Pennsylvania Cancer Registry

Reporting Manual

2021

pennsylvania
DEPARTMENT OF HEALTH

PREFACE

The *Pennsylvania Cancer Registry (PCR) Manual 2021* provides definitions and detailed instructions for abstracting all data items required by the PCR. The manual also describes the types of cases that must be reported to the PCR.

Due to the changes in cancer registration at the national level effective in 2021, the *PCR Manual 2021* has undergone numerous revisions since the last major modification in 2018. Driven by advances in the diagnosis and treatment of cancer, these changes impact all reporting sources and provide an opportunity to expand our knowledge of cancer as we learn to collect new and complex cancer data. This valuable information is extremely beneficial in the continued efforts to address the cancer burden in Pennsylvania and nationally.

The changes for 2021 include a new record layout for electronic transmission to the PCR, new rules for determining multiple primaries and coding histology of solid tumors, newly reportable conditions, new reportable terms, the implementation of ICD-O-3.2 codes, new data items, changes to existing data items, and data items no longer required to be reported. The *PCR Manual 2021* has been updated to explain the new PCR reporting requirements in detail.

The new PCR reporting requirements effective for **cases diagnosed on or after January 1, 2021** are summarized below. Details are provided throughout the *PCR Manual 2021*.

Please note: The term "**Registry Hospital**" is used throughout the manual. For PCR purposes in simple terms, a Registry Hospital is any hospital that uses vendor software and does not use Abstract Plus. It is further defined as a hospital with a cancer registry functioning as an integral component of the hospital cancer program. They may or may not be accredited by the American College of Surgeons Commission on Cancer.

1. **New Software (NAACCR V21):** NAACCR Version 21 is the record format required to submit all cases diagnosed 1/1/2021 or later and for cases diagnosed before 1/1/2021 identified after installation of V21 compatible software. The NAACCR fixed width data transmission format has been formally retired. NAACCR V21 will be in an XML format. Due to this change and the changes outlined below the new software must be used to report these cases. **Do not abstract 2021 cases with the 2018 version of your software.**

    a. **Registry Hospitals:** Abstracting 2021 cases will require a software upgrade and conversion of the hospital registry database by the software vendor. Contact your vendor to determine when the V21 upgrade will be available. Priority should be given to completing your 2019 and 2020 cases while waiting for the V21 upgrade.
    b. **Abstract Plus Hospitals**: Abstracting 2021 cases will require an Abstract Plus upgrade. A definite release date for V21 Abstract Plus is currently not available. Priority should be given to completing your 2019 and 2020 cases while waiting for the V21 upgrade.

2. **Edits: New Version 21 PA Edits Metafile**

   a. **Registry Hospitals**: Version 21 PA Edits Metafile will be provided to cancer registry software vendors soon.
   b. **Abstract Plus Hospitals**: Version V21 PA Edits Metafile will be incorporated into the 2021 version of Abstract Plus.

3. **Stage Requirements:**

   There are no changes to the staging requirements. Continue to use SEER Summary Stage 2018: https://seer.cancer.gov/tools/ssm/

4. **Site Specific Data Items (SSDI)**

   Some SSDI codes and code descriptions were changed to reflect changes in clinical management and/or staging and to improve clarity or to address questions that were raised in the various forums. There have also been revisions to notes and additional notes for many SSDIs; due to the addition of new notes, many of the note numbers have changed. The SSDI Manual, Version 2.0 must be used starting with V21. Version 2 is available at https://apps.naaccr.org/ssdi/list/.

   There are no changes to PCR list of required SSDI.

5. **New Required Data Items**

   The following table lists the newly required data items effective with V21. Each NAACCR Item # is hyperlinked to the NAACCR V21 Data Dictionary.

Newly Required Data Items	
NAACCR Item #	Item Name
1068	Grade Post Therapy Clin (yc)
2232	Name--Birth Surname
2315	Medicare Beneficiary Identifier (when available)

   NOTE: The PCR is not requiring the new COVID data items required by the Commission on Cancer.

6. **No Longer Required Data Items**

   The following table lists data items that are no longer required for cases diagnosed on 1/1/2021 and after.

Items No Longer Required	
NAACCR Item #	Item Name
2390	Name--Maiden

7. Changes to Data Items

The following table outlines data items that have been changed/updated:

Data Item Changes	
NAACCR Item #	Item Name
1506	*Phase I Radiation Treatment Modality*- Code 98: Radiation given; modality unknown
3845	*Grade Post Therapy* now called *Grade Post Therapy Path*
1068; 3843; 3844 3845	*Grade:* • Lacrimal Gland- codes A-D were removed, and Code 4 was added • Lymphoma Ocular Adnexa- codes 5 and L were removed and text for codes 3 and 4 was revised. • Notes have been added throughout the manual Changes are documented in Grade Coding Instructions and Tables Manual, Version 2 found at https://www.naaccr.org/wp-content/uploads/2020/08/Grade-Manual_v-2.0.pdf?v=1607528533

8. International Classification of Diseases (ICD-O-3.2)

Beginning with cases diagnosed January 1, 2021, ICD-O-3.2 is the preferred morphology coding reference manual. The NAACCR *2021 Guidelines for ICD-O-3 Histology code and Behavior Update Implementation,* the *2021 ICD-O-3.2 Coding Tables* and the *2021 ICD-O-3.2 Coding Table Excel* must be used. These guidelines and tables address implementation of the ICD-O-3.2 updated histology terms and codes. Use of these guidelines and tables is required for determining reportability and accurate coding. The guidelines and tables can be found at: https://www.naaccr.org/icdo3/

9. Reportability

To determine reportability of solid tumors refer to the tables found at https://www.naaccr.org/icdo3/. Below is a description of what is in each table:

Table	Description	# Items
1	Behavior code changes- non-reportable to reportable	16
2	Behavior code changes- reportable to non-reportable	9
3	Deleted codes- histology terms moved to other codes	10
4	Change in reportable terminology	13
5	New codes and terms	12
		Order
6	Tables 1-5 plus new preferred & related terms, synonyms	Numerical
7	Tables 1-5 plus new preferred & related terms, synonyms	Alphabetical

Cancer Registry reportability rules based on behavior still apply when reviewing any of the above ICD-O-3.2 tables and *ICD-O-3.2 Coding Table Excel*

- /2 and /3 behavior reportable for all sites
- /0 and /1 behavior reportable for primary intracranial and CNS
- Certain exceptions apply, refer to the PCR Manual

Note: Clarification has been provided that early or evolving melanoma in situ, or any other early or evolving melanoma, are reportable effective 1/1/2021. This is not noted in table 1 but is documented in table 6 and 7. It is also documented in the Cutaneous Melanoma Solid Tumor Rules.

10. 2018 Solid Tumor Coding Rules

The 2018 Solid Tumor Rules have been updated. ICD-0-3.2 changes have also been added to applicable site modules. Most changes are minor: terminology, additional definitions, new notes and examples. In order to **clarify** histology coding instructions, new rules have been added and histology tables updated. The December 2020 rules replace the current rules and should be used now for Brain (benign and malignant), Breast, Colon, Head and Neck, Kidney, Lung, and Renal pelvis/ureter.

In addition, the rules for Cutaneous Melanoma have been revised and are effective for cases diagnosed January 1, 2021 and after. The 2007 rules for Other sites are still effective.

All Solid Tumor Rules can be found at: https://seer.cancer.gov/tools/solidtumor/

11. SEER Hematopoietic and Lymphoid Database

The updated SEER Hematopoietic and Lymphoid Neoplasm Database will continue to be applicable for cases diagnosed 2010 and forward. There are a few minor changes to the database along with the inclusions of *NAACCR 2021 Implementation Guidelines*. The database should be used to determine reportability of hematopoietic and lymphoid neoplasms. A change log is available along with the database at https://seer.cancer.gov/tools/heme/

12. NAACCR 2021 Implementation Guidelines and Recommendations

For additional information on the implementation of the 2021 changes on a national level please review the NAACCR 2021 Implementation Guidelines and Recommendations at https://www.naaccr.org/implementation-guidelines/

ABOUT THE PENNSYLVANIA CANCER REGISTRY

The rate of new cancer cases in Pennsylvania is among the highest in the nation. More than 70,000 Pennsylvania residents are diagnosed with cancer each year. Without information on these new cases of cancer, it is difficult to plan prevention, education, screening, early detection, treatment, and rehabilitation programs. The Pennsylvania Cancer Registry (PCR) records the incidence of cancer for the Commonwealth of Pennsylvania and provides data to help physicians, researchers, and other health professionals plan and evaluate cancer programs.

Probably not surprising to learn is the impetus for the PCR was public concern about excess radiation exposure to persons living near a nuclear-powered utility plant. What might be surprising, however, is this plant was not the Three Mile Island nuclear plant; site of the 1979 accident, but rather a plant located at Shippingport, Pennsylvania, and the year was 1973.

Then Governor Milton Shapp appointed a committee of epidemiologists and radiation physicists to examine the question of possible increased risk of cancer for individuals residing near the nuclear-powered plant. That committee reported in 1974 no conclusions could be reached due to the absence of reliable data. As a result, a task force of physicians and laypersons was appointed to examine the Commonwealth's role in helping to combat cancer, specifically emphasizing consideration of a statewide cancer registry. In 1976, the task force published a report with several recommendations for cancer control, including mandating a statewide population-based cancer incidence registry and requiring cancer be made a reportable disease.

In 1977, legislation was introduced which proposed funding for cancer research and control programs in the Commonwealth. The Pennsylvania Cancer Control, Prevention, and Research Act, Act 224 (see *Appendix A, Pennsylvania Cancer Control, Prevention and Research Act)* was signed into law on December 18, 1980. Passage of the bill into law resulted from the work of the Governor's Task Force on Cancer, the Pennsylvania and Philadelphia Divisions of the American Cancer Society, the Pennsylvania Cancer Coordination Committee, and many other concerned Pennsylvania organizations and individuals.

The Act provided enabling legislation for the Pennsylvania Department of Health to establish nine cancer control priorities, which are as follows:

1) Cancer Registry
2) Cancer screening, detection, and prevention
3) Cancer epidemiology and biostatistical studies
4) Cancer community outreach programs
5) Cancer rehabilitation
6) Communication and planning among cancer institutions
7) Cancer education and information
8) Cancer training
9) Cancer clinical research

The Pennsylvania Cancer Control, Prevention, and Research Act identified the cancer registry as the number one priority for cancer control, mandated reporting of cancer cases, and clearly outlined reporting responsibility. In addition, the law established a Cancer Control, Prevention, and Research Advisory Board to advise the Secretary of Health with respect to cancer control, prevention and research in Pennsylvania and to approve and implement the *Pennsylvania Cancer Plan*. Act 224 was, and continues to be, a key element in the success of the PCR and statewide cancer control activities.

The Act mandated all hospitals and laboratories to report cancer cases to the PCR. The implementation of reporting by acute care hospitals took place in four geographic regions over a period from July 1982 to September 1984 with 1985 being the first full year of statewide reporting. To assure complete statewide incidence statistics, efforts to increase reporting by freestanding laboratories and other non- hospital sources began in 1995 and continue to be an ongoing challenge as more patients are diagnosed and treated in these settings.

As a population-based cancer incidence registry, the PCR collects demographic, diagnostic, and first course treatment information on all Pennsylvania residents diagnosed with cancer. All information collected and maintained in the PCR database is strictly confidential. Only summary statistical information is published for general distribution and public knowledge. The Department of Health may permit use of in-depth information for research, subject to careful screening, strict supervision, and only to accomplish approved program objectives.

PCR data is used for cancer research and surveillance activities, as well as epidemiologic and other special studies. State-specific incidence and mortality data are published annually in *Pennsylvania Cancer Incidence and Mortality* that includes the most recent five years of data. Data from this and other statistical reports and publications are available on the Department of Health website at https://www.health.pa.gov/topics/HealthStatistics

With a strong and stable history, the PCR is recognized as a state-of-the-art cancer reporting system, an important component in the Department of Health's Cancer Program, and a valuable resource for cancer data. The PCR uses current technology and national data collection standards to continually enhance the completeness, accuracy and timeliness of cancer data. As the volume of PCR incidence data increases over time, the utility of this data for program planning, evaluation, and epidemiologic studies increases as well. The PCR depends on the support, cooperation, and accurate reporting by each facility for the ongoing operation of the statewide cancer registry. Working together, sufficient and reliable cancer incidence data will continue to be available to provide answers to our questions, to reduce the burden of cancer in Pennsylvania, and to improve the lives of both present and future patients with cancer.

PART ONE

Reporting Requirements

PCR MANUAL, 2021 EDITION

Cancer registries in the year 2021 have experienced changes nationally. The 2021 edition of the *Pennsylvania Cancer Registry (PCR) Manual* was written to convey these changes and their effect on PCR reporting requirements.

This updated manual must be used to abstract and submit reportable cases with a Date of Diagnosis of January 1, 2021 and after to the PCR. Cases diagnosed prior to January 1, 2021 may be abstracted using this manual after the conversion has been completed.

WHAT IS THE PCR

The Pennsylvania Cancer Registry (PCR) is a population-based cancer incidence registry responsible for the collection of demographic, diagnostic, and treatment information on all patients diagnosed and treated at hospitals, laboratories, and other health care facilities in Pennsylvania.

The PCR is also defined as an incidence only cancer registry. Incidence only registries gather only the information necessary to determine the incidence of cancer by geographic areas, by demographic characteristics and by stage at diagnosis for each type of cancer. Treatment information and other prognostic factors have also been added to the information collected.

The term *central cancer registry* is also used in referring to the PCR. Although a central registry does not have to be population-based, this term is frequently used to mean a statewide cancer registry. A central registry is designed to aggregate data from various sources. The contributing sources required to report to the PCR provide statewide coverage of the population.

WHY REPORT TO THE PCR

The mission of the PCR is to collect and provide complete, accurate, and timely statewide cancer incidence data for determination of cancer rates, trends in the population, and use in cancer control and research. To fulfill this mission, the PCR depends on complete ascertainment of cases and use of the data.

1. The Law and Regulations: Statewide collection and dissemination of data on cancer by the Pennsylvania Department of Health is mandated in two state laws and Pennsylvania Department of Health disease-reporting regulations. The state laws include the Pennsylvania Cancer Control, Prevention and Research Act, 35 P.S. §5631 *et seq.,* and the Disease Prevention and Control Law of 1955, 35 P.S. §521.1 *et seq. (Appendix A)* According to these statutes, each designated hospital and laboratory in the Commonwealth shall report all cases of cancer, which are diagnosed and/or treated at the hospital or laboratory. These cases shall be submitted in the format prescribed by the Pennsylvania Cancer Registry. Regulations mandating reporting cancer cases by hospitals, clinical laboratories, other health care facilities and health care practitioners appear in Section 27.31(b) of 28 Pa. Code Chapter 27 (Communicable and Noncommunicable Diseases). *(Appendix B)*

2. Cancer Control: The ultimate value of the registry lies not in collection of the data but in the degree to which the data are used for cancer control. The basis for any successful cancer control program is a comprehensive registry system. Registry data provide answers to questions, the means to target limited cancer control resources, and the mechanism to evaluate cancer control activities.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA allows for the reporting of identifiable cancer data to public health entities. Because the PCR falls under the definition of a public health entity, HIPAA allows facilities to report data to the PCR in compliance with Pennsylvania state laws and regulations. Written informed consent from each cancer patient reported to public health entities is not required under HIPAA.
The PCR depends on reporting facilities to submit quality data. Through the dedicated efforts of these facilities, the PCR is able to provide accurate information used to establish and enhance cancer control programs, and thus improve the lives of present and future patients with cancer.

PCR REFERENCE DATE

Reference date refers to the start date after which all eligible records must be included in the registry. The PCR reference date is January 1, 1985. This means complete statewide cancer incidence data are available from the PCR from 1985 to the present.

PCR REPORTING SOURCES

Act 224 mandates each designated hospital and laboratory in the Commonwealth shall report all cases of cancer, which are diagnosed and/or treated at the hospital or laboratory. In addition, the PCR has agreements with other states to exchange data.

Hospitals

1. Registry Hospitals**:** The term *registry hospital* refers to hospitals with a cancer registry functioning as an integral component of the hospital cancer program. They may or may not be accredited by the American College of Surgeons Commission on Cancer. Generally, the cancer registrar or cancer program manager at a registry hospital is delegated the responsibility of reporting to the PCR.

2. Non- Registry Hospitals: The term *non-registry hospital* refers to hospitals that do not have cancer registries functioning as an integral component of a hospital cancer program. Personnel in the Health Information Management (HIM) Department are usually delegated the responsibility of reporting to the PCR.

Laboratories

The addition of these cases provides the PCR data on cases never seen in the hospital setting, thereby increasing the overall completeness of PCR data.

1. Hospital Laboratories: Required reporting of cases by hospital laboratories is performed by cancer registry or HIM personnel as described above.

2. Free-Standing Pathology Laboratories: Reporting of cases by designated free-standing laboratories is performed through electronic submission of pathology reports.

Non-Hospital Sources

The Department of Health's regulations concerning the Reporting of Communicable and Non-Communicable Disease were revised in January 2002 to expand cancer reporting requirements to include additional non-hospital sources. Two types of non-hospital sources were added to Chapter 27, Section 27.31:

1. Other Health Care Facilities: The requirement for reporting by other health care facilities that provide screening, diagnostic or therapeutic service for cancer patients was added to Section 27.31(a). Other health care facilities include facilities such as Radiation Centers and Ambulatory Surgery Centers.
2. Health Care Practitioners: The requirement for reporting by health care practitioners who provide screening, diagnostic, or therapeutic services to cancer patients for cancer was added as Section 27.31(b).

Data Exchange

The PCR has written agreements to exchange data with other cancer registries including all contiguous states. This ensures a resident of Pennsylvania who was diagnosed and/or treated out-of-state will be included in the PCR database.

HOSPITAL REPORTING METHODS

Reporting hospitals are required to abstract all cases electronically using commercial or Abstract Plus software. Electronic files of reportable cases are submitted to the PCR via Web Plus. Web Plus is an internet-based application developed by the Centers for Disease Control and Prevention (CDC), National Program of Cancer Registries (NPCR). Web Plus has been designed as a highly secure application that can transmit data between reporting facilities and the PCR safely over the internet. See *Appendix C, Web Plus File Upload Instructions.*

1. Commercial Software: Registry hospitals are required to report cases included in the hospital cancer registry electronically using commercial software.

2. Abstract Plus Software - Non-registry hospitals report electronically using Abstract Plus Software provided by the PCR at no cost. Abstract Plus is developed and maintained by the CDC.

REPORTABLE DIAGNOSES

ICD-9-CM and ICD-10-CM Codes

Use the list of ICD-9-CM and ICD-10-CM codes documented in *Appendix D* to identify reportable conditions.

Solid Tumors

1. To determine reportability of solid tumors refer to the tables found at https://www.naaccr.org/icdo3/. Below is a description of what is in each table:

Table	Description	# Items
1	Behavior code changes- non-reportable to reportable	16
2	Behavior code changes- reportable to non-reportable	9
3	Deleted codes- histology terms moved to other codes	10
4	Change in reportable terminology	13
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		Order
6	Tables 1-5 plus new preferred & related terms, synonyms	Numerical
7	Tables 1-5 plus new preferred & related terms, synonyms	Alphabetical

Note: Clarification has been provided that early or evolving melanoma in situ, or any other early or evolving melanoma, are reportable effective 1/1/2021. This is not noted in table 1 but is documented in table 6 and 7. It is also documented in the Cutaneous Melanoma Solid Tumor Rules.

2. Behavior- Cancer Registry reportability rules based on behavior still apply when reviewing any of the above ICD-O-3.2 tables and *ICD-O-3.2 Coding Table Excel*
   - /2 and /3 behavior reportable for all sites

     Exception 1: Cervical intraepithelial neoplasia, grade III, also called CIN III (code 8077/2 with primary site C53.X in ICD-O-3) is not reportable.

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

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

   - /0 and /1 behavior reportable for **primary to the intracranial and central nervous system (CNS) sites listed below** are reportable when diagnosed on or after **January 1, 2004.**

Reportable Intracranial and Central Nervous System (CNS) Primary Sites Effective January 1, 2004	
Meninges (C70.0 - C70.9)	Other CNS (C72.8, C72.9)
Brain (C71.0 - C71.9)	Pituitary gland (C75.1)
Spinal Cord (C72.0)	Craniopharyngeal duct (C75.2)
Cauda equina (C72.1)	Pineal gland (C75.3)
Cranial nerves (C72.2 - C72.5)	

3. Basal and Squamous Cell Carcinomas: Basal and squamous cell carcinomas are reportable except when primary to the skin, C44.0-C44.9 (see *Part One, Exclusions*). Carcinomas originating in **mucoepidermoid sites** are reportable. These sites include: lip (C00.0-C00.9), anus (C21.0), vulva (C51.0-C51.9), vagina (C52.9), penis (C60.0-C60.9), and scrotum (C63.2). Basal and squamous cell carcinomas originating in the nasal cavity (C30.0) and middle ear (C30.1) are also reportable.

4. Class IV and Class V Cytologies: Cytology results of Class IV or Class V are reportable to the PCR.

Exception: If the terminology on the cytology report further defines the Class IV and Class V as *suspicious* then the record is not reportable. Report this record only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings. Suspicious cytology only is not diagnostic of cancer.

5. Intraepithelial Neoplasia: Patients with the following diagnoses of intraepithelial neoplasia are reportable. See also *Part One, Exclusions, Intraepithelial Neoplasia.*

- Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211)
- High grade biliary intraepithelial neoplasia (BiIN III) of the gallbladder (C239)
- Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)
- Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) of breast (C500-C509)
- Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259)
- Penile intraepithelial neoplasia, grade III (PeIN III) (C600-C609)
- Squamous intraepithelial neoplasia III (SIN III) excluding cervix and skin sites coded to C44_
- Vaginal intraepithelial neoplasia III (VAIN III) (C529)
- Vulvar intraepithelial neoplasia 3 (VIN III) (C519)

6. Lobular Carcinoma In-Situ (LCIS) of the breast is reportable.

7. Carcinoid of the Appendix: Effective with cases diagnosed January 1, 2015 and after, all *Carcinoids of the appendix* **are reportable** and should be coded to 8240/3.

8. Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high-grade dysplasia (8470/2) is reportable.

9. Mature Teratoma: of the testes in adults is reportable (9080/3).

10. Gastrointestinal Stromal Tumors (GIST): As of 01/01/2021, all GIST tumors are reportable and classified as 8936/3 in ICD-O-3.2.

11. Thymoma: As of 01/01/2021, nearly all thymomas are reportable; the exceptions are microscopic thymoma or thymoma benign (8580/0), micronodular thymoma with lymphoid stroma (8580/1), and ectopic hamartomatous thymoma (8587/0).

12. Severe/High Grade Dysplasia of the Colon and/or Esophagus: If your facility considers the terminology of severe dysplasia or high-grade dysplasia of the colon and/or esophagus as synonymous with carcinoma in-situ; use the following guidelines for reporting these cases to the PCR:

    a. Obtain a statement from your pathologists 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.

    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 will be abstracted as carcinoma in-situ based on the pathologists approved statements.

    d. Add the policy to your Operations Manual attaching the approved statement(s) from your pathologists.

    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. In the text for each abstract, document the final pathologic diagnosis along with the statement "in-situ per pathologist".

Hematopoietic and Lymphoid Neoplasms

1. Reportability Instructions: For all hematopoietic or lymphoid neoplasms, refer to the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*, *Case Reportability Instructions.* http://seer.cancer.gov/seertools/hemelymph/

Note: The Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual must be used because not all reportable hematopoietic or lymphoid terms are indexed in ICD-O-3.

Example: Essential Thrombocytosis is coded to ICD-9-CM code 238.71. It is not indexed in ICD-O-3. However, when checked in the *Hematopoietic and Lymphoid Neoplasm Database*, it is considered reportable; therefore, the case is reportable and must be abstracted and submitted to the PCR.

2. Behavior Code Change from /1 to /3: The behavior code for hematopoietic neoplasms listed below changed from /1 (borderline or uncertain) to /3 (malignant) and are reportable when diagnosed on or after **January 1, 2010**.

Histologic Terms and Codes with Changes in Case Reportability Effective January 1, 2010	
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	9751/3
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	9975/3
Myeloproliferative neoplasm, unclassifiable	9975/3

AMBIGUOUS TERMINOLOGY FOR SOLID TUMORS

As part of the registry casefinding activities, all diagnostic reports should be reviewed to confirm whether or not is reportable. If the terminology is ambiguous, use the following guidelines to determine whether or not is reportable.

This section clarifies the use of Ambiguous Terminology for case reportability. The first and foremost resource for the registrar for questionable cases is the physician who diagnosed and/or staged the tumor. The ideal way to approach abstracting situations when the medical record is not clear is to follow up with the physician. If the physician is not available, the medical record, and any other pertinent reports (e.g., pathology, etc.) should be read closely for the required information. The purpose of the Ambiguous Terminology lists is so that in the case where wording in the patient record is ambiguous with respect to reportability and no further information is available from any resource, registrars will make consistent decisions. When there is a clear statement of malignancy (i.e., the registrar can determine malignancy), they should not refer to the Ambiguous Terminology lists. Registrars should only rely on these lists

when the situation is not clear, and the case cannot be discussed with the appropriate physician/pathologist.

1. Terms That Constitute a Diagnosis: Interpret the following terms as a reportable diagnosis when used with a term such as carcinoma, sarcoma, etc:

apparent(ly)	*consistent with*	*neoplasm***	*suspicious (for)*
appears	*favor(s)*	*presumed*	*tumor***
comparable with	*malignant appearing*	*probable*	*typical (of)*
compatible with	*most likely*	*suspect(ed)*	

**Beginning with 2004 diagnoses and only for meninges, brain, central nervous system, pituitary gland, craniopharyngeal duct, and pineal gland (C70.0-C72.9, C75.1-C75.3).

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

Exception: Do not report a case based only on suspicious cytology. The case is reported only if proven by positive cytology or other diagnostic methods including a physician's clinical diagnosis.

2. Terms That **DO NOT** Constitute a Diagnosis- Do not interpret the following terms as a diagnosis. Do not report patients who have a final diagnosis consisting only of these terms without additional information to support reportability:

cannot be ruled out	*potentially malignant*	*suggests*
equivocal	*questionable*	*worrisome*
possible	*rule(d) out*	

How to Use Ambiguous Terminology For Case Ascertainment

1. In Situ and Invasive (Behavior codes /2 and /3)

   a. If any of the reportable **ambiguous terms precede** a word that is **synonymous** with an in situ or invasive tumor (e.g., cancer, carcinoma, malignant neoplasm, etc.), the case is reportable.

   b. Discrepancies: If one section of the medical record(s) uses a reportable term such as "apparently" and another section of the medical record(s) uses a non-reportable term such as "cannot be ruled out", accept the reportable term and report the case.

Exception: Do not report a case based only on suspicious cytology. The case is reported only if proven by positive cytology or other diagnostic methods including a physician's clinical diagnosis.

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

Note: If the ambiguous diagnosis is proven to be not reportable by biopsy, cytology, or physician's statement, do not report the case.

d. Suspicious Cytology: Do not report a case based only on suspicious cytology. The case is reported only if proven by positive cytology or other diagnostic methods including a physician's clinical diagnosis

e. Benign and borderline primary intracranial and CNS tumors

1. Use the "Ambiguous Terms that are Reportable" list to identify benign and borderline primary intracranial and CNS tumors that are reportable.

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

3. Discrepancies: If one section of the medical record(s) uses a reportable term such as "apparently" and another section of the medical record(s) uses a non-reportable term such as "cannot be ruled out", accept the reportable term and accession the case.

Exception: Do not report a case based only on suspicious cytology. The case is reported only if proven by positive cytology or other diagnostic methods including a physician's clinical diagnosis.

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

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

Note: If the ambiguous diagnosis is proven to be not reportable by biopsy, cytology, or physician's statement, do not report the case

AMBIGUOUS TERMINOLOGY FOR HEMATOPOIETIC AND LYMPHOID NEOPLASMS

For all hematopoietic or lymphoid neoplasms, refer to the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*, *Case Reportability Instructions.*
http://seer.cancer.gov/seertools/hemelymph/

DATE OF DIAGNOSIS REPORTABILITY

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**. Known diagnosis date means the **year, or the month and year, or the month, day and year** are known or can be estimated. Patients with a completely unknown date of diagnosis are **not** reportable.

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 or unknown.

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.

Example 1: If a patient is admitted on January 3, 2010 and is diagnosed with lung cancer on January 7, 2010, the case is reportable.

Example 2: If a patient is admitted on January 3, 2010 and receives palliative care for bone metastasis from a breast primary diagnosed in 1999, the case is reportable.

Example 3: If a patient is admitted on January 3, 2010 and receives a blood transfusion for polycythemia vera, originally diagnosed in November 1999, the case is not reportable per *Exception 1* above.

Example 4: If a patient is admitted on January 3, 2010 and receives treatment for hemangioblastoma, originally diagnosed in November 2003, the case is not reportable per *Exception 2* above.

REPORTABLE SITUATIONS

A case is reportable to the PCR if it is a condition included under *Part One, Reportable Diagnoses* and meets the following criteria:

1. Patients diagnosed or treated in your inpatient or outpatient departments, emergency room, ambulatory care center, or other units included under your hospital license.

    a. Patients Diagnosed at Your Hospital: The reportable diagnosis has been made at your hospital. This diagnosis can be made on the basis of histology (including autopsy), hematology, cytology, endoscopy or other direct visualization, diagnostic radiology or clinical findings.

        Clinical Diagnosis Only: A "clinical diagnosis only" is a diagnosis based solely on clinical judgment; diagnostic procedures were not performed or did not confirm the diagnosis. Patients diagnosed clinically are reportable to the PCR.

    b. Patients Treated at Your Hospital: The PCR requires patients receiving treatment, cancer-directed or non- cancer-directed, to be reported provided they have not been previously reported by your hospital.

        The PCR recognizes the following definitions of treatment:

        1. Cancer-Directed Treatment: Cancer-directed treatment is tumor directed, and its purpose is to modify, control, remove or destroy primary or metastatic cancer tissue. Physicians administer the therapy (ies) to remove or minimize the size of tumor or to delay the spread of disease.

        2. Non- Cancer-Directed Treatment: Non-cancer-directed treatments prolong the patient's life, alleviate pain, make the patient comfortable, or prepare the patient for cancer-directed therapy. They are not meant to destroy or control the tumor or delay the spread of disease. Non- cancer-directed procedures include diagnostic tests and supportive care (treatments designed to relieve symptoms and minimize the effects of the disease).

            Examples of non- cancer-directed treatment include: Incisional biopsy, exploratory procedures with or without biopsies, port-a-catheter insertion, IV access for chemotherapy, pain medications, oxygen, antibiotics for an associated infection, transfusions, intravenous fluids to maintain fluid or nutritional balance, and laser therapy for relieving symptoms.

Note for registry hospitals: Because some patients receiving non-cancer-directed treatment are nonanalytic, registry hospitals following ACOS Commission on Cancer guidelines may choose not to include these records in their hospital-based registries. These records, however, must be abstracted and reported to the PCR.

2. Patients Diagnosed at Autopsy: Final autopsy reports containing reportable diagnoses or incidental findings of reportable conditions must be reported to the PCR. Although autopsies performed as coroner's cases are not required to be reported, hospitals are encouraged to submit them to the PCR.

3. Patients Diagnosed Elsewhere: Patients diagnosed elsewhere and newly admitted to your hospital for further diagnostic workup or treatment, cancer-directed or non-cancer-directed are to be reported.

   Although this may result in multiple records on one patient, it enables the PCR to assure complete statewide casefinding and to have the most comprehensive information on each patient. Because the PCR is a population-based registry, every attempt must be made to receive all cases diagnosed within Pennsylvania to provide accurate statistical reports.

4. Brain and CNS Tumors Identified by Diagnostic Imaging Only: Patients with a brain or CNS tumor identified by diagnostic imaging (CT scans, MRI scans, or ultrasounds/sonography) are reportable even when no other information is available (from biopsy or resection, for example). The behavior for the tumor is coded as /1 (uncertain whether benign or malignant).

5. Residual Tumor: The PCR requires all records in which the pathology report states "no residual tumor" to be reported. The re-excision is considered cancer-directed treatment.

   Example: Outside the hospital setting, a patient has a biopsy and is diagnosed with a malignant melanoma. The patient is seen at your hospital for a wide excision. The tissue report from the excision states no residual tumor. This record is reportable to the PCR. Even though the cancer was diagnosed elsewhere, the patient's hospital visit was for cancer related treatment.

6. Private Outpatient Specimens (POP) (Path Only): Private outpatient specimens (POP) 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. The patient is not registered as an inpatient or outpatient at the hospital. POPs are reportable to the PCR.

   Example: A physician performs a biopsy in the office and sends the specimen to your Pathology Department where a reportable diagnosis is made.

   a. POP reports should be held for two to three months because many of these patients may return for treatment and more information can be obtained from these records.

b. If the patient does not return as an inpatient or hospital outpatient, abstract the record using all available information. Every effort must be made to obtain accurate information. This information can be found through hospital billing systems, clinical history, or if needed by contacting physician offices.

c. Data items should be completed as *unknown* only after further investigation does not provide more specific information.

d. The specimen date should not be considered the date of diagnosis without further confirmation from the clinical history or physician.

7. Ownership of the Medical Record: When the distinction between a hospital department and a freestanding facility cannot readily be made, such as a radiation therapy group practice versus a hospital unit; the ownership of the medical record is used to determine whether or not a record must be reported. If the medical record is the property of the institution, the record **must** be reported. If the hospital is part of a corporation, ownership of the record refers to the facility, not the corporation.

EXCLUSIONS

Non-Reportable Diagnosis

The following diagnoses are **not** reportable to the PCR.

1. Skin Cancers

   a. The following site/histology combinations for skin cancers are not reportable:

8000-8005	Neoplasms malignant, NOS of the skin (C44.0-C44.9)
8010-8046	Epithelial carcinomas of the skin (C44.0-C44.9)
8050-8084	Papillary and squamous cell carcinomas of the skin (C44.0-C44.9)
8090-8110	Basal cell carcinomas of the skin (C44.0-C44.9)

   b. ICD-O codes C44.0-C44.9 include skin of the lip, eyelid, external ear, face, nose, scalp, neck, trunk, perineum, (peri) anus, umbilicus, upper and lower limbs, shoulders, hips, and skin around ostomy sites.

   Note: The above lesions are reportable when the primary tumor originates in a mucoepidermoid site (See Part One, Reportable Diagnoses).

   c. Skin of nose: Basal and squamous cell carcinomas originating in the external nose (C44.3) are not reportable; however, those primary to the nasal cavity (C30.0) such as nostril, nasal septum, and nares are reportable.

   d. Metastasis from non-reportable sites: If the primary site is not reportable but the cancer has metastasized to other sites, the record is still not reportable.

2. Carcinoma-In-Situ of the Cervix (CIS): The diagnosis carcinoma in situ of the cervix (CIS) is not reportable. Terms indicating in situ include: *noninvasive, preinvasive, intraepithelial,* and *FIGO Stage 0.* A diagnosis of carcinoma in situ with endocervical gland involvement is still considered in situ and is not reportable.

   Note: Diagnoses of invasive carcinoma of the cervix are reportable. A diagnosis of carcinoma in situ of the cervix with microinvasion is considered invasive and is therefore reportable.

3. Intraepithelial Neoplasia: Patients with the following diagnoses of intraepithelial neoplasia are not reportable:

   - Cervical intraepithelial neoplasia (CIN)
   - Prostatic intraepithelial neoplasia (PIN)

   See also *Part One, Reportable Diagnoses, Intraepithelial Neoplasia.*

4. Other Precancerous Conditions and Benign Tumors: Patients with precancerous conditions or benign tumors are not reportable. An example of such a diagnosis includes atypical adenoma. Registry hospitals may elect to collect these cases; however, they are not reportable to the PCR.

Exception 1: Ovary and Peritoneum: Cystadenomas or tumors primary to the ovary or peritoneum qualified by the phrases *borderline malignancy* or *low malignant potential* are reportable if diagnosed prior to January 1, 2001.

Exception 2: Brain and Central Nervous System: All primary intracranial and central nervous system (CNS) tumors are reportable beginning with cases diagnosed on or after January 1, 2004. This includes benign and borderline tumors for the following sites:

Reportable Intracranial and Central Nervous System (CNS) Primary Sites Effective January 1, 2004	
Meninges (C70.0 - C70.9)	Other CNS (C72.8, C72.9)
Brain (C71.0 - C71.9)	Pituitary gland (C75.1)
Spinal Cord (C72.0)	Craniopharyngeal duct (C75.2)
Cauda equina (C72.1)	Pineal gland (C75.3)
Cranial nerves (C72.2 - C72.5)	

Non-Reportable Situations

A case is **not** reportable to the PCR if it meets any of the following criteria:

1. Consult Only Records: Patients seen in consultation to provide a second opinion to confirm an established diagnosis or treatment plan are not reportable. Also, if the reporting institution provides services not available at the diagnosing or treatment facility, such as Computerized Tomography (CT) scans or Magnetic Resonance Imaging (MRI) scans, the case is not reportable.

   - Consults are reportable if they are done to establish a diagnosis or to develop and document a treatment plan. See *Part Three, First Course of Treatment Guidelines* for a definition of a treatment plan.

Example	The primary care physician (PCP) sends the patient to a consulting physician for his opinion and the consulting physician subsequently develops a treatment plan, the case is reportable.

2. Slide Reviews: Records in which slides are sent to your hospital's pathologist for a second opinion are encouraged to be reported but are not required. Since the slide was already read by another pathologist, the facility requesting the slide review is required to report the final diagnosis as determined after the slide review.

3. History of: Patients with a history of a reportable condition who are clinically free of disease are not reportable. If, however, the patient has actually received treatment during this admission the record must be reported. For example: if a patient is admitted for an unrelated condition, has a history of breast cancer and the hospital administers Tamoxifen during their admission, the case is reportable.

4. Positive Imaging Study: Facilities are not expected to report non-brain/CNS cases based on a positive imaging study only. However, if the patient meets reporting requirements at a later time, the case must be reported.

   Exception: A brain or a CNS 'neoplasm' identified by diagnostic imaging is reportable even when no other information is available.

5. Suspicious cytology only is not diagnostic of cancer. Report this record only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

6. Transient Care: Patients receiving transient care at the reporting institution to prevent interruption of the first course of treatment are not reportable. This only applies to patients vacationing or visiting in the area, or equipment failure at the primary treating institution which requires the patient to temporarily receive treatment elsewhere.

   Exception: Cancer patients evacuated to other states due to natural disasters may receive diagnostic/treatment services in facilities in that state. If this occurs at your facility, consider these cases reportable to the Pennsylvania Cancer Registry (PCR). They should not be excluded as transient care or consult only cases.

   When abstracting these cases, please record the **patient's usual residence when the tumor was diagnosed** in the Address at Diagnosis fields. Do not enter the patient's current address if the patient was diagnosed prior to relocating permanently or temporarily to Pennsylvania or other nearby state.

7. Readmitted Patients: If a patient is readmitted and new or additional metastatic sites are diagnosed or documented, the record is not reportable provided it has already been reported for the original primary site. Records of readmitted patients must be reviewed to determine if a new primary site has been diagnosed. Each new primary must be reported separately.

8. Metastatic Sites: Do not report the metastatic or secondary sites of a malignant neoplasm; however, check to make sure the primary site was previously reported. A diagnosis of metastatic cancer with an unknown primary site not previously reported should be submitted with the primary site documented or coded as **unknown.**

9. Special Units: Patients admitted to a skilled nursing unit or other separately licensed units are encouraged to be reported but are not required. These patients are either discharged from an acute care hospital unit and readmitted to a separately licensed unit or are admitted directly to the separately licensed unit.

10. Diagnosed Prior to 1995: Patients with a date of diagnosis prior to January 1, 1995 are not reportable.

11. Unknown Date of Diagnosis: Cases with a fully unknown month, day and year of diagnosis are not reportable.

Note: ***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.***

MULTIPLE PRIMARY DETERMINATION

Solid Malignant Tumors and Benign/Borderline Central Nervous System Tumors

1. Cases diagnosed on or after January 1, 2018: Effective with cases diagnosed on or after January 1, 2018 the PCR requires the use of The Solid Tumor Coding Rules for multiple primary determination and histology coding of solid malignant tumors and benign borderline Central Nervous System tumors. The 2018 Solid Tumor Coding Manual can be found at: https://seer.cancer.gov/tools/solidtumor/

2. Cases diagnosed on or after January 1, 2007: Effective with cases diagnosed on or after January 1, 2007 the PCR requires the use of *The Multiple Primary and Histology Coding Rules (MP/H Rules)* for multiple primary determination and histology coding of solid malignant tumors and benign and borderline Central Nervous System tumors. The *MP/H Rules Manual* can be downloaded from the following site: http://seer.cancer.gov/tools/mphrules/download.html

3. Cases diagnosed prior to January 1, 2007: Pages 7-18 of the *SEER Program Coding and Staging Manual 2004* should be used for solid malignant tumors and benign and borderline Central Nervous System tumors diagnosed prior to January 1, 2007. The *SEER Program Coding and Staging Manual 2004* can be downloaded from the following site**:** http://seer.cancer.gov/archive/manuals/2004Revision1/SPM_2004_maindoc.r1.pdf

Hematopoietic and Lymphoid neoplasms

1. Cases diagnosed on or after January 1, 2010: Effective with cases diagnosed on or after January 1, 2010 the PCR requires the use of The *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and *The Hematopoietic Database* for multiple primary determination, primary site and histology coding of hematopoietic and lymphoid neoplasms. The manual and database can be found at: http://seer.cancer.gov/seertools/hemelymph/

2. Cases diagnosed prior to January 1, 2010: The SEER table *Definitions of Single and Subsequent Primaries for Hematologic Malignancies* should be used to determine multiple primaries for hematopoietic and lymphoid neoplasms diagnosed prior to January 1, 2010. The SEER table *Definitions of Single and Subsequent Primaries for Hematologic Malignancies* can be downloaded from the following site: http://seer.cancer.gov/archive/icd-o-3/hematopoietic_primaries.d03152001.pdf

CONFLICTING STANDARDS

When standards of regulatory agencies differ, hospitals must implement procedures to comply with PCR standards.

WHEN IN DOUBT

When in doubt about submitting records to the PCR, ask the following questions:

1. Did your facility diagnose and/or treat the patient for a condition included under *Part One, Reportable Diagnoses?*
2. Is the Date of Diagnosis known and is it on or after January 1, 1995?

If the answer to both questions is yes and the record was not previously submitted by your hospital, report the record. If you are in doubt about a record, call your PCR Field Representative at 1-800-272-1850.

PCR REQUIRED DATA ITEMS

The PCR requires specific data items to be completed for each reportable case. These data items include demographic, cancer identification, treatment, hospital-specific and text information. A listing of the PCR Required Data Set is included in *Appendix F.* Instructions on completing each data item are provided in *Part Three, Data Item Instructions.*

All data items required for participation in the National Program of Cancer Registries (NPCR) are included in the PCR data set. PCR-required codes and definitions comply with national standards established by the North American Association of Central Cancer Registries (NAACCR) and American College of Surgeons Commission on Cancer (ACOS COC).

CHANGING INFORMATION

A change includes updating or correcting previously submitted information.

Importance of Change/Deletion Procedure

The change procedure ensures the most accurate information is available to users of PCR data by enabling reporting facilities to provide updated or corrected information after a record has been accessioned by the PCR.

Changes are submitted electronically as an M record. An M record is any record Modified since previous submission to central registry (identical in format to the “A” record type).

Example: At the time a record was reported to the PCR, the primary site was unknown. On a subsequent admission, the primary site was documented as upper lobe of left lung. A modification record must be submitted to update the primary site, laterality, and stage (as was known during first course of treatment). The PCR will update this information on the patient's record on the PCR data file.

What to Change

1. Change any PCR required data item when incorrect or unknown information was initially reported or when more specific/correct information is later available.

2. Change Collaborative Stage data items, SEER Summary Stage and TNM Staging only if additional information is 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.

3. Submit a change for name when incorrectly spelled on record and when name is changed due to marital status or other reason.

4. **Do not** submit changes to update address changes or admission/discharge dates when the patient is readmitted.

How to Change Information Electronically

1. Make the change to the case in your database. Follow the procedures provided by your vendor to generate an M record. Abstract Plus users refer to the *Abstract Plus Users Guide* for instructions.

2. When creating your normal file for submission (A Records) in **January, April, July and October**, a separate file of M records should also be created. The A and M records cannot be combined into one file; a separate file of each is needed.

Note: ***M record files should only be submitted quarterly in Janaury, April, July and October. Do not submit M records every month. Your software will extract all changes made since the last M record file was created. This will help reduce the volume of M records received when multiple changes are made to the same patient.***

3. Upload both your A record file and your M record file in Web Plus each month. For your M record file, write "### M Records" in the comment box indicating the number of M records being submitted.

How to Notify PCR of a Deletion

1. If it is later determined a previously reported case is NOT reportable, contact your PCR Field Representative and provide the following information:

    a. Patient Name
    b. Patient Date of Birth
    c. Patient Social Security Number
    d. Reason for deleting the case

    Example: At the time a record was reported to the PCR, the patient's initial diagnosis was *probable carcinoma*. After further review, it was determined the patient does not have cancer. Such cases must be deleted. Contact your PCR Field Representative with the above information. The case will then be deleted from the PCR database.

2. Delete the case from your database.

HOW TO REPORT

Records containing all required data items must be uploaded to the PCR using Web Plus. Detailed instructions for completing the required data items can be found in the *Part Three, Data Item Instructions*. See *Appendix C* for instructions to upload files via Web Plus.

WHEN TO REPORT

Submission Dates

Reporting facilities must upload abstract files on the 15th of every month. If the 15th falls on a weekend or holiday, files must be uploaded on the last working day **before** the 15th. Abstract files may be uploaded more than once per month but **no more frequently than once a week**. Special submissions such as reconciliations, death clearance cases, etc, are not considered regular reporting and therefore may be transmitted the same week as a routine transmission.

Timeliness of Reporting

1. 180 Days: The PCR requires 90% of abstracts submitted by reporting facilities to be received by the PCR within 180 days from *Date of Inpatient Disch* if an inpatient or *Date of 1st Contact* if an outpatient. The months of May and June 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 requirement was established at 90% to provide a cushion of 10% to encourage late reporting of missed cases to assure reporting completeness.

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

FACILITY CONTACT PEOPLE FOR PCR

One person at each reporting facility is designated as the PCR contact person. This person will receive all PCR correspondence regarding PCR requirements and quality control results. For example: changes in reporting requirements and timeliness reports. Each facility must designate the Managing PCR contact person such as the supervisor or manager that oversees the staff responsible for reporting to the PCR.

The reporting facility can inform the PCR of additional staff they would like included in all email correspondence. To maintain proper communication, inform the PCR of any changes in the contact people at your facility by calling 1-800-272-1850 or emailing your PCR Field Representative.

CONTACTING THE PCR

If you have any questions regarding the PCR, contact us at: 1-800-272-1850.

All faxes for PCR staff should be sent to 1-866-531-8238.

Trainings

The PCR offers trainings through Fundamental Learning Collaborative for the Cancer Surveillance Community (FLccSC). The trainings provide specific information on state reporting requirements and cancer data collection.

The Fundamental Learning Collaborative for the Cancer Surveillance Community (FLccSC pronounced Flossy) is a cancer surveillance community educational collaboration. FLccSC is a web-based portal, which allows Central Cancer Registries (CCR) to customize a fully functioning state-specific Learning Management System (LMS). For more information visit http://flccsc-info.fcdslms.med.miami.edu/.

To sign up for a FLccSC membership please visit:
https://pas.fcdslms.med.miami.edu/ords/f?p=105:LOGIN_DESKTOP:1007680470255:::::

Click on the “New Users – Register Here” button on the bottom right of the home screen.

PART TWO

Casefinding

Casefinding Procedures

Casefinding is a system for identifying patients with a reportable diagnosis. Because cancer incidence can be most accurately reflected only when every reportable diagnosis is identified and submitted to the central registry, effective casefinding procedures are essential.

Although casefinding procedures will vary among reporting facilities, the key to effective casefinding is the identification of reportable conditions in all areas where patients are diagnosed or treated in a routine and systematic manner. The following concepts should be considered when developing procedures to insure complete identification of cases reportable to the PCR.

Reportable Conditions

The first step in establishing effective casefinding procedures is to know what conditions are reportable. These conditions are defined in the following references:

- ICD-9-CM AND ICD-10-CM Codes: *Appendix D, List of Reportable ICD-9-CM and ICD-10-CM Codes* provides a list of ICD-9-CM and ICD-10-CM codes used to identify reportable diagnoses.

Casefinding Sources

The second step in establishing effective casefinding procedures is to identify all areas in the facility where these reportable conditions are either diagnosed or treated and the sources for casefinding in each area. The Health Information Management (HIM) Department and Pathology Department must be included as casefinding sources by all facilities; the remaining sources listed below should be included as applicable.

The term "records" as used in the descriptions below refers to all electronic and paper patient records, i.e., inpatient, outpatient, Emergency Room, ambulatory care, short stay procedures, radiation therapy, chemotherapy. For each source, review all of the following reports and records.

1. Health Information Management Department (HIM) - Disease Index: Records assigned an ICD-9-CM or ICD-10-CM code included in *Appendix D* should be reviewed to identify reportable cases. In addition to casefinding, the disease index should also be used as a quality control measure to make sure all reportable diagnoses have been submitted. See also *Part Four, Quality Control: Reporting Facilities.*

2. Pathology Department/Laboratory Medicine: Casefinding from Pathology Department/Laboratory Medicine must include identification of reportable diagnoses made on inpatient, outpatient, and private outpatient (POP) specimens.

3. Histology: Surgical pathology reports should be reviewed for a reportable diagnosis. If your Pathology Department screens the reports and forwards those reports to the person responsible for PCR reporting, they must be provided with a copy of *Appendix D.* Surgical pathology reports showing "no residual malignancy (or tumor)" and reports resulting from orchiectomy or oophorectomy performed for prostate or breast malignancies should be included in what is copied and forwarded to the person responsible for PCR reporting.

    a. Cytology: All cytology reports should be reviewed for a malignant diagnosis and, when identified, forwarded to the person responsible for PCR reporting. An alternative would be to review positive or abnormal cytologies.

    b. Hematology: Peripheral blood reports should be reviewed for a diagnosis of malignancy and, when identified, a copy forwarded to the person responsible for PCR reporting.

    c. Bone Marrow: All bone marrow reports should be reviewed for a diagnosis of malignancy and, when identified, a copy forwarded to the person responsible for PCR reporting.

    d. Autopsy: All final autopsy reports should be reviewed for reportable diagnoses including incidental findings and, when identified, a copy forwarded to the person responsible for PCR reporting. Reportable diagnoses on autopsy reports from coroner's cases should also be identified. See *Part One, Patients Diagnosed at Autopsy.*

4. Outpatient Departments

    a. Short Procedure/Same Day Surgery/Ambulatory Care Unit: A system must be implemented to routinely review all outpatient records maintained within or separate from the HIM Department for diagnoses. If reporting criteria are met, cases must be submitted to the PCR.

    b. Emergency Room (ER): Pathology and cytology reports from procedures performed in the ER should be screened and reported if a reportable diagnosis is made.

5. Oncology Services

    a. Radiation Therapy: Radiation therapy records must be reviewed. If reporting criteria are met, cases must be submitted to the PCR. Patients diagnosed elsewhere but treated at your facility must be reported.

    b. Medical Oncology/Chemotherapy: Chemotherapy records must be reviewed. If reporting criteria are met, cases must be submitted to the PCR. Patients diagnosed elsewhere but treated at your facility must be reported.

6. Other Areas: Records from other areas of the hospital where reportable conditions are either diagnosed or treated must be reviewed and submitted if a reportable diagnosis is made.

7. Records Maintained Separately from the HIM Department: Reporting cases when records are maintained separately from the HIM Department is based on ownership of the medical record. The determination must be made as to who owns the medical record - either the hospital or the medical practitioner who uses space/equipment within the hospital to perform procedures and/or treat private patients. If the hospital owns the record, the case must be reported. If the hospital does not own the record, the PCR requests but does not require the case to be reported.

Completeness of Casefinding

After all reportable diagnoses have been identified through routine casefinding procedures; the final step to effective casefinding is quality control. Procedures should be in place to verify all cases were identified and reported to the PCR. *PCR Manual Part Four, Quality Control* describes various quality control strategies to assure complete casefinding and reporting.

Most Effective Casefinding Procedure

The most effective approach to identifying all reportable diagnoses for reporting to the PCR should include the following:

1. Review the ICD-9-CM or ICD-10-CM disease index daily, weekly or monthly of all inpatient and outpatient medical records with an ICD-9-CM or ICD-10-CM diagnosis code listed in *Appendix D.*

2. Review reports from all inpatient, outpatient, and private outpatient (POP) pathology, cytology, bone marrow, hematology, and autopsy specimens analyzed at your facility.

3. Perform quality control procedures to assure all reportable cases were identified and reported to the PCR.

PART THREE

Data Item Instructions

GENERAL INFORMATION

Data Item Completion

Each case reported to the PCR must include all data items identified in *Appendix F, Required Data Set for Reporting Facilities.* These data items must be completed according to codes, definitions, and instructions specified for each item in this section. The codes and definitions for each required data item conform to national cancer registration standards as defined by NAACCR (North American Association of Central Cancer Registries) and ACOS COC (American College of Surgeons Commission on Cancer).

Every effort must be made to obtain specific, complete, and accurate information for each required data item. Inpatient and outpatient health records, clinical history on pathology reports, hospital billing records, and contact with physician offices should be used as sources of information in completing data items.

Recording Unknown or Not Applicable Information

Data items should be recorded as *unknown* only after **all** efforts to obtain specific information prove unsuccessful.

1. Unknown, Text: When specific information is not available for any data item requiring an alphabetic entry, record the word *unknown* in the field as specified in the data item instructions in this section.

2. Unknown, Code 9: When specific information is not available for any data item requiring a numeric entry, record the code for unknown, *9,* in the field as specified in the data item instructions in this section.

Recording Dates

1. Date Format: Beginning in 2010, the way dates are transmitted was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date.

   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. If full or partial date is entered, the date flag fields are left blank.

2. Date Flag Fields: Only actual known dates are entered in interoperable date items, date flags explain the reason when there is no value in the corresponding date item. Date flag fields are left blank when a full or partial date is entered.

Note: ***Lower case 'b' will be used throughout the PCR Manual to illustrate blanks in the date fields but are not to be recorded.***

Date Flag Codes and Definitions		
Flag Codes	**Description**	**Definition**
bb (blank)	Date provided	Full or partial date was provided; therefore, Date Flag field is left blank.
10	No Information	No information whatsoever can be inferred from this exceptional value. It is unknown if this event occurred. (e.g., surgery)
11	Not Applicable	No proper value is applicable in this context. (e.g., no surgery performed)
12	Unknown	A proper value is applicable but not known. The event occurred but the date is unknown. (e.g., birth date)
13	Not Asked	This information has not been sought. (i.e., the patient was not asked)
14	Asked but unknown	Information was sought but not found. (i.e., the patient was asked but did not know)
15	Temporarily unavailable	Information is not available at this time, but it is expected that it will be available later.

