CHAPTER X:

DATA DICTIONARY

In this chapter, data items are presented in alphabetical order by item names. For each item, a general description, specific codes and definitions are provided. For many items, the document provides a brief rationale for collecting the data item or for using the codes listed. The at-a-glance header for each data item has alternate name(s), item number, length, source of standard, year and version implemented, and column numbers (for a discussion of NAACCR's standard naming conventions, see Chapter I).

Differences from Version 16 are marked "Revised" or "New" following the item name. Changes are highlighted in the table or indicated by black vertical lines in the outside margins of the text portion of a data item. Text of previous versions is revealed by hovering over a highlighted cell. Revised and new items are summarized in Appendix F.

Alternate names by which the same item is called under NAACCR's naming convention are listed alphabetically in Appendix D.

The Source of Standard designates the reference for detailed coding instructions for many of the data items. References can be found in Chapter VI. A list of reference manuals for Version 16 (and prior versions) is provided in Chapter II, Table 1. Websites for the standard setting organizations:

SEER: http://seer.cancer.gov/registrars/
CoC: http://www.facs.org/cancer/coc/fordsmanual.html
NPCR: http://www.cdc.gov/cancer/npcr/
CCCR: http://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=3207&lang=en&db=imdb&adm=8&dis=2

The Collaborative Staging website serves as the main repository for CS-related items including publications, software, educational activities, etc., for cancer registrars and cancer registry software vendors: http://www.cancerstaging.org/cstage/index.html.

The date format (YYYYMMDD) specifically addresses the NAACCR standard data transmission format; not how the data should be stored in an individual registry's database or viewed on the screen. Only valid portions of the date should be transmitted. Below are the common formats to handle the situation where only certain components of date are known.

YYYYMMDD – when complete date is known and valid
YYYYMM – when year and month are known and valid, and day is unknown
YYYY – when year is known and valid, and month and day are unknown
Blank – when no known date applies

The field is fixed-length and left-justified. Any missing component should be replaced by spaces. If there are no known date components, the fixed-length variable will be completely blank.

For unknown values and codes that have meanings other than dates the HL7 Flavors of Null Table (Appendix H) has been adopted for flagging each non-system-generated missing date as a way to eliminate the ambiguity of missing values. A date flag field, to serve as a flag or indicator, is used for each date field for which an "unknown" or "not applicable" value is appropriate. This item would be blank if a valid date is transmitted in its associated date item. The only date fields that would not have a flag are system-generated dates (e.g., Date Case Completed [2090]), for which "unknown" would never be a legitimate value.

ABSTRACTED BY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	570	3	CoC					742 - 744

Description
An alphanumeric code assigned by the reporting facility that identifies the individual abstracting the case.

ACCESSION NUMBER--HOSP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Accession Number (CoC)	550	9	CoC					731 - 739

Description
Provides a unique identifier for the patient consisting of the year in which the patient was first seen at the reporting facility and the consecutive order in which the patient was abstracted.

The first four numbers specify the year and the last five numbers are the numeric order in which the patient was entered into the registry database. Within a registry, all primaries for an individual must have the same accession number. The first four digits must be greater than or equal to 1944.

Rationale
This data item protects the identity of the patient and allows cases to be identified on a local, state, and national level. If the central registry preserves this number, they can refer to it when communicating with the reporting facilities. It also provides a way to link computerized follow-up reports from reporting facilities into the central database.

ADDR AT DX--CITY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
City or Town (pre-96 CoC) City/Town at Diagnosis (CoC)	70	50	CoC					95 - 144

Description
Name of the city in which the patient resides at the time the reportable tumor was diagnosed. If the patient resides in a rural area, record the name of the city used in the mailing address. If the patient has multiple primaries, the city of residence may be different for each primary.

Codes (in addition to valid City)

UNKNOWN	City at diagnosis unknown

ADDR AT DX--COUNTRY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	102	3	NAACCR	2013	13			436 - 438

Description
Country code for the address of the patient's residence at the time the reportable tumor is diagnosed. If the patient has multiple tumors, the country of residence may be different for each tumor. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item Addr at Dx--State [80].

Rationale
Country of patient's residence at the time of diagnosis is an important element of the patient's residential history profile and might be useful for understanding risk factors, assessment of patient prognosis, and chances for survival.

Codes Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes, whenever possible, augmented by custom codes. See Appendix B for complete list of country names and corresponding three character alpha codes.

Custom codes for both historic and future use	
ZZN	North America NOS
ZZC	Central America NOS
ZZS	South America NOS
ZZP	Pacific NOS
ZZE	Europe NOS
ZZF	Africa NOS
ZZA	Asia NOS
ZZX	Non-US NOS
ZZU	Unknown
Custom codes for historic use only	
XNI	North American Islands
XCB	Other Caribbean Islands
XEN	England, Channel islands, Isle of Man
XSC	Scandinavia
XGR	Germanic Countries
XSL	Slavic Countries
CSK	Czechoslovakia (former)
YUG	Yugoslavia
XUM	Ukraine and Moldova
XNF	North Africa
XSD	Sudanese Countries
XWF	West Africa
XSF	South Africa
XEF	East Africa
XIF	African Islands
XET	Ethiopia and Eritrea
XAP	Arabian Peninsula
XIS	Israel and Palestine

XCR	Caucasian Republics of former USSR
XOR	Other Asian Republics of former USSR
XSE	Southeast Asia
XMS	Malaysia, Singapore, Brunei
XCH	China, NOS
XML	Melanesian Islands
XMC	Micronesian Islands
XPL	Polynesian Islands

ADDR AT DX--NO & STREET

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Patient Address (Number and Street) at Diagnosis (CoC) Number and Street (pre-96 CoC)	2330	60	CoC					3628 - 3687

Description
The number and street address or the rural mailing address of the patient's residence at the time the reportable tumor was diagnosed. If the patient has multiple tumors, address at diagnosis may be different for each tumor. Additional address information such as facility, nursing home, or name of apartment complex should be entered in Addr At DX--Supplementl [2335]. Do not update this item if patient moves after diagnosis.

U.S. addresses should conform to the U.S. Postal Service (USPS) *Postal Addressing Standards*. These standards are referenced in USPS Publication 28, July 2008, *Postal Addressing Standards*. The current USPS Pub. 28 may be found and downloaded from the following website: http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf.

Canadian addresses should conform to the *Canada Postal Guide.* The current Canadian Postal Address standards may be found at the following website: http://www.canadapost.ca.

Rationale
Addresses that are formatted to conform to USPS *Postal Addressing Standards* can be more properly geocoded by geographic information systems (GIS) software and vendors to the correct census tract, which is required by NPCR and SEER registries. The USPS Standards also address a number of issues that are problematic in producing precise addresses, including the use of punctuation, abbreviations, and proper placement of address elements, such as street direction, apartment and suite numbers, and unusual addressing situations. Spanish-language addresses also are covered by the USPS Standard.

Coding Instructions (summary of USPS guidelines) The address should be fully spelled out with standardized use of abbreviations and punctuation per USPS postal addressing standards (USPS *Postal Addressing Standards*, Pub. 28, July 2008). Upper case recommended. Mixed case allowed.

Abbreviations should be limited to those recognized by USPS standard abbreviations, these include but are not limited to (A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub. 28):

APT	apartment	N	north
BLDG	building	NE	northeast
FL	floor	NW	northwest
STE	suite	S	south
UNIT	unit	SE	Southeast
RM	room	SW	southwest
DEPT	department	E	east
		W	west

Punctuation marks should be avoided, except when punctuation is necessary to convey the meaning. 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). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (e.g., 425 FLOWER BLVD # 72).

Codes (in addition to valid street address)

UNKNOWN	Patient's address is unknown

ADDR AT DX--POSTAL CODE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Zip Code (pre-CoC) Postal Code (CCCR) Postal Code at Diagnosis (CoC)	100	9	CoC					147 - 155

Description
Postal code for the address of the patient's residence at the time the reportable tumor is diagnosed. If the patient has multiple tumors, the postal code may be different for each tumor. For U.S. residents, use either the 5-digit or the extended 9-digit ZIP code. Blanks follow the 5-digit code if the 4-digit extension is not collected.For Canadian residents, use the 6-character alphanumeric postal code. Blanks follow the 6-character code.When available, enter the postal code for other countries.

Codes (in addition to known US and Canadian or other postal codes)

888888888	Resident of country other than the United States, U.S. possessions or territories, or Canada and the postal code is unknown
999999999	Resident of the United States (including its possessions, etc.) and the postal code is unknown
999999	Resident of Canada and postal code is unknown

ADDR AT DX--STATE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
State at Diagnosis (CoC) State (pre-96 CoC)	80	2	CoC	2011	12.2			145 - 146

Description
USPS abbreviation for the state, territory, commonwealth, U.S. possession, or CanadaPost abbreviation for the Canadian province/territory in which the patient resides at the time the reportable tumor is diagnosed. If the patient has multiple primaries, the state of residence may be different for each tumor. Effective with NAACCR Volume II, Version 13 a new data item, Addr at Dx--Country [102] was added to the standard transmission record layout. The UDS Committee expects the new items to supplement the use of Addr at Dx--State [80].

Codes (in addition to USPS abbreviations)

CD	Resident of Canada, NOS (province/territory unknown)
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
XX	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known
YY	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown
ZZ	Residence unknown

ADDR AT DX--SUPPLEMENTL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Patient Address (Number and Street) at Diagnosis--Supplemental (CoC)	2335	60	CoC	2003	10			3688 - 3747

Description
This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex. If the patient has multiple tumors, address at diagnosis may be different for each tumor. Do not use this item for information stored in other address items such as Addr At DX--NO&Street [2330].

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

ADDR CURRENT--CITY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
City/Town--Current (CoC)	1810	50	CoC					2131 - 2180

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

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

ADDR CURRENT--COUNTRY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1832	3	NAACCR	2013	13			439 - 441

Description
Country code for the address of patient's current usual residence. If the patient has multiple tumors, the current country of residence should be the same for all tumors. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item Addr Current--State [1820].

Rationale
Country of patient's current residence is an important element of the patient's residential history profile and is useful for understanding risk factors, assessment of patient prognosis, and chances for survival.

Codes Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes, whenever possible, augmented by custom codes, see below. See Appendix B for complete list of country names and corresponding three character alpha codes.

Custom codes for historic use only
ZZN North America NOS
ZZC Central America NOS
ZZS South America NOS
ZZP Pacific NOS
ZZE Europe NOS
ZZF Africa NOS
ZZA Asia NOS
ZZX Non-US NOS
ZZU Unknown
Custom codes for historic use only
XNI North American Islands
SCB Other Caribbean Islands
XEN England, Channel Island, Isle of Man
XSC Scandinavia
XGR Germanic Countries
XSL Slavic Countries
CSK Czechoslovakia (former)
YUG Yugoslavia (former)
XUM Ukraine and Moldova
XNF North Africa
XSD Sudanese Countries
XWF West Africa
XSF South Africa
XEF East Africa
XIF African Islands
XET Ethiopia and Eritrea
XAP Arabian Peninsula
XIS Israel and Palestine
XCR Caucasian Republics of former USSR
XOR Other Asian Republics of former USSR
XSE Southeast Asia
XMS Malaysia, Singapore, Brunei
XCH China, NOS
XML Melanesian Islands
XMC Micronesian Islands
XPL Polynesian Islands

ADDR CURRENT--NO & STREET

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Patient Address (Number and Street)-Current (CoC)	2350	60	CoC					3748 - 3807

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

U.S. addresses should conform to the USPS *Postal Addressing Standards*. These standards are referenced in USPS Pub. 28, July, 2008, *Postal Addressing Standards*. The current USPS Pub. 28 may be found and downloaded from the following website: http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf.

Canadian addresses should conform to the *Canada Postal Guide*. The current Canadian Postal Address standards may be found at the following website: http://www.canadapost.ca.

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

Addresses that are formatted to conform to USPS *Postal Addressing Standards* can be more properly geocoded by GIS software and vendors to the correct census tract. The USPS Standards also address a number of issues that are problematic in producing precise addresses, including the use of punctuation, abbreviations, and proper placement of address elements, such as street direction, apartment and suite numbers, and unusual addressing situations. Spanish-language addresses also are covered by the USPS Standard.

Coding Instructions (summary of USPS guidelines)
The address should be fully spelled out with standardized use of abbreviations and punctuation per USPS postal addressing standards (USPS Postal Addressing Standards, Pub. 28, July 2008). Upper case recommended. Mixed case allowed.

Abbreviations should be limited to those recognized by USPS standard abbreviations, these include but are not limited to (a complete list of recognized street abbreviations is provided in Appendix C of USPS Pub. 28.):

APT	apartment	N	north
BLDG	building	NE	northeast
FL	floor	NW	northwest
STE	suite	S	south
UNIT	unit	SE	Southeast
RM	room	SW	southwest
DEPT	department	E	east
		W	west

Punctuation marks should be avoided, except when punctuation is necessary to convey the meaning. 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). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (e.g., 425 FLOWER BLVD # 72).

ADDR CURRENT--POSTAL CODE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Postal Code--Current (CoC)	1830	9	CoC					2183 - 2191

Description
Postal code for the address of the patient's current usual residence. If the patient has multiple tumors, the postal codes should be the same. For U.S. residents, use either the 5-digit or the extended 9-digit ZIP code. Blanks follow the 5-digit code. For Canadian residents, use the 6-character alphanumeric postal code. Blanks follow the 6-character code. When available, enter postal code for other countries.

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

Codes (in addition to U.S., Canadian, and Foreign postal codes)

999999	Resident of Canada and postal code unknown
888888888	Resident of country other than the United States (including its possessions, etc.) or Canada, and postal code unknown
999999999	Resident of the United States (including its possessions, etc.) and postal code unknown

ADDR CURRENT--STATE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
State--Current (CoC)	1820	2	CoC					2181 - 2182

Description
USPS abbreviation for the state, territory, commonwealth, U.S. possession, or CanadaPost abbreviation for the Canadian province/territory of the

patient's current usual residence. If the patient has multiple tumors, the current state of residence should be the same for all tumors. Effective with NAACCR Volume II, Version 13 a new data item, Addr Current--Country [1832] was added to the standard transmission record layout. The UDS Committee expects the new items to supplement the use of Addr Current--State [80].

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

Codes (in addition to the U.S. and Canadian postal service abbreviations)

CD	Resident of Canada, NOS (province/territory unknown)
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
XX	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known
YY	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown
ZZ	Residence unknown

ADDR CURRENT--SUPPLEMENTL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Patient Address (Number and Street) Current--Supplemental (CoC)	2355	60	CoC	2003	10			3808 - 3867

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

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

AGE AT DIAGNOSIS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	230	3	SEER/CoC					193 - 195

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

Codes

000	Less than 1 year old; diagnosed in utero
001	1 year old, but less than 2 years
002	2 years old
...	
101	101 years old
...	
120	120 years old
999	Unknown age

AMBIGUOUS TERMINOLOGY DX

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Ambiguous Terminology Ambiguous Terminology as Basis for Diagnosis	442	1	SEER	2006	11			566 - 566

Description
Identifies all cases, including death certificate only and autopsy only, for which an ambiguous term is the most definitive word or phrase used to establish a cancer diagnosis (i.e., to determine whether or not the case is reportable). Ambiguous terminology may originate from any source document, such as pathology report, radiology report, or from a clinical report. This data item is used only when ambiguous terminology is used to establish diagnosis. It is not used when ambiguous terminology is used to clarify a primary site, specific histology, histologic group, or stage of

disease.

Rationale
Cases with a reportable cancer diagnosis that has been established based only on reports that contain ambiguous terminology to describe final diagnostic findings cannot currently be identified. Multiple surveys have identified a lack of consensus in the interpretation and use of ambiguous terms across physician specialties. These cases may or may not have an actual cancer diagnosis based on clinician, radiologist, and pathologist review. Furthermore, the historical interpretation and use of ambiguous terms by cancer registrars and registries has not been consistent or compatible with physician use of these terms.

This data item will identify specific primary sites where the ambiguous terminology is commonly used to describe or establish a cancer diagnosis. Data collected will be used as the basis for modifications to case inclusion and reportable rules following complete analysis and impact assessment. This data item will allow cases to be identified within an analysis file and be excluded from patient contact studies.

Codes (refer to http://seer.cancer.gov/tools/mphrules/index.html for additional instructions.)

0 Conclusive term
1 Ambiguous term only
2 Ambiguous term followed by conclusive term
9 Unknown term

Refer to Table 2 in Chapter III for a list of ambiguous terms.

ARCHIVE FIN

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3100	10	CoC	2003	10			721 - 730

Description
This field identifies the CoC Facility Identification Number (FIN) of the facility at the time it originally accessioned the tumor.

Rationale
When CoC accredited facilities merge or join networks, their unique CoC Facility Identification Number (FIN) [540] may change. Archive FIN preserves the identity of the facility at the time the case was originally accessioned so that records resubmitted subsequent to such a reorganization can be recognized as belonging to the same facility

Instructions for Coding
CoC maintains the codes, including those for non-hospital sources of reporting.

For facilities with 7-digit FINs in the range of 6020009-6953290 that were assigned by CoC before January 1, 2001, the coded FIN will consist of three leading zeroes followed by the full 7-digit number.

For facilities with FINs greater than or equal to 10000000 that were assigned by CoC after January 1, 2001, enter FIN codes of this type as two zeroes followed by the full 8-digit code. These sometimes are called CoC FIN 10-digit codes.

AUTOPSY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1930	1	NAACCR					2274 - 2274

Description
Code indicating whether or not an autopsy was performed.

Codes

0	Not applicable; patient alive
1	Autopsy performed
2	No autopsy performed
9	Patient expired, unknown if autopsy performed

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

BEHAVIOR (73-91) ICD-O-1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1972	1	SEER					1917 - 1917

Description

Area for retaining behavior portion (1 digit) of the ICD-O-1 or field trial morphology codes entered before a conversion to ICD-O-2. See grouped data item Morph (73-91) ICD-O-1 [1970] in Appendix E. The item name includes years 73-91. However, some states may have used the codes for cases before 1973. It is a subfield of the morphology code.

Codes

For tumors diagnosed before 1992, contains the ICD-O-1 or field trial 1-digit behavior code as originally coded, if available. Blank for tumors coded directly into a later version of ICD-O.

BEHAVIOR (92-00) ICD-O-2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
ICD-O-2 Behaviour (CCCR)	430	1	SEER/CoC					549 - 549

Description
Code for the behavior of the tumor being reported using ICD-O-2. NAACCR adopted ICD-O-2 as the standard coding system for tumors diagnosed from January 1, 1992, through December 31, 2000. In addition, NAACCR recommended that cases diagnosed prior to 1992 be converted to ICD-O-2. See Behavior (73-91) ICD-O-1 [1972], for ICD-O-1 and field trial codes.

Clarification of Required Status This data item was required by all standard-setting organizations for tumors diagnosed from January 1, 1992, through December 31, 2000, and recommended for tumors diagnosed before 1992.

When the histologic type is coded according to the ICD-O-2, the histology code must be reported in Histology (92-00) ICD-O-2 [420], with behavior coded in Behavior (92-00) ICD-O-2 [430].

For information on required status for related data items for histologic type and behavior when coded according to ICD-O-3, see Histologic Type ICD-O-3 [522] and Behavior Code ICD-O-3 [523].

Codes

Valid codes are 0-3. See ICD-O-2,[15] page 22, for behavior codes and definitions.

BEHAVIOR CODE ICD-O-3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Behavior Code (CoC) ICD-O-3 Behaviour (CCCR)	523	1	SEER/CoC	2001	9			554 - 554

Description
Code for the behavior of the tumor being reported using ICD-O-3. NAACCR adopted ICD-O-3 as the standard coding system for tumors diagnosed beginning January 1, 2001, and later recommended that prior cases be converted from ICD-O-2. See Behavior (92-00) ICD-O-2 [430], for ICD-O-2 codes.

Juvenile astrocytoma is coded as borderline in ICD-O-3; North American registries report as 9421/3.

Clarification of Required Status
Behavior is required by all standard-setting organizations for tumors diagnosed on or after January 1, 2001, and recommended (by conversion from ICD-O-2 codes) for tumors diagnosed before 2001.

When the histologic type is coded according to the ICD-O-3, the histology code must be reported in Histologic Type ICD-O-3 [522], with behavior coded in Behavior Code ICD-O-3 [523].

For information on required status for related data items for histologic type and behavior when coded according to ICD-O-2, see Histology (92-00) ICD-O-2 [420] and Behavior (92-00) ICD-O-2 [430].

Codes

Valid codes are 0-3. See ICD-O-3,[14] page 66, for behavior codes and definitions.

BIRTHPLACE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Place of Birth (SEER/CoC)	250	3	SEER/CoC					206 - 208

Description
Code for place of birth of the patient. If a patient has multiple tumors, all records should contain the same code.

Rationale
Place of Birth is helpful for patient matching and can be used when reviewing race and ethnicity. In addition, adding birthplace data to race and ethnicity allows for a more specific definition of the population being reported. Careful descriptions of ancestry, birthplace, and immigration history of populations studied are needed to make the basis for classification into ethnic groups clear. Birthplace has been associated with variation in genetic, socioeconomic, cultural, and nutritional characteristics that affect patterns of disease. A better understanding of the differences within racial and ethnic categories also can help states develop effective, culturally sensitive public health prevention programs to decrease the prevalence of high-risk behaviors and increase the use of preventive services.

Codes

See Appendix B for numeric and alphabetic lists of places and codes (also see Appendix B of the *SEER Program Code Manual* at seer.cancer.gov/tools/codingmanuals/index.html).

BIRTHPLACE--COUNTRY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	254	3	NAACCR	2013	13			444 - 446

Description
Code for the country in which the patient was born. If the patient has multiple tumors, all records should contain the same code. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item BIRTHPLACE--STATE [252]. These two data items are intended to replace the use of BIRTHPLACE [250].

Rationale
Place of Birth is helpful for patient matching and can be used when reviewing race and ethnicity. It is an important item in algorithms for imputing race and ethnicity. In addition, adding birthplace data to race and ethnicity allows for a more specific definition of the population being reported. Careful descriptions of ancestry, birthplace, and immigration history of populations studied are needed to make the basis for classification into ethnic groups clear. Birthplace has been associated with variation in genetic, socioeconomic, cultural, and nutritional characteristics that affect patterns of disease. A better understanding of the differences within racial and ethnic categories also can help states develop effective, culturally-sensitive public health prevention programs to decrease the prevalence of high-risk behaviors and increase the use of preventive services.

Codes

Custom codes for historic use only
ZZN North America NOS
ZZC Central American NOS
ZZS South America NOS
ZZP Pacific NOS
ZZE Europe NOS
ZZF Africa NOS
ZZA Asia NOS
ZZX Non-US NOS
ZZU Unknown
Custom codes for historic use only
XNI North American Islands
XCB Other Caribbean Islands
XEN England, Channel Islands, Isle of Man
XSC Scandinavia
XGR Germanic Countries
XSL Slavic Countries
CSK Czechoslovakia (former)
YUG Yugoslavia (former)
XUM Ukraine and Moldova
XNF North Africa
XSD Sudanese Countries
XWF West Africa
XSF South Africa
XEF East Africa
XIF African Islands
XET Ethiopia and Eritrea
XAP Arabian Peninsula
XIS Israel and Palestine
XCR Caucasian Republics of former USSR
XOR Other Asian Republics of former USSR
XSE Southeast Asia
XMS Malaysia, Singapore, Brunei

XCH China, NOS
XML Melanesian Islands
XMC Micronesian Islands
XPL Polynesian Islands

See Appendix B for numeric and alphabetic lists of places and codes (also see Appendix B of the *SEER Program Code Manual* at seer.cancer.gov/tools/codingmanuals/index.html).

BIRTHPLACE--STATE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	252	2	NAACCR	2013	13			442 - 443

Description
USPS abbreviation for the state, commonwealth, U.S. possession; or CanadaPost abbreviation for the Canadian province/territory in which the patient was born. If the patient has multiple primaries, the state of birth is the same for each tumor. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item BIRTHPLACE--COUNTRY [254]. These two data items are intended to replace the item BIRTHPLACE [250].

Rationale
This is a modification of the current item Birthplace [250] item in order to make use of standard codes, rather than using geographic codes that are only used by cancer registries. The intention is that item 250 be converted to populate the new corresponding, more standard, data items.

Codes

See Appendix B for numeric and alphabetic lists of places and codes (also see Appendix B of the *SEER Program Code Manual* at seer.cancer.gov/tools/codingmanuals/index.html).

CANCER STATUS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1770	1	CoC					2127 - 2127

Description
Records the presence or absence of clinical evidence of the patient's malignant or non-malignant tumor as of the Date of Last Contact [1750]. If the patient has multiple primaries, the values may be different for each primary.

Rationale
This item can be used to compute disease-free survival. By maintaining this data item, central registries can assist hospital registries by sharing this information with other hospital registries that serve the same patients, if the state's privacy laws so permit.

Codes

1 No evidence of this tumor
2 Evidence of this tumor
9 Unknown, indeterminate whether this tumor is present, not stated in patient record

CASEFINDING SOURCE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	501	2	NAACCR	2006	11			564 - 565

Description
This variable codes the earliest source of identifying information. For cases identified by a source other than reporting facilities (such as through death clearance or as a result of an audit), this variable codes the type of source through which the tumor was first identified. This data item cannot be used by itself as a data quality indicator. The timing of the casefinding processes (e.g., death linkage) varies from registry to registry, and the coded value of this variable is a function of that timing.

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

Coding Instructions
This variable is intended to code the source that first identified the tumor. Determine where the case was first identified and enter the appropriate code. At the regional or central level, if a hospital and a non-hospital source identified the case independently of each other, enter the code for the

non-hospital source (i.e., codes 30-95 have priority over codes 10-29). If the case was first identified at a reporting facility (codes 10-29), code the earliest source (based on patient or specimen contact at the facility) of identifying information.

If a death certificate, independent pathology laboratory report, consultation-only report from a hospital, or other report was used to identify a case that was then abstracted from a different source, enter the code for the source that first identified the case, not the source from which it was subsequently abstracted. If a regional or central registry identifies a case and asks a reporting facility to abstract it, enter the code that corresponds to the initial source, not the code that corresponds to the eventual reporting facility.

Codes

10 Reporting Hospital, NOS
20 Pathology Department Review (surgical pathology reports, autopsies, or cytology reports)
21 Daily Discharge Review (daily screening of charts of discharged patients in the medical records department)
22 Disease Index Review (review of disease index in the medical records department)
23 Radiation Therapy Department/Center
24 Laboratory Reports (other than pathology reports, code 20)
25 Outpatient Chemotherapy
26 Diagnostic Imaging/Radiology (other than radiation therapy, codes 23; includes nuclear medicine)
27 Tumor Board
28 Hospital Rehabilitation Service or Clinic
29 Other Hospital Source (including clinic, NOS or outpatient department, NOS)
30 Physician-Initiated Case
40 Consultation-only or Pathology-only Report (not abstracted by reporting hospital)
50 Independent (non-hospital) Pathology-Laboratory Report
60 Nursing Home-Initiated Case
70 Coroner's Office Records Review
75 Managed Care Organization (MCO) or Insurance Records
80 Death Certificate (case identified through death clearance)
85 Out-of-State Case Sharing
90 Other Non-Reporting Hospital Source
95 Quality Control Review (case initially identified through quality control activities such as casefinding audit of a regional or central registry)
99 Unknown

CAUSE OF DEATH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Underlying Cause of Death (SEER) Underlying Cause of Death (ICD Code) (pre-96 CoC)	1910	4	SEER					2269 - 2272

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

Rationale
Cause of death is used for calculation of adjusted survival rates by the life table method. The adjustment corrects for deaths other than from the diagnosed cancer.

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

Special codes in addition to ICD-7, ICD-8, ICD-9, and ICD-10 (refer to *SEER Program Code Manual* for additional instructions.)

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

CENSUS BLOCK GROUP 2000

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Census Tract Block Group	362	1	Census					174 - 174

Description
This field is provided for coding the block group of patient's residence at time of diagnosis, as defined by the 2000 Census.

Rationale
A block group is a subdivision of a census tract designed to have an average of 1500 people, versus a census tract's average of 4500 people. All land area in the United States is described by a census block group in the 2000 Census. The Census Bureau publishes detailed population and

socioeconomic data at this level.

Block groups thus offer a high level of specificity for geographical and socioeconomic analyses.A block group has no meaning in the absence of a census tract. Refer to Census Tr Certainty 2000 [365] to ascertain basis of assignment of Census Block Group 2000.

Comment
Numerous registries find the distinction between “attempted, could not be determined” (zero) and “not coded” (blank) to be useful for geocoding planning purposes.

Note: The values 1 through 9 are nominal, with no hierarchy of values. This number determines the first digit of all the blocks which comprise the block group; for instance, census block group 3 would contain blocks numbered 3000 to 3999.

Codes

0	Census block group assignment was attempted, but the value could not be determined
1-9	Census block group values as defined by the Census Bureau
Blank	Census Block Group 2000 not coded

CENSUS BLOCK GROUP 2010

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	363	1	Census	2011	12.1			434 - 434

Description
This field is provided for coding the block group of patient’s residence at time of diagnosis, as defined by the 2010 Census.

Rationale
A block group is a subdivision of a census tract designed to have an average of 1500 people, versus a census tract's average of 4500 people. All land area in the United States is described by a census block group in the 2010 Census. The Census Bureau publishes detailed population and socioeconomic data at this level. Block groups thus offer a high level of specificity for geographical and socioeconomic analyses.

A block group has no meaning in the absence of a census tract. Refer to Census Tr Certainty 2010 [367] to ascertain basis of assignment of Census Block Group 2010.

Comment
Numerous registries find the distinction between “attempted, could not be determined” (zero) and “not coded” (blank) to be useful for geocoding planning purposes.

Note: The values 1 through 9 are nominal, with no hierarchy of values. This number determines the first digit of all the blocks which comprise the block group; for instance, census block group 3 would contain blocks numbered 3000 to 3999.

Codes

0	Census block group assignment was attempted, but the value could not be determined
1-9	Census block group values as defined by the Census Bureau
Blank	Census Block Group 2010 not coded

CENSUS BLOCK GRP 1970-90

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	368	1	Census	2008	11.2			165 - 165

Description
This field is provided for coding the block group of patient’s residence at time of diagnosis, as defined by the 1970, 1980, or 1990 Census.

Formerly CensusBlockGroup 70/80/90.

Rationale
A block group is a subdivision of a census tract or block numbering area (BNA). Not all of the United States was described by a census block group or BNA prior to the 2000 Census, but for areas assigned to block groups or BNAs, the Census Bureau published detailed population and socioeconomic data. Block groups thus offer a high level of specificity for geographical and socioeconomic analyses, where available.

A block group has no meaning in the absence of a census tract. Refer to Census Tr Cert 1970/80/90 [364] to ascertain the basis of assignment of Census Block Grp 1970-90 [368]. Refer to Census Cod Sys 1970/80/90 [120] to ascertain the decade of reference.

CommentNumerous registries find the distinction between “attempted, could not be determined” (zero) and “not coded” (blank) to be useful for geocoding planning purposes.

Note: The values 1 through 9 are nominal, with no hierarchy of values. This number determines the first digit of all the blocks which comprise the block group; for instance, census block group 3 would contain blocks numbered 3000 to 3999

Codes

0	Census block group assignment was attempted, but the value could not be determined
1-9	Census block group values as defined by the Census Bureau
Blank	Census Block Grp 1970-90 [368] not coded

CENSUS COD SYS 1970/80/90

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Coding System for Census Tract (pre-96 SEER/CoC) Census Coding System (CoC)	120	1	SEER					166 - 166

Description
Identified the set of Census Bureau census tract definitions (boundaries) that were used to code the census tract in Census Tract 1970/80/90 [110] for a specific record.

Rationale
Allows for changes in census tracts over time. The census tract definition used to code the case must be recorded so that data are correctly grouped and analyzed. If the coding system were not recorded, the census codes would have to be converted or recoded every time the census tracts were changed.

Codes

0	Not tracted
1	1970 Census Tract Definitions
2	1980 Census Tract Definitions
3	1990 Census Tract Definitions
Blank	Census Tract 1970/80/90 not coded

Clarification of NPCR Required Status

Census-1990 data items:
Census Tract 1970/80/90 [110]
Census Tr Cert 1970/80/90 [364]
Census Tract Cod Sys--1970/80/90 [120]

Census-2000 data items:
Census Tract 2000 [130]
Census Tr Certainty 2000 [365]

Information on census tract, census tract certainty, and census tract coding system is required. For tumors diagnosed in or after 2003, Census Tract 2000 [130] and Census Tr Certainty 2000 [365] (Census-2000 data items) are required. For tumors diagnosed in or before 2002, the requirement can be met by collecting either the Census-1990 data items [110, 364, 120] or the Census-2000 data items, although the Census-2000 data items [130 and 365] are recommended for tumors diagnosed in 1998 through 2002.

CENSUS IND CODE 1970-2000

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Industry Code--Census	280	3	Census/NPCR					212 - 214

Description
Code for the patient's usual industry, using U.S. Census Bureau codes (2000 Census[26] is preferable) according to coding procedures recommended for death certificates.[25] This data item applies only to patients who are age 14 years or older at the time of diagnosis.

Note: Occupation/industry coding should NOT be performed by reporting facilities. This is a central cancer registry data item. Specially trained and qualified personnel should perform coding.
Formerly Industry Code--Census.

Note: 2000 Census codes for occupation and industry are recommended for tumors diagnosed on or after January 1, 2003.[26] The 1990 Census codes are recommended for tumors diagnosed before January 1, 2003.[24] For more information, see the U.S. Census Bureau website at: http://www.census.gov/hhes/www/ioindex/ioindex.html.

Rationale
Use of the Census Bureau classification system improves consistency of data collected from multiple sources. The Census Bureau industrial classification system is used for coding industry information from death certificates and from the U.S. Census of Population. The system includes specific coding rules. [22-27]

Codes
Software for automated coding of industry and occupation to 1990 Census classifications is available from the Division of Safety Research, National Institute for Occupational Safety and Health, CDC (http://www.cdc.gov/niosh/SOIC/). As of press time, NIOSH is developing new web-based software for automated coding of industry and occupation to appropriate year Census (1990, 2000, or 2010) classifications. The contact person for this software (which will be available after October 2012) is Sue Nowlin, who can be contacted at sxn1@cdc.gov or (513) 841-4467.

Registries may want to wait to code industry and occupation until *NAACCR Standards Volume II, Version 13* is released and the NIOSH autocoding software is available.

CENSUS IND CODE 2010 CDC

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Census Industry Code--2010 Census Ind Code 2010	272	4	Census/NPCR	2013	13			455 - 458

Description
Code for the patient‘s usual industry, using U.S. Census Bureau codes and NIOSH non-paid worker codes. This data item applies only to patients who are age 14 years or older at the time of diagnosis. Usual industry refers to the type of activity at the patient's place of work for most of his or her working life. Formerly Census Ind Code 2010.

Rationale
Use of a standard industry classification system and associated codes improves the consistency of data collected from multiple sources and facilitates the use of data by researchers.

Coding Instructions
Occupation/industry coding should NOT be performed by reporting facilities. This is a central cancer registry data item. Specially trained and qualified personnel should perform coding.

Codes for industry are routinely updated to include new or more detailed codes. The 4-digit 2010 industry codes from the U.S. Census Bureau and NIOSH are the most recent codes for industry. When assigning industry codes, central registries should use the most recent code set available. The industry codes for 2010 may be used for earlier diagnosis years. Cases already coded with older industry codes do not have to be recoded to the 2010 codes.

Codes
Valid codes for industry include the U.S. Census codes and the NIOSH non-paid worker codes (listed below). CDC has combined these two sets of codes into a PHIN-VADS value set located here: http://phinvads.cdc.gov/vads/SearchAllVocab_search.action?searchOptions.searchText=2.16.840.1.114222.4.11.7187.

2010 NIOSH Codes for Non-Paid Worker Titles:	
9880	Retired
9890	Housewife, homemaker, volunteers, student, child or infant, patient, disabled, inmate, or individual who did not work
9990	Blank text, unknown, don't know, not applicable, refused, or information is inadequate to select a code
Blank	Coding of Census Ind Code 2010 CDC not attempted

The Division of Safety Research at CDC’s National Institute for Occupational Safety and Health (NIOSH) has developed new web-based software for automated coding of industry and occupation to appropriate year Census (1990, 2000, or 2010) classifications. This system also includes the NIOSH non-paid worker codes. The contact person for this software is Sue Nowlin, who can be contacted at sxn1@cdc.gov or (513) 841-4467.

For more information related to the U.S. Census Bureau codes, see the following websites:

- Crosswalk: http://www.census.gov/people/io/methodology/. Utilize the following file: 1990-2012 Census Industry Codes with Crosswalk.

- Index: http://www.census.gov/people/io/methodology/indexes.html

CENSUS OCC CODE 1970-2000

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Occupation Code--Census	270	3	Census/NPCR					209 - 211

Description
Code for the patient’s usual occupation, using U.S. Census Bureau codes (see note below) according to coding procedures recommended for death certificates.[22] This data item applies only to patients who are age 14 years or older at the time of diagnosis. Usual occupation is defined as type of job the patient was engaged in for most of his or her working life.
Note : Occupation/industry coding should NOT be performed by reporting facilities. This is a central registry data item. Specially trained and qualified personnel should perform coding.

Note : The 3-digit 2000 Census codes for occupation are recommended for tumors diagnosed on or after January 1, 2003, and prior to January 1, 2013.[23, 25] The 3 digit 1990 Census codes for occupation are recommended for tumors diagnosed before January 1, 2003.[24 , 26] The 4-digit Census occupation codes are

recommended for tumors diagnosed on or after January 1, 2013, and should be reported in NAACCR data item Census Occ Code 2010 CDC [282]. For more information, see the U.S. Bureau of the Census website at: http://www.census.gov/hhes/www/ioindex/ioindex.html .

Formerly Occupation Code--Census.

Rationale
Use of the Census Bureau classification system improves consistency of data collected from multiple sources. The Census Bureau occupation classification system is used for coding occupation information from death certificates and from the U.S. Census of Population. The system includes specific coding rules. [22-26, 40]

Codes
Software for automated coding of industry and occupation to 1990 Census classifications is available from the Division of Safety Research, National Institute for Occupational Safety and Health, CDC (http://www.cdc.gov/niosh/SOIC/) . As of press time, NIOSH is developing new web-based software for automated coding of industry and occupation to appropriate year Census (1990, 2000, or 2010) classifications. The contact person for this software (which will be available after October 2012) is Sue Nowlin, who can be contacted at sxn1@cdc.gov or (513) 841-4467.

Registries may want to wait to code industry and occupation until *NAACCR Standards Volume II, Version 13* is released and the NIOSH autocoding software is available.

CENSUS OCC CODE 2010 CDC

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Census Occ Code 2010	282	4	Census/NPCR	2013	13			459 - 462

Description
Code for the patient's usual occupation, using U.S. Census Bureau codes and NIOSH non-paid worker codes. This data item applies only to patients who are age 14 years or older at the time of diagnosis. Usual occupation is defined as the type of job the patient was engaged in for most of his or her working life. Formerly Census Occ Code 2010.

Rationale
Use of a standard occupation classification system and associated codes improves the consistency of data collected from multiple sources and facilitates the use of data by researchers.

Coding Instructions
Occupation/industry coding should NOT be performed by reporting facilities. This is a central registry data item. Specially trained and qualified personnel should perform coding.

Codes for occupation are routinely updated to include new or more detailed codes. The 4-digit 2010 occupation codes from the U.S. Census Bureau and NIOSH are the most recent codes for occupation. When assigning occupation codes, central registries should use the most recent code set available. The occupation codes for 2010 may be used for earlier diagnosis years. Cases already coded with older occupation codes do not have to be recoded to the 2010 codes.

Valid codes for occupation include the U.S. Census codes and the NIOSH non-paid worker codes (listed below). CDC has combined these two sets of codes into a PHIN-VADS value set located here: http://phinvads.cdc.gov/vads/ViewValueSet.action?id=1445D71C-F37F-4504-8B6C-BA48C5A3F4CA

2010 NIOSH Occupation Codes for Non-Paid Worker Titles:

9010	Housewife, homemaker
9020	Volunteers
9050	Student
9060	Retired
9100	Child or infant, patient, disabled, inmate, or individual who did not work
9900	Blank text, unknown, don't know, not applicable, refused or information is inadequate to select a code
Blank	Coding of Census Occ Code 2010 CDC not attempted

Note: The Division of Safety Research at CDC's National Institute for Occupational Safety and Health (NIOSH) has developed new web-based software for automated coding of industry and occupation to appropriate year Census (1990, 2000, or 2010) classifications. This system also includes the NIOSH non-paid worker codes. The contact person for this software is Sue Nowlin, who can be contacted at sxn1@cdc.gov or (513) 841-4467.

For more information related to the U.S. Census Bureau codes, see the following websites:
- Crosswalk: http://www.census.gov/people/io/methodology/. Utilize the 3rd tab of the following file: 2010 Census Occupation Codes with Crosswalk. The 2002 Census codes are the same as the 2000 codes with a "0" added to the end of the number due to the change from a 3-digit to 4-digit field.

- Index: http://www.census.gov/people/io/methodology/indexes.html

CENSUS OCC/IND SYS 70-00

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Occup/Ind Coding System	330	1	NPCR					417 - 417

Description
Code that identifies coding system used for occupation and industry. This is a central cancer registry data item (i .e., codes should be applied by a central or regional registry rather than collected from reporting facilities).

Formerly Occup/Ind Coding System.

Codes

1	1970 Census
2	1980 Census
3	1990 Census
4	2000 Census
5	2010 Census
7	Other coding system
9	Unknown coding system
Blank	Not collected

Note: 2000 Census codes for occupation and industry are recommended for tumors diagnosed on or after January 1, 2003.[26] The 1990 Census codes are recommended for tumors diagnosed before January 1, 2003.[24] For more information, see the U.S. Bureau of the Census website at: http://www.census.gov/hhes/www/ioindex/ioindex.html.

CENSUS TR CERT 1970/80/90

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Census Tract Certainty	364	1	SEER	1997	5.1			167 - 167

Description
Code indicating basis of assignment of census tract or block numbering area (BNA) for an individual record.Helpful in identifying cases tracted from incomplete information or P.O. Box. This item is not coded by the hospital. Central registry staff manually assign the code.

Codes

1	Census tract/BNA based on complete and valid street address of residence
2	Census tract/BNA based on residence ZIP + 4
3	Census tract/BNA based on residence ZIP + 2
4	Census tract/BNA based on residence ZIP code only
5	Census tract/BNA based on ZIP code of P.O. Box
6	Census tract/BNA based on residence city where city has only one census tract, or based on residence ZIP code where ZIP code has only one census tract
9	Not assigned, geocoding attempted
Blank	Not assigned, geocoding not attempted

Clarification of NPCR Required Status

Census-1990 data items:
Census Tract 1970/80/90 [110]
Census Tr Cert 1970/80/90 [364]
Census Tract Cod Sys--1970/80/90 [120]

Census-2000 data items:
Census Tract 2000 [130]
Census Tr Certainty 2000 [365]

Information on census tract, census tract certainty, and census tract coding system is required. For tumors diagnosed in or after 2003, Census Tract 2000 [130] and Census Tr Certainty 2000 [365] (Census-2000 data items) are required. For tumors diagnosed in or before 2002, the requirement can be met by collecting either the Census-1990 data items [110, 364, 120] or the Census-2000 data items, although the Census-2000 data items [130 and 365] are recommended for tumors diagnosed in 1998 through 2002.

CENSUS TR CERTAINTY 2000

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	365	1	NAACCR	2003	10			175 - 175

Description
Code indicating basis of assignment of census tract for an individual record. Helpful in identifying cases tracted from incomplete information or

P.O. Box. This item is not coded by the hospital. Central registry staff assign the code.

Codes

1	Census tract based on complete and valid street address of residence
2	Census tract based on residence ZIP + 4
3	Census tract based on residence ZIP + 2
4	Census tract based on residence ZIP code only
5	Census tract based on ZIP code of P.O. Box
6	Census tract/BNA based on residence city where city has only one census tract, or based on residence ZIP code where ZIP code has only one census tract
9	Not assigned, geocoding attempted
Blank	Not assigned, geocoding not attempted

Clarification of NPCR Required Status

Census-1990 data items:	Census-2000 data items:
Census Tract 1970/80/90 [110]	Census Tract 2000 [130]
Census Tr Cert 1970/80/90 [364]	Census Tr Certainty 2000 [365]
Census Tract Cod Sys--1970/80/90 [120]	

Information on census tract, census tract certainty, and census tract coding system is required. For tumors diagnosed in or after 2003, Census Tract 2000 [130] and Census Tr Certainty 2000 [365] (Census-2000 data items) are required. For tumors diagnosed in or before 2002, the requirement can be met by collecting either the Census-1990 data items [110, 364, 120] or the Census-2000 data items, although the Census-2000 data items [130 and 365] are recommended for tumors diagnosed in 1998 through 2002.

CENSUS TR CERTAINTY 2010

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	367	1	NAACCR	2011	12.1			435 - 435

Description

Code indicating basis of assignment of census tract for an individual record. Helpful in identifying cases tracted from incomplete information or P.O. Box. This item is not coded by the hospital. Central registry staff assign the code.

Codes

1	Census tract based on complete and valid street address of residence
2	Census tract based on residence ZIP + 4
3	Census tract based on residence ZIP + 2
4	Census tract based on residence ZIP code only
5	Census tract based on ZIP code of P.O. Box
6	Census tract/BNA based on residence city where city has only one census tract, or based on residence ZIP code where ZIP code has only one census tract
9	Not assigned, geocoding attempted
Blank	Not assigned, geocoding not attempted

Clarification of NPCR Required Status

Census-1990 data items:	Census-2000 data items:	Census-2010 data items:
Census Tract 1970/80/90 [110]	Census Tract 2000 [130]	Census Tract 2010 [135]
Census Tr Cert 1970/80/90 [364]	Census Tr Certainty 2000 [365]	Census Tr Certainty 2010 [367]
Census Tract Cod Sys--1970/80/90 [120]		

Information on census tract and census tract certainty is required. Census Tract and Census Tract Certainty should be recorded in the year-appropriate data item fields in order to reflect demographic information at the time of diagnosis. Until the 2010 Census is completed and data are available for geocoding, tumors diagnosed in 2010 or later, should be coded to the 2000 census definitions and recorded in Census Tract 2000 [130] and Census Tr Certainty 2000 [365]. When the 2010 Census data are available for geocoding, tumors diagnosed in 2010 or later must be coded to the 2010 census tract definitions and recorded in Census Tract 2010 [135] and Census Tract Certainty 2010 [367]. For tumors diagnosed between January 1, 2008, and December 31, 2009, use of Census Tract 2010 [135] and Census Track Certainty 2010 [367] is recommended.

CENSUS TR POVERTY INDICTR

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	145	1	NAACCR	2013	13			463 - 463

Description

Assigns a code for neighborhood poverty level based on the census tract of diagnosis address. Cases diagnosed between 1995 and 2004 are assigned

a code based on the 2000 U.S. Census, the last decennial census for which poverty level was collected. Cases diagnosed since 2005 are assigned a code based on the American Community Survey (ACS).

The ACS publishes tract-level poverty data annually, on a rolling five-year window, with a two-year lag (e.g., poverty data for 2006-2010 will be available in 2012). Cases for a given diagnosis year are initially coded using the most recent file available when the cancer data are first released, and the item is subsequently coded using the ACS file centered on the year of diagnosis. For example, cases diagnosed in 2012 will initially be coded using the 2008-2012 ACS file, and two years later using the 2010-2014 ACS file. An exception to this rule is that cases diagnosed in 2005 and 2006 will be coded using the 2005-2009 ACS file, because this was the first such file released. Codes may be automatically assigned by running the Poverty and Census Tract Linkage Program available through the Data Analysis Tools section of the NAACCR website.

Rationale
Many cancers are associated with socioeconomic status and it is useful to include a measure of this in analyses. A detailed rationale for this data item was published in *Journal of Registry Management* 2010; 37(4): 148-151.

Codes

1 0% - <5% poverty
2 5% - <10% poverty
3 10% - <20% poverty
4 20% - 100% poverty
9 Unknown or not applicable

CENSUS TRACT 1970/80/90

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Census Tract/Block Numbering Area (BNA) (SEER) Census Tract	110	6	SEER					159 - 164

Description
Code for the census tract or BNA of the patient's residence at the time of diagnosis. SEER used this field for tumors reported before 1998. If the patient has more than one tumor, the codes may be different for each tumor.

Codes are those used by the U.S. Census Bureau. Census Bureau codes for BNA also are entered in this field.

Both census tracts and BNAs have a 4-digit basic number and also may have a 2-digit suffix. Census tract numbers range from 0001.00 to 9499.99. BNA numbers range from 9501.00 to 9989.99. See the Census Bureau's "Area Classifications"[35] for further details.

Rationale
Allows central registries to calculate incidence rates for geographical areas having population estimates. The Census Bureau provides population data for census tracts. Those rates can be used for general surveillance or special geographical and socioeconomic analysis.

Codes

Census Tract Codes	000100-949999
BNA Codes	950100-998999
000000	Area not census-tracted
999999	Area census-tracted, but census tract is not available
Blank	Census Tract 1970/80/90 not coded

Clarification of NPCR Required Status
Information on census tract, census tract certainty, and census tract coding system is required. Tumors diagnosed in 2003 or later, must be coded to the 2000 census definitions and recorded in Census Tract 2000 [130] and Census Tr Certainty 2000 [365]. Tumors diagnosed in 2002, or before must be coded to the 2000 census tract definitions OR to 1990 definitions OR to both the 2000 and 1990 census definitions. Census tract, census tract certainty and census tract coding system should be recorded in the year appropriate data item fields. For tumors diagnosed between January 1, 1998, and December 31, 2002, (inclusive) use of the 2000 census tract definitions is recommended.

