9511/31 Retinoblastoma, differentiated
9512/34 Retinoblastoma, undifferentiated

ICD-0-3
8020/34 Carcinoma, undifferentiated
8021/34 Carcinoma, anaplastic
8331/31 Follicular Adenocarcinoma, well differentiated
9082/34 Malignant teratoma, undifferentiated
9083/32 Malignant teratoma, intermediate type
9401/34 Astrocytoma, anaplastic
9451/34 Oligodendroglioma, anaplastic
9511/31 Retinoblastoma, differentiated
9512/34 Retinoblastoma, undifferentiated

Coding Instructions:

1. Leave blank if the program does not generate an error message.
2. If an item is discovered to be incorrectly coded, correct the error and leave this field blank.
3. Code 1, 2, or 3 as indicated if review of all items in the error or warning message confirms that all are correct.
4. If this field is code 1, 2 or 3, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed- Data coded correctly for edits of the type Morphology-Type/Behavior

Over-ride Histology

Code Number	Code Description
2	Reviewed and confirmed- Data coded correctly for edits of the type Diagnostic Confirmation, Behavior Code
3	Reviewed and confirmed that conditions 1 and 2 both apply
Blank	Not reviewed or reviewed and corrected

Over-ride HospSeq/DxConf

Field Length: 1

Source of Standard: CoC

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software:

Diagnostic Confirm, Seq Num--Hosp (CoC)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- The edit, Diagnostic Confirm, Seq Num--Hosp (CoC), does the following:

    A. If any case is one of multiple primaries and is not microscopically confirmed or lacks a positive lab test/marker study, i.e., Diagnostic Confirmation > 5 and Sequence Number--Hospital > 00 (more than one primary), review is required.

    B. If Primary Site specifies an ill-defined or unknown primary (C760-C768, C809), no further checking is done.

    C. If Sequence Number--Hospital is in the range of 60-88, this edit is skipped.

- It is important to verify that the non-microscopically confirmed case is indeed a separate primary from any others that may have been reported. This edit forces review of multiple primary cancers when one of the primaries is coded to a site other than ill-defined or unknown and is not microscopically confirmed or confirmed by a positive lab test/marker study.

Over-ride HospSeq/DxConf

Coding Instructions:

1. Leave blank if the program does not generate an error message.

2. If the suspect case is confirmed accurate as coded and the number of primaries is correct, set the Over-ride HospSeq/DxConf to 1. Do not set the over-ride flag on the patient's other primary cancers.

3. If it turns out that the non-microscopically confirmed cancer is considered a manifestation of one of the patient's other cancers, delete the non-microscopically confirmed case. Check the sequence numbers of remaining cases, correcting them if necessary. Also check for other data items on the remaining cases that may need to be changed as a result of the corrections, such as stage and treatment.

4. If this field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed-Data coded accurately
Blank	Not reviewed or reviewed and corrected

Over-ride HospSeq/Site

Field Length: 1

Source of Standard: CoC

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Seq Num--Hosp, Primary Site, Morph ICDO2 (CoC)

Seq Num--Hosp, Primary Site, Morph ICDO3 (CoC)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- Edits of this type differ in use of ICD-O-2 or ICD-O-3 morphology. They force review of multiple primary cancers when one of the primaries is coded to a site/morphology combination that could indicate a metastatic site rather than a primary site.

- If Sequence Number--Hospital indicates the person has had more than one primary, then any case with one of the following site/histology combinations requires review:

    - C760-C768 (Ill-defined sites) or C809 (unknown primary) and Histologic Type ICD-O-3 < 9590. (Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry and should not be abstracted as a second primary.)

- C770-C779 (lymph nodes) and Histologic Type ICD-O-3 not in range 9590-9729
- C420-C424 and Histologic Type ICD-O-3 not in range 9590-9989
- Any site code and Histologic Type ICD-O-3 9740-9758.

- If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

Coding Instructions:

1. Leave blank if the program does not generate an error message for an edit of the type Seq Num--Hosp, Primary Site, Morph.

2. Ill-defined sites (C76.0 - C76.8) or unknown primary (C80.9) and histology code less than 9590: Look for evidence that the unknown or ill-defined primary is a secondary site (extension or metastasis) from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian carcinoma known to the registry, and should not be entered as a second primary.

3. Lymph nodes (C77.0-C77.9) and histology code not in the range 9590-9729: Primary malignancies of lymph nodes are almost exclusively the lymphomas coded in the range 9590-9729. A carcinoma, sarcoma, leukemia, or other diagnosis outside that range in a lymph node is most likely a metastatic (secondary) lesion. Check whether the lymph node lesion could be a manifestation of one of the patient's other cancers. If the lesion in the lymph node is considered a separate primary, try to ascertain a more appropriate primary site than lymph nodes.

4. Hematopoietic and reticuloendothelial systems (C42.0-C42.4) and histology not in the range 9590-9989: Primary cancers of the blood, bone marrow, spleen, etc. are almost exclusively lymphomas, leukemias, and related conditions coded in the range 9590-9989. A carcinoma, sarcoma, or other diagnosis outside that range in one of these sites is most likely a metastatic (secondary) lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers. If the lesion is considered a separate primary, try to ascertain a more appropriate primary site other than those in the C42 group.

5. Other lymphoreticular neoplasms and mast cell tumors of any site (histologies 9740-9758): Verify that these diagnoses are coded correctly and are indeed separate primaries from the other reported ones.

Over-ride HospSeq/Site

6. Leave blank and correct any errors for the case if an item is discovered to be incorrect.

7. If review of all items in the error or warning message confirms the data is coded correctly, assign code 1.

8. If this data field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed -Data coded accurately
Blank	Not reviewed or reviewed and corrected

Over-ride Ill-Define Site

Field Length: 1

Source of Standard: SEER

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software:

Seq Num—Central, Prim Site, Morph ICDO2 (SEER IF22)

Seq Num—Central, Prim Site, Morph ICD03 (SEER IF22)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- The edit, Ill-Defined Site checks the following for review:

    A. If the primary site is C760-C768 (ill-defined sites) or C809 (unknown primary) and ICD-O-2 or ICD-O-3 histology. Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian cystadenocarcinonma already in the registry, and should not be entered as a second primary.

    B. C770-C779 (lymph nodes) and ICD-O-2 histology not in the range 9590-9717 or ICD-O-3 histology not in the range 9590-9729; or C420-C424 and ICD-O-2 histology not in the range 9590-9941 or ICD-O-3 histology not in the range 9590-9989. That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.

Over-ride Ill-Define Site

C. Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741 or ICD-O-3 histology in the range 9740-9758. Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.

- There are some exceptions to the above rules. Over-ride Ill-Define Site may be used to override the edit when the circumstances fit the following situation or one similar to it:

  The case has been reviewed and the new ill-defined site malignancy is truly a confirmed second primary malignancy.

Coding Instructions:

1. If an edit error is generated, verify that the Sequence Number, Primary Site, and Morphology are correct. If an item is discovered to be incorrectly coded, correct the error and leave this field blank. If the information is determined to be accurate, enter code 1 in this field.

2. If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

3. If this field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

4. If the case does not generate an error for the edit Over-ride Ill-Defined Site, leave this field blank.

Codes:

Code Number	Code Description
1	Review and confirmed as reported: a second or subsequent primary reported with an ill-defined primary site (C760-C768, C809) has been reviewed and is an independent primary.
Blank	Not reviewed

Over-ride Leuk, Lymphoma

Field Length: 1

Source of Standard: SEER

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Diagnostic Confirmation, Histology ICDO2 (SEER IF48)

Diagnostic Confirmation, Histology ICDO3 (SEER IF48)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma or leukemia that have diagnostic confirmation 6 (direct visualization).

- These edits check the case for the following:

    - If Histologic Type ICD-O-3 = 9590 - 9992 (lymphoma and leukemia) then Diagnostic Confirmation cannot be 6 (direct visualization) or 8 (clinical).

    - If Diagnostic Confirmation is 3 (positive histology PLUS positive immunophenotyping AND/OR positive genetic studies), then Histologic Type ICD-O-3 must = 9590-9992.

    - If Histology (92-00) ICD-O-2 = 9590 - 9717 (lymphoma) then Diagnostic Confirmation cannot be 6 (direct visualization) or 8 (clinical).

Over-ride Leuk, Lymphoma

- If Histology (92-00) ICD-O-2 = 9720 - 9941 (leukemia and other) then Diagnostic Confirmation cannot be 6 (direct visualization).

Coding Instructions:

1. Leave blank if the program does not generate an error message.

2. If an item is discovered to be incorrectly coded, correct the error and leave this field blank.

3. If the edit produces an error or warning message, check that the Histologic Type and Diagnostic Confirmation are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in Diagnostic Confirmation) for leukemias. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract.

4. If upon review all items are coded correctly, enter a 1 in this field.

5. If this data field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed-Data coded accurately
Blank	Not reviewed or reviewed and corrected

Over-ride Report Source

Field Length: 1

Source of Standard: SEER

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Type of Rep Srce (DC), Seq Num--Cent, ICD02 (SEER IF04)

Type of Rep Srce (DC), Seq Num--Cent, ICDO3 (SEER IF04)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- Edits of the type "Type of Rep Srce (DC), Seq Num--Cent' checks that if the case is a death-certificate-only case and the histology is not a lymphoma, leukemia, immunoproliferative or myeloproliferative disease (ICD-O-2 or ICD-O-3 histology is less than 9590), then the tumor sequence number must specify one primary only (sequence '00').

Coding Instructions:

1. Leave blank if the program does not generate an error message.

2. If an item is discovered to be incorrectly coded, correct the error and leave this field blank.

3. Code 1 if review of type of reporting source, histologic type and tumor sequence number verified that a second or subsequent primary with a reporting source of death-certificate-only has been reviewed and is needed an independentprimary.

Over-ride Report Source

4. If this data field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Over-ride Seq/DxConf

Field Length: 1

Source of Standard: SEER

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software:

Diagnostic Confirm, Seq Num--Central (SEER IF23)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- The edit, Diagnostic Confirm, Seq Num--Central, does the following:

    A. If any case is one of multiple primaries and is not microscopically confirmed or lacks a positive lab test/marker study, i.e., Diagnostic Confirmation > 5 and Sequence Number--Hospital > 00 (more than one primary), review is required.

    B. If Sequence Number--Hospital is in the range of 60-99, this edit is skipped.

- It is important to verify that the non-microscopically confirmed case is indeed a separate primary from any others that may have been reported. This edit forces review of multiple primary cancers when one of the primaries is coded to a site other than ill-defined or unknown and is not microscopically confirmed or confirmed by a positive lab test/marker study.

Coding Instructions:

Over-ride Seq/DxConf

1. Leave blank if the program does not generate an error message.

2. If the suspect case is confirmed accurate as coded and the number of primaries is correct, set the Over-ride HospSeq/DxConf to 1. Do not set the over-ride flag on the patient's other primary cancers.

3. If it turns out that the non-microscopically confirmed cancer is considered a manifestation of one of the patient's other cancers, delete the non-microscopically confirmed case. Check the sequence numbers of remaining cases, correcting them if necessary. Also check for other data items on the remaining cases that may need to be changed as a result of the corrections, such as stage and treatment.

4. If this field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed-Data coded accurately
Blank	Not reviewed or reviewed and corrected

Over-ride Site/Behavior

Field Length: 1

Source of Standard: SEER

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, Behavior Code ICDO2 (SEER IF39)

Primary Site, Behavior Code ICDO3 (SEER IF39)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- Edits of this type require review of the following primary sites with a behavior of in situ (ICD-O-2 or ICD-O-3 behavior = 2):

C269	Gastrointestinal tract, NOS
C399	Ill-defined sites within respiratory system
C559	Uterus, NOS
C579	Female genital tract, NOS
C639	Male genital organs, NOS
C689	Urinary system, NOS
C729	Nervous system, NOS
C759	Endocrine gland, NOS
C760-C768	Ill-defined sites
C809	Unknown primary site

Over-ride Site/Behavior

- Since the designation of in situ is very specific and almost always requires microscopic confirmation, ordinarily specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being in situ is reliable.

- If an in situ diagnosis is stated, try to obtain a more specific primary site. A primary site within an organ system can sometimes be identified based on the diagnostic procedure or treatment given or on the histologic type. If no more specific site can be determined, it is usually preferable to code a behavior code of 3. In the exceedingly rare situation in which it is certain that the behavior is in situ and no more specific site code is applicable, set Over-ride Site/Behavior to 1.

Coding Instructions:

1. Leave blank if the program does not generate an error message.

2. If an item is discovered to be incorrectly coded, correct the error and leave this field blank.

3. If review of site and behavior verifies that the patient has an in situ cancer of a nonspecific site and no further information about the primary site is available, assign code 1 to this field.

4. If this data field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed-Data coded accurately
Blank	Not reviewed or reviewed and corrected

Over-ride Site/EOD/DX Dt

Field Length: 1

Source of Standard: SEER

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, EOD, ICDO2 (SEER IF40)

Primary Site, EOD, ICDO3 (SEER IF40)

Primary Site, CS Extension (SEER IF 176)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- Edits of this type do not allow "localized" disease with nonspecific sites, such as mouth, NOS; colon, NOS (except ICD-O-2 or ICD-O-3 histology 8210, 8220, 8261, or 8263); bone, NOS; female genital system, NOS; male genital organs, NOS; and others.

Coding Instructions:

1. Leave blank if the program does not generate an error message.

2. If the case has been reviewed and it has been verified that the patient had “localized” disease with a nonspecific site and no further information about the primary site is available, assign code 1.

Over-ride Site/EOD/DX Dt

3. If this data field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed- Data coded accurately
Blank	Not reviewed or reviewed and corrected

Over-ride Site/Lat/EOD

Field Length: 1

Source of Standard: SEER

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, Laterality, EOD, ICDO2 (SEER IF41)

Primary Site, Laterality, EOD, ICDO3 (SEER IF41)

Primary Site, Laterality, CS Extension (SEER IF177)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- Edits of this type apply to paired organs and do not allow the extension to be coded specifically if laterality is coded as “bilateral, site unknown,” or “laterality unknown.”

Coding Instructions:

1. Leave blank if the program does not generate an error message.

2. If the case has been reviewed and it has been verified that the patient had laterality coded nonspecifically and extension coded specifically, assign code 1.

3. If this data field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Over-ride Site/Lat/EOD

Codes:

Code Number	Code Description
1	Reviewed and confirmed-Data coded accurately
Blank	Not reviewed or reviewed and corrected

Over-ride Site/Lat/Morph

Field Length: 1

Source of Standard: SEER

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Laterality, Primary Site, Morph ICDO2 (SEER IF42)

Laterality, Primary Site, Morph ICDO3 (SEER IF42)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- Edits of the type Laterality, Primary Site, Morph differ in use of ICD-O-2 or ICD-O-3 morphology and do the following:

- If the Primary Site is a paired organ and ICD-O-2 or ICD-O-3 behavior is in situ (2), then laterality must be 1, 2, 3, or 5.

Coding Instructions:

1. Leave blank if the program does not generate an error message.

2. If an item is discovered to be incorrectly coded, correct the error and leave this field blank.

3. If review of site, laterality and morphology verifies that the case is coded correctly, assign code 1.

Over-ride Site/Lat/Morph

4. If this data field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed-Data coded accurately
Blank	Not reviewed or reviewed and corrected

Over-ride Site/TNM-StgGrp

Field Length: 1

Source of Standard: CoC

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software:

Primary Site, AJCC Stage Group - Ed 6, ICDO3 (CoC)

Primary Site, AJCC Stage Group - Ed 7, ICDO3 (CoC)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit in the future.

- These edits, check that the pathologic and clinical AJCC stage group codes are valid for the site and histology group according to the *AJCC Cancer Staging Manual Sixth/Seventh Edition*, using the codes described for the items TNM Clin Stage Group [970] and TNM Path Stage Group [910].

- Since pediatric cancers whose sites and histologies have an AJCC scheme may be coded according to a pediatric scheme instead, use *Override Site/TNM-Stage Group* to indicate the case was coded according to a pediatric staging system if it was not also coded according to the AJCC manual. Pediatric stage groups should not be recorded in the *Clinical Stage Group* or *Pathologic Stage Group* items. When neither clinical nor pathologic AJCC staging is used for pediatric cases, code all AJCC items 88. When any AJCC component is used to stage a pediatric case, follow the instructions for coding AJCC items and leave *Over-Ride Site/TNM-StgGrp* blank.

Coding Instructions:

Over-ride Site/TNM-StgGrp

1. Leave blank if the program does not generate an error message.

2. If an item is discovered to be incorrectly coded, correct the error and leave this field blank.

3. If the case is confirmed to be a pediatric case that was coded using a pediatric coding system, assign code 1.

4. If this data field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed-Data is coded accurately
Blank	Not reviewed or reviewed and corrected

Over-ride Site/Type

Field Length: 1

Source of Standard: SEER

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, Morphology-Type ICDO2 (CoC)

Primary Site, Morphology-Type ICDO3 (CoC)

Primary Site, Morphology-Type ICDO2 (SEER IF25)

Primary Site, Morphology-Type ICDO3 (SEER IF25)

Primary Site, Morphology-Type, Behavior ICDO3 (SEER IF25)

Primary Site, Morphology-Type, Behavior ICDO3 (CoC)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case then the over-ride flag is used to skip the edit in the future.

- Edits of this type check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different over-ride flag. The CoC version of the edit will accept Over-ride CoC-Site/Type or Over-ride Site/Type as equivalent.

- The Site/Histology validation list (available on the SEER web site) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not included. These edits require review of all combinations not listed.

Over-ride Site/Type

- Review of these cases requires investigating whether a) the combination is biologically implausible, or b) there are cancer registry coding conventions that would dictate different codes for the diagnosis. Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.

Coding Instructions:

1. Leave blank if the program does not generate an error message.

2. If an item is discovered to be incorrectly coded, correct the error and leave this field blank.

3. If the case has been reviewed and both the site and histology are correct, assign code 1.

4. If this data field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed-Data coded accurately
Blank	Not reviewed or reviewed and corrected

Over-ride SS/NodesPos

Field Length: 1

Source of Standard: NAACCR

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Summary Stage 1977, Regional Nodes Pos (NAACCR)

Summary Stage 2000, Regional Nodes Pos (NAACCR)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error or warning message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- The edit Summary Stage 1977, Regional Nodes Pos (NAACCR) checks SEER Summary Stage 1977 against Regional Nodes Positive and generates an error or warning if there is an incompatibility between the two data items. The edit Summary Stage 2000, Regional Nodes Pos (NAACCR) checks SEER Summary Stage 2000 against Regional Nodes Positive and generates an error or warning if there is an incompatibility between the two data items.

Coding Instructions:

1. Leave blank if the program does not generate an error message.

2. If an item is discovered to be incorrectly coded, correct the error and leave this field blank.

Over-ride SS/NodesPos

3. If the case has been reviewed and it has been verified that the case has both SEER Summary Stage 1977 and Nodes Positive coded correctly or SEER Summary Stage 2000 and Nodes Positive coded correctly, assign code 1.

4. If this field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed-Data coded accurately
Blank	Not reviewed or reviewed and corrected

Over-ride SS/TNM-M

Field Length: 1

Source of Standard: NAACCR

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Summary Stage 1977, TNM-M (NAACCR)

Summary Stage 2000, TNM-M (NAACCR)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error or warning message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- The edit Summary Stage 1977, TNM-M (NAACCR) checks the SEER Summary Stage 1977 against the TNM-M and generates a warning if the SEER Summary Stage 1977 is 'distant' and the TNM-M is '0'. (TNM-M is derived from TNM Path M and TNM Clin M, with TNM Path M having precedence.) It also checks if the SEER Summary Stage 1977 is not 'distant' and the TNM-M is greater than or equal to '1' and generates an error or a warning. The edit Summary Stage 2000, TNM-M (NAACCR) checks the SEER Summary Stage 2000 against the TNM-M and generates a warning if the SEER Summary Stage 2000 is 'distant' and the TNM-M is '0'. It also checks if the SEER Summary Stage 2000 is not 'distant' and the TNM-M is greater than or equal to '1' and generates an error or a warning.

Coding Instructions:

1. Leave blank if the program does not generate an error message.

Over-ride SS/TNM-M

2. If an item is discovered to be incorrectly coded, correct the error and leave this field blank.

3. If the case has been reviewed and it has been verified that both SEER Summary Stage 1977 and TNM-M have been coded correctly or that SEER Summary Stage 2000 and TNM-M have been coded correctly, assign code 1.

4. If this field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed-Data coded accurately
Blank	Not reviewed or reviewed and corrected

Over-ride SS/TNM-N

Field Length: 1

Source of Standard: NAACCR

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Summary Stage 1977, TNM-N (NAACCR)

Summary Stage 2000, TNM-N (NAACCR)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- The edit Summary Stage 1977, TNM-N (NAACCR) checks SEER Summary Stage 1977 against the TNM-N and generates an error if the SEER Summary Stage 1977 indicates regional nodal involvement and the TNM-N does not. (TNM-N is derived from TNM Path N and TNM Clin N, with TNM Path N having precedence.) It also generates an error if the SEER Summary Stage 1977 is 'in situ' or 'localized' and the TNM-N is greater than or equal to '1'. The edit Summary Stage 2000, TNM-N (NAACCR) checks SEER Summary Stage 2000 against the TNM-N and generates an error if the SEER Summary Stage 2000 indicates regional nodal involvement and the TNM-N does not. It also generates an error if the SEER Summary Stage 2000 is 'in situ' or 'localized' and the TNM-N is greater than or equal to '1'.

Coding Instructions:

1. Leave blank if the program does not generate an error message.

Over-ride SS/TNM-N

2. If an item is discovered to be incorrectly coded, correct the error and leave this field blank.

3. If the case has been reviewed and it has been verified that both SEER Summary Stage 1977 and TNM-N or both SEER Summary Stage 2000 and TNM-N have been coded correctly, assign code 1.

4. If this field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed-Data coded accurately
Blank	Not reviewed or reviewed and corrected

Over-ride Surg/DxConf

Field Length: 1

Source of Standard: SEER

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

RX Summ--Surg Prim Site, Diag Conf (SEER IF76)

RX Summ--Surg Site 98-02, Diag Conf (SEER IF106)

RX Summ--Surgery Type, Diag Conf (SEER IF46)

General Guidance:

- Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

- Edits of this type check that cases with a primary site surgical procedure coded 20-90 are histologically confirmed.

- If the patient had a surgical procedure, most likely there was a microscopic examination of the cancer. Verify the surgery and diagnostic confirmation codes, and correct any errors. Sometimes there are valid reasons why no microscopic confirmation is achieved with the surgery; for example, the tissue removed may be inadequate for evaluation.

Over-ride Surg/DxConf

Coding Instructions:

1. Leave blank if the program does not generate an error message.

2. If an item is discovered to be incorrectly coded, correct the error and leave this field blank.

3. If review confirms that they are correct. The patient had surgery, but the tissue removed was not sufficient for microscopic confirmation, assign code 1.

4. If this data field is coded 1, documentation supporting the override must be entered into the Text Remarks field of the abstract.

Codes:

Code Number	Code Description
1	Reviewed and confirmed-Data coded accurately
Blank	Not reviewed or reviewed and corrected

CoC Coding Sys--Original

Field Length: 2

Source of Standard: CoC

Description:

Code for the ACoS CoC coding system originally used to code the record.

General Guidance:

- This data field may be coded by the software vendor.

Codes:

Code Number	Code Description
00	No CoC coding system used
01	Pre-1988 (Cancer Program Manual Supplement)
02	1988 Data Acquisition Manual
03	1989 Data Acquisition Manual Revisions
04	1990 Data Acquisition Manual Revisions
05	1994 Data Acquisition Manual (Interim/Revised)
06	ROADS (effective with cases diagnosed 1996-1997)
07	ROADS and 1998 Supplement (effective with cases diagnosed 1998-2002)
08	FORDS (effective with cases diagnosed 2003 and forward)
99	Original CoC coding system is not known

CoC Coding Sys--Current

Field Length: 2

Source of Standard: CoC

Description:

Code describing the ACoS CoC coding system currently used in the record. CoC codes may be converted from an earlier version.

General Guidance:

- This data field may be coded by the software vendor.

Codes:

Code Number	Code Description
00	No CoC coding system used
01	Pre-1988 (Cancer Program Manual Supplement)
02	1988 Data Acquisition Manual
03	1989 Data Acquisition Manual Revisions
04	1990 Data Acquisition Manual Revisions
05	1994 Data Acquisition Manual (Interim/Revised)
06	ROADS (effective with cases diagnosed 1996-1997)
07	ROADS and 1998 Supplement (effective with cases diagnosed 1998-2002)
08	FORDS (effective with cases diagnosed 2003 and forward)
99	Unknown coding system

ICD-O-3 Conversion Flag

Field Length: 1

Source of Standard: SEER/CoC

Description:

Code specifying how the conversion of site and morphology codes from ICD-O-2 to ICD-O-3 was accomplished.

Codes:

Code Number	Code Description
0	Morphology (Morph--Type&Behav ICD-O-3 [521]) originally coded in ICD-O-3
1	Morphology (Morph--Type&Behav ICD-O-3 [521]) converted from (Morph--Type&Behav ICD-O-2 [419]) without review
3	Morphology (Morph--Type&Behav ICD-O-3 [521]) converted from (Morph--Type&Behav ICD-O-2 [419]) with review
Blank	Not converted (clarification for cases diagnosed as of January 1, 2007: cases coded in prior ICD-O version and not converted to ICD-O-3)

Morph Coding Sys--Originl

Field Length: 1

Source of Standard: NAACCR

Description:

Code that best describes how morphology was originally coded. If later converted, this field shows the original codes used.

Codes:

Code Number	Code Description
1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6	ICD-O, Second Edition, plus FAB codes effective 1/1/98
7	ICD-O, Third Edition
8	ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms effective 1/1/2010
9	Other

Morph Coding Sys--Current

Field Length: 1

Source of Standard: NAACCR

Description:

Code that best describes how morphology is currently coded. If converted, this field shows the system it is converted to.

Codes:

Code Number	Code Description
1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6	ICD-O, Second Edition, plus FAB codes effective 1/1/98
7	ICD-O, Third Edition
8	ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms effective 1/1/2010
9	Other

Race Coding Sys--Original

Field Length: 1

Source of Standard: NAACCR

Description:

Code that best describes how the race fields were originally coded. If data have been converted, this field identifies the coding system originally used to code the case.

Codes:

Code Number	Code Description
1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	SEER < 1988 (1-digit)
3	1988-1990 SEER & CoC (2-digit)
4	1991-1993 SEER & CoC (added codes 20-97, additional Asian and Pacific Islander codes)
5	1994-1999 SEER & CoC (added code 14, Thai)
6	2000+ SEER & CoC (added code 88 for Race 2, 3, 4, and 5)
7	2010+ SEER & CoC (added codes 15, 16, and 17; removed 09)
9	Other

Race Coding Sys--Current

Field Length: 1

Source of Standard: NAACCR

Description:

Code that best describes how the race fields are currently coded. If the data have been converted, this field shows the system to which it has been converted.

