Pennsylvania Cancer Registry (PCR)

Policy Statements

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Statement #1

Commonwealth of Pennsylvania

Department of Health

HARRISBURG

Pennsylvania Cancer Registry

Policy Statement #1.86

REPORTING OF NONANALYTICAL & CARCINOMA IN-SITU CASES

The Pennsylvania Cancer Registry requires that nonanalytic and carcinoma in-situ cases be reported. Although the American College of Surgeons does not require the abstracting of such cases, the National Cancer Institute (SEER Program) does require these cases to be abstracted. Since the Pennsylvania Cancer Registry parallels the National Cancer Institute, we also require such cases to be reported to us. Abstracting of this information will ensure that data among central registries is compatible for future statistical comparisons.

8/21/86

P.O. BOX 90 HARRISBURG, PA

Commonwealth of Pennsylvania

Department of Health

HARRISBURG

Pennsylvania Cancer Registry

Policy Statement #2.86

CHANGES IN REPORTING DATES

In an effort to evenly distribute the Registry's internal workload the PCR has revised the requirement for all hospitals to report by the 15th of each month. Effective September 1, 1986 hospitals will be asked to report by a specified date dependent upon the geographical locale of the facility.

For the purpose of the new monthly reporting dates each county has been placed in one of three geographical areas (see lists below). The county in which your hospital is located will determine the date by which you are to submit abstracts each month. The new reporting dates are as follows:

Central - 5th of each month
Western - 10th of each month
Eastern - 15th of each month

Monthly reporting areas (by county):

Central		Western	Eastern
Adams	Lancaster	Allegheny	Bucks
Bedford	Lebanon	Armstrong	Chester
Berks	Luzerne	Beaver	Delaware
Blair	Lycoming	Butler	Lehigh
Bradford	Mifflin	Cambria	Monroe
Carbon	Montour	Clarion	Montgomery
Centre	Northumberland	Crawford	Northampton
Clearfield	Potter	Elk	Philadelphia
Clinton	Schuylkill	Erie	Wayne
Columbia	Susquehanna	Fayette	
Cumberland	Tioga	Franklin	
Dauphin	Union	Greene	
Fulton	Wyoming	Indiana	
Huntingdon	York	Jefferson	
Lackawanna		Lawrence	
		McKean	
		Mercer	
		Somerset	
		Venango	
		Warren	
		Washington	
		Westmoreland	

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Pennsylvania Cancer Registry

Policy Statement #3.86

BOWEN'S DISEASE

Effective immediately Bowen's Disease of the skin will be reportable to the PCR only when it arises on the penis and at mucocutaneous junctures. As always the mucocutaneous junctures are recognized as the lips, eyes, nostril, peri-anal, peri-vulvar, and ostomy sites.

Please note this change in Section III, Reportable Conditions of your PCR Manual.

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Statement #4

Commonwealth of Pennsylvania

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Pennsylvania Cancer Registry

Policy Statement #4.86

SUBSTANTIATION OF DIAGNOSIS

In order to assure the accuracy of diagnostic data to the Pennsylvania Cancer Registry, a copy of the report(s) which support(s) the malignant diagnosis and the primary site must accompany the completed PCR abstract.

Explanation: In most cases the pathology report is sufficient, however, in cases where the pathology report does not clearly identify the primary site and in cases where means of diagnosis was by radiology, cytology, clinically, etc., other documentation to support the diagnosis must be submitted. This documentation must be some type of medical report that specifies and confirms the diagnosis. Such reports include: laboratory reports, radiology reports, face sheet, discharge summary, etc.

If there are discrepancies which you cannot resolve, your should:

1. Consult a physician.

   or

2. Write a note of explanation and staple it to the PCR form.

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Pennsylvania Cancer Registry

Policy Statement #5.86

COLLECTION OF OCCUPATION & INDUSTRY DATA

One of the most important factors relating to the health of the working population is the risk involved in the working environment. Proper reporting of occupation and industry information is essential for identifying exposures that may contribute to cancer. Every attempt should be made to document and report adequate occupation and industry data.* While interviews provide the most accurate data, we realize that this is often not possible and that you must rely on the patient's medical record. There are several areas you should check. Although the admission sheet is a starting point, this information is frequently insufficient (i.e. retired, disabled, unemployed, and self-employed are not acceptable) and you must go on to check the history and physical, physician consultations, social service consultations, nursing assessments, and any correspondence.

*Refer to "Guidelines for Collecting Occupation and Industry Data," December 1985, pages 12-16 or the Pennsylvania Cancer Registry Manual, 1986 (both to be available through the Cancer Registry by October 1986).

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Pennsylvania Cancer Registry

Policy Statement #6.86
(Revised 11/4/86)

CLARIFICATION OF PCR ABSTRACT ITEMS #19 & #22

Two items on the Pennsylvania Cancer Registry Report form which need clarification are numbers nineteen (19) and twenty-two (22) concerning the initial diagnosis of cancer.

Item #19 - Date of Initial Diagnosis

Enter the date of the first diagnosis of this cancer by any recognized medical practitioner. The date of initial diagnosis refers to a physician's definite diagnosis of cancer and not just an indication of a mass, probable malignancy or suspicion of cancer. This may be a clinical diagnosis and may not ever be confirmed histologically. Even if histologically confirmed later, the date refers to the date of the original diagnosis of cancer.

If the cancer was diagnosed at your facility, the date of initial diagnosis will most frequently be the date of the pathology report or other method of diagnosis. For patients diagnosed without positive tissue while in the hospital, the date of discharge may be used as the best estimate of the date of diagnosis.

In the ABSENCE OF AN EXACT DATE OF DIAGNOSIS, the best approximation is acceptable. Approximation is preferred to coding the date unknown. If the exact date is not known, the best approximation on the basis of available information will be acceptable.

AT NO TIME SHOULD THE YEAR OF DIAGNOSIS BE CODED AS UNKNOWN. It is imperative that a definite year be given in light of the different years in which the various regions began reporting to the PCR. If year is unknown and cannot be approximated, the case should not be reported.

Item #22 - Was First Diagnosis Made Elsewhere?

Item 22 refers to where the first diagnosis of the malignant neoplasm was made. Enter the appropriate number, i.e., "1" for "YES", "2" for "NO", or "9" for "UNKNOWN." If entered "1", "YES," provide the name (do not abbreviate), city, and state of the facility where the patient was first diagnosed, i.e., hospital, physician's office, clinic, etc.

When diagnosed elsewhere, the date of initial diagnosis is always prior to the date of admission to the reporting facility and refers to the date of diagnosis at the facility documented in Item 22. Always be sure to identify the diagnosing facility or document UNKNOWN if name is not known.

Also, when a hospital is reported in Item 22 as having been the facility where the patient was initially diagnosed, the diagnosis from that facility must have been a definite diagnosis and not suspected, probable, or suspicious.

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PENNSYLVANIA CANCER REGISTRY

Policy Statement #1.87

Clarification on Reporting Cases Diagnosed Elsewhere*

According to the Pennsylvania Cancer Control, Prevention, and Research Act and its corresponding regulations:

> "Every hospital and laboratory where cancer is diagnosed or treated or both shall report their finding to the Cancer Registry, Pennsylvania Department of Health, State Health Data Center, Health and Welfare Building, P.O. Box 90, Harrisburg, Pennsylvania, 17108."

The PCR recognizes the following definitions:

1) Treatment

   a. Definitive Treatment refers to any and all procedures or therapies administered which modify, control, remove, or destroy proliferating cancer tissue.

   b. Supportive Treatment refers to all non-definitive therapy directed at alleviation of the patient's subjective symptoms and relief from the mechanical effects of the cancer. Usually there is no expectation of reducing tumor size or delaying the spread of the disease.

2) Consultation refers to those cases in which a patient is neither diagnosed nor treated at your facility. In such cases the patient or tissue sample is examined at a hospital in order to provide a second opinion or suggest a course of treatment.

3) Transient Care refers to those cases which receive a temporary course of definitive treatment (radiation or chemotherapy) at your facility as a result of some unusual circumstance which caused the patient's referral to your hospital. Such unusual circumstance may result from an equipment breakdown at a nearby hospital or a patient's visiting or vacationing in your area.

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PENNSYLVANIA CANCER REGISTRY

Policy Statement #1.88

*Clarification on Updating Information on Cancer Patient Abstracts

The Pennsylvania Cancer Registry (PCR) allows patient information to be updated by checking the box in the top left hand corner of the PCR abstract form. These change forms may be submitted along with your regular monthly shipment of abstracts to the PCR, please document the number of change sheets included in your shipment on the transmittal sheet in the space provided.

When submitting changes to the PCR, do not complete the entire abstract, only complete the data items that need to be changed, in addition to required data items which need to be included. The data items that need to be included on every change sheet are the following : patient's name, social security number, and date of report.

When updating information, please complete the specific items to be updated on the PCR abstract, and note any of the specific instructions concerning corrected information. Please refer to Page #6 of the PCR reporting guidelines manual to obtain a listing of the only items which should be updated on cancer patient abstracts.

Several hospitals submit inappropriate changes to the PCR, and therefore, the following is a clarification of some of the items that should not be updated:

1) If a change in stage has taken place after two months of initial diagnosis of a patient's disease, this should not be reported to the PCR as a change since the normal progression of a cancer tends to spread. Therefore, it is given that the stage of disease will change, but the PCR is interested in the stage of disease only at the time of initial diagnosis.

2) If there is a change in the name of the attending physician, this does not need to be reported to the PCR.

3) The date of death does not need to be submitted to the PCR as a change since the PCR has access to death records, and our files are updated annually.

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Policy Statement #2.88

Reporting of Basosquamous Carcinoma & Waldenstom's Macroglobulinemia

Please note that the following changes in reporting of basosquamous/basal squamous carcinoma and Waldenstrom's macroglobulinemia are as follows:

1) Basosquamous/basal squamous carcinoma of the skin has always been reportable to the Pennsylvania Cancer Registry irregardless of the primary site. Effective July 1, 1988, any basosquamous/basal squamous carcinoma diagnosed after this date is only to be reported to the Pennsylvania Cancer Registry when it arises at mucocutaneous junctures or external genital sites. For the purpose of PCR reporting mucocutaneous junctures are the lips, eyes, nostril, anus, and all artificial ostomy sites. External genital sites include the vagina, clitoris, vulva, prepuce, penis, scrotum, and perineum. Eyelid is reportable unless documentation is detailed enough to determine site of lesion is not near the mucocutaneous juncture.

2) Waldenstrom's macroglobulinemia is now considered a malignancy reportable to the PCR for all cases diagnosed and/or treated since January 1, 1988. The primary site for Waldenstrom's is blood unless otherwise specified. The ICD-O histology code is M-9761/3 (T-169.0).

5/88

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PENNSYLVANIA CANCER REGISTRY

Policy Statement #1.89

New Reporting Start Dates

Effective January 1, 1989, you should no longer report any cases with a diagnosis date prior to January 1, 1985.

EXPLANATION: Data received from the period through December 31, 1984, has been validated and prepared for publishing by the Pennsylvania Cancer Registry. Therefore, as of January 1, 1989, your former start dates listed below are no longer in effect.

Southcentral - July 1, 1982
Southeastern - March 1, 1983
Western - January 1, 1984
Northeastern - September 1, 1984

All hospitals within the Commonwealth will abide by the new start date of January 1, 1985.

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Policy Statement #2.89

*Clarification on Reporting "No Residual Tumor" cases

The Pennsylvania Cancer Registry (PCR) requires all cases in which the pathology report states "no residual tumor" to be reported. The following is an example of one particular case.

EXAMPLE: Outside of the hospital setting or as a private outpatient, an individual has a biopsy and is diagnosed with a malignant melanoma. The patient is admitted to your hospital for further treatment such as a wide excision. The pathology report from the excision states no residual tumor. This case is reportable to the PCR.

EXPLANATION: Even though the cancer was diagnosed elsewhere the patient's hospital admission was for cancer-related treatment. In addition, the wide excision was part of the first course of cancer-directed treatment regardless of the results of the pathology report.

* Please note the policy statement represents a clarification and not a change to the existing PCR policy.

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Policy Statement #12, issued 12/91

New Reporting Start Date

Effective January 1, 1992, the start date for all hospitals is January 1, 1990. All reportable cases of cancer with an initial year of diagnosis of 1990 and after must be submitted to the Pennsyvlania Cancer Registry (PCR). Cases diagnosed in 1989 and before are no longer reportable.

Shipments submitted in February 1992 and after should not include any cases diagnosed in 1989 or before regardless of the year you are currently abstracting.

(The start date of January 1, 1985 is no longer in effect. The change coincides with internal processing of data and report generation.)

12/11/91

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PENNSYLVANIA CANCER REGISTRY

Policy Statement #13, issued 3/92

Reporting of Occupation and Industry Information

Effective immediately, the Pennsylvania Cancer Registry (PCR) will no longer require occupation and industry information to be recorded when reporting cancer cases to the Registry. Items 12, 13, 14, 15, and 16 on the PCR abstract shall be left blank.

Since the implementation of the Pennsylvania Cancer Registry in 1982, the importance of reporting occupation and industry informaton has been stressed; however, efforts to collect this information in a consistent and meaningful manner have not been successful. Researchers who have requested this information from the PCR data base have found it unsatisfactory for their use.

Considering the amount of time spent collecting occupation and industry information, the limitations of the documentation in the medical record, and the end result, the decision has been made to eliminate the requirement to report these data items.

An alternative approach to collecting data which would be useful in investigating the relative cancer risk of various occupations and industries may be taken in the future. Should this occur, you would be given sufficient advance notification to implement necessary data collection procedures.

3/4/92

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Policy Statement #14, issued 3/94

Effectively immediately, the diagnosis of PIN III or PIN 3 (prostatic intraepithelial neoplasia, grade III) is NOT reportable to the Pennsylvania Cancer Registry (PCR). This diagnosis is not included on the PCR List of Reportable Conditions but is referenced in the section titled "Intraepithelial Neoplasia 3" on page 1.5 in the pink section of the PCR Manual. Please delete "PIN 3 (prostatic intraepithelial neoplasia, grade III)" on the fourth and fifth lines of this paragraph. The diagnoses of CIN III, VIN III and VAIN III ARE still reportable to the PCR.

Rationale: This decision is based on the following information recently published in The Abstract, Journal of the National Cancer Registrars Association: "**Prostate**: We are now faced with the dilemma of whether to record cases of prostatic intraepithelial neoplasia (PIN). While this diagnosis was rarely made prior to the advent of PSA, it is becomming more common with the widespread utilization of fine needle biopsy in conjunction with an elevated PSA. Since epithelial tumors arising in the prostate are adenocarcinomas and not squamous carcinomas, there is no specific code to accommodate PIN if we wish to track these diagnoses separately. Certainly M-8077/2 now reserved in the International Classification of Diseases - Oncology - 2nd Edition* for CIN III, VIN III, and VAIN III is not appropriate. M-8140/2 could be utilized, but then all cases of PIN would be lumped with the specific diagnosis of in situ carcinoma and undistinguishable. For the time being, the SEER Program has declared PIN III to be non-reportable and most other population-based as well as hospital registries have followed their lead."**

In order to be able to compare PCR data to national cancer data, the PCR has tried to remain compatible with reporting requirements of the National Cancer Institute's SEER (Surveillance, Epidemiology and End Results) Program and will continue to do so on this issue.

If your hospital registry includes these cases, do not report or transmit them to the PCR.

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* Percy C, Van Holten V, Muir C (eds), International Classification of Diseases for Oncology, Second Edition, World Health Organization, Geneva, 1990.

** John L. Young, Jr., DrPH, CTR, "The In Situ Dilemma," The Abstract, Journal of the National Cancer Registrars Association, Volume 20, Number 2, pp. 3-4, January, 1994.

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PENNSYLVANIA CANCER REGISTRY

Policy Statement #15, issued 4/94

Squamous Intraepithelial Lesion (SIL)

Effective immediately, a cytopathologic diagnosis of high grade squamous intraepithelial lesion (SIL) is reportable to the Pennsylvania Cancer Registry (PCR) only when further specified as CIN 3 (CIN III) or carinoma in situ. Prior to this statement, high grade SILs if not further specified were reportable; however, effective with this statement, when not further specfied high grade SILs are NOT reportable.

The PCR Manual section titled Squamous Intraepithelial Lesion (SIL) on page 1.5 shall be changed to read:

"The term Squamous Intraepithelial Lesion (SIL) was introduced by The Bethesda System as developed by the National Cancer Institute Workshop for classifying vaginal/ectocervical/ endocervical cytopathology. SILs can be high grade or low grade. **High grade SILs are reportable only when further specified as CIN 3 (CIN III) or carcinoma in situ. If a high grade SIL is not further specified or is further specified as CIN 2 (CIN II) or mild or moderate dysplasia, it is NOT reportable.** Low grade SILs are not reportable."

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Policy Statement #16, issued 12/94

Ambiguous Terminology

Effective with the abstracting of patients diagnosed in 1995, interpret the following terms as clinical diagnosis of cancer:

- **Consistent with**
- **Compatible with**
- **Mostly likely**
- **Probable**
- **Suspect**
- **Suspicious**

Any final diagnosis containing any one of these terms is considered **reportable** to the PCR.

EXCEPTION: If a cytology report says "suspicious", do not interpret as a diagnosis of cancer. Report the case only if a positive biopsy or physician's clinical impression of cancer supports the cytology.

The PCR Manual section titled Phrases on page 1.6 shall be changed to read:

"Phrases- Such as "compatible with..., consistent with..., **most likely..., probable..., suspect...,** and **suspicious..."** are acceptable as reportable diagnoses.

EXCEPT- If a cytology report says "suspicious", do not interpret as a diagnosis of cancer. Report the case only if a positive biopsy or physician's clinical impression of cancer supports the cytology.

Delete the second, third and fourth paragraphs of this section.

The PCR Manual section titled Inconclusive Diagnosis on page 1.7 shall be changed to read:

"DO NOT REPORT Diagnosis described as **possible, borderline, presumptive, equivocal, questionable, worrisome, or any term not listed as reportable.**

Delete the second paragraph of this section.

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Policy Statement #17, issued 12/94

Reporting of Skin Cancers

Effective for all cases abstracted on or after January 1, 1995, the following site/histology combinations for skin cancers are **NOT** reportable to the Pennsylvania Cancer Registry (PCR):

8000-8004	Neoplasms, malignant, NOS of the skin (C44.0-C44.9)
8010-8045	Epithelial carcinomas of the skin (C44.0-C44.9)
8050-8082	Papillary and squamous cell carcinomas of the skin (C44.0-C44.9)
8090-8110	Basal cell carcinomas of any site except genital sites

The above lesions **ARE** reportable when the primary tumor originates in a mucous membrane site:

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

Malignancies with the above histologies occurring in the skin of the lip (C44.0), eyelid (C44.1), perianal skin (C44.5) and skin around an ostomy site (C44._) are not reportable.

Malignancies with the above histologies primary to the external nose (C44.3, skin) are not reportable but primaries occurring internally (C30) such as in the nostril, nasal septum and nares are reportable.

If you are not sure if a skin malignancy is reportable, call your field representative for assistance or attach a note to the abstract in question.

Please make these changes in your PCR Manual, PART ONE: GENERAL PROCEDURES, WHAT CASES ARE NOT REPORTABLE, page 1.7.

*NOTE: Hospitals which follow ACOS guidelines should be aware AJCC stage II, III and IV skin cancers are reportable for ACOS purposes but are not reportable to the PCR.

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Policy Statement #18, issued 12/94

Laterality - Additions to List of Paired Sites

Effective with cases abstracted on or after January 1, 1995, the following two sites have been added to the list of paired sites for reporting cancer cases to the Pennsylvania Cancer Registry (PCR):

Face, skin of other and unspecified parts (ICD-O-2 code C44.3)
Trunk, skin (ICD-O-2 code C44.5)

Laterality at diagnosis for these two sites as well as the other paired sites listed on pages 4.34 and 4.35 of the PCR Manual should be specified as right, left, both or unknown. Primary sites of the midline of the face and trunk should be coded to unknown. Please add these sites to the list of paired organs in your PCR Manual(s), pages 4.34 and 4.35.

Rationale: With the addition of the above mentioned sites, the PCR list of paired sites is now consistent with national data collection guidelines. (ACoS Commission on Cancer and National Cancer Institute SEER Program.)

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Policy Statement #19 , issued 12/94, revised 1/95

Additional Cases to be Reported

Effective with specimens received on or after January 1, 1995, private outpatient specimens (POP) with a malignant diagnosis listed on the Pennsylvania Cancer Registry (PCR) Reportable list (refer to Part V of your PCR Manual) are to be reported to the PCR.

- **Private Outpatient Specimens (POP)-** Specimens obtained from patients not registered as inpatients or outpatients of the hospital analyzed to provide an initial diagnosis.

Slide Reviews, laboratory specimens examined to provide a second opinion (consultation only), are required to be reported to the PCR by the hospital/facility requesting the second opinion with the final microscopic diagnosis as determined after slide review. The hospital/facility providing the second opinion is not required to report the case. However, if slide reviews are abstracted for a hospital's cancer registry, reporting them to the PCR is encouraged and is beneficial to assure the most complete and accurate statewide incidence data.

NOTE: Hospitals which subcontract their pathology services to another facility are responsible for reporting all malignancies diagnosed from their specimens.

Diagnoses made at autopsy have always been reportable to the PCR. This includes autopsies performed on patients who have expired during an admission at your facility and autopsies performed on bodies brought to your facility for the sole purpose of the autopsy. The *final* report must be used when abstracting autopsies.

Rationale: Reporting regulation 28 PA Code, § 27.5 of Act 224, the Pennsylvania Control and Prevention Act, states 'Every hospital and *laboratory* where cancer is diagnosed or treated or both shall report their finding to the Cancer Registry, Pennsylvania Department of Health, State Center for Health Statistics and Research, Health and Welfare Building, P.O. Box 90, Harrisburg, PA, 17108.'

In order to increase the completeness of case reporting to the PCR, private outpatient specimens are now required to be reported. This will help ensure all reportable cancer patients are included in the PCR for calculation of statewide cancer incidence.

The PCR Manual will be updated to include this requirement and will include instructions for reporting these cases. Until the revised pages are finalized, refer to the attached page for instructions on submitting these cases.

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PENNSYLVANIA CANCER REGISTRY

Instructions for Reporting Private Outpatient Specimens

Private outpatient specimens (POP) should be abstracted using all available information on the report, including any clinical history information. If any item is not available on the report use the following instructions:

***Patient's Address,*Residence, *Age at Diagnosis, *Date of Birth, *Sex, *Place of Birth, *Race, *Marital Status, & Medical Record Number-** If any of these items are unavailable record *Unknown*.

***Social Security Number-** If the Social Security number is not available, leave blank.

NOTE:* ***ALL OF THESE ITEMS ARE REQUIRED BY THE REPORTING REGULATIONS OF ACT 224 AND EVERY ATTEMPT SHOULD BE BY MADE BOTH HOSPITAL AND PHYSICIAN OFFICE PERSONNEL TO MAKE THIS INFORMATION AVAILABLE ON THE REPORTS.*

Date of Initial Diagnosis- If there is no information on the report indicating the patient may have been diagnosed prior to this report, use the date of procedure as the date of diagnosis.

Date of Admission- Use the date of the procedure and put an "x" next to *Outpatient Only*

Date of Discharge- Leave blank.

Was First Diagnosis of Neoplasm made Elsewhere?- For paper abstracts, enter "1", and write "POP" for location. For electronic reporting, enter "999990" in diagnosing facility field.