CENSUS TRACT 2000

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Census Tract--Alternate (pre-2003)	130	6	NAACCR					168 - 173

Description
This field is provided for coding census tract of patient's residence at time of diagnosis. See Census Tract 1970/80/90 [110]. Codes are those used by the U.S. Census Bureau for the Year 2000 Census. Census tract codes have a 4-digit basic number and also may have a 2-digit suffix. Census tract numbers range from 0001.00 to 9999.98. See the Census Bureau's "Area Classifications" at the following website: http://www.census.gov/prod/cen2000/doc/sf1.pdf for further details.

Rationale
Census tract codes allow central registries to calculate incidence rates for geographical areas having population estimates. This field allows a central registry to add Year 2000 Census tracts to tumors diagnosed in previous years, without losing the codes in data item 110.

The Census Bureau provides population data for census tracts. Those rates can be used for general surveillance or special geographical and socioeconomic analysis.

Because census tracts for particular cases can change between censuses, the central registry may wish to assign an alternate census tract code to its cases. For example, a registry may code its 2005 cases using both the 2000 and 2010 census tract boundaries. The central registry can use this information for different comparisons.

Codes

Census Tract Codes	000100-999998
000000	Area not census tracted
999999	Area census-tracted, but census tract is not available
Blank	Census Tract 2000 not coded

Clarification of NPCR Required Status
Information on census tract, census tract certainty, and census tract coding system is required. Tumors diagnosed in 2003 or later, must be coded to the 2000 census definitions and recorded in Census Tract 2000 [130] and Census Tr Certainty 2000 [365]. Tumors diagnosed in 2002, or before must be coded to the 2000 census tract definitions OR to 1990 definitions OR to both the 2000 and 1990 census tract definitions. Census tract, census tract certainty and census tract coding system should be recorded in the year appropriate data item fields. For tumors diagnosed between January 1, 1998, and December 31, 2002, (inclusive) use of the 2000 cases tract definitions is recommended.

CENSUS TRACT 2010

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	135	6	NAACCR	2011	12.1			428 - 433

Description
This field is provided for coding census tract of patient's residence at time of diagnosis. See Census Tract 1970/80/90 [110]; CENSUS TRACT 2000[130]. Codes are those used by the U.S. Census Bureau for the Year 2010 Census. Census tract codes have a 4-digit basic number and also may have a 2-digit suffix. Census tract numbers range from 0001.00 to 9999.98.

Rationale
Census tract codes allow central registries to calculate incidence rates for geographical areas having population estimates. This field allows a central registry to add Year 2010 Census tracts to tumors diagnosed in previous years, without losing the codes in data items 110 and 130.

The Census Bureau provides population data for census tracts. Those rates can be used for general surveillance or special geographical and socioeconomic analysis.

Because census tracts for particular cases can change between censuses, the central registry may wish to assign an alternate census tract code to its cases. For example, a registry may code its 2005 cases using both the 2000 and 2010 census tract boundaries. The central registry can use this information for different comparisons.

Codes

Census Tract Code	000100-999998
000000	Area not census tracted
999999	Area census tracted, but census tract is not available
Blank	Census Tract 2010 not coded

Clarification of NPCR Required Status
Information on census tract and census tract certainty is required. Census Tract and Census Tract Certainty should be recorded in the year-appropriate data item fields in order to reflect demographic information at the time of diagnosis. Until the 2010 Census is completed and data are available for geocoding, tumors diagnosed in 2010 or later, should be coded to the 2000 census definitions and recorded in Census Tract 2000 [130] and Census Tr Certainty 2000 [365]. When the 2010 Census data are available for geocoding, tumors diagnosed in 2010 or later must be coded to the 2010 census tract definitions and recorded in Census Tract 2010 [135] and Census Tract Certainty 2010 [367]. For tumors diagnosed between January 1, 2008, and December 31, 2009, use of Census Tract 2010 [135] and Census Track Certainty 2010 [367] is recommended.

CLASS OF CASE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	610	2	CoC	1990	pre V4			776 - 777

Description
Class of Case divides cases into two groups. Analytic cases (codes 00-22) are those that are required by CoC to be abstracted because of the

program's primary responsibility in managing the cancer. Analytic cases are grouped according to the location of diagnosis and treatment. Treatment and outcome reports may be limited to analytic cases. Nonanalytic cases (codes 30-49 and 99) may be abstracted by the facility to meet central registry requirements or because of a request by the facility's cancer program. Nonanalytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.

Class of Case can be used in conjunction with Type of Reporting Source [500]. Type of Reporting Source is designed to document the source of documents used to abstract the cancer being reported.

Rationale

Class of Case reflects the facility's role in managing the cancer, whether the cancer is required to be reported by CoC, and whether the case was diagnosed after the program's Reference Date.

Note: This expanded list of coded values is effective with Version 12. *Indicates Class of Case codes appropriate for abstracting cases from non-hospital sources such as physician offices, ambulatory surgery centers, freestanding pathology laboratories, radiation therapy centers. When applied to these types of facilities, the non-hospital source is the reporting facility. The codes are applied the same way as if the case were reported from a hospital. By using Class of Case codes in this manner for non-hospital sources, the central cancer registry is able to retain information reflecting the facility's role in managing the cancer consistent with the way it is reported from hospitals. Using Class of Case in conjunction with Type of Reporting Source [500] which identifies the source documents used to abstract the cancer being reported, the central cancer registry has two distinct types of information to use in making consolidation decisions

Codes

Analytic Classes of Case (Required by CoC to be abstracted by accredited cancer programs; refer to *FORDS* for additional instructions)

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 a staff physician's office AND PART OR ALL of first course treatment or a decision not to treat was at the reporting facility, NOS

11 Initial diagnosis in staff physician's office AND PART of first course treatment was done at the reporting facility

12 Initial diagnosis in staff physician's office AND ALL first course treatment or a decision not to treat was done at the reporting facility

13* Initial diagnosis at the reporting facility AND PART of first course treatment was done at the reporting facility

14* Initial diagnosis at the reporting facility AND ALL first course treatment or a decision not to treat was done at the reporting facility

INITIAL DIAGNOSIS ELSEWHERE, FACILITY INVOLVED IN FIRST COURSE TREATMENT

20* Initial diagnosis elsewhere AND PART OR ALL of first course treatment was done at the reporting facility, NOS

21* Initial diagnosis elsewhere AND PART of treatment was done at the reporting facility

22* Initial diagnosis elsewhere AND ALL first course treatment was done at the reporting facility

Classes of Case not required by CoC to be abstracted (May be required by Cancer Committee, state or regional registry, or other entity)

PATIENT APPEARS IN PERSON AT REPORTING FACILITY; BOTH INITIAL DIAGNOSIS AND TREATMENT ELSEWHERE

30* Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in DIAGNOSTIC WORKUP (for example, consult only, staging workup after initial diagnosis elsewhere)

31* Initial diagnosis and all first course treatment elsewhere AND reporting facility provided IN-TRANSIT care

32* Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease RECURRENCE OR PERSISTENCE

33* Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease HISTORY ONLY

34 Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility

35 Case diagnosed before program's Reference Date AND initial diagnosis AND PART OR ALL of first course treatment by reporting facility

36 Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND part of all of first course treatment by reporting facility

37 Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility

38* Initial diagnosis established by AUTOPSY at the reporting facility, cancer not suspected prior to death

PATIENT DOES NOT APPEAR IN PERSON AT REPORTING FACILITY

40 Diagnosis AND all first course treatment given at the same staff physician's office

41 Diagnosis and all first course treatment given in two or more different staff physician offices

42 Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)

43* PATHOLOGY or other lab specimens ONLY

49* DEATH CERTIFICATE ONLY

UNKNOWN RELATIONSHIP TO REPORTING FACILITY

99* Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases.); UNKNOWN

Note: This expanded list of coded values is effective with Version 12.

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

By using Class of Case codes in this manner for non-hospital sources, the central cancer registry is able to retain information reflecting the facility's

role in managing the cancer consistent with the way it is reported from hospitals. Using Class of Case in conjunction with Type of Reporting Source [500] which identifies the source documents used to abstract the cancer being reported, the central cancer registry has two distinct types of information to use in making consolidation decisions

COC CODING SYS--CURRENT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Commission on Cancer Coding System-Current (CoC)	2140	2	CoC					1932 - 1933

Description
Code the ACoS CoC coding system currently used in the record. CoC codes may be converted from an earlier version.

Codes

00 No CoC coding system used
01 Pre-1988 (Cancer Program Manual Supplement)
02 1988 *Data Acquisition Manual*
03 1989 *Data Acquisition Manual* Revisions
04 1990 *Data Acquisition Manual* Revisions
05 1994 *Data Acquisition Manual* (Interim/Revised)
06 ROADS (effective with cases diagnosed 1996-1997)
07 ROADS and 1998 Supplement (effective with cases diagnosed 1998-2002)
08 *FORDS* (effective with cases diagnosed 2003 and forward)
99 Unknown coding system

COC CODING SYS--ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2150	2	CoC					1934 - 1935

Description
Code for the ACoS CoC coding system originally used to code the record.

Codes

00 No CoC coding system used
01 Pre-1988 (Cancer Program Manual Supplement)
02 1988 *Data Acquisition Manual*
03 1989 *Data Acquisition Manual* Revisions
04 1990 *Data Acquisition Manual* Revisions
05 1994 *Data Acquisition Manual* (Interim/Revised)
06 ROADS (effective with cases diagnosed 1996-1997)
07 ROADS and 1998 Supplement (effective with cases diagnosed 1998-2002)
08 *FORDS* (effective with cases diagnosed 2003 and forward)
99 Original CoC coding system is not known

CODING SYSTEM FOR EOD

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Coding System for Extent of Disease (SEER)	870	1	SEER	1995	5			937 - 937

Description
Indicates the type of SEER EOD code applied to the tumor. Should be used whenever EOD coding is applied.

Rationale
Used in data editing and analysis.

Codes

0 2-Digit Nonspecific Extent of Disease (1973-82)
1 2-Digit Site-Specific Extent of Disease (1973-82)
2 13-Digit (expanded) Site-Specific Extent of Disease (1973-1982)
3 4-Digit Extent of Disease (1983-87)
4 10-Digit Extent of Disease, 1988 (1988-2003)

Blank Cases diagnosed 2004+; or the item is not collected

COMORBID/COMPLICATION 1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Comorbidities and Complications #1	3110	5	CoC	2003	10			1186 - 1190

Description
Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses

Rationale
Pre-existing medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)
ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049.

00000 No secondary diagnoses documented

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMORBID/COMPLICATION 10

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Comorbidities and Complications #10	3164	5	CoC	2006	11			1231 - 1235

Description
Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale
Pre-existing medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)
ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049.

Leave blank if no further secondary diagnosis.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMORBID/COMPLICATION 2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Comorbidities and Complications #2	3120	5	CoC	2003	10			1191 - 1195

Description
Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale
Pre-existing medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)
ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-

V4589, and V5041-V5049.

Leave blank if no further secondary diagnosis.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMORBID/COMPLICATION 3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Comorbidities and Complications #3	3130	5	CoC	2003	10			1196 - 1200

Description
Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale
Pre-existing medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)
ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049.

Leave blank if no further secondary diagnoses.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMORBID/COMPLICATION 4

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Comorbidities and Complications #4	3140	5	CoC	2003	10			1201 - 1205

Description
Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale
Pre-existing medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)
ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049.

Leave blank if no further secondary diagnoses.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMORBID/COMPLICATION 5

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Comorbidities and Complications #5	3150	5	CoC	2003	10			1206 - 1210

Description
Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale
Pre-existing medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)
ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049.

Leave blank if no further secondary diagnoses.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMORBID/COMPLICATION 6

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Comorbidities and Complications #6	3160	5	CoC	2003	10			1211 - 1215

Description
Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale
Pre-existing medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)
ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049.

Leave blank if no further secondary diagnoses.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMORBID/COMPLICATION 7

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Comorbidities and Complications #7	3161	5	CoC	2006	11			1216 - 1220

Description
Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale
Pre-existing medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)
ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049.

Leave blank if no further secondary diagnosis.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMORBID/COMPLICATION 8

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #

Comorbidities and Complications #8	3162	5	CoC	2006	11			1221 - 1225

Description
Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale
Pre-existing medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)
ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049.

Leave blank if no further secondary diagnosis.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMORBID/COMPLICATION 9

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Comorbidities and Complications #9	3163	5	CoC	2006	11			1226 - 1230

Description
Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale
Pre-existing medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)
ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049.

Leave blank if no further secondary diagnosis.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMPUTED ETHNICITY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	200	1	SEER	1995	4			190 - 190

Description
Code identifying those cases for which ethnicity was determined by matching Name--Last [2230] and Name--Maiden [2390] to a computer list of Spanish/Hispanic names or by a software algorithm. This field was adopted for use for tumors diagnosed 1994 forward. See also Computed Ethnicity Source [210].

Rationale
One method of identifying persons of Hispanic origin is to apply a standard computer list or algorithm to items 2230 and 2390, the patient's surname and/or maiden name. This has advantages across large populations of being reproducible and facilitating comparisons between areas using identical methods. It may sometimes be possible to identify population denominators in which the same method was used to identify Hispanics. Generally, only central registries will have this capability.

This field provides coding to indicate both that such a computerized name-based method was applied and the results of the method. Coding is independent of that in Spanish/Hispanic Origin [190]. The computer-derived ethnicity may be different from the ethnicity reported by registries in Spanish/Hispanic Origin [190] as code 7 (Spanish Surname Only), because that field may include manual review. This field shows the results of computer-derived ethnicity only.

Codes

0	No match was run (for 1994 and later tumors)
1	Non-Hispanic last name and non-Hispanic maiden name
2	Non-Hispanic last name, did not check maiden name or patient was male
3	Non-Hispanic last name, missing maiden name
4	Hispanic last name, non-Hispanic maiden name
5	Hispanic last name, did not check maiden name or patient was male
6	Hispanic last name, missing maiden name
7	Hispanic Maiden name (females only) (regardless of last name)
Blank	1993 and earlier tumors, no match was run

Note: For SEER, blanks are required for all cases diagnosed before 1994 and blanks are not allowed for any case diagnosed 1994 and after. Other registries may have computed this item for earlier years.

Note: NAACCR recognizes that available definitions and abstracting instructions for the data items Name--Last and Name--Maiden may be inadequate for describing names used in some cultures, including Hispanic cultures. Explicit instructions have not been provided for entering compound names, with or without hyphens or "De." Order of names, use of maternal and paternal names, and use of hyphens can vary across cultures. It is likely, too, that abstracting and coding practice for these items varies across registries. Limitations inherent in these definitions should be kept in mind in any use of the data.

COMPUTED ETHNICITY SOURCE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	210	1	SEER					191 - 191

Description
Code identifying the method used to determine ethnicity as recorded in Computed Ethnicity [200].

Codes

0	No match was run, for 1994 and later tumors
1	Census Bureau list of Spanish surnames, NOS
2	1980 Census Bureau list of Spanish surnames
3	1990 Census Bureau list of Spanish surnames
4	GUESS Program
5	Combination list including South Florida names
6	Combination of Census and other locally generated list
7	Combination of Census and GUESS, with or without other lists
8	Other type of match
9	Unknown type of match
Blank	1993 and earlier tumors, no match was run

Note: For SEER, blanks are required for all cases diagnosed before 1994 and blanks are not allowed for any case diagnosed 1994 and after. Other registries may have computed this item for earlier years.

COUNTY AT DX

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
County (pre-96 SEER/CoC) County at Diagnosis (CoC)	90	3	FIPS/SEER					156 - 158

Description
Code for the county of the patient's residence at the time the tumor was diagnosed. For U.S. residents, standard codes are those of the FIPS publication "Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas." If the patient has multiple tumors, the county codes may be different for each tumor.

Detailed standards have not been set for Canadian provinces/territories. Use code 998 for Canadian residents.

Note: See Appendix A for standard FIPS county codes. See EDITS Table BPLACE.DBF in Appendix B for geocodes used by CoC.

Note: SEER does not use code 998. CoC uses country geocodes for nonresidents of the United States (see Appendix B) and 998 for residents of other states.

Codes (in addition to FIPS and Geocodes)

998	Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution

(must meet all criteria)

999 County unknown

COUNTY AT DX GEOCODE1990 **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	94	3	NAACCR	2016	16			464 - 466

Description

Code for the county of the patient's residence at the time the tumor was diagnosed is a derived (geocoded) variable based on Census Boundary files from 1990 Decennial Census. **This code should be used for county and county-based (such as CHSDA) rates and analysis for all cases diagnosed prior to 2000.**

Rationale

County of diagnosis is essential for investigating epidemiologic pattern at both the county and the census tract level. Census tracts are nested within counties and designated with a 6-digit number code. A given census tract code is commonly repeated within a state in different counties, making census tract numbers unique only when paired with the state and the county. Example from Massachusetts: Rural Franklin County contains a tract 040600 with 2010 population 4,612 people, and urban Suffolk County contains a tract 040600 with 2,444 people.

County borders occasionally change over time. For instance, part of Adams County in Colorado become a new county, Broomfield County, in 2001. Because the historic NAACCR county code, County at DX [90], is not associated with any particular date, census tract codes can be paired with the wrong county if these changes occur. Thus, county-level rates may be generated using temporally incorrect county populations. Further, this county code is derived (through geocoding) and, therefore, generally more accurate than those provided manually. Finally, some variables, like the Tract-Level Poverty Indicator (Census Tr Poverty Indictr [145]), requires census information closest to year of diagnosis and not the decade of diagnosis. Having separate geocoded county codes for each decennial census, as we do for census tract, enables registries to retain the original, reported county as needed but will ensure the correct pairing by county and tract occur.

Recording a county at diagnosis that reflects the relevant date (decade) and relies on geocoded data will improve the accuracy of county and census tract assignments and of links with geographic data (i.e., population, poverty category, urban/rural designation).

Codes

001-997 County at diagnosis. Valid FIPS code

998 Outside state/county code unknown. Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria)

999 County unknown. The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.

Note: For U.S. residents, historically, standard codes are those of the FIPS publication "Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas." These FIPS codes (FIPS 6-4) have been replaced by INCITS standard codes, however, there is no impact on this variable as the codes align with the system the Census used for each decennial census and will automatically be accounted for during geocoding.

COUNTY AT DX GEOCODE2000 **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	95	3	NAACCR	2016	16			467 - 469

Description

Code for the county of the patient's residence at the time the tumor was diagnosed is a derived (geocoded) variable based on Census Boundary files from 2000 Decennial Census. **This code should be used for county and county-based (such as CHSDA) rates and analysis for all cases diagnosed in 2000-2009.**

Rationale

County of diagnosis is essential for investigating epidemiologic pattern at both the county and the census tract level. Census tracts are nested within counties and designated with a 6-digit number code. A given census tract code is commonly repeated within a state in different counties, making census tract numbers unique only when paired with the state and the county. Example from Massachusetts: Rural Franklin County contains a tract 040600 with 2010 population 4,612 people, and urban Suffolk County contains a tract 040600 with 2,444 people.

County borders occasionally change over time. For instance, part of Adams County in Colorado become a new county, Broomfield County, in 2001. Because the historic NAACCR county code, County at DX [90], is not associated with any particular date, census tract codes can be paired with the wrong county if these changes occur. Thus, county-level rates may be generated using temporally incorrect county populations. Further, this county code is derived (through geocoding) and, therefore, generally more accurate than those provided manually. Finally, some variables, like the Tract-Level Poverty Indicator (Census Tr Poverty Indictr [145]), requires census information closest to year of diagnosis and not the decade of diagnosis. Having separate geocoded county codes for each decennial census, as we do for census tract, enables registries to retain the original, reported county as needed but will ensure the correct pairing by county and tract occur.

Recording a county at diagnosis that reflects the relevant date (decade) and relies on geocoded data will improve the accuracy of county and census tract assignments and of links with geographic data (i.e., population, poverty category, urban/rural designation).

Codes

001-997	County at diagnosis. Valid FIPS code.
998	Outside state/county code unknown. Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria).
999	County unknown. The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.

Note: For U.S. residents, historically, standard codes are those of the FIPS publication "Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas." These FIPS codes (FIPS 6-4) have been replaced by INCITS standard codes, however, there is no impact on this variable as the codes align with the system the Census used for each decennial census and will automatically be accounted for during geocoding.

COUNTY AT DX GEOCODE2010 **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	96	3	NAACCR	2016	16			470 - 472

Description
Code for the county of the patient's residence at the time the tumor was diagnosed is a derived (geocoded) variable based on Census Boundary files from 2010 Decennial Census. **This code should be used for county and county-based (such as CHSDA) rates and analysis for all cases diagnosed in 2010-2019.**

Rationale
County of diagnosis is essential for investigating epidemiologic pattern at both the county and the census tract level. Census tracts are nested within counties and designated with a 6-digit number code. A given census tract code is commonly repeated within a state in different counties, making census tract numbers unique only when paired with the state and the county. Example from Massachusetts: Rural Franklin County contains a tract 040600 with 2010 population 4,612 people, and urban Suffolk County contains a tract 040600 with 2,444 people.

County borders occasionally change over time. For instance, part of Adams County in Colorado become a new county, Broomfield County, in 2001. Because the historic NAACCR county code, County at DX [90], is not associated with any particular date, census tract codes can be paired with the wrong county if these changes occur. Thus, county-level rates may be generated using temporally incorrect county populations. Further, this county code is derived (through geocoding) and, therefore, generally more accurate than those provided manually. Finally, some variables, like the Tract-Level Poverty Indicator (Census Tr Poverty Indictr [145]), requires census information closest to year of diagnosis and not the decade of diagnosis. Having separate geocoded county codes for each decennial census, as we do for census tract, enables registries to retain the original, reported county as needed but will ensure the correct pairing by county and tract occur.

Recording a county at diagnosis that reflects the relevant date (decade) and relies on geocoded data will improve the accuracy of county and census tract assignments and of links with geographic data (i.e., population, poverty category, urban/rural designation).

Codes

001-997	County at diagnosis. Valid FIPS code.
998	Outside state/county code unknown. Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria).
999	County unknown. The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.

Note: For U.S. residents, historically, standard codes are those of the FIPS publication "Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas." These FIPS codes (FIPS 6-4) have been replaced by INCITS standard codes, however, there is no impact on this variable as the codes align with the system the Census used for each decennial census and will automatically be accounted for during geocoding.

COUNTY AT DX GEOCODE2020 **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	97	3	NAACCR	2016	16			473 - 475

Description
Code for the county of the patient's residence at the time the tumor was diagnosed is a derived (geocoded) variable based on Census Boundary files from 2020 Decennial Census. **This code should be used for county and county-based (such as CHSDA) rates and analysis for all cases diagnosed in 2020-2029.**

Rationale
Census tracts are areas geographically nested within counties and designated with a 6-digit number code. This 6-digit code is commonly repeated within a state in different counties. Census tract numbers are only unique when paired with the state and the county. Therefore, a tract cannot be accurately identified without knowing the county. Example from Massachusetts: Rural Franklin County contains a tract 040600 with 2010 population 4,612 people. Urban Suffolk County contains a tract 040600 with 2,444 people. The county must be known in order to distinguish between the two tract codes. Because we historically used a single variable for County at DX [90], correct tract codes were frequently paired with the wrong county due to incorrect county assignment during abstracting or a change of county over time. Also, some variables, such as the Census Tract Poverty Indicator [145] require the use of the decennial Census County codes closest to year of diagnosis and not the decade of year of diagnosis. Using a single county at diagnosis, and using the reported versus geocoded data, may result in erroneous assignment of geographic location as well as invalid links with census data (i.e. population, poverty category, urban/rural designation).

Instructions for Coding
- This variable is generated through the process of geocoding either during abstracting or at the central registry level. For U.S. residents, this data item stores the county codes issued by the Federal Information Processing Standards (FIPS) publication Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas. The information in this publication is available in Appendix A.
- It is recommended that geocoding be performed using the NAACCR geocoder.
- It is recommended that all cases diagnosed through 2029 should have a geocoded County at DX Geocode2020.
- At a minimum, all cases diagnosed through 2016-2029 should have a geocoded County at DX Geocode2020. Some cases, such as those diagnosed in 2019, must have both County at DX Geocode2010 and County at DX Geocode2020 codes for proper assignment of the Census Tract Poverty Indicator [145].
- Do not update this item if the patient's county of residence changes. Store address update information in the affiliated current address data items. Only update based on improved information on the residential address at time of diagnosis.
- PO Box address information should not be used to geocode this data item except in the infrequent case when no other address information is available.
- For cases with a 9 or blank in Census Tr Certainty 2020 AND a valid FIPS code in County at DX [90], the valid FIPS code from Item [90] should be used.
- If the patient has multiple tumors, the county codes may be different for each tumor.
- Detailed standards have not been set for Canadian provinces/territories. Use code 998 for Canadian residents.
- Blank "Not geocoded" is allowable for cases diagnosed before 2015 and after 2029. However, it is preferred to have all cases diagnosed through 2029 geocoded to a County at DX Geocode2020 to allow for both retrospective and cross-sectional analyses.

Codes

001-997	County at diagnosis. Valid FIPS code.
998	Outside state/county code unknown. Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria).
999	County unknown. The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.

Note: For U.S. residents, historically, standard codes are those of the FIPS publication "Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas." These FIPS codes (FIPS 6-4) have been replaced by INCITS standard codes, however, there is no impact on this variable as the codes align with the system the Census used for each decennial census and will automatically be accounted for during geocoding.

COUNTY--CURRENT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1840	3	NAACCR					2192 - 2194

Description
Code for county of patient's current residence. See Chapter V, Unresolved Issues, for further discussion.

Note: This item was used by CoC only. CoC recommended use of FIPS codes (see Appendix A). The *ROADS Manual* also provided for use of geocodes for countries of residence outside the United States and Canada to be used in the county fields.

Rationale
This item may be used in administrative reports to define a referral area.

Codes (in addition to FIPS and geocodes)

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

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

CRC CHECKSUM

			Source of	Year	Version	Year	Version	

Alternate Name	Item #	Length	Standard	Implemented	Implemented	Retired	Retired	Column #
	2081	10	NAACCR	1998	6			1920 - 1929

Description
Cyclic Redundancy Code (CRC) CHECKSUM for the NAACCR record in which it resides. A unique value is calculated for each unique record in a NAACCR file. The value is calculated by applying a CRC algorithm to all data fields of the NAACCR record (excluding the CRC CHECKSUM field). Following a transmission, the CRC CHECKSUM can be recalculated and compared with the transmitted CHECKSUM. Identical values indicate an error-free transmission; differing values indicate an error in transmission.

The algorithm recommended by NAACCR is on the NAACCR website at: http://www.naaccr.org. Users must provide recipients of the data with the algorithm used to create the data transmission file. Otherwise, the item should be left blank.

Rationale
The CHECKSUM can be used to determine if a record-level error occurred during transmission and can also be used to correct any such errors. Record-level CRC CHECKSUMs also allow portions of a NAACCR file to be salvaged in the event of a transmission error.

CS EXTENSION

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2810	3	AJCC	2003	10			988 - 990

Description
Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in CS Extension.

Rationale
Tumor extension at diagnosis is a prognostic indicator used by Collaborative Staging to derive some TNM-T codes and some SEER Summary Stage codes.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

Note: For cases diagnosed prior to 2010, this was a 2 character field in CS version 1 which was converted to a 3 character field in CS version 2. Most 2 character codes were converted by adding a zero as the third character. For example, code 05 was usually converted to 050, 10 to 100, 11 to 110, etc. Special codes such as 88 and 99 were usually converted to 888 and 999, respectively.

CS LYMPH NODES

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
CS Lymph Nodes (SEER EOD)	2830	3	AJCC	2003	10			992 - 994

Description
Identifies the regional lymph nodes involved with cancer at the time of diagnosis.

Rationale
The involvement of specific regional lymph nodes is a prognostic indicator used by Collaborative Staging to derive some TNM-N codes and SEER Summary Stage codes.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

Note: For cases prior to 2010, this was a 2 character field in CS version 1 which was converted to a 3 character field in CS version 2. Most 2 character codes were converted by adding a zero as the third character. For example, code 05 was usually converted to 050, 10 to 100, 11 to 110, etc. Special codes such as 88 and 99 were usually converted to 888 and 999 respectively.

CS LYMPH NODES EVAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
CS Regional Nodes Evaluation CS Reg Nodes Eval	2840	1	AJCC					995 - 995

Description
Records how the code for CS Lymph Nodes [2830] was determined, based on the diagnostic methods employed.

Rationale

This data item is used by Collaborative Staging to describe whether the staging basis for the TNM-N code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS METS AT DX

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
CS Metastasis at Diagnosis	2850	2	AJCC	2003	10			996 - 997

Description
Identifies the distant site(s) of metastatic involvement at time of diagnosis.

Rationale
The presence of metastatic disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS METS AT DX-BONE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2851	1	AJCC	2010	12			999 - 999

Description
Identifies the presence of distant metastatic involvement of bone at time of diagnosis.

Rationale
The presence of metastatic bone disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

Note: This includes only the bone, not the bone marrow.

CS METS AT DX-BRAIN

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2852	1	AJCC	2010	12			1000 - 1000

Description
The presence of metastatic brain disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

Rationale
The presence of metastatic brain disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

Note: This includes only the brain, not spinal cord or other parts of the central nervous system.

CS METS AT DX-LIVER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2853	1	AJCC	2010	12			1001 - 1001

Description
Identifies the presence of distant metastatic involvement of the liver at time of diagnosis.

Rationale

The presence of metastatic liver disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

Note: This includes only the liver.

CS METS AT DX-LUNG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2854	1	AJCC	2010	12			1002 - 1002

Description
Identifies the presence of distant metastatic involvement of the lung at time of diagnosis.

Rationale
The presence of metastatic lung disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

Note: This includes only the lung, not pleura or pleural fluid.

CS METS EVAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
CS Metastasis Evaluation	2860	1	AJCC	2003	10			998 - 998

Description
Records how the code for CS Mets at Dx [2850] was determined based on the diagnostic methods employed.

Rationale
This data item is used by Collaborative Staging to describe whether the staging basis for the TNM-M code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS POSTRX EXTENSION

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2775	3	AJCC	2010	12			1095 - 1097

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. The post-treatment data items measure the amount of tumor remaining after neoadjuvant therapy (systemic therapy or radiation therapy prior to surgery).

The implementation of this data item has been deferred indefinitely.

Rationale
The post-treatment data items will be used for analysis of the effectiveness of neoadjuvant therapy.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS POSTRX LYMPH NODES

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2780	3	AJCC	2010	12			1098 - 1100

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th

editions. The post-treatment data items measure the amount of tumor remaining after neoadjuvant therapy (systemic therapy or radiation therapy prior to surgery).

The implementation of this data item has been deferred indefinitely.

Rationale
The post-treatment data items will be used for analysis of the effectiveness of neoadjuvant therapy.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS POSTRX METS AT DX

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2785	2	AJCC	2010	12			1101 - 1102

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. The post-treatment data items measure the amount of tumor remaining after neoadjuvant therapy (systemic therapy or radiation therapy prior to surgery).

The implementation of this data item has been deferred indefinitely.

Rationale
The post-treatment data items will be used for analysis of the effectiveness of neoadjuvant therapy.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS POSTRX TUMOR SIZE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2770	3	AJCC	2010	12			1092 - 1094

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. The post-treatment data items measure the amount of tumor remaining after neoadjuvant therapy (systemic therapy or radiation therapy prior to surgery).

The implementation of this data item has been deferred indefinitely.

Rationale
The post-treatment data items will be used for analysis of the effectiveness of neoadjuvant therapy.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS PRERX EXTENSION

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2735	3	AJCC	2010	12			1081 - 1083

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. The CS pre-treatment data items include all information prior to the start of therapy. In rare circumstances where workup could not be completed prior to therapy, these items may be based on testing after limited treatment in the absence of progression or regression of disease, such as delayed planned or usual diagnostic workup. This does not include diagnostic workup for progression of disease or regression.

The implementation of this data item has been deferred indefinitely.

Rationale
The CS pre-treatment data items will record the pre-treatment (clinical) stage. This is used for analysis of appropriate treatment selection. These items are a companion to the AJCC clinical stage information required by CoC, and likely will eventually replace the required AJCC staging. Codes are exactly the same as the regular CS codes. For these data fields, the eval fields also remain the same although the valid options will be limited by edits, in order to use the same tables in CS. The pre-treatment data items will be used for analysis of the effectiveness of neoadjuvant therapy.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS PRERX LYMPH NODES

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2750	3	AJCC	2010	12			1085 - 1087

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. The CS pre-treatment data items include all information prior to the start of therapy. In rare circumstances where workup could not be completed prior to therapy, these items may be based on testing after limited treatment in the absence of progression or regression of disease, such as delayed planned or usual diagnostic workup. This does not include diagnostic workup for progression of disease or regression.

The implementation of this data item has been deferred indefinitely.

Rationale
The CS pre-treatment data items will record the pre-treatment (clinical) stage. This is used for analysis of appropriate treatment selection. These items are a companion to the AJCC clinical stage information required by CoC, and likely will eventually replace the required AJCC staging. Codes are exactly the same as the regular CS codes. For these data fields, the eval fields also remain the same although the valid options will be limited by edits, in order to use the same tables in CS. The pre-treatment data items will be used for analysis of the effectiveness of neoadjuvant therapy.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS PRERX METS AT DX

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2760	2	AJCC	2010	12			1089 - 1090

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. The CS pre-treatment data items include all information prior to the start of therapy. In rare circumstances where workup could not be completed prior to therapy, these items may be based on testing after limited treatment in the absence of progression or regression of disease, such as delayed planned or usual diagnostic workup. This does not include diagnostic workup for progression of disease or regression.

The implementation of this data item has been deferred indefinitely.

Rationale
The CS pre-treatment data items will record the pre-treatment (clinical) stage. This is used for analysis of appropriate treatment selection. These items are a companion to the AJCC clinical stage information required by CoC, and likely will eventually replace the required AJCC staging. Codes are exactly the same as the regular CS codes. For these data fields, the eval fields also remain the same although the valid options will be limited by edits, in order to use the same tables in CS. The pre-treatment data items will be used for analysis of the effectiveness of neoadjuvant therapy.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS PRERX METS EVAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2765	1	AJCC	2010	12			1091 - 1091

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. The CS pre-treatment data items include all information prior to the start of therapy. In rare circumstances where workup could not be completed prior to therapy, these items may be based on testing after limited treatment in the absence of progression or regression of disease, such as delayed planned or usual diagnostic workup. This does not include diagnostic workup for progression of disease or regression.

The implementation of this data item has been deferred indefinitely.

Rationale
The CS pre-treatment data items will record the pre-treatment (clinical) stage. This is used for analysis of appropriate treatment selection. These items are a companion to the AJCC clinical stage information required by CoC, and likely will eventually replace the required AJCC staging. Codes are exactly the same as the regular CS codes. For these data fields, the eval fields also remain the same although the valid options will be limited by edits, in order to use the same tables in CS. The pre-treatment data items will be used for analysis of the effectiveness of neoadjuvant therapy.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS PRERX REG NODES EVAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2755	1	AJCC	2010	12			1088 - 1088

Description
The CS pre-treatment data items include all information prior to the start of therapy. In rare circumstances where workup could not be completed prior to therapy, these items may be based on testing after limited treatment in the absence of progression or regression of disease, such as delayed planned or usual diagnostic workup. This does not include diagnostic workup for progression of disease or regression.

The implementation of this data item has been deferred indefinitely.

Rationale
The CS pre-treatment data items will record the pre-treatment (clinical) stage. This is used for analysis of appropriate treatment selection. These items are a companion to the AJCC clinical stage information required by CoC, and likely will eventually replace the required AJCC staging. Codes are exactly the same as the regular CS codes. For these data fields, the eval fields also remain the same although the valid options will be limited by edits, in order to use the same tables in CS. The pre-treatment data items will be used for analysis of the effectiveness of neoadjuvant therapy.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS PRERX TUM SZ/EXT EVAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2740	1	AJCC	2010	12			1084 - 1084

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. The CS pre-treatment data items include all information prior to the start of therapy. In rare circumstances where workup could not be completed prior to therapy, these items may be based on testing after limited treatment in the absence of progression or regression of disease, such as delayed planned or usual diagnostic workup. This does not include diagnostic workup for progression of disease or regression.

The implementation of this data item has been deferred indefinitely.

Rationale
The CS pre-treatment data items will record the pre-treatment (clinical) stage. This is used for analysis of appropriate treatment selection. These items are a companion to the AJCC clinical stage information required by CoC, and likely will eventually replace the required AJCC staging. Codes are exactly the same as the regular CS codes. For these data fields, the eval fields also remain the same although the valid options will be limited by edits, in order to use the same tables in CS. The pre-treatment data items will be used for analysis of the effectiveness of neoadjuvant therapy.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS PRERX TUMOR SIZE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2730	3	AJCC	2010	12			1078 - 1080

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. The CS pre-treatment data items include all information prior to the start of therapy. In rare circumstances where workup could not be completed prior to therapy, these items may be based on testing after limited treatment in the absence of progression or regression of disease, such as delayed planned or usual diagnostic workup. This does not include diagnostic workup for progression of disease or regression.

The implementation of this data item has been deferred indefinitely.

Rationale
The CS pre-treatment data items will record the pre-treatment (clinical) stage. This is used for analysis of appropriate treatment selection. These items are a companion to the AJCC clinical stage information required by CoC, and likely will eventually replace the required AJCC staging. Codes are exactly the same as the regular CS codes. For these data fields, the eval fields also remain the same although the valid options will be limited by edits, in order to use the same tables in CS. The pre-treatment data items are used for analysis of the effectiveness of neoadjuvant therapy.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR 1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2880	3	AJCC	2003	10			1003 - 1005

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor 1 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR 2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2890	3	AJCC	2003	10			1006 - 1008

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor 2 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR 3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2900	3	AJCC	2003	10			1009 - 1011

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor 3 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR 4

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2910	3	AJCC	2003	10			1012 - 1014

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor 4 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR 5

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2920	3	AJCC	2003	10			1015 - 1017

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor 5 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR 6

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2930	3	AJCC	2003	10			1018 - 1020

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor 6 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR 7

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2861	3	AJCC	2010	12			1021 - 1023

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor 7 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR 8

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2862	3	AJCC	2010	12			1024 - 1026

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor 8 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR 9

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #

	2863	3	AJCC	2010	12			1027 - 1029

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor 9 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR10

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2864	3	AJCC	2010	12			1030 - 1032

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor10 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR11

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2865	3	AJCC	2010	12			1033 - 1035

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor11 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR12

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2866	3	AJCC	2010	12			1036 - 1038

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor12 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR13

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2867	3	AJCC	2010	12			1039 - 1041

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor13 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR14

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2868	3	AJCC	2010	12			1042 - 1044

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor14 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR15

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2869	3	AJCC	2010	12			1045 - 1047

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor15 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR16

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2870	3	AJCC	2010	12			1048 - 1050

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor16 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR17

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2871	3	AJCC	2010	12			1051 - 1053

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor17 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR18

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2872	3	AJCC	2010	12			1054 - 1056

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor18 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR19

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2873	3	AJCC	2010	12			1057 - 1059

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor19 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR20

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2874	3	AJCC	2010	12			1060 - 1062

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor20 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR21

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2875	3	AJCC	2010	12			1063 - 1065

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor21 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR22

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2876	3	AJCC	2010	12			1066 - 1068

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor22 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR23

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2877	3	AJCC	2010	12			1069 - 1071

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor23 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR24

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2878	3	AJCC	2010	12			1072 - 1074

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes (The information recorded in CS Site-Specific Factor24 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR25

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2879	3	AJCC	2010	12			1075 - 1077

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
CS Site-Specific Factor25 is used to discriminate between CS staging schema or between AJCC chapters where site and histology alone are insufficient to identify the tumor type or location to identify the applicable stagingmethod.

Codes (The information recorded in CS Site-Specific Factor25 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS TUMOR SIZE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #

	2800	3	AJCC	2003	10			985 - 987

Description
Records the largest dimension or diameter of the **primary tumor** in millimeters.

Rationale
Tumor size at diagnosis is an independent prognostic indicator for many tumors and it is used by Collaborative Staging to derive some TNM-T codes.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS TUMOR SIZE/EXT EVAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
CS Tumor Size/Extension Evaluation CS TS/Ext-Eval	2820	1	AJCC	2003	10			991 - 991

Description
Records how the codes for the two items CS Tumor Size [2800] and CS Extension [2810] were determined, based on the diagnostic methods employed.

Rationale
This item is used by Collaborative Staging to describe whether the staging basis for the TNM-T code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS VERSION DERIVED

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
CS Version Latest	2936	6	AJCC					1173 - 1178

Description
This data item is recorded the first time the CS output fields are derived and should be updated each time the CS Derived items are recomputed. The CS version number is returned as part of the output of the CS algorithm.

Rationale
The CS algorithm may be re-applied to compute the CS Derived items; for example, when the data are to be used for a special study, transmitted, or when an updated CS algorithm is produced. This item identifies the specific algorithm used to obtain the CS Derived values in the data record.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS Version Derived is a 6-digit code (e.g., 010100). The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation results.

This item should not be blank if the CS Derived items contain values. It should be blank if the CS Derived items are empty or the CS algorithm has not been applied.

CS VERSION INPUT CURRENT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2937	6	AJCC	2010	12			1161 - 1166

Description
This item indicates the version of CS input fields after they have been updated or recoded. This data item is recorded the first time the CS input fields are entered and should be updated each time the CS input fields are modified.

Rationale
Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS Version Input Current is a 6-digit code (e.g., 020100). The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results.

CS VERSION INPUT ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
CS Version 1ST	2935	6	AJCC					1167 - 1172

Description
This item indicates the number of the version initially used to code Collaborative Staging (CS) fields. The CS version number is returned as part of the output of the CS algorithm.

Rationale
Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS Version Input Original is a 6-digit code (e.g., 010100). The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results.

DATE 1ST CRS RX COC

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date Started (pre 96 CoC) Date of First Course Treatment (CoC) Date of 1st Crs RX--CoC	1270	8	CoC					1446 - 1453

Description
Date of initiation of the first therapy for the cancer being reported, using the CoC definition of first course. The date of first treatment includes the date a decision was made not to treat the patient. See *FORDS* for details. See Chapter V, Unresolved Issues for further discussion of the difference between SEER and CoC items. See Chapter X for date format. Use Date 1st Crs RX CoC Flag [1271] if there is no appropriate or known date for this item.

Formerly Date of 1st Crs RX--CoC.

Clarification of NPCR Required Status
Central registries funded by NPCR are required to collect either Date Initial RX SEER [1260] or Date 1st Crs RX CoC [1270].

DATE 1ST CRS RX COC FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date of 1st Crs Rx Flag	1271	2	NAACCR	2010	12			1454 - 1455

Description
This flag explains why no appropriate value is in the field, Date 1st Crs RX CoC [1270].

Formerly Date of 1st Crs Rx Flag.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g, unknown whether treatment was administered)
11	No proper value is applicable in this context (Autopsy only)
12	A proper value is applicable but not known (e.g., treatment administered but date is unknown)
Blank	A valid date value is provided in item Date 1st Crs RX CoC [1270], or the date was not expected to have been transmitted

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE CASE COMPLETED

Alternate Name	Item #	Length	Source of	Year	Version	Year	Version	Column #

			Standard	Implemented	Implemented	Retired	Retired	
	2090	8	NAACCR					1959 - 1966

Description
The date that: (1) the abstractor decided that the tumor report was complete and (2) the case passed all edits that were applied. Definitions may vary among registries and software providers. This field is locally used by central registries. See Chapter X for date format. Standard edits check that no dates are later than the current date. These specifications will not necessarily be the same as those used for Date Case Completed--CoC [2092].

DATE CASE COMPLETED--COC

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2092	8	CoC	2010	12			1967 - 1974

Description
Identifies the date that specified items are completed, based on the Class of Case, where those items pass the relevant edits. Follow-up information, including delayed treatment received elsewhere, may be coded after the Date Case Completed--CoC. See the current *FORDS* for details. This item should be autocoded by the registry software; specifications may be obtained from NCDB. The CoC specifications will not necessarily be the same as those used for Date Case Completed [2090]. See Chapter X for date format.

DATE CASE INITIATED

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2085	8	NAACCR	2010	12			1951 - 1958

Description
Date the electronic abstract is initiated in the reporting facility's cancer registry database. See Chapter X for date format. Standard edits check that no dates are later than the current date or the date completed.

Rationale
This item is used to assess and monitor the timeliness of reporting. Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations and consequently, timeliness standards have been established. Examples of use are as follows:

- This item can be used with the Date of 1st Contact [580] to measure timeliness of abstracting by individual reporting facilities
- This item can be used with Date Case Report Exported [2110] to determine the "residency time" of a case report within a reporting facility's database prior to data transmission to a central cancer registry
- This item can be used with Date Case Report Received [2111] to monitor central registry timeliness in entering case reports (for case reports abstracted in-house from hardcopy provided by a reporting facility)
- This item can be used with Date Case Completed [2090] to monitor timeliness of case report completion

DATE CASE LAST CHANGED

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2100	8	NAACCR					1975 - 1982

Description
Date the case was last changed or updated. See Chapter X for date format. Standard edits check that no dates are later than the current date.

DATE CASE REPORT EXPORTED

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date Case Transmitted (pre-98 NAACCR)	2110	8	NPCR					1983 - 1990

Description
Date the reporting facility exports the electronic abstract to a file for transmission to the central registry. See Chapter X for date format. Standard edits check that no dates are later than the current date. Definitions may vary among registries and software providers.

DATE CASE REPORT LOADED

			Source of	Year	Version	Year	Version	

Alternate Name	Item #	Length	Standard	Implemented	Implemented	Retired	Retired	Column #
	2112	8	NPCR	1997	5.1			1999 - 2006

Description
Date the tumor report is loaded into a central registry computerized processing file for initiation of quality control activities (e.g., visual editing, application of computerized edits, etc.). See Chapter X for date format.

DATE CASE REPORT RECEIVED

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2111	8	NPCR	1997	5.1			1991 - 1998

Description
Date the abstract (or source record) is received by the central cancer registry for the respective tumor. If multiple reports are received from two or more sources and if a single date is needed, use the date the first abstract (or source record) was received from any source. See Chapter X for date format.

Rationale
This item is used to assess and monitor the timeliness of reporting. Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations. This item can be used with the Date of 1st Contact [580] or the Path--Date of Specimen Collection [7320] to measure timeliness of reporting to central cancer registries by individual reporting facilities. This data item also can be used with the Date Tumor Record Availbl [2113] to measure timeliness of processing within the central cancer registry.

DATE CONCLUSIVE DX

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date of Conclusive Diagnosis Date of Conclusive Terminology Date of Conclusive DX	443	8	SEER	2006	11			567 - 574

Description
Documents the date when a conclusive cancer diagnosis (definite statement of malignancy) is made following an initial diagnosis that was based only on ambiguous terminology. See Chapter X for date format. Use DATE CONCLUSIVE DX FLAG [448] if there is no appropriate or known date for this item.

Formerly Date of Conclusive DX.

Rationale
This date will allow analysis of the primary site locations and frequency of cases that were originally diagnosed by ambiguous terminology and later confirmed by other conclusive method.

This date will also allow for analysis of the time interval between cancer diagnosis based on ambiguous terminology and confirmation of the cancer diagnosis by conclusive means.

Codes (refer to http://seer.cancer.gov/tools/mphrules/index.html for additional instructions).

DATE CONCLUSIVE DX FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	448	2	NAACCR	2010	12			575 - 576

Description
This flag explains why no appropriate value is in the field, Date Conclusive DX [443]. This data item was first available in Volume II Version 12.

Rationale
Before Version 12, date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10 No information whatsoever can be inferred from this exceptional (non-date) value. (e.g., unknown if the diagnosis was initially based on ambiguous terminology).
11 No proper value is applicable in this context. (e.g., not applicable, initial diagnosis made by unambiguous terminology (Code 0 in data item Ambiguous Terminology DX [442]).

12	A proper value is applicable but not known (e.g., the initial ambiguous diagnosis was followed by a conclusive term, but the date of the conclusive term is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., accessioned based on ambiguous terminology only (Code 1 in data item Ambiguous Terminology DX [442]).
Blank	A valid date value is provided in item Date Conclusive DX [443], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE INITIAL RX SEER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date Therapy Initiated (SEER) Date Started (SEER) Date of Initial RX--SEER	1260	8	SEER					1436 - 1443

Description
Date of initiation of the first course therapy for the tumor being reported, using the SEER definition of first course. See also Date 1st Crs RX CoC [1270]. See Chapter V, Unresolved Issues, for further discussion of the difference between SEER and CoC items. See Chapter X for date format. Use Date Initial RX SEER Flag [1261] if there is no appropriate or known date for this item.

Formerly Date of Initial RX--SEER.

Clarification of NPCR Required Status Central registries funded by NPCR are required to collect either Date Initial RX SEER [1260] or Date 1st Crs RX CoC [1270].

DATE INITIAL RX SEER FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date of Initial RX Flag	1261	2	NAACCR	2010	12			1444 - 1445

Description
This flag explains why no appropriate value is in the field, Date Initial RX SEER [1260].

Formerly Date of Initial RX Flag.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g, unknown if therapy was administered)
11	No proper value is applicable in this context (e.g., therapy was not administered)
12	A proper value is applicable but not known (e.g., therapy was administered and date is unknown)
Blank	A valid date value is provided in item Date Initial RX SEER [1260], or the date was not expected to have been transmitted

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF 1ST CONTACT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date of Adm/First Contact	580	8	CoC					745 - 752

Description
Date of first patient contact, as inpatient or outpatient, with the reporting facility for the diagnosis and/or treatment of the tumor. The date may represent the date of an outpatient visit for a biopsy, x-ray, scan, or laboratory test. See Chapter X for date format.

