# *Commonwealth of Virginia*

## *Department of Health*

***The Honorable Tim Kaine,***
***Governor***

***Robert B Stroube, MD, MPH,***
***State Health Commissioner***

# *VIRGINIA CANCER REGISTRY MANUAL*

*October 2007*

*Commonwealth of Virginia*
*Department of Health*

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*Governor*

*Robert B Stroube, MD, MPH*
*State Health Commissioner*

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# PREFACE

The rate of new cancer cases in Virginia is a public health concern. More than 30,000 Virginia residents are diagnosed with cancer each year. Without information on these new cases of cancer, it is difficult to plan prevention, education, screening, early detection, treatment, and rehabilitation programs. The Virginia Cancer Registry (VCR) records the incidence of cancer for the Commonwealth of Virginia and provides data to help public health authorities, physicians, researchers, and other health professionals plan and evaluate cancer programs. The registry also directly serves the citizens of the Commonwealth by providing and interpreting statistical information on cancer in the state.

In 1970, hospitals began voluntarily contributing cancer reports to the Virginia Tumor Registry. In 1990, the Virginia General Assembly mandated that the Virginia Cancer Registry be established in the Virginia Department of Health (see Appendix A). The legislation prescribed the purpose of the statewide cancer registry to include:

- Determining means of improving the diagnosis and treatment of cancer patients.
- Determining the need for and means of providing better long-term, follow-up care of cancer patients.
- Conducting epidemiological analyses of the incidence, prevalence, survival, and risk factors associated with the occurrence of cancer in Virginia.
- Collecting data to evaluate the possible carcinogenic effects of environmental hazards including exposure to dioxin and the defoliant, Agent Orange.
- Improving rehabilitative programs for cancer patients.
- Assisting in the training of hospital personnel.
- Determining other needs of cancer patients and health personnel.

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

To fulfill some of the goals the state legislature set for the registry, VCR is an active partner with Virginia Department of Health programs that promote cancer prevention and control. These programs include the Virginia Comprehensive Cancer Control Program and the Virginia Breast and Cervical Early Detection Program. VCR data are used for cancer research and surveillance activities, and for epidemiologic and other special studies. Virginia incidence and mortality data are published annually in the national summary *United States Cancer Statistics (USCS, http://apps.nccd.cdc.gov/uscs/)*. USCS is a joint publication that CDC and the National Cancer Institute (NCI) produce. It includes the most recent five years of data. A large variety of cancer incidence data broken out by site and demographic variables is available on the VCR website at http://www.vahealth.org/cdpc/cancer/index.asp. Virginia data are also published in *Cancer in North America* (*CINA*), which is an annual report the North American Association of central Cancer Registries (NAACCR) publishes. *CINA* is available at the NAACCR web site, http://www.naaccr.org/.

VCR is recognized as an up-and-coming cancer reporting system and a valuable resource for cancer data. VCR uses current technology and national data collection standards to enhance the completeness, accuracy, and timeliness of cancer data. As the volume of VCR incidence data increases over time, the utility of these data for program planning, evaluation, and epidemiologic studies increases as well. The VCR depends on all cancer reporters for support, cooperation, and accurate reporting for the ongoing operation of the statewide cancer registry. As VCR staff work together with staff of reporting facilities statewide, complete and reliable cancer incidence data will continue to be available to provide answers to our questions, to reduce the burden of cancer in Virginia, and to improve the lives of both present and future patients.

# PART ONE:
# REPORTING REQUIREMENTS

# VCR MANUAL, OCTOBER 2007 EDITION

This manual shall be used to submit reportable cases with a Date Diagnosis on or after January 1, 2008 except where noted.

## WHAT IS THE VCR

The Virginia Cancer Registry (VCR) is a population-based cancer incidence registry responsible for the collection of demographic, diagnostic, and treatment information on all cancer patients diagnosed and treated at hospitals, laboratories, and other health care facilities in Virginia with reportable cancer. Population-based cancer registries collect information on cancers among the entire population for which they are responsible.

The VCR is also defined as an incidence only cancer registry rather than a multi-purpose registry. Incidence only registries gather only the information necessary to determine the incidence of cancer by geographic areas, by demographic characteristics, and by stage at diagnosis for each type of cancer. Treatment information has also been added to the information collected.