Primary Site- If there is no information to prove otherwise, record the specimen as the primary site. If specimen is a metastatic site and primary site is not known, record as "Unknown".

Laterality- Record as "Unknown" if the specimen is a paired site, but the side is not specified. Enter "Not a Paired Organ" if the specimen is not a paired organ.

Stage of Disease- If there is no other information, record as "Unknown"

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Policy Statement #20, issued 9/96

Expanded Data Set

The Pennsylvania Cancer Registry (PCR) has expanded the data set required to be reported by hospitals. All cases submitted to the PCR on or after January 1, 1997, regardless of date of diagnosis must contain the additional data items listed below in addition to the current data set.

- Spanish Origin
- Sequence Number
- Usual Occupation
- Usual Industry
- Text to support coded data*
- First Course of Treatment:
  - Date of First Course Treatment
  - Cancer Directed Surgery and Date
  - Reason for No Surgery
  - Radiation and Date Radiation Started
  - Radiation Therapy to CNS
  - Radiation/Surgery Sequence
  - Chemotherapy and Date Chemotherapy Started
  - Hormone Therapy and Date Hormone Therapy Started
  - Immunotherapy and Date Immunotherapy Started
  - Other Treatment and Date Other Treatment Started

The PCR Manual is being revised to include descriptions of each of the newly reportable data items. **Hospitals with hospital-based registries please note:** With the exception of the item 'text to support coded data', the instructions for reporting these data items are identical to the corresponding data items in the Commission on Cancer, *Registry Operations and Data Standards (ROADS)* Manual.

The reason for expanding the data set is to bring Pennsylvania into compliance with the national standard data set as required for participation in the National Program of Cancer Registries (NPCR). The NPCR is a federally funded program designed to standardize, enhance and expand central cancer registration to improve national cancer surveillance activities.

* Hospitals without hospital based cancer registries will comply with this requirement by documenting as instructed on the revised PCR abstract and attaching appropriate copies of the medical record. Hospitals with hospital based cancer registries will comply with this requirement by providing appropriate documentation in the text fields of their computerized abstract as described in the supplement *Submitting Text Information to the PCR.*

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SUBMITTING TEXT INFORMATION
TO THE
PENNSYLVANIA CANCER REGISTRY (PCR)
NAACCR, VERSION 4.0, ELECTRONIC REPORTING FORMAT

The Pennsylvania Cancer Registry (PCR) requires that all electronically reported cases include text information to support specific coded fields. The following information will assist you in providing the required text information to the PCR.

General Information and Guidelines

Questions	Answers
1. Why is text required?	The purpose of text information is quality control. Text is used by central and hospital based cancer registries to validate coded data items, to verify potential errors identified through standard edits, to document explanations and clarification, to determine multiple primaries, and to reconcile data item discrepancies when the same patient is submitted by several facilities. "Defensive abstracting", as this documentation is often called, is a standard that separates a good data-base from a high quality database.
2. How is text submitted?	Your cancer registry software should include specific fields designed for you to document free text in specifically defined text fields. These fields are then transmitted to the PCR along with the other required data fields when your electronic shipments are prepared.
3. What information should be documented in the text fields?	The following guideliness provide a general overview of text requirements. Refer also to the *Instructions and Examples* section of this document: a) Document text to support your exact codes for primary site, laterality, histology, grade, stage and treatment. b) Document text to support unusual site/histology combinations. c) Document text to explain any unusual or potentially questionable entry on the abstract. This will help you remember the situation and justify your entries on the abstract without having to remember or pull the chart. d) Document text to make note of particular issues you clarified or resolved prior to completing the abstract. e) Document dates when appropriate or helpful, such as to differentiate text describing first course and subsequent treatment. f) Use the text fields to your advantage to document information that will answer questions and support the accuracy of your data to anyone using your data base.

Instructions and Examples

Text Fields	PCR Maximum Field Lengths	Instructions for Text Information	Examples of Text Information
Text-Dx Proc-PE	200	Record text information from history/physical examination.	Mass palpated in UOQ rt breast
Text-Dx Proc-X-ray or scan	250	Record text information from diagnostic imaging reports.	9/11/96 sonogram-cystic neoplasm of ovary, represents cystadenoma or cystadenocarcinoma
Text- Dx Proc-Scopes	250	Record text information from endoscopic examinations.	Extrinsic compression of sigmoid colon most likely secondary to pelvic mass.
Text- Dx Proc-Lab Tests	250	Record information from laboratory examinations other than cytology or histopathology.	4/3/96 elevated PSA 11ng/mL
Text-Dx Proc-Op	250	Record text information from operative reports.	Lg rt cystic ovarian lesion
Text-Dx Proc-Path	250	Record text information from cytology and histopathology reports. Include differential diagnoses, notes, comments, addenda, and results of consultation or second opinions.	Malignant brain tumor; AFIP report confirms glioblastoma multiforme OR Lung CA vs. Mesothelioma. 2nd opinion confirms mesothelioma
Text-Primary Site Title	40	Record text information briefly describing the primary site in natural language; text supports exact ICD-O-2 topography and laterality codes.	Lung, LUL
Text-Histology Title	40	Record text information briefly describing histologic type, behavior, and grade in natural language. Include nouns, adjectives, and phrases describing the histology and grade to support exact ICD-O-2 histology code.	Inv duct CA w/ lobular features
Text-Staging	300	Record text information to support general summary stage; document stage and describe mets or negative findings.	Reg to axillary LN OR Local, neg nodes, neg workup

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PENNSYLVANIA CANCER REGISTRY

Policy Statement #21, issued 11/96

Carcinoma In Situ of the Cervix

Effective immediately the diagnosis of **carcinoma in situ of the cervix** (CIS) is no longer reportable to the Pennsylvania Cancer Registry (PCR).

Terms indicating in situ carcinoma of the cervix include: *noninvasive, preinvasive, intraepithelial, and FIGO Stage 0.* Carcinoma in situ of the cervix with endocervical gland involvement is considered in situ and is therefore not reportable.

Note: Diagnoses of invasive carcinoma of the cervix are still reportable. Carcinoma in situ of the cervix with microinvasion is considered invasive and is reportable. In situ diagnoses of all other sites are still reportable.

Cervical intraepithelial neoplasia (CIN) is no longer reportable; however, vaginal intraepithelial neoplasia, grade 3 (VAIN III) and vulvar intraepithelial neoplasia, grade 3 (VIN III) remain reportable conditions.

Rationale: The use of 3 and 4 tiered systems for classification of cervical neoplasia in combination with the implementation of The Bethesda System (TBS) has resulted in ambiguity in terminology used by pathologists. Data collected are no longer comparable. See table below for further explanation.

Simplified Comparison of Diagnostic Systems for Pre-Invasive Cervical Neoplasia*

4-tier	3-tier	The Bethesda System
mild dysplasia	CIN I	LGSIL (low grade squamous epithelial lesions)
moderate dysplasia	CIN II	HGSIL (high grade squamous epithelial lesions)
marked or severe dysplasia	CIN III	
carcinoma in situ		

(**Working Group on Pre-Invasive Cervical Neoplasia and Population-Based Cancer Registries Final Subcommittee Report, April 1993, page 5.)*

If you have any questions regarding this policy change, please contact your PCR Field Representative at 1-800-272-1850.

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PENNSYLVANIA CANCER REGISTRY

Policy Statement #22, issued 3/97

PCR Paper Abstract Item 29a. Cancer Directed Surgery

Effective immediately, non cancer-directed surgeries, codes 01-09, are no longer reportable to the Pennsylvania Cancer Registry (PCR) and should not be recorded in Item 29a or any field on the PCR Paper Abstract.

Code only cancer-directed surgery and the appropriate date in PCR Paper Abstract Item 29a. Valid codes for cancer-directed surgery are 10-90. If no cancer-directed surgery was performed, enter "00" in Item 29a and zero-fill the date field.

Examples: A patient with breast cancer enters the reporting institution for an incisional biopsy only. No other tests or treatment were performed. Record 00 in the field "Cancer Directed Surgery", Item 29a on the PCR Paper Abstract, and zero-fill the corresponding date field.

A patient with breast cancer enters the reporting institution and has an incisional biopsy performed followed by a lumpectomy and axillary node dissection. Code the field "Cancer Directed Surgery", Item 29a on the PCR Paper Abstract, to a partial or less than total mastectomy with axillary node dissection (20) and the date of the lumpectomy in the corresponding date field.

Hospitals reporting electronically shall follow the guidelines for reporting cancer-directed and non cancer-directed surgeries as described in the Commission on Cancer *Registry Operations and Data Standards Manual (ROADS).*

Note: The instructions in this policy statement differ from the current PCR Manual and the instructions provided at the training sessions held for hospitals using the paper abstract. The attached pages reflect the changes to the PCR Manual and should be reviewed, replaced and implemented immediately. A table describing the changes is also included as a quick reference to the updated pages.

If you have any questions regarding this policy change, please contact your PCR Field Representative at 1-800-272-1850.

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PENNSYLVANIA CANCER REGISTRY

Policy Statement #23, issued 6/97

Update to PCR Manual Part Six: General Summary Staging

Effective immediately please write in the following additions on the appropriate pages of the PCR Manual Part Six: General Summary Staging (May 1997):

Page	Site	Stage	Addition (Clarification)
88	Bronchus and Lung	Distant, Direct Ext or Mets	Malignant pleural effusion (Other distant involvement)
97	Cervix Uteri	Distant, Direct Ext or Mets	Positive ascites (Other distant involvement)
99	Corpus Uteri	Distant, Direct Ext or Mets	Positive ascites (Other distant involvement)
100	Ovary	Distant, Direct Ext or Mets	Positive ascites (Other distant involvement)
101	Fallopian Tube	Distant, Direct Ext or Mets	Positive ascites (Other distant involvement)
102	Vagina	Distant, Direct Ext or Mets	Positive ascites (Other distant involvement)
105	Vulva	Distant, Direct Ext or Mets	Positive ascites (Other distant involvement)

Rationale: In response to questions from hospital staff, the PCR requested interpretation of the General Summary Staging guidelines for lung primaries with malignant pleural effusion and gynecologic primaries with positive ascites. The additions as noted above are based upon clarifications as provided by April Fritz, ART, CTR of the National Cancer Institute SEER Program.

If you have any questions regarding this policy clarification, please contact your PCR Field Representative at 1-800-272-1850

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Policy Statement #24, issued 6/97

Unknown State at Diagnosis

Effective immediately, if after following the general guidelines for recording patient address as documented in the PCR Manual Part Four, page 7 the address for the patient is unknown, the **State at Diagnosis** should be recorded as **ZZ.**

Instructions for recording State at Diagnosis are:

> Record the US postal service abbreviation for the state or Canadian province (see PCR Manual Part Four, page 10) of the patient's usual residence when the tumor was diagnosed and treated. If the patient has multiple tumors, the address may be different for subsequent primaries. If the patient is a resident of a country other than Canada or the United States, record XX. If it is known that the patient is not a resident of Canada or the United States, and the country of residence is unknown, code YY. **If it not known whether the patient is a resident of Canada, the United States or another country, record ZZ.**

Note: Address at Diagnosis should be recorded as unknown only if you are unable to obtain either the patient's address at the time of diagnosis OR at the time he/she was seen at the reporting institution.

Rationale: The Pennsylvania Cancer Registry (PCR) has required the reporting of private outpatient specimens (POP) since January 1, 1995. Recognizing that POP cases are not registered as inpatients or outpatients of the hospital and may not return to the reporting hospital for treatment, the PCR must accept an unknown address at diagnosis. Additionally, by adopting the use of ZZ for unknown State of diagnosis the PCR will maintain consistency with the North American Association of Central Cancer Registries (NAACCR) standard definition for this item.

If you have any questions regarding this policy change, please contact your PCR Field Representative at 1-800-272-1850.

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PENNSYLVANIA CANCER REGISTRY

Policy Statement #25, issued 1/98

Addition of Reportable Condition "Lobular Neoplasia"

Effective immediately consider a final pathologic diagnosis of "lobular neoplasia", also known as "LN2," a condition reportable to the Pennsylvania Cancer Registry (PCR).

These terms should be added immediately to the *PCR Manual, Part Five: List of Reportable Conditions*.

Rationale: Lobular neoplasia of the breast is considered synonymous with lobular carcinoma in-situ under SEER* rules (page 93, *SEER Program Manual)* and ROADS** rules (page 110, *ROADS*). The North American Association of Central Cancer Registries (NAACCR) considers this a reportable neoplasm. Therefore, since all in-situ neoplasms, except carcinoma in-situ of the cervix, are considered reportable by nationally recognized cancer data collection standards, the PCR also considers lobular neoplasia a reportable condition.

Note: The correct ICD-9-CM code for a diagnosis of lobular neoplasia is 233.0. Please make sure your hospital coding staff are coding this diagnosis to in-situ. If it is coded to benign, uncertain behavior, or unspecified, you will not be able to identify these cases on the diagnostic index.

If you have any questions regarding this policy change, please contact your Field Representative at 1-800-272-1850.

* Surveillance, Epidemiology, End Results Program of the National Cancer Institute
** Registry Operations and Data Standards of the American College of Surgeon's Commission on Cancer

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PENNSYLVANIA CANCER REGISTRY

Policy Statement #26, issued 7/98

Ambiguous Terminology for Cancer Diagnosis

Effective immediately, the following terms should be used to determine cases reportable to the Pennsylvania Cancer Registry (PCR).

- **Additions to *Terms That Constitute a Diagnosis***

  Interpret these terms as a reportable diagnosis of cancer and add them to the list under *Terms that Constitute a Diagnosis* in the PCR Manual Part One: General Procedures, page 7:

apparent(ly)	*favor(s)*	*suspect(ed)*
appears to	*malignant appearing*	*suspicious (for)*
comparable with	*presumed*	*typical of*

- **Additions to *Terms That Do Not Constitute a Diagnosis***

  Add these terms to the list of *Terms That Do Not Constitute a Diagnosis* in the PCR Manual Part One: General Procedures, page 10. Do not interpret them as a diagnosis of malignancy without additional information to support reportabilility:

cannot be ruled out	*potentially malignant*	*rule out*

Rationale: The above terms were added to the lists of ambiguous terms used by the American College of Surgeons Commission on Cancer and SEER (Surveillance, Epidemiology, End Results Program of the National Cancer Institute). To maintain consistency with these organizations for data collection and comparison, they are being added to the PCR lists of ambiguous terminology.

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PENNSYLVANIA CANCER REGISTRY

Policy Statement #27, issued 7/98

Ambiguous Terminology for General Summary Staging

Effective immediately, the following terms should be added to the lists of terms used to determine tumor involvement/extension for the purposes of General Summary Staging for the Pennsylvania Cancer Registry (PCR).

- **Additions to *Terms That Constitute Tumor Involvement/Extension***

  Interpret these terms as evidence of tumor involvement and add them to the list under *#10 Terms That Constitute Tumor Involvement/Extension* in the PCR Manual Part Six: General Summary Staging, page 4. The description may be clinical, operative, or pathologic.

adherent	*fixed*	*intrude*
appears to	*impending perforation of*	*invasion to, into, onto, out onto*
comparable with	*impinging upon*	*most likely*
contiguous/continuous with	*impose/imposing on*	*overstep*
extension to, into, onto, out onto	*incipient invasion*	*presumed*
features of	*induration*	*protruding into (unless encapsulated)*
fixation to another structure	*infringe/infringing*	*up to*

- **Additions to *Terms That Do Not Constitute Tumor Involvement/Extension***

  Do not interpret these terms as involvement. Add them to the list under *#11 Terms That Do Not Constitute Tumor Involvement/Extension* in the PCR Manual Part Six: General Summary Staging, page 5.

abuts	*encased/encasing*	*kiss/kissing*
approximates	*encompass(ed)*	*matted (except lymph nodes)*
attached	*entrapped*	*reaching*
cannot be excluded/ruled out	*extension to without invasion/involvement of*	*rule out*
efface/effacing/effacement		*worrisome*

Rationale: The above terms have been adopted by SEER (Surveillance, Epidemiology, End Results Program of the National Cancer Institute) for interpreting ambiguous terminology for extent of disease (EOD) coding. They are added to the PCR lists to provide consistency in determining tumor involvement. Hospital-based registries should use these terms for General Summary Staging only and use the corresponding lists adopted by the American College of Surgeons Commission on Cancer for AJCC staging.

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PENNSYLVANIA CANCER REGISTRY

Policy Statement #28, issued 7/98

Mailing Dates

Effective August 1998 the mailing dates for reporting to the Pennsylvania Cancer Registry (PCR) are changed from the 5th, 10th and 15th of the month for Central, Western and Eastern Regions respectively to the following:

- **Electronic Reporting**

  Facilities reporting electronically shall **mail diskettes on the first working day of every other month**, regardless of region or county in which the hospital is located. The month in which the hospital reports is still determined by the first digit of the four digit PCR facility identification number: odd numbers report in odd numbered months, even numbers report in even numbered months.

- **Paper Abstracts**

  Facilities using the PCR paper abstract to report shall **mail abstracts on the first working day of every month**.

Rationale: The mailing dates are being changed to facilitate more timely processing and availability of records reported to the PCR.

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #29, issued 12/98

Recording *Address at Diagnosis - Street Address*

Effective immediately, the following format rules shall be applied whenever possible for recording *Address at Diagnosis - Street Address* on paper and electronic abstracts submitted to the PCR:

1. Punctuation: Do not use punctuation of any kind including commas, semicolons, colons, periods, dashes, hyphens, question marks, exclamation points, apostrophes, parentheses, brackets, braces, or quotation marks. Do not use pound signs (#) or asterisks (*) when recording address.

   Example: Address: 1234 Main St., Apartment #12
   Record as: 1234 MAIN ST APT 12

2. Abbreviations: Enter complete street names without abbreviation. Abbreviate only directional prefixes, directional suffixes and street type suffixes as listed on the attached abbreviations table. Use of abbreviations for these terms will enable the entire street address including street type suffix to be recorded.

   Examples: 101 W PINE ST HOMESTEAD PA 15120 is in Whitaker Borough
   101 W PINE WAY HOMESTEAD PA 15120 is in Homestead Borough

3. Street Address: Include all components of street address when applicable:

   a. *House or building number* as in 1234 W MAIN ST

   b. *Directional prefix or suffix* as in 1234 W MAIN ST

   c. *Street name* including U.S., State or County if a highway as in 1234 W MAIN ST or STATE HIGHWAY 15

   d. *Street type suffix* as in 1234 W MAIN ST

4. PO Box: Avoid using PO Box numbers in place of street address.

   Example: Address: PO Box 20, 221 Springfield Rd
   Record as: 221 SPRINGFIELD RD

(continued)

PENNSYLVANIA CANCER REGISTRY (PCR)
STANDARDIZED ABBREVIATIONS FOR STREET ADDRESS

Directional Prefix or Suffix Abbreviations:

Prefix/Suffix	Abb
North	N
South	S

Prefix/Suffix	Abb
East	E
West	W

Prefix/Suffix	Abb
Northeast	NE
Northwest	NW

Prefix/Suffix	Abb
Southeast	SE
Southwest	SW

Street Prefix Abbreviations:

Prefix	Abb
Avenue	AV
Boulevard	BLV
Calle	CLL
Caminito	CMT

Prefix	Abb
Camino	CMN
Circulo	CIR
Corte	CT
Drive	DR

Prefix	Abb
Paseo	PAS
Place/Placita	PL
Plaza	PLZ
Rue	RUE

Prefix	Abb
Via	VIA
Vista	VISTA

Street Suffix Abbreviations:

Suffix	Abb
Alley	AL
Alley	ALY
Arcade	ARC
Avenue	AV
Boulevard	BLV
Bypass	BYP
Calle	CLL
Causeway	CSWY
Center	CTR
Circle	CIR
Concourse	CONC
Court	CT
Crescent	CRES

Suffix	Abb
Crossing	CRSG
Drive	DR
Expressway	EXWY
Expressway	EXY
Freeway	FRWY
Freeway	FWY
Gardens	GDNS
Highway	HWY
Lane	LA
Loop	LOOP
Mews	MEWS
Motorway	MTWY
Oval	OVAL

Suffix	Abb
Overpass	OVPS
Park	PARK
Parkway	PKWY
Parkway	PKY
Pass	PASS
Path	PATH
Pike	PKE
Place	PL
Plaza	PLZ
Road	RD
Row	ROW
Rue	RUE
Skyway	SKWY

Suffix	Abb
Square	SQ
Street	ST
Terrace	TER
Trafficway	FWY
Throughway	THWY
Trail	TRL
Turnpike	TPKE
Underpass	UNP
Walk	WALK
Way	WY

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #30, issued 12/98

Collection of Treatment Data Items:
Radiation to CNS* and *Surgery/Radiation Sequence

Effective immediately, the PCR no longer requires the treatment data items *Radiation to CNS* and *Surgery/Radiation Sequence* to be reported.

- **Electronic Reporting** - The fields *Radiation Therapy to CNS* and *Surgery/Radiation Sequence* should be left blank. If your facility continues to collect these items, it will not be a problem if they are transmitted to the PCR. No programming changes are needed.

- **Paper Abstracts** - The following data items on the PCR Report Form shall be left blank:
  Item 29d. *Treatment Provided/Planned, Radiation to CNS*
  Item 29e. *Treatment Provided/Planned, Surgery/Radiation Sequence*

Rationale: *Radiation to CNS* is an optional data item according to the American College of Surgeons Commission on Cancer (ACOS COC) *Registry Operations and Data Standards* (*ROADS*) manual and is no longer required by the Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries (NPCR). *Surgery/Radiation Sequence* is also an optional data item according to the ACOS COC *ROADS* and can be obtained by the PCR using reported date fields to fulfill NPCR data requirements.

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #31, issued 4/1/99

Newly Effective Multiple Primary Determination Rule

Effective with cases diagnosed January 1999 and after, if an in situ tumor is followed by an invasive cancer in the same site more than two months apart, report as two primaries even if stated to be a recurrence. The invasive primary should be reported with the date of the *invasive* diagnosis.

Rationale: The purpose of this rule is to ensure the case is counted as an incident case (i.e., invasive) when incidence data are analyzed and compared to SEER* and other national data.

Note: For hospitals with hospital-based cancer registries: registry hospitals following American College of Surgeons Commission on Cancer guidelines may not include the invasive primary as a subsequent primary in their hospital-based registries. These primaries, however, must be abstracted and reported to the PCR. They may be submitted electronically or on a PCR report form.

* Surveillance Epidemiology End-Results Program of the National Cancer Institute

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #32, issued 12/99

Monthly Reporting

Effective January 4, 2000 all hospitals are required to report to the Pennsylvania Cancer Registry (PCR) on the first working day of every month.

Hospitals using the PCR Report Form have always been required to report monthly; however, hospitals reporting electronically had been instructed to report every other month. This policy statement represents a change for electronically reporting hospitals and a reinforcement of existing policy for hospitals reporting on the PCR Report Form.

Rationale: The PCR will be modifying the method for calculating timeliness of hospital reporting. We will be using the *Date Case Report Received* by the PCR rather than the *Date Case Completed* to determine timeliness. This means records must be received by the PCR within six months from Date of Adm/1st Contact (EDS) or Date of Admission/First Service (paper abstract). While reporting every other month did not affect timeliness in the past, under the revised method a facility's timeliness will be negatively affected by reporting bi-monthly.

The PCR is changing the timeliness calculation to be consistent with requirements of the National Program of Cancer Registries (NPCR). The NPCR requirement for timely reporting reinforces the need for central registries to receive records from reporting facilities within six months in order to publish an annual report of statewide cancer incidence within twelve months of end of diagnosis year.