When pathology-specimen-only tumors are collected (Class of Case 43, Type of Reporting Source 3), the date of specimen collection from the pathology report should be used as the Date of 1st Contact. If a pathology-specimen-only case is followed by patient contact with a facility for diagnosis and/or treatment of the respective tumor, ACoS coding rules require the hospital registry to change the Date of 1st Contact to reflect the date the patient first registered at that facility. Central registries, however, should retain the earlier date in their consolidated files, as that shows the patient's first recorded contact with the healthcare system for this disease.

When death certificate only (Class of Case 49, Type of Reporting Source 7) tumors are collected, the date of death should be used as the Date of 1st Contact. When Autopsy Only (Class of Case 38, Type of Reporting Source 6) tumors are collected, the date of death should be used as the Date of 1st Contact.

Rationale
Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations. Date of 1st Contact is one of several data items that can be used to measure timeliness of reporting to central cancer registries by individual facilities. For tumors that are not diagnosed at the reporting facility following its Reference Date (Class of Case 20-22, 30-37), the Date of 1st Contact [580] can be used in conjunction with the Date Case Report Received [2111] to measure timeliness of reporting by individual facilities.

Comment: To accurately measure the timeliness of data collection and submission of abstracts that are first diagnosed at autopsy (Class of Case 38, Type of Reporting Source 6) the date of death should be used as the Date of 1st Contact since the diagnosis was not determined until the autopsy was performed. Death Certificate Only cases (Class of Case 49, Type of Reporting Source 7) are created only by the central registry. For these cases, Date of 1st Contact should be filled with the date of death, and timeliness for DCO cases should be measured by different criteria.

DATE OF 1ST CONTACT FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date of First Contact Flag	581	2	NAACCR	2010	12			753 - 754

Description
This flag explains why no appropriate value is in the field Date of 1st Contact [580]. This data item was first available in Volume II Version 12.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

12	A proper value is applicable but not known (e.g., date of 1st contact is unknown)
Blank	A valid date value is provided in item Date of 1st Contact [580], or the date was not expected to have been transmitted

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF BIRTH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Birth Date(SEER/CoC/CCCR)	240	8	SEER/CoC					196 - 203

Description
Date of birth of the patient. See Chapter X for date format. If age at diagnosis and year of diagnosis are known, but year of birth is unknown, then year of birth should be calculated and so coded. Only the year should be entered, left-justified. Estimate date of birth when information is not available. It is better to estimate than to leave birth date unknown.

DATE OF BIRTH FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	241	2	NAACCR	2010	12			204 - 205

Description
This flag explains why no appropriate value is in the field, Date of Birth [240]. This data item was first available in Volume II Version 12.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions. Use code 12 when date of birth is unknown.)

12	A proper value is applicable but not known (i.e., birth date is unknown)
Blank	A valid date value is provided in item Date of Birth [240], or the date was not expected to have been transmitted

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF DEATH--CANADA

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1755	8	CCCR	2009	11.3			2280 - 2287

Description
This field is used by the Canadian provinces/territories to record the patient's date of death. See Chapter X for date format.

DATE OF DEATH--CANADAFLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1756	2	NAACCR	2010	12			2288 - 2289

Description
This flag explains why no appropriate value is in the field, Date of Death--Canada [1755]. This data item was first available in Volume II Version 12.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g, patient is not known to be deceased)
11	No proper value is applicable in this context (e.g. patient is alive)
12	A proper value is applicable but not known (e.g., date of death is unknown)
Blank	A valid date value is provided in item Date of Death--Canada [1755], or the date was not expected to have been transmitted

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF DIAGNOSIS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date of Initial Diagnosis (CoC)	390	8	SEER/CoC					530 - 537

Description
Date of initial diagnosis by a recognized medical practitioner for the tumor being reported whether clinically or microscopically confirmed. See Chapter X for date format.

For more discussion on determining date of diagnosis, consult the *SEER Program Coding and Staging Manual* or CoC *FORDS* manual.

DATE OF DIAGNOSIS FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	391	2	NAACCR	2010	12			538 - 539

Description
This flag explains why no appropriate value in in the field, Date of Diagnosis [390]. This data item was first available in Volume II Version 12.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

12	A proper value is applicable but not known. (e.g., date of diagnosis is unknown)
Blank	A valid date value is provided in item Date of Diagnosis [390], or the date was not expected to have been transmitted

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF INPT ADM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date of Inpatient Admission (CoC) Date of Inpatient Adm	590	8	NAACCR					755 - 762

Description
Date of the inpatient admission to the reporting facility for the most definitive surgery. In the absence of surgery, use date of inpatient admission for any other therapy. In the absence of therapy, use date of inpatient admission for diagnostic evaluation. See Chapter X for date format. Use DATE OF INPT ADM FLAG [591] if there is no appropriate or known date for this item.

Formerly Date of Inpatient Adm.

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

DATE OF INPT ADM FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	591	2	NAACCR	2010	12			763 - 764

Description
This flag explains why no appropriate value is in the field, Date of Inpt Adm [590].

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g, unknown if patient was an inpatient).
11	No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., the patient was an inpatient but the date is unknown).
Blank	A valid date value is provided in item Date of Inpt Adm [590], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF INPT DISCH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date of Inpatient Discharge (CoC) Date of Inpatient Disch	600	8	NAACCR					765 - 772

Description
Date of the inpatient discharge from the reporting facility after the most definitive surgery. In the absence of surgery, use date of inpatient discharge for other therapy. In the absence of therapy, use date of inpatient discharge for diagnostic evaluation. This discharge date corresponds to the admission date described by Date of Inpt Adm [590]. See Chapter X for date format. Use DATE OF INPT DISCH FLAG [601] if there is no appropriate or known date for this item. *Note:* This item is not the same as the old NAACCR item, Date of Discharge, which has been deleted from the NAACCR layout.

Formerly Date of Inpatient Disch.

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

DATE OF INPT DISCH FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	601	2	NAACCR	2010	12			773 - 774

Description
This flag explains why no appropriate value is in the field, Date of Inpt Disch [600]. This data item was first available in Volume II Version 12.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g, unknown if patient was an inpatient).
11	No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., the patient was an inpatient but the date is unknown).
Blank	A valid date value is provided in item Date of Inpt Disch [600], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF LAST CONTACT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date of Last Contact or Death (CoC) Date of Last Follow-Up or of Death (SEER)	1750	8	SEER/CoC					2116 - 2123

Description
Date of last contact with the patient, or date of death. If the patient has multiple tumors, Date of Last Contact should be the same for all tumors. See Chapter X for date format.

Rationale
Used for recording Date of Last Contact from active or passive follow-up. Used to record date of death and to calculate survival.

DATE OF LAST CONTACT FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1751	2	NAACCR	2010	12			2124 - 2125

Description
This flag explains why no appropriate value is in the field, Date of Last Contact [1750].

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., date of last contact is unknown).
Blank	A valid date value is provided in item Date of Last Contact [1750], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF MULT TUMORS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date of Multiple Tumors	445	8	SEER	2006	11			579 - 586

Description
This data item is used to identify the month, day and year the patient is diagnosed with multiple tumors reported as a single primary using the SEER, IARC, or Canadian Cancer Registry multiple primary rules. See Chapter X for date format. Use DATE OF MULT TUMORS FLAG [439] if there is no appropriate or known date for this item.

Formerly Date of Multiple Tumors.

Rationale
Patients with multiple tumors may have a worse prognosis or more extensive treatment than patients with a single tumor. This data item will make it possible to identify important information about these cases for data analysis. The Date of Multiple Tumors will allow separation of cases with multiple tumors present at the time of initial diagnosis from cases with subsequent tumors abstracted as the same primary. The date will allow tracking of the time interval between the date of original diagnosis and the first date of subsequent tumor(s) for specific primary sites and tumor histologies.

Codes (refer to http://seer.cancer.gov/tools/mphrules/index.html for additional instructions).

DATE OF MULT TUMORS FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	439	2	NAACCR	2010	12			587 - 588

Description
This flag explains why no appropriate value is in the field, Date of Mult Tumors [445]. This data item was first available in Volume II Version 12.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

11	No proper value is applicable in this context (e.g., information on multiple tumors not collected/not applicable for this site).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., patient was diagnosed with multiple tumors and the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., single tumor).
Blank	A valid date value is provided in item Date of Mult Tumors [445], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE TUMOR RECORD AVAILBL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2113	8	NPCR	1997	5.1			2007 - 2014

Description
Date the demographic and tumor identification information on a primary/reportable neoplasm, compiled from one or more source records, from one or more facilities, is available in the central cancer registry database to be counted as an incident tumor. Cancer identification information includes, at a minimum, site, histology, laterality, behavior, and date of diagnosis. See Chapter X for date format.

Rationale
This item is used to assess and monitor the timeliness of reporting. Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations. This data item can be used with the Date Case Report Received [2111] to measure timeliness of processing within the central cancer registry. This item also can be used with the Date of 1st Contact [580] or the Path--Date of Specimen Collection [7320] to measure overall timeliness.

DC STATE FILE NUMBER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2380	6	State	2011	12.2			3878 - 3883

Description
Death certificate identification number as assigned by the vital statistics office in the place recorded in Place of Death [1940].

DERIVED AJCC-6 M

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived 6 M Storage Code Derived AJCC M	2980	2	AJCC	2003	10			1109 - 1110

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for AJCC 6th edition "M" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED AJCC-6 M DESCRIPT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived AJCC M Descriptor Derived 6 M Descriptor Storage Code	2990	1	AJCC	2003	10			1111 - 1111

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for AJCC 6th edition "M Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED AJCC-6 N

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived 6 N Descriptor Storage Code Derived AJCC N	2960	2	AJCC	2003	10			1106 - 1107

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for AJCC 6th edition "N" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED AJCC-6 N DESCRIPT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived AJCC N Descriptor Derived 6 N Descriptor Storage Code	2970	1	AJCC	2003	10			1108 - 1108

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for AJCC 6th edition "N Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M,

and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED AJCC-6 STAGE GRP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived 6 Stage Group Storage Code Derived AJCC Stage Group	3000	2	AJCC	2003	10			1112 - 1113

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the AJCC 6th edition "Stage Group" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED AJCC-6 T

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived T Derived AJCC T	2940	2	AJCC	2003	10			1103 - 1104

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the AJCC 6th edition "T" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED AJCC-6 T DESCRIPT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived AJCC T Descriptor Derived 6 T Descriptor Storage Code	2950	1	AJCC	2003	10			1105 - 1105

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th

editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the AJCC 6th edition "T Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED AJCC-7 M

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived 7 M Storage Code	3420	3	AJCC	2010	12			1122 - 1124

Description
This item is the derived AJCC "M" staging element from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
Derived AJCC-7 M can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED AJCC-7 M DESCRIPT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived 7 M Descript Storage Code	3422	1	AJCC	2010	12			1125 - 1125

Description
This item is the derived AJCC "M Descriptor" from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
Derived AJCC-7 M Descript can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED AJCC-7 N

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived 7 N Storage Code	3410	3	AJCC	2010	12			1118 - 1120

Description
This item is the derived AJCC "N" staging element from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
The CS Derived AJCC-7 N can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED AJCC-7 N DESCRIPT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived 7 N Descript Storage Code	3412	1	AJCC	2010	12			1121 - 1121

Description
This item is the derived AJCC "N Descriptor" from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
Derived AJCC-7 N Descript can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED AJCC-7 STAGE GRP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived 7 Stage Grp Storage Code	3430	3	AJCC	2010	12			1126 - 1128

Description
This item is the derived AJCC "Stage Group" from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
The CS Derived AJCC-7 Stage Group can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED AJCC-7 T

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived 7 T Storage Code	3400	3	AJCC	2010	12			1114 - 1116

Description
This item is the derived AJCC "T" staging element from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
Derived AJCC-7 T can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED AJCC-7 T DESCRIPT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived 7 T Descript Storage Code	3402	1	AJCC	2010	12			1117 - 1117

Description
This item is the derived AJCC "T Descriptor" from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
Derived AJCC-7 T Descript can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED AJCC--FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
AJCC Conversion Flag	3030	1	AJCC	2003	10			1158 - 1158

Description
Flag to indicate whether the derived AJCC stage was derived from CS or EOD codes.

Codes

blank	Not derived
1	AJCC fields derived from Collaborative Stage
2	AJCC fields derived from EOD (prior to 2004)

DERIVED NEOADJUV RX FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3600	1	AJCC	2010	12			1157 - 1157

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. This field indicates whether the patient received neoadjuvant therapy (systemic therapy or radiation therapy prior to first course surgical treatment) as part of first course of treatment.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

0 Neoadjuvant therapy was not administered as part of the first course of therapy
1 Neoadjuvant therapy was administered as part of the first course of therapy
9 Unknown

This data item will record whether neoadjuvant therapy was administered. This will be a derived field based on RX SUMM--SYTEMIC/SUR SEQ [1639] & RX SUMM--SURG/RAD SEQ [1380].
Comments:

1. This data field is used to record that neoadjuvant therapy was administered as part of the first course of treatment.
2. This item is derived based on whether systemic therapy and/or radiation therapy was administered prior to surgical treatment.
3. If the initial surgical therapy is not performed following the systemic therapy or radiation therapy, then this will be derived as 0, i.e., it is not considered neoadjuvant therapy.

DERIVED POSTRX-7 M

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived PostRX 7 M Storage Code	3490	2	AJCC	2010	12			1150 - 1151

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the post-treatment AJCC 7th edition "M" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13]

The display code should be used for display on the screen and in reports.The implementation of this data item has been deferred indefinitely.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED POSTRX-7 N

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived PostRX 7 N Storage Code	3482	3	AJCC	2010	12			1147 - 1149

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the post-treatment AJCC 7th edition "N" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13]

The display code should be used for display on the screen and in reports.The implementation of this data item has been deferred indefinitely.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED POSTRX-7 STGE GRP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived PostRX 7 Stge Grp Storage Code	3492	3	AJCC	2010	12			1152 - 1154

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the post-treatment AJCC 7th edition "Stage Group"and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html).[13]

The display code should be used for display on the screen and in reports. The implementation of this data item has been deferred indefinitely.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED POSTRX-7 T

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived PostRX 7 T Storage Code	3480	3	AJCC	2010	12			1144 - 1146

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus the post-treatment AJCC 7th edition "T" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13]

The display code should be used for display on the screen and in reports.The implementation of this data item has been deferred indefinitely.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to

meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED PRERX-7 M

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived PreRX 7 M Storage Code	3460	3	AJCC	2010	12			1137 - 1139

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition "M" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13]

The display code should be used for display on the screen and in reports. The implementation of this data item has been deferred indefinitely.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED PRERX-7 M DESCRIP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived PreRX 7 M Descrip Storage Code	3462	1	AJCC	2010	12			1140 - 1140

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for pre-treatment AJCC 7th edition "M Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13]

The display code should be used for display on the screen and in reports. The implementation of this data item has been deferred indefinitely.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED PRERX-7 N

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived PreRX 7 N Storage Code	3450	3	AJCC	2010	12			1133 - 1135

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition "N" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13]

The display code should be used for display on the screen and in reports. The implementation of this data item has been deferred indefinitely.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED PRERX-7 N DESCRIP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived PreRX 7 N Descrip Storage Code	3452	1	AJCC	2010	12			1136 - 1136

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition "N Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13]

The display code should be used for display on the screen and in reports. The implementation of this data item has been deferred indefinitely.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED PRERX-7 STAGE GRP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived PreRX 7 Stge Grp Storage Code	3470	3	AJCC	2010	12			1141 - 1143

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition "Stage Group" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13]

The display code should be used for display on the screen and in reports. The implementation of this data item has been deferred indefinitely.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are

separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED PRERX-7 T

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived PreRX 7 T Storage Code	3440	3	AJCC	2010	12			1129 - 1131

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition "T" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13]

The display code should be used for display on the screen and in reports. The implementation of this data item has been deferred indefinitely.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED PRERX-7 T DESCRIP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived PreRX 7 T Descrip Storage Code	3442	1	AJCC	2010	12			1132 - 1132

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition "T Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13]

The display code should be used for display on the screen and in reports. The implementation of this data item has been deferred indefinitely.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED SEER CLIN STG GRP **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3610	5	SEER	2016	16			858 - 862

Description
This data item is needed to store the results of the derived algorithmic calculation of Derived SEER Clinical Stage Group.

Rationale
The SEER Program is developing an algorithm to calculate clinical and pathologic stage group based on their T, N, and M components and additional information as needed to calculate stage. For example, for thyroid, additional information is needed on histology and age to calculate stage. Once the T, N, and M are known an algorithm can assign the stage group instead of a registrar having to look up the stage. There are also provisions for a separate field for directly assigned stage group if the registrar prefers entering it.

Codes

0	Stage 0
0A	Stage 0A
01S	Stage 0is
1	Stage I
1A	Stage IA
1A1	Stage IA1
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1C	Stage IC
1S	Stage IS
2	Stage 2
2A	Stage 2A
2A1	Stage 2A1
2A2	Stage 2A2
2B	Stage 2B
2C	Stage 2C
3	Stage 3
3A	Stage 3A
3B	Stage 3B
3C	Stage 3C
3C1	Stage 3C1
3C2	Stage 3C2
4	Stage 4
4A	Stage 4A
4A1	Stage 4A1
4A2	Stage 4A2
4B	Stage 4B
4C	Stage 4C
OC	Stage OC
88	Not applicable
99	Unknown
Blank	The algorithm has not been run

DERIVED SEER CMB M SRC **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived SEER Combined M Source	3626	1	SEER	2016	16			885 - 885

Description
This item is needed to store the results of the source information selected for the derived algorithmic calculation of Derived SEER Combined M [3620].

Codes

1	Clinical
2	Pathologic
3	Clinical and pathologic information used
9	Unknown

DERIVED SEER CMB N SRC **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived SEER Combined N Source	3624	1	SEER	2016	16			884 - 884

Description

This item is needed to store the results of the source information selected for the derived algorithmic calculation of Derived SEER Combined N [3618].

Codes

1 Clinical
2 Pathologic
3 Clinical and pathologic information used
9 Unknown

DERIVED SEER CMB STG GRP **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3614	5	SEER	2016	16			863 - 867

Description
This data item is needed to store the results of the derived algorithmic calculation of Derived SEER Clinical Stage Group.

Rationale
Rationale for change proposal (potential benefits of change): The SEER Program is developing an algorithm to calculate clinical and pathologic stage group based on their T, N, and M components and additional information as needed to calculate stage. For example, for thyroid, additional information is needed on histology and age to calculate stage. Once the T, N, and M are known an algorithm can assign the stage group instead of a registrar having to look up the stage. There are also provisions for a separate field for directly assigned stage group if the registrar prefers entering it.

Codes

0A	Stage 0
0IS	Stage 0is
1	Stage I
1A	Stage IA
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1B2	Stage IB2
1C	Stage IC
1S	Stage IS
2	Stage 2
2A	Stage 2A
2A1	Stage
2A2	Stage IIA2
2B	Stage IIB
2C	Stage IIC
3	Stage III
3A	Stage IIIA
3B	Stage IIIB
3C	Stage IIIC
3C1	Stage IIIC1
3C2	Stage IIIC2
4	Stage IV
4A	Stage IVA
4A1	Stage IVA1
4A2	Stage IV42
4B	Stage IVB
4C	Stage IV4C
OC	Occult
88	Not applicable
99	Unknown
Blank	The algorithm has not been run

DERIVED SEER CMB T SRC **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived SEER Combined T Source	3622	1	SEER	2016	16			883 - 883

Description
This item is needed to store the results of the source information selected for the derived algorithmic calculation of Derived SEER Combined T [3616].

Codes

1 Clinical
2 Pathologic
3 Clinical and pathologic information used
9 Unknown

DERIVED SEER COMBINED M **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3620	5	SEER	2016	16			878 - 882

Description
This item is used to store the results of the source information selected for the derived algorithmic calculation of Combined T, N, and M.

Rationale
The SEER Program has collected data from 2004 on AJCC 6th T, N, M and stage and from 2010 on AJCC 7th T, N, M and stage based on algorithmic derivation from Collaborative Stage (CS) data. These data were based on combining information from both the clinical and pathologic into a combined (or 'best') derived T, N, M and stage group. SEER would like to continue to be able to derive a combined T, N, M and stage group in order to evaluate time trends in cancer incidence by stage. SEER is designing an algorithm to combine the clinical and pathologic information for T, N, and M into a derived combined T, N and M and then the combined T, N, and M and additional information as needed are used to derive a combined stage. These derived combined T, N, M and stage items need to be new data items.

Codes (See the most recent versions of the *AJCC Cancer Staging Manual* and *FORDS* manual)

88 Not applicable
Blank Not derived

DERIVED SEER COMBINED N **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3618	5	SEER	2016	16			873 - 877

Description
This item is used to store the results of the source information selected for the derived algorithmic calculation of Combined T, N, and M.

Rationale
The SEER Program has collected data from 2004 on AJCC 6th T, N, M and stage and from 2010 on AJCC 7th T, N, M and stage based on algorithmic derivation from Collaborative Stage (CS) data. These data were based on combining information from both the clinical and pathologic into a combined (or 'best') derived T, N, M and stage group. SEER would like to continue to be able to derive a combined T, N, M and stage group in order to evaluate time trends in cancer incidence by stage. SEER is designing an algorithm to combine the clinical and pathologic information for T, N, and M into a derived combined T, N and M and then the combined T, N, and M and additional information as needed are used to derive a combined stage. These derived combined T, N, M and stage items need to be new data items.

Codes (See the most recent versions of the *AJCC Cancer Staging Manual* and *FORDS* manual)

88 Not applicable
Blank Not derived

DERIVED SEER COMBINED T **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3616	5	SEER					868 - 872

Description
This new data item is needed to store the results of the derived algorithmic calculation of Derived SEER Combined T.

Rationale
The SEER Program has collected data from 2004 on AJCC 6th T, N, M and stage and from 2010 on AJCC 7th T, N, M and stage based on algorithmic derivation from Collaborative Stage (CS) data. These data were based on combining information from both the clinical and pathologic into a combined (or 'best') derived T, N, M and stage group. SEER would like to continue to be able to derive a combined T, N, M and stage group in order to evaluate time trends in cancer incidence by stage. SEER is designing an algorithm to combine the clinical and pathologic information for

T, N, and M into a derived combined T, N and M and then the combined T, N, and M and additional information as needed are used to derive a combined stage.

Codes (See the most recent versions of the *AJCC Cancer Staging Manual* and *FORDS* manual)

88	Not applicable
Blank	Not derived

DERIVED SEER PATH STG GRP **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3605	5	SEER					853 - 857

Description
This data item is needed to store the results of the derived algorithmic calculation of Derived SEER Pathologic Stage Group.

Rationale
The SEER Program is developing an algorithm to calculate clinical and pathologic stage group based on their T, N, and M components and additional information as needed to calculate stage. For example, for thyroid, additional information is needed on histology and age to calculate stage. Once the T, N, and M are known an algorithm can assign the stage group instead of a registrar having to look up the stage. There are also provisions for a separate field for directly assigned stage group if the registrar prefers entering it.

Codes

0	Stage 0
0A	Stage 0A
0IS	Stage 0is
1	Stage I
1A	Stage IA
1A1	Stage IA1
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1B2	Stage IB2
1C	Stage IC
1S	Stage IS
2	Stage II
2A	Stage IIA
2A1	Stage IIA1
2A2	Stage IIA2
2B	Stage IIB
2C	Stage IIC
3	Stage III
3A	Stage IIIA
3B	Stage IIIB
3C	Stage IIIC
3C1	Stage IIIC1
3C2	Stage IIIC2
4	Stage IV
4A	Stage IVA
4A1	Stage IVA1
4A2	Stage IVA2
4B	Stage IVB
4C	Stage IVC
OC	Occult
88	Not applicable
99	Unknown
Blank	Algorithm has not been run

DERIVED SS1977

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived SEER Summary Stage 1977	3010	1	AJCC	2003	10			1155 - 1155

Description
This item is the derived "SEER Summary Stage 1977" from the CS algorithm (or EOD codes) effective with 2004 diagnosis.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED SS1977--FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
SS1977 Conversion Flag	3040	1	AJCC	2003	10			1159 - 1159

Description
Flag to indicate whether the derived SEER Summary Stage 1977 was derived from CS or EOD codes.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

Blank	Not derived
1	SS1977 derived from Collaborative Stage
2	SS1977 derived from EOD (prior to 2004)

DERIVED SS2000

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived SEER Summary Stage 2000	3020	1	AJCC	2003	10			1156 - 1156

Description
This item is the derived "SEER Summary Stage 2000" from the CS algorithm (or EOD codes) effective with 2004 diagnosis.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

DERIVED SS2000--FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
SS2000 Conversion Flag	3050	1	AJCC	2003	10			1160 - 1160

Description
Flag to indicate whether the derived SEER Summary Stage 2000 was derived from CS or EOD codes.

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M,

and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes (See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html),[13] for rules and site-specific codes and coding structures.)

1	SS2000 derived from Collaborative Stage
2	SS2000 derived from EOD (prior to 2004)
Blank	Not derived

DERIVED SS2017 **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Derived Summary Stage 2017	762	1	SEER	2016	16			894 - 894

Description
These two new items are needed to store the results of a 2017 version of Summary Stage (SS) based on a computer algorithm, Derived SEER SS2017 [762], and to allow for the direct assignment of this variable, Directly Assigned SEER SS2017 [764].

Rationale
The SEER program has collected staging information on cases since its inception in 1973. For many cancer sites, the different versions of AJCC stage over time have made the analyses of long term trends in stage very difficult. Therefore, for long-term staging trends, SEER has relied on a more simplified summary stage. When Collaborative Stage (CS) information is no longer available, SEER will need to derive summary stage via computer algorithm based on T, N, or M (clinical, pathologic, Derived SEER combined) or SEER Primary Tumor, SEER Regional Nodes, and SEER Mets and other information as needed. The SEER Derived SS2017 criteria may be applied to earlier CS and EOD data for cases prior to 2017. The SEER Directly Assigned SS2017 data item is provided for those wishing to collect summary stage but who aren't collecting all of the fields needed by the computer algorithm to derive SS2017.

Codes

0	In situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant
8	Not applicable
9	Unstaged

DIAGNOSTIC CONFIRMATION

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	490	1	SEER/CoC					562 - 562

Description
Code for the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history.

Rationale
Diagnostic confirmation is useful to calculate rates based on microscopically confirmed cancers. Full incidence calculations must also include tumors that are only confirmed clinically. The percentage of tumors that not micropscopically confirmed is an indication of whether case finding is including sources outside of pathology reports.

Codes

1	Positive histology
2	Positive cytology
3	Positive histology PLUS - positive immunophenotyping AND/OR positive genetic studies (Used only for hematopoietic and lymphoid neoplasms M-9590/3-9992/3)
4	Positive microscopic confirmation, method not specified
5	Positive laboratory test/marker study
6	Direct visualization without microscopic confirmation
7	Radiography and/or other imaging techniques without microscopic confirmation
8	Clinical diagnosis only (other than 5, 6, or 7)
9	Unknown whether or not microscopically confirmed; death certificate only

Note: Code 3 (used only for hematopoietic and lymphoid neoplasms M-9590/3-9992/3) was adopted for use effective with 2010 diagnoses.

DIAGNOSTIC PROC 73-87

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Diagnostic Procedures (1973-87 SEER)	2200	2	SEER	1995	5			1949 - 1950

Description
Data item required by SEER for tumors of certain sites for the years 1973-87. This item is no longer collected. See Appendix D of the *SEER Program Code Manual* for details.

DIRECTLY ASSIGNED SS2017 **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Directly Assigned Summary Stage 2017	764	1	SEER					895 - 895

Description
These two new items are needed to store the results of a 2017 version of Summary Stage (SS) based on a computer algorithm, Derived SEER SS2017 [762], and to allow for the direct assignment of this variable, Directly Assigned SEER SS2017 [764].

Rationale
The SEER program has collected staging information on cases since its inception in 1973. For many cancer sites, the different versions of AJCC stage over time have made the analyses of long term trends in stage very difficult. Therefore, for long-term staging trends, SEER has relied on a more simplified summary stage. When Collaborative Stage (CS) information is no longer available, SEER will need to derive summary stage via computer algorithm based on T, N, or M (clinical, pathologic, Derived SEER combined) or SEER Primary Tumor, SEER Regional Nodes, and SEER Mets and other information as needed. The SEER Derived SS2017 criteria may be applied to earlier CS and EOD data for cases prior to 2017. The SEER Directly Assigned SS2017 data item is provided for those wishing to collect summary stage but who aren't collecting all of the fields needed by the computer algorithm to derive SS2017.

Codes

0 In situ
1 Localized
2 Regional, direct extension only
3 regional, regional lymph nodes only
4 Regional, direct extension and regional lymph nodes
5 Regional, NOS
7 Distant
8 Not applicable
9 Unstaged

EOD--EXTENSION

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Extension (SEER EOD) (96 CoC) Extension (pre-96 SEER/CoC)	790	2	SEER					909 - 910

Description
Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from January 1, 1988, through December 31, 2003.

Codes were revised effective January 1, 1998, to reflect changes in the *AJCC Cancer Staging Manual*, Fifth Edition.

Rationale
Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See *Comparative Staging Guide for Cancer*[6].

Codes (See *SEER Extent of Disease, 1988: Codes and Coding Instructions*, Third Edition[8] for site-specific codes and coding rules for all EOD fields.)

EOD--EXTENSION PROST PATH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #

	800	2	SEER	1995	4			911 - 912

Description
Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from January 1, 1988, through December 31, 2003.

Codes were revised effective January 1, 1998, to reflect changes in the *AJCC Cancer Staging Manual*, Fifth Edition.

Rationale
Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See *Comparative Staging Guide for Cancer*.

EOD--Extension Prost Path is an additional field for prostate cancer only to reflect information from radical prostatectomy, effective for January 1, 1995, through December 31, 2003, diagnoses. The field is left blank for all other primaries.

Codes (See *SEER Extent of Disease, 1988: Codes and Coding Instructions*, Third Edition[8] for site-specific codes and coding rules for all EOD fields.)

EOD--LYMPH NODE INVOLV

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Lymph Nodes (pre 96-SEER/CoC) Lymph Nodes (SEER EOD) (96 CoC)	810	1	SEER					913 - 913

Description
Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from January 1, 1988, through December 31, 2003.

Codes were revised effective January 1, 1998, to reflect changes in the *AJCC Cancer Staging Manual*, Fifth Edition.

Rationale
Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See *Comparative Staging Guide for Cancer*.

Codes (See *SEER Extent of Disease, 1988: Codes and Coding Instructions*, Third Edition[8] for site-specific codes and coding rules for all EOD fields.)

EOD--OLD 13 DIGIT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
SEER EEOD (SEER) 13-Digit (Expanded) Site-Specific Extent of Disease (SEER)	840	13	SEER					918 - 930

Description
Detailed site-specific codes for EOD used by SEER for selected sites of cancer for tumors diagnosed 1973-1982, except death-certificate-only cases.

Codes (See *Extent of Disease: Codes and Coding Instructions (SEER 1977)*[10] for codes.)

EOD--OLD 2 DIGIT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
2-Digit Nonspecific and 2-Digit Site-Specific Extent of Disease (1973-1982 SEER)	850	2	SEER					931 - 932

Description
Site-specific codes for EOD used by SEER for tumors diagnosed from January 1, 1973, to December 31, 1982, for cancer sites that did not have a 13-digit scheme see EOD--Old 13 Digit [840].

Codes (See *Extent of Disease: Codes and Coding Instructions (SEER 1977)*[10] for codes.)

EOD--OLD 4 DIGIT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
4-Digit Extent of Disease (1983-1987 SEER)	860	4	SEER					933 - 936

Description
Codes for site-specific EOD used by SEER for tumors diagnosed from January 1, 1983, to December 31, 1987, for all cancer sites.

Codes (See *SEER Extent of Disease: New 4-Digit Schemes: Codes and Coding Instructions*[9] for codes.)

EOD--TUMOR SIZE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Size of Primary Tumor (SEER) Size of Tumor (CoC)	780	3	SEER/CoC					906 - 908

Description
Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from January 1, 1988, through December 31, 2003.

This field was included in the CoC dataset, separate from EOD.

Codes were revised effective January 1, 1998, to reflect changes in the *AJCC Cancer Staging Manual*, Fifth Edition.

Rationale
Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See *Comparative Staging Guide for Cancer*.

Codes
See *SEER Extent of Disease, 1988: Codes and Coding Instructions*, Third Edition, for site-specific codes and coding rules for all EOD fields. The CoC codes for Tumor Size are in the *FORDS* manual.

Note: See Chapter V, Unresolved Issues, for a discussion of coding differences between CoC and SEER.

EXTENT OF DISEASE 10-DIG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	779	12						906 - 917

Description
The name for a group of subfields that contain detailed site-specific codes for the anatomic EOD. SEER uses the subfields for tumors diagnosed from January 1, 1988, through December 31, 2003.

Group names appear only in the data dictionary and in Appendix E.

Subfields
EOD--Tumor Size [780]
EOD--Extension [790]
EOD--Extension Prost Path [800]
EOD--Lymph Node Involv [810]
Regional Nodes Positive [820]
Regional Nodes Examined [830]

FOLLOWING REGISTRY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2440	10	CoC					4295 - 4304

Description
Records the FIN of the registry responsible for following the patient.

Rationale

The number is essential to NCDB for monitoring data submissions, ensuring the accuracy of data, and identifying areas for special studies.

Instructions for Coding
CoC maintains the codes, including those for non-hospital sources of reporting.

For facilities with 7-digit FINs, consisting of a constant "6" followed by 6-digit facility-specific codes in the range of 6020009-6953290 that were assigned by CoC before January 1, 2001: Enter all FIN codes of this type as 3 zeroes, followed by the constant "6" and the 6-digit facility-specific codes.

For facilities with FINs greater than or equal to 10000000 that were assigned by CoC after January 1, 2001: Enter FIN codes of this type as 2 zeroes followed by the full 8-digit code. These sometimes are called CoC FIN 10-digit codes.

Note: This item is not supported by CoC as of January 1, 2010, (the respective NPI item is required).

Codes (in addition to CoC assigned codes)

0000000000	Case not reported by a facility
0099999999	Case reported, but facility number is unknown

FOLLOW-UP CONTACT--CITY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1842	50	SEER	1997	5.1			2208 - 2257

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

Rationale
Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

FOLLOWUP CONTACT--COUNTRY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1847	3	NAACCR	2013	13			447 - 449

Description
Country code for the address of follow-up contact's current usual residence. If the patient has multiple tumors, the country of follow-up contact residence should be the same for all tumors. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item FOLLOW UP CONTACT--STATE [1844].

Rationale
Country of patient's residence at follow-up is an important element of patient's residential history profile and is useful for understanding risk factors, assessment of patient prognosis, and chances for survival.

Codes
Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes, whenever possible, augmented by custom codes. See Appendix B for complete list of country names and corresponding three character alpha codes.

Custom codes for historic use only

ZZN	North America NOS
ZZC	Central America NOS
ZZS	South America NOS
ZZP	Pacific NOS
ZZE	Europe NOS
ZZF	Africa NOS
ZZA	Asia NOS
ZZX	Non-US NOS
ZZU	Unknown

Custom codes for historic use only

XNI	North American Islands
XCB	Other Caribbean Islands
XEN	England, Channel Islands, Isle of Man

XSC	Scandinavia
XGR	Germanic Countries
XSL	Slavic Countries
CSK	Czechoslovakia (former)
YUG	Yugoslavia (former)
XUM	Ukraine and Moldova
XNF	North Africa
XSD	Sudanese Countries
XWF	West Africa
XSF	South Africa
XEF	East Africa
XIF	African Islands
XET	Ethiopia and Eritrea
XAP	Arabian Peninsula
XIS	Israel and Palestine
XCR	Caucasian Republics of former USSR
XOR	Other Asian Republics of former USSR
XSE	Southeast Asia
XMS	Malaysia, Singapore, Brunei
XCH	China, NOS
XML	Melanesian Islands
XMC	Micronesian Islands
XPL	Polynesian Islands

FOLLOW-UP CONTACT--NAME

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2394	60	SEER	1997	5.1			3884 - 3943

Description
First and last name, in natural order, of a person, other than the patient or a physician, who can be contacted to obtain follow-up information for the patient. If the patient has multiple tumors, Follow-up Contact-Name should be the same for all tumors.

Rationale
Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

FOLLOW-UP CONTACT--NO&ST

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2392	60	SEER	1997	5.1			3944 - 4003

Description
The number and street address or the rural mailing address of the follow-up contact's current usual residence. This can be used to generate a follow-up inquiry, and must correspond to the other fields in the follow-up contact address. If the patient has multiple tumors, Follow-Up Contact--No&St should be the same for all tumors.

U.S. addresses should conform to the USPS *Postal Addressing Standards*. These standards are referenced in USPS Pub. 28, November 2000, *Postal Addressing Standards*. The current USPS Pub. 28 may be found and downloaded from the following website: http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf.

Canadian addresses should conform to the *Canada Postal Guide*. The current Canadian Postal Address standards may be found at the following website: http://www.canadapost.ca.

Rationale
Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

Note: Prior to Version 5, Follow-Up Contact fields may have been used for patient current address in the NAACCR record layout.

FOLLOW-UP CONTACT--POSTAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1846	9	SEER	1997	5.1			2260 - 2268

Description
Postal code for the address of the follow-up contact's current usual residence. If the patient has multiple tumors, the Follow-up Contact-Postal should be the same for all tumors. For U.S. residents, use either the 5-digit or the extended 9-digit ZIP code. Blanks follow the 5-digit code. For Canadian residents, use the 6-character, alphanumeric postal code. Blanks follow the 6-character code. When available, enter postal code for other countries.

Rationale
Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

Codes (in addition to U.S., Canadian, and foreign postal codes)

888888888	Resident of country other than the United States (including its possessions, etc.) or Canada, and postal code unknown
999999999	Resident of the United States (including its possessions, etc.) or Canada, and postal code unknown

FOLLOW-UP CONTACT--STATE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1844	2	SEER	1997	5.1			2258 - 2259

Description
USPS abbreviation for the state (including U.S. territories, commonwealths, or possessions), or Canada Post abbreviation for the Canadian province/territory of the follow-up contact's current usual residence. If the patient has multiple tumors, the follow-up contact state should be the same for all tumors. Effective with NAACCR Volume II, Version 13, a new data item, FollowUp Contact--Country [1847] was added to the standard transmission record layout. The UDS Committee expects the new item to supplement the use of Follow-Up Contact--State [1844].

Rationale
Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

Codes (in addition to USPS and Canadian Postal Service abbreviations)

CD	Resident of Canada, NOS (province/territory unknown)
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
XX	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known
YY	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown
ZZ	Residence unknown

FOLLOW-UP CONTACT--SUPPL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2393	60	SEER	2003	10			4004 - 4063

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

Rationale
Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

FOLLOW-UP SOURCE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Follow-Up Method (pre-96 CoC)	1790	1	CoC					2129 - 2129

Description
Records the source from which the latest follow-up information was obtained.

Rationale
For registries performing follow-up, this field helps evaluate the success rates of various methods of follow-up. It also can be used to report to institutions the source of follow-up information that is sent to them. When there is a conflict in follow-up information, knowing the source can help resolve the inconsistency.

Codes

0 Reported hospitalization
1 Readmission
2 Physician
3 Patient
4 Department of Motor Vehicles
5 Medicare/Medicaid file
7 Death certificate
8 Other
9 Unknown, not stated in patient record

FOLLOW-UP SOURCE CENTRAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1791	2	NAACCR	2006	11			2278 - 2279

Description
This field is created by the central registry. It records the source from which the consolidated information was obtained on a patient's vital status and date of last contact. Follow-up Source Central would be updated when new or more reliable information becomes available. However, when the existing date of last contact/vital status is deemed to be more reliable than newly obtained information, then neither the date of last contact/vital status nor the follow-up source central would be changed.

Rationale
For central registries performing follow-up, this field could help evaluate the success rates of various methods of follow-up. When new follow-up information conflicts with the existing information, knowing the follow-up source can help resolve any discrepancies.

Codes

00 Follow-up not performed for this patient
(01-29) File Linkages
01 Medicare/Medicaid File
02 Center for Medicare and Medicaid Services (CMS, formerly HCFA)
03 Department of Motor Vehicle Registration
04 National Death Index (NDI)
05 State Death Tape/Death Certificate File
06 County/Municipality Death Tape/ Death Certificate File
07 Social Security Administration Death Master File
08 Hospital Discharge Data
09 Health Maintenance Organization (HMO) file
10 Social Security Epidemiological Vital Status Data
11 Voter Registration File
12 Research/Study Related Linkage
29 Linkages, NOS
(30-39) Hospitals and Treatment Facilities
30 Hospital in-patient/outpatient
31 Casefinding
32 Hospital cancer registry
33 Radiation treatment center
34 Oncology clinic
35 Ambulatory surgical center
39 Clinic/facility, NOS
(40-49) Physicians
40 Attending physician

41	Medical oncologist
42	Radiation oncologist
43	Surgeon
48	Other specialist
49	Physician, NOS
(50-59)	Patient
50	Patient contact
51	Relative contact
59	Patient, NOS
(60-98)	Other
60	Central or Regional cancer registry
61	Internet sources
62	Hospice
63	Nursing homes
64	Obituary
65	Other research/study related sources
98	Other, NOS
99	Unknown source

GIS COORDINATE QUALITY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	366	2	NAACCR	366	11			422 - 423

Description
Code indicating the basis of assignment of latitude and longitude coordinates for an individual record from an address. This data item is helpful in identifying cases that were assigned coordinates based on incomplete information, post office boxes, or rural routes. This item is coded at the central registry, not by the reporting facility. Most of the time, this information is provided by geocoding software. Alternatively, a central registry staff member manually assigns the code. Codes are hierarchical, with lower numbers having priority.

Rationale
Spatial analysis of cancer data often requires identifying data records with a high degree of geographic precision. Researchers can use this code as a basis for selecting records with a degree of precision that is appropriate to the study.

Codes

00	Coordinates derived from local government-maintained address points, which are based on property parcel locations, not interpolation over a street segment's address range
01	Coordinates assigned by Global Positioning System (GPS)
02	Coordinates are match of house number and street, and based on property parcel location
03	Coordinates are match of house number and street, interpolated over the matching street segment's address range
04	Coordinates are street intersections
05	Coordinates are at mid-point of street segment (missing or invalid building number)
06	Coordinates are address ZIP code+4 centroid
07	Coordinates are address ZIP code+2 centroid
08	Coordinates were obtained manually by looking up a location on a paper or electronic map
09	Coordinates are address 5-digit ZIP code centroid
10	Coordinates are point ZIP code of Post Office Box or Rural Route
11	Coordinates are centroid of address city (when address ZIP code is unknown or invalid, and there are multiple ZIP codes for the city)
12	Coordinates are centroid of county
98	Latitude and longitude are assigned, but coordinate quality is unknown
99	Latitude and longitude are not assigned, but geocoding was attempted; unable to assign coordinates based on available information
Blank	GIS Coordinate Quality not coded

Instructions for Coding: Where multiple codes are applicable, use the lower code value. Note: This data item is similar in function to Census Tract Certainty 1970/80/90 [364] and Census Tract Certainty 2000 [365]. The codes for this data item and the two census tract data items all describe how location information was assigned based on the patient's resident address at the time of diagnosis.

This data item must be populated if Latitude [2352] and Longitude [2354] are also populated.

GRADE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Grade, Differentiation, or Cell Lineage Indicator (SEER/CCCR)	440	1	SEER/CoC					555 - 555

Grade/Differentiation (CoC)								

Description
Code for the grade or degree of differentiation of the reportable tumor. For lymphomas and leukemias, field also is used to indicate T-, B-, Null-, or NK-cell origin.

Note: Code 8 was adopted for use with lymphoma cases diagnosed in 1995 and later.

Codes
See the grade tables on page 67 of ICD-O-3.[16] See also the most recent CoC *FORDS* manual and *SEER Program Code Manual*, for site specific coding rules and conversions.

1 Grade I
2 Grade II
3 Grade III
4 Grade IV
5 T-cell
6 B-cell
7 Null cell
8 NK (natural killer) cell
9 Grade/differentiation unknown, not stated, or not applicable

Comment: Use the most recent Hematopoietic and Lymphoid rules for assigning grades 5-8.

GRADE (73-91) ICD-O-1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1973	1	SEER					1918 - 1918

Description
Area for retaining the grade portion (1 digit) of the ICD-O-1 or field trial grade code entered before a conversion to ICD-O-2. See grouped data item Morph (73-91) ICD-O-1 [1970] in Appendix E. The item name includes years 1973-91. However, some states may have used the codes for cases before 1973.

Codes
For cases diagnosed before 1992, contains the ICD-O-1 or field trial 1-digit grade code as originally coded, if available.[18, 19]

GRADE PATH SYSTEM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	449	1	AJCC	2010	12			557 - 557

Description
Indicates whether a two, three or four grade system is used.

Rationale
This item is used to show whether a two, three or four grade system is used. This is the grade system stated in the path report; it is not converted. This item is used in conjunction with Grade Path Value [441] and is abstracted in addition to Grade Differentiation [440].

Codes (Refer to the most recent version of *FORDS* for additional instructions.)

2 Two-Grade System
3 Three-Grade System
4 Four-Grade System
Blank Not a two, three or four grade system; unknown

GRADE PATH VALUE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	441	1	AJCC	2010	12			556 - 556

Description
Describes the actual grade according to the grading system in Grade Path System [449].

Rationale
This data item will record grade specified in Grade Path System. This does not replace Grade [440].

Codes (Refer to the most recent version of *FORDS* for additional instructions.)

1	Recorded as Grade I or 1
2	Recorded as Grade II or 2
3	Recorded as Grade III or 3
4	Recorded as Grade IV or 4
Blank	No Two, Three or Four System Grade is available; unknown

HISTOLOGIC TYPE ICD-O-3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
ICD-O-3 Histology (CCCR)	522	4	SEER/CoC	2001	9			550 - 553

Description
Codes for the histologic type of the tumor being reported using ICD-O-3. NAACCR adopted ICD-O-3 as the standard coding system for tumors diagnosed in 2001 and later, and recommended that prior tumors be converted from ICD-O-2. Effective with 2010 diagnoses, this item also includes histology codes as per the 2008 WHO Hematopoietic/Lymphoid publication[39], which are listed on pages 3-5 of the NAACCR 2010 Implementation Guidelines. http://www.naaccr.org/StandardsandRegistryOperations/ImplementationGuidelines.aspx.

Note: See Histology (92-00) ICD-O-2 [420] for ICD-O-2 codes. Effective with 2010 diagnoses, this item also includes histology codes as per the 2008 WHO Hematopoietic/Lymphoid publication [39], which are listed on pages 3-5 of the NAACCR 2010 Implementation Guidelines. http://www.naaccr.org/LinkClick.aspx?fileticket=U-3o31G2Lik%3d&tabid=126&mid=466

Codes
See ICD-O-3,[14] Morphology Section and the SEER Hematopoietic database.

Clarification of Required Status
This data item is required by all standard-setting organizations for tumors diagnosed on or after January 1, 2001, and recommended (by conversion from ICD-O-2 codes when conversion algorithms and tables are available) for tumors diagnosed before 2001.

When the histologic type is coded according to ICD-O-3, the histology code must be reported in Histologic Type ICD-O-3 [522], with behavior coded in Behavior Code ICD-O-3 [523].

For information on required status for related data items for histologic type and behavior when coded according to ICD-O-2, see Histology (92-00) ICD-O-2 [420] and Behavior (92-00) ICD-O-2 [430].

HISTOLOGY (73-91) ICD-O-1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1971	4	SEER					1913 - 1916

Description
Area for retaining the histology portion (4 digits) of the ICD-O-1 or field trial morphology codes entered before a conversion to ICD-O-2. See grouped data item Morph (73-91) ICD-O-1 [1970], in Appendix E. The item name includes years 1973-91. However, some states may have used the codes for cases before 1973.

Codes For cases diagnosed before 1992, contains the ICD-O-1 or field trial 4-digit histology code as originally coded, if available. Blank for tumors coded directly into ICD-O-2 or ICD-O-3 (i.e., 1992 and later cases).

HISTOLOGY (92-00) ICD-O-2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Histology (CoC) ICD-O-2 Histology (CCCR)	420	4	SEER/CoC					545 - 548

Description
Codes for the histologic type of the tumor being reported using ICD-O-2. NAACCR adopted ICD-O-2 as the standard coding system for tumors diagnosed in 1992 and later and recommended that prior cases be converted to ICD-O-2.

Note: See Histology (73-91) ICD-O-1 [1971] for ICD-O-1 and field trial codes.

Codes See ICD-O-2,[15] Morphology Section.

Clarification of Required Status
This data item is required by all standard-setting organizations for tumors diagnosed from January 1, 1992, through December 31, 2000, and recommended for tumors diagnosed before 1992.

When the histologic type is coded according to ICD-O-2, the histology code must be reported in Histology (92-00) ICD-O-2 [420], with behavior coded in Behavior (92-00) ICD-O-2 [430].

For information on required status for related data items for histologic type and behavior when coded according to ICD-O-3, see Histologic Type ICD-O-3 [522] and Behavior Code ICD-O-3 [523].

ICD REVISION COMORBID

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
ICD Revision Comorbidities	3165	1	CoC	2006	11			1185 - 1185

Description
This item indicates the coding system in which the Comorbidities and Complications (secondary diagnoses) codes are provided.

Rationale
The CoC currently requires the collection and reporting of up to 10 ICD-9-CM codes describing secondary diagnoses for patients hospitalized for cancer treatment. Currently the use of ICD-10-CM is not mandatory in U.S. hospitals, though it may become so in the future. In the event this occurs cancer registries that maintain or collect this information will need to differentiate between ICD-9-CM and ICD-10-CM code use. The code values and definitions for this item would be expanded as necessary. Allowable codes reported in the Comorbidity and Complications items in *FORDS* would be re-assessed at the same time.