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

## WHY REPORT TO THE VCR

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

1. The Law and Regulations - Statewide collection and dissemination of data on cancer by the Virginia Department of Health is mandated in the *Code of Virginia* and Virginia Department of Health disease reporting regulations. The state laws include Chapter 2 (§32.1-70 *et seq.)* of Title 32.1*(VCR Manual Appendix A)* According to these statutes, each hospital, clinic, and independent pathology laboratory in the Commonwealth is required to report all cases of cancer, which are diagnosed or treated at the hospital, clinic or laboratory. Physicians are required to report when they know the case has not been reported by a hospital, clinic or in-state laboratory. These cases are to be submitted in the format prescribed by the Virginia Cancer Registry. Regulations mandating reporting cancer cases by hospitals, clinics, laboratories, other health care facilities and health care practitioners appear Part VIII of the State Board of Health publication *Regulations for Disease Reporting and Control*. *(VCR Manual Appendix B)*

## WHY REPORT TO THE VCR, continued

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

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA allows for the reporting of identifiable cancer data to public health entities. Because the VCR falls under the definition of a public health entity, HIPAA allows you to report data to the VCR in compliance with Virginia state laws and regulations. Written informed consent from each cancer patient reported to public health entities is not required under HIPAA.

The VCR depends on reporting facilities to submit quality data. Through the dedicated efforts of these facilities, the VCR is able to provide accurate information used to establish and enhance cancer control programs, and thus improve the lives of present and future patients with cancer.

## VCR REFERENCE DATE

*Reference date* refers to the start date after which all eligible records must be included in the registry. The VCR reference date is January 1, 1990. This means complete statewide cancer incidence data are available from the VCR for 1990 to the present.

*Note:* In order to assure complete case ascertainment, reference date is not used to determine what cases are reportable to the VCR. See *VCR Manual Part One, Date of Diagnosis Reportability*.

## VCR REPORTING SOURCES

*The Code of Virginia* mandates each designated hospital, physician and laboratory in the Commonwealth shall report all cases of cancer, which are diagnosed and/or treated at the hospital, physician office, or laboratory. In addition, the VCR has agreements with other states to exchange data.

**VCR REPORTING SOURCES, continued**

## Hospitals

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

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

## Laboratories

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

1. Hospital Laboratories - Required reporting of cases by hospital laboratories is performed by cancer registry or HIM personnel as described above.
2. Free-Standing Pathology Laboratories - Reporting of cases by designated free-standing laboratories is required.

## Non-Hospital Sources

The Board of Health's regulations concerning the Regulations for Disease Reporting were revised in January 2002 to expand cancer reporting requirements to include additional non-hospital sources.

Part VIII, 12 VAC 5-90-170 requires hospitals, clinical laboratories, or other health care facilities providing screening, diagnostic or therapeutic services for cancer patients to report cases of cancer. Reporting by "other health care facilities" will be phased in as follows: 1) Radiation Centers, 2) Medical Oncology Centers, 3) Hematology/Oncology Practices, and 4) Ambulatory Surgery Centers.

## Data Exchange

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

## HOSPITAL REPORTING METHODS

Reporting facilities are encouraged to submit all their cases electronically. Electronic reporting is the submission of reportable cases to the VCR on media (diskette or compact disc (CD)) using commercial, hospital-developed or AbstractPlus software. Written approval from the VCR is required to report electronically. See *VCR Manual Appendix C, Electronic Reporting.*

1. Commercial/Hospital-Developed Software - Registry hospitals are required to electronically report cases included in the hospital cancer registry using commercial or hospital-developed software after all VCR approval criteria are met.

## REPORTABLE CONDITIONS

### VCR List of Reportable Conditions

The *VCR List of Reportable Conditions* is found in the *VCR Manual Appendix D*. This section identifies diagnoses that must be reported to the VCR. Conditions are to be reported if the diagnosis includes the words *malignant, cancer, carcinoma,* and *lymphoma.* Most *leukemias* and *sarcomas* are reportable except when noted as exclusions on the listing. In addition, there are other conditions, which do not include these particular terms but are reportable such as *Wilms tumor, blastoma,* and *carcinoid*. It is therefore very important to refer to the *VCR List of Reportable Conditions* to make sure all reportable conditions are identified.