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #33, issued 3/15/2000

Reporting Minor Civil Division

Effectively immediately, the data item *Minor Civil Division* is no longer reportable to the Pennsylvania Cancer Registry (PCR). The field for *Minor Civil Division* shall be left blank on all PCR Report forms and electronically-reported source records completed after you receive this policy statement.

Rationale: The PCR implemented an automated geocoding system that replaces the need to collect minor civil division information. Geocoding is the process of matching an address to latitude/longitude coordinates and census tract data and provides more precise and extensive data on geographic allocation of patient residence. Matching is based on the street address of the patient whenever possible and on ZIP code for records where the street address does not match any entry in the geocoding software.

Because automated geocoding requires specific street addresses to obtain the most precise residence information, the PCR will monitor the quality of addresses using the format rules documented in the enclosed Policy Statement #29, *Address at Diagnosis-Street Address* previously sent to you in January 1999. We encourage you to review this information and also to share it with hospital personnel involved in patient registration.

Enclosure

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #34, issued 6/15/2000

Additional Required and Recommended Data Items

The Pennsylvania Cancer Registry (PCR) *requires* the following data items to be reported on all cancer cases abstracted July 3, 2000 and after:

- **Date of Last Contact**: (NAACCR* Item #1750) Date of last contact with the patient, or date of death. This data item is required for central cancer registry participation in the National Program of Cancer Registries.

- **Vital Status**: (NAACCR* Item #1760) Code identifying the vital status of the patient as of the date entered in Date of Last Contact. This data item is required for central cancer registry participation in the National Program of Cancer Registries.

- **Type of Reporting Source**: (NAACCR* Item #500) Code identifying source documents used to abstract the cancer being reported rather than the source of original casefinding. This data item is required for central cancer registry participation in the National Program of Cancer Registries.

- **Date of Admission/First Contact**: (NAACCR* Item #580) Date of the first admission to (first contact with) the facility for diagnosis and/or treatment of reportable tumor.

The PCR *recommends* the following data items to be reported on all cancer cases abstracted July 3, 2000 and after:

- **Name – Alias**: (NAACCR Item #2280) Records an alternate name or "AKA" (also known as) used by the patient, if known. The PCR uses this data item in record linkage for determining incidence cases.

- **Place of Diagnosis**: (NAACCR Item #2690) Text area for information about the facility, city, state, or county where the diagnosis was made. The PCR uses this data item in multiple primary determination.

Required data items *must* be reported; recommended data items *should* be reported when available. Instructions for reporting these data items are provided on the enclosed Data Item Instruction pages. Please insert these pages in the appropriate location in Part Four of your PCR Manual.

*NAACCR – North American Association of Central Cancer Registries

Enclosures

DEPARTMENT OF HEALTH
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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #35, issued 12/20/2000

International Classification of Disease for Oncology, Third Edition (ICD-O-3)
(Applicable to hospital-based registries only)

Effective for all cases diagnosed on or after January 1, 2001, the *International Classification of Disease for Oncology, Third Edition (ICD-O-3)* must be used to code primary site, histology, behavior and grade for submission to the Pennsylvania Cancer Registry (PCR). Conditions with a behavior code of /2 (in situ) or /3 (malignant) in ICD-O-3 and a diagnosis date on or after January 1, 2001 are reportable malignancies with the following exceptions:

- Prostatic intraepithelial neoplasia, grade III, also called PIN III (code 8148/2 in ICD-O-3) is not reportable.

- Pilocytic/Juvenile astrocytoma (code 9421/3 in ICD-O-2 and 9421/1 in ICD-O-3) will continue to be reportable and must be coded with a behavior of /3 (malignant).

All cases diagnosed prior to January 1, 2001 must continue to be coded using the *International Classification of Disease for Oncology, Second Edition (ICD-O-2)*. Conditions with a behavior code of /2 (in situ) or /3 (malignant) in ICD-O-2 and a diagnosis date prior to January 1, 2001 are reportable malignancies.

Rationale: Immense changes have occurred over the past decade in techniques for diagnosing neoplasms. As a result, pathologists have been able to provide much more specific information about certain cancers. In some cases, the names of the diseases have changed to reflect the additional information. As a consequence, cancer registries and pathology departments using the *International Classification of Disease for Oncology, Second Edition (ICD-O-2)* have been unable to code these new entities satisfactorily. Responding to requests for assignment of new code numbers, ICD-O-3 was developed.

ICD-O-3 is being implemented throughout North America effective with cases diagnosed on or after January 1, 2001. National standards established by SEER*, the North American Association of Central Cancer Registries (NAACCR) and the American College of Surgeons Commission on Cancer (CoC) require cases diagnosed prior to January 1, 2001 be coded according to ICD-O-2 in order to maintain consistency within a diagnosis year.

Note: A web-based training module for implementation of ICD-O-3 can be found at the SEER Program web site at http://www.training.seer.cancer.gov. The module includes a quiz on educational content, coding exercises and learning games. The National Cancer Registrars Association approved three continuing education hours to Certified Tumor Registrars who complete the module.

* Surveillance, Epidemiology and End Results Program of the National Cancer Institute

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #36, issued 12/20/2000

Changes to Reportable Conditions

Effective for all cases diagnosed on or after January 1, 2001, the following conditions are considered malignant, are added to the PCR List of Reportable Conditions, and must be reported to the PCR:

Chronic myeloproliferative disease, NOS
Chronic myeloproliferative disorder
Endolymphatic stromal myosis
Endometrial stromal sarcoma, low grade
Endometrial stromatosis
Essential thrombocythemia
Essential hemorrhagic thrombocythemia
Idiopathic thrombocythemia
Idiopathic hemorrhagic thrombocythemia
Intravascular bronchial alveolar tumor
Megakaryocytic myelosclerosis
Myelofibrosis with myeloid metaplasia
Myelosclerosis with myeloid metaplasia
Papillary ependymoma
Papillary meningioma
Polycythemia rubra vera
Polycythemia vera
Refractory anemia, NOS
Refractory anemia with excess blasts
Refractory anemia with excess blasts in transformation
Refractory anemia with ringed sideroblasts
Refractory anemia with sideroblasts
Refractory anemia without sideroblasts
Stromal endometriosis
Stromal myosis, NOS

Effective for all cases diagnosed on or after January 1, 2001, the following conditions are no longer considered malignant and should not be reported to the PCR. These conditions must still be reported when the diagnosis date is prior to January 1, 2001:

Atypical proliferative papillary serous tumor
Cystadenoma, borderline malignancy, (serous) (papillary) (mucinous) (pseudomucinous)
Cystic tumor, low malignant potential, of the ovary/peritoneum, (serous) (papillary) (mucinous) (pseudomucinous)
Tumor, low malignant potential, of the ovary/peritoneum, (serous) (papillary) (mucinous) (pseudomucinous)

Rationale: The PCR considers all cases with a behavior code of /2 (in situ) or /3 (malignant) in the *International Classification of Diseases for Oncology (ICD-O)* to be reportable conditions. The *ICD-O,* Third *Edition (ICD-O-3)* is being implemented throughout North America effective with cases diagnosed on or after January 1, 2001. The newly reportable conditions listed above had behavior codes changed to malignant in ICD-O-3 to reflect current medical understanding about the behavior of these neoplasms. Additionally, a careful review of survival rates for borderline cystadenomas indicate their behavior was much closer to benign than malignant with an overall survival rate of nearly 100%. This is reflected in ICD-O-3 with the change in behavior code to /1 (uncertain whether benign or malignant).

(continued)

Note: One additional condition, juvenile or pilocytic astrocytoma, including the obsolete synonym spongioblastoma NOS, will also revert to borderline behavior (/1) in ICD-O-3. However, this condition will continue to be reportable in accordance with national standards established by SEER*, the North American Association of Central Cancer Registries (NAACCR) and the American College of Surgeons Commission on Cancer (CoC).

The following documents are enclosed with this policy statement for your reference:

- List of Reportable Conditions – Replace the current list in the PCR Manual, Appendix D, pages 1-28.
- Terms Changing from Borderline to Malignant – This list should be shared with personnel in other areas of your hospital who assist with casefinding.
- Terms Changing from Malignant to Borderline – This list should be shared with personnel in other areas of your hospital who assist with casefinding. Conditions on this list must still be reported to the PCR when the initial diagnosis date was prior to January 1, 2001.
- ICD-9-CM Reportable Codes – This list should be used to screen medical record ICD-9-CM codes for reportable conditions starting in 2001.

* Surveillance, Epidemiology and End Results Program of the National Cancer Institute.

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #37, issued 12/20/2000

SEER* Summary Stage 2000

Effective for all cases diagnosed on or after January 1, 2001, the Pennsylvania Cancer Registry (PCR) requires use of the new SEER Summary Staging Manual 2000 (SSSM2K) for completing summary stage. Summary Stage Guide 1977 (PCR Manual, Appendix H) must continue to be used for all cases diagnosed prior to January 1, 2001.

A major change from the Summary Staging Guide 1997 (PCR Manual, Appendix H) to the SSSM2K is the change in the "time rule" as follows:

> *Summary stage should include all information available through completion of surgery (ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.*

Other SSSM2K changes and noteworthy items include:

1. Every anatomic site now has a staging scheme.
2. It is now a manual with rules, definitions, and standardized codes.
3. The colon subsite schemes are now grouped into one colon scheme.
4. Pleural effusion is now specifically stated under Distant for lung.
5. For the lymphomas, the code choices are 1 for Stage I, 5 for Stage II and 7 for Stage III and Stage IV. The use of code 5 for Stage II lymphomas alleviates the confusion of using code 2 (Regional by Direct Extension), code 3 (Regional to Lymph Nodes) or code 4 (Regional by Direct Extension and Regional to Lymph Nodes).
6. For breast cases, some cases will shift from Localized to Regional Direct Extension.
7. There are marks (*) denoting those things that are now different from the current summary staging.

Note: SSSM2K informational material can be found on SEER's Training Web Site at http://www.training.seer.cancer.gov.

Rationale: SSSM2K is being implemented throughout North America effective with cases diagnosed on or after January 1, 2001. National standards established by SEER, the North American Association of Central Cancer Registries (NAACCR) and the American College of Surgeons Commission on Cancer (CoC) require that cases diagnosed prior to January 1, 2001 be summary staged according to the Summary Staging Guide 1997 (PCR Manual, Appendix H) in order to maintain consistency within a diagnosis year.

* Surveillance, Epidemiology and End Results Program of the National Cancer Institute

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #38, issued 12/20/2000

Date of Diagnosis Reportability

All malignant cases diagnosed or treated at your facility on or after January 1, 2001 are required to be reported to the Pennsylvania Cancer Registry (PCR) regardless of the Date of Diagnosis. This includes patients with an unknown date of initial diagnosis.

This policy change eliminates the PCR reference date of January 1, 1990. It also makes an unknown year of diagnosis (9999) acceptable.

Examples:

- If a patient is admitted to your facility on January 3, 2001 and receives palliative care for bone metastasis from a breast primary diagnosed in 1988, the case is now required to be reported.
- If a patient is admitted to your facility on January 3, 2001 and receives palliative care for bone metastasis from a breast primary for which a diagnosis date is not stated in the medical record, the case is now required to be reported using 99999999 for the Date of Diagnosis.

Rationale: Reporting these cases will eliminate the need for re-review of patients with unknown dates of diagnosis or patients diagnosed prior to January 1, 1990 at the time of reconciliation and quality assessment review. The cases will be abstracted and reported at the time of initial review. Once the cases are reported and processed by the PCR, they will match against your disease index when the reconciliation and quality assessment review reports are run and no further verification will be needed.

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #39, issued 12/20/2000

Newly Required Data Items

The Pennsylvania Cancer Registry (PCR) requires the following additional data items to be reported for cases diagnosed on or after January 1, 2001:

- **Histologic Type ICD-O-3** (NAACCR* Item # 522) For hospital-based registries only to record the code for histologic type of the tumor being reported using *International Classification of Diseases-Oncology, Third Edition* (ICD-O-3).

- **Behavior Code ICD-O-3** (NAACCR Item # 523) For hospital-based registries only to record the code for the behavior of the tumor being reported using ICD-O-3.

- **SEER** Summary Stage 2000** (NAACCR Item # 759) For all reporting facilities to record the code for the summary stage at the initial diagnosis or treatment of the reportable tumor.

The PCR requires the following additional data items to be reported by all reporting facilities, for cases with a Date of Admission/ 1st Contact on or after January 1, 2001, regardless of their Date of Diagnosis:

- Additional Race fields to record the patient's race. If the patient is multi-racial, records all races using the Race 1 (NAACCR Item # 160) to Race 5 fields.
    - **Race 2** (NAACCR Item # 161)
    - **Race 3** (NAACCR Item # 162)
    - **Race 4** (NAACCR Item # 163)
    - **Race 5** (NAACCR Item # 164)

- **RX Summ—Scope Reg LN Sur** (NAACCR Item # 1292) To record site-specific codes for the type of surgery to regional lymph nodes performed as part of the first course of treatment.

- **RX Summ—Surg Oth Reg/Dis** (NAACCR Item # 1294) To record site-specific codes for the type of surgery to sites other than the primary site and regional lymph nodes, performed as part of the first course of treatment.

- **RX Summ—Reg LN Examined** (NAACCR Item # 1296) To record the number of lymph nodes examined in conjunction with surgery performed as part of the first course of treatment.

- ~~**Name – Alias** (NAACCR Item # 2280) To record an alternate name or "AKA" (also known as) used~~ by the patient, if known. (Formerly, this item was recommended to be collected but is now required.)

(continued)

Policy Statement #39, Additional and Newly Required Data Items (continued)

- **Place of Diagnosis** (NAACCR Item # 2690) Text area to record information about the facility name, city, county, and/or state where original diagnosis was made. (Formerly, this item was recommended to be collected but is now required.)

- **Date Case Last Changed** (NAACCR Item # 2100) To record the latest date the case was modified after completion at the reporting facility. This item is only for use by hospitals using commercial, hospital-based, or AbstractPlus software and is usually completed automatically rather than manually entered.

- **Date Case Report Exported** (NAACCR Item # 2110) To record the date the reporting facility exported the electronic abstract to a file for transmission to the central registry. This item is only for use by hospitals using commercial, hospital-based, or AbstractPlus software and is usually completed automatically rather than manually entered.

Rationale: Collection of these data items is required for central registry participation in the National Program of Cancer Registries (NPCR) and to assure consistency with national standards.

* North American Association of Central Cancer Registries
** Surveillance, Epidemiology and End Results Program of the National Cancer Institute

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #40, issued 12/20/2000

Reporting Format for 2001 Cases

Effective for all cases with a Date of Admission/1st Contact on or after January 1, 2001, the reporting format for submitting cases to the Pennsylvania Cancer Registry (PCR) will change. Hospitals using commercial, hospital-developed, or AbstractPlus software will be required to transmit electronically to the PCR using the NAACCR* Version 9 Record Layout. Hospitals reporting on the paper PCR Report Form will be required to use the 01/01 revised version of the form.

Electronic Reporting (Users of commercial, hospital-developed, and AbstractPlus software) The PCR requires hospitals reporting electronically to continue to format data transmitted from 2000 cases according to NAACCR Version 6. Cases from 2001 must be transmitted to the PCR using NAACCR Version 9 in order to accommodate all new data requirements. Once 2001 case reporting begins, missed cases from previous years must be transmitted in the NAACCR Version 9 format but staged using the SEER Summary Stage 1977 Guide plus time rules and, for hospital-based registries, coded using ICD-O-2.

Formatting to the required version of the NAACCR Record Layout is done by the software when the registrar creates the export files. Installation of a software upgrade is necessary to format 2001 cases to NAACCR Version 9. These upgrades are provided by the software vendor for commercial software, by the PCR for AbstractPlus, or must be prepared by the hospital for hospital-developed software.

The PCR will accept 2001 cases only after the hospital has installed the software upgrade and is able to transmit cases in the NAACCR Version 9 layout. An internal software upgrade is also necessary for the PCR. 2001 cases will be accepted by the PCR only after this upgrade has been successfully installed and reporting facilities have been notified.

Paper Reporting (Users of the paper PCR Report Form) The PCR requires hospitals using the paper PCR Report Form to continue to report 2000 cases using PCR Report Form, H106.070 (9/99). Cases from 2001 must be reported using PCR Report Form, H106.070 (01/01) in order to accommodate all new data requirements. Once 2000 cases have been reported, discard all copies of the 9/99 version. Missed cases from previous years must be submitted on the 01/01 version of the paper abstract but staged using the SEER Summary Stage 1977 Guide plus time rules.

Recommended Implementation Procedure: Due to the extensive changes effective for 2001 cases, the PCR strongly recommends hospitals complete 2000 case reporting prior to abstracting any 2001 cases. The PCR also recommends hospitals implement the attached procedure(s) to make the transition to 2001 reporting requirements as smooth as possible.

Rationale: The PCR must implement updated reporting formats to accommodate changes effective for 2001 case reporting in order to collect data that meet national standards.

*North American Association of Central Cancer Registries

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #41, issued May 2001

Completion of Private Outpatient Specimen (POP) Cases

Effective for Private Outpatient Specimens* (POP) with a specimen date on or after January 1, 2001, every effort must be made to obtain complete information for all required data items.

Information can be found through hospital billing systems, clinical history, and if needed by contacting physician offices. Data items should be recorded as *unknown* or code 9 only after all efforts to obtain specific information prove unsuccessful.

Data item instructions documented in the *PCR Manual* should be used to complete abstracts of POP cases. The following special instructions apply specifically to POPs:

- ***Date of Diagnosis:*** The specimen date should not be considered the date of diagnosis without further confirmation from the clinical history or physician. If the date of diagnosis cannot be confirmed after further investigation, enter 99999999 in the *Date of Diagnosis* field.
- ***Date of Admission/1st Contact:*** *Date of Admission/First Contact* is the date the specimen was received in your facility pathology laboratory.
- ***Institution Referred From:*** *Institution Referred From* is always 000000000000000.
- ***Class of Case:*** Record *Class of Case* 9 only if the record does not meet *Class of Case* 6 requirements.
- ***Type of Reporting Source:*** *Type of Reporting Source* is always code 3 (Lab Only).

Please Note: If a POP patient subsequently comes to your facility as a hospital inpatient or outpatient for diagnosis or treatment of the cancer, update and add information as appropriate; however, *Date of Admission/1st Contact* should not be updated since the date the POP specimen was received in your facility pathology laboratory still reflects the first contact with your facility.

Rationale: More cancer patients are being diagnosed and treated solely in non-hospital settings. In order for POP records to be included in statewide statistics the information submitted to the PCR must conform to the same standards for completeness, accuracy and timeliness as inpatient and outpatient cases.

*Private outpatient specimens (POPs) are specimens submitted from a physician's office to be read by the hospital pathologist as part of the Pathology Department's regular course of business.

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #42, issued May 2001

New Requirements for Data Item *Institution Referred From*
(Applicable to Electronic Reporting Hospitals Only)

Effective for cases with a Date of Admission/1st Contact on or after January 1, 2001, *Institution Referred From* is expanded to a 15-character field and the following Pennsylvania Cancer Registry (PCR)-specific codes for *Institution Referred From* are no longer valid:

999990	Private Outpatient
999992	Nursing Home/Long Term Care Facility
999994	Unspecified out of state hospital
999995	Non-hospital, NOS
999996	Physician's office/clinic/surgicenter/freestanding radiation center

- Referring Facility - To complete the data item *Institution Referred From,* use the codes in your current selection of facility ID numbers (FIN), i.e., Commission on Cancer codes, to identify the facility from which the patient was referred. In the past, the FINs were a seven-digit code reported in a six digit NAACCR field by deleting the number 6 in the first position of all FINs. Since this field has been expanded to 15 characters, enter the seven digit FIN right justified with the remaining eight spaces zero-filled to make a total of 15 characters, e.g., 000000006231234. *Note:* Most abstracting software including AbstractPlus will automatically zero-fill these remaining spaces when the selection is made from a table of facility codes.

- Referred But Facility ID Number Unknown - Code *Institution Referred From* to 999999999999999 if the patient was referred but the referring institution's ID number is unknown.

- Not Referred - Code *Institution Referred From* to 000000000000000 if the patient was not referred to the reporting institution from another institution. *Institution Referred From* for Private Outpatient Specimens (POP) is coded to 000000000000000.

Rationale: The PCR is eliminating the use of PCR-specific codes for *Institution Referred From* in order to comply with national data collection standards. Information previously provided by these codes can be sufficiently obtained from data submitted in items *Type of Reporting Source, Class of Case,* and *Place of Diagnosis.* The field length for *Institution Referred From* was expanded from six to 15 characters nationally to accommodate proposed lengthened facility ID numbers and the addition of codes for provider and other non hospital sources. This expanded field length is incorporated into the NAACCR Version 9 Record Format required for reporting 2001 cases.

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #43, issued May 2001

New Requirements for Data Item *Reporting Hospital*
(Applicable to Electronic Reporting Hospitals Only)

Effective for cases with a Date of Admission/1st Contact on or after January 1, 2001, *Reporting Hospital* is expanded to a 15-character field.

The codes used to complete the data item *Reporting Hospital* are maintained by the American College of Surgeons Commission on Cancer. They are referred to as Facility ID Numbers (FIN). In the past, the FINs were a seven-digit code reported in a six-digit NAACCR field by deleting the number '6' in the first position of all FINs. Since this field is now expanded to 15 characters, *Reporting Hospital* must include the seven-digit FIN right justified with the remaining eight spaces zero-filled to make a total of 15 characters, e.g., 000000006231234.

For hospitals reporting electronically, the hospital-specific FIN required to be reported in the field *Reporting Facility* is generally set or defaulted in the software and does not have to be entered for each case.

- Commercial Registry Software - Registry hospitals using commercial cancer registry software should make sure the FIN in the *Reporting Facility* field meets the above specifications.

- AbstractPlus Software - Non registry hospitals using the PCR's AbstractPlus software will be given instructions to set their hospital-specific FIN after installing the AbstractPlus upgrade.

Rationale: The field length for *Reporting Hospital* was expanded from six to 15 characters nationally to accommodate proposed lengthened facility ID numbers and the addition of codes for provider and other non hospital sources. This expanded field length is incorporated into the NAACCR Version 9 Record Format required for reporting 2001 cases.

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #44, issued June 2002

Change in Reporting Instructions for Cases With Unknown Date of Diagnosis

Effective immediately the following instructions shall be used to report cases with unknown Date of Diagnosis:

> Every effort should be made to estimate Date of Diagnosis whenever possible if Date of Diagnosis is unknown. If the **Date of Diagnosis** is unknown and cannot be estimated, the **Date of Admission/1st Contact** should be used to determine the correct coding and staging manuals to use. **For cases with an unknown Date of Diagnosis and Date of Admission/1st Contact on or after January 1, 2001, use SEER Summary Stage 2000 (all facilities) and ICD-O-3 (registry hospitals only).**

This policy statement changes the previously documented instructions to use SEER Summary Stage 1977 and ICD-O-2 to code all cases with unknown Date of Diagnosis. Cases with unknown Date of Diagnosis and Date of Admission/1st Contact prior to January 1, 2001 shall continue to be coded using SEER Summary Stage 1977 (all reporting facilities) and ICD-O-2 (registry hospital only). No change sheets are necessary for abstracts previously reported.

Rationale: This change is being made to remain consistent with standards recommended by the North American Association of Central Cancer Registries (NAACCR) as published in the Fall 2001 issue of *The NAACCR Narrative*, page 8 under Uniform Data Standards Committee News.