Codes

0	No comorbidities or complications recorded in patient's record
1	ICD-10-CM
9	ICD-9-CM
Blank	Comorbidities and Complications not collected

ICD REVISION NUMBER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
ICD Code Revision Used for Cause of Death (SEER)	1920	1	SEER					2273 - 2273

Description
Indicator for the coding scheme used to code the cause of death.

Codes

0	Patient alive at last follow-up
1	ICD-10
7	ICD-7
8	ICDA-8
9	ICD-9

ICD-O-2 CONVERSION FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Review Flag for 1973-91 Cases (SEER)	1980	1	SEER					1919 - 1919

Description
Code specifying how the conversion of site and morphology codes from ICD-O-1 and the field trial editions to ICD-O-2 was accomplished. The item names include years 1973-91. However, some states may have used the codes for tumors before 1973. The code also covers morphology conversions from ICD-O-3 to ICD-O-2.

Codes

0	Primary site and morphology originally coded in ICD-O-2
1	Primary site and morphology converted without review
2	Primary site converted with review; morphology machine-converted without review
3	Primary site machine-converted without review, morphology converted with review
4	Primary site and morphology converted with review
5	Morphology converted from ICD-O-3 without review
6	Morphology converted from ICD-O-3 with review
Blank	Not converted

ICD-O-3 CONVERSION FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2116	1	SEER/CoC	2001	9			2015 - 2015

Description
Code specifying how the conversion of site and morphology codes from ICD-O-2 to ICD-O-3 was accomplished.

Codes

0	Morphology (Morph--Type&Behav ICD-O-3 [521]) originally coded in ICD-O-3
1	Morphology (Morph--Type&Behav ICD-O-3 [521]) converted from (Morph--Type&Behav ICD-O-2 [419]) without review
3	Morphology (Morph--Type&Behav ICD-O-3 [521]) converted from (Morph--Type&Behav ICD-O-2 [419]) with review
Blank	Not converted (clarification for cases diagnosed as of January 1, 2007: cases coded in prior ICD-O version and not converted to ICD-O-3)

IHS LINK

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Indian Health Service Linkage	192	1	NPCR	2006	11			421 - 421

Description
This variable captures the results of the linkage of the registry database with the Indian Health Service patient registration database.

Rationale
The IHS linkage identifies cancer cases among American Indians who were misclassified as non-Indian in the registry database in order to improve the quality of cancer surveillance data on American Indians in individual registries and in all registries as a whole. The goal is to include cancer incidence data for American Indians in the United States Cancer Statistics by use of this variable as well as the race variable.

Codes

0	Record sent for linkage, no IHS match
1	Record sent for linkage, IHS match
Blank	Record not sent for linkage or linkage result pending

INDUSTRY SOURCE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	300	1	NPCR					216 - 216

Description
Code that best describes the source of industry information provided on this patient. This is a central cancer registry data item (i.e., codes should be applied by a central or regional registry rather than collected from reporting facilities).

Rationale
Industry information may come from a variety of sources. The most valid and reliable source of industry information for patients has not yet been determined.

Codes

0	Unknown industry/no industry available
1	Reporting facility records
2	Death certificate
3	Interview
7	Other source
8	Not applicable, patient less than 14 years of age at diagnosis

9	Unknown source
Blank	Not collected

INPATIENT STATUS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	605	1	NAACCR	2010	12			775 - 775

Description
This data item records whether there was an inpatient admission for the most definitive therapy, or in the absence of therapy, for diagnostic evaluation. This data item was first available in Volume II Version 12 (effective January 2010).

Rationale
Before Version 12 (through 2009 diagnosis), date fields included information in addition to dates. This data item incorporates the non-date meanings for the Date of Inpt Adm [590] and Date of Inpt Disch [600] in order to retain the non-date information with the transition to interoperable dates.

Codes

0	Patient was never an inpatient
1	Patient was inpatient
9	Unknown if patient was an inpatient (only used for consolidated cases)
Blank	Not collected

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

INSTITUTION REFERRED FROM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Facility Referred From	2410	10	CoC					4315 - 4324

Description
Identifies the facility that referred the patient to the reporting facility.

Rationale
This number is used to document and monitor referral patterns.

Instructions for Coding
CoC maintains the codes, including those for non-hospital sources of reporting.

For facilities with 7-digit FINs, consisting of a constant “6” followed by 6-digit facility-specific codes in the range of 6020009-6953290 that were assigned by CoC before January 1, 2001: Enter all FIN codes of this type as 3 zeroes, followed by the constant “6” and the 6-digit facility-specific codes.

For facilities with FINs greater than or equal to 10000000 that were assigned by CoC after January 1, 2001: Enter FIN codes of this type as 2 zeroes followed by the full 8-digit code. These sometimes are called CoC FIN 10-digit codes.

Note: This item is not supported by CoC as of January 1, 2010, (the respective NPI item is required).

Codes (in addition to CoC assigned codes)

0000000000	Case not referred from a facility
0099999999	Case referred from a facility, but facility number is unknown

INSTITUTION REFERRED TO

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Facility Referred To	2420	10	CoC					4335 - 4344

Description
Identifies the facility to which the patient was referred for further care.

Rationale
This number is used to document and monitor referral patterns.

Instructions for Coding
CoC maintains the codes, including those for non-hospital sources of reporting.

For facilities with 7-digit FINs, consisting of a constant “6” followed by 6-digit facility-specific codes in the range of 6020009-6953290 that were assigned by CoC before January 1, 2001: Enter all FIN codes of this type as 3 zeroes, followed by the constant “6” and the 6-digit facility-specific codes.

For facilities with FINs greater than or equal to 10000000 that were assigned by CoC after January 1, 2001: Enter FIN codes of this type as 2 zeroes followed by the full 8-digit code. These sometimes are called CoC FIN 10-digit codes.

Note: This item is not supported by CoC as of January 1, 2010, (the respective NPI item is required).

Codes (in addition to CoC assigned codes)

0000000000	Case not referred to a facility
0099999999	Case referred to a facility, but facility number is unknown

LATERALITY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Laterality at Diagnosis (SEER)	410	1	SEER/CoC					544 - 544

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

Codes

0	Not a paired site
1	Right: origin of primary
2	Left: origin of primary
3	Only one side involved, right or left origin unspecified
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms' tumors
5	Paired site: midline tumor
9	Paired site, but no information concerning laterality

LATITUDE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2352	10	NAACCR	2003	10			4064 - 4073

Description
Paired with Longitude [2354], this represents the point location of the individual’s residence on the earth’s surface. It is typically determined by matching an address to a reference file or by identifying the residence using satellite imagery. This item is coded at the central registry, not by the reporting facility.

Rationale
Latitude and Longitude comprise the universal standard for designating location on the earth’s surface. Geographic Information Systems software can be used to convert these values into projected coordinates for map display.

Allowable values and format
Latitude is a 10- digit numeric field, right justified, with up to six decimal places and an explicit decimal point. The format is x12.345678, where “x” is reserved for a negative sign for locations south of the equator. Latitude north of the equator is positive. The datum of the decimal degree data shall be North American Datum of 1983 (NAD 83).

Values are in decimal degrees, not degrees/minutes/seconds.
Correct: Latitude: 41. 890833

Not this: Latitude: 41 deg 53' 27"

LONGITUDE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2354	11	NAACCR	2003	10			4074 - 4084

Description
Paired with Latitude [2352], this represents the point location of the individual’s residence on the earth’s surface. It is typically determined by matching an address to a reference file or by identifying the residence using satellite imagery. This item is coded at the central registry, not by the

reporting facility.

Rationale
Latitude and Longitude comprise the universal standard for designating location on the earth's surface. Geographic Information Systems software can be used to convert these values into projected coordinates for map display.

Allowable values and format
Latitude is an 11 digit numeric field, right justified, with up to six decimal places and an explicit decimal point. The format is x123.456789, where "x" is reserved for a negative sign for locations west of the Prime Meridian (0 degrees) and east of 180 degrees. The datum of the decimal degree data shall be North American Datum of 1983 (NAD 83).

Values are in decimal degrees, not degrees/minutes/seconds.
Longitude: -123.128943
Longitude: -71 deg 7' 44"

LYMPH-VASCULAR INVASION

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1182	1	AJCC	2010	12			984 - 984

Description
Indicates whether lymphatic duct or blood vessel (LVI) is identified in the pathology report.

Rationale
This data item will record the information as stated in the record. Presence or absence of cancer cells in the lymphatic ducts or blood vessels is useful for prognosis.

Codes

0 Lymph-vascular Invasion stated as Not Present
1 Lymph-vascular Invasion Present/Identified
8 Not Applicable
9 Unknown/Indeterminate/not mentioned in path report

MARITAL STATUS AT DX

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Marital Status at Diagnosis (SEER/CoC) Marital Status at Initial Diagnosis (pre-96 CoC)	150	1	SEER					176 - 176

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

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

Codes

1 Single (never married)
2 Married (including common law)
3 Separated
4 Divorced
5 Widowed
6 Unmarried or Domestic Partner (same sex or opposite sex, registered or unregistered, other than common law marriage)
9 Unknown

MEDICAL RECORD NUMBER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2300	11	CoC					3606 - 3616

Description
Records medical record number used by the facility to identify the patient. The CoC *FORDS* manual instructs registrars to record numbers assigned by the facility's Health Information Management (HIM) Department only, not department-specific numbers.

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

Codes (in addition to the medical record number)

UNK	Medical record number unknown
RT	Radiation therapy department patient without HIM number
SU	1-day surgery clinic patient without HIM number

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

METS AT DX-BONE **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1112	1	SEER	2016	16			838 - 838

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

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

Codes

0	None; no bone metastases
1	Yes; distant bone metastases
8	Not applicable
9	Unknown whether bone is an involved metastatic site. Not documented in patient record.

METS AT DX-BRAIN **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1113	1	SEER	2016	16			839 - 839

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

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

Codes

0	None; no brain metastses
1	Yes; distant brain metastases
2	Not applicable
9	Unknown whether brain is involved metastatic site. Not documented in patient record.

METS AT DX-DISTANT LN **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1114	1	SEER	2016	16			840 - 840

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

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

at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors.

Codes

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.

METS AT DX-LIVER **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1115	1	SEER	2016	16			841 - 841

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

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

Codes

0 None; no liver metastases
1 Yes; distant liver metastases
8 Not applicable
9 Unknown whether liver is involved metastatic site. Not documented in patient record.

METS AT DX-LUNG **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1116	1	SEER	2016	16			842 - 842

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

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

Codes

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.

METS AT DX-OTHER **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1117	1	SEER	2016	16			843 - 843

Description
This field identifies whether other metastatic involvement, other than bone, brain, liver, lung or distant lymph nodes exists. Some examples include but are not limited to the adrenal gland, bone marrow, pleura, peritoneum and skin. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

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

Codes

0 None; no other metastases
1 Yes; distant metastases in known site(s) other than bone, brain, liver, lung or distant lymph nodes
8 Not applicable
9 Unknown whether any other metastatic site. Not documented in patient record.

MILITARY RECORD NO SUFFIX

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Military Medical Record Number Suffix (CoC)	2310	2	CoC					3617 - 3618

Description
Patient identifier used by military hospitals to record relationship of the patient to the sponsor.

Codes

01-19 Child
20 Sponsor
30-39 Spouse
40-44 Mother
45-49 Father
50-54 Mother-in-law
55-59 Father-in-law
60-69 Other eligible dependents
98 Civilian emergency (Air Force/Navy)
99 Not classified elsewhere/stillborn
Blank Not a military facility

MORPH (73-91) ICD-O-1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1970	6						1913 - 1918

Description
The name for a group of subfields describing the type and behavior of the tumor being reported using ICD-O-1 codes.

Group names appear only in the data dictionary and Appendix E.

Subfields
Histology (73-91) ICD-O-1 [1971]
Behavior (73-91) ICD-O-1 [1972]
Grade (73-91) ICD-O-1 [1973]

MORPH CODING SYS--CURRENT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	470	1	NAACCR					560 - 560

Description
Code that best describes how morphology is currently coded. If converted, this field shows the system it is converted to.

Codes

1 ICD-O, First Edition
2 ICD-O, 1986 Field Trial
3 ICD-O, 1988 Field Trial
4 ICD-O, Second Edition
5 ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6 ICD-O, Second Edition, plus FAB codes effective 1/1/98
7 ICD-O, Third Edition
8 ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms used for conditions diagnosed 1/1/2010 and later
9 Other

MORPH CODING SYS--ORIGINL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	480	1	NAACCR					561 - 561

Description
Code that best describes how morphology was originally coded. If later converted, this field shows the original codes used.

Codes

1 ICD-O, First Edition
2 ICD-O, 1986 Field Trial
3 ICD-O, 1988 Field Trial
4 ICD-O, Second Edition
5 ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6 ICD-O, Second Edition, plus FAB codes effective 1/1/98
7 ICD-O, Third Edition
8 ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms used for conditions diagnosed 1/1/2010 and later
9 Other

MORPH--TYPE&BEHAV ICD-O-2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	419	5						545 - 549

Description
The name for a group of subfields describing the type and behavior of the tumor being reported using ICD-O-2 codes.

Group names appear only in the data dictionary and Appendix E.

Subfields
Histology (92-00) ICD-O-2 [420]
Behavior (92-00) ICD-O-2 [430]

MORPH--TYPE&BEHAV ICD-O-3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	521	5		2001	9			550 - 554

Description
The name for a group of subfields describing the type and behavior of the tumor being reported using ICD-O-3 codes.

Group names appear only in the data dictionary and Appendix E.

Subfields
Histologic Type ICD-O-3 [522]
Behavior Code ICD-O-3 [523]

MULT TUM RPT AS ONE PRIM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Multiple Tumors Reported as Single Primary Type of Multiple Tumors Reported As One Primary	444	2	SEER	2006	11			577 - 578

Description
This data item is used to identify the type of multiple tumors in cases with multiple tumors that are abstracted and reported as a single primary using the SEER, IARC, or Canadian Cancer Registry multiple primary rules. Multiple tumors may individually exhibit *in situ*, invasive, or a combination of *in situ* and invasive behaviors. Multiple intracranial and central nervous system tumors may individually exhibit benign, borderline, malignant, or a combination of these behaviors. Multiple tumors found in the same organ or in a single primary site may occur at the time of initial diagnosis or later.

Rationale
Patients with multiple tumors that are currently reported as a single primary may have a worse prognosis or more extensive treatment than patients

with a single tumor. This data item will make it possible to identify important information about these cases for data analysis, and to compare individually reported cancer cases with historical data if the rules are changed.

Codes (refer to http://seer.cancer.gov/tools/mphrules/index.html for additional instructions).

00 Single tumor
10 Multiple benign
11 Multiple borderline
12 Benign and borderline
20 Multiple *in situ*
30 *In situ* and invasive
31 Polyp and adenocarcinoma
32 FAP with carcinoma
40 Multiple invasive
80 Unknown *in situ* or invasive
88 NA
99 Unknown

MULTIPLICITY COUNTER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	446	2	SEER	2006	11			589 - 590

Description
This data item is used to count the number of tumors (multiplicity) that are reported as a single primary, when present at the time of diagnosis or occurring later.

Rationale
Patients with multiple tumors reported as a single primary for surveillance purposes may have a worse prognosis or more extensive treatment than patients with a single tumor. This data item will make it possible to identify important information about these cases for data analysis.

Codes (refer to http://seer.cancer.gov/tools/mphrules/index.html for additional instructions).

00 No primary tumor identified
01 One tumor only
02 Two tumors present; bilateral ovaries involved with cystic carcinoma
03 Three tumors present
..
..
88 Information on multiple tumors not collected/not applicable for this site
89 Multicentric, multifocal, number unknown
99 Unknown if multiple tumors; not documented
Blank Information not collected for this diagnosis date (e.g., all cases diagnosed prior to 2007)

Note: Codes 00 and 89 were added effective for 2011.

NAACCR RECORD VERSION

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	50	3	NAACCR					17 - 19

Description
This item applies only to record types I, C, A, and M. Code the NAACCR record version used to create the record. The correction record (U) has its own record version data item.

Rationale
The NAACCR Layout version is necessary to communicate to the recipient of data in NAACCR form where the various items are found and how they are coded. It should be added to the record when the recorded is created.

Codes

120 2010 Version 12
121 2011 Version 12.1
122 2012 Version 12.2
130 2013 Version 13
140 2014 Version 14
150 2015 Version 15

160 2016 Version 16

Historically (before 2010), this was a 1-character field with the following codes in column 19:

1 1992-1994 Version 2 and Version 3
4 1995 Version 4.0
5 1996 and 1997 Version 5.0 or Version 5.1
6 1998 Version 6
7 1999 Version 7
8 2000 Version 8
9 2001 and 2002 Version 9 and 9.1
A 2003, 2004, and 2005 Version 10, 10.1, and 10.2
B 2006, 2007, and 2008 Version 11, 11.1, 11.2, and 11.3
Blank September 1989 Version

Note: Code 4 was assigned to the 1995 Version to synchronize the document version and the layout version numbers. Layout document Versions 2 and 3 are coded as 1.

NAME--ALIAS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Alias (CoC)	2280	40	NAACCR					3466 - 3505

Description
Records an alternate name or "AKA" (also known as) used by the patient, if known. Note that maiden name is entered in Name--Maiden [2390].

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

NAME--FIRST

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
First Name (CoC)	2240	40	CoC					3380 - 3419

Description
First name of the patient.

Note: The CoC *FORDS* manual allows this field to be blank. If facilities with CoC-approved cancer programs submit blanks to the central registry, it is suggested that the central registry devise procedures for completing the last and first name with text, such as UNKNOWN, after verifying with the hospital that the field was left intentionally blank.

Note: See the most recent *FORDS* for CoC allowable values.

NAME--LAST

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Last Name (CoC)	2230	40	CoC	2011	12.2			3340 - 3379

Description
Last name of the patient.

Note: See the most recent *FORDS* for CoC allowable values.

NAME--MAIDEN

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Maiden Name (CoC)	2390	40	NAACCR					3506 - 3545

Description
Maiden name of female patients who are or have been married.

Rationale
This is used to link reports on a woman who changed her name between reports. It also is critical when using Spanish surname algorithms to categorize ethnicity.

The field should be left blank if the maiden name is not known or not applicable. Since a value in this field may be used by linkage software or

other computer algorithms, only legitimate surnames are allowable, and any variation of "unknown" or "not applicable" is not allowable.

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

NAME--MIDDLE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Middle Name (CoC) Middle Initial (pre-96 CoC)	2250	40	CoC					3420 - 3459

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

Note: See the most recent *FORDS* for CoC allowable values.

NAME--PREFIX

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Name Prefix (CoC)	2260	3	NAACCR	2011	12.2			3460 - 3462

Description
Abbreviated title that precedes name in a letter (e.g., "Rev," "Ms").

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

NAME--SPOUSE/PARENT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2290	60	NAACCR	2011	12.2			3546 - 3605

Description
NAACCR has not adopted standards for this item. Use varies by area.

NAME--SUFFIX

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Name Suffix (CoC)	2270	3	NAACCR	2011	12.2			3463 - 3465

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

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

NEXT FOLLOW-UP SOURCE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Next Follow-Up Method (pre-96 CoC)	1800	1	CoC					2130 - 2130

Description
Identifies the method planned for the next follow-up.

Codes

0 Chart requisition
1 Physician letter
2 Contact letter
3 Phone call
4 Other hospital contact
5 Other, NOS
8 Foreign residents (not followed)
9 Not followed, other cases for which follow-up is not required

NHIA DERIVED HISP ORIGIN

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	191	1	NAACCR	2005	10.2			418 - 418

Description
The NAACCR Hispanic Identification Algorithm (NHIA) uses a combination of standard variables to directly or indirectly classify cases as Hispanic for analytic purposes. It is possible to separate Hispanic ancestral subgroups (e.g., Mexican) when indirect assignment results from birthplace information but not from surname match. The algorithm uses the following standard variables: Spanish/Hispanic Origin [190], Name--Last [2230], Name--Maiden [2390], Birthplace [250], Race 1 [160], IHS Link [192], and Sex [220].

Code 7 (Spanish surname only) of the Spanish/Hispanic Origin [190] data item became effective with 1994 diagnoses. It is recommended that NHIA should be run on 1995 and later diagnoses. However, a central registry may run it on their data for prior years. For greater detail, please refer to the technical documentation: http://www.naaccr.org/LinkClick.aspx?fileticket=6E20OT41TcA%3d&tabid=118&mid=458.

Rationale
Sometimes despite best efforts to obtain complete information directly from the medical record, information is not available and is reported to the cancer registry as a missing data item. With regard to Hispanic ethnicity, some cancer registries have found it necessary to rely on indirect methods to populate this data element. Registries often have significant numbers or proportions of Hispanic populations in their jurisdiction.

Codes

0	Non-Hispanic
1	Mexican, by birthplace or other specific identifier
2	Puerto Rican, by birthplace or other specific identifier
3	Cuban, by birthplace or other specific identifier
4	South or Central American (except Brazil), by birthplace or other specific identifier
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic), by birthplace or other specific identifier
6	Spanish, NOS; Hispanic, NOS; Latino, NOS
7	NHIA surname match only
8	Dominican Republic
Blank	Algorithm has not been run

Note: Code 8 was added in Standards Volume II Version 10.2 effective January 2005.

NPCR DERIVED CLIN STG GRP **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3650	4	NPCR	2016	16			896 - 899

Description
This item is needed to store the results of NPCR's derived algorithmic calculation of clinical stage group based on AJCC T, N, and M and relevant biomarkers and prognostic factors. At this time the algorithm derives AJCC 7th ed. Stage group only; however, updates to future AJCC editions are anticipated.

Rationale
The purpose of the derived stage fields is to segregate the data values for AJCC clinical and pathological stage groups derived from the NPCR algorithm from the values directly entered from the medical record or by the registrar. NPCR's primary interest is in the directly-entered values, but derived values will have a purpose primarily at the central registry. It is important to not mix data values from the two sources in the same data items.

Codes: (Refer to the most recent version of *FORDS* for additional coding instructions)

88	Not applicable
99	Unknown
Blank	Not staged

NPCR DERIVED PATH STG GRP **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3655	4	NPCR	2016	16			900 - 903

Description
This new item is needed to store the results of NPCR's derived algorithmic calculation of pathological stage group based on AJCC T, N, and M and relevant biomarkers and prognostic factors. At this time the algorithm derives AJCC 7th ed. Stage group only; however, updates to future AJCC editions is anticipated.

Rationale
The purpose of the derived stage fields is to segregate the data values for AJCC clinical and pathological stage groups derived from the NPCR algorithm from the values directly entered from the medical record or by the registrar. NPCR's primary interest is in the directly-entered values, but derived values will have a purpose primarily at the central registry. It is important to not mix data values from the two sources in the same data items.

Codes: (Refer to the most recent version of *FORDS* for additional coding instructions)

88	Not applicable
99	Unknown
Blank	Not staged

NPCR SPECIFIC FIELD

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3720	75	NPCR	2013	13			1306 - 1380

Description
A 75 character field to be used when information for a particular primary site needs to be collected by NPCR.

Rationale
This field allows NPCR to retain data collected through the CER project and is a place holder when additional site-specific information is needed.

Codes
To be determined for each site where needed.

Blank	Field not coded

NPI--ARCHIVE FIN

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3105	10	CMS	2007	11.1			711 - 720

Description
This field identifies the NPI number (National Provider Identifier) of the facility at the time it initially accessioned the tumor.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI-Archive FIN is the functional equivalent of Archive FIN [3100].

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

NPI--FOLLOWING REGISTRY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2445	10	CMS	2007	11.1			4285 - 4294

Description
The NPI (National Provider Identifier) code that records the registry responsible for following the patient.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The number is essential to NCDB for monitoring data submissions, ensuring the accuracy of data, and identifying areas for special studies.

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

Blank

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2415	10	CMS	2007	11.1			4305 - 4314

Description
The NPI (National Provider Identifier) code that identifies the facility that referred the patient to the reporting facility.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
This number is used to document and monitor referral patterns.

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

Blank

NPI--INST REFERRED TO

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2425	10	CMS	2007	11.1			4325 - 4334

Description
The NPI (National Provider Identifier) code that identifies the facility to which the patient was referred for further care.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
This number is used to document and monitor referral patterns.

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

Blank

NPI--PHYSICIAN 3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Radiation Oncologist (CoC)	2495	10	CMS	2007	11.1			4449 - 4458

Description
The NPI (National Provider Identifier) code for another physician involved in the care of the patient. NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
Used to monitor patient radiotherapy care.

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

Blank

NPI--PHYSICIAN 4

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Medical Oncologist (CoC)	2505	10	CMS	2007	11.1			4467 - 4476

Description
The NPI (National Provider Identifier) code for another physician involved in the care of the patient.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
Used to monitor patient medical oncology care.

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

Blank

NPI--PHYSICIAN--FOLLOW-UP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2475	10	CMS	2007	11.1			4413 - 4422

Description
The NPI (National Provider Identifier) code for the physician currently responsible for the patient's medical care.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
Used to monitor post-treatment patient care.

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

Blank

NPI--PHYSICIAN--MANAGING

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2465	10	CMS	2007	11.1			4395 - 4404

Description
The NPI (National Provider Identifier) code that identifies the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
Used to monitor patient care.

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

Blank

NPI--PHYSICIAN--PRIMARY SURG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2485	10	CMS	2007	11.1			4431 - 4440

Description
The NPI (National Provider Identifier) code for the physician who performed the most definitive surgical procedure.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale

Used to monitor patient surgical care.

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

Blank

NPI--REGISTRY ID

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	45	10	CMS	2007	11.1			20 - 29

Description
The NPI (National Provider Identifier) code that represents the data transmission source. This item stores the NPI of the facility registry that transmits the record.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

If the transmission source is not a health care provider or a covered entity, this item will be blank and the item Registry ID [40] should be used to identify the transmission source.

Rationale
The NPI equivalent of Registry ID [40].

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

NPI--REPORTING FACILITY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	545	10	CMS	2007	11.1			691 - 700

Description
The NPI (National Provider Identifier) code for the facility submitting the data in the record.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI equivalent of Reporting Facility [540].

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

OCCUPATION SOURCE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	290	1	NPCR					215 - 215

Description
Code that best describes the source of occupation information provided on this patient. This is a central cancer registry data item (i.e., codes should be applied by a central or regional registry rather than collected from reporting facilities).

Rationale
Occupation information may come from a variety of sources. The most valid and reliable source of occupation information for patients has not yet been determined.

Codes

0	Unknown occupation/no occupation available
1	Reporting facility records
2	Death certificate
3	Interview
7	Other source

8	Not applicable, patient less than 14 years of age at diagnosis
9	Unknown source
Blank	Not collected

OVER-RIDE ACSN/CLASS/SEQ

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Over-ride Accession/Class of Case/Sequence	1985	1	CoC	2001	9			1891 - 1891

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software: Accession Number, Class of Case, Seq Number (CoC).

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
The edit, Accession Number, Class of Case, Seq Number (CoC), checks the following:

1. If the case is the only case or the first of multiple cases diagnosed at the facility (Sequence Number--Hospital = 00, 01, 60, or 61, and Class of Case = 00, 10-14, or 40), then the first 4 characters of the Accession Number--Hosp must equal the year of the Date of 1st Contact.

2. If the case is first diagnosed at autopsy (Class of Case = 38) and the case is the only case or the first of multiple cases for a patient (Sequence Number--Hospital = 00, 01, 60, or 61), then the first 4 characters of the Accession Number--Hosp must equal the year of the Date of Last Contact AND must equal the year of the Date of 1st Contact.

3. If the case is first diagnosed at autopsy (Class of Case = 38) and the case is not the first case for a patient (Sequence Number--Hospital) greater than 01 or greater than 61), then the year of the Date of 1st Contact must equal the year of Date of Last Contact.

There are some exceptions to the above rules. Over-ride Acsn/Class/Seq may be used to override the edit when the circumstances fit the following situation or one similar to it:
The case may be the only or the first of multiple malignant cases for a patient (Sequence Number--Hospital = 00 or 01), but there is an earlier benign case (with an earlier year of the Date of 1st Contact) to which the Accession Number--Hosp applies.

Instructions for Coding

1. If edit generates an error or warning message, verify that the Accession Number--Hosp, Sequence Number--Hospital, and Class of Case are correct.

2. Leave blank if the program does not generate an error message for the edit Accession Number, Class of Case, Seq Number (CoC).

3. Leave blank and correct any errors for the case if an item is discovered to be incorrect.

4. Code 1 if review of accession number, sequence number and class of case verifies that they have been coded correctly and there is an unusual combination of these data items.

Codes

Blank	Not reviewed or reviewed and corrected
1	Reviewed and confirmed as reported

OVER-RIDE AGE/SITE/MORPH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Age/Site/Histology Interfield Review (Interfield Edit 15) (SEER #3)	1990	1	SEER					1896 - 1896

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Age, Primary Site, Morphology ICDO2 (SEER IF15)
Age, Primary Site, Morphology ICDO3 (SEER IF15)
Age, Primary Site, Morph ICDO3--Adult (SEER)
Age, Primary Site, Morph ICDO3--Pediatric (NPCR)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Some cancers occur almost exclusively in certain age groups.

Edits of the type Age, Primary Site, Morphology require review if a site/morphology combination occurs in an age group for which it is extremely rare. The edit Age, Primary Site, Morph ICDO3--Adult (SEER) edits cases with an Age at Diagnosis of 15 and older. The edit Age, Primary Site, Morph ICDO3--Pediatric (NPCR) edits cases with an Age at Diagnosis of less than 15. The edits Age, Primary Site, Morphology ICDO2 (SEER IF15) and Age, Primary Site, Morphology ICDO3 (SEER IF15) contain logic for all ages.

Instructions for Coding
1. Leave blank if the program does not generate an error message (and if the case was not diagnosed *in utero*) for the edits of the type Age, Primary Site, Morphology.

2. Correct any errors for the case if an item is discovered to be incorrect.

3. Code 1 or 3 as indicated if review of items in the error or warning message confirms that all are correct.

Codes

1	Reviewed and confirmed that age/site/histology combination is correct as reported
2	Reviewed and confirmed that case was diagnosed *in utero*
3	Reviewed and confirmed that conditions 1 and 2 both apply
Blank	Not reviewed or reviewed and corrected.

OVER-RIDE COC-SITE/TYPE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1987	1	CoC	2001	9			1893 - 1893

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Primary Site, Morphology-Type ICDO2 (CoC)
Primary Site, Morphology-Type ICDO3 (CoC)
Primary Site, Morphology-Type, Behavior ICDO3 (CoC)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Multiple versions of edits of the type Primary Site, Morphology-Type check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus, uses a different over-ride flag. The CoC version of the edit will accept Over-ride CoC Site/Type or Over-ride Site/Type (the SEER edit) as equivalent.

The Site/Histology validation list (available on the SEER web site) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not included. These edits require review of all combinations not listed.

Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if primary site is in the range C440-C449 (skin), and ICD-O-2 histology is in the range 8000-8004 (neoplasms, malignant, NOS), 8010-8045 (epithielial carcinomas), 8050-8082 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), or ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No over-ride is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether the combination is biologically plausible or whether cancer registry coding conventions would allow different codes for the diagnosis. Review of these rare combinations often results in a change to either the site or histology.

Instructions for Coding

1. Leave blank if the program does not generate an error message for the CoC edits of the type Primary Site, Morphology-Type.
2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.
3. Code 1 if review of all items in the error or warning message confirms they are correct and coded in conformance with coding rules.

Codes

Blank	Not reviewed or reviewed and corrected
1	Reviewed and confirmed as reported

OVER-RIDE CS 1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3750	1	AJCC	2011	12.1			2016 - 2016

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 10

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3759	1	AJCC	2011	12.1			2025 - 2025

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 11

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3760	1	AJCC	2011	12.1			2026 - 2026

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 12

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3761	1	AJCC	2011	12.1			2027 - 2027

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 13

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3762	1	AJCC	2011	12.1			2028 - 2028

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 14

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3763	1	AJCC	2011	12.1			2029 - 2029

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 15

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3764	1	AJCC	2011	12.1			2030 - 2030

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 16

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3765	1	AJCC	2011	12.1			2031 - 2031

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 17

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3766	1	AJCC	2011	12.1			2032 - 2032

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 18

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3767	1	AJCC	2011	12.1			2033 - 2033

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 19

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3768	1	AJCC	2011	12.1			2034 - 2034

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3751	1	AJCC	2011	12.1			2017 - 2017

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 20

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Direct Summary Stage 2000 Flag	3769	1	AJCC/NPCR	2011	12.1			2035 - 2035

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Over-ride CS 20 has been designated as a flag for directly coded SEER Summary Stage 2000 [759] to support CDC's National Program of Cancer Registries (NPCR) requirements.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. For diagnosis years 2012 and later, NPCR permits the use of SEER Summary Stage 2000 [759] in those cases where collection of Collaborative Stage version 2 data items is not feasible due to a lack of data or staffing and time constraints at the local or central cancer registry. Over-ride CS 20 has been designated as a special-purpose flag to identify cases where SEER Summary Stage 2000 [759] is directly coded and reported in lieu of Derived SS2000 [3020], in

accordance with NPCR reporting requirements.

The Over-ride CS 20 value of "1", set by the user, identifies a record with NAACCR data item 759 used to report Summary Stage 2000 as permitted by NPCR requirements only; Over-ride CS 20 is left blank for all other cases.

Codes

1	Directly coded SEER Summary Stage 2000 [759] used to report Summary Stage; Derived Summary Stage 2000 [3020] must be blank.
Blank	Derived Summary Stage 2000 [3020] reported using Collaborative Stage Data Collection System or case diagnosed prior to 2012.

OVER-RIDE CS 3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3752	1	AJCC	2011	12.1			2018 - 2018

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 4

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3753	1	AJCC	2011	12.1			2019 - 2019

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 5

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3754	1	AJCC	2011	12.1			2020 - 2020

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3755	1	AJCC	2011	12.1			2021 - 2021

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 7

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3756	1	AJCC	2011	12.1			2022 - 2022

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 8

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3757	1	AJCC	2011	12.1			2023 - 2023

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 9

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3758	1	AJCC	2011	12.1			2024 - 2024

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are

correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE HISTOLOGY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Histology/Behavior Interfield Review (Field Item Edit Morph)	2040	1	SEER					1901 - 1901

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Diagnostic Confirmation, Behavior ICDO2 (SEER IF31)
Diagnostic Confirmation, Behavior ICDO3 (SEER IF31)
Morph (1973-91) ICD-O-1 (SEER MORPH)
Morphology--Type/Behavior ICDO2 (SEER MORPH)
Morphology--Type/Behavior ICDO3 (SEER MORPH)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flags as Used in the EDITS Software Package
Edits of the type Diagnostic Confirmation, Behavior differ in the use of ICD-O-2 or ICD-O-3 and check that, for *in situ* cases (Behavior = 2), Diagnostic Confirmation specifies microscopic confirmation (1, 2, or 4).

The distinction between *in situ* and invasive is very important to a registry, since prognosis is so different. Since the determination that a neoplasm has not invaded surrounding tissues, i.e., *in situ*, is made microscopically, cases coded *in situ* in behavior should have a microscopic confirmation code. However, very rarely, a physician will designate a case noninvasive or *in situ* without microscopic evidence.
If an edit of the type, Diagnostic Confirmation, Behavior, gives an error message or warning, check that Behavior and Diagnostic Confirmation have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding.
Edits of the type, Morphology--Type/Behavior, perform the following check:

1. Codes listed in ICD-O-2 or ICD-O-3 with behavior codes of only 0 or 1 are considered valid, since the behavior matrix of ICD-O-2 and ICD-O-3 allows for the elevation of the behavior of such histologies when the tumor is *in situ* or malignant. This edit forces review of these rare cases to verify that they are indeed *in situ* or malignant.

2. The following histologies are generally not accepted as *in situ*: ICD-O-2 histologies 8000-8004, 8020, 8021, 8331, 8332, 8800-9054, 9062, 9082, 9083, 9110-9491, 9501-9989, ICD-O-3 histologies 8000-8005, 8020, 8021, 8331, 8332, 8800-9055, 9062, 9082, 9083, 9110-9493, 9501-9989. This edit forces review of these cases.

3. If a Morphology-Type/Behavior edit produces an error or warning message and the case is one in which the 4-digit morphology code is one that appears in ICD-O-2 or ICD-O-3 only with behavior codes of 0 or 1, or the case is one in which the 4-digit morphology code is not generally accepted with a behavior code of 2, verify the coding of morphology and that the behavior should be coded malignant or *in situ*. The registrar may need to consult a pathologist or medical advisor in problem cases.

   Exceptions:
   If year of Date of Diagnosis > 2000, then a behavior code of 1 is valid for the following ICD-O-2 histologies and no over-ride flag is needed: 8931, 9393, 9538, 9950, 9960-9962, 9980-9984, and 9989. Similarly, the following ICD-O-3 histologies are valid with a behavior code of 1: 8442, 8451, 8462, 8472, and 8473.If year of Date of Diagnosis > 2003, the following ICD-O-3 benign histologies will pass without review: 8146, 8271, 8861, 8897, 9121, 9122, 9131, 9161, 9350, 9351, 9352, 9360, 9361, 9383, 9384, 9394, 9412, 9413, 9444, 9492, 9493, 9506, 9531, 9532, 9533, 9534, 9537, 9541, 9550, 9562, and 9570.

4. Grade 5-8 with histologies not in the range of 9590-9948 is impossible.

5. Some terms in ICD-O-2 and ICD-O-3 carry an implied statement of grade. These histologies must be reported with the correct grade as stated below. An error of this type cannot be over-ridden.

ICD-O-2
8020/34 Carcinoma, undifferentiated
8021/34 Carcinoma, anaplastic
8331/31 Follicular adenocarcinoma, well differentiated
8851/31 Liposarcoma, well differentiated
9062/34 Seminoma, anaplastic
9082/34 Malignant teratoma, undifferentiated
9083/32 Malignant teratoma, intermediate type
9401/34 Astrocytoma, anaplastic
9451/34 Oligodendroglioma, anaplastic
9511/31 Retinoblastoma, differentiated
9512/34 Retinoblastoma, undifferentiated

ICD-O-3
8020/34 Carcinoma, undifferentiated
8021/34 Carcinoma, anaplastic
8331/31 Follicular adenocarcinoma, well differentiated
9082/34 Malignant teratoma, undifferentiated
9083/32 Malignant teratoma, intermediate type
9401/34 Astrocytoma, anaplastic
9451/34 Oligodendroglioma, anaplastic
9511/31 Retinoblastoma, differentiated
9512/34 Retinoblastoma, undifferentiated

Instructions for Coding

1. Leave blank if the program does not generate an error message for the edits of the types, Diagnostic Confirmation, Behav Code or Morphology--Type/Behavior.

2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.

3. Code 1, 2, or 3 as indicated if review of all items in the error or warning message confirms that all are correct.

Codes

1	Reviewed and confirmed that the pathologist states the primary to be "*in situ*" or "malignant" although the behavior code of the histology is designated as "benign" or "uncertain" in ICD-O-2 or ICD-O-3
2	Reviewed and confirmed that the behavior code is "*in situ,*" but the case is not microscopically confirmed
3	Reviewed and confirmed that conditions 1 and 2 both apply
Blank	Not reviewed or reviewed and corrected

OVER-RIDE HOSPSEQ/DXCONF

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Over-ride Hospital Sequence/Diagnostic Confirmation	1986	1	CoC	2001	9			1892 - 1892

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software:
Diagnostic Confirm, Seq Num--Hosp (CoC)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
The edit, Diagnostic Confirm, Seq Num--Hosp (CoC), does the following:
1. If any case is one of multiple primaries and is not microscopically confirmed or lacks a positive lab test/marker study, i.e., Diagnostic Confirmation > 5 and Sequence Number--Hospital > 00 (more than one primary), review is required.

2. If Primary Site specifies an ill-defined or unknown primary (C760-C768, C809), no further checking is done.

3. If Sequence Number--Hospital is in the range of 60-88, this edit is skipped.

It is important to verify that the non-microscopically confirmed case is indeed a separate primary from any others that may have been reported. This edit forces review of multiple primary cancers when one of the primaries is coded to a site other than ill-defined or unknown and is not microscopically confirmed or confirmed by a positive lab test/marker study.

1. If the suspect case is confirmed accurate as coded and if the number of primaries is correct, set the Over-ride HospSeq/DxConf to 1. Do not set the over-ride flag on the patient's other primary cancers.

2. If it turns out that the non-microscopically confirmed cancer is considered a manifestation of one of the patient's other cancers, delete the non-microscopically confirmed case. Check the sequence numbers of remaining cases, correcting them if necessary. Also check for other data items on the remaining cases that may need to be changed as a result of the corrections, such as stage and treatment.

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Diagnostic Confirm, Seq Num--Hosp (CoC).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE HOSPSEQ/SITE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Over-ride Hospital Sequence/Site	1988	1	CoC	2001	9			1894 - 1894

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Seq Num--Hosp, Primary Site, Morph ICDO2 (CoC)
Seq Num--Hosp, Primary Site, Morph ICDO3 (CoC)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Seq Num--Hosp, Primary Site, Morph differ in use of ICD-O-2 or ICD-O-3 morphology. They force review of multiple primary cancers when one of the primaries is coded to a site/morphology combination that could indicate a metastatic site rather than a primary site.

1. If Sequence Number--Hospital indicates the person has had more than one primary, then any case with one of the following site/histology combinations requires review:
   - C760-C768 (ill-defined sites) or C809 (unknown primary) and ICD-O-2 or ICD-O-3 histology < 9590. Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry, and should not be entered as a second primary.
   - C770-C779 (lymph nodes) and ICD-O-2 histology not in range 9590-9717 or ICD-O-3 histology not in the range 9590-9729; or C420-C424 and ICD-O-2 histology not in range 9590-9941 or ICD-O-3 histology not in the range 9590-9989. That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.
   - Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741 or ICD-O-3 histology in the range 9740-9758. Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.

2. If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

Instructions for Coding
- Leave blank if the program does not generate an error message for an edit of the type Seq Num--Hosp, Primary Site, Morph.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that hospital sequence number and site are both correct.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE ILL-DEFINE SITE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Sequence Number/Ill-defined Site Interfield Review (Interfield Edit 22)	2060	1	SEER					1903 - 1903

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Seq Num--Central, Prim Site, Morph ICDO2 (SEER IF22)
Seq Num--Central, Prim Site, Morph ICDO3 (SEER IF22)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Seq Num--Central, Primary Site, Morph differ in use of ICD-O-2 or ICD-O-3 morphology. They force review of multiple primary cancers when one of the primaries is coded to a site/morphology combination that could indicate a metastatic site rather than a primary site.

1. If Sequence Number-Central indicates the person has had more than one primary, then any case with one of the following site/histology combinations requires review:

    - C760-C768 (ill-defined sites) or C809 (unknown primary) and ICD-O-2 or ICD-O-3 histology < 9590. Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry, and should not be entered as a second primary.
    - C770-C779 (lymph nodes) and ICD-O-2 histology not in the range 9590-9717 or ICD-O-3 histology not in the range 9590-9729; or C420-C424 and ICD-O-2 histology not in the range 9590-9941 or ICD-O-3 histology not in the range 9590-9989. That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.
    - Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741 or ICD-O-3 histology in the range 9740-9758. Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.

2. If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

Instructions for Coding
- Code 1 can be used if a second or subsequent primary reporting with an ill-defined primary site has been reviewed and is indeed an independent primary.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

Codes

1	Reviewed and confirmed as reported: a second or subsequent primary reported with an ill-defined primary site (C76.0-C76.8, C80.9) has been reviewed and is an independent primary
Blank	Not reviewed or reviewed and corrected

OVER-RIDE LEUK, LYMPHOMA

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Leukemia or Lymphoma/Diagnostic Confirmation Interfield Review (Interfield Edit 48)	2070	1	SEER					1904 - 1904

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Diagnostic Confirmation, Histology ICDO2 (SEER IF48)
Diagnostic Confirmation, Histology ICDO3 (SEER IF48)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Diagnostic Confirmation, Histology differ in use of ICD-O-2 or ICD-O-3 and check the following:

1. Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma that have diagnostic confirmation of direct visualization or clinical, and any leukemia with a diagnostic confirmation of direct visualization.

2. If histology = 9590-9717 for ICD-O-2 or 9590-9729 for ICD-O-3 (lymphoma) then Diagnostic Confirmation cannot be 6 (direct visualization) or 8 (clinical).

3. If histology = 9720-9941 for ICD-O-2 or 9731-9948 for ICD-O-3 (leukemia and other) then Diagnostic Confirmation cannot be 6 (direct visualization).

Instructions for Coding

- Leave blank if the program does not generate an error message for the edits of the type Diagnostic Confirmation, Histology.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- If the edit produces an error or warning message, verify that the ICD-O-2 or ICD-O-3 histology and diagnostic confirmation are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in Diagnostic Confirmation) for leukemia. Code 1 indicates that a review has taken place and histologic type and diagnostic confirmation are correctly coded.

Codes

Blank	Not reviewed or reviewed and corrected
1	Reviewed and confirmed as reported

OVER-RIDE REPORT SOURCE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Type of Reporting Source/Sequence Number Interfield Review (Interfield Edit 04) (Seer #7)	2050	1	SEER					1902 - 1902

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Type of Rep Srce(DC), Seq Num--Cent, ICDO2 (SEER IF04)
Type of Rep Srce(DC), Seq Num--Cent, ICDO3 (SEER IF04)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Date Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type 'Type of Rep Srce(DC), Seq Num--Cent' checks that if the case is a death-certificate-only case and the histology is not a lymphoma, leukemia, immunoproliferative or myeloproliferative disease (ICD-O-2 or ICD-O-3 histology is less than 9590), then the tumor sequence number must specify one primary only (sequence '00').

Instructions for Coding

- Leave blank if the program does not generate an error message for the report source edit.
- Code 1 if review of type of reporting source, histologic type and tumor sequence number verified that a second or subsequent primary with a reporting source of death-certificate-only has been reviewed and is indeed an independent primary.

Codes

Blank	Not reviewed or reviewed and corrected
1	Reviewed and confirmed as reported

OVER-RIDE SEQNO/DXCONF

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Sequence Number/Diagnostic Confirmation Interfield Review (Interfield Edit 23)	2000	1	SEER					1897 - 1897

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Diagnostic Confirm, Seq Num--Central (SEER IF23)

Rationale
Some edits check for code combinations that are impossible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
- The edit checks if the case is one of multiple primaries and is not microscopically confirmed or has only positive lab test/marker studies (i.e., Diagnostic Confirmation >5) and tumor sequence number >00 (more than one primary).
- The edit is skipped if the Sequence Number--Central is in the range of 60-99.

Instructions for Coding
- Leave blank if the program does not generate an error message for the Diagnostic Confirmation and Sequence Number Central edit.
- Code 1 if the cases have been reviewed and it is verified that there are multiple primaries of specific sites in which at least one diagnosis has not been microscopically confirmed.

Codes

Blank	Not reviewed or reviewed and corrected
1	Reviewed and confirmed as reported

OVER-RIDE SITE/BEHAVIOR

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Over-ride Flag for Site/Behavior (IF39)	2071	1	SEER	1997	5.1			1905 - 1905

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Primary Site, Behavior Code ICDO2 (SEER IF39)
Primary Site, Behavior Code ICDO3 (SEER IF39)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type, Primary Site, Behavior Code, require review of the following primary sites with a behavior of *in situ* (ICD-O-2 or ICD-O-3 behavior = 2):

C269	Gastrointestinal tract, NOS
C399	Ill-defined sites within respiratory system
C559	Uterus, NOS
C579	Female genital tract, NOS

C639	Male genital organs, NOS
C689	Urinary system, NOS
C729	Nervous system, NOS
C759	Endocrine gland, NOS
C760-C768	Ill-defined sites
C809	Unknown primary site

Since the designation of *in situ* is very specific and almost always requires microscopic confirmation, ordinarily specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being *in situ* is reliable.
If an *in situ* diagnosis is stated, try to obtain a more specific primary site. A primary site within an organ system can sometimes be identified based on the diagnostic procedure or treatment given or on the histologic type. If no more specific site can be determined, it is usually preferable to code a behavior code of 3. In the exceedingly rare situation in which it is certain that the behavior is *in situ* and no more specific site code is applicable, set Over-ride Site/Behavior to 1.

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Primary Site, Behavior Code ICDO2 (SEER IF39) and/or the edit Primary Site, Behavior Code ICDO3 (SEER IF39).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of site and behavior verifies that the patient has an *in situ* cancer of a nonspecific site and no further information about the primary site is available.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Note: The IF 39 edit does not allow*in situ*cases of nonspecific sites, such as gastrointestinal tract, NOS; uterus, NOS; female genital tract, NOS; male genital organs, NOS; and others. The over-ride indicates that the conflict has been reviewed.

OVER-RIDE SITE/EOD/DX DT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Over-ride Flag for Site/EOD/Diagnosis Date (IF40) (SEER #13) Over-ride Flag for Site/CS Extension/Diagnosis Date (IF176)	2072	1	SEER	1997	5.1			1906 - 1906

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Primary Site, EOD, ICDO2 (SEER IF40)
Primary Site, EOD, ICDO3 (SEER IF40)
Primary Site, CS Extension (SEER IF 176)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of this type Primary Site, EOD do not allow “localized” disease with nonspecific sites, such as mouth, NOS; colon, NOS (except ICD-O-2 or ICD-O-3 histology 8210, 8220, 8261, or 8263); bone, NOS; female genital system, NOS; male genital organs, NOS; and others.

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Primary Site, EOD, ICDO2 (SEER IF40) and/or the edit Primary Site, EOD, ICDO3 (SEER IF40).
- Code 1 if the case has been reviewed and it has been verified that the patient had “localized” disease with a nonspecific site and no further information about the primary site is available.