Codes:

Code Number	Code Description
1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	SEER < 1988 (1-digit)
3	1988-1990 SEER & CoC (2-digit)
4	1991-1993 SEER & CoC (added codes 20-97, additional Asian and Pacific Islander codes)
5	1994-1999 SEER & CoC (added code 14, Thai)
6	2000+ SEER & CoC (added code 88 for Race 2, 3, 4, and 5)
7	2010+ SEER & CoC (added codes 15, 16, and 17; removed 09)
9	Other

RX Coding System--Current

Field Length: 2

Source of Standard: NAACCR

Description:

Code describing how treatment for this tumor now is coded.

Codes:

Code Number	Code Description
00	Treatment data not coded/transmitted (i.e., all treatment fields [items 1200-1450 and 1500-1645] blank)
01	Treatment data coded using 1-digit surgery codes (obsolete)
02	Treatment data coded according to 1983-1992 SEER manuals and 1983-1995 CoC manuals
03	Treatment data coded according to 1996 *ROADS Manual*
04	Treatment data coded according to 1998 *ROADS* Supplement
05	Treatment data coded according to 1998 *SEER Manual*
06	Treatment data coded according to *FORDS* manual
07	Treatment data coded according to 2010 SEER Coding Manual
99	Other coding, including partial or nonstandard coding

SEER Coding Sys--Original

Field Length: 1

Source of Standard: NAACCR

Description:

This shows the SEER coding system best describing the way the majority of SEER items in the record were originally coded.

Codes:

Code Number	Code Description
0	No SEER coding
1	Pre-1988 SEER Coding Manuals
2	1988 SEER Coding Manual
3	1989 SEER Coding Manual
4	1992 SEER Coding Manual
5	1998 SEER Coding Manual
6	2003 SEER Coding Manual
7	2004 SEER Coding Manual
8	2007 SEER Coding Manual
9	2007 SEER Coding Manual with 2008 changes
A	2010 SEER Coding Manual
B	2011 SEER Coding Manual
C	2012 SEER Coding Manual
D	2013 SEER Coding Manual
E	2014 SEER Coding Manual
F	2015 SEER Coding Manual

SEER Coding Sys--Current

Field Length: 1

Source of Standard: NAACCR

Description:

This shows the SEER coding system best describing the majority of SEER items as they are in the record (after conversion).

Codes:

Code Number	Code Description
0	No SEER coding
1	Pre-1988 SEER Coding Manuals
2	1988 SEER Coding Manual
3	1989 SEER Coding Manual
4	1992 SEER Coding Manual
5	1998 SEER Coding Manual
6	2003 SEER Coding Manual
7	2004 SEER Coding Manual
8	2007 SEER Coding Manual
9	2007 SEER Coding Manual with 2008 changes
A	2010 SEER Coding Manual
B	2011 SEER Coding Manual
C	2012 SEER Coding Manual
D	2013 SEER Coding Manual
E	2014 SEER Coding Manual
F	2015 SEER Coding Manual

Site Coding Sys--Original

Field Length: 1

Source of Standard: NAACCR

Description:

Code that best describes how primary site was originally coded. If converted, this field shows the original coding system used.

Codes:

Code Number	Code Description
1	ICD-8 and MOTNAC
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

Site Coding Sys--Current

Field Length: 1

Source of Standard: NAACCR

Description:

Code that best describes how the primary site currently is coded. If converted, this field shows the system to which it is converted.

Codes:

Code Number	Code Description
1	ICD-8 and MOTNAC
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

Section Three:

Appendices

APPENDIX A

COUNTRY AND STATE CODES

Appendix A: Alphabetic Code List by Country/State

Name of Country/State	ISO country code	USPS state code
Afghanistan	AFG	XX
Africa, NOS[1]	ZZF	YY
Alabama	USA	AL
Aland Islands	ALA	XX
Alaska	USA	AK
Albania	ALB	XX
Alberta	CAN	AB
Algeria	DZA	XX
American Samoa	ASM	AS
Andorra	AND	XX
Angola	AGO	XX
Anguilla	AIA	XX
Antarctica	ATA	XX
Antigua and Barbuda	ATG	XX
Argentina	ARG	XX
Arizona	USA	AZ
Arkansas	USA	AR
Armed Forces Americas	USA	AA
Armed Forces Canada, Europe, Middle East, Africa	USA	AE
Armed Forces Pacific	USA	AP
Armenia	ARM	XX
Aruba	ABW	XX
Asia, NOS[1]	ZZA	YY
Australia	AUS	XX
Austria	AUT	XX
Azerbaijan	AZE	XX
Bahamas	BHS	XX
Bahrain	BHR	XX
Bangladesh	BGD	XX
Barbados	BRB	XX
Belarus	BLR	XX
Belgium	BEL	XX
Belize	BLZ	XX
Benin	BEN	XX
Bermuda	BMU	XX
Bhutan	BTN	XX
Bolivia	BOL	XX

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
Bonaire, Saint Eustatius and Saba	BES	XX
Bosnia and Herzogovina	BIH	XX
Botswana	BWA	XX
Bouvet Island	BVT	XX
Brazil	BRA	XX
British Columbia	CAN	BC
British Indian Ocean Territory	IOT	XX
British Virgin Islands	VGB	XX
Brunei	BRN	XX
Bulgaria	BGR	XX
Burkina Faso	BFA	XX
Burundi	BDI	XX
California	USA	CA
Cambodia	KHM	XX
Cameroon	CMR	XX
Canada	CAN	CD
Cape Verde	CPV	XX
Cayman Islands	CYM	XX
Central African Republic	CAF	XX
Central America, NOS[1]	ZZC	YY
Chad	TCD	XX
Chile	CHL	XX
China	CHN	XX
Christmas Island	CXR	XX
Cocos (Keeling) Islands	CCK	XX
Colombia	COL	XX
Colorado	USA	CO
Comoros	COM	XX
Congo	COG	XX
Congo, Democratic Republic of	COD	XX
Connecticut	USA	CT
Cook Islands	COK	XX
Costa Rica	CRI	XX
Cote d'Ivoire	CIV	XX
Croatia	HRV	XX
Cuba	CUB	XX
Curacao	CUW	XX
Cyprus	CYP	XX

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
Czech Republic	CZE	XX
Czechoslovakia	CSK	XX
Delaware	USA	DE
Denmark	DNK	XX
District of Columbia	USA	DC
Djibouti	DJI	XX
Dominica	DMA	XX
Dominican Republic	DOM	XX
Ecuador	ECU	XX
Egypt	EGY	XX
El Salvador	SLV	XX
England	ENG	XX
Equatorial Guinea	GNQ	XX
Eritrea	ERI	XX
Estonia	EST	XX
Ethiopia	ETH	XX
Europe, NOS[1]	ZZE	YY
Falkland Islands	FLK	XX
Faroe Islands	FRO	XX
Fiji	FJI	XX
Finland	FIN	XX
Florida	USA	FL
France	FRA	XX
French Guiana	GUF	XX
French Polynesia	PYF	XX
French Southern Territories	ATF	XX
Gabon	GAB	XX
Gambia	GMB	XX
Georgia	USA	GA
Georgia	GEO	XX
Germany	DEU	XX
Ghana	GHA	XX
Gibraltar	GIB	XX
Greece	GRC	XX
Greenland	GRL	XX
Grenada	GRD	XX
Guadeloupe	GLP	XX
Guam	GUM	GU

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
Guatemala	GTM	XX
Guernsey	GGY	XX
Guinea	GIN	XX
Guinea Bissau	GNB	XX
Guyana	GUY	XX
Haiti	HTI	XX
Hawaii	USA	HI
Heard Island and McDonald Islands	HMD	XX
Honduras	HND	XX
Hong Kong	HKG	XX
Hungary	HUN	XX
Iceland	ISL	XX
Idaho	USA	ID
Illinois	USA	IL
India	IND	XX
Indiana	USA	IN
Indonesia (Dutch East Indies)	IDN	XX
Iowa	USA	IA
Iran	IRN	XX
Iraq	IRQ	XX
Ireland	IRL	XX
Isle of Man	IMN	XX
Israel	ISR	XX
Italy	ITA	XX
Jamaica	JAM	XX
Japan	JPN	XX
Jersey	JEY	XX
Jordan	JOR	XX
Kansas	USA	KS
Kazakhstan	KAZ	XX
Kentucky	USA	KY
Kenya	KEN	XX
Kiribati	KIR	XX
Korea, NOS	KOR	XX
Kuwait	KWT	XX
Kyrgyzstan	KGZ	XX
Laos	LAO	XX
Latvia	LVA	XX

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
Lebanon	LBN	XX
Lesotho	LSO	XX
Liberia	LBR	XX
Libya	LBY	XX
Liechtenstein	LIE	XX
Lithuania	LTU	XX
Louisiana	USA	LA
Luxembourg	LUX	XX
Macao	MAC	XX
Macedonia	MKD	XX
Madagascar	MDG	XX
Maine	USA	ME
Malawi	MWI	XX
Malaysia	MYS	XX
Maldives	MDV	XX
Mali	MLI	XX
Malta	MLT	XX
Manitoba	CAN	MB
Marshall Islands	MHL	MH
Martinique	MTQ	XX
Maryland	USA	MD
Massachusetts	USA	MA
Mauritania	MRT	XX
Mauritius	MUS	XX
Mayotte	MYT	XX
Mexico	MEX	XX
Michigan	USA	MI
Micronesia	FSM	FM
Minnesota	USA	MN
Mississippi	USA	MS
Missouri	USA	MO
Moldova	MDA	XX
Monaco	MCO	XX
Mongolia	MNG	XX
Montana	USA	MT
Montenegro	MNE	XX
Montserrat	MSR	XX
Morocco	MAR	XX

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
Mozambique	MOZ	XX
Myanmar	MMR	XX
Namibia	NAM	XX
Nauru	NRU	XX
Nebraska	USA	NE
Nepal	NPL	XX
Netherlands	NLD	XX
Nevada	USA	NV
New Brunswick	CAN	NB
New Caledonia	NCL	XX
New Hampshire	USA	NH
New Jersey	USA	NJ
New Mexico	USA	NM
New York	USA	NY
New Zealand	NZL	XX
Newfoundland and Labrador	CAN	NL
Nicaragua	NIC	XX
Niger	NER	XX
Nigeria	NGA	XX
Niue	NIU	XX
Non-US/Canada NOS[1]	ZZX	YY
Norfolk Island	NFK	XX
North America, NOS[1]	ZZN	YY
North Carolina	USA	NC
North Dakota	USA	ND
North Korea	PRK	XX
Northern Ireland (Ulster)	NIR	XX
Northern Mariana Islands	MNP	MP
Northwest Territories	CAN	NT
Norway	NOR	XX
Nova Scotia	CAN	NS
Nunavut	CAN	NU
Ohio	USA	OH
Oklahoma	USA	OK
Oman	OMN	XX
Ontario	CAN	ON
Oregon	USA	OR
Pacific, NOS[1]	ZZP	YY

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
Pakistan	PAK	XX
Palau (Trust Territory of Pacific Islands)	PLW	PW
Palestine Territory, Occupied	PSE	XX
Panama	PAN	XX
Papua New Guinea	PNG	XX
Paraguay	PRY	XX
Pennsylvania	USA	PA
Peru	PER	XX
Philippines	PHL	XX
Pitcairn Islands	PCN	XX
Poland	POL	XX
Portugal	PRT	XX
Prince Edward Island	CAN	PE
Puerto Rico	PRI	PR
Qatar	QAT	XX
Quebec	CAN	QC
Republic of South Africa	ZAF	XX
Réunion	REU	XX
Rhode Island	USA	RI
Romania	ROU	XX
Russia	RUS	XX
Rwanda	RWA	XX
Saint Martin (French part)	MAF	XX
Samoa	WSM	XX
San Marino	SMR	XX
Sao Tome & Principe	STP	XX
Saskatchewan	CAN	SK
Saudi Arabia	SAU	XX
Scotland	SCT	XX
Senegal	SEN	XX
Serbia	SRB	XX
Seychelles	SYC	XX
Sierra Leone	SLE	XX
Singapore	SGP	XX
Sint-Maarten	SXM	XX
Slovakia	SVK	XX
Slovenia	SVN	XX
Solomon Islands	SLB	XX

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
Somalia	SOM	XX
South America, NOS[1]	ZZS	YY
South Carolina	USA	SC
South Dakota	USA	SD
South Georgia and the South Sandwich Islands	SGS	XX
South Korea	KOR	XX
South Sudan	SSD	XX
Spain	ESP	XX
Sri Lanka	LKA	XX
St Pierre and Miquelon	SPM	XX
St. Barthelemy	BLM	XX
St. Helena	SHN	XX
St. Kitts and Nevis	KNA	XX
St. Lucia	LCA	XX
St. Vincent and the Grenadines	VCT	XX
Sudan	SDN	XX
Suriname	SUR	XX
Svalbard and Jan Mayen	SJM	XX
Swaziland	SWZ	XX
Sweden	SWE	XX
Switzerland	CHE	XX
Syria	SYR	XX
Taiwan	TWN	XX
Tajikistan	TJK	XX
Tanzania	TZA	XX
Tennessee	USA	TN
Texas	USA	TX
Thailand	THA	XX
Timor-Leste	TLS	XX
Togo	TGO	XX
Tokelau Islands (New Zealand)	TKL	XX
Tonga	TON	XX
Trinidad and Tobago	TTO	XX
Tunisia	TUN	XX
Turkey	TUR	XX
Turkmenistan	TKM	XX
Turks and Caicos	TCA	XX
Tuvalu	TUV	XX

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
U.S. Minor Outlying Islands	UMI	UM
U.S. Virgin Islands	VIR	VI
Uganda	UGA	XX
Ukraine	UKR	XX
United Arab Emirates	ARE	XX
United Kingdom	GBR	XX
United States	USA	US
Unknown[1]	ZZU	ZZ
Uruguay	URY	XX
Utah	USA	UT
Uzbekistan	UZB	XX
Vanuatu	VUT	XX
Vatican City	VAT	XX
Venezuela	VEN	XX
Vermont	USA	VT
Vietnam	VNM	XX
Virginia	USA	VA
Wales	WLS	XX
Wallis and Fotuna	WLF	XX
Washington	USA	WA
West Virginia	USA	WV
Western Sahara	ESH	XX
Wisconsin	USA	WI
Wyoming	USA	WY
Yemen	YEM	XX
Yugoslavia	YUG	XX
Yukon Territory	CAN	YT
Zambia	ZMB	XX
Zimbabwe	ZWE	XX

[1]Custom codes for both historic and future use

Alphabetic List by Code

ISO country code	USPS state code	Name of Country/State
ABW	XX	Aruba
AFG	XX	Afghanistan
AGO	XX	Angola
AIA	XX	Anguilla
ALA	XX	Aland Islands
ALB	XX	Albania
AND	XX	Andorra
ARE	XX	United Arab Emirates
ARG	XX	Argentina
ARM	XX	Armenia
ASM	AS	American Samoa
ATA	XX	Antarctica
ATF	XX	French Southern Territories
ATG	XX	Antigua and Barbuda
AUS	XX	Australia
AUT	XX	Austria
AZE	XX	Azerbaijan
BDI	XX	Burundi
BEL	XX	Belgium
BEN	XX	Benin
BES	XX	Bonaire, Saint Eustatius and Saba
BFA	XX	Burkina Faso
BGD	XX	Bangladesh
BGR	XX	Bulgaria
BHR	XX	Bahrain
BHS	XX	Bahamas
BIH	XX	Bosnia and Herzogovina
BLM	XX	St. Barthelemy
BLR	XX	Belarus
BLZ	XX	Belize
BMU	XX	Bermuda
BOL	XX	Bolivia
BRA	XX	Brazil
BRB	XX	Barbados

ISO country code	USPS state code	Name of Country/State
BRN	XX	Brunei
BTN	XX	Bhutan
BVT	XX	Bouvet Island
BWA	XX	Botswana
CAF	XX	Central African Republic
CAN	AB	Alberta
CAN	BC	British Columbia
CAN	CD	Canada
CAN	MB	Manitoba
CAN	NB	New Brunswick
CAN	NL	Newfoundland and Labrador
CAN	NS	Nova Scotia
CAN	NT	Northwest Territories
CAN	NU	Nunavut
CAN	ON	Ontario
CAN	PE	Prince Edward Island
CAN	QC	Quebec
CAN	SK	Saskatchewan
CAN	YT	Yukon Territory
CCK	XX	Cocos (Keeling) Islands
CHE	XX	Switzerland
CHL	XX	Chile
CHN	XX	China
CIV	XX	Cote d'Ivoire
CMR	XX	Cameroon
COD	XX	Congo, Democratic Republic of
COG	XX	Congo
COK	XX	Cook Islands
COL	XX	Colombia
COM	XX	Comoros
CPV	XX	Cape Verde
CRI	XX	Costa Rica
CSK	XX	Czechoslovakia
CUB	XX	Cuba
CUW	XX	Curacao
CXR	XX	Christmas Island
CYM	XX	Cayman Islands
CYP	XX	Cyprus

ISO country code	USPS state code	Name of Country/State
CZE	XX	Czech Republic
DEU	XX	Germany
DJI	XX	Djibouti
DMA	XX	Dominica
DNK	XX	Denmark
DOM	XX	Dominican Republic
DZA	XX	Algeria
ECU	XX	Ecuador
EGY	XX	Egypt
ENG	XX	England
ERI	XX	Eritrea
ESH	XX	Western Sahara
ESP	XX	Spain
EST	XX	Estonia
ETH	XX	Ethiopia
FIN	XX	Finland
FJI	XX	Fiji
FLK	XX	Falkland Islands
FRA	XX	France
FRO	XX	Faroe Islands
FSM	FM	Micronesia
GAB	XX	Gabon
GBR	XX	United Kingdom
GEO	XX	Georgia
GGY	XX	Guernsey
GHA	XX	Ghana
GIB	XX	Gibraltar
GIN	XX	Guinea
GLP	XX	Guadeloupe
GMB	XX	Gambia
GNB	XX	Guinea Bissau
GNQ	XX	Equatorial Guinea
GRC	XX	Greece
GRD	XX	Grenada
GRL	XX	Greenland
GTM	XX	Guatemala
GUF	XX	French Guiana
GUM	GU	Guam

ISO country code	USPS state code	Name of Country/State
GUY	XX	Guyana
HKG	XX	Hong Kong
HMD	XX	Heard Island and McDonald Islands
HND	XX	Honduras
HRV	XX	Croatia
HTI	XX	Haiti
HUN	XX	Hungary
IDN	XX	Indonesia (Dutch East Indies)
IMN	XX	Isle of Man
IND	XX	India
IOT	XX	British Indian Ocean Territory
IRL	XX	Ireland
IRN	XX	Iran
IRQ	XX	Iraq
ISL	XX	Iceland
ISR	XX	Israel
ITA	XX	Italy
JAM	XX	Jamaica
JEY	XX	Jersey
JOR	XX	Jordan
JPN	XX	Japan
KAZ	XX	Kazakhstan
KEN	XX	Kenya
KGZ	XX	Kyrgyzstan
KHM	XX	Cambodia
KIR	XX	Kiribati
KNA	XX	St. Kitts and Nevis
KOR	XX	Korea, NOS
KOR	XX	South Korea
KWT	XX	Kuwait
LAO	XX	Laos
LBN	XX	Lebanon
LBR	XX	Liberia
LBY	XX	Libya
LCA	XX	St. Lucia
LIE	XX	Liechtenstein
LKA	XX	Sri Lanka
LSO	XX	Lesotho

ISO country code	USPS state code	Name of Country/State
LTU	XX	Lithuania
LUX	XX	Luxembourg
LVA	XX	Latvia
MAC	XX	Macao
MAF	XX	Saint Martin (French part)
MAR	XX	Morocco
MCO	XX	Monaco
MDA	XX	Moldova
MDG	XX	Madagascar
MDV	XX	Maldives
MEX	XX	Mexico
MHL	MH	Marshall Islands
MKD	XX	Macedonia
MLI	XX	Mali
MLT	XX	Malta
MMR	XX	Myanmar
MNE	XX	Montenegro
MNG	XX	Mongolia
MNP	MP	Northern Mariana Islands
MOZ	XX	Mozambique
MRT	XX	Mauritania
MSR	XX	Montserrat
MTQ	XX	Martinique
MUS	XX	Mauritius
MWI	XX	Malawi
MYS	XX	Malaysia
MYT	XX	Mayotte
NAM	XX	Namibia
NCL	XX	New Caledonia
NER	XX	Niger
NFK	XX	Norfolk Island
NGA	XX	Nigeria
NIC	XX	Nicaragua
NIR	XX	Northern Ireland (Ulster)
NIU	XX	Niue
NLD	XX	Netherlands
NOR	XX	Norway
NPL	XX	Nepal

ISO country code	USPS state code	Name of Country/State
NRU	XX	Nauru
NZL	XX	New Zealand
OMN	XX	Oman
PAK	XX	Pakistan
PAN	XX	Panama
PCN	XX	Pitcairn Islands
PER	XX	Peru
PHL	XX	Philippines
PLW	PW	Palau (Trust Territory of Pacific Islands)
PNG	XX	Papua New Guinea
POL	XX	Poland
PRI	PR	Puerto Rico
PRK	XX	North Korea
PRT	XX	Portugal
PRY	XX	Paraguay
PSE	XX	Palestine Territory, Occupied
PYF	XX	French Polynesia
QAT	XX	Qatar
REU	XX	Réunion
ROU	XX	Romania
RUS	XX	Russia
RWA	XX	Rwanda
SAU	XX	Saudi Arabia
SCT	XX	Scotland
SDN	XX	Sudan
SEN	XX	Senegal
SGP	XX	Singapore
SGS	XX	South Georgia and the South Sandwich Islands
SHN	XX	St. Helena
SJM	XX	Svalbard and Jan Mayen
SLB	XX	Solomon Islands
SLE	XX	Sierra Leone
SLV	XX	El Salvador
SMR	XX	San Marino
SOM	XX	Somalia
SPM	XX	St Pierre and Miquelon
SRB	XX	Serbia

ISO country code	USPS state code	Name of Country/State
SSD	XX	South Sudan
STP	XX	Sao Tome & Principe
SUR	XX	Suriname
SVK	XX	Slovakia
SVN	XX	Slovenia
SWE	XX	Sweden
SWZ	XX	Swaziland
SXM	XX	Sint-Maarten
SYC	XX	Seychelles
SYR	XX	Syria
TCA	XX	Turks and Caicos
TCD	XX	Chad
TGO	XX	Togo
THA	XX	Thailand
TJK	XX	Tajikistan
TKL	XX	Tokelau Islands (New Zealand)
TKM	XX	Turkmenistan
TLS	XX	Timor-Leste
TON	XX	Tonga
TTO	XX	Trinidad and Tobago
TUN	XX	Tunisia
TUR	XX	Turkey
TUV	XX	Tuvalu
TWN	XX	Taiwan
TZA	XX	Tanzania
UGA	XX	Uganda
UKR	XX	Ukraine
UMI	UM	U.S. Minor Outlying Islands
URY	XX	Uruguay
USA	AA	Armed Forces Americas
USA	AE	Armed Forces Canada, Europe, Middle East, Africa
USA	AK	Alaska
USA	AL	Alabama
USA	AP	Armed Forces Pacific
USA	AR	Arkansas
USA	AZ	Arizona
USA	CA	California
USA	CO	Colorado

ISO country code	USPS state code	Name of Country/State
USA	CT	Connecticut
USA	DC	District of Columbia
USA	DE	Delaware
USA	FL	Florida
USA	GA	Georgia
USA	HI	Hawaii
USA	IA	Iowa
USA	ID	Idaho
USA	IL	Illinois
USA	IN	Indiana
USA	KS	Kansas
USA	KY	Kentucky
USA	LA	Louisiana
USA	MA	Massachusetts
USA	MD	Maryland
USA	ME	Maine
USA	MI	Michigan
USA	MN	Minnesota
USA	MO	Missouri
USA	MS	Mississippi
USA	MT	Montana
USA	NC	North Carolina
USA	ND	North Dakota
USA	NE	Nebraska
USA	NH	New Hampshire
USA	NJ	New Jersey
USA	NM	New Mexico
USA	NV	Nevada
USA	NY	New York
USA	OH	Ohio
USA	OK	Oklahoma
USA	OR	Oregon
USA	PA	Pennsylvania
USA	RI	Rhode Island
USA	SC	South Carolina
USA	SD	South Dakota
USA	TN	Tennessee
USA	TX	Texas

ISO country code	USPS state code	Name of Country/State
USA	US	United States
USA	UT	Utah
USA	VA	Virginia
USA	VT	Vermont
USA	WA	Washington
USA	WI	Wisconsin
USA	WV	West Virginia
USA	WY	Wyoming
UZB	XX	Uzbekistan
VAT	XX	Vatican City
VCT	XX	St. Vincent and the Grenadines
VEN	XX	Venezuela
VGB	XX	British Virgin Islands
VIR	VI	U.S. Virgin Islands
VNM	XX	Vietnam
VUT	XX	Vanuatu
WLF	XX	Wallis and Fotuna
WLS	XX	Wales
WSM	XX	Samoa
YEM	XX	Yemen
YUG	XX	Yugoslavia
ZAF	XX	Republic of South Africa
ZMB	XX	Zambia
ZWE	XX	Zimbabwe
ZZA[1]	YY	Asia, NOS
ZZC[1]	YY	Central America, NOS
ZZE[1]	YY	Europe, NOS
ZZF[1]	YY	Africa, NOS
ZZN[1]	YY	North America, NOS
ZZP[1]	YY	Pacific, NOS
ZZS[1]	YY	South America, NOS
ZZU[1]	ZZ	Unknown
ZZX[1]	YY	Non-US/Canada NOS

Geographic Code List

Name of Country/State	ISO country code	USPS state code
North America, NOS[1]	ZZN	YY
United States	USA	US
Maine	USA	ME
New Hampshire	USA	NH
Vermont	USA	VT
Massachusetts	USA	MA
Rhode Island	USA	RI
Connecticut	USA	CT
New Jersey	USA	NJ
New York	USA	NY
Pennsylvania	USA	PA
Delaware	USA	DE
Maryland	USA	MD
District of Columbia	USA	DC
Virginia	USA	VA
West Virginia	USA	WV
North Carolina	USA	NC
South Carolina	USA	SC
Tennessee	USA	TN
Georgia	USA	GA
Florida	USA	FL
Alabama	USA	AL
Mississippi	USA	MS
Michigan	USA	MI
Ohio	USA	OH
Indiana	USA	IN
Kentucky	USA	KY
Wisconsin	USA	WI
Minnesota	USA	MN
Iowa	USA	IA
North Dakota	USA	ND
South Dakota	USA	SD
Montana	USA	MT
Illinois	USA	IL
Missouri	USA	MO