All primary intracranial and central nervous system (CNS) tumors are reportable. This includes benign, malignant and borderline tumors for the following sites:

- Meninges (C70.0 - C70.9)
- Brain (C71.0 - C71.9)
- Spinal Cord (C72.0)
- Cauda equina (C72.1)
- Cranial nerves (C72.2 - C72.5)
- Other CNS (C72.8, C72.9)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)

### Ambiguous Terminology

A patient has a reportable condition if a *recognized medical practitioner* says so. In most cases the patient's record clearly presents the diagnosis by use of specific terms, which are synonymous with the diagnosis. However, the physician may not always be certain or the recorded language definitive. VCR rules concerning the usage of ambiguous terminology are as follows:

## REPORTABLE CONDITIONS, continued

1. Terms That Constitute a Diagnosis **-** Interpret the following terms as a reportable diagnosis:

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

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

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

3. How To Use Ambiguous Terminology For Case Ascertainment

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

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

         *Example 1:* The pathology report says: Prostate biopsy with markedly abnormal cells that are typical of adenocarcinoma. Report the case.

         *Example 2*: The final diagnosis on the outpatient report reads: Rule out leukemia. Do not report the case.

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

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

**REPORTABLE CONDITIONS, continued**

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

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

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

b. Benign and borderline primary intracranial and CNS tumors

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

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

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

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

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

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

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

c. Confirmation of an Ambiguous Diagnosis - Subsequent admissions for patients whose initial diagnosis contained ambiguous terminology must be reviewed. It is established practice to accept the information at the time of the latest admission, or the most complete or detailed information.

**REPORTABLE CODES**

## ICD-9-CM Codes

Use the following ICD-9-CM codes to identify reportable conditions. Conditions in *italics* are reportable only when diagnosed on or after January 1, 2001. Conditions in brackets [ ] are only reportable when the diagnosis date is prior to January 1, 2001.

| | | |
|---|---|---|
| 140 - 199 | | Malignant Neoplasms |
| 200 - 208 | | Lymphoma/Leukemia/Multiple Myeloma |
| 210 – 229.9 | | Benign Neoplasms |
| | 225.0- 225.4 | Benign neoplasm of brain, cranial nerves, cerebral meninges, spinal cord, cauda equina, spinal meninges |
| | 225.8 | Benign neoplasm of other specified sites of nervous system |
| | 225.9 | Benign of nervous system, part unspecified |
| | 227.3 | Benign neoplasm of pituitary, craniopharyngeal duct, craniobuccal pouch, hypophysis, Rathke's pouch, sella turcica |
| | 227.4 | Benign neoplasm of pineal gland, pineal body |
| 230 – 234 | | Carcinoma in situ (Exclude 233.1*) |
| 235.0 – 238.9 | | Neoplasms of uncertain behavior |
| | [235.4] | [Peritoneum/Cystadenoma, Borderline Malignancy] |
| | *236.0* | *Endolymphatic Stromal Myosis/Endometrial Stromatosis/ Stromal Endometriosis/Stromal Myosis* |
| | [236.2] | [Tumor of Ovary/Cystadenoma, Borderline Malignancy of Low Malignant Potential] |
| | 237.0 | Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct |
| | 237.1 | Neoplasm of uncertain behavior of pineal gland |
| | 237.5 | Neoplasm of uncertain behavior of brain and spinal cord. *Papillary Ependymoma* |
| | 237.6 | Neoplasm of uncertain behavior of meninges: NOS, cerebral, spinal. *Papillary Meningioma* |
| | 237.70 | Neurofibromatosis, Unspecified von Recklinghausen's Disease |
| | 237.71** | Neurofibromatosis, Type One von Recklinghausen's Disease |
| | 237.72 | Neurofibromatosis, Type Two von Recklinghausen's Disease |
| | 237.9 | Neoplasm of uncertain behavior of other & unspecified parts of nervous system; cranial nerves |
| | 238.3 | Phyllodes Tumor, Malignant (Cystosarcoma Phyllodes) |
| | *238.4* | *Polycythemia Vera (Proliferative, Primary or Rubra Vera)* |
| | 238.6 | Plasmacytoma/Solitary Myeloma |
| | 238.7 | Acute Panmyelosis/*Chronic Myeloproliferative Disease/Myelosclerosis with Myeloid Metaplasia/ Essential Thrombocythemia/Refractory Cytopenia with Multilineage Dysplasia/Myelodysplastic Syndrome with 5q-Syndrome/Therapy-Related Myelodysplastic Syndrome/Myelodysplastic Syndrome, NOS* |
| 273.2 | | Alpha Heavy Chain Disease/Franklin disease/Gamma Heavy Chain Disease |
| 273.3 | | Waldenstrom Macroglobulinemia |
| 273.9 | | Unspecified disorder of immune mechanism (screen for potential 273.3 miscodes) |
| *284.9 - 285.0* | | *Refractory Anemia* |
| *288.3* | | *Hypereosinophilic Syndrome* |
| 289.8 | | Acute Myelofibrosis |
| V58.0 | | Admission for Radiotherapy |
| V58.1 | | Admission for Chemotherapy |
| V67.1 | | Radiation therapy follow-up |
| V67.2 | | Chemotherapy follow-up |