Codes

Blank	Not reviewed or reviewed and corrected
1	Reviewed and confirmed as reported

OVER-RIDE SITE/LAT/EOD

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Over-ride Flag for Site/Laterality/CS Extension (IF177) Over-ride Flag for Site/Laterality/EOD (IF41)	2073	1	SEER	1997	5.1			1907 - 1907

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Primary Site, Laterality, EOD, ICDO2 (SEER IF41)
Primary Site, Laterality, EOD, ICDO3 (SEER IF41)
Primary Site, Laterality, CS Extension (SEER IF177)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of this type Primary Site, Laterality, EOD apply to paired organs and do not allow EOD to be specified as *in situ*, localized, or regional by direct extension if laterality is coded as "bilateral, site unknown," or "laterality unknown."

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Primary Site, Laterality, EOD, ICDO2 (SEER IF41) and/or Primary Site, Laterality, EOD, ICDO3 (SEER IF41).
- Code 1 if the case has been reviewed and it has been verified that the patient had laterality coded nonspecifically and EOD coded specifically.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SITE/LAT/MORPH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Over-ride Flag for Site/Laterality/Morphology (IF42)	2074	1	SEER	1997	5.1			1908 - 1908

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Laterality, Primary Site, Morph ICDO2 (SEER IF42)
Laterality, Primary Site, Morph ICDO3 (SEER IF42)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Laterality, Primary Site, Morph differ in use of ICD-O-2 or ICD-O-3 morphology and do the following:
1. If the Primary Site is a paired organ and ICD-O-2 or ICD-O-3 behavior is *in situ* (2), then laterality must be 1, 2, or 3.
2. If diagnosis year less than 1988 and ICD-O-2 or ICD-O-3 histology = 9590, no further editing is performed.
3. If diagnosis year greater than 1987 and ICD-O-2 or ICD-O-3 histology = 9140, 9700, 9701, 9590-9980, no further editing is performed.

The intent of this edit is to force review of *in situ* cases for which laterality is coded 4 (bilateral) or 9 (unknown laterality) as to origin.In rare instances when the tumor is truly midline (9) or the rare combination is otherwise confirmed correct, enter a code 1 for Override Site/Lat/Morph.

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Laterality, Primary site, Morph ICDO2 (SEER IF42) and/or the edit Laterality, Primary site, Morph ICDO3 (SEER IF42).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of site, laterality and morphology verifies that the case had behavior code of "*in situ*" and laterality is not stated as "right: origin of primary;" "left: origin of primary;" or "only one side involved, right or left origin not specified".

Codes

Blank	Not reviewed or reviewed and corrected
1	Reviewed and confirmed as reported

OVER-RIDE SITE/LAT/SEQNO

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Site/Histology/Laterality/Sequence Number Interrecord Review (Interrecord Edit 09)	2010	1	SEER					1898 - 1898

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following Interrecord Edit from the SEER Program: Verify Same Primary Not Reported Twice for a Person (SEER IR09)
Presently, documentation on interrecord edits is not included in the EDITS software.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Verify Same Primary Not Reported Twice for a Person (SEER IR09) applies to paired organs and does not allow two cases with the same primary site group, laterality and three digit histology code. This edit verifies that the same primary is not reported twice for a person.**Instructions for Coding**

- Leave blank if the program does not generate an error message for the edit Verify Same Primary Not Reported Twice for a Person (SEER IR09).
- Code 1 if the case has been reviewed and it has been verified that the patient had multiple primaries of the same histology (3 digit) in the same primary site group.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SITE/TNM-STGGRP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1989	1	CoC	2001	9			1895 - 1895

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Primary Site, AJCC Stage Group - Ed 6, (NAACCR)
Primary Site, AJCC Stage Group - Ed 6, ICDO3 (CoC)
Primary Site, AJCC Stage Group - Ed 7, ICDO3 (CoC)
Primary Site, AJCC Stage Group - Ed 7, ICDO3 (NPCR)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Primary Site, AJCC Stage Group - Ed 6 and Primary Site, AJCC Stage Group - Ed 7 check that the pathologic and clinical AJCC stage group codes are valid for the site and histology group according to the AJCC Cancer Staging Manual Sixth Edition and AJCC Cancer Staging Manual Seventh Edition, using the codes described for the items TNM Clin Stage Group [970] and TNM Path Stage Group [910]. Combinations of site and histology not represented in any AJCC schema must be coded 88. Unknown stage groups must be coded 99. Blanks are not permitted.

Since pediatric cancers whose sites and histologies have an AJCC scheme may be coded according to a pediatric scheme instead, Override Site/TNM-Stage Group is used to indicate pediatric cases not coded according to the AJCC manual. Pediatric Stage groups should not be recorded in the TNM Clin Stage Group or TNM Path Stage Group items. When neither clinical nor pathologic AJCC staging is used for pediatric cases, code all AJCC items 88. When any components of either is used to stage a pediatric case, follow the instructions for coding AJCC items and leave Override Site/TNM-Stage Group blank.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edits of the type Primary Site, AJCC Stage Group - Ed 6 and Primary Site, AJCC Stage Group - Ed 7.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case is confirmed to be a pediatric case that was coded using a pediatric coding system.

Codes

Blank	Not reviewed or reviewed and corrected
1	Reviewed and confirmed as reported

OVER-RIDE SITE/TYPE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Site/Type Interfield Review (Interfield Edit 25)	2030	1	SEER					1900 - 1900

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Primary Site, Morphology-Type ICDO2 (CoC)
Primary Site, Morphology-Type ICDO3 (CoC)
Primary Site, Morphology-Type ICDO2 (SEER IF25)
Primary Site, Morphology-Type ICDO3 (SEER IF25)
Primary Site, Morphology-Type, Behavior ICDO3 (SEER IF25)
Primary Site, Morphology-Type, Behavior ICDO3 (CoC)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Multiple versions of edits of the type Primary site, Morphology-Type check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different over-ride flag. The CoC version of the edit will accept Over-ride CoC-Site/Type or Over-ride Site/Type as equivalent.

1. The Site/Histology validation list (available on the SEER web site) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not included. These edits require review of all combinations not listed.

2. Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if Primary Site is in the range C440-C449 (skin), and ICD-O-2 histology is in the range 8000-8004 (neoplasms, malignant, NOS), 8010-8045 (epithelial carcinomas), 8050-8082 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), or ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No over-ride is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether a) the combination is biologically implausible, or b) there are cancer registry coding conventions that would dictate different codes for the diagnosis. Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edits of the type Primary Site, Morphology-Type.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1 if the case has been reviewed and both the site and histology are correct.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SS/NODESPOS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Over-ride Summary Stage/Nodes Positive	1981	1	NAACCR	2001	9			1888 - 1888

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Summary Stage 1977, Regional Nodes Pos (NAACCR)
Summary Stage 2000, Regional Nodes Pos (NAACCR)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error or warning message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
The edit Summary Stage 1977, Regional Nodes Pos (NAACCR) checks SEER Summary Stage 1977 against Regional Nodes Positive and generates an error or warning if there is an incompatibility between the two data items. The edit Summary Stage 2000, Regional Nodes Pos (NAACCR) checks SEER Summary Stage 2000 against Regional Nodes Positive and generates an error or warning if there is an incompatibility between the two data items.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Summary Stage 1977, Regional Nodes Pos (NAACCR) or the edit Summary Stage 2000, Regional Nodes Pos (NAACCR).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case has been reviewed and it has been verified that the case has both SEER Summary Stage 1977 and Nodes Positive coded correctly or SEER Summary Stage 2000 and Nodes Positive coded correctly.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SS/TNM-M

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Over-ride Summary Stage/TNM-M	1983	1	NAACCR	2001	9			1890 - 1890

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Summary Stage 1977, TNM-M (NAACCR)
Summary Stage 2000, TNM-M (NAACCR)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error or warning message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
The edit Summary Stage 1977, TNM-M (NAACCR) checks the SEER Summary Stage 1977 against the TNM-M and generates a warning if the SEER Summary Stage 1977 is ‘distant’ and the TNM-M is ‘0’. (TNM-M is derived from TNM Path M and TNM Clin M, with TNM Path M

having precedence.) It also checks if the SEER Summary Stage 1977 is not 'distant' and the TNM-M is greater than or equal to '1' and generates an error or a warning. The edit Summary Stage 2000, TNM-M (NAACCR) checks the SEER Summary Stage 2000 against the TNM-M and generates a warning if the SEER Summary Stage 2000 is 'distant' and the TNM-M is '0'. It also checks if the SEER Summary Stage 2000 is not 'distant' and the TNM-M is greater than or equal to '1' and generates an error or a warning.

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Summary Stage 1977, TNM-M (NAACCR) or the edit Summary Stage 2000, TNM-M (NAACCR).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case has been reviewed and it has been verified that both SEER Summary Stage 1977 and TNM-M have been coded correctly or that SEER Summary Stage 2000 and TNM-M have been coded correctly.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SS/TNM-N

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Over-ride Summary Stage/TNM-N	1982	1	NAACCR					1889 - 1889

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Summary Stage 1977, TNM-N (NAACCR)
Summary Stage 2000, TNM-N (NAACCR)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
The edit Summary Stage 1977, TNM-N (NAACCR) checks SEER Summary Stage 1977 against the TNM-N and generates an error if the SEER Summary Stage 1977 indicates regional nodal involvement and the TNM-N does not. (TNM-N is derived from TNM Path N and TNM Clin N, with TNM Path N having precedence.) It also generates an error if the SEER Summary Stage 1977 is '*in situ*' or 'localized' and the TNM-N is greater than or equal to '1'. The edit Summary Stage 2000, TNM-N (NAACCR) checks SEER Summary Stage 2000 against the TNM-N and generates an error if the SEER Summary Stage 2000 indicates regional nodal involvement and the TNM-N does not. It also generates an error if the SEER Summary Stage 2000 is '*in situ*' or 'localized' and the TNM-N is greater than or equal to '1'.

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Summary Stage 1977, TNM-N (NAACCR) or the edit Summary Stage 2000, TNM-N (NAACCR).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case has been reviewed and it has been verified that both SEER Summary Stage 1977 and TNM-N or both SEER Summary Stage 2000 and TNM-N have been coded correctly.

Codes

Blank	Not reviewed or reviewed and corrected
1	Reviewed and confirmed as reported

OVER-RIDE SURG/DXCONF

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Surgery/Diagnostic Confirmation Interfield Review (Interfield Edit 46)	2020	1	SEER					1899 - 1899

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
RX Summ--Surg Prim Site, Diag Conf (SEER IF76)
RX Summ--Surg Site 98-02, Diag Conf (SEER IF106)
RX Summ--Surgery Type, Diag Conf (SEER IF46)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type RX Summ--Surg Prim Site, Diag Conf check that cases with a primary site surgical procedure coded 20-90 are histologically confirmed.If the patient had a surgical procedure, most likely there was a microscopic examination of the cancer. Verify the surgery and diagnostic confirmation codes, and correct any errors. Sometimes there are valid reasons why no microscopic confirmation is achieved with the surgery; for example, the tissue removed may be inadequate for evaluation.

Instructions for Coding
- Leave blank if the program does not generate an error message for edits of the type, RX Summ--Surg Prim Site, Diag Conf.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review confirms that they are correct. The patient had surgery, but the tissue removed was not sufficient for microscopic confirmation.

Codes

Blank	Not reviewed or reviewed and corrected
1	Reviewed and confirmed as reported

PATH DATE SPEC COLLECT 1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
OBR-7 Observation Date/Time #00241 (HL7) Path--Date Spec Collection	7320	14	HL7	2010	12			4580 - 4593

Description
Records the date and time the specimen for the report on the cancer was collected, not the date read, interpreted or typed.

This is a field to record when specimens are collected; can be used as approximate date of diagnosis in absence of other information. HL7 OBR-7 records the date and time (YYYYMMDDHHMMSS). NAACCR records the date (YYYYMMDD).

This data item accommodates only one path report. If additional reports were prepared, enter the date specimen collected in Path Date Spec Collect 2 through Path Date Spec Collect 5 [7321 - 7324]. Information in this data item should refer to the path report described in data items 7010, 7090, 7100, 7190 and 7480.

Rationale
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH DATE SPEC COLLECT 2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Path--Date Spec Collection OBR-7 Observation Date/Time #00241 (HL7)	7321	14	HL7	2010	12			4686 - 4699

Description
Records the date and time the specimen for the report on the cancer was collected, not the date read, interpreted or typed.

This data item accommodates only one path report; if additional path reports were prepared, enter the date the specimen was collected in Path Date Spec Collect No 3 through Path Date Spec Collect No 5 [7322-7324]. Information in this data item should refer to the path report described in data items 7011, 7091, 7101, 7191, and 7481.

This is a field to record when specimens are collected; can be used as approximate date of diagnosis in absence of other information. HL7 OBR-7 records the date and time (YYYYMMDDHHMMSS). NAACCR records the date (YYYYMMDD).

Rationale
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH DATE SPEC COLLECT 3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
OBR-7 Observation Date/Time #00241 (HL7) Path--Date Spec Collection	7322	14	HL7	2010	12			4792 - 4805

Description
Records the date and time the specimen for the report on the cancer was collected, not the date read, interpreted or typed.

This is a field to record when specimens are collected; can be used as approximate date of diagnosis in absence of other information. HL7 OBR-7 records the date and time (YYYYMMDDHHMMSS). NAACCR records the date (YYYYMMDD).
This data item accommodates only one path report; if additional path reports were prepared, enter the date the specimen was collected in Path Date Spec Collect No 4 through Path Date Spec Collect No 5 [7323-7324]. Information in this data item should refer to the path report described in data items 7012, 7092, 7102, 7192, and 7482.

Rationale
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH DATE SPEC COLLECT 4

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Path--Date Spec Collection OBR-7 Observation Date/Time #00241 (HL7)	7323	14	HL7	2010	12			4898 - 4911

Description
Records the date and time the specimen for the report on the cancer was collected, not the date read, interpreted or typed.

This is a field to record when specimens are collected; can be used as approximate date of diagnosis in absence of other information. HL7 OBR-7 records the date and time (YYYYMMDDHHMMSS). NAACCR records the date (YYYYMMDD).

This data item accommodates only one path report; if additional path reports were prepared, enter the date the specimen was collected in Path Date Spec Collect No 5 [7324]. Information in this data item should refer to the path report described in data items 7013, 7093, 7103, 7193, and 7483.

Rationale
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH DATE SPEC COLLECT 5

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
OBR-7 Observation Date/Time #00241 (HL7) Path--Date Spec Collection	7324	14	HL7	2010	12			5004 - 5017

Description
Records the date and time the specimen for the report on the cancer was collected, not the date read, interpreted or typed.

This is a field to record when specimens are collected; can be used as approximate date of diagnosis in absence of other information. HL7 OBR-7 records the date and time (YYYYMMDDHHMMSS). NAACCR records the date (YYYYMMDD).
This data item accommodates only one path report. Information in this data item should refer to the path report described in data items 7014, 7094, 7104, 7194, and 7484.

Rationale

Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH ORDER PHYS LIC NO 1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
OBR-16 Ordering Provider (License Number) #00226 Path Ordering Client/Phys--Lic No.	7100	20	HL7	2010	12			4621 - 4640

Description
License number of physician submitting specimens for the first path report.

This data item accommodates only one path report. If additional reports were prepared, enter the license number of physician in Path Order Phys Lic No 2 through Path Order Phys Lic No 5 [7101-7104]. Information in this data item should refer to the path report described in data items 7010, 7090, 7190, 7320, and 7480.

Rationale
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH ORDER PHYS LIC NO 2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Path Ordering Client/Phys--Lic No. OBR-16 Ordering Provider (License Number) #00226	7101	20	HL7	2010	12			4727 - 4746

Description
License number of physician submitting specimens for the second path report.

This data item accommodates only one path report; if additional path reports were prepared, enter the license number of physician in Path Order Phys Lic No 3 through Path Order Phys Lic No 5 [7102-7104]. Information in this data item should refer to the path report described in data items 7011, 7091, 7191, 7321, and 7481.

Rationale
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH ORDER PHYS LIC NO 3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
OBR-16 Ordering Provider (License Number) #00226 Path Ordering Client/Phys--Lic No.	7102	20	HL7	2010	12			4833 - 4852

Description
License number of physician submitting specimens for the third path report.

This item accommodates only one path report; if additional path reports were prepared, enter the license number of physician in Path Order Phys Lic No 4 through Path Order Phys Lic No 5 [7103-7104]. Information in this data item should refer to the path report described in data items 7012, 7022, 7192, 7322, and 7482.

Rationale
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Path Ordering Client/Phys--Lic No. OBR-16 Ordering Provider (License Number) #00226	7103	20	HL7	2010	12			4939 - 4958

Description
License number of physician submitting specimens for the fourth path report.

This data item accommodates only one path report; if an additional path report was prepared, enter the license number of physician in Path Order Phys Lic No 5 [7104]. Information in this data item should refer to the path report described in data items 7013, 7023, 7193, 7323, and 7483.

Rationale
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH ORDER PHYS LIC NO 5

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	7104	20	HL7	2010	12			5045 - 5064

Description
License number of physician submitting specimens for the fifth path report.

Information in this data item should refer to the path report described in data items 7014, 7024, 7194, 7324, and 7484.

Rationale
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH ORDERING FAC NO 1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)	7190	25	HL7	2010	12			4596 - 4620

Description
Facility ID number of the facility where the specimen described in the first path report was removed/collected.

Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).

This item accommodates only one path report; if additional path reports were prepared, enter the facility ID number(s) in Path Ordering Fac No 2 through Path Ordering Fac No 5 [7191-7194]. Information in this data item should refer to the path report described in data items 7010, 7090, 7100, 7320, and 7480.

Rationale
The facility where the specimen was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH ORDERING FAC NO 2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Path Ordering Facility Number (AHA Number) ORC-21 Ordering Facility Name #01311 (HL7)	7191	25	HL7	2010	12			4702 - 4726

Description
Facility ID number of the facility where the specimen described in the second path report was removed/collected. Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).This item accommodates only one path report; if additional path reports were prepared, enter the facility ID number(s) in Path Ordering Fac No 3 through Path Ordering Fac No 5 [7192-7194]. Information in this data item should refer to the path report described in data items 7011, 7091, 7101, 7321, and 7481.

Rationale
The facility where the specimen was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH ORDERING FAC NO 3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)	7192	25	HL7	2010	12			4808 - 4832

Description
Facility ID number of the facility where the specimen described in the third path report was removed/collected.

Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).

This item accommodates only one path report; if additional path reports were prepared, enter the facility ID number(s) in Path Ordering Fac No 4 through Path Ordering Fac No 5 [7193-7194]. Information in this data item should refer to the path report described in data items 7012, 7092, 7102, 7322, and 7482.

Rationale
The facility where the specimen was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH ORDERING FAC NO 4

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Path Ordering Facility Number (AHA Number) ORC-21 Ordering Facility Name #01311 (HL7)	7193	25	HL7	2010	12			4914 - 4938

Description
Facility ID number of the facility where the specimen described in the fourth path report was removed/collected.

Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).

This item accommodates only one path report; if an additional path report was prepared, enter the facility ID number in Path Ordering Fac No 5 [7194]. Information in this data item should refer to the path report described in data items 7013, 7093, 7103, 7323, and 7483.

Rationale
The facility where the specimen was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH ORDERING FAC NO 5

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #

ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)	7194	25	HL7	2010	12			5020 - 5044

Description
Facility ID number of the facility where the specimen described in the fifth path report was removed/collected.

Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).

This item accommodates only one path report. Information in this data item should refer to the path report described in data items 7014, 7094, 7104, 7324, and 7484.

Rationale
The facility where the specimen was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH REPORT NUMBER 1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Path Report Number OBR-3 Filler Order Number #00217 (HL7)	7090	20	HL7	2010	12			4560 - 4579

Description
Unique sequential number assigned by a laboratory to the first report for this case.

This item accommodates only one path report. When information is available for more than one path report, enter the path report number(s) in Path Report No 2 through Path Report No 5 [7091-7094]. Information in this data item should refer to the path report described in data items 7010, 7100, 7190, 7320, and 7480.

Note: In some cases the HL7 field length as sent by the laboratory may be longer than 20.

Rationale
The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow back with the pathology facility.

Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH REPORT NUMBER 2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
OBR-3 Filler Order Number #00217 (HL7) Path Report Number	7091	20	HL7	2010	12			4666 - 4685

Description
Unique sequential number assigned by a laboratory to the second report for this case.

This item accommodates only one path report. When information is available for more than two path reports, enter the path report number(s) in Path Report No 3 through Path Report No 5 [7092-7094]. Information in this data item should refer to the path report described in data items 7011, 7101, 7191, 7321, and 7481.

Note: In some cases the HL7 field length as sent by the laboratory may be longer than 20.

Rationale
The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow back with the pathology facility.
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Path Report Number OBR-3 Filler Order Number #00217 (HL7)	7092	20	HL7	2010	12			4772 - 4791

Description
Unique sequential number assigned by a laboratory to the third report for this case.

This item accommodates only one path report. When information is available for more than three path reports, enter the path report number(s) in Path Report No 4 through Path Report No 5 [7093-7094]. Information in this data item should refer to the path report described in data items 7012, 7102, 7192, 7322, and 7482.

Note: In some cases the HL7 field length as sent by the laboratory may be longer than 20.

Rationale
The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow back with the pathology facility.
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH REPORT NUMBER 4

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
OBR-3 Filler Order Number #00217 (HL7) Path Report Number	7093	20	HL7	2010	12			4878 - 4897

Description
Unique sequential number assigned by a laboratory to the fourth report for this case.

This item accommodates only one path report. When information is available for more than four path reports, enter the path report number in Path Report No 5 [7094]. Information in this data item should refer to the path report described in data items 7013, 7103, 7193, 7323, and 7483.

Note: In some cases the HL7 field length as sent by the laboratory may be longer than 20.

Rationale
The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow back with the pathology facility.
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH REPORT NUMBER 5

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Path Report Number OBR-3 Filler Order Number #00217 (HL7)	7094	20	HL7	2010	12			4984 - 5003

Description
Unique sequential number assigned by a laboratory to the fifth report for this case.

This item accommodates only one path report. Information in this data item should refer to the path report described in data items 7014, 7104, 7194, 7324, and 7484.

Note: In some cases the HL7 field length as sent by the laboratory may be longer than 20.

Rationale
The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow back with the pathology facility.
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH REPORT TYPE 1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Path--Report Type OBR-4 Universal Service ID #00238 (HL7)	7480	2	HL7	2010	12			4594 - 4595

Description
This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the path report type(s) in Path Report Type 2 through Path Report Type 5 [7481-7484]. Information in this data item should refer to the path report described in data items 7010, 7100, 7090, 7190, and 7320.

Rationale
This variable is primarily used for administrative purposes at the cancer registry.

Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

Codes

01 Pathology (includes pathology report, addendum, synoptic reports, etc.)
02 Cytology
03 Gyn Cytology
04 Bone Marrow (biopsy/aspirate)
05 Autopsy
06 Clinical Laboratory Blood Work, NOS
07 Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)
08 Cytogenetics
09 Immunohistochemical Stains
10 Molecular Studies
11 Flow Cytometry, Immunophenotype
98 Other
99 Unknown

PATH REPORT TYPE 2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
OBR-4 Universal Service ID #00238 (HL7) Path--Report Type	7481	2	HL7	2010	12			4700 - 4701

Description
This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the path report type(s) in Path Report Type 3 through Path Report Type 5 [7482-7484]. Information in this data item should refer to the path report described in data items 7011, 7101, 7091, 7191, and 7321.

Rationale
This variable is primarily used for administrative purposes at the cancer registry.
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

Codes

01 Pathology (includes pathology report, addendum, synoptic reports, etc.)
02 Cytology
03 Gyn Cytology
04 Bone Marrow (biopsy/aspirate)
05 Autopsy
06 Clinical Laboratory Blood Work, NOS
07 Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)

08 Cytogenetics
09 Immunohistochemical Stains
10 Molecular Studies
11 Flow Cytometry, Immunophenotype
98 Other
99 Unknown

PATH REPORT TYPE 3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Path--Report Type OBR-4 Universal Service ID #00238 (HL7)	7482	2	HL7	2010	12			4806 - 4807

Description
This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the path report type(s) in Path Report Type 4 through Path Report Type 5 [7433-7484]. Information in this data item should refer to the path report described in data items 7012, 7102, 7092, 7192, and 7322.

Rationale
This variable is primarily used for administrative purposes at the cancer registry.
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

Codes

01 Pathology (includes pathology report, addendum, synoptic reports, etc.)
02 Cytology
03 Gyn Cytology
04 Bone Marrow (biopsy/aspirate)
05 Autopsy
06 Clinical Laboratory Blood Work, NOS
07 Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)
08 Cytogenetics
09 Immunohistochemical Stains
10 Molecular Studies
11 Flow Cytometry, Immunophenotype
98 Other
99 Unknown

PATH REPORT TYPE 4

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
OBR-4 Universal Service ID #00238 (HL7) Path--Report Type	7483	2	HL7	2010	12			4912 - 4913

Description
This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. If an additional path report was prepared, enter the path report type in Path Report Path Report Type 5 [7484]. Information in this data item should refer to the path report described in data items 7013, 7103, 7093, 7193, and 7323.

Rationale
This variable is primarily used for administrative purposes at the cancer registry.
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

Codes

01 Pathology (includes pathology report, addendum, synoptic reports, etc.)

02 Cytology
03 Gyn Cytology
04 Bone Marrow (biopsy/aspirate)
05 Autopsy
06 Clinical Laboratory Blood Work, NOS
07 Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)
08 Cytogenetics
09 Immunohistochemical Stains
10 Molecular Studies
11 Flow Cytometry, Immunophenotype
98 Other
99 Unknown

PATH REPORT TYPE 5

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Path--Report Type OBR-4 Universal Service ID #00238 (HL7)	7484	2	HL7	2010	12			5018 - 5019

Description
This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. Information in this data item should refer to the path report described in data items 7014, 7104, 7094, 7194, and 7324.

Rationale
This variable is primarily used for administrative purposes at the cancer registry.
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

Codes

01 Pathology (includes pathology report, addendum, synoptic reports, etc.)
02 Cytology
03 Gyn Cytology
04 Bone Marrow (biopsy/aspirate)
05 Autopsy
06 Clinical Laboratory Blood Work, NOS
07 Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)
08 Cytogenetics
09 Immunohistochemical Stains
10 Molecular Studies
11 Flow Cytometry, Immunophenotype
98 Other
99 Unknown

PATH REPORTING FAC ID 1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084	7010	25	HL7	2010	12			4535 - 4559

Description
An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the first report of the case.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the identifying code of pathology facility sending the report in Path Reporting Fac ID 2 through Path Reporting Fac ID 5 [7011-7014]. Information in this data item should refer to the path report described in data items 7100, 7090, 7190, 7320, and 7480.

Rationale
Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.

Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent

cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH REPORTING FAC ID 2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
BHS-4 Batch Sending Facility #0084 MSH-4 Sending Facility (Name) #00004 (HL7)	7011	25	HL7					4641 - 4665

Description
An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the second report of the case.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the identifying code of pathology facility sending the report in Path Reporting Fac ID 3 through Path Reporting Fac ID 5 [7012-7014]. Information in this data item should refer to the path report described in data items 7101, 7091, 7191, 7321, and 7481.

Rationale
Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH REPORTING FAC ID 3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084	7012	25	HL7	2010	12			4747 - 4771

Description
An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the third report of the case.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the identifying code of pathology facility sending the report in Path Reporting Fac ID 4 through Path Reporting Fac ID 5 [7013-7014]. Information in this data item should refer to the path report described in data items 7102, 7092, 7192, 7322, and 7482.

Rationale
Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH REPORTING FAC ID 4

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
BHS-4 Batch Sending Facility #0084 MSH-4 Sending Facility (Name) #00004 (HL7)	7013	25	HL7	2010	12			4853 - 4877

Description
An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the fourth report of the case.

This data item accommodates information for only one path report. If an additional path report was prepared, enter the identifying code of pathology facility sending the report in Path Reporting Fac ID 5 [7014]. Information in this data item should refer to the path report described in data items 7103, 7093, 7193, 7323, and 7483.

Rationale
Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATH REPORTING FAC ID 5

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084	7014	25	HL7	2010	12			4959 - 4983

Description
An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the fifth report of the case.

Information in this data item should refer to the path report described in data items 7104, 7094, 7194, 7324, and 7484.

Rationale
Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.
Cancer registries collect cancer information from various sources including pathology laboratories. Pathology reports of different types may be sent via HL7 messages. Included here are data items coming from such a message to be included in the cancer registry database to aid in consolidating a cancer case when there is information from multiple sources. Traditionally, these data items were not part of the NAACCR Standards Volume II record layout and therefore provide a link to NAACCR Standards Volume V. http://www.naaccr.org/standardsandregistryoperations/volumev.aspx

PATIENT ID NUMBER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	20	8	Reporting Registry					42 - 49

Description
Unique number assigned to an individual patient by the central registry. The central registry will assign this same number to all of the patient's subsequent tumors (records).

Patient ID Number will only differ when multiple central registries accession the same patient. Each central registry will assign their unique Patient ID Number.

NAACCR recommends that the registry should not reissue or reuse this number when a patient's record is deleted from the files.

In the transmit file (data exchange) this number will be the Patient ID Number assigned by the sending registry as defined in Registry ID [40].

Rationale
Provides the central registry with a unique identification number that will link all records (multiple tumors) for the same patient. The unique number also allows the central registry to identify the patient when there are multiple reports from different hospitals.

PATIENT SYSTEM ID-HOSP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	21	8	NAACCR	2006	11			50 - 57

Description
The unique, non-repeating number automatically assigned to patients by the hospital tumor registry software system. The same number is used for all the patient's subsequent tumors. This Patient System ID-Hosp number should not be reused when a patient is deleted.

This number is different from Accession Number-Hosp [550]. While Accession Number-Hosp [550] is subject to change, the Patient System ID-Hosp number is created and maintained by the hospital tumor registry's software system, and requires no key entry. Because the Patient System ID-Hosp number is unchanging, it affords an absolute linkage between a hospital patient record and a central registry's patient record.

Rationale
This provides a stable identifier to link back to all reported tumors for a patient. It also serves as a reliable linking identifier; useful when central registries send follow-up information back to hospitals. Other identifiers such as social security number and medical record number, while useful, are subject to change and are thus less useful for this type of record linkage.

PEDIATRIC STAGE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1120	2	CoC					976 - 977

Description
Code for stage of pediatric tumor in an AJCC stage scheme, a pediatric intergroup study scheme, or a pediatric cooperative group scheme.

Rationale

Staging of pediatric tumors requires very different schemes from those used to stage adult tumors.

Codes
See the *ROADS* manual for allowable codes for this field.

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

PEDIATRIC STAGED BY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Staged By (Pediatric Stage) (CoC)	1140	1	CoC					980 - 980

Description
Code for person who documented the pediatric staging system and stage.

Codes

0 Not staged
1 Managing physician
2 Pathologist
3 Other physician
4 Any combination of 1, 2, or 3
5 Registrar
6 Any combination of 5 with 1, 2, or 3
7 Other
8 Staged, individual not specified
9 Unknown if staged

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

PEDIATRIC STAGING SYSTEM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Type of Staging System (Pediatric) (CoC)	1130	2	CoC					978 - 979

Description
Staging system used to assign the Pediatric Stage.

Rationale
Staging of pediatric tumors requires very different schemes from those used to stage adult tumors.

Codes

00 None
01 AJCC
02 Ann Arbor
03 Children's Cancer Group (CCG)
04 Evans
05 General Summary
06 Intergroup Ewings
07 Intergroup Hepatoblastoma
08 Intergroup Rhabdomyosarcoma
09 International System
10 Murphy
11 NCI (pediatric oncology)
12 National Wilms's Tumor Study
13 Pediatric Oncology Group (POG)
14 Reese-Ellsworth
15 SEER Extent of Disease
88 Not applicable (not pediatric case)
97 Other
99 Unknown

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

PHYSICIAN 3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Physician #3 (CoC) Other Physician (pre-96 CoC)	2490	8	CoC					4459 - 4466

Description
Code for another physician involved in the care of the patient. Registry may use physicians' medical license numbers or may create individual numbering systems.

Rationale
Used to monitor patient radiotherapy care.

Note: This item is not supported by CoC as of January 1, 2010, (the respective NPI item is required).

Codes in addition to medical license numbers or facility-generated codes

00000000	None, no additional physician
99999999	Physician is unknown or an identification number is not assigned

PHYSICIAN 4

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Other Physician (pre-96 CoC) Physician #4 (CoC)	2500	8	CoC					4477 - 4484

Description
Code for another physician involved in the care of the patient. Registry may use physicians' medical license numbers or may create individual numbering systems.

Rationale
Used to monitor patient medical oncology care.

Note: This item is not supported by CoC as of January 1, 2010, (the respective NPI item is required).

Codes in addition to medical license numbers or facility-generated codes

99999999	Physician is unknown or an identification number is not assigned
00000000	None, no additional physician

PHYSICIAN--FOLLOW-UP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Follow-Up Physician (pre-96 CoC) Following Physician (CoC)	2470	8	CoC					4423 - 4430

Description
Code for the physician currently responsible for the patient's medical care. Registry may use physicians' medical license numbers or may create individual numbering systems.

Rationale
Used to monitor post-treatment patient care.

Note: This item is not supported by CoC as of January 1, 2010, (the respective NPI item is required).

Codes in addition to medical license numbers or facility-generated codes

99999999	Follow-up physician unknown or ID number not assigned

PHYSICIAN--MANAGING

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Managing Physician (CoC) Attending Physician (pre-96 CoC)	2460	8	NAACCR					4405 - 4412

Description
Code for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer. Registry may use physicians' medical license numbers or may create individual numbering systems.

Used to monitor patient care.

Note: This item is not supported by CoC as of January 1, 2010, (the respective NPI item is required).

Codes in addition to medical license numbers or facility-generated codes

99999999	Managing physician unknown or ID number not assigned

PHYSICIAN--PRIMARY SURG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Primary Surgeon (CoC)	2480	8	CoC					4441 - 4448

Description
Code for physician who performed the most definitive surgical procedure. Registry may use physician's medical license numbers or may create individual numbering systems.

Rationale
Used to monitor patient surgical care.

Note: This item is not supported by CoC as of January 1, 2010, (the respective NPI item is required).

Codes in addition to medical license numbers or facility-generated codes

00000000	Patient had no surgery and no surgical consultation
88888888	Physician who performed a surgical procedure was not a surgeon (i.e., radiation oncologist, diagnostic radiologist, or general practitioner)
99999999	Primary Surgeon unknown or ID number not assigned

PLACE OF DEATH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1940	3	NPCR					2275 - 2277

Description
State or country where the patient died and where certificate of death is filed. Effective with NAACCR Volume II, Version 13 two new data items, Place of Death--State [1942] and Place of Death--Country [1944] were added to the standard transmission record layout. The UDS Committee expects the new items to replace the use of Place of Death [1940] since the new items use interoperable codes.

Rationale
This field also helps carry out death clearance. When a hospital reports a place of death, the information can help in death certificate matching. It can also signal an out-of-state death for which the death certificate is to be requested.

Codes in addition to geocodes

997	Not applicable, patient alive
999	Place of death unknown

Note: See Appendix B for geocodes.

PLACE OF DEATH--COUNTRY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1944	3	NAACCR	2013	13			452 - 454

Description
Code for the country in which the patient died and where certificate of death is filed. If the patient has multiple tumors, all records should contain the same code. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item Place of Death--State [1942]. It replaces the use of Place of Death [1940].

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

Codes
Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes, whenever possible, augmented by custom codes. See

Appendix B for complete list of country names and corresponding three-character alpha codes.

ZZN	North America NOS
ZZC	Central America NOS
ZZS	South America NOS
ZZP	Pacific NOS
ZZE	Europe NOS
ZZF	Africa NOS
ZZA	Asia NOS
ZZX	Non-US NOS
ZZU	Unknown

Custom codes for historic use only

XNI	North American Islands
ZCB	Other Caribbean Islands
XEN	England, Channel Islands, Isle of Man
XSC	Scandinavia
XGR	Germanic Countries
XSL	Slavic Countries
CSK	Czechoslovakia (former)
YUG	Yugoslavia (former)
XUM	Ukraine and Moldova
XNF	North Africa
XSD	Sudanese Countries
XWF	West Africa
XSF	South Africa
XEF	East Africa
XIF	African Islands
XET	Ethiopia and Eritrea
XAP	Arabian Peninsula
XIS	Israel and Palestine
XCR	Caucasian Republics of former USSR
XOR	Other Asian Republics of former USSR
XSE	Southeast Asia
XMS	Malaysia, Singapore, Brunei
XCH	China, NOS
XML	Melanesian Islands
XMC	Micronesian Islands
XPL	Polynesian Islands
Blank	Not applicable, patient alive

PLACE OF DEATH--STATE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1942	2	NAACCR	2013	13			450 - 451

Description
State or Province where the patient died and where certificate of death is filed. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item PLACE OF DEATH--COUNTRY [1944]. It replaces the use of PLACE OF DEATH [1940].

Rationale
This field also helps carry out death clearance. When a reporting facility reports a place of death, the information can help in death certificate matching. It can also signal an out-of-state death for which the death certificate is to be requested.

Codes

Blank	Not applicable, patient alive

See Appendix B for numeric and alphabetic lists of places and codes (also see Appendix B of the *SEER Program Code Manual* at seer.cancer.gov/tools/codingmanuals/index.html).

PRIMARY PAYER AT DX

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #

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

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

Codes

01 Not insured
02 Not insured, self-pay
10 Insurance, NOS
20 Private Insurance: Managed care, HMO, or PPO
21 Private Insurance: Fee-for-Service
31 Medicaid
35 Medicaid - Administered through a Managed Care plan
60 Medicare/Medicare, NOS
61 Medicare with supplement, NOS
62 Medicare - Administered through a Managed Care plan
63 Medicare with private supplement
64 Medicare with Medicaid eligibility
65 TRICARE
66 Military
67 Veterans Affairs
68 Indian/Public Health Service
99 Insurance status unknown

PRIMARY SITE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
IDC-O-2/3 Topography (CCCR)	400	4	SEER/CoC					540 - 543

Description
Code for the primary site of the tumor being reported using either ICD-O-2 or ICD-O-3. NAACCR adopted ICD-O-2 as the standard coding system for tumors diagnosed beginning January 1, 1992. In addition, NAACCR recommended that tumors diagnosed prior to 1992 be converted to ICD-O-2. The topography (primary site) codes did not change between ICD-O-2 and ICD-O-3.

Codes
See ICD-O-2,[14] or ICD-O-3,[13] Topography Section, for the codes for primary site.

Note: See data item Site (73-91) ICD-O-1 [1960] for ICD-O-1 cases.

QUALITY OF SURVIVAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1780	1	CoC					2128 - 2128

Description
Records patient's ability to carry on the activities of daily living at the date of last contact.

Codes

0 Normal activity
1 Symptomatic and ambulatory
2 Ambulatory more than 50 percent of the time, occasionally needs assistance
3 Ambulatory less than 50 percent of the time, nursing care needed
4 Bedridden, may require hospitalization
8 Not applicable, dead
9 Unknown or unspecified

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

RACE 1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #

Race	160	2	SEER/CoC					177 - 178

Description
Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current *SEER Program Coding and Staging Manual*[3].

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf (Appendix G).

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Codes

01 White
02 Black
03 American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)
04 Chinese
05 Japanese
06 Filipino
07 Hawaiian
08 Korean
*
10 Vietnamese
11 Laotian
12 Hmong
13 Kampuchean (Cambodian)
14 Thai
15 Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16 Asian Indian
17 Pakistani
20 Micronesian, NOS
21 Chamorro/Chamoru
22 Guamanian, NOS
25 Polynesian, NOS
26 Tahitian
27 Samoan
28 Tongan
30 Melanesian, NOS
31 Fiji Islander
32 New Guinean
96 Other Asian, including Asian, NOS and Oriental, NOS
97 Pacific Islander, NOS
98 Other
99 Unknown

*Code 09 was retired effective with Version 12. See codes 15-17.

RACE 2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	161	2	SEER/CoC					179 - 180

Description
Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current *SEER Program Coding and Staging Manual*[3].

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf (Appendix G).

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to

allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Codes

01	White
02	Black
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
*	
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani
20	Micronesian, NOS
21	Chamorro/Chamoru
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
88	No further race documented
96	Other Asian, including Asian, NOS and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown
Blank	Race 2-5 not coded

**Code 09 was retired effective with Version 12. See codes 15-17.*

Note: If diagnosed prior to 2000 and any race code (Race 2, 3, 4, or 5) is blank, all subsequent race codes must be blank. If diagnosed after 1999 and any race code (for Race 2, 3, 4, and 5) is 88 (no further race documented), then all subsequent race codes also must be 88. If any race equals 99, then all race codes (Race 1, 2, 3, 4, and 5) must be 99.

RACE 3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	162	2	SEER/CoC					181 - 182

Description
Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current *SEER Program Coding and Staging Manual*[3].

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf (Appendix G).

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Codes

01	White
02	Black

04 Chinese
05 Japanese
06 Filipino
07 Hawaiian
08 Korean
*
10 Vietnamese
11 Laotian
12 Hmong
13 Kampuchean (Cambodian)
14 Thai
15 Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16 Asian Indian
17 Pakistani
20 Micronesian, NOS
21 Chamorro/Chamoru
22 Guamanian, NOS
25 Polynesian, NOS
26 Tahitian
27 Samoan
28 Tongan
30 Melanesian, NOS
31 Fiji Islander
32 New Guinean
88 No further race documented
96 Other Asian, including Asian, NOS and Oriental, NOS
97 Pacific Islander, NOS
98 Other
99 Unknown
Blank Race 2-5 not coded

*Code 09 was retired effective with Version 12. See codes 15-17.

Note: If diagnosed prior to 2000 and any race code (Race 2, 3, 4, or 5) is blank, all subsequent race codes must be blank. If diagnosed after 1999 and any race code (for Race 2, 3, 4, and 5) is 88 (no further race documented), then all subsequent race codes also must be 88. If any race equals 99, then all race codes (Race 1, 2, 3, 4, and 5) must be 99.

RACE 4

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	163	2	SEER/CoC					183 - 184

Description
Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current *SEER Program Coding and Staging Manual*[3].

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf (Appendix G).

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Codes

01 White
02 Black
03 American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere).
04 Chinese
05 Japanese
06 Filipino
07 Hawaiian
08 Korean

10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani
20	Micronesian, NOS
21	Chamorro/Chamoru
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
88	No further race documented
96	Other Asian, including Asian, NOS and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown
Blank	Race 2-5 not coded

** Code 09 was retired effective with Version 12. See codes 15-17., Codes*

Note: If diagnosed prior to 2000 and any race code (Race 2, 3, 4, or 5) is blank, all subsequent race codes must be blank. If diagnosed after 1999 and any race code (for Race 2, 3, 4, and 5) is 88 (no further race documented), then all subsequent race codes also must be 88. If any race equals 99, then all race codes (Race 1, 2, 3, 4, and 5) must be 99.

RACE 5

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	164	2	SEER/CoC					185 - 186

Description
Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current *SEER Program Coding and Staging Manual*[3].

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf (Appendix G).

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

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Codes

01	White
02	Black
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
*	
10	Vietnamese
11	Laotian
12	Hmong

14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani
20	Micronesian, NOS
21	Chamorro/Chamoru
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
88	No further race documented
96	Other Asian, including Asian, NOS and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown
Blank	Race 2-5 not coded

*Code 09 was retired effective with Version 12. See codes 15-17.

Note: If diagnosed prior to 2000 and any race code (Race 2, 3, 4, or 5) is blank, all subsequent race codes must be blank. If diagnosed after 1999 and any race code (for Race 2, 3, 4, and 5) is 88 (no further race documented), then all subsequent race codes also must be 88. If any race equals 99, then all race codes (Race 1, 2, 3, 4, and 5) must be 99

RACE CODING SYS--CURRENT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	170	1	NAACCR					187 - 187

Description
Code that best describes how Race [160] currently is coded. If the data have been converted, this field shows the system to which it has been converted.

Rationale
Race 1 - 5 codes [160 - 164] have changed over time. To be able to accurately group and analyze the data, it is necessary to record the system used to record the race codes.

Codes

1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	SEER < 1988 (1-digit)
3	1988-1990 SEER & CoC (2-digit)
4	1991-1993 SEER & CoC (added codes 20-97, additional Asian and Pacific Islander codes)
5	1994-1999 SEER & CoC (added code 14, Thai)
6	2000+ SEER & CoC (added code 88 for Race 2, 3, 4, and 5)
7	2010+ SEER & CoC (added codes 15, 16, and 17; removed 09)
9	Other

RACE CODING SYS--ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	180	1	NAACCR					188 - 188

Description
Code that best describes how Race [160] originally was coded. If data have been converted, this field identifies the coding system originally used to code the case.

Rationale
Race 1 - 5 codes [160 - 164] have changed over time. Identifying both original and current coding systems used to code race promotes accurate data grouping and analysis.

9 Other
1 4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2 SEER < 1988 (1-digit)
3 1988-1990 SEER & CoC (2-digit)
4 1991-1993 SEER & CoC (added codes 20-97, additional Asian and Pacific Islander codes)
5 1994-1999 SEER & CoC (added code 14, Thai)
6 2000+ SEER & CoC (added code 88 for Race 2, 3, 4, and 5)
7 2010+ SEER & CoC (added codes 15, 16, and 17; removed 09)

RACE--NAPIIA(DERIVED API)

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Race--NAPIIA	193	2	NAACCR	2009	11.3			419 - 420

Description
NAPIIA is an acronym for NAACCR Asian and Pacific Islander Identification Algorithm. Race--NAPIIA(derived API) recodes some single-race cases with a Race 1 [160] code of 96 to a more specific Asian race category, based on an algorithm that makes use of the birthplace and name fields (first, last, and maiden names). For single-race cases with a Race 1 code other than 96, it returns the Race 1 code. Multiple-race cases (those with information in Race 2 through Race 5, [161-164]) are handled variously; for greater detail please refer to the technical documentation: http://www.naaccr.org/LinkClick.aspx?fileticket=3HnBhlmhkBs%3d&tabid=118&mid=458

In Version 1.1 of the algorithm, birthplace can be used to indirectly assign a specific race to one of eight Asian race groups (Chinese, Japanese, Vietnamese, Korean, Asian Indian, Filipino, Thai, and Cambodian), and names can be used to indirectly assign a specific race to one of seven Asian groups (Chinese, Japanese, Vietnamese, Korean, Asian Indian, Filipino, and Hmong). Subsequent versions of NAPIIA may incorporate Pacific Islanders and may potentially incorporate name lists for Thai, Cambodian, and Laotians.

Rationale
The use of more specific Asian and Pacific Islander codes will enhance surveillance and research activities focused on specific API subgroups.

Codes

01 White
02 Black
03 American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western Hemisphere)
04 Chinese
05 Japanese
06 Filipino
07 Hawaiian
08 Korean
*
10 Vietnamese
11 Laotian
12 Hmong
13 Kampuchean (Cambodian)
14 Thai
15 Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16 Asian Indian
17 Pakistani
20 Micronesian, NOS
21 Chamorro/Chamoru
22 Guamanian, NOS
25 Polynesian, NOS
26 Tahitian
27 Samoan
28 Tongan
30 Melanesian, NOS
31 Fiji Islander
32 New Guinean
96 Other Asian, including Asian, NOS and Oriental, NOS
97 Pacific Islander, NOS
98 Other
99 Unknown
Blank Algorithm was not run

RAD--BOOST DOSE CGY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Boost Radiation Dose: cGy	3210	5	CoC	2003	10			1611 - 1615

Description
Records the additional dose delivered to that part of the treatment volume encompassed by the boost fields or devices. The unit of measure is centiGray (cGy).

Rationale
To evaluate patterns of radiation oncology care, it is necessary to describe the boost radiation dose. A boost dose is administered to a volume within the regional volume. As in chemotherapy, outcomes are strongly related to the dose delivered.

Codes (In addition to value dose. Refer to the most recent version of *FORDS* for additional instructions.)

(Fill blanks)	Record the actual boost dose delivered
00000	Boost radiation therapy was not administered
88888	Not applicable, brachytherapy or radioisotopes administered to the patient
99999	Boost radiation therapy administered, boost dose unknown

RAD--BOOST RX MODALITY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Boost Radiation Treatment Modality	3200	2	CoC	2003	10			1609 - 1610

Description
Records the dominant modality of radiation therapy used to deliver the most clinically significant boost dose to the primary volume of interest during the first course of treatment. This is accomplished with external beam fields of reduced size (relative to the regional treatment fields), implants, stereotactic radiosurgery, conformal therapy, or intensity-modulated radiation therapy. External beam boosts may consist of two or more successive phases with progressively smaller fields, and they are generally coded as a single entity. This field is used with Rad--Regional RX Modality [1570].

Rationale
Radiation treatment frequently is delivered in two or more phases that can be summarized as regional and boost treatments. A boost dose is administered to a volume within the regional volume. For outcomes analysis, the modalities used for each of these phases can be very important

Codes

00	No boost treatment
20	External beam, NOS
21	Orthovoltage
22	Cobalt-60, Cesium-137
23	Photons (2-5 MV)
24	Photons (6-10 MV)
25	Photons (11-19 MV)
26	Photons (> 19 MV)
27	Photons (mixed energies)
28	Electrons
29	Photons and electrons mixed
30	Neutrons, with or without photons/electrons
31	IMRT
32	Conformal or 3-D therapy
40	Protons
41	Stereotactic radiosurgery, NOS
42	Linac radiosurgery
43	Gamma Knife
50	Brachytherapy, NOS
51	Brachytherapy, Intracavitary, LDR
52	Brachytherapy, Intracavitary, HDR
53	Brachytherapy, Interstitial, LDR
54	Brachytherapy, Interstitial, HDR
55	Radium
60	Radio-isotopes, NOS

62 Strontium - 90
98 Other, NOS
99 Unknown

RAD--LOCATION OF RX

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Location of Radiation Treatment (CoC)	1550	1	CoC					1606 - 1606

Description
Identifies the location of the facility where radiation treatment was administered during first course of treatment. See also RX Summ--Radiation [1360].