3. Approximating Dates: If the exact date is unknown, use guidelines below to estimate dates from descriptive terms.

   a. Approximating Year**:** Use the following guidelines to estimate year from descriptive terms:
      1. Code 'a couple of years' to two years earlier.
      2. Code 'a few years' to three years earlier.
      3. Use whatever information is available to calculate the year, such as 7 years ago.
      4. If a descriptive term is not included in this guideline or if there are no descriptive terms available, **do not enter fictitious dates or default values, leave blank**.

   b. Approximating Month**:** Use the following guidelines to estimate month from descriptive terms:
      1. Code 'spring of' to April (04);
      2. Code 'summer' or 'middle of year' to July (07);
      3. Code 'fall' or 'autumn' to October (10);
      4. For 'winter of', try to determine whether the physician means the first of the year or the end of the year and code January (01) or December (12) as appropriate;
      5. Code 'early in year' to January (01);
      6. Code 'late in year' to December (12);
      7. Use whatever information is available to calculate the month, such as 7 months ago;
      8. If a descriptive term is not included in this guideline or if there are no descriptive terms available, **do not enter fictitious dates or default values, leave blank.**

c. Approximating Day: No approximation of day is acceptable. **Do not enter fictitious days or default values, leave blank.**

5. Unknown Dates: If the month, day, or year is unknown with no descriptions or information to calculate, leave the appropriate date field position blank. If the date is completely unknown, assign appropriate Date Flag.

6. Fictitious Dates: If any part of a date is unknown and there is no description or guideline to approximate a date for fields where this is acceptable, leave blank for interoperable date entry. Do not enter fictitious dates or default values such as 15 for unknown day or 0101 when month and day are unknown. Because fictitious dates or default values cannot be differentiated from exact dates when comparing dates reported by different facilities, incorrect dates may be chosen over exact dates during the record consolidation process.

Ill-defined Sites

Throughout the *PCR Manual* "ill-defined sites" is referenced and often has special rules. Below is a listing of what is considered an ill-defined site.

Ill-defined Sites	
C76.0	Head, face and neck, NOS
C76.1	Thorax, NOS
C76.2	Abdomen, NOS
C76.3	Pelvis, NOS
C76.4	Upper limb, NOS
C76.5	Lower limb, NOS
C76.7	Other ill-defined sites
C76.8	Overlapping ill-defined sites

Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative diseases

Throughout the *PCR Manual* "hematopoietic, reticuloendothelial, immunoproliferative, and myeloproliferative diseases" are referenced and often have special rules. Generally, these diseases fall into the ranges in the table below. Refer to *The Hematopoietic and Lymphoid Database,* http://seer.cancer.gov/seertools/hemelymph/, to identify if specific diseases fall into this category.

Primary Site	Histology
C000-C809	9740-9809, 9840-9992
C420, C421, C424	9811-9818, 9823, 9827, 9837
C000-C440, C442-C689, C691-C694, C698-C809	9733, 9820, 9826, 9831-9836

Name-Last

Record the patient's full last name. Do not leave blank.

1. Blanks, Spaces, Hyphens and Apostrophes are allowed. No other special characters are allowed.

2. Change to Name: This data item should be updated on the hospital abstract if the last name changes and the change must be submitted to the PCR. See *Part One, Changing Information*.

   Example: Janet White marries and becomes Janet Black. Change the last name to Black and record White in the maiden name field; forward the change to the PCR.

3. Suffixes and Prefixes: Name suffixes when available must be entered in the field *Name-Suffix* and not included in the *Name-Last* field. Do **not** include name prefixes (e.g., Sister, Reverend, Brother, Dr.) as part of the patient last name. Name prefixes are not collected by the PCR and must not be included in any of the required name fields.

Name-Suffix

Record the patient's name suffix.

Name suffix is a title that follows a patient's last name. The suffix can identify the generation order in families and provide credential status.

1. Blanks, Spaces, Hyphens and Apostrophes are allowed. No other special characters are allowed.

2. No Suffix: Leave this data item blank if the patient does not have a name suffix.

Suggested Abbreviation:

Title	Abbreviation
Doctor	MD, PhD
Junior	Jr
Senior	Sr
Third	III

3. Multiple Suffixes: If multiple suffixes are used, the generation specific suffix is to be recorded.

4. Prefixes: Do **not** include name prefixes (e.g., Sister, Reverend, Brother, Dr.) as part of the patient name suffix. Name prefixes are not collected by the PCR and must not be included in any of the required name fields.

Name-First

Record the patient's full first name. Do not leave blank.

1. Blanks, Spaces, Hyphens and Apostrophes are allowed. No other special characters are allowed.

2. First Initial Only: If the patient uses the initial of their first name and their full middle name, enter the patient's first initial in the *Name - First* field. Record the middle name in the *Name - Middle* field.

   Example: Patient's name is M. Jane
   (*Name - First*) = M
   (*Name - Middle*) = Jane

3. Prefixes: Do **not** include name prefixes (e.g., Sister, Reverend, Brother, Dr) as part of the patient first name. Name prefixes are not collected by the PCR and must not be included in any of the required name fields.

Name-Middle

Record the patient's middle name.

1. Middle Initial: Record the middle initial if full name is unknown.

2. No Middle Name or Unknown: Leave this item blank if the patient does not have a middle name or initial, or if the middle name or initial is unknown. Do **not** record *not applicable*, *N/A* or *unknown*.

3. Punctuation: Do not use any punctuation.

Name-Birth Surname

Record the patients last name at birth regardless of gender or marital status. Other alternative names should be recorded in Name-Alias.

1. Blanks, Spaces, Hyphens and Apostrophes are allowed. No other special characters are allowed.

2. This data item was introduced in 2021 conversion and is to be a gender-neutral birth-surname data item, like a Maiden Name

   Note: Maiden Name is no longer collected for cases diagnosed 1/1/2021 and later

3. Leave blank if unknown or not applicable

Name-Alias

Record any alternate name or "AKA" (also known as) used by the patient, if known. This item is useful for matching multiple records on the same patient.

1. Unknown or Not Applicable: Leave this data item blank if the patient does not have an alias or if the information is not available. Do **not** record *not applicable*, *N/A* or *unknown*.

2. Maiden Name: Do not record maiden name in this field. It should be recorded in the *Name-Maiden* field.

ADDRESS AT DIAGNOSIS

Guidelines for Recording Patient Address

The address is the home or residence named by the patient at the time they were diagnosed. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to, or comparable with, the rules of the United States Census Bureau whenever possible. Resolve residency questions by using the Census Bureau's definition "the place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home." Vital Statistic rules may differ from census rules. Do not record residence from the death certificate. Review each record carefully to determine correct residence. If address at diagnosis is unavailable, use current address.

The address is a part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies. Do not update this data item if the patient's address changes over time. Changing this data item would destroy its usefulness.

Coding Priority

1. Code the Street Address of usual residence as stated by the patient.

2. A post office box is not a reliable source to identify the residency at diagnosis. Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Use the post office box address only if no street address information is available.

Rules for Persons without Apparent Residences:

1. Persons with More Than One Residence (summer and winter homes): Record the address where the patient spends most of time (usual residence). If usual residence is not known or information is not available, code the residence the patient specifies at the time of diagnosis.

2. Persons with No Usual Residence (transients, homeless): Use the address of the place they were staying when the cancer was diagnosed. This could be a shelter or the diagnosing institution.

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

4. Persons in Institutions: The Census Bureau states "Persons under formally authorized, supervised care or custody" are residents of the institution. This includes the following:
   - Incarcerated persons
   - Persons in nursing, convalescent, and rest homes
   - Persons in homes, schools, hospitals, or wards for the physically disabled, mentally retarded, or mentally ill
   - Long-term residents of other hospitals, such as Veterans Administration (VA) hospitals

5. Persons in the Armed Forces and on Maritime Ships: Members of the armed forces are residents of the installation area. Use the stated address for military personnel and their family. Military personnel may use the installation address or the surrounding community's address.

Addr at DX - No & Street

Record the number and street address of the patient's usual residence at the time the tumor was initially diagnosed.

Patient address is used to provide census tract and other geocodes for incidence statistics and epidemiologic research. The PCR uses geocoding software for automated assignment of geocodes. To increase the rate of automated geocoding, improve the quality of residence data, and enhance the specificity of residence information available for research, addresses must conform to the following format rules.

1. Blanks: Leave a blank between numbers and words if space permits.

2. Capital Letters: The use of capital letters is preferred.

3. Multiple Tumors: If patient has multiple tumors; address may be different for each primary.

4. No Address at Diagnosis: If no information is available on address at diagnosis, assume the current address was also address at time of original diagnosis.

5. Unknown: If the patient's current address is not known, record UNKNOWN only after **all** efforts to obtain this information prove unsuccessful.

6. Do Not Update this data item if the patient's address changes over time.

7. Punctuation: Punctuation marks should be avoided, except when punctuation is necessary to convey the meaning.

    a. Punctuation normally is limited to periods when the period carries meaning (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 ½ MAIN ST) and hyphens when the hyphen carries meaning (e.g., 289-01 MONTGOMERY AVE).

    b. Pound signs: The use of pound signs (#) to designate address units should be avoided whenever possible.

    c. Do not use commas, semicolons, colons, dashes, question marks, exclamation points, apostrophes, parentheses, brackets, braces, quotation marks or asterisks (*) when recording address.

8. Abbreviations: Enter complete street names without abbreviation. Abbreviate only directional prefixes, directional suffixes and street type suffixes. Use of abbreviations for these terms will enable the entire street address to be recorded.

9. PO Box: Avoid using PO Box numbers in place of street address. Use of street address is necessary for more accurate geocoding.

10. Postal Route Numbers: Avoid using postal route numbers in place of street address. Confirm the house number is not part of the postal route. Use of street address is necessary for more accurate geocoding.

11. Apartment Numbers or Letters: Enter apartment numbers or letters in *Address at DX- Supplemental* field.

12. Nursing Home or Other Institution: If residence is a nursing home or other institution, enter the street address given in this field. The name of the institution should be entered in the *Address at DX- Supplemental* field.

Addr At DX - Supplementl

Record additional address information such as the name of a place or facility (e.g., a nursing home or name of an apartment complex) at the time of diagnosis.

1. Not Applicable: If additional address space is not needed, leave blank.

2. Do Not Update this data item if the patient's address changes over time.

Addr At DX - City

Record the city or town of the patient's usual residence when the tumor was initially diagnosed. The address is a part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies.

1. Do Not Update this data item if the patient's address changes over time. Changing this data item would destroy its usefulness.

2. Punctuation: Do not use punctuation, special characters, or abbreviations.

3. Capital Letters: The use of capital letters is preferred.

4. Multiple Tumors: If patient has multiple tumors; address may be different for each primary.

5. Unknown: If the city is not known, record UNKNOWN only after **all** efforts to obtain this information prove unsuccessful.

7. No Information: If no information is available on address at time of diagnosis, use current address.

Addr At DX – State

Record the US postal service abbreviation for the state or Canadian province of the patient's usual residence when the tumor was diagnosed.

1. Multiple Tumors: If the patient has multiple tumors; the address may be different for each primary.

2. Do Not Update this data item if the patient's address changes over time. Changing this data item would destroy its usefulness.

3. Abbreviations: See *Appendix I* for a list of state abbreviations and their respective country abbreviations. The following table provides abbreviations for other countries and unknown values.

Other Country or Unknown	
Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is known.	XX
Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is unknown.	YY
Resident of U.S., NOS (including its territories, commonwealths, or possessions); Canada, NOS; residence unknown.	ZZ

Addr At DX - Postal Code

For US residents, record the patient's nine-digit extended postal (ZIP) code when the tumor was diagnosed. The address is a part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies.

1. Only Five-digit Available: When the nine-digit extended code is unavailable, record the five-digit postal code.

2. Canadian Residents: For Canadian residents, record the six-character postal code.

3. Hyphens: Do not record hyphens.
4. Do Not Update this data item if patient's address changes over time. Changing this data item would destroy its usefulness.

5. Multiple Tumors: If the patient has multiple tumors; the postal code may be different for each primary.

6. Other countries: When available, record the postal code for other countries.

7. Unknown Postal Code: If the street address, city and state are known, but the postal code is unknown, the following US Postal Service's web site may be used to determine the correct postal code: http://www.usps.com/

8. Unknown Address: If street address, city, state and postal code are unknown and the information cannot be obtained from any other sources, use the following codes:

Code	Definition
888888888	Permanent address in a country other than Canada, United States or US possessions **and** postal code is unknown.
999999999	Permanent address in Canada, United States, or US possession, **and** postal code is unknown. Permanent address (street, city and state) is totally unknown.

County at DX

Record the county of the patient's usual residence when the tumor was diagnosed using county codes issued by the Bureau of Standards in the Federal Information Processing Standards (FIPS). The FIPS codes for Pennsylvania counties are listed in *Appendix H FIPS County Codes for Pennsylvania* and are incorporated into abstracting software.

1. Multiple Tumors: If the patient has multiple tumors; the county may be different for each primary.

2. Do Not Leave Blank: This data item must contain either the specific code for county at diagnosis or the appropriate unknown code. If the city and state are known, but the county is unknown, the following web site may be used to determine the correct county: http://www.melissadata.com/Lookups/addressverify.asp.

3. Pennsylvania Resident: If the patient is a Pennsylvania resident, the specific county must be recorded when known.

4. Outside of Pennsylvania: If the patient resides in a state other than Pennsylvania, in Canada, or in a US possession, the specific county is not required but encouraged to be reported if known.

5. Known Other Countries: If the patient resides outside the US, Canada, or a US possession and the country is known. (XX is entered for *Addr at Dx - State)*; the country of residence at diagnosis is recorded in this data item.

    - SEER Geo-Codes: Record the three-digit country code in which the patient resided at diagnosis. These codes are incorporated into abstracting software, but they are also listed in *Appendix H, SEER Geo-Codes for Country*.

6. Unknown Other Country: If the patient resides outside the US, Canada, or a US possession but the country is unknown. (YY is entered for *Addr at Dx - State*); Record 999.

7. Additional Codes and Definitions: In addition to the FIPS and Geo-codes, the following codes are acceptable:

Code	Definition
998	Patient resides outside of Pennsylvania and exact county code cannot be found.
999	Unknown country

AGE AT DIAGNOSIS

Record the patient's age at their last birthday before diagnosis

000	Less than one year old
001	One year old, but less than two years old
002	Two years old
...	(Actual age in years)
101	One hundred one years old
...	
999	Unknown age

1. Calculating Age: If age at diagnosis is unavailable, but the year of diagnosis and year of birth are known, calculate approximate age at diagnosis.

2. Date of Birth Unknown: Use 999 if the date of birth is unknown.

DATE OF BIRTH

Record the patient's date of birth.

1. Date Format: Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, the day in the last two spaces.

2. Date Unavailable, but Age Known: When age is known, estimate year of birth when further information is not available. It is better to estimate than to record as an unknown year.

3. Calculating Date of Birth: If date of birth is unavailable, but the year of diagnosis and age are known, calculate approximate date of birth. Leave this field blank only if the age at diagnosis is also unknown.

4. Unknown Month, Day and/or Year: If date is not known, leave blank. If only part of the date is known, record what is known and enter approximation for month and/or year if descriptions are available or leave blank for what is unknown. No approximation of day is acceptable. Fictitious dates or default values are not acceptable to be entered for month, day, or year.

DATE OF BIRTH FLAG

Record the date flag in the event a complete *Date of Birth* was not entered to explain why.

1. Full or Partial Date: Leave this field blank if *Date of Birth* has a full or partial date recorded.

2. Unknown Date: Code 12 if the *Date of Birth* cannot be determined at all.

3. Enter Directly: This field should be entered directly (when appropriate).

Code	Definition
12	A proper value is applicable but not known (for example, date of birth is unknown)
(blank)	A valid date value is provided in item *Date of Birth*

BIRTHPLACE- STATE

Record the state, US possession or Canadian Province in which the patient was born. This item corresponds to *Birthplace-Country*. See *Appendix I* for list state abbreviations and their respective country abbreviations.

Born in the United States/Canada

1. United States: Record the patient's state of birth using the standard US Postal Service Abbreviations.

2. Canada: Record the patient's province/territory of birth using the standard Canada Post Abbreviations.

3. Unknown State: If it is known the patient was born in the US but the specific state is unknown, record *US*.

4. Unknown Province/territory: If it is known the patient was born in Canada but the specific province/territory is unknown, record *CD*.

Born Outside the United States

1. Country of Birth: If patient was born in a country other than the US (including territories, commonwealths or possessions) or Canada and the country is known, enter *XX* and code the country of birth in *Birthplace-Country*.

2. Unknown Country: If patient was born in a country other than the US (including territories or possessions) or Canada and the country is unknown, enter *YY*.

Birth Place Unavailable

- Information Unavailable: Record *ZZ* when place of birth is unavailable.

Non-Standard Codes and Definitions

Code	Definition
XX	Born in a country other than the US or Canada and the country is known
YY	Born in a country other than the US or Canada and the country is unknown
US	Born in the US and the state is unknown
CD	Born in Canada and the province/territory is unknown
ZZ	Place of birth is unknown, not mentioned in patient record

BIRTHPLACE- COUNTRY

Record the country in which the patient was born. This item corresponds to *Birthplace-State*.

1. United States: If it is known the patient was born in the US record *USA*. The corresponding state is recorded in *Birthplace-State.*

2. Canada: If it is known the patient was born in Canada record *CAN*. The corresponding province/territory is recorded in *Birthplace-State.*

3. Other Countries: If it known the patient was born in a country other than the US or Canada, record the patient's country of birth using the country codes provided in *Appendix I*. The codes are based on International Organization for Standardization (ISO) with some custom codes.

4. Unknown Place of Birth: If it is completely unknown where the patient was born, record *ZZU.*

SOCIAL SECURITY NUMBER

Record the patient's Social Security Number (SSN) without dashes.

1. No Social Security Number: When a patient does not have a Social Security Number, or the information is not available, record 999999999.

2. Correct Social Security Number: It is important to enter the correct Social Security Number since this data item is used for record linkage to match patients at the PCR as well as to match PCR information with the Social Security Number on the hospital's Disease Index. Verify entries for missing values and transpositions. Do not record Social Security Numbers that end with B or D. These are the spouse's Social Security Number.

3. Invalid Entry: According to how a Social Security Number is assigned by the Social Security Administration, the following are invalid entries:

    a. First three digits cannot = 000 or 666

    b. Fourth and Fifth digits cannot = 00

    c. Last four digits cannot = 0000

    d. First digit cannot = 8 or 9 unless entire SSN is unknown (999999999)

4. Correction- If a correction is made to the Social Security Number, a modification record must be submitted to the PCR. See *Part One, Changing Information*.

SEX

Record the patient's sex.

Code	Definition
1	Male
2	Female
3	Other (Hermaphrodite, Intersexed, persons with sex chromosome abnormalities)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not stated/Unknown

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

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

3. Intersexed: Assign code 3 for Intersexed (persons with sex chromosome abnormalities).

4. Natally Male/Male Primary Sites: Assign code 5 for transsexuals who are natally male or transsexuals with primary site of C600-C639.

5. Natally Female/Female Primary Sites: Assign code 6 for transsexuals who are natally female or transsexuals with primary site of C510-C589.

6. Unknown Natal Sex/Non gender specific primary site: Assign code 4 for transsexuals with unknown natal sex and primary site is not C510-C589 or C600-C639.

7. Unknown Gender: When gender is not known:

   a. Assign code **1** when the primary site is C600-C639

   b. Assign code **2** when the primary site is C510-C589

   c. Assign code **9** for primary sites not included above

SPANISH/HISPANIC ORIGIN

Record Spanish/Hispanic origin. This item identifies persons of Spanish or Hispanic ethnicity.

Code	Definition
0	Non-Spanish, Non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS; (There is evidence other than surname or maiden name the person is Hispanic, but cannot be assigned to a category of 1-5)
7	Spanish surname only (the only evidence of the person's Hispanic origin is surname or maiden name and there is no contrary evidence that the person is not Hispanic)
8	Dominican Republic
9	Unknown whether Spanish or not

Recording Spanish/Hispanic Origin

1. Any race: A person of Spanish/Hispanic origin may be any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.

2. Portuguese and Brazilian: Code 0 (Non-Spanish; non-Hispanic) for Portuguese and Brazilian persons.

3. Multiple Tumors: If a patient has multiple tumors all records should have the same code.

4. Hispanic Surname or Maiden Name: Code 7 (Spanish surname only) when the only evidence of the patient's Hispanic origin is a surname or maiden name and there is no evidence that the patient is not Hispanic.

5. Unknown: Code 9 (Unknown) if the Spanish/Hispanic information is unknown.

6. Use All Information: All information should be used to determine the Spanish/Hispanic Origin including:
   - The stated ethnicity in the medical record
   - Stated Hispanic origin on the death certificate
   - Birthplace
   - Information about life history and/or language spoken found in the abstracting process
   - A last name or maiden name found on a list of Hispanic/Spanish names

RACE (RACE 1, RACE 2, RACE 3, RACE 4, RACE 5)

Record the appropriate codes for the patient's race(s) in *Race 1, Race 2, Race 3, Race 4*, and *Race 5*. Race is coded separately from Spanish/Hispanic Origin.

Race (and ethnicity) is defined by specific physical, hereditary and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship. 'Origin' is defined by the US Census Bureau as the heritage, nationality group, lineage, or in some cases, the country of birth of the person or the person's parents or ancestors before their arrival in the US.

All resources in the facility, including the medical record, face sheet, physician and nursing notes, photographs, and any other sources, must be used to determine race. If a facility does not print race in the medical record but does maintain it in electronic form, the electronic data must also be reviewed.

Code	Definition	Code	Definition
01	White	20	Micronesian
02	Black	21	Chamorro
03	American Indian, Aleutian, Eskimo	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	88	No further race documented (Do **Not** use in Race 1)
13	Kampuchean, includes Khmer & Cambodian	96	Other Asian, includes Asian NOS & Oriental NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian, Pakistani, NOS	98	Other
16	Asian Indian	99	Unknown
17	Pakistani, NOS		

Single Race

1. One Race: If only one race is reported for the patient, in *Race 1* enter the race code and in *Race 2* through *Race 5*, enter 88.

2. A specific race code (other than 88 or 99) must not occur more than once.

Multiple Races

1. Primary Race(s): Code primary race(s) of the patient in fields *Race 1, Race 2, Race 3, Race 4*, and *Race 5*. The five race fields allow for the coding of multiple races consistent with the Census 2000. Rules 2-6 further specify how to code *Race 1* through *Race 5*.

2. Less Than Five Specific Races: If less than five specific race codes apply for a patient, code 88 in the remaining race fields.

   Example: A patient has a Hawaiian father, black mother, Japanese grandfather, and Korean grandmother. Code *Race 1* as 07 Hawaiian, *Race 2* as 02 Black, *Race 3* as 05 Japanese, *Race 4* as 08 Korean, and *Race 5* as 88.

3. White and Other Races: If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white in the next race field.

4. Hawaiian and Other Races: If a person's race is a combination of Hawaiian and any other race(s), code *Race 1* as 07 Hawaiian and code the other races in *Race 2, Race 3, Race 4*, and *Race 5* as appropriate.

5. Combination without Hawaiian: If the person is not Hawaiian, code *Race 1* to the first stated non-white race (02-98).

6. Specific Race and Non-Specific Race: Code only the specific race when both a specific race code and a non-specific race code apply.

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

7. Stated Race: Code the patient's stated race. Refer to Appendix D "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" of the SEER Program and Staging Manual for guidance. http://seer.cancer.gov/tools/codingmanuals/index.html

   Example 1: Patient is stated to be Japanese. *Code Race 1* as 05 Japanese and *Race 2* through *Race 5* as 88.

Exception: When the race is recorded as Oriental, Mongolian, or Asian (coded to 96 Other Asian) and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on birthplace information.

Example 2: The person's race is recorded as Asian and the place of birth is recorded as Japan. Code *Race 1* as 05 Japanese because it is more specific than 96 Asian, NOS and *Race 2* through *Race 5* as 88.

8. Based on Race of Relatives: If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race other than to list the non-white race(s) first.

No Race Stated

1. Race Category: If no race is stated in the medical record, or if the stated race cannot be coded, review the documentation for a statement of race category.

Example: Patient described as a black female in physical exam, consultation or nursing notes, Code *Race 1* as 02 Black and *Race 2* -*Race 5* as 88.

2. If race is unknown, not stated in the medical record, or not stated specifically: Refer to the race-specific guidelines on the next page. If none apply, code *Race 1* through *Race 5* as unknown (99). Do not use patient name in determining race.

Race-Specific Guidelines

1. White (01) includes Mexican, Central American, South American, Puerto Rican, Cuban, and all other Caucasians.

2. Black (02) includes the designations Negro or African-Americans.

3. Native American (03) should be used for any person stated to be Native American or [western hemisphere] Indian, whether from North, Central, South, or Latin America.

4. Birthplace Information: Race is based on birthplace information when place of birth is given as China, Japan, or the Philippines and race is reported only as Asian, Oriental, or Mongolian.

Example: If the patient's race is recorded as Asian and the place of birth is recorded as Japan, code *Race 1* as 05 Japanese and *Race 2* through *Race 5* as 88.

5. Asian: Do not code Asian in a subsequent race field if a specific Asian race has already been coded.

Use of Code 88 (No further race documented)

1. Race 1: Code 88 is valid for *Race 2* through *Race 5*; it is not valid for *Race 1*.

2. Race 2-5: If *Race 2* is coded to 88, then *Race 3* through *Race 5* must be coded to 88.

Use of Code 99 (Unknown)

1. If the patient's race is unknown: Enter 99 in *Race 1* through *Race 5*.

2. If any race equals 99 then all race codes (Race 1, 2, 3, 4, and 5) must equal 99.

PRIMARY PAYER AT DIAGNOSIS

Record the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

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

Code	Definition
01	*Not Insured*- Patient has no insurance and is declared a charity write-off.
02	*Not Insured, Self-Pay*- Patient has no insurance and is declared responsible for charges.
10	*Insurance, NOS*- Type of insurance is unknown or other than types listed in codes 20, 21, 31, 35, 60-68.
20	*Private Insurance*: *Managed Care, HMO, or PPO*- An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network, or a staff model. "Gate-keeper-model" is another term for describing this type of insurance.
21	*Private Insurance: Fee-for-Service*- An insurance plan that does not have a negotiated fee structure with the participating facility. Type of insurance plan not coded as 20.
31	*Medicaid*- State government administered insurance for persons who are uninsured, below poverty level, or covered under entitlement programs. Medicaid other than described in code 35.
35	*Medicaid-Administered through a Managed Care plan*- Patient is enrolled in Medicaid through a Managed Care program (e.g., HMO or PPO). The managed care plan pays for incurred costs.
60	*Medicare without supplement, Medicare, NOS*- Federal government funded insurance for persons who are 62 years of age and older or are chronically disabled (social security insurance eligible). Not described in codes 61, 62, or 63.
61	*Medicare with supplement, NOS*- patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare.
62	*Medicare-Administered through a Managed Care Plan*- patient is enrolled in Medicare through a Managed Care plan (e.g., HMO or PPO). The Managed Care plan pays for all incurred costs.
63	*Medicare with private supplement*- patient has Medicare and private insurance to pay costs not covered by Medicare.

Code	Definition
64	*Medicare with Medicaid eligibility*- Federal government Medicare with State Medicaid administered supplement.
65	*TRICARE*- Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents. Formerly CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)
66	*Military*- military personnel or their dependents that are treated at a military facility.
67	*Veterans Affairs*- veterans who are treated in Veterans Affairs facilities.
68	*Indian/Public Health Service*- patient who receives care at an Indian Health Service facility or another facility, and the costs are reimbursed by the Indian Health Service. Patient receives care at a Public Health Service facility or at another facility, and medical costs are reimbursed by the Public Health Service.
99	*Insurance Status Unknown*- it is unknown from the patient's medical record whether or not the patient is insured.

Recording Primary Payer at Diagnosis

1. Type of Insurance: Record the type of insurance reported on the patient's admission page.

2. More than One Payer: If more than one payer or insurance carrier is listed on the patient's admission page, record the first.

3. Changes in Payer: If the patient's payer or insurance carrier changes do not change the initially recorded code.

MEDICARE BENEFICIARY IDENTIFIER

Record the patient's Medicare Beneficiary Identifier number without dashes, if available.

- No Medicare Beneficiary Identifier: When a patient does not have a Medicare Beneficiary Identifier, or the information is not available, leave blank.

TEXT-USUAL OCCUPATION

Record the patient's usual occupation, the kind of work performed during most of the patient's working life before diagnosis of this tumor.

This data item is used to identify new work-related health hazards, serves as an additional measure of socioeconomic status, and identifies occupational groups in which cancer screening or prevention activities may be beneficial.

Usual occupation is defined identically as on death certificates and conforms to the 1989 revision of the US Standard Certificate of Death.

Recording Text-Usual Occupation

1. Retired: **Do not record "retired".**

2. If Not Available or Unknown: If ***usual*** occupation is not available or is unknown, record the patient's current or most recent occupation or any known occupation.

3. Update this data item if better information is obtained as to the usual occupation of the patient. However, it is not the responsibility of facility abstractors to update abstracts with information provided on death certificates. Comparison with death certificate information is the function of the PCR.

4. Housewife/househusband: If the patient was a housewife/househusband and also worked outside the home most of her/his adult life, record the usual occupation outside the home. If the patient was a housewife/househusband and did not work outside the home for most of her/his adult life, record *housewife* or *househusband*.

5. Never Worked: If the patient was not a student or housewife and never worked, record *never worked* as the usual occupation.

6. No Information: If no information is available, record *unknown*.

7. This data item cannot be blank unless the patient is under 14 years old: It applies only to patients who are 14 years or older at the time of diagnosis. For patients under the age of 14, leave blank.

8. Finding the Information: The patient's occupation may be found on the face sheet, nursing assessment, history and physical or consult reports in the medical record.

TEXT - USUAL INDUSTRY

Record the primary type of activity carried on by the business/industry where the patient was employed for the most number of years before diagnosis of this tumor.

Both occupation and business/industry are required to accurately describe an individual's occupation. These data items are used to identify new work-related health hazards, serve as an additional measure of socioeconomic status, and identify occupational groups in which cancer screening or prevention activities may be beneficial.

Usual industry (also known as "kind of business/industry") is defined identically as on death certificates and conforms to the 1989 revision of the US Standard Certificate of Death.

Recording Text-Usual Industry

1. Distinguish the Component: Be sure to distinguish among *manufacturing*, *wholesale*, *retail*, and *service* components of an industry that performs more than one of these components.

2. Primary Activity Unknown: If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient to record the name of the company (with city or town) for which the patient performed his/her usual occupation. In these situations, if resources permit, the PCR may be able to use the employer name and city/town to determine the type of activity conducted at that location.

3. If Most Recent Occupation was Recorded: If current or most recent occupation, rather than usual occupation was recorded, record the patient's current or most recent business/industry.

4. Update this data item if better information is obtained as to the usual industry of the patient. However, it is not the responsibility of facility abstractors to update abstracts with industry information provided on death certificates. Comparison with death certificate information is the function of the PCR.

5. No Information Available: There must be an entry for usual industry when any occupation is reported. If no information is available regarding the industry in which the reported occupation was carried out or the occupation is unknown, record *unknown*.

6. This data item cannot be blank unless the patient is under 14 years old: It applies only to patients who are 14 years or older at the time of diagnosis. For patients under the age of 14, leave blank.

MEDICAL RECORD NUMBER

Record the patient's medical record number. The medical record number is a patient identification number usually assigned by the reporting facility.

Recording Medical Record Number

1. Match to Disease Index: This item is used to locate the medical record. It may also be used to link records and should be recorded **exactly** as it is recorded on your Disease Index.

2. Fewer Than Eleven Characters: If the medical record number is fewer than 11 characters, right justify the characters and allow leading blanks.

   Example: Medical record number 811234 would be recorded bbbbb811234 (b=blank).

3. Departments without Medical Record Numbers: Record standard abbreviations for departments that do not use medical record numbers.

   Examples: Radiation Therapy record bbbbbbbbbRT (b=blank)

   One-day surgery clinic record bbbbbbbbbSU (b=blank).

4. Unknown: If the medical record number is unknown, record bbbbbbbbUNK (b=blank)

ACCESSION NUMBER - HOSP

Record the registry accession number assigned by your facility. This data item is optional for the PCR.

Recording Accession Number-Hosp

1. First Four Numbers: The first four numbers of the registry accession number specify the century and year in which the patient was first seen at the reporting institution for diagnosis and/or treatment.

2. Last Five Numbers: The last five numbers are the numeric order in which the registry entered the record into the database.

   Example: A patient is diagnosed at the reporting institution in 2018. The first four digits of the registry accession number are 2018. This is the 33rd patient accessioned in 2018, making the last five digits of the registry accession number 00033. The full registry accession number is 201800033.

3. Unique Number for Each Patient: Assign a unique accession number to each patient. The accession number identifies the patient even if multiple primaries exist. Use the same accession number for all subsequent primaries. A patient's accession number should not be reassigned.

4. Options: Hospitals may choose one of the following three options for completing this data item:

   a. Complete as described above (For more detailed instructions on assigning accession number, refer to *ACOS COC Facility Standards for Oncology Registry Entry (STORE)*.

   b. Use to sequentially number your records forwarded to the PCR.

   c. Leave this item blank.

SEQUENCE NUMBER – HOSPITAL

Record the sequence number representing the order of this primary. Sequence number counts the occurrence of *independent, malignant and non-malignant neoplasms* except basal and squamous cell cancer of the skin **during the patient's lifetime**. Each neoplasm is assigned a different number. This number may change over the lifetime of the patient.

Codes 00-35 and 99 indicate neoplasms of in situ or malignant behavior (/2 or /3). Codes 60-88 indicate neoplasms of non-malignant behavior (/0, benign or /1, borderline).

Sequence Numbers for Malignant or In Situ Primaries

00	One malignant or in situ primary only in the patient's lifetime
01	First of two or more independent malignant or in situ primaries
02	Second of two or more independent malignant or in situ primaries
...	(Actual sequence of this malignant or in situ primary)
35	Thirty-fifth of thirty-five independent malignant or in-situ primaries
99	Unspecified malignant or in situ sequence number or unknown

Sequence Numbers for Non-Malignant Tumors

60	Only one non-malignant primary in the patient's lifetime
61	First of two or more independent non-malignant primaries
62	Second of two or more independent non-malignant primaries
...	(Actual number of this primary)
87	Twenty-seventh of twenty-seven independent non-malignant primaries
88	Unspecified number of neoplasms in this category

Recording Sequence Number

1. Single Malignant Primary Tumor: Code 00 only if the patient has a single malignant primary.

2. Subsequent Malignant or In Situ Primary Tumor: If the patient develops a subsequent malignant primary or in situ primary tumor, change the sequence number for the first tumor from 00 to 01, and number subsequent tumors sequentially.

   Example: In January 2017, the registry assigns sequence number 00 to a patient with malignant melanoma. The patient develops a second primary cancer of the lung in July 2018. Assign sequence number 02 to the second cancer (lung). Change the sequence number of the first cancer (malignant melanoma) to 01.

   Note: Reporting institutions are not required to forward a change sheet to the PCR when changing sequence number from 00 to 01.

3. Single Non-Malignant Primary Tumor: Code 60 only if the patient has a single non-malignant primary.

4. Subsequent Non-Malignant Primary Tumor: If the patient develops a subsequent non-malignant primary, change the sequence number of the first tumor from 60 to 61, and number subsequent non-malignant tumors sequentially.

> ***Note:*** ***Reporting institutions are not required to forward a change sheet to the PCR when changing sequence number from 60 to 61.***

4. Two or More Malignant Neoplasms Diagnosed at the Same Time: If two or more malignant or in situ neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.

Example 1: A patient enters the reporting institution with simultaneous carcinoma in situ of the breast and invasive adenocarcinoma of the colon. Assign sequence number 01 to the colon primary and sequence number 02 to the breast primary.

Example 2: A patient has simultaneous adenocarcinoma in situ in a colon polyp and squamous cell carcinoma in situ in a vocal cord polyp. Assign sequence numbers in any order, since both primaries have similar prognoses.

5. Two or More Non-Malignant Neoplasms Diagnosed at the Same Time: If two or more non-malignant neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.

6. Location and Date of Diagnosis: The sequence number counts the patient's independent, primary tumors regardless of the location(s) or institution(s) where those primaries were diagnosed and treated or the date of diagnosis.

Example: The reporting institution diagnosed colon cancer. The patient has a history of kidney cancer diagnosed in 1980. The colon cancer is the second of this patient's primary cancers. Assign a sequence number 02 to colon cancer.

7. Newly Reportable Conditions: If the patient has a condition that was diagnosed prior to the condition being reportable, do not count that condition when assigning sequence number.

Example: A patient was diagnosed with refractory anemia on June 25, 1999 (not reportable until 2001) and then was later diagnosed with acute myelogenous leukemia on March 21, 2010 at your facility. Abstract only the acute myelogenous leukemia and assign a Sequence Number of 00.

8. Un-accessioned Tumor: Sequence numbers should be reassigned if the facility learns later of an un-accessioned tumor that affects the sequence.

9. Unknown: Use the sequence number 99 when it is impossible to estimate whether the patient has been diagnosed with an earlier malignancy (primary). If more information becomes available, change the sequence number(s).

Example: A patient is diagnosed in the reporting facility with cancer of the colon. The medical record contains the statement "The patient recently had a salivary gland tumor removed. The patient does not know if the lesion was malignant." Assign a 99-sequence number to the colon primary. The patient returns to the reporting facility a year later for treatment of prostate cancer. The medical record says, "The patient has a history of a malignant salivary gland tumor." Change the sequence number of the colon cancer from 99 to 02. Assign the sequence number 03 to the prostate cancer.

CLASS OF CASE

Record the Class of Case code to reflect facility's role in managing the cancer, whether the cancer is required to be reported and whether the case was diagnosed before a program's Reference Date.

Analytic and Nonanalytic Cases

Class of Case shows the role the reporting institution played in the patient's diagnosis or treatment. *Class of Case* divides cases into two groups. Analytic cases (codes 00–22) and Nonanalytic cases (codes 30–49 and 99). Both analytic and nonanalytic cases are reportable to the PCR.

1. Analytic Cases (Class of Case 00-22)**:** Cases diagnosed and/or administered any of the first course of treatment at the accessioning facility (after the registry's reference date) are analytic (Class of Case 00-22). A network clinic or outpatient center belonging to the facility is considered part of the facility.

2. Nonanalytic Cases (Class of Case 30-49 and 99): are to be abstracted by the facility to meet PCR reporting requirements.

Analytic Classes of Case		
Initial Diagnosis At Reporting Facility		
00		Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10		Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
11		Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility
12		Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility
13		Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.
14		Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility.
Initial Diagnosis Elsewhere		
20		Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS.
21		Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.
22		Initial diagnosis elsewhere AND all first course treatment was done at the reporting facility or a decision not to treat was done at the reporting facility.

Non-Analytic Classes of Case		
Patient Appears In Person At Reporting Facility		
30		Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere).
31		Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example stent placement).
32		Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease).
33		Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active).
34		Type of case not required to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility.
35		Case diagnosed before program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility.
36		Type of case not required to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility.
37		Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility.
38		Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death.
Patient Does Not Appear In Person At Reporting Institution		
40		Diagnosis AND all first course treatment given at the same staff physician's office.
41		Diagnosis and all first course treatment given in two or more offices of physicians with admitting privileges.
42		Non-staff physician or clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility).
43		Pathology or other lab specimens only.
49		Death certificate only.
99		Nonanalytic case of unknown relationship to facility (not for use for analytic cases).

Recording Class of Case:

1. Admitting Privileges: Physicians who are not employed by the hospital but are under contracts with it or have admitting privileges there, are described in codes 10-12 and 41.

2. Ownership of Physician Practice: If the hospital has purchased a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved have routine admitting privileges or not, as with any other physician.

TYPE OF REPORTING SOURCE

Record the code identifying the source documents used to abstract the majority of information being reported. This may be different than the source used for the original case finding.

Code	Definition	Source Document	Priority

1	**Hospital inpatient**, Managed health plans with comprehensive, unified medical records	• Hospital inpatient
		• Offices/facilities with unit record
		  ○ HMO physician office or group
		  ○ HMO affiliated free-standing laboratory, surgery, radiation or oncology clinic
		• Includes outpatient services of HMOs and large multi-specialty physician group practices with unit records.
			1

2	**Radiation Treatment Ctrs/ Medical Oncology Ctrs** hospital-affiliated or independent	• Facilities with serial record (not a unit record)
		  ○ Radiation treatment centers
		  ○ Medical oncology centers (hospital affiliated or independent)
		• No source documents from code 1
			2

3	**Laboratory only** hospital/private, POP	• Laboratory with serial record (not a unit record) • No source documents from codes 1, 2, 8, or 4.	5
4	**Physician office**/private medical practitioner	• Physician's office that is NOT an HMO or large multi-specialty physician group practice. • No source documents from codes 1, 2 or 8.	4
5	**Nursing home**, convalescent home/hospital, hospice	• Nursing or convalescent home or a hospice • There were no source documents from codes 1, 2, 8, 4, or 3.	6
6	**Autopsy Only**	• Autopsy • The cancer was first diagnosed on autopsy. There are no source documents from codes 1, 2, 8, 4, 3, or 5.	7
7	**Death certificate only (PCR use only)**	• Death certificate • Death certificate is the only source of information; follow-back activities did not identify source documents from codes 1, 2, 8, 4, 3, 5 or 6. • If another source document is subsequently identified, code must be changed to the appropriate code in the range of 1, 2, 8, 4, 3 or 6.	8

Code	Definition	Source Document	Priority
8	**Other hospital outpatient units/ surgery centers**	• Other hospital outpatient units/surgery centers. Includes, but not limited to, outpatient surgery and nuclear medicine services. • No source documents from codes 1 or 2.	3

Definitions

1. Comprehensive, unified medical record: A hospital or managed health care system that maintains a single record for each patient. That record includes all encounters in affiliated locations.

2. Stand-alone medical record: An independent facility; a facility that is not part of a hospital or managed care system. An independent medical record containing only information from encounters with that specific facility.

3. Managed health plan**:** Any facility where all of the diagnostic and treatment information is maintained in one-unit record. The abstractor is able to use the unit record when abstracting the case.

4. Physician office: A physician office performs examinations and tests. Some physician offices may perform limited surgical procedures.

5. Serial record: The office or facility stores information separately for each patient encounter (has a separate record for each encounter).

6. Surgery center: Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. The patient does not stay overnight.

7. Unit record**:** The office or facility stores information for all of a patient's encounters in one record with one record number.

Recording Type of Reporting Source

Priority Order: Assign codes in the following priority: 1, 2, 8, 4, 3, 5, 6, 7

Example:	The patient was first found through your pathology department as a private outpatient specimen (Code 3). The patient was admitted as an inpatient to your hospital a month later for surgery. The inpatient record is used for abstracting (Code 1). Code this data item to *1*.

DATE OF 1ST CONTACT

Record the date of the first contact with your facility for diagnosis and/or first course treatment of this reportable condition.

Recording Date of 1st Contact

1. Date Format: Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, the day in the last two spaces.

2. Outpatient Visit: *Date of 1st Contact* may be an outpatient visit for a biopsy, x-ray or laboratory test or the date of a pathology specimen was collected at the facility.

3. **Report Actual Date Only: Blank or approximation of month, day, century, or year is not acceptable when reporting this data item to the PCR. Fictitious dates or default values are also not acceptable.**

4. Never Leave Blank: This data item can never be blank.

5. Analytic Cases: The *Date of 1st Contact* is the date the patient qualifies as an analytic case Class of Case 00-22. Usually, the *Date of 1st Contact* is the date of admission for diagnosis or for treatment. If the patient was initially diagnosed at the facility and went elsewhere for treatment (Class of Case 00), but then returned for treatment that was initially expected to occur elsewhere, the Class of Case is updated to 13 or 14 but the *Date of 1st Contact* is not changed because it still represents the date the patient became analytic.

6. Nonanalytic Cases: The *Date of 1st Contact* is the date the patient's nonanalytic status begins with respect to the cancer. For example, for a patient receiving supportive care (Class of Case 32), the date the patient received the supportive care is the *Date of 1st Contact*.

7. Non-Analytic Case Changes to Analytic: If the Class of Case changes from nonanalytic (for example, staging workup after initial diagnosis, Class of Case 30) to analytic (for example, part of first course treatment administered at the facility, Class of Case 21), the *Date of 1st Contact* is updated to the date the case became analytic (the date the patient was admitted for treatment).

8. Autopsy Only: If an autopsy-only case, use date of death.

9. Earlier than Date of Inpatient Discharge: *Date of 1st Contact* must be earlier than the date of inpatient discharge.

10. Admission Unrelated to Cancer: If a patient is admitted for other reasons not related to cancer; use the diagnosis date as the *Date of 1st Contact*.

Example: Patient is admitted for a reason unrelated to cancer on 1/15/2018 and 1/17/2018 is incidentally diagnosed with cancer, the *Date of 1st Contact* is 20180117.

11. For Private Outpatient (POP) cases record the date the specimen was taken. If a patient was first identified as a POP and comes to your facility as an inpatient or outpatient during the three-month holding period (See *Part One, Private Outpatient Specimens*) for further diagnosis or treatment, the *Date of 1st Contact* is the date of the patient's first in-person contact with your facility.

    Example: Patient undergoes a biopsy in a physician's office on 1/8/2018. The pathology specimen was sent to your facility and was read as malignant melanoma. The patient enters your facility on 1/14/2018 for a wide excision. The *Date of 1st Contact* is 20180114.

12. Positive Imaging Study: Hospitals are not expected to report cases on the basis of a positive imaging study **only**. However, if the patient meets reporting requirements at a later time, the case must be reported using the date of the positive imaging study as the *Date of 1st Contact*.

    Example: The patient has an outpatient mammogram on 4/10/2018 that is suspicious for cancer. The patient returns for a biopsy which is diagnostic of cancer on 4/17/2018. This case would be reportable at the time of the biopsy with a *Date of 1st Contact* of 20100410.

DATE OF 1st CONTACT FLAG

The PCR requires *Date of 1st Contact* to be entered on all cases; therefore, this field will always be left blank.

Code	Definition
(blank)	A valid date value is provided in item *Date of 1st Contact.*

DATE OF INPATIENT ADM

Record the date of the inpatient admission to the facility for the most definitive surgery.

Recording Date of Inpatient Adm

1. Date Format: Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, the day in the last two spaces.

2. No Surgery: If the patient does not have surgery, use the Date of Inpatient Admission for any other cancer-directed therapy.

3. No Cancer-Directed Therapy: If the patient has no cancer-directed therapy, use the Date of Inpatient Admission for diagnostic evaluation.

4. Never Admitted as an Inpatient: If the patient was never admitted as an inpatient for this reportable condition, leave *Date of Inpatient Adm* blank.

5. **Report Actual Date Only: Approximation of month, day, century, or year is not acceptable when reporting to the PCR. Fictitious dates or default values are also not acceptable.**

DATE OF INPT ADM FLAG

Record the date flag in the event a complete Date of Inpatient Admission was not entered to explain why.

Recording Date of Inpt Adm Flag

1. Date Recorded: Leave this field blank if *Date of Inpt Adm* has a date recorded.

2. Not an Inpatient: Code 11 if the patient was never an inpatient.

3. Enter Directly: This field should be entered directly (when appropriate).

Code	Definition
11	No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility)
(blank)	A valid date value is provided in item Date of Inpatient Admission

DATE OF INPATIENT DISCH

Record the date of the inpatient discharge from the facility for the most definitive surgery.

Recording Date of Inpatient Disch

1. Date Format: Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, the day in the last two spaces.

2. No Surgery: If the patient does not have surgery, use the Date of Inpatient Discharge for any other cancer-directed therapy.

3. No Cancer-Directed Therapy: If the patient has no cancer-directed therapy, use the Date of Inpatient Discharge for diagnostic evaluation.

4. Never Admitted as an Inpatient: If the patient was never admitted as an inpatient for this reportable condition, leave *Date of Inpatient Disch* blank.

5. **Report Actual Date Only: Approximation of month, day, century, or year is not acceptable when reporting to the PCR. Fictitious dates or default values are also not acceptable**.

DATE OF INPT DISCH FLAG

Record the date flag in the event a complete Date of Inpatient Discharge was not entered to explain why.

Recording Date of Inpt Disch Flag

1. Date Recorded: Leave this field blank if *Date of Inpt Disch* has a date recorded.

2. Not an Inpatient: Code 11 if the patient was never an inpatient.

3. Enter Directly: This field should be entered directly (when appropriate).

Code	Definition
11	No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility)
(blank)	A valid date value is provided in item Date of Inpatient Discharge

INSTITUTION REFERRED FROM

Record the facility that referred the patient to the reporting institution. The codes used to identify facilities in the PCR database are the Facility Identification Numbers (FIN) assigned by the American College of Surgeons Commission on Cancer (ACOS COC).

Recording Institution Referred From

1. Do not leave blank: This data item may not be blank.

2. Own Facility: Do not enter your own facility ID number.

3. Not Referred: Code 0000000000 if the patient was not referred to the reporting institution from another institution.

4. Private Outpatient Specimens (POP): Code 0000000000 if the patient is being reported as a POP.

5. Referring Facility: Assign the facility ID numbers (FIN) to identify the facility from which the patient was referred. This field is 10 characters. For facilities with seven-digit FINs, the coded FIN will consist of three leading zeros followed by the full seven-digit number, e.g., 0006231234. For facilities with eight-digit FINs assigned, the coded FIN will consist of two leading zeroes, followed by the full eight-digit number, e.g., 0010000000.

> ***Note:*** ***Most abstracting software including Abstract Plus will automatically zero-fill these remaining spaces when the selection is made from a table of facility codes.***

6. Referred but Facility ID Number Unknown: Code 0099999999 if the patient was referred but the referring institution's ID number is unknown.

PHYSICIAN - FOLLOW-UP

Record the number used by your facility to uniquely identify the physician currently responsible for the patient's medical care.

Recording Physician-Follow-up

1. Do Not Leave Blank: This data item may not be blank.

2. Format: The identification number may include numbers, letters (8 characters or less) and embedded spaces but may not include any punctuation.

3. If No Numbers are Assigned: When identification number is not assigned, enter up to eight characters of the physician's last name.

4. If Following Physician is Unknown: Enter 99999999 if the following physician is unknown.

DATE OF DIAGNOSIS

Record the date this reportable condition was first diagnosed by a recognized medical practitioner.

Note: In the examples below the lowercase letter "b" is used to represent each blank space.

Recording Date of Diagnosis

1. Date Format: Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, the day in the last two spaces.

2. Date Reportable: Use the earliest date of diagnosis whether clinically or histologically confirmed.

   Example: On May 15, 2018, physician states patient has lung cancer based on clinical findings. The patient has a positive biopsy of the lung in June 3, 2018. The date of diagnosis remains May 15, 2018.

3. Exact Date Unavailable: If the exact date is not available, refer to *Part Three: General Information-Dates* for instructions regarding approximating dates and unknown dates. For analytic cases, at least the year of diagnosis should be known or be able to be approximated (month and day may be unknown).

   Example: Patient is admitted on January 15, 2018 with severe flank pain with history of lung cancer diagnosed five years ago. The correct *Date of Diagnosis* is 2013bbbb. **Do not** leave entire date blank when descriptive information can be used to approximate the year.

4. Partial Dates: If only the month and/or year is known or can be approximated record what is available and leave the remaining parts of the date blank. No approximation of day is acceptable.

   Example: Documentation in the patient's record from a June 2018 admission indicates the patient was diagnosed 'last year'. The correct *Date of Diagnosis* is 2017bbbb.

5. Unknown Date: If the date of diagnosis cannot be identified and is truly unknown, the case is not reportable. See *Part One, Date of Diagnosis Reportability*.

6. Default Values: Fictitious dates or default values are not acceptable to be entered for month, day, or year.

   Example: Patient receives palliative treatment for breast cancer diagnosed in June 2015. The correct *Date of Diagnosis* is 201506bb. **Do not** record 20150615 where 15 is a default value for day.

7. Clinical Diagnosis: Use the date of diagnosis whether clinically or histologically confirmed. A clinical diagnosis often includes ambiguous terminology. See *Part One, Reportable Conditions* for a list of terms that constitute a diagnosis. Do not change the *Date of Diagnosis* when a later biopsy or cytology provides confirmation of a clinical diagnosis.

Example:	A March 12, 2018 mammogram reveals a mass in the upper-outer quadrant of a patient's right breast compatible with carcinoma. On March 20, 2018, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma. *Date of Diagnosis* is 20180312.

8. Earlier Date: If the physician states, in retrospect, the patient had a reportable condition at an earlier date, use the earlier date as the date of diagnosis.

Example:	A patient has a total abdominal hysterectomy for endometriosis in January 2016. The patient is admitted to the hospital with abdominal pain in November 2018. An omental biopsy shows metastatic cystadenocarcinoma. Pathologists re-review the 2016 hysterectomy specimen. They identify an area of cystadenocarcinoma in the left ovary. *Date of Diagnosis* is 201601bb.

9. Diagnosed at Autopsy: The date of death is the date of diagnosis for a case diagnosed at autopsy.

10. Treatment Before a Definitive Diagnosis: Use the date therapy was started as the date of diagnosis if the patient receives cancer-directed treatment before a definitive diagnosis.

11. Suspicious Cytology Only is not diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.

12. Diagnosed In Utero: Use the actual date of diagnosis for an *in utero* diagnosis, for cases diagnosed on or after January 1, 2009. For cases diagnosed prior to January 1, 2009 use the date of birth as the date of diagnosis.

13. Positive Tumor Markers alone are not diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.

DATE OF DIAGNOSIS FLAG

The PCR requires a full or partial *Date of Diagnosis* to be reported on all cases; therefore, this field will always be left blank.

Code	Definition
(blank)	A valid date value is provided in item *Date of Diagnosis.*

PRIMARY SITE

This data item records the topography code for the primary site of the cancer/tumor being reported using ICD-O-3 (*International Classification of Diseases for Oncology, Third Edition)* published by the World Health Organization. Beginning with cases diagnosed January 1, 2021, ICD-O-3.2 is the preferred morphology coding reference manual.

1. Cases Diagnosed on or after January 1, 2001**:** Code according to ICD-O-3.

2. Cases Diagnosed on or after January 1, 2018: Coding according to ICD-O-3 and the *2018 Solid Tumor Rules.* https://seer.cancer.gov/tools/solidtumor/

3. Cases Diagnosed on or after January 1, 2021: Coding according toe ICD-3.2 and the 2021 ICD-O Histology and Behavior Code Update tables, Hematopoietic and Lymphoid Neoplasm Database, and Solid Tumor (MP/H) rules https://seer.cancer.gov/icd-o-3/

Coding Primary Site

1. Use all information available in the medical record for determining primary site. Operative reports, oncology consults and pathology reports will help in determining the correct primary site. If you cannot make this determination, consult a physician.

2. Be Specific: When determining the primary site, be as specific as possible. Many organs can be divided into specific segments or tissue types. It is important to code the exact segment or tissue involved.

Example:	The wrist contains several tissue types; skin (C44.6), bone (C40.1), soft tissue (C49.1).

3. Primary Tumor Originated: Code the site in which the primary tumor originated, even if it extends onto/into an adjacent subsite**.**

Example:	Patient has a right brachial cleft cyst; the pathology report identifies an adenocarcinoma arising in an ectopic focus of thyroid tissue within the brachial cleft cyst. Thyroidectomy pathology is negative. Code the primary site to brachial cleft (C104).

4. Invasive and In situ Tumors: Code the site of the invasive tumor when there is an invasive tumor and in situ tumor in different subsites of the same anatomic site.

Example:	Patient has invasive breast tumor in the upper-outer quadrant of the left breast and an in situ tumor in the lower-outer quadrant of the left breast. Code the primary site to C504 (upper-outer quadrant of breast).

5. Overlapping Tumor: Code the last digit of the primary site code to .8 when a **single tumor overlaps** an adjacent subsite(s) of an organ and the point of origin cannot be determined.

Example:	The patient has a 5cm tumor that involves the dorsal surface and anterior 2/3 of tongue. Code the primary site to C028 (overlapping lesion of tongue).

6. Multiple Tumors/Different Subsites: Code the last digit of the primary site code to .9 or NOS for single primaries, when **multiple tumors arise** in **different subsites** of the same anatomic site and the point of origin cannot be determined.