* Carcinoma in situ of the cervix is not reportable; quality control procedures must be in place to make sure if micro-invasion is present the medical record is not coded to 233.1.

** Code 237.71 may not be reportable; however, this diagnosis may indicate a reportable condition and should be reviewed.

**REPORTABLE CODES, continued**

If time and resources permit, review of the following codes may assist in casefinding activities:

| | |
|---|---|
| 042 | AIDS (review cases for AIDS-related malignancies) |
| 273.9 | Unspecified disorder of immune mechanism (screen for potential 273.3 miscodes) |
| V07.3 | Other Prophylactic Chemotherapy (screen carefully for miscoded malignancies) |
| V07.8 | Other specified prophylactic measure |
| V10 | Personal history of malignancy (screen for subsequent primaries and/or subsequent treatment) |
| V66.1 | Convalescence following Radiotherapy |
| V66.2 | Convalescence following Chemotherapy |
| V71.1 | Observation for suspected malignant neoplasm |
| V76 | Special screening for malignant neoplasm |

## ICD-O Behavior Codes

All records with a behavior code of /2 (in situ) or /3 (malignant) in the *International Classification of Diseases for Oncology, Second Edition* (ICD-O-2) or *Third Edition* (ICD-O-3) are reportable. (These references are used primarily by registry hospitals.)

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

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

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

If a pathologist verifies a /0 (benign) or /1 (uncertain whether benign or malignant) behavior code term in ICD-O as /2 (in situ) or /3 (malignant), these records are reportable.

Cases diagnosed with primary intracranial and central nervous system tumors with a behavior code of **/0** or **/1** (benign and borderline or "non-malignant") are reportable regardless of histologic type for the sites listed below:

- Meninges (C70.0 - C70.9)
- Brain (C71.0 - C71.9)
- Spinal Cord (C72.0)
- Cauda equina (C72.1)
- Cranial nerves (C72.2 - C72.5)
- Other CNS (C72.8, C72.9)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)

## MULTIPLE PRIMARY DETERMINATION

### More Than One Cancer

If more than one primary is diagnosed, a separate record must be submitted on each primary.

### Determining Multiple Primary Cancers

The VCR, like most registries in the United States, follows the rules of the Surveillance, Epidemiology and End Results (SEER) Program for determination of multiple primary cancers. Beginning with cases diagnosed on January 1, 2007 the SEER rules for determining multiple primary cancers are documented in the SEER *2007 Multiple Primary and Histology Coding Rules.* For cases diagnosed prior to 2007, the SEER rules for determining multiple primary cancers are documented in the *VCR Manual Appendix E, Multiple Primary Determination.*

## DATE OF DIAGNOSIS REPORTABILITY

All reportable cases included on the *VCR List of Reportable Conditions* (See *VCR Manual Appendix D, Reportable Conditions*) diagnosed or treated at the facility are required to be reported to the VCR regardless of Date of Diagnosis. This includes patients with an unknown date of initial diagnosis.