Codes

0 No radiation treatment
1 All radiation treatment at this facility
2 Regional treatment at this facility, boost elsewhere
3 Boost radiation at this facility, regional elsewhere
4 All radiation treatment elsewhere
8 Other, NOS
9 Unknown

RAD--NO OF TREATMENT VOL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Number of Treatments to this Volume (CoC)	1520	3	CoC					1601 - 1603

Description
Records the total number of treatment sessions (fractions) administered during the first course of therapy. See also RX--Treatment Volume [1540].

Codes

000 None
001-998 Number of treatments
999 Unknown

RAD--REGIONAL DOSE: CGY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Regional Dose: cGy (CoC)	1510	5	CoC					1596 - 1600

Description
The dominant or most clinically significant total dose of regional radiation therapy delivered to the patient during the first course of treatment. The unit of measure is centiGray (cGy). See also Rad--Regional RX Modality [1570].

Codes (in addition to actual doses)

(Fill spaces) Record the actual regional dose delivered
00000 Radiation therapy was not administered
88888 Not applicable, brachytherapy or radioisotopes administered to the patient
99999 Regional radiation therapy was administered, but the dose is unknown

RAD--REGIONAL RX MODALITY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Regional Treatment Modality (CoC)	1570	2	CoC					1607 - 1608

Description
Records the dominant modality of radiation therapy used to deliver the clinically most significant regional dose to the primary volume of interest during the first course of treatment.

Rationale

radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Codes

00 No radiation treatment
20 External beam, NOS
21 Orthovoltage
22 Cobalt-60, Cesium-137
23 Photons (2-5 MV)
24 Photons (6-10 MV)
25 Photons (11-19 MV)
26 Photons (> 19 MV)
27 Photons (mixed energies)
28 Electrons
29 Photons and electrons mixed
30 Neutrons, with or without photons/electrons
31 IMRT
32 Conformal or 3-D therapy
40 Protons
41 Stereotactic radiosurgery, NOS
42 Linac radiosurgery
43 Gamma Knife
50 Brachytherapy, NOS
51 Brachytherapy, Intracavitary, Low Dose Rate (LDR)
52 Brachytherapy, Intracavitary, High Dose Rate (HDR)
53 Brachytherapy, Interstitial, Low Dose Rate (LDR)
54 Brachytherapy, Interstitial, High Dose Rate (HDR)
55 Radium
60 Radio-isotopes, NOS
61 Strontium - 89
62 Strontium - 90
80* Combination modality, specified
85* Combination modality, NOS
98 Other, NOS
99 Unknown

Note: For tumors diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation administered to the patient as part or all of the first course of therapy.

*Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to *Volume II ROADS*, and *DAM* rules and should only be used to record regional radiation for tumors diagnosed prior to January 1, 2003.

RAD--TREATMENT VOLUME

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Radiation Treatment Volume (CoC)	1540	2	CoC					1604 - 1605

Description
Identifies the volume or anatomic target of the most clinically significant regional radiation therapy delivered to the patient during the first course of therapy. See also Rad--Regional RX Modality [1570].

Codes

00 No radiation therapy, not applicable
01 Eye/orbit
02 Pituitary
03 Brain (NOS)
04 Brain (limited)
05 Head and neck (NOS)
06 Head and neck (limited)
07 Glottis
08 Sinuses
09 Parotid
10 Chest/lung (NOS)

11 Lung (limited)
12 Esophagus
13 Stomach
14 Liver
15 Pancreas
16 Kidney
17 Abdomen (NOS)
18 Breast
19 Breast/lymph nodes
20 Chest wall
21 Chest wall/lymph nodes
22 Mantle, mini-mantle
23 Lower extended field
24 Spine
25 Skull
26 Ribs
27 Hip
28 Pelvic bones
29 Pelvis (NOS)
30 Skin
31 Soft tissue
32 Hemibody
33 Whole body
34 Bladder and pelvis
35 Prostate and pelvis
36 Uterus and Cervix
37 Shoulder
38 Extremities bone, NOS
39 Inverted Y
40 Spinal cord
41 Prostate
50 Thyroid
60 Lymph node region, NOS
98 Other
99 Unknown

READM SAME HOSP 30 DAYS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Readmission to the Same Hospital Within 30 Days of Surgical Discharge	3190	1	CoC	2003	10			1619 - 1619

Description
Records a readmission to the same hospital within 30 days of discharge following hospitalization for surgical resection of the primary site for the same illness.

Rationale
This data item provides information related to the quality of care. A patient may have a readmission related to the primary diagnosis on discharge if the length of stay was too short, and then needed to return due to problems or complications. A patient may also need to be readmitted if discharge planning and/or follow-up instructions were ineffective. It is important to distinguish a planned from an unplanned readmission, since a planned readmission is not an indicator of quality of care problems.

Codes

0 No surgical procedure of the primary site was performed. Patient not readmitted to the same hospital within 30 days of discharge.
1 Patient was surgically treated and was then readmitted to the same hospital within 30 days of being discharged. This readmission was unplanned.
2 Patient was surgically treated and was then readmitted to the same hospital within 30 days of being discharged. This readmission was planned (chemotherapy port insertion, revision of colostomy, etc.).
3 Patient was surgically treated and, within 30 days of being discharged, had both a planned and an unplanned readmission to the same hospital.
9 It is unknown whether surgery of the primary site was recommended or performed. It is unknown whether the patient was readmitted to the same hospital within 30 days of discharge. Death certificate only.

REASON FOR NO RADIATION

Alternate Name	Item #	Length	Standard	Implemented	Implemented	Retired	Retired	Column #
Reason for No Regional Radiation Therapy	1430	1	CoC					1592 - 1592

Description
Code the reason the patient did not receive radiation treatment as part of first course of therapy. See also RX--Regional RX Modality [1570].

Codes

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

REASON FOR NO SURGERY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Reason for No Cancer-Directed Surgery (SEER) Reason for No CA Dir Surgery (CoC) Reason for No Surgery to Primary Site	1340	1	SEER/CoC					1576 - 1576

Description
Records the reason that no surgery was performed on the primary site.

Rationale
This data item provides information related to the quality of care and describes why primary site surgery was not performed.

Codes

0 Surgery of the primary site was performed.
1 Surgery of the primary site was not performed because it was not part of the planned first-course treatment.
2 Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.).
5 Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6 Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first-course therapy. No reason was noted in the patient's record.
7 Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8 Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9 It is unknown if surgery of the primary site was recommended or performed. Death certificate-only cases and autopsy-only cases.

RECORD TYPE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	10	1	NAACCR		pre V4			1 - 1

Description
Generated field that identifies which of the six NAACCR data exchange record types is being used in a file of data exchange records. A file should have records of only one type.

Codes

I **I**ncidence-only record type nonconfidential coded data) Length = 3339
C **C**onfidential record type(incidence record plus confidential data) Length = 5564
A Full case **A**bstract record type(incidence and confidential data plus text summaries; used for reporting to central registries) Length = 22824
U Correction/**U**pdate record type short format record used to submit corrections to data already submitted) Length = 1543
M Record **M**odified since previous submission to central registry (identical in format to the “A” record type) Length = 22824
L Pathology **L**aboratory

RECURRENCE DATE--1ST

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date of First Recurrence (CoC)	1860	8	CoC					2196 - 2203

Description
The date of the first recurrence of this tumor. See Chapter X for date format.

RECURRENCE DATE--1ST FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1861	2	NAACCR	2010	12			2204 - 2205

Description
This flag explains why no appropriate value is in the field, Recurrence Date--1st [1860].

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g, unknown if the patient had a first recurrence)
11	No proper value is applicable in this context (e.g., patient became disease-free after treatment; never had a recurrence; or patient was never disease-free; autopsy only case)
12	A proper value is appicable but not known (i.e., there was a recurrence, but the date is unknown)
Blank	A valid date value is provided in item Recurrence Date--1st [1860], or the date was not expected to have been transmitted

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RECURRENCE TYPE--1ST

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Type of First Recurrence (CoC)	1880	2	CoC					2206 - 2207

Description
Code for the type of first recurrence after a period of documented disease free intermission or remission.

Codes

00	Patient became disease-free after treatment and has not had a recurrence; leukemia in remission.
04	*In situ* recurrence of an invasive tumor.
06	*In situ* recurrence of an *in situ* tumor.
10	Local recurrence and there is insufficient information available to code to 13-17. Recurrence is confined to the remnant of the organ of origin; to the organ of origin; to the anastomosis; or to scar tissue where the organ previously existed.
13	Local recurrence of an invasive tumor.
14	Trocar recurrence of an invasive tumor. Includes recurrence in the trocar path or entrance site following prior surgery.
15	Both local and trocar recurrence of an invasive tumor (both 13 and 14)
16	Local recurrence of an *in situ* tumor.
17	Both local and trocar recurrence of an *in situ* tumor.
20	Regional recurrence, and there is insufficient information available to code to 21-27.
21	Recurrence of an invasive tumor in adjacent tissue or organ(s) only.
22	Recurrence of an invasive tumor in regional lymph nodes only.
25	Recurrence of an invasive tumor in adjacent tissue or organ(s) and in regional lymph nodes (both 21 and 22) at the same time.
26	Regional recurrence of an *in situ* tumor, NOS.
27	Recurrence of an *in situ* tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time.
30	Both regional recurrence of an invasive tumor in adjacent tissue or organ(s) and/or regional lymph nodes (20-25) and local and/or trocar recurrence (10, 13, 14, or 15).
36	Both regional recurrence of an *in situ* tumor in adjacent tissue or organ(s) and/or regional lymph nodes (26 or 27) and local and/or trocar recurrence (16 or 17).
40	Distant recurrence and there is insufficient information available to code to 46-62.
46	Distant recurrence of an *in situ* tumor.
51	Distant recurrence of an invasive tumor in the peritoneum only. Peritoneum includes peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
52	Distant recurrence of an invasive tumor in the lung only. Lung includes the visceral pleura.
53	Distant recurrence of an invasive tumor in the pleura only. Pleura includes the pleural surface of all structures within the thoracic cavity

54 Distant recurrence of an invasive tumor in the liver only.
55 Distant recurrence of an invasive tumor in bone only. This includes bones other than the primary site.
56 Distant recurrence of an invasive tumor in the CNS only. This includes the brain and spinal cord, but not the external eye.
57 Distant recurrence of an invasive tumor in the skin only. This includes skin other than the primary site.
58 Distant recurrence of an invasive tumor in lymph node only. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site.
59 Distant systemic recurrence of an invasive tumor only. This includes leukemia, bone marrow metastasis, carcinomatosis, and generalized disease.
60 Distant recurrence of an invasive tumor in a single distant site (51-58) and local, trocar, and/or regional recurrence (10-15, 20-25, or 30).
62 Distant recurrence of an invasive tumor in multiple sites (recurrences that can be coded to more than one category 51-59).
70 Since diagnosis, patient has never been disease-free. This includes cases with distant metastasis at diagnosis, systemic disease, unknown primary, or minimal disease that is not treated.
88 Disease has recurred, but the type of recurrence is unknown.
99 It is unknown whether the disease has recurred or if the patient was ever disease-free.

REGIONAL NODES EXAMINED

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Number of Regional Lymph Nodes Examined (SEER) Regional Lymph Nodes Examined Pathologic Review of Regional Lymph Nodes (SEER)	830	2	SEER/CoC					916 - 917

Description
Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system.

Rationale
This data item serves as a quality measure of the pathologic and surgical evaluation and treatment of the patient.

Codes

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

REGIONAL NODES POSITIVE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Pathologic Review of Regional Lymph Nodes (SEER) Regional Lymph Nodes Positive Number of Positive Regional Lymph Nodes (SEER)	820	2	SEER/CoC					914 - 915

Description
Records the exact number of regional nodes examined by the pathologist and found to contain metastases. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system. For tumors diagnosed from 1988 through 2003, this item was part of the 10-digit EOD [779], detailed site-specific codes for anatomic EOD.

Rationale
This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient.

Codes

00 All nodes examined are negative
01-89 1-89 nodes are positive (code exact number of nodes positive)

95 Positive aspiration of lymph node(s) was performed
97 Positive nodes are documented, but the number is unspecified
98 No nodes were examined
99 It is unknown whether nodes are positive; not applicable; not stated in patient record

Note: See Chapter V, Unresolved Issues, for a discussion of coding differences between CoC and SEER.

REGISTRY ID

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	40	10	NAACCR					30 - 39

Description
A unique code that represents the data transmission source. This item should be used for central registries and non-US health care providers. Refer to Registry ID table in Appendix B.

For cases diagnosed on or after 2008, this item may be blank if NPI--Registry ID (item 45) is used to represent the data transmission source.

Rationale
Used to track data submission flow and to resolve transmission issues.

Codes (in addition to CoC assigned codes or NAACCR assigned codes)

0000000000 Case not reported by a facility
0099999999 Case reported, but facility number is unknown

Note: Prior to 2008, this field may contain data from reporting facilities.

REGISTRY TYPE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	30	1	NAACCR					2 - 2

Description
A computer-generated code that best describes the type of registry generating the record; used when cases are pooled from multiple registries (a hospital-based registry reporting to a state should have a "3" in this field).

Rationale
Facilitates tracking of data sources when data from multiple registries are pooled.

Codes

1 Central registry (population-based)
2 Central registry or hospital consortium (not population-based)
3 Single hospital/freestanding center

REPORTING FACILITY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Facility Identification Number (CoC) Reporting Hospital Institution ID Number (CoC)	540	10	CoC					701 - 710

Description
CoC code for the facility whose data are described in the record.

Rationale
The Reporting Facility identification number or FIN is used to identify a reporting facility in the central registry database and is useful for monitoring data submission, ensuring the accuracy of data and identifying areas for special studies.

Codes (in addition to CoC assigned codes)

0000000000 Case not reported by a facility
0099999999 Case reported, but facility number is unknown

A listing of valid FINs can be found at http://www.facs.org/cancer/coc/fin.html.

Note: When this special code is being used, the length in 9s should correspond to the length indicated by the code in FIN coding system [35]. The 9s must be right justified in the field, and the remaining spaces should be filled with leading zeroes to a total length of 10.

RESERVED 00

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	37	14		2011	12.2			3 - 16

RESERVED 01

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	370	37		2011	12.2			58 - 94

RESERVED 02

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	530	50		2011	12.2			478 - 527

RESERVED 03

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	680	100		2011	12.2			591 - 690

RESERVED 04

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	750	30		2011	12.2			804 - 833

RESERVED 05

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1180	55		2011	12.2			1381 - 1435

RESERVED 06

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1190	100		2011	12.2			1624 - 1723

RESERVED 07

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1300	100		2011	12.2			1788 - 1887

RESERVED 08

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1650	80		2011	12.2			2036 - 2115

RESERVED 09

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1740	14		2011	12.2			2326 - 2339

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1835	200		2011	12.2			4085 - 4284

RESERVED 11

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1900	50		2011	12.2			4345 - 4394

RESERVED 12

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2510	50		2011	12.2			4485 - 4534

RESERVED 13

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2080	500		2011	12.2			5065 - 5564

RESERVED 14

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2210	2000		2011	12.2			20825 - 22824

RESERVED 15

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2400	1		2011	12.2			780 - 780

RESERVED 16

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2450	1		2011	12.2			788 - 788

RESERVED 17

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2700	1		2013	13			2195 - 2195

RESERVED 18

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2161	1		2013	13			1595 - 1595

RESERVED 19 **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2162	1		2016	16			957 - 957

Codes

RESERVED 20 **New**

			Source of	Year	Version	Year	Version	

	2163	1						975 - 975

Codes

RURALURBAN CONTINUUM 1993

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Beale Code	3300	2	NAACCR	2003	10			424 - 425

Description
The RuralUrban Continuum (1993) codes (usually known as the Beale Codes) separate counties into four metropolitan and six non-metropolitan categories, based on the size their populations and form a classification scheme that distinguishes metropolitan counties by size and non-metropolitan counties by degree of urbanization and proximity to metro areas.

These codes can be derived electronically, using patients' state and county at diagnosis, so registrars do not need to provide them. FIPS state and county code mappings to Beale Codes can be obtained in an Excel file at http://www.ers.usda.gov/data-products/rural-urban-continuum-codes.aspx .

The code is a 10-point continuum, transmitted in standard NAACCR record form with a leading 0, (00-09). Abstractors do not enter these codes. Areas that are not included in the Rural-Urban Continuum code table, such as Canadian provinces/territories and U.S. territories (other than Puerto Rico) will be coded 98. Records for non-residents of the state of the reporting institution (County at DX = 998) also will be coded 98. If Addr at DX--State is XX, YY or ZZ, or if County at DX = 999, the Rural-Urban Continuum will be coded 99.

Rationale
Categorizing counties by population size helps researchers investigate geographic correlates of the burden of cancer in the area of interest.

Codes

Metropolitan Counties (00-03)	
00	Central counties of metropolitan areas of 1 million population or more
01	Fringe counties of metropolitan areas of 1 million population or more
02	Counties in metropolitan areas of 250,000-1,000,000 population
03	Counties in metropolitan areas of less than 250,000 population
Nonmetropolitan Counties (04-09)	
04	Urban population of 20,000 or more, adjacent to a metropolitan area
05	Urban population of 20,000 or more, not adjacent to a metropolitan area
06	Urban population of 2,500-19,999, adjacent to a metropolitan area
07	Urban population of 2,500-19,999, not adjacent to a metropolitan area
08	Completely rural (no places with a population of 2,500 or more) adjacent to a metropolitan area
09	Completely rural (no places with a population of 2,500 or more) not adjacent to a metropolitan area
98	Program run, but: (1) area is not included in Rural-Urban Continuum code table, or (2) record is for resident outside of state of reporting institution
99	Unknown
Blank	Program not run; record not coded

RURALURBAN CONTINUUM 2003

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Beale Code RuralUrban Continuum 2000	3310	2	NAACCR	2003	10			426 - 427

Description
The RuralUrban Continuum (2003) codes (usually known as the Beale Codes) separate counties into four metropolitan and six non-metropolitan categories, based on the size their populations and form a classification scheme that distinguishes metropolitan counties by size and non-metropolitan counties by degree of urbanization and proximity to metro areas.

These codes can be derived electronically, using patients' state and county at diagnosis, so registrars do not need to provide them. FIPS state and county code mappings to Beale Codes can be obtained in an Excel file at http://www.ers.usda.gov/data-products/rural-urban-continuum-codes.aspx.

The code is a 9-point continuum, transmitted in standard NAACCR record form with a leading 0, (01-09). Abstractors do not enter these codes.

Areas that are not included in the Rural-Urban Continuum code table, such as Canadian provinces/territories and U.S. territories (other than Puerto Rico) will be coded 98. Records for non-residents of the state of the reporting institution (County at DX = 998) also will be coded 98. If Addr at

Rationale
Categorizing counties by population size helps researchers investigate geographic correlates of the burden of cancer in the area of interest.

Codes

Metropolitan Counties (01-03)	
01	Counties in metro areas of 1 million population or more
02	Counties in metro areas of 250,000 to 1 million population
03	Counties in metro areas of fewer than 250,000 population
Metropolitan Counties (01-03)	
04	Urban population of 20,000 or more, adjacent to a metro area
05	Urban population of 20,000 or more, not adjacent to a metro area
06	Urban population of 2,500 to 19,999, adjacent to a metro area
07	Urban population of 2,500 to 19,999, not adjacent to a metro area
08	Completely rural or less than 2,500 urban population, adjacent to a metro area
09	Completely rural or less than 2,500 urban population, not adjacent to a metro area
98	Program run, but: (1) area is not included in Rural-Urban Continuum code table, or (2) record is for resident outside of state of reporting institution
99	Unknown
Blank	Program not run; record not coded
Metropolitan Counties (01-03)	

RURALURBAN CONTINUUM 2013 **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3312	2	NAACCR	2016	16			476 - 477

Description
Comment: The RuralUrban Continuum (2013) codes separate counties into four metropolitan and six non-metropolitan categories, based on the size their populations and form a classification scheme that distinguishes metropolitan counties by size and non-metropolitan counties by degree of urbanization and proximity to metro areas.

These codes can be derived electronically, using patients' state and county at diagnosis, so registrars do not need to provide them. FIPS state and county code mappings to Beale Codes can be obtained in an Excel file athttp://www.ers.usda.gov/Data/RuralUrbanContinuumCodes.

The code is a 9-point continuum, transmitted in standard NAACCR record form with a leading 0, (01-09). Abstractors do not enter these codes.

Areas that are not included in the Rural-Urban Continuum code table, such as Canadian provinces/territories and U.S. territories (other than Puerto Rico) will be coded 98. Records for non-residents of the state of the reporting institution (County at DX = 998) also will be coded 98. If Addr at DX–State is XX, YY or ZZ, or if County at DX = 999, the Rural-Urban Continuum will be coded 99.

Rationale
Categorizing counties by population size helps researchers investigate geographic correlates of the burden of cancer in the area of interest.

Codes

Metropolitan Counties (00-03)	
01	Counties in metro areas of 1 million population or more
02	Counties in metro areas of 250,000 to 1 million population
03	Counties in metro areas of fewer than 250,000 population
Nonmetropolitan Counties (04-09)	
04	Urban population of 20,000 or more, adjacent to a metro area
05	Urban population of 20,000 or more, not adjacent to a metro area
06	Urban population of 2,500 to 19,999, adjacent to a metro area
07	Urban population of 2,500 to 19,999, not adjacent to a metro area
08	Completely rural or less than 2,500 urban population, adjacent to a metro area
09	Completely rural or less than 2,500 urban population, not adjacent to a metro area
98	Program run, but: (1) area is not included in Rural-Urban Continuum code table, or (2) record is for resident outside of state of reporting institution
99	Unknown
Blank	Program not run; record not coded

RX CODING SYSTEM--CURRENT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1460	2	NAACCR					1593 - 1594

Description
Code describing how treatment for this tumor now is coded.

Codes

00 Treatment data not coded/transmitted (i.e., all treatment fields [items 1200-1450 and 1500-1645] blank)
01 Treatment data coded using 1-digit surgery codes (obsolete)
02 Treatment data coded according to 1983-1992 SEER manuals and 1983-1995 CoC manuals
03 Treatment data coded according to 1996 *ROADS Manual*
04 Treatment data coded according to 1998 *ROADS* Supplement
05 Treatment data coded according to 1998 *SEER Manual*
06 Treatment data coded according to *FORDS* manual
07 Treatment data coded according to 2010 SEER Coding Manual
99 Other coding, including partial or nonstandard coding

RX DATE BRM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date Immunotherapy Started (CoC) RX Date--BRM	1240	8	CoC					1536 - 1543

Description
Date of initiation for immunotherapy (a.k.a. biological response modifier) that is part of the first course of treatment. See also RX Summ--BRM [1410]. See Chapter X for date format.

Formerly RX Date--BRM.

Rationale
The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first course of therapy and to reconstruct the sequence of first-course treatment modes.

Note: CoC discontinued support of this item from 2003 through 2009.

RX DATE BRM FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
RX Date--BRM Flag	1241	2	NAACCR	2010	12			1544 - 1545

Description
This flag explains why no appropriate value is in the field, RX Date BRM [1240].

Formerly RX Date--BRM Flag.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10 No information whatsoever can be inferred from this exceptional value (e.g, unknown if immunotherapy administered).
11 No proper value is applicable in this context (e.g., no immunotherapy administered; autopsy only case).
12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., immunotherapy administered but date is unknown).
15 Information is not available at this time, but it is expected that it will be available later (e.g., immune therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank A valid date value is provided in item RX Date BRM [1240], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE CHEMO

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date Chemotherapy Started (CoC) RX Date--Chemo	1220	8	CoC					1516 - 1523

Description
Date of initiation of chemotherapy that is part of the first course of treatment. See also RX Summ--Chemo [1390]. See Chapter X for date format.

Formerly RX Date--Chemo.

Rationale
The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

Note: CoC discontinued support of this item from 2003 through 2009.

RX DATE CHEMO FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
RX Date--Chemo Flag	1221	2	NAACCR	2010	12			1524 - 1525

Description
This flag explains why no appropriate value is in the field, RX Date Chemo [1220].

Formerly RX Date--Chemo Flag

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if chemotherapy administered).
11	No proper value is applicable in this context (e.g., no chemotherapy administered; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date Chemo [1220], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE DX/STG PROC

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date of Non Cancer-Directed Surgery (CoC) Date of Diagnostic, Staging or Palliative Procedures (1996-2002) Date of Surgical Diagnostic and Staging Procedure (CoC) RX Date--DX/Stg/Pall Proc RX Date--DX/Stg Proc	1280	8	CoC					1556 - 1563

Description
Records the date on which the surgical diagnostic and/or staging procedure was performed. See Surgical and Diagnostic Staging Procedure [1350]. See Chapter X for date format.

Formerly RX Date--DX/Stg Proc.

Note: This is a CoC item and for tumors diagnosed from January 1, 1996, through December 31, 2002, this may have been the date on which diagnostic, staging, and palliative procedures were performed. Beginning with tumors diagnosed on or after January 1, 2003, palliative procedures are collected in RX Summ--Palliative Proc [3270] and RX Hosp--Palliative Proc [3280].

RX DATE DX/STG PROC FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
RX Date--Dx/Stg Proc Flag	1281	2	NAACCR	2010	12			1564 - 1565

Description
This flag explains why no appropriate value is in the field, RX Date DX/Stg Proc [1280].

Formerly RX Date--Dx/Stg Proc Flag.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g, unknown if any diagnostic or staging procedure performed).
11	No proper value is applicable in this context (e.g., no diagnostic or staging procedure performed; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., diagnostic or staging procedure performed but date is unknown).
Blank	A valid date value is provided in item RX Date DX/Stg Proc [1280], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE HORMONE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date Hormone Therapy Started (CoC) RX Date--Hormone	1230	8	CoC					1526 - 1533

Description
Date of initiation for hormone therapy that is part of the first course of treatment. See also RX Summ--Hormone [1400]. See Chapter X for date format.

Formerly RX Date--Hormone.

Rationale
The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

Note: CoC discontinued support of this item from 2003 through 2009.

RX DATE HORMONE FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
RX Date--Hormone Flag	1231	2	NAACCR	2010	12			1534 - 1535

Description
This flag explains why no appropriate value is in the field, RX Date Hormone [1230].

Formerly RX Date--Hormone Flag.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any hormone therapy administered).
11	No proper value is applicable in this context (e.g., no hormone therapy administered; autopsy only cases).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., hormone therapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., hormone therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date Hormone [1230], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE MST DEFN SRG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #

the Primary Site RX Date--Most Defin Surg								

Description
Date of most definitive surgical resection of the primary site performed as part of the first course of treatment. See Chapter X for date format. Use RX DATE MST DEFN SRG FLAG [3171] if there is no appropriate or known date for this item.

Formerly RX Date--Most Defin Surg.

Rationale
This item is used to measure lag time between diagnosis and the most definitive surgery of the primary site or survival following the procedure. It also is used in conjunction with RX Date Surg Disch [3180] to calculate the duration of hospitalization following the most definitive primary site surgical procedure to evaluate treatment efficacy.

RX DATE MST DEFN SRG FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3171	2	NAACCR	2010	12			1474 - 1475

Description
This flag explains why no appropriate value is in the field, RX Date Mst Defn Srg [3170].

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value. (e.g, unknown if any surgical procedure of the primary site was performed).
11	No proper value is applicable in this context (e.g., no surgical resection of the primary site was performed and for cases diagnosed at autopsy).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., surgical procedure of the primary site was performed but the date is unknown).
Blank	A valid date value is provided in item RX Date Mst Defn Srg [3170], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE OTHER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date Other Treatment Started (CoC) RX Date--Other	1250	8	CoC					1546 - 1553

Description
Date of initiation for other treatment that is part of the first course of treatment at any facility. See RX Summ--Other [1420]. See Chapter X for date format.

Formerly RX Date--Other.

Rationale
The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

RX DATE OTHER FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
RX Date--Other Flag	1251	2	NAACCR	2010	12			1554 - 1555

Description
This flag explains why no appropriate value is in the field, RX Date Other [1250].

Formerly RX Date--Other Flag.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g, unknown if other therapy administered).
11	No proper value is applicable in this context (e.g., no other treatment administered; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., other therapy administered but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., other therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date Other [1250], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE RAD ENDED

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date Radiation Ended RX Date--Radiation Ended	3220	8	CoC	2003	10			1496 - 1503

Description
The date on which the patient completes or receives the last radiation treatment at any facility. See Chapter X for date format. Use RX DATE RAD ENDED FLAG [3221] if there is no appropriate or known date for this item.

Formerly RX Date--Radiation Ended.

Rationale
The length of time over which radiation therapy is administered to a patient is a factor in tumor control and treatment morbidity. It is useful in evaluating the quality-of-care and the success of patient support programs designed to maintain continuity of treatment.

RX DATE RAD ENDED FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3221	2	NAACCR	2010	12			1504 - 1505

Description
This flag explains why no appropriate value is in the field, RX Date Rad Ended [3220].

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if radiation therapy administered).
11	No proper value is applicable in this context (e.g., radiation therapy was not administered; diagnosed at autopsy).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., date radiation ended is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., radiation was administered and was ongoing at the time of most recent follow-up).
Blank	A valid date value is provided in item RX Date Rad Ended [3220], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE RADIATION

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date Radiation Started (CoC) RX Date--Radiation	1210	8	CoC					1486 - 1493

Description
Records the date on which radiation therapy began at any facility that is part of the first course of treatment. See Chapter X for date format. Use RX DATE RADIATION FLAG [1211] if there is no appropriate or known date for this item.

Formerly RX Date--Radiation

Rationale
The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

RX DATE RADIATION FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
RX Date--Radiation Flag	1211	2	NAACCR	2010	12			1494 - 1495

Description
This flag explains why no appropriate value is in the field, RX Date Radiation [1210].

Formerly RX Date--Radiation Flag.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown whether any radiation therapy administered).
11	No proper value is applicable in this context (e.g., no radiation therapy administered; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., radiation therapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date Radiation [1210], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE SURG DISCH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date of Surgical Discharge RX Date--Surgical Disch	3180	8	CoC	2003	10			1476 - 1483

Description
Records the date the patient was discharged following primary site surgery. The date corresponds to the event recorded in RX Date Mst Defn Srg [3170]. See Chapter X for date format. Use RX DATE SURG DISCH FLAG [3181] if there is no appropriate or known date for this item.

Formerly RX Date--Surgical Disch.

Rationale
Length of stay is an important quality-of-care and financial measure among hospital administrations, those who fund public and private health care, and public health users. This date, in conjunction with the data item RX Date Mst Defn Srg [3170], will allow for the calculation of a patient's length of hospitalization associated with primary site surgery.

RX DATE SURG DISCH FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3181	2	NAACCR	2010	12			1484 - 1485

Description
This flag explains why no appropriate value is in the field, RX Date Surg Disch [3180].

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown whether surgical treatment was performed).
11	No proper value is applicable in this context (e.g., no surgical treatment of the primary site was performed; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., surgical treatment performed but the date of discharge is unknown).
Blank	A valid date value is provided in item RX Date Surg Disch [3180], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE SURGERY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date of Cancer-Directed Surgery (CoC) Date of Surgery Date of First Surgical Procedure (CoC) RX Date--Surgery	1200	8	CoC					1456 - 1463

Description
Date the first surgery of the type described under Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes was performed. See also RX Summ--Surg Prim Site [1290], RX Summ--Scope Reg LN Sur [1292], and RX Summ--Surg Oth Reg/Dis [1294]. See Chapter X for date format.

Formerly RX Date--Surgery.

Rationale
The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

RX DATE SURGERY FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
RX Date--Surgery Flag	1201	2	NAACCR	2010	12			1464 - 1465

Description
This flag explains why no appropriate value is in the field, RX Date Surgery [1200].

Formerly RX Date--Surgery Flag.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any surgical procedure site was performed).
11	No proper value is applicable in this context (e.g., no surgical procedure was performed; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., surgery was performed but the date is unknown).
Blank	A valid date value is provided in item RX Date Surgery [1200], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE SYSTEMIC

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Date Systemic Therapy Started RX Date--Systemic	3230	8	CoC	2003	10			1506 - 1513

Description
Date of initiation of systemic therapy that is part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormone agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy. See Chapter X for date format. Use RX DATE SYSTEMIC FLAG [3231] if there is no appropriate or known date for this item.

Formerly RX Date--Systemic.

Rationale
Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

RX DATE SYSTEMIC FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #

	3231	2	NAACCR	2010	12			1514 - 1515

Description
This flag explains why no appropriate value is in the field, RX Date Systemic [3230].

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if systemic therapy was administered).
11 No proper value is applicable in this context (e.g., no systemic therapy was administered; autopsy only case).
12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., systemic therapy administered but date is unknown).
15 Information is not available at this time, but it is expected that it will be available later (e.g., systemic therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank A valid date value is provided in item RX Date Systemic [3230], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX HOSP--BRM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Immunotherapy at this Facility (CoC)	720	2	CoC					794 - 795

Description
Records whether immunotherapeutic agents (biologic response modifiers) were administered as first-course treatment at this facility or the reason they were not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Rationale
Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of immunotherapeutic agents given as part of the first course of therapy. Furthermore, it is useful to know the reason immunotherapy was not administered when evaluating quality of care.

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Note: Prior to 2013, targeted therapies that invoke an immune response, such as Herceptin, had been coded as chemotherapy. Effective with cases diagnosed January 1, 2013, and forward these therapies are classified as biological response modifiers. Coding instructions for these changes have been added to the remarks field for the applicable drugs in the SEER*RX Interactive Drug Database (http://seer.cancer.gov/tools/seerrx/).

Codes (Refer to the most recent *FORDS* and SEER Rx for complete coding instructions.)

00 None, immunotherapy was not part of the planned first course of therapy; not customary therapy for this cancer. Diagnosed at autopsy.
01 Immunotherapy administered as first course therapy.
82 Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.) or there was progression of disease prior to administration.
85 Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86 Immunotherapy was not administered. It was recommended by the patient's physician but was not administered as part of the first-course of therapy. No reason was noted in the patient record.
87 Immunotherapy was not administered. It was recommended by the patient's physician but was refused by the patient or the patient's family or guardian. The refusal was noted in the patient record.
88 Immunotherapy was recommended, but it is unknown if it was administered.
99 It is unknown if immunotherapy was recommended or administered because it was not stated in the patient record. Death certificate-only case.

Note: For tumors diagnosed on or after January 1, 2003, information on bone marrow and stem cell transplants is no longer coded under this item. *ROADS* codes 02-06 should not be used in this field. For diagnosed on or after January 1, 2003, this information should be coded in the new field RX SUMM--Transplnt/Endocr [3250].

RX HOSP--CHEMO

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Chemotherapy at this Facility (CoC)	700	2	CoC					790 - 791

Description
Records the type of chemotherapy administered at the reporting facility as a part of first course therapy or the reason chemotherapy was not given.

Rationale
Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of chemotherapeutic agents given as part of the first course of therapy. Furthermore, it is useful to know the reason chemotherapy was not administered when evaluating quality of care.

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Note: Prior to 2013, targeted therapies that invoke an immune response, such as Herceptin, had been coded as chemotherapy. Effective with cases diagnosed January 1, 2013, and forward these therapies are classified as biological response modifiers. Coding instructions for these changes have been added to the remarks field for the applicable drugs in the SEER*RX Interactive Drug Database (http://seer.cancer.gov/tools/seerrx/).

Codes (Refer to the most recent *FORDS* and SEER RX for additional complete coding directions.)

00 None, chemotherapy was not part of the first course of therapy or there was progression of disease prior to administration; Not customary therapy for this cancer. Diagnosed at autopsy.
01 Chemotherapy was administered, but type and number of agents is not documented in patient record.
02 Chemotherapy, single agent.
03 Chemotherapy, multiple agents.
82 Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age) or there was progression of disease prior to planned administration.
85 Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86 Chemotherapy was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87 Chemotherapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88 Chemotherapy was recommended, but it is unknown if it was administered.
99 It is unknown whether chemotherapy was recommended or administered because it is not stated in patient record. Death certificate-only case

RX HOSP--DX/STG PROC

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Non Cancer-Directed Surgery at this Facility (CoC) Surgical Diagnostic & Staging Procedure at this Facility (1996-2002) RX Hosp--DX/Stg/Pall Proc	740	2	CoC					797 - 798

Description
Identifies the surgical procedure(s) performed in an effort to diagnose and/or stage disease at this facility.

Rationale
This data item is used to track the use of surgical procedure resources that are not considered treatment.

If central registries wish to study the procedures performed at particular facilities, the facility-level fields must be used. The summary fields, conversely, combine information for all facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and diagnostic/staging procedures by type of healthcare setting. Knowing what part of the diagnostic or staging process was performed at a particular facility also helps resolve consolidation issues.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)

00 No surgical diagnostic or staging procedure was performed.
01 A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02 A biopsy (incisional, needle, or aspiration) was done of the primary site or biopsy of a lymph node was done to diagnose or stage lymphoma.
03 A surgical exploration only. The patient was not biopsied or treated during the procedure.
04 A surgical procedure with a bypass was performed, but no biopsy was done.
05 An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06 A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07 A procedure was done, but the type of procedure is unknown.
09 No information about whether a diagnostic or staging procedure was performed.

Note: This item has been used for tumors diagnosed in 1996 and later. For cases diagnosed before 1996, this item may have been converted from the *DAM*, and cases with surgery would have been converted to 09 in this field. For cases diagnosed between 1996 and 2002, this field may have described palliative care according to coding rules in *ROADS*. For tumors diagnosed on or after January 1, 2003, palliative care is coded in a new

RX HOSP--HORMONE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Hormone Therapy at this Facility (CoC)	710	2	CoC					792 - 793

Description
Records whether systemic hormonal agents were administered as first-course treatment at this facility or the reason they were not given. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Rationale
Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of hormonal agents given as part of the first course of therapy. Furthermore, it is useful to know the reason hormone therapy was not administered when evaluating quality of care for certain tumors.

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all reporting facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)

00 None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01 Hormone therapy was administered as first course therapy.
82 Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age) or there was progression of disease prior to administration.
85 Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86 Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87 Hormone therapy was not administered. It was recommended by the patient's physician, but was refused by the patient, or the patient's family member or guardian. The refusal was noted in the patient record.
88 Hormone therapy was recommended, but it is unknown if it was administered.
99 It is unknown whether hormone therapy was recommended or administered because it is not stated in the patient record; death certificate-only cases.

Note: Codes 02-03 entered under the *ROADS* rules for tumors diagnosed prior to January 1, 2003, should have been converted to the appropriate code in the new field RX SUMM--Transplnt/Endocr [3250] implemented with *FORDS*. Endocrine surgery and endocrine radiation therapy are no longer coded as Hormone Therapy for tumors diagnosed on or after January 1, 2003.

RX HOSP--OTHER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Other Treatment at this Facility (CoC)	730	1	CoC					796 - 796

Description
Identifies treatment given at this facility that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. 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. Supportive care such as phlebotomy, transfusions, or aspirin may be recorded for hematopoietic diseases ONLY.

Rationale
Information on other therapy is used to describe treatment practices and evaluate quality of care. If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all reporting facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes

0 None; all cancer treatment was coded in other treatment fields. Patient received no cancer treatment. Diagnosed at autopsy.
1 Cancer treatment that cannot be assigned to specified treatment data items.
2 Other-Experimental; this code is not defined. It may be used to record participation in institution-based clinical trials.
3 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. Treatment listed in code 1, 2 or 3 was recommended by the patient's physician but was refused by the patient or the patient's family or 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.

case.

RX HOSP--PALLIATIVE PROC

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Palliative Care at this Facility Palliative Procedure at this Facility	3280	1	CoC	2003	10			799 - 799

Description
Identifies care provided at the reporting facility in an effort to palliate or alleviate symptoms. Palliative procedures may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or pain management.

Rationale
This data item allows reporting facilities to track care that is considered palliative rather than diagnostic or curative in intent. If central registries wish to study types of palliative care given at particular facilities, the facility-level fields must be used. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what palliative procedures and care was performed at a particular facility also helps resolve consolidation issues.

Codes

0 No palliative care provided. Diagnosed at autopsy
1 Surgery (which may involve a bypass procedure) performed to alleviate symptoms, but no attempt to diagnose, stage, or treat the tumor is made.
2 Radiation therapy given to alleviate symptoms, but no attempt to produce cure is made.
3 Chemotherapy, hormone therapy, or other systemic drugs given to alleviate symptoms without curative intent.
4 Patient received or was referred for pain management only.
5 Any combination of codes 1, 2, and/or 3 without code 4.
6 Any combination of codes 1, 2, and/or 3 with code 4.
7 Palliative care was performed or recommended, but no information on the type of procedure is available in the patient record.
9 Unknown if palliative care was performed or recommended. Not stated in patient record.

RX HOSP--RADIATION

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Radiation at this Facility (CoC)	690	1	SEER					789 - 789

Description
Defines the type of radiation therapy the patient received at the reporting facility as a part of the first course of treatment.

Rationale
If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes

0 None
1 Beam radiation
2 Radioactive implants
3 Radioisotopes
4 Combination of 1 with 2 or 3
5 Radiation, NOS—method or source not specified
9 Unknown if radiation therapy administered

Note: CoC no longer requires this item effective January 1, 2002. SEER continues to support it as a historically collected and currently transmitted data item.

RX HOSP--REG LN REMOVED

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
RX Hosp--Reg LN Examined Number of Regional Lymph Nodes Examined at This Facility (CoC)	676	2	CoC	1997	5.1			786 - 787

Description
Describes number of regional lymph nodes removed at the reporting facility as part of the first course of treatment.

Rationale
If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all reporting facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing the extent of treatment given at a particular facility also helps resolve consolidation issues.

Codes (Refer to ROADS for additional coding instructions.)

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as a dissection and number of lymph 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
99 Unknown; not stated; death certificate-only

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

RX HOSP--SCOPE REG 98-02

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Scope of Regional Lymph Node Surgery at this Facility (CoC)	747	1	CoC					802 - 802

Description
Describes the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at the reporting facility. This field is to be used for *ROADS* codes after the *ROADS* to *FORDS* conversion. It is also to be used to code Scope of Regional Lymph Node Surgery at the reporting facility for all tumors diagnosed before January 1, 2003.

Rationale
In evaluating quality of care and treatment practices it is important to identify the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

If central registries wish to study the treatment given at particular reporting facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information across all reporting facilities that provide first course of treatment for the tumor. Reporting facility-specific fields allow studies of detailed referral patterns and treatment by type of hospital. Knowing the extent of treatment given at a particular reporting facility also helps resolve coding issues.

Codes (See the CoC *ROADS Manual 1998 Supplement* and the *SEER Program Code Manual* for site-specific codes.

RX HOSP--SCOPE REG LN SUR

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Scope of Regional Lymph Node Surgery at this Facility (CoC)	672	1	CoC	1997	5.1			784 - 784

Description
Describes the removal, biopsy, or aspiration of regional lymph node(s) performed at the reporting facility for diagnosis and/or staging or as a part of the first course of therapy.

Rationale
This item is important for evaluating quality of care and treatment practices relating to initial diagnosis, staging and/or first course of therapy. If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all reporting facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing the extent of treatment given at a particular facility also helps resolve consolidation issues. If central registries wish to study the treatment given at particular reporting facilities, the reporting facility-level treatment fields must be used. The summary treatment fields, conversely, combine information across all reporting facilities that provide first course of treatment for the tumor. Reporting facility-specific fields allow studies of detailed referral patterns and treatment by type of reporting facility. Knowing the extent of treatment given at a particular reporting facility also helps resolve coding issues.

cancers.) The treatment of breast and skin cancers are where the distinction between sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes is most frequently encountered. For all other sites, non-sentinel regional node dissections are typical, and codes 2, 6 and 7 are infrequently used.

0 No regional lymph nodes removed. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1 Biopsy or aspiration of regional lymph node, NOS.
2 Sentinel lymph node biopsy.
3 Regional lymph node(s) removed and the number of nodes removed is unknown or not stated; the procedure is not specified as sentinel node biopsy. Regional lymph nodes removed, NOS.
4 1 to 3 regional lymph nodes removed.
5 4 or more regional lymph nodes removed.
6 Sentinel node biopsy and code 3, 4, or 5 at same time or timing not stated.
7 Sentinel node biopsy and code 3, 4, or 5 at different times.
9 Unknown or not applicable. It is unknown whether regional lymph node surgery was performed. Death certificate only case; unknown or ill-defined primary site; hematopoietic, reticuloendothelial, ummunoproliferative or myeloproliferative disease.

Note: One important use of registry data is the tracking of treatment patterns over time. To compare contemporary treatment to previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is very important to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than 4 nodes was not reflected in surgery codes. It is not intended to reflect clinical significance when applied to a particular surgical procedure. It is important to avoid inferring, by data presentation or other methods, that one category is preferable to another within the intent of these items.

RX HOSP--SURG APP 2010

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	668	1	CoC	2010	12			781 - 781

Description
This item is used to describe the method of surgical approach used for patients undergoing surgery of the primary site at the reporting facility. If the patient has multiple surgeries to the primary site, this item describes the approach used for the most invasive, definitive surgery

Rationale
This item is used to monitor patterns and trends in the adoption and use of minimally-invasive surgical techniques.

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing the extent of treatment given at a particular facility also helps resolve consolidation issues.

Codes

0 No surgical procedure of primary site at this facility. Diagnosed at autopsy.
1 Robotic assisted.
2 Robotic converted to open.
3 Endoscopic or laparoscopic.
4 Endoscopic or laparoscopic converted to open.
5 Open. Approach not specified.
9 Unknown whether surgery was performed; Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

RX HOSP--SURG OTH 98-02

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) at this Facility (CoC) Surgical Procedure/Other Site at this Facility	748	1	CoC					803 - 803

Description
Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site at this facility. This field is to be used for *ROADS* codes after the *ROADS* to *FORDS* conversion. It is also to be used to code Surgery Other Regional/Distant Sites at the reporting facility for all tumors diagnosed before January 1, 2003.

Rationale
The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment

studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes (See the CoC *ROADS Manual* 1998 Supplement and the SEER Program Code Manual for site-specific codes.)

RX HOSP--SURG OTH REG/DIS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) at this Facility (CoC) Surgical Procedure/Other Site at this Facility	674	1	CoC	1997	5.1			785 - 785

Description
Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site performed at this facility as a part of first course of treatment.

Rationale
The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all reporting facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)

0 None; no non-primary site resection was performed. Diagnosed at autopsy.
1 Non-primary surgical procedure performed, unknown if whether site is regional or distant.
2 Non-primary surgical procedure to other regional sites
3 Non-primary surgical procedure to *distant lymph node(s)*.
4 Non-primary surgical procedure to distant site.
5 Any combination of codes 2, 3, or 4.
9 Unknown; it is unknown whether any surgical procedure of a non-primary site was performed. Death certificate only.

RX HOSP--SURG PRIM SITE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Cancer-Directed Surgery at This Facility (pre-96 CoC) Surgical Procedure of Primary Site RX Hosp--CA Dir Surgery (pre-96 NAACCR)	670	2	CoC					782 - 783

Description
Describes surgical procedures used to treat the primary site of the reportable tumor. This item records that portion of the first course of treatment given at the reporting facility. See Chapter V, Unresolved Issues, for a discussion of differences in treatment coding among groups and over time.

Rationale
This data item can be used to compare the efficacy of treatment options.

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all reporting facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes in addition to the site-specific codes (Refer to the most recent version of *FORDS* for additional instructions.)

00 None. No surgical procedure of primary site. Diagnosed at autopsy.
10-19 Site-specific codes. Tumor destruction; no pathologic specimen produced.
20-80 Site-specific codes. Resection. Path specimen produced.
90 Surgery, NOS; surgical treatment of the primary site was done, but no information on the type of procedure is provided.
98 Site specific codes; special.
99 Unknown. Patient record does not state whether surgical treatment of the primary site was performed, and no information is available. Death certificate-only.

RX HOSP--SURG SITE 98-02

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
RX Hosp--CA Dir Surgery (pre-96 NAACCR) Surgical Procedure of Primary Site Cancer-Directed Surgery at this Facility (pre-96 CoC)	746	2	CoC					800 - 801

Description
Describes surgical procedures used to treat the primary site of the reportable tumor. This item records that portion of the first course of treatment given at the reporting facility. This field is to be used for *ROADS* codes after the *ROADS* to *FORDS* conversion. It is also to be used to code Surgery Primary Site at the reporting facility for all tumors diagnosed before January 1, 2003. See Chapter V, Unresolved Issues, for a discussion of differences in treatment coding among groups and over time.

Rationale
This data item can be used to compare the efficacy of treatment options.

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all reporting facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes (in addition to the site-specific codes)

00 No surgery performed
99 Unknown if surgery performed

Note: See the CoC *ROADS* Manual 1998 Supplement and the *SEER Program Code Manual* for site-specific codes.

RX SUMM--BRM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Biological Response Modifiers (pre-96 SEER) Immunotherapy (SEER/CoC)	1410	2	SEER/CoC					1589 - 1590

Description
Records whether immunotherapeutic (biologic response modifiers) agents were administered as first-course treatment at all facilities or the reason they were not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Rationale
Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of immunotherapeutic agents as part of the first course of therapy.

Note: Prior to 2013, targeted therapies that invoke an immune response, such as Herceptin, had been coded as chemotherapy. Effective with cases diagnosed January 1, 2013, and forward these therapies are classified as biological response modifiers. Coding instructions for these changes have been added to the remarks field for the applicable drugs in the SEER*RX Interactive Drug Database (http://seer.cancer.gov/tools/seerrx/).

Codes (Refer to the most recent version of *FORDS* and the *SEER Program Code Manual* for additional instructions.)