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
Kansas	USA	KS
Nebraska	USA	NE
Arkansas	USA	AR
Louisiana	USA	LA
Oklahoma	USA	OK
Texas	USA	TX
Idaho	USA	ID
Wyoming	USA	WY
Colorado	USA	CO
Utah	USA	UT
Nevada	USA	NV
New Mexico	USA	NM
Arizona	USA	AZ
Alaska	USA	AK
Washington	USA	WA
Oregon	USA	OR
California	USA	CA
Hawaii	USA	HI
Armed Forces Americas	USA	AA
Armed Forces Canada, Europe, Middle East, Africa	USA	AE
Armed Forces Pacific	USA	AP
Greenland	GRL	XX
Canada	CAN	CD
New Brunswick	CAN	NB
Newfoundland and Labrador	CAN	NL
Nova Scotia	CAN	NS
Prince Edward Island	CAN	PE
Quebec	CAN	QC
Ontario	CAN	ON
Alberta	CAN	AB
Manitoba	CAN	MB
Saskatchewan	CAN	SK
Northwest Territories	CAN	NT
Yukon Territory	CAN	YT
British Columbia	CAN	BC
Nunavut	CAN	NU
Mexico	MEX	XX
Puerto Rico	PRI	PR

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
U.S. Virgin Islands	VIR	VI
Cuba	CUB	XX
Haiti	HTI	XX
Dominican Republic	DOM	XX
Jamaica	JAM	XX
Anguilla	AIA	XX
Antigua and Barbuda	ATG	XX
Aruba	ABW	XX
Barbados	BRB	XX
Bonaire, Saint Eustatius and Saba	BES	XX
British Virgin Islands	VGB	XX
Cayman Islands	CYM	XX
Curacao	CUW	XX
Dominica	DMA	XX
Grenada	GRD	XX
Guadeloupe	GLP	XX
Martinique	MTQ	XX
Montserrat	MSR	XX
St. Barthelemy	BLM	XX
St. Kitts and Nevis	KNA	XX
St. Lucia	LCA	XX
Sint-Maarten	SXM	XX
Saint Martin (French part)	MAF	XX
St. Vincent and the Grenadines	VCT	XX
Trinidad and Tobago	TTO	XX
Turks and Caicos	TCA	XX
Bermuda	BMU	XX
Bahamas	BHS	XX
St Pierre and Miquelon	SPM	XX
Central America, NOS[1]	ZZC	YY
Guatemala	GTM	XX
Belize	BLZ	XX
Honduras	HND	XX
El Salvador	SLV	XX
Nicaragua	NIC	XX
Costa Rica	CRI	XX
Panama	PAN	XX

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
South America, NOS[1]	ZZS	YY
Colombia	COL	XX
Venezuela	VEN	XX
Guyana	GUY	XX
Suriname	SUR	XX
French Guiana	GUF	XX
Brazil	BRA	XX
Ecuador	ECU	XX
Peru	PER	XX
Bolivia	BOL	XX
Chile	CHL	XX
Argentina	ARG	XX
Paraguay	PRY	XX
Uruguay	URY	XX
Falkland Islands	FLK	XX
Europe, NOS[1]	ZZE	YY
United Kingdom	GBR	XX
England	ENG	XX
Guernsey	GGY	XX
Isle of Man	IMN	XX
Jersey	JEY	XX
Wales	WLS	XX
Scotland	SCT	XX
Northern Ireland (Ulster)	NIR	XX
Ireland	IRL	XX
Iceland	ISL	XX
Norway	NOR	XX
Svalbard and Jan Mayen	SJM	XX
Denmark	DNK	XX
Faroe Islands	FRO	XX
Sweden	SWE	XX
Finland	FIN	XX
Aland Islands	ALA	XX
Germany	DEU	XX
Netherlands	NLD	XX
Belgium	BEL	XX
Luxembourg	LUX	XX
Switzerland	CHE	XX

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
Austria	AUT	XX
Liechtenstein	LIE	XX
France	FRA	XX
Monaco	MCO	XX
Spain	ESP	XX
Andorra	AND	XX
Portugal	PRT	XX
Italy	ITA	XX
San Marino	SMR	XX
Vatican City	VAT	XX
Romania	ROU	XX
Poland	POL	XX
Czech Republic	CZE	XX
Czechoslovakia	CSK	XX
Slovakia	SVK	XX
Bosnia and Herzogovina	BIH	XX
Croatia	HRV	XX
Macedonia	MKD	XX
Montenegro	MNE	XX
Serbia	SRB	XX
Slovenia	SVN	XX
Yugoslavia	YUG	XX
Bulgaria	BGR	XX
Russia	RUS	XX
Ukraine	UKR	XX
Moldova	MDA	XX
Belarus	BLR	XX
Estonia	EST	XX
Latvia	LVA	XX
Lithuania	LTU	XX
Greece	GRC	XX
Hungary	HUN	XX
Albania	ALB	XX
Gibraltar	GIB	XX
Malta	MLT	XX
Cyprus	CYP	XX
Africa, NOS[1]	ZZF	YY
Morocco	MAR	XX

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
Algeria	DZA	XX
Tunisia	TUN	XX
Libya	LBY	XX
Egypt	EGY	XX
Burkina Faso	BFA	XX
Chad	TCD	XX
Mali	MLI	XX
Mauritania	MRT	XX
Niger	NER	XX
Sudan	SDN	XX
South Sudan	SSD	XX
Western Sahara	ESH	XX
Nigeria	NGA	XX
Benin	BEN	XX
Cameroon	CMR	XX
Cape Verde	CPV	XX
Central African Republic	CAF	XX
Cote d'Ivoire	CIV	XX
Congo	COG	XX
Equatorial Guinea	GNQ	XX
Gambia	GMB	XX
Gabon	GAB	XX
Ghana	GHA	XX
Guinea	GIN	XX
Guinea Bissau	GNB	XX
Liberia	LBR	XX
Senegal	SEN	XX
Sierra Leone	SLE	XX
Togo	TGO	XX
Congo, Democratic Republic of	COD	XX
Angola	AGO	XX
Sao Tome & Principe	STP	XX
Republic of South Africa	ZAF	XX
Botswana	BWA	XX
Lesotho	LSO	XX
Namibia	NAM	XX
Swaziland	SWZ	XX
Zimbabwe	ZWE	XX

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
Zambia	ZMB	XX
Malawi	MWI	XX
Mozambique	MOZ	XX
Madagascar	MDG	XX
Tanzania	TZA	XX
Uganda	UGA	XX
Kenya	KEN	XX
Rwanda	RWA	XX
Burundi	BDI	XX
Somalia	SOM	XX
Djibouti	DJI	XX
Ethiopia	ETH	XX
Eritrea	ERI	XX
Comoros	COM	XX
Mauritius	MUS	XX
Mayotte	MYT	XX
Réunion	REU	XX
St. Helena	SHN	XX
Seychelles	SYC	XX
Asia, NOS[1]	ZZA	YY
Turkey	TUR	XX
Syria	SYR	XX
Lebanon	LBN	XX
Jordan	JOR	XX
Iraq	IRQ	XX
Bahrain	BHR	XX
Kuwait	KWT	XX
Oman	OMN	XX
Qatar	QAT	XX
Saudi Arabia	SAU	XX
United Arab Emirates	ARE	XX
Yemen	YEM	XX
Israel	ISR	XX
Palestine Territory, Occupied	PSE	XX
Armenia	ARM	XX
Azerbaijan	AZE	XX
Georgia	GEO	XX
Kazakhstan	KAZ	XX

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
Kyrgyzstan	KGZ	XX
Tajikistan	TJK	XX
Turkmenistan	TKM	XX
Uzbekistan	UZB	XX
Iran	IRN	XX
Afghanistan	AFG	XX
Pakistan	PAK	XX
Maldives	MDV	XX
British Indian Ocean Territory	IOT	XX
India	IND	XX
Nepal	NPL	XX
Bhutan	BTN	XX
Bangladesh	BGD	XX
Sri Lanka	LKA	XX
Myanmar	MMR	XX
Thailand	THA	XX
Laos	LAO	XX
Cambodia	KHM	XX
Vietnam	VNM	XX
Malaysia	MYS	XX
Singapore	SGP	XX
Brunei	BRN	XX
Indonesia (Dutch East Indies)	IDN	XX
Timor-Leste	TLS	XX
Philippines	PHL	XX
China	CHN	XX
Hong Kong	HKG	XX
Taiwan	TWN	XX
Macao	MAC	XX
Mongolia	MNG	XX
Japan	JPN	XX
Korea, NOS	KOR	XX
South Korea	KOR	XX
North Korea	PRK	XX
Christmas Island	CXR	XX
Cocos (Keeling) Islands	CCK	XX
Pacific, NOS[1]	ZZP	YY
Australia	AUS	XX

[1]Custom codes for both historic and future use

Name of Country/State	ISO country code	USPS state code
New Zealand	NZL	XX
U.S. Minor Outlying Islands	UMI	UM
Fiji	FJI	XX
New Caledonia	NCL	XX
Papua New Guinea	PNG	XX
Solomon Islands	SLB	XX
Vanuatu	VUT	XX
Wallis and Fotuna	WLF	XX
Micronesia	FSM	FM
Guam	GUM	GU
Kiribati	KIR	XX
Marshall Islands	MHL	MH
Northern Mariana Islands	MNP	MP
Nauru	NRU	XX
Palau (Trust Territory of Pacific Islands)	PLW	PW
American Samoa	ASM	AS
Cook Islands	COK	XX
Norfolk Island	NFK	XX
Niue	NIU	XX
Pitcairn Islands	PCN	XX
French Polynesia	PYF	XX
Tokelau Islands (New Zealand)	TKL	XX
Tonga	TON	XX
Tuvalu	TUV	XX
Samoa	WSM	XX
Bouvet Island	BVT	XX
French Southern Territories	ATF	XX
Heard Island and McDonald Islands	HMD	XX
South Georgia and the South Sandwich Islands	SGS	XX
Antarctica	ATA	XX
Non-US/Canada NOS[1]	ZZX	YY
Unknown[1]	ZZU	ZZ

[1]Custom codes for both historic and future use

Custom Codes for Historic Use Only

Name of Country/State	ISO country code	USPS state code
Maritime Provinces (New Bruns, Newfound, Nova Scotia,	CAN	MM
Prairie Provinces (Alberta, Manitoba, Saskatchewan)	CAN	PP
Northwest Territories, Yukon Territory	CAN	YN
New England and New Jersey	USA	NN

Name of Country/State	ISO country code	USPS state code
Arabian Peninsula	XAP	YY
Other Caribbean Islands	XCB	YY
China, NOS	XCH	YY
Caucasian Republics of the USSR	XCR	YY
Czechoslovakia (former)	CSK	YY
East Africa	XEF	YY
England, Channel Islands, Isle of Man	XEN	XX
Ethiopia (Abyssinia), Eritrea	XET	YY
Germanic Countries	XGR	YY
African Coastal Islands (previously in South Africa,	XIF	YY
Israel and former Jewish Palestine	XIS	YY
Micronesian Islands	XMC	YY
Melanesian Islands, Solomon Islands	XML	YY
Malaysia, Singapore, Brunei	XMS	YY
North Africa	XNF	YY
North American Islands	XNI	YY
Other Asian Republics of the USSR	XOR	YY
Polynesian Islands	XPL	YY
Scandinavia	XSC	YY
Sudanese Countries	XSD	YY
Southeast Asia	XSE	YY
South Africa, NOS	XSF	YY
Slavic Countries	XSL	YY
Ukraine and Moldavia	XUM	YY
West Africa, NOS (French Africa, NOS)	XWF	YY
Yugoslavia (former)	YUG	YY

APPENDIX B

FIPS County Codes

FIPS CODES FOR COUNTIES AND EQUIVALENT ENTITIES

STATE NAME: ALABAMA
ALPHABETIC CODE: AL
NUMERIC CODE: 01

CODE COUNTY NAME
001 Auatauga
003 Baldwin
005 Barbour
007 Bibb
009 Blount
011 Bullock
013 Butler
015 Calhoun
017 Chambers
019 Cherokee
021 Chilton
023 Choctaw
025 Clarke
027 Clay
029 Cleburne
031 Coffee
033 Colbert
035 Conecuh
037 Coosa
039 Covington
041 Crenshaw
043 Cullman
045 Dale
047 Dallas
049 DeKalb
051 Elmore
053 Escambia
055 Etowah
057 Fayette
059 Franklin
061 Geneva
063 Greene
065 Hale
067 Henry
069 Houston
071 Jackson
073 Jefferson
075 Lamar
077 Lauderdale
079 Lawrence
081 Lee
083 Limestone
085 Lowndes
087 Macon
089 Madison
091 Marengo
093 Marion
095 Marshall
097 Mobile
099 Monroe
101 Montgomery
103 Morgan
105 Perry
107 Pickens
109 Pike
111 Randolph
113 Russell
115 St. Clair
117 Shelby
119 Sumter
121 Talladega
123 Tallapoosa
125 Tuscaloosa
127 Walker
129 Washington
131 Wilcox
133 Winston

STATE NAME: ALASKA
ALPHABETIC CODE: AK
NUMERIC CODE: 02
Note: The following is a complete list of all current Alaska county equivalents where (B) identifies a borough and (C) identifies a census area per FIPS Publication Change Notice (Reissue 12/21/92).

CODE BOROUGH/ CENSUS AREA
013 Aleutians East (B)
016 Aleutians West (C)
020 Anchorage (B)
050 Bethel (C)
060 Bristol Bay (B)
068 Denali (B)
070 Dillingham (C)
090 Fairbanks North Star (B)
100 Haines (B)
110 Juneau (B)
122 Kenai Peninsula (B)
130 Ketchikan Gateway (B)
150 Kodiak Island (B)
164 Lake and Peninsula (B)
170 Matanuska-Susitna (B)
180 Nome (C)
185 North Slope (B)
(B)
188 Northwest Arctic (B)
201 Prince of Wales-Outer Ketchikan (C)
220 Sitka (B)
232 Skagway-Hoonah-Angoon (C)
240 Southeast Fairbanks (C)
261 Valdez-Cordova (C)
270 Wade Hampton (C)
280 Wrangell-Petersburg (C)
282 Yakutat (B)
290 Yukon-Koyukuk (C)

STATE NAME: ARIZONA
ALPHABETIC CODE: AZ
NUMERIC CODE: 03

CODE COUNTY NAME
001 Apache
003 Cochise
005 Coconino
007 Gila
009 Graham
011 Greenlee
012 LaPaz
013 Maricopa
015 Mohave
017 Navajo
019 Pima
021 Pinal
023 Santa Cruz
025 Yavapai
027 Yuma

La Paz was established from part of Yuma (1/1/83).

STATE NAME: ARKANSAS
ALPHABETIC CODE: AR
NUMERIC CODE: 05

CODE COUNTY NAME
001 Arkansas
003 Ashley
005 Baxter
007 Benton
009 Boone
011 Bradley
013 Calhoun
015 Carroll
017 Chicot
019 Clark
021 Clay
023 Cleburne
025 Cleveland
027 Columbia
029 Conway
031 Craighead
033 Crawford
035 Crittenden
037 Cross
039 Dallas
041 Desha
043 Drew
045 Faulkner
047 Franklin
049 Fulton
051 Garland
053 Grant
055 Greene
057 Hempstead
059 Hot Spring
061 Howard
063 Independence
065 Izard
067 Jackson
069 Jefferson
071 Johnson
073 Lafayette
075 Lawrence
077 Lee
079 Lincoln
081 Little River
083 Logan
085 Lonoke
087 Madison
089 Marion

STATE NAME:
ARKANSAS (Cont.'d)
ALPHABETIC CODE:
AR
NUMERIC CODE: 05

CODE COUNTY NAME
091 Miller
093 Mississippi
095 Monroe
097 Montgomery
099 Nevada
101 Newton
103 Ouachita
105 Perry
107 Phillips
109 Pike
111 Poinsett
113 Polk
115 Pope
117 Prairie
119 Pulaski
121 Randolph
123 St. Francis
125 Saline
127 Scott
129 Searcy
131 Sebastian
133 Sevier
135 Sharp
137 Stone
139 Union
141 Van Buren
143 Washington
145 White
147 Woodruff
149 Yell

STATE NAME:
CALIFORNIA
ALPHABETIC CODE: CA
NUMERIC CODE: 06

CODE COUNTY NAME
001 Alameda
003 Alpine
005 Amador
007 Butte
009 Calaveras
011 Colusa
013 Contra Costa
015 Del Norte
017 El Dorado
019 Fresno
021 Glenn
023 Humboldt
025 Imperial
027 Inyo
029 Kern
031 Kings
033 Lake
035 Lassen
037 Los Angeles
039 Madera
041 Marin
043 Mariposa
045 Mendocino
047 Merced
049 Modoc
051 Mono
053 Monterey
055 Napa
057 Nevada
059 Orange
061 Placer
063 Plumas
065 Riverside
067 Sacramento
069 San Benito
071 San Bernardino
073 San Diego
075 San Francisco
077 San Joaquin
079 San Luis Obispo
081 San Mateo
083 Santa Barbara
085 Santa Clara
087 Santa Cruz
089 Shasta
091 Sierra
093 Siskiyou
095 Solano
097 Sonoma
099 Stanislaus
101 Sutter
103 Tehama
105 Trinity
107 Tulare
109 Tuolomne
111 Ventura
113 Yolo
115 Yuba

STATE NAME:
COLORADO
ALPHABETIC CODE:
CO
NUMERIC CODE: 08

CODE COUNTY NAME
001 Adams
003 Alamosa
005 Arapahoe
007 Archuleta
009 Baca
011 Bent
013 Boulder
014 Broomfield
015 Chaffee
017 Cheyenne
019 Clear Creek
021 Conejos
023 Costilla
025 Crowley
027 Custer
029 Delta
031 Denver
033 Dolores
035 Douglas
037 Eagle
039 Elbert
041 El Paso
043 Fremont
045 Garfield
047 Gilpin
049 Grand
051 Gunnison
053 Hinsdale
055 Huerfano
057 Jackson
059 Jefferson
061 Kiowa
063 Kit Carson
065 Lake
067 La Plata
069 Larimer
071 Las Animas
073 Lincoln
075 Logan
077 Mesa
079 Mineral
081 Moffat
083 Montezuma
085 Montrose
087 Morgan
089 Otero
091 Ouray
093 Park
095 Phillips
097 Pitkin
099 Prowers
101 Pueblo
103 Rio Blanco
105 Rio Grande
107 Routt
109 Saguache
111 San Juan
113 San Miguel
115 Sedgwick
117 Summit
119 Teller
121 Washington
123 Weld
125 Yuma

Broomfield County, Colorado, has been created from parts of Adams (001), Boulder (013), Jefferson (059) and Weld (123) counties effective November 15, 2001. The boundaries of Broomfield County reflect the boundaries of Broomfield city legally in effect on November 15, 2001. To maintain alphanumeric sequences of counties, Broomfield County will have a code of 014 for FIPS 6-4.

STATE NAME:
CONNECTICUT
ALPHABETIC CODE: CT
NUMERIC CODE: 09

CODE COUNTY NAME
001 Fairfield
003 Hartford
005 Litchfield
007 Middlesex
009 New Haven
011 New London
013 Tolland
015 Windham

STATE NAME:
DELAWARE
ALPHABETIC CODE: DE
NUMERIC CODE: 10

CODE COUNTY NAME
001 Kent
003 New Castle
005 Sussex

STATE NAME: DISTRICT OF COLUMBIA
ALPHABETIC CODE: DC
NUMERIC CODE: 11

CODE SUBDIVISION NAME
001 District of Columbia

Name was reported incorrectly as “Washington” in FIPS PUB 6-3. The District has no first-order subdivisions, and therefore “District of Columbia” also serves as the countyequivalent entity.

STATE NAME: FLORIDA
ALPHABETIC CODE: FL
NUMERIC CODE: 12

CODE COUNTY NAME
001 Alachua
003 Baker
005 Bay
007 Bradford
009 Brevard
011 Broward
013 Calhoun
015 Charlotte
017 Citrus
019 Clay
021 Collier
023 Columbia
027 DeSoto
029 Dixie
031 Duval
033 Escambia
035 Flagler
037 Franklin
039 Gadsden
041 Gilchrist
043 Glades
045 Gulf
047 Hamilton
049 Hardee
051 Hendry
053 Hernando
055 Highlands
057 Hillsborough
059 Holmes
061 Indian River
063 Jackson
065 Jefferson
067 Lafayette
069 Lake
071 Lee
073 Leon
075 Levy
077 Liberty
079 Madison
081 Manatee
083 Marion
085 Martin
087 Monroe
089 Nassau
091 Okaloosa
093 Okeechobee
095 Orange
097 Osceola
099 Palm Beach
101 Pasco
103 Pinellas
105 Polk
107 Putnam
109 St. Johns
111 St. Lucie
113 Santa Rosa
115 Sarasota
117 Seminole
119 Sumter
121 Suwannee
123 Taylor
125 Union
127 Volusia
129 Wakulla
131 Walton
133 Washington

STATE NAME: GEORGIA
ALPHABETIC CODE: GA
NUMERIC CODE: 13

CODE COUNTY NAME
001 Appling
003 Atkinson
005 Bacon
007 Baker
009 Baldwin
011 Banks
013 Barrow
015 Bartow
017 Ben Hill
019 Berrien
021 Bibb
023 Bleckley
025 Brantley
027 Brooks
029 Bryan
031 Bulloch
033 Burke
035 Butts
037 Calhoun
039 Camden
043 Candler
045 Carroll
047 Catoosa
049 Charlton
051 Chatham
053 Chattahoochee
055 Chattooga
057 Cherokee
059 Clarke
061 Clay
063 Clayton
065 Clinch
067 Cobb
069 Coffee
071 Colquitt
073 Columbia
075 Cook
077 Coweta
079 Crawford
081 Crisp
083 Dade
085 Dawson
087 Decatur
089 DeKalb
091 Dodge
093 Dooly
095 Dougherty
097 Douglas
099 Early
101 Echols
103 Effingam
105 Elbert
107 Emanuel
109 Evans
111 Fannin
113 Fayette
115 Floyd
117 Forsyth
119 Franklin
121 Fulton
123 Gilmer
125 Glascock
127 Glynn
129 Gordon
131 Grady
133 Greene
135 Gwinnett
137 Habersham
139 Hall
141 Hancock
143 Haralson
145 Harris
147 Hart
149 Heard
151 Henry
153 Houston
155 Irwin
157 Jackson
159 Jasper
161 Jeff Davis
163 Jefferson
165 Jenkins
167 Johnson
169 Jones
171 Lamar
173 Lanier
175 Laurens
177 Lee
179 Liberty
181 Lincoln
183 Long
185 Lowndes
187 Lumpkin
189 McDuffie
191 McIntosh
193 Macon
195 Madison
197 Marion
199 Meriwether
201 Miller
205 Mitchell
207 Monroe
209 Montgomery
211 Morgan
213 Murray
215 Muscogee
217 Newton
219 Oconee
221 Oglethorpe
223 Paulding
225 Peach
227 Pickens
229 Pierce
231 Pike
233 Polk
235 Pulaski
237 Putnam
239 Quitman
241 Rabun
243 Randolph
245 Richmond
247 Rockdale
249 Schley
251 Screven
253 Seminole
255 Spalding
257 Stephens
259 Stewart
261 Sumter
263 Talbot
265 Taliaferro
267 Tattnall
269 Taylor

STATE NAME:
GEORGIA (Cont.'d)
ALPHABETIC CODE: GA
NUMERIC CODE: 13

CODE COUNTY NAME
271 Telfair
273 Terrell
275 Thomas
277 Tift
279 Toombs
281 Towns
283 Treutlen
285 Troup
287 Turner
289 Twiggs
291 Union
293 Upson
295 Walker
297 Walton
299 Ware
301 Warren
303 Washington
305 Wayne
307 Webster
309 Wheeler
311 White
313 Whitfield
315 Wilcox
317 Wilkes
319 Wilkinson
321 Worth

Muscogee was reported incorrectly as “Columbus (consolidated government)” (510) in FIPS PUB6-3.

STATE NAME:
HAWAII
ALPHABETIC CODE: HI
NUMERIC CODE: 15

CODE COUNTY NAME
001 Hawaii
003 Honolulu
005 Kalawao
007 Kauai
009 Maui

Kalawao does not have its own local government; it is administered by the State of Hawaii. It may be included with Maui for statistical purposes.