Example:	During a TURB, the physician describes multiple papillary tumors in the bladder neck (C675) and the lateral wall of the bladder (C672). Code the primary site as bladder, NOS (C679).

7. Related Site Code: Some histology/behavior terms in ICD-O-3 have a related site code in parenthesis; for example: hepatoma (C220).

   a. Code the site as documented in the medical record and ignore the suggested ICD-O-3.2 code when another primary site is specified in the medical record.

Example:	The pathology report says, "ductal carcinoma of the head of the pancreas." The listing in ICD-O-3 is ductal carcinoma 8500/3 (C50_). Code primary site to head of pancreas (C250), NOT breast (C50_) as suggested by ICD-O-3.

   b. Use the site code suggested by ICD-O-3 when the primary site is the same as the site code suggested or the primary site is unknown

Example:	Biopsy is positive for hepatoma, but there is no information available about primary site. Code the primary site to liver (C220) as suggested by ICD-O-3.

8. Hematopoietic and Lymphoid Neoplasms: Effective with cases diagnosed on or after January 1, 2010 the PCR requires the use of *The Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and *The Hematopoietic Database* for coding primary site of hematopoietic and lymphoid neoplasms. The manual and database can be found at: http://seer.cancer.gov/seertools/hemelymph/

9. Melanoma: If a patient is diagnosed with metastatic melanoma and the primary site is not identified, the primary site is *skin NOS* (C44.9).

10. Kaposi Sarcoma**:** Kaposi sarcoma is a rare condition. When not AIDS-related, it usually presents as localized disease with an easily recognized primary site. AIDS-related Kaposi sarcoma usually presents as a disseminated disease with involvement of mucosal surfaces, visceral surfaces of organs, and skin. It is important to review consecutive records carefully to determine the extent of involvement at diagnosis. Review of a single record may reveal only the site being treated during that admission.

a. Code the Kaposi sarcoma to the primary site in which it arises.

b. If the Kaposi sarcoma is present in the skin and another site simultaneously, code to the specified skin site, (C44_).

c. If the primary site is unknown or cannot be determined, code skin, NOS (C449).

11. Sarcoma: The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system. The musculoskeletal system includes the fat, muscles, blood vessels, deep skin tissues, nerves, bones and cartilage. The default code for sarcomas of unknown primary site is C499 rather than C809.

    Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. Code the primary site to the organ of origin.

Example:	The pathology identifies a mixed Mullerian tumor of the uterus. Code the primary site to uterus, NOS (C559).

12. Waldenstrom Macroglobulinemia: The primary site is *blood* (C42.0).

13. Unknown: When the primary site is not known, record as described below. Do not record a metastatic site when the primary is not known.

    a. Osteosarcoma with unknown primary, record primary site as *bone NOS* (C41.9)

    b. Other histologies with unknown primary, record primary site as *Unknown* (C80.9)

Text

Text to support this data item must be recorded in the specific text field. See *Part Three, Data Item Instructions, Text-Primary Site Title.* This text field is used by the PCR to validate the ICD-O topography and laterality codes reported.

LATERALITY

Record appropriate laterality code. Laterality describes the side of a paired organ or side of the body on which the reportable tumor originated.

Code	Definition
0	Not a paired organ
1	Right: origin of primary
2	Left: origin of primary
3	Only one side involved, right or left origin unspecified
4	Bilateral involvement, side of origin unknown, stated to be a single primary
5	Paired site: midline tumor
9	Paired site, but no information concerning laterality

Recording Laterality

1. Unknown Primary Site: Record laterality for unknown primary site (C80.9) as 0 (not a paired site).

2. Metastatic Sites: Do not code laterality of metastatic sites.

3. Listing of Paired Sites:

   a. Use codes 1-9 for the sites listed on the following pages, except as noted.

   b. Major categories: The listing includes major categories. Code laterality for all subheadings included in *ICD-O* under these headings, unless specifically excluded.

   c. Exclusions should be coded to "0."

4. Single Side, Laterality Unknown: Assign code 3 if the laterality is not known but the tumor is confined to a single side of a paired organ.

   Example: Pathology report: Patient has a 2 cm carcinoma in the upper pole of the kidney. Code laterality as 3 because there is documentation that the disease exists in only one kidney, but it is unknown if the disease originated in the right or left kidney.

5. Code 4 is seldom used **except** for the following diseases:
   - Both ovaries involved simultaneously, single histology
   - Bilateral retinoblastomas
   - Bilateral Wilms tumors

6. Midline tumors, code 5 can only occur in the following sites:
   - C700 (Cerebral Meninges)
   - C710-C714 (Brain)
   - C722-C725 (Cranial Nerves)
   - C443 (Skin of Face)
   - C445 (Skin of Trunk)

7. Laterality Unknown: Assign code 9 when the disease originated in a paired site, but the laterality is unknown.

   Example: Admitting history says patient was diagnosed with lung cancer based on positive sputum cytology. Patient is treated for painful bony metastases. There is no information about laterality in the diagnosis of this lung cancer, code to 9.

PAIRED SITE	ICD-O CODE
Acoustic nerve (excluding diagnoses prior to 2004)*	C72.4
Adrenal gland	C74.0-C74.9
Breast	C50.0-C50.9
Carotid body	C75.4
Cerebral meninges, NOS (excluding diagnoses prior to 2004)*	C70.0
Cerebrum (excluding diagnoses prior to 2004)*	C71.0
Connective, subcutaneous, and other soft tissues of lower limb and hip	C49.2
Connective, subcutaneous, and other soft tissues of upper limb and	C49.1
Cranial nerve, NOS (excluding diagnoses prior to 2004)*	C72.5
Epididymis	C63.0
Eye and lacrimal gland	C69.0-C69.9
Fallopian tube	C57.0
Frontal lobe (excluding diagnoses prior to 2004)*	C71.1
Frontal sinus	C31.2
Kidney, NOS	C64.9
Long bones of lower limb	C40.2
Long bones of upper limb and scapula	C40.0
Lung	C34.1-C34.9
Main bronchus (excluding carina, code to “0”)	C34.0
Maxillary sinus	C31.0
Middle ear	C30.1

PAIRED SITE	ICD-O CODE
Nasal cavity (excluding nasal cartilage and nasal septum, code to “0”)	C30.0
Occipital lobe (excluding diagnoses prior to 2004)*	C71.4
Olfactory nerve (excluding diagnoses prior to 2004)*	C72.2
Optic nerve (excluding diagnoses prior to 2004)*	C72.3
Ovary	C56.9
Parietal lobe (excluding diagnoses prior to 2004)*	C71.3
Parotid gland	C07.9
Pelvic bones (excluding sacrum, coccyx, and symphysis, code to “0”)	C41.4
Peripheral nerves and autonomic nervous system of lower limb and hip	C47.2
Peripheral nerves and autonomic nervous system of upper limb and	C47.1
Pleura	C38.4
Renal Pelvis	C65.9
Rib and clavicle (excluding sternum, code to “0”)	C41.3
Short bones of lower limb	C40.3
Short bones of upper limb	C40.1
Skin of eyelid	C44.1
Skin of external ear	C44.2
Skin of lower limb and hip	C44.7
Skin of other and unspecified parts of face (midline, code to “5”)	C44.3
Skin of trunk (midline, code to “5”)	C44.5
Skin of upper limb and shoulder	C44.6
Spermatic cord	C63.1
Sublingual gland	C08.1
Submandibular gland	C08.0
Temporal lobe (excluding diagnoses prior to 2004)*	C71.2
Testis	C62.0-C62.9
Tonsillar fossa	C09.0
Tonsillar pillar	C09.1
Tonsil, NOS	C09.9
Tonsil, Overlapping	C09.8
Ureter	C66.9

*For cases diagnosed prior to January 1, 2004 these sites are considered non-paired and should be coded to 0.

HISTOLOGIC TYPE

Record the code for histologic type of the cancer/tumor being reported.

References for Cases Diagnosed on or after January 1, 2021

1. 2018 Solid Tumor Rules apply to all cases diagnosed in 2018 and provide site-specific instructions for Brain, Breast, Colon, Head and Neck, Kidney, Lung, Cutaneous Melanoma and Renal Pelvis/Ureter/Bladder. https://seer.cancer.gov/tools/solidtumor/

2. SEER Hematopoietic and Lymphoid Database and Manual continues to apply to hematopoietic and lymphoid cases diagnosed 2010 and after. https://seer.cancer.gov/tools/heme/

3. ICD-0-3.2 is the preferred morphology coding reference manual. The NAACCR *2021 Guidelines for ICD-O-3 Histology code and Behavior Update Implementation,* the *2021 ICD-O-3.2 Coding Tables* and the *2021 ICD-O-3.2 Coding Table Excel* must be used. These guidelines and tables address implementation of the ICD-O-3.2 updated histology terms and codes. Use of these guidelines and tables is required for determining reportability and accurate coding. The guidelines and tables can be found at: https://www.naaccr.org/icdo3/

4. ICD-O-3 should continue to be used when the above references are not applicable

5. 2021 ICD-O Histology and Behavior Code Update Tables. Use of these guidelines is required for determining reportability and accurate coding. The 2021 ICD-O-3 histology code and behavior update includes comprehensive tables listing all changes made after the 2018 update and is effective for cases diagnosed January 1, 2021 and forward. The 2021 tables include coding instructions for cases diagnosed prior to January 1, 2021. https://www.naaccr.org/icdo3/

References for Cases Diagnosed on or after January 1, 2018

1. 2018 Solid Tumor Rules apply to all cases diagnosed in 2018 and provide site-specific instructions for Brain, Breast, Colon, Head and Neck, Kidney, Lung and Renal Pelvis/Ureter/Bladder. https://seer.cancer.gov/tools/solidtumor/

2. SEER Hematopoietic and Lymphoid Database and Manual continues to apply to hematopoietic and lymphoid cases diagnosed 2010 and after. https://seer.cancer.gov/tools/heme/

3. NAACCR Guidelines for ICD-O-3 Histology code and Behavior Update Implementation provide guidelines for the implementation of updated histology terms and codes. https://www.naaccr.org/2018-implementation/#Histology

4. ICD-O-3 should continue to be used when the above references are not applicable.

Guidelines for Cases Diagnosed prior to 2018

1. Hematopoietic and lymphoid neoplasms diagnosed on or after January 1, 2010: Effective with cases diagnosed on or after January 1, 2010 the PCR requires the use of *The Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and *The Hematopoietic Database* for histology coding of hematopoietic and lymphoid neoplasms. http://seer.cancer.gov/seertools/hemelymph/

2. Solid tumors diagnosed on or after January 1, 2007: Effective with cases diagnosed on or after January 1, 2007 the PCR requires the use of *The Multiple Primary and Histology Coding Rules (MP/H Rules)* for coding histology coding of solid malignant tumors and benign and borderline Central Nervous System tumors. http://seer.cancer.gov/tools/mphrules/download.html
3. Cases Diagnosed on or after January 1, 2001: Code according to ICD-O-3.

4. Cases Diagnosed prior to January 1, 2001: Code according to ICD-O-2.

Text

Text to support this data item must be recorded in the specific text fields. These text fields are used by the PCR to validate ICD-O histology codes reported.

BEHAVIOR

Record the code for the behavior of the cancer/tumor being reported using ICD-O-3.2 Update, ICD-O-3, or ICD-O-2 (*International Classification of Diseases for Oncology, Third or Second Edition)* published by the World Health Organization.

1. Cases Diagnosed on or after January 1, 2021. The ICD-O-3.2 Implementation Work Group strongly recommends using ICD-O-3.2 jointly with the 2021 ICD-O Histology and Behavior Code Update tables, Hematopoietic and Lymphoid Neoplasm Database, and Solid Tumor (MP/H) rules. The 2021 guidelines include specific tables listing histologies which have changed behavior codes. **These new behavior codes resulted in a change to reportability.** Along with changes to behavior codes, several histology terms that were previously non-reportable are now reportable. https://www.naaccr.org/icdo3/

   The 2021 ICD-O Histology and Behavior Code Update tables:

Table	Description	# Items
1	Behavior code changes- non-reportable to reportable	16
2	Behavior code changes- reportable to non-reportable	9
3	Deleted codes- histology terms moved to other codes	10
4	Change in reportable terminology	13
5	New codes and terms	12

		Order
6	Tables 1-5 plus new preferred & related terms, synonyms	Numerical
7	Tables 1-5 plus new preferred & related terms, synonyms	Alphabetical

2. Cases Diagnosed on or after January 1, 2018: The NAACCR Guidelines for ICD-O-3 Histology code and Behavior Update Implementation must be used. These guidelines provide information for the implementation of updated histology terms and behaviors. https://www.naaccr.org/2018-implementation/#Histology

3. Cases Diagnosed on or after January 1, 2001**:** Code according to ICD-O-3.

4. Cases Diagnosed prior to January 1, 2001: Code according to ICD-O-2.

Coding Behavior

Behavior is part of the diagnosis. The behavior indicates whether a tumor is malignant, benign, in situ, or uncertain whether malignant or benign.

1. Reportable In-Situ and Malignant Behaviors: The PCR requires the reporting of /2 (in situ) and /3 (malignant) tumors.

2. Behavior from Metastatic Site: If the only specimen is from a metastatic site, the behavior is malignant.

3. Reportable Benign and Borderline Behaviors: Effective with cases diagnosed on or after **January 1, 2004** primary intracranial and central nervous system tumors with a behavior code of /0 or /1 (benign and borderline or "non-malignant") are reportable regardless of histologic type for the sites listed below.

Reportable Intracranial and Central Nervous System (CNS) Primary Sites Effective January 1, 2004	
Meninges (C70.0 - C70.9)	Other CNS (C72.8, C72.9)
Brain (C71.0 - C71.9)	Pituitary gland (C75.1)
Spinal cord (C72.0)	Craniopharyngeal duct (C75.2)
Cauda equina (C72.1)	Pineal gland (C75.3)
Cranial nerves (C72.2 - C72.5)	

4. In Situ Terminology, the following terms are synonymous with in situ (behavior code 2):

   - *Bowen's disease*
   - *Clark's level 1 for melanoma*
   - *Confined to epithelium*
   - *Hutchinson's melanotic freckle, NOS*
   - *Intracystic, noninfiltrating*
   - *Intraductal*
   - *Intraepidermal, NOS*
   - *Intraepithelial, NOS*
   - *Intraepithelial neoplasia, Grade III*
   - *Involvement up to but not including the basement membrane*
   - *Lentigo maligna*
   - *Lobular, noninfiltrating*
   - *Noninfiltrating*
   - *Noninvasive*
   - *No stromal involvement*
   - *Papillary, noninfiltrating or intraductal*
   - *Precancerous melanosis*
   - *Queyrat's erythroplasia*
   - *Stage 0*

5. Areas of Invasion: Record behavior as /3 (malignant) if any invasion is present, no matter how limited.

6. Severe/High Grade Dysplasia of the Colon and/or Esophagus: If your facility considers the terminology of severe dysplasia or high-grade dysplasia of the colon and/or esophagus as synonymous with carcinoma in-situ; use the following guidelines for reporting these cases:

   a. Obtain a statement from your pathologists 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.

   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 will be abstracted as carcinoma in-situ based on the pathologists approved statements.

   d. Add the policy to your Operations Manual attaching the approved statement(s) from your pathologists.

   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. In the text for each abstract, document the final pathologic diagnosis along with the statement "in-situ per pathologist".

Text

Text to support this data item must be recorded in the specific text fields. These text fields are used by the PCR to validate ICD-O behavior codes reported.

GRADE CLINICAL

Record the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant).

For cases diagnosed January 1, 2018 and later, this data item, along with *Grade Pathological* and *Grade Post Therapy Path*, replaces the data item *Grade*.

Recording Grade Clinical

Refer to the most recent version of the *Grade Coding Instructions and Tables* for detailed coding instructions and additional site-specific instructions.
https://www.naaccr.org/SSDI/Grade-Manual.pdf

GRADE PATHOLOGICAL

Record the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. This may include the grade from the clinical workup. Since all clinical information is used in pathological staging, record the highest grade documented from any microscopic specimen of the primary site

Note: For cases where neoadjuvant therapy is administered, this item is left blank and Grade Post Therapy is completed.

For cases diagnosed January 1, 2018 and later, this data item, along with Grade Clinical and Grade Post Therapy, replaces the data item Grade.

Recording Grade Pathological

Refer to the most recent version of the *Grade Coding Instructions and Tables* for detailed coding instructions and additional site-specific instructions.
https://www.naaccr.org/SSDI/Grade-Manual.pdf

GRADE POST THERAPY CLINICAL

Effective 01/01/2021, records the grade of a solid primary tumor that has been microscopically sampled following neoadjuvant therapy or primary systemic/radiation therapy. Refer to the most recent version of the Grade Coding Instructions and Tables.

GRADE POST THERAPY PATH

Record the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. This may include the grade from the clinical workup. Since all clinical information is used in pathological staging, record the highest grade documented from any microscopic specimen of the primary site. The name was updated from Grade Post Therapy to Grade Post Therapy Path in 2021

Refer to the most recent version of the *Grade Coding Instructions and Tables* for detailed coding instructions and additional site-specific instructions.
https://www.naaccr.org/SSDI/Grade-Manual.pdf

GRADE

This data item records the code for grade or differentiation of the cancer/tumor being reported.

1. Cases Diagnosed on or after January 1, 2018: Leave this field blank. See *Grade Clinical*, *Grade Pathological* and *Grade Post Therapy*.

2. Cases Diagnosed on or after January 1, 2014**:** Code grade according the guidelines provided in Appendix E.

3. Cases Diagnosed prior to January 1, 2014: Code grade according to guidelines in the *SEER Program Coding and Staging Manual 2013.*
   http://seer.cancer.gov/tools/codingmanuals/

Text

Text to support *Grade Clinical, Grade Pathological* and *Grade Post Therapy* or *Grade* must be recorded in the specific text fields. These text fields are used by the PCR to validate reported grade codes.
Grade post clinical path

DIAGNOSTIC CONFIRMATION

Record the diagnostic confirmation which specifies whether a diagnosis was confirmed microscopically at any time during the disease course.

Code	Definition
Microscopically Confirmed	
1	*Positive histology.* Histologic confirmation (tissue microscopically examined)
2	*Positive cytology.* Cytology confirmation (no tissue examined; fluid cells microscopically examined)
3	*Positive histology PLUS* • *Positive immunophenotyping AND/OR* • *Positive genetic studies* **Code 3 is used ONLY for hematopoietic and lymphoid neoplasms**
4	*Positive microscopic confirmation, method not specified.* The record is reported as microscopically confirmed but it is unknown if the cells were from histology or cytology.
Not Microscopically Confirmed	
5	*Positive laboratory test/marker study.* A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer.
6	*Direct visualization without microscopic confirmation*. Use this code only in the absence of positive histology or cytology. Diagnosis made at surgical exploration or by endoscopy. Autopsy only record (only information is from gross autopsy report).
7	*Radiography and other imaging techniques without microscopic confirmation*. The malignancy was reported by the physician based on an imaging report only.
8	*Clinical diagnosis only (other than 5, 6, or 7)*. Records diagnosed by clinical methods not mentioned previously.
Confirmation Unknown	
9	*Unknown whether or not microscopically confirmed.* Death-certificate-only records (PCR use only). Method of confirmation is unknown.

Recording Diagnostic Confirmation for Solid Tumors

1. Solid Tumors: These guidelines should be used for solid tumors only. See section on *Recording Diagnostic Confirmation for Hematopoietic and Lymphoid Neoplasms* following.

2. Priority: This is a hierarchical coding scheme with code 1 taking precedence. **A lower number takes priority over all higher numbers**.

3. Changing Information: This data item is dynamic and must be changed to the lower code if a more definitive method confirms the diagnosis at any time during the course of the disease. See *Part One, Changing Information* for instructions on how to submit a change.

Example:	A patient is admitted on 01/28/2017. A chest x-ray dated 02/01/2018 diagnoses a probable lung cancer. The patient refuses a diagnostic workup. The registry codes the diagnostic confirmation to radiography (7). The patient consents to a lymph node biopsy on 06/03/2018. The biopsy confirms small cell carcinoma. Change the diagnostic confirmation code to positive histology (1).

4. Assign **code 1** when the microscopic diagnosis is based on:

   a. Tissue specimens from biopsy, frozen section, surgery, autopsy or D&C

   b. Bone marrow specimens (aspiration and biopsy)

5. Assign **code 2** when the microscopic diagnosis is based on:

   a. Examination of cells (rather than tissue) including but not limited to: sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears.

   b. Paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid

6. Assign **code 4** when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.

7. Assign **code 5** when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer.

Example 1:	The presence of alpha-fetoprotein for liver cancer.
Example 2:	If the workup for a prostate cancer patient is limited to a highly elevated PSA and the physician diagnoses and/or treats the patient based only on that PSA, code the diagnostic confirmation to 5.

8. Assign **code 6** when the diagnosis is based only on:

   a. The surgeon's operative report from a surgical exploration or endoscopy such as colonoscopy, mediastinoscopy, or peritoneoscopy and no tissue was examined.

   b. Gross autopsy findings (no tissue or cytologic confirmation).

9. Assign **code 7** when the only confirmation of malignancy was diagnostic imaging such as computerized axial tomography (CT scans), magnetic resonance imaging (MRI scans), or ultrasounds/ sonography.

10. Assign **code 8** when the case was diagnosed by any clinical method not mentioned in preceding codes. The diagnostic confirmation is coded 8 when the only confirmation of disease is a physician's clinical diagnosis.

    Example: CT diagnosis is possible lung cancer. Patient returns to the nursing home with a DNR order. Physician enters a diagnosis of lung cancer in the medical record. Code the diagnostic confirmation to 8 since there is a physician's clinical diagnosis.

11. Assign **code 9** if it is unknown if the diagnosis was confirmed microscopically and for Death certificate only cases.

Recording Diagnostic Confirmation for Hematopoietic and Lymphoid Neoplasms

See the *Hematopoietic Database* for specific information on the definitive diagnostic confirmation for the neoplasm being abstracted. The database can be downloaded from the following site: http://seer.cancer.gov/seertools/hemelymph/

Text

Record text to describe the findings of the diagnostic procedures in natural language.

SCHEMA ID

This field is derived based on primary site, histology and schema discriminators fields (when required). The Schema ID links the Site-Specific Data Items with the appropriate site/histology groupings.

SCHEMA DISCRIMINATOR 1 and 2

Record additional information needed to generate Schema ID for some anatomic sites. Discriminators are based on sub site, histology or other features which effect prognosis.

Assigning Discriminators

1. Schema Discriminator 1: The following are Schema Discriminator 1.

    - BileDuctsDistal/BileDuctsPerihilar/CysticDuct
    - EsophagusGEJunction (EGJ)/Stomach
    - Histology Discriminator for 9591/3
    - Lacrimal Gland/Sac
    - Melanoma Ciliary Body/Melanoma Iris
    - Nasopharynx/Pharyngeal Tonsil
    - Occult Head and Neck Lymph Nodes
    - Plasma Cell Myeloma Terminology
    - Primary Peritoneum Tumor
    - Thyroid Gland/Thyroglossal Duct
    - Urethra/Prostatic Urethra

2. Schema Discriminator 2: The following are Schema Discriminator 2:

    - Histology Discriminator for 8020/3
    - Oropharyngeal p16

    Soft Tissue Abdomen and Thoracic, Soft Tissue Trunk and Extremities, and Soft Tissue Other based on Schema Discriminator 2, Code 8 cannot be used for a case diagnosed Jan 1 2021 or later.

3. Determining Codes: Refer to the SSDI Manual to determine appropriate code. Codes will also be provided in abstracting software. https://apps.naaccr.org/ssdi/list/

Text

Text to support this data item must be recorded in the specific text fields. See *Part Three, Data Item Instructions*

TUMOR SIZE SUMMARY

Record the most definitive size of a solid primary tumor.

Code	Definition
000	No mass/tumor found
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2 mm to 988 mm)
990	Microscopic focus or foci only and no size of focus is given
998	Alternate descriptions of tumor size for the following specific sites: • Familial/multiple polyposis: **Colon, Rectosigmoid and Rectum** If no size is documented: • Circumferential: **Esophagus** • Diffuse; widespread: 3/4s or more; linitis plastica- **Stomach and Esophagus GE Junction** • Diffuse, entire lung or NOS: **Lung and main stem bronchus** • Diffuse: **Breast**

999	• Unknown; size not stated
	• Not documented in patient record
	• Size of tumor cannot be assessed
	• Not Applicable:
	  ○ Kaposi Sarcoma
	  ○ Melanoma Choroid
	  ○ Melanoma Ciliary Body
	  ○ Melanoma Iris
	  ○ Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms; histology codes 9590-9992

Recording Tumor Size Summary

1. Millimeters: Measurements recorded must be in millimeters.

2. Priority Order: Record size of the tumor in the following specified order:

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

   b. Neoadjuvant therapy before surgery: Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size as 999.

c. No Surgery: code the largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures prior to any other form of treatment.

d. None of the above: code the largest size from all information available within four (4) months of the date of diagnosis, in the absence of disease progression.

3. Depth or Thickness: Do not record the depth or thickness for Tumor Size Summary; tumor size is the diameter of the tumor.

4. "Between, Less or Greater Than:" See below for specific instructions on how to record size of tumor when "between", "less than" or "greater than" is stated only.

   a. "Between:" If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two.

Example:	"The size of the tumor is between 2 and 3 cm." Convert the size to mm and record the tumor size summary as 025, the midpoint.

   b. "Less Than" If the tumor size is stated as "less than" x mm, record the size as 1mm less than stated. If size is less than 1 mm, use code 001.

Example:	"The size of the tumor is <10mm in greatest diameter." Code tumor size summary as 009.

   c. "Greater Than:" If the tumor size is stated as "more than" x mm, record the size as 1mm higher than stated. If size is described as anything greater than 989 mm, code as 989.

Example:	"The size of the tumor is >10 mm." Code tumor size summary as 011.

5. Rounding: Round the size only if it is described in fractions of millimeters. Round tenths of millimeters in the 1-4 range down to the nearest whole millimeter and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. Do NOT round tumor size expressed in centimeters to the nearest whole centimeter; rather, move the decimal point one space to the right, converting the measurement to millimeters, then round if necessary.

Example #1:	"Breast cancer described as 4.5 mm in size." Round up the tumor size to 5 mm and record the tumor size summary as 005.
Example #2:	"Focus of cancer described as 1.3 mm in size. Round down the size to 1 mm and record the tumor size summary as 001.

6. Discrepancies in Size among Imaging and Radiographic Reports: Unless the physician specifies which imaging is most accurate, record the largest size in the record, regardless of which imaging technique reports it.

7. Polyp, Cyst, Distant Mets: Do not record the size of a polyp, cyst, or distant metastasis.

Exception: If the tumor is described as a "cystic mass" and only the size of the entire mass is given, code the size of the entire mass since cysts are part of the tumor itself.

8. In Situ Only: Record the size as stated for purely in situ lesions.

9. In Situ and Invasive Components: Record the size of the invasive component, if given.

   a. Both In-Situ and Invasive size given: If both an in situ and an invasive component are present and the invasive component is measured, record the size of the invasive component even if it is smaller than the in-situ component.

   Example: Tumor is mixed in situ and invasive carcinoma, total 4.1 cm in size, of which 1.7 cm is invasive. Record the tumor size as 017 (17 mm).

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

10. Largest Dimension or Diameter of Tumor: Record the largest dimension or diameter of the tumor whether it is from an excisional biopsy or the complete resection of the tumor.

    Example: Tumor is described as 3.2 x 6.2 x 1.6 cm in size. Record tumor size as 062 (62 mm).

11. Residual or Positive Surgical Margins: Disregard microscopic residual or positive surgical margins when coding tumor size. Microscopic residual tumor does not affect tumor size.

12. Pieces or Chips of Tumor: Do not add the size of pieces or chips together to create a whole. The pieces or chips may not be from the same location or they may represent only a very small portion of a large tumor. If the only measurement describes pieces or chips, record the tumor size as 999.

13. Multifocal and Muticentric Tumors: If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor or if all the tumors are in situ, code the size of the largest in situ tumor.

14. Unknown and Not Applicable: Use code 999 when size is unknown or not applicable. See *Codes and Definitions* table above for a list of not applicable sites and morphologies.

Text

Text to support this data item must be recorded in the specific text fields. See *Part Three, Data Item Instructions.* These text fields are used by the PCR to validate the tumor size for each primary.

REGIONAL NODES EXAMINED

Record the total number of regional lymph nodes that were removed and examined by the pathologist.

Code	Definition
00	No nodes examined
01 - 89	1 to 89 nodes examined (code the exact number of regional nodes examined)
90	90 or more nodes examined
95	No regional nodes removed, but aspiration or core biopsy of regional nodes performed.
96	Regional lymph node removal documented as a sampling, and the number of nodes unknown/not stated.
97	Regional lymph node removal documented as dissection, and the number of nodes unknown/not stated.
98	Regional lymph nodes surgically removed, but number of lymph nodes unknown/not stated and not documented as sampling or dissection; nodes examined, but the number unknown.
99	Unknown whether nodes were examined; not applicable or negative; not documented in patient record.

Recording Regional Nodes Examined

1. Regional Lymph Nodes: Record information about regional lymph nodes only in this field.

2. Pathologic Information Only: This field is based on pathologic information only.

3. Cumulative Nodes: The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment with the exception of aspiration or core biopsies coded to 95.

    a. Core Needle Biopsy or FNA of SAME LN Chain: if there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain.

    b. Core Needle Biopsy or FNA of DIFFERENT LN Chain: If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Positive.

    c. Core Needle Biopsy or FNA of UNKNOWN LN Chain: If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Positive.

    d. Unknown type of removal and unknown number: When neither the type of lymph node removal procedure that was done nor the number of lymph nodes examined is known, code to 98.

4. No Nodes Examined: Record code 00 (no regional lymph nodes examined) when the assessment of lymph nodes is clinical or when no lymph nodes are removed and examined.

5. Priority: If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority order: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic and gross.

6. Cytology/Core Biopsy: Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

7. Lymph Node Biopsy: If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, use code 96.

8. Sampling: A lymph node "sampling" is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.

9. Dissection: A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed, and the number is unknown.

10. Multiple Lymph Node Procedures: If both a lymph node sampling and a lymph node dissection are performed, and the total number of lymph nodes examined is unknown, use code 97.

11. Unknown/Not Applicable: Code 99 if it is unknown whether nodes were removed or examined. Code 99 (Not Applicable) for the following sites: Placenta, Brain and Cerebral Meninges, Other Parts of CNS, Intracranial Gland, Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms, Hodgkin and non-Hodgkin Lymphoma, Myeloma and Plasma Cell Disorders, Other and Ill-Defined Primary Sites, and Unknown Primary Site.

Text

Text to support this data item must be recorded in the specific text fields. See *Part Three, Data Item Instructions.* These text fields are used by the PCR to validate the numbers of regional lymph nodes examined.

REGIONAL NODES POSITIVE

Record the total number of positive regional lymph nodes that were examined by the pathologist.

Code	Definition
00	All nodes examined negative
01 - 89	1 to 89 nodes positive (code exact number of nodes positive)
90	90 or more nodes positive
95	Positive aspiration or core biopsy of lymph node(s).
97	Positive nodes - number unspecified.
98	No nodes examined.
99	Unknown whether nodes are positive; not applicable; not documented in patient record.

Recording Regional Nodes Positive

1. Regional Lymph Nodes: Record information about regional lymph nodes only in this field.

2. Pathologic Information Only**:** This field is based on pathologic information only.

3. In-Situ Cases: True in situ cases cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined).

4. Cumulative Nodes: The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

    a. Core Needle Biopsy or FNA of SAME LN Chain: if there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain.

    b. Core Needle Biopsy or FNA of DIFFERENT LN Chain: If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Positive.

    c. Core Needle Biopsy or FNA of UNKNOWN LN Chain: If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Positive.

5. Priority: If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority order: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic and gross.

6. Positive Nodes in Multiple Primaries in Same Organ: If there are multiple primary cancers with different histologic types in the same organ and the pathology report just states the number of nodes positive, the registrar should first try to determine the histology of the metastases in the nodes and code the nodes as positive for the primary with that histology. If no further information is available, code the nodes as positive for all primaries.

7. Isolated Tumor Cells (ITCs): For all primary sites except cutaneous melanoma and Merkel cell carcinoma of skin, count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size). Do not include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs). If the path report indicates that nodes are positive, but the size of metastasis is not stated, assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive.
   - For cutaneous melanoma and Merkel cell carcinoma, count nodes with ITCs as positive lymph nodes.

8. Cytology/Core Biopsy: Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

9. Cannot Determine Number of Positive Nodes: Use code 97 for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.

10. No Nodes Examined: Use Code 98 when the assessment of lymph nodes is clinical only or when no lymph nodes are removed/examined. Code 98 is used often when regional lymph nodes examined is coded to 00.

11. Unknown/Not Applicable: Code 99 if it is unknown whether nodes were positive. Code 99 (Not Applicable) for the following sites: Placenta, Brain and Cerebral Meninges, Other Parts of CNS, Intracranial Gland, Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms, Hodgkin and non-Hodgkin Lymphoma, Myeloma and Plasma Cell Disorders, Other and Ill-Defined Primary Sites, and Unknown Primary Site.

Text

Text to support this data item must be recorded in the specific text fields. See *Part Three, Data Item Instructions.* These text fields are used by the PCR to validate the numbers of regional lymph nodes positive.

LYMPH-VASCULAR INVASION (LVI)

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

For cases diagnosed January 1, 2018 and later, new codes indicating lymphatic, small vessel, and/or large vessel invasion were added.

Code	Definition
0	Lymph-vascular invasion not present, absent, not identified
1	Lymph-vascular invasion present/identified
2	Lymphatic and small vessel invasion only (L)
3	Venous (large vessel) invasion only (V)
4	Both lymphatic and small vessel AND venous (large vessel) invasion
8	Not applicable
9	Unknown if lymph-vascular invasion present/ Indeterminate

Recording Lymph-Vascular Invasion

1. Code from pathology report(s). If not available, code the absence or presence of lymph-vascular invasion as described in the medical record.

    a. The primary sources of information about lymph-vascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from other sections of the pathology report or a physician's statement, in that order.

    b. Do not code perineural invasion in this field.

    c. Information to code this field can be taken from any specimen from the primary tumor. (biopsy or resection).

    d. If lymph-vascular invasion is identified in any primary tumor specimen, code as present/identified.

    e. LVI is impossible for benign, borderline, or in situ cases. These cases should be coded to 0.

    f. For cases treated with neoadjuvant (preoperative) therapy, refer to the following table to code this field. However, if documentation in the medical record conflicts with this table, code lymph-vascular invasion based on the documentation in the medical record.

LVI on path report PRIOR to neoadjuvant therapy	LVI on path report AFTER to neoadjuvant therapy	Code LVI to:
0- Not Present/Not Identified	0- Not Present/Not Identified	**0- Not Present/Not Identified**
0- Not Present/Not Identified	1- Present/Identified	**1- Present/Identified**
0- Not Present/Not Identified	9- Unknown/Indeterminate	**9- Unknown/Indeterminate**
1- Present/Identified	0- Not Present/Not Identified	**1- Present/Identified**
1- Present/Identified	1- Present/Identified	**1- Present/Identified**
1- Present/Identified	9- Unknown/Indeterminate	**1- Present/Identified**
9- Unknown/Indeterminate	0- Not Present/Not Identified	**9- Unknown/Indeterminate**
9- Unknown/Indeterminate	1- Present/Identified	**1- Present/Identified**
9- Unknown/Indeterminate	9- Unknown/Indeterminate	**9- Unknown/Indeterminate**

2. No vascular invasion: When the pathology report indicates that there is no lymph-vascular invasion, assign code 0. This includes cases of purely in-situ carcinoma, which biologically do not access lymphatic or vascular channels below the basement membrane.

3. Invasion Present: When the pathology report or a physician's statement indicates that lymph-vascular invasion (or one of its synonyms) is present in the specimen, assign code 1.

Note: ***Synonyms include, but are not limited to:***

- ***Angiolymphatic invasion***
- ***Blood vessel invasion***
- ***Lymph vascular emboli***
- ***Lymphatic invasion***
- ***Lymphovascular invasion***
- ***Vascular invasion***

4. Not Applicable- Assign code 8 (not applicable) for the following schema:

Schema Name	Schema ID
Adnexa Uterine Other	00558
Adrenal Gland, NET	00770
Biliary Other	00278
Brain	00721
Cervical Lymph Nodes, Occult Head and Neck	00060
CNS other	00722
Conjunctiva	00650
Cutaneous Carcinoma, Head and Neck	00150
Digestive Other	00288
Endocrine Other	00778
Eye Other	00718
Fallopian Tube	00553

Schema Name	Schema ID
Genital Female Other	00559
Genital Male other	00598
Heme/Retic	00830
Ill-Defined Other	99999
Intracranial Gland	00723
Kaposi Sarcoma	00458
Lacrimal Gland	00690
Lacrimal Sac	00698
Lymphoma	00790
Lymphoma (CLL/SLL)	00795
Lymphoma Ocular Adnexa	00710
Melanoma Head and Neck	00140
Middle ear	00119
Mycosis Fungoides	00811
Ovary	00551
Pharynx Other	00118
Plasma Cell Disorders	00822
Plasma Cell Myeloma	00821
Pleural Mesothelioma	00370
Primary Cutaneous Lymphoma non MF	00812
Primary Peritoneal Carcinoma	00552
Respiratory Other	00378
Retinoblastoma	00680
Sinus other	00128
Skin Other	00478
Trachea	00358
Urinary Other	00638

5. Unknown: Use code 9 (Unknown) for the following situations:
   a. there is no microscopic examination of a primary tissue specimen
   b. the primary site specimen is cytology only or a fine needle aspiration
   c. the biopsy is only a very small tissue sample
   d. it is not possible to determine whether lymph-vascular invasion is present
   e. the pathologist indicates specimen is insufficient to determine lymph-vascular invasion
   f. lymph-vascular invasion is not mentioned in the pathology report
   g. primary site is unknown

Text

Text to support this data item must be recorded in the specific text fields. See *Part Three, Data Item Instructions.* These text fields are used by the PCR to validate the presence or absence of lymph vascular invasion.

METS AT DIAGNOSIS-BONE

Record for presence of BONE metastasis from the primary site at the time of diagnosis. Code information about bone metastases only (discontinuous or distant metastases to bone) identified at the time of diagnosis.

Code	Definition
0	None; no bone metastases
1	Yes; distant bone metastases
8	Not applicable
9	Unknown whether bone is involved metastatic site; Not documented in patient record

Recording Mets at Diagnosis–Bone

1. Discontinuous Only: Only record discontinuous or distant metastases to bone. Do NOT code continuous bone invasion from primary site.

2. Bone Marrow Involvement: This data item should not be coded for bone marrow involvement.

   Note: Bone Marrow involvement is coded to code 1 in the field Mets at Dx-Other.

3. Primary Site: This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

4. Clinical or Pathologic Information: Any clinical and/or pathologic information about bone involvement may be used to code this data item.

5. Preoperative Systemic Therapy: Code this data item for bone metastases even if the patient had any preoperative systemic therapy.

6. No Distant (discontinuous) Metastases: Assign code 0 when there are no bone metastases.

7. Distant (discontinuous) Metastases: Assign code 1 when bone is mentioned as an involved site.

8. Bone Primaries:

   a. Assign code 1 if the medical record indicates that there are metastases in a different bone or bones than the primary site.

   b. Do not assign code 1 for a bone primary with multifocal bone involvement of the same bone.

9. Not Applicable: Use code 8 for the following site/histology combinations for which a code for

distant metastasis is not clinically relevant:

ICD-O-3 Site	ICD-O-3 Histology	Description
C00.0-C80.9	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C420, C421, C424	9811-9818, 9823,9827,9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic.
C00.0-C44.0, C44.2-C68.9, C69.1-C69.4, C69.8-C80.9	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

10. Unknown: Use code 9 when there are known distant metastases, but it is not known whether the distant metastases includes bone.

METS AT DIAGNOSIS-BRAIN

Record for presence of BRAIN metastasis from the primary site at the time of diagnosis. Code

information about brain metastases only (discontinuous or distant metastases to brain) identified at the time of diagnosis.

Code	Definition
0	None; no brain metastases
1	Yes; distant brain metastases
8	Not applicable
9	Unknown whether brain is involved metastatic site; Not documented in patient record

Recording Mets at Diagnosis–Brain

1. Spinal Cord & CNS Involvement: This data item should not be coded for spinal cord or other parts of the central nervous system involvement.

   Note: ***Involvement of the spinal cord or other parts of the central nervous system are coded to code 1 in the field Mets at Dx-Other.***

2. Primary Site: This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

3. Clinical or Pathologic Information: Any clinical and/or pathologic information about brain involvement may be used to code this data item.

4. Preoperative Systemic Therapy: Code this data item for brain metastases even if the patient had any preoperative systemic therapy.

5. No Distant (discontinuous) Metastases: Assign code 0 when no brain metastases are mentioned.

6. Distant (discontinuous) Metastases: Assign code 1 when brain is mentioned as an involved site.

7. Not Applicable: Use code 8 for the following site/histology combinations for which a code for distant metastasis is not clinically relevant:

ICD-O-3 Site	ICD-O-3 Histology	Description
C00.0-C80.9	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias

C420, C421, C424	9811-9818, 9823,9827,9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic.
C00.0-C44.0, C44.2-C68.9, C69.1-C69.4, C69.8-C80.9	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

8. Unknown: Use code 9 when there are known distant metastases, but it is not known whether the distant metastases includes brain.

METS AT DIAGNOSIS–DISTANT LYMPH NODES

Record for presence of DISTANT LYMPH NODE(S) metastasis from the primary site at the time of diagnosis. Code information about distant lymph node(s) metastases only identified at the time of diagnosis.

Code	Definition
0	None; no distant lymph node metastases
1	Yes; distant lymph node metastases
8	Not applicable
9	Unknown whether distant lymph node(s) are involved metastatic site Not documented in patient record

Recording Mets at Diagnosis – Distant Lymph Nodes

1. Regional Lymph Nodes: This data item should not be coded for regional lymph node involvement with the exception of lymph nodes for placenta which are M1.

2. Lymphomas: Assign code 0 for all lymphomas. The distinction between regional and distant lymph nodes is not relevant.

3. Primary Site: This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

4. Clinical or Pathologic Information: Any clinical and/or pathologic information about distant lymph node involvement may be used to code this data item.

5. Preoperative Systemic Therapy: Code this data item for distant lymph node metastases even if the patient had any preoperative systemic therapy.

6. No Distant (discontinuous) Metastases: Assign code 0 when there is no distant lymph node metastases mentioned.

7. Distant (discontinuous) Metastases: Assign code 1 when distant lymph node is mentioned as an involved site.

8. Not Applicable: Use code 8 for the following site/histology combinations for which a code for distant metastasis is not clinically relevant:

ICD-O-3 Site	ICD-O-3 Histology	Description
C00.0-C80.9	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C420, C421, C424	9811-9818, 9823,9827,9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic.

C00.0-C44.0, C44.2-C68.9, C69.1-C69.4, C69.8-C80.9	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

9. Unknown: Use code 9 when there are known distant metastases, but it is not known whether the distant metastases include distant lymph node(s).

METS AT DIAGNOSIS–LIVER

Record for presence of LIVER metastasis from the primary site at the time of diagnosis. Code information about liver metastases only identified at the time of diagnosis.

Code	Definition
0	None; no liver metastases
1	Yes; liver metastases
8	Not applicable
9	Unknown whether liver is involved metastatic site; Not documented in patient record

Recording Mets at Diagnosis – Liver

1. Discontinuous Only: Only record discontinuous or distant metastases to liver. Do NOT code continuous involvement of liver from primary site.

2. Primary Site: This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

3. Clinical or Pathologic Information: Any clinical and/or pathologic information about liver involvement may be used to code this data item.

4. Preoperative Systemic Therapy: Code this data item for liver metastases even if the patient had any preoperative systemic therapy.

5. No Distant (discontinuous) Metastases: Assign code 0 when there is no liver metastases mentioned.

6. Distant (discontinuous) Metastases: Assign code 1 when liver is mentioned as involved site.

7. Not Applicable: Use code 8 for the following site/histology combinations for which a code for distant metastasis is not clinically relevant:

ICD-O-3 Site	ICD-O-3 Histology	Description
C00.0-C80.9	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C420, C421, C424	9811-9818, 9823,9827,9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic.
C00.0-C44.0, C44.2-C68.9, C69.1-C69.4, C69.8-C80.9	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

8. Unknown: Use code 9 when there are known distant metastases, but it is not known whether the distant metastases includes liver.

METS AT DIAGNOSIS–LUNG

Record for presence of LUNG metastasis from the primary site at the time of diagnosis. Code information about distant lung metastases only identified at the time of diagnosis.

Code	Definition
0	None; no lung metastases
1	Yes; distant lung metastases
8	Not applicable
9	Unknown whether lung is involved metastatic site; Not documented in patient record

Recording Mets at Diagnosis–Lung

1. Pleura or Pleural Fluid: This data item should not be coded for pleural or pleural fluid involvement.

   Note: ***Pleural nodules, malignant pleural or pericardial effusion are coded to code 1 in the field Mets at Dx-Other.***

2. Primary Site: This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

3. Clinical or Pathologic Information: Any clinical and/or pathologic information about lung involvement may be used to code this data item.

4. Preoperative Systemic Therapy: Code this data item for lung metastases even if the patient had any preoperative systemic therapy.

5. No Distant (discontinuous) Metastases: Assign code 0 when there is no lung metastases mentioned.

6. Distant (discontinuous) Metastases: Assign code 1 when lung is mentioned as an involved site.

7. Lung Primaries:

   a. Assign code 1 if the medical record indicates that there are metastases in the contralateral lung.

   b. Do not assign code 1 for a lung primary with multifocal involvement of the same lung.

8. Not Applicable: Use code 8 for the following site/histology combinations for which a code for distant metastasis is not clinically relevant:

ICD-O-3 Site	ICD-O-3 Histology	Description
C00.0-C80.9	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C420, C421, C424	9811-9818, 9823,9827,9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic.
C00.0-C44.0, C44.2-C68.9, C69.1-C69.4, C69.8-C80.9	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

9. Unknown: Use code 9 when there are known distant metastases, but it is not known whether the distant metastases include lung.

METS AT DIAGNOSIS–OTHER

Record for presence of any (OTHER) metastasis (excluding bone, brain, liver, lung, or distant lymph node) from the primary site at the time of diagnosis. This includes involvement of other sites and more generalized metastases such as carcinomatosis.

Some examples of other sites include: adrenal gland, bone marrow, pleura, peritoneum, and skin.

Code	Definition
0	None; no other metastases
1	Yes; distant metastases in known site(s) other than bone, brain, liver, lung or distant lymph nodes ***Note: includes bone marrow involvement for lymphomas***
2	Generalized metastases such as carcinomatosis
8	Not applicable
9	Unknown whether any other metastatic site is involved or if there is generalized metastases; Not documented in patient record

Recording Mets at Diagnosis – Other

1. Metastatic Sites: Do not code this data item for bone, brain, liver, lung, or distant lymph node metastases.

2. Primary Site: This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

3. Clinical or Pathologic Information: Any clinical and/or pathologic information about lung involvement may be used to code this data item.

4. Preoperative Systemic Therapy: Code this data item for lung metastases even if the patient had any preoperative systemic therapy.

5. No Distant (discontinuous) Metastases: Assign code 0 when there is no other site(s) metastases mentioned.

6. Distant (discontinuous) Metastases: Assign code 1 when:

    a. another site(s) is mentioned as an involved site
    b. bone marrow is involved for lymphomas

    Exception: Do NOT include lymphomas or lymphoma/leukemias where primary site is C421 (bone marrow).

7. Carcinomatosis: If a patient has carcinomatosis, assign code 2. Carcinomatosis is the condition in which cancer is spread widely throughout the body or in some cases to a relatively large region in the body.

Note: ***It is possible to have metastatic disease to a specific organ AND have carcinomatosis. If a patient has metastatic disease to bone, brain, liver, lung or distant nodes AND carcinomatosis, use code 1 for the appropriate field (bone, brain, liver, lung, or distant nodes) and use code 2 for carcinomatosis. If a patient has metastatic disease to a site other than bone, brain, liver, lung or distant nodes AND carcinomatosis, assign code 2 for carcinomatosis. Code 2 for carcinomatosis takes priority.***

8. Not Applicable: Use code 8 for the following site/histology combinations for which a code for distant metastasis is not clinically relevant:

ICD-O-3 Site	ICD-O-3 Histology	Description
C00.0-C80.9	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C420, C421, C424	9811-9818, 9823,9827,9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic.
C00.0-C44.0, C44.2-C68.9, C69.1-C69.4, C69.8-C80.9	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

9. Unknown: Use code 9 when there are known distant metastases, but it is not known specifically where they are.

STAGE AT DIAGNOSIS REQUIREMENTS

Staging requirements have changed throughout the years based on date of diagnosis. Refer to the table below to determine what staging systems are required per year of diagnosis.

Staging System	2018	2016-2017	2015	2010-2014	2004-2009	2001-2003	Prior to 2001
SEER Summary Stage 2018	X						
Site Specific Data Items (SSDI)	X						
SEER Summary Stage 2000		X	X			X	
AJCC TNM 7th Edition		X					
Collaborative Stage SSF only		X					
Collaborative Stage V2			X	X			
Collaborative Stage V1					X		
SEER Summary Stage 1977							X

The following sections will provide instructions for each system.

SEER SUMMARY STAGE

Record the SEER Summary Stage at diagnosis in the appropriate Summary Stage field according to SEER Summary Stage 2018 (SS2018), Summary Stage 2000 (SS2000) or SEER Summary Staging 1977 (SS77) based on *Date of Diagnosis.*

Effective Dates

1. Diagnosed January 1, 2018 and after: Directly coded SEER Summary Stage 2018 is required. Instructions and guidelines are found in *SEER Summary Stage 2018 Manual*: https://seer.cancer.gov/tools/ssm/

2. Date of Diagnosis 2015 through 2017: Directly coded SEER Summary Stage 2000 is required. Instructions and guidelines are found in *SEER Summary Stage 2000 Manual* found at: https://seer.cancer.gov/tools/ssm/ssm2000/

3. Date of Diagnosis 2004-2014: Directly coded SEER Summary Stage was not required. SEER Summary Stage was derived from Collaborative Stage Data Collection System.

Note: For diagnosis years that SEER Summary Stage was not required leave all SEER Summary Stage fields blank.

4. Date of Diagnosis 2001-2003**:** Directly coded SEER Summary Stage 2000 is required. Instructions and guidelines are found in *SEER Summary Stage 2000 Manual* found at: https://seer.cancer.gov/tools/ssm/ssm2000/

5. Date of Diagnosis Prior to 2001: Directly coded SEER Summary Stage 1977 is required. Instructions and guidelines are found in *SEER Summary Stage 1977 Manual* found at: https://seer.cancer.gov/archive/manuals/historic/ssm_1977.pdf

Text

Text to support this data item must be recorded in the specific text fields. Positive and negative findings describing how far the cancer has spread from the organ of origin and the corresponding dates of the findings must be recorded in the appropriate *Text-DX* fields.

AJCC-TNM CLINICAL AND PATHOLOGIC STAGE

Record all clinical and pathological AJCC-TNM 7th Edition fields for cases diagnosed in 2016-2017. TNM fields should be left blank for all other cases.

Note for Abstract Plus Hospitals: Leave all AJCC TNM fields blank for cases not diagnosed between January 1, 2016 - December 31, 2017.

AJCC Cancer Staging Manual (AJCC Manual), 7th Edition

The complete instructions and site-specific defined codes are documented in the *AJCC Cancer Staging Manual, 7th Edition.* This is manual is not available on-line. Most registry hospitals have a book available for reference. Codes are also included in cancer abstracting software.

Text

Text to support all AJCC-TNM data items must be recorded in the specific text fields. See *Part Three, Data Item Instructions, Text-Path, Text-DX Proc-X-ray/Scans, Text-DX Proc-OP,* and *Text-DX Proc-Scopes.*

COLLABORATIVE STAGE

The Collaborative Stage Data Collection System (CS) is a set of data items that describe how far a cancer has spread at the time of diagnosis. The CS data items are used to derive the sixth and seventh editions of the AJCC TNM system (TNM), Summary Stage 1977 (SS77), and SEER Summary Stage 2000 (SS2000).

CS Instructions and Schema

CS coding instructions and schema for all CS versions can be found at:
https://cancerstaging.org/cstage/Pages/default.aspx

Effective Dates

1. Date of Diagnosis 2016 and after: *Collaborative Stage Data Collection System Version 02.05 (CSv02.05*) is only used for the collection of the Site-Specific Factors (SSFs). All other CS input data items are not required and should be left blank. PCR Required SSFs are documented in *Appendix J*.

2. Date of Diagnosis 2010 to 2015: Stage cases using the *Collaborative Stage Data Collection System Version 02.05 (CSv02.05).*

3. Date of Diagnosis 2004 to 2009: Stage using the *Collaborative Stage Data Collection System Version 01.04 (CSv01.04).*

4. Date of Diagnosis prior to 2004**:** Collaborative Stage was not required for cases diagnosed prior to 2004. Leave all CS fields blank.

Note: For diagnosis years that Collaborative Stage was not required leave all Collaborative Stage fields blank.

Text

Text to support all Collaborative Stage data items must be recorded in the specific text fields. See *Part Three, Data Item Instructions, Text-Path, Text-DX Proc-X-ray/Scans, Text-DX Proc-OP,* and *Text-DX Proc-Scopes.*

SITE SPECIFIC DATA ITEMS (SSDI)

Site Specific Data Items are used for the collection of site-specific information.

PCR Required SSDI

Effective with cases diagnosed January 1, 2018 and after, the Site-Specific Data Items in the table below are required by the PCR.

Detailed descriptions and instructions are provided in the SSDI Manual, https://apps.naaccr.org/ssdi/list/. Codes and information are also provided in cancer registry abstracting software.

PCR Required SSDI	
NAACCR Item #	**Item Name**
3816	Brain Molecular Markers
3817	Breslow Tumor Thickness
3827	Estrogen Receptor Summary
3835	Fibrosis Score
3838	Gleason Patterns Clinical
3839	Gleason Patterns Pathological
3840	Gleason Score Clinical
3841	Gleason Score Pathological
3843	Grade Clinical
3844	Grade Pathological
3845	Grade Post Therapy
3855	HER2 Overall Summary
3890	Microsatellite Instability (MSI)
3893	Mitotic Rate Melanoma
3915	Progesterone Receptor Summary
3920	PSA (Prostatic Specific Antigen) Lab Value
3926	Schema Discriminator 1
3927	Schema Discriminator 2
3932	LDH Pretreatment Lab Value
3936	Ulceration

FIRST COURSE OF TREATMENT GUIDELINES

First course of treatment includes all methods of cancer-directed therapy recorded in the treatment plan and administered to the patient before disease progression or recurrence**.** **Never** code treatment unless you know it has actually been administered at your facility or any other facility.

Note: This section applies to all solid neoplasms (including benign and borderline brain and CNS tumors) ONLY. For information regarding first course of therapy of hematopoietic and lymphoid neoplasm, refer to the SEER Hematopoietic and Lymphoid Neoplasm Coding Manual, http://seer.cancer.gov/seertools/hemelymph/

"No therapy" is a treatment option (the patient refused therapy, the family/guardian refused therapy, the patient expired before therapy started, or the physician recommended no therapy). Therefore, first course of treatment may be no treatment. Use the date the decision was made not to treat as *Date of 1st Crs Rx*.

All modalities of treatment are included regardless of sequence or degree of completion of any component method.