***Exception 1***: Conditions only reportable if diagnosed on January 1, 2001 and after (the conditions with ** in *VCR Manual, Appendix D*) are not reportable if the date of diagnosis is unknown.

*Example 1*: If a patient is admitted on January 3, 2004 and is diagnosed with lung cancer on January 7, 2004, the case is reportable.

*Example 2*: If a patient is admitted on January 3, 2004 and receives palliative care for bone metastasis from a breast primary diagnosed in 1990, the case is reportable.

*Example 3*: If a patient is admitted on January 3, 2004 and receives palliative care for bone metastasis from a breast primary for which a diagnosis date is not stated in the medical record, the case is required to be reported using 99999999 for the Date of Diagnosis.

*Example 4*: If a patient is admitted on January 3, 2004 and receives a blood transfusion for polycythemia vera, originally diagnosed in November 1999, the case is not reportable per the *VCR List of Reportable Conditions* and *Exception 1* above.

**REPORTABLE CASES**

## Reportable Diagnosis

A diagnosis is reportable to the VCR if it is included on the *VCR List of Reportable Conditions* (See *VCR Manual Appendix D, Reportable Conditions*). The following guidelines provide further clarification for the specified conditions:

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

2. Class IV and Class V Cytologies – Cytology results of Class IV or Class V are reportable to the VCR.

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

   *Note:* See *VCR Manual Part Three, Data Item Instructions, Diagnostic Confirmation* for clarification of histology and cytology using cell block and smear preparation of specimens.

3. Low Malignant Potential/Borderline Malignancy of Ovary or Peritoneum- Cystadenomas or tumors primary to the ovary or peritoneum qualified by the phrases *borderline malignancy* or *low malignant potential* are reportable only if diagnosed prior to January 1, 2001.

4. Intraepithelial Neoplasia – Patients with the following diagnoses of intraepithelial neoplasia are reportable:
   - Vaginal intraepithelial neoplasia 3 (VAIN III)
   - Vulvar intraepithelial neoplasia 3 (VIN III)
   - Anal intraepithelial neoplasia 3 (AIN III)

   See also *VCR Manual Appendix D, Reportable Conditions* and *VCR Manual Part One, Exclusions, Intraepithelial Neoplasia.*

5. Non-Malignant Intracranial and Central Nervous System Tumors – All primary intracranial and central nervous system (CNS) tumors are reportable. This includes benign, malignant and borderline tumors for the following sites:

   - Meninges (C70.0 - C70.9)
   - Brain (C71.0 - C71.9)
   - Spinal Cord (C72.0)
   - Cauda equina (C72.1)
   - Cranial nerves (C72.2 - C72.5)
   - Other CNS (C72.8, C72.9)
   - Pituitary gland (C75.1)
   - Craniopharyngeal duct (C75.2)
   - Pineal gland (C75.3)

**REPORTABLE CASES, continued**

## Reportable Situations

A case is reportable to the VCR if it is a condition included on the *VCR List of Reportable Conditions* (See *VCR Manual Appendix D, Reportable Conditions*) and meets the following criteria:

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

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

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

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

      **The VCR recognizes the following definitions of treatment:**

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

2. Patients Diagnosed at Autopsy – Final autopsy reports containing reportable diagnoses or incidental findings of reportable conditions must be reported to the VCR.

3. Patients Diagnosed Elsewhere – Patients diagnosed elsewhere and newly admitted to your hospital for further diagnostic workup or treatment, cancer-directed or non cancer-directed are to be reported. Although this may result in multiple records on one patient, it enables the VCR to assure complete statewide casefinding and to have the most comprehensive information on each patient. Because the VCR is a population-based registry, every attempt must be made to receive all cases diagnosed within Virginia to provide accurate statistical reports.

4. Recurrence - Recurrence refers to the same cancer arising in or from the same primary site where it appeared earlier. A recurrent diagnosis is reportable as instructed in the *Multiple Primary and Histology Coding Rules, January 01, 2007.*

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

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

## REPORTABLE CASES, continued

6. Private Outpatient Specimens (POP) (Path Only) – Private outpatient specimens (POP) are specimens submitted from a physician's office to be read by the hospital pathologist as part of the Pathology Department's regular course of business. The patient is not registered as an inpatient or outpatient at the hospital. POPs are reportable to the VCR as a Class of Case 7 and a Reporting Source code of 3.