STATE NAME:
IDAHO
ALPHABETIC CODE: ID
NUMERIC CODE: 16

CODE COUNTY NAME
001 Ada
003 Adams
005 Bannock
007 Bear Lake
009 Benewah
011 Bingham
013 Blaine
015 Boise
017 Bonner
019 Bonneville
021 Boundary
023 Butte
025 Camas
027 Canyon
029 Caribou
031 Cassia
033 Clark
035 Clearwater
037 Custer
039 Elmore
041 Franklin
043 Fremont
045 Gem
047 Gooding
049 Idaho
051 Jefferson
053 Jerome
055 Kootenai
057 Latah
059 Lemhi
061 Lewis
063 Lincoln
065 Madison
067 Minidoka
069 Nez Perce
071 Oneida
073 Owyhee
075 Payette
077 Power
079 Shoshone
081 Teton
083 Twin Falls
085 Valley
087 Washington

STATE NAME:
ILLINOIS
ALPHABETIC CODE: IL
NUMERIC CODE: 17

CODE COUNTY NAME
001 Adams
003 Alexander
005 Bond
007 Boone
009 Brown
011 Bureau
013 Calhoun
015 Carroll
017 Cass
019 Champaign
021 Christian
023 Clark
025 Clay
027 Clinton
029 Coles
031 Cook
033 Crawford
035 Cumberland
037 DeKalb
039 De Witt
041 Douglas
043 DuPage
045 Edgar
047 Edwards
049 Effingham
051 Fayette
053 Ford
055 Franklin
057 Fulton
059 Gallatin
061 Greene
063 Grundy
065 Hamilton
067 Hancock
069 Hardin
071 Henderson
073 Henry
075 Iroquois
077 Jackson
079 Jasper
081 Jefferson
083 Jersey
085 Jo Daviess
087 Johnson
089 Kane
091 Kankakee
093 Kendall
095 Knox
097 Lake
099 La Salle
101 Lawrence
103 Lee
105 Livingston
107 Logan
109 McDonough
111 McHenry
113 McLean
115 Macon
117 Macoupin
119 Madison
121 Marion
123 Marshall
125 Mason
127 Massac
129 Menard
131 Mercer
133 Monroe
135 Montgomery
137 Morgan
139 Moultrie
141 Ogle
143 Peoria
145 Perry
147 Piatt
149 Pike
151 Pope
153 Pulaski
155 Putnam
157 Randolph
159 Richland
161 Rock Island
163 St. Clair
165 Saline
167 Sangamon
169 Schuyler
171 Scott
173 Shelby
175 Stark
177 Stephenson
179 Tazewell
181 Union
183 Vermilion
185 Wabash
187 Warren
189 Washington
191 Wayne
193 White
195 Whiteside
197 Will
199 Williamson
201 Winnebago
203 Woodford

STATE NAME:
INDIANA
ALPHABETIC CODE: IN
NUMERIC CODE: 18

CODE COUNTY NAME
001 Adams

STATE NAME:
INDIANA (Cont.'d)
ALPHABETIC CODE: IN
NUMERIC CODE: 18

CODE COUNTY NAME
003 Allen
005 Bartholomew
007 Benton
009 Blackford
011 Boone
013 Brown
015 Carroll
017 Cass
019 Clark
021 Clay
023 Clinton
025 Crawford
027 Daviess
029 Dearborn
031 Decatur
033 DeKalb
035 Delaware
037 Dubois
039 Elkhart
041 Fayette
043 Floyd
045 Fountain
047 Franklin
049 Fulton
051 Gibson
053 Grant
055 Greene
057 Hamilton
059 Hancock
061 Harrison
063 Hendricks
065 Henry
067 Howard
069 Huntington
071 Jackson
073 Jasper
075 Jay
077 Jefferson
079 Jennings
081 Johnson
083 Knox
085 Kosciusko
087 Lagrange
089 Lake
091 LaPorte
093 Lawrence
095 Madison
097 Marion
099 Marshall
101 Martin
103 Miami
105 Monroe
107 Montgomery
109 Morgan
111 Newton
113 Noble
115 Ohio
117 Orange
119 Owen
121 Parke
123 Perry
125 Pike
127 Porter
129 Posey
131 Pulaski
133 Putnam
135 Randolph
137 Ripley
139 Rush
141 St. Joseph
143 Scott
145 Shelby
147 Spencer
149 Starke
151 Steuben
153 Sullivan
155 Switzerland
157 Tippecanoe
159 Tipton
161 Union
163 Vanderburgh
165 Vermillion
167 Vigo
169 Wabash
171 Warren
173 Warrick
175 Washington
177 Wayne
179 Wells
181 White
183 Whitley

STATE NAME:
IOWA
ALPHABETIC CODE: IA
NUMERIC CODE: 19

CODE COUNTY NAME
001 Adair
003 Adams
005 Allamakee
007 Appanoose
009 Audubon
011 Benton
013 Black Hawk
015 Boone
017 Bremer
019 Buchanan
021 Buena Vista
023 Butler
025 Calhoun
027 Carroll
029 Cass
031 Cedar
033 Cerro Gordo
035 Cherokee
037 Chickasaw
039 Clarke
041 Clay
043 Clayton
045 Clinton
047 Crawford
049 Dallas
051 Davis
053 Decatur
055 Delaware
057 Des Moines
059 Dickinson
061 Dubuque
063 Emmet
065 Fayette
067 Floyd
069 Franklin
071 Fremont
073 Greene
075 Grundy
077 Guthrie
079 Hamilton
081 Hancock
083 Hardin
085 Harrison
087 Henry
089 Howard
091 Humboldt
093 Ida
095 Iowa
097 Jackson
099 Jasper
101 Jefferson
103 Johnson
105 Jones
107 Keokuk
109 Kossuth
111 Lee
113 Linn
115 Louisa
117 Lucas
119 Lyon
121 Madison
123 Mahaska
125 Marion
127 Marshall
129 Mills
131 Mitchell
133 Monona
135 Monroe
137 Montgomery
139 Muscatine
141 O'Brien
143 Osceola
145 Page
147 Palo Alto
149 Plymouth
151 Pocahontas
153 Polk
155 Pottawattamie
157 Poweshiek
159 Ringgold
161 Sac
163 Scott
165 Shelby
167 Sioux
169 Story
171 Tama
173 Taylor
175 Union
177 Van Buren
179 Wapello
181 Warren
183 Washington
185 Wayne
187 Webster
189 Winnebago
191 Winneshiek
193 Woodbury
195 Worth
197 Wright

STATE NAME:
KANSAS
ALPHABETIC CODE: KS
NUMERIC CODE: 20

CODE COUNTY NAME
001 Allen
003 Anderson
005 Atchison
007 Barber
009 Barton
011 Bourbon
013 Brown
015 Butler
017 Chase
019 Chautauqua
021 Cherokee
023 Cheyenne
025 Clark
027 Clay
029 Cloud
031 Coffey
033 Comanche
035 Cowley
037 Crawford
039 Decatur
041 Dickinson

STATE NAME:
KANSAS (Cont.'d)
ALPHABETIC CODE:
KS
NUMERIC CODE: 20

CODE COUNTY NAME
043 Doniphan
045 Douglas
047 Edwards
049 Elk
051 Ellis
053 Ellsworth
055 Finney
057 Ford
059 Franklin
061 Geary
063 Gove
065 Graham
067 Grant
069 Gray
071 Greeley
073 Greenwood
075 Hamilton
077 Harper
079 Harvey
081 Haskell
083 Hodgeman
085 Jackson
087 Jefferson
089 Jewell
091 Johnson
093 Kearny
095 Kingman
097 Kiowa
099 Labette
101 Lane
103 Leavenworth
105 Lincoln
107 Linn
109 Logan
111 Lyon
113 McPherson
115 Marion
117 Marshall
119 Meade
121 Miami
123 Mitchell
125 Montgomery
127 Morris
129 Morton
131 Nemaha
133 Neosho
135 Ness
137 Norton
139 Osage
141 Osborne
143 Ottawa
145 Pawnee
147 Phillips
149 Pottawatomie
151 Pratt
153 Rawlins
155 Reno
157 Republic
159 Rice
161 Riley
163 Rooks
165 Rush
167 Russell
169 Saline
171 Scott
173 Sedgwick
175 Seward
177 Shawnee
179 Sheridan
181 Sherman
183 Smith
185 Stafford
187 Stanton
189 Stevens
191 Sumner
193 Thomas
195 Trego
197 Wabaunsee
199 Wallace
201 Washington
203 Wichita
205 Wilson
207 Woodson
209 Wyandotte

STATE NAME:
KENTUCKY
ALPHABETIC CODE:
KY
NUMERIC CODE: 21

CODE COUNTY NAME
001 Adair
003 Allen
005 Anderson
007 Ballard
009 Barren
011 Bath
013 Bell
015 Boone
017 Bourbon
019 Boyd
021 Boyle
023 Bracken
025 Breathitt
027 Breckinridge
029 Bullitt
031 Butler
033 Caldwell
035 Calloway
037 Campbell
039 Carlisle
041 Carroll
043 Carter
045 Casey
047 Christian
049 Clark
051 Clay
053 Clinton
055 Crittenden
057 Cumberland
059 Daviess
061 Edmonson
063 Elliott
065 Estill
067 Fayette
069 Fleming
071 Floyd
073 Franklin
075 Fulton
077 Gallatin
079 Garrard
081 Grant
083 Graves
085 Grayson
087 Green
089 Greenup
091 Hancock
093 Hardin
095 Harlan
097 Harrison
099 Hart
101 Henderson
103 Henry
105 Hickman
107 Hopkins
109 Jackson
111 Jefferson
113 Jessamine
115 Johnson
117 Kenton
119 Knott
121 Knox
123 Larue
125 Laurel
127 Lawrence
129 Lee
131 Leslie
133 Letcher
135 Lewis
137 Lincoln
139 Livingston
141 Logan
143 Lyon
145 McCracken
147 McCreary
149 McLean
151 Madison
153 Magoffin
155 Marion
157 Marshall
159 Martin
161 Mason
163 Meade
165 Menifee
167 Mercer
169 Metcalfe
171 Monroe
173 Montgomery
175 Morgan
177 Muhlenberg
179 Nelson
181 Nicholas
183 Ohio
185 Oldham
187 Owen
189 Owsley
191 Pendleton
193 Perry
195 Pike
197 Powell
199 Pulaski
201 Roberston
203 Rockcastle
205 Rowan
207 Russell
209 Scott
211 Shelby
213 Simpson
215 Spencer
217 Taylor
219 Todd
221 Trigg
223 Trimble
225 Union
227 Warren
229 Washington
231 Wayne
233 Webster
235 Whitley
237 Wolfe
239 Woodford

LOUISIANA
ALPHABETIC CODE:
LA
NUMERIC CODE: 22

CODE COUNTY NAME
001 Acadia
003 Allen
005 Ascension
007 Assumption

STATE NAME:
LOUISIANA (Cont.'d)
ALPHABETIC CODE:
LA
NUMERIC CODE: 22

CODE COUNTY NAME
009 Avoylelles
011 Beauregard
013 Bienville
015 Bossier
017 Caddo
019 Calcasieu
021 Caldwell
023 Cameron
025 Catahoula
027 Claiborne
029 Concordia
031 DeSoto
033 East Baton Rouge
035 East Carroll
037 East Feliciana
039 Evangeline
041 Franklin
043 Grant
045 Iberia
047 Iberville
049 Jackson
051 Jefferson
053 Jefferson Davis
055 Lafayette
057 Lafourche
059 La Salle
061 Lincoln
063 Livingston
065 Madison
067 Morehouse
069 Natchitoches
071 Orleans
073 Ouachita
075 Plaquemines
077 Pointe Coupee
079 Rapides
081 Red River
083 Richland
085 Sabine
087 St. Bernard
089 St. Charles
091 St. Helena
093 St. James
095 St. John the Baptist
097 St. Landry
099 St. Martin
101 St. Mary
103 St. Tammany
105 Tangipahoa
107 Tensas
109 Terrebonne
111 Union
113 Vermilion
115 Vernon
117 Washington
119 Webster
121 West Baton Rouge
123 West Carroll
125 West Feliciana
127 Winn

STATE NAME:
MAINE
ALPHABETIC CODE:
ME
NUMERIC CODE: 23

CODE COUNTY NAME
001 Androscoggin
003 Aroostook
005 Cumberland
007 Franklin
009 Hancock
011 Kennebec
013 Knox
015 Lincoln
017 Oxford
019 Penobscot
021 Piscataquis
023 Sagadahoc
025 Somerset
027 Waldo
029 Washington
031 York

STATE NAME:
MARYLAND
ALPHABETIC CODE:
MD
NUMERIC CODE: 24

CODE COUNTY NAME
001 Allegany
003 Anne Arundel
005 Baltimore
009 Calvert
011 Caroline
013 Carroll
015 Cecil
017 Charles
019 Dorchester
021 Frederick
023 Garrettt
025 Harford
027 Howard
029 Kent
031 Montgomery
033 Prince George's
035 Queen Anne's
037 St. Mary's
039 Somerset
041 Talbot
043 Washington
045 Wicomico
047 Worcester

CODE
INDEPENDENT CITY

510 Baltimore (City)

STATE NAME:
MASSACHUSETTS
ALPHABETIC CODE:
MA
NUMERIC CODE: 25

CODE COUNTY NAME
001 Barnstable
003 Berkshire
005 Bristol
007 Dukes
009 Essex
011 Franklin
013 Hampden
015 Hampshire
017 Middlesex
019 Nantucket
021 Norfolk
023 Plymouth
025 Suffolk
027 Worcester

STATE NAME:
MICHIGAN
ALPHABETIC CODE:
MI
NUMERIC CODE: 26

CODE COUNTY NAME
001 Alcona
003 Alger
005 Allegan
007 Alpena
009 Antrim
011 Arenac
013 Baraga
015 Barry
017 Bay
019 Benzie
021 Berrien
023 Branch
025 Calhoun
027 Cass
029 Charlevoix
031 Cheboygan
033 Chippewa
035 Clare
037 Clinton
039 Crawford
041 Delta
043 Dickinson
045 Eaton
047 Emmet
049 Genesee
051 Gladwin
053 Gogebic
055 Grand Traverse
057 Gratiot
059 Hillsdale
061 Houghton
063 Huron
065 Ingham
067 Ionia
069 Iosco
071 Iron
073 Isabella
075 Jackson
077 Kalamazoo
079 Kalkaska
081 Kent
083 Keweenaw
085 Lake
087 Lapeer
089 Leelanau
091 Lenawee
093 Livingston
095 Luce
097 Mackinac
099 Macomb
101 Manistee
103 Marquette
105 Mason
107 Mecosta
109 Menominee
111 Midland
113 Missaukee
115 Monroe
117 Montcalm
119 Montmorency
121 Muskegon
123 Newaygo
125 Oakland
127 Oceana
129 Ogemaw
131 Ontonagon
133 Osceola
135 Oscoda
137 Otsego

STATE NAME:
MICHIGAN
ALPHABETIC CODE:
MI
NUMERIC CODE: 26

CODE COUNTY NAME
139 Ottawa
141 Presque Isle
143 Roscommon
145 Saginaw
147 St. Clair
149 St. Joseph
151 Sanilac
153 Schoolcraft
155 Shiawassee
157 Tuscola
159 Van Buren
161 Washtenaw
163 Wayne
165 Wexford

STATE NAME:
MINNESOTA
ALPHABETIC CODE:
MN
NUMERIC CODE: 27

CODE COUNTY NAME
001 Aitkin
003 Anoka
005 Becker
007 Beltrami
009 Benton
011 Big Stone
013 Blue Earth
015 Brown
017 Carlton
019 Carver
021 Cass
023 Chippewa
025 Chisago
027 Clay
029 Clearwater
031 Cook
033 Cottonwood
035 Crow Wing
037 Dakota
039 Dodge
041 Douglas
043 Faribault
045 Fillmore
047 Freeborn
049 Goodhue
051 Grant
053 Hennepin
055 Houston
057 Hubbard
059 Isanti
061 Itasca
063 Jackson
065 Kanabec
067 Kandiyohi
069 Kittson
071 Koochiching
073 Lac qui Parle
075 Lake
077 Lake of the Woods
079 Le Sueur
081 Lincoln
083 Lyon
085 McLeod
087 Mahnomen
089 Marshall
091 Martin
093 Meeker
095 Mille Lacs
097 Morrison
099 Mower
101 Murray
103 Nicollet
105 Nobles
107 Norman
109 Olmsted
111 Otter Tail
113 Pennington
115 Pine
117 Pipestone
119 Polk
121 Pope
123 Ramsey
125 Red Lake
127 Redwood
129 Renville
131 Rice
133 Rock
135 Roseau
137 St. Louis
139 Scott
141 Sherburne
143 Sibley
145 Stearns
147 Steele
149 Stevens
151 Swift
153 Todd
155 Traverse
157 Wabasha
159 Wadena
161 Waseca
163 Washington
165 Watonwan
167 Wilkin
169 Winona
171 Wright
173 Yellow Medicine

STATE NAME:
MISSISSIPPI
ALPHABETIC CODE:
MS
NUMERIC CODE: 28

CODE COUNTY NAME
001 Adams
003 Alcorn
005 Amite
007 Attala
009 Benton
011 Bolivar
013 Calhoun
015 Carroll
017 Chickasaw
019 Choctaw
021 Claiborne
023 Clarke
025 Clay
027 Coahoma
029 Copiah
031 Covington
033 DeSoto
035 Forrest
037 Franklin
039 George
041 Greene
043 Grenada
045 Hancock
047 Harrison
049 Hinds
051 Holmes
053 Humphreys
055 Issaquena
057 Itawamba
059 Jackson
061 Jasper
063 Jefferson
065 Jefferson Davis
067 Jones
069 Kemper
071 Lafayette
073 Lamar
075 Lauderdale
077 Lawrence
079 Leake
081 Lee
083 Leflore
085 Lincoln
087 Lowndes
089 Madison
091 Marion
093 Marshall
095 Monroe
097 Montgomery
099 Neshoba
101 Newton
103 Noxubee
105 Oktibbeha
107 Panola
109 Pearl River
111 Perry
113 Pike
115 Pontotoc
117 Prentiss
119 Quitman
121 Rankin
123 Scott
125 Sharkey
127 Simpson
129 Smith
131 Stone
133 Sunflower
135 Tallahatchie
137 Tate
139 Tippah
141 Tishomingo
143 Tunica
145 Union
147 Walthall
149 Warren
151 Washington
153 Wayne
155 Webster
157 Wilkinson
159 Winston
161 Yalobusha
163 Yazoo

STATE NAME:
MISSOURI
ALPHABETIC CODE:
MO
NUMERIC CODE: 29

CODE COUNTY NAME
001 Adair
003 Andrew
005 Atchison
007 Audrain
009 Barry
011 Barton
013 Bates
015 Benton
017 Bollinger
019 Boone
021 Buchanan
023 Butler
025 Caldwell
027 Callaway
029 Camden

STATE NAME:
MISSOURI (Cont.'d)
ALPHABETIC CODE:
MO
NUMERIC CODE: 29

CODE COUNTY NAME
031 Cape Girardeau
033 Carroll
035 Carter
037 Cass
039 Cedar
041 Chariton
043 Christian
045 Clark
047 Clay
049 Clinton
051 Cole
053 Cooper
055 Crawford
057 Dade
059 Dallas
061 Daviess
063 DeKalb
065 Dent
067 Douglas
069 Dunklin
071 Franklin
073 Gasconade
075 Gentry
077 Greene
079 Grundy
081 Harrison
083 Henry
085 Hickory
087 Holt
089 Howard
091 Howell
093 Iron
095 Jackson
097 Jasper
099 Jefferson
101 Johnson
103 Knox
105 Laclede
107 Lafayette
109 Lawrence
111 Lewis
113 Lincoln
115 Linn
117 Livingston
119 McDonald
121 Macon
123 Madison
125 Maries
127 Marion
129 Mercer
131 Miller
133 Mississippi
135 Moniteau
137 Monroe
139 Montgomery
141 Morgan
143 New Madrid
145 Newton
147 Nodaway
149 Oregon
151 Osage
153 Ozark
155 Pemiscot
157 Perry
159 Pettis
161 Phelps
163 Pike
165 Platte
167 Polk
169 Pulaski
171 Putnam
173 Ralls
175 Randolph
177 Ray
179 Reynolds
181 Ripley
183 St. Charles
185 St. Clair
186 Ste. Genevieve
187 St. Francois
189 St. Louis County
195 Saline
197 Schuyler
199 Scotland
201 Scott
203 Shannon
205 Shebly
207 Stoddard
209 Stone
211 Sullivan
213 Taney
215 Texas
217 Vernon
219 Warren
221 Washington
223 Wayne
225 Webster
227 Worth
229 Wright

CODE INDEPENDENT CITY

510 St. Louis City

STATE NAME:
MONTANA
ALPHABETIC CODE:
MT
NUMERIC CODE: 30

CODE COUNTY NAME
001 Beaverhead
003 Big Horn
005 Blaine
007 Broadwater
009 Carbon
011 Carter
013 Cascade
015 Chouteau
017 Custer
019 Daniels
021 Dawson
023 Deer Lodge
025 Fallon
027 Fergus
029 Flathead
031 Gallatin
033 Garfield
035 Glacier
037 Golden Valley
039 Granite
041 Hill
043 Jefferson
045 Judith Basin
047 Lake
049 Lewis and Clark
051 Liberty
053 Lincoln
055 McCone
057 Madison
059 Meagher
061 Mineral
063 Missoula
065 Musselshell
067 Park
069 Petroleum
071 Phillips
073 Pondera
075 Powder River
077 Powell
079 Prairie
081 Ravalli
083 Richland
085 Roosevelt
087 Rosebud
089 Sanders
091 Sheridan
093 Silver Bow
095 Stillwater
097 Sweet Grass
099 Teton
101 Tooke
103 Treasure
105 Valley
107 Wheatland
109 Wibaux

111 Yellowstone
NIST has been notified by the Bureau of Census that Yellowstone National Park, MT, is legally part of Gallatin County and Park County. This eliminates Yellowstone National Park (FIPS Code 113) as a county equivalent.

STATE NAME:
NEBRASKA
ALPHABETIC CODE:
NE
NUMERIC CODE: 31

CODE COUNTY NAME
001 Adams
003 Antelope
005 Arthur
007 Banner
009 Blaine
011 Boone
013 Box Butte
015 Boyd
017 Brown
019 Buffalo
021 Burt
023 Butler
025 Cass
027 Cedar
029 Chase
031 Cherry
033 Cheyenne
035 Clay
037 Colfax
039 Cuming
041 Custer
043 Dakota
045 Dawes
047 Dawson
049 Deuel
051 Dixon
053 Dodge
055 Douglas
057 Dundy
059 Fillmore
061 Franklin
063 Frontier
065 Furnas

STATE NAME:
NEBRASKA (Cont.'d)
ALPHABETIC CODE:
NE
NUMERIC CODE: 31

CODE COUNTY NAME
067 Gage
069 Garden
071 Garfield
073 Gosper
075 Grant
077 Greeley
079 Hall
081 Hamilton
083 Harlan
085 Hayes
087 Hitchcock
089 Holt
091 Hooker
093 Howard
095 Jefferson
097 Johnson
099 Kearney
101 Keith
103 Keya Paha
105 Kimball
107 Knox
109 Lancaster
111 Lincoln
113 Logan
115 Loup
117 McPherson
119 Madison
121 Merrick
123 Morrill
125 Nance
127 Nemaha
129 Nuckolls
131 Otoe
133 Pawnee
135 Perkins
137 Phelps
139 Pierce
141 Platte
143 Polk
145 Red Willow
147 Richardson
149 Rock
151 Saline
153 Sarpy
155 Saunders
157 Scotts Bluff
159 Seward
161 Sheridan
163 Sherman
165 Sioux
167 Stanton
169 Thayer
171 Thomas
173 Thurston
175 Valley
177 Washington
179 Wayne
181 Webster
183 Wheeler
185 York

STATE NAME:
NEVADA
ALPHABETIC CODE:
NV
NUMERIC CODE: 32

CODE COUNTY NAME
001 Churchill
003 Clark
005 Doulgas
007 Elko
009 Esmeralda
011 Eureka
013 Humboldt
015 Lander
017 Lincoln
019 Lyon
021 Mineral
023 Nye
027 Pershing
029 Storey
031 Washoe
033 White Pine

CODE INDEPENDENT CITY

510 Carson City
Carson City does not include a legal designation (such as "city").

STATE NAME:
NEW HAMPSHIRE
ALPHABETIC CODE:
NH
NUMERIC CODE: 33

CODE COUNTY NAME
001 Belknap
003 Carroll
005 Cheshire
007 Coos
009 Grafton
011 Hillsborough
013 Merrimack
015 Rockingham
017 Strafford
019 Sullivan

STATE NAME:
NEW JERSEY
ALPHABETIC CODE: NJ
NUMERIC CODE: 34

CODE COUNTY NAME
001 Atlantic
003 Bergen
005 Burlington
007 Camden
009 Cape May
011 Cumberland
013 Essex
015 Gloucester
017 Hudson
019 Hunterdon
021 Mercer
023 Middlesex
025 Monmouth
027 Morris
029 Ocean
031 Passaic
033 Salem
035 Somerset
037 Sussex
039 Union
041 Warren

STATE NAME:
NEW MEXICO
ALPHABETIC CODE:
NM
NUMERIC CODE: 35

CODE COUNTY NAME
001 Bernalillo
003 Catron
005 Chaves
006 Cibola
007 Colfax
009 Curry
011 DeBaca
013 Dona Ana
015 Eddy
017 Grant
019 Guadalupe
021 Harding
023 Hidalgo
025 Lea
027 Lincoln
028 Los Alamos
029 Luna
031 McKinley
033 Mora
035 Otero
037 Quay
039 Rio Arriba
041 Roosevelt
043 Sandoval
045 San Juan
047 San Miguel
049 Santa Fe
051 Sierra
053 Socorro
055 Taos
057 Torrance
059 Union
061 Valencia

Cibola was established from part of Valencia (6/19/81).