Treatment Plan

A treatment plan describes the cancer-directed treatment intended to modify, control, remove or destroy proliferating cancer cells. The documentation confirming a treatment plan may be fragmented. It is frequently found in several different sources, e.g., medical or clinic records, consultation reports, and outpatient records. All cancer-directed therapies specified in the physicians treatment plan are a part of the first course of treatment. When a treatment plan is not available or unclear, consult a physician.

A discharge plan may contain part or the entire treatment plan.

A treatment plan may specify one or more modalities of therapy (surgery, radiation, chemotherapy, hormone therapy, immunotherapy, or other therapy). A treatment "regimen" may include combinations of concurrent or adjuvant therapies.

Timing Rules for Recording First Course of Treatment

1. If there is a documented, planned first course of treatment, first course ends at the completion of this treatment plan, regardless of the duration of the treatment plan.

2. If the patient is treated according to a facility's standards of practice (established protocol), first course ends at the completion of the treatment.

3. If there is no documented treatment plan, established protocol, or management guidelines, and consultation with a physician is not possible, use the principle: "initial treatment must begin within four months of the date of initial diagnosis."

4. If the patient refuses all treatment modalities, then changes his/her mind and the treatment is initiated, consult a physician to determine if this is part of first course of treatment.

Watchful Waiting

If a treatment plan is given for symptoms/disease progression after period of *watchful waiting*, this treatment is not considered part of first course. For example, if physician and patient choose a *wait and watch* approach to prostate cancer and the patient becomes symptomatic, consider the symptoms to be an indication the disease has progressed, and any further treatment is not part of first course.

Treatment Failure

Treatment failure or disease progression may prompt the physician to stop therapy before the full course has been completed. Any therapy administered after the discontinuation of first course must be considered as secondary or subsequent treatment.

Treatment for Recurrence or Progression

Treatment for recurrence or progression of disease includes all cancer-directed therapies administered after the first course of treatment is complete.

If the patient does not respond or if the disease progresses, a physician may stop the first course of treatment before it is complete. Therapy administered after the first course ends is not recorded as first course of treatment.

Non-Cancer-Directed Treatment

Non-cancer-directed treatments prolong the patient's life, alleviate pain, make the patient comfortable, or prepare the patient for cancer-directed therapy. They are not meant to destroy or control the tumor or delay the spread of disease. Non-cancer-directed procedures include diagnostic tests and supportive care (treatments designed to relieve symptoms and minimize the effects of the cancer). Surgical procedures performed to diagnose/stage disease (exploratory) or for relief of symptoms (palliative) are non-cancer-directed surgeries. **Non-cancer-directed therapies should not be coded as treatment.**

Non-cancer-directed therapies include:

Diagnostic procedures:

- Incisional biopsies
- Exploratory procedures/surgery with or without biopsies, such as laparotomy, cystotomy, nephrotomy, gastrotomy, thoracotomy
- Brushings, washings, aspiration of cells, and hematologic findings (peripheral blood smears) are not surgical procedures

Palliative procedures:

- Colostomy
- Nephrostomy
- Esophagostomy
- Tracheostomy
- Gastrostomy

Supportive care/relieving symptoms:

- Pain medication
- Oxygen
- Antibiotics administered for an associated infection
- Intravenous therapy to maintain fluid or nutritional balance
- Laser therapy directed at relieving symptoms

Exception: Treatment for hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue". See *Part Three, RX Summ-Other.*

Cancer-Directed Treatment

Cancer-directed treatment is tumor directed, and its purpose is to modify, control, remove, or destroy primary or metastatic cancer tissue. Physicians administer the therapy to remove or minimize the size of tumor or to delay the spread of disease. Record all cancer-directed therapy administered to the patient. For complete treatment information, record therapies given in other institutions and failed treatments (the patient did not respond).

RX SUMM-SURG PRIM SITE

Record the most invasive, definitive cancer-directed procedure performed to the primary site as part of the first course of treatment at the reporting institution and other institutions. Cancer-directed surgery modifies, controls, removes, or destroys proliferating cancer tissue.

Recording Surgery to Primary Site

1. An excisional biopsy is cancer-directed surgery.

   Example: The surgeon states the procedure is an excisional biopsy, the pathology report shows microscopic involvement of the margins. Record the code for an excisional biopsy as *Rx Summ - Surg Prim Site*.

   Note: ***Biopsies that remove all gross tumor or leave only microscopic margins should be coded to surgery of the primary site.***

2. If no cancer-directed surgery was performed, code to 00.

3. If it is unknown if cancer-directed surgery was performed, code to 99.

4. Best Information: Use the best information in the operative/pathology reports to determine the operative procedure. Do **not** depend on the name of the procedure since it may be incomplete. If the operative report is unclear as to what was excised or if there is a discrepancy between the operative and pathology reports, use the pathology report, unless there is reason to doubt its accuracy.

5. Site-Specific Surgery Codes**:** Refer to *Appendix K* for surgical codes.

   - Codes 10 through 18 are site-specific descriptions of tumor-destruction procedures that do not produce a pathologic specimen.
   - Codes 20 through 79 are site-specific descriptions of resection procedures.
   - Codes 80 and 90 are NOS terms and should only be used if more precise information about the surgery is not available.

6. Hierarchy: For codes 00 through 79, the descriptions of the surgical procedures are hierarchical. Last-listed responses take precedence over earlier-listed responses. (Regardless of code or numeric value).

Example: A rectosigmoid primary surgically treated by polypectomy with electrocautery, which is listed after polypectomy alone, is coded 22.

20 Local tumor excision, NOS
26 Polypectomy
27 Excisional biopsy
Combination of 20 or 26-27 WITH
21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation

7. Special Code 98: applies to specific tumors that cannot be clearly defined in terms of primary or nonprimary site. Code 98 takes precedence over all other codes**.** Surgical Procedure of Primary Site should be coded 98 for *Unknown and Ill-defined Primary Sites and Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease* (See *Part Three, General Information* for a list of these sites and conditions). The item *RX Summ--Surg Oth Reg/Dis Site* is used to indicate whether surgery was performed for these tumors.

8. Total Resection: If a surgical procedure removes the remaining portion of an organ which had been partially resected previously for any condition, code as total removal of the organ. If none of the primary organ remains, the code should indicate this is the case.

Example: Resection of a stomach which had been partially excised previously is coded as total removal of stomach.

9. Biopsies that remove the entire tumor and/or leave only microscopic margins are to be coded in this item.

10. Extranodal Lymphomas: Surgery for extranodal lymphomas should be recorded using the scheme for the extranodal site.

Example: Use the scheme for the stomach to record a gastrectomy for a primary lymphoma of the stomach.

11. Surgery for Multiple Primaries: If multiple primaries are treated by a single surgical event, code the appropriate surgical items for each primary.

Example: If a total colectomy was done for a patient with multiple primaries in several segments of the colon, code total colectomy for each of the primary segments.

12. Regional Tissue or Organs: Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted in *Appendix K*.

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text - Surgery.*

Special Instructions

1. Registry Hospitals**:** If you can record multiple surgical procedures in your registry software, make sure the data item transmitted to the PCR as *RX Summ-Surg Prim Site* reflects the most extensive code.

2. Abstract Plus**:** You can only record one surgical procedure. If you have more than one procedure use the code for the most extensive.

RX DATE-SURGERY

Record the earliest date on which the patient had cancer-directed surgery for this primary or metastatic site. This includes *RX Summ-Surg Prim Site, RX Summ-Scope Reg LN Surg, and RX Summ-Surg Oth Reg/Dis*.

Recording RX Date-Surgery

1. Date Format: Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, the day in the last two spaces.

2. No Surgery of Primary Site: This data item may contain a date even when surgery to the primary site equals 00 (none).

   Example: Patient has excision of a brain lesion on January 15, 2018; final pathology diagnosis is metastatic lung carcinoma. Patient refuses further work-up.

   RX Summ-Surg Prim Site code = 00
   RX Date-Surgery = 20180115
   RX Summ-Surg Oth Reg/Dis = 4

3. Collecting the dates: for each treatment modality allows sequencing of multiple treatments and aids evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

4. Exact Date Unavailable: If the exact date of cancer-directed surgery is not available, record an approximate date. Refer to *Part Three, General Information*.

5. Leave RX Date- Surgery blank and assign the appropriate *RX Date-Surgery Flag* for the following reasons:
   a. when no cancer-directed surgery is performed
   b. when it is unknown if any cancer-directed surgery was performed
   c. when the patient had surgery, but the date is unknown
   d. when the record was identified by death certificate only
   e. when it is an autopsy-only case

Special Instructions

1. Registry Hospitals**:** If you can record multiple surgery dates, make sure the data item transmitted to the PCR *as RX Date-Surgery* reflects the earliest date of cancer-directed surgery.

2. Abstract Plus**:** You can only record one date and one surgical procedure. If you have more than one procedure, use the date of the first, but the code for the most invasive, extensive surgical procedure performed during the first course of treatment.

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text-Surgery.*

RX DATE-SURGERY FLAG

Record the date flag in the event a complete *RX Date-Surgery* was not entered to explain why.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed)
11	No proper value is applicable in this context (for example, no surgery performed)
12	A proper value is applicable but not known (for example, *RX Date-Surgery* is unknown)
(blank)	A valid date value is provided in item *RX Date-Surgery*

Recording RX Date-Surgery Flag

1. Full or Partial Date: Leave this field blank if *RX Date-Surgery* has a full or partial date recorded.

2. Unknown if Surgery Performed: Code 10 if it is unknown whether any surgery was performed.

3. No Surgery: Code 11 if no surgical procedure was performed.

4. Unknown Date: Code 12 if the *RX Date-Surgery* cannot be determined at all, but the patient did receive first course surgery.

RX DATE--MOST DEFIN SURG

Records the date of the most definitive surgical procedure of the primary site performed as part of the first course of treatment. By definition, this would be the date on which the surgery coded in Surgical Procedure of Primary Site was performed at this or any facility.

Recording RX Date-Most Definitive Surgery

1. Date Format: Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, the day in the last two spaces.

2. Collecting this date: Enables the measurement of the lag time between diagnosis and the most definitive surgery of the primary site.

3. Exact Date Unavailable: If the exact date of cancer-directed surgery is not available, record an approximate date. Refer to *Part Three, General Information*.

4. Leave RX Date- Most Defin Surg Blank: and assign the appropriate *RX Date*-Most Defin Surg *Flag* for the following reasons:

    a. when no surgery to the primary site is performed
    b. when it is unknown if surgery to the primary site was performed
    c. when the patient had surgery to the primary site, but the date is unknown
    d. when the record was identified by death certificate only
    e. when it is an autopsy-only case

RX DATE-MOST DEFIN SURG FLAG

Record the date flag explain why a complete *RX Date-Most Definitive Surgery* was not entered.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery to the primary site was performed)
11	No proper value is applicable in this context (for example, no surgery to the primary site was performed)
12	A proper value is applicable but not known (for example, *RX Date-Most Definitive Surgery* is unknown)
(blank)	A valid date value is provided in item *RX Date-Most Definitive Surgery*

Recording RX Date-Most Definitive Surgery Flag

1. Full or Partial Date: Leave this field blank if *RX Date-Most Defin Surg* has a full or partial date.

2. Unknown if Surgery Performed: Code 10 if it is unknown whether any surgery was performed.

3. No Surgery: Code 11 if no surgery to the primary site was performed.

4. Unknown Date: Code 12 if the *RX Date-Most Defin Surg* cannot be determined at all, but the patient did receive surgery to the primary site.

RX SUMM-SCOPE REG LN SURG

Record the code for the removal, biopsy or aspiration of regional lymph nodes performed as first course of treatment. This includes treatment given at all facilities as part of the first course of treatment.

Code	Definition
0	No regional lymph nodes removed or aspirated; diagnosed at autopsy
1	Biopsy or aspiration of regional lymph node, NOS
2	Sentinel lymph node biopsy (only)
3	Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed NOS
4	1-3 regional lymph nodes removed
5	4 or more regional lymph nodes removed
6	Sentinel node biopsy and code 3, 4, or 5 at the same time or timing not noted
7	Sentinel node biopsy and code 3, 4 or 5 at different times
9	Unknown or not applicable

The following instructions should be applied to all surgically treated cases for all types of cancers. It is important to distinguish between sentinel lymph node biopsies (SLNBx) and more extensive regional lymph node dissection.

Note: There are additional instructions for breast primaries. See Breast Primary Coding Instructions.

General Coding Instructions

1. Operative Reports: Use the operative report as the primary source document to determine whether the operative procedure was a SLNBx, or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.

2. Distant Lymph Nodes: Only code regional lymph node procedures in this data item. Record distant lymph node removal in *RX SUMM - SURG OTH REG/DIS.*

Note: Refer to SEER Summary Stage 2018 Manual to identify regional lymph nodes.

3. Aspiration, biopsy or removal of lymph nodes: Record all surgical procedures that remove, biopsy, or aspirate regional lymph node(s) whether or not there were any surgical procedures of the primary site. The regional lymph node surgical procedure(s) may be done to diagnose cancer, stage the disease, or as a part of the initial treatment.

4. First Course of Treatment: Include lymph nodes obtained or biopsied during any procedure within the first course of treatment. A separate lymph node surgery is not required.

5. Total Number: Add the number of all the lymph nodes removed during each surgical procedure performed as part of the first course of treatment. The Scope of Regional Lymph Node field is cumulative.

   Example: Patient has excision of a positive cervical node. The pathology report from a subsequent node dissection identifies three cervical nodes. Assign code 5 (4 or more regional lymph nodes removed).

6. Two Primary Sites: Code the removal of regional nodes for both primaries when the patient has two primaries with common regional lymph nodes

   Example: Patient has a cystoprostatectomy and pelvic lymph node dissection for bladder cancer. Pathology identifies prostate cancer as well as the bladder cancer and 4/21 nodes positive for metastatic adenocarcinoma. Code Scope of Regional Lymph Node Surgery to 5 (4 or more regional lymph nodes removed) for both primaries.

7. Code 0: Assign code 0 when:
   - Regional lymph node removal procedure was **not** performed

   Note: Excludes all sites and histologies that should be coded 9. (See #12)

   OR

   a. First course of treatment was active surveillance/watchful waiting,

   OR

   b. The operative report lists a lymph node dissection, but no nodes were found by the pathologist

8. Code 2: Assign code **2** when:
   a. The operative report states that a SLNBx was performed,

   OR

   b. The operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination

   Note: When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. Code this as a SLNBx (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.

9. Codes 3, 4, and 5: The operative report states a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure)
   - Code 3: Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7)
   - Code 4: Should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only.
   - Code 5: If a relatively small number of nodes were examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes were examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7).

> ***Note: Infrequently, a SLNBx is attempted and the patient fails to map (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. Code these cases as 2 if no further dissection of regional lymph nodes was undertaken, or 6 when regional lymph nodes were dissected during the same operative event.***

10. Code 6: SLNBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known.
    - Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes.
    - If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.
    - Infrequently, a SLNBx is attempted and the patient fails to map (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6.

11. Code 7: SLNBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events
    - Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes.
    - If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only

12. Code 9: The status of regional lymph node evaluation should be known for surgically treated cases. Review surgically treated cases coded as 9 in Scope of Regional Lymph Node Surgery to confirm the code. Code 9 can be assigned for:

a. Primary Sites:
   - Brain (C700-C709), OR
   - Spinal cord (C710-C719), OR
   - Cranial nerves and other parts of the central nervous system (C720-C729, C75.1-C75.3)
   - Unknown or ill-defined sites (C760-C768, C809) (all histology's) (including cases diagnosed at autopsy)

b. Lymphoma with primary site in Lymph Nodes (C770-C779) AND
   - 9590, 9726, 9735-9738 OR
   - 9727, 9811-9818, 9823, 9827, 9837 (Leukemia/Lymphoma histology's)

c. Hematopoietic neoplasms
   - Primary site: C421 (all histology's)
   - Histology's: 9740, 9751, 9754-9759, 9762, 9930

d. Death certificate only (DCO) cases

Breast Primary Coding Instructions

1. Operative Reports: Use the operative report as the primary source document to determine whether the operative procedure was a SLNBx, an axillary lymph node dissection (ALND), or a combination of both SLNBx and ALND. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and ALND, or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and an ALND.

2. Code 1: Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7.

3. Code 2:
   - If a relatively large number of lymph nodes, more than 5, are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an axillary lymph node dissection (ALND)
   - Infrequently, a SLNBx is attempted and the patient fails to map (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. Review the operative report to confirm that an axillary incision was made, and a node exploration was conducted. Patients undergoing SLNBx who fail to map will often undergo ALND. Use code 2 if no ALND was performed, or 6 when ALND was performed during the same operative event. Enter the appropriate number of nodes examined and positive in the data items Regional Lymph Nodes Examined (NAACCR Item #830) and Regional Lymph Nodes Positive (NAACCR Item #820).

4. Codes 3, 4, and 5: Generally, ALND removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same procedure (code 6 or 7).

5. Code 6:
   - Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes.
   - If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed

6. Code 7:

   - Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes.
   - If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only, or whether a SLNBx plus an ALND was performed

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text - Surgery.*

RX SUMM - SURG OTH REG/DIS

Record the code 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. This includes treatment given at all facilities as part of the first course of treatment.

This data item describes the removal of tissues and organs other than the primary tumor or organ of origin. This data item is for all procedures that do not meet the definition of *RX Summ-Surgery of Primary Site* or *RX Summ - Scope of Regional Lymph Node Surgery*.

Code	Definition
0	*None*- No surgical procedure of nonprimary site was performed. Diagnosed at autopsy.
1	*Nonprimary surgical procedure performed*- Nonprimary surgical resection to other site(s), unknown if the site(s) is regional or distant.
2	*Nonprimary surgical procedure to other regional sites*- Resection of regional site.
3	*Nonprimary surgical procedure to distant lymph node(s)*-Resection of distant lymph node(s).
4	*Nonprimary surgical procedure to distant site*- Resection of distant site.
5	*Combination of codes*- Any combination of surgical procedures 2, 3, or 4.
9	*Unknown*- It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only.

Recording Surgery to Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)

1. Hierarchy: The codes are hierarchical. Code the procedure numerically higher in this data item.

2. Suspicion of malignancy: Code the removal of non-primary tissue the surgeon suspected was involved with the malignancy even if the pathology is negative.

3. Unknown or ill-defined primary sites or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease: Assign code 1 if any surgical procedure is performed to treat these cases.

   Example: Surgical biopsy of metastatic lesion from liver; unknown primary is coded to 1.

4. Incidental removal: Do not code the incidental removal of tissue. Incidental is defined as tissue removed for reasons other than the malignancy.

   Example: The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon is not coded therefore; this case would be coded to 0.

5. No surgery- This data item may not be blank. If there was no surgery to other regional sites, distant sites or distant lymph nodes, record 0.

Special Instructions

1. Registry Hospitals: If you can record multiple surgical procedures in your registry software, make sure the data item transmitted to the PCR as *RX Summ - Surg Oth Reg/Dis* reflects the most extensive (numerically highest) code.

2. Abstract Plus: You can only record one surgical procedure. If you have more than one procedure use the code for the most extensive (numerically highest).

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text - Surgery.*

REASON FOR NO SURGERY

Record the reason for no Surgery of Primary Site. Codes 1-9 are valid only when *RX Summ - Surg Prim Site* is coded 00.

Code	Definition
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician but was not performed as part of the first course of therapy. No reason was noted in patient record.
7	Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only.

Recording Reason for No Surgery

1. No surgery in plan: Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include surgery of the primary site, or if the option of "no treatment" was accepted by the patient.

2. If *Surgical Procedure of Primary Site* is coded 98, code *Reason for No Surgery* to 1.

3. Patient refused: If the patient refused recommended surgical treatment, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended, code to 7.

4. Unknown treatment- If the treatment plan offered multiple choices, but it is unknown which treatment, if any was provided, code to 9.

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text - Surgery.*

Phase I Radiation Treatment Modality

Record the radiation modality administered during the first phase of radiation treatment delivered during first course of treatment.

Code	Definition
00	No Radiation
01	External Beam, NOS
02	External Beam, photons
03	External Beam, protons
04	External Beam, electrons
05	External Beam, neutrons
06	External Beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary LDR
09	Brachytherapy, intracavitary HDR
10	Brachytherapy, interstitial LDR
11	Brachytherapy, interstitial HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-232
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
98	Radiation given modality unknown
99	Treatment radiation modality unknown; Unknown is radiation treatment administered

Recording Phase 1 Radiation Treatment Modality

1. January 1, 2018: This field is required for cases diagnosed on January 1, 2018 or after. If the case is diagnosed prior to 2018, *Rad–Regional RX Modality* is required.

2. Radiation Volume Information: Radiation treatment volume will typically be found in the radiation oncologist's summary letter for first course of treatment. Determination of the exact treatment volume may require assistance from the radiation oncologist.

3. First Phase: The first phase might be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down. Only record first phase.

4. New Phase: A new phase begins when there is clinically meaningful change in target volume, treatment fraction size, modality or treatment technique. Any one of these changes will mean a new radiation plan will be generated in the treatment plan and it would no longer be considered Phase 1.

5. Radioembolization: Is the embolization combined with injection of a small radioactive beads or coils into an organ or tumor. Assign code 13, Radioisotopes NOS for radioembolization procedures.

RX DATE-RADIATION

Record the date radiation started.

Recording RX Date- Radiation

1. Date Format: Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, the day in the last two spaces.

2. Collecting dates for each treatment modality allows sequencing of multiple treatments and evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

3. Exact Date Unavailable: If the exact date the radiation started is not available, record an approximate date. Refer to *Part Three, General Information*.

4. Leave RX Date- Radiation blank and assign the appropriate *RX Date-Radiation Flag* for the following reasons:

    a. when no radiation is given
    b. when radiation is planned, but has not yet started
    c. when it is unknown if any radiation was given
    d. when the patient received radiation, but the date is unknown
    e. when the record was identified by death certificate only
    f. when it is an autopsy-only case

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text - Radiation (Beam)* or *RX Text - Radiation Other.*

RX DATE-RADIATION FLAG

Record the date flag in the event a complete *RX Date-Radiation* was not entered to explain why.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any radiation was given)
11	No proper value is applicable in this context (for example, no radiation given)
12	A proper value is applicable but not known (for example, *RX Date-Radiation* is unknown)
15	Information is not available at this time, but it is expected it will be available later (for example, radiation therapy is planned as part of the first course of therapy, but had not been started at the time the case was abstracted)
(blank)	A valid date value is provided in item *RX Date-Radiation*

Recording RX Date-Radiation Flag

1. Full or Partial Date: Leave this field blank if *RX Date-Radiation* has a full or partial date recorded.

2. Unknown if Radiation Given: Code 10 if it is unknown whether any radiation was given.

3. No Radiation: Code 11 if no radiation is planned or given.

4. Unknown Date: Code 12 if *RX Date-Radiation* cannot be determined at all, but the patient did receive radiation.

5. Radiation Planned but Not Started: Code 15 if radiation is planned but has not yet started and the start date is not yet available. If radiation is later started, update this item, *RX Date-Radiation*, and *Phase I Radiation Treatment Modality* in your database and submit a modification record to the PCR. See *Part One, Changing Information.*

RX SUMM-SURG/RAD SEQ

Record the sequencing of radiation and surgical procedures given as part of first course of treatment.

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

Code	Definition
0	*No radiation therapy and/or surgical procedures; unknown if surgery and/or radiation given*-No radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node (s) or it is unknown whether any surgery and/or radiation was given. Diagnosed at autopsy.
2	*Radiation therapy before surgery*-Radiation therapy given before surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
3	*Radiation therapy after surgery*-Radiation therapy given after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
4	*Radiation therapy both before and after surgery*-At least two courses of radiation therapy are given before and after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
5	*Intraoperative radiation therapy*-Intraoperative therapy given during surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	*Intraoperative radiation therapy with other therapy administered before and/or after surgery*-Intraoperative radiation therapy given during surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node (s) with other radiation administered before and/or after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node (s).
7	*Surgery both before and after radiation*-Radiation therapy given before and after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	*Sequence unknown, but both surgery and radiation were given*-Administration of radiation therapy and surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record.

Recording RX Summ-Surg/Rad Seq

1. Surgical procedures include *RX Summ- Surg Prim Site*; *RX Summ- Scope LN Surg*; and *RX Summ- Surg Oth Reg/Dis*

2. No Surgery: If all surgery procedures listed above are coded to none, then this item should be coded to 0.

3. Unknown if Surgery or Radiation Given: If it is unknown if surgery and/or radiation were given, this item should be coded to 0.

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text - Surgery, RX Text - Radiation (Beam)* and *RX Text - Radiation Other.*

REASON FOR NO RADIATION

Record the reason no regional radiation therapy was administered to the patient. Codes 1-9 are valid only when *Phase 1 Radiation Treatment Modality* is coded 00.

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

Recording Reason for No Radiation

1. No radiation therapy in plan: Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include radiation therapy, or if the option of "no treatment" was accepted by the patient.

   Example: A patient with Stage I prostate cancer is offered either surgery or brachytherapy to treat his disease. The patient elects to be surgically treated, code to 1

2. Patient refused: If the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended, code to 7.

3. Recommended, but unknown if given: If it is known that a physician recommended radiation treatment, but no further documentation is available to confirm its administration, code to 8.

4. Unknown treatment: If the treatment plan offered multiple choices, but it is unknown which treatment if any was provided, code to 9.

RX SUMM-CHEMO

Record the type of chemotherapy administered as first course of treatment at your institution and at all other institutions. If chemotherapy was not administered, then this item records the reason it was not administered to the patient. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Code	Definition
00	None- Chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Chemotherapy NOS- Chemotherapy administered as first course therapy, but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as first course therapy.
03	Multiagent chemotherapy administered as first course therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Recording Chemotherapy

1. Chemotherapy not usually given for this condition: If chemotherapy was not administered to the patient, and it is known it is not usually administered for this stage of cancer or type of condition, code to 00.

2. Patient did not select chemotherapy: If the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy, code to 00.

3. Chemotherapy usually given for this condition: If it is known chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

    a. Code to 82 when chemotherapy is a customary option for the primary site/histology, but it was not administered due to patient risk factors, such as advanced age or comorbid condition(s) (heart disease, kidney failure, other cancer, etc.)

b. Code to 87 when:

- The patient refused recommended chemotherapy
- The patient made a blanket refusal of all recommended treatment and chemotherapy is a customary option for the primary site/histology
- The patient refused all treatment before any was recommended and chemotherapy is a customary option for the primary site/histology

4. Physician Recommended: If it is known a physician recommended the patient receive chemotherapy, but no further documentation is available to confirm it was administered, code to 88.

5. Chemoembolization: Code as chemotherapy when the embolizing agent(s) is a chemotherapy drug(s).

6. Unknown: If it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered, code to 99.

7. Change to regimen: If the managing physician changes one of the agents in a combination regimen and the replacement agent belongs to a different group (see *Chemotherapy Group Classifications*) than the original agent, the new regimen represents the start of subsequent therapy, and *only the original agent or regimen is recorded as first course therapy*.

Example: The physician documents a multimodality treatment plan that includes a combination regimen of chemotherapy. Velban is one of the drugs in the chemotherapy regimen. After two cycles of chemotherapy, the physician says the Velban will be replaced with Oncovin and the chemotherapy will continue as planned. This is a continuation of the planned first course of therapy since they are in the same group.

8. List of chemotherapeutic agents: Use *SEER RX* to determine if a drug is a chemotherapy agent. *SEER RX* is an interactive antineoplastic drug data base and it can be downloaded from this website: http://seer.cancer.gov/tools/seerrx/

Chemotherapy Group Classifications

Group	Subgroup	Example
Alkylating agents	Mustard Gas derivatives/ Nitrogen mustard	mechlorethamine, cyclophosphamide, chlorambucil, melphalan, and ifosfamide
	Ethylenimines	Ethylenimines: thiotepa and hexamethylmelamine
	Alkylsulfonates	Busulfan
	Hydrazines and Trizines	altretamine, procarbazine, dacarbazine, and temozolomide
	Nitrosureas	carmustine, lomustine, streptozocin, and nitrosourea
	Metal Salts	carboplatin, cisplatin, and oxaliplatin
Antimetabolites	Folic acid antagonist	Methotrexate
	Pyrimidine antagonist	5-fluorouracil, floxuridine, cytarabine, capecitabine, and gemcitabine
	Purine antagonist	6-mercaptopurine and 6-thioguanine
	Adenosine deaminase inhibitor	ladribine, fludarabine, nelarabine, and pentostatin
Natural products	Anti-tumor antibiotics	• Anthracyclines: doxorubicin, daunorubicin, epirubicin, mitotane, and idarubicin • Chromomycins: dactinomycin and plicamycin • Miscellaneous: mitomycin and bleomycin
	Plant alkaloids	• Vinca alkaloids: vincristine, vinblastine, and vinorelbine • Taxanes: paclitaxel and docetaxel • Podophyllotoxins: etoposide and teniposide • Camptothecan analogs: irinotecan and topotecan
	Topoisomerase inhibitors	• Topoisomerase I inhibitors: irinotecan, topotecan • Topoisomerase II inhibitors: amsacrine, etoposide, etoposide phosphate, teniposide
Miscellaneous		Hydroxyurea, mitotane, asparaginase and pegaspargase, estramustine, bexarotene, isotretinoin, tretinoin (ATRA)

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text - Chemo.*

RX DATE-CHEMO

Record the date chemotherapy started.

Recording RX Date- Chemo

1. Date Format: Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, the day in the last two spaces.

2. Collecting dates for each treatment modality allows sequencing of multiple treatments and evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

3. Exact Date Unavailable: If the exact date the chemotherapy was started is not available, record an approximate date. Refer to *Part Three, General Information*.

4. Leave RX Date-Chemo blank and assign the appropriate *RX Date-Chemo Flag* for the following reasons:

    a. when no chemotherapy is given
    b. when chemotherapy is planned, but has not yet started
    c. when it is unknown if any chemotherapy was given
    d. when the patient received chemotherapy, but the date is unknown
    e. when the record was identified by death certificate only
    f. when it is an autopsy-only case

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text - Chemotherapy.*

RX DATE-CHEMO FLAG

Record the date flag in the event a complete *RX Date-Chemo* was not entered to explain why.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any chemotherapy given.)
11	No proper value is applicable in this context (for example, no chemotherapy given).
12	A proper value is applicable but not known (for example, *RX Date-Chemo* is unknown)
15	Information is not available at this time, but it is expected that it will be available later (for example, chemotherapy therapy is planned as part of the first course of therapy but had not been started at the time the case was abstracted).
(blank)	A valid date value is provided in item *RX Date-Chemo*

Recording RX Date-Chemo Flag

1. Full or Partial Date: Leave this field blank if *RX Date-Chemo* has a full or partial date recorded.

2. Unknown if Chemotherapy Given: Code 10 if it is unknown whether any chemotherapy was given.

3. No Chemotherapy: Code 11 if no chemotherapy is planned or given.

4. Unknown Date: Code 12 if the *RX Date-Chemo* cannot be determined at all, but the patient did receive chemotherapy.

5. Chemotherapy Planned but Not Started: Code 15 if chemotherapy is planned but has not yet started and the start date is not yet available. If chemotherapy is later started, update this item, *RX Date-Chemo*, and *RX Summ-Chemo* in your database and submit a change sheet to the PCR. See *Part One, Changing Information.*

RX SUMM-HORMONE

Record the type of hormone therapy the patient received as a part of first course of treatment at your institution and all other institutions. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth.

Hormone therapy achieves its effect on cancer tissue through change of the hormone balance. Included are the administration of hormones, agents acting via hormonal mechanisms, antihormones, and steroids.

Code	Definition
00	None- hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Hormone therapy administered as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Recording Hormone Therapy

1. All sites (primary and metastatic): Hormones, agents acting via hormonal mechanisms, and antihormones (cancer-directed only) are to be coded for all sites (primary and metastatic).

2. Prednisone:

   a. Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

   b. Do not code prednisone as hormone therapy when it is administered for reasons other than cancer treatment.

Example: A patient has advanced lung cancer with metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormone therapy.

3. Hormone replacement therapy: Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.

   Example: Patients with breast cancer may be treated with aminoglutethimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. These patients must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (Florinef) as a replacement therapy. Code *Rx Summ- Hormone* to 00, None.

4. Hormone therapy not usually given for this condition: If hormone therapy was not administered to the patient, and it is known it is not usually administered for this type and stage of cancer, code to 00.

5. Patient selected treatment option without hormone therapy: If the treatment plan offered multiple options, and the patient selected treatment that did not include hormone therapy, code to 00.

6. Thyroid replacement therapy: Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.

7. Hormone therapy usually given for this condition: If it is known hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

   a. Assign Code 82: when hormone therapy is a customary option for the primary site/histology, but it was not administered due to patient risk factors, such as advanced age or comorbid condition(s) (heart disease, kidney failure, other cancer, etc.)

   b. Assign Code 87 when:
      - The patient refused recommended hormone therapy
      - The patient made a blanket refusal of all recommended treatment and hormone therapy is a customary option for the primary site/histology
      - The patient refused all treatment before any was recommended and hormone therapy is a customary option for the primary site/histology

8. Physician Recommended: If it is known a physician recommended the patient receive hormone therapy, but no further documentation is available to confirm it was administered, code to 88.

9. Unknown: If it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered, code to 99.

10. List of hormonal agents: Use *SEER RX* to determine if a drug is a hormonal agent. *SEER RX* is an interactive antineoplastic drug data base and it can be downloaded from this website: http://seer.cancer.gov/tools/seerrx/

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text - Hormone.*

RX DATE-HORMONE

Record the date hormone therapy started.

Recording RX Date- Hormone

1. Date Format: Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, the day in the last two spaces.

2. Collecting dates for each treatment modality allows sequencing of multiple treatments and evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

3. Exact Date Unavailable: If the exact date the hormone therapy started is not available, record an approximate date. Refer to *Part Three, General Information*.

4. Leave RX Date-Hormone blank and assign the appropriate *RX Date-Hormone Flag* for the following reasons:

    a. when no hormone therapy is given
    b. when hormone therapy is planned, but has not yet started
    c. when it is unknown if any hormone therapy was given
    d. when the patient received hormone therapy, but the date is unknown
    e. when the record was identified by death certificate only
    f. when it is an autopsy-only case

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text - Hormone.*

RX DATE-HORMONE FLAG

Record the date flag in the event a complete *RX Date-Hormone* was not entered to explain why.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any hormone therapy given)
11	No proper value is applicable in this context (for example, no hormone therapy given)
12	A proper value is applicable but not known (for example, *RX Date-Hormone* is unknown)
15	Information is not available at this time, but it is expected that it will be available later (for example, hormone therapy is planned as part of the first course of therapy, but had not been started at the time the case was abstracted)
(blank)	A valid date value is provided in item *RX Date-Hormone*

Recording RX Date-Hormone Flag

1. Full or Partial Date: Leave this field blank if *RX Date-Hormone* has a full or partial date recorded.

2. Unknown if Hormone Therapy Given: Code 10 if it is unknown whether any hormone therapy was given.

3. No Hormone Therapy: Code 11 if no hormone therapy is planned or given.

4. Unknown Date: Code 12 if the *RX Date-Hormone* cannot be determined at all, but the patient did receive hormone therapy.

5. Hormone Therapy Planned but Not Started: Code 15 if hormone therapy is planned but has not yet started and the start date is not yet available. If hormone therapy is later started, update this item, *RX Date-Hormone*, and *RX Summ-Hormone* in your database and submit a change sheet to the PCR. See *Part One, Changing Information.*

RX SUMM-BRM

Record the immunotherapy (biological response modifier BRM) the patient received as a part of first course of treatment at the reporting institution and all other institutions. If immunotherapy was not administered, then this item records the reason it was not administered to the patient. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells.

Code	Definition
00	None- Immunotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Immunotherapy administered as first course therapy.
82	Immunotherapy was not recommended/administered because it was contra-indicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Recording Immunotherapy

1. Immunotherapy not usually given for this condition: If immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer, code to 00.

2. Patient selected treatment option without immunotherapy: If the treatment plan offered multiple options, and the patient selected treatment that did not include immunotherapy, code to 00.

3. Immunotherapy usually given for this condition: If it is known immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

    a. Assign Code 82 when immunotherapy is a customary option for the primary site/histology, but it was not administered due to patient risk factors, such as advanced age or comorbid condition(s) (heart disease, kidney failure, other cancer, etc.)

b. Assign Code 87 when:

- The patient refused recommended immunotherapy
- The patient made a blanket refusal of all recommended treatment and immunotherapy is a customary option for the primary site/histology
- The patient refused all treatment before any was recommended and immunotherapy is a customary option for the primary site/histology

4. Physician Recommended: If it is known a physician recommended the patient receive immunotherapy, but no further documentation is available to confirm it was administered, code to 88.

5. Unknown: If it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered, code to 99.

6. List of Immunotherapy Agents: Use *SEER RX* to determine if a drug is an immunotherapy agent. *SEER RX* is an interactive antineoplastic drug data base and it can be accessed at this website: http://seer.cancer.gov/tools/seerrx/

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text - BRM.*

RX DATE-BRM

Record the date immunotherapy started.

Recording RX Date-BRM

1. Date Format: Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, the day in the last two spaces.

2. Collecting dates for each treatment modality allows sequencing of multiple treatments and evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

3. Exact Date Unavailable: If the exact date the immunotherapy started is not available, record an approximate date. Refer to *Part Three, General Information*.

4. Leave RX Date-BRM blank and assign the appropriate *RX Date-BRM Flag* for the following reasons:

   a. when no immunotherapy is given
   b. when immunotherapy is planned, but has not yet started

c. when it is unknown if any immunotherapy was given
d. when the patient received immunotherapy, but the date is unknown
e. when the record was identified by death certificate only
f. when it is an autopsy-only case

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text-BRM.*

RX DATE-BRM FLAG

Record the date flag in the event a complete *RX Date-BRM* was not entered to explain why.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any immunotherapy given)
11	No proper value is applicable in this context (for example, no immunotherapy given)
12	A proper value is applicable but not known (for example, *RX Date-BRM* is unknown)
15	Information is not available at this time, but it is expected that it will be available later (for example, immunotherapy is planned as part of the first course of therapy, but had not been started at the time the case was abstracted)
(blank)	A valid date value is provided in item *RX Date-BRM*

Recording RX Date-BRM Flag

1. Full or Partial Date: Leave this field blank if *RX Date-BRM* has a full or partial date recorded.

2. Unknown if Immunotherapy Given: Code 10 if it is unknown whether any immunotherapy was given.

3. No Immunotherapy: Code 11 if no immunotherapy is planned or given.

4. Unknown Date: Code 12 if the *RX Date-BRM* cannot be determined at all, but the patient did receive immunotherapy.

5. Immunotherapy Planned but Not Started: Code 15 if immunotherapy is planned but has not yet started and the start date is not yet available. If immunotherapy is later started, update this item, *RX Date-BRM*, and *RX Summ-BRM* in your database and submit a change sheet to the PCR. See *Part One, Changing Information.*

RX SUMM-OTHER

Record other cancer-directed therapy received by the patient as part of the first course of treatment at the reporting institution and all other institutions. Other treatment includes therapies designed to modify or control the cancer cells that are not defined in *Surgery, Radiation,* or *Systemic Therapy* fields.

Code	Definition
0	None- All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.
1	Other- Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases.
2	Other-Experimental- This code is not defined. It may be used to record participation in institution-based clinical trials.
3	Other-Double Blind- A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven Cancer treatments administered by nonmedical personnel.
7	Refusal- Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Recommended; unknown if administered- Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown- It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.

Recording Other Treatment

1. Hematopoietic diseases: Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Such treatments include phlebotomy, transfusion, or aspirin. Refer to the *SEER Hematopoietic Lymphoid Neoplasm Data Base and Coding Manual* for instructions for coding this item. https://seer.cancer.gov/tools/heme/

2. Embolization: Assign code 1 for embolization using alcohol as an embolizing agent and for embolization to a site other than liver where the embolizing agent is unknown.

   Note: Do not code pre-surgical embolization given for purpose of shrinking tumor.

3. PUVA: Assign code 1 in the rare event Psoralen (P) and long-wave ultraviolet radiation (UVA) it is used as treatment for extremely thin melanomas or cutaneous T-cell lymphomas.

4. Physician Recommended: If it is known a physician recommended a treatment coded as Other Treatment and no further documentation is available to confirm its administration, code to 8.

5. Diagnosed at Autopsy: If patient was diagnosed at autopsy, code to 0.

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text - Other*

RX DATE-OTHER

Record the date other treatment started.

Recording RX Date- Other

1. Date Format: Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, the day in the last two spaces.

2. Collecting the dates for each treatment modality allows sequencing of multiple treatments and aids evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

3. Exact Date Unavailable: If the exact date of other treatment is not available, record an approximate date. Refer to *Part Three, General Information*.

4. Leave RX Date-Other blank and assign the appropriate *RX Date-Other Flag* for the following reasons:
   a. when no other therapy is given
   b. when other therapy is planned, but has not yet started
   c. when it is unknown if any other therapy was given
   d. when the patient received other therapy, but the date is unknown
   e. when the record was identified by death certificate only
   f. when it is an autopsy-only case

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text-Other*

RX DATE-OTHER FLAG

Record the date flag in the event a complete *RX Date-Other* was not entered to explain why.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if other therapy given)
11	No proper value is applicable in this context (for example, no other therapy given)
12	A proper value is applicable but not known (for example, *RX Date-Other* is unknown)
15	Information is not available at this time, but it is expected that it will be available later (for example, other therapy is planned as part of the first course of therapy, but had not been started at the time the case was abstracted)
(blank)	A valid date value is provided in item *RX Date-Other*

Recording RX Date-Other Flag

1. Full or Partial Date: Leave this field blank if *RX Date-Other* has a full or partial date recorded.

2. Unknown if other therapy Given: Code 10 if it is unknown whether other therapy was given.

3. No Other Therapy: Code 11 if no other therapy is planned or given.

4. Unknown Date: Code 12 if the *RX Date-Other* cannot be determined at all, but the patient did receive other therapy.

5. Other Therapy Planned but Not Started: Code 15 if other therapy is planned but has not yet started and the start date is not yet available. If other therapy is later started, update this item, *RX Date-Other*, and *RX Summ-Other* in your database and submit a change sheet to the PCR. See *PCR Manual, Part One, Changing Information.*

RX SUMM-TRANS PLNT/ENDROCR

Record the systemic therapeutic procedures administered as part of the first course of treatment at this and all other facilities. If none of these procedures were administered, then this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

Code	Definition
00	No transplant procedure or endocrine therapy was administered as part of first course therapy. Diagnosed at autopsy.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant- autologous.
12	Bone marrow transplant- allogeneic.
20	Stem cell harvest and infusion.
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20.)
82	Hematologic transplant and/or endocrine surgery/radiation was not recommended/ administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record. Death certificate only.

Recording Hematologic Transplant and Endocrine Procedures

1. Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.

2. Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation.

3. Endocrine irradiation and/or endocrine surgery
   - Procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or affect the long-term control of the cancer's growth.
   - These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.

4. These procedures are not usually administered for this condition: Code 00 if a transplant or endocrine procedure was not administered to the patient, and it is known these procedures are not usually administered for this type and stage of cancer.

5. Patient selected treatment option that did not include one of these procedures: Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include a transplant or endocrine procedure.

6. These procedures are usually administered for this condition: If it is known a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to patient, use code 82, 85, 86, or 87 to record reason why it was not.

7. Patient refused: If the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended, code to 87.

8. Physician Recommended: If it is known a physician recommended a hematologic transplant or endocrine procedure, but no further documentation is available to confirm its administration, code to 88.

9. Unknown: If it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered, code to 99.

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text - Surgery.*

RX SUMM-SYSTEMIC SUR SEQ

Record the sequencing of systemic therapy and surgical procedures given as part of first course of treatment.

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

Code	Definition
0	*No systemic therapy and/or surgical procedures; unknown if any surgery and/or systemic therapy given*-No systemic therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s) or it is unknown whether any surgery and/or systemic therapy was given. Or Diagnosed at autopsy
2	*Systemic therapy before surgery*-Systemic therapy given before surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
3	*Systemic therapy after surgery*-Systemic therapy given after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
4	*Systemic therapy both before and after surgery*-At least two courses of systemic therapy were given before and after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
5	*Intraoperative systemic therapy*-Intraoperative systemic therapy given during surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	*Intraoperative systemic therapy with other therapy administered before and/or after surgery*-Intraoperative systemic therapy given during surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node (s) with other systemic therapy administered before and/or after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
7	*Surgery both before and after systemic therapy*-Systemic therapy given before and after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	*Sequence unknown*-Administration of systemic therapy and surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record

Recording RX Summ-Systemic Sur Seq

1. Surgical Procedures include RX Summ- Surg Prim Site; RX Summ- Scope LN Surg; and RX Summ- Surg Oth Reg/Dis.

2. No Surgery: If all surgery procedures listed above are coded to none, then this item should be coded to 0.

3. Unknown if Surgery or Systemic Therapy Given: If it is unknown if either surgery and/or systemic therapy were given, this item should be coded to 0.

Text

Text to support this data item must be recorded in specific text fields. See *Part Three, Data Item Instructions, RX Text - Surgery, RX Text -Chemo, RX Text - BRM, and RX Text -Hormone.*

DATE OF 1ST CRS RX-COC

Record the date of first course treatment. This is the date of initiation of the first cancer-directed therapy for the cancer being reported

Recording Date of 1st CRS RX- COC

1. Date Format: Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, the day in the last two spaces.

2. Earliest Date: Record the earliest of the following dates: *RX Date-Surgery*, *RX Date-Radiation*, *RX Date-Chemo, RX Date-Hormone*, *RX Date-BRM*, or *RX Date-Other*.

3. Physician Decides Not to Treat: If the physician decides not to treat the patient, record the date of this decision as the *Date of 1st CRS RX-COC*. The physician may decide not to treat the patient because of co-morbid conditions, advanced disease, or because the accepted management of the cancer is to observe until the disease progresses or until the patient becomes symptomatic.

   Example: On February 12, 2018 the physician says a low-stage prostate cancer patient will be observed until the Prostatic Specific Antigen (PSA) level starts to rise. Enter 20180212 as the date of first course treatment.

4. Patient Refuses Treatment: If the patient refuses treatment; record the date of this decision as the *Date of 1st CRS RX-COC*. If the patient is diagnosed at the reporting facility and no further information is available record the date the patient was last seen at the reporting institution.

5. Incisional Biopsy: Do not record the date of incisional, core, or fine needle biopsy as the *Date of 1st CRS RX-COC*.

6. Exact Date Unavailable: If the exact date of first course of treatment is not available, record an approximate date. Refer to *Part Three, General Information*.

7. Leave Date of 1st CRS RX-COC blank and assign the appropriate *Date of 1st CRS RX* Flag only for the following reasons:

   a. when it is unknown if any cancer-directed treatment was given
   b. when the patient had cancer-directed treatment, but the date is unknown
   c. when the record was identified by death certificate only
   d. when it is an autopsy-only case

DATE OF 1ST CRS RX FLAG

Record the date flag in the event a complete date of first course treatment was not entered to explain why.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any cancer-directed treatment was given.)
11	No proper value is applicable in this context (autopsy only)
12	A proper value is applicable but not known (for example, *Date of 1st CRS RX – COC* is unknown)
(blank)	A valid date value is provided in item *Date of 1st CRS RX – COC*

Recording Date of 1st CRS RX Flag

1. Full or Partial Date: Leave this field blank if *Date of 1st CRS RX-COC* has a full or partial date recorded.

2. Unknown if Cancer-Directed Treatment Given: Code 10 if it is unknown whether any cancer-directed treatment was given.

3. No Treatment: Code 11 if the initial diagnosis was at autopsy.

4. Unknown Date: Code 12 if the *Date of 1st CRS RX-COC* cannot be determined at all, but the patient did receive first course treatment.

RX SUMM-TREATMENT STATUS

Summarize whether the patient received any treatment or if the tumor is under active surveillance.

Code	Definition
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment was given

Recording Rx Summ-Treatment Status

1. Diagnosed Prior to January 1, 2010: This item may be left blank for cases diagnosed prior to January 1, 2010.

2. Code 0: Assign code 0 when:

   a. No treatment is given.
   b. Patient refused treatment.
   c. Physician decides not to treat for any reason, such as the presence of comorbidities.

   Example: An elderly patient with pancreatic cancer requested no treatment. Code *Rx Summ Treatment Status* to 0

3. Active Surveillance (watchful waiting): Assign code 2 when the patient will be under active surveillance.

   Example: Treatment plan for a lymphoma patient is active surveillance. Code *Rx Summ-Treatment Status* to 2

4. Subsequent Treatment: Treatment given after a period of active surveillance is considered subsequent treatment and is not coded in this item.

DATE OF LAST CONTACT

Record the date of last contact.

Recording Date of Last Contact

1. Date Format Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, the day in the last two spaces.

2. Report Actual Date Only: Blank or approximation of month, day, century, or year is not acceptable when reporting this data item to the PCR. Fictitious dates or default values are also not acceptable

   Exception: If a patient is known to have expired after discharge from your facility, the month and/or day may be left blank if the exact month and/or day are not known.

3. Inpatient Admission: If the last contact with a patient is an inpatient admission, record the date of discharge.

4. Outpatient Visit: If the last contact with the patient was an outpatient visit, record the outpatient date.

5. Treatment After Discharge: If the patient receives treatment after discharge record the date of the treatment.

6. Patient Deceased: If the patient is deceased, record the date of death.

Note: Date of Last Contact does not have to be submitted as a change or update if the patient is readmitted or expires after the initial record was submitted.

DATE OF LAST CONTACT FLAG

The PCR requires a *Date of Last Contact* to be entered on all cases; therefore, this field will be left blank.

Code	Definition
(blank)	A valid date value provided in item *Date of Last Contact.*

VITAL STATUS

Record the appropriate code for the patient's vital status as of the date recorded in data item *Date of Last Contact*. Use the most accurate information available.

Code	Definition
0	Dead
1	Alive

Note: Vital Status does not have to be submitted as a change or update if the patient expires after the initial record was submitted. The PCR periodically matches records in the PCR database against Pennsylvania death certificate files. As a result of this match, the PCR will send each hospital a list of its reported patients who have expired.

REPORTING HOSPITAL

Record the reporting facility identification (ID) number as described under special instructions below.

Special Instructions

1. Registry Hospitals: Record the ID number assigned to your facility by the American College of Surgeons, Commission on Cancer.

2. Abstract Plus**:** The ID number assigned to your facility by the American College of Surgeons, Commission on Cancer has been defaulted in your software.

ABSTRACTED BY

Record the initials of the individual completing the abstract.

Special Instructions

1. Registry Hospitals**:** Record the initials or assigned code of the individual who abstracted this record. Do not code the data entry person **unless** that person is also the abstractor.

2. Abstract Plus: Initials have been defaulted to the person logged into the software.

GUIDELINES FOR REPORTING TEXT

Text Requirements

The PCR requires all records to include text information to support specified fields. Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. Text is used to validate data items, verify potential errors identified through standard edits, document clarifications, determine multiple primaries, and reconcile data item discrepancies when the same patient is submitted by several facilities.

The text fields must contain descriptions entered by the abstractor independently from code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. Cancer abstracting software must include specific fields designed to document text as defined by NAACCR fields. These fields must be transmitted to the PCR in addition to the other required data items when electronic shipments are prepared.

Completion of Text Fields

Text should be complete but concise. The text fields must summarize all cancer information recorded in the medical record. Text must be completed for primary site, laterality, histology, grade, and collaborative stage or summary stage on every record. Text should be completed for pathology and other diagnostic and treatment text fields as appropriate for studies performed and treatment provided. If information is missing from the record, state that it is missing. The text fields should be used to document information that will support the accuracy of data so anyone reviewing the abstract will be able to justify the coded information.

Amount of Text

Quality of text is more important than amount or quantity of text. The most useful text is brief, concise, and addresses pertinent issues. Often it is necessary to use abbreviations to provide adequate descriptions within the limited size of the text fields. Use standard medical abbreviations whenever possible. Refer to *Appendix L* for a list of PCR acceptable abbreviations. Include dates (month, day, and year) when appropriate.

Note the maximum field lengths for each text field. These lengths indicate how many characters will be transmitted to the PCR. Do not include irrelevant information. Do not repeat information from other text fields.

TEXT-DX PROC-PE

Maximum Field Length - 1000 characters

Record text information from the history/physical examination that supports the diagnosis and history of the tumor as applicable.

Source Records

The history/physical examination findings may be found in, but are not limited to, the following source records:

- History and Physical Report
- Consultation Reports
- Progress Notes

Suggestions for Text

- Date of physical exam.
- Age, sex, race/ethnicity.
- History that relates to cancer diagnosis.
- Primary site.
- Histology (if diagnosis prior to this admission).
- Tumor location.
- Tumor size.
- Palpable lymph nodes.
- Record positive and negative clinical findings. Record positive results first.
- Treatment plan.

Examples:

1. 5 cm mass palpated in UOQ rt breast
2. Abdominal pain, constipation
3. Enlarged lymph node in neck, fatigue
4. 35-year-old white male with unexplained 30 lb. weight loss.

TEXT-DX PROC-X-RAY/SCAN

Maximum Field Length - 1000 characters

Record text information from diagnostic imaging reports as applicable. Document both positive and negative findings and the date(s) of the imaging result(s).

Source Records

The diagnostic imaging findings may be found in, but are not limited to, the following source records:

- All Diagnostic X-ray reports including mammograms and CT scans
- History and Physical Report
- Consultation Reports
- Discharge Summary

Suggestions for Text

- Date(s) of X-ray/Scan(s).
- Primary site.
- Histology (if given).
- Tumor location.
- Tumor size.
- Lymph nodes.
- Record positive and negative clinical findings. Record positive results first.
- Distant disease or metastasis.

Examples:

1. 01/15/2018 mammo-2 cm mass in UOQ rt breast; 01/16/2018 normal CXR;
2. 01/15/2018 CT-abd-large mass in sigmoid colon with possible extension into pericolic fat; 01/16/2018 negative bone scan;
3. 01/15/2018 CT-abd-diffuse adenopathy involving retroperitoneal, periaortic, and inguinal LN;
4. 1/15/2018 MRI glioblastoma multiforme, WHO grade. III

TEXT-DX PROC-SCOPES

Maximum Field Length - 1000 characters

Record text information from endoscopic examinations as applicable. Document both positive and negative findings and the date(s) of the scope(s).

Source Records

The endoscopic examination findings may be found in, but are not limited to, the following source records:

- Endoscopy Reports (i.e., Bronchoscopy, Colonoscopy, Laryngoscopy, Esophagoscopy)
- History and Physical Report
- Discharge Summary
- Consultation Reports

Suggestions for Text

- Date(s) of endoscopic exam(s).
- Primary site.
- Histology (if given).
- Tumor location.
- Tumor size.
- Lymph nodes.
- Record positive and negative clinical findings. Record positive results first.

Examples:

1. Sigmoidoscopy 2/15/2018-Extrinsic compression of sigmoid most likely secondary to mass
2. Sigmoidoscopy 2/15/2018-Ulcerated lesion in rectosigmoid with invasion through serosa
3. EGD 2/1/2018-5 cm constricting mass in lower esophagus with metastasis to the cervical lymph nodes

TEXT-DX PROC-LAB TESTS

Maximum Field Length - 1000 characters

Record information from laboratory tests or marker studies other than cytology/histopathology that are clinically diagnostic of cancer as applicable. Document pertinent positive and negative findings with the date(s) of these test(s).

Source Records

The laboratory examination findings may be found in, but are not limited to, the following source records:

- Laboratory Reports
- History and Physical Reports
- Consultation Reports

Suggestions for Text

- Type of laboratory test/tissue specimen(s).
- Record both positive and negative findings. Record positive test results first.
- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Date(s) of laboratory test(s).
- Tumor markers included, but are not limited to:
  - Breast Cancer: Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu.
  - Prostate Cancer: Prostatic Specific Antigen (PSA).
  - Testicular Cancer: Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH).
  - Polycythemia Vera- JAK2

Examples:

1. 1/15/2018 ER/PR studies positive
2. 1/15/2018 CEA = 10.4
3. 2/01/2018 Elevated WBC

TEXT-DX PROC-OP

Maximum Field Length - 1000 characters

Record text information from operative reports that support the diagnosis as applicable. Document both positive and negative findings and the date(s) of the procedure(s).