00 None, immunotherapy was not part of the planned first course of therapy.
01 Immunotherapy administered as first course therapy.
82 Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85 Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86 Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87 Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88 Immunotherapy was recommended, but it is unknown if it was administered.
99 It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record; death certificate-only cases.

*Note :*For tumors diagnosed on or after January 1, 2003, information on bone marrow transplants and stem cell transplants should be coded in the new field, RX SUMM--Transplnt/Endocr [3250]. The CoC standards for hospitals do not allow use of codes 02-06 in tumors diagnosed on or after January 1, 2003.

RX SUMM--CHEMO

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #

Chemotherapy (SEER/CoC)	1390	2	SEER/CoC					1585 - 1586

Description
Codes for chemotherapy given as part of the first course of treatment or the reason chemotherapy was not given. Includes treatment given at all facilities as part of the first course.

Note: Prior to 2013, targeted therapies that invoke an immune response, such as Herceptin, had been coded as chemotherapy. Effective with cases diagnosed January 1, 2013, and forward these therapies are classified as biological response modifiers. Coding instructions for these changes have been added to the remarks field for the applicable drugs in the SEER*RX Interactive Drug Database (http://seer.cancer.gov/tools/seerrx/).

Codes (Refer to the most recent version of *FORDS* for additional instructions.)

00 None, chemotherapy was not part of the planned first course of therapy.
01 Chemotherapy, NOS.
02 Chemotherapy, single agent.
03 Chemotherapy, multiple agents.
82 Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85 Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86 Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87 Chemotherapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88 Chemotherapy was recommended, but it is unknown if it was administered.
99 It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record; death certificate-only cases.

RX SUMM--DX/STG PROC

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
RX Summ--DX/Stg/Pall Proc Surgical Diagnostic and Staging Procedure (1996-2002) Non Cancer-Directed Surgery (CoC)	1350	2	CoC					1577 - 1578

Description
Identifies the surgical procedure(s) performed in an effort to diagnose and/or stage disease.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)

00 No surgical diagnostic or staging procedure was performed.
01 A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02 A biopsy (incisional, needle, or aspiration) was done of the primary site.
03 A surgical exploratory only. The patient was not biopsied or treated.
04 A surgical procedure with a bypass was performed, but no biopsy was done.
05 An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06 A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07 A procedure was done, but the type of procedure is unknown.
09 No information about whether a diagnostic or staging procedure was performed.

Note: CoC recommends this item for tumors diagnosed 1996 and forward. For tumors diagnosed before 1996, this item may have been converted, and tumors with surgery would have been converted to 09 in this field. See also RX Summ--Surg Prim Site [1290] and RX Summ--Reconstruct 1st [1330]. For SEER and pre-1996 CoC, see RX Summ--Surgery Type [1640]. For tumors diagnosed between 1996 and 2002 this field may have described palliative care. For tumors diagnosed on or after January 1, 2003, palliative care is coded in a new field RX Summ--Palliative Proc [3270].

RX SUMM--HORMONE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Hormone Therapy (SEER/CoC) Endocrine (Hormone/Steroid) Therapy (pre-96 SEER)	1400	2	SEER/CoC					1587 - 1588

Description
Records whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Rationale
Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy.

Codes (Refer to the most recent version of *FORDS* and the *SEER Program Code Manual* for additional instructions.)

00 None, hormone therapy was not part of the planned first course of therapy.
01 Hormone therapy administered as first course therapy.
82 Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85 Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86 Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87 Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88 Hormone therapy was recommended, but it is unknown if it was administered.
99 It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in the patient record. Death certificate-only cases.

Note: For tumors diagnosed on or after January 1, 2003, information on endocrine surgery and/or endocrine radiation should be coded in the new field, RX Summ--Transplnt/Endocr [3250]. The CoC standards for hospitals do not allow use of codes 02-03 in tumors diagnosed on or after January 1, 2003.

RX SUMM--OTHER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Other Treatment (CoC) Other Cancer-Directed Therapy (SEER/pre-96 CoC)	1420	1	SEER/CoC					1591 - 1591

Description
Identifies other treatment given at all facilities that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. 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, transfusions, and aspirin.

Rationale
Information on other therapy is used to describe and evaluate the quality-of-care and treatment practices.

Codes (Refer to the most recent version of *FORDS* for additional coding instructions)

0 None
1 Other
2 Other Experimental
3 Other-Double Blind
6 Other-Unproven
7 Refusal
8 Recommended
9 Unknown; unknown if administered

RX SUMM--PALLIATIVE PROC

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Palliative Procedure Palliative Care	3270	1	CoC	2003	10			1579 - 1579

Description
Identifies any care provided in an effort to palliate or alleviate symptoms. Palliative care is performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or pain management therapy.

Rationale
This data item allows reporting facilities to track care that is considered palliative rather than diagnostic or curative intent.

Codes

0 No palliative care provided; diagnosed at autopsy
1 Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made

3 Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made
4 Patient received or was referred for pain management therapy with no other palliative care
5 Any combination of codes 1, 2, and/or 3 without code 4
6 Any combination of codes 1, 2, and/or 3 with code 4
7 Palliative care was performed or referred, but no information on the type of procedure is available in the patient record
9 Unknown if palliative care was performed or referred; not stated in patient record

RX SUMM--RAD TO CNS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Radiation to the Brain and/or Central Nervous System (SEER) Radiation Therapy to CNS (CoC)	1370	1	SEER/CoC					1581 - 1581

Description
For lung and leukemia cases only, codes for radiation given to the brain or central nervous system. Includes treatment given at all facilities as part of the first course. See Chapter V, Unresolved Issues, for more information.

Note: SEER does not collect this data item beginning with 1998 cases. They retain the codes for older cases in this field, and they have also recoded radiation coded here as radiation in RX Summ--Radiation [1360]. CoC does not collect this data item beginning with 1996 cases.

Codes
For Lung and Leukemia Cases only

0 No radiation to the brain and/or central nervous system
1 Radiation
7 Patient or patient's guardian refused
8 Radiation recommended, unknown if administered
9 Unknown

For all other cases (primaries other than lung or leukemia):
9 Not Applicable

RX SUMM--RADIATION

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Radiation (SEER/CoC) Radiation Therapy (pre-96 CoC)	1360	1	SEER					1580 - 1580

Description
Codes for the type of radiation therapy performed as part of the first course of treatment.

Note: Radiation to brain and central nervous system for leukemia and lung cases is coded as radiation in this field.

Codes

0 None
1 Beam radiation
2 Radioactive implants
3 Radioisotopes
4 Combination of 1 with 2 or 3
5 Radiation, NOS-method or source not specified
6 Currently allowable for historic cases only; see note below
7 Patient or patient's guardian refused*
8 Radiation recommended, unknown if administered*
9 Unknown if radiation administered

Note: CoC discontinued collection of this item in 2003 when FORDS was implemented. For CoC, codes 7 and 8 were used for tumors diagnosed before 1996, but should have been converted to 0 in this field and to the appropriate code in the new field Reason for No Radiation [1430]. SEER continues to use codes 7 and 8 for all years. See Chapter V, Unresolved Issues, for further discussion.

In the SEER program, a code 2 for other radiation was used between 1973 and 1987. When the radiation codes were expanded to add codes ‘2’ radioactive implants and ‘3’ radioisotopes, all cases with a code ‘2’ and diagnosed in 1973-1987 were converted to a code ‘6’ radiation other than beam radiation.

RX SUMM--RECONSTRUCT 1ST

Alternate Name	Item #	Length	Standard	Implemented	Implemented	Retired	Retired	Column #
Reconstruction/Restoration-First Course (CoC) Reconstruction--First Course (SEER)	1330	1	SEER					1575 - 1575

Description
Codes for surgical procedures done to reconstruct, restore, or improve the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or therapies. Reconstructive/restorative procedures are coded here when started during the first course of therapy.

CoC introduced site-specific codes for this item in the CoC *ROADS Manual* 1998 Supplement. RX Coding System--Current [1460] identifies which coding system applies.

SEER collects reconstructive procedures for breast cancer tumors only.For reconstructive/restorative procedures performed later, see Subseq RX--Reconstruct Del [1741]. See also RX Summ--Surgery Type [1640].

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

RX SUMM--REG LN EXAMINED

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Number of Regional Lymph Nodes Removed (CoC) Number of Regional Lymph Nodes Examined (SEER/CoC)	1296	2	SEER/CoC	1997	5.1			1571 - 1572

Description
Codes for the number of regional lymph nodes examined in conjunction with surgery performed as part of the first-course treatment. This includes treatment given at all facilities as part of the first course of treatment. See also RX Summ--Scope Reg LN Sur [1292].

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
..
90 90 or more regional lymph nodes examined
..
95 No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as sampling, and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as a dissection, and number of lymph 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
99 Unknown; not stated; death certificate-only

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

RX SUMM--SCOPE REG 98-02

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Scope of Regional Lymph Node Surgery (SEER/CoC)	1647	1	SEER/CoC					1622 - 1622

Description
Describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at all facilities. This field is to be used for *ROADS* codes after the *ROADS* to *FORDS* conversion. It is also to be used to code Scope of Regional Lymph Node Surgery at all facilities for all tumors diagnosed before January 1, 2003.

Rationale
In evaluating quality of care and treatment practices it is important to identify the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

Codes (See the CoC *ROADS* Manual 1998 Supplement and the *SEER Program Code Manual* for site-specific codes.)

RX SUMM--SCOPE REG LN SUR

			Source of	Year	Version	Year	Version	

Scope of Regional Lymph Node Surgery (SEER/CoC)	1292	1	SEER/CoC	1997	5.1			1569 - 1569

Description
Describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at all facilities.

Rationale
In evaluating quality-of-care and treatment practices it is important to identify the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

Codes (Refer to the most recent versions of *FORDS* and the *SEER Program Code Manual* for instructions that should be applied to all surgically treated cases for all types of cancers.) The treatment of breast and skin cancers are where the distinction between sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes is most frequently encountered. For all other sites, non-sentinel regional node dissections are typical, and codes 2, 6 and 7 are infrequently used.

0 None
1 Biopsy or aspiration of regional lymph node, NOS
2 Sentinel lymph node biopsy
3 Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS
4 1 to 3 regional lymph nodes removed
5 4 or more regional lymph nodes removed
6 Sentinel node biopsy and code 3, 4, or 5 at same time or timing not noted
7 Sentinel node biopsy and code 3, 4, or 5 at different times
9 Unknown or not applicable

Note: One important use of registry data is the tracking of treatment patterns over time. To compare contemporary treatment to previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is very important to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than 4 nodes was not reflected in surgery codes. It is not intended to reflect clinical significance when applied to a particular surgical procedure. It is important to avoid inferring, by data presentation or other methods, that one category is preferable to another within the intent of these items.

RX SUMM--SURG OTH 98-02

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes (SEER/CoC) Surgical Procedure/Other Site	1648	1	SEER/CoC					1623 - 1623

Description
Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site given at all facilities as part of the first course of treatment. This field is to be used for *ROADS* codes after the *ROADS* to *FORDS* conversion. It is also to be used to code Surgery Regional/Distant Sites at all facilities for all tumors diagnosed before January 1, 2003.

Rationale
The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Codes (See the CoC ROADS Manual 1998 Supplement and the SEER Program Code Manual for site-specific codes.)

RX SUMM--SURG OTH REG/DIS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes (SEER/CoC) Surgical Procedure/Other Site	1294	1	SEER/CoC	1997	5.1			1570 - 1570

Description
Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

Rationale
The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Codes (Refer to the most recent version of *FORDS* and *SEER Program Code Manual* for additional instructions.)

0 None; diagnosed at autopsy

2 Non-primary surgical procedure to other regional sites
3 Non-primary surgical procedure to distant lymph node(s)
4 Non-primary surgical procedure to distant site
5 Any combination of codes 2, 3, or 4
9 Unknown; death certificate only

RX SUMM--SURG PRIM SITE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Surgery of Primary Site (SEER/CoC) Cancer-Directed Surgery (pre-96 CoC)	1290	2	SEER/CoC	1997	5.1			1567 - 1568

Description
Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment. This includes treatment given at all facilities as part of the first course of treatment.

Codes (in addition to the site-specific codes; Refer to the most recent version of *FORDS* and SEER Program Code manual for additional instructions.)

00 None
10-19 Site-specific code; tumor destruction
20-80 Site-specific codes; resection
90 Surgery, NOS
98 Site specific codes; special
99 Unknown

RX SUMM--SURG SITE 98-02

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Surgery of Primary Site (SEER/CoC) Cancer-Directed Surgery (pre-96 CoC)	1646	2	SEER/CoC					1620 - 1621

Description
Site-specific codes for the type of surgery to the primary site 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 field is to be used for *ROADS* codes after the *ROADS* to *FORDS* conversion. It is also to be used to code Surgery Primary Site at all facilities for all tumors diagnosed before January 1, 2003.

Rationale
If central registries wish to study the treatment given at particular hospitals, the hospital-level treatment fields must be used.

Codes (in addition to the site-specific codes)

00 No primary site surgery performed
99 Unknown if primary site surgery performed

Note: See the CoC *ROADS Manual*, 1998 Supplement, CoC Coding System [2140] code 7, and the *SEER Program Code Manual*, RX Coding System [1460] code 5, 1998 for site-specific codes.

RX SUMM--SURG/RAD SEQ

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Radiation Sequence with Surgery (pre-96 SEER/CoC) Radiation/Surgery Sequence (CoC)	1380	1	SEER/CoC					1582 - 1582

Description
Codes for the sequencing of radiation and surgery given as part of the first course of treatment. See also RX Summ--Surg Prim Site [1290], RX Summ--Scope LN Surg [1292], RX Summ--Surg Oth Reg/Dis [1294], and RX Summ--Radiation [1360].

Codes

0 No radiation and/or no surgery; unknown if surgery and/or radiation given
2 Radiation before surgery
3 Radiation after surgery
4 Radiation both before and after surgery

6 Intraoperative radiation with other radiation given before and/or after surgery
7 Surgery both before and after radiation
9 Sequence unknown, but both surgery and radiation were given

RX SUMM--SURGERY TYPE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Site--Specific Surgery (pre-98 SEER)	1640	2	SEER	2011	12.2			1617 - 1618

Description
Field for pre-1996 surgery codes for CoC and pre-1998 surgery codes for SEER. Surgery codes used 1998 and later can be backward converted into the older codes and the converted value can be stored in this field. See Chapter V, Unresolved Issues, for discussion of CoC/SEER differences in coding treatment.

RX SUMM--SURGICAL APPROCH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Surgical Approach (CoC)	1310	1	CoC					1573 - 1573

Description
Codes for method used to approach the surgical field for the primary site.

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained. This former item should not be confused with NAACCR item [668] RX HOSP--SURG APP 2010 .

Codes (See the CoC *ROADS Manual*, 1998 Supplement, for site-specific codes.)

RX SUMM--SURGICAL MARGINS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Surgical Margins (CoC) Residual Primary Tumor Following Cancer-Directed Surgery (pre-96 CoC)	1320	1	CoC					1574 - 1574

Description
Codes describe the final status of surgical margins after resection of the primary tumor. See also RX Summ--Surg Prim Site [1290].

Rationale
This item serves as a quality measure for pathology reports, is used for staging, and may be a prognostic factor in recurrence. This item is not limited to cases that have been staged. It applies to all cases that have a surgical procedure of the primary site.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)

0 No residual tumor
1 Residual tumor, NOS
2 Microscopic residual tumor
3 Macroscopic residual tumor
7 Margins not evaluable
8 No primary site surgery
9 Unknown or not applicable

Note: Codes were site specific (1998-2002), and have been changed to be generic across all disease sites.

RX SUMM--SYSTEMIC/SUR SEQ

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Systemic/Surgery Sequence	1639	1	CoC	2006	11			1616 - 1616

Description
Records the sequencing of systemic therapy (RX Summ-Chemo [1390], RX Summ-Hormone [1400], RX Summ-BRM [1410], and RX Summ-Transplnt/Endocr [3250]) and surgical procedures given as part of the first course of treatment. See also RX Summ--Surg Prim Site [1290], RX Summ--Scope LN Surg [1292], and RX Summ--Surg Oth Reg/Dis [1294].

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

Codes

0 No systemic therapy and/or surgical procedures; unknown if surgery and/or systemic therapy given
2 Systemic therapy before surgery
3 Systemic therapy after surgery
4 Systemic therapy both before and after surgery
5 Intraoperative systemic therapy
6 Intraoperative systemic therapy with other therapy administered before and/or after surgery
7 Surgery both before and after systemic therapy
9 Sequence unknown, but both surgery and systemic therapy given

RX SUMM--TRANSPLNT/ENDOCR

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Hematologic Transplant and Endocrine Procedures	3250	2	CoC	2003	10			1583 - 1584

Description
Identifies 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.

Rationale
This data item allows the evaluation of patterns of treatment, which involve the alteration of the immune system or change the patient's response to tumor cells but do not involve the administration of antineoplastic agents.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)

00 No transplant procedure or endocrine therapy was administered as part of first course therapy; diagnosed at autopsy
10 Bone marrow transplant procedure was administered, but the type was not specified.
11 Bone marrow transplant-autologous
12 Bone marrow transplant-allogeneic
20 Stem cell harvest 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 first-course therapy. No reason was stated in the 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, the patient's family member, or the patient's guardian; refusal 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 cases

RX SUMM--TREATMENT STATUS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1285	1	SEER/CoC	2010	12			1566 - 1566

Description
This data item is a summary of the status for all treatment modalities. It is used in conjunction with Date Initial RX SEER [1260] and/or Date 1st Crs RX CoC [1270] and each modality of treatment with their respective date field to document whether treatment was given or not given, whether it is unknown if treatment was given, or whether treatment was given on an unknown date. Also indicates active surveillance (watchful waiting). This data item is effective for January 2010+ diagnoses.

Rationale
This field will document active surveillance (watchful waiting) and eliminate searching each treatment modality to determine whether treatment was given.

Codes

0 No treatment given
1 Treatment given
2 Active surveillance (watchful waiting)
9 Unknown if treatment was given

RX TEXT--BRM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2660	1000	NPCR					17765 - 18764

Description
Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- Date treatment began
- Where 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

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date Initial RX SEER	1260
Date 1st Crs RX CoC	1270
RX Hosp--BRM	720
RX Date Systemic	3230
RX Summ--Tranplnt/Endocr	3250
RX Summ--BRM	1410
RX Date BRM	1240
RX Summ--Systemic/Sur Seq	1639

RX TEXT--CHEMO

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2640	1000	NPCR					15765 - 16764

Description
Text area for manual documentation of information regarding chemotherapy treatment of the reported tumor.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- Date 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

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date Initial RX SEER	1260
Date 1st Crs RX CoC	1270
RX Hosp--Chemo	700
RX Date Systemic	3230
RX Summ--Tranplnt/Endocr	3250
RX Summ--Chemo	1390
RX Date Chemo	1220
RX Summ--Systemic/Sur Seq	1639

RX TEXT--HORMONE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2650	1000	NPCR					16765 - 17764

Description
Text area for information about hormonal treatment.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).

- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

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

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date Initial RX SEER	1260
Date 1st Crs RX CoC	1270
RX Hosp--Hormone	710
RX Date Systemic	3230
RX Summ--Tranplnt/Endocr	3250
RX Summ--Hormone	1400
RX Date Hormone	1230
RX Summ--Systemic/Sur Seq	1639

RX TEXT--OTHER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2670	1000	NPCR					18765 - 19764

Description
Text area for manual documentation of information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- Date treatment was started
- Where treatment was given, e.g., at this facility, at another facility

- Other treatment information, e.g., treatment cycle incomplete; unknown if other treatment was given

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date Initial RX SEER	1260
Date 1st Crs RX CoC	1270
RX Summ--Other	1420
RX Date Other	1250
RX Hosp--Other	730

RX TEXT--RADIATION (BEAM)

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2620	1000	NPCR					13765 - 14764

Description
Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- Date 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 5 treatments; unknown if radiation was given

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date Initial RX SEER	1260
Date 1st Crs RX CoC	1270
RX Summ--Radiation	1360
RX Summ--Surg/Rad Seq	1380
Reason For No Radiation	1430
RX Date Radiation	1210
Rad Regional RX Modality	1570
RX Hosp--Radiation	690
RX Date Rad Ended	3220
RX Summ--Rad to CNS	1370
Rad--No of Treatment Vol	1520

Rad Treatment Volume	1540
Rad Location of RX	1550
Rad Boost RX Modality	3200
Rad Boost Dose cGy	3210

RX TEXT--RADIATION OTHER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2630	1000	NPCR					14765 - 15764

Description
Text area for manual documentation of information regarding treatment of the tumor being reported with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

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

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date Initial RX SEER	1260
Date 1st Crs RX CoC	1270
RX Summ--Radiation	1360
RX Summ--Surg/Rad Seq	1380
Reason For No Radiation	1430
RX Date Radiation	1210
Rad Regional RX Modality	1570
RX Hosp--Radiation	690
RX Date Rad Ended	3220
RX Summ--Rad to CNS	1370
Rad--No of Treatment Vol	1520
Rad--Regional Dose cGy	1510
Rad Treatment Volume	1540
Rad Location of RX	1550
Rad Boost RX Modality	3200
Rad Boost Dose cGy	3210

RX TEXT--SURGERY

			Standard	Implemented	Implemented	Retired	Retired	
	2610	1000	NPCR					12765 - 13764

Description
Text area for information describing all surgical procedures performed as part of treatment.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

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.
- Other treatment information, e.g., planned procedure aborted; unknown if surgery performed.

Data Item(s) to be verified/validated using the text entered in this field After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date Initial RX SEER	1260
Date 1st Crs RX CoC	1270
RX Date Surgery	1200
RX Summ--Surg Prim Site	1290
RX Hosp--Surg Prim Site	670
RX Summ--Scope Reg LN Sur	1292
RX Hosp--Scope Reg LN Sur	672
RX Summ--Surg Oth Reg/Dis	1294
RX Hosp--Surg Oth Reg/Dis	674
Reason for No Surgery	1340
RX Summ--Surgical Margins	1320
RX Hosp--Palliative Proc	3280
RX Summ--Palliative Proc	3270
Text--Place of Diagnosis	2690
RX Summ--Surg/Rad Seq	1380
RX Summ--Systemic/Sur Seq	1639

SECONDARY DIAGNOSIS 1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Secondary Dx ICD-10 1	3780	7	CoC	2013	13			1236 - 1242

Description

are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care. ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Rationale
The current Comorbidity and complication items are based on ICD-9-CM codes and only allow 5 characters, with the introduction of ICD-10-CM in to common use the NAACCR transmission record needs to be able to carry these new codes (that are longer in length and different in structure).

Codes

A00.0 - B99.9	infectious and parasitic diseases
E00.0 - E89.89	endocrine and metabolic diseases
G00.0 - P96.9	diseases of the nervous system, eye, ear, skin, circulatory, respiratory, and digestive , musculoskeletal, genitourinary systems, pregnancy, childbirth and perinatal conditions
R00.0 - S99.929	symptoms, signs and abnormal clinical and lab findings
T36.0 - T50.996	medical poisonings
Y62.0 - Y84.9	medical misadventures
Z14.0 - Z22.9	genetic susceptibility / infection disease carrier
Z68.1 - Z68.54	BMI
Z80.0 - Z80.9	family history of malignant neoplasms
Z85.0 - Z86.03	personal history of malignant neoplasms
Z86.1 - Z99.89	other personal health status

SECONDARY DIAGNOSIS 10

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Secondary Dx ICD10 10	3798	7	CoC	2013	13			1299 - 1305

Description
Records the patient’s preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer. Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care. ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Rationale
The current Comorbidity and complication items are based on ICD-9-CM codes and only allow 5 characters, with the introduction of ICD-10-CM in to common use the NAACCR transmission record needs to be able to carry these new codes (that are longer in length and different in structure).

Codes

A00.0 - B99.9	infectious and parasitic diseases
E00.0 - E89.89	endocrine and metabolic diseases
G00.0 - P96.9	diseases of the nervous system, eye, ear, skin, circulatory, respiratory, and digestive , musculoskeletal, genitourinary systems, pregnancy, childbirth and perinatal conditions
R00.0 - S99.929	symptoms, signs and abnormal clinical and lab findings
T36.0 - T50.996	medical poisonings
Y62.0 - Y84.9	medical misadventures
Z14.0 -	

Z68.1 - Z68.54	BMI
Z80.0 - Z80.9	family history of malignant neoplasms
Z85.0 - Z86.03	personal history of malignant neoplasms
Z86.1 - Z99.89	other personal health status

SECONDARY DIAGNOSIS 2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Secondary Dx ICD10 2	3782	7	CoC	2013	13			1243 - 1249

Description
Records the patient's preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer. Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care. ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Rationale
The current Comorbidity and complication items are based on ICD-9-CM codes and only allow 5 characters, with the introduction of ICD-10-CM in to common use the NAACCR transmission record needs to be able to carry these new codes (that are longer in length and different in structure).

Codes

A00.0 - B99.9	infectious and parasitic diseases
E00.0 - E89.89	endocrine and metabolic diseases
G00.0 - P96.9	diseases of the nervous system, eye, ear, skin, circulatory, respiratory, and digestive , musculoskeletal, genitourinary systems, pregnancy, childbirth and perinatal conditions
R00.0 - S99.929	symptoms, signs and abnormal clinical and lab findings
T36.0 - T50.996	medical poisonings
Y62.0 - Y84.9	medical misadventures
Z14.0 - Z22.9	genetic susceptibility / infection disease carrier
Z68.1 - Z68.54	BMI
Z80.0 - Z80.9	family history of malignant neoplasms
Z85.0 - Z86.03	personal history of malignant neoplasms
Z86.1 - Z99.89	other personal health status

SECONDARY DIAGNOSIS 3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Secondary Dx ICD10 3	3784	7	CoC	2013	13			1250 - 1256

Description
Records the patient's preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer. Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care. ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Rationale

The current Comorbidity and complication items are based on ICD-9-CM codes and only allow 5 characters, with the introduction of ICD-10-CM in to common use the NAACCR transmission record needs to be able to carry these new codes (that are longer in length and different in structure).

Codes

A00.0 - B99.9	infectious and parasitic diseases
E00.0 - E89.89	endocrine and metabolic diseases
G00.0 - P96.9	diseases of the nervous system, eye, ear, skin, circulatory, respiratory, and digestive , musculoskeletal, genitourinary systems, pregnancy, childbirth and perinatal conditions
R00.0 - S99.929	symptoms, signs and abnormal clinical and lab findings
T36.0 - T50.996	medical poisonings
Y62.0 - Y84.9	medical misadventures
Z14.0 - Z22.9	genetic susceptibility / infection disease carrier
Z68.1 - Z68.54	BMI
Z80.0 - Z80.9	family history of malignant neoplasms
Z85.0 - Z86.03	personal history of malignant neoplasms
Z86.1 - Z99.89	other personal health status

SECONDARY DIAGNOSIS 4

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Secondary Dx ICD10 4	3786	7	CoC	2013	13			1257 - 1263

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer. Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care. ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Rationale

The current Comorbidity and complication items are based on ICD-9-CM codes and only allow 5 characters, with the introduction of ICD-10-CM in to common use the NAACCR transmission record needs to be able to carry these new codes (that are longer in length and different in structure).

Codes

A00.0 - B99.9	infectious and parasitic diseases
E00.0 - E89.89	endocrine and metabolic diseases
G00.0 - P96.9	diseases of the nervous system, eye, ear, skin, circulatory, respiratory, and digestive , musculoskeletal, genitourinary systems, pregnancy, childbirth and perinatal conditions
R00.0 - S99.929	symptoms, signs and abnormal clinical and lab findings
T36.0 - T50.996	medical poisonings
Y62.0 - Y84.9	medical misadventures
Z14.0 - Z22.9	genetic susceptibility / infection disease carrier
Z68.1 - Z68.54	BMI
Z80.0 - Z80.9	family history of malignant neoplasms
Z85.0 - Z86.03	personal history of malignant neoplasms

Z99.89	other personal health status

SECONDARY DIAGNOSIS 5

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Secondary Dx ICD10 5	3788	7	CoC	2013	13			1264 - 1270

Description
Records the patient's preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer. Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care. ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Rationale
The current Comorbidity and complication items are based on ICD-9-CM codes and only allow 5 characters, with the introduction of ICD-10-CM in to common use the NAACCR transmission record needs to be able to carry these new codes (that are longer in length and different in structure).

Codes

A00.0 - B99.9	infectious and parasitic diseases
E00.0 - E89.89	endocrine and metabolic diseases
G00.0 - P96.9	diseases of the nervous system, eye, ear, skin, circulatory, respiratory, and digestive , musculoskeletal, genitourinary systems, pregnancy, childbirth and perinatal conditions
R00.0 - S99.929	symptoms, signs and abnormal clinical and lab findings
T36.0 - T50.996	medical poisonings
Y62.0 - Y84.9	medical misadventures
Z14.0 - Z22.9	genetic susceptibility / infection disease carrier
Z68.1 - Z68.54	BMI
Z80.0 - Z80.9	family history of malignant neoplasms
Z85.0 - Z86.03	personal history of malignant neoplasms
Z86.1 - Z99.89	other personal health status

SECONDARY DIAGNOSIS 6

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Secondary Dx ICD10 6	3790	7	CoC	2013	13			1271 - 1277

Description
Records the patient's preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer. Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care. ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Rationale
The current Comorbidity and complication items are based on ICD-9-CM codes and only allow 5 characters, with the introduction of ICD-10-CM in to common use the NAACCR transmission record needs to be able to carry these new codes (that are longer in length and different in structure).

Codes

A00.0 - B99.9	infectious and parasitic diseases
E00.0 -	endocrine and metabolic diseases

G00.0 - P96.9	diseases of the nervous system, eye, ear, skin, circulatory, respiratory, and digestive , musculoskeletal, genitourinary systems, pregnancy, childbirth and perinatal conditions
R00.0 - S99.929	symptoms, signs and abnormal clinical and lab findings
T36.0 - T50.996	medical poisonings
Y62.0 - Y84.9	medical misadventures
Z14.0 - Z22.9	genetic susceptibility / infection disease carrier
Z68.1 - Z68.54	BMI
Z80.0 - Z80.9	family history of malignant neoplasms
Z85.0 - Z86.03	personal history of malignant neoplasms
Z86.1 - Z99.89	other personal health status

SECONDARY DIAGNOSIS 7

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Secondary Dx ICD10 7	3792	7	CoC	2013	13			1278 - 1284

Description
Records the patient's preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer. Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care. ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Rationale
The current Comorbidity and complication items are based on ICD-9-CM codes and only allow 5 characters, with the introduction of ICD-10-CM in to common use the NAACCR transmission record needs to be able to carry these new codes (that are longer in length and different in structure).

Codes

A00.0 - B99.9	infectious and parasitic diseases
E00.0 - E89.89	endocrine and metabolic diseases
G00.0 - P96.9	diseases of the nervous system, eye, ear, skin, circulatory, respiratory, and digestive , musculoskeletal, genitourinary systems, pregnancy, childbirth and perinatal conditions
R00.0 - S99.929	symptoms, signs and abnormal clinical and lab findings
T36.0 - T50.996	medical poisonings
Y62.0 - Y84.9	medical misadventures
Z14.0 - Z22.9	genetic susceptibility / infection disease carrier
Z68.1 - Z68.54	BMI
Z80.0 - Z80.9	family history of malignant neoplasms
Z85.0 - Z86.03	personal history of malignant neoplasms
Z86.1 - Z99.89	other personal health status

SECONDARY DIAGNOSIS 8

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Secondary Dx ICD10 8	3794	7	CoC	2013	13			1285 - 1291

Description
Records the patient's preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer. Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care. ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Rationale
The current Comorbidity and complication items are based on ICD-9-CM codes and only allow 5 characters, with the introduction of ICD-10-CM in to common use the NAACCR transmission record needs to be able to carry these new codes (that are longer in length and different in structure).

Codes

A00.0 - B99.9	infectious and parasitic diseases
E00.0 - E89.89	endocrine and metabolic diseases
G00.0 - P96.9	diseases of the nervous system, eye, ear, skin, circulatory, respiratory, and digestive , musculoskeletal, genitourinary systems, pregnancy, childbirth and perinatal conditions
R00.0 - S99.929	symptoms, signs and abnormal clinical and lab findings
T36.0 - T50.996	medical poisonings
Y62.0 - Y84.9	medical misadventures
Z14.0 - Z22.9	genetic susceptibility / infection disease carrier
Z68.1 - Z68.54	BMI
Z80.0 - Z80.9	family history of malignant neoplasms
Z85.0 - Z86.03	personal history of malignant neoplasms
Z86.1 - Z99.89	other personal health status

SECONDARY DIAGNOSIS 9

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Secondary Dx ICD10 9	3796	7	CoC	2013	13			1292 - 1298

Description
Records the patient's preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer. Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care. ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Rationale
The current Comorbidity and complication items are based on ICD-9-CM codes and only allow 5 characters, with the introduction of ICD-10-CM in to common use the NAACCR transmission record needs to be able to carry these new codes (that are longer in length and different in structure).

Codes

A00.0 - B99.9	infectious and parasitic diseases
E00.0 - E89.89	endocrine and metabolic diseases
G00.0 - P96.9	diseases of the nervous system, eye, ear, skin, circulatory, respiratory, and digestive , musculoskeletal, genitourinary systems, pregnancy, childbirth and perinatal conditions
R00.0 - S99.929	symptoms, signs and abnormal clinical and lab findings
T36.0 - T50.996	medical poisonings
Y62.0 -	

Z14.0 - Z22.9	genetic susceptibility / infection disease carrier
Z68.1 - Z68.54	BMI
Z80.0 - Z80.9	family history of malignant neoplasms
Z85.0 - Z86.03	personal history of malignant neoplasms
Z86.1 - Z99.89	other personal health status

SEER CODING SYS--CURRENT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2120	1	NAACCR					1930 - 1930

Description
This shows the SEER coding system best describing the majority of SEER items as they are in the record (after conversion).

Rationale
Change the allowable values to alpha-numeric in order to accommodate SEER Program Manual editions.

Codes

0 No SEER coding
1 Pre-*1988 SEER Coding Manuals*
2 *1988 SEER Coding Manual*
3 *1989 SEER Coding Manual*
4 *1992 SEER Coding Manual*
5 *1998 SEER Coding Manual*
6 *2003 SEER Coding Manual*
7 *2004 SEER Coding Manual*
8 *2007 SEER Coding Manual*
9 *2007 SEER Coding Manual* with 2008 changes
A *2010 SEER Coding Manual*
B *2011 SEER Coding Manual*
C *2012 SEER Coding Manual*
D *2013 SEER Coding Manual*
E *2014 SEER Coding Manual*
F *2015 SEER Coding Manual*
G *2016 SEER Coding Manual*

SEER CODING SYS--ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2130	1	NAACCR					1931 - 1931

Description
This shows the SEER coding system best describing the way the majority of SEER items in the record were originally coded.

Rationale
Change the allowable values to alpha-numeric in order to accommodate SEER Program Manual editions.

Codes

0 No SEER coding
1 Pre-*1988 SEER Coding Manuals*
2 *1988 SEER Coding Manual*
3 *1989 SEER Coding Manual*
4 *1992 SEER Coding Manual*
5 *1998 SEER Coding Manual*
6 *2003 SEER Coding Manual*
7 *2004 SEER Coding Manual*

9 *2007 SEER Coding Manual* with 2008 changes
A *2010 SEER Coding Manual*
B *2011 SEER Coding Manual*
C *2012 SEER Coding Manual*
D *2013 SEER Coding Manual*
E *2014 SEER Coding Manual*
F *2015 SEER Coding Manual*
G *2016 SEER Coding Manual*

SEER METS **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	776	2	SEER	2016	16			892 - 893

Description
There are a number of schemas or portions of schemas which are not staged under TNM. Under CS, these have been Summary Staged algorithmically using CS Extension, CS Lymph Nodes, and CS Mets and other information as needed. Beginning with cases diagnosed in 2016 this will no longer be the case. These three newly proposed data items will be used to simply collect information on the primary tumor, regional nodes, and mets so that a summary stage can be easily derived for these cases.

Rationale
There are a number of schemas or portions of schemas which are not staged under TNM. Under CS, these have been Summary Staged algorithmically using CS Extension, CS Lymph Nodes, and CS Mets and other information as needed. Beginning with cases diagnosed in 2016 this will no longer be the case. These three newly proposed data items will be used to simply collect information on the primary tumor, regional nodes, and mets so that a summary stage can be easily derived for these cases.

Codes

000 None
70 Mets present
88 Not applicable – e.g., Leukemia
99 Unknown

SEER PRIMARY TUMOR **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	772	3	SEER	2016	16			886 - 888

Description
There are a number of schemas or portions of schemas which are not staged under TNM. Under CS, these have been Summary Staged algorithmically using CS Extension, CS Lymph Nodes, and CS Mets and other information as needed. Beginning with cases diagnosed in 2016 this will no longer be the case. These three newly proposed data items will be used to simply collect information on the primary tumor, regional nodes, and mets so that a summary stage can be easily derived for these cases.

Rationale
The SEER program has collected staging information on cases since its inception in 1973. When Collaborative Stage (CS) data are no longer collected, SEER will no longer have staging information for cases which AJCC does not provide T, N, M and/or stage groups. To fill this gap, SEER is proposing to collect simplified information to be able to derive a summary stage such as in situ, localized, regional (by extension, regional nodes, or both), and distant plus unknown for the cases which have no staging information under AJCC's criteria.

Codes

000 In Situ
100 Localized
200 Regional – Direct Extension
500 Regional NOS
700 Distant
800 No evidence of primary tumor
999 Unknown

SEER RECORD NUMBER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #

Description
A unique sequential number assigned by the SEER participant to each record for the person for each submission. The number may change from submission to submission. See also Tumor Record Number [60].

Codes

01 One or first of more than one record for person
02 Second record for person
..
..
nn Last of nn records for person

SEER REGIONAL NODES **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	774	3	SEER	2016	16			889 - 891

Description
There are a number of schemas or portions of schemas which are not staged under TNM. Under CS, these have been Summary Staged algorithmically using CS Extension, CS Lymph Nodes, and CS Mets and other information as needed. Beginning with cases diagnosed in 2016 this will no longer be the case. These three newly proposed data items will be used to simply collect information on the primary tumor, regional nodes, and mets so that a summary stage can be easily derived for these cases.

Rationale
The SEER program has collected staging information on cases since its inception in 1973. When Collaborative Stage (CS) data are no longer collected, SEER will no longer have staging information for cases which AJCC does not provide T, N, M and/or stage groups. To fill this gap, SEER is proposing to collect simplified information to be able to derive a summary stage such as in situ, localized, regional (by extension, regional nodes, or both), and distant plus unknown for the cases which have no staging information under AJCC's criteria.

Codes

000 None
300 Regional node involvement
888 Not applicable – e.g., CNS, hematopoietic
999 Unknown

SEER SITE-SPECIFIC FACT 1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3700	1	SEER	2010	12			1179 - 1179

Description
A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale
This field is a place holder when site-specific information is needed for SEER.

Codes (To be determined for each site where needed. Refer to the most current version of the *SEER Program Coding and Staging Manual*,[3] for details.)

Blank Field not coded

SEER SITE-SPECIFIC FACT 2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3702	1	SEER	2010	12			1180 - 1180

Description
A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale
This field is a place holder when site-specific information is needed for SEER.

Codes (To be determined for each site where needed. Refer to the most current version of the *SEER Program Coding and Staging*

Blank Field not coded

SEER SITE-SPECIFIC FACT 3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3704	1	SEER	2010	12			1181 - 1181

Description
A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale
This field is a place holder when site-specific information is needed for SEER.

Codes (To be determined for each site where needed. Refer to the most current version of the *SEER Program Coding and Staging Manual*,[3] for details.)

Blank Field not coded.

SEER SITE-SPECIFIC FACT 4

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3706	1	SEER	2010	12			1182 - 1182

Description
A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale
This field is a place holder when site-specific information is needed for SEER.

Codes (To be determined for each site where needed. Refer to the most current version of the *SEER Program Coding and Staging Manual*,[3] for details.)

Blank Field not coded

SEER SITE-SPECIFIC FACT 5

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3708	1	SEER	2010	12			1183 - 1183

Description
A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale
This field is a place holder when site-specific information is needed for SEER.

Codes (To be determined for each site where needed. Refer to the most current version of the *SEER Program Coding and Staging Manual*,[3] for details.)

Blank Field not coded

SEER SITE-SPECIFIC FACT 6

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	3710	1	SEER	2010	12			1184 - 1184

Description
A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale
This field is a place holder when site-specific information is needed for SEER.

Codes (To be determined for each site where needed. Refer to the most current version of the *SEER Program Coding and Staging*

Blank Field not coded

SEER SUMMARY STAGE 1977

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
General Summary Stage (SEER/CoC)	760	1	SEER					905 - 905

Description
Code for summary stage at the initial diagnosis or treatment of the reportable tumor. This has traditionally been used by central registries to monitor time trends. For hospital registries, CoC requires its use in the absence of a defined AJCC classification. For site-specific definitions of categories, see the SEER Summary Staging Guide.

SEER Summary Stage 1977 is limited to information available within 2 months of the date of diagnosis. NAACCR approved extension of this time period to 4 months for prostate tumors diagnosed beginning January 1, 1995.

Rationale
Stage information is important when evaluating the effects of cancer control programs. It is crucial for understanding whether changes over time in incidence rates or outcomes are due to earlier detection of the cancers. In addition, cancer treatment cannot be studied without knowing the stage at diagnosis.

To study historical trends in stage, the coding system must be relatively unchanged (stable) over time. AJCC's TNM system is updated periodically to maintain clinical relevance with changes in diagnosis and treatment. The surveillance registries often rely on the Summary Stage, which they consider to be more "stable." Summary Stage has been in widespread use, either as the primary staging scheme or a secondary scheme, in most central and hospital registries since 1977.

Codes

9 Unstaged
0 *In situ*
1 Localized
2 Regional, direct extension only
3 Regional, regional lymph nodes only
4 Regional, direct extension and regional lymph nodes
5 Regional, NOS
7 Distant
8 Not applicable

Note: Code 8 has been added in Version 10.1 to be used when there is not an applicable code to reflect stage (e.g., benign brain, borderline ovarian).

Note: See also the item Derived SS1977 [3010] for the value of SEER Summary Stage 1977 as generated by the Collaborative Staging algorithm.

Clarification of NAACCR and NPCR Required Status
Summary stage is required. The correct data item to use (and corresponding code manual) is determined by the year in which the cancer was diagnosed. Tumors diagnosed on or after January 1, 2004, should be assigned a summary stage based upon the Collaborative Stage data item algorithms and retained in Derived SS2000 [3020]. Tumors diagnosed on or after January 1, 2001, should be assigned a summary stage according to the SEER *Summary Staging Manual 2000*, and the code should be reported in SEER Summary Stage 2000 [759]. Tumors diagnosed before January 1, 2001, should be assigned a summary stage according to *SEER Summary Stage Guide 1977*, and the code should be reported in SEER Summary Stage 1977 [760].

SEER SUMMARY STAGE 2000

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	759	1	SEER	2001	9			904 - 904

Description
Code for summary stage at the initial diagnosis or treatment of the reportable tumor. For hospital registries, CoC requires its use in the absence of a defined AJCC classification. For site-specific definitions of categories, see SEER *Summary Staging Manual 2000*.

Summary stage should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Rationale
Stage information is important when evaluating the effects of cancer control programs. It is crucial in understanding whether changes over time in incidence rates or outcomes are due to earlier detection of the cancers. In addition, cancer treatment cannot be studied without knowing the stage at diagnosis.

0 *In situ*
1 Localized
2 Regional, direct extension only
3 Regional, regional lymph nodes only
4 Regional, direct extension and regional lymph nodes
5 Regional, NOS
7 Distant
8 Not applicable
9 Unstaged

Note: Code 8 has been added in Version 10.1 to be used when there is not an applicable code to reflect stage (e.g., benign brain, borderline ovarian).

Note: See also the item Derived SS2000 [3020] for the value of SEER Summary Stage 2000 as generated by the collaborative Staging algorithm.

Clarification of NAACCR and NPCR Required Status
Summary stage is required. The correct data item to use (and corresponding code manual) is determined by the year in which the cancer was diagnosed. Tumors diagnosed on or after January 1, 2004, should be assigned a summary stage based upon the Collaborative Stage data item algorithms and retained in Derived SS2000 [3020]. Tumors diagnosed on or after January 1, 2001, should be assigned a summary stage according to the SEER *Summary Staging Manual 2000*, and the code should be reported in SEER Summary Stage 2000 [759]. Tumors diagnosed before January 1, 2001, should be assigned a summary stage according to *SEER Summary Stage Guide 1977*, and the code should be reported in SEER Summary Stage 1977 [760].

SEER TYPE OF FOLLOW-UP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Type of Follow-Up (SEER)	2180	1	SEER	1995	4			1946 - 1946

Description
Codes for the type of follow-up expected for a SEER case.

Codes

1 "Autopsy-Only" or "Death Certificate-Only" case
2 Active follow-up case
3 *In situ* cancer of the cervix uteri only
4 Case not originally in active follow-up, but in active follow-up now (San Francisco-Oakland only)

SEQUENCE NUMBER--CENTRAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Sequence Number (pre-96 SEER)	380	2	SEER					528 - 529

Description
Code indicates the sequence of all reportable neoplasms over the lifetime of the person. This data item differs from Sequence Number-Hospital [560], because the definitions of reportable neoplasms often vary between a hospital and a central registry. Each neoplasm is assigned a different number. Sequence Number 00 indicates that the person has had only one *in situ* or one malignant neoplasm as defined by the Federal reportable list (regardless of central registry reference date). Sequence Number 01 indicates the first of two or more reportable neoplasms, but 02 indicates the second of two or more reportable neoplasms, and so on. Because the time period of Sequence Number is a person's lifetime, reportable neoplasms not included in the central registry (those that occur outside the registry catchment area or before the reference date) also are allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm preceded the central registry's reference date.

Reporting Requirements: Federally Required and State/Province Defined
The Federal or SEER/NPCR standard defining the reportable neoplasms is described in Chapter III, Standards For Tumor Inclusion and Reportability. It is assumed that this shared standard is the "minimum" definition of reportability. Individual central cancer registries may define additional neoplasms as reportable.

Numeric codes in the 00-59 range indicate the sequence of neoplasms of *in situ* or malignant behavior (2 or 3) at the time of diagnosis, which SEER/NPCR standards require to be reported. Codes 60 to 87 indicate the sequence of non-malignant tumors (as defined in Chapter III) and any other neoplasms that the central registry has defined as reportable. Neoplasms required by SEER/NPCR with an *in situ* or malignant behavior at the time of diagnosis are sequenced completely independently of this higher-numbered category. Sequence Number-Hospital does not affect Sequence Number-Central. The two notational systems are independent but central registries should take Sequence Number-Hospital [560] into account when coding Sequence Number Central.

Rationale

lifetimes for survival analysis. If a central registry sequences by just what is reported to them, then it will be unclear whether 00 means the person only had one malignant primary in his lifetime or the person had one malignant primary since the central registry started collecting data. The Federally required reportable list has changed throughout the years, so the registry must use the appropriate reportable list for the year of diagnosis. The central registry reference date will not affect Sequence Number-Central.

Codes

....
00 One primary in the patient's lifetime
01 First of two or more primaries
02 Second of two or more primaries
....
....
59 Fifty-ninth or higher of fifty-nine or more primaries
99 Unspecified or unknown sequence number of Federally required *in situ* or malignant tumors. Sequence number 99 can be used if there is a malignant tumor and its sequence number is unknown. If there is known to be more than one malignant tumor, then the tumors must be sequenced.)
....
60 One non-malignant tumor or central registry-defined neoplasm
61 First of two or more non-malignant tumor or central registry-defined neoplasms
62 Second of two or more non-malignant tumor or central registry-defined neoplasms
....
88 Unspecified or unknown sequence number for non-malignant tumor or central registry-defined neoplasms. (Sequence number 88 can be used if there is a non-malignant tumor and its sequence number is unknown. If there is known to be more than one non-malignant tumor, then the tumors must be sequenced.)
98 Cervix carcinoma *in situ* (CIS)/CIN III, Diagnosis Years 1996-2002.

The table that follows shows which sequence number series to use by type of neoplasm.

Neoplasm	***SeqNum-Central***
In Situ/Malignant as Federally Required based on Diagnosis Year	***(Numeric Series)***
In Situ (behavior code = 2) (Cervix CIS/CIN III, Diagnosis Year before 1996) (includes VIN III, VAIN III, AIN III)	*00 -- 59*
Malignant (behavior code = 3)	*00 -- 59*
Juvenile Astrocytoma, Diagnosis Year 2001+ (*)	*00 -- 59*
Invasive following In Situ--New primary as defined by CoC	*00 -- 59*
Invasive following In Situ--New primary as defined by SEER	*00 -- 59*
Unspecified Federally Required Sequence Number or Unknown	*99*
Non-malignant Tumor as Federally Required based on Diagnosis Year or State/Province Registry-Defined	
Examples:	
Non-malignant Tumor/Benign Brain	*60 -- 87*
Borderline Ovarian, Diagnosis Year 2001+	*60 -- 87*
Other Borderline/Benign	*60 -- 87*
Skin SCC/BCC	*60 -- 87*
PIN III	*60 -- 87*
Cervix CIS/CIN III, Diagnosis Year 2003+	*60 -- 87*

Defined Sequence Number	
Cervix CIS/CIN III, Diagnosis Year 1996-2002	*98*

Note: See the section on Sequence Number--Central in The *SEER Program Code Manual*.

Note: Conversion Guidance: The sequence numbers for neoplasms whose histologies were associated with behavior codes that changed from *in situ*/malignant to benign/borderline or vice versa during the conversion from ICD-O-2 to ICD-O-3 should not be re-sequenced.