STATE NAME:
NEW YORK
ALPHABETIC CODE:
NY
NUMERIC CODE: 36

CODE COUNTY NAME
001 Albany
003 Allegany
005 Bronx
007 Broome
009 Cattaraugus
011 Cayuga
013 Chautauqua
015 Chemung
017 Chenango
019 Clinton
021 Columbia
023 Cortland
025 Delaware
027 Dutchess
029 Erie
031 Essex
033 Franklin
035 Fulton
037 Genesee
039 Greene
041 Hamilton
043 Herkimer
045 Jefferson
047 Kings
049 Lewis

STATE NAME:
NEW YORK (Cont.'d)
ALPHABETIC CODE:
NY
NUMERIC CODE: 36

CODE COUNTY NAME
051 Livingston
053 Madison
055 Monroe
057 Montgomery
059 Nassau
061 New York
063 Niagara
065 Oneida
067 Onondaga
069 Ontario
071 Orange
073 Orleans
075 Oswego
077 Otsego
079 Putnam
081 Queens
083 Rensselaer
085 Richmond
087 Rockland
089 St. Lawrence
091 Saratoga
093 Schenectady
095 Schoharie
097 Schuyler
099 Seneca
101 Steuben
103 Suffolk
105 Sullivan
107 Tioga
109 Tompkins
111 Ulster
113 Warren
115 Washington
117 Wayne
119 Westchester
121 Wyoming
123 Yates

STATE NAME:
NORTH CAROLINA
ALPHABETIC CODE:
NC
NUMERIC CODE: 37

CODE COUNTY NAME
001 Alamance
003 Alexander
005 Alleghany
007 Anson
009 Ashe
011 Avery
013 Beaufort
015 Bertie
017 Bladen
019 Brunswick
021 Buncombe
023 Burke
025 Cabarrus
027 Caldwell
029 Camden
031 Carteret
033 Caswell
035 Catawba
037 Chatham
039 Cherokee
041 Chowan
043 Clay
045 Cleveland
047 Columbus
049 Craven
051 Cumberland
053 Currituck
055 Dare
057 Davidson
059 Davie
061 Duplin
063 Durham
065 Edgecombe
067 Forsyth
069 Franklin
071 Gaston
073 Gates
075 Graham
077 Granville
079 Greene
081 Guilford
083 Halifax
085 Harnett
087 Haywood
089 Henderson
091 Hertford
093 Hoke
095 Hyde
097 Iredell
099 Jackson
101 Johnston
103 Jones
105 Lee
107 Lenoir
109 Lincoln
111 McDowell
113 Macon
115 Madison
117 Martin
119 Mecklenburg
121 Mitchell
123 Montgomery
125 Moore
127 Nash
129 New Hanover
131 Northampton
133 Onslow
135 Orange
137 Pamlico
139 Pasquotank
141 Pender
143 Perquimans
145 Person
147 Pitt
149 Polk
151 Randolph
153 Richmond
155 Robeson
157 Rockingham
159 Rowan
161 Rutherford
163 Sampson
165 Scotland
167 Stanly
169 Stokes
171 Surry
173 Swain
175 Transylvania
177 Tyrrell
179 Union
181 Vance
183 Wake
185 Warren
187 Washington
189 Watauga
191 Wayne
193 Wilkes
195 Wilson
197 Yadkin
199 Yancey

STATE NAME:
NORTH DAKOTA
ALPHABETIC CODE:
ND
NUMERIC CODE: 38

CODE COUNTY NAME
001 Adams
003 Barnes
005 Benson
007 Billings
009 Bottineau
011 Bowman
013 Burke
015 Burleigh
017 Cass
019 Cavalier
021 Dickey
023 Divide
025 Dunn
027 Eddy
029 Emmons
031 Foster
033 Golden Valley
035 Grand Forks
037 Grant
039 Griggs
041 Hettinger
043 Kidder
045 LaMoure
047 Logan
049 McHenry
051 McIntosh
053 McKenzie
055 McLean
057 Mercer
059 Morton
061 Mountrail
063 Nelson
065 Oliver
067 Pembina
069 Pierce
071 Ramsey
073 Ransom
075 Renville
077 Richland
079 Rolette
081 Sargent
083 Sheridan
085 Sioux
087 Slope
089 Stark
091 Steele
093 Stutsman
095 Towner
097 Traill
099 Walsh
101 Ward
103 Wells
105 Williams

STATE NAME:
OHIO
ALPHABETIC CODE:
OH
NUMERIC CODE: 39

CODE COUNTY NAME
001 Adams
003 Allen
005 Ashland
007 Ashtabula
009 Athens
011 Auglaize
013 Belmont
015 Brown

STATE NAME:
OHIO
ALPHABETIC CODE:
OH
NUMERIC CODE: 39

CODE COUNTY NAME

017 Butler
019 Carroll
021 Champaign
023 Clark
025 Clermont
027 Clinton
029 Columbiana
031 Coshocton
033 Crawford
035 Cuyahoga
037 Darke
039 Defiance
041 Delaware
043 Erie
045 Fairfield
047 Fayette
049 Franklin
051 Fulton
053 Gallia
055 Geauga
057 Greene
059 Guernsey
061 Hamilton
063 Hancock
065 Hardin
067 Harrison
069 Henry
071 Highland
073 Hocking
075 Holmes
077 Huron
079 Jackson
081 Jefferson
083 Knox
085 Lake
087 Lawrence
089 Licking
091 Logan
093 Lorain
095 Lucas
097 Madison
099 Mahoning
101 Marion
103 Medina
105 Meigs
107 Mercer
109 Miami
111 Monroe
113 Montgomery
115 Morgan
117 Morrow
119 Muskingum
121 Noble
123 Ottawa
125 Paulding
127 Perry
129 Pickaway
131 Pike
133 Portage
135 Preble
137 Putnam
139 Richland
141 Ross
143 Sandusky
145 Scioto
147 Seneca
149 Shelby
151 Stark
153 Summit
155 Trumbull
157 Tuscarawas
159 Union
161 VanWert
163 Vinton
165 Warren
167 Washington
169 Wayne
171 Williams
173 Wood
175 Wyandot

STATE NAME:
OKLAHOMA
ALPHABETIC CODE:
OK
NUMERIC CODE: 40

CODE COUNTY NAME
001 Adair
003 Alfalfa
005 Atoka
007 Beaver
009 Beckham
011 Blaine
013 Bryan
015 Caddo
017 Canadian
019 Carter
021 Cherokee
023 Choctaw
025 Cimarron
027 Cleveland
029 Coal
031 Comanche
033 Cotton
035 Craig
037 Creek
039 Custer
041 Delaware
043 Dewey
045 Ellis
047 Garfield
049 Garvin
051 Grady
053 Grant
055 Greer
057 Harmon
059 Harper
061 Haskell
063 Hughes
065 Jackson
067 Jefferson
069 Johnston
071 Kay
073 Kingfisher
075 Kiowa
077 Latimer
079 Le Flore
081 Lincoln
083 Logan
085 Love
087 McClain
089 McCurtain
091 McIntosh
093 Major
095 Marshall
097 Mayes
099 Murray
101 Muskogee
103 Noble
105 Nowata
107 Okfushee
109 Oklahoma
111 Okmulgee
113 Osage
115 Ottawa
117 Pawnee
119 Payne
121 Pittsburg
123 Pontotoc
125 Pottawatomie
127 Pushmataha
129 Roger Mills
131 Rogers
133 Seminole
135 Sequoyah
137 Stephens
139 Texas
141 Tillman
143 Tulsa
145 Wagoneer
147 Washington
149 Washita
151 Woods
153 Woodward

STATE NAME:
OREGON
ALPHABETIC CODE:
OR
NUMERIC CODE: 41

CODE COUNTY NAME
001 Baker
003 Benton
005 Clackamas
007 Clatsop
009 Columbia
011 Coos
013 Crook
015 Curry
017 Deschutes
019 Douglas
021 Gilliam
023 Grant
025 Harney
027 Hood River
029 Jackson
031 Jefferson
033 Josephine
035 Klamath
037 Lake
039 Lane
041 Lincoln
043 Linn
045 Malheur
047 Marion
049 Morrow
051 Multnomah
053 Polk
055 Sherman
057 Tillamook
059 Umatilla
061 Union
063 Wallowa
065 Wasco
067 Washington
069 Wheeler
071 Yamhill

STATE NAME:
PENNSYLVANIA
ALPHABETIC CODE:
PA
NUMERIC CODE: 42

CODE COUNTY NAME
001 Adams
003 Allegheny
005 Armstrong
007 Beaver
009 Bedford

STATE NAME:
PENNSYLVANIA
ALPHABETIC CODE:
PA
NUMERIC CODE: 42

CODE COUNTY NAME
011 Berks
013 Blair
015 Bradford
017 Bucks
019 Butler
021 Cambria
023 Cameron
025 Carbon
027 Centre
029 Chester
031 Clarion
033 Clearfield
035 Clinton
037 Columbia
039 Crawford
041 Cumberland
043 Dauphin
045 Delaware
047 Elk
049 Erie
051 Fayette
053 Forest
055 Franklin
057 Fulton
059 Greene
061 Huntingdon
063 Indiana
065 Jefferson
067 Juniata
069 Lackawanna
071 Lancaster
073 Lawrence
075 Lebanon
077 Lehigh
079 Luzerne
081 Lycoming
083 McKean
085 Mercer
087 Mifflin
089 Monroe
091 Montgomery
093 Montour
095 Northampton
097 Northumberland
099 Perry
101 Philadelphia
103 Pike
105 Potter
107 Schuylkill
109 Snyder
111 Somerset
113 Sullivan
115 Susquehanna
117 Tioga
119 Union
121 Venango
123 Warren
125 Washington
127 Wayne
129 Westmoreland
131 Wyoming
133 York

STATE NAME:
RHODE ISLAND
ALPHABETIC CODE: RI
NUMERIC CODE: 44

CODE COUNTY NAME
001 Bristol
003 Kent
005 Newport
007 Providence
009 Washington

STATE NAME:
SOUTH CAROLINA
ALPHABETIC CODE:
SC
NUMERIC CODE: 45

CODE COUNTY NAME
001 Abbeviille
003 Aiken
005 Allendale
007 Anderson
009 Bamberg
011 Barnwell
013 Beaufort
015 Berkeley
017 Calhoun
019 Charleston
021 Cherokee
023 Chester
025 Chesterfield
027 Clarendon
029 Colleton
031 Darlington
033 Dillon
035 Dorchester
037 Edgefield
039 Fairfield
041 Florence
043 Georgetown
045 Greenville
047 Greenwood
049 Hampton
051 Horry
053 Jasper
055 Kershaw
057 Lancaster
059 Laurens
061 Lee
063 Lexington
065 McCormick
067 Marion
069 Marlboro
071 Newberry
073 Oconee
075 Orangeburg
077 Pickens
079 Richland
081 Saluda
083 Spartanburg
085 Sumter
087 Union
089 Williamsburg
091 York

STATE NAME:
SOUTH DAKOTA
ALPHABETIC CODE:
SD
NUMERIC CODE: 46

CODE COUNTY NAME
003 Aurora
005 Beadle
007 Bennett
009 Bon Homme
011 Brookings
013 Brown
015 Brule
017 Buffalo
019 Butte
021 Campbell
023 Charles Mix
025 Clark
027 Clay
029 Codington
031 Corson
033 Custer
035 Davison
037 Day
039 Deuel
041 Dewey
043 Douglas
045 Edmunds
047 Fall River
049 Faulk
051 Grant
053 Gregory
055 Haakon
057 Hamlin
059 Hand
061 Hanson
063 Harding
065 Hughes
067 Hutchinson
069 Hyde
071 Jackson
073 Jerauld
075 Jones
077 Kingsbury
079 Lake
081 Lawrence
083 Lincoln
085 Lyman
087 McCook
089 McPherson
091 Marshall
093 Meade
095 Mellette
097 Miner
099 Minnehaha
101 Moody
103 Pennington
105 Perkins
107 Potter
109 Roberts
111 Sanborn
113 Shannon
115 Spink
117 Stanley
119 Sully
121 Todd
123 Tripp
125 Turner
127 Union
129 Walworth
135 Yankton
137 Ziebach

STATE NAME:
TENNESSEE
ALPHABETIC CODE:
TN
NUMERIC CODE: 47

CODE COUNTY NAME
001 Anderson
003 Bedford
005 Benton
007 Bledsoe
009 Blount
011 Bradley
013 Campbell
015 Cannon
017 Carroll
019 Carter

STATE NAME:
TENNESSEE (Cont.'d)
ALPHABETIC CODE:
TN
NUMERIC CODE: 47
021 Cheatham
023 Chester
025 Claiborne
027 Clay
029 Cocke
031 Coffee
033 Crockett
035 Cumberland
037 Davidson
039 Decatur
041 DeKalb
043 Dickson
045 Dyer
047 Fayette
049 Fentress
051 Franklin
053 Gibson
055 Giles
057 Grainger
059 Greene
061 Grundy
063 Hamblen
065 Hamilton
067 Hancock
069 Hardeman
071 Hardin
073 Hawkins
075 Haywood
077 Henderson
079 Henry
081 Hickman
083 Houston
085 Humphreys
087 Jackson
089 Jefferson
091 Johnson
093 Knox
095 Lake
097 Lauderdale
099 Lawrence
101 Lewis
103 Lincoln
105 Loudon
107 McMinn
109 McNairy
111 Macon
113 Madison
115 Marion
117 Marshall
119 Maury
121 Meigs
123 Monroe
125 Montgomery
127 Moore
129 Morgan
131 Obion
133 Overton
135 Perry
137 Pickett
139 Polk
141 Putnam
143 Rhea
145 Roane
147 Robertson
149 Rutherford
151 Scott
153 Sequatchie
155 Sevier
157 Shelby
159 Smith
161 Stewart
163 Sullivan
165 Sumner
167 Tipton
169 Trousdale
171 Unicoi
173 Union
175 Van Buren
177 Warren
179 Washington
181 Wayne
183 Weakley
185 White
187 Williamson
189 Wilson

STATE NAME:
TEXAS
ALPHABETIC CODE:
TX
NUMERIC CODE: 48

CODE COUNTY NAME
001 Anderson
003 Andrews
005 Angelina
007 Aransas
009 Archer
011 Armstrong
013 Atascosa
015 Austin
017 Bailey
019 Bandera
021 Bastrop
023 Baylor
025 Bee
027 Bell
029 Bexar
031 Blanco
033 Borden
035 Bosque
037 Bowie
039 Brazoria
041 Brazos
043 Brewster
045 Briscoe
047 Brooks
049 Brown
051 Burleson
053 Burnet
055 Caldwell
057 Calhoun
059 Callahan
061 Cameron
063 Camp
065 Carson
067 Cass
069 Castro
071 Chambers
073 Cherokee
075 Childress
077 Clay
079 Cochran
081 Coke
083 Coleman
085 Collin
087 Collingsworth
089 Colorado
091 Comal
093 Comanche
095 Concho
097 Cooke
099 Coryell
101 Cottle
103 Crane
105 Crockett
107 Crosby
109 Culberson
111 Dallam
113 Dallas
115 Dawson
117 Deaf Smith
119 Delta
121 Denton
123 DeWitt
125 Dickens
127 Dimmit
129 Donley
131 Duval
133 Eastland
135 Ector
137 Edwards
139 Ellis
141 El Paso
143 Erath
145 Falls
147 Fannin
149 Fayette
151 Fisher
153 Floyd
155 Foard
157 Fort Bend
159 Franklin
161 Freestone
163 Frio
165 Gaines
167 Galveston
169 Garza
171 Gillespie
173 Glasscock
175 Goliad
177 Gonzales
179 Gray
181 Grayson
183 Gregg
185 Grimes
187 Guadalupe
189 Hale
191 Hall
193 Hamilton
195 Hansford
197 Hardeman
199 Hardin
201 Harris
203 Harrison
205 Hartley
207 Haskell
209 Hays
211 Hemphill
213 Henderson
215 Hidalgo
217 Hill
219 Hockley
221 Hood
223 Hopkins
225 Houston
227 Howard
229 Hudspeth
231 Hunt
233 Hutchinson
235 Irion
237 Jack
239 Jackson
241 Jasper
243 Jeff Davis
245 Jefferson
247 Jim Hogg
249 Jim Wells
251 Johnson
253 Jones
255 Karnes
257 Kaufman
259 Kendall
261 Kenedy
263 Kent
265 Kerr
267 Kimble
269 King
271 Kinney

STATE NAME:
TEXAS (Cont.'d)
ALPHABETIC CODE:
TX
NUMERIC CODE: 48

CODE COUNTY NAME
273 Kleberg
275 Knox
277 Lamar
279 Lamb
281 Lampasas
283 La Salle
285 Lavaca
287 Lee
289 Leon
291 Liberty
293 Limestone
295 Lipscomb
297 Live Oak
299 Llano
301 Loving
303 Lubbock
305 Lynn
307 McCulloch
309 McLennan
311 McMullen
313 Madison
315 Marion
317 Martin
319 Mason
321 Matagorda
323 Maverick
325 Medina
327 Menard
329 Midland
331 Milam
333 Mills
335 Mitchell
337 Montague
339 Montgomery
341 Moore
343 Morris
345 Motley
347 Nacogdoches
349 Navarro
351 Newton
353 Nolan
355 Nueces
357 Ochiltree
359 Oldham
361 Orange
363 Palo Pinto
365 Panola
367 Parker
369 Parmer
371 Pecos
373 Polk
375 Potter
377 Presidio
379 Rains
381 Randall
383 Reagan
385 Real
387 Red River
389 Reeves
391 Refugio
393 Roberts
395 Robertson
397 Rockwall
399 Runnels
401 Rusk
403 Sabine
405 San Augustine
407 San Jacinto
409 San Patricio
411 San Saba
413 Schleicher
415 Scurry
417 Shackleford
419 Shelby
421 Sherman
423 Smith
425 Somervell
427 Starr
429 Stephens
431 Sterling
433 Stonewall
435 Sutton
437 Swisher
439 Tarrant
441 Taylor
443 Terrell
445 Terry
447 Throckmorton
449 Titus
451. Tom Green
453 Travis
455 Trinity
457 Tyler
459 Upshur
461 Upton
463 Uvalde
465 Val Verde
467 Van Zandt
469 Victoria
471 Walker
473 Waller
475 Ward
477 Washington
479 Webb
481 Wharton
483 Wheeler
485 Wichita
487 Wilbarger
489 Willacy
491 Williamson
493 Wilson
495 Winkler
497 Wise
499 Wood
501 Yoakum
503 Young
505 Zapata
507 Zavala

STATE NAME:
UTAH
ALPHABETIC CODE:
UT
NUMERIC CODE: 49

CODE COUNTY NAME
001 Beaver
003 Box Elder
005 Cache
007 Carbon
009 Daggett
011 Davis
013 Duchesne
015 Emery
017 Garfield
019 Grand
021 Iron
023 Juab
025 Kane
027 Millard
029 Morgan
031 Piute
033 Rich
035 Salt Lake
037 San Juan
039 Sanpete
041 Sevier
043 Summit
045 Tooele
047 Uintah
049 Utah
051 Wasatch
053 Washington
055 Wayne
057 Weber

STATE NAME:
VERMONT
ALPHABETIC CODE:
VT
NUMERIC CODE: 50

CODE COUNTY NAME
001 Addison
003 Bennington

STATE NAME:
VERMONT (Cont.'d)
ALPHABETIC CODE:
VT
NUMERIC CODE: 50

CODE	COUNTY NAME
005	Caldedonia
007	Chittenden
009	Essex
011	Franklin
013	Grand Isle
015	Lamoille
017	Orange
019	Orleans
021	Rutland
023	Washington
025	Windham
027	Windsor

STATE NAME:
VIRGINIA
ALPHABETIC CODE:
VA
NUMERIC CODE: 51

CODE	COUNTY NAME
001	Accomack
003	Albermarle
005	Alleghany
007	Amelia
009	Amherst
011	Appomattox
013	Arlington
015	Augusta
017	Bath
019	Bedford
021	Bland
023	Botetourt
025	Brunswick
027	Buchanan
029	Buckingham
031	Campbell
033	Caroline
035	Carroll
036	Charles City
037	Charlotte
041	Chesterfield
043	Clarke
045	Craig
047	Culpeper
049	Cumberland
051	Dickenson
053	Dinwiddie
057	Essex
059	Fairfax
061	Fauquier
063	Floyd
065	Fluvanna
067	Franklin
069	Frederick
071	Giles
073	Gloucester
075	Goochland
077	Grayson
079	Greene
081	Greensville
083	Halifax
085	Hanover
087	Henrico
089	Henry
091	Highland
093	Isle of Wight
095	James City
097	King And Queen
099	King George
101	King William
103	Lancaster
105	Lee
107	Loudoun
109	Louisa
111	Lunenburg
113	Madison
115	Mathews
117	Mecklenburg
119	Middlesex
121	Montgomery
125	Nelson
127	New Kent
131	Northampton
133	Northumberland
135	Nottoway
137	Orange
139	Page
141	Patrick
143	Pittsylvania
145	Powhatan
147	Prince Edward
149	Prince George
153	Prince William
155	Pulaski
157	Rappahannock
159	Richmond
161	Roanoke
163	Rockbridge
165	Rockingham
167	Russell
169	Scott
171	Shenandoah
173	Smyth
175	Southampton
177	Spotsylvania
179	Stafford
181	Surry
183	Sussex
185	Tazewell
187	Warren
191	Washington
193	Westmoreland
195	Wise
197	Wythe
199	York

The codes for Charles City and Charlotte Counties, reported respectively as 037 and 039 in FIPS PUB 6-3, have been corrected. The Bureau of Economic Analysis, U.S. Department of Commerce has defined codes in the 900 series to represent county/independent city combination in Virginia.

CODE	INDEPENDENT CITY
510	Alexandria (city)
515	Bedford (city)
520	Bristol (city)
530	Buena Vista (city)
540	Charlottsville (city)
550	Chesapeake (city)
560	Clifton Forge (city)
570	Colonial Heights (city)
580	Covington (city)
590	Danville (city)
595	Emporia (city)
600	Fairfax (city)
610	Falls Church (city)
620	Franklin (city)
630	Fredericksburg (city)
640	Galax (city)
650	Hampton (city)
660	Harrisonburg (city)
670	Hopewell (city)
678	Lexington (city)
680	Lynchburg (city)
683	Manassas (city)
685	Manassas Park (city)
690	Martinsville (city)
700	Newport News (city)
710	Norfolk (city)
720	Norton (city)
730	Petersburg (city)
735	Poquoson (city)
740	Portsmouth (city)
750	Radford (city)
760	Richmond (city)
770	Roanoke (city)
775	Salem (city)
790	Staunton (city)
800	Suffolk (city)
810	Virginia Beach (city)
820	Waynesboro (city)
830	Williamsburg (city)
840	Winchester (city)

The FIPS county code of 780 for South Boston, VA, is deleted. South Boston will be incorporated within Halifax County rather than a separate county-equivalent surrounded by Halifax County.

STATE NAME:
WASHINGTON
ALPHABETIC CODE:
WA
NUMERIC CODE: 53

CODE	COUNTY NAME
001	Adams
003	Asotin
005	Benton
007	Chelan
009	Clallam
011	Clark
013	Columbia
015	Cowlitz
017	Douglas
019	Ferry
021	Franklin
023	Garfield
025	Grant
027	Grays Harbor
029	Island
031	Jefferson
033	King
035	Kitsap
037	Kittitas
039	Klickitat
041	Lewis
043	Lincoln
045	Mason
047	Okanogan
049	Pacific
051	Pend Oreille
053	Pierce
055	San Juan

STATE NAME:
WASHINGTON (Cont.'d)
ALPHABETIC CODE:
WA
NUMERIC CODE: 53

CODE COUNTY NAME
057 Skagit
059 Skamania
061 Snohomish
063 Spokane
065 Stevens
067 Thurston
069 Wahkiakum
071 Walla Walla
073 Whatcom
075 Whitman
077 Yakima

STATE NAME:
WEST VIRGINIA
ALPHABETIC CODE:
WV
NUMERIC CODE: 54

CODE COUNTY NAME
001 Barbour
003 Berkeley
005 Boone
007 Braxton
009 Brooke
011 Cabell
013 Calhoun
015 Clay
017 Doddridge
019 Fayette
021 Gilmer
023 Grant
025 Greenbrier
027 Hampshire
029 Hancock
031 Hardy
033 Harrison
035 Jackson
037 Jefferson
039 Kanawha
041 Lewis
043 Lincoln
045 Logan
047 McDowell
049 Marion
051 Marshall
053 Mason
055 Mercer
057 Mineral
059 Mingo
061 Monongalia
063 Monroe
065 Morgan
067 Nicholas
069 Ohio
071 Pendleton
073 Pleasants
075 Pocahontas
077 Preston
079 Putnam
081 Raleigh
083 Randolph
085 Ritchie
087 Roane
089 Summers
091 Taylor
093 Tucker
095 Tyler
097 Upshur
099 Wayne
101 Webster
103 Wetzel
105 Wirt
107 Wood
109 Wyoming

STATE NAME:
WISCONSIN
ALPHABETIC CODE:
WI
NUMERIC CODE: 55

CODE COUNTY NAME
001 Adams
003 Ashland
005 Barron
007 Bayfield
009 Brown
011 Buffalo
013 Burnett
015 Calumet
017 Chippewa
019 Clark
021 Columbia
023 Crawford
025 Dane
027 Dodge
029 Door
031 Douglas
033 Dunn
035 Eau Claire
037 Florence
039 Fond du Lac
041 Forest
043 Grant
045 Green
047 Green Lake
049 Iowa
051 Iron
053 Jackson
055 Jefferson
057 Juneau
059 Kenosha
061 Kewaunee
063 La Crosse
065 Lafayette
067 Langlade
069 Lincoln
071 Manitowoc
073 Marathon
075 Marinette
077 Marquette
078 Menominee
079 Milwaukee
081 Monroe
083 Oconto
085 Oneida
087 Outagamie
089 Ozaukee
091 Pepin
093 Pierce
095 Polk
097 Portage
099 Price
101 Racine
103 Richland
105 Rock
107 Rusk
109 St. Croix
111 Sauk
113 Sawyer
115 Shawano
117 Sheboygan
119 Taylor
121 Trempealeau
123 Vernon
125 Vilas
127 Walworth
129 Washburn
131 Washington
133 Waukesha
135 Waupaca
137 Waushara
139 Winnebago
141 Wood

STATE NAME:
WYOMING
ALPHABETIC CODE:
WY
NUMERIC CODE: 56

CODE COUNTY NAME
001 Albany
003 Big Horn
005 Campbell
007 Carbon
009 Converse
011 Crook
013 Fremont
015 Goshen
017 Hot Springs
019 Johnson
021 Laramie
023 Lincoln
025 Natrona
027 Niobrara
029 Park
031 Platte
033 Sheridan
035 Sublette
037 Sweetwater
039 Teton
041 Uinta
043 Washakie
045 Weston

AREA NAME:
AMERICAN SAMOA
ALPHABETIC CODE:
AS
NUMERIC CODE: 60
CODE

DISTRICT/ISLAND
NAME
010 Eastern (District)
020 Manu'a (District)
030 Rose Island
040 Swains Island
050 Western (District)

"Island" is part of the name of Rose Island and Swains Island. The entities called "counties" in American Samoa are subdivisions of the districts, and therefore are second-order subdivisions of American Samoa.

AREA NAME:
GUAM
ALPHABETIC CODE:
GU
NUMERIC CODE: 66

CODE SUBDIVISION
NAME
010 Guam

Guam has no first-order subdivisions, and therefore "Guam" also serves as the county-equivalent entity.

AREA NAME:
NORTHERN MARINA
ISLANDS
ALPHABETIC CODE:
MP
NUMERIC CODE: 69

CODE
MUNICIPALITY NAME
085 Northern Islands
100 Rota
110 Saipan
120 Tinian

AREA NAME:
PALAU
ALPHABETIC CODE:
PW
NUMERIC CODE: 70

CODE STATE NAME
002 Aimeliik
004 Airai
010 Angaur
050 Hatoboheit
100 Kayangel
150 Koror
212 Melekeok
214 Ngaraard
218 Ngarchelong
222 Ngardmau
224 Ngatpang
226 Ngchesar
227 Ngernmlengui
228 Ngiwal
350 Peleliu
370 Sonsorol

Palau also is known as Beau, and may be referred to as the Republic of..." Changes since recognition of Palau in Change Notice No. 9 to FIPS PUB 6-3. The first-order subdivisions of Palau have been revised from municipalities to states; the name of Melekeiok has been revised to Melekeok; the name and code for Ngaremlengui (223) have been revised to Ngeremlengui (227); the name and code for Tobi (380) have been revised to Hatobohei (050); the Palau Islands (unorganized territory) (300) is no longer included because that area is part of Koror and Peleliu.

AREA NAME:
PUERTO RICO
ALPHABETIC CODE:
PR
NUMERIC CODE: 72

CODE
MUNICIPALITY NAME
001 Adjuntas
003 Aguada
005 Aguadilla
007 Aguas Buenas
009 Aibonito
011 Anasco
013 Arecibo
015 Arroyo
017 Barceloneta
019 Barranquitas
021 Bayamo'n
023 Cabo Rojo
025 Caguas
027 Camuy
029 Canovanas
031 Carolina
033 Catano
035 Cayey
037 Ceiba
039 Ciales
041 Cidra
043 Coamo
045 Comerio
047 Corozal
049 Culebra
051 Dorado
053 Fajardo
054 Florida
057 Guayama
059 Guayanilla
061 Guaynabo
063 Gurabo
065 Hatillo
067 Hormigueros
069 Humacao
071 Isabela
073 Jayuya
075 Juana Diaz
077 Juncos
079 Lajas
081 Lares
083 Las Marias
085 Las Piedras
087 Loiza
089 Luquillo
091 Manati
093 Maricao
095 Maunabo
097 Mayaguez
099 Moca
101 Morovis
103 Naguabo
105 Naranjito
107 Orocovis
109 Patillas
111 Penuelas
113 Ponce
115 Quebradillas
117 Rincon
119 Rio Grande
121 Sabana Grande
123 Salinas
125 San German
127 San Juan
129 San Lorenzo
131 San Sebastian
133 Santa Isabel
135 Toa Alta
137 Toa Baja
139 Trujillo Alto
141 Utuado
143 Vega Alta
145 Vega Baja
147 Vieques
149 Villalba
151 Yabucoa
153 Yauco

AREA NAME: U.S.
OUTLYING ISLANDS
ALPHABETIC CODE:
UM
NUMERIC CODE: 74

CODE ISLAND NAME
050 Baker Island
100 Howland Island
150 Jarvis Island
200 Johnston Island
250 Kingman Reef
300 Midway Islands
350 Navassa Island
400 Palmyra Atoll
450 Wake Island

An FIPS State numeric code is available for each area; FIPS PUB 5-2 identifies the codes and explains their usage. The State codes can be used in combination with the "county" codes listed here.