Note: For Hospitals using AbstractPlus software: The updated edits metafile (enclosed for AbstractPlus users only) must be installed to implement this policy change.

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #45, issued July 2002

Clarification of Reportable Condition - Lobular Neoplasia

Effective immediately a diagnosis of lobular neoplasia, grade 2 (LN2, LN II) of the breast is not reportable to the Pennsylvania Cancer Registry. Lobular neoplasia, grade 3 (LN3, LN III) is considered synonymous with lobular carcinoma in situ and is reportable to the PCR.

Rationale: In April 1997 the North American Association of Central Cancer Registries (NAACCR) stated that lobular neoplasia (LN2) was synonymous with lobular carcinoma in situ and should be reported. Recent review of the American College of Surgeons Commission on Cancer (COC) Inquiry & Response system revealed the COC considers only LN3 reportable. Clarification was requested and received from NAACCR further supporting this change in policy.

Note: This Policy Statement rescinds Policy Statement #25, Issued 1/98. Do not submit change sheets to delete diagnoses of LN2 previously reported.

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #46, issued January 2006

Revised Data Set for Reporting 2006 Cases

The following data items have been added to the PCR-required data set in order to comply with requirements for participation in the CDC National Program of Cancer Registries. These data items must be included on all reportable cases with *Date of 1st Contact* on or after January 1, 2006 and on missed cases from previous years.

1. **Name--Alias:** Records an alternate name or "AKA" (also known as) used by the patient, if known.

   Rationale: This data item assists with record linkage on cases with conflicting demographic information.

2. **Primary Payer at Dx**: Records primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

   Rationale: This item is used in financial analysis and as an indicator for quality and outcome analyses. The Joint Commission on Accreditation of Healthcare Organizations requires the patient admission page document the type of insurance or payment structure that will cover the patient while being cared for at the hospital.

3. **Casefinding Source**: This variable codes the earliest source of identifying information. For cases identified by a source other than reporting facilities (such as through death clearance or as a result of an audit), this variable codes the type of source through which the tumor was first identified.

   Rationale: This data item will help reporting facilities as well as regional and central registries in prioritizing their casefinding activities. It will identify reportable tumors that were first found through death clearance or sources other than traditional reporting facilities. It provides more detail than *Type of Reporting Source.*

4. **RX Summ--Surg/Rad Seq**: Records the sequencing of radiation and surgery given as part of the first course of treatment.

Rationale: The sequence of radiation therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the time of delivery of treatment to the patient.

5. **RX Summ--Systemic Sur Seq**: Records the sequencing of systemic therapy (*RX Summ-Chemo, RX Summ-Hormone,* and *RX Summ-Transplnt/Endocr*) and surgical procedures given as part of the first course of treatment.

   Rationale: The sequence of systemic therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the time of delivery of treatment to the patient.

The updated *PCR Manual* available in February 2006 will include detailed definitions and codes for these new data items.

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PENNSYLVANIA CANCER REGISTRY (PCR)

Policy Statement #47, issued January 2006

Timeliness Requirements, New Mailing Dates, Revised Reporting Schedule

Timeliness Requirements: In an effort to increase timeliness of abstract submission to comply with cancer reporting regulations, timeliness will be measured against the following two requirements:

- **180 Days** - 90% of abstracts must be received by the PCR within 180 days from *Date of Inpatient Disch* if an inpatient or *Date of 1st Contact* if an outpatient.

- **Year End Deadline** - The first working day in July is the deadline for submitting all reportable cases from the previous year.

Compliance to these requirements will be monitored by the PCR as follows:

- 2005 Data - Facilities are encouraged to evaluate current reporting procedures and timeframes against the revised reporting schedule below and implement improvements to enable submission of abstracts to meet the 180-day requirement. All 2005 cases must be submitted to the PCR by the first working day in July 2006 (Monday, July 3, 2006).

- 2006 Data - The PCR will begin monitoring timeliness of 2006 data by providing periodic timeliness reports to reporting facilities. All 2006 cases must be submitted to the PCR by the first working day in July 2007 (Monday, July 2, 2007).

- 2007 Data - The PCR expects to be receiving at least 90% of 2007 abstracts within 180 days. All 2007 cases must be submitted to the PCR by the first working day in July 2008 (Tuesday, July 1, 2008).

To facilitate more timely submission of abstracts, the PCR revised the following two reporting procedures:

Mailing Date: Effective February 2006, shipments must be mailed on the 15th of every month. When the 15th falls on a weekend or holiday, shipments must be mailed on the last working day before the 15th. This is a change from the previous requirement to mail shipments by the first of every month.

Reporting Schedule: In conjunction with the change in mailing date, the Reporting Schedule on page 235 of the current *PCR Manual* was revised as follows to provide better guidance for complying with timeliness requirements.

Abstracts with a Date of Discharge/ Date of 1st Contact in:	**Mail on or before the 15th of:**
January	June of same year
February	July of same year
March	August of same year
April	September of same year
May	October of same year
June	November of same year
July	December of same year
August	January of following year
September	February of following year
October	March of following year
November	April of following year
December	May* of following year

Example 1: All abstracts with a *Date of Inpatient Disch* or *Date of 1st Contact* on or between January 1 and January 31, 2006 must be sent no later than June 15, 2006.

Example 2: All abstracts with a *Date of Inpatient Disch* or *Date of 1st Contact* on or between December 1 and December 31, 2006 must be sent no later than May 15, 2007.

* The time between May 15th and the first working day in July should be used to perform quality assurance procedures to ensure all cases have been identified and reported. These cases may fall into the 10% over 180 days. This is expected and acceptable. The timeliness goal was set at 90% to provide a cushion of 10% to encourage late reporting of missed cases to assure reporting completeness.

Note: This schedule will not be used to determine exact timeliness rates. Timeliness will be calculated using *Date of Inpatient Disch* and Date Case Received by the PCR for inpatients and *Date of 1st Contact* and Date Case Received by the PCR for outpatients. Facility-specific reports will be provided periodically by the PCR to inform facilities of their exact timeliness rates.

The updated *PCR Manual* available in February 2006 will include these revised reporting procedures.

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)
Policy Statement: New PCR Reporting Requirements for Cases Diagnosed On or After January 1, 2010	
Number: 2010-48	**Date Issued: March 24, 2010** **Revised: September 3, 2010**

The purpose of this Policy Statement is to provide a brief description of the new PCR reporting requirements effective for **cases diagnosed on or after January 1, 2010**. The changes include a new record layout for electronic transmission to the PCR, major changes to Collaborative Stage, new rules for abstracting hematopoietic and lymphoid conditions, newly reportable conditions, new reportable terms and ICD-O-3 codes, new data items, changes to existing data items, and data items no longer required to be reported. Details and training to implement these changes will be announced in future communications.

The changes in PCR reporting requirements for **cases diagnosed on or after January 1, 2010** are as follows:

1.0 New North American Association of Central Cancer Registries (NAACCR) Record Layout (Version 12)

2010 cases must be reported to the PCR in the NAACCR 12 record layout which will be incorporated into new 2010 software. This new layout is not available in current software; therefore, **2010 cases cannot be reported to the PCR until the new 2010 version of abstracting software (Abstract Plus as well as software used by registry hospitals) is available.**

The Version 12 NAACCR record layout has been expanded from 6,694 characters per abstract to 22,824. This new layout was required to accommodate the new 2010 reporting requirements described in this policy statement.

Hospitals should provide this information to Information Technology (IT) staff to identify any potential transmission issues with the greatly expanded record length for each abstract in the export file. The PCR is working with Department of Health IT staff and Centers for Disease Control and Prevention (CDC) to make sure Web Plus and the PCR server will accommodate the increased file size.

2.0 New Collaborative Stage Data Collection System (CSv2)

The most significant change for 2010 is in the Collaborative Staging system. The name has been changed to the Collaborative Stage Data Collection System (CSv2) to emphasize that CSv2 is a tool for the collection of data used to derive different staging systems as well as capture other useful information such as prognostic factors. The changes are based on American Joint Committee on Cancer (AJCC) Cancer Staging Manual, 7th edition. The new fields required for CSv2 and the program to convert appropriate data items to CSv2 are incorporated into the new 2010 software.

Many new site-specific factors (SSF) have been added to CSv2. Appendix A identifies SSF required by the PCR and will be sent as soon as the list has been finalized.

3.0 New Hematopoietic and Lymphoid Neoplasm Rules

New hematopoietic rules go into effect for cases diagnosed January 1, 2010 and after. These new rules are based on the 2008 *World Health Organization (WHO) Classification of Tumours of Haematopoietic and Lymphoid Tissues*. The result is the addition of newly reportable conditions, newly reportable terms and conditions, new codes, and new rules that will affect multiple primary determination for these cases. One such change is myeloproliferative diseases that transform to leukemias will no longer be considered the same primary; the leukemia will be a new primary. The newly reportable hematopoietic/lymphoid conditions, new reportable terms, and corresponding *International Classification of Disease, 3rd Edition* (ICD-O-3) codes are listed in Appendix B.

A hematopoietic database and series of online training modules have been developed to assist in learning and applying the new codes and multiple primary determination rules for hematopoietic and lymphoid diagnoses. Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Rules on-line training is available on the Surveillance Epidemiology End Results (SEER) website at http://seer.cancer.gov/tools/heme/ and must be completed to properly abstract 2010 hematopoietic and lymphoid cases.

4.0 Newly Reportable Conditions, New Reportable Terms, and ICD-O-3 Histology Codes

4.1 Newly Reportable Conditions:

Newly Reportable Hematopoietic/Lymphoid Conditions – Based on changes to the hematopoietic and lymphoid neoplasm rules, the behavior of the following diseases has changed from borderline or uncertain (/1) to malignant (/3) and as a result, **are now reportable when diagnosed January 1, 2010 and after:**

- Chronic lymphoproliferative disorder of NK-cells
- T-cell large granular lymphocytic leukemia
- Langerhans cell histiocytosis, NOS
- Langerhans cell histiocytosis, unifocal
- Langerhans cell histiocytosis, multifocal
- Myelodysplastic/Myeloproliferative neoplasm, unclassifiable
- Myeloproliferative disease, NOS
- Myeloproliferative neoplasm, unclassifiable

Appendix B, Table 4.1 provides a listing of the newly reportable hematopoietic conditions and corresponding ICD-O-3 histology codes. **Update the histology and behavior codes in both the alphabetic and tabular listing in the ICD-O-3 code book to assure these conditions are identified as reportable and appropriate ICD-O-3 histology and behavior codes are assigned.**

4.2 New Reportable Hematopoietic/Lymphoid Terms

New reportable terms are included in the new hematopoietic rules. These conditions were previously reportable but coded to the Not Otherwise Specified (NOS) category because they were not specifically indexed in ICD-O-3. With the implementation of the new hematopoietic rules for cases diagnosed on or after January 1, 2010, these conditions will be coded using new histology codes assigned by the World Health Organization (WHO) that did not previously exist.

Appendix B, Table 4.2, provides a list of the new reportable terms and the more-specific ICD-O-3 histology codes. **Add these terms and codes to both the alphabetic and tabular listing in the ICD-O-3 code book to assure the appropriate ICD-O-3 histology code is assigned.**

5.0 New Data Items

5.1 Date Flags – Prior to 2010, date fields included codes that provided information other than dates (such as 00000000, 88888888, 99999999). As part of an initiative to obtain conformance with other electronic healthcare standards (interoperability), date flags **associated with each required date field are now required**. Since only actual known dates are entered in interoperable date items, date flags explain the reason when there is no value in the corresponding year, month, and day of the corresponding date field.

5.2 Treatment Date Fields – Collection of treatment dates for chemotherapy, hormone therapy, and immunotherapy was replaced by the collection of RX Date Systemic in 2003. Effective for 2010, collection of the treatment-specific dates **will again be required** because they are necessary to evaluate adherence to recommended treatment practices.

The following data items are required:

- RX Date--Chemo
- RX Date--Hormone
- RX Date--BRM

5.3 RX Summ--Treatment Status – This data item provides a summary indicator of whether the patient received any treatment from any facility, is managed by active surveillance (watchful waiting), or is untreated.

5.4 Grade Path Value and Grade Path System – These data items record the original pathologist's designation of 2, 3, or 4-grade system and its value. They supplement, not replace, the original ICD-O-3 Grade field.

5.5 Lymph-vascular Invasion – This data item records pathologic evidence of the presence or absence of cancer cells in the lymphatic ducts or blood vessels of the primary tumor.

5.6 CS Mets at DX Data Items - These data items identify the sites of metastatic involvement at the time of diagnosis:

- CS Mets at Dx-Bone
- CS Mets at Dx-Brain
- CS Mets at Dx-Liver
- CS Mets at Dx-Lung

5.7 CS Site-Specific Factors 7 – 25 – The possible number of site-specific factors (SSF) for Collaborative Stage (CS) schema has been increased from six to 25. These additional SSFs provide information on prognostic factors that have an effect on stage or survival. Not all are used by CS and not all are required by the PCR to be coded. Appendix A identifies SSFs required by the PCR and will be sent as soon as the list has been finalized.

5.8 CS Version Input Current – This data item is used for tracking CS version. It is automatically populated by registry and Abstract Plus software.

5.9 Date Case Completed – CoC –

- ***For Registry Hospitals only.*** ~~The PCR will accept this new field instead of Date Case Completed from registry hospitals. This date is inserted automatically by the registry software when data that should be available to the registry following the patient's main contact with the facility have been successfully abstracted, based on Class of Case.~~ Because the field Date Case Completed – COC is not recommended for use by central registries, the PCR will no longer require it to be reported by Registry Hospitals. The PCR requires the field Date Case Completed to be reported consistent with prior years.

- ***Non-Registry Hospitals only.*** Date Case Completed continues to be required for non-registry hospitals and is automatically populated by Abstract Plus.

5.10 ICD-O-3 Primary Site, Histology, Behavior, and Grade Codes - ***For Non-Registry Hospitals only (hospitals using Abstract Plus)*** Effective for 2010 cases, abstracts reported using Abstract Plus will require primary site, histology, behavior, and grade to be coded using ICD-O-3. With the new CS requirements, ICD-O-3 site and histology codes will be necessary to determine the appropriate CS schema to select and SSFs to complete. The PCR will provide information regarding on-line training modules and will conduct in-person ICD-O-3 training classes across the state to prepare hospital staff for this new requirement.

6.0 Changes to Existing Data Items

6.1 Date Fields – Beginning in 2010, the way dates are electronically transmitted changed from the traditional format to an interoperable format to improve communication of cancer registry data with other electronic record systems.

- Traditional Date Format – Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions and 99999999 representing a

completely unknown date. In the traditional form, some dates also permit 88888888 or 00000000 to convey non-date information.

- Interoperable Date Format – Interoperable dates are displayed in CCYYMMDD form with the unknown portions of the date filled with blank spaces. If a date is entirely blank, an associated date flag is used to explain the missing date. (See 5.1)

The format registry abstracting software will use for displaying and entering dates will be either the traditional manner or the interoperable format. If displayed in the traditional manner, the software must convert the date to the interoperable format for transmission. Dates in Abstract Plus will be entered and displayed in the interoperable format. Registry hospitals must contact their software vendor to determine the format for entering and displaying dates in their software.

6.2 Class of Case – Class of case has been changed from a one-digit code to a two-digit code. The expanded codes provide more flexibility in reflecting the facility's role in managing the cancer.

6.3 Diagnostic Confirmation – A new code 3 was added to reflect diagnostic methods used for hematopoietic and lymphoid tumors.

6.4 Laterality – A new code 5 was added to reflect when the tumor arises from the midline of a paired site (previously coded as 9). Code 9 no longer records midline tumor information and is used only when there is no laterality information for a paired site. The rules now permit coding non-paired sites to right or left when applicable.

6.5 Race Codes – Codes used in fields Race1 - Race5 were modified. Code 09 (Asian Indian or Pakistani) was converted to 15, to avoid accidental use of the code 09 for "unknown". New codes 16 and 17 are now available to differentiate between Asian Indian and Pakistani.

6.6 Date of Diagnosis – For analytic cases, if the date of diagnosis is entirely unknown, rules now require the year portion to be estimated using guidelines in the *PCR Manual 2010* (month and day may be unknown). For non-analytic cases, if the date of diagnosis cannot be identified, the date may still be recorded as unknown month, day and year.

6.7 Date of First Contact – For analytic cases, the *Date of First Contact* is the date the case became analytic. For nonanalytic cases, the *Date of First Contact* is the date the case becomes assignable to the respective *Class of Case.* Instructions have also been added for determining when *Date of First Contact* should be changed if *Class of Case* changes.

6.8 Treatment Fields: Modifications in coding instructions were made to the following fields:

6.8.1 RX Summ--Surg Prim Site: Brain – Surgery codes for Brain were modified to add more specificity for resection of brain tumors.

6.8.2 RX Summ--Surg Prim Site: Bladder – Instructions for surgery codes for bladder were modified to clarify the coding of surgical procedures used for men and women with bladder cancer.

6.8.3 RX Summ--Surg/Rad Seq – The definitions of codes 0 and 9 were changed for consistency with SEER (Surveillance Epidemiology and End Results) Program. For cases diagnosed in 2010 or later, code 0 (not 9) is used if it is unknown whether the patient was treated with either surgery or systemic therapy.

6.8.4 RX Summ—Systemic Sur Seq – The definitions of codes 0 and 9 were changed for consistency with the SEER Program. For cases diagnosed in 2010 or later, code 0 (not 9) is used if it is unknown whether the patient was treated with either surgery or systemic therapy.

6.9 Changes to Field Length: The field length for the following data items has been increased:

6.9.1 Name Fields – Fields used to record patient name have been expanded to provide additional space for recording this information and also to permit the use of blanks, spaces, and apostrophes in the patient's name items which were not permitted before. Hyphens, permitted previously, continue to be acceptable in the name fields.

6.9.2 Address Fields – All address fields for City, No & Street, and Supplemental have expanded to provide additional space for recording this information.

6.9.3 Class of Case – This field expanded from one to two characters.

6.9.4 CS Extension and CS Lymph Nodes – These fields expanded from two to three digits.

6.9.5 Text Fields – Fields for documenting text information to support coded data items were greatly expanded. Text--Primary Site Title and Text--Histology Title expanded to 100 characters and the remaining Text fields expanded to 1,000 characters each.

6.9.6 Other – Fields to record occupation/industry and place of diagnosis also expanded.

6.10 Data Item Name Changes – The name for the following data items changed:

6.10.1 Date of Birth – The field Birth Date was changed to Date of Birth.

6.10.2 CS Lymph Node Eval – The field CS Reg Node Eval was changed to CS Lymph Node Eval.

7.0 Data Items No Longer Required to be Reported to the PCR

As soon as the new version of software to abstract 2010 cases is implemented, the following data items will no longer be required to be reported to the PCR:

7.1 Marital Status

7.2 RX Date--Systemic

7.3 Casefinding Source

7.4 Accession Number (considered optional; may be submitted if beneficial to hospital)

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)	
Policy Statement: Appendix A, Site Specific Factors (SSF) Required to be Reported to the PCR		
Number: 2010-48	**Effective Date: Cases Diagnosed on or after January 1, 2010**	**Date Issued: July 27, 2010**

The purpose of Appendix A of Policy Statement 2010-48, New PCR Reporting Requirements for Cases Diagnosed On or After January 1, 2010, is to list the Site Specific Factors (SSF) required to be reported to the PCR for all cases diagnosed on or after January 1, 2010 or any case originally coded in CSV2 (Collaborative Stage Version 2).

Note to Registry Hospitals: All SSFs required by the PCR are also required by the American College of Surgeons (ACOS) Commission on Cancer (COC).

CS Schema Name	SSF Number	SSF Description
Appendix	2	Clinical Assessment of Regional Lymph Nodes
	11	Histopathological Grading
BileDuctsDistal	25	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
BileDuctsPerihilar	25	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
Bladder	1	WHO/ISUP Grade
	2	Size of Metastasis in Lymph Nodes
Brain	1	WHO Grade Classification
Breast	1	Estrogen Receptor Assay (ERA)
	2	Progesterone Receptor Assay (PRA)
	3	Number of Positive Ipsilateral Level I-II Axillary Lymph Nodes
	4	Immunohistochemistry (IHC) of Regional Lymph Nodes
	5	Molecular Studies of Regional Lymph Nodes
	7	Nottingham or Bloom-Richardson (BR) Score/Grade
	8	HER2: IHC Test Lab Value
	9	HER2: IHC Test Interpretation
	10	HER2: FISH Test Lab Value
	11	HER2: FISH Test Interpretation
	12	HER2: CISH Test Lab Value
	13	HER2: CISH Test Interpretation
	14	HER2: Result of other or unknown test

CS Schema Name	SSF Number	SSF Description
BuccalMucosa	1	Size of Lymph Nodes
CarcinoidAppendix	2	Clinical Assessment of Regional Lymph Nodes
CNSOther	1	WHO Grade Classification
Colon	2	Clinical Assessment of Regional Lymph Nodes
Conjunctiva	1	Tumor Size
CorpusAdenosarcoma	2	Peritoneal Cytology
CorpusCarcinoma	2	Peritoneal Cytology
CorpusSarcoma	2	Peritoneal Cytology
CysticDuct	25	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
EpiglottisAnterior	1	Size of Lymph Nodes
Esophagus	1	Clinical Assessment of Regional Lymph Nodes
EsophagusGEJunction	1	Clinical Assessment of Regional Lymph Nodes
	25	Schema Discriminator: Involvement of Cardia and Distance from Esophagogastric Juncture (EGJ)
FloorMouth	1	Size of Lymph Nodes
GISTAppendix	11	Mitotic Count
GISTColon	11	Mitotic Count
GISTEsophagus	6	Mitotic Count
GISTPeritoneum	5	Mitotic Count
	10	Location of Primary Tumor
GISTRectum	11	Mitotic Count
GISTSmallIntestine	6	Mitotic Count
GISTStomach	6	Mitotic Count
GumLower	1	Size of Lymph Nodes
GumOther	1	Size of Lymph Nodes
GumUpper	1	Size of Lymph Nodes
HeartMediastinum	1	Grade for Sarcomas
HemeRetic	1	JAK-2
Hypopharynx	1	Size of Lymph Nodes
IntracranialGland	1	WHO Grade Classification
KidneyParenchyma	6	Fuhrman Nuclear Grade
KidneyRenalPelvis	1	WHO/ISUP Grade

CS Schema Name	SSF Number	SSF Description
LacrimalGland	25	Schema Discriminator: Lacrimal Gland/Lacrimal Sac
LacrimalSac	25	Schema Discriminator: Lacrimal Gland/Lacrimal Sac
LarynxGlottic	1	Size of Lymph Nodes
LarynxOther	1	Size of Lymph Nodes
LarynxSubglottic	1	Size of Lymph Nodes
LarynxSupraglottic	1	Size of Lymph Nodes
LipLower	1	Size of Lymph Nodes
LipOther	1	Size of Lymph Nodes
LipUpper	1	Size of Lymph Nodes
Lung	1	Separate Tumor Nodules/Ipsilateral Lung
Lymphoma	2	Systemic Symptoms at Diagnosis
LymphomaOccularAdnexa	2	Systemic Symptoms at Diagnosis
MelanomaChoroid	2	Measured Basal Diameter
	3	Measured Thickness (Depth)
	4	Size of Largest Metastasis
MelanomaCiliaryBody	2	Measured Basal Diameter
	3	Measured Thickness (Depth)
	4	Size of Largest Metastasis
	25	Schema Discriminator: Melanoma Ciliary Body/Melanoma Iris
MelanomaConjunctiva	1	Measured Thickness (Depth)
	2	Quadrants
MelanomaIris	4	Size of Largest Metastasis
	25	Schema Discriminator: Melanoma Ciliary Body/Melanoma Iris
MelanomaSkin	1	Measured Thickness (Depth), Breslow's Measurement
	2	Ulceration
	3	Clinical Status of Lymph Node Mets
	4	LDH
	7	Primary Tumor Mitotic Count/Rate
MerkelCellPenis	3	Clinical Status of Lymph Node Mets
MerkelCellScrotum	3	Clinical Status of Lymph Node Mets
MerkelCellSkin	3	Clinical Status of Lymph Node Mets