SEQUENCE NUMBER--HOSPITAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Sequence Number (CoC)	560	2	CoC					740 - 741

Description
Item indicates the sequence of all malignant and non-malignant neoplasms over the lifetime of the patient. The code may differ from the Sequence Number--Central [380] because the definitions of reportable neoplasms often vary between a hospital and a central registry. The two items also handle some types of tumors differently. Each neoplasm is assigned a different number. Sequence Number 00 indicates that the person has only one malignant neoplasm in his lifetime (regardless of hospital registry reference date). Sequence Number 01 indicates the first of two or more malignant neoplasms, while 02 indicates the second of two or more malignant neoplasms, and so on. Because the time period of Sequence Number is a person's lifetime, reportable neoplasms not included in the hospital registry are also allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the hospital registry's reference date. Similarly, Sequence Number 60 indicates the patient has only one non-malignant neoplasm, and Sequence Number 61 represents the first of multiple non-malignant neoplasms.

Sequence numbers should be reassigned if the facility subsequently learns of an unaccessioned tumor that affects sequencing. Sequence Number-Central [380] does not affect Sequence Number-Hospital. The two notational systems are independent.

Timing Rule
If two or more malignant tumors are diagnosed at the same time, the lowest sequence number will be assigned to the diagnosis with the worst prognosis. Likewise, if two or more non-malignant tumors are diagnosed at the same time, the lowest sequence number is assigned to the diagnosis with the worse prognosis. If no difference in prognosis is evident, the decision is arbitrary.

Codes

...
00 One malignant primary only in the patient's lifetime
01 First of two or more malignant primaries
02 Second of two or more malignant primaries
.. (Actual number of this malignant primary)
59 Fifty-ninth or higher of fifty-nine or more malignant primaries
99 Unspecified sequence number of a primary malignant tumor or unknown. When a patient has multiple tumors with unspecified/unknown sequence numbers code 99 should only be used once.)
...
60 Only one non-malignant tumor in the patient's lifetime
61 First of two or more non-malignant tumors
62 Second of two or more non-malignant tumors
...
88 Unspecified number of non-malignant tumors (When a patient has multiple unspecified neoplasms in this category code 88 should only be used once.)

The table that follows shows which sequence number series to use by type of neoplasm .

Neoplasm	**SeqNum-Hospital**
***In situ*/Malignant**	**(code range)**
One *in situ* (behavior code = 2) or malignant (behavior code =3) primary tumor only in the patient's lifetime	00
First of multiple *in situ* or malignant primary tumors in the patient's lifetime	01
Actual sequence of two or more *in situ* or malignant primary tumors	02 -- 59

Non-Malignant	
One benign (behavior code = 0) or borderline (behavior code = 1) primary tumor only in the patient's lifetime	60
First of two or more benign or borderline primary tumors in the patient's lifetime	61
Actual sequence of two or more non-malignant primary tumors	62 -- 87
Unspecified non-malignant sequence number or unknown	88

*Juvenile astrocytomas should be reported as 9421/3.

Note: See the section on Sequence Number in CoC (*FORDS*) manual.

SEX

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	220	1	SEER/CoC					192 - 192

Description
Code for the sex of the patient.

Codes

1 Male
2 Female
3 Other (intersex, disorders of sexual development/DSD). The word hermaphrodite formally classified under this code is an outdated term.
4 Transsexual, NOS
5 Transsexual, natal male
6 Transsexual, natal female
9 Not stated/Unknown

SITE (73-91) ICD-O-1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Primary Site (1973-91) (SEER)	1960	4	SEER					1909 - 1912

Description
Area for retaining the ICD-O-1 primary site code entered before conversion to ICD-0-2. The item name includes years 1973-91. However, some states may have used the codes for cases before 1973.

Codes
For tumors diagnosed before 1992, contains the ICD-O-1 site code as originally coded, if available. Blank for tumors coded directly into ICD-O-2 (i.e., 1992 and later tumors).

SITE CODING SYS--CURRENT

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	450	1	NAACCR					558 - 558

Description
Code that best describes how the primary site currently is coded. If converted, this field shows the system to which it is converted.

Codes

1 ICD-8 and MOTNAC
2 ICD-9
3 ICD-O, First Edition
4 ICD-O, Second Edition
5 ICD-O, Third Edition

9 Other

SITE CODING SYS--ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	460	1	NAACCR					559 - 559

Description
Code that best describes how primary site was originally coded. If converted, this field shows the original coding system used.

Codes

1 ICD-8 and MOTNAC
2 ICD-9
3 ICD-O, First Edition
4 ICD-O, Second Edition
5 ICD-O, Third Edition
6 ICD-10
9 Other

SOCIAL SECURITY NUMBER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2320	9	CoC					3619 - 3627

Description
Records patient's social security number. The number is entered without dashes and without any letter suffix. This is not always identical to the Medicare claim number.

Codes (in addition to social security number)

999999999 Unknown

SPANISH/HISPANIC ORIGIN

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Spanish Origin--All Sources (96 CoC) Spanish Surname or Origin (SEER)	190	1	SEER/CoC					189 - 189

Description
Code identifying persons of Spanish or Hispanic origin. This code is used by hospital and central registries to show the "best guess" as to whether or not the person should be classified as Hispanic for purposes of calculating cancer rates. If the patient has multiple tumors, all records should have the same code.

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf. All information resources should be used to determine the correct code, including:

- Stated ethnicity in the medical record
- Stated Hispanic origin on the death certificate
- Birthplace
- Information about life history and/or language spoken found during the abstracting process
- Patient's last name [2230] or maiden name [2390] found on a list of Hispanic names

Some registries code the information from the medical record, others code ethnicity based on Spanish names, and others use a combination of methods.

Persons of Spanish or Hispanic origin may be of any race, but these categories generally are not used for Native Americans, Filipinos, etc., who may have Spanish names. If a patient has an Hispanic name, but there is reason to believe they are not Hispanic (e.g., the patient is Filipino, or the patient is a woman known to be non-Hispanic who has a Hispanic married name), the code in this field should be 0 (non-Spanish, non-Hispanic). The code in item Computed Ethnicity [200], however, would reflect the Hispanic name.

Assign code 7 if Hispanic ethnicity is based strictly on a computer list or algorithm (unless contrary evidence is available) and also code in Computed Ethnicity [200].

See also Computed Ethnicity [200].

inadequate for describing names used in some cultures, including Hispanic cultures. Explicit instructions have not been provided for entering compound names, with or without hyphens or “De.” Order of names, use of maternal and paternal names, and use of hyphens can vary across cultures. It is likely that abstracting and coding practice for these items varies across registries. Limitations inherent in these definitions should be kept in mind when using the data.

Rationale
See the rationales for the Race 1-5 [160-164] and Computed Ethnicity [200]. Ethnic origin has a significant association with cancer rates and outcomes. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the “white” category of Race [160].

Codes

0 Non-Spanish; non-Hispanic
1 Mexican (includes Chicano)
2 Puerto Rican
3 Cuban
4 South or Central American (except Brazil)
5 Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6 Spanish, NOS Hispanic, NOS Latino, NOS There is evidence, other than surname or maiden name, that the person is Hispanic, but he/she cannot be assigned to any of the other categories 1-5.
7 Spanish surname only (Code 7 is ordinarily for central registry use only, hospital registrars may use code 7 if using a list of Hispanic surnames provided by their central registry; otherwise, code 9 'unknown whether Spanish or not' should be used.) The only evidence of the person's Hispanic origin is the 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

Note: Code 7 was adopted for use effective with 1994 diagnosis and modified December 1994. *Note:* Code 8 was added in Standards Volume II Version 10.2, effective January 2005, however, abstractors may assign code 8 to tumors diagnosed prior to 2005.

STATE/REQUESTOR ITEMS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2220	1000	Varies	2011	12.2			2340 - 3339

Description
Reserved for use by individual states or central registries, or for use by special studies.

SUBSQ RX 2ND COURSE BRM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1675	1	CoC	2011	12.2			1743 - 1743

Description
Codes for the type of biological response modifier therapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Immunotherapy, *1998 ROADS Manual*, p. 243. See also First Course Calc Method [1500].

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

SUBSQ RX 2ND COURSE CHEMO

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1673	1	CoC	2011	12.2			1741 - 1741

Description
Codes for the type of chemotherapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Chemotherapy, *1998 ROADS Manual*, p. 228. See also First Course Calc Method [1500].

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

SUBSQ RX 2ND COURSE CODES

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #

Description
The name for a group of subfields that describe the second course or set of subsequent therapy. As of January 1, 2003, CoC no longer supports Subsequent Therapy data items.

Group names appear only in the data dictionary and Appendix E.

Subfields
- Subsq RX 2nd Course Surg [1671]
- Subsq RX 2nd Course Rad [1672]
- Subsq RX 2nd Course Chemo [1673]
- Subsq RX 2nd Course Horm [1674]
- Subsq RX 2nd Course BRM [1675]
- Subsq RX 2nd Course Oth [1676]

SUBSQ RX 2ND COURSE DATE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Second Course of Therapy-Date Started (pre-96 CoC)	1660	8	CoC					1724 - 1731

Description
Date of initiation of second-course treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. See Chapter X for date format. Use SUBSQ RX 2NDCRS DATE FLAG [1661] if there is no appropriate or known date for this item.

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

SUBSQ RX 2ND COURSE HORM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1674	1	CoC					1742 - 1742

Description
Codes for the type of hormonal therapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Hormone Therapy, *1998 ROADS Manual*, p. 238. See also First Course Calc Method [1500].

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

SUBSQ RX 2ND COURSE OTH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1676	1	CoC	2011	12.2			1744 - 1744

Description
Codes for the type of other treatment given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Other Treatment, *1998 ROADS Manual*, p. 246. See also First Course Calc Method [1500].

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

SUBSQ RX 2ND COURSE RAD

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1672	1	CoC	2011	12.2			1740 - 1740

Description
Codes for the type of radiation given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Radiation, *1998 ROADS Manual*, p. 199. See also First Course Calc Method [1500].

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

SUBSQ RX 2ND COURSE SURG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1671	2	CoC	2011	12.2			1734 - 1735

Description
Codes for the type of primary site surgery given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Surgery of Primary Site, *1998 ROADS Manual*, p. 187. See also First Course Calc Method [1500].

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

SUBSQ RX 2NDCRS DATE FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1661	2	NAACCR	2010	12			1732 - 1733

Description
This flag explains why no appropriate value is in the field, Subsq RX 2nd Course Date [1660].

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any subsequent therapy)
11	No proper value is applicable in this context (e.g., no subsequent therapy)
Blank	A valid date value is provided in item Subsq RX 2nd Course Date [1660], or the date was not expected to have been transmitted

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

SUBSQ RX 2ND--REG LN REM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1679	2	CoC	1997	5.1			1738 - 1739

Description
Codes for the number of regional lymph nodes removed as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Number of Regional Lymph Nodes Removed, *1998 ROADS Manual*, p. 193. See also First Course Calc Method [1500].

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

SUBSQ RX 2ND--SCOPE LN SU

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1677	1	CoC	1997	5.1			1736 - 1736

Description
Codes for the type of surgery performed to remove regional lymph nodes as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Scope of Regional Lymph Node Surgery, *1998 ROADS Manual*, p. 192. See also First Course Calc Method [1500].

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

SUBSQ RX 2ND--SURG OTH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1678	1	CoC	1997	5.1			1737 - 1737

Description
Codes for the type of surgery performed on tissue or organs other than the primary site and regional lymph nodes as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s), *1998 ROADS Manual*, p. 194. See also First Course Calc Method [1500].

SUBSQ RX 3RD COURSE BRM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1695	1	CoC	2011	12.2			1764 - 1764

Description
Codes for the type of biological response modifier therapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Immunotherapy, *1998 ROADS Manual*, p. 243

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

SUBSQ RX 3RD COURSE CHEMO

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1693	1	CoC	2011	12.2			1762 - 1762

Description
Codes for the type of chemotherapy given as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Chemotherapy, *1998 ROADS Manual*, p. 228.

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

SUBSQ RX 3RD COURSE CODES

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1690	11						1755 - 1765

Description
The name for a group of subfields that describe the third course or set of subsequent therapy. As of January 1, 2003, CoC no longer supports Subsequent Therapy data items.

Group names appear only in the data dictionary and Appendix E.

Subfields
Subsq RX 3rd Course Surg [1691]
Subsq RX 3rd Course Rad [1692]
Subsq RX 3rd Course Chemo [1693]
Subsq RX 3rd Course Horm [1694]
Subsq RX 3rd Course BRM [1695]
Subsq RX 3rd Course Oth [1696]

SUBSQ RX 3RD COURSE DATE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1680	8	CoC					1745 - 1752

Description
Date of initiation of third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. See Chapter X for date format. Use SUBSQ RX 3RDCRS DATE FLAG [1681] if there is no appropriate or known date for this item.

SUBSQ RX 3RD COURSE HORM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1694	1	CoC	2011	12.2			1763 - 1763

Description
Codes for the type of hormonal therapy given as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Hormone Therapy, *1998 ROADS Manual*, p. 238.

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

SUBSQ RX 3RD COURSE OTH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1696	1	CoC	2011	12.2			1765 - 1765

Description
Codes for the type of other treatment given as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Other Treatment, *1998 ROADS Manual*, p. 246.

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

SUBSQ RX 3RD COURSE RAD

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1692	1	CoC	2011	12.2			1761 - 1761

Description
Codes for the type of radiation given as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Radiation, *1998 ROADS Manual*, p. 199.

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

SUBSQ RX 3RD COURSE SURG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1691	2	CoC	2011	12.2			1755 - 1756

Description
Codes for the type of primary site surgery given as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Surgery of Primary Site, *1998 ROADS Manual*, p. 187.

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

SUBSQ RX 3RDCRS DATE FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1681	2	NAACCR	2010	12			1753 - 1754

Description
This flag explains why no appropriate value is in the field, Subsq RX 3rd Course Date [1680].

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any subsequent therapy)
11	No proper value is applicable in this context (e.g., no subsequent therapy)
Blank	A valid date value is provided in item Subsq RX 3rd Course Date [1680], or the date was not expected to have been transmitted

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

SUBSQ RX 3RD--REG LN REM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1699	2	CoC	1997	5.1			1759 - 1760

Description
Codes for the number of regional lymph nodes removed as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Number of Regional Lymph Nodes Removed, *1998 ROADS Manual*, p. 193.

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

SUBSQ RX 3RD--SCOPE LN SU

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1697	1	CoC	1997	5.1			1757 - 1757

Description
Codes for the type of surgery performed to remove regional lymph nodes as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Scope of Regional Lymph Node Surgery, *1998 ROADS Manual*, p. 192.

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

SUBSQ RX 3RD--SURG OTH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1698	1	CoC	1997	5.1			1758 - 1758

Description
Codes for the type of surgery performed on tissue or organs other than the primary site and regional lymph nodes as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s), *1998 ROADS Manual*, p. 194.

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

SUBSQ RX 4TH COURSE BRM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1715	1	CoC	2011	12.2			1785 - 1785

Description
Codes for the type of biological response modifier therapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Immunotherapy, *1998 ROADS Manual*, p. 243

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

SUBSQ RX 4TH COURSE CHEMO

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1713	1	CoC	2011	12.2			1783 - 1783

Description
Codes for the type of chemotherapy given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Chemotherapy, *1998 ROADS Manual*, p. 228.

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

SUBSQ RX 4TH COURSE CODES

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1710	11						1776 - 1786

Description
The name for a group of subfields that describe the fourth course or set of subsequent therapy. As of January 1, 2003, CoC no longer support Subsequent Therapy data items.

Group names appear only in the data dictionary and Appendix E.

Subfields

Subsq RX 4th Course Surg [1711]
Subsq RX 4th Course Rad [1712]
Subsq RX 4th Course Chemo [1713]
Subsq RX 4th Course Horm [1714]

Subsq RX 4th Course Oth [1716]

SUBSQ RX 4TH COURSE DATE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1700	8	CoC					1766 - 1773

Description
Date of initiation of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. See Chapter X for date format. Use SUBSQ RX 4THCRS DATE FLAG [1701] if there is no appropriate or known date for this item.

SUBSQ RX 4TH COURSE HORM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1714	1	CoC	2011	12.2			1784 - 1784

Description
Codes for the type of hormonal therapy given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Hormone Therapy, *1998 ROADS Manual*, p. 238.

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

SUBSQ RX 4TH COURSE OTH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1716	1	CoC	2011	12.2			1786 - 1786

Description
Codes for the type of other treatment given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Other Treatment, *1998 ROADS Manual*, p. 246.

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

SUBSQ RX 4TH COURSE RAD

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1712	1	CoC	2011	12.2			1782 - 1782

Description
Codes for the type of radiation given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Radiation, *1998 ROADS Manual*, p. 199.

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

SUBSQ RX 4TH COURSE SURG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1711	2	CoC	2011	12.2			1776 - 1777

Description
Codes for the type of primary site surgery given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Surgery of Primary Site, *1998 ROADS Manual*, p. 187.

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

SUBSQ RX 4THCRS DATE FLAG

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1701	2	NAACCR	2010	12			1774 - 1775

This flag explains why no appropriate value is in the field, Subsq RX 4th Course Date [1700].

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any subsequent therapy)
11	No proper value is applicable in this context (e.g., no subsequent therapy)
Blank	A valid date value is provided in item Subsq RX 4th Course Date [1700], or the date was not expected to have been transmitted

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

SUBSQ RX 4TH--REG LN REM

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1719	2	CoC	1997	5.1			1780 - 1781

Description
Codes for the number of regional lymph nodes removed as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Number of Regional Lymph Nodes Removed, *1998 ROADS Manual*, p. 193.

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

SUBSQ RX 4TH--SCOPE LN SU

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1717	1	CoC	1997	5.1			1778 - 1778

Description
Codes for the type of surgery performed to remove regional lymph nodes as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Scope of Regional Lymph Node Surgery, *1998 ROADS Manual*, p. 192.

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

SUBSQ RX 4TH--SURG OTH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1718	1	CoC	1997	5.1			1779 - 1779

Description
Codes for the type of surgery performed on tissue or organs other than the primary site and regional lymph nodes as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s), *1998 ROADS Manual*, p. 194.

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

SUBSQ RX--RECONSTRUCT DEL

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Reconstruction/Restoration--Delayed (CoC)	1741	1	CoC	1997	5.1			1787 - 1787

Description
Code for surgical procedure done to reconstruct, restore, or improve shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or therapies. Reconstructive/restorative procedures are coded here when started after the first course of therapy. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. For reconstructive/restorative procedures started during the first course of therapy, see RX Summ--Reconstruct 1st [1330]. See also RX Summ--Surgery Type [1640].

Codes
See the CoC *ROADS* Manual, 1998 Supplement, for site-specific codes.

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

SURV-DATE ACTIVE FOLLOWUP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1782	8	NAACCR	2015	15			2292 - 2299

Description
The Surv-Date Active Followup is defined as the earlier of the Date of Last Contact [1750] and a study cutoff date. The study cut-off date is a pre-determined date based on the year of data submission and is set in the survival program used to derive the seven survival variables. If the Date of Last Contact [1750] is earlier than the study cut-off date and either the day or month is unknown or not available, the values are imputed by the survival program. The survival program is available from your standard setter or NAACCR.

Example 1
Date of Last Contact: 20111120
Study Cut-off Date: 20111231
Surv-Date Active Followup: 20111120
Note: The date of last contact is earlier than the study cut-off date, and the date of last contact is complete, so the date of last contact is used in Surv-Date Active Followup.

Example 2
Date of Last Contact: 201111
Study Cut-off Date: 20111231
Surv-Date Active Followup: 20111115
Note: Rationale is to take mid-point of possible values. For Nov (30 days) it would be FLOOR((1+30)/2) = 15, where FLOOR is a function that rounds a decimal down to an integer.

Rationale
The Surv-Date Active Followup is needed to be able to recalculate survival months if a different study cut-off date is used and provides flexibility to recalculate survival without needing to rerun the survival program on the original data.

Additional information about the survival algorithm and what specific values are assigned in given missing date situations are available here: http://seer.cancer.gov/survivaltime/.

Codes

If Date of Last Contact [1750] is blank, Surv-Date Active Followup will also be blank.

SURV-DATE DX RECODE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1788	8	NAACCR	2015	15			2318 - 2325

Description
The survival date of diagnosis recode is calculated using the month, day, and year of the Date of Diagnosis [390]. If the Date of Diagnosis [390] has complete month and day information, the Surv-Date Dx Recode will be the same as the Date of Diagnosis [390]. If the day or month is unknown or not available, the values are imputed by the survival program used to derive the seven survival variables. The survival program is available from your standard setter or NAACCR.

Example 1
Date of diagnosis: 20111199
Date of Last Contact: 20111120
Surv-Date of DX Recode: 20111110
Note: The recoded value is the mid-point between 11/1 and 11/20.

Example 2
Date of diagnosis: 2011
Date of Last Contact: 20111120
Surv-Date of DX Recode: 20110611
Note: The recoded value is the mid-point between 20110101 and 20111120.

Rationale
The Surv-Date DX Recode is needed to be able to match to a lifetable entry to obtain expected survival. If a case is diagnosed in January 2000, the first 12 months of expected survival will be from the 2000 life table. If a case is diagnosed in December 2000, only one month will be from the 2000 life table and then the 2001 life table is used.

Additional information about the survival algorithm and what specific values are assigned in given missing date situations are available here: http://seer.cancer.gov/survivaltime/.

SURV-DATE PRESUMED ALIVE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1785	8	NAACCR	2015	15			2305 - 2312

Description
The Surv-Date Presumed Alive is the last date for which complete death ascertainment is available from the registry at the time a file is transmitted. Because not all central cancer registries conduct active patient follow-up, it is necessary to have an option for calculating survival times based on the assumption that the registry has ascertained all available deaths (state/province and national), and persons not known to be deceased are presumed to be alive as of the last date for which complete death ascertainment is available. This variable is set in the survival program used to derive the seven survival variables. The survival program is available from your standard setter or NAACCR.

Example 1
Vital Status: Alive
Date of Last Contact: 20111120
Study Cut-off Date: 20111231
Latest date for complete death ascertainment: 20111231
Surv-Date Presumed Alive: 20111231

Rationale
The Surv-Date Presumed Alive is needed to be able to recalculate survival months if a different study cut-off date is used and provides flexibility to recalculate survival without needing to rerun the survival program on the original data.

Additional information about the survival algorithm and what specific values are assigned in given missing date situations are available here: http://seer.cancer.gov/survivaltime/.

SURV-FLAG ACTIVE FOLLOWUP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1783	1	NAACCR	2015	15			2300 - 2300

Description
This flag is generated by the program that creates Surv-Mos Active Followup [1784] and describes how complete the date information is that was used to calculate survival months. This item is one of seven survival variables designed to facilitate a common approach to survival analysis by NAACCR registries.

Rationale
The flag will enable analysts to easily select a subset of cases.

Codes

0	Complete dates are available and there are 0 days of survival (i.e., date last contact = date of diagnosis)
1	Complete dates are available and there are more than 0 days of survival (i.e., date last contact > date diagnosis)
2	Incomplete dates are available and there could be zero days of follow-up (i.e., known components are equal, e.g., 2006 and 20061002)
3	Incomplete dates are available and there cannot be zero days of follow-up (i.e., any difference in known date components, e.g., 200602 and 200603)
8	Not calculated because a Death Certificate Only or Autopsy Only case
9	Unknown
Blank	Not coded

SURV-FLAG PRESUMED ALIVE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1786	1	NAACCR	2015	15			2313 - 2313

Description
This flag is generated by the program that creates Surv-Mos Presumed Alive [1787] and describes how complete the date information is that was used to calculate survival months. This item is one of seven survival variables designed to facilitate a common approach to survival analysis by NAACCR registries.

Rationale
The flag will enable analysts to easily select a subset of cases.

Codes

0	Complete dates are available and there are 0 days of survival (i.e., presumed alive date last contact = date of diagnosis)
1	Complete dates are available and there are more than 0 days of survival (i.e., presumed alive date last contact > date diagnosis)
2	Incomplete dates are available and there could be zero days of follow-up (i.e., known components are equal, e.g., 2006 and 20061002)

and 200603)
8 Not calculated because a Death Certificate Only or Autopsy Only case
9 Unknown
Blank Not coded

SURV-MOS ACTIVE FOLLOWUP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1784	4	NAACCR	2015	15			2301 - 2304

Description
The survival interval in months is calculated using the month, day, and year of the Surv-Date DX Recode [1788] and the month, day, and year of the Surv-Date Active Followup [1782]. The survival interval is calculated by a program available from your standard setter or NAACCR.

Example of a case diagnosed in 2011 and submitted in 2013.
Date of submission: 20131101
Date of diagnosis: 20110915
Date of last contact: 20111017
Vital status: Alive
Study cutoff date: 20111231
20111017 would be used as the date of last contact for the survival calculation. The survival time would be 1 month.

Rationale
Accurate survival estimates are crucial for monitoring trends in population-based cancer survival and assessing the effectiveness of healthcare delivery to cancer patients. With the aim of obtaining the most precise estimates of survival, it is necessary to use complete dates (month, day, and year components) in the calculation of the survival interval. The survival interval in months is calculated using complete dates, and the algorithm imputes missing components of dates when they are not available in central registry records.

Additional information about the algorithm and what specific values are assigned in given missing date situations are available here: http://seer.cancer.gov/survivaltime/.

Codes
A value of 9999 is for missing and matches the Surv- Flag Active Followup value of 9 or blank. Leading zeros will be used when needed to left fill the field.

Calculation
Survival months = FLOOR((endpoint – date of diagnosis) / days in a month)

The FLOOR function rounds a decimal down to an integer, e.g., FLOOR(1.68) = 1. Days in a month is assigned as 365.24/12.

SURV-MOS PRESUMED ALIVE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1787	4	NAACCR	2015	15			2314 - 2317

Description
Because not all central cancer registries conduct active patient follow-up, it is necessary to have an option for calculating survival times based on the assumption that the registry has ascertained all available deaths (state/province and national), and persons not known to be deceased are presumed to be alive as of the last date for which complete death ascertainment is available. The survival interval in months is calculated using the month, day, and year of the Surv-Date DX Recode [1788] and the month, day, and year of the Surv-Date Presumed Alive [1785]. The survival program is available from your standard setter or NAACCR.

Example of a case diagnosed in 2011 and submitted in 2013.
Date of submission: 20131101
Date of diagnosis: 20110915
Date of last contact: 20111017
Latest date for complete death ascertainment: 20111231
Vital status: Alive
Study cutoff date: 20111231
Under the "presumed alive" scenario, 20111231 would be used as the endpoint for the survival calculation. The presumed alive survival time would be 3 months, while the survival time using the date of last contact (assuming active follow-up) would be 1 month.

Rationale
Accurate survival estimates are crucial for monitoring trends in population-based cancer survival and assessing the effectiveness of healthcare delivery to cancer patients. With the aim of obtaining the most precise estimates of survival, it is necessary to use complete dates (month, day, and year components) in the calculation of the survival interval. The survival interval in months is calculated using complete dates, and the algorithm imputes missing components of dates when they are not available in central registry records.

http://seer.cancer.gov/survivaltime/.

Codes

A value of 9999 is for missing and matches the Surv-Flag Presumed Alive [1786] value of 9 or blank. Leading zeros will be used when needed to left fill the field.

TELEPHONE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2360	10	CoC					3868 - 3877

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

Codes (in addition to valid telephone number)

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

Note: Prior to Version 5, Follow-Up Contact fields may have been used for patient current telephone in the NAACCR record layout.

TEXT--DX PROC--LAB TESTS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2550	1000	NPCR					8565 - 9564

Description
Text area for manual documentation of information from laboratory examinations other than cytology or histopathology.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- Type of lab test/tissue specimen(s)
- Record both positive and negative findings. Record positive test results first.
- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Date(s) of lab 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)

Data Item(s) to be verified/validated using the text entered in this field:
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Primary Site	400
Grade	440
Diagnostic Confirmation	490
Collaborative Stage variables	2800-2930
Date of Diagnosis	390

TEXT--DX PROC--OP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2560	1000	NPCR					9565 - 10564

Description
Text area for manual documentation of all surgical procedures that provide information for staging.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived
- Number of lymph nodes removed
- Size of tumor removed
- Documentation of residual tumor
- Evidence of invasion of surrounding areas
- Reason primary site surgery could not be completed

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Diagnosis	390
RX Summ--Dx/Stg Proc	1350
Diagnostic Confirmation	490
Primary Site	400
RX Hosp--Dx/Stg Proc	740
RX Summ--Surg Prim Site	1290
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759
Reason for No Surgery	1340

TEXT--DX PROC--PATH

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2570	1000	NPCR					10565 - 11564

Description
Text area for manual documentation of information from cytology and histopathology reports.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- Date(s) of procedure(s)
- Anatomic source of specimen
- Type of tissue specimen(s)
- Tumor type and grade (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.)
- Gross tumor size
- Extent of tumor spread
- Involvement of resection margins
- Number of lymph nodes involved and examined
- Record both positive and negative findings. Record positive test results first.
- Note if pathology report is a slide review or a second opinion from an outside source, i.e., AFIP, Mayo, etc.
- Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Diagnosis	390
Primary Site	400
Laterality	410
Histologic Type ICD-O-3	522
Grade	440
Collaborative Stage variables	2800-2930
Diagnostic confirmation	490
RX Hosp--Surg Prim Site	670
RX Hosp--Scope Reg LN Sur	672
RX Hosp--Surg Oth Rg/Dis	674
RX Summ--Surg Prim Site	1290
RX Summ--Scope Reg LN Sur	1292
RX Summ--Surg Oth Reg/Dis	1294
SEER Summary Stage 2000	759
SEER Summary Stage 1977	760
Regional Nodes Positive	820
Regional Nodes Examined	830
RX Date Surgery	1200
Reason for No Surgery	1340
RX Summ--Surg/Rad Seq	1380
RX Summ--Systemic/Sur Seq	1639

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2520	1000	NPCR					5565 - 6564

Description
Text area for manual documentation from the history and physical examination about the history of the current tumor and the clinical description of the tumor.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

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
- Impression (when stated and pertains to cancer diagnosis)
- Treatment plan

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Diagnosis	390
Primary Site	400
Laterality	410
Histologic Type ICD-O-3	522
Grade	440
Collaborative Stage variables	2800-2930
Diagnostic confirmation	490
RX Hosp--Surg Prim Site	670
RX Hosp--Scope Reg LN Sur	672
RX Hosp--Surg Oth Rg/Dis	674
RX Summ--Surg Prim Site	1290
RX Summ--Scope Reg LN Sur	1292
RX Summ--Surg Oth Reg/Dis	1294
SEER Summary Stage 2000	759
SEER Summary Stage 1977	760
Regional Nodes Positive	820
Regional Nodes Examined	830
RX Date Surgery	1200

RX Summ--Surg/Rad Seq	1380
RX Summ--Systemic/Sur Seq	1639

TEXT--DX PROC--SCOPES

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2540	1000	NPCR					7565 - 8564

Description
Text area for manual documentation from endoscopic examinations that provide information for staging and treatment.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- Date(s) of endoscopic exam(s)
- Primary site
- Histology (if given)
- Tumor location
- Tumor size
- Record site and type of endoscopic biopsy
- Record positive and negative clinical findings. Record positive results first

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Diagnosis	390
RX Summ--Dx/Stg Proc	1350
Diagnostic Confirmation	490
Primary Site	400
Laterality	410
Histology (92-00) ICD-O-2	420
Histologic Type ICD-O-3	522
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759
RX Hosp--Surg Prim Site	670
RX Date Surgery	1200

TEXT--DX PROC--X-RAY/SCAN

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2530	1000	NPCR					6565 - 7564

Text area for manual documentation from all X-rays, scan, and/or other imaging examinations that provide information about staging.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- Date(s) and type(s) of X-ray/Scan(s)
- Primary site
- Histology (if given)
- Tumor location
- Tumor size
- Lymph nodes
- Record positive and negative clinical findings. Record positive results first
- Distant disease or metastasis

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Diagnosis	390
RxSumm--Dx/Stg Proc	1350
Primary Site	400
Laterality	410
Histology (92-00) ICD-O-2	420
Histologic Type ICD-O-3	522
Collaborative Stage variables	2800-2930
SEER Summary Stage 2000	759
SEER Summary Stage 1977	760

TEXT--HISTOLOGY TITLE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2590	100	NPCR					11665 - 11764

Description
Text area for manual documentation of information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Information on histologic type and behavior
- Information on differentiation from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc.

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Histology (92-00) ICD-O-2	420
Behavior (92-00) ICD-O-2	430
Histologic Type ICD-O-3	522
Behavior Code ICD-O-3	523
Grade	440

TEXT--PLACE OF DIAGNOSIS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Place of Diagnosis	2690	60	NPCR					20765 - 20824

Description

Text area for manual documentation of the facility, physician office, city, state, or county where the diagnosis was made.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions

- Prioritize entered information in the order of the fields listed below.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- The complete name of the hospital or the physician office where diagnosis occurred. The initials of a hospital are not adequate.
- For out-of-state residents and facilities, include the city and the state where the medical facility is located.

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item Numbers: 2410, 2420, 500, 540, 610, 670, 740

TEXT--PRIMARY SITE TITLE

			Standard	Implemented	Implemented	Retired	Retired	
	2580	100	NPCR					11565 - 11664

Description
Text area for manual documentation of information regarding the primary site and laterality of the tumor being reported.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- State the specific location of the primary site, including subsite.
- Include available information on tumor laterality

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Primary site	400
Laterality	410

TEXT--REMARKS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2680	1000	NPCR					19765 - 20764

Description
Text area for information that is given only in coded form elsewhere or for which the abstract provides no other place. Overflow data can also be placed here. Problematic coding issues can also be discussed in this section.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments from other text fields can be continued in the Remarks field. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Smoking history
- Family and personal history of cancer
- Comorbidities
- Information on sequence numbers if a person was diagnosed with another primary out-of-state or before the registry's reference date
- Place of birth
- Justification of over-ride flags
- •Information clarifying anything unusual such as reason for reporting a case seemingly not reportable for that facility or reason for coding numerous fields as "unknown."

TEXT--STAGING

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2600	1000	NPCR					11765 - 12764

Description
Additional text area for staging information not already entered in other Text fields.

Rationale
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

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 specialty and comments

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
RxDate Dx/Stg Proc	1280
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759
Regional Nodes Positive	820
Regional Nodes Examined	830
RX Hosp--Surg Prim Site	670
RX Summ--Surg Prim Site	1290
RX Hosp--Scope Reg LN Sur	672
RX Summ--Scope Reg LN Sur	1292
RX Hosp--Surg Oth Rg/Dis	674

Mult Tum Rpt as One Prim	444
Lateraltiy	410

TEXT--USUAL INDUSTRY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	320	100	NPCR					317 - 416

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

Rationale
Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

The data item "usual industry" is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death.[25] See related materials in reference list, Chapter VII.

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

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

As noted in the Text--Usual Occupation [310] section, in those situations where the usual occupation is not available or is unknown, the patient's current or most recent occupation is recorded, if available. The information for industry should be based upon the information in occupation. Therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient's current or most recent business/industry.

If later documentation in the patient's record provides an industry that is more likely to be the usual industry than what was originally recorded, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with industry information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

There should be an entry for Text--Usual Industry if any occupation is recorded. If no information is available regarding the industry in which the reported occupation was carried out, record "unknown." If the patient was not a student or homemaker and had never worked, record "never worked" as the usual industry. This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

TEXT--USUAL OCCUPATION

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	310	100	NPCR					217 - 316

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

Rationale
Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies occupational groups in which cancer screening or prevention activities may be beneficial.

The data item "usual occupation" is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death.[25] See related materials in reference list, Chapter VII.

Abstracting Instructions
Record the patient's usual occupation (i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor). Do not record "retired." If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation.

If later documentation in the patient's record provides an occupation that is more likely to be the usual occupation than what was originally recorded, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with occupation information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

the patient was a homemaker and did not work outside the home for most of his/her adult life, record “homemaker.” If the patient was not a student or homemaker and had never worked, record “never worked” as the usual occupation.

If no information is available, record “unknown.”

This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

TNM CLIN DESCRIPTOR

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Clinical Stage (Prefix/Suffix) Descriptor (CoC)	980	1	CoC					974 - 974

Description
Identifies the AJCC clinical stage (prefix/suffix) descriptor as recorded by the physician. AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout. CoC defines a descriptor and “Staged By” item for each of these three areas.

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

Codes

0 None
1 E (Extranodal, lymphomas only)
2 S (Spleen, lymphomas only)
3 M (Multiple primary tumors in a single site)
5 E & S (Extranodal and spleen, lymphomas only)
9 Unknown, not stated in patient record

TNM CLIN M

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Clinical M (CoC)	960	4	AJCC					966 - 969

Description
Detailed site-specific codes for the clinical metastases (M) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

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

Codes (in addition to those published in the *AJCC Cancer Staging Manual*

88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
This field is left blank if no information at all is available to code this item.

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

TNM CLIN N

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Clinical N (CoC)	950	4	AJCC					962 - 965

Description
Detailed site-specific codes for the clinical nodes (N) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

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

Codes (in addition to those published in the *AJCC Cancer Staging Manual)*

88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
This field is left blank if no information at all is available to code this item.

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

TNM CLIN STAGE GROUP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Clinical Stage Group (CoC)	970	4	AJCC					970 - 973

Description
Detailed site-specific codes for the clinical stage group as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

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

Codes (in addition to those published in the *AJCC Cancer Staging Manual*)

88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
99 Unknown, not staged

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

TNM CLIN STAGED BY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Staged By (Clinical Stage) (CoC)	990	2	CoC					836 - 837

Description
Identifies the person who recorded the clinical AJCC staging elements and the stage group in the patient's medical record.

Rationale
Data captured in this field can be used to evaluate the source of clinical staging and form the basis for quality management and improvement studies. This item can be used to monitor application of the CoC Staging Standard.

Codes (Refer to the most recent version of *FORDS* for additional coding instructions)

00 Not Staged
10 Physician, NOS, or physician type not specified in codes 11-15
11 Surgeon
12 Radiation Oncologist
13 Medical Oncologist
14 Pathologist
15 Multiple Physicians; tumor board, etc.
20 Cancer registrar
30 Cancer registrar and physician
40 Nurse, physician assistant, or other non-physician medical staff
50 Staging assigned at another facility
60 Staging by Central Registry
88 Case is not eligible for staging
99 Staged but unknown who assigned stage

TNM CLIN T

Alternate Name	Item #	Length	Source of	Year	Version	Year	Version	Column #

Clinical T (CoC)	940	4	AJCC					958 - 961

Description
Detailed site-specific codes for the clinical tumor (T) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

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

Codes (in addition to those published in the *AJCC Cancer Staging Manual*)

88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
This field is left blank if no information at all is available to code this item.

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

TNM EDITION NUMBER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1060	2	CoC					938 - 939

Description
A code that indicates the edition of the AJCC manual used to stage the case. This applies to the manually coded AJCC fields. It does not apply to the Derived AJCC T, N, M and AJCC Stage Group fields [2940, 2960, 2980, and 3000].

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

Codes

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

TNM PATH DESCRIPTOR

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Pathologic Stage (Prefix/Suffix) Descriptor (CoC)	920	1	CoC					956 - 956

Description
Identified the AJCC pathologic stage (prefix/suffix) descriptor as recorded by the physician. AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout. CoC defines a descriptor and "Staged By" item for each of these three areas.

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

Codes

1 E (Extranodal, lymphomas only)
2 S (Spleen, lymphomas only)
3 M (Multiple primary tumors in a single site)
4 Y (Classification during or after initial multimodality therapy)—pathologic staging only
5 E & S (Extranodal and spleen, lymphomas only)
6 M & Y (Multiple primary tumors and initial multimodality therapy)
9 Unknown, not stated in patient record

TNM PATH M

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Pathologic M (CoC)	900	4	AJCC					948 - 951

Description
Detailed site-specific codes for the pathologic metastases (M) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

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

Codes (in addition to those published in the *AJCC Cancer Staging Manual*)

88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
This field is left blank if no information at all is available to code this item.

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

TNM PATH N

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Pathologic N (CoC)	890	4	AJCC					944 - 947

Description
Detailed site-specific codes for the pathologic nodes (N) as defined by AJCC and recorded by physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

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

Codes (in addition to those published in the *AJCC Cancer Staging Manual*)

88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
This field is left blank if no information at all is available to code this item.

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

TNM PATH STAGE GROUP

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Pathologic Stage Group (CoC)	910	4	AJCC					952 - 955

Description
Detailed site-specific codes for the pathologic stage group as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale

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

Codes (in addition to those published in the *AJCC Cancer Staging Manual*)

88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
99 Unknown, unstaged

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

TNM PATH STAGED BY

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Staged By (Pathologic Stage) (CoC)	930	2	CoC					834 - 835

Description
Identifies the person who recorded the pathologic AJCC staging elements and the stage group in the patient's medical record.

Rationale
Data captured in this field can be used to evaluate the source of pathologic staging and form the basis for quality management and improvement studies.

Codes (Refer to the most recent version of *FORDS* for additional coding instructions)

00 Not staged
10 Physician, NOS, or physician type not specified in codes 11-15
11 Surgeon
12 Radiation Oncologist
13 Medical Oncologist
14 Pathologist
15 Multiple Physicians; tumor board, etc
20 Cancer registrar
30 Cancer registrar and physician
40 Nurse, physician assistant, or other non-physician medical staff
50 Staging assigned at another facility
60 Staging by Central Registry
88 Case is not eligible for staging
99 Staged but unknown who assigned stage

TNM PATH T

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Pathologic T (CoC)	880	4	AJCC					940 - 943

Description
Detailed site-specific codes for the pathologic tumor (T) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

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

Codes (in addition to those published in the *AJCC Cancer Staging Manual*)

88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
This field is left blank if no information at all is available to code this item.

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

TUMOR MARKER 1

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #

Description
Records prognostic indicators for specific sites or histologies. CoC offered these items for optional use for cases diagnosed 1996 and forward. See the CoC *ROADS Manual*, 1998 Supplement, for a list of specific sites and histologies.

For SEER requirements for the specific sites, histologies, and diagnosis years for which this item is coded, see the 1998 *SEER Program Code Manual*.

Codes

0	None done (SX)
1	Positive/elevated
2	Negative/normal; within normal limits (S0)
3	Borderline; undetermined whether positive/elevated or negative/normal
Three-tiered system:	
4	Range 1 (S1)
5	Range 2 (S2)
6	Range 3 (S3)
8	Ordered, but results not in chart
9	Not applicable
For sites for which Tumor Marker 1 is not collected	
9	Not applicable

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

TUMOR MARKER 2

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Tumor Marker Two (CoC)	1160	1	SEER					982 - 982

Description
Records prognostic indicators for specific sites or histologies. CoC offered these items for optional use for cases diagnosed 1996 and forward. See the CoC *ROADS Manual*, 1998 Supplement, for a list of specific sites and histologies.

For SEER requirements for the specific sites, histologies, and diagnosis years for which this item is coded, see the 1998 *SEER Program Code Manual*.

Codes

0	None done (SX)
1	Positive/elevated
2	Negative/normal; within normal limits (S0)
3	Borderline; undetermined whether positive/elevated or negative/normal
Three-tiered system:	
4	Range 1 (S1)
5	Range 2 (S2)
6	Range 3 (S3)
8	Ordered, but results not in chart
9	Not applicable
For sites for which Tumor Marker 2 is not collected:	
9	Not applicable

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

TUMOR MARKER 3

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
Tumor Marker Three (CoC)	1170	1	SEER					983 - 983

Description
Records prognostic indicators for specific sites or histologies. CoC offered these items for optional use for cases diagnosed 1996 and forward. See the CoC *ROADS Manual*, 1998 Supplement, for a list of specific sites and histologies.

Manual.

Codes

0	None done (SX)
1	Positive/elevated
2	Negative/normal; within normal limits (S0)
3	Borderline; undetermined whether positive/elevated or negative/normal
Three-tiered system:	
4	Range 1 (S1)
5	Range 2 (S2)
6	Range 3 (S3)
8	Ordered, but results not in chart
9	Not applicable
For sites for which Tumor Marker 3 is not collected:For sites for which Tumor Marker 3 is not collected:	
9	Not applicable

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

TUMOR RECORD NUMBER

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	60	2	NAACCR	2011	12.2			40 - 41

Description
A system-generated number assigned to each tumor. The number should never change even if the tumor sequence is changed or a record (tumor) is deleted.

Rationale
This is a unique number that identifies a specific tumor so data can be linked. “Sequence Number” cannot be used as a link because the number is changed if a report identifies an earlier tumor or if a tumor record is deleted.

TUMOR SIZE CLINICAL **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	752	3	SEER	2016	16			844 - 846

Description
This data item records the size of a solid primary tumor before **any** treatment.

Rationale
Clinical tumor size (pretreatment size) is essential for treatment decision making and prognosis determination for many types of cancer.

Codes (Refer to the most recent version of *SEER Program Coding and Staging Manual* for additional instructions.)

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)
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
998	Alternate descriptions of tumor size for specific sites:

Familial/multiple polyposis:
Rectosigmoid and rectum (C19.9, C20.9)
Colon (C18.0, C18.2-C18.9)

If no size is documented:
Circumferential:
Esophagus (C15.0 C15.5, C15.8 C15.9)

Diffuse; widespread: 3/4s or more; linitis plastica:
Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9)

Diffuse, entire lung or NOS:
Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9)

Diffuse:
Breast (C50.0 C50.6, C50.8 C50.9)

999 Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed; Not applicable

TUMOR SIZE PATHOLOGIC **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	754	3	SEER	2016	16			847 - 849

Description
This data item records the size of a solid primary tumor that has been resected.

Rationale
Pathologic tumor size is an important prognostic indicator and valuable for clinical practice and research on surgically treated patients.

Codes (Refer to the most recent version of *SEER Program Coding and Staging Manual* for additional instructions.)

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)
989 989 millimeters or larger
990 Microscopic focus or foci only and no size of focus is given
998 Alternate descriptions of tumor size for specific sites:

Familial/multiple polyposis:
Rectosigmoid and rectum (C19.9, C20.9)
Colon (C18.0, C18.2-C18.9)

If no size is documented:
Circumferential:
Esophagus (C15.0 C15.5, C15.8 C15.9)

Diffuse; widespread: 3/4s or more; linitis plastica:
Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9)

Diffuse, entire lung or NOS:
Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9)

Diffuse:
Breast (C50.0 C50.6, C50.8 C50.9)

999 Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed; Not applicable

TUMOR SIZE SUMMARY **New**

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	756	3	NPCR/CoC	2016	16			850 - 852

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

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

Codes: (See the most recent version of the *FORDS* manual for additional instructions.)

000 No mass/tumor found
001 1 mm or described as less than 1 mm
002-988 Exact size in millimeters (2mm-988mm)
989 989 millimeters or larger
990 Microscopic focus or foci only and no size of focus is given
998 SITE-SPECIFIC CODES

Alternate descriptions of tumor size for specific sites:

Familial/multiple polyposis:

Colon (C18.0, C18.2-C18.9)

If no size is documented:
Circumferential:
Esophagus (C15.0 C15.5, C15.8 C15.9)

Diffuse; widespread: 3/4s or more; linitis plastica:
Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9)

Diffuse, entire lung or NOS:
Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9)

Diffuse:
Breast (C50.0 C50.6, C50.8 C50.9)

999 Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed; Not applicable

TYPE OF REPORTING SOURCE

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	500	1	SEER					563 - 563

Description
This variable codes the source documents used to abstract the majority of information on the tumor being reported. This may not be the source of original case finding (for example, if a case is identified through a pathology laboratory report review and all source documents used to abstract the case are from the physician's office, code this item 4).

Rationale
The code in this field can be used to explain why information may be incomplete on a tumor. For example, death certificate only cases have unknown values for many data items, so one may want to exclude them from some analyses. The field also is used to monitor the success of non-hospital case reporting and follow-back mechanisms. All population-based registries should have some death certificate-only cases where no hospital admission was involved, but too high a percentage can imply both shortcomings in case-finding and that follow-back to uncover missed hospital reports was not complete.

Coding Instructions
Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. This is a change to reflect the addition of codes 2 and 8 and to prioritize laboratory reports over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.

This data item is intended to indicate the completeness of information available to the abstractor. Reports from health plans (e.g., Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally and is available to the abstractor are expected to be at least as complete as reports for hospital inpatients, which is why these sources are grouped with inpatients and given the code with the highest priority.

Sources coded with '2' usually have complete information on the cancer diagnosis, staging, and treatment.

Sources coded with '8' would include, but would not be limited to, outpatient surgery and nuclear medicine services. A physician's office that calls itself a surgery center should be coded as a physician's office. Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. If a physician's office calls itself a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

Codes

7 Death certificate only
8 Other hospital outpatient units/surgery centers
1 Hospital inpatient; Managed health plans with comprehensive, unified medical records
2 Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
3 Laboratory only (hospital-affiliated or independent)
4 Physician's office/private medical practitioner (LMD)
5 Nursing/convalescent home/hospice
6 Autopsy only

UNUSUAL FOLLOW-UP METHOD

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1850	2	NAACCR					2290 - 2291

User-defined numeric codes used to flag cases that need unusual follow-up methods.

Codes

User-defined

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

VENDOR NAME

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	2170	10	NAACCR	2011	12.2			1936 - 1945

Description
System-generated. Name of the computer services vendor who programmed the system submitting the data. Abbreviate as necessary and keep a consistent name throughout all submissions. Include software version number where available. Code is self-assigned by vendor.

Rationale
This is used to track which vendor and which software version submitted the case. It helps define the source and extent of a problem discovered in data submitted by a software provider.

VITAL STATUS

Alternate Name	Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
	1760	1	SEER/CoC					2126 - 2126

Description
Vital status of the patient as of the date entered in Date of Last Contact [1750]. If the patient has multiple tumors, vital status should be the same for all tumors.

Codes

0 Dead (CoC)
1 Alive
4 Dead (SEER)