AREA NAME:
VIRGIN ISLANDS OF THE
UNITED STATES
ALPHABETIC CODE: VI
NUMERIC CODE: 78

CODE ISLAND NAME
010 St. Croix
020 St. John
030 St. Thomas

AREA NAME:
FEDERATED STATES
OF MICRONESIA
ALPHABETIC CODE:
FM
NUMERIC CODE: 64

CODE STATE NAME
002 Chuuk
005 Kosrae
040 Pohnpeit
060 Yap

AREA NAME:
FEDERATED STATES
OF MICRONESIA (Cont.'d)
ALPHABETIC CODE:
FM
NUMERIC CODE: 64

The Federated States of Micronesia (FSM) became a freely associated state on 11/3/86. Its first-order subdivisions are called states. Changes since recognition of the FSM in Change Notice No. 9 to FIPS PUB 6-3. Ponape was renamed Pohnpei (11/8/84), and retained code 040; Truk (050) was renamed Chuuk (10/1/89).

390 Ujae
400 Ujelang
410 Utrik
420 Wotho
430 Wotle

The Marshall Islands became a freely associated state on 11/3/86. Its first-order subdivisions also may be referred to as “islands” and “atolls.” Since the recognition of the Marshall Islands in Change Notice No. 9, Jemo has been revised from Jemo Island to a municipality. Toke also may be spelled “Taka.”

AREA NAME:
MARSHALL ISLANDS
ALPHABETIC CODE:
MH
NUMERIC CODE: 68

CODE
MUNICIPALITY NAME
007 Ailinginaie
010 Ailinglaplap
030 Ailuk
040 Arno
050 Aur
060 Bikar
070 Bikini
073 Bokak
080 Ebon
090 Enewetak
100 Erikub
110 Jabat
120 Jaluit
130 Jemo
140 Kili
150 Kwajalein
160 Lae
170 Lib
180 Likiep
190 Majuro
300 Maloelap
310 Mejit
320 Mili
330 Namorik
340 Namu
350 Rongelap
360 Rongrik
385 Toke

APPENDIX C

Surgery Codes

Oral Cavity

Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9, Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9, Other Parts of Mouth C06.0-C06.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

No specimen sent to pathology from surgical events 10-14

00 None; no surgery of primary site; autopsy only

10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

Specimen sent to pathology from surgical events 20-43

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH:
- 21 Photodynamic Therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

- *Codes 20-27 include shave and wedge resection*

30 Wide excision, NOS

- *Code 30 includes:*
  Hemiglossectomy
  Partial Glossectomy

40 Radical excision of tumor, NOS
- 41 Radical excision of tumor ONLY
- 42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
- 43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

- ***Codes 40-43 include:***
  Total Glossectomy
  Radical Glossectomy

- *"In continuity with " or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen.*

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Parotid and Other Unspecified Glands

Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

No specimen sent to pathology from surgical events 10-14

00 None; no surgery of primary site; autopsy only

10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

Specimen sent to pathology from surgical events 20-80

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH:
- 21 Photodynamic Therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

- *Codes 30-80 include major salivary gland, NOS*
- *Codes 30-36 are with or without superficial lobe*
- *Codes 40-80 may include submandibulectomy and submaxillectomy*

30 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS
- 31 Facial nerve spared
- 32 Facial nerve sacrificed

33 Superficial lobe ONLY
- 34 Facial nerve spared
- 35 Facial nerve sacrificed

36 Deep lobe (Total)
- 37 Facial nerve spared
- 38 Facial nerve sacrificed

40 Total parotidectomy, NOS; total removal of major salivary gland, NOS
- 41 Facial nerve spared
- 42 Facial nerve sacrificed

50 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
- 51 WITHOUT removal of temporal bone
- 52 WITH removal of temporal bone
- 53 WITH removal of overlying skin (requires graft or flap coverage)

80 Parotidectomy, NOS

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Pharynx

Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9, Pyriform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

No specimen sent to pathology from surgical events 10-15

00 None; no surgery of primary site; autopsy only

10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

Specimen sent to pathology from surgical events 20-52

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH:
- 21 Photodynamic Therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

28 Stripping

30 Pharyngectomy, NOS
- 31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy tonsillectomy
- 32 Total pharyngectomy

40 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)

- *Code 40 includes mandibulectomy (marginal, segmental, hemi-, and/or laryngectomy) NOS. Contiguous bone tissue refers to mandible*

41 WITH Laryngectomy (laryngopharyngectomy)

42 WITH bone (mandibulectomy)

43 WITH both 41 and 42

- *Use code 40 when the patient had a pharyngectomy and maybe some sort of mandibulectomy and/or maybe a laryngectomy, but the exact procedures are not clear. Use code 41 when the patient had pharyngectomy and laryngectomy but no mandibulectomy. Use code 42 when the patient had pharyngectomy and mandibulectomy but no laryngectomy. Use code 43 when it is known that the patient had both a mandibulectomy and laryngectomy in addition to the*

Specimen sent to pathology from surgical events 20-52

pharyngectomy.

50 Radical pharyngectomy (includes total mandibular resection), NOS
- 51 WITHOUT laryngectomy
- 52 WITH laryngectomy

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Esophagus

C15.0-C15.9

(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

No specimen sent to pathology from surgical events 10-14

00 None; no surgery of primary site; autopsy only

10 Local tumor destruction, NOS

- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

Specimen sent to pathology from surgical events 20-80

20 Local tumor excision, NOS

- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH:

- 21 Photodynamic Therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial esophagectomy

40 Total esophagectomy, NOS

50 Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS

- *Codes 50-55 include partial esophagectomy, total esophagectomy, or esophagectomy, NOS.*

51 WITH laryngectomy

52 WITH gastrectomy, NOS

53 Partial gastrectomy

54 Total gastrectomy

55 Combination of 51 WITH any of 52-54

80 Esophagectomy, NOS

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Stomach
C16.0-C16.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

No specimen sent to pathology from surgical events 10-14

00 None; no surgery of primary site; autopsy only
10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

Specimen sent to pathology from surgical events 20-80

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH:
- 21 Photodynamic Therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Gastrectomy, NOS (partial, subtotal, hemi-)
- 31 Antrectomy, lower (distal-less than 40% of stomach) ***
- 32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
- 33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

- *Code 30 includes:*
  Partial gastrectomy, including a sleeve resection of the stomach
  Billroth I: anastomosis to duodenum (duodenostomy)
  Billroth II: anastomosis to jejunum (jejunostomy)

- **** Incidental splenectomy NOT included*

40 Near-total or total gastrectomy, NOS
- 41 Near-total gastrectomy
- 42 Total gastrectomy

- *A total gastrectomy may follow a previous partial resection of the stomach.*

50 Gastrectomy, NOS WITH removal of a portion of esophagus
- 51 Partial or subtotal gastrectomy
- 52 Near total or total gastrectomy

- *Codes 50-52 are used for gastrectomy resection when only portions of esophagus are included in procedure.*

Specimen sent to pathology from surgical events 20-80

60 Gastrectomy with a resection in continuity with the resection of other organs, NOS ***

- 61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***
- 62 Near total or total gastrectomy, in continuity with the resection of other organs***
- 63 Radical gastrectomy, in continuity with the resection of other organs***

- *** *Incidental splenectomy NOT included*
- *Codes 60-63 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection.*
- *Codes 60-63 may include omentectomy among the organs/tissues removed*
- *"In continuity with" or "en bloc" means that all of the tissues were removed during the same procedures, but not necessarily in a single specimen*

80 Gastrectomy, NOS

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Colon

C18.0-C18.9

(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

- *Code removal/surgical ablation of single or multiple liver metastases under the data item RX Summ--Surg Oth Reg/Dis*

No specimen sent to pathology from surgical events 10-14

00 None; no surgery of primary site; autopsy only

10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

Specimen sent to pathology from surgical events 20-80

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy, NOS
- 28 Polypectomy-endoscopic
- 29 Polypectomy-surgical excision

Any combination of 20 or 26-29 WITH:
- 21 Photodynamic Therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

30 Partial colectomy, (but less than hemicolectomy) segmental resection
- 32 Plus resection of contiguous organs; example: small bowel, bladder

- *Code 30 includes but is not limited to the following procedures: Appendectomy (for an appendix primary only), enterocolectomy, ileocolectomy, partial colectomy, NOS, partial resection of transverse colon and flexures,and segmental resection (such as cecectomy or sigmoidectomy). Note that the removal of a short portion of the distal ileum is NOT "removal of a contiguous organ".*

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)
- 41 Plus resection of contiguous organs; example: small bowel, bladder

- *Code 40 includes extended (but less than total) right or left colectomy. Note that the removal of a short portion of the distal ileum is NOT "removal of a contiguous organ".*

50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)

Specimen sent to pathology from surgical events 20-80

51 Plus resection of contiguous organs; example: small bowel, bladder

- *Removal of a short portion of the distal ileum is NOT "removal of a contiguous organ"*

60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)

Code 60 is commonly used for familial polyposis or polyposis coli

61 Plus resection of contiguous organs; example: small bowel, bladder

- *Removal of a short portion of the distal ileum is NOT "removal of a contiguous organ"*

70 Colectomy or coloproctotectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)

- *Code 70 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.*

- *"In continuity with" or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen.*

80 Colectomy, NOS

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Rectosigmoid
C19.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

- *Code removal/surgical ablation of single or multiple liver metastases under the data item RX Summ--Surg Oth Reg/Dis*

No specimen sent to pathology from surgical events 10-14

00 None; no surgery of primary site; autopsy only
10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

Specimen sent to pathology from surgical events 20-80

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH:
- 21 Photodynamic Therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Wedge or segmental resection; partial proctosigmoidectomy, NOS
- 31 Plus resection of contiguous organs; example: small bowel, bladder

- *Procedures coded 30 include, but are not limited to:*
  Anterior resection
  Hartmann operation
  Low anterior resection (LAR)
  Partial colectomy, NOS
  Rectosigmoidectomy, NOS
  Sigmoidectomy

40 Pull through WITH sphincter perservation (colo-anal anastomosis)

- *Procedures coded 40 include, but are not limited to:*
  Altemeier's operation
  Duhamel's operation
  Soave's submucosal resection
  Swenson's operation
  Turnbull's operation

Specimen sent to pathology from surgical events 20-80

50 Total proctectomy

- *Procedures coded to 50 include, but are not limited to:*
  Abdominoperineal resection (A&P resection)
  Anterior/posterior resection (A/P resection)
  Mile's operation
  Rankin's operation

51 Total colectomy

- *Removal of the colon from cecum to rectosigmoid or portion of the rectum.*

55 Total colectomy WITH ileostomy, NOS
  56 Ileorectal reconstruction
  57 Total colectomy WITH other pouch; example: Koch pouch

60 Total proctocolectomy, NOS (**Combination of code 50 and 51**)
  65 Total proctocolectomy WITH ileostomy, NOS
  66 Total proctocolectomy WITH ileostomy and pouch

- *Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.*

70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration

- *Procedures that may be part of an en bloc resection include, but are not limited to:*
  An oophorectomy and a rectal mucosectomy

- *Code 70 includes any colectomy (partial, hemicolectomy or total) with an en bloc resection of any other organs. The "other organs" may be partially or totally resected. "In continuity with" or "en bloc" means that all of the tissues were removed during the same procedure, but no necessarily in a single specimen.*

80 Colectomy, NOS or
Proctectomy, NOS

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Rectum
C20.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

- *Code removal /surgical ablation of single or multiple liver metastases under the data item RX Summ-- Surg Oth Reg/Dis*

No specimen sent to pathology from surgical events 10-14

00 None; no surgery of primary site; autopsy only
10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

Specimen sent to pathology from surgical events 20-80

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy

Any combination of 20 or 26-27 WITH:
- 21 Photodynamic Therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision
28 Curette and fulguration

30 Wedge or segmental resection; partial proctectomy, NOS

- *Procedures coded 30 include, but are not limited to:*
  Anterior resection
  Hartmann's operation
  Low anterior resection (LAR)
  Transsacral rectosigmoidectomy
  Total mesorectal excision (TME)

40 Pull through WITH sphincter perservation (colo-anal anastomosis)

- *Procedures coded 40 include but not limited to:*
  Altemeier's operation
  Duhamel's operation
  Soave's submucosal resection
  Swenson's operation
  Turnbull's operation

50 Total proctectomy

- *Procedure coded 50 includes, but is not limited to:*

Specimen sent to pathology from surgical events 20-80

Abdominoperineal resection (Miles Procedure)- Also called A&P resection, anterior/posterior (A/P) resection/ Mile's operation, Rankin's operation

60 Total proctocolectomy, NOS

70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration

- *In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen*

80 Proctectomy, NOS

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Anus

C21.0-C21.8

(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

- *Do not code infrared coagulation as treatment*

No specimen sent to pathology from surgical events 10-15

00 None; no surgery of primary site; autopsy only

10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal ablation

Specimen sent to pathology from surgical events 20-63

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH:
- 21 Photodynamic Therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

- *Margins of resection may have microscopic involvement*

60 Abdominal perineal resection, NOS (APR; Miles procedure)
- 61 APR and sentinel node excision
- 62 APR and unilateral inguinal lymph node dissection
- 63 APR and bilateral inguinal lymph node dissection

- *The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery*

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Liver and Intrahepatic Bile Ducts
C22.0-C22.1
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

No specimen sent to pathology from surgical events 10-17

00 None; no surgery of primary site; autopsy only
10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Alcohol (Percutaneous Ethanol Injection-PEI)

- *Code 15 (Alcohol (Percutaneous Ethanol Injection-PEI)) can also be described as an "intrtumoral injection of alcohol" or "alcohol ablation"*

- 16 Heat-Radio-frequency ablation (RFA)
- 17 Other (ultrasound, acetic acid)

Specimen sent to pathology from surgical events 20-75

20 Wedge or segmental resection, NOS
- 21 Wedge resection
- 22 Segmental resection, NOS
  - 23 One
  - 24 Two
  - 25 Three

- *Codes 23-25 mean one, two, or three wedges or segments of the liver were removed.*

- 26 Segmental resection AND local tumor destruction

30 Lobectomy, NOS
- 36 Right lobectomy
- 37 Left lobectomy
- 38 Lobectomy AND local tumor destruction

- *Code 30 also referred to as simple lobectomy*

50 Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe)
- 51 Right lobectomy
- 52 Left lobectomy
- 59 Extended lobectomy AND local tumor destruction

60 Hepatectomy, NOS

Specimen sent to pathology from surgical events 20-75

61 Total hepatectomy and transplant

65 Excision of a bile duct (for an intra-hepatic bile duct primary only)

66 Excision of an intrahepatic bile duct PLUS partial hepatectomy

75 Extrahepatic bile duct and hepatectomy WITH transplant

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Pancreas

C25.0-C25.9

(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy only

25 Local excision of tumor, NOS

30 Partial pancreatectomy, NOS; example: distal

35 Local or partial pancreatectomy and duodenectomy
- 36 WITHOUT distal/partial gastrectomy
- 37 WITH partial gastrectomy (Whipple)

40 Total pancreatectomy

60 Total pancreatecomy and subtotal gastrectomy or duodenectomy

70 Extended pancreatoduodenectomy

80 Pancreatectomy, NOS

90 Surgery, NOS

- *Assign code 90 for NanoKnife, or irreversible electroporation (IRE)*

99 Unknown if sugery performed; death certificate only

Larynx

C32.0-C32.9

(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

No specimen sent to pathology from surgical events 10-15

00 None; no surgery of primary site; autopsy only

10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

Specimen sent to pathology from surgical events 20-80

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH:
- 21 Photodynamic Therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

28 Stripping

30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy, NOS
- 31 Vertical laryngectomy

- *Vertical laryngectomy: Removal of involved true vocal cord, ipsilateral false vocal cord, intervening ventricle, and/or ipsilateral thyroid and may include removal of the arytenoids*

32 Anterior commissure laryngectomy

33 Supraglottic laryngectomy

- *Supraglottic laryngectomy: Conservative surgery intended to preserve the laryngeal function. Standard procedure involves removal of epiglottis, false vocal cords, aryepiglottic folds, arytenoid cartilages, ventricle, upper one third of thyroid cartilage, and/or thyroid membrane. The true vocal cords and arytenoids remain in place to allow vocalization and deglutition*

40 Total or radical laryngectomy, NOS
- 41 Total laryngectomy ONLY
- 42 Radical laryngectomy ONLY

- *Radical laryngectomy: Includes removal of adjacent sites. Do not code the removal of adjacent sites in RX Summ-- Surg Oth*

Larynx (Continued)		
Specimen sent to pathology from surgical events 20-80	50	Pharyngolaryngectomy
	80	Laryngectomy, NOS
	90	Surgery, NOS
	99	Unknown if sugery performed; death certificate only

Lung
C34.0-C34.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Unknown whether a specimen was sent to pathology for surgical events coded 19*

00 None; no surgery of primary site; autopsy only

19 Local tumor destruction or excision, NOS

- **Principally for cases diagnosed prior to January 1, 2003.*

No specimen sent to pathology from surgical events 12-13 and 15

15 Local tumor desctruction, NOS
- 12 Laser ablation or cryosurgery
- 13 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

- *Assign code 15 for radiofrequency ablation (RFA)*

Specimen sent to pathology from surgical events 20-80

20 Excision or resection of less than one lobe, NOS
- 23 Excision, NOS
- 24 Laser excision
- 25 Bronchial sleeve resection ONLY
- 21 Wedge resection
- 22 Segmental resection, including lingulectomy

30 Resection of (at least one) lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)
- 33 Lobectomy WITH mediastinal lymph node dissection

- *Assign code 30 when lymph node dissection is not performed, but lymph nodes are obtained as part of the lobectomy specimen.*

- *The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery*

45 Lobe or bilobectomy extended, NOS
- 46 WITH chest wall
- 47 WITH pericardium
- 48 WITH diaphram

55 Pneumonectomy, NOS

- *Code 55 includes the following procedures:*
  Complete pneumonectomy *Resection of whole lung*
  Sleeve pneumonectomy *Total pneumonectomy*
  Standard pneumonectomy

Specimen sent to pathology from surgical events 20-80

56 WITH mediastinal lymph node dissection (radical pneumonectomy)

- *The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery*

65 Extended pneumonectomy

66 Extended pneumonectomy plus pleura or diaphragm

70 Extended radical pneumonectomy

- *The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery*

- *An extended radical pneumonectomy is a radical pneumonectomy (including removal of mediastinal nodes) and the removal of other tissues or nodes.*

80 Resection of lung, NOS

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease
C42.0, C42.1, C42.3, C42.4 (with any histology)
OR
M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992 (with any site)

98 All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies WITH or WITHOUT surgical treatment.

- *Surgical procedures for hematopoietic/ reticuloendothelial/ immunoproliferative/ myeloproliferative primaries are to be recorded using the data item: RX Summ-Surg Oth Reg/Dis*

99 Death certificate only

Bones, Joints, Articular Cartilage, Peripheral Nerves, Autonomic Nervous System, Connective, Subcutaneous, and other Soft Tissues

C40.0-C41.9, C47.0-C47.9, C49.0-C49.9

(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Unknown whether a specimen was sent to pathology for surgical events coded 19*

00 None; no surgery of primary site; autopsy only

19 Local tumor destruction or excision, NOS

- **Principally for cases diagnosed prior to January 1, 2003.*

No specimen sent to pathology from surgical event 15

15 Local tumor destruction

Specimen sent to pathology from surgical events 25-54

25 Local excision

26 Partial resection

30 Radical excision or resection of lesion WITH limb salvage

40 Amputation of limb
- 41 Partial amputation of limb
- 42 Total amputation of limb

50 Major amputation, NOS
- 51 Forequarter, including scapula
- 52 Hindquarter, including ilium/hip bone
- 53 Hemipelvectomy, NOS
- 54 Internal hemipelvectomy

90 Surgery, NOS

99 Unknown if surgery performed; death certificate only

Spleen

C42.2

(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Unknown whether a specimen was sent to pathology for surgical events coded 19*

00 None; no surgery of primary site; autopsy only

19 Local tumor destruction, NOS

- **Principally for cases diagnosed prior to January 1, 2003.*

Specimen sent to pathology from surgical events 21-80

21 Partial splenectomy

22 Total splenectomy

80 Splenectomy, NOS

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Skin

C44.0-C44.9

(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

No specimen sent to pathology from surgical events 10-14

00 None; no surgery of primary site; autopsy only

10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

Specimen sent to pathology from surgical events 20-60

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH:
- 21 Photodynamic Therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

- *Codes 20-27 include shave and wedge resection*

- *Assign code 11 if there is no pathology specimen. Assign code 21 if there is a pathology specimen.*

30 Biopsy of primary tumor followed by a gross excision of the lesion (does not have to be done under the same anesthesia)
- 31 Shave biopsy followed by a gross excision of the lesion
- 32 Punch biopsy followed by a gross excision of the lesion
- 33 Incisional biopsy followed by a gross excision of the lesion
- 34 Mohs surgery, NOS
  - Assign code 34 for shave biopsy followed by MOHS surgery for melanoma of the skin.
- 35 Mohs with 1-cm margin or less
- 36 Mohs with more than 1-cm margin

- *Codes 30 -35 include:*
  Less than a wide excision or
  Less than or equal to 1 cm margin or
  Status of margin is unknown

- *If it is stated to be a WIDE EXCISION or REEXCISION, but the margins are unknown, code to 30.*

- *Assign a surgery code from the 30-35 range when any margin is less than 1 cm.*
- *Example: Melanoma: with surgical margins greater than 1 cm for length and width but less than 1 cm for depth. Assign a surgery code in the 30-35 range.*

  (Tumor thickness is an important prognostic factor for cutaneous melanoma, the deep margin is of particular importance.)

Specimen sent to pathology from surgical events 20-60

45 Wide excision or reexcision of lesion or minor (local) amputation with margins more than 1 cm, NOS, Margins MUST be microscopically negative.
- 46 WITH margins more than 1 cm and less than or equal to 2 cm
- 47 WITH margins greater than 2 cm

- *Assign code 45 when there is a wide excision AND it is known that the margins of excision are greater than 1 cm.*
- *If the excision does not have microscopically negative margins greater than 1 cm, use the appropriate code 20-36.*
- *Assign code 47 for amputation of finger.*
- *Example: Amputation of finger for subungual melanoma.*

60 Major amputation

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Breast
C50.0-C50.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

- *Tissue for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants). Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course treatment. When an expander is placed, code the mastectomy and the reconstruction.*

No specimen sent to pathology from surgical events coded 19*

00 None; no surgery of primary site; autopsy only
19 Local tumor destruction, NOS

- **Principally for cases diagnosed prior to January 1, 2003.*

Specimen sent to pathology from surgical events 20-80

20 Partial mastectomy, NOS; less than total mastectomy, NOS
- 21 Partial mastectomy WITH nipple resection
- 22 Lumpectomy or excisional biopsy
- 23 Reexcision of the biopsy site for gross or microscopic residual disease
- 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

- *Procedures coded 20-24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.*

30 Subcutaneous mastectomy

- *A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.*

40 Total (simple) mastectomy, NOS
- 41 WITHOUT removal of uninvolved contralateral breast
- 43 With reconstruction, NOS
  - 44 Tissue
  - 45 Implant
  - 46 Combined (Tissue and implant)
- 42 WITH removal of uninvolved contralateral breast
- 47 With reconstruction, NOS
  - 48 Tissue
  - 49 Implant
  - 75 Combined (Tissue and implant)

Specimen sent to pathology from surgical events 20-80

- *"Tissue" for reconstruction is defined as human thissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants). Placement of a tissue expander at the time of orginial surgery indicates that reconstruction is planned as part of the 1st course treatment.*

- *A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed.*

- *For single primaries only, code removal of the* ***involved*** *contralateral breast under the data item Rx Summ-Surg Oth Reg/Dis.*

- *Example: Inflammatory carcinoma involving both breasts. Bilateral simple mastectomies. Code Rx Summ-Surg Psite 41 and Rx Summ-Surg Oth Reg/Dis 1.*

- *If the contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.*

- *Reconstruction that is planned as part of first course treatment is coded 43-49 or 75, regardless of whether it is done at the time of mastectomy or later. Code 43-49 or 75 if the operative report or medical record states reconstruction will be done later, or if a tissue expander is inserted during the mastectomy procedure.*

76 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.

50 Modified radical mastectomy
- 51 WITHOUT removal of uninvolved contralateral breast
- 53 Reconstruction, NOS
  - 54 Tissue
  - 55 Implant
  - 56 Combined (Tissue and implant)

- 52 WITH removal of uninvolved contralateral breast
  - 57 Reconstruction, NOS
    - 58 Tissue
    - 59 Implant
    - 63 Combined (Tissue and implant)

- *Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not*

Specimen sent to pathology from surgical events 20-80

include a portion of the pectoralis major muscle. If only sentinel lymph nodes are removed, the procedure should be coded as a simple mastectomy.

- *"In continuity with" or "en bloc" means that all the tissues were removed during the same procedure, but not necessarily in a single specimen.*

- *Assign code 51 or 52 if a patient has an excisional biopsy and axillary dissection followed by a simple mastectomy during the first course of therapy.*

- *Code the cumulative result of the surgeries, which is a modified radical mastectomy in this case. Code the most invasive, extensive or definitive surgery in surgery in RX Summ-Surg Prim Site.*

- *If contralateral breast reveals a second primary, it is abstracted separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed for that site.*

- *For single primaries only, code removal of involved contralateral breast under the data item RX Summ--Surg Oth Reg/Dis.*

60 Radical mastectomy, NOS
- 61 WITHOUT removal of uninvolved contralateral breast
  - 64 Reconstruction, NOS
    - 65 Tissue
    - 66 Implant
    - 67 Combined (Tissue and implant)
- 62 WITH removal of uninvolved contralateral breast
  - 68 Reconstruction, NOS
    - 69 Tissue
    - 73 Implant
    - 74 Combined (Tissue and implant)

- *Involves removal of breast tissues, nipple, areolar complex, variable amount of skin, pectoralis minor, and/or pectoralis major, as well as en bloc axillary dissection.*

70 Extended radical mastectomy
- 71 WITHOUT removal of uninvolved contralateral breast
- 72 WITH removal of uninvolved contralateral breast

- *Involves removal of breast tissue, nipple, areolar complex, variable amounts of skin, pectoralis minor, and/or pectoralis major, as well as removal of internal mammary nodes and en bloc axillary dissection.*

Breast (Continued)		
Specimen sent to pathology from surgical events 20-80		
	80	Mastectomy, NOS
	90	Surgery, NOS
	99	Unknown if sugery performed; death certificate only

Cervix Uteri
C53.0-C53.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

- *For invasive cancers, dilation and curettage (D&C) is considered an incisional biopsy and not coded as a surgical procedure in this data field.*

No specimen sent to pathology from surgical events 10-17

00 None; no surgery of primary site; autopsy only
10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Laser ablation
- 17 Thermal ablation

Specimen sent to pathology from surgical events 20-74

20 Local tumor excision, NOS

- *Procedures in code 20 include but are not limited to: cryosurgery, electrocautery, excisional biopsy, laser ablation, or thermal ablation. Margins may be microscopically involved.*

26 Excisional biopsy, NOS
27 Cone biopsy
24 Cone biopsy WITH gross excision of lesion
29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27 or 29 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

25 Dilatation and curettage; endocervical curettage (for in situ ONLY)
28 Loop Electrocautery Excision Procedure (LEEP)

- *Margins of resection may have microscopic involvement.*

30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries

- *Total hysterectomy removes both the corpus and the cervix uteri and may also include a portion of the vaginal cuff.*

40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary

- *Total hysterectomy removes both the corpus and cervix uteri and may also include*

Specimen sent to pathology from surgical events 20-74

a portion of vaginal cuff.