Source Records

The operative findings may be found in, but are not limited to, the following source records:

- Operative Reports
- Consultation Reports

Suggestions for Text

- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived.
- Number of lymph nodes removed.
- Size of tumor removed.
- Documentation of residual tumor.
- Evidence of invasion of surrounding areas.

Examples:

1. MRM 2/1/2018-Firm 3 cm mass excised from rt UOQ
2. Hemicolectomy 2/15/2018-No metastatic nodules noted in liver
3. Exp Lap 2/1/2018-Tumor arising from ileum and enlarged spleen consistent with lymphoma
4. Mastectomy 2/22/2018- 3 out of 12 lymph nodes found to have metastasis

TEXT-DX PROC-PATH

Maximum Field Length-1000 characters

Record text from cytology and histopathology reports to support the final pathologic diagnosis. Include all descriptive terms from the histology or cytology **final diagnosis** to describe the specific diagnosis including nouns, adjectives, and phrases. Also include documentation to support unusual site/histology combinations, notes, comments, addenda, and results of consults and second opinions.

Either *Text-Histology Title* or *Text-Dx Proc-Path* must be completed on each record. Information to support the exact diagnosis has to appear in one of these two fields. *Text-Histology Title* is a 100-character field generally used to record clinical or other non-pathologic diagnoses; *Text-Dx Proc-Path* is a 1000-character field generally used to record histologically and cytologically confirmed diagnoses from pathology reports.

This field should also include text to support multiple primaries diagnosed simultaneously and discrepancies between pathology reports. For example, if a definitive surgery pathology report has a more specific or differing diagnosis than the biopsy report, document the physician's final diagnosis. Include text to clarify site and/or histology information for cases discussed at Cancer Conference, especially if the site was unknown.

Terminology

If the reporting facility considers the terminology of severe dysplasia or high-grade dysplasia of the colon as synonymous with carcinoma in-situ, follow the procedure described in *PCR Manual Part Three, Behavior*. Include text in this field to support the final pathologic diagnosis along with the statement "in-situ per pathologist". If any colon cases diagnosed with severe dysplasia and/or high-grade dysplasia are submitted to the PCR without the text documentation "in-situ per pathologist", the cases will be deleted since the terminology alone is not reportable.

Mixed or multiple histologies may have documentation of various phrases describing the tumor. When documenting the description of the tissue, include the terminology type in the description. These terms are important because they impact the ICD-O code assignment.

Source Records

The pathology findings may be found in, but are not limited to, the following source records:

- Pathology and Cytology Reports, Autopsy Reports
- Slide Consultation Reports

Suggestions for Text

- Date(s) of procedure(s).
- Type of tissue specimen(s).
- Tumor type and grade (include all modifying adjectives (i.e., predominantly, with features of, with foci of, elements of, etc.).
- Gross tumor size.
- Extent of tumor spread.
- Involvement of resected margins.
- Number of lymph nodes involved and examined.
- Record both positive and negative findings. Record positive test results first.
- Note if pathology report is a slide review or a second opinion from an outside source (i.e., AFIP, Mayo, etc.).

Examples:

1. Poorly diff infiltrating duct and tubular carcinoma
2. Thyroidectomy specimen yields 8mm mass in RUL
3. Stains positive for mucin producing adenocarcinoma
4. Transitional cell Ca with foci of squamous differentiation
5. Negative bone marrow
6. Tumor directly extends into the trachea
7. 2 out of 10 peribronchial lymph nodes examined are positive on biopsy
8. Positive brain metastasis
9. Meningioma, WHO grade I

TEXT-PRIMARY SITE TITLE

Maximum Field Length - 100 characters

Record text describing the primary site including subsite information. Always document laterality when the site is paired.

Text-Primary Site Title must be completed on each record.

Source Records

The primary site and laterality may be found in, but are not limited to, the following source records:

- Pathology Report
- Operative Report
- X-rays/Scans
- Discharge Summary
- Consultation Reports

Suggestions for Text

- Include information on the location of the primary site of the tumor.
- Include available information on tumor laterality.

Examples:

1. Rt breast, UOQ
2. Sigmoid Colon
3. Cervical and Inguinal LNs
4. R Frontal Lobe of Brain

TEXT-HISTOLOGY TITLE

Maximum Field Length - 100 characters

Record text to support the patient's final diagnosis: clinical, other non-pathologic diagnosis, or histologic diagnosis including cell type, behavior, and grade.

Either *Text-Histology Title* or *Text-Dx Proc-Path* must be completed on each record.

Information to support the exact diagnosis has to appear in one of these two fields. *Text-Histology Title* is a 100-character field generally used to record clinical or other non-pathologic diagnoses; *Text-Dx Proc-Path* is a 1000 character field generally used to record histologically and cytologically confirmed diagnoses from pathology reports.

Source Records

The histologic diagnosis may be found in, but is not limited to, the following source records:

- Pathology and Cytology Reports
- History and Physical Report
- Discharge Summary
- Consultation Reports
- Slide Consultation Reports

Suggestions for Text

- Information on histologic type and behavior.
- Information on differentiation from scoring systems such as Gleason's Score, Bloom-Richardson, Grade, etc.

Examples:

1. Ductal Ca w/ lobular features, well diff
2. Moderately to poorly diff Adenoca
3. Diffuse large B-cell lymphoma
4. Cancer

TEXT-STAGING

Maximum Field Length - 1000 characters

Record text to support required staging items not already supported in other text fields (see *Part Three, Data Item Instructions, Stage at Diagnosis*).

Document the extension of the disease that justifies stage based on imaging studies, lab tests, scopes, and operative procedures performed. Also include both positive and negative findings and appropriate dates not already recorded in other *Text-DX* fields.

Sources Records

Information to determine Collaborative Stage data items and Summary Stage may be found in, but is not limited to, the following reports:

- Pathology Reports
- Operative procedures
- X-Rays/Scans
- Scopes
- Lab Tests
- Discharge Summary
- Consultations

Suggestions for Text

- Date(s) of procedure(s), including clinical procedures that provided information for assigning stage.
- Organs involved by direct extension.
- Size of tumor.
- Status of margins.
- Number and sites of positive lymph nodes.
- Site(s) of distant metastasis.
- Physician's comments.

Example:

Work up and initial treatment for prostate primary included lung scan, bone scan, and CT/Pelvis. Based on these procedures, the Summary Stage is determined to be *Distant,* code 7. Document the following in the appropriate text fields:

Text-Dx Proc-X-ray/Scan: Bone Scan 1/15/2018-mets to pelvis; Lung scan 1/20/2018 no evidence of metastatic disease; CT/Pelvis-1/15/2018-positive iliac adenopathy

Text-Staging: Pelvic bone mets

RX TEXT-SURGERY

Maximum Field Length - 1000 characters

Record all surgical procedures, including dates, performed as first course of treatment as applicable. Surgical procedures used to treat regional lymph nodes and other regional and/or distant sites as first course of treatment should be documented. If applicable, text should also be included to describe the number of regional lymph nodes examined as part of the first course of treatment.

Source Records

The surgical procedure information may be found in, but is not limited to, the following source records:

- Operative Reports
- Discharge Summary
- Consultation Reports
- History and Physical Report

Suggestions for Text

- Date of each procedure
- Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites
- Lymph nodes removed
- Regional tissues removed
- Metastatic sites
- Facility where each procedure was performed
- Record positive and negative findings; record positive findings first
- Reason surgery to primary site not performed

Examples:

1. 01/15/2010 Rt lumpectomy; 1/25/01 Rt MRM with LND (10 LN removed)
2. 01/15/2010 Rt hemicolectomy with LND (12 LN removed) & wedge resection of liver
3. 01/15/2010 Excision of cervical LN

RX TEXT-RADIATION (BEAM)

Maximum Field Length - 1000 characters

Record all beam radiation, including dates, given as first course of treatment as applicable.

Source Records

The radiation information may be found in, but is not limited to, the following source records:

- Radiation Records or treatment letters
- Discharge Summary
- Consultation Reports

Suggestions for Text

- Date when radiation treatment began
- Where treatment was given (e.g., at this facility, at another facility)
- Type(s) of beam radiation (e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities)
- Other treatment information (e.g., patient discontinued after five treatments; unknown if radiation was given)
- Reason no radiation therapy was administered

Examples:

1. Began 01/15/2010, 6000 cGy, 30fx
2. Radiation planned, patient refused
3. None

RX TEXT-RADIATION OTHER

Maximum Field Length - 1000 characters

Record all other radiation, including dates, given as first course of treatment as applicable.

Source Records

The other radiation treatment may be found in, but is not limited to, the following source records:

- Radiation logbooks or treatment letters
- Discharge Summary
- Consultation Reports

Suggestions for Text

- Date treatment was started
- Where treatment was given (e.g., at this facility, at another facility)
- Type(s) of nonbeam radiation (e.g., High Dose rate brachytherapy, seed implant, Radioisotopes [I-131])
- Other treatment information (e.g., unknown if radiation was given)
- Reason no radiation therapy was administered

Examples:

1. None
2. 01/15/2010 Brachytherapy
3. 01/15/2010 Iodine-131 at Cancer Radiation Center

RX TEXT-CHEMO

Maximum Field Length - 1000 characters

Record all chemotherapy, including dates, administered as first course of treatment as applicable.

Source Records

The chemotherapy treatment information may be found in, but is not limited to, the following source records:

- Chemotherapy logbooks or treatment letters
- Discharge Summary
- Consultation Reports
- History and Physical Report

Suggestions for Text

- Date when chemotherapy began
- Where treatment was given (e.g., at this facility, at another facility)
- Type of chemotherapy (e.g., name of agent(s) or protocol)
- Other treatment information (e.g., treatment cycle incomplete, unknown if chemotherapy was given)

Examples:

1. 01/15/2010 Cisplatin & VP16 started, failed after 3 mths; Carboplatin & Taxol started
2. 01/15/2010 5 FU started
3. 01/15/2010 CHOP started at Cancer Treatment Center.

RX TEXT-HORMONE

Maximum Field Length - 1000 characters

Record all hormone therapy, including dates, administered as first course of treatment as applicable.

Source Records

The hormone therapy information may be found in, but is not limited to, the following source records:

- Discharge Summary
- Consultation Reports
- History and Physical Report

Suggestions for Text

- Date treatment was started
- Where treatment was given (e.g., at this facility, at another facility)
- Type of hormone or antihormone (e.g., Tamoxifen)
- Type of endocrine surgery or radiation (e.g., orchiectomy)
- Other treatment information (e.g., treatment cycle incomplete; unknown if hormones were given)

Examples:

1. 01/15/2010 Tamoxifen prescription given to pt; unknown if filled
2. 01/15/2010 Prednisone started as part of CHOP regimen

RX TEXT-BRM

Maximum Field Length-1000 characters

Record biological-response modifier treatment, including dates, administered as first course of therapy for cancer as applicable. This is also referred to as immunotherapy.

Source Records

The biological-response modifier treatment information may be found in, but is not limited to, the following source records:

- Discharge Summary
- Consultation Reports
- History and Physical Report

Suggestions for Text

- When treatment was given (e.g., at this facility; at another facility)
- Type of BRM agent (e.g., Interferon, BCG)
- BRM procedures (e.g., bone marrow transplant, stem cell transplant)
- Other treatment information (e.g., treatment cycle incomplete; unknown if BRM was given)

Examples:

1. 01/15/2010 Levamisole started
2. 01/15/2010 Stem cell transplant done at University Hospital.
3. 01/15/2010 Interferon started

RX TEXT-OTHER

Maximum Field Length-1000 characters

Record all other treatment, including dates, performed as first course of treatment as applicable.

Source Records

Other treatment may be found in, but is not limited to, the following source records:

- Discharge Summary
- Consultation Reports
- History and Physical Reports

Suggestions for Text

- Date treatment was started
- Where treatment was given (e.g., at this facility, at another facility)
- Type of other treatment (e.g., blinded clinical trial, hyperthermia)
- Other treatment information (e.g., treatment cycle incomplete; unknown if other treatment was given)

Examples:

1. 01/15/2010 hyperbaric oxygen started at General Hospital
2. 01/15/2010 PUVA
3. None

TEXT-REMARKS

Maximum Field Length-1000 characters

Record text information not elsewhere provided for or as an overflow from other text fields. The following information should be included in this field as applicable to the case:

- Document the site, laterality if applicable, histology, and date of diagnosis for all known previous primaries.
- Document text to explain any unusual or potentially questionable entry on the abstract. This will reduce the need to re-pull medical records at a later date.
- Document text to note particular issues or clarifications that were resolved prior to completion of the abstract. For example, clarifications made with a physician through quality assurance studies.

Source Records

Information for this field may be found in, but is not limited to, the following source records:

- History and Physical Report
- Pathology Reports
- Discharge Summary
- Consultation Reports
- Cancer Conference Documentation

Suggestions for Text

- Personal history of cancer.
- Comorbidities.
- Information on sequence numbers if a person was diagnosed with another cancer out-of-state or before the registry's reference date.
- Justification for unusual site/histology combinations.

Examples:

1. Simultaneous tumors: mucinous adenoca of sigmoid invading pericolic fat, 2/15 + LN and adenoca of cecum with lamina propria invasion.
2. Primary site determined at Cancer Conference upon review of clinical presentation and diagnostic evaluation.
3. Hx of thyroid cancer diagnosed in 1992 in New York.
4. Hx of benign meningioma 2003.

TEXT-PLACE OF DIAGNOSIS

Maximum Field Length-60 characters

Record text to indicate the facility, city, state or country where the diagnosis was made. This data item is required only when the patient was not diagnosed at the reporting facility.

Source Records

Information for this field may be found in, but is not limited to, the following source records:

- Admission record
- History and Physical Report
- Consultation Reports

Suggestions for Text

- Record the complete name of the hospital or the physician office where the diagnosis occurred. The initials of the hospital are not adequate.
- For out-of-state residents and facilities, include the city and state where the medical facility is located.

Examples:

1. University General Hospital, Anytown, NJ
2. Medical Center of London, England

PART FOUR

Quality Control

QUALITY CONTROL

The purpose of cancer data collection varies with the type and goals of the registry. The primary goal of hospital-based cancer registries is the improvement of patient care, and the primary goal of non-registry hospitals is to provide data to the central cancer registry. The primary objective of the central or population-based incidence registries is the determination of cancer rates and trends in the population. Whether data are reported to the Pennsylvania Cancer Registry (PCR) or reported by the PCR, there is a universal need for the data collected in any type of registry to be of the highest quality.

Quality can be defined as fitness for use. To assure data are of sufficient quality for use in meeting registry goals, quality control must be an integral component of the data collection system. Quality control involves the systematic execution of a carefully planned set of activities to monitor data quality and take appropriate action to positively affect future quality.

Activities and procedures to assure data quality should focus on three areas: completeness, accuracy and timeliness. Completeness refers to both case ascertainment and data collection. Accuracy refers to how well the abstracted data reflect the patient's diagnosis and treatment. Timeliness measures how the abstracting and reporting process are accomplished according to an expected schedule.

Evaluation of completeness, accuracy, and timeliness is the first step in quality control. To be effective, the registry's quality control plan must also involve a continuous loop of monitoring, communication, and feedback.

The following two sections describe various strategies used by reporting facilities and the PCR to assure data are as complete, accurate and timely as possible. The activities described for reporting facilities will enhance compliance to PCR reporting standards. Since communication and feedback are essential to the success of any quality control program, the major quality control procedures used by the PCR are described in order for hospital contacts to more fully understand the rationale for PCR requirements as well as verbal and written requests and questions made by the PCR.

QUALITY CONTROL: REPORTING FACILITIES

Reporting facilities must ensure cancer data collected and submitted to the PCR are complete, accurate, and timely. Although some facilities may incorporate additional activities to assure quality, at a minimum, all facilities must include the following procedures to meet PCR reporting requirements and standards.

Completeness

1. Casefinding Sources**:** All areas where cancer patients are diagnosed or treated must be included in the casefinding system. This includes outpatient treatment areas, e.g., Radiation Therapy, Chemotherapy, Same Day Surgery Units, and Emergency Room. Review of pathology reports including private outpatient specimens and autopsy reports should also be included in casefinding.

2. Disease Index: View of a Disease Index should be performed to verify all reportable cases are submitted to the PCR. If performed monthly, this review will simplify the annual reconciliation procedure (See *Part Four, Quality Control: PCR*) and aid in timeliness of reporting.

3. Required Fields: All data items required by the PCR must be submitted for each record. For a listing of these items, refer to *Appendix F.* Entries for each required data item must include specific demographic, diagnostic and treatment information that accurately reflects what is documented in the health record.

Accuracy

1. Text Fields**:** The *Required Data Set for Reporting Facilities* includes text fields (See *Appendix F*). The reason for requiring text is to enhance data accuracy. These fields give hospitals the ability to convey information to validate data items, document clarifications, reconcile data item discrepancies, support unusual site/histology combinations, provide history of previous cancers/reportable tumors, and explain any unusual or potentially questionable entry on the abstract. Required text information must be recorded in the designated text fields. (See also *Part Three, Data Item Instructions, Guidelines for Reporting Text).*

2. Computer Edits**:** Computer edits should be an integral component of any electronic abstracting system. These edits should check for completion of all required fields, allowable values and ranges, and inter-field consistency. Edit checks should be performed on each completed abstract. Abstracts should be re-edited if any changes are made.

3. Abstract Plus includes the PCR required edits. A copy of the PCR edits is also provided to commercial cancer registry software vendors. All cases submitted to the PCR should be error free.

4. Visual Editing: The completed abstract should be visually reviewed to identify errors not detectable by the computer. Inconsistencies among data items could be identified when comparing text to coded items, e.g., stage coded to local with text indicating lymph node involvement.

5. Physician Input: Physicians should serve as resources to the abstractor. They should be consulted when questions arise during abstracting. Physician input may assist in identifying a primary site or provide clarification of conflicting statements or reports in the health record. Documentation of the physician input should be included in the text to support abstracted data.

Timeliness

1. 180 Days: 90% of the records must be received by the PCR within 180 days from *Date of Inpatient Discharge* if an inpatient, *or, Date of 1st Contact* if an outpatient.

2. PCR Deadline: The first working day in July is the deadline for submitting all reportable cases seen at the reporting facility during the previous year.

3. PCR Reporting Schedule: This schedule should be followed to assure abstracts are received by the PCR within the required 180 days.

Cases with a Date of Inpatient Discharge/ Date of 1st Contact in:	**Upload 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 cases with a Date of Inpatient Discharge/Date of 1st Contact on or between January 1 and January 31, 2017 must be uploaded by June 15, 2017.

Example 2: All cases with a Date of Inpatient Discharge/Date of 1st Contact on or between December 1 and December 31, 2017 must be uploaded by May 15, 2018.

**The PCR deadline has not changed. The six weeks between May 15th and July 1st should be used to perform Quality Assurance procedures to ensure all cases for the year have been identified and reported. These cases may fall into the 10% over 180 days. This is expected and acceptable.

Note: **This schedule should be used by reporting facilities as a guideline to assess timeliness of reporting but will not be used by the PCR to determine exact timeliness rates for reporting facilities. Reports provided by the PCR will show specific timeliness rates based on the number of days from *Date of Inpatient Discharge* or *Date of 1st Contact* and the date the abstract was received by the PCR.**

4. Incomplete and Suspense Cases**:** At a registry hospital, after identifying a potential case for the registry from a casefinding source, cases unable to be completely abstracted may be placed in an electronic suspense file. At a non-registry hospital using Abstract Plus software, incomplete abstracts may be saved as incomplete creating an electronic suspense file. A system should be in place to monitor these cases so they are completed and reported in a timely manner. A case will not export out of Abstract Plus if it is incomplete.

Note: **Incomplete/suspense cases should not be submitted to the PCR.**

5. Method to Assure Timeliness**:** Review the Disease Index monthly using the reporting schedule as a guide to verify all reportable cases have been submitted within the 180-day timeframe.

QUALITY CONTROL: PCR

Quality control activities are conducted by the PCR to assure data in the central registry are complete, accurate, and timely. These activities fall into three categories: 1) internal procedures as data are processed, 2) on-site quality assessment reviews, and 3) trainings conducted by PCR staff or in conjunction with other organizations. These three major aspects of the PCR quality control program are described below.

Internal Quality Control Procedures

The quality control procedures described below are performed by the PCR routinely to enhance the quality of cancer data in the central cancer registry.

1. Completeness
   a. PCR Reporting Sources: The PCR establishes reporting from sources required to report and reporting through state data exchange agreements to assure all reportable cases are received. The PCR reporting sources (See *Part One, Reporting Requirements, PCR Reporting Sources)* include the following:

      - Acute Care Hospitals
      - Laboratories
      - Non-Hospital Sources
      - States with Data Exchange Agreements

   b. Non-Reporting: All hospitals are required to submit on the 15th of every month or the last working day before the 15th if the 15th falls on a weekend or holiday. A listing of hospitals that have not submitted for two consecutive months is generated monthly at the PCR. A PCR Field Representative contacts hospital appearing on this list and appropriate action is taken.

   c. Reconciliation: An annual comparison is made of each hospital's Disease Index with the PCR database to assure all cases have been reported. Each hospital receives a listing of cases identified as not being reported to the PCR with instructions to review each record to determine if the case is reportable. Cases missed, but now identified, must be reported. Cases that are not reportable must have justification documented on the listing explaining why the case is not reportable. Missed cases and listings must be returned to the PCR by a specified deadline.

   d. Death Clearance: The PCR conducts a Death Clearance procedure annually. This process involves identifying Pennsylvania Death Certificates with a reportable cause of death and matching them to the PCR files. Non-matched death certificates are potentially missed cases. Hospital contacts receive a listing of non-matched patients who expired at their hospital to determine if they were reportable. Missed cases must be reported. Cases that were not reportable must have justification documented on the listing. Missed cases and listings must be returned to the PCR by a specified deadline.

At the conclusion of this process, the remaining non-matched cases are reviewed and may be abstracted at the PCR from the death certificates and defined as Death Certificate Only (DCO) cases. A DCO percentage (the number of DCO cases divided by the total number of incidence cases for that year) is computed. The PCR DCO percentage is measured against the North American Association of Central Cancer Registries (NAACCR) DCO standard, which states a registry should have fewer than 5% DCOs in a given year.

2. Accuracy
   a. Computer Edits: Computer edits are performed on 100% of abstracts and consolidated records. The PCR utilizes a combination of NAACCR, SEER, and COC edits from the NAACCR metafile with PCR-developed edits added. These edits check for completion of all required fields, allowable ranges, allowable values, and inter-field consistency. They check for invalid entries such as impossible site/histology combinations or flag unusual entries for review. PCR Field Representatives follow-up with hospital contacts and provide feedback on errors found.

   b. Visual Editing: Records are reviewed for consistency between coded data items and text documentation. This type of review is performed to discover discrepancies not detectable by the computer. PCR Field Representatives provide hospital contacts with feedback on these reviews.

   c. Electronic Reporting Approvals: An approval process is required for new contacts, hospital software changes, and updated NAACCR formats. Hospital shipments are monitored, and PCR Field Representatives provide feedback to hospital contacts until acceptable accuracy is achieved. PCR Field Representatives can provide assistance with onboarding procedures.

      The steps required for approval of electronic reporting are as follows:

      i. Trial Shipment: After all electronic reporting specifications have been met and records have been abstracted into the software, a trial shipment shall be prepared and submitted to the PCR for evaluation. The following must be included in the trial shipment:

         a. Electronic File: The electronic file must be uploaded and contain 10-20 actual records not previously submitted to the PCR.
         b. Paper Abstracts: An abstract from your software must be printed for each record on the trial shipment. All PCR required data items including text to support diagnostic findings, primary site, laterality, histology, behavior, grade, summary stage, and treatment must be printed on each abstract.
         c. Copies of Supportive Documentation: Copies of supportive documentation from the medical record including pathology report, discharge summary, operative report, consultations, progress notes, radiology reports, and admission record must be included for each record on the electronic file. Paper documentation is used to verify the accuracy of required data fields reported in the electronic record.

ii. Evaluation: The trial shipment is evaluated by the PCR for compliance to electronic reporting specifications, format, data quality, and completion of text fields. Hospitals may continue to abstract cases into their software system while the PCR is reviewing the trial shipment; however, no additional cases shall be submitted to the PCR until feedback is received on the current trial shipment.

iii. Feedback: The PCR Field Representative will provide written feedback to the hospital contact to convey the results of the review. Errors and/or data items needing clarification will be identified and must be corrected or addressed in the trial shipment and for cases completed while the trial shipment was being reviewed. Additional trial shipments may be requested to resolve problems identified during evaluation(s).

iv. Approval: When all aspects of the evaluation are acceptable, written approval for electronic reporting will be sent to the hospital contact. Approved hospitals do not have to send paper abstracts and supporting paper documentation with electronic files.

d. Unknown Values: The frequency of "*unknown"* or code for unknown in data items, such as age at diagnosis, sex, race, state, and county is monitored and follow-up is performed to eliminate as many unknowns as possible.

e. Resolution of Duplicates: To assure accuracy of incidence statistics, an incidence file containing all cases for a specified time period is created and a report is generated listing all cases alphabetically by last name. Cases with the same name are identified. Those determined to be the same person are then reviewed manually to determine whether they represent multiple primaries or duplications. While cases determined to be duplicates are deleted from the file, source records are retained and attached to the appropriate tumor in the PCR database.

3. Timeliness
   a. PCR Timeliness Standard: At least 90% of the records must be received by the PCR within 180 days from *Date of Inpatient Discharge* if an inpatient or *Date of 1st Contact* if an outpatient.

   b. Closeout Deadline: The first working in July is the deadline for submitting all reportable cases diagnosed/treated in the prior year.

   c. Closeout Notification: Hospitals are notified annually of the closeout deadline and requested to notify the PCR when they anticipate closing out. Failure to meet the July deadline results in referral of the hospital to the Department of Health, Bureau of Facility Licensure and Certification.

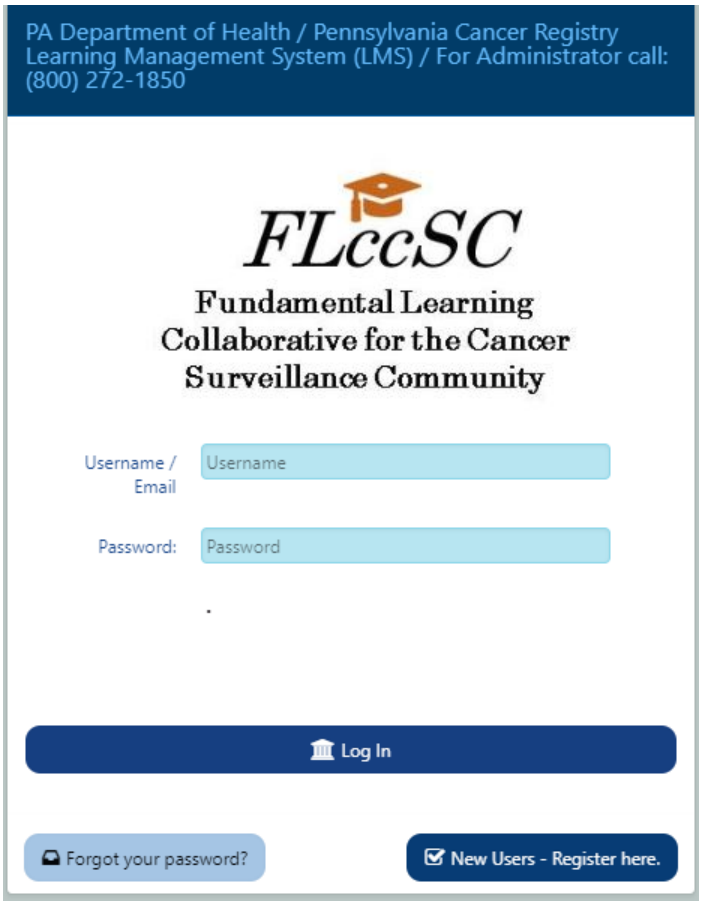
Trainings

Education is an important part of quality control. The PCR offers trainings through *Fundamental Learning Collaborative for Cancer Surveillance Community (FLccSC pronounced Flossy*). FLccSC is a cancer surveillance community educational collaboration. FLccSC is a web-based portal, which allows Central Cancer Registries to customize a fully functioning state-specific Learning Management System (LMS). For more information visit http://flccsc-info.fcdslms.med.miami.edu/

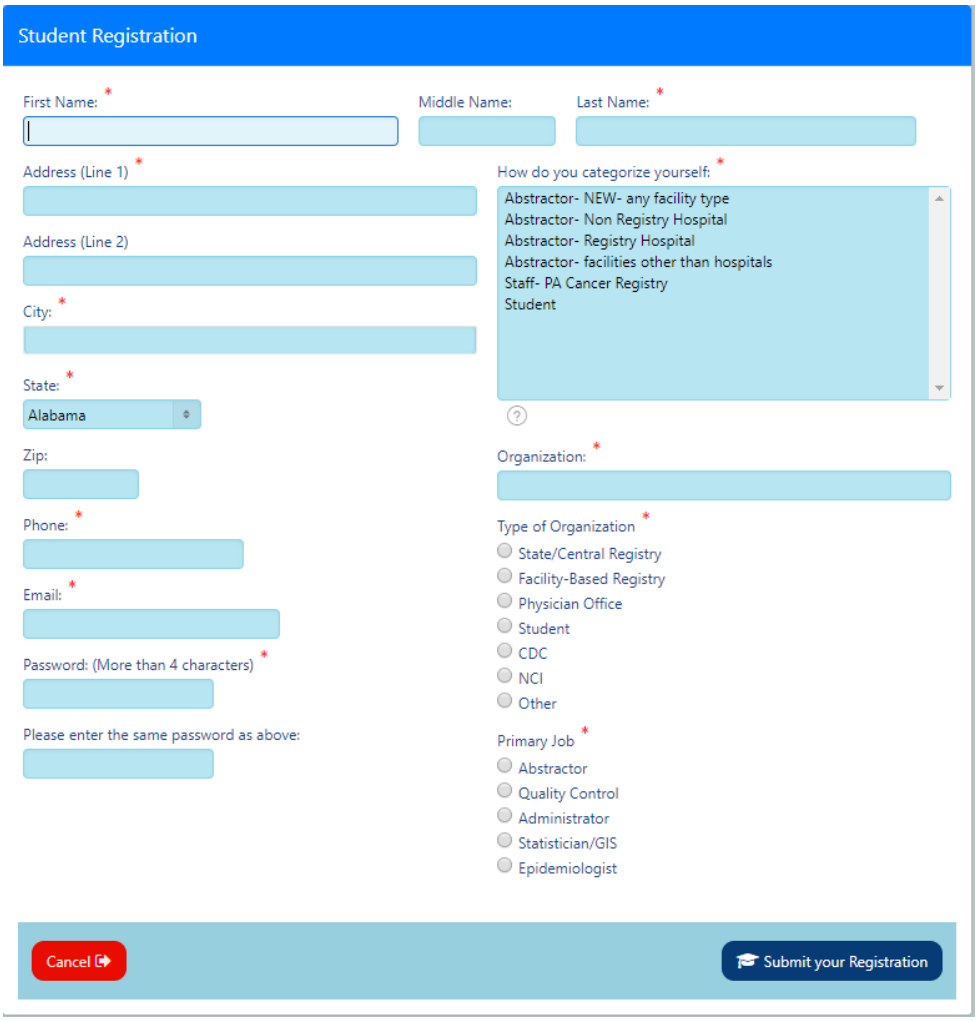
The Pennsylvania Cancer Registry is proud to be in collaboration with FLccSC and share educational materials on its platform. The PCR encourages Pennsylvania state CTRs to register for an account to view up to date training materials, including Webinars for continuing education.

To sign up for a FLccSC membership please visit:
https://pas.fcdslms.med.miami.edu/ords/f?p=105:LOGIN_DESKTOP:1007680470255:::::

Click on the "New Users – Register Here" button on the bottom right of the home screen:

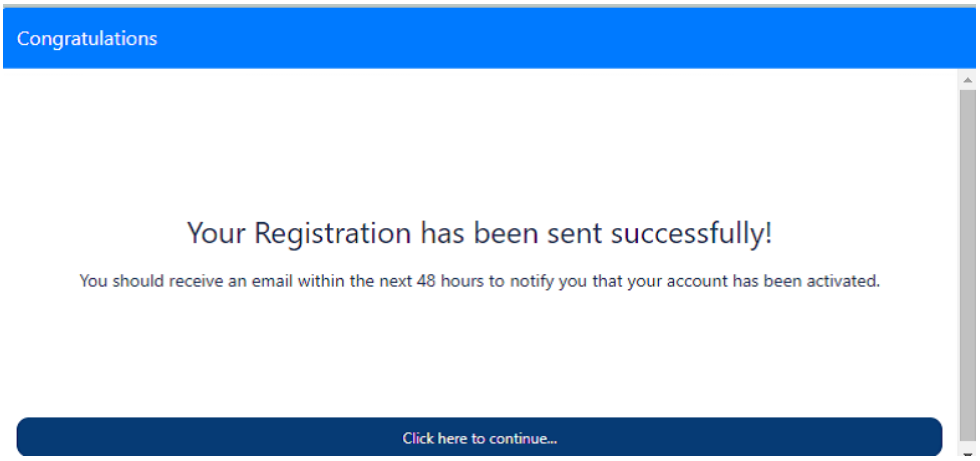


And you'll be redirected to the following page:



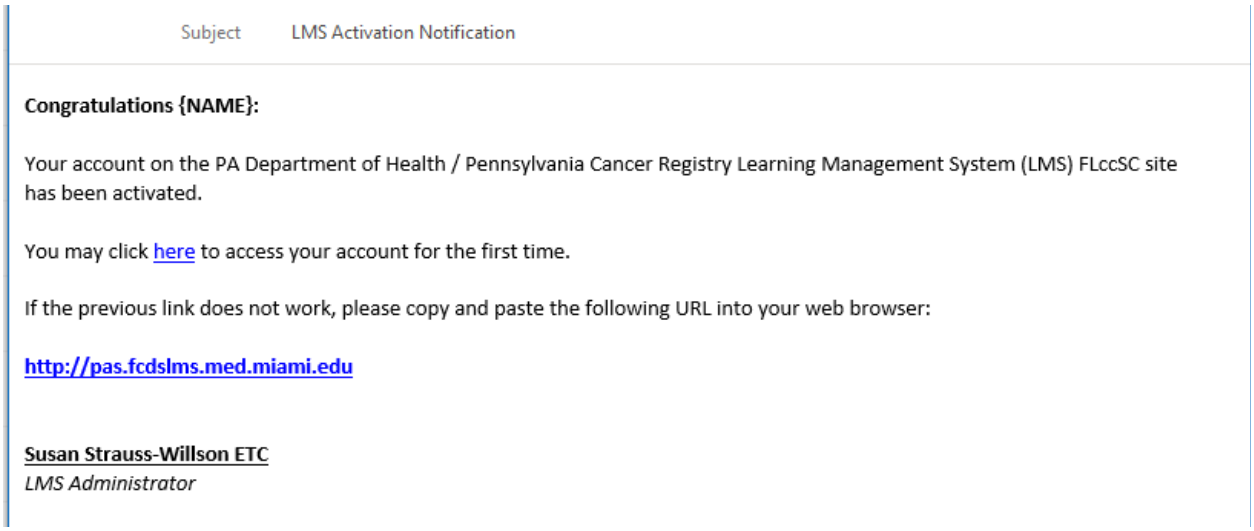
- Password – must be more than 4 characters. It is very important not to forget this password. (The PCR Administrator doesn't have access to this information; so if you forget, you'll have to go through the "Forgot Password" process also on the main log in page.)
- "Please Enter the Same Password As Above"
- "How Do You Categorize Yourself" – this is another extremely important step. How you categorize yourself will determine what courses you can, and can't, register for. Select Staff- PA Cancer Registry
- Organization - fill in PA Cancer Registry
- Type of Organization – select State/Central Registry
- Primary Job – most likely, select Abstractor

Once you've completed filling out all the necessary information, click "Submit your Registration" on the bottom right of the form. Then "Click here to continue" on the message below and the Administrator for you state will be notified of a new registration. They will then be able to Activate or Reject your registration attempt:



Once you've pressed "Click here to continue" you'll be redirected back to the main login page but will not be able to enter the site yet.

Once your registration attempt has been Activated (usually in 48 hours or less), you'll receive a email similar to one below:



Click the hyperlinked word "here" and you'll automatically be redirected back to the PCR FLccSC login page to be able to begin.

Questions about this procedure can be directed to the PCR's Education and Training Coordinator (ETC) at (800) 272-1850.

APPENDIX A

Pennsylvania Cancer Control, Prevention and Research Act (P.L. 1241, No. 224)

Official Advance Copy of Statute Enacted at 1980 Session

No. 1980-224

AN ACT

HB 230

Creating the Pennsylvania Cancer Control, Prevention and Research Advisory Board, providing authorization for the Secretary of Health, upon the recommendation of the Pennsylvania Cancer Control, Prevention and Research Advisory Board, to award grants and contracts for cancer control, prevention and research to associations organized in Pennsylvania and to governmental agencies in Pennsylvania.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short title.

This act shall be known and may be cited as the "Pennsylvania Cancer Control, Prevention and Research Act!'

Section 2. Definitions.

The following words and phrases when used in this act shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Board." The Pennsylvania Cancer Control, Prevention and Research Advisory Board established by this act.

"Cancer". All malignant neoplasms, regardless of the tissue of origin, including malignant lymphoma and leukemia.

"Secretary." The Secretary of Health of the Commonwealth of Pennsylvania.

Section 3. Pennsylvania Cancer Control, Prevention and Research Advisory Board.

1. There is hereby created in the Department of Health the "Pennsylvania Cancer Control, Prevention and Research Advisory Board." The board shall consist of 11 members, all of whom shall be Pennsylvania residents, ten of whom the Governor shall appoint by and with the consent of a majority of the Senate, Of the ten appointed, three shall be distinguished scientists and physicians in the field of cancer, one shall be a qualified professional nurse engaged in the practice of oncological nursing, one shall be skilled in health care administration and two with substantial experience in the field of public health, one of whom shall be a professional nurse engaged in the practice of community health nursing, and three consumer members. The Secretary of Health shall be a member of the board.

2. The terms of the members shall be four years from the respective date of their appointment except that the initial appointments shall be made in such a manner so that four members be appointed for terms of four years, three members be appointed for terms of three years, and three members be appointed for terms of two years.

(c) A chairman shall be appointed by the Governor for a term *of* four years.

(d) The board shall meet no less than four times annually at the call of the chairman or, in his absence or incapacity at the call of the Secretary of Health. Six members of the board shall constitute a quorum for the purpose of exercising all of the powers of the board. A vote of the majority of the members present shall be sufficient for all actions of the board.

(e) Each board member, except the secretary, shall receive actual travelling expenses and other necessary expenses.

(f) No member of the board shall participate in any discussions and decisions to recommend grants or contracts to any qualified association or to any agency of the Commonwealth or its political subdivisions with which the member is associated as a member of the governing body or as an employee, or with which the member has entered into any contractual arrangement.

Section 4. Responsibilities of the board.

(a) The board shall have the power to prescribe, amend and repeal bylaws governing the manner in which the business of the board is conducted.

(b) The board shall advise the secretary with respect to cancer control, prevention and research in Pennsylvania.

(c) The board shall approve each year a program for cancer control, prevention and research to be known as the "Pennsylvania Cancer Plan."

(d) In order to implement in whole or in part the Pennsylvania Cancer Plan, the board shall recommend to the secretary the awarding of grants and contracts to qualified associations or governmental agencies in order to plan, establish or conduct programs in cancer control or prevention, cancer education and training and cancer clinical research.

(e) Grants and contracts may be recommended for:

(1) Cancer registry.
(2) Cancer screening, detection and prevention.
(3) Cancer epidemiology and biostatistica1 studies.
(4) Cancer Community outreach programs.
(5) Cancer rehabilitation,
(6) Communication and planning among cancer institutions.
(7) Cancer education and information.
(8) Cancer training.
(9) Cancer clinical research.

(f) Consistent with the Pennsylvania Cancer Plan the board shall give its first priority to funding grants and contracts relating to subsection (e)(l), (2) and (3); second priority to funding grants and contracts relating to subsection (e)(4), (5) and (6); third priority to funding grants and contracts relating -to subsection (e)(7), (8) and (9).

(g) The following criteria shall be given consideration for recommending grants and contracts for programs:

(1) the relevancy of applicant's proposal to the Pennsylvania Cancer Plan; and

(2) the feasibility of the applicant's proposal.

(h) The board shall recommend to the secretary rules and regulations consistent with law as it may deem necessary for the performance of its duties and the proper administration of this act.

(i) The board shall report annually to the Governor and the General Assembly. The report shall include, but not be limited to, a full description of the grants and contracts funded pursuant to this act, the amount of the grant or contract, an outline of the proposal on which the grant was based, and the results achieved as a result of the grant.

Section 5. Responsibilities of the secretary.

(a) The secretary shall award grants and contracts only from among those recommended by the board to qualified Pennsylvania associations and governmental agencies in order to plan, establish or conduct programs in cancer control and prevention, cancer education and training and cancer research. The secretary may request additional recommendations from the board.

(b) The secretary shall provide such staff, information and other assistance as the secretary may deem necessary for the completion of the board's responsibilities. Such staff shall be responsible to the secretary.

Section 6. Cancer registry.

(a) The Department of Health shall establish a system for the Statewide collection and dissemination of data on cases of cancer by anatomical site, medical and occupational history of patients, stage of disease and other data necessary to effectuate the provisions of this act as determined by the department.

(b) Persons in charge of hospitals and laboratories shall be required by the Department of Health, in accordance with its regulations adopted with the advice of the board to report cases of cancer on forms furnished by the department.

(c) The reports required pursuant to this act shall be confidential and not open to public inspection or dissemination. This shall not restrict the collection and analysis of data by the Department of Health or those with whom the department contracts, subject to strict supervision by the Department of Health to insure that the use of the reports is limited to specific research purposes.

Section 7. Sunset provisions.

With the exception of section 6, this act shall expire on June 30, 1984, unless otherwise extended by an act of the General Assembly.

Section 8. Effective date.

This act shall take effect January 1, 1981.

APPROVED-The 18th day of December, A. D. 1980.

DICK THORNBURGH

PRINTER'S NO. 2130

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1607 Session of 1996

INTRODUCED BY THOMPSON, ROBBINS, PETERSON, ULIANA, DELP, HART, WERNER AND MADIGAN, JUNE 18, 1996

REFERRED TO PUBLIC HEALTH AND WELFARE, JUNE 18, 1996

AN ACT

Amending the act of December 18, 1980 (P.L.1241, No.224), entitled "An act creating the Pennsylvania Cancer Control. Prevention and Research Advisory Board, providing authorization for the of Health, upon the recommendation of the Pennsylvania Cancer, Control, Prevention and Research Advisory Board, to award and contracts for cancer control, prevention and research to associations organized in Pennsylvania and to governmental agencies in Pennsylvania," extending the expiration date.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Section 7 of the act of December 18,1980 (P.L.1241, No.224), known as. the Pennsylvania Cancer Control, Prevention and Research Act, reenacted and amended November 25, 1988 (P.L.1086, No.126) and amended June 30, 1992 (P.L.334, No. 67), is amended to read:

Section 7. Sunset provisions

With exception of section 6, this act shall expire on June 30, [1996] 2006, unless otherwise extended by an act of the General Assembly.

Section 2. This act sha11 take effect immediately.

E29L35JS/19960S1607B2130

APPENDIX B

TITLE 28. HEALTH and SAFETY PART III. PREVENTION of DISEASES CHAPTER 27. COMMUNICABLE and NONCOMMUNICABLE DISEASES

Annex A

TITLE 28. HEALTH AND SAFETY
PART III. PREVENTION OF DISEASES
CHAPTER 27. COMMUNICABLE AND NONCOMMUNICABLE DISEASES

Subchapter A. GENERAL PROVISIONS

§ 27.1. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

ACIP--The Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, United States Department of Health and Human Services.

Caregiver--The entity or individual responsible for the safe and healthful care or education of a child in a child care group setting.

Case--A person or animal that is determined to have or suspected of having a disease, infection or condition.

Case report form--The form designated by the Department for reporting a case or a carrier.

Central office--Department headquarters located in Harrisburg.

Child--A person under 18 years of age.

Child care group setting--The premises in which care is provided at any one time to four or more children, unrelated to the operator.

Clinical laboratory--A laboratory for which a permit has been issued to operate as a clinical laboratory under the Clinical Laboratory Act (35 P. S. §§ 2151--2165).

Communicable disease--An illness which is capable of being spread to a susceptible host through the direct or indirect transmission of an infectious agent or its toxic product by an infected person, animal or arthropod, or through the inanimate environment.

Communicable period--The time during which an etiologic agent may be transferred directly or indirectly from an infected person to another person, or from an infected animal to a person.

Contact--A person or animal known to have had an association with an infected person or animal which presented an opportunity for acquiring the infection.

District office--One of the district headquarters of the Department located within this Commonwealth.

Health care facility--

(i) A chronic disease, or other type of hospital, a home health care agency, a hospice, a long-term care nursing facility, a cancer treatment center using radiation therapy on an ambulatory basis, an ambulatory surgical facility, a birth center, and an inpatient drug and alcohol treatment facility, regardless of whether the health care facility is operated for profit, nonprofit or by an agency of the Commonwealth or local government.

(ii) The term does not include:
a) An office used primarily for the private practice of a health care practitioner.
b) A facility providing treatment solely on the basis of prayer or spiritual means in accordance with the tenets of any church or religious denomination.

c) A facility conducted by a religious organization for the purpose of providing health care services exclusively to clergy or other persons in a religious profession who are members of a religious denomination.

Health care practitioner--An individual who is authorized to practice some component of the healing arts by a license, permit, certificate or registration issued by a Commonwealth licensing agency or board.

Health care provider--An individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies and insurance companies), the Commonwealth, or a political subdivision, or instrumentality (including a municipal corporation or authority) thereof, that operates a health care facility.

Household contact--A person living in the same residence as a case, including a spouse, child, parent, relation or other person, whether or not related to the case.

Infectious agent--Any organism, such as a virus, bacterium, fungus or parasite, that is capable of being communicated by invasion and multiplication in body tissues and capable of causing disease.

Isolation--The separation for the communicable period of an infected person or animal from other persons or animals, in such a manner as to prevent the direct or indirect transmission of the infectious agent from infected persons or animals to other persons or animals who are susceptible or who may spread the disease to others.

LMRO--Local morbidity reporting office--A district office of the Department or a local health department.

Local health authority--A county or municipal department of health, or board of health of a municipality that does not have a department of health. The term includes a sanitary board.

Local health department--Each county department of health under the Local Health Administration Law (16 P. S. §§ 12001--12028), and each department of health in a municipality approved for a Commonwealth grant to provide local health services under section 25 of the Local Health Administration Law (16 P. S. § 12025).

Local health officer--The person appointed by a local health authority to head the daily administration of duties imposed upon or permitted of local health authorities by State laws and regulations.

Medical record--An account compiled by physicians and other health professionals including a patient's medical history; present illness; findings on physical examination; details of treatment; reports of diagnostic tests; findings and conclusions from special examinations; findings and diagnoses of consultants; diagnoses of the responsible physician; notes on treatment, including medication, surgical operations, radiation, and physical therapy; and progress notes by physicians, nurses and other health professionals.

Modified quarantine--A selected, partial limitation of freedom of movement determined on the basis of differences in susceptibility or danger of disease transmission which is designated to meet particular situations. The term includes the exclusion of children from school and the prohibition, or the restriction, of those exposed to a communicable disease from engaging in particular activities.

Monitoring of contacts--The close supervision of persons and animals exposed to a communicable disease without restricting their movement.

Operator--The legal entity that operates a child care group setting or a person designated by the legal entity to serve as the primary staff person at a child care group setting.

Outbreak--An unusual increase in the number of cases of a disease, infection or condition, whether reportable or not as a single case, above the number of cases that a person required to report would expect to see in a particular geographic area or among a subset of persons (defined by a specific demographic or other features).

Physician--An individual licensed to practice medicine or osteopathic medicine within this Commonwealth.
Placarding--The posting on a home or other building of a sign or notice warning of the presence of communicable disease within the structure and the danger of infection there from.

Quarantine--

(i) The limitation of freedom of movement of a person or an animal that has been exposed to a communicable disease, for a period of time equal to the longest usual incubation period of the disease, or until judged noninfectious by a physician, in a manner designed to prevent the direct or indirect transmission of the infectious agent from the infected person or animal to other persons or animals.

(ii) The term does not exclude the movement of a person or animal from one location to another when approved by the Department or a local health authority under § 27.67 (relating to the movement of persons and animals subject to isolation or quarantine by action of a local health authority or the Department).

Reportable disease, infection, or condition--A disease, infection, or condition, made reportable by § 27.2 (relating to specific identified reportable diseases, infections and conditions)

SHC--State Health Center--The official headquarters of the Department in a county, other than a district office.

Segregation--The separation for special control or observation of one or more persons or animals from other persons or animals to facilitate the control of a communicable disease.

Sexually transmitted disease--A disease which, except when transmitted perinatally, is transmitted almost exclusively through sexual contact.

Surveillance of disease--The continuing scrutiny of all aspects of occurrence and spread of disease that are pertinent to effective control.

Volunteer--A person who provides services to a school or child care group setting without receiving remuneration.

§ 27.2. Specific identified reportable diseases, infections and conditions.

The diseases, infections and conditions in Subchapter B (relating to the reporting of diseases, infections and conditions) are reportable to the Department or the appropriate local health authority by the persons or entities in the manner and within the time frames set out in this chapter.

§ 27.3. Reporting outbreaks and unusual diseases, infections and conditions.

a) A person required to report under this chapter shall report an outbreak within 24 hours, and in accordance with § 27.4 (relating to reporting cases)
b) A person required to report under this chapter who suspects a public health emergency, shall report an unusual occurrence of a disease, infection or condition not listed as reportable in Subchapter B (relating to reporting of diseases, infections and conditions) or defined as an outbreak, within 24 hours, and in accordance with § 27.4.
c) Any unusual or group expression of illness which the Department designates as a public health emergency shall be reported within 24 hours, and in accordance with § 27.4.

§ 27.4. Reporting cases.

a) Except for reporting by a clinical laboratory, a case is to be reported to the LMRO serving the area in which a case is diagnosed or identified unless another provision of this chapter directs that a particular type of case is to be reported elsewhere. A clinical laboratory shall make reports to the appropriate office of the Department.

b) Upon the Department's implementation of its electronic disease surveillance system for certain types of case reports, persons who make those reports shall do so electronically using an application and

reporting format provided by the Department. At least 6 months in advance of requiring a type of case report to be reported electronically, the Department will publish a notice in the *Pennsylvania Bulletin* announcing when electronic reporting is to begin.

c) This section does not prohibit a reporter from making an initial report of a case to the Department or an LMRO by telephone. The reporter will be instructed on how to make a complete case report at the time of the telephone call.

d) Department offices to which this chapter requires specified case reports to be filed are as follows:

1) Cancer Registry, Division of Health Statistics, Bureau of Health Statistics and Research.
2) Division of Infectious Disease Epidemiology, Bureau of Epidemiology.
3) HIV/AIDS Epidemiology Section, Division of Infectious Disease Epidemiology, Bureau of Epidemiology
4) Division of Maternal and Child Health, Bureau of Family Health.

e) A case shall be reported using the appropriate case report format. Information solicited by the case report form shall be provided by the reporter, irrespective of whether the report is made by submitting the form directly in hard copy or by telecommunication or electronic submission. An appropriate case report form or format may be procured from the office to which the type of case is reportable.

§ 27.5a. Confidentiality of case reports.

Case reports submitted to the Department or to an LMRO are confidential. Neither the reports, nor any information contained in them which identifies or is perceived by the Department or the LMRO as capable of being used to identify a person named in a report, will be disclosed to any person who is not an authorized employe or agent of the Department or the LMRO, and who has a legitimate purpose to access case information, except for any of the following reasons:

1) When disclosure is necessary to carry out a purpose of the act, as determined by the Department or LMRO, and disclosure would not violate another act or regulation.
2) When disclosure is made for a research purpose for which access to the information has been granted by the Department or an LMRO. Access shall be granted only when disclosure would not violate another act or regulation. The research shall be subject to strict supervision by the LMRO to ensure that the use of information disclosed is limited to the specific research purpose and will not involve the further disclosure of information which identifies or is perceived as being able to be used to identify a person named in a report.

§ 27.6. Disciplinary consequences for violating reporting responsibilities

a) Failure of a clinical laboratory to comply with the reporting provisions of this chapter may result in restrictions being placed upon or revocation of the laboratory's permit to operate as a clinical laboratory, as provided for in the Clinical Laboratory Act (35 P. S. §§ 2151--2165) unless failure to report is due to circumstances beyond the control of the clinical laboratory.
b) Failure of a Department licensed health care facility to comply with the reporting provisions of this chapter may result in restrictions being placed upon or revocation of the health care facility's license, as provided for in the Health Care Facilities Act (35 P. S. §§ 448.101--448.904b)
c) Failure of a health care practitioner to comply with the reporting provisions of this chapter may result in referral of that matter to the appropriate licensure board for disciplinary action.
d) Failure of a child care group setting to comply with the reporting provisions of this chapter may result in referral of that matter to the appropriate licensing agency for appropriate action.

§ 27.7. Cooperation between clinical laboratories and persons who order laboratory tests.

To facilitate the reporting of cases by clinical laboratories, the following is required:

1) When a clinical laboratory is requested to conduct a test which, depending upon the results, would impose a reporting duty upon the clinical laboratory, the clinical laboratory shall provide to the person who orders the testing, a form that solicits all information which is required for

completion of the applicable case report form.

2) A person who orders testing subject to paragraph (1) shall, at the time of ordering the test, provide the clinical laboratory with the information solicited by the form which that person either possesses or may readily obtain.

§27.8. Criminal penalties for violating the act or this chapter.

a) A person who violates any provision of the act or this chapter shall, for each offense, upon conviction thereof in a summary proceeding before a district justice in the county wherein the offense was committed, be sentenced to pay a fine of not less than $25 and not more than $300, together with costs, and in default of payment of the fine and costs, shall be imprisoned in the county jail for a period not to exceed 30 days.

b) A person afflicted with communicable tuberculosis, ordered to be quarantined or isolated in an institution, who leaves without consent of the medical director of the institution, is guilty of a misdemeanor, and upon conviction thereof, shall be sentenced to pay a fine of not less than $100 nor more than $500, or undergo imprisonment for not less than 30 days nor more than 6 months, or both.

c) Prosecutions may be instituted by the Department, by a local health authority, or by any person having knowledge of a violation of the act or this chapter.

Subchapter B. REPORTING OF DISEASES, INFECTIONS AND CONDITIONS GENERAL

§ 27.21. Reporting of AIDS cases by physicians and hospitals.

A physician or a hospital is required to report a case of AIDS within 5 workdays after it is identified to the local health department if the case resides within the jurisdiction of that local health department. In all other cases, the physician or hospital shall report the case to the HIV/AIDS Epidemiology Section, Division of Infectious Disease Epidemiology, Bureau of Epidemiology.