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

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

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

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

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

**EXCLUSIONS**

## Non-Reportable Diagnosis

The following diagnoses are not reportable to the VCR:

1. Skin Cancers

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

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

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

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

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

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

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

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

3. Intraepithelial Neoplasia – Patients with the following diagnoses of intraepithelial neoplasia are not reportable:
   - Cervical intraepithelial neoplasia (CIN)
   - Prostatic intraepithelial neoplasia (PIN)

See also *VCR Manual Part One, Reportable Cases, Intraepithelial Neoplasia.*

**EXCLUSIONS, continued**

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

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

   ***Exception 2***: Brain and Central Nervous System- All primary intracranial and central nervous system (CNS) tumors are reportable. This includes benign and borderline tumors for the following sites:

   - Meninges (C70.0 - C70.9)
   - Brain (C71.0 - C71.9)
   - Spinal Cord (C72.0)
   - Cauda equina (C72.1)
   - Cranial nerves (C72.2 - C72.5)
   - Other CNS (C72.8, C72.9)
   - Pituitary gland (C75.1)
   - Craniopharyngeal duct (C75.2)
   - Pineal gland (C75.3)

## Non-Reportable Situations

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

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

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

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

   ***Exception:*** If a patient expires at your facility with a history of cancer, even though the patient was clinically disease free, the case **is** reportable

## EXCLUSIONS, continued

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

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

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

5. Recurrence – Recurrence is defined as the same cancer arising in or from the same primary site where it appeared earlier and is not considered a new primary cancer by the physician. Do not report a recurrent diagnosis when you have previously reported it.

   ***Exception*:** If an in situ tumor is followed by an invasive cancer in the same site more than two months apart, report as two primaries even if stated to be a recurrence. The invasive primary should be reported with the date of the *invasive* diagnosis. See also *VCR Manual Part One, Reportable Cases, Recurrence*.

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

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

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

## CONFLICTING STANDARDS

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

## WHEN IN DOUBT

When in doubt about submitting records to the VCR, ask the following question:

> Did your facility diagnose and/or treat the patient for a condition included on the *VCR List of Reportable Conditions? (*See *VCR Manual Appendix D, Reportable Conditions)*

If the answer is yes to this question and the record was not previously submitted by your hospital, report the record. If you are in doubt about a particular record, submit the record with a note of explanation or call your VCR Cancer Surveillance Specialist at (804) 864-7877

## VCR REQUIRED DATA ITEMS

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

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

## PHOTOCOPIES OF HEALTH RECORD DOCUMENTATION FOR NON-ELECTRONIC REPORTERS

### When Must Photocopies Be Submitted?

Photocopies of health record documentation are required to supplement the text fields for non-electronic reporters for the following reasons:

1. For data evaluation in facilities when there is a new VCR contact, new software or updated reporting format

2. For periodic quality control monitoring of reported data

3. Facilities without electronic reporting capabilities.

See *VCR Manual Appendix C, Electronic Reporting, Approval Process.*

**PHOTOCOPIES OF HEALTH RECORD DOCUMENTATION FOR NON-ELECTRONIC REPORTERS**

## What Photocopies Must Be Submitted?

A copy of the pathology and/or autopsy report and operative report is required for all histologically confirmed cases for electronic approval/evaluation. The discharge summary, consultations, progress notes, radiology reports and other reports should be attached as needed to describe pertinent diagnostic findings and treatment and to provide information on previously diagnosed primaries. If the diagnosis of a reportable condition was not histologically confirmed but was made by radiology, cytology, physician's final diagnosis on the discharge summary, a copy of the report that confirms or supports the diagnosis must be attached. A copy of the face sheet must be attached to support the demographic information.

**CHANGING INFORMATION**

A change includes updating or correcting previously submitted information.

## Importance of Change/Deletion Procedure

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

*Example 1:* At the time a record was reported to the VCR, the primary site was unknown. On a subsequent admission, the primary site was documented as upper lobe of left lung. A change sheet must be submitted to update the primary site, laterality, and stage (as was known during first course of treatment). The VCR will update this information on the patient's record on the VCR data file.