50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 51 Modified radical hysterectomy
- 52 Extended hysterectomy
- 53 Radical hysterectomy; Wertheim procedure
- 54 Extended radical hysterectomy

60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
- 61 WITHOUT removal of tubes and ovaries
- 62 WITH removal of tubes and ovaries

70 Pelvic exenteration
- 71 Anterior exenteration

- *Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.*
- *Do not code removal of pelvic lymph nodes under RX Summ-- Surg Oth Reg/Dis*

- 72 Posterior exenteration

- *Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.*
- *Do not code removal of pelvic lymph nodes under RX Summ-- Surg Oth Reg/Dis*

- 73 Total exenteration

- *Includes removal of all pelvic contents and pelvic lymph nodes.*
- *Do not code removal of pelvic lymph nodes under RX Summ-- Surg Oth Reg/Dis*

74 Extended exenteration

- *Includes pelvic blood vessels or bony pelvis.*

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Corpus Uteri
C54.0-C55.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

- *For invasive cancers, dilation and curettage (D&C) is considered an incisional biopsy and not coded as a surgical procedure in this data field.*

Unknown whether a specimen was sent to pathology for surgical events coded 19*

00 None; no surgery of primary site; autopsy only

19 Local tumor destruction or excision, NOS

- **Principally for cases diagnosed prior to January 1, 2003.*

No specimen sent to pathology from surgical events 10-16

10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Thermal ablation

Specimen sent to pathology from surgical events 20-79

20 Local tumor excision, NOS; simple excision, NOS
- 24 Excisional biopsy
- 25 Polypectomy
- 26 Myomectomy

Any combination of 20 or 24-26 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

- *Margins of resection may have microscopic involvement*

30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies)
- 31 WITHOUT tube(s) and ovary(ies)
- 32 WITH tube(s) and ovary(ies)

- *For these procedures, the cervix is left in place*

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)

- *Removes both the corpus and cervix uteri. It may also include a portion of vaginal cuff.*

Specimen sent to pathology from surgical events 20-79

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)

- *Removes both the corpus and cervix uteri. It may also include a portion of vaginal cuff.*

60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 61 Modified radical hysterectomy
- 62 Extended hysterectomy
- 63 Radical hysterectomy; Wertheim procedure

- *Use code 63 for "Type III" hysterectomy*

- 64 Extended radical hysterectomy

65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)
- 66 WITHOUT removal of tube(s) and ovary(ies)
- 67 WITH removal of tube(s) and ovary(ies)

75 Pelvic exenteration
- 76 Anterior exenteration

- *Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.*

- *Do not code removal of pelvic lymph nodes under RX Summ-- Surg Oth Reg/Dis*

- 77 Posterior exenteration

- *Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.*

- *Do not code removal of pelvic lymph nodes under RX Summ-- Surg Oth Reg/Dis*

- 78 Total exenteration

- *Includes removal of all pelvic contents and pelvic lymph nodes.*

- *Do not code removal of pelvic lymph nodes under RX Summ-- Surg Oth Reg/Dis*

- 79 Extended exenteration

- *Includes pelvic blood vessels or bony pelvis.*

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Ovary
C56.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

No specimen sent to pathology from surgical event 17

00 None; no surgery of primary site; autopsy only

17 Local tumor destruction, NOS

Specimen sent to pathology from surgical events 25-80

25 Total removal of tumor or (single) ovary, NOS
- 26 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
- 27 WITHOUT hysterectomy
- 28 WITH hysterectomy

- *Use code 28 for current unilateral (salpingo-) oophorectomy with previous history of hysterectomy.*

35 Unilateral (salpingo-)oophorectomy; unknown if hysterectomy done
- 36 WITHOUT hysterectomy
- 37 WITH hysterectomy

- *Use code 37 for current unilateral (salpingo-) oophorectomy with previous history of hysterectomy.*

50 Bilateral (slapingo-)oophorectomy; unknown if hysterectomy done
- 51 WITHOUT hysterectomy
- 52 WITH hysterectomy

- *Use code 52 for current bilateral (salpingo-) oophorectomy with previous history of hysterectomy.*

55 Unilateral or bilateral (salpingo-)oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done
- 56 WITHOUT hysterectomy
- 57 WITH hysterectomy

- *Use code 57 for current unilateral (salpingo-) oophorectomy with previous history of hysterectomy.*

60 Debulking; cytoreductive surgery, NOS
- 61 WITH colon (including appendix) and/or small intestine resection (not incidental)
- 62 WITH partial resection of urinary tract (not incidental)

63 Combination of 61 and 62

- *Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.*

- *Debulking or cytoreductive surgery is implied by the following phrases in the operative report, pathology report, discharge summary, or consultation. (This is not intended to be a complete list. Other phrases may also imply debulking):*
  Adjuvant treatment pending surgical reduction of tumor
  Ovaries, tubes buried in tumor
  Tumor burden
  Tumor cakes
  Very large tumor mass

Specimen sent to pathology from surgical events 25-80

- *Do not code debulking or cytoreductive surgery based on: multiple biopsies alone, the mention of "multiple tissue fragments" or "removal of multiple implants." Multiple biopsies and multiple specimens confirm the presence of absence of metastasis.*

70 Pelvic exenteration, NOS

71 Anterior exenteration

- *Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.*

- *Do not code removal of pelvic lymph nodes under RX Summ-Surg Oth Reg/Dis*

72 Posterior exenteration

- *Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.*

- *Do not code removal of pelvic lymph nodes under RX Summ-Surg Other Reg/Dis*

73 Total exenteration

- *Includes removal of all pelvic contents and pelvic lymph nodes.*

- *Do not code removal of pelvic lymph nodes under Rx Summ-Surg Other Reg/Dis*

Ovary (Continued)	
Specimen sent to pathology from surgical events 25-80	74 Extended exenteration • *Includes pelvic blood vessels or bony pelvis.* 80 (Salpingo-)oophorectomy, NOS 90 Surgery, NOS 99 Unknown if sugery performed; death certificate only

Prostate
C61.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

- *Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item: RX Summ--Transplant/Endocr*

Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19*

00 None; no surgery of primary site; autopsy only
18 Local tumor destruction or excision, NOS
19 Transurethral resection (TURP), NOS, and no specimen sent to pathology or unknown if sent

- **Principally for cases diagnosed prior to January 1, 2003.*

No specimen sent to pathology from surgical events 10-17

10 Local tumor destruction (or excision), NOS
- 14 Cryoprostatectomy
- 15 Laser ablation
- 16 Hyperthermia
- 17 Other method of local tumor destruction

- *Assign code 15 for Niagara laser photovaporization of the prostate.*
- *Assign code 16 for Transurethral Microwave Thermotherapy (TUMT).*
- *Assign code 17 for High Intensity Focused Ultrasonography (HIFU) and for Transurethral Needle Ablation (TUNA).*

Specimen sent to pathology from surgical events 20-80

20 Local tumor excision, NOS
- 21 Transurethral resection (TURP), NOS, with specimen sent to pathology
- 22 TURP cancer is incidental finding during surgery for benign disease
- 23 TURP patient has suspected/ known cancer

Any combination of 20-23 WITH
- 24 Cryosurgery
- 25 Laser
- 26 Hyperthermia

30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

- *May include suprapubic prostatectomy*

50 Radical prostatectomy, NOS; total prostatectomy, NOS

- *Includes excision of the prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s); and may include a narrow cuff of bladder neck.*

Specimen sent to pathology from surgical events 20-80

70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration

- *Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to: cystoprostatectomy, radical cystectomy, and prostatectomy.*
- *In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen.*

80 Prostatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate only

Testis

C62.0-C62.9

(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

No specimen sent to pathology from surgical events

00 None; no surgery of primary site; autopsy only

12 Local tumor destruction, NOS

Specimen sent to pathology from surgical events 20-80

20 Local or partial excision of testicle

30 Excision of testicle WITHOUT cord

- *Orchiectomy not including spermatic cord*

40 Excision of testicle WITH cord or cord not mentioned (radical orchiectomy)

- *Orchiectomy with or without spermatic cord*

80 Orchiectomy, NOS (unspecified whether partial or total testicle removed)

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Kidney, Renal Pelvis, and Ureter
C64.9, C65.9, C66.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

No specimen sent to pathology from surgical events 10-15

00 None; no surgery of primary site; autopsy only
10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal ablation

Specimen sent to pathology from surgical events 20-80

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH:
- 21 Photodynamic Therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)

- *Procedures coded 30 include, but are not limited to:*
  Segmental resection
  Wedge resection

40 Complete/total/simple nephrectomy--for kidney parenchyma
Nephroureterectomy

- *Includes bladder cuff for renal pelvis or ureter.*

50 Radical nephrectomy

- *May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter.*

70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with the resection of other organ(s) (colon, bladder)

- *The other organs, such as colon or bladder, may be partially or totally removed.*
- *"In continuity with" or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen.*

Specimen sent to pathology from surgical events 20-80

80	Nephrectomy, NOS Ureterectomy, NOS
90	Surgery, NOS
99	Unknown if sugery performed; death certificate only

Bladder

C67.0-C67.9

(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

No specimen sent to pathology from surgical events 10-16

00 None; no surgery of primary site; autopsy only

10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Intravesical therapy
- 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy

- *Also code the BCG/ introduction of immunotherapy in the RX Summ-BRM field. However, if immumotherapy is followed by surgery of the type coded 20-80, code that surgery instead and code the immunotherapy only in the RX Summ-BRM field.*

Specimen sent to pathology from surgical events 20-80

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

- *Code TURB as 27*

Any combination of 20 or 26-27 WITH:
- 21 Photodynamic Therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Complete cystectomy with reconstruction

- *Use code 71 for cystoprostatectomy*

- 61 Radical cystectomy PLUS ileal conduit
- 62 Radical cystectomy PLUS continent reservoir or pouch, NOS
- 63 Radical cystectomy PLUS abdominal pouch (cutaneous)
- 64 Radical cystectomy PLUS in situ pouch (orthotopic)

- *When the procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64).*

Specimen sent to pathology from surgical events 20-80

70 Pelvic exenteration, NOS

71 Radical cystectomy including anterior exenteration

- *Use code 71 for cystoprostatectomy*
- *For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra. For males, includes removal of the prostate. When a procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy.*

72 Posterior exenteration

- *For females, also includes removal of vagina, rectum and anus. For males, also includes prostate, rectum, and anus.*

73 Total exenteration

- *Includes all tissue and organs removed for an anterior and posterior exenteration.*
- *Includes removal of all pelvic contents and pelvic lymph nodes. The lymph node dissection should also be coded under RX Summ-Scope of Reg LN Surg*

74 Extended exenteration

- *Includes pelvic blood vessels or bony pelvis*

80 Cystectomy, NOS

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Brain, Meninges, Spinal Cord, Cranial Nerves, and Other Parts of Central Nervous System
C70.0-C70.9, C71.0-C71.9. C72.0-C72.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

- *Do not code laminectomies for spinal cord primaries.*

No specimen sent to pathology from surgical event 10

00 None; no surgery of primary site; autopsy only

10 Tumor destruction, NOS
Local tumor destruction, NOS; laser interstitial thermal therapy (LITT)-- code 10 if no specimen set to pathology

- *Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as surgical tumor destruction. All of these modalities are recorded in the radiation treatment fields.*

Specimen sent to pathology from surgical events 20-55

20 Local excision of tumor, lesion or mass; excisional biopsy
- 21 Subtotal resection of tumor, lesion or mass in brain
- 22 Resection of tumor of spinal cord or nerve

- *Assign code 20 for stereotactic biopsy of brain tumor*

30 Radical, total, gross resection of tumor, lesion or mass in brain

40 Partial resection of lobe of brain, when the surgery can not be coded as 20-30.

55 Gross total resection of lobe of brain (lobectomy)

- *Codes 30-55 are not applicable for spinal cord or spinal nerve primary sites.*

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Thyroid Gland
C73.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

No specimen sent to pathology from surgical event 13

- 00 None; no surgery of primary site; autopsy only
- 13 Local tumor destruction, NOS

Specimen sent to pathology from surgical events 25-80

- 25 Removal of less than a lobe, NOS
  - 26 Local surgical excision
  - 27 Removal of a partial lobe ONLY
- 20 Lobectomy and/or isthmectomy
  - 21 Lobectomy ONLY
  - 22 Isthmectomy ONLY
  - 23 Lobectomy WITH isthmus
- 30 Removal of a lobe and partial removal of the contralateral lobe
- 40 Subtotal or near total thyroidectomy
- 50 Total thyroidectomy
- 80 Thyroidectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if sugery performed; death certificate only

Lymph Nodes
C77.0-C77.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Unknown whether a specimen was sent to pathology for surgical events coded 19*

00 None; no surgery of primary site; autopsy only

19 Local tumor destruction or excision, NOS

- **Principally for cases diagnosed prior to January 1, 2003.*

No specimen sent to pathology from surgical event 15

15 Local tumor desctruction, NOS

Specimen sent to pathology from surgical events 25-62

25 Local tumor excision, NOS

- *Less than a full chain, includes an excisional biopsy of a single lymph node.*
- *The use of code 25 in Rx Summ-Surg Prim Site is for a primary in one and only one lymph node. The single involved lymph node is removed by an excisional biopsy only.*

30 Lymph node dissection, NOS
- 31 One chain
- 32 Two or more chains

40 Lymph node dissection, NOS PLUS splenectomy
- 41 One chain
- 42 Two or more chains

50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
- 51 One chain
- 52 Two or more chains

60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy (Includes staging laparotomy for lymphoma).
- 61 One chain
- 62 Two or more chains

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

All Other Sites

C14.2-C14.8, C17.0-C17.9, C23.9, C24.0-C24.9, C26.0-C26.9, C30.0-C30.1, C31.0-C31.9, C33.9, C37.9, C38.0-C38.8, C39.0-C39.9, C48.0-C48.8, C51.0-C51.9, C52.9, C57.0-C57.9, C58.9, C60.0-C60.9, C63.0-C63.9, C68.0-C68.9, C69.0-C69.9, C74.0-C74.9, C75.0-C75.9
(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

No specimen sent to pathology from surgical events 10-14

00 None; no surgery of primary site; autopsy only

10 Local tumor destruction, NOS
- 11 Photodynamic Therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

- Assign code 14 for laser hyperthermia of eye for retinoblastoma

Specimen sent to pathology from surgical events 20-60

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH:
- 21 Photodynamic Therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation
- 41 Total enucleation (for eye surgery only)

50 Surgery stated to be "debulking"

60 Radical surgery

- *Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.*

- *In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen*

90 Surgery, NOS

99 Unknown if sugery performed; death certificate only

Unknown and Ill-Defined Primary Sites

C76.0-C76.8, C80.9

(Except for M-9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

98 All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment

- *Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item: RX Summ-- Surg Oth Reg/Dis.*

99 Death certificate only

Appendix D

Race and Nationality Descriptions From the 2000 Census and Bureau of Vital Statistics

Revised August 25, 2010

Appendix D

Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics

Note: Use these lists only when race is not stated but other information is provided in the medical record.

References:

1. "Race and Ethnicity Code Set, Version 1.0," Centers for Disease Control and Prevention, March 2000.
2. "Instruction manual, part 4: Classification and Coding Instructions for Death Records, 1999-2001," Division of Vital Statistics, National Center for Health Statistics, undated

Key:
+ Use this code unless patient is stated to be Native American (Indian)
* Term listed in reference 2, above.
^ Description of religious affiliation rather than stated nationality or ethnicity, should be used with caution when determining appropriate race code.

Code 01 White:

Afghan, Afghanistani
Afrikaner
Albanian
Algerian*
Amish*
Anglo-Saxon*
Arab, Arabian
Argentinian*+
Armenian
Assyrian
Australian*
Austrian*
Azores*
Basque*
Bavarian*
Bolivian*+
Bozniak/Bosnian
Brava/Bravo*
Brazilian+
Bulgarian
Cajun
Californio
Canadian*

Code 01 White (Continued):

Caucasian*
Central American+
Chechnyan
Chicano*
Chilean+
Colombian*+
Costa Rican*+
Creole*
Croat/Croatian
Crucian*
Cuban (unless specified as Black)*
Cypriot
Czechoslovakian*
Eastern European
Ebian*
Ecuadorian*+
Egyptian
English
English-French*
English-Irish*
European*
Finnish*
French
French Canadian*
Georgian*
German
Greek*
Guatemalan+
Gypsy*
Hebrew*‡
Herzegovenian
Hispanic*
Honduran†
Hungarian*
Iranian, Iran
Iraqi
Irish
Islamic*^
Israeli
Italian
Jordanian*
Kurd/Kurdish
Kuwaitian*
Ladina/Ladino*
Latin American*+
Latino

Code 01 White (Continued):

Latvian*
Lebanese
Libyan*
Lithuanian*
Maltese*
Marshenese*
Mauritian*
Moroccan*
Mediterranean*
Mexican+
Middle Eastern
Moroccan*
Moslem*^
Muslim*
Near Easterner
Nicaraguan+
Nordic*
North African
Norwegian*
Other Arab
Palestinian
Panamanian+
Paraguayan+
Parsi*
Persian*
Peruvian*+
Polish
Portuguese*
Puerto Rican (unless specified as Black)
Romanian*
Rumanian
Russian*
Salvadoran+
Saudi Arabian*
Scandanavian*
Scottish, Scotch
Semitic*^
Serbian*
Servian*
Shi'ite^
Sicilian*
Slavic, Slovakian*
South American+
Spanish*, Spaniard
Sunni*^
Swedish*

Code 01 White (Continued):

Syrian
Tunisian*
Turkish, Turk*
Ukranian*
United Arab Emirati
Uruguayan+
Venezuelan*+
Welsh*
White
Yemenite*
Yugoslavian*
Zoroastrian*

Code 2 Black or African American:

African
African American
Afro-American
Bahamian
Barbadian
Bilalian*
Black
Botswana
Cape Verdean*
Dominica Islander (unless specified as White)
Dominican/Dominican Republic (unless specified as White)
Eritrean*
Ethiopian
Ghanian*
Haitian
Hamitic*
Jamaican
Kenyan*
Liberian
Malawian*
Mugandan*
Namibian
Nassau*
Negro
Nigerian
Nigritian
Nubian*
Other African
Santo Domingo*

Code 2 Black or African American (Continued):

Seychelloise*
Sudanese*
Tanzanian*
Tobagoan
Togolese*
Trinidadian
West Indian
Zairean

Code 3 American Indian and Alaska Native:
(See separate list of tribes)

Alaska Native
Aleut
American Indian
Central American Indian
Eskimo
Meso American Indian
Mexican American Indian
South American Indian
Spanish American Indian

Asian Race Codes:

Code	Definition
96	Amerasian
16	Asian Indian (Effective with 1/1/2010 dx.)
96	Asian
96	Asiatic
96	Bangladeshi
96	Bhutanese
96	Bornean
96	Bruneian
96	Burmese
13	Cambodian
96	Celebesian
96	Ceram
96	Ceylonese
04	Chinese
96	Eurasian
06	Filipino
12	Hmong
16	Indian (from India) (Effective with 1/1/2010 dx.)

Asian Race Codes (Continued):

96	Indo-Chinese
96	Indonesian
05	Iwo Jiman
05	Japanese
96	Javanese
13	Kampuchean
08	Korean
11	Laotian
96	Maldivian
96	Madagascar
96	Malaysian
96	Mongolian
96	Montagnard
96	Nepalese
05	Okinawan
96	Oriental
96	Other Asian
17	Pakistani (Effective with 1/1/2010 dx.)
96	Sikkimese
96	Singaporean
96	Sri Lankan
96	Sumatran
04	Taiwanese
14	Thai
96	Tibetan
10	Vietnamese
96	Whello
96	Yello

Native Hawaiian and Other Pacific Islander Codes:

Code	Definition
20	Bikinian
20	Carolinian
21	Chamorro
20	Chuukese
25	Cook Islander
20	Eniwetok, Enewetak
31	Fijian
22	Guamanian
07	Hawaiian

Native Hawaiian and Other Pacific Islander Codes (Continued):

20	Kirabati
20	Kosraean
20	Kwajalein
97	Maori
20	Mariana Islander
20	Marshallese
30	Melanesian
20	Micronesian, NOS
07	Native Hawaiian
97	Nauruan
30	New Caledonian
30	New Hebrides
97	Other Pacific Islander
97	Pacific Islander
20	Palauan
32	Papua New Guinean
07	Part Hawaiian
20	Pohnpeian
25	Polynesian
20	Ponapean
20	Saipanese
27	Samoan
30	Solomon Islander
26	Tahitian
20	Tarawan
20	Tinian
25	Tokelauan
28	Tongan
20	Trukese
25	Tuvaluan
30	Vanuatuan
20	Yapese

Other Race, Not Elsewhere Classified: 98
(Do not use this code for Hispanic, Latino, or Spanish, NOS.)

Unknown: 99
(See Note 1 and Note 2 below.)

Other Race Descriptions:

Note 1: The following descriptions of ethnic origin cannot be coded to a specific race code. Look for other descriptions of race in the medical record. If no further information is available, code as 99 (Unknown).

Aruba Islander
Azerbaijani
Belizean
Bermudan
Cayenne
Cayman Islander
Guyanese
Indian (not specified as Native American, Eastern Indian, Northern, Central, or South American Indian)
Mestizo
Morena
South African
Surinam
Tejano

Note 2: The following terms self-reported in the 2000 Census cannot be coded to a specific race code. Look for other descriptions of race in the medical record. If no further information is available, code as 99 (Unknown).

Biracial
Interracial
Mixed
Multiethnic
Multinational
Multiracial

Indian Tribes of the United States, Canada and Mexico (Race Code 03):

Source: National Center for Health Statistics: Appendix C, Instruction Manual, part 4: Classification and Coding Instructions For Death Records, 1999-2001.

Abnaki
Absentee-Shawnee
Acoma
Ak Chin
Alabama-Coushatt Tribes of Texas
Alsea
Apache
Arapaho

Indian Tribes of the United States, Canada and Mexico (Race Code 03)(Continued):

Arikara
Assiniboin
Atacapa
Athapaskan
Atsina
Aztec
Bear River
Beaver
Bella Coola
Beothuk
Blackfoot
Boold Piegan
Blue Lake
Brotherton
Caddo
Cakchiquel-lenca
Calapooya
Carrier
Catawba
Cattaraugus
Cayuga
Cayuse
Chasta Costa
Chehalis
Chemehuevi
Cherokee
Chetco
Cheyenne
Cheyenne River Sioux
Chickahominy
Chickasaw
Chinook
Chipewyan
Chippewa
Chippewa-Ojibwa
Chiricahua Apache
Chitimacha
Choctaw
Chol
Chontal
Chorti
Chuckchansi
Chumash
Clallam
Clatsop
Clackamus

Indian Tribes of the United States, Canada and Mexico (Race Code 03)(Continued):

Clear Lake
Coast Salish
Cochimi
Cochiti
Cocopa
Coeur D'Alene Tribe of Idaho
Cocopah
Columbia
Colville
Comox
Comanche
Concow
Conquille
Coushatta
Covelo
Cow Creek
Cowichan
Cowlitz
Coyotero Apache
Cree
Creek
Crow
Crow Creek Sioux
Dakota
Delaware
Diegueno
Digger
Dog Rib
Duckwater
Eskimo
Euchi
Eyak
Flathead
Fort Hall Res. Tribe of Idaho
French Indian
Gabrieleno
Galice Creek
Gay Head
Gosiute
Gros Ventre
Haida
Han
Hare
Hat Creek
Hawasupai
Hidatsa

Indian Tribes of the United States, Canada and Mexico (Race Code 03)(Continued):

Hoh
Hoopa
Hopi
Houma
Hualapai
Huastec
Humboldt Bay
Hupa
Huron
Illinois
Ingalik
Iowa
Iroquois
Isleta
Jemez
Joshua
Juaneno
Jicarilla Apache
Kaibah
Kalispel
Kanosh Band of Paiutes
Kansa
Karankawa
Karok
Kaska
Kaw
Kawai
Keresan Pueblos
Kern River
Kichai
Kickapoo
Kiowa
Kiowa Apache
Kitamat
Klamath
Klikitat
Koasati
Kootenai Tribe of Idaho
Kusa
Kutchin
Kutenai
Kwakiutl
Lac Courte Dreille
Laguna
Lakmuit
Lipan Apache

Indian Tribes of the United States, Canada and Mexico (Race Code 03)(Continued):

Lower Brule Sioux
Luiseno
Lummi
Maidu
Makah
Malecite
Mandan
Maricopa
Mary's River
Mashpee
Mattaponi
Maya
Mayo
Mdewakanton Sioux
Menominee
Menomini
Mequendodon
Mescalero Apache
Miami
Micmac
Mission Indians
Missouri
Miwok
Mixe
Mixtec
Modoc
Mohave
Mohawk
Mohegan
Molala
Monachi
Mono
Montagnais
Montauk
Muckleshoot
Munsee
Nambe
Namsemond
Nanticoke
Narragansett
Naskapi
Natchez
Navaho
Navajo
Nez Perce
Niantic

Indian Tribes of the United States, Canada and Mexico (Race Code 03)(Continued):

Nipmuck
Nisenan-Patwin
Nisqually
Nomelaki
Nooksak
Nootka
Northern Paiute
Oglala Sioux
Okanogan
Omaha
Oneida
Onondaga
Opata
Opato
Osage
Oto
Otoe
Otomi
Ottawa
Ozette
Paiute
Pamunkey
Panamint
Papago
Passamaquoddy
Patwin
Pawnee
Pen d'Oreille
Penobscot
Peoria
Pequot
Picuris
Pima
Pit River
Pojoaque
Pomo
Ponca
Poosepatuck
Potawatomi
Potomac
Powhatan
Pueblos
Puyallup
Quapaw
Quechan
Quileute

Indian Tribes of the United States, Canada and Mexico (Race Code 03)(Continued):