§ 27.21a. Reporting of cases by health care practitioners and health care facilities.

a) Except as set forth in this section or as otherwise set forth in this chapter, a health care practitioner or health care facility is required to report a case of a disease, infection or condition in subsection (b) as specified in § 27.4 (relating to reporting cases), if the health care practitioner or health care facility treats or examines a person who is suffering from, or who the health care practitioner suspects, because of symptoms or the appearance of the individual, of having a reportable disease, infection or condition:

    1) A health care practitioner or health care facility is not required to report a case if that health care practitioner or health care facility has reported the case previously.
    2) A health care practitioner or health care facility is not required to report a case of influenza unless the disease is confirmed by laboratory evidence of the causative agent.
    3) A health care practitioner or health care facility is not required to report a case of chlamydia trachomatis infection unless the disease is confirmed by laboratory evidence of the infectious agent.
    4) A health care practitioner or health care facility is not required to report a case of cancer unless the health care practitioner or health care facility provides screening, therapy or diagnostic services to cancer patients.
    5) Only physicians and hospitals are required to report cases of AIDS.

b) The following diseases, infections and conditions in humans are reportable by health care practitioners and health care facilities within the specified time periods and as otherwise required by

c) this chapter:

1) The following diseases, infections and conditions are reportable within 24 hours after being identified by symptoms, appearance or diagnosis:

Animal bite.
Anthrax.
Arboviruses.
Botulism.
Cholera.
Diphtheria.
Enterohemorrhagic E. coli.
Food poisoning outbreak.
Haemophilus influenzae invasive disease.
Hantavirus pulmonary syndrome.
Hemorrhagic fever.
Lead poisoning.
Legionellosis.
Measles (rubeola).
Meningococcal invasive disease.
Plague.
Poliomyelitis.
Rabies.
Smallpox
Typhoid fever

2) The following diseases, infections and conditions are reportable within 5 work days after being identified by symptoms, appearance or diagnosis:

AIDS
Amebiasis.
Brucellosis.
Campylobacteriosis.
Cancer.
Chancroid.
Chickenpox (varicella)
Chlamydia trachomatis infections.
Creutzfeldt-Jakob Disease.
Cryptosporidiosis.
Encephalitis.
Giardiasis.
Gonococcal infections.
Granuloma inguinale.
Guillain-Barre syndrome.
Hepatitis, viral, acute & chronic cases.
Histoplasmosis.
Influenza.
Leprosy (Hansen's disease).
Leptospirosis.
Listeriosis.
Lyme disease.
Lymphogranuloma venereum.
Malaria.
Maple syrup urine disease (MSUD) in children under 5 years of age.
Meningitis (All types not caused by invasive Haemophilus influenza or Neisseria meningitis).
Mumps.
Pertussis (whooping cough).
Phenylketonuria (PKU) in children under 5 years of age.
Primary congenital hypothyroidism in children under 5 years of age.
Psittacosis (ornithosis).
Rickettsial diseases.
Rubella (German measles) and congenital rubella syndrome.
Salmonellosis.
Shigellosis.
Sickle cell hemoglobinopathies in children under 5 years of age.
Staphylococcus aureus, Vancomycin-resistant (or intermediate) invasive disease.
Streptococcal invasive disease (group A).
Streptococcus pneumoniae, drug-resistant invasive disease.
Syphilis (all stages).
Tetanus.
Toxic shock syndrome.
Toxoplasmosis.
Trichinosis.
Tuberculosis, suspected or confirmed active disease (all sites).
Tularemia.

c) A school nurse shall report to the LMRO any unusual increase in the number of absentees among school children. A caregiver at a child care group setting shall report to the LMRO any unusual increase in the number of absentees among children attending the child care group setting.

d) A health care facility or health care practitioner providing screening, diagnostic or therapeutic services to patients with respect to cancer shall also report cases of cancer as specified in § 27.31 (relating to reporting cases of cancer).

§ 27.22. Reporting of cases by clinical laboratories.

a) A person who is in charge of a clinical laboratory in which a laboratory examination of a specimen derived from a human body yields evidence significant from a public health standpoint of the presence of a disease, infection or condition listed in subsection (b) shall promptly report the findings, no later than the next work day after the close of business on the day on which the examination was completed, except as otherwise noted in this chapter.

b) The diseases, infections and conditions to be reported include the following:

Amebiasis.
Anthrax.
An unusual cluster of isolates.
Arboviruses
Botulism--all forms.
Brucellosis.
Campylobacteriosis.
Cancer.
Chancroid.
Chickenpox (varicella).
Chlamydia trachomatis infections.
Cholera.
Creutzfeldt-Jakob disease.
Cryptosporidiosis.
Diphtheria infections.
Enterohemorrhagic E. coli 0157 infections, or infections caused by other sub-types producing shiga-like toxin.
Giardiasis.
Gonococcal infections.
Granuloma inguinale.
Haemophilus influenzae infections--invasive from sterile sites.
Hantavirus.
Hepatitis, viral, acute and chronic cases.
Histoplasmosis.
Influenza.
Lead poisoning.
Legionellosis.
Leprosy (Hansen's disease).
Leptospirosis.
Listeriosis.
Lyme disease.
Lymphogranuloma venereum.
Malaria.
Maple syrup urine disease (MSUD) in children under 5 years of age.
Measles (rubeola).
Meningococcal infections--invasive from sterile sites.
Mumps.
Pertussis.

Phenylketonuria (PKU) in children under 5 years of age.
Primary congenital hypothyroidism in children under 5 years of age.
Plague.
Poliomyelitis.
Psittacosis (ornithosis).
Rabies.
Respiratory syncytial virus.
Rickettsial infections.
Rubella.
Salmonella.
Shigella.
Sickle cell hemoglobinopathies in children under 5 years of age.
Staphylococcus Aureus Vancomycin-resistant (or intermediate) invasive disease.
Streptococcus pneumoniae, drug-resistant invasive disease.
Syphilis.
Tetanus.
Toxoplasmosis.
Trichinosis.
Tuberculosis, confirmation of positive smears or cultures, including results of drug susceptibility testing.
Tularemia.
Typhoid.

c) The report shall include the following:

1) The name, age, address and telephone number of the person from whom the specimen was obtained.
2) The date the specimen was collected.
3) The source of the specimen (such as, serum, stool, CSF, wound).
4) The name of the test or examination performed and the date it was performed.
5) The results of the test.
6) The range of normal values for the specific test performed.
7) The name, address, and telephone number of the physician for whom the examination or test was performed.
8) Other information requested in case reports or formats specified by the Department.

d) The report shall be submitted by the person in charge of a laboratory, in either a hard copy format or an electronic transmission format specified by the Department.
e) Reports made on paper shall be made to the LMRO where the case is diagnosed or identified. Reports made electronically shall be submitted to the Division of Infectious Disease Epidemiology, Bureau of Epidemiology. Reports of maple syrup urine disease, phenylketonuria, primary congenital hypothyroidism, sickle cell hemoglobinopathies, cancer and lead poisoning shall be reported to the location specifically designated in this subchapter. See §§ 27.30, 27.31 and 27.34 (relating to reporting cases of certain diseases in the newborn child; reporting cases of cancer; and reporting cases of lead poisoning).
f) A clinical laboratory shall submit isolates of salmonella and shigella to the Department's Bureau of laboratories for serotyping within 5 work days of isolation.
g) A clinical laboratory shall submit isolates of Neisseria meningitidis obtained from a normally sterile site to the Department's Bureau of Laboratories for serogrouping within 5 work days of isolation.
h) A clinical laboratory shall send isolates of enterohemorrhagic E. coli to the Department's Bureau of Laboratories for appropriate further testing within 5 work days of isolation.
i) A clinical laboratory shall send isolates of Haemophilus influenzae obtained from a normally sterile site to the Department's Bureau of Laboratories for serotyping within 5 work days of isolation.
j) The Department, upon publication of a notice in the *Pennsylvania Bulletin*, may authorize changes in the requirements for submission of isolates based upon medical or public health developments when the departure is determined by the Department to be necessary to protect the health of the people of this Commonwealth. The change will not remain in effect for more than 90 days after publication unless the Board acts to affirm the change within that 90-day period.

§ 27.23. Reporting of cases by persons other than health care practitioners, health care facilities, veterinarians or laboratories.

Except with respect to reporting cancer, individuals in charge of the following types of group facilities identifying a disease, infection or condition listed in § 27.21a (relating to reporting of cases by health care practitioners and health care facilities) by symptom, appearance or diagnosis shall make a report within the time frames required in § 27.21a.

1) Institutions maintaining dormitories and living rooms.
2) Orphanages.
3) Child care group settings.

§ 27.24. (Reserved).

§ 27.24a. Reporting of cases by veterinarians.

A veterinarian is required to report a case, as specified in § 27.4 (relating to reporting cases), only if the veterinarian treats or examines an animal which the veterinarian suspects of having a disease set forth in § 27.35(a) (relating to reporting cases of disease in animals).

§§ 27.25--27.28. (Reserved).

§ 27.29. Reporting for special research projects.

A person in charge of a hospital or other institution for the treatment of disease shall, upon request of the Department, make reports of a disease or condition for which the Board has approved a specific study to enable the Department to determine and employ the most efficient and practical means to protect and to promote the health of the people by the prevention and control of the disease or condition. The reports shall be made on forms prescribed by the Department and shall be transmitted to the Department or to local health authorities as directed by the Department.

DISEASES AND CONDITIONS REQUIRING SPECIAL REPORTING

§ 27.30. Reporting cases of certain diseases in the newborn child.

Reports of maple syrup urine disease, phenylketonuria, primary congenital hypothyroidism and sickle cell hemoglobinopathies shall be made to the Division of Maternal and Child Health, Bureau of Family Health, as specified in Chapter 28 (relating to metabolic diseases of the newborn) and those provisions of § 27.4 (relating to reporting cases) consistent with Chapter 28 and this section.

§ 27.31. Reporting cases of cancer.

a) A hospital, clinical laboratory, or other health care facility providing screening, diagnostic or therapeutic services for cancer to cancer patients shall report each case of cancer to the Department in a format prescribed by the Cancer Registry, Bureau of Health Statistics and Research, within 180 days of the patient's discharge, if an inpatient or, if an outpatient, within 180 days following diagnosis or initiation of treatment.
b) A health care practitioner providing screening, diagnostic or therapeutic services to cancer patients for cancer shall report each cancer case to the Department in a format prescribed by the Cancer Registry, Bureau of Health Statistics and Research, within 5 work days of diagnosis. Cases directly referred to or previously admitted to a hospital or other health care facility providing screening, diagnostic or therapeutic services to cancer patients in this Commonwealth, and reported by those facilities, are exceptions and do not need to be reported by the health care practitioner.
c) The Department or its authorized representative shall be afforded physical access to all records of physicians and surgeons, hospitals, outpatient clinics, nursing homes and all other facilities, individuals or agencies providing services to patients which would identify cases of cancer or would establish characteristics of the cancer, treatment of the cancer or medical status of any identified cancer patient.
d) Reports submitted under this section are confidential and may not be open to public inspection or dissemination. Information for specific research purposes may be released in accordance with procedures established by the Department with the advice of the Pennsylvania Cancer Control, Prevention and Research Advisory Board.
e) Case reports of cancer shall be sent to the Cancer Registry, Division of Health Statistics, Bureau of Health Statistics and Research, unless otherwise directed by the Department.

APPENDIX C

WEB PLUS UPLOAD INSTRUCTIONS

pennsylvania
DEPARTMENT OF HEALTH

Procedure: **Web Plus file upload**

Purpose: To send files via a secure website to the Pennsylvania Cancer Registry (PCR). This procedure is used when facilities have files ready to submit to the PCR.

General Information:

1. Security: Web Plus is an Internet-based application developed by the Centers for Disease Control and Prevention (CDC), National Program of Cancer Registries (NPCR). Web Plus has been designed as a highly secure application that can be used to transmit data between reporting facilities and the PCR safely over the public internet.

   Security is achieved by a combination of software features and network infrastructure. Web Plus is hosted on a secure Web server; the communication between the client and the server is encrypted with 128-bit encryption Secure Socket Layer (SSL) technology.

   Security features of the application include:

   - Web Plus keeps an extensive log of user logins, data accesses, and updates for auditing purposes.
   - User accounts can be locked out if invalid login attempts exceed a threshold value, configurable by the PCR Central Administrator.
   - Initial passwords are randomly generated by the system and the user will be forced to change it after their first successful logon.
   - Current user activities are visible to the PCR Central Administrator through the Current User Activities page.
   - User passwords are stored in the database using a one-way hash encryption method.
   - The Web Plus configuration file will store the connection string to the SQL Server database in encrypted format.
   - The application times out after a specified time period.
   - Web Plus uses form-based authentication where users are required to enter their unique user ID and strong password to be authenticated by the application.

2. Screen Resolution: The resolution for Web Plus should be 1024 X 768. If the resolution set on your PC is different, you may still be able to use Web Plus, but Web Plus has been designed to be viewed best at 1024 X 768 or higher. You will receive a message on the Web Plus log-in screen if your resolution is not set correctly. Contact your IT department if you are unsure how to change your screen resolution.

3. Web Plus icon on desk top: It is recommended your IT Department create an icon on your desk top from the Web Plus link for easy access to the application.

4. Password protected or encrypted files: Files uploaded to the PCR via Web Plus MUST NOT be password protected or encrypted. The security features of Web Plus replaces the need to password protect or encrypt files.

5. Password changes: You will be prompted to change your password the first time you log into Web Plus and then every 60 days after that.

6. Edits: When you upload your data file, edits will be run and an edit report will be made available for your review. PCR staff will monitor files submitted with errors and work individually with those facilities to determine the reason for the edit errors and the best way to correct errors before submission. **Note for Abstract Plus users**: Web Plus contains the same edit set that is in Abstract Plus. Since records cannot be exported until all errors are corrected, you should not receive any edit errors when uploading files through Web Plus.

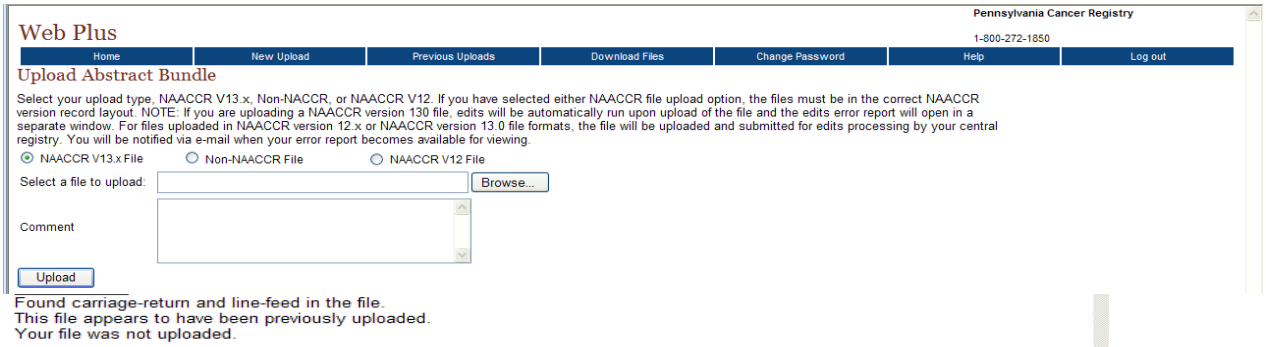
7. What and when to submit: Reporting facilities must upload files by the 15th of every month as stated in the PCR Manual under "When To Report". Files may be submitted more than once per month but no more frequently than once a week. Accession lists for the files uploaded are not required. A hard copy of the PCR Transmittal Form is no longer required unless you have zero (0) records to report (see #8).

8. No records to report: If a facility has no cancer records to report, an electronic PCR transmittal form with zero (0) entered for the number of new records must be completed and submitted via Web Plus by the 15th of the month. In addition, the reason for not submitting any records must be documented on the transmittal form in the space provided.

9. Changing Information: Updates or changes to previously submitted records should be electronically through the creation of an M record. See "*Changing Information in Part One* of the *PCR Manual*". M record files are uploaded separately from A record files.

10. File size: There is no limit to the number of records in each upload file.

11. Duplicate files: Web Plus has restrictions on uploading files that are exact duplicates of a previously uploaded file. If you attempt to upload a duplicate file, you will receive the below message:



If it is necessary to re-submit a file already exported, contact the PCR for assistance.

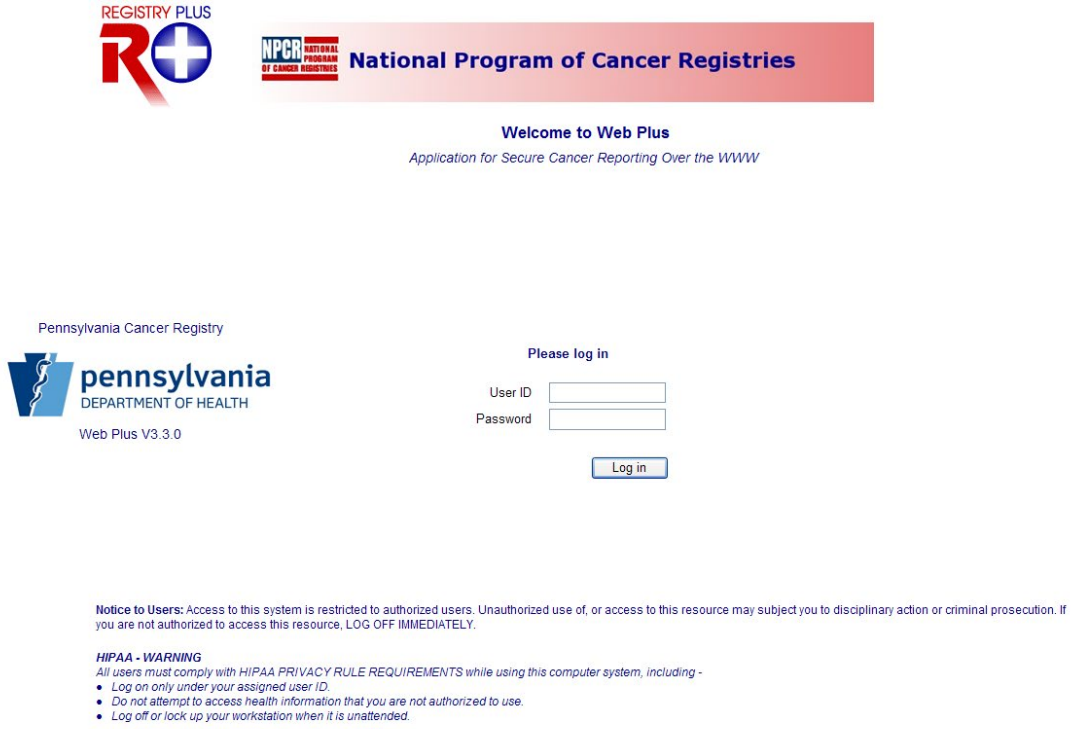
Procedure:

Uploading files

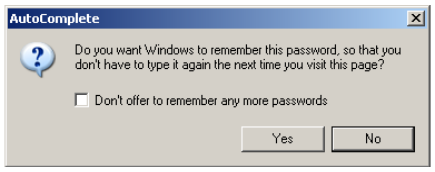
1. Open Web Plus using the following link: https://pcr.health.pa.gov/WebPlus/logonen.aspx

2. Type your User ID and Password. Note: Your User ID and Password were previously sent to you via e-mail.

   Click Log in.

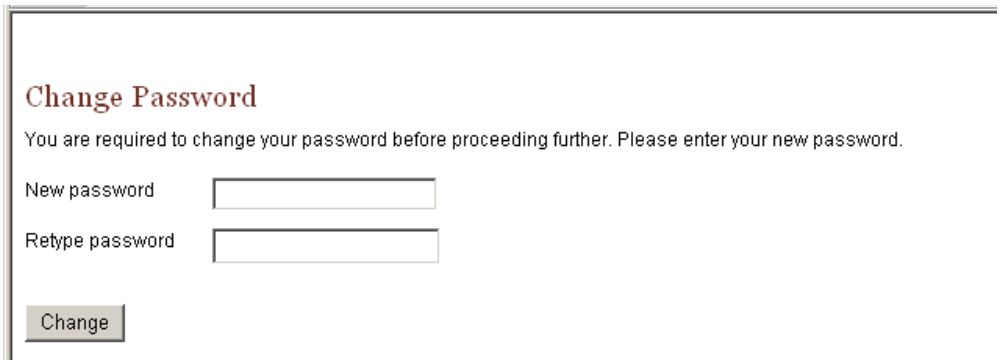


   If the following message appears, click on No.



   *The first time you log in, the following screen below appear, forcing you to change your password.

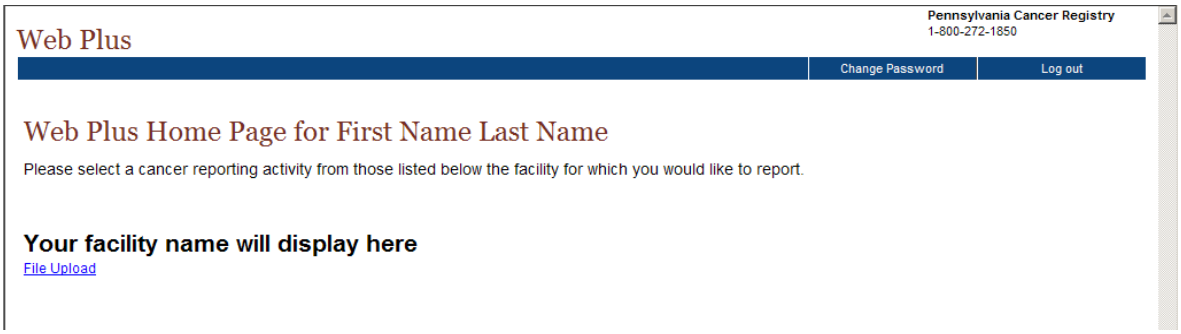
   Enter a new password using the following criteria "Password must be between 8 to 20 characters, contain at least one digit and one alphabetic character, and must not contain any special characters".



Click on Change.

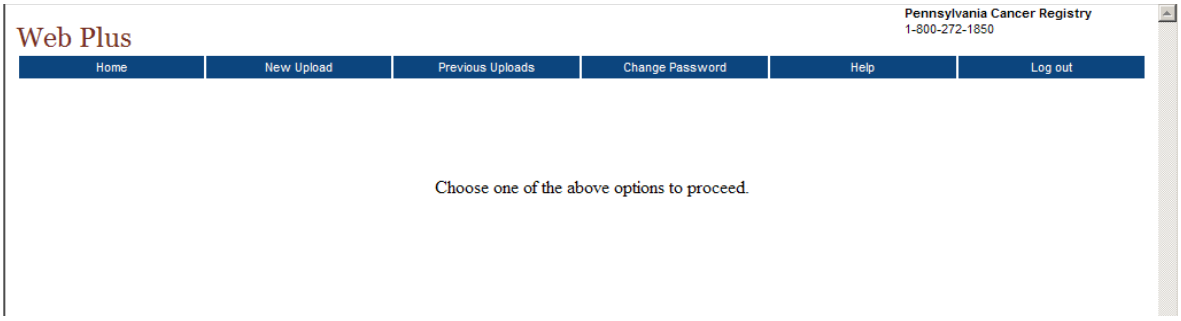
If the password does not meet the criteria specified above or if the new password does not match the retype password line, you will receive a message 'Password not changed'. The Change Password screen will remain until the password meets the criteria and the two password lines match.

3. The Web Plus home page for your facility opens.



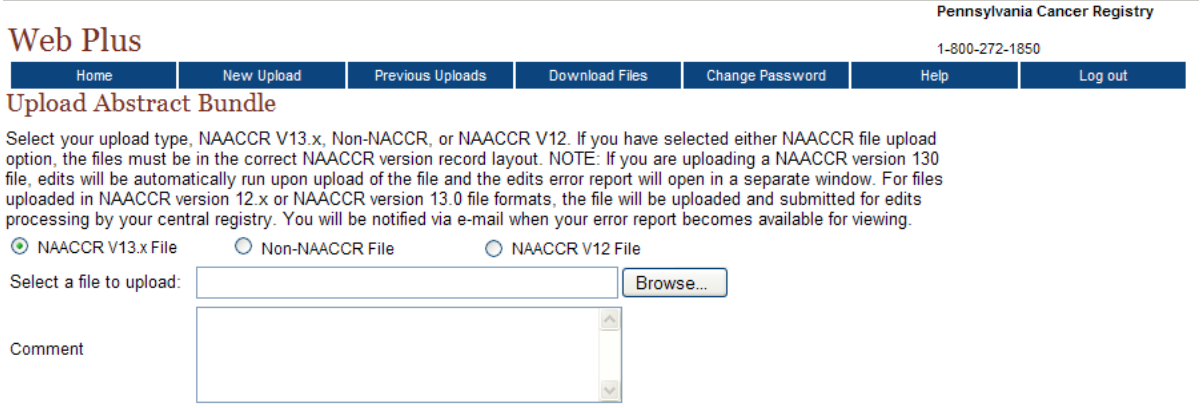
4. Click on File Upload.

The following screen will display:



5. Click on New Upload.

   The following screen will display:



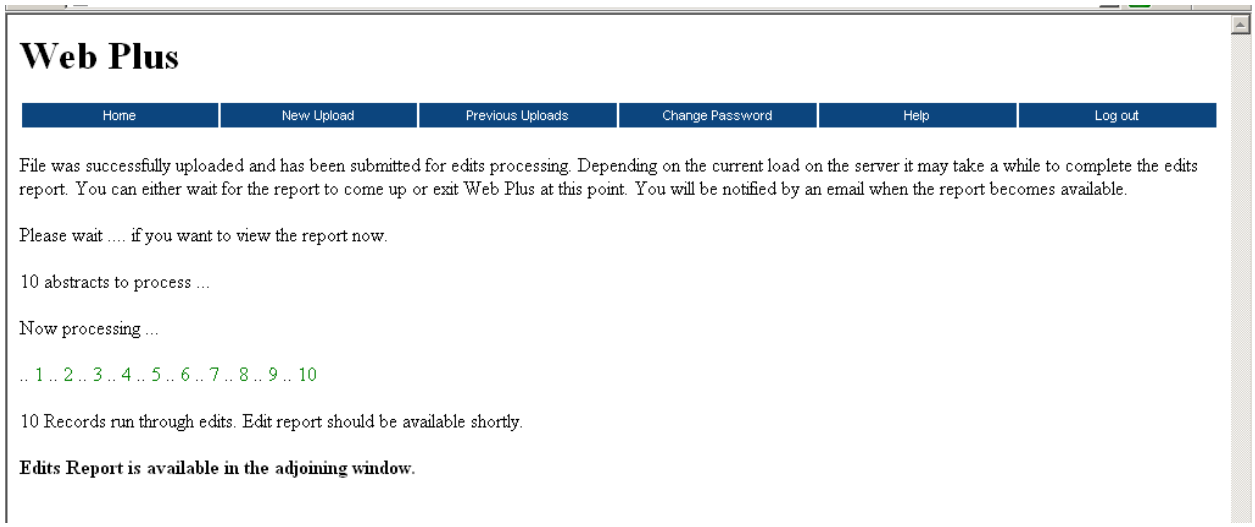
   Uploading data files:

6. The button beside NAACCR vXX.x File is defaulted, but make sure this button is selected prior to uploading the data file. **When uploading the actual data file, the button beside NAACCR file <u>MUST</u> be selected.** Select the data file to upload by clicking on the Browse button and navigating to the location of the file.

7. **In the comment section, you <u>MUST</u> enter the number of abstracts you are exporting**. The comment section can also be used for any special information. For example, if you are uploading a trial shipment, close-out or reconciliation file, this could be indicated here.

8. Click on Upload. The following screen will appear and as the records are processing, the case count will display under 'Now processing'. Numbers in green indicate the record is error-free and numbers in red indicate the record has errors.

Note about edits: See #6 under General Information.



An edit report will display in an adjoining window. You can view and/or print the edit report now or close it by selecting File/Close or clicking on the X in the top right corner. You will also receive the following e-mail when the edit report is available and it can be viewed at any time:

Dear First Name Last Name,

Edit report of the abstracts bundle, C:\yourdatafile.txt submitted on 12/5/2008 10:22:27 AM, is ready. Please log on to Web Plus and select "Previous Uploads" option from the menu. All your previous uploads will be listed on this page. Click on "View Edit Report" link to view the report of this bundle. The report will open in a separate window.

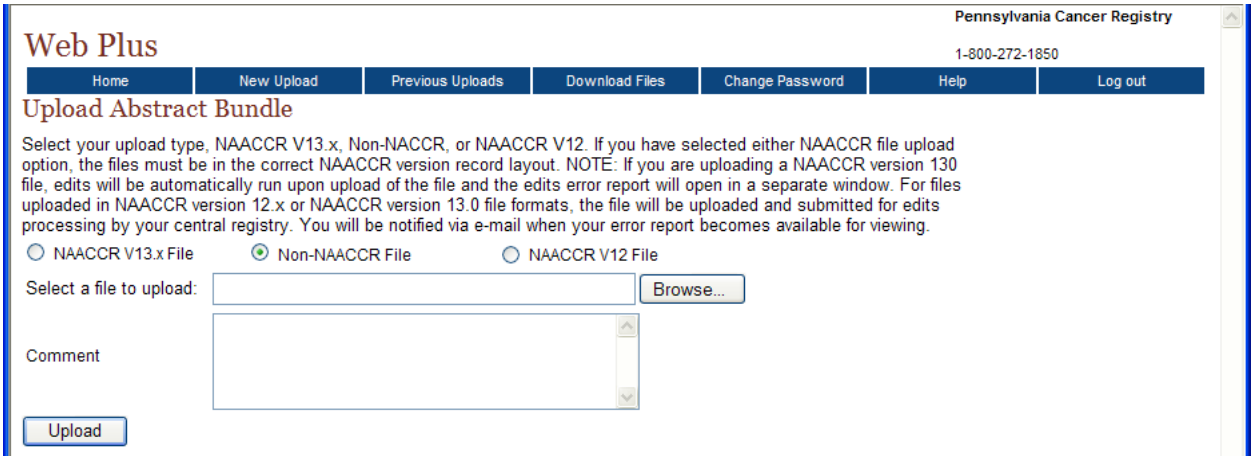
The bundle does not have any edit errors and has been accepted.

Thank you,
Web Plus System Administrator
Pennsylvania Cancer Registry

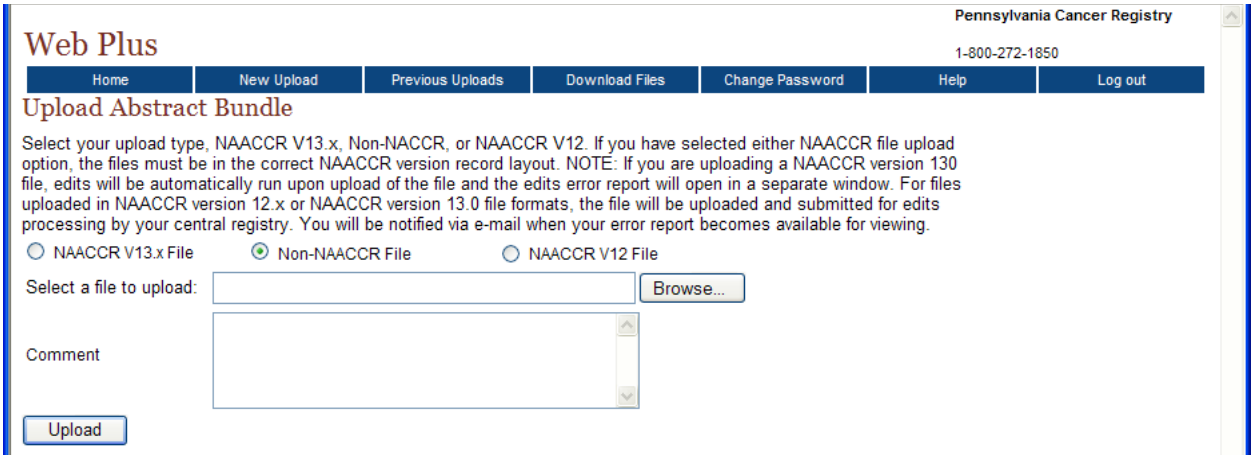
Uploading PCR Transmittal Form (Only necessary when zero records to report. See #8 under General Information):

1. Click on New Upload.

2. Click on the button beside Non-NAACCR File. Select the PCR Transmittal Form to upload by clicking on the Browse button and navigating to the location of the file.



3. Click on Upload. A message will appear at the bottom of the screen stating 'The file has been uploaded as a Non-NAACCR file'.



You will receive the following e-mail:

Dear First Name Last Name,

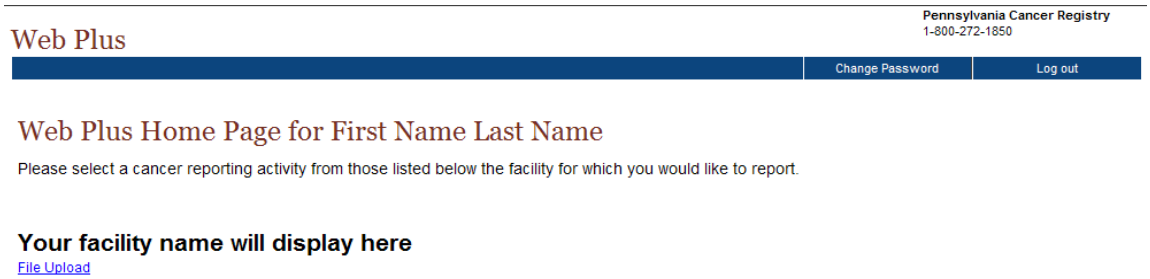
Your non-NAACCR file: C:\PCR Transmittal Form.doc was successfully uploaded to Web Plus and received by Pennsylvania Cancer Registry on 12/5/2008 10:40:08 AM.

Web Plus System Administrator
Pennsylvania Cancer Registry

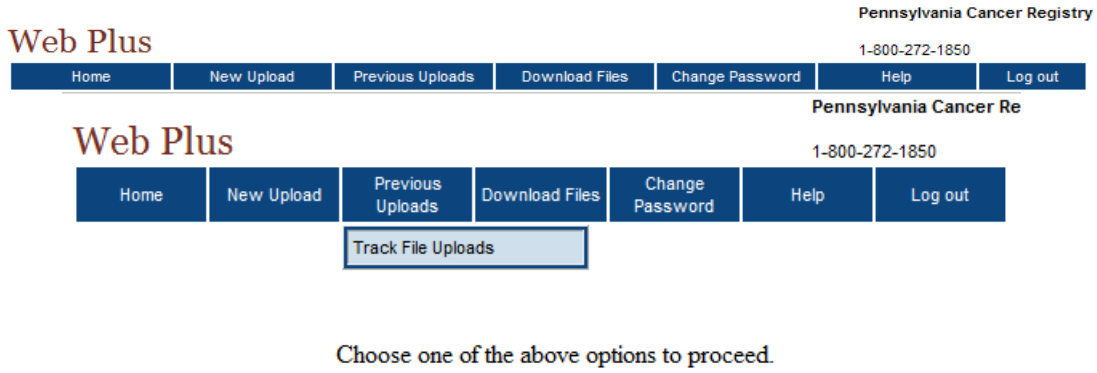
4. Click on Log out to close Web Plus.

View Cases Submitted to the Pennsylvania Cancer Registry via Web Plus

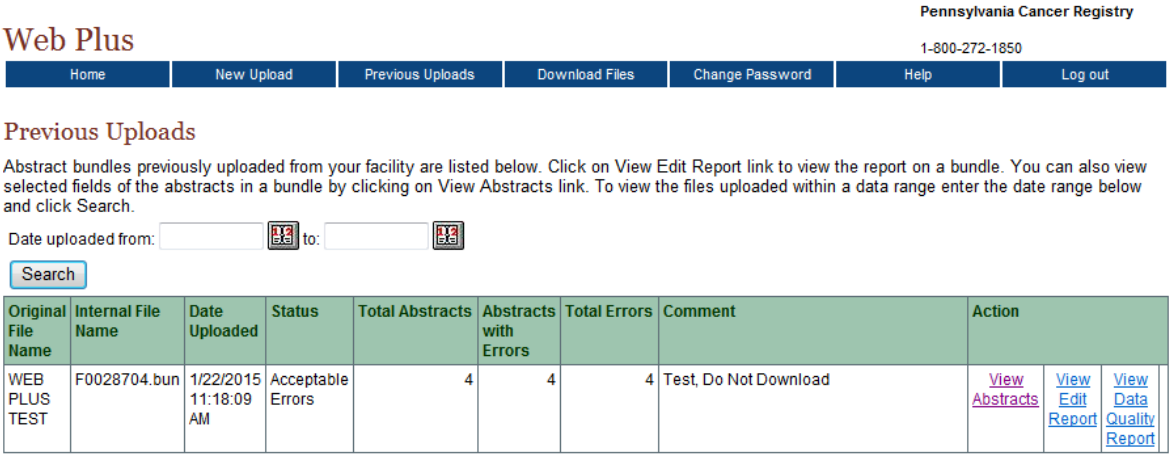
1. Log into Web Plus.
2. The Web Plus home page for your facility opens.



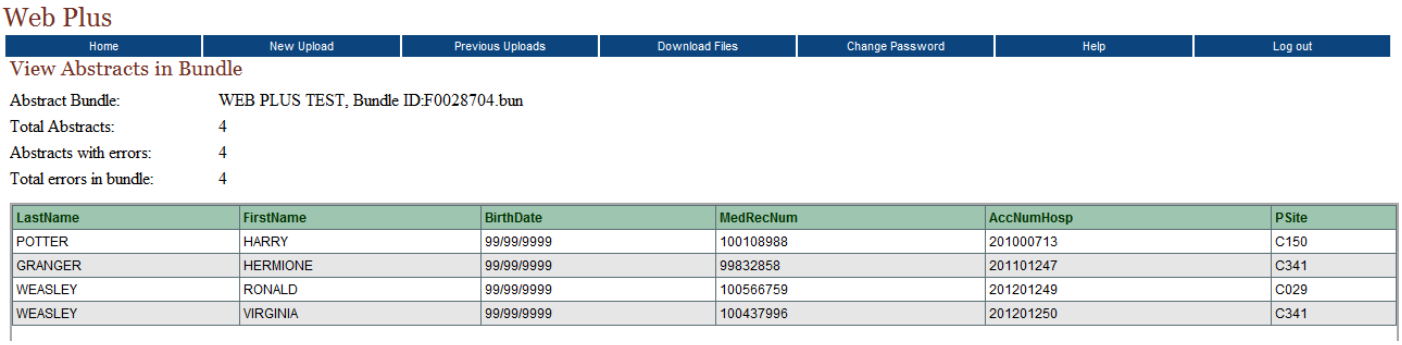
3. Click on File Upload.
    a. The following screen will display:



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.



Web Plus

Home | New Upload | Previous Uploads | Download Files | Change Password | Help | Log out

View Abstracts in Bundle

Abstract Bundle: WEB PLUS TEST, Bundle ID:F0028704.bun
Total Abstracts: 4
Abstracts with errors: 4
Total errors in bundle: 4

LastName	FirstName	BirthDate	MedRecNum	AccNumHosp	PSite
POTTER	HARRY	99/99/9999	100108988	201000713	C150
GRANGER	HERMIONE	99/99/9999	99832858	201101247	C341
WEASLEY	RONALD	99/99/9999	100566759	201201249	C029
WEASLEY	VIRGINIA	99/99/9999	100437996	201201250	C341

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.

APPENDIX D

ICD-10-CM Casefinding Lists For Reportable Conditions

ICD-10-CM Codes

The following ICD-10-CM list will be used to identify potentially reportable conditions. To determine if a diagnosis identified from the ICD-10-CM codes is reportable, refer to the reportability guidelines in Part One.

ICD-10-CM Code	Description
C00._ – C96._	Malignant neoplasms (excluding category C44), stated or presumed to be primary (of specified site) and certain specified histologies
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.10_, C44.19_	Unspecified/other malignant neoplasm of skin of eyelid
C44.13_	Sebaceous cell carcinoma of the skin of eyelid, including canthus (Effective 10/1/2018)
C44.20_, C44.29_	Unspecified/other malignant neoplasm skin of ear and external auricular canal
C44.30_, C44.39_	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.40, C44.49	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50_, C44.59_	Unspecified/other malignant neoplasm of skin of trunk
C44.60_, C44.69_	Unspecified/other malignant neoplasm of skin of upper limb, incl. shoulder
C44.70_, C44.79_	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin
C49.A_	Gastrointestinal Stromal Tumors Note: All GIST tumors are now reportable starting in 2021 (per ICD-O-3.2), including GIST, NOS
D00._ – D09._	In-situ neoplasms (*Note: Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable*).
D18.02	Hemangioma of intracranial structures and any site
D32._	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33._	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42._, D43._	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 – D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3)
D46._	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)

Some ICD-10-CM codes contain conditions that are not reportable. These records still need to be reviewed and assessed individually to verify whether or not they are reportable to the PCR.

ICD-10-CM Code	Description
D47.1	Chronic myeloproliferative disease (9960/3, 9963/3) **ICD-10-CM Coding instruction note:** Excludes the following: Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_) Chronic myeloid leukemia BCR/ABL-positive (C92.1_) Myelofibrosis & Secondary myelofibrosis (D75.81) Myelophthisic anemia & Myelophthisis (D61.82)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3)
D47.4	Osteomyelofibrosis (9961/3)
D47.9	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis Myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.Z_	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3)
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1	Encounter for antineoplastic chemotherapy and immunotherapy

Electronic Look up Lists

For an electronic detailed list of each individual code, go to the SEER Website:

https://seer.cancer.gov/tools/casefinding/

APPENDIX E

Grade

GRADE

This data item records the code for grade or differentiation of the cancer/tumor being reported.

1. Cases Diagnosed on or after January 1, 2018: Leave this field blank. See *Grade Clinical*, *Grade Pathological* and *Grade Post Therapy*.

2. Cases Diagnosed on or after January 1, 2014**:** Code grade according the guidelines provided below.

3. Cases Diagnosed prior to January 1, 2014: Code grade according to guidelines in the *SEER Program Coding and Staging Manual 2013.* http://seer.cancer.gov/tools/codingmanuals/

Hematopoietic and Lymphoid Neoplasms

Cell Indicator Codes 5, 6, 7, 8 describe 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/seertools/hemelymph/

2. Determine the Cell Indicator by applying the "Grade of Tumor Rules" within the current Hematopoietic and Lymphoid Neoplasm Manual to code the grade http://seer.cancer.gov/seertools/hemelymph/

   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, not applicable	9

Solid Tumors

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 Grade 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 #7-8.

Coding Grade 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.

   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 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: In transitional cell carcinoma for bladder, the terminology high grade TCC and low grade TCC are coded in the 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

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	
Medium grade, intermediate grade	II-III	3	2
Moderately poorly differentiated	III	3	
Moderately undifferentiated	III	3	
Poorly differentiated	III	3	
Relatively poorly differentiate	III	3	
Slightly differentiated	III	3	

Description	Grade	Assign Grade Code	Exception for Breast and Prostate Grade Code
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 System Rules

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

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

Soft Tissue

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

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.

Text

Text to support this data item must be recorded in the specific text fields. These text fields are used by the PCR to validate ICD-O grade codes reported.

APPENDIX F

Required Data Set

Required Data Set

The **bolded** items are new for 2021. The items in blue font are system generated codes.

*If the M Record column has an x, a Modification Record should be generated if the values in these fields change. If the column is blank, DO NOT generate a Modification Record

PCR Required Item	NAACCR Item #	Required	M Record Trigger	Required based on diagnosis year
Record Type	10	x		
Patient ID Number	20	x		
Registry Type	30	x		
NAACCR Record Version	50	x		
Addr at DX--City	70	x	x	
Addr at DX--State	80	x	x	
County at DX Reported	90	x		
Addr at DX--Postal Code	100	x	x	
Race 1	160	x	x	
Race 2	161	x	x	
Race 3	162	x	x	
Race 4	163	x	x	
Race 5	164	x	x	
Spanish/Hispanic Origin	190	x	x	
Sex	220	x	x	
Age at Diagnosis	230	x	x	
Date of Birth	240	x	x	
Date of Birth Flag	241	x	x	
Birthplace	250		x	x
Birthplace--State	252	x	x	
Birthplace--Country	254	x	x	
Text--Usual Occupation	310	x	x	
Text--Usual Industry	320	x	x	
Date of Diagnosis	390	x	x	
Date of Diagnosis Flag	391	x	x	
Primary Site	400	x	x	
Laterality	410	x	x	
Histology (92-00) ICD-O-2	420		x	x
Behavior (92-00) ICD-O-2	430		x	x
Grade	440		x	x
Site Coding Sys--Current	450	x		
Morph Coding Sys--Current	470	x		
Diagnostic Confirmation	490	x	x	
Type Of Reporting Source	500	x	x	
Histologic Type ICD-O-3	522	x	x	
Behavior Code ICD-O-3	523	x	x	
Reporting Facility	540	x		
Accession Number--Hosp	550	x		

PCR Required Item	NAACCR Item #	Required	M Record Trigger	Required based on diagnosis year
Sequence Number--Hospital	560	x	x	
Abstracted By	570	x		
Date of 1st Contact	580	x	x	
Date of 1st Contact Flag	581	x	x	
Date of Inpt Adm	590	x	x	
Date of Inpt Adm Flag	591	x	x	
Date of Inpt Disch	600	x	x	
Date of Inpt Disch Flag	601	x	x	
Class Of Case	610	x	x	
Primary Payer at DX	630	x	x	
Tumor Size Summary	756	x	x	
SEER Summary Stage 2000	759		x	x
SEER Summary Stage 1977	760		x	x
Summary Stage 2018	764	x	x	
Regional Nodes Positive	820	x	x	
Regional Nodes Examined	830	x	x	
TNM Path T	880		x	x
TNM Path N	890		x	x
TNM Path M	900		x	x
TNM Path Stage Group	910		x	x
TNM Path Descriptor	920		x	x
TNM Clin T	940		x	x
TNM Clin N	950		x	x
TNM Clin M	960		x	x
TNM Clin Stage Group	970		x	x
TNM Clin Descriptor	980		x	x
AJCC ID	995	x		
TNM Edition Number	1060		x	x
Grade Post Therapy Clin (yc)	**1068**	**x**	x	x
Mets at DX-Bone	1112	x	x	
Mets at DX-Brain	1113	x	x	
Mets at DX-Distant LN	1114	x	x	
Mets at DX-Liver	1115	x	x	
Mets at DX-Lung	1116	x	x	
Mets at DX-Other	1117	x	x	
Lymph-vascular Invasion	1182	x	x	
RX Date Surgery	1200	x	x	
RX Date Surgery Flag	1201	x	x	
RX Date Radiation	1210	x	x	
RX Date Radiation Flag	1211	x	x	
RX Date Chemo	1220	x	x	
RX Date Chemo Flag	1221	x	x	
RX Date Hormone	1230	x	x	
RX Date Hormone Flag	1231	x	x	

PCR Required Item	NAACCR Item #	Required	M Record Trigger	Required based on diagnosis year
RX Date BRM	1240	x	x	
RX Date BRM Flag	1241	x	x	
RX Date Other	1250	x	x	
RX Date Other Flag	1251	x	x	
Date 1st Crs RX CoC	1270	x	x	
Date 1st Crs RX CoC Flag	1271	x	x	
RX Summ--Treatment Status	1285	x	x	
RX Summ--Surg Prim Site	1290	x	x	
RX Summ--Scope Reg LN Sur	1292	x	x	
RX Summ--Surg Oth Reg/Dis	1294	x	x	
Reason for No Surgery	1340	x	x	
RX Summ--Surg/Rad Seq	1380	x	x	
RX Summ--Chemo	1390	x	x	
RX Summ--Hormone	1400	x	x	
RX Summ--BRM	1410	x	x	
RX Summ--Other	1420	x	x	
Reason for No Radiation	1430	x	x	
RX Coding System--Current	1460	x		
Phase I Radiation Treatment Modality	1506	x	x	
Rad--Regional RX Modality	1570		x	x
RX Summ--Systemic/Sur Seq	1639	x	x	
Date of Last Contact	1750	x		
Date of Last Contact Flag	1751	x		
Vital Status	1760	x		
ICD Revision Number	1920	x		
Date Case Completed	2090	x		
Date Case Last Changed	2100	x		
Date Case Report Exported	2110	x		
ICD-O-3 Conversion Flag	2116	x	x	
Schema ID Version Current	**2117**	x		
Schema ID Version Original	**2118**	x		
COC Accredited Flag	2152	x		
Vendor Name	2170	x		
Name--Last	2230	x	x	
Name—Birth Surname	**2232**	**x**	**x**	x
Name--First	2240	x	x	
Name--Middle	2250	x	x	
Name--Suffix	2270	x		
Name--Alias	2280	x	x	
Medical Record Number	2300	x		
Medicare Beneficiary Identified	**2315**	**x**	x	x
Social Security Number	2320	x	x	
Addr at DX--No & Street	2330	x	x	
Addr at DX--Supplementl	2335	x	x	

PCR Required Item	NAACCR Item #	Required	M Record Trigger	Required based on diagnosis year
Institution Referred From	2410	x	x	
Physician--Follow-Up	2470	x	x	
Text--DX Proc--PE	2520	x		
Text--DX Proc--X-ray/scan	2530	x		
Text--DX Proc--Scopes	2540	x		
Text--DX Proc--Lab Tests	2550	x		
Text--DX Proc--Op	2560	x		
Text--DX Proc--Path	2570	x		
Text--Primary Site Title	2580	x		
Text--Histology Title	2590	x		
Text--Staging	2600	x		
RX Text--Surgery	2610	x		
RX Text--Radiation (Beam)	2620	x		
RX Text--Radiation Other	2630	x		
RX Text--Chemo	2640	x		
RX Text--Hormone	2650	x		
RX Text--BRM	2660	x		
RX Text--Other	2670	x		
Text--Remarks	2680	x		
Text--Place Of Diagnosis	2690	x		
CS Tumor Size	2800			x
CS Extension	2810			x
CS Tumor Size/Ext Eval	2820			x
CS Lymph Nodes	2830			x
CS Lymph Nodes Eval	2840			x
CS Mets at DX	2850			x
CS Mets Eval	2860			x
CS Site-Specific Factor 7	2861			x
CS Site-Specific Factor 8	2862			x
CS Site-Specific Factor 9	2863			x
CS Site-Specific Factor10	2864			x
CS Site-Specific Factor11	2865			x
CS Site-Specific Factor12	2866			x
CS Site-Specific Factor13	2867			x
CS Site-Specific Factor14	2868			x
CS Site-Specific Factor15	2869			x
CS Site-Specific Factor16	2870			x
CS Site-Specific Factor17	2871			x
CS Site-Specific Factor25	2879			x
CS Site-Specific Factor 1	2880			x
CS Site-Specific Factor 2	2890			x
CS Site-Specific Factor 3	2900			x
CS Site-Specific Factor 4	2910			x
CS Site-Specific Factor 5	2920			x

PCR Required Item	NAACCR Item #	Required	M Record Trigger	Required based on diagnosis year
CS Site-Specific Factor 6	2930			x
CS Version Input Original	2935			x
CS Version Derived	2936			x
CS Version Input Current	2937			x
Derived SS2000	3020			x
Derived SS2000--Flag	3050			x
RX Date Mst Defn Srg	3170	x	x	
RX Date Mst Defn Srg Flag	3171	x	x	
RX Summ--Transplnt/Endocr	3250	x	x	
Schema ID	3800	x	x	
Brain Molecular Markers	3816	x	x	
Breslow Tumor Thickness	3817	x	x	
Estrogen Receptor Summary	3827	x	x	
Fibrosis Score	3835	x	x	
Gleason Patterns Clinical	3838	x	x	
Gleason Patterns Pathological	3839	x	x	
Gleason Score Clinical	3840	x	x	
Gleason Score Pathological	3841	x	x	
Gleason Tertiary Pattern	**3842**	**x**	**x**	
Grade Clinical	3843	x	x	
Grade Pathological	3844	x	x	
Grade Post Therapy Path	3845	x	x	
HER2 Overall Summary	3855	x	x	
Microsatellite Instability (MSI)	3890	x	x	
Mitotic Rate Melanoma	3893	x	x	
Progesterone Receptor Summary	3915	x	x	
PSA (Prostatic Specific Antigen) Lab Value	3920	x	x	
Schema Discriminator 1	3926	x	x	
Schema Discriminator 2	3927	x	x	
LDH Pretreatment Lab Value	3932	x	x	
Ulceration	3936	x	x	

APPENDIX G

PCR Transmittal Form

pennsylvania
DEPARTMENT OF HEALTH

Date Received:

PENNSYLVANIA CANCER REGISTRY
TRANSMITTAL FORM

FACILITY NAME: _____

ACOS #: _____

DATE SUBMITTED: _____

NUMBER OF CHANGE RECORDS: _____

NUMBER OF NEW RECORDS: _____

Comments:

_____

_____

_____

APPENDIX H

FEDERAL INFORMATION PROCESSING STANDARDS (FIPS) COUNTY CODES FOR PENNSYLVANIA

Federal Information Processing Standards Publication, Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas. U.S. Department of Commerce, National Institute of Standards and Technology, Gaithersburg, MD, August 31, 1990, pp. 21-22

SEER GEOCODES FOR COUNTRY AT DIAGNOSIS

Note: All codes are used in County at DX field

FIPS COUNTY CODES FOR PENNSYLVANIA

001	Adams
003	Allegheny
005	Armstrong
007	Beaver
009	Bedford
011	Berks
013	Blair
015	Bradford
017	Bucks
019	Butler
021	Cambria
023	Cameron
025	Carbon
027	Centre
029	Chester
031	Clarion
033	Clearfield
035	Clinton
037	Columbia
039	Crawford
041	Cumberland
043	Dauphin
045	Delaware
047	Elk
049	Erie
051	Fayette
053	Forest
055	Franklin
057	Fulton
059	Greene
061	Huntington
063	Indiana
065	Jefferson
067	Juniata
069	Lackawanna
071	Lancaster
073	Lawrence
075	Lebanon
077	Lehigh
079	Luzerne
081	Lycoming
083	McKean
085	Mercer
087	Mifflin
089	Monroe
091	Montgomery
093	Montour
095	Northampton
097	Northumberland
099	Perry
101	Philadelphia
103	Pike
105	Potter
107	Schuylkill
109	Snyder
111	Somerset
113	Sullivan
115	Susquehanna
117	Tioga
119	Union
121	Venango
123	Warren
125	Washington
127	Wayne
129	Westmoreland
131	Wyoming
133	York

SEER GEOCODES

A

585	Abyssinia
629	Aden
583	Afars and Issas
638	Afghanistan
500	Africa
570	Africa, East
510	Africa, North
540	Africa, South
545	Africa, South West
530	Africa, West
580	African Coastal Islands (previously included in 540)
037	Alabama
091	Alaska
481	Albania
224	Alberta
513	Algeria
250	America, Central
260	America, North (use more specific term if possible)
300	America, South
121	American Samoa
611	Anatolia
641	Andaman Islands
443	Andorra
543	Angola
245	Anguilla
665	Annam
750	Antartica
245	Antigua
245	Antilles, NOS
245	Antilles, Netherlands
625	Arab Palestine
629	Arabia, Saudi
629	Arabian Peninsula
365	Argentina
087	Arizona
071	Arkansas
633	Armenia (U.S.S.R.)
611	Armenia (Turkey)
245	Aruba
600	Asia, NOS

680 Asia, East
640 Asia, Mid-East
610 Asia Minor, NOS
610 Asia, Near-East
650 Asia, Southeast
620 Asian Arab countries
634 Asian Republics of the former U.S.S.R.
109 Atlantic/Caribbean area, other U.S. possessions
100 Atlantic/Caribbean area, U.S. possessions
711 Australia
711 Australian New Guinea
436 Austria
633 Azerbaijan
633 Azerbaizhan S.S.R.
445 Azores

B

247 Bahamas
629 Bahrain
443 Balearic Islands
463 Baltic Republic, NOS
463 Baltic States, NOS
645 Bangladesh
245 Barbados
245 Barbuda
545 Basutoland
431 Bavaria
545 Bechuanaland
457 Belarus
541 Belgian Congo
433 Belgium
252 Belize
539 Benin
246 Bermuda
456 Bessarabia
643 Bhutan
539 Bioko (Fernando Poo)
452 Bohemia
355 Bolivia
545 Bophuthatswana
673 Borneo
453 Bosnia-Herzogovina
545 Botswana
341 Brazil

226 British Columbia
331 British Guiana
252 British Honduras
245 British Virgin Islands
245 British West Indies, NOS
671 Brunei
454 Bulgaria
520 Burkina Faso (Upper Volta)
649 Burma (see Myanmar)
579 Burundi
457 Byelorussian S.S.R.