CS Schema Name	SSF Number	SSF Description
MerkelCellVulva	3	Clinical Status of Lymph Node Mets
	11	Regional Lymph Node - Laterality
MouthOther	1	Size of Lymph Nodes
MycosisFungoides	1	Peripheral Blood Involvement
NasalCavity	1	Size of Lymph Nodes
Nasopharynx	1	Size of Lymph Nodes
	25	Schema Discriminator
NETColon	2	Clinical Assessment of Regional Lymph Nodes
NETRectum	2	Clinical Assessment of Regional Lymph Nodes
NETStomach	1	Clinical Assessment of Regional Lymph Nodes
Oropharynx	1	Size of Lymph Nodes
PalateHard	1	Size of Lymph Nodes
PalateSoft	1	Size of Lymph Nodes
ParotidGland	1	Size of Lymph Nodes
Penis	17	Extranodal Extension of Regional Lymph Nodes
Peritoneum	1	Grade for Sarcomas
	25	Schema Discriminator
PeritoneumFemaleGen	25	Schema Discriminator
PharyngealTonsil	1	Size of Lymph Nodes
	25	Schema Discriminator
Placenta	1	Prognostic Scoring Index Table 1
Pleura	1	Pleural Effusion
Prostate	1	Prostatic Specific Antigen (PSA) Lab avalue
	3	CS Extension – Pathologic Extension
	7	Gleason's Primary Pattern and Secondary Pattern Value on Needle Core Biopsy/TURP
	8	Gleason's Score on Needle Core Biopsy/TURP
	9	Gleason's Primary Pattern and Secondary Pattern Value on Prostatectomy/Autopsy
	10	Gleason's Score on Prostatectomy /Autopsy
Rectum	2	Clinical Assessment of Regional Lymph Nodes
Retinoblastoma	1	Extension Evaluated at Enucleation

CS Schema Name	SSF Number	SSF Description
Retroperitoneum	1	Grade for Sarcomas
SalivaryGlandOther	1	Size of Lymph Nodes
Scrotum	12	High Risk Features
	16	Size of Lymph Nodes
SinusEthmoid	1	Size of Lymph Nodes
SinusMaxillary	1	Size of Lymph Nodes
Skin	12	High Risk Features
	16	Size of Lymph Nodes
SkinEyelid	6	Perineural Invasion
SmallIntestine	2	Clinical Assessment of Regional Lymph Nodes
SoftTissue	1	Grade for Sarcomas
Stomach	1	Clinical Assessment of Regional Lymph Nodes
	25	Involvement of Cardia and Distance from Esophagogastric Junction (EGJ)
SubmandibularGland	1	Size of Lymph Nodes
Testis	4	Radical Orchiectomy Performed
	5	Size of Metastasis in Lymph Nodes
	7	Preorchiectomy Alpha Fetoprotein (AFP) Interpretation
	9	Preorchiectomy Human chorionic gonadotropin (hCG) Interpretation
	10	Preorchiectomy LDH Interpretation
	11	Persistence of Elevated Serum Tumor Markers
TongueAnterior	1	Size of Lymph Nodes
TongueBase	1	Size of Lymph Nodes
Urethra	1	WHO/ISUP Grade
Vulva	11	Regional Lymph Node - Laterality

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)	
Policy Statement: Appendix B, Newly Reportable Conditions, New Reportable Terms, and ICDO3 Histology Codes, Tables 4.2 and 4.3 Corresponding to Policy Statement 2010-48		
Number: 2010-48B	**Effective Date: Cases Diagnosed on or after January 1, 2010**	**Date Issued: March 24, 2010**

Table 4.2 shows newly reportable hematopoietic conditions effective for cases diagnosed on or after January 1, 2010. **Update the histology and behavior codes in both the alphabetic and tabular listings in the ICD-O-3 code book to assure these conditions are identified as reportable and appropriate ICD-O-3 histology and behavior codes are assigned.**

Table Corresponding to 4.2 of Policy Statement 2010-48 Histologic Terms and Codes with Changes in Case Reportability (Newly Reportable Conditions)	
Name	**ICD-O-3 Code**
Chronic lymphoproliferative disorder of NK-cells	9831/3
T-cell large granular lymphocytic leukemia	9831/3
Langerhans cell histiocytosis, NOS (9751/1)	9751/3
Langerhans cell histiocytosis, unifocal (9752/1)	9751/3
Langerhans cell histiocytosis, multifocal (9753/1)	9751/3
Myelodysplastic/Myeloproliferative neoplasm, unclassifiable	9975/3
Myeloproliferative disease, NOS (9975/1)	9975/3
Myeloproliferative neoplasm, unclassifiable	9975/3

Table 4.3 shows new reportable terms and codes. These conditions were previously reportable but coded to the Not Otherwise Specified (NOS) category because they were not specifically indexed in ICD-O-3. With implementation of the new hematopoietic rules for cases diagnosed on or after January 1, 2010, these conditions will be coded using new histology codes assigned by the World Health Organization (WHO) that did not previously exist.

Column 1 is the more specific histology term; Column 2 is the new histology code. **Add these terms and codes to both the alphabetic and tabular listings in the ICD-O-3 code book to assure the appropriate ICD-O-3 histology code is assigned.**

Table Corresponding to 4.3 of Policy Statement 2010-48 2008 WHO Classification of Tumours of Hematopoietic and Lymphoid Tissues Newly Reportable Terms and Codes – Numerical Order	
Name	**ICD-O-3 Code**
Primary cutaneous follicle centre lymphoma	9597/3
T-cell/histiocyte rich large B-cell lymphoma	9688/3
Intravascular large B-cell lymphoma	9712/3
Systemic EBV positive T-cell lymphoproliferative disease of childhood	9724/3
Hydroa vacciniforme-like lymphoma	9725/3
Primary cutaneous gamma-delta T-cell lymphoma	9726/3

Table Corresponding to 4.3 of Policy Statement 2010-48 2008 WHO Classification of Tumours of Hematopoietic and Lymphoid Tissues Newly Reportable Terms and Codes – Numerical Order	
Name	**ICD-O-3 Code**
Plasmablastic lymphoma	9735/3
ALK positive large B-cell lymphoma	9737/3
Large B-cell lymphoma arising in HHV8- associated multicentric Castleman disease	9738/3
Fibroblastic reticular cell tumor	9759/3
Mixed phenotype acute leukemia with t(9;22)(q34;q11.2); BCR-ABL1	9806/3
Mixed phenotype acute leukemia with t(v;11q23); MLL rearranged	9807/3
Mixed phenotype acute leukemia, B/myeloid, NOS	9808/3
Mixed phenotype acute leukemia, T/myeloid, NOS	9809/3
B lymphoblastic leukemia/lymphoma, NOS	9811/3
B lymphoblastic leukemia/lymphoma with t(9;22)(q34;q11.2); BCR-ABL1	9812/3
B lymphoblastic leukemia/lymphoma with t(v;11q23); MLL rearranged	9813/3
B lymphoblastic leukemia/lymphoma, with t(12;21)(p13;q22); TEL-AML1 (ETV6-RUNX1)	9814/3
B lymphoblastic leukemia/lymphoma with hyperdiploidy	9815/3
B lymphoblastic leukemia/lymphoma with hypodiploidy (hypodiploid ALL)	9816/3
B lymphoblastic leukemia/lymphoma with t(5;14)(q31;q32); IL3-IGH	9817/3
B lymphoblastic leukemia/lymphoma with t(1;19)(q23;p13.3); E2A PBX1 (TCF3 PBX1)	9818/3
T lymphoblastic leukemia/lymphoma	9837/3
Acute myeloid leukemia with t(6;9)(p23;q34) DEK-NUP214	9865/3
Acute myeloid leukemia with inv(3)(q21q26.2) or t(3;3)(q21;q26.2); RPN1-EVI1	9869/3
Myeloid leukemia associated with Down Syndrome	9898/3
Acute myeloid leukemia (megakaryoblastic) with t(1;22)(p13;q13); RBM15-MKL1	9911/3
Myeloid and lymphoid neoplasms with PDGFRB rearrangement	9965/3
Myeloid and lymphoid neoplasms with PDGFRB arrangement	9966/3
Myeloid and lymphoid neoplasm with FGFR1 abnormalities	9967/3
Polymorphic PTLD	9971/3
Refractory neutropenia	9991/3
Refractory thrombocytopenia	9992/3

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)
Policy Statement:	**Reportability of Carcinoid Tumors of the Appendix**
Number: 2010-49	**Date Issued: April 28, 2010**

The purpose of this Policy Statement is to clarify reporting carcinoid tumors of the appendix effective for cases diagnosed on or after January 1, 2010:

Carcinoid Tumors of the Appendix

Carcinoid tumors of the appendix **are reportable only if** stated as malignant by the pathologist or by virtue of metastasis, e.g. positive lymph nodes and/or metastatic implants with the pathologist reporting the history as carcinoid arising in the appendix. When metastasis occurs, carcinoid tumors of the appendix become reportable and the behavior code is changed from /0 to /3.

Carcinoid tumors are the most common of all appendix tumors. The tumors are small, slow growing and rarely metastasize. The term "malignant" is applied to carcinoids that have metastasized to other areas of the body. Carcinoids greater than 2 cm are more likely to metastasize. The most common metastatic sites are liver or lymph nodes.

In the Collaborative Stage Schema *CarcinoidAppendix*, Note 1 states that carcinoid tumors of the appendix are typically not reportable. However, when any of the following conditions are met, the carcinoid is considered malignant and must be reported using the *CarcinoidAppendix* schema to complete Collaborative Stage fields:

- When the pathologist states the carcinoid of the appendix is malignant
- When the carcinoid of the appendix metastasizes to lymph nodes
- When implants are attributed to a carcinoid of the appendix and the implants are stated to be malignant; the carcinoid is **not** reportable unless the implants are malignant.

If a carcinoid of the appendix is found on appendectomy and patient returns later with regional or widespread disease, the case is to be back-coded to the date of the appendectomy and the first course of treatment date is the appendectomy date.

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)
Policy Statement: Brain and CNS Tumors Identified by Diagnostic Imaging	
Number: 2010-50	**Date Issued: 9/9/2010**

The purpose of this policy statement is to clarify reporting of brain or CNS (central nervous system) tumors identified by diagnostic imaging.

Brain and CNS Tumors Identified by Diagnostic Imaging

A brain or CNS tumor identified by diagnostic imaging* is reportable even when no other information is available (from biopsy or resection, for example). The behavior for the tumor may be reported as /1 (uncertain whether benign or malignant) until further diagnostic confirmation of benign or malignant behavior is received.

*Diagnostic imaging includes CT (computerized axial tomography) scans, MRI (magnetic resonance imaging) scans, or ultrasounds/sonography.

Rationale: Since brain and CNS tumors are reportable when behavior is malignant, benign, or uncertain, reports of diagnostic imaging of brain and CNS sites must be reviewed to identify reportable cases.

Tumors of sites other than brain or CNS identified by diagnostic imaging require further diagnostic confirmation of malignancy to be considered reportable.

pennsylvania
DEPARTMENT OF HEALTH

Pennsylvania Cancer Registry (PCR)

Policy Statement: Reportability of High Grade Dysplasia or Severe Dysplasia of the Esophagus and Colon

Number: 2010-51	Date Issued: 9/15/2010

The purpose of this Policy Statement is to clarify when the following diagnoses are reportable to the PCR:

High Grade Dysplasia or Severe Dysplasia of the Colon and Esophagus

The diagnoses high-grade dysplasia and severe dysplasia of the esophagus and colon are reportable to the PCR as carcinoma in situ only when this terminology has been verified with the pathologist and/or cancer committee that these terms are considered synonymous.

To identify if the diagnoses are to be reported, first determine whether the pathologists at your facility use the terms severe dysplasia and high grade dysplasia interchangeably with carcinoma in situ for esophagus and/or colon cases. If severe dysplasia and high grade dysplasia are not used to describe carcinoma in situ, do not report these cases. If your pathologist does consider them to be in situ, these cases are reportable to the PCR.

If the pathologists at your facility use the terms severe dysplasia or high grade dysplasia of the colon and/or esophagus interchangeably with carcinoma in-situ, use the following guidelines for reporting to the PCR:

a. Obtain a statement from your pathologist(s) outlining the terminology policy of their department. The statements should be separate, one for colon and one for esophagus, because different physicians may be involved in reviewing the statement for each site.

   Note: If you have already submitted a statement to the PCR to address colon, no additional documentation is required for colon cases. A separate statement for esophagus cases must be submitted if not already on file at the PCR.

b. Submit the statement(s) to the appropriate medical staff committee for approval. Registry hospitals will normally submit the statement(s) to the Cancer Committee.

c. Document a policy that states the sites diagnosed with severe dysplasia and/or high grade dysplasia that will be abstracted as carcinoma in-situ based on the pathologists approved statements.

d. Add the policy to the Registry Operations Manual attaching the approved statement(s).

e. Forward a copy of the policy and statement(s) to the PCR to keep on permanent file.

f. Abstract all colon and/or esophagus cases diagnosed with severe dysplasia and/or high grade dysplasia as carcinoma in-situ according to the statement(s) and policy and report these cases to the PCR. In the text for each abstract, document the final pathologic diagnosis along with the statement "in-situ per pathologist".

Rationale: The *American Joint Committee on Cancer (AJCC) Cancer Staging Manual, Seventh Edition,* page 109, redefined carcinoma in situ (Tis) of the esophagus as follows: "High-grade dysplasia includes all noninvasive neoplastic epithelia that was formerly called carcinoma in situ, a diagnosis no longer used for columnar mucosae anywhere in the gastrointestinal tract." The PCR reporting requirement for high-grade and severe dysplasia of the colon has been in effect for the past several years. With the publication of AJCC 7th Edition, the diagnosis of high grade or severe dysplasia of the esophagus is also required to be reported to the PCR when the pathologist and/or cancer committee verify these terms are considered synonymous or used interchangeably by the facility pathologists.

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)
Policy Statement: New PCR Reporting Requirements for Cases Diagnosed On or After January 1, 2011	
Number: 2011-52	**Date Issued: March 11, 2011**

The purpose of this Policy Statement is to describe the new PCR reporting requirements effective for **cases diagnosed on or after January 1, 2011**.

1.0 Collaborative Stage (CS) Data Collection System (CSv02.03)

Revisions to the current CSv2 (CSv02.02) were made for 2011 (referred to as CSv02.03). A description of the changes can be found under the heading "Contents of Release" at http://www.cancerstaging.org/cstage/.

Implementation of CSv02.03 is required as follows:

1.1 Effective Dates

- Cases with a diagnosis date on or after 1/1/2011 must be coded in CS 02.03 or higher.
- Cases with a diagnosis date of 2010 must be coded in a CS version higher than 02.00.

1.2 Coding Instructions

- Code all cases diagnosed on or after 1/1/2011 using CSv02.03.
- **Implement CSv02.03 before abstracting any cases diagnosed on or after 1/1/2011**.
  - Registry Hospitals: Implementation of CSv02.03 will require a software update and conversion of the hospital registry database by the software vendor. Conversion of the registry database to CSv02.03 plus incorporation of the PA V12.1 edits metafile must be completed before cases coded to CSv02.03 can be submitted to the PCR.
  - Abstract Plus Hospitals: Do not use CSv02.03 until all 2010 cases have been entered into the 2010 version of Abstract Plus expected to be released by CDC in the next two to three weeks. Once all 2010 cases have been submitted, the PCR will provide instructions for abstracting 2011 cases.
- After CSv02.03 has been implemented, all cases need to be abstracted using CSv02.03 regardless of diagnosis year.
- **Access Coding Instructions for CSv02.03 (Manual Part 1 and Site Specific Schema), at** http://www.cancerstaging.org/cstage/manuals/coding0203.html**.**

1.3 Site-Specific Factors (SSF)

- New SSFs required in CSv02.03:
  - BileDuctsIntrahepatic, SSF 10
  - Breast: SSF 15, 16
  - Testis: SSF 13, 15, 16

- SSF no longer required in CSv02.03:
    - Testis: SSF 11 (obsolete in CSv02.03)

See Appendix A, *Site Specific Factors (SSF) Required to be Reported to the PCR for Cases Diagnosed on or after 1/1/2011* for a complete list of required SSFs.

2.0 Required Data Items

2.1 Reason for No Radiation: This data item is now required to provide a code for the reason the patient did not receive radiation treatment as part of first course therapy. See attached data item page that will be added to the PCR Manual.

2.2 For Registry Hospitals Only: The following data items are still required to be reported to the PCR even though effective with 2011 cases they are no longer required by the American College of Surgeons Commission on Cancer (ACOS COC):

- **Date of Diagnosis Flag (NAACCR #391)** – Since the PCR requires cases with unknown dates of diagnosis to be reported, this flag is required.
- **Institution Referred From (NAACCR #2410)**
- **Physician-Follow-Up (NAACCR #2470)**

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)	
Policy Statement: Appendix A, Site Specific Factors (SSF) Required to be Reported to the PCR for Cases Diagnosed 1/1/2011 and After		
Number: 2011-52	**Effective Date: Cases Diagnosed on or after January 1, 2011**	**Date Issued: March 11, 2011** **Date Revised: July 25, 2011**

The purpose of Appendix A of Policy Statement 2011-52, New PCR Reporting Requirements for Cases Diagnosed On or After January 1, 2011, is to list the Site Specific Factors (SSF) required to be reported to the PCR for all cases diagnosed on or after January 1, 2011 or any case abstracted after conversion to CSv02.03. Changes from Policy Statement 2010-48, Appendix A are noted.

Note to Registry Hospitals: All SSFs required by the PCR are also required by the American College of Surgeons (ACOS) Commission on Cancer (COC).

Revision 07/25/2011: Effective 7/25/2011, CS SSF 16 in the Breast Schema is no longer required to be reported to the PCR for 2011 cases. SSF16 in the Breast Schema was not reportable for 2010 but was added to the list of 2011 PCR-required SSFs. Because Breast CS SSF 16 is based on information coded in Breast CS SSFs 1, 2, and 15, the PCR will electronically derive the value for SSF 16 for 2011 cases rather than have registrars report it.

CS Schema Name	SSF Number	SSF Description
Appendix	2	Clinical Assessment of Regional Lymph Nodes
	11	Histopathological Grading
BileDuctsDistal	25	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
BileDuctsIntraHepatic	**10***	**Tumor Growth Pattern**
BileDuctsPerihilar	25	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
Bladder	1	WHO/ISUP Grade
	2	Size of Metastasis in Lymph Nodes
Brain	1	WHO Grade Classification
Breast	1	Estrogen Receptor Assay (ERA)
	2	Progesterone Receptor Assay (PRA)
	3	Number of Positive Ipsilateral Level I-II Axillary Lymph Nodes
	4	Immunohistochemistry (IHC) of Regional Lymph Nodes
	5	Molecular Studies of Regional Lymph Nodes
	7	Nottingham or Bloom-Richardson (BR) Score/Grade
	8	HER2: IHC Test Lab Value
	9	HER2: IHC Test Interpretation
	10	HER2: FISH Test Lab Value

CS Schema Name	SSF Number	SSF Description
Breast (continued)	11	HER2: FISH Test Interpretation
	12	HER2: CISH Test Lab Value
	13	HER2: CISH Test Interpretation
	14	HER2: Result of other or unknown test
	15*	**HER2: Summary Result of Testing**
	~~**16*****~~	~~**Combinations of ER, PR, and HER2 Results**~~**(deleted 07/25/2011)**
BuccalMucosa	1	Size of Lymph Nodes
CarcinoidAppendix	2	Clinical Assessment of Regional Lymph Nodes
CNSOther	1	WHO Grade Classification
Colon	2	Clinical Assessment of Regional Lymph Nodes
Conjunctiva	1	Tumor Size
CorpusAdenosarcoma	2	Peritoneal Cytology
CorpusCarcinoma	2	Peritoneal Cytology
CorpusSarcoma	2	Peritoneal Cytology
CysticDuct	25	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
EpiglottisAnterior	1	Size of Lymph Nodes
Esophagus	1	Clinical Assessment of Regional Lymph Nodes
EsophagusGEJunction	1	Clinical Assessment of Regional Lymph Nodes
	25	Schema Discriminator: Involvement of Cardia and Distance from Esophagogastric Juncture (EGJ)
FloorMouth	1	Size of Lymph Nodes
GISTAppendix	11	Mitotic Count
GISTColon	11	Mitotic Count
GISTEsophagus	6	Mitotic Count
GISTPeritoneum	5	Mitotic Count
	10	Location of Primary Tumor
GISTRectum	11	Mitotic Count
GISTSmallIntestine	6	Mitotic Count
GISTStomach	6	Mitotic Count
GumLower	1	Size of Lymph Nodes
GumOther	1	Size of Lymph Nodes
GumUpper	1	Size of Lymph Nodes

CS Schema Name	SSF Number	SSF Description
HeartMediastinum	1	Grade for Sarcomas
HemeRetic	1	JAK-2
Hypopharynx	1	Size of Lymph Nodes
IntracranialGland	1	WHO Grade Classification
KidneyParenchyma	6	Fuhrman Nuclear Grade
KidneyRenalPelvis	1	WHO/ISUP Grade
LacrimalGland	25	Schema Discriminator: Lacrimal Gland/Lacrimal Sac
LacrimalSac	25	Schema Discriminator: Lacrimal Gland/Lacrimal Sac
LarynxGlottic	1	Size of Lymph Nodes
LarynxOther	1	Size of Lymph Nodes
LarynxSubglottic	1	Size of Lymph Nodes
LarynxSupraglottic	1	Size of Lymph Nodes
LipLower	1	Size of Lymph Nodes
LipOther	1	Size of Lymph Nodes
LipUpper	1	Size of Lymph Nodes
Lung	1	Separate Tumor Nodules/Ipsilateral Lung
Lymphoma	2	Systemic Symptoms at Diagnosis
LymphomaOccularAdnexa	2	Systemic Symptoms at Diagnosis
MelanomaChoroid	2	Measured Basal Diameter
	3	Measured Thickness (Depth)
	4	Size of Largest Metastasis
MelanomaCiliaryBody	2	Measured Basal Diameter
	3	Measured Thickness (Depth)
	4	Size of Largest Metastasis
	25	Schema Discriminator: Melanoma Ciliary Body/Melanoma Iris
MelanomaConjunctiva	1	Measured Thickness (Depth)
	2	Quadrants
MelanomaIris	4	Size of Largest Metastasis
	25	Schema Discriminator: Melanoma Ciliary Body/Melanoma Iris
MelanomaSkin	1	Measured Thickness (Depth), Breslow's Measurement
	2	Ulceration