*Example 2*: At the time a record was reported to the VCR, the patient's initial diagnosis was *probable carcinoma*. After further review, it was determined the patient does not have cancer. Such cases must be deleted. Complete change records as indicated below, mark "DELETE" and document reason for deletion.

## What to Change

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

2. Change Collaborative Stage data items only if additional information is available through completion of surgery (ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression whichever is longer.

3. Change SEER Summary Stage 2000 only if additional information is available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression whichever is longer for cases diagnosed on or after January 1, 2001. Change SEER Summary Stage 1977 only if additional information is available within two months of diagnosis (four months for prostate primaries) for cases diagnosed prior to January 1, 2001.

**CHANGING INFORMATION, continued**

4. Submit a change for name when incorrectly spelled on a record and when name is changed due to marital status or other reason. Clearly indicate previous and current name.

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

## When to Submit Changes

Changes should be included with the next monthly shipment.

## How to Change Information

1. As corrections are made to records previously accessioned by the VCR, print a consolidated paper abstract from your software system and **highlight** the changed information. Include these changes with your regular shipments as change records. (If name and/or spelling of name changes, indicate original name or spelling above corrected name.)

2. Document number of change records on VCR Submission Form on the *Total Number of Change Records* line. Do not include these with *Total Number of New Records.*

   **Note***:* Corrections ***may NOT*** be transmitted electronically.

**VCR SUBMISSION FORM**

The VCR Submission Form must be included for each electronic file. (See copy of submission form on next page.) Facility-specific submission forms with facility name; VCR four-digit identification number and ACOS COC facility identification number are available from the VCR.

## Instructions

1. Date – Enter date shipment was sent.

2. File Name – Enter name of electronic output transmit file.

3. Number of Change Records Enclosed – Enter number of change records enclosed.

4. Number of New Records Enclosed – Enter number of records enclosed (excluding change records).

5. *No Records To Report* – If a facility has no cancer records to report, a completed submission form with zero (0) entered for number of new records must be forwarded to the VCR on the 5th of the month. In addition, the reason for not submitting any records must be documented on the submission form in the space provided.

VCR Use Only

Date Received

Facility # **1**

**Virginia Cancer Registry**
**Submission Report**
**for Electronic Registries**

_____
**(Month of Submission)**

## Facility Information

Facility: St. Elsewhere Hospital (sample)

City: Planet Kozar

Your Name: _____

Phone: 999 999-9999

## Submission Information

Date: _____

Date Last Submission: _____

Method *(check)*: - Disk _____

- Vendor* _____

- E-mail** _____

*Password:* _____

## File Information

Name of File:

NAACCR Version: _____ (*Specify*)

NAACCR Edits Available? _____ Run? (check): _____ Yes _____ No

Accession # Range (approx.) :

Number of

- Analytic Cases *(Class of Case 0-2)*: _____
- Non-Analytic Cases *(Class of Case 3-6; 9)*: _____
- Pathology-Only Cases: _____
- Total New Cases For This Report: _____

Comments:

Instructions: Complete all fields on this form and return it with each diskette or set of diskettes submitted to the Virginia Cancer Registry **by the 5th of each month**. Please note in "Comments" field any information that will facilitate loading and merging your facility's data. If during this reporting period your facility has no cancer cases to report, we request that you notify us by completing this form and indicating zero ("0") for "Total Number of New Cases for This Report".

*If your software vendor sends your data to the VCR, forward this form to us whenever you transmit data to your vendor.
**If you are submitting your facility's cases by E-mail, please fax or mail this completed report (including your password) when you send your E-mail.

Virginia Cancer Registry
109 Governor Street, 10th Floor
Richmond, VA 23219
Phone (804) 864-7866
Fax (804) 864-7870

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

## HOW TO REPORT

Records containing all required data items must be submitted to the VCR electronically. Detailed instructions for completing the required data items can be found in the *VCR Manual Part Three, Data Item Instructions*.

Use the following instructions to prepare shipments:

1. Create Media (email file, diskette or CD) - Create the media containing all records to be reported to the VCR since your last shipment. Create a file for email transmission or use a