C

543 Cabinda
245 Caicos Islands
097 California
663 Cambodia
539 Cameroon
220 Canada
110 Canal Zone
443 Canary Islands
122 Canton Islands
545 Cape Colony
445 Cape Verde Islands
245 Caribbean, NOS
245 Caribbean Islands, other
123 Caroline Islands
711 Cartier Islands
633 Caucasian Republics of the former U.S.S.R.
245 Cayman Islands
500 Central Africa, NOS
539 Central African Republic
250 Central America
499 Central Europe, NOS
060 Central Midwest States
647 Ceylon
520 Chad
401 Channel Islands (British)
361 Chile
681 China, NOS
665 China, Cochin
682 China, People's Republic of
684 China, Republic of
723 Christmas Island

545 Ciskel
665 Cochin China
711 Cocos (Keeling) Islands
311 Columbia
083 Colorado
580 Comoros
226 Columbia, British
022 Columbia, District of
539 Congo-Brazzaville
541 Congo-Leopoldville
541 Congo, Belgian
539 Congo, French
541 Congo Kinshasa
007 Connecticut
124 Cook Islands
441 Corsica
256 Costa Rica
539 Cote d'Ivoire (Ivory Coast)
471 Crete
453 Croatia
241 Cuba
245 Curacao
495 Cyprus
517 Cryonic
452 Czechoslovakia
452 Czech Republic

D

539 Dahomey
453 Dalmatia
017 Delaware
425 Denmark
022 District of Columbia
583 Djibouti
449 Dobruja
245 Dominica
243 Dominican Republic
673 Dutch East Indies
332 Dutch Guiana

E

570 East Africa
680 East Asia

431	East Germany
673	East Indies, Dutch
645	East Pakistan
499	Eastern Europe, NOS
345	Ecuador
519	Egypt
410	Eire
254	El Salvador
125	Ellice Islands
122	Enderbury Islands
401	England
500	Equatorial Africa, NOS
539	Equatorial Guinea (Spanish Guinea)
585	Eritrea
458	Estonia
458	Estonian S.S.R. (Estonia)
585	Ethiopia
499	Europe, NOS
470	Europe, other mainland

F

420	Faroe (Faeroe) Islands
381	Falkland Islands
431	Federal Republic of Germany
539	Fernando Poo
721	Fiji
429	Finland
035	Florida
684	Formosa
721	Fortuna
441	France
545	Free State (Orange Free State)
539	French Congo
333	French Guiana
725	French Polynesia
583	French Somaliland
530	French West Africa, NOS
245	French West Indies

G

539	Gabon
345	Galapagos Islands
539	Gambia

631 Gaza Strip
033 Georgia (U.S.A.)
633 Georgia (U.S.S.R.)
430 Germanic countries
431 German Democratic Republic
431 Germany
431 Germany, East
431 Germany, Federal Republic of
431 Germany, West
539 Ghana
485 Gibraltar
122 Gilbert Islands
471 Greece
210 Greenland
245 Grenada
245 Grenadines, The
245 Guadeloupe
126 Guam
251 Guatemala
401 Guernsey
331 Guiana, British
332 Guiana, Dutch
333 Guiana, French
539 Guinea
539 Guinea-Bissau (Portuguese Guinea)
539 Guinea, Equatorial
--- Guinea, New (See New Guinea)
539 Guinea, Portuguese
331 Guyana

H

242 Haiti
099 Hawaii
432 Holland
253 Honduras
252 Honduras, British
683 Hong Kong
475 Hungary

I

421 Iceland
081 Idaho
061 Illinois

641 India
045 Indiana
673 Indies, Dutch East
660 Indochina
673 Indonesia
053 Iowa
637 Iran
627 Iraq
620 Iraq-Saudi Arabian Neutral Zone
410 Ireland (Eire)
404 Ireland, Northern
410 Ireland, NOS
410 Ireland, Republic of
401 Isle of Man
631 Israel
583 Issas
447 Italy
539 Ivory Coast

J

244 Jamaica
423 Jan Mayen
693 Japan
673 Java
401 Jersey
631 Jewish Palestine
127 Johnston Atoll
625 Jordan
453 Jugoslavia

K

539 Kameroon
663 Kampuchea
065 Kansas
634 Kazakh S.S.R.
634 Kazakhstan
047 Kentucky
575 Kenya
634 Kirghiz S.S.R.
122 Kiribati
695 Korea
695 Korea, North
695 Korea, South

629 Kuwait
634 Kyrgys tan
634 Kyrgyz

L

221 Labrador
661 Laos
420 Lapland, NOS
265 Latin America, NOS
459 Latvia
459 Latvian S.S.R. (Latvia)
623 Lebanon
245 Leeward Island, NOS
545 Lesotho
539 Liberia
517 Libya
437 Liechtenstein
122 Line Islands, Southern
461 Lithuania
461 Lithuanian S.S.R. (Lithuania)
073 Louisiana
434 Luxembourg

M

686 Macao
686 Macau
453 Macedonia
555 Madagascar
445 Madeira Islands
002 Maine
555 Malagasy Republic
551 Malawi
671 Malay Peninsula
671 Malaysia
640 Maldives
520 Mali
491 Malta
224 Manitoba
129 Mariana Islands
221 Maritime Provinces, Canada
131 Marshall Islands
245 Martinique
021 Maryland

005 Massachusetts
520 Mauritania
580 Mauritius
580 Mayotte
490 Mediterranean Islands, other
721 Melanesian Islands
610 Mesopotamia, NOS
230 Mexico
041 Michigan
123 Micronesian Islands (Caroline Islands, Trust Territory of Pacific Islands)
723 Micronesian Islands (except possessions of the U.S.A.)
640 Mid-East Asia
132 Midway Islands
052 Minnesota
249 Miquelon
039 Mississippi
063 Missouri
456 Moldavia
456 Moldavian S.S.R.
456 Moldova
441 Monaco
691 Mongolia
056 Montana
453 Montenegro
245 Montserrat
452 Moravia
511 Morocco
080 Mountain States
553 Mozambique
629 Muscat
649 Myanmar (see Burma)

N

545 Namibia
133 Nampo-shoto, Southern
545 Natal
723 Nauru
610 Near-East Asia
067 Nebraska
643 Nepal
432 Netherlands
245 Netherlands Antilles
332 Netherlands Guiana
085 Nevada

245 Nevis
221 New Brunswick
724 New Caledonia
001 New England
673 New Guinea, except Australian and North East
711 New Guinea, Australian
711 New Guinea, North East
003 New Hampshire
721 New Hebrides
008 New Jersey
086 New Mexico
011 New York
715 New Zealand
221 Newfoundland
255 Nicaragua
520 Niger
531 Nigeria
715 Niue
711 Norfolk Island
510 North Africa, NOS
260 North America, NOS (use more specific term if possible)
240 North American Islands
671 North Borneo (Malaysia)
025 North Carolina
040 North Central States
054 North Dakota
711 North East New Guinea
695 North Korea
010 North Mid-Atlantic States
499 Northern Europe, NOS
404 Northern Ireland
129 Northern Mariana Islands
050 Northern Midwest States
549 Northern Rhodesia
225 Northwest Territories (Canada)
423 Norway
998 Not United States, NOS
221 Nova Scotia
227 Nunavut
551 Nyasaland

O

043 Ohio
075 Oklahoma

629 Oman
223 Ontario
545 Orange Free State
095 Oregon
403 Orkney

P

120 Pacific area, U.S. possessions
090 Pacific Coast States
720 Pacific Islands
123 Pacific Islands, Trust Territory of the (code to specific islands if possible)
639 Pakistan
645 Pakistan, East
639 Pakistan, West
139 Palau (Trust Territory of the Pacific Islands)
625 Palestine, Arab
631 Palestine, Jewish
631 Palestine, NOS
631 Palestinian National Authority--PNA
257 Panama
711 Papua New Guinea
371 Paraguay
014 Pennsylvania
629 People's Democratic Republic of Yemen
682 People's Republic of China
637 Persia
629 Persian Gulf States, NOS
351 Peru
675 Philippine Islands
675 Philippines
725 Pitcairn
451 Poland
725 Polynesian Islands
445 Portugal
539 Portuguese Guinea
224 Prairie Provinces, Canada
221 Prince Edward Island
543 Principe
101 Puerto Rico

Q

629 Qatar
222 Quebec

R

684 Republic of China
545 Republic of South Africa
580 Reunion
006 Rhode Island
547 Rhodesia
549 Rhodesia, Northern
547 Rhodesia, Southern
539 Rio Muni
440 Romance-language countries
449 Romania
449 Roumania
577 Ruanda
449 Rumania
455 Russia, NOS
455 Russia S.F.S.R.
457 Russian, White
455 Russian Federation (former U.S.S.R.)
577 Rwanda
134 Ryukyu Islands

S

520 Sahara, Western
121 Samoa, American
725 Samoa, Western
245 St. Christopher-Nevis
580 St. Helena
245 St. Kitts (see St. Christopher-Nevis)
245 St. Lucia
249 St. Pierre
245 St. Vincent
447 San Marino
543 Sao Tome
447 Sardinia
224 Saskatchewan
629 Saudi Arabia
420 Scandinavia
403 Scotland
539 Senegal
453 Serbia
580 Seychelles
403 Shetland Islands
651 Siam

447	Sicily
539	Sierra Leone
643	Sikkim
671	Singapore
450	Slavic countries
453	Slavonia
452	Slovak Republic
452	Slovakia
453	Slovenia
721	Solomon Islands
581	Somali Republic
581	Somalia
581	Somaliland
583	Somaliland, French
540	South Africa
545	South Africa, Republic of
545	South Africa, Union of
300	South America
380	South American Islands
026	South Carolina
055	South Dakota
695	South Korea
020	South Mid-Atlantic States
545	South West Africa
650	Southeast Asia
030	Southeastern States
499	Southern Europe, NOS
122	Southern Line Islands
070	Southern Midwest States
133	Southern Nampo-shoto
547	Southern Rhodesia
629	Southern Yemen
---	Soviet Union (see individual republics)
443	Spain
520	Spanish Sahara
647	Sri Lanka
520	Sudan (Anglo-Egyptian Sudan)
520	Sudanese countries
673	Sumatra
332	Suriname
423	Svalbard
135	Swan Islands
545	Swaziland
427	Sweden

435	Switzerland
621	Syria

T

634	Tadzhik S.S.R.
684	Taiwan
634	Tajikistan
571	Tanzania
571	Tanganyika
571	Tanzanyika
031	Tennessee
077	Texas
651	Thailand (Siam)
685	Tibet
245	Tobago
539	Togo
136	Tokelau Islands
725	Tonga
665	Tonkin
625	Trans-Jordan
545	Transkei
545	Transvaal
449	Transylvania
245	Trinidad
517	Tripoli
517	Tripolitania
629	Trucial States
515	Tunisia
611	Turkey
634	Turkmen S.S.R.
634	Turkmenistan
245	Turks Islands
125	Tuvalu

U

573	Uganda
456	Ukraine
456	Ukrainian S.S.R.
404	Ulster
545	Union of South Africa
---	Union of Soviet Socialist Republics (U.S.S.R.) (see individual republics)
629	United Arab Emirates

519 United Arab Republic
400 United Kingdom
000 United States
102 U.S. Virgin Islands
999 Unknown
520 Upper Volta
375 Uruguay
579 Urundi
084 Utah
634 Uzbekistan
634 Uzbek, S.S.R.

V

721 Vanuatu
447 Vatican City
545 Venda
321 Venezuela
004 Vermont
665 Vietnam
245 Virgin Islands (British)
102 Virgin Islands (U.S.)
023 Virginia

W

137 Wake Island
402 Wales
449 Wallachia
721 Wallis
093 Washington (state)
022 Washington D.C.
530 West Africa, NOS
539 West African countries, other
631 West Bank
431 West Germany
245 West Indies, NOS (see also individual islands)
639 West Pakistan
024 West Virginia
499 Western Europe, NOS
520 Western Sahara
725 Western Samoa
457 White Russia
245 Windward Islands
051 Wisconsin

082 Wyoming

Y

629 Yemen
629 Yemen, People's Democratic Republic of
453 Yugoslavia (former Yugoslavia region)
225 Yukon Territory

Z

541 Zaire
549 Zambia
571 Zanzibar
547 Zimbabwe

APPENDIX I

International Organization for Standardization (ISO) for Birthplace-State and Birthplace-Country

United States Country Code = USA	
State	**Code**
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
Armed Forces Americas	AA
Armed Forces Canada, Europe, Middle East, Africa	AE
Armed Forces Pacific	AP
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
District of Columbia	DC
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT

United States Country Code = USA	
State	**Code**
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY
United States, NOS (specific state unknown)	US

Canada (Province and Territory) Country Code = CAN	
Province/Territory	**Code**
Alberta	AB
British Columbia	BC
Manitoba	MB
New Brunswick	NB
Newfoundland and Labrador	NL
Northwest Territories	NT
Northwest Territories, Yukon Territory	YN
Nova Scotia	NS
Nunavut	NU
Ontario	ON
Prince Edward Island	PE
Quebec	QC
Saskatchewan	SK
Yukon Territory	YT
Canada, NOS (specific Province/Territory unknown)	CD

Countries outside the United States and Canada		
Country	Country Code	State Code
Afghanistan	AFG	XX
African Coastal Islands (previously in South Africa, NOS)	XIF	YY
Aland Islands	ALA	XX
Albania	ALB	XX
Algeria	DZA	XX
American Samoa	ASM	AS
Andorra	AND	XX
Angola (Sao Tome, Principe, Cabinda)	AGO	XX
Anguilla	AIA	XX
Antarctica	ATA	XX
Antigua and Barbuda	ATG	XX
Arabian Peninsula	XAP	YY
Argentina	ARG	XX
Armenia	ARM	XX

Countries outside the United States and Canada		
Country	Country Code	State Code
Aruba	ABW	XX
Australia	AUS	XX
Australia and Australian New Guinea	AUS	XX
Austria	AUT	XX
Azerbaijan	AZE	XX
Bahamas	BHS	XX
Bahrain	BHR	XX
Bangladesh (East Pakistan)	BGD	XX
Barbados	BRB	XX
Belgium	BEL	XX
Belize (British Honduras)	BLZ	XX
Benin	BEN	XX
Bermuda	BMU	XX
Bhutan	BTN	XX
Bolivia	BOL	XX
Bonaire, Saint Eustatius and Saba	BES	XX
Bosnia and Herzogovina	BIH	XX
Botswana	BWA	XX
Bouvet Island	BVT	XX
Brazil	BRA	XX
British Indian Ocean Territory	IOT	XX
British Virgin Islands	VGB	XX
Brunei	BRN	XX
Bulgaria	BGR	XX
Burkina Faso	BFA	XX
Burma	MMR	XX
Burundi (Urundi)	BDI	XX
Byelorus (Byelorussian SSR, White Russia)	BLR	XX
Cambodia	KHM	XX
Cameroon	CMR	XX
Canal Zone	PAN	XX
Cape Verde	CPV	XX
Caucasian Republics of the USSR	XCR	YY
Cayman Islands	CYM	XX
Central African Republic	CAF	XX
Ceylon (Sri Lanka)	LKA	XX
Chad	TCD	XX
Chile	CHL	XX
China (Peoples Republic of China)	CHN	XX
China, NOS	XCH	YY
Christmas Island	CXR	XX
Cocos (Keeling) Islands	CCK	XX
Colombia	COL	XX
Comoros	COM	XX
Congo	COG	XX
Cook Islands (New Zealand)	COK	XX
Costa Rica	CRI	XX

Countries outside the United States and Canada		
Country	Country Code	State Code
Cote d'Ivoire	CIV	XX
Croatia	HRV	XX
Cuba	CUB	XX
Curacao	CUW	XX
Cyprus	CYP	XX
Czech Republic	CZE	XX
Czechoslovakia (former)	CSK	YY
Denmark, Faroe Islands	DNK	XX
Djibouti	DJI	XX
Dominica	DMA	XX
Dominican Republic	DOM	XX
East Africa	XEF	YY
Ecuador	ECU	XX
Egypt (United Arab Republic)	EGY	XX
El Salvador	SLV	XX
England	ENG	XX
England, Channel Islands, Isle of Man	XEN	XX
Equatorial Guinea	GNQ	XX
Eritrea	ERI	XX
Estonian SSR (Estonia)	EST	XX
Ethiopia	ETH	XX
Ethiopia (Abyssinia), Eritrea	XET	YY
Falkland Islands	FLK	XX
Faroe Islands	FRO	XX
Fiji	FJI	XX
Finland	FIN	XX
France, Corsica, Monaco	FRA	XX
French Guiana	GUF	XX
French Polynesia	PYF	XX
French Southern Territories	ATF	XX
Gabon	GAB	XX
Gambia	GMB	XX
Georgia	GEO	XX
Germanic Countries	XGR	YY
Germany (East and West)	DEU	XX
Ghana	GHA	XX
Gibraltar	GIB	XX
Greece	GRC	XX
Greenland	GRL	XX
Grenada	GRD	XX
Guadeloupe	GLP	XX
Guam	GUM	GU
Guatemala	GTM	XX
Guernsey	GGY	XX
Guinea	GIN	XX
Guinea Bissau	GNB	XX
Guyana (British Guiana)	GUY	XX

Countries outside the United States and Canada		
Country	Country Code	State Code
Haiti	HTI	XX
Heard Island and McDonald Islands	HMD	XX
Honduras	HND	XX
Hong Kong	HKG	XX
Hungary	HUN	XX
Iceland	ISL	XX
India	IND	XX
Indochina	XSE	YY
Indonesia (Dutch East Indies)	IDN	XX
Iran (Persia)	IRN	XX
Iraq	IRQ	XX
Ireland (Eire) (Ireland NOS, Republic of Ireland)	IRL	XX
Isle of Man	IMN	XX
Israel	ISR	XX
Israel and former Jewish Palestine	XIS	YY
Italy (Sardinia, Sicily), San Marino, Vatican City	ITA	XX
Jamaica	JAM	XX
Japan	JPN	XX
Jersey	JEY	XX
Johnston Atoll	UMI	UM
Jordan (Transjordan) and former Arab Palestine	JOR	XX
Kazakhstan	KAZ	XX
Kenya	KEN	XX
Kiribati (Canton, Enderbury, Gilbert, S Lines, Phoenix)	KIR	XX
Korea (North and South)	KOR	XX
Kuwait	KWT	XX
Kyrgyzstan	KGZ	XX
Laos	LAO	XX
Latvian SSR (Latvia)	LVA	XX
Lebanon	LBN	XX
Lesotho	LSO	XX
Liberia	LBR	XX
Libya (Tripoli, Tripolitania, Cyrenaica)	LBY	XX
Liechtenstein	LIE	XX
Lithuania (Lithuanian SSR)	LTU	XX
Luxembourg	LUX	XX
Macao (Macau)	MAC	XX
Macedonia	MKD	XX
Madagascar (Malagasy Republic)	MDG	XX
Malawi (Nyasaland)	MWI	XX
Malaysia	MYS	XX
Malaysia, Singapore, Brunei	XMS	YY
Mali	MLI	XX
Malta	MLT	XX
Mariana Islands (Trust Territory of Pacific Islands)	MNP	MP
Marshall Islands (Trust Territory Pacific Islands)	MHL	MH
Martinique	MTQ	XX

Countries outside the United States and Canada		
Country	Country Code	State Code
Mauritania	MRT	XX
Mauritius	MUS	XX
Mayotte	MYT	XX
Melanesian Islands, Solomon Islands	XML	YY
Mexico	MEX	XX
Micronesia (Fed States of) (Caroline, Trust Terr of Pacific)	FSM	FM
Micronesian Islands	XMC	YY
Mid-East Asia NOS, Maldives	MDV	XX
Moldova	MDA	XX
Monaco	MCO	XX
Mongolia	MNG	XX
Montenegro	MNE	XX
Montserrat	MSR	XX
Morocco	MAR	XX
Mozambique	MOZ	XX
Namibia	NAM	XX
Nampo-Shoto, Southern	JPN	XX
Nauru	NRU	XX
Nepal, Bhutan, Sikkim	NPL	XX
Netherlands	NLD	XX
New Caledonia	NCL	XX
New Zealand	NZL	XX
Nicaragua	NIC	XX
Niger	NER	XX
Nigeria	NGA	XX
Niue	NIU	XX
Norfolk Island	NFK	XX
North Africa	XNF	YY
North American Islands	XNI	YY
North Korea	PRK	XX
Northern Ireland (Ulster)	NIR	XX
Norway (Svalbard, Jan Mayen)	NOR	XX
Oman	OMN	XX
Other Asian Republics of the USSR	XOR	YY
Other Caribbean Islands	XCB	YY
Other West African Countries	XWF	YY
Pakistan (West Pakistan)	PAK	XX
Palau (Trust Territory of Pacific Islands)	PLW	PW
Palestine Territory, Occupied	PSE	XX
Panama	PAN	XX
Papua New Guinea	PNG	XX
Paraguay	PRY	XX
Peru	PER	XX
Philippines (Philippine Islands)	PHL	XX
Pitcairn Islands	PCN	XX
Poland	POL	XX
Polynesian Islands	XPL	YY

Countries outside the United States and Canada		
Country	Country Code	State Code
Portugal (Madeira Islands, Azores, Cape Verde Islands)	PRT	XX
Puerto Rico	PRI	PR
Qatar	QAT	XX
Republic of South Africa	ZAF	XX
Republic of South Africa, Botswana, Lesotho, Namibia, Swaziland	XSF	YY
Réunion	REU	XX
Romania	ROU	XX
Russian SFSR (Russia)	RUS	XX
Rwanda (Ruanda)	RWA	XX
Ryukyu Islands (Japan)	JPN	XX
Samoa	WSM	XX
San Marino	SMR	XX
Sao Tome & Principe	STP	XX
Saudi Arabia	SAU	XX
Scandinavia	XSC	YY
Scotland	SCT	XX
Senegal	SEN	XX
Serbia	SRB	XX
Seychelles	SYC	XX
Sierra Leone	SLE	XX
Singapore	SGP	XX
Sint-Maarten	SXM	XX
Slavic Countries	XSL	YY
Slovakia	SVK	XX
Slovenia	SVN	XX
Solomon Islands	SLB	XX
Somalia (Somali Republic, Somaliland)	SOM	XX
South Africa, NOS	XSF	YY
South Georgia and the South Sandwich Islands	SGS	XX
South Sudan	SSD	XX
Southeast Asia	XSE	YY
Spain (Canary Islands, Balearic Islands), Andorra	ESP	XX
St Pierre and Miquelon	SPM	XX
St. Barthelemy	BLM	XX
St. Helena	SHN	XX
St. Kitts and Nevis	KNA	XX
St. Lucia	LCA	XX
St. Martin (French part)	MAF	XX
St. Vincent and the Grenadines	VCT	XX
Sudan	SDN	XX
Sudanese Countries	XSD	YY
Suriname (Dutch Guiana)	SUR	XX
Svalbard and Jan Mayen	SJM	XX
Swan Islands	UMI	UM
Swaziland	SWZ	XX
Sweden	SWE	XX

Countries outside the United States and Canada		
Country	Country Code	State Code
Switzerland	CHE	XX
Syria	SYR	XX
Taiwan (Formosa) (Republic of China)	TWN	XX
Tajikistan	TJK	XX
Tanzania (Tanganyika, Zanzibar)	TZA	XX
Thailand (Siam)	THA	XX
Tibet	CHN	XX
Timor-Leste	TLS	XX
Togo	TGO	XX
Tokelau Islands (New Zealand)	TKL	XX
Tonga	TON	XX
Trinidad and Tobago	TTO	XX
Tunisia	TUN	XX
Turkey	TUR	XX
Turkmenistan	TKM	XX
Turks and Caicos	TCA	XX
Tuvalu (Ellice Islands)	TUV	XX
U.S. Virgin Islands	VIR	VI
Uganda	UGA	XX
Ukraine	UKR	XX
Ukraine and Moldavia	XUM	YY
United Arab Emirates	ARE	XX
United Kingdom	GBR	XX
Uruguay	URY	XX
Uzbekistan	UZB	XX
Vanuatu	VUT	XX
Vatican City	VAT	XX
Venezuela	VEN	XX
Vietnam (Tonkin, Annam, Cochin China)	VNM	XX
Wake Island	UMI	UM
Wales	WLS	XX
Wallis and Fotuna	WLF	XX
West Africa, NOS (French Africa, NOS)	XWF	YY
Western Sahara	ESH	XX
Yemen	YEM	XX
Yugoslavia (former)	YUG	YY
Zaire (Congo-Leopoldville, Belgian Congo, Congo/Kinshasa)	COD	XX
Zambia (Northern Rhodesia)	ZMB	XX
Zimbabwe (Rhodesia, Southern Rhodesia)	ZWE	XX

General Codes Only use in the absence of more specific information		
Country	Country Code	State Code
Africa, NOS (Central, Equatorial)	ZZF	YY
Asia, NOS	ZZA	YY
Asian and Arab Countries	ZZA	YY
Atlantic/Caribbean Area	ZZN	YY
Baltic Republic(s), NOS (Baltic States, NOS)	ZZE	YY
Central America	ZZC	YY
East Asia	ZZA	YY
Europe, NOS (Central, Eastern, Northern, Southern, Western)	ZZE	YY
Latin America, NOS	ZZU	YY
Near East	ZZA	YY
North America, NOS	ZZN	YY
Not U.S., but no other information	ZZX	YY
Other Atlantic/Caribbean Area	ZZN	YY
Other Mainland Europe	ZZE	YY
Other Mediterranean Isles	ZZE	YY
Other Pacific Area	ZZP	YY
Pacific Area	ZZP	YY
Pacific Islands	ZZP	YY
Romance-Language Countries	ZZE	YY
South America, NOS	ZZS	YY
South American Islands	ZZS	YY
Trust Territories	ZZP	TT
Unknown	ZZU	ZZ

APPENDIX J

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 to December 31, 2017. If a schema is not listed, the PCR does not require any SSF for that schema. SSF fields are left blank for all other years.

CS Schema Name	SSF #	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
CorpusAdenosarcoma	2	Peritoneal Cytology
CorpusCarcinoma	2	Peritoneal Cytology

CS Schema Name	SSF #	SSF Description
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
LarynxSupraglottic	1	Size of Lymph Nodes
LipLower	1	Size of Lymph Nodes

CS Schema Name	SSF #	SSF Description
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
Nasopharynx	1	Size of Lymph Nodes
	25	Schema Discriminator

CS Schema Name	SSF #	SSF Description
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
Skin	12	High Risk Features
	16	Size of Lymph Nodes

CS Schema Name	SSF #	SSF Description
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

APPENDIX K

Surgery to Primary Site Codes

ORAL CAVITY

Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9, Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9, Other Parts of Mouth C06.0-C06.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Wide excision, NOS

Code 30 includes:
- Hemiglossectomy
- Partial glossectomy

40 Radical excision of tumor, NOS
- 41 Radical excision of tumor ONLY
- 42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
- 43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

Codes 40–43 include:
- Total glossectomy
- Radical glossectomy

Specimen sent to pathology from surgical events 20–43.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PAROTID AND OTHER UNSPECIFIED GLANDS

Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS
- 31 Facial nerve spared
- 32 Facial nerve sacrificed

33 Superficial lobe ONLY
- 34 Facial nerve spared
- 35 Facial nerve sacrificed

36 Deep lobe (Total)
- 37 Facial nerve spared
- 38 Facial nerve sacrificed

40 Total parotidectomy, NOS; total removal of major salivary gland, NOS
- 41 Facial nerve spared
- 42 Facial nerve sacrificed

50 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
- 51 WITHOUT removal of temporal bone
- 52 WITH removal of temporal bone
- 53 WITH removal of overlying skin (requires graft or flap coverage)

80 Parotidectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PHARYNX

Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9, Pyriform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsies

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablations

- 25 Laser excision
- 28 Stripping

30 Pharyngectomy, NOS
- 31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
- 32 Total pharyngectomy

40 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)
- 41 WITH Laryngectomy (laryngopharyngectomy)
- 42 WITH bone
- 43 WITH both 41 and 42

50 Radical pharyngectomy (includes total mandibular resection), NOS
- 51 WITHOUT laryngectomy
- 52 WITH laryngectomy

Specimens sent to pathology from surgical events 20–52.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ESOPHAGUS

C15.0-C15.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial esophagectomy

40 Total esophagectomy, NOS

50 Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
- 51 WITH laryngectomy
- 52 WITH gastrectomy, NOS
- 53 Partial gastrectomy
- 54 Total gastrectomy
- 55 Combination of 51 WITH any of 52–54

80 Esophagectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

STOMACH

C16.0-C16.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Gastrectomy, NOS (partial, subtotal, hemi-)
- 31 Antrectomy, lower (distal-less than 40% of stomach)***
- 32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
- 33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:

Partial gastrectomy, including a sleeve resection of the stomach
Billroth I: anastomosis to duodenum (duodenostomy)
Billroth II: anastomosis to jejunum (jejunostomy)

40 Near-total or total gastrectomy, NOS
- 41 Near-total gastrectomy
- 42 Total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach.

50 Gastrectomy, NOS WITH removal of a portion of esophagus
- 51 Partial or subtotal gastrectomy
- 52 Near total or total gastrectomy

Codes 50–52 are used for gastrectomy resection when only portions of esophagus are included in procedure.

60 Gastrectomy with a resection in continuity with the resection of other organs, NOS***
- 61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***
- 62 Near total or total gastrectomy, in continuity with the resection of other organs***
- 63 Radical gastrectomy, in continuity with the resection of other organs***

Codes 60–63 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection.

80 Gastrectomy, NOS

Specimen sent to pathology from surgical events 20–80

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included

COLON

C18.0-C18.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site.*

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy, NOS
- 28 Polypectomy-endoscopic
- 29 Polypectomy-surgical excision

Any combination of 20 or 26–29 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial colectomy, segmental resection
- 32 Plus resection of contiguous organ; example: small bowel, bladder

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)
- 41 Plus resection of contiguous organ; example: small bowel, bladder

50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)
- 51 Plus resection of contiguous organ; example: small bowel, bladder

60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
61 Plus resection of contiguous organ; example: small bowel, bladder

70 Colectomy or coloproctotectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)

Code 70 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

80 Colectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

RECTOSIGMOID

C19.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site*.

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser ablation
No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
26 Polypectomy
27 Excisional biopsy
Combination of 20 or 26–27 WITH
21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

30 Wedge or segmental resection; partial proctosigmoidectomy, NOS
31 Plus resection of contiguous organs; example: small bowel, bladder
Procedures coded 30 include, but are not limited to:
Anterior resection
Hartmann operation
Low anterior resection (LAR)
Partial colectomy, NOS
Rectosigmoidectomy, NOS
Sigmoidectomy

40 Pull through WITH sphincter preservation (colo-anal anastomosis)

50 Total proctectomy

51 Total colectomy

55 Total colectomy WITH ileostomy, NOS
56 Ileorectal reconstruction
57 Total colectomy WITH other pouch; example: Koch pouch

60 Total proctocolectomy, NOS
65 Total proctocolectomy WITH ileostomy, NOS
66 Total proctocolectomy WITH ileostomy and pouch
Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.

70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration

80 Colectomy, NOS; Proctectomy, NOS

Specimen sent to pathology from surgical events 20–27.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

RECTUM

C20.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site.*

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

- 25 Laser excision
- 28 Curette and fulguration

30 Wedge or segmental resection; partial proctectomy, NOS

Procedures coded 30 include, but are not limited to:
- Anterior resection
- Hartmann's operation
- Low anterior resection (LAR)
- Transsacral rectosigmoidectomy

40 Pull through WITH sphincter preservation (coloanal anastomosis)

50 Total proctectomy- **Procedure coded 50 includes, but is not limited to**: Abdominoperineal resection (Miles Procedure)

60 Total proctocolectomy, NOS

70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration

80 Proctectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ANUS

C21.0-C21.8

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal Ablation

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

60 Abdominal perineal resection, NOS (APR; Miles procedure)
- 61 APR and sentinel node excision
- 62 APR and unilateral inguinal lymph node dissection
- 63 APR and bilateral inguinal lymph node dissection

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery.*

Specimen sent to pathology from surgical events 20–63.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LIVER AND INTRAHEPATIC BILE DUCTS

C22.0-C22.1

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Alcohol (Percutaneous Ethanol Injection-PEI)
- 16 Heat-Radio-frequency ablation (RFA)
- 17 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events 10–17.

20 Wedge or segmental resection, NOS
- 21 Wedge resection
- 22 Segmental resection, NOS
  - 23 One
  - 24 Two
  - 25 Three
  - 26 Segmental resection AND local tumor destruction

30 Lobectomy, NOS
- 36 Right lobectomy
- 37 Left lobectomy
- 38 Lobectomy AND local tumor destruction

50 Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe)
- 51 Right lobectomy
- 52 Left lobectomy
- 59 Extended lobectomy AND local tumor destruction

60 Hepatectomy, NOS
- 61 Total hepatectomy and transplant

65 Excision of a bile duct (for an intra-hepatic bile duct primary only)
- 66 Excision of an intrahepatic bile duct PLUS partial hepatectomy

75 Extrahepatic bile duct and hepatectomy WITH transplant

Specimen sent to pathology from surgical events 20–75.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PANCREAS

C25.0-C25.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

25 Local excision of tumor, NOS

30 Partial pancreatectomy, NOS; example: distal

35 Local or partial pancreatectomy and duodenectomy
- 36 WITHOUT distal/partial gastrectomy
- 37 WITH partial gastrectomy (Whipple)

40 Total pancreatectomy

60 Total pancreatectomy and subtotal gastrectomy or duodenectomy

70 Extended pancreatoduodenectomy

80 Pancreatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LARYNX

C32.0-C32.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

- 25 Laser excision
- 28 Stripping

30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy, NOS
- 31 Vertical laryngectomy
- 32 Anterior commissure laryngectomy
- 33 Supraglottic laryngectomy

40 Total or radical laryngectomy, NOS
- 41 Total laryngectomy ONLY
- 42 Radical laryngectomy ONLY

50 Pharyngolaryngectomy

80 Laryngectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LUNG

C34.0-C34.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19

15 Local tumor destruction, NOS
12 Laser ablation or cryosurgery
13 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
No specimen sent to pathology from surgical events 12–13 and 15.

20 Excision or resection of less than one lobe, NOS
23 Excision, NOS
24 Laser excision
25 Bronchial sleeve resection ONLY
21 Wedge resection
22 Segmental resection, including lingulectomy

30 Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)
33 Lobectomy WITH mediastinal lymph node dissection
The lymph node dissection should be coded under *Scope of Regional Lymph Node Surgery.*

45 Lobe or bilobectomy extended, NOS
46 WITH chest wall
47 WITH pericardium
48 WITH diaphragm

55 Pneumonectomy, NOS
56 WITH mediastinal lymph node dissection (radical pneumonectomy)
The mediastinal lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery.*

65 Extended pneumonectomy
66 Extended pneumonectomy plus pleura or diaphragm

70 Extended radical pneumonectomy
The mediastinal lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery.*

80 Resection of lung, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

HEMATOPOIETIC/RETICULOENDOTHELIAL/ IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE

C42.0, C42.1, C42.3, C42.4 (with any histology) or 9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992 (with any site)

Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative diseases	
C42.0	Blood
C42.1	Bone marrow
C42.3	Reticuloendothelial system
C42.4	Hematopoietic system
9731/9734	Plasmacytoma
9732	Multiple myeloma
9733	Plasma cell leukemia
9734	Plasmacytoma, extramedullary
9740-9742	Mast cell tumors
9750-9754	Malignant histiocytosis
9755	Histiocytic sarcoma
9756	Langerhans cell sarcoma
9758	Follicular dendritic cell sarcoma
9760	Immunoproliferative disease, NOS
9761	Waldenstrom macroglobulinemia
9762	Heavy chain disease
9764	Immunoproliferative small intestinal disease (Mediterranean lymphoma)
9800-9827, 9831-9920, 9940-9948	Leukemias
9930	Myeloid sarcoma
9931	Acute panmyelosis with fibrosis
9950	Polycythemia vera
9960	Chronic myeloproliferative disorder
9961	Myelosclerosis with myeloid metaplasia
9962	Essential thrombocythemia
9963	Chronic neutrophilic leukemia
9964	Hypereosinophilic syndrome
9965-9967	Myeloid and lymphoid neoplasms
9971	Polymorphic PTLD
9975	Myelodysplastic/Myeloproliferative neoplasm, unclassifiable, Myeloproliferative disease, NOS, Myeloproliferative neoplasm, unclassifiable
9980-9985	Refractory anemias
9986	Myelodysplastic syndrome with 5q deletion syndrome
9945	Therapy-related myelodysplastic syndrome, NOS
9989	Myelodysplastic syndrome, NOS
9991	Refractory neutropenia
9992	Refractory thrombocytopenia

98 All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment.

BONES, JOINTS, AND ARTICULAR CARTILAGE
PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM
CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES

C40.0-C41.9, C47.0-C47.9, C49.0-C49.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction
No specimen sent to pathology from surgical event 15.

25 Local excision

26 Partial resection

30 Radical excision or resection of lesion WITH limb salvage

40 Amputation of limb
- 41 Partial amputation of limb
- 42 Total amputation of limb

50 Major amputation, NOS
- 51 Forequarter, including scapula
- 52 Hindquarter, including ilium/hip bone
- 53 Hemipelvectomy, NOS
- 53 Internal hemipelvectomy

Specimen sent to pathology from surgical events 25–54.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SPLEEN

C42.2

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19 principally for cases diagnosed prior to January 1, 2003).

21 Partial splenectomy

22 Total splenectomy

80 Splenectomy, NOS

Specimen sent to pathology from surgical events 21–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SKIN

C44.0-C44.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Biopsy of primary tumor followed by a gross excision of the lesion (does not have to be done under the same anesthesia)
- 31 Shave biopsy followed by a gross excision of the lesion
- 32 Punch biopsy followed by a gross excision of the lesion
- 33 Incisional biopsy followed by a gross excision of the lesion
- 34 Mohs surgery, NOS
- 35 Mohs with 1-cm margin or less
- 36 Mohs with more than 1-cm margin

45 Wide excision or reexcision of lesion or minor (local) amputation with margins more than 1 cm, NOS. Margins MUST be microscopically negative.
- 46 WITH margins more than 1 cm and less than or equal to 2 cm
- 47 WITH margins greater than 2 cm

If the excision does not have microscopically negative margins greater than 1 cm, use the appropriate code, 20-36.

60 Major amputation

Specimen sent to pathology from surgical events 20–60.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

BREAST

C50.0-C50.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS

No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

20 Partial mastectomy, NOS; less than total mastectomy, NOS
- 21 Partial mastectomy WITH nipple resection
- 22 Lumpectomy or excisional biopsy
- 23 Reexcision of the biopsy site for gross or microscopic residual disease
- 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

30 Subcutaneous mastectomy

A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.

40 Total (simple) mastectomy
- 41 WITHOUT removal of uninvolved contralateral breast
  - 43 Reconstruction NOS
    - 44 Tissue
    - 45 Implant
    - 46 Combined (Tissue and Implant)
- 42 WITH removal of uninvolved contralateral breast
  - 47 Reconstruction NOS
    - 48 Tissue
    - 49 Implant
    - 75 Combined (Tissue and Implant)

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site.*

If contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

Reconstruction that is planned as part of first course treatment is coded 43-49 or 75, whether it is done at the time of mastectomy or later

76 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.

50 Modified radical mastectomy
- 51 WITHOUT removal of uninvolved contralateral breast
  - 53 Reconstruction, NOS
    - 54 Tissue
    - 55 Implant
    - 56 Combined (Tissue and Implant)
- 52 WITH removal of uninvolved contralateral breast
  - 57 Reconstruction, NOS
    - 58 Tissue
    - 59 Implant
    - 63 Combined (Tissue and Implant)

Removal of all breast tissue, nipple, areolar complex, and variable amounts of breast skin in continuity with axilla. Specimen may or may not include portion of pectoralis major muscle.

If contralateral breast reveals a second primary, it is abstracted separately. The surgical procedure is coded 41 or 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site.*

60 Radical mastectomy, NOS
- 61 WITHOUT removal of uninvolved contralateral breast
  - 64 Reconstruction, NOS
    - 65 Tissue
    - 66 Implant
    - 67 Combined (Tissue and Implant)
- 62 WITH removal of uninvolved contralateral breast
  - 68 Reconstruction, NOS
    - 69 Tissue
    - 73 Implant
    - 74 Combined (Tissue and Implant)

70 Extended radical mastectomy
- 71 WITHOUT removal of uninvolved contralateral breast
- 72 WITH removal of uninvolved contralateral breast

80 Mastectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

CERVIX UTERI

C53.0-C53.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Laser ablation
- 17 Thermal ablation

No specimen sent to pathology from surgical events 10–17.

20 Local tumor excision, NOS
- 26 Excisional biopsy, NOS
- 27 Cone biopsy
- 24 Cone biopsy WITH gross excision of lesion
- 29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27 or 29 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

- 25 Dilatation and curettage; endocervical curettage (for in situ only)
- 28 Loop electrocautery excision procedure (LEEP)

30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 51 Modified radical hysterectomy
- 52 Extended hysterectomy
- 53 Radical hysterectomy; Wertheim procedure
- 54 Extended radical hysterectomy

60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
- 61 WITHOUT removal of tubes and ovaries
- 62 WITH removal of tubes and ovaries

70 Pelvic exenteration
- 71 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

72 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

73 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20–29.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

CORPUS UTERI

C54.0-C55.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser
15 Loop Electrocautery Excision Procedure (LEEP)
16 Thermal ablation
No specimen sent to pathology from surgical events 10–16.

20 Local tumor excision, NOS; simple excision, NOS
24 Excisional biopsy
25 Polypectomy
26 Myomectomy
Any combination of 20 or 24–26 WITH
21 Electrocautery
22 Cryosurgery
23 Laser ablation or excision

30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies).
31 WITHOUT tube(s) and ovary(ies)
32 WITH tube(s) and ovary(ies)

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)

Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 61 Modified radical hysterectomy
- 62 Extended hysterectomy
- 63 Radical hysterectomy; Wertheim procedure
- 64 Extended radical hysterectomy

65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)
- 66 WITHOUT removal of tube(s) and ovary(ies)
- 67 WITH removal of tube(s) and ovary(ies)

75 Pelvic exenteration

76 Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

77 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

78 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

79 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20–79.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

OVARY

C56.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

17 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 17.

25 Total removal of tumor or (single) ovary, NOS
- 26 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
- 27 WITHOUT hysterectomy
- 28 WITH hysterectomy

35 Unilateral (salpingo-)oophorectomy; unknown if hysterectomy done
- 36 WITHOUT hysterectomy
- 37 WITH hysterectomy

50 Bilateral (salpingo-)oophorectomy; unknown if hysterectomy done
- 51 WITHOUT hysterectomy
- 52 WITH hysterectomy

55 Unilateral or bilateral (salpingo-)oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done
- 56 WITHOUT hysterectomy
- 57 WITH hysterectomy

60 Debulking; cytoreductive surgery, NOS
- 61 WITH colon (including appendix) and/or small intestine resection (not incidental)
- 62 WITH partial resection of urinary tract (not incidental)
- 63 Combination of 61 and 62

Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.

70 Pelvic exenteration, NOS
- 71 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

- 72 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

- 73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

- 74 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

80 (Salpingo-)oophorectomy, NOS
Specimen sent to pathology from surgical events 25–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PROSTATE

C61.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item *Hematologic Transplant and Endocrine Procedures.*

00 None; no surgery of primary site; autopsy ONLY

18 Local tumor destruction or excision, NOS

19 Transurethral resection (TURP), NOS and no specimen sent to pathology or unknown if sent
Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19 (principally for cases diagnosed prior to January 1, 2003).

10 Local tumor destruction, NOS
- 14 Cryoprostatectomy
- 15 Laser ablation
- 16 Hyperthermia
- 17 Other method of local tumor destruction

No specimen sent to pathology from surgical events 10–17.

20 Local tumor excision, NOS
- 21 Transurethral resection (TURP), NOS, with specimen sent to pathology
- 22 TURP—cancer is incidental finding during surgery for benign disease
- 23 TURP—patient has suspected/known cancer

Any combination of 20–23 WITH
- 24 Cryosurgery
- 25 Laser
- 26 Hyperthermia

30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

50 Radical prostatectomy, NOS; total prostatectomy, NOS
Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.

80 Prostatectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

TESTIS

C62.0-C62.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

12 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 12.

20 Local or partial excision of testicle

30 Excision of testicle WITHOUT cord

40 Excision of testicle WITH cord/or cord not mentioned (radical orchiectomy)

80 Orchiectomy, NOS (unspecified whether partial or total testicle removed)

Specimen sent to pathology from surgical event 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

KIDNEY, RENAL PELVIS, AND URETER

Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal ablation

No specimen sent to pathology from this surgical event 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)
Procedures coded 30 include, but are not limited to:
Segmental resection; Wedge resection

40 Complete/total/simple nephrectomy—for kidney parenchyma
Nephroureterectomy
Includes bladder cuff for renal pelvis or ureter.

50 Radical nephrectomy
May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter.

70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with the resection of other organ(s) (colon, bladder)
The other organs, such as colon or bladder, may be partially or totally removed.

80 Nephrectomy, NOS; Ureterectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

BLADDER

C67.0-C67.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Intravesical therapy
- 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy

No specimen sent to pathology from surgical events 10–16.

20 Local tumor excision, NOS

26 Polypectomy
27 Excisional biopsy
Combination of 20 or 26–27 WITH
21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Complete cystectomy with reconstruction
61 Radical cystectomy PLUS ileal conduit
62 Radical cystectomy PLUS continent reservoir or pouch, NOS
63 Radical cystectomy PLUS abdominal pouch (cutaneous)
64 Radical cystectomy PLUS in situ pouch (orthotopic)

When the procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64)

70 Pelvic exenteration, NOS
71 Radical cystectomy including anterior exenteration
For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra. For males, includes removal of the prostate. When a procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64).

72 Posterior exenteration
For females, also includes removal of vagina, rectum and anus. For males, also includes prostate, rectum and anus

73 Total exenteration
Includes all tissue and organs removed for an anterior and posterior exenteration

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis

80 Cystectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

BRAIN

Meninges C70.0-C70.9, Brain C71.0-C71.9, Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C72.0-C72.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code laminectomies for spinal cord primaries.

00 None; no surgery of primary site; autopsy ONLY

10 Tumor destruction, NOS
No specimen sent to pathology from surgical event 10.

Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as surgical tumor destruction. All of these modalities are recorded in the radiation treatment fields.

20 Local excision of tumor, lesion or mass; excisional biopsy

21 Subtotal resection of tumor, lesion or mass in brain

22 Resection of tumor of spinal cord or nerve

30 Radical, total, gross resection of tumor, lesion or mass in brain

40 Partial resection of lobe of brain, when the surgery can not be coded as 20-30.

55 Gross total resection of lobe of brain (lobectomy)

Codes 30 - 55 are not applicable for spinal cord or spinal nerve primary sites.

Specimen sent to pathology from surgical events 20–55.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

THYROID

C73.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

13 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 13.

25 Removal of less than a lobe, NOS
26 Local surgical excision
27 Removal of a partial lobe ONLY

20 Lobectomy and/or isthmectomy

21 Lobectomy ONLY
22 Isthmectomy ONLY
23 Lobectomy WITH isthmus

30 Removal of a lobe and partial removal of the contralateral lobe

40 Subtotal or near total thyroidectomy

50 Total thyroidectomy

80 Thyroidectomy, NOS

Specimen sent to pathology from surgical events 25–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LYMPH NODES

C77.0-C77.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 15.

25 Local tumor excision, NOS
Less than a full chain, includes an excisional biopsy of a single lymph node.

30 Lymph node dissection, NOS
31 One chain
32 Two or more chains

40 Lymph node dissection, NOS PLUS splenectomy
41 One chain
42 Two or more chains

50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
51 One chain
52 Two or more chains

60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy. (Includes staging laparotomy for lymphoma)
61 One chain
62 Two or more chains

Specimen sent to pathology from surgical events 25–62.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ALL OTHER SITES

C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation
- 41 Total enucleation (for eye surgery only)

50 Surgery stated to be "debulking"

60 Radical surgery

Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.

Specimen sent to pathology from surgical events 20–60.

90 Surgery, NOS
99 Unknown if surgery performed; death certificate ONLY

TESTIS

C76.0-C76.8, C80.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

98 All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item *Surgical Procedure/Other Site.*

APPENDIX L

Abbreviations and Symbols

The PCR requires all cases to include text information to support specific coded fields. Complete and descriptive text is vital to the quality control efforts of the PCR. Often it is necessary to use abbreviations to provide adequate descriptions within the limited size of the text fields. However, a reader may interpret many standard medical abbreviations differently. The PCR will rely on the attached abbreviation list to indicate how PCR staff will interpret the abbreviation when its use is unclear. It is a combination of the North American Association of Central Cancer Registries (NAACCR)'s *Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary--Appendix G: Recommended Abbreviations for Abstractors* and the abbreviation list provided in previous *PCR Manuals*.

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

The listings are not exhaustive, but many of the most commonly used terms were included. Abbreviations for chemotherapy drugs and/or regimens are not included. For short names and acronyms of antineoplastic drugs, consult the SEER Program *Self Instructional Manual for Tumor Registrars: Book 8-Antineoplastic Drugs, Third Edition or SEER RX* at http://seer.cancer.gov/tools/seerrx/.

Please note although abbreviations are presented in uppercase, either upper- or lower-case may be utilized when entering abbreviations within abstraction software. When abstracting into text fields, the use of abbreviations should be limited to those that appear on these lists whenever practical. Abbreviations and symbols should be used carefully.

The abbreviations list does not include an abbreviation for the word **cancer**. While the abbreviation "CA" is often used in the medical record to mean either the term **cancer** or **carcinoma**, it should be used in text reported to the PCR to indicate the histologic term of carcinoma. This distinction is very important when verifying histologic coding for cancer, NOS (8000/3) and carcinoma, NOS (8010/3).

This appendix contains two tables for abbreviations, one in term order and one in abbreviation order.