Quinaielt
Quinault
Rappahannock
Rogue River
Rosebud Sioux
Sac and Fox
Saginaw
Salish
Sandia
San Felipe
San Ildefonso
San Juan
San Lorenzo
San Luis Obispo
San Luiseno
Sanpoil
Sanpoil Nespelem
Sant'ana
Santa Barbara
Santa Clara
Santa Ynez
Santee
Santee Sioux
Santiam
Sauk and Fox
Scaticook
Sekane
Seminole
Seneca
Seri
Shasta
Shawnee
Shinnecock
Shivwits Band of Paiutes
Shoshone
Shoshone-Bannock
Shuswap
Siouans
Sioux
Sisseton
Sisseton-Wahpeton Sioux
Siuslaw
Skagit Suiattle
Skokomish
Slave
Smith River

Indian Tribes of the United States, Canada and Mexico (Race Code 03)(Continued):

Snake
Snohomish
Snoqualmi
Songish Southern Paiute
Squaxin
Stockbridge
Sumo-Mosquito
Suquamish
Swinomish
Taimskin
Tanana
Tanoan Pueblos
Taos
Tarahumare
Tarascan
Tawakoni
Tejon
Tenino or Warm Springs
Tesuque
Teton
Teton Sioux
Tillamook
Timucua
Thlinget
Tolowa
Tonawanda
Tonkawa
Tonto Apache
Topinish
Totonac
Tsimshian
Tulalip
Tule River Indians
Tunica
Tuscarora
Tututni
Umatilla
Umpqua
Upper Chinook
Ute
Waca
Waicuri-Pericue
Wailaki
Walapai
Walla Walla
Wampanoag

Indian Tribes of the United States, Canada and Mexico (Race Code 03)(Continued):

Wapato
Warm Springs
Wasco
Washo
Washoe
Western Apache
Western Shoshone
Whilkut
Wichita
Wikchamni
Wind River Shoshone
Winnebago
Wintu
Wintun
Wishram
Wyandotte
Xicaque
Yahooskin
Yakima
Yamel
Yana
Yankton
Yanktonnais Sioux
Yaqui
Yaquina
Yavapai
Yawilmani
Yellow Knife
Yerington Paiute
Yokuts
Yokuts-Mono
Yomba Shoshone
Yuchi
Yuki
Yuma
Yurok
Zacatec
Zapotec
Zia
Zoque
Zuni

Alphabetic Index to Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics

A

03	Abnaki
03	Absentee -Shawnee
03	Acoma
01	Afghan, Afghanistani
02	African
02	African American
01	Afrikaner
02	Afro-American
03	Ak Chin
03	Alabama –Coushatt Tribes of Texas
03	Alaska Native
01	Albanian
03	Aleut
01	Algerian*
03	Alsea
96	Amerasian
03	American Indian
01	Amish*
01	Anglo-Saxon*
03	Apache
01	Arab, Arabian
03	Arapaho
01	Argentinian*+
03	Arikara
01	Armenian
96	Asian
16	Asian Indian (Effective with 1/1/2010 dx.)
96	Asiatic
03	Assiniboin
01	Assyrian
03	Atacapa
03	Athapaskan
03	Atsina
01	Australian*
01	Austrian*
01	Azores*
03	Aztec

B

02	Bahamian

96	Bangladeshi
02	Barbadian
01	Basque*
01	Bavarian*
03	Bear River
03	Beaver
03	Bella Coola
03	Beothuk
96	Bhutanese
20	Bikinian
02	Bilalian*
02	Black
03	Blackfoot
03	Blue Lake
01	Bolivian*+
03	Boold Piegan
96	Bornean
02	Botswana
01	Bozniak/Bosnian
01	Brava/Bravo*
01	Brazilian
03	Brotherton
96	Bruneian
01	Bulgarian
96	Burmese

C

03	Caddo
01	Cajun
03	Cakchiquellenca
03	Calapooya
01	Californio
13	Cambodian
01	Canadian*
02	Cape Verdean*
20	Carolinian
03	Carrier
03	Catawba
03	Cattaraugus
01	Caucasian*
03	Cayuga
03	Cayuse
96	Celebesian
01	Central American+
03	Central American Indian
96	Ceram

96	Ceylonese
21	Chamorro
03	Chasta Costa
01	Chechnyan
03	Chehalis
03	Chemehuevi
03	Cherokee
03	Chetco
03	Cheyenne
03	Cheyenne River Sioux
01	Chicano*
03	Chickahominy
03	Chickasaw
01	Chilean+
04	Chinese
03	Chinook
03	Chipewyan
03	Chippewa
03	Chippewa -Ojibwa
03	Chiricahua Apache
03	Chitimacha
03	Choctaw
03	Chol
03	Chontal
03	Chorti
03	Chuckchansi
03	Chumash
20	Chuukese
03	Clackamus
03	Clallam
03	Clatsop
03	Clear Lake
03	Coast Salish
03	Cochimi
03	Cochiti
03	Cocopa
03	Cocopah
03	Coeur D'Alene Tribe of Idaho
01	Colombian*+
03	Columbia
03	Colville
03	Comanche
03	Comox
03	Concow
03	Conquille
25	Cook Islander
01	Costa Rican*+
03	Coushatta

03	Covelo
03	Cow Creek
03	Cowichan
03	Cowlitz
03	Coyotero Apache
03	Cree
03	Creek
01	Creole*
01	Croat/Croatian
03	Crow
03	Crow Creek Sioux
01	Crucian*
01	Cuban (unless specified as Black)*
01	Cypriot
01	Czechoslovak -ian*

D

03	Dakota
03	Delaware
03	Diegueno
03	Digger
03	Dog Rib
02	Dominica Islander(unless specified as White)
02	Dominican/Dominican Republic (unless specified as White)
03	Duckwater

E

01	Eastern European
01	Ebian*
01	Ecuadorian*+
01	Egyptian
01	English
01	English-French*
01	English-Irish*
20	Eniwetok, Enewetak
02	Eritrean*
03	Eskimo
02	Ethiopian
03	Euchi
96	Eurasian
01	European*
03	Eyak

F

31	Fijian
06	Filipino
01	Finnish*
03	Flathead
03	Fort Hall Res. Tribe of Idaho
01	French
01	French Canadian*
03	French Indian

G

03	Gabrieleno
03	Galice Creek
03	Gay Head
01	Georgian*
01	German
02	Ghanian*
03	Gosiute
01	Greek*
03	Gros Ventre
22	Guamanian
01	Guatemalan+
01	Gypsy*

H

03	Haida
02	Haitian
02	Hamitic*
03	Han
03	Hare
03	Hat Creek
07	Hawaiian
03	Hawasupai
01	Hebrew*^
01	Herzegovenian
03	Hidatsa
01	Hispanic*
12	Hmong
03	Hoh
01	Honduran+
03	Hoopa
03	Hopi
03	Houma
03	Hualapai

03	Huastec
03	Humboldt Bay
01	Hungarian*
03	Hupa
03	Huron

I

03	Illinois
16	Indian (from India) (Effective with 1/1/2010 dx.)
96	Indo-Chinese
96	Indonesian
03	Ingalik
03	Iowa
01	Iranian, Iran
01	Iraqi
01	Irish
03	Iroquois
01	Islamic*^
03	Isleta
01	Israeli
01	Italian
05	Iwo Jiman

J

02	Jamaican
05	Japanese
96	Javanese
03	Jemez
03	Jicarilla Apache
01	Jordanian*
03	Joshua
03	Juaneno

K

03	Kaibah
03	Kalispel
13	Kampuchean
03	Kanosh Band of Paiutes
03	Kansa
03	Karankawa

03	Karok
03	Kaska
03	Kaw
03	Kawai
02	Kenyan*
03	Keresan Pueblos
03	Kern River
03	Kichai
03	Kickapoo
03	Kiowa
03	Kiowa Apache
20	Kirabati
03	Kitamat
03	Klamath
03	Klikitat
03	Koasati
03	Kootenai Tribe of Idaho
08	Korean
20	Kosraean
01	Kurd/Kurdish
03	Kusa
03	Kutchin
03	Kutenai
01	Kuwaitian*
20	Kwajalein
03	Kwakiutl

L

03	Lac Courte Dreille
01	Ladina/Ladino*
03	Laguna
03	Lakmuit
11	Laotian
01	Latin American*+
01	Latino/Latina
01	Latvian*
01	Lebanese
02	Liberian
01	Libyan*
03	Lipan Apache
01	Lithuanian*
03	Lower Brule Sioux
03	Luiseno
03	Lummi

M

96	Madagascar
03	Maidu
03	Makah
02	Malawian*
96	Malaysian
96	Maldivian
03	Malecite
01	Maltese*
03	Mandan
97	Maori
20	Mariana Islander
03	Maricopa
20	Marshallese
01	Marshenese*
03	Mary's River
03	Mashpee
03	Mattaponi
01	Mauritian*
03	Maya
03	Mayo
03	Mdewakanton Sioux
01	Mediterranean*
30	Melanesian
03	Menominee
03	Menomini
03	Mequendodon
03	Mescalero Apache
03	Meso American Indian
01	Mexican+
03	Mexican American Indian
03	Miami
03	Micmac
20	Micronesian, NOS
01	Middle Eastern
03	Mission Indians
03	Missouri
03	Miwok
03	Mixe
03	Mixtec
03	Modoc
03	Mohave
03	Mohawk
03	Mohegan
03	Molala
03	Monachi
96	Mongolian
03	Mono

03	Montagnais
96	Montagnard
03	Montauk
01	Moroccan*
01	Moroccan*
01	Moslem*^
03	Muckleshoot
02	Mugandan*
03	Munsee
01	Muslim*^

N

03	Nambe
02	Namibian
03	Namsemond
03	Nanticoke
03	Narragansett
03	Naskapi
02	Nassau*
03	Natchez
07	Native Hawaiian
97	Nauruan
03	Navaho
03	Navajo
01	Near Easterner
02	Negro
96	Nepalese
30	New Caledonian
30	New Hebrides
03	Nez Perce
03	Niantic
01	Nicaraguan+
02	Nigerian
02	Nigritian
03	Nipmuck
03	Nisenan-Patwin
03	Nisqually
03	Nomelaki
03	Nooksak
03	Nootka
01	Nordic*
01	North African
03	Northern Paiute
01	Norwegian*
02	Nubian

O

03	Oglala Sioux
03	Okanogan
05	Okinawan
03	Omaha
03	Oneida
03	Onondaga
03	Opata
03	Opato
96	Oriental
03	Osage
02	Other African
01	Other Arab
96	Other Asian
97	Other Pacific Islander
98	Other race, not elsewhere classified
03	Oto
03	Otoe
03	Otomi
03	Ottawa
03	Ozette

P

97	Pacific Islander
03	Paiute
17	Pakistani (Effective with 1/1/2010 dx.)
20	Palauan
01	Palestinian
03	Pamunkey
01	Panamanian+
03	Panamint
03	Papago
32	Papua New Guinean
01	Paraguayan+
01	Parsi*
07	Part Hawaiian
03	Passamaquoddy
03	Patwin
03	Pawnee
03	Pen d'Oreille
03	Penobscot
03	Peoria
03	Pequot
01	Persian*

01	Peruvian*+
03	Picuris
03	Pima
03	Pit River
20	Pohnpeian
03	Pojoaque
01	Polish
25	Polynesian
03	Pomo
20	Ponapean
03	Ponca
03	Poosepatuck
01	Portuguese*
03	Potawatomi
03	Potomac
03	Powhatan
03	Pueblos
01	Puerto Rican (unless specified as Black)
03	Puyallup

Q

03	Quapaw
03	Quechan
03	Quileute
03	Quinaielt
03	Quinault

R

03	Rappahannock
03	Rogue River
01	Romanian*
03	Rosebud Sioux
01	Rumanian
01	Russian*

S

03	Sac and Fox
03	Saginaw
20	Saipanese
03	Salish
01	Salvadoran+
27	Samoan

03	San Felipe
03	San Ildefonso
03	San Juan
03	San Lorenzo
03	San Luis Obispo
03	San Luiseno
03	Sandia
03	Sanpoil
03	Sanpoil Nespelem
03	Santa Barbara
03	Santa Clara
03	Santa Ynez
03	Sant'ana
03	Santee
03	Santee Sioux
03	Santiam
02	Santo Domingo*
01	Saudi Arabian*
03	Sauk and Fox
01	Scandanavian*
03	Scaticook
01	Scottish, Scotch
03	Sekane
03	Seminole
01	Semitic*^
03	Seneca
01	Serbian*
03	Seri
01	Servian*
02	Seychelloise*
03	Shasta
03	Shawnee
01	Shi'ite^
03	Shinnecock
03	Shivwits Band of Paiutes
03	Shoshone
03	Shoshone-Bannock
03	Shuswap
01	Sicilian*
96	Sikkimese
96	Singaporean
03	Siouans
03	Sioux
03	Sisseton
03	Sisseton -Wahpeton Sioux
03	Siuslaw
03	Skagit Suiattle
03	Skokomish

03	Slave
01	Slavic, Slovakian*
03	Smith River
03	Snake
03	Snohomish
03	Snoqualmi
30	Solomon Islander
03	Songish Southern Paiute
01	South American
03	South American Indian
03	Spanish American Indian
01	Spanish*, Spaniard
03	Squaxin
96	Sri Lankan
03	Stockbridge
02	Sudanese*
96	Sumatran
03	Sumo-Mosquito
01	Sunni*^
03	Suquamish
01	Swedish*
03	Swinomish
01	Syrian

T

26	Tahitian
03	Taimskin
04	Taiwanese
03	Tanana
03	Tanoan Pueblos
02	Tanzanian*
03	Taos
03	Tarahumare
03	Tarascan
20	Tarawan
03	Tawakoni
03	Tejon
03	Tenino or Warm Springs
03	Tesuque
03	Teton
03	Teton Sioux
14	Thai
03	Thlinget
96	Tibetan
03	Tillamook
03	Timucua

20	Tinian
02	Tobagoan
02	Togolese*
25	Tokelauan
03	Tolowa
03	Tonawanda
28	Tongan
03	Tonkawa
03	Tonto Apache
03	Topinish
03	Totonac
02	Trinidadian
20	Trukese
03	Tsimshian
03	Tulalip
03	Tule River Indians
03	Tunica
01	Tunisian*
01	Turkish, Turk*
03	Tuscarora
03	Tututni
25	Tuvaluan

U

01	Ukranian*
03	Umatilla
03	Umpqua
01	United Arab Emirati
03	Upper Chinook
01	Uruguayan+
03	Ute

V

30	Vanuatuan
01	Venezuelan*+
10	Vietnamese

W

03	Waca
03	Waicuri-Pericue

03	Wailaki
03	Walapai
03	Walla Walla
03	Wampanoag
03	Wapato
03	Warm Springs
03	Wasco
03	Washo
03	Washoe
01	Welsh*
02	West Indian
03	Western Apache
03	Western Shoshone
96	Whello
03	Whilkut
01	White
03	Wichita
03	Wikchamni
03	Wind River Shoshone
03	Winnebago
03	Wintu
03	Wintun
03	Wishram
03	Wyandotte

X

03	Xicaque

Y

03	Yahooskin
03	Yakima
03	Yamel
03	Yana
03	Yankton
03	Yanktonnais Sioux
20	Yapese
03	Yaqui
03	Yaquina
03	Yavapai
03	Yawilmani
96	Yello
03	Yellow Knife
01	Yemenite*
03	Yerington Paiute

03	Yokuts
03	Yokuts-Mono
03	Yomba Shoshone
03	Yuchi
01	Yugoslavian*
03	Yuki
03	Yuma
03	Yurok

Z

03	Zacatec
02	Zairean
03	Zapotec
03	Zia
03	Zoque
01	Zoroastrian*^
03	Zuni

Appendix E

Schema Names, Site Codes, and Other Characteristics of CS Schemas

Appendix E
Schema Names, Site Codes, and Other Characteristics of CS Schemas

Column Definitions:

- **ICD-O Codes-** Topography codes for which schema is applicable
- **Schema Name-** Name of schema in computer algorithm
- **No TNM Mapping-** Schemas which have no mapping to T, N, M and/or Stage Group, by TNM edition
- **Histology Specific-** Schemas for which ICD-O morphology code is important
- **Size necessary for T-** Schemas for which size is a critical part of correct mapping of T (Tumor) category in TNM
- **Number of SSFs-** Number of site-specific factors used in CSv2; does not include SSFs made obsolete. For list of SSFs by schema and name, see Appendix 7 of the Collaborative Stage manual.

ICD-O Codes	Schema Name	No TNM Mapping	Histology Specific	Size necessary for T	Number of SSFs
	* Schema discriminator (SSF25) required	6-6th ed only 7-7th ed only X-both 6th and 7th eds		6-6th ed only 7-7th ed only Y-both 6th and 7th eds	
C00.0, C00.3	LipUpper		Y	Y	10
C00.0, C00.3	MelanomaLipUpper	6	Y		10
C00.1, C00.4, C00.6	LipLower		Y	Y	10
C00.1, C00.4, C00.6	MelanomaLipLower	6	Y		10
C00.2, C00.5, C00.8-C00.9	LipOther		Y	Y	10
C00.2, C00.5, C00.8-C00.9	MelanomaLipOther	6	Y		10
C01.9,	TongueBase			Y	9

C02.4					
C01.9, C02.4	MelanomaTongueBase	6	Y		10
C02.0-C02.3, C02.8-C02.9	TongueAnterior		Y	Y	10
C02.0-C02.3, C02.8-C02.9	MelanomaTongueAnterior	6	Y		10
C03.0	GumUpper		Y	Y	10
C03.0	MelanomaGumUpper	6	Y		10
C03.1, C06.2	GumLower		Y	Y	9
C03.1, C06.2	MelanomaGumLower	6	Y		10
C03.9	GumOther		Y	Y	10
C03.9	MelanomaGumOther	6	Y		10
C04.0-C04.1, C04.8-C04.9	FloorMouth		Y	Y	10
C04.0-C04.1, C04.8-C04.9	MelanomaFloorMouth	6	Y		10
C05.0	PalateHard		Y	Y	10
C05.0	MelanomaPalateHard	6	Y		10
C05.1-C05.2	PalateSoft		Y	Y	9
C05.1-C05.2	MelanomaPalateSoft	6	Y		10
C05.8-C05.9, C06.8-C06.9	MouthOther		Y	Y	10
C05.8-C05.9, C06.8-C06.9	MelanomaMouthOther	6	Y		10
C06.0-C06.1	BuccalMucosa		Y	Y	10
C06.0-C06.1	MelanomaBuccalMucosa	6	Y		10
C07.9	ParotidGland			Y	8
C08.0	SubmandibularGland		Y	Y	8
C08.1, C08.8-C08.9	SalivaryGlandOther			Y	8
C09.0-C09.1, C09.8-	Oropharynx		Y	Y	9

C09.9, C10.0, C10.2-C10.4, C10.8-C10.9					
C09.0-C09.1, C09.8-C09.9, C10.0, C10.2-C10.4, C10.8-C10.9	MelanomaOropharynx	6	Y		10
C10.1	EpiglottisAnterior		Y		9
C10.1	MelanomaEpiglottisAnterior	6	Y		10
C11.0-C11.3, C11.8-C11.9	Nasopharynx*		Y		9
C11.0-C11.3, C11.8-C11.9	MelanomaNasopharynx	6	Y		10
C11.1	PharyngealTonsil*		Y	Y	9
C12.9, C13.0-C13.2, C13.8-C13.9	Hypopharynx		Y	Y	9
C12.9, C13.0-C13.2, C13.8-C13.9	MelanomaHypopharynx	6	Y		10
C14.0, C14.2, C14.8	PharynxOther	X	Y		9
C14.0, C14.2-C14.8	MelanomaPharynxOther	6	Y		10
C15.0-C15.5, C15.8-C15.9	Esophagus		Y		5
C15.0-C15.5, C15.8-C15.9	GISTEsophagus	6	Y	Y	5
C16.0, C16.1, C16.2	EsophagusGEJunction*		Y		4
C16.1-C16.6, C16.8-	Stomach*		Y		5

C16.9					
C16.0-C16.6, C16.8-C16.9	GISTStomach	6	Y	Y	5
C16.0-C16.6, C16.8-C16.9	NETStomach		Y	Y	3
C17.0-C17.3, C17.8-C17.9	SmallIntestine		Y		5
C17.0-C17.3, C17.8-C17.9	GISTSmallIntestine	6	Y	Y	5
C17.0-C17.3, C17.8-C17.9	NETSmallIntestine		Y	Y	3
C18.0, C18.2-C18.9	Colon		Y		10
C18.0, C18.2-C18.9	GISTColon	6	Y	Y	5
C18.0, C18.2-C18.9	NETColon		Y	Y	4
C18.1	Appendix		Y		8
C18.1	CarcinoidAppendix		Y	Y	2
C18.1	GISTAppendix	6	Y	Y	5
C19.9, C20.9	Rectum		Y		10
C19.9, C20.9	GISTRectum	6	Y	Y	5
C19.9, C20.9	NETRectum		Y	Y	4
C21.0-C21.2, C21.8	Anus			Y	1
C22.0	Liver		Y	Y	8
C22.1	BileDuctsIntraHepat		Y	6	6
C23.9	Gallbladder				1
C24.0	BileDuctsPerihilar*	6			5
C24.0	CysticDuct*	6			0
C24.0	BileDuctsDistal*	6			3
C24.1	AmpullaVater				3
C24.1	NETAmpulla		Y	Y	3
C24.8-C24.9	BiliaryOther	7			0

C25.0	PancreasHead			Y	3
C25.1-C25.2	PancreasBodyTail			Y	3
C25.3-C25.4, C25.7-C25.9	PancreasOther			Y	3
C26.0, C26.8-C26.9	DigestiveOther	X			0
C30.0	NasalCavity		Y		10
C30.0	MelanomaNasalCavity	6	Y		10
C30.1	MiddleEar	X			9
C31.0	SinusMaxillary		Y		10
C31.0	MelanomaSinusMaxillary	6	Y		10
C31.1	SinusEthmoid		Y		10
C31.1	MelanomaSinusEthmoid	6	Y		10
C31.2-C31.3, C31.8-C31.9	SinusOther	X	Y		10
C31.2-C31.3, C31.8-C31.9	MelanomaSinusOther	X	Y		10
C32.0	LarynxGlottic		Y		9
C32.0	MelanomaLarynxGlottic	6	Y		10
C32.1	LarynxSupraglottic		Y		9
C32.1	MelanomaLarynxSupraglottic	6	Y		10
C32.2	LarynxSubglottic		Y		9
C32.2	MelanomaLarynxSubglottic	6	Y		10
C32.3, C32.8-C32.9	LarynxOther		Y		9
C32.0, C32.8-C32.9	MelanomaLarynxOther	6	Y		10
C33.9	Trachea	X			0
C34.0-C34.3, C34.8-C34.9	Lung			Y	2
C38.4	Pleura		Y		5
C38.0-C38.3, C38.8	HeartMediastinum			Y	4
C39.0, C39.8-C39.9	RespiratoryOther	X			0

C40.0-C40.3, C40.8-C40.9, C41.0-C41.4, C41.8-C41.9	Bone			Y	4
C44.0, C44.2-C44.9	Skin			Y	5
C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2	MelanomaSkin	6	Y		9
C44.1	SkinEyelid		Y	Y	16
C44.0, C44.2-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2	MerkelCellSkin		Y	Y	9
C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2	MycosisFungoides		Y		1
C47.0-C47.6, C47.8-C47.9, C49.0-C49.6, C49.8-C49.9	SoftTissue		Y	Y	4
C48.0	Retroperitoneum	6	Y	Y	4
C48.1-	Peritoneum*		Y	Y	4

C48.2, C48.8					
C48.0-C48.2, C48.8	GISTPeritoneum*	6	Y	Y	5
C50.0-C50.6, C50.8-C50.9	Breast			Y	24
C51.0-C51.2, C51.8-C51.9	Vulva			Y	6
C51.0-C51.2, C51.8-C51.9	MerkelCellVulva		Y	Y	10
C52.9	Vagina				7
C53.0-C53.1, C53.8-C53.9	Cervix			Y	9
C54.0-C54.3, C54.8-C54.9, C55.9	CorpusCarcinoma		Y		8
C54.0-C54.3, C54.8-C54.9, C55.9	CorpusAdenosarcoma		Y		8
C54.0-C54.3, C54.8-C54.9, C55.9	CorpusSarcoma		Y	Y	8
C56.9	Ovary				5
C57.0	FallopianTube				7
C57.1-C57.4	AdnexaUterineOther	X			0
C57.7-C57.9	GenitalFemaleOther	X			0
C58.9	Placenta		Y		2
C48.0-C48.2, C48.8	PeritoneumFemaleGen*		Note 1	Y	5
C60.0-C60.2, C60.8-C60.9	Penis		Y		5
C60.0-C60.2, C60.8-C60.9	MerkelCellPenis		Y	Y	9

C61.9	Prostate		Note 1		13
C62.0-C62.1, C62.9	Testis				12
C63.0-C63.1, C63.7-C63.9	GenitalMaleOther	X			0
C63.2	Scrotum		Y	Y	5
C63.2	MerkelCellScrotum		Y	Y	9
C64.9	KidneyParenchyma			Y	8
C65.9, C66.9	KidneyRenalPelvis				2
C67.0-C67.9	Bladder				3
C68.0	Urethra				1
C68.1, C68.8-C68.9	UrinaryOther	X			0
C69.0	Conjunctiva		Y	Y	2
C69.0	MelanomaConjunctiva		Y		3
C69.1-C69.4, C69.8-C69.9	EyeOther	X			0
C69.1, C69.2, C69.5, C69.8-C69.9	MelanomaEyeOther	X	Y		0
C69.4	MelanomaChoroid		Y	Y	13
C69.4	MelanomaCiliaryBody*		Y	Y	13
C69.4	MelanomaIris*		Y		13
C69.5	LacrimalGland*			Y	8
C69.5	LacrimalSac*	7		Y	0
C69.6	Orbit			Y	0
C69.0-C69.6, C69.8-C69.9	Retinoblastoma		Y		6
C44.1, C69.0, C69.5-C69.6	LymphomaOcularAdnexa	7	Y		13
C70.0, C71.0-C71.9	Brain	X			8
C70.1, C70.9, C72.0-C72.5, C72.8-	CNSOther	X			8

C72.9					
C75.1-C75.3	IntracranialGland	X			1
C73.9	Thyroid		Y	Y	1
C74.0-C74.1, C74.9	AdrenalGland	6	Note 1	7	2
C37.9, C75.0-C75.5, C75.8-C75.9	EndocrineOther	X			0
--	KaposiSarcoma	X	Y		4
--	Lymphoma		Y		5
--	HemeRetic	X	Y		1
-- (except C44.1, C69.0, C69.5-C69.6)	MyelomaPlasmaCellDisorder	X	Y		2
C42.0-C42.4, C76.0-C76.5, C76.7-C76.8, C77.0-C77.5, C77.8-C77.9, C80.9	IllDefinedOther	X			0

- **NOTE: All histologies are coded, but only a specific subset of histologies is used to derive TNM.**