CS Schema Name	SSF Number	SSF Description
MelanomaSkin (continued)	3	Clinical Status of Lymph Node Mets
	4	LDH
	7	Primary Tumor Mitotic Count/Rate
MerkelCellPenis	3	Clinical Status of Lymph Node Mets
MerkelCellScrotum	3	Clinical Status of Lymph Node Mets
MerkelCellSkin	3	Clinical Status of Lymph Node Mets
MerkelCellVulva	3	Clinical Status of Lymph Node Mets
	11	Regional Lymph Node - Laterality
MouthOther	1	Size of Lymph Nodes
MycosisFungoides	1	Peripheral Blood Involvement
NasalCavity	1	Size of Lymph Nodes
Nasopharynx	1	Size of Lymph Nodes
	25	Schema Discriminator
NETColon	2	Clinical Assessment of Regional Lymph Nodes
NETRectum	2	Clinical Assessment of Regional Lymph Nodes
NETStomach	1	Clinical Assessment of Regional Lymph Nodes
Oropharynx	1	Size of Lymph Nodes
PalateHard	1	Size of Lymph Nodes
PalateSoft	1	Size of Lymph Nodes
ParotidGland	1	Size of Lymph Nodes
Penis	17	Extranodal Extension of Regional Lymph Nodes
Peritoneum	1	Grade for Sarcomas
	25	Schema Discriminator
PeritoneumFemaleGen	25	Schema Discriminator
PharyngealTonsil	1	Size of Lymph Nodes
	25	Schema Discriminator
Placenta	1	Prognostic Scoring Index Table 1
Pleura	1	Pleural Effusion
Prostate	1	Prostatic Specific Antigen (PSA) Lab Value
	3	CS Extension – Pathologic Extension
	7	Gleason's Primary Pattern and Secondary Pattern Value on Needle Core Biopsy/TURP

CS Schema Name	SSF Number	SSF Description
Prostate (continued)	8	Gleason's Score on Needle Core Biopsy/TURP
	9	Gleason's Primary Pattern and Secondary Pattern Value on Prostatectomy/Autopsy
	10	Gleason's Score on Prostatectomy /Autopsy
Rectum	2	Clinical Assessment of Regional Lymph Nodes
Retinoblastoma	1	Extension Evaluated at Enucleation
Retroperitoneum	1	Grade for Sarcomas
SalivaryGlandOther	1	Size of Lymph Nodes
Scrotum	12	High Risk Features
	16	Size of Lymph Nodes
SinusEthmoid	1	Size of Lymph Nodes
SinusMaxillary	1	Size of Lymph Nodes
Skin	12	High Risk Features
	16	Size of Lymph Nodes
SkinEyelid	6	Perineural Invasion
SmallIntestine	2	Clinical Assessment of Regional Lymph Nodes
SoftTissue	1	Grade for Sarcomas
Stomach	1	Clinical Assessment of Regional Lymph Nodes
	25	Involvement of Cardia and Distance from Esophagogastric Junction (EGJ)
SubmandibularGland	1	Size of Lymph Nodes
Testis	4	Radical Orchiectomy Performed
	5	Size of Metastasis in Lymph Nodes
	7	Preorchiectomy Alpha Fetoprotein (AFP) Interpretation
	9	Preorchiectomy Human chorionic gonadotropin (hCG) Interpretation
	10	Preorchiectomy LDH Interpretation
	~~11**~~	~~Persistence of Elevated Serum Tumor Markers~~
	13*	**Post-Orchiectomy Alpha Fetoprotein (AFP) Range**
	15*	**Post-Orchiectomy Human Chorionic Gonadotropin (hCG) Range**
	16*	**Post-Orchiectomy Lactate Dehydrogenase (LDH) Range**
TongueAnterior	1	Size of Lymph Nodes
TongueBase	1	Size of Lymph Nodes

CS Schema Name	SSF Number	SSF Description
Urethra	1	WHO/ISUP Grade
Vulva	11	Regional Lymph Node - Laterality

*New for 2011 or cases abstracted in CS2 02.30
** Required for 2010 but deleted for 2011 or cases abstracted in CS2 02.03
***Not required to be reported effective 07/25/2011; will be derived

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)
Policy Statement: Reportability of Hematopoietic Conditions	
Number: 2011-53	**Date Issued: May 4, 2011**

The purpose of this Policy Statement is to clarify when hematopoietic conditions and their synonyms are reportable to the PCR effective immediately:

Determine reportability of hematopoietic conditions as follows:

- Date of diagnosis 2010 and after- If the date of diagnosis is 2010 or after, the SEER Hematopoietic Manual and Database should be used to determine reportability.

- Date of diagnosis between 2001 and 2009-If the date of diagnosis is between 2001 and 2009, only the hematopoietic conditions listed as /3 in ICD-O-3 are reportable.

- Date of diagnosis prior to 2001- If the date of diagnosis is prior to 2001, only the hematopoietic conditions listed as /3 in ICD-O-2 should be reported.

Rationale:

The following information was obtained through the AskSEERCTR program:

March 22, 2011- SEER Ask a Registrar (ASW00849): Hematopoietic Rules (database and manual)

For the years 2001-2009 only the terms in ICD-O-3 are reportable. For the years 2010 and later, all of the terms in the Hematopoietic Database are reportable.

I do realize that some of the terms were published in the Red Book; however none of the standard setters (CoC, NPCR, or SEER) made the Red Book the standard for reporting diseases. The use of the Red Book was not mandated by any of these agencies. Because the Red Book was not the standard for case reporting, we cannot ask you to pick up any of those cases described by terms only found in the Red Book.

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)
Policy Statement: New PCR Reporting Requirements for 2012 Cases	
Number: 2012-54	**Date Issued: April 17, 2012**

The purpose of this Policy Statement is to describe the new PCR reporting requirements effective for **cases diagnosed on or after January 1, 2012 and for all other cases abstracted after 2012 software has been implemented**.

1.0 Software: New Software for 2012 Reporting (NAACCR V12.2)

NAACCR Version 12.2 record format is required to submit 2012 cases. Due to the change from NAACCR Version 12.1 to V12.2, new software must be used to report 2012 cases. **Do not abstract 2012 cases with the 2011 version of your software.**

Web Plus: The PCR is waiting for CDC to release the 2012 version of Web Plus. After receiving and testing the updated version of Web Plus, we will notify hospitals that 2012 cases may be submitted. If you are ready to submit 2012 cases before receiving this update, please hold until you receive notification that the PCR is ready to accept 2012 cases.

1.1 Registry Hospitals: Abstracting 2012 cases will require a software update and conversion of the hospital registry database by the software vendor. Complete 2011 cases in the current version of your hospital registry software. After closing out 2011, contact your cancer registry software vendor to provide the 2012 update and database conversion.

1.2 Abstract Plus Hospitals: Abstracting 2012 cases will require a software update. Complete 2011 cases in the current version of Abstract Plus. After closing out 2011, contact your PCR Field Representative for instructions for abstracting 2012 cases.

2.0 Edits: New Version 12.2 PA Edits Metafile

A new PA Edits Metafile is being compiled for incorporation into the Version 12.2 software.

2.1 Registry Hospitals: Version 12.2B PA Edits Metafile will be sent via email to cancer registry software vendors as soon as it has been completed. Hospitals will be copied on the email.

2.2 Abstract Plus Hospitals: Version 12.2B PA Edits Metafile will be incorporated into the 2012 version of Abstract Plus. After closing out 2011, contact your PCR Field Representative for instructions for abstracting 2012 cases.

3.0 Collaborative Stage (CS) Data Collection System: New CS Version for 2012 Reporting (CSv02.04)

The primary reason for updating to 2012 software is to accommodate changes to the Collaborative Stage (CS) Data Collection System. A description of the changes can be found under the heading "CS Release Notes Version 02.04" at http://www.cancerstaging.org/cstage/news/release-notes.pdf.

Implementation of CSv02.04 is required as follows:

3.1 Effective Dates: Use CSv02.04 to code all cases diagnosed on or after 1/1/2012. After conversion to 2012 software, use CSv02.04 to code all cases diagnosed from 2004 forward. (2004 was the first year for which Collaborative Stage was collected.) For cases diagnosed prior to 2004 and for those with an unknown date of diagnosis, leave CS fields blank.

3.2 CS Manual: Access Coding Instructions for CSv02.04 (Manual Part 1 and Site Specific Schema) at http://www.cancerstaging.org/cstage/manuals/coding0204.html. **Do not use the CSv02.04 manual until you have implemented Version 2012 software.**

4.0 CS Site-Specific Factors (SSF): No Change for 2012 Reporting

4.1 No new Site-Specific Factors (SSFs) are required for 2012 reporting.

4.2 See PCR Manual, Appendix J, *PCR Required Site Specific Factors (SSFs)* for a complete list of required SSFs.

5.0 Data Items: Changes to Required Data Items

5.1 Physician Follow-Up:

- Registry Hospitals: Effective with 2012 case reporting, use the field **NPI-Physician Follow-Up** (NAACCR #2475) to report physician information. This change is now consistent with ACoS COC requirements.
- Abstract Plus Hospitals: Hospitals using Abstract Plus software shall continue to enter the hospital-specific physician number in the field Physician Follow-Up. If there is no hospital-specific number assigned, enter up to eight characters of the physician's last name.

5.2 Scope of Regional Lymph Node Surgery: Current coding instructions for this data item have caused sentinel lymph node biopsies for breast cancer cases to be significantly under-reported. New instructions and clarifications emphasizing the use of the operative report as the priority source to code this data item will be incorporated into the PCR Manual 2012. The new instructions will be effective for cases abstracted in the 2012 version of software. Training on the revised instructions will be provided.

For a complete description of the issue, refer to the document posted on the Commission on Cancer website at http://www.facs.org/cancer/ncdb/scope-regional-lymph-node-surgery.pdf.

5.3 RX Summ Fields: The following changes were made to RX SUMM Fields:

- RX Summ-Surg/Rad Seq**:** Code 6 was revised and Code 7 was added.
  - Code 6: Intraoperative radiation with other radiation given before and/or after surgery.
  - Code 7: Surgery both before and after radiation

- RX Summ-Systemic/Sur/Seq: Code 6 was revised and Code 7 was added.
  - Code 6: Intraoperative systemic therapy with other therapy administered before and/or after surgery.
  - Code 7: Surgery both before and after systemic therapy.

5.4 **Grade/Differentiation**: The American College of Surgeons Commission on Cancer (ACOS COC) recently issued the following instructions for coding grade/differentiation, and incorporated this information into the 2012 FORDS:

"The Commission on Cancer (CoC) no longer supports conversion from other systems into *Grade/Differentiation* if the information can properly be recorded in one of the other more specific items. However, conversion may be required by some state or regional registries. If so, follow the instructions provided by the respective central registry."

The PCR is not adopting this change to coding grade for 2012 cases at this time. Reporting facilities shall continue to follow conversion instructions in the current PCR Manual. If grade/ differentiation can be recorded in one of the other more specific items (Site Specific Factor and/or Grade Path Value/Grade Path System), record in the appropriate field(s) but also apply the conversion to code the ICD-O-3 data item Grade/Differentiation.

5.4 **For Registry Hospitals Only**: The following data items are still required to be reported to the PCR even though they are not required by the ACOS COC:

- **Date of Diagnosis Flag (NAACCR #391)** – This flag is required because the PCR requires cases with unknown dates of diagnosis (including year) to be reported.
- **Type of Reporting Source (NAACCR #500)**
- **Date of Inpatient Adm (NAACCR #590)**
- **Date of Inpatient Disch (NAACCR #600)**
- **Institution Referred From (NAACCR #2410)** – The PCR continues to use COC codes to identify facilities.

The following data item is no longer required by the PCR:

- **Fin Coding System (NAACCR #35)**

6.0 SEER Hematopoietic Database: New Version to be Released for 2012 Reporting

New reportability instructions and data collection rules for hematopoietic and lymphoid neoplasms go into effect for cases diagnosed beginning January 1, 2012. The new database is expected to be released by SEER in May 2012. As soon as the PCR receives the new database, we will forward the link to you.

7.0 PCR Manual: New Version of PCR Manual to be Released for 2012 Reporting

The *PCR Manual 2012* is currently being updated to reflect changes identified in this policy statement. As soon as the new Hematopoietic Database is released, we will complete the revisions and post the new manual on the PCR website. A blast e-mail will be sent to announce its release.

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)
Policy Statement: New PCR Reporting Requirements for 2013 Cases	
Number: 2013-55	**Date Issued: January 10, 2013**

The purpose of this Policy Statement is to describe the new PCR reporting requirements effective for **cases diagnosed on or after January 1, 2013 and for all other cases abstracted after 2013 software has been implemented**.

1.0 Software: New Software for 2013 Reporting (NAACCR V13)

NAACCR Version 13 is the record format required to submit 2013 cases. Due to changes from NAACCR V12.2 to V13, new software must be used to report 2013 cases. If you complete 2012 reporting and are ready to abstract 2013 cases before you receive the updated 2013 software, please contact your PCR Field Representative.

Web Plus: The PCR is waiting for CDC to release the V13 version of Web Plus. After receiving and testing the updated version of Web Plus, we will notify hospitals that V13 shipments may be submitted. If you are ready to submit V13 shipments before receiving this update, please hold until you receive notification that the PCR is ready to accept V13 shipments.

1.1 Registry Hospitals: Abstracting 2013 cases will require a minor software update and conversion of the hospital registry database by the software vendor. Complete 2012 cases in the current version of your hospital registry software. After closing out 2012, contact your cancer registry software vendor to provide the 2013 update and database conversion.

1.2 Abstract Plus Hospitals: Abstracting 2013 cases will require a software update. Complete 2012 cases in the current version of Abstract Plus. After closing out 2012, contact your PCR Field Representative for instructions for abstracting 2013 cases.

2.0 Edits: New Version 13 PA Edits Metafile

A new PA Edits Metafile is being compiled for incorporation into the V13 software. V13 metafile contains many new Collaborative Stage (CS) edits. Cases abstracted and edited prior to implementation of V13 may fail new CS edits incorporated into this metafile and have to be corrected when opened after 2013 software has been installed.

2.1 Registry Hospitals: Version 13 PA Edits Metafile will be sent via email to cancer registry software vendors as soon as it has been completed. Registrars will be copied on the email.

2.2 Abstract Plus Hospitals: Version V13 PA Edits Metafile will be incorporated into the 2013 version of Abstract Plus. After closing out 2012, contact your PCR Field Representative for instructions for abstracting 2013 cases.

3.0 Collaborative Stage (CS) Data Collection System: No change for 2013 reporting.

4.0 CS Site-Specific Factors (SSF): No change for 2013 reporting. See PCR Manual, Appendix J, *PCR Required Site Specific Factors (SSFs)* for a complete list of required SSFs.

5.0 Data Items: Changes to Required Data Items

5.1 Delete Place of Birth (Birthplace): [NAACCR Data Item 250] Place of Birth has been replaced by Birthplace--State [252] and Birthplace--Country [254] in order to include state and country separately using standard, interoperable codes rather than codes used only by cancer registries.

5.2 Add Birthplace--State: [NAACCR Data Item 252] USPS abbreviation for the state, commonwealth, U.S. possession; or CanadaPost abbreviation for the Canadian province/territory in which the patient was born. Codes provided in *PCR Manual.*

5.3 Add Birthplace--Country: [NAACCR Data Item 254] Code for the country in which the patient was born. Codes provided in *PCR Manual.*

5.4 Grade/Differentiation: As a reminder effective with cases diagnosed in 2012, the Commission on Cancer (CoC) of the American College of Surgeons no longer supports the conversion from other grading systems into Grade/Differentiation [440] if the information can be properly recorded in one of the other more specific grade items (Grade Path Value and Grade Path System or CS SSFs for special grades.)

Consistent with guidance from CDC and SEER, the PCR will continue to require reporting facilities to follow conversion instructions in the current PCR Manual. If grade/ differentiation can be recorded in one of the other more specific items (Site Specific Factor and/or Grade Path Value/Grade Path System), record in the appropriate field(s) but also apply the conversion to code the ICD-O-3 data item Grade/Differentiation.

5.5 System Codes: The following system codes* are no longer required by the PCR:

- Race Coding System Current [170]
- COC Coding System Current [2140]
- First Course Calc Method [1500]

* System Codes are codes programmed into your registry software or Abstract Plus and entered automatically into the abstract.

6.0 PCR Manual: New Version of PCR Manual to be Released for 2013 Reporting

The *PCR Manual 2013* is currently being updated to reflect changes identified in this policy statement. A blast e-mail will be sent to announce its release.

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)
Policy Statement: Date of Diagnosis Reportability Change	
Number: 2013-56	**Date Issued: January 25, 2013**

The purpose of this Policy Statement is to convey an important change to reporting requirements.

Date of Diagnosis Reportability Policy

Effective immediately, cases diagnosed **prior to January 1, 1985 or with an unknown diagnosis date** are no longer reportable to the Pennsylvania Cancer Registry (PCR).

- Cases Diagnosed Prior to January 1, 1985 - Only reportable cases included in *PCR Manual Part One, Reportable Diagnoses* diagnosed or treated at the facility **with a known diagnosis date on or after January 1, 1985** are required to be reported to the PCR. **Known diagnosis date** means the year or the month and year, or the month, day and year are known or can be estimated.

  Exception : Histologic diagnoses with a behavior code of /0 (benign) or /1(borderline or uncertain) when **primary to the intracranial and central nervous system (CNS) sites** as listed in the *PCR Manual* are reportable when diagnosed on or after **January 1, 2004.**

- Cases with Unknown Diagnosis Date – Cases with an unknown month, day and year of diagnosis are no longer required to be reported to the PCR.

- Estimating Diagnosis Date - If information is available to estimate at a minimum the year of diagnosis, the case is reportable. Instructions provided in the *PCR Manual Part Three: Data Item Instructions, General Information-Dates* should be used to approximate the diagnosis date whenever possible.

While this change is effective immediately, cases submitted to the PCR in the NAACCR V13 format with dates of diagnosis prior to January 1, 1985 or unknown will be rejected and listed as such on the PCR Accession List.

The PCR strongly recommends creating a list or electronic file containing at least patient name, date of birth, primary site, laterality, histology, diagnosis date, and reason for not being reportable to assist in the annual reconciliation procedure.

Rationale

Since the year 2000 when the policy to report all cases of cancer regardless of diagnosis date was implemented, the number of data items to be abstracted has increased dramatically. This in turn has significantly increased the time required by facility staff to abstract these cases and by PCR staff to process them. Due to the length of time since diagnosis, no valuable information relative to their initial diagnosis and treatment is obtained from these abstracts. The only benefit to abstracting these cases is in the reconciliation process which can be accomplished in a less time-consuming manner.

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)
Policy Statement: New PCR Reporting Requirements for 2014 Cases (Revised)	
Number: 2014-57	**Date Issued: February 6, 2014** **Revised: 3/6/2014**

The purpose of this Policy Statement is to describe the new PCR reporting requirements effective for **cases diagnosed on or after January 1, 2014, and for cases diagnosed before 1/1/2014.**

1.0 Software: New Software for 2014 Reporting (NAACCR V14)

NAACCR Version 14 is the record format required to submit all cases diagnosed 1/1/2014 or later and for cases diagnosed before 1/1/2014 that are identified after installation of V14 compatible software. Due to changes in reporting requirements and algorithms, new software must be used to submit these cases.

1.1 Registry Hospitals: Submitting cases diagnosed in 2014 will require an update to your registry software and to Web Plus. You may continue to abstract and submit cases diagnosed in 2013 or prior in the 2013 version of your software. You may also abstract 2014 cases in the 2013 software, but you may not transmit 2014 cases in the 2013 software.

Prior to the 2014 upgrade, if you complete 2014 diagnosed cases and you cannot prevent them from being included in export files, please continue to abstract but do not submit any cases until you receive your 2014 software. If any 2014 cases are submitted to the PCR prior to the 2014 update, the 2014 cases will be rejected by the PCR and the facility contact will be instructed to resubmit after conversion.

After you have converted to the 2014 software and you have been notified by the PCR that the 2014 version of Web Plus is ready, you may submit all cases.

1.2 Abstract Plus Hospitals: Submitting 2014 cases will require an update to Abstract Plus and Web Plus. You may continue to abstract and submit cases diagnosed in 2013 or prior in the current version of Abstract Plus. After closing out 2013, contact your PCR Field Representative for instructions for installing the 2014 Abstract Plus update.

If you need to abstract 2014 diagnosed cases before the Abstract Plus upgrade is ready, contact your PCR Field Representative. After you have converted to the 2014 version of Abstract Plus and you have been notified by the PCR that the 2014 version of Web Plus is ready, you may abstract and submit all cases.

Web Plus: CDC has released the V14 compatible version of Web Plus, and the PCR has requested the version customized for Pennsylvania. After receiving and testing this updated version of Web Plus, the PCR will notify hospitals that V14 shipments may be submitted. If you are ready to submit V14 shipments before receiving this update, please hold until you receive notification that the PCR is ready to accept V14 shipments.

2.0 Edits: New Version 14 PA Edits Metafile

A new PA Edits Metafile has been compiled for incorporation into the V14 software.

2.1 **Registry Hospitals**: Version 14 PA Edits Metafile will be sent via email to cancer registry software vendors within the next two weeks. Registrars will be copied on the email.

2.2 **Abstract Plus Hospitals**: Version V14 PA Edits Metafile will be incorporated into the 2014 version of Abstract Plus. After closing out 2013, contact your PCR Field Representative for instructions for abstracting 2014 cases.

3.0 Collaborative Stage (CS) Data Collection System: CS Version 02.05 (CSv0205) will be required for use with cancers diagnosed 1/1/2014 and later and for cases diagnosed before 1/1/2014 that are identified after installation of V14 compatible software. Most of the changes in CSv0205 were to the mapping within the CS programs and algorithms. There are no new codes.

4.0 CS Site-Specific Factors (SSF): The following two SSFs for Breast are no longer required to be reported to the PCR for all cases diagnosed in 2014 and later and for cases diagnosed prior to 1/1/2014 that are identified after installation of V14 compatible software.

- SSF 10: HER2: FISH Test Lab Value
- SSF 12: HER2: CISH Test Lab Value

PCR Manual 2014, Appendix J, *PCR Required Site Specific Factors (SSFs)* is included as Attachment B to provide an updated list of required SSFs for 2014.

5.0 International Classification of Diseases (ICD)

5.1 **ICD-O-3 Changes Effective January 1, 2014:** Use the new terms, synonyms, and related terms for existing ICD-O-3 codes listed below for all cases diagnosed 1/1/2014 and forward. (See *NAACCR NARRATIVE*, Summer 2013, Implementation of ICD-0-3 Updates.)

Note: This listing does not change reportability requirements. Reportable histologies are still based on the following criteria:

- ICD-O Behavior /2 or /3- All histologic diagnoses with a behavior code of /2 (in situ) or /3 (malignant) in the *ICD, Second Edition* (ICD-O-2) or *Third Edition* (ICD-O-3) are reportable.

- ICD-O Behavior /0 or /1 – All histologic diagnoses with a behavior code of /0 (benign) or /1 (borderline or uncertain) when **primary to the intracranial and central nervous system (CNS) sites listed below** are reportable when diagnosed on or after **January 1, 2004.**

Add these new terms into your ICD-O-3 Coding Manual including the effective date.

New preferred term	8150/0 Pancreatic endocrine tumor, benign (C25._)
Move former preferred term to synonym	8150/0 Islet cell adenoma (C25._)
New related term	8150/0 Pancreatic microadenoma (C25._)
New preferred term	8150/1 Pancreatic endocrine tumor, NOS (C25._)
Move former preferred term to synonym	8150/1 Islet cell tumor, NOS (C25._)
New preferred term	8150/3 Pancreatic endocrine tumor, malignant (C25._)
Move former preferred term to synonym	8150/3 Islet cell carcinoma (C25._)
New related term	8150/3 Pancreatic endocrine tumor, nonfunctioning (C25._)
New related term	8152/1 L-cell tumor
New related term	8152/1 Glucagon-like peptide-producing tumor (C25._)
New related term	8152/1 Pancreatic peptide and pancreatic peptide-like peptide within terminal tyrosine amide producing tumor
New synonym for related term	8152/1 PP/PYY producing tumor
New preferred term	8154/3 Mixed pancreatic endocrine and exocrine tumor, malignant (C25._)
New related term	8154/3 Mixed endocrine and exocrine adenocarcinoma (C25._)
New synonym for related term	8154/3 Mixed islet cell and exocrine adenocarcinoma (C25._)
New related term	8154/3 Mixed acinar-endocrine-ductal carcinoma
New related term	8201/3 Cribriform comedo-type carcinoma (C18._, C19.9, C20.9)
New synonym	8201/3 Adenocarcinoma, cribriform comedo-type (C18._, C19.9, C20.9)
New synonym to primary term	8213/0 Traditional serrated adenoma
New related term	8213/0 Sessile serrated adenoma
New related term	8213/0 Sessile serrated polyp
New related term	8213/0 Traditional sessile serrated adenoma

New related term	8240/3 Neuroendocrine tumor, grade 1
New related term	8240/3 Neuroendocrine carcinoma, low grade
New related term	8240/3 Neuroendocrine carcinoma, well-differentiated
New preferred term	8244/3 Mixed adenoneuroendocrine carcinoma
Move former preferred term to synonym	8244 Composite carcinoid
New synonym	8244/3 Combined/mixed carcinoid and adenocarcinoma
New synonym	8244/3 MANEC
New synonym	8249/3 Neuroendocrine tumor, grade 2
New related term	8249/3 Neuroendocrine carcinoma, moderately differentiated
New synonym	8263/0 Tubulo-papillary adenoma
New related term	8290/0 Spindle cell oncocytoma (C75.1)
New related term	8490/3 Poorly cohesive carcinoma
New related term	8811/0 Plexiform fibromyxoma
New related term	8970/3 Hepatoblastoma, epithelioid (C22.0)
New related term	8970/3 Hepatoblastoma, mixed epithelial-mesenchymal (C22.0)
New related term	9471/3 Medulloblastoma with extensive nodularity
New related term	9474/3 Anaplastic medulloblastoma
New related term	9506/1 Extraventricular neurocytoma

5.2 ICD-9-CM Casefinding List for Reportable Conditions: The ICD-9-CM code list to identify reportable conditions was updated. The revisions reflect changes to codes assigned to existing reportable conditions and do not represent any new reportable conditions.

- Code 173 - 173 codes (malignant neoplasm of skin) were listed individually to eliminate non-reportable basal and squamous cell carcinomas of the skin

- Code 238.6 - deleted from list. Plasmacytoma and solitary myeloma are now coded to 203.8.

- Code 288.4 – deleted from list. Langerhans cell histiocytosis is now coded to 277.89

- Code 277.89 – added to list. This code includes other specified disorders of metabolism (reportable terms include: Hand-Schuller Christian disease, histiocytosis (acute)

(chronic), histiocytosis X (chronic)

- Supplemental list – Effective January 1, 2014, the PCR will no longer maintain a supplemental casefinding list. If time and resources permit, facilities may use the SEER supplemental list located on the SEER website at http://seer.cancer.gov/tools/casefinding/.

5.3 ICD-10-CM Casefinding List for Reportable Conditions: The ICD-10-CM code list to identify reportable conditions effective October 1, 2014 to December 31, 2014 is currently being developed. You will be notified when it is posted to the PCR website

6.0 Data Item: Changes to Required Data Items

6.1 Delete Grade Path Value: [NAACCR Data Item 441] Grade Path Value will no longer be required to be reported to the PCR for all cases diagnosed 1/1/2014 or later and for cases diagnosed before 1/1/2014 that are identified after installation of V14 compatible software.

6.2 Delete Grade Path System: [NAACCR Data Item 449] Grade Path System will no longer be required to be reported to the PCR for all cases diagnosed 1/1/2014 or later and for cases diagnosed before 1/1/2014 that are identified after installation of V14 compatible software.

6.3 Grade: [NAACCR Data Item 440] New instructions for coding grade were developed for implementation for all cases diagnosed 1/1/2014 and forward. No codes have been added or deleted, and no software changes are needed to accommodate these new instructions. The new instructions are included in Attachment A and will be incorporated into the *PCR Manual 2014*, Part Three: Data Item Instructions. Please review and be prepared to begin using the new instructions when abstracting 2014 diagnosed cases.

Note: The relationship of Gleason Score to grade changed for 1/1/2014 and later diagnoses in order to have the grade field in sync with AJCC 7th edition. According to the new instructions, a Gleason Score of 7 equates to grade 2 for cases diagnosed on or after 1/1/2014. This is a change from instructions for cases diagnosed from 2003-2013 when Gleason Score 7 was coded to grade 3.

7.0 PCR Manual: New Version of PCR Manual to be Released for 2014 Reporting

The *PCR Manual 2014* is currently being updated to reflect changes identified in this policy statement. A blast e-mail will be sent to announce its release.

With so many different effective dates for various data collection standards, the following table has been included as an easy reference and will be incorporated into the *PCR Manual 2014* as an appendix.

Data Collection Standard	Effective Date
2014	
ICD-O-3 Changes - New terms, synonyms, and related terms	Date of Diagnosis 1/1/2014 and after
Grade – New instructions for coding grade	Date of Diagnosis 1/1/2014 and after
2012	
Scope Regional Lymph Node Surgery Instructions revised	Date of Diagnosis 1/1/2012 and after
Hematopoietic and Lymphoid Database and Manual revised	Date of Diagnosis 1/1/2012 and after; current web-based version should be used
2010	
Collaborative Stage Revised (Version 2)	Date of Diagnosis 1/1/2010 and after
Hematopoietic and Lymphoid Database and Manual Implemented	Date of Diagnosis 1/1/2010-12/31/2011
New Reportable Hematopoietic/Lymphoid Conditions and terms added	Date of Diagnosis 1/1/2010 and after
2007	
SEER Multiple Primary and Histology Coding Manual Implemented	Date of Diagnosis 1/1/2007 and after
2005	
SEER RX Implemented	Date of Diagnosis 1/1/2005; current web version should be used
2004	
Collaborative Stage Implemented (Version 1)	Date of Diagnosis 1/1/2004 and after
Benign Brain and Central Nervous System tumors became reportable	Date of Diagnosis 1/1/2004 and after
2001	
ICD-O-3 Implemented	Date of Diagnosis 1/1/2001 and after

Instructions for Coding Grade for 2014+

GRADE, DIFFERENTIATION OR CELL INDICATOR
Item Length: 1
NAACCR Item #: 440
NAACCR Name: Grade
Grade, Differentiation for solid tumors (Codes 1, 2, 3, 4, 9) and Cell Indicator for Lymphoid Neoplasms (Codes 5, 6, 7, 8, 9)
Note: These instructions pertain to the data item Grade, Differentiation or Cell Indicator.

These are coding instructions for **cases diagnosed 1/1/2014** and forward.

Hematopoietic and Lymphoid Neoplasms

Cell Indicator (Codes 5, 6, 7, 8, 9)

Cell Indicator (Codes 5, 6, 7, 8) describes the lineage or phenotype of the cell. Codes 5, 6, 7, and 8 are used only for hematopoietic and lymphoid neoplasms. Code 9 indicates cell type not determined, not stated, or not applicable.

Coding Grade for Hematopoietic and Lymphoid Neoplasms

1. Determine the histology based on the current Hematopoietic and Lymphoid Neoplasm Manual [http://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules/].
2. Determine the Cell Indicator by applying the "Grade of Tumor Rules" within the current Hematopoietic and Lymphoid Neoplasm Manual [http://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules/] to code the grade.

Grade codes for hematopoietic and lymphoid neoplasms

Terminology	Grade Code
T-cell; T-precursor	5
B-Cell; Pre-B; B-precursor	6
Null cell; Non T-non B	7
NK cell (natural killer cell)	8
Grade unknown, not stated, or not applicable	9

Solid tumors

Grade, Differentiation (Codes 1, 2, 3, 4, 9)

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

(poorly differentiated) or no (undifferentiated) 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:

1. Two levels of similarity; also called a two-grade system
2. Three levels of similarity; also called a three-grade system (code according to "Coding for solid tumors."
    a. Grade I, well
    b. Grade II, moderately
    c. 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).
3. Four levels of similarity; also called a four-grade system. The four-grade system describes the tumor as
    a. Grade I; also called well-differentiated
    b. Grade II; also called moderately differentiated
    c. Grade III; also called poorly differentiated
    d. Grade IV; also called undifferentiated or anaplastic

Breast and prostate grades may convert differently than other sites. These exceptions are noted in "Coding for Solid Tumors", #7-8 below.

Coding for Solid Tumors

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 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 primary site is unknown, code grade to 9.

3. Code the grade shown below (6th digit) for specific histologic terms that imply a grade.
    Carcinoma, undifferentiated (8020/34)
    Carcinoma, anaplastic (8021/34)
    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 its grade 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 the sites listed in Coding for Solid Tumors #6
   b. differentiation: use Coding for Solid Tumors #7: 2-, 3-, or 4- grade system
   c. nuclear grade: use Coding for Solid Tumors #7: 2-, 3-, or 4- grade system
   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.
   e. Terminology (use Coding for Solid Tumors #8)

6. Use the information from the special grade systems first. If no special grade can be coded, continue with Coding for Solid Tumors #7-9.

Special grade systems for solid tumors

Grade information based on CS Site-specific factors for breast, prostate, heart, mediastinum, peritoneum, retroperitoneum, soft tissue, and kidney parenchyma is used to code grade. See **Special Grade System Rules** section below for details on how to use this information to code grade.

CS Schema	Special grade system
Breast	Nottingham or Bloom-Richardson (BR) Score/Grade (SSF7)
Prostate	Gleason's Score on Needle Core Biopsy/Transurethral Resection of Prostate (TURP) (SSF 8)
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 Parenchyma	Fuhrman Nuclear Grade (SSF 6)

Do not use these tables to code grade for any other groups including WHO (CNS tumors), WHO/ISUP (bladder, renal pelvis), or FIGO (female gynecologic sites) grades.

7. Use the Two-, Three- or Four-grade system information

a. Two-grade system

Term	Description	Grade Code	Exception for Breast and Prostate Grade Code
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

Term	Description	Grade Code	Exception for Breast and Prostate Grade Code
1/3	Low grade	2	1
2/3	Intermediate grade	3	2
3/3	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	Grade I; Well differentiated	1
2/4	Grade II; Moderately differentiated	2
3/4	Grade III; Poorly differentiated	3
4/4	Grade IV; Undifferentiated	4

8. Terminology: use the 'Description' column or the 'Grade' column to code grade. Breast & Prostate use the same grade code with a few noted exceptions.

Description	Grade	Assign Grade Code	Exception for Breast and Prostate Grade Code
Differentiated, NOS	I	1	
Well differentiated	I	1	
Only stated as 'Grade I'	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	

Description	Grade	Assign Grade Code	Exception for Breast and Prostate Grade Code
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).

SPECIAL GRADE SYSTEMS RULES

Breast (site: breast excluding lymphomas; CS schema: breast)

Use Bloom Richardson (BR) or Nottingham score/grade to code grade based on CSv2 site-specific factor 7 (SSF) as stated below. If your registry does not collect this SSF, use the description in the table below to determine grade. If you collect this SSF, codes 030-130 could be automatically converted into the grade field.

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.

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 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. Continue with the next priority according to "Coding for Solid Tumors" #7 above.

Code the highest score if multiple scores are reported (exclude scores from tests after neoadjuvant therapy began). 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.

CS Site-Specific Factor 7
Nottingham or Bloom-Richardson (BR) Score/Grade

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 (Site: kidney parenchyma excluding lymphomas; CS schema: KidneyParenchyma): Fuhrman Nuclear Grade

The Fuhrman Nuclear Grade should be used to code grade for kidney parenchyma only based on CSv2 SSF 6 as stated below. Do not use for kidney renal pelvis. If your registry does not collect this SSF, use the description in the table to determine grade. If you collect this SSF, the information could be automatically converted into the grade field if it is coded 010-040. 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.

Description	CS Code	Grade Code
Grade 1	010	1
Grade 2	020	2
Grade 3	030	3
Grade 4	040	4

SoftTissue (sites excluding lymphomas: soft tissue, heart, mediastinum, peritoneum, and retroperitoneum; for CS users: SoftTissue, HeartMediastinum, Peritoneum, Retroperitoneum schemas): Grade for Sarcomas

The Grade for Sarcomas should be used to code grade based on CSv2 SSF 1 as stated below. If your registry does not collect this SSF, use the description in the table to determine grade. If you collect this SSF, the information could be automatically converted into the grade field if it is coded 010-200. The grading system of the French Federation of Cancer Centers Sarcoma Group (FNCLCC) is the preferred system.

Record the grade from any three-grade sarcoma grading system the pathologist uses. For terms such as "well differentiated" or "poorly differentiated," go to Coding for Solid Tumors #8.

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.”

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 (site: prostate excluding lymphomas; CS schema: prostate)

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) as stated below. Use the table below to determine grade even if your registry does not collect these SSFs. If you collect these SSFs, the information could be converted into the grade field automatically.

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 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 secondary 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.

Historic Perspective

Gleason score	Description					
	CS Code	Grade Code	AJCC 7th	SEER 2003-2013	AJCC 6th	SEER prior 2003
2	002	1	G1	G1	G1	G1
3	003	1	G1	G1	G1	G1
4	004	1	G1	G1	G1	G1
5	005	1	G1	G2	G2	G2
6	006	1	G1	G2	G2	G2
7	007	2	G2	G3	G3	G2
8	008	3	G3	G3	G3	G3
9	009	3	G3	G3	G3	G3
10	010	3	G3	G3	G3	G3

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.

Computer algorithm to derive grade for prostate based on SSF 8 and SSF 10: if SSF 8 or SSF 10 has known values for Gleason's, the information could be used to automatically derive the grade field.

SSF 8 Code	SSF 10 Grade Code											
	002	003	004	005	006	007	008	009	010	988	998	999
002	1	1	1	1	1	2	3	3	3	*	1	1
003	1	1	1	1	1	2	3	3	3	*	1	1
004	1	1	1	1	1	2	3	3	3	*	1	1
005	1	1	1	1	1	2	3	3	3	*	1	1
006	1	1	1	1	1	2	3	3	3	*	1	1
007	2	2	2	2	2	2	3	3	3	*	2	2
008	3	3	3	3	3	3	3	3	3	*	3	3
009	3	3	3	3	3	3	3	3	3	*	3	3
010	3	3	3	3	3	3	3	3	3	*	3	3
988	*	*	*	*	*	*	*	*	*	*	*	*
998	1	1	1	1	1	2	3	3	3	*	*	*
999	1	1	1	1	1	2	3	3	3	*	*	*

* Grade can't be automatically calculated based on SSF 8 and SSF 10; Go to Step 7

APPENDIX J:

Pennsylvania Cancer Registry (PCR)

Required Site Specific Factors (SSFs)

PCR REQUIRED SITE SPECIFIC FACTORS

Below is a list of the Site Specific Factors (SSF) required to be reported to the PCR for all cases diagnosed on or after January 1, 2010 or any case originally coded in CSv2 (Collaborative Stage Version 2). If a schema is not listed, the PCR does not require any SSF for that schema.

Note to Registry Hospitals: All SSFs required by the PCR are also required by the American College of Surgeons (ACOS) Commission on Cancer (COC).

CS Schema Name	SSF Number	SSF Description
Appendix	2	Clinical Assessment of Regional Lymph Nodes
	11	Histopathological Grading
BileDuctsDistal	25	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
BileDuctsIntraHepatic	10	Tumor Growth Pattern
BileDuctsPerihilar	25	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
Bladder	1	WHO/ISUP Grade
	2	Size of Metastasis in Lymph Nodes
Brain	1	WHO Grade Classification
Breast	1	Estrogen Receptor Assay (ERA)
	2	Progesterone Receptor Assay (PRA)
	3	Number of Positive Ipsilateral Level I-II Axillary Lymph Nodes
	4	Immunohistochemistry (IHC) of Regional Lymph Nodes
	5	Molecular Studies of Regional Lymph Nodes
	7	Nottingham or Bloom-Richardson (BR) Score/Grade
	8	HER2: IHC Test Lab Value
	9	HER2: IHC Test Interpretation
	11	HER2: FISH Test Interpretation
	13	HER2: CISH Test Interpretation
	14	HER2: Result of other or unknown test
	15	HER2: Summary Result of Testing
BuccalMucosa	1	Size of Lymph Nodes
CarcinoidAppendix	2	Clinical Assessment of Regional Lymph Nodes
CNSOther	1	WHO Grade Classification
Colon	2	Clinical Assessment of Regional Lymph Nodes
Conjunctiva	1	Tumor Size

CS Schema Name	SSF Number	SSF Description
CorpusAdenosarcoma	2	Peritoneal Cytology
CorpusCarcinoma	2	Peritoneal Cytology
CorpusSarcoma	2	Peritoneal Cytology
CysticDuct	25	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
EpiglottisAnterior	1	Size of Lymph Nodes
Esophagus	1	Clinical Assessment of Regional Lymph Nodes
EsophagusGEJunction	1	Clinical Assessment of Regional Lymph Nodes
	25	Schema Discriminator: Involvement of Cardia and Distance from Esophagogastric Juncture (EGJ)
FloorMouth	1	Size of Lymph Nodes
GISTAppendix	11	Mitotic Count
GISTColon	11	Mitotic Count
GISTEsophagus	6	Mitotic Count
GISTPeritoneum	5	Mitotic Count
	10	Location of Primary Tumor
GISTRectum	11	Mitotic Count
GISTSmallIntestine	6	Mitotic Count
GISTStomach	6	Mitotic Count
GumLower	1	Size of Lymph Nodes
GumOther	1	Size of Lymph Nodes
GumUpper	1	Size of Lymph Nodes
HeartMediastinum	1	Grade for Sarcomas
HemeRetic	1	JAK-2
Hypopharynx	1	Size of Lymph Nodes
IntracranialGland	1	WHO Grade Classification
KidneyParenchyma	6	Fuhrman Nuclear Grade
KidneyRenalPelvis	1	WHO/ISUP Grade
LacrimalGland	25	Schema Discriminator: Lacrimal Gland/Lacrimal Sac
LacrimalSac	25	Schema Discriminator: Lacrimal Gland/Lacrimal Sac
LarynxGlottic	1	Size of Lymph Nodes
LarynxOther	1	Size of Lymph Nodes
LarynxSubglottic	1	Size of Lymph Nodes

CS Schema Name	SSF Number	SSF Description
LarynxSupraglottic	1	Size of Lymph Nodes
LipLower	1	Size of Lymph Nodes
LipOther	1	Size of Lymph Nodes
LipUpper	1	Size of Lymph Nodes
Lung	1	Separate Tumor Nodules/Ipsilateral Lung
Lymphoma	2	Systemic Symptoms at Diagnosis
LymphomaOccularAdnexa	2	Systemic Symptoms at Diagnosis
MelanomaChoroid	2	Measured Basal Diameter
	3	Measured Thickness (Depth)
	4	Size of Largest Metastasis
MelanomaCiliaryBody	2	Measured Basal Diameter
	3	Measured Thickness (Depth)
	4	Size of Largest Metastasis
	25	Schema Discriminator: Melanoma Ciliary Body/Melanoma Iris
MelanomaConjunctiva	1	Measured Thickness (Depth)
	2	Quadrants
MelanomaIris	4	Size of Largest Metastasis
	25	Schema Discriminator: Melanoma Ciliary Body/Melanoma Iris
MelanomaSkin	1	Measured Thickness (Depth), Breslow's Measurement
	2	Ulceration
	3	Clinical Status of Lymph Node Mets
	4	LDH
	7	Primary Tumor Mitotic Count/Rate
MerkelCellPenis	3	Clinical Status of Lymph Node Mets
MerkelCellScrotum	3	Clinical Status of Lymph Node Mets
MerkelCellSkin	3	Clinical Status of Lymph Node Mets
MerkelCellVulva	3	Clinical Status of Lymph Node Mets
	11	Regional Lymph Node - Laterality
MouthOther	1	Size of Lymph Nodes
MycosisFungoides	1	Peripheral Blood Involvement
NasalCavity	1	Size of Lymph Nodes

CS Schema Name	SSF Number	SSF Description
Nasopharynx	1	Size of Lymph Nodes
	25	Schema Discriminator
NETColon	2	Clinical Assessment of Regional Lymph Nodes
NETRectum	2	Clinical Assessment of Regional Lymph Nodes
NETStomach	1	Clinical Assessment of Regional Lymph Nodes
Oropharynx	1	Size of Lymph Nodes
PalateHard	1	Size of Lymph Nodes
PalateSoft	1	Size of Lymph Nodes
ParotidGland	1	Size of Lymph Nodes
Penis	17	Extranodal Extension of Regional Lymph Nodes
Peritoneum	1	Grade for Sarcomas
	25	Schema Discriminator
PeritoneumFemaleGen	25	Schema Discriminator
PharyngealTonsil	1	Size of Lymph Nodes
	25	Schema Discriminator
Placenta	1	Prognostic Scoring Index Table 1
Pleura	1	Pleural Effusion
Prostate	1	Prostatic Specific Antigen (PSA) Lab Value
	3	CS Extension – Pathologic Extension
	7	Gleason's Primary Pattern and Secondary Pattern Value on Needle Core Biopsy/TURP
	8	Gleason's Score on Needle Core Biopsy/TURP
	9	Gleason's Primary Pattern and Secondary Pattern Value on Prostatectomy/Autopsy
	10	Gleason's Score on Prostatectomy /Autopsy
Rectum	2	Clinical Assessment of Regional Lymph Nodes
Retinoblastoma	1	Extension Evaluated at Enucleation
Retroperitoneum	1	Grade for Sarcomas
SalivaryGlandOther	1	Size of Lymph Nodes
Scrotum	12	High Risk Features
	16	Size of Lymph Nodes
SinusEthmoid	1	Size of Lymph Nodes
SinusMaxillary	1	Size of Lymph Nodes

CS Schema Name	SSF Number	SSF Description
Skin	12	High Risk Features
	16	Size of Lymph Nodes
SkinEyelid	6	Perineural Invasion
SmallIntestine	2	Clinical Assessment of Regional Lymph Nodes
SoftTissue	1	Grade for Sarcomas
Stomach	1	Clinical Assessment of Regional Lymph Nodes
	25	Involvement of Cardia and Distance from Esophagogastric Junction (EGJ)
SubmandibularGland	1	Size of Lymph Nodes
Testis	4	Radical Orchiectomy Performed
	5	Size of Metastasis in Lymph Nodes
	7	Preorchiectomy Alpha Fetoprotein (AFP) Interpretation
	9	Preorchiectomy Human chorionic gonadotropin (hCG) Interpretation
	10	Preorchiectomy LDH Interpretation
	13	Post-Orchiectomy Alpha Fetoprotein (AFP) Range
	15	Post-Orchiectomy Human Chorionic Gonadotropin (hCG) Range
	16	Post-Orchiectomy Lactate Dehydrogenase (LDH) Range
TongueAnterior	1	Size of Lymph Nodes
TongueBase	1	Size of Lymph Nodes
Urethra	1	WHO/ISUP Grade
Vulva	11	Regional Lymph Node - Laterality

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)
Policy Statement: New PCR Reporting Requirements for 2015 Cases	
Number: 2015-58	**Date Issued: January 29, 2015**

The purpose of this Policy Statement is to describe the new PCR reporting requirements effective for **cases diagnosed on or after January 1, 2015 or immediately as indicated below.**

1.0 Software: New Software for 2015 Reporting (NAACCR V15)

NAACCR Version 15 is the record format required to submit all cases diagnosed 1/1/2015 or later and for cases diagnosed before 1/1/2015 identified after installation of V15 compatible software. Due to changes in reporting requirements and algorithms, new software must be used to report these cases. **Do not abstract 2015 cases with the 2014 version of your software.**

Web Plus: CDC will be releasing the V15 compatible version of Web Plus, and the PCR has requested the version customized for Pennsylvania. After receiving and testing this updated version of Web Plus, the PCR will notify hospitals that V15 shipments may be submitted. If you are ready to submit V15 shipments before receiving this update, please hold shipments until you receive notification that the PCR is ready to accept V15 shipments.

1.1 Registry Hospitals: Abstracting 2015 cases will require a software update and conversion of the hospital registry database by the software vendor. Complete 2014 cases in the current version of your hospital registry software. After closing out 2014, contact your cancer registry software vendor to provide the 2015 update and database conversion.

1.2 Abstract Plus Hospitals: Abstracting 2015 cases will require a software update. Complete 2014 cases in the current version of Abstract Plus. After closing out 2014, contact your PCR Field Representative for instructions for abstracting 2015 cases.

2.0 Edits: New Version 15 PA Edits Metafile

A new PA Edits Metafile will be compiled for incorporation into the V15 software as soon as it is released by NAACCR.

2.1 Registry Hospitals: Version 15 PA Edits Metafile will be sent via email to cancer registry software vendors. Registrars will be copied on the email.

2.2 Abstract Plus Hospitals: Version V15 PA Edits Metafile will be incorporated into the 2015 version of Abstract Plus. After closing out 2014, contact your PCR Field Representative for instructions for abstracting 2015 cases.

3.0 Collaborative Stage (CS) Data Collection System: CS Version 02.05 (CSv0205) will continue to be required for cases diagnosed on or after 1/1/2015.

4.0 SEER Summary Stage 2000 (SS2000): Directly coded SEER SS2000 will be required for all cases diagnosed on 1/1/ 2015 and after and for cases diagnosed before 1/1/2015 identified after installation of V15 compatible software. The PCR is currently developing SS2000 trainings. More information will be provided soon. The SS2000 Manual is located at http://seer.cancer.gov/tools/ssm/ Pages 1-25 provide guidelines to help get you started.

5.0 International Classification of Diseases (ICD)/Reportability Changes. Refer to the *NAACCR Guidelines for ICD-0-3 Update Implementation* (http://www.naaccr.org/LinkClick.aspx?fileticket=u7d3sB71t5w%3d&tabid=126&mid=466) for details and further explanations of the following**.**

5.1 Behavior code/Reportability changes- Effective with cases diagnosed on or after 1/1/2015 Carcinoids, NOS of the appendix are now reportable and should be coded to 8240/3. Document this change in your ICD-O-3

5.2 Enteroglucagonoma, malignant Effective with cases diagnosed on or after 1/1/2015, Enteroglucagonoma, malignant is now coded to 8152/3. Instead of 8157/3. Document this change in your ICD-O-3

5.3 New codes and terms- Many of the new codes slated to be effective in 2015 cannot be used because they are not among the acceptable histologies for the Collaborative Stage algorithms. The below table lists the new terms and what code to use for 2015. New instructions will be provided in 2016 for coding these terms, when Collaborative Stage is discontinued.

New Term	Code to use for 2015*
Pancreatobiliary-type carcinoma (C24.1) Adenocarcinoma, pancreatobiliary- type (C24.1)	8255/3
Serrated adenocarcinoma	8213/3
Micropapillary carcinoma, NOS (C18._, C19.9, C20.9)	8507/3
Mixed acinar ductal carcinoma	8523/3
Papillary tumor of the pineal region	9361/3
Pilomyxoid astrocytoma	9421/3
Angiocentric glioma	9380/1
Pituicytoma	9380/1
Papillary glioneuronal tumor	9505/1
Rosette-forming glioneuronal tumor	9505/1

*ICD-O-3 rule F applies (code the behavior stated by the pathologist).

5.4 ICD-9-CM and ICD-10-CM Casefinding List for Reportable Conditions: Thereare no changes to the ICD-9-CM and ICD-10 CM casefinding lists.

5.5 GISTs (Gastrointestinal Stromal Tumors) and Thymomas- Standard setters are still working on additional reportability guidelines for GIST and thymomas. For now they have agreed on the following statement if the pathology report does not state "malignant"**:**

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

6.0 SEER Hematopoietic Database: New Version Released for 2015 Reporting

A new version of the Hematopoietic and Lymphoid Database has been released for coding cases diagnosed beginning January 1, 2015. There are no changes to the multiple primary rules or the primary and histology rules. Obsolete codes have been removed and should no longer be used. During the V15 conversion, obsolete codes will be converted to make data consistent over time. Because of this conversion, registry hospitals may have manual review of old cases to complete. Abstract Plus hospitals may have edits to correct if any old cases are opened and reviewed.

The 2015 Hematopoietic and Lymphoid Database is found at: http://seer.cancer.gov/tools/heme/

A summary of the major changes that includes a description of the conversion is found at: http://seer.cancer.gov/tools/heme/update.html

7.0 Required Data Items: New Data Items and Changes to Existing Data Items

7.1 RX Date Mst Deft Srg (RX Date Most Definitive Surgical Resection of Primary Site) has been added as a required data item.

Definition: Records the date of the definitive surgical procedure of the primary site performed as part of first course of treatment.

7.2 RX Date Mst Deft Srg- Flag (RX Date Most Definitive Surgical Resection of Primary Site Flag) has been added as a required data item.

Definition: This flag explains why there is no appropriate value in the corresponding date field, Date Most Definitive Surgical Resection of Primary Site

7.3 Sex- The following new codes have been added.

5- Transsexual, natal male
6- Transsexual, natal female

8.0 PCR Manual: New Version of PCR Manual to be Released for 2015 Reporting

The *PCR Manual 2015* is currently being updated to reflect changes identified in this policy statement. A blast e-mail will be sent to announce its release.

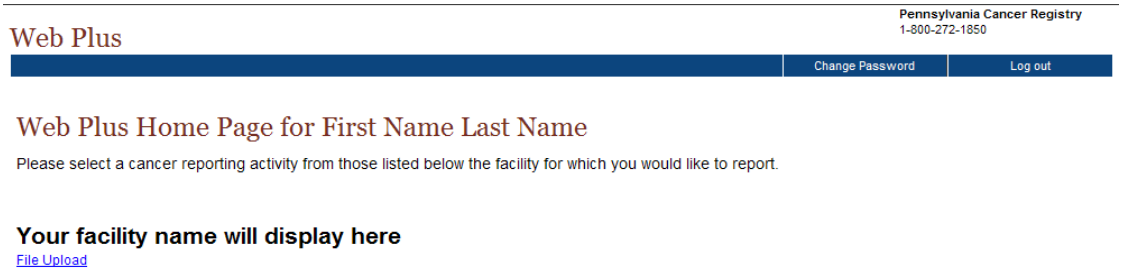
9.0 PCR Web Site: Along with the rest of the Pennsylvania government, the PCR has a new website. Please use the below link:

http://www.health.pa.gov/MyRecords/Registries/Cancer/Pages/CancerRegistry.aspx

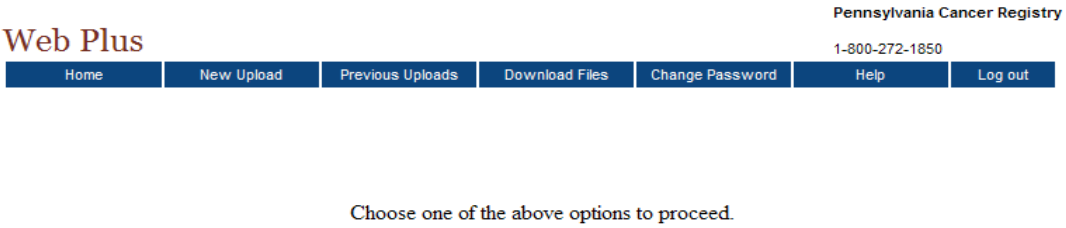
10.0 Records Accessioned by the PCR: The **"***Records Accessioned by the PCR"* list will no longer be sent to hospitals effective with shipments received in February 2015. This list was generated at the time of receipt at the PCR. This same information is available in Web Plus. See *Web Plus Submission List Procedure* starting on the next page.

Procedure: **View Cases Submitted to the Pennsylvania Cancer Registry via Web Plus**

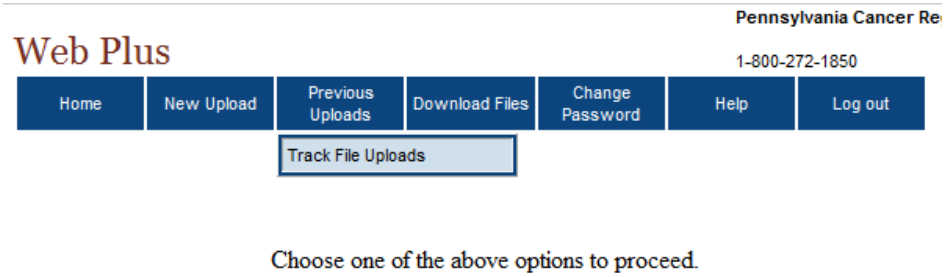
1. Log into Web Plus.
2. The Web Plus home page for your facility opens.



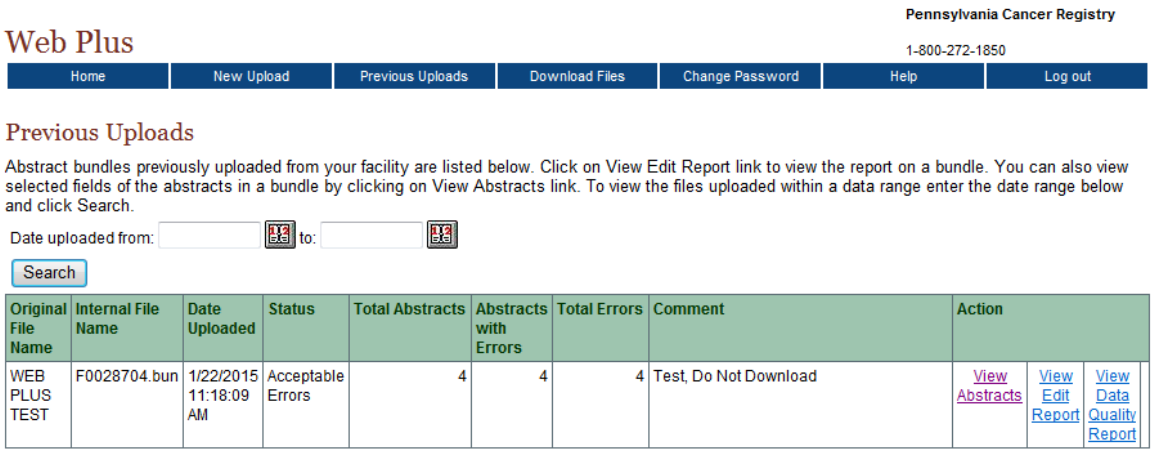
3. Click on File Upload.
    a. The following screen will display:



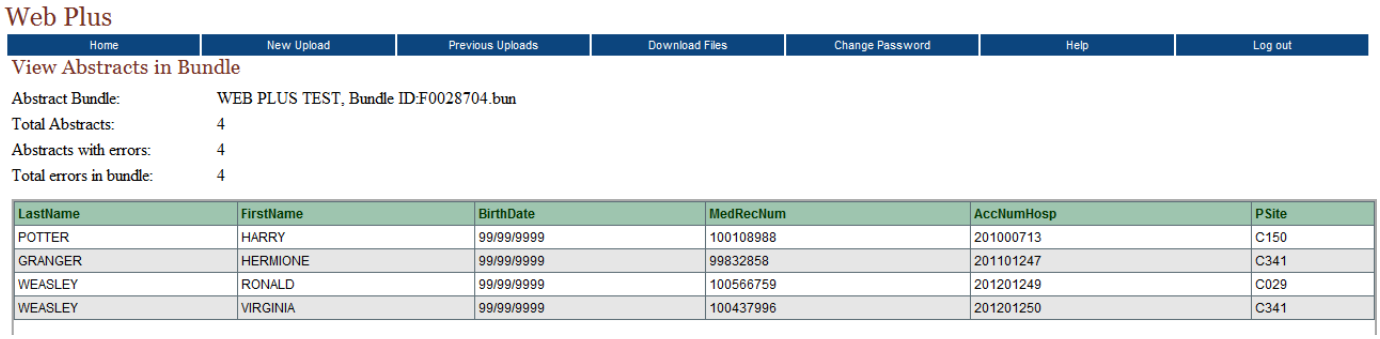
4. Click on Previous Uploads and Click Track File Uploads



5. A List of previous Abstract Uploads will be displayed. Click the View Abstracts for any selected shipment you would like to review.



6. The list of Patients submitted for that shipment will be displayed.



7. If you would like to save a copy of this list for your files, this screen can be saved as an HTML document using the *save as* function in your browser. All browsers are different, so if you need assistence, please contact your IT staff.

   Note: These lists will remain available until Web Plus is purged. Typically Web Plus is purged in July and anything >18 months old is removed. So in July of 2015 anything from 2013 and earlier will be removed.

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)
Policy Statement: Date of Diagnosis Reportability Change	
Number: 2015-59	**Date Issued: June 1, 2015**

The purpose of this Policy Statement is to convey an important change to reporting requirements.

Date of Diagnosis Reportability Policy

Effective immediately, cases diagnosed **prior to January 1, 1995** are no longer reportable to the Pennsylvania Cancer Registry (PCR).

All reportable cases included under *Part One, Reportable Diagnoses* diagnosed or treated at the facility are required to be reported to the PCR only if the date of diagnosis is **known to be on January 1, 1995 or after**.

Exception 1: Conditions only reportable if diagnosed on January 1, 2001 and after are **not** reportable if the date of diagnosis is between January 1, 1995 and December 31, 2000. Refer to the *Hematopoietic and Lymphoid Neoplasm Database* for reportability dates. http://seer.cancer.gov/seertools/hemelymph/

Exception 2: Benign and borderline tumors of the intracranial and central nervous system are only reportable if diagnosed on or after January 1, 2004 and are **not** reportable if the date of diagnosis is prior to January 1, 2004 or unknown.

Rationale

Due to the length of time since diagnosis, no valuable information relative to their initial diagnosis and treatment is obtained from these abstracts.

Reminder

As stated in PCR Policy Statement 2013-56 cases with an unknown month, day and year of diagnosis are not required to be reported to the PCR.

pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Cancer Registry (PCR)
Policy Statement: New PCR Reporting Requirements for 2016 Cases	
Number: 2016-60	**Date Issued: January 2016**

The purpose of this Policy Statement is to describe the new PCR reporting requirements effective for **cases diagnosed on or after January 1, 2016.**

1. Software: New Software for 2016 Reporting (NAACCR V16)

NAACCR Version 16 is the record format required to submit all cases diagnosed 1/1/2016 or later and for cases diagnosed before 1/1/2016 identified after installation of V16 compatible software. Due to changes in reporting requirements, new software must be used to report these cases. **Do not abstract 2016 cases with the 2015 version of your software.**

Web Plus: CDC will be releasing the V16 compatible version of Web Plus, and the PCR has requested the version customized for Pennsylvania. After receiving and testing this updated version of Web Plus, the PCR will notify hospitals that V16 shipments may be submitted. If you are ready to submit V16 shipments before receiving this update, please hold shipments until you receive notification the PCR is ready to accept V16 shipments.

a. **Registry Hospitals**: Abstracting 2016 cases will require a software update and conversion of the hospital registry database by the software vendor. Complete 2015 cases in the current version of your hospital registry software. After closing out 2015, contact your cancer registry software vendor for the 2016 update and database conversion.

b. **Abstract Plus Hospitals:** Abstracting 2016 cases will require a software update. Complete 2015 cases in the current version of Abstract Plus. After closing out 2015, contact your PCR Field Representative for instructions for abstracting 2016 cases.

2. Edits: New Version 16 PA Edits Metafile

A new PA Edits Metafile will be compiled for incorporation into the V16 software as soon as it is released by NAACCR.

a. **Registry Hospitals**: Version 16 PA Edits Metafile will be sent via email to cancer registry software vendors. Registrars will be copied on the email.

b. **Abstract Plus Hospitals**: Version V16 PA Edits Metafile will be incorporated into the 2016 version of Abstract Plus. After closing out 2015, contact your PCR Field Representative for instructions for abstracting 2016 cases.

3. AJCC-TNM Clinical and Pathologic Stage

Directly coded clinical and pathologic AJCC-TNM stage is required for all cases diagnosed on 1/1/2016 and after.

Clinical and pathologic indicators are being added to the AJCC T, N, and M data items. The indicators are to be added by modifying the existing values for the individual T, N, and M data items. The revisions will be incorporated into software look ups to allow for selection of necessary ‘p’ values within the clinical codes and selection of necessary ‘c’ values within the pathologic codes

when abstracting. For a detailed explanation, see section 4.2 of the *2016 NAACCR Implementation Guide* at: http://www.naaccr.org/StandardsandRegistryOperations/ImplementationGuidelines.aspx

Web-based training is available at: https://cancerstaging.org/CSE/Registrar/Pages/default.aspx The PCR will also be developing training.

4. Collaborative Stage (CS) Data Collection System

The Collaborative Stage Data Collection System Version 02.05 will continue to be used for cases diagnosed 2004-2015 and for the collection of the Site-Specific Factors (SSFs) for cases diagnosed 1/1/2016 and forward. There are no changes to the list of PCR required SSFs. In addition to the SSFs, Regional Nodes Positive and Examined and Lymph-vascular Invasion will continue to be required. All other CS input data items are no longer required.

5. SEER Summary Stage 2000 (SS2000)

Directly coded SEER SS2000 will be continue to be required for all cases diagnosed on 1/1/ 2016 and after.

6. International Classification of Diseases (ICD-O-3)

New codes and terms- The following was included in the *New PCR Reporting Requirements for 2015 Cases* policy statement. However, the use of the new codes was once again postponed by the standard setters until 2017. Continue to use the codes provided for the new terms.

2015 Many of the new codes slated to be effective in 2015 cannot be used because they are not among the acceptable histologies for the Collaborative Stage algorithms. The below table lists the new terms and what code to use for 2015. New instructions will be provided in 2016 for coding these terms, when Collaborative Stage is discontinued.

New Term	Code to use for 2015*
Pancreatobiliary-type carcinoma (C24.1) Adenocarcinoma, pancreatobiliary- type (C24.1)	8255/3
Serrated adenocarcinoma	8213/3
Micropapillary carcinoma, NOS (C18._, C19.9, C20.9)	8507/3
Mixed acinar ductal carcinoma	8523/3
Papillary tumor of the pineal region	9361/3
Pilomyxoid astrocytoma	9421/3
Angiocentric glioma	9380/1
Pituicytoma	9380/1
Papillary glioneuronal tumor	9505/1
Rosette-forming glioneuronal tumor	9505/1

*ICD-O-3 rule F applies (code the behavior stated by the pathologist).

7. Newly reportable Conditions/Tumors

In 2014 and 2015 SEER added new reportable histology terms to their Program and Coding Manual. These terms had not been included in any ICD-O-3 errata and therefore were not addressed throughout the cancer surveillance community. NPCR has reviewed the terms and determined that the following are reportable. Therefore, they are now reportable to the PCR. While there has not been an official errata to address these histology terms, the PCR recommends adding them your ICD-O-3 Manuals.

a. Non-invasive mucinous cystic neoplasm of the pancreas with high-grade dysplasia replaces mucinous cystadenocarcinoma, non-invasive (8470/2).

b. Solid pseudopapillary neoplasm of pancreas (8452/3) is synonymous with solid pseudopapillary carcinoma (C25._)

c. Based on pathologist consultation, 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 are REPORTABLE using histology code 8150/3, unless the tumor is specified as a neuroendocrine tumor, grade 1 (assign code 8240/3) or neuroendocrine tumor, grade 2 (assign code 8249/3)

d. Laryngeal intraepithelial neoplasia, grade III (LINIII) (8077/2), C320-C329)

e. Squamous intraepithelial neoplasia, grade III (SINIII) (8077/2), except Cervix and Skin

f. 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 (physical history, etc.) 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 that the patient is a child, or pre-pubescent, and the tumor is benign.

8. ICD-9-CM and ICD-10-CM Casefinding List for Reportable Conditions

There are no changes to the ICD-9-CM and ICD-10 CM casefinding lists.

9. Required Data Items: New Data Items and Deleted Data Items

Newly Required Data Items (for cases diagnosed on 1/1/16 and after)	
Data Item	**Definition**
Mets at DX-Bone	Identifies whether bone is an involved metastatic site. Replaces CS Mets at DX-Bone
Mets at DX-Brain	Identifies whether brain is an involved metastatic site Replaces CS Mets at DX-Brain

Newly Required Data Items (for cases diagnosed on 1/1/16 and after)	
Data Item	**Definition**
Mets at DX-Distant LN	Identifies whether a distant lymph node is an involved metastatic site
Mets at DX-Liver	Identifies whether liver is an involved metastatic site Replaces CS Mets at DX-Liver
Mets at DX-Lung	Identifies whether lung is an involved metastatic site Replaces CS Mets at DX-Lung
Mets at DX-Other	Identifies whether other metastatic involvement, other than bone, brain, liver, lung or distant lymph nodes exists
Tumor Size Summary	Records the most accurate measurement of a solid primary tumor
TNM Path T	AJCC pathologic tumor*
TNM Path N	AJCC pathologic nodes*
TNM Path M	AJCC pathologic metastases*
TNM Path Stage Grp	AJCC pathologic stage group*
TNM Path Descriptor	Identifies the AJCC pathologic stage (prefix/suffix) descriptor.*
TNM Clin T	AJCC clinical tumor*
TNM Clin N	AJCC clinical nodes*
TNM Clin M	AJCC clinical metastases*
TNM Clin Stage Grp	AJCC clinical stage group*
TNM Clin Descriptor	Identifies the AJCC clinical stage (prefix/suffix) descriptor.*
TNM Edition Number	A code that indicates the edition of the AJCC manual used to stage the case.*

*Detailed site-specific codes for the TNM fields are defined by AJCC.

Deleted Data Items (for cases diagnosed on 1/1/2016 and after)	
CS Tumor Size	CS Extension
CS Tumor Size/Ext Eval	CS Lymph Nodes
CS Lymph Node Eval	CS Met at DX
CS Mets Eval	CS Mets at DX-Brain
CS Mets at DX-Bone	CS Mets at DX-Liver
CS Mets at DX-Lung	CS Version Derived
Derived SS2000	Derived SS2000 Flag
Derived AJCC-7 T	Derived AJCC-7 T Descript
Derived AJCC-7 N	Derived AJCC-7 N Descript
Derived AJCC-7 M	Derived AJCC-7 M Descript
Derived AJCC-7 Stage Grp	

10. PCR Manual: New Version of PCR Manual to be Released for 2016 Reporting

The *PCR Manual 2016* is currently being updated to reflect changes identified in this policy statement. A blast e-mail will be sent to announce its release.