ORDERED BY WORD/TERM

WORD/TERM (S)	ABBREVIATION/SYMBOL
Abdomen (abdominal)	ABD
Abdominal hysterectomy	ABD HYST
Abdominal perineal (Abdominoperineal)	AP
Abdominoperineal resection	APR
Abnormal	ABN
Abnormal liver function test	ALFT
Above	^
Above knee (amputation)	AK(A)
Absent/Absence	ABS
Abstract/Abstracted	ABST
Achilles tendon reflex	ATR
Acid phosphatase	ACID PHOS
Acquired Immune Deficiency Syndrome	AIDS
Acral lentiginous melanoma	ALM
Activities of daily living	ADL
Acute erythroleukemia	AEL
Acute granulocytic leukemia	AGL
Acute leukemia	AL
Acute lymphocytic leukemia	ALL
Acute megakaryoblastic leukemia	AMEGL
Acute myeloblastic leukemia	AMBL
Acute myelogenous leukemia	AML
Acute myelomonocytic leukemia	AMML
Acute myocardial infarction	AMI
Acute promyelocytic leukemia	APL
Acute renal failure	ARF
Acute Respiratory Distress (Disease) Syndrome	ARDS
Acute tubular necrosis	ATN
Acute undifferentiated leukemia	AUL
Adenocarcinoma	ADENOCA, ACA
Adenosine triphosphate	ATP
Adjacent	ADJ
Admission/Admit	ADM
Adrenal cortex	AC
Adrenal cortical hormone	ACH
Adrenocorticotrophic hormone	ACTH
Adult T-cell leukemia	ATL
Adult T-cell leukemia/lymphoma	ATLL
Adult-onset Diabetes Mellitus	AODM

WORD/TERM (S)	ABBREVIATION/SYMBOL
Affirmative	AFF
Against medical advice	AMA
AIDS-related condition (complex)	ARC
AIDS-related disease	ARD
Air contrast barium enema	ACBE
Albumin	ALB
Alcohol	ETOH
Alkaline phosphatase	ALK PHOS
Alpha chain disease	ACD
Alpha-fetoprotein	AFP
Also known as	AKA
Alternate	ALT
Ambulatory	AMB
Amount	AMT
Amputation	AMP
Amyotrophic lateral sclerosis	ALS
Anal intraepithelial neoplasia, grade III	AIN III
Anaplastic	ANAP
And	&
Angioblastic immunoblastic lymphadenopathy	AIL
Angiography/Angiogram	ANGIO
Anterior	ANT
Anteroposterior	AP
Antidiuretic hormone	ADH
Antigen	AG
Aortic stenosis	A-STEN
Apparently	APPL'Y
Appendix	APP
Approximately	APPROX
Arrhythmia	ARRHY
Arterial blood gases	ABG
Arteriosclerosis/Arteriosclerotic	AS
Arteriosclerotic cardiovascular disease	ASCVD
Arteriosclerotic heart disease	ASHD
Arteriosclerotic Peripheral Vascular Disease	ASPVD
Arteriovenous	AV
Arteriovenous malformation	AVM
Artery (ial)	ART
As soon as possible	ASAP
Ascending	ASC
Ascending colon	A-COLON
Aspiration	ASP

WORD/TERM (S)	ABBREVIATION/SYMBOL
Aspiration biopsy cytology	ABC
Aspirin, Acetylsalicylic acid	ASA
At	@
Atrial fibrillation	A FIB
Atrial flutter	A FLUTTER
Atrial premature complexes	APC
Atrial stenosis/insufficiency/incompetence	AI
Auscultation & percussion	A&P
Autoimmune hemolytic anemia	AIHA
Autologous bone marrow	ABM
Autologous bone marrow transplantation	ABMT
Autonomic nervous system	ANS
Autopsy	AUT
Average	AVG
Axilla(ry)	AX
Bacillus Calmette-Guerin	BCG
Barium	BA
Barium enema	BE
Barium swallow	BAS
Bartholin's, Urethral & Skene's	BUS
Basal cell carcinoma	BCC
Before noon	AM
Below knee (amputation)	BK(A)
Benign prostatic hypertrophy/hyperplasia	BPH
Bilateral	BIL
Bilateral hilar lymphadenopathy	BHL
Bilateral lower lobes	BLL
Bilateral pelvic lymph node dissection	BPLND
Bilateral salpingo-oophorectomy	BSO
Bile duct	BD
Biological response modifier	BRM
Biopsy	BX
Bipolar affective disorder	BAD
Black female	B/F
Black male	B/M
Bladder outlet obstruction	BOO
Bladder tumor	BT
Blood pressure	BP
Blood urea nitrogen	BUN
Blood volume	BV
Bone Marrow	BM
Bone marrow aspirate	BMA

WORD/TERM (S)	ABBREVIATION/SYMBOL
Bone marrow biopsy	BMBX
Bone Marrow Transplant	BMT
Bowel Movement	BM
Bowel sounds	BS
Breast self examination	BSE
Breath sounds	BRS
Bright red blood	BRB
Bright red blood per rectum	BRBPR
Bronchial lymph node	BLN
Bronchoalveolar washing	BAW
Bronchogenic carcinoma	BGCA
Burkitt lymphoma	BL
Calcium	CA
Capsule (s)	CAP(S)
Carcinoembryonic antigen	CEA
Carcinoma	CA
Carcinoma *in situ*	CIS
Carcinoma unknown primary	CUP
Cardioesophageal junction	CEJ
Cardiovascular disease	CVD
CAT/CT scan/Computerized axial tomography	CT
Ceased to breath	CTB
Centigram	CGM
Centigray	CGY
Centimeter	CM
Central nervous system	CNS
Cerebrospinal fluid	CSF
Cerebrovascular accident	CVA
Cervical intraepithelial neoplasia	CIN
Cervical intraepithelial neoplasia, grade III	CIN III
Cervical spine	C-SPINE
Cervical vertebrae	C1-C7
Cervix	CX
Change	CHG
Chemotherapy	CHEMO
Chest X-ray	CXR
Chief complaint	C/C
Cholecystectomy	CHOLE
Chronic	CHR
Chronic granulocytic leukemia	CGL
Chronic leukemia	CL
Chronic lymphocytic leukemia	CLL

WORD/TERM (S)	ABBREVIATION/SYMBOL
Chronic lymphosarcoma leukemia	CLSL
Chronic myelodysplastic syndrome	CMS
Chronic myeloid (myelocytic) leukemia	CML
Chronic myelomonocytic leukemia	CMML
Chronic obstructive lung disease	COLD
Chronic obstructive pulmonary disease	COPD
Chronic renal failure	CRF
Chronic ulcerative colitis	CUC
Cigarettes	CIG
Clear	CLR
Clinical tumor, nodes, metastases	CTNM
Cobalt 60	CO60
Collaborative stage	CS
Colon, Ascending	A-COLON
Colon, Descending	D-COLON
Colon, Sigmoid	SIG-COLON
Colon, Transverse	TRANS-COLON
Colony-stimulating factor	C-SF
Common bile duct	CBD
Complaint (-ning) of	C/O
Complete blood count	CBC
Complete continuous remission	CCR
Computerized axial tomography scan	CT, CAT
Congenital heart disease	CHD
Congestive heart failure	CHF
Consistent with	C/W
Continue/continuous	CONT
Contralateral	CONTRA
Coronary artery bypass graft	CABG
Coronary artery disease	CAD
Coronary care unit	CCU
Cubic centimeter	CC
Curie	CU
Cutaneous	CUT
Cutaneous T-cell lymphoma	CTCL
Cystic fibrosis	CF
Cystoscopy	CYSTO
Cytology	CYTO
Date of birth	DOB
Date of death	DOD
Dead on arrival	DOA
Debridement	DEB

WORD/TERM (S)	ABBREVIATION/SYMBOL
Decrease(d)	DECR
Deep tendon reflex	DTR
Deep vein thrombosis	DVT
Deoxyribonucleic acid	DNA
Dermatofibrosarcoma protuberans	DFSP
Dermatology	DERM
Descending	DESC
Descending colon	D-COLON
Diabetes mellitus	DM
Diagnosis	DX
Diagnostic laparoscopy	DL
Diameter	DIAM
Died of other causes	DOC
Died with disease	DWD
Diethylstilbestrol	DES
Differentiated/differential	DIFF
Digital rectal examination	DRE
Dilatation and curettage	D&C
Direct extension	DE
Discharge	DISCH
Discontinue(d)	DC
Disease	DZ
Disease free interval	DFI
Disseminated	DISSEM
Disseminated intravascular coagulopathy	DIC
Distant metastases	DM
Doctor	DR
Ductal carcinoma *in situ*	DCIS
Dyspnea on exertion	DOE
Ears, nose, and throat	ENT
Electrocardiogram	ECG/EKG
Electroencephalogram	EEG
Electromyogram	EMG
Emergency room	ER
Endoscopic retrograde cholangiopancreatography	ERCP
Enlarged	ENLGD
Equal(s)	=
Esophagogastro-duodenoscopy	EGD
Esophagus	ESO
Estrogen receptor assay	ERA
Evaluation	EVAL
Every	Q

WORD/TERM (S)	ABBREVIATION/SYMBOL
Every day	QD
Examination	EXAM
Examination under anesthesia	EUA
Excision/excised	EXC(D)
Expired	EXP
Exploratory	EXPL
Exploratory laparotomy	EXPL LAP
Extend/extension	EXT
Extended care facility	ECF
External	EX
Extremity	EXTR
Eyes, ears, nose and throat	EENT
Family history	FHX
Family medical history	FMH
Fever of unknown origin	FUO
Fine needle aspiration	FNA
Fine needle aspiration biopsy	FNAB
Fingerbreadth	FB
Flexible sigmoidoscopy	FLEX SIG
Floor of mouth	FOM
Fluid	FL
Fluoroscopy	FLURO
Follow-up	FU
For example	E.G
Fracture	FX
French-American-British	FAB
Frequent/Frequency	FREQ
Frozen section	FS
Full thickness skin graft	FTSG
Gallbladder	GB
Gastroesophageal	GE
Gastroesophageal reflux disease	GERD
Gastrointestinal	GI
General/Generalized	GEN
Genitourinary	GU
Grade	GR
Gram	GM
Greater/Greater than	>
Gynecology	GYN
Head, eyes, ears, nose, throat	HEENT
Hematocrit	HCT
Hematology	HEMO

WORD/TERM (S)	ABBREVIATION/SYMBOL
Hemoglobin	HGB
Hepatitis A (virus)	HAV
Hepatitis B (virus)	HBV
Hepatitis C (virus)	HCV
Hepatitis D (virus)	HDV
Hepatocellular carcinoma	HCC
Hepatosplenomegaly	HSM
History	HX
History and physical	H&P
History of	H/O
History of present illness	HPI
Hodgkin disease	HD
Hormone	HORM
Hospital	HOSP
Hour/Hours	HR(S)
Human chorionic gonadotropin	HCG
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymphotrophic Virus, (Type III)	HTLV
Hypertension	HTN
Hypertensive cardiovascular disease	HCVD
Hypertensive vascular disease	HVD
Hysterectomy	HYST
Idiopathic hypertrophic subaortic stenosis	IHSS
Idiopathic thrombocytopenia	ITP
Immunoglobulin	IG
Immunohistochemical	IHC
Impression	IMP
Inch	IN
Incision & drainage	I&D
Includes/Including	INCL
Increase(d)	INCR
Inferior	INF
Inferior vena cava	IVC
Infiltrating	INFILT
Inflammatory bowel disease	IBD
Inpatient	IP
Insulin-dependent diabetes mellitus	IDDM
Intensive care unit	ICU
Intercostal margin	ICM
Intercostal space	ICS
Intermittent positive pressure breathing	IPPB

WORD/TERM (S)	ABBREVIATION/SYMBOL
Internal	INT
Internal mammary artery	IMA
Interstitial lung disease	ILD
Intra abdominal	IAB
Intramuscular	IM
Intrathecal	IT
Intravenous	IV
Intravenous cholangiogram	IVCA
Intravenous pyelogram	IVP
Invade(s)/invading/invasion	INV
Involve(s)/involvement/involving	INVL
Iodine	I
Ipsilateral	IPSI
Irregular	IRREG
Joule	J
Jugular venous distention	JVD
Junction	JCT, JX
Juvenile rheumatic arthritis	JRA
Kaposi sarcoma	KS
Kidneys, ureters, bladder	KUB
Kilogram	KG
Kilovolt	KV
Laboratory	LAB
Lactic dehydrogenase	LDH
Laparotomy	LAP
Large	LRG
Large bowel resection	LBR
Large cleaved cell	LCC
Last menstrual period	LMP
Lateral	LAT
Left	LT
Left breast biopsy	LBBX
Left bundle branch block	LBBB
Left costal margin	LCM
Left eye	OS
Left lower extremity	LLE
Left lower lobe	LLL
Left lower quadrant	LLQ
Left salpingo-oophorectomy	LSO
Left upper extremity	LUE
Left upper lobe	LUL
Left upper outer quadrant	LUOQ

WORD/TERM (S)	ABBREVIATION/SYMBOL
Left upper quadrant	LUQ
Left ureteral orifice	LUO
Less/Less than	<
Licensed practical nurse	LPN
Linear accelerator	LINAC
Liver, kidney, spleen	LKS
Liver, kidney, spleen, bladder	LKSB
Liver/spleen scan	LS SCAN
Lobular carcinoma in situ	LCIS
Lobular in situ	LIS
Lobular neoplasia, grade 2	LN2
Long Term Care Facility	LTCF
Lower extremity	LE
Lower inner quadrant	LIQ
Lower outer quadrant	LOQ
Lower right quadrant	LRQ
Lumbar puncture	LP
Lumbar spine	L-SPINE
Lumbar vertebra	L1-L5
Lumbosacral	LS
Lupus erythematosus	LUP ERYTH
Lymph node biopsy	LNBX
Lymph node dissection	LND
Lymph node resection	LNR
Lymph node(s)	LN(S)
Lymphadenopathy-associated virus	LAV
Lymphangiography/lymphangiogram	LAG
Macrophage colony-stimulating factor	M-CSF
Magnetic resonance cholangiopancreatography	MRCP
Magnetic resonance imaging	MRI
Main stem bronchus	MSB
Malignant	MALIG
Malignant carcinoid syndrome	MCS
Malignant fibrous histiocytoma	MFH
Mandible/mandibular	MAND
Mastectomy	MAST, MX
Maximum	MAX
Medical center	MC
Medical history	MHX
Medication	MED
Melanoma associated antigen	MAA
Metastatic/Metastasis	METS

WORD/TERM (S)	ABBREVIATION/SYMBOL
Methicillin Resistant Staphylococcus Aureus	MRSA
Microgram	MCG
Microscopic	MICRO
Midclavicular line	MCL
Middle	MID
Middle lobe	ML
Millicurie (hours)	MC(H)
Milligram (hours)	MG(H)
Milliliter	ML
Millimeter	MM
Million electron volts	MEV
Minimum	MIN
Minus	-
Minute	MIN
Mitral valve prolapse	MVP
Mixed combined immunodeficiency	MCID
Mixed connective tissue disease	MCTD
Moderate (ly)	MOD
Moderately differentiated	MD, MOD DIFF
Modified radical mastectomy	MRM
Monoclonal antibody	MC-AB, MCAB, MAB, MOAB
More/More than	>
Multifocal arterial tachycardia	MAT
Multifocal premature ventricular contraction	MPVC
Multiple	MULT
Multiple myeloma	MM
Multiple sclerosis	MS
Myasthenia gravis	MG
Myelodysplasia/myelodysplastic syndrome	MDS
Myeloproliferative disease	MPD
Myocardial infarction	MI
Natural killer	NK
Nausea and vomiting	N&V
Neck vein distention	NVD
Needle biopsy	NBX
Needle liver biopsy	NLBX
Negative	NEG, -
Neoplasm	NEOPL
Neoplasm embryonic antigen	NEA
Nephrectomy	NX
Nerves, Cranial 1-12	N-I - N-XII
Neurology	NEURO

WORD/TERM (S)	ABBREVIATION/SYMBOL
No acute/active disease	NAD
No evidence of disease	NED
No evidence of recurrence	NER
No significant findings	NSF
Nodular & diffuse lymphoma	NDL
Non small cell carcinoma	NSCCA
Non-Hodgkin malignant lymphoma	NHML
Non-Hodgkins lymphoma	NHL
Non-small cell lung cancer	NSCLC
Normal	NL
Not applicable	NA
Not elsewhere classified/classifiable	NEC
Not otherwise specified	NOS
Not recorded	NR
Number	#
Nursing home	NH
Obstetrics	OB
Obstructed (-ing, -ion)	OBST
Occult primary malignancy	OPM
Oncology	ONC
Operating room	OR
Operation	OP
Operative report	OP RPT
Organic brain syndrome	OBS
Orthopedics	ORTHO
Otology	OTO
Ounce	OZ
Outpatient	OP
Outpatient surgery	OPS
Packs per day	PPD
Palpated (-able)	PALP
Papanicolaou smear	PAP
Papillary	PAP
Past/personal (medical) history	PMH
Pathologic tumor, nodes, metastases	PTNM
Pathology	PATH
Patient	PT
Pediatrics	PEDS
Pelvic inflammatory disease	PID
Peptic ulcer disease	PUD
Percussion and auscultation	P&A
Percutaneous	PERC

WORD/TERM (S)	ABBREVIATION/SYMBOL
Percutaneous transhepatic cholecystogram	PTC
Peripheral vascular disease	PVD
Phosphorus 32	P32
Physical examination	PE
Physiotherapy/Physical therapy	PT
Plasma cell leukemia	PCL
Platelets	PLT
Plus	+
Polycythemia vera	PV
Poorly differentiated	PD, POOR DIFF
Positive	POS, +
Positron emission tomography	PET
Possible	POSS
Posterior	POST
Posteroanterior	PA
Postoperative (-ly)	POST OP
Pound(s)	LB(S), #
Premature atrial contraction	PAC
Preoperative (-ly)	PRE OP
Prescription	RX
Present illness	PI
Previous	PREV
Primary medical physician	PMP
Primitive neuroectodermal tumor	PNET
Prior to admission	PTA
Probable (-ly)	PROB
Proctoscopy	PROCTO
Progesterone receptor assay	PRA
Prolymphocyctic leukemia	PLL
Prostatic intraepithelial neoplasia	PIN
Prostatic intraepithelial neoplasia, grade III	PIN III
Prostatic specific antigen	PSA
Pulmonary	PULM
Pulmonary artery	PULM ART
Quadrant	QUAD
Radiation absorbed dose	RAD
Radiation therapy	RT
Radical neck dissection	RND
Radioactive iodine	RAI
Radioimmunoassay	RIA
Received	REC'D
Red blood cells (count)	RBC

WORD/TERM (S)	ABBREVIATION/SYMBOL
Regarding	RE
Regional medical center	RMC
Regular	REG
Regular sinus rhythm	RSR
Resection (ed)	RESEC
Respiratory	RESPIR, RESP
Review of outside films	ROF
Review of outside slides	ROS
Rheumatic heart disease	RHD
Rheumatoid arthritis	RA
Right	RT
Right breast biopsy	RBBX
Right bundle branch block	RBBB
Right costal margin	RCM
Right eye	OD
Right inner quadrant	RIQ
Right lower extremity	RLE
Right lower lobe	RLL
Right lower quadrant	RLQ
Right middle lobe	RML
Right outer quadrant	ROQ
Right salpingo-oophorectomy	RSO
Right upper extremity	RUE
Right upper lobe	RUL
Right upper quadrant	RUQ
Right ureteral orifice	RUO
Rule out	R/O
Sacral spine	S-SPINE
Sacral vertebra	S1-S5
Salpingo-oophorectomy	SO
Sarcoma	SARC
Satisfactory	SATIS
Sequential multiple analysis	SMA
Serum glutamic oxaloacetic transaminase	SGOT
Serum glutamic pyruvic transaminase	SGPT
Severe combined immunodeficiency syndrome	SCID
Short(ness) of breath	SOB
Sick sinus syndrome	SSS
Sigmoid colon	SIG COLON
Skilled nursing facility	SNF
Small	SM
Small bowel	SB

WORD/TERM (S)	ABBREVIATION/SYMBOL
Small bowel obstruction	SBO
Small bowel resection	SBR
Small cell lung carcinoma	SCLC
Specimen	SPEC
Spine, Cervical	C-SPINE
Spine, Lumbar	L-SPINE
Spine, Sacral	S-SPINE
Spine, Thoracic	T-SPINE
Split thickness skin graft	STSG
Squamous	SQ
Squamous cell carcinoma	SCC
Status post	S/P
Subcutaneous	SUBCU
Summary stage	SS
Superior vena cava	SVC
Surgery/Surgical	SURG
Suspicious/suspected	SUSP
Symptoms	SX
Syndrome of inappropriate	ADH SIADH
Systemic lupus erythematosus	SLE
T-cell acute lymphoblastic leukemia	T-ALL
T-cell chronic lymphatic leukemia	T-CLL
Thoracic spine	T-SPINE
Thromboticthrombocytopenia purpura	TTP
Times	X
Total abdominal hysterectomy	TAH
Total abdominal hysterectomy- bilateral salpingo-oophorectomy	TAH-BSO
Total axial (lymph) node irradiation	TANI
Total parenteral nutrition	TPN
Total vaginal hysterectomy	TVH
Transbronchial biopsy	TBBX
Transient ischemic attack	TIA
Transitional cell carcinoma	TCC
Transrectal ultrasound	TRUS
Transrectal ultrasound of prostate	TRUSP
Transurethral resection	TUR
Transurethral resection bladder	TURB
Transurethral resection bladder tumor	TURBT
Transurethral resection prostate	TURP
Transverse colon	TRANS-COLON
Transverse rectus abdominous myocutaneous	TRAM
Treatment	TX

WORD/TERM (S)	ABBREVIATION/SYMBOL
True vocal cord	TVC
Tumor size	TS
Tumor, node, metastasis	TNM
Twice a day (daily)	BID
Ultrasound	US
Undetermined	UNDET
Undetermined origin	UDO
Undifferentiated	UNDIFF
Unilateral salpingo-oophorectomy	USO
Unknown	UNK
Upper extremity	UE
Upper gastrointestinal (series)	UGI
Upper inner quadrant	UIQ
Upper outer quadrant	UOQ
Upper respiratory infection	URI
Upper right quadrant	URQ
Urinary tract infection	UTI
Vagina/Vaginal	VAG
Vaginal hysterectomy	VAG HYST
Vaginal intraepithelial neoplasia	VAIN
Vaginal intraepithelial neoplasia (grade III)	VAIN III
Vascular	VASC
Versus	VS
Vulvar intraepithelial neoplasia	VIN
Vulvar intraepithelial neoplasia (grade III)	VIN III
Well differentiated	WD, WELL DIFF
White blood cells (count)	WBC
White female	W/F
White male	W/M
Will follow (in) office	WF-O
Wilms (tumor), aniridia, genitourinary (abnormalities), and (mental)	WAGR
With	W/
Within normal limits	WNL
Without	W/O
Work-up	W/U
Xray	XR
Year	YR
Yolk Sac Tumor	YST

ORDER BY ABBREVIATION

ABBREVIATION	WORD/TERM(S)
A FIB	Atrial fibrillation
A FLUTTER	Atrial flutter
A&P	Auscultation & percussion
ABC	Aspiration biopsy cytology
ABD	Abdomen (abdominal)
ABD HYST	Abdominal hysterectomy
ABG	Arterial blood gases
ABM	Autologous bone marrow
ABMT	Autologous bone marrow transplantation
ABN	Abnormal
ABS	Absent/Absence
ABST	Abstract/Abstracted
AC	Adrenal cortex
ACA	Adenocarcinoma
ACBE	Air contrast barium enema
ACD	Alpha chain disease
ACH	Adrenal cortical hormone
ACID PHOS	Acid phosphatase
A-COLON	Ascending colon
ACTH	Adrenocorticotrophic hormone
ADENOCA, ACA	Adenocarcinoma
ADH	Antidiuretic hormone
ADH SIADH	Syndrome of inappropriate
ADJ	Adjacent
ADL	Activities of daily living
ADM	Admission/Admit
AEL	Acute erythroleukemia
AFF	Affirmative
AFP	Alpha-fetoprotein
AG	Antigen
AGL	Acute granulocytic leukemia
AI	Atrial stenosis/insufficiency/incompetence
AIDS	Acquired Immune Deficiency Syndrome
AIHA	Autoimmune hemolytic anemia
AIL	Angioblastic immunoblastic lymphadenopathy
AIN III	Anal intraepithelial neoplasia, grade III
AK(A)	Above knee (amputation)
AKA	Also known as
AL	Acute leukemia

ABBREVIATION	WORD/TERM(S)
ALB	Albumin
ALFT	Abnormal liver function test
ALK PHOS	Alkaline phosphatase
ALL	Acute lymphocytic leukemia
ALM	Acral lentiginous melanoma
ALS	Amyotrophic lateral sclerosis
ALT	Alternate
AM	Before noon
AMA	Against medical advice
AMB	Ambulatory
AMBL	Acute myeloblastic leukemia
AMEGL	Acute megakaryoblastic leukemia
AMI	Acute myocardial infarction
AML	Acute myelogenous leukemia
AMML	Acute myelomonocytic leukemia
AMP	Amputation
AMT	Amount
ANAP	Anaplastic
ANGIO	Angiography/Angiogram
ANS	Autonomic nervous system
ANT	Anterior
AODM	Adult-onset Diabetes Mellitus
AP	Abdominal perineal (Abdominoperineal)
AP	Anteroposterior
APC	Atrial premature complexes
APL	Acute promyelocytic leukemia
APP	Appendix
APPL'Y	Apparently
APPROX	Approximately
APR	Abdominoperineal resection
ARC	AIDS-related condition (complex)
ARD	AIDS-related disease
ARDS	Acute Respiratory Distress (Disease) Syndrome
ARF	Acute renal failure
ARRHY	Arrhythmia
ART	Artery (ial)
AS	Arteriosclerosis/Arteriosclerotic
ASA	Aspirin, Acetylsalicylic acid
ASAP	As soon as possible
ASC	Ascending
ASCVD	Arteriosclerotic cardiovascular disease
ASHD	Arteriosclerotic heart disease

ABBREVIATION	WORD/TERM(S)
ASP	Aspiration
ASPVD	Arteriosclerotic Peripheral Vascular Disease
A-STEN	Aortic stenosis
ATL	Adult T-cell leukemia
ATLL	Adult T-cell leukemia/lymphoma
ATN	Acute tubular necrosis
ATP	Adenosine triphosphate
ATR	Achilles tendon reflex
AUL	Acute undifferentiated leukemia
AUT	Autopsy
AV	Arteriovenous
AVG	Average
AVM	Arteriovenous malformation
AX	Axilla(ry)
B/F	Black female
B/M	Black male
BA	Barium
BAD	Bipolar affective disorder
BAS	Barium swallow
BAW	Bronchoalveolar washing
BCC	Basal cell carcinoma
BCG	Bacillus Calmette-Guerin
BD	Bile duct
BE	Barium enema
BGCA	Bronchogenic carcinoma
BHL	Bilateral hilar lymphadenopathy
BID	Twice a day (daily)
BIL	Bilateral
BK(A)	Below knee (amputation)
BKA	Below knee amputation
BL	Burkitt lymphoma
BLL	Bilateral lower lobes
BLN	Bronchial lymph node
BM	Bone Marrow
BM	Bowel Movement
BMA	Bone marrow aspirate
BMBX	Bone marrow biopsy
BMT	Bone Marrow Transplant
BOO	Bladder outlet obstruction
BP	Blood pressure
BPH	Benign prostatic hypertrophy/hyperplasia
BPLND	Bilateral pelvic lymph node dissection

ABBREVIATION	WORD/TERM(S)
BRB	Bright red blood
BRBPR	Bright red blood per rectum
BRM	Biological response modifier
BRS	Breath sounds
BS	Bowel sounds
BSE	Breast self examination
BSO	Bilateral salpingo-oophorectomy
BT	Bladder tumor
BUN	Blood urea nitrogen
BUS	Bartholin's, Urethral & Skene's
BV	Blood volume
BX	Biopsy
C/C	Chief complaint
C/O	Complaint (-ning) of
C/W	Consistent with
C1-C7	Cervical vertebrae
CA	Calcium
CA	Carcinoma
CABG	Coronary artery bypass graft
CAD	Coronary artery disease
CAP(S)	Capsule (s)
CBC	Complete blood count
CBD	Common bile duct
CC	Cubic centimeter
CCR	Complete continuous remission
CCU	Coronary care unit
CEA	Carcinoembryonic antigen
CEJ	Cardioesophageal junction
CF	Cystic fibrosis
CGL	Chronic granulocytic leukemia
CGM	Centigram
CGY	Centigray
CHD	Congenital heart disease
CHEMO	Chemotherapy
CHF	Congestive heart failure
CHG	Change
CHOLE	Cholecystectomy
CHR	Chronic
CIG	Cigarettes
CIN	Cervical intraepithelial neoplasia
CIN III	Cervical intraepithelial neoplasia, grade III
CIS	Carcinoma *in situ*

ABBREVIATION	WORD/TERM(S)
CL	Chronic leukemia
CLL	Chronic lymphocytic leukemia
CLR	Clear
CLSL	Chronic lymphosarcoma leukemia
CM	Centimeter
CML	Chronic myeloid (myelocytic) leukemia
CMML	Chronic myelomonocytic leukemia
CMS	Chronic myelodysplastic syndrome
CNS	Central nervous system
CO60	Cobalt 60
COLD	Chronic obstructive lung disease
CONT	Continue/continuous
CONTRA	Contralateral
COPD	Chronic obstructive pulmonary disease
CRF	Chronic renal failure
CS	Collaborative stage
CSF	Cerebrospinal fluid
C-SF	Colony-stimulating factor
C-SPINE	Cervical spine
CT	CAT/CT scan/Computerized axial tomography
CT, CAT	Computerized axial tomography scan
CTB	Ceased to breath
CTCL	Cutaneous T-cell lymphoma
CTNM	Clinical tumor, nodes, metastases
CU	Curie
CUC	Chronic ulcerative colitis
CUP	Carcinoma unknown primary
CUT	Cutaneous
CVA	Cerebrovascular accident
CVD	Cardiovascular disease
CX	Cervix
CXR	Chest X-ray
CYSTO	Cystoscopy
CYTO	Cytology
D&C	Dilatation and curettage
DC	Discontinue(d)
DCIS	Ductal carcinoma *in situ*
D-COLON	Descending colon
DE	Direct extension
DEB	Debridement
DECR	Decrease(d)
DERM	Dermatology

ABBREVIATION	WORD/TERM(S)
DES	Diethylstilbestrol
DESC	Descending
DFI	Disease free interval
DFSP	Dermatofibrosarcoma protuberans
DIAM	Diameter
DIC	Disseminated intravascular coagulopathy
DIFF	Differentiated/differential
DISCH	Discharge
DISSEM	Disseminated
DL	Diagnostic laparoscopy
DM	Diabetes mellitus
DM	Distant metastases
DNA	Deoxyribonucleic acid
DOA	Dead on arrival
DOB	Date of birth
DOC	Died of other causes
DOD	Date of death
DOE	Dyspnea on exertion
DR	Doctor
DRE	Digital rectal examination
DTR	Deep tendon reflex
DVT	Deep vein thrombosis
DWD	Died with disease
DX	Diagnosis
DZ	Disease
E.G	For example
ECF	Extended care facility
ECG/EKG	Electrocardiogram
EEG	Electroencephalogram
EENT	Eyes, ears, nose and throat
EGD	Esophagogastro-duodenoscopy
EMG	Electromyogram
ENLGD	Enlarged
ENT	Ears, nose, and throat
ER	Emergency room
ERA	Estrogen receptor assay
ERCP	Endoscopic retrograde cholangiopancreatography
ESO	Esophagus
ETOH	Alcohol
EUA	Examination under anesthesia
EVAL	Evaluation
EX	External

ABBREVIATION	WORD/TERM(S)
EXAM	Examination
EXC(D)	Excision/excised
EXP	Expired
EXPL	Exploratory
EXPL LAP	Exploratory laparotomy
EXT	Extend/extension
EXTR	Extremity
FAB	French-American-British
FB	Fingerbreadth
FHX	Family history
FL	Fluid
FLEX SIG	Flexible sigmoidoscopy
FLURO	Fluoroscopy
FMH	Family medical history
FNA	Fine needle aspiration
FNAB	Fine needle aspiration biopsy
FOM	Floor of mouth
FREQ	Frequent/Frequency
FS	Frozen section
FTSG	Full thickness skin graft
FU	Follow-up
FUO	Fever of unknown origin
FX	Fracture
GB	Gallbladder
GE	Gastroesophageal
GEN	General/Generalized
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GM	Gram
GR	Grade
GU	Genitourinary
GYN	Gynecology
H&P	History and physical
H/O	History of
HAV	Hepatitis A (virus)
HBV	Hepatitis B (virus)
HCC	Hepatocellular carcinoma
HCG	Human chorionic gonadotropin
HCT	Hematocrit
HCV	Hepatitis C (virus)
HCVD	Hypertensive cardiovascular disease
HD	Hodgkin disease

ABBREVIATION	WORD/TERM(S)
HDV	Hepatitis D (virus)
HEENT	Head, eyes, ears, nose, throat
HEMO	Hematology
HGB	Hemoglobin
HIV	Human Immunodeficiency Virus
HORM	Hormone
HOSP	Hospital
HPI	History of present illness
HPV	Human Papilloma Virus
HR(S)	Hour/Hours
HSM	Hepatosplenomegaly
HTLV	Human T-Lymphotrophic Virus, (Type III)
HTN	Hypertension
HVD	Hypertensive vascular disease
HX	History
HYST	Hysterectomy
I	Iodine
I&D	Incision & drainage
IAB	Intra abdominal
IBD	Inflammatory bowel disease
ICM	Intercostal margin
ICS	Intercostal space
ICU	Intensive care unit
IDDM	Insulin-dependent diabetes mellitus
IG	Immunoglobulin
IHC	Immunohistochemical
IHSS	Idiopathic hypertrophic subaortic stenosis
ILD	Interstitial lung disease
IM	Intramuscular
IMA	Internal mammary artery
IMP	Impression
IN	Inch
INCL	Includes/Including
INCR	Increase(d)
INF	Inferior
INFILT	Infiltrating
INT	Internal
INV	Invade(s)/invading/invasion
INVL	Involve(s)/involvement/involving
IP	Inpatient
IPPB	Intermittent positive pressure breathing
IPSI	Ipsilateral

ABBREVIATION	WORD/TERM(S)
IRREG	Irregular
IT	Intrathecal
ITP	Idiopathic thrombocytopenia
IV	Intravenous
IVC	Inferior vena cava
IVCA	Intravenous cholangiogram
IVP	Intravenous pyelogram
J	Joule
JCT	Junction
JRA	Juvenile rheumatic arthritis
JVD	Jugular venous distention
JX	Junction
KG	Kilogram
KS	Kaposi sarcoma
KUB	Kidneys, ureters, bladder
KV	Kilovolt
L1-L5	Lumbar vertebra
LAB	Laboratory
LAG	Lymphangiography/lymphangiogram
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-associated virus
LB(S)	Pound(s)
LBBB	Left bundle branch block
LBBX	Left breast biopsy
LBR	Large bowel resection
LCC	Large cleaved cell
LCIS	Lobular carcinoma in situ
LCM	Left costal margin
LDH	Lactic dehydrogenase
LE	Lower extremity
LINAC	Linear accelerator
LIQ	Lower inner quadrant
LIS	Lobular in situ
LKS	Liver, kidney, spleen
LKSB	Liver, kidney, spleen, bladder
LLE	Left lower extremity
LLL	Left lower lobe
LLQ	Left lower quadrant
LMP	Last menstrual period
LN(S)	Lymph node(s)
LN2	Lobular neoplasia, grade 2

ABBREVIATION	WORD/TERM(S)
LNBX	Lymph node biopsy
LND	Lymph node dissection
LNR	Lymph node resection
LOQ	Lower outer quadrant
LP	Lumbar puncture
LPN	Licensed practical nurse
LRG	Large
LRQ	Lower right quadrant
LS	Lumbosacral
LS SCAN	Liver/spleen scan
LSO	Left salpingo-oophorectomy
L-SPINE	Lumbar spine
LT	Left
LTCF	Long Term Care Facility
LUE	Left upper extremity
LUL	Left upper lobe
LUO	Left ureteral orifice
LUOQ	Left upper outer quadrant
LUP ERYTH	Lupus erythematosus
LUQ	Left upper quadrant
MAA	Melanoma associated antigen
MAB	Monoclonal antibody
MALIG	Malignant
MAND	Mandible/mandibular
MAST	Mastectomy
MAT	Multifocal arterial tachycardia
MAX	Maximum
MC	Medical center
MC(H)	Millicurie (hours)
MC-AB, MCAB	Monoclonal antibody
MCG	Microgram
MCID	Mixed combined immunodeficiency
MCL	Midclavicular line
MCS	Malignant carcinoid syndrome
M-CSF	Macrophage colony-stimulating factor
MCTD	Mixed connective tissue disease
MD	Moderately differentiated
MDS	Myelodysplasia/myelodysplastic syndrome
MED	Medication
MED	Medicine
METS	Metastatic/Metastasis
MEV	Million electron volts

ABBREVIATION	WORD/TERM(S)
MFH	Malignant fibrous histiocytoma
MG	Myasthenia gravis
MG(H)	Milligram (hours)
MHX	Medical history
MI	Myocardial infarction
MICRO	Microscopic
MID	Middle
MIN	Minimum
MIN	Minute
ML	Middle lobe
ML	Milliliter
MM	Millimeter
MM	Multiple myeloma
MOAB	Monoclonal antibody
MOD	Moderate (ly)
MOD DIFF	Moderately differentiated
MPD	Myeloproliferative disease
MPVC	Multifocal premature ventricular contraction
MRCP	Magnetic resonance cholangiopancreatography
MRI	Magnetic resonance imaging
MRM	Modified radical mastectomy
MRSA	Methicillin Resistant Staphylococcus Aureus
MS	Multiple sclerosis
MSB	Main stem bronchus
MULT	Multiple
MVP	Mitral valve prolapse
MX	Mastectomy
N&V	Nausea and vomiting
NA	Not applicable
NAD	No acute/active disease
NBX	Needle biopsy
NDL	Nodular & diffuse lymphoma
NEA	Neoplasm embryonic antigen
NEC	Not elsewhere classified/classifiable
NED	No evidence of disease
NEG	Negative
NEOPL	Neoplasm
NER	No evidence of recurrence
NEURO	Neurology
NH	Nursing home
NHL	Non-Hodgkins lymphoma
NHML	Non-Hodgkin malignant lymphoma

ABBREVIATION	WORD/TERM(S)
N-I - N-XII	Nerves, Cranial 1-12
NK	Natural killer
NL	Normal
NLBX	Needle liver biopsy
NOS	Not otherwise specified
NR	Not recorded
NSCCA	Non small cell carcinoma
NSCLC	Non-small cell lung cancer
NSF	No significant findings
NVD	Neck vein distention
NX	Nephrectomy
OB	Obstetrics
OBS	Organic brain syndrome
OBST	Obstructed (-ing, -ion)
OD	Right eye
ONC	Oncology
OP	Operation
OP	Outpatient
OP RPT	Operative report
OPM	Occult primary malignancy
OPS	Outpatient surgery
OR	Operating room
ORTHO	Orthopedics
OS	Left eye
OTO	Otology
OZ	Ounce
P&A	Percussion and auscultation
P32	Phosphorus 32
PA	Posteroanterior
PAC	Premature atrial contraction
PALP	Palpated (-able)
PAP	Papanicolaou smear
PAP	Papillary
PATH	Pathology
PCL	Plasma cell leukemia
PV	Polycythemia vera
PD	Poorly differentiated
PE	Physical examination
PEDS	Pediatrics
PERC	Percutaneous
PET	Positron emission tomography
PI	Present illness

ABBREVIATION	WORD/TERM(S)
PID	Pelvic inflammatory disease
PIN	Prostatic intraepithelial neoplasia
PIN III	Prostatic intraepithelial neoplasia, grade III
PLL	Prolymphocyctic leukemia
PLT	Platelets
PMH	Past/personal (medical) history
PMP	Primary medical physician
PNET	Primitive neuroectodermal tumor
POOR DIFF	Poorly differentiated
POS	Positive
POSS	Possible
POST	Posterior
POST OP	Postoperative (-ly)
PPD	Packs per day
PRA	Progesterone receptor assay
PRE OP	Preoperative (-ly)
PREV	Previous
PROB	Probable (-ly)
PROCTO	Proctoscopy
PSA	Prostatic specific antigen
PT	Patient
PT	Physiotherapy/Physical therapy
PTA	Prior to admission
PTC	Percutaneous transhepatic cholecystogram
PTNM	Pathologic tumor, nodes, metastases
PUD	Peptic ulcer disease
PULM	Pulmonary
PULM ART	Pulmonary artery
PVD	Peripheral vascular disease
Q	Every
QD	Every day
QUAD	Quadrant
R/O	Rule out
RA	Rheumatoid arthritis
RAD	Radiation absorbed dose
RAI	Radioactive iodine
RBBB	Right bundle branch block
RBBX	Right breast biopsy
RBC	Red blood cells (count)
RCM	Right costal margin
RE	Regarding
REC'D	Received

ABBREVIATION	WORD/TERM(S)
REG	Regular
RESEC	Resection (ed)
RESP	Respiratory
RESPIR	Respiratory
RHD	Rheumatic heart disease
RIA	Radioimmunoassay
RIQ	Right inner quadrant
RLE	Right lower extremity
RLL	Right lower lobe
RLQ	Right lower quadrant
RMC	Regional medical center
RML	Right middle lobe
RND	Radical neck dissection
ROF	Review of outside films
ROQ	Right outer quadrant
ROS	Review of outside slides
RSO	Right salpingo-oophorectomy
RSR	Regular sinus rhythm
RT	Radiation therapy
RT	Right
RUE	Right upper extremity
RUL	Right upper lobe
RUO	Right ureteral orifice
RUQ	Right upper quadrant
RX	Prescription
S/P	Status post
S1-S5	Sacral vertebra
SARC	Sarcoma
SATIS	Satisfactory
SB	Small bowel
SBO	Small bowel obstruction
SBR	Small bowel resection
SCC	Squamous cell carcinoma
SCID	Severe combined immunodeficiency syndrome
SCLC	Small cell lung carcinoma
SGOT	Serum glutamic oxaloacetic transaminase
SGPT	Serum glutamic pyruvic transaminase
SIG COLON	Sigmoid colon
SLE	Systemic lupus erythematosus
SM	Small
SMA	Sequential multiple analysis
SNF	Skilled nursing facility

ABBREVIATION	WORD/TERM(S)
SO	Salpingo-oophorectomy
SOB	Short(ness) of breath
SPEC	Specimen
SQ	Squamous
SS	Summary stage
S-SPINE	Sacral spine
SSS	Sick sinus syndrome
STSG	Split thickness skin graft
SUBCU	Subcutaneous
SURG	Surgery/Surgical
SUSP	Suspicious/suspected
SVC	Superior vena cava
SX	Symptoms
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy- bilateral salpingo-oophorectomy
T-ALL	T-cell acute lymphoblastic leukemia
TANI	Total axial (lymph) node irradiation
TBBX	Transbronchial biopsy
TCC	Transitional cell carcinoma
T-CLL	T-cell chronic lymphatic leukemia
TIA	Transient ischemic attack
TNM	Tumor, node, metastasis
TPN	Total parenteral nutrition
TRAM	Transverse rectus abdominous myocutaneous
TRANS-COLON	Transverse colon
TRUS	Transrectal ultrasound
TRUSP	Transrectal ultrasound of prostate
TS	Tumor size
T-SPINE	Thoracic spine
TTP	Thromboticthrombocytopenia purpura
TUR	Transurethral resection
TURB	Transurethral resection bladder
TURBT	Transurethral resection bladder tumor
TURP	Transurethral resection prostate
TVC	True vocal cord
TVH	Total vaginal hysterectomy
TX	Treatment
UDO	Undetermined origin
UE	Upper extremity
UGI	Upper gastrointestinal (series)
UIQ	Upper inner quadrant
UNDET	Undetermined

ABBREVIATION	WORD/TERM(S)
UNDIFF	Undifferentiated
UNK	Unknown
UOQ	Upper outer quadrant
URI	Upper respiratory infection
URQ	Upper right quadrant
US	Ultrasound
USO	Unilateral salpingo-oophorectomy
UTI	Urinary tract infection
VAG	Vagina/Vaginal
VAG HYST	Vaginal hysterectomy
VAIN	Vaginal intraepithelial neoplasia
VAIN III	Vaginal intraepithelial neoplasia (grade III)
VASC	Vascular
VIN	Vulvar intraepithelial neoplasia
VIN III	Vulvar intraepithelial neoplasia (grade III)
VS	Versus
W/	With
W/F	White female W/F
W/M	White male
W/O	Without
W/U	Work-up
WAGR	Wilms (tumor), aniridia, genitourinary (abnormalities), and (mental)
WBC	White blood cells (count)
WD	Well differentiated
WELL DIFF	Well differentiated
WF-O	Will follow (in) office
WNL	Within normal limits
XR	Xray
YR	Year
YST	Yolk Sac Tumor

CONTEXT-SENSITIVE ABBREVIATIONS

When using these abbreviations, make sure the meaning of the abbreviation is readily apparent in the context in which it is used.

ABBREVIATION	WORD/TERM(S)
AP	Anteroposterior
	Abdominal perineal
BM	Bone marrow
	Bowel movement
CA	Calcium
	Carcinoma
DM	Diabetes mellitus
	Distant metastases
MIN	Minimum
	Minute
ML	Milliliter
	Middle lobe
MM	Millimeter
	Multiple myeloma
OP	Operation
	Outpatient
PAP	Papillary
	Papanicolaou smear
PT	Patient
	Physiotherapy/Physical therapy
RT	Right
	Radiation therapy

SYMBOLS

SYMBOL	WORD/TERM (S)
-	Minus
#	Number
&	And
@	At
^	Above
+	Plus, Positive
<	Less/Less than
=	Equal(s)
>	Greater/Greater than, More/more than
X	Times

APPENDIX M

Web Plus Download Instructions

pennsylvania
DEPARTMENT OF HEALTH

Procedure: Web Plus file download

Purpose: To receive files sent from the Pennsylvania Cancer Registry (PCR), via a secure website.
This procedure is used when facilities have been sent a document from the PCR (for example, yearly reconciliation listing). Web Plus replaces the need to send confidential data in an email file attachment or on paper through post-mail.

General Information:

1. Security: Web Plus is an Internet-based application developed by the Centers for Disease Control and Prevention, National Program of Cancer Registries. Web Plus has been designed as a highly secure application that can be used to safely transmit data between reporting facilities and the PCR over the internet.

   Security is achieved by a combination of software features and network infrastructure. Web Plus is hosted on a secure Web server; the communication between the client and the server is encrypted with 128-bit encryption Secure Socket Layer technology.

   Security features of the application include:

   - Web Plus keeps an extensive log of user logins, data accesses, and updates for auditing purposes.
   - User accounts can be locked out if invalid login attempts exceed a threshold value, configurable by the PCR Central Administrator.
   - Initial passwords are randomly generated by the system and the user will be forced to change it after their first successful logon.
   - Current user activities are visible to the PCR Central Administrator through the Current User Activities page.
   - User passwords are stored in the database using a one-way hash encryption method.
   - The Web Plus configuration file will store the connection string to the SQL Server database in encrypted format.
   - The application times out after a specified time period.
   - Web Plus uses form-based authentication where users are required to enter their unique user ID and strong password to be authenticated by the application.

2. Screen Resolution: The resolution for Web Plus should be 1024 X 768. If the resolution set on your PC is different you may still be able to use Web Plus, but Web Plus has been designed to be viewed best at 1024 X 768 or higher. You will receive a message on the Web Plus log-in screen if your resolution is not set correctly. Contact your Information Technology (IT) department if you are unsure how to change your screen resolution.

3. Web Plus icon on desk top: It is recommended that your IT department create an icon on your desktop from the Web Plus link for easy access to the application.

4. Email notification: When you have files to retrieve in WebPlus, you will receive an email from your PCR Field Representative telling you about the file and reminding you of these instructions on how to get it.

5. Password protected or encrypted files: Files uploaded to your facility from the PCR via Web Plus will not be password protected or encrypted. The security features of Web Plus replaces the need to password protect or encrypt files.

6. Password changes: You will be prompted to change your password the first time you log into Web Plus and then every 60 days after that. If you forget your password, contact your PCR Field Representative at (800) 272-1850 or (717) 783-2548.

7. User ID or website location: If you forget your User ID or cannot locate the Web Plus website, contact your PCR Field Representative at (800) 272-1850 or (717) 783-2548.

Procedure:

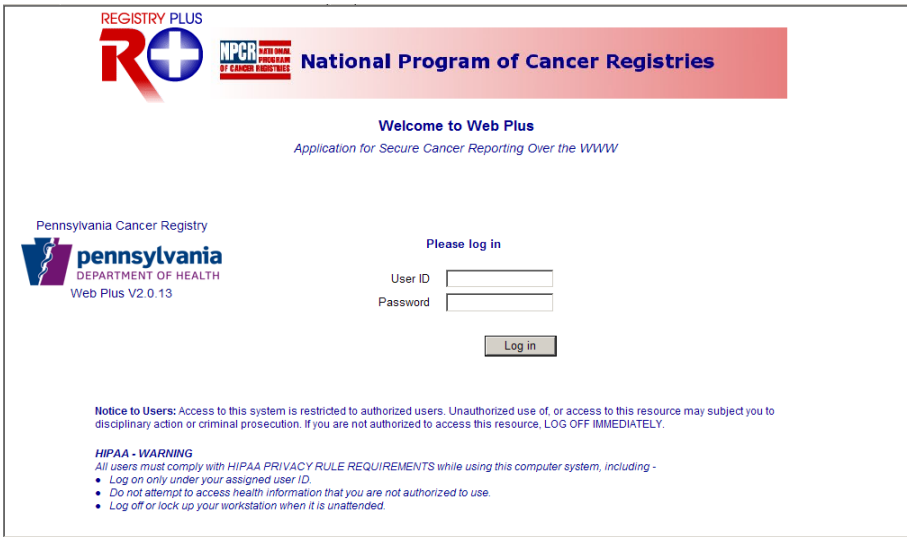
Downloading files

1. Open Web Plus using the link in the email previously sent by the PCR or type the following into your web address line

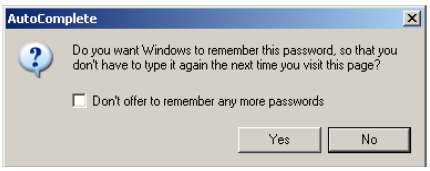
   https://pcr.health.pa.gov/webplus

2. Type your User ID and password into the appropriate boxes. Note: Your User ID and password were previously sent via email by the PCR.

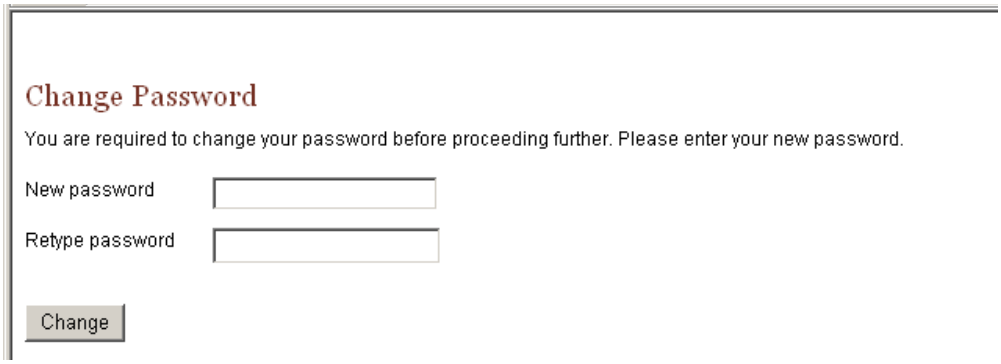
   Click Log in.



   If the following message appears, click No.



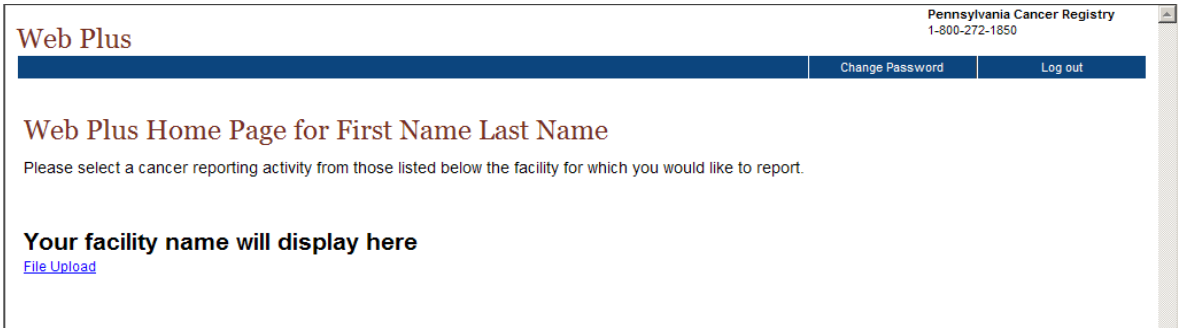
*The first time you log in, the screen below will appear forcing you to change your password.
Enter a new password using the following criteria: "Password must be between 8 to 20 characters, contain at least one digit and one alphabetic character, and must not contain any special characters".



Click on Change.

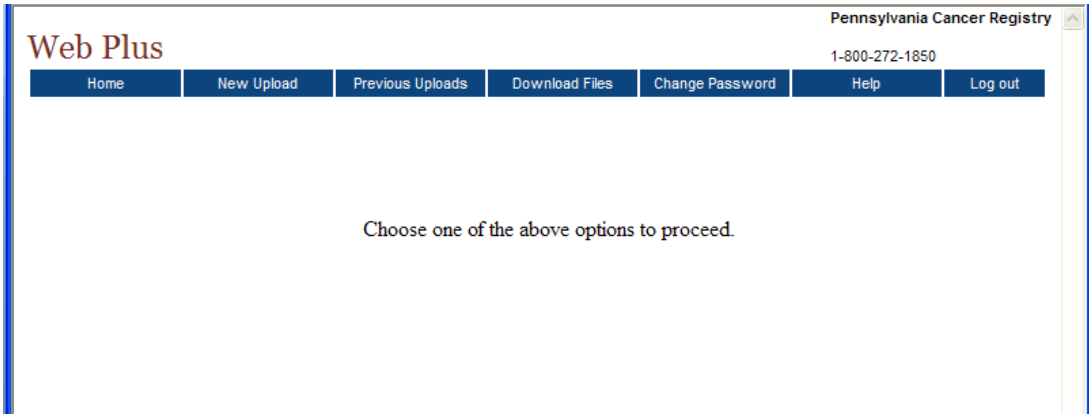
If the password does not meet the criteria specified above or if the new password does not match the retype password line, you will receive a message 'Password not changed'. The Change Password screen will remain until the password meets the criteria and the two password lines match.

3. The Web Plus home page for your facility opens.



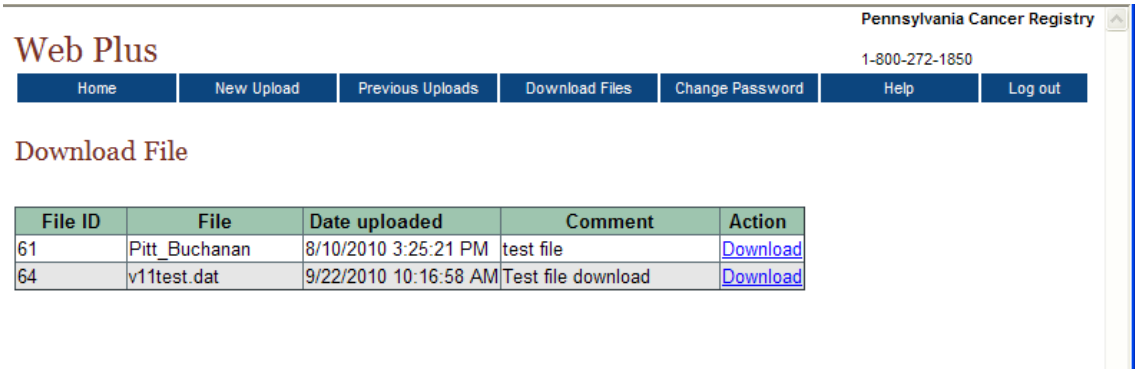
4. Click on File Upload under your Facility name.

   The following screen will display:



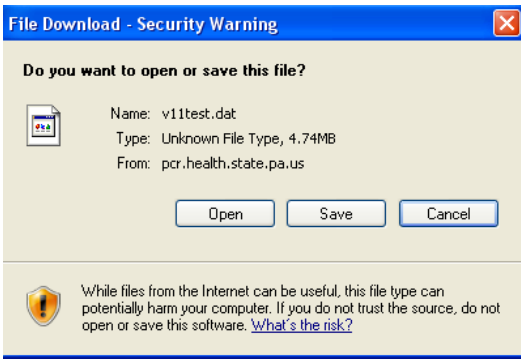
5. Click on the Download Files blue box.

   The following screen will display:



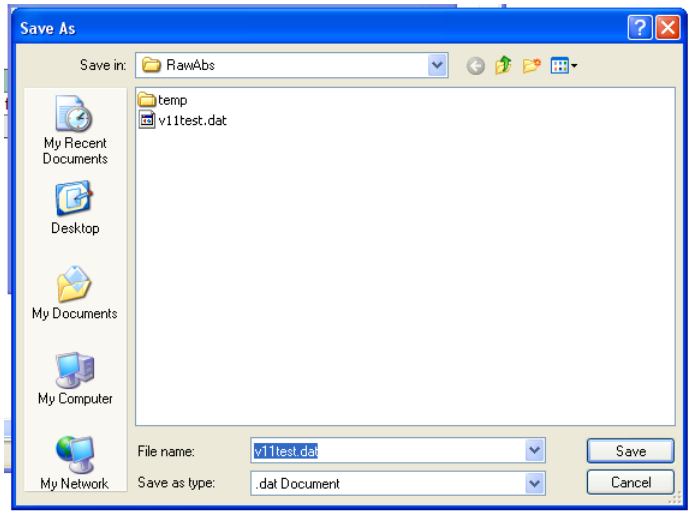
6. Click on Download under Action on the line with the file you want to retrieve.

   The following screen will display:



7. Click Save.

   The following screen will display:

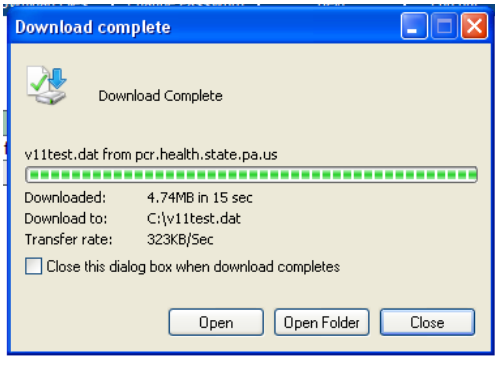


8. Rename the file (optional).

9. Select the location in which to save the file.

10. Click Save.

    The following screen will display when the download is complete.



11. Click Close. Screen will return to display as in #5.

12. Repeat steps #6 to #11 for each additional file.

13. Click on Log Out blue box to close Web Plus when finished.

APPENDIX N

Summary of Changes in Data Collection Standards

Data collection standards have changed numerous times over the years. The following table summarizes these changes including the dates the changes became effective.

Data Collection Standard	Effective Date
2021	
The NAACCR *2021 Guidelines for ICD-O-3 Histology code and Behavior Update Implementation (ICD-O-3.2)*	Date of Diagnosis 1/1/2021
2018	
AJCC-TNM 8th Edition (not collected by PCR)	Date of Diagnosis 1/1/2018 and after
Site Specifice Data Items	Date of Diagnosis 1/1/2018 and after
SEER Summary Stage 2018	Date of Diagnosis 1/1/2018 and after
2018 Grade Rules	Date of Diagnosis 1/1/2018 and after
SEER Solid Tumor Rules	Date of Diagnosis 1/1/2018 and after
NAACCR Guidelines for ICD-O-3 Histology Code and Behavior Update	Date of Diagnosis 1/1/2018 and after
2016	
Directly Coded AJCC-TNM Clinical and Pathologic Stage required	Date of Diagnosis 1/1/2016 and after
Collaborative Stage – SSF's, Lymph-vascular Invasion, Regional LN Positive and Regional Lymph Nodes Examined required only	Date of Diagnosis 1/1/2016 and after
ICD-O-3 Changes-New terms, synonyms, and related terms	Date of Diagnosis 1/1/2016 and after
2015	
ICD-O-3 Changes-New terms, synonyms, and related terms	Date of Diagnosis 1/1/2015 and after
Directly Coded SEER Summary Stage required once again	Date of Diagnosis 1/1/2015 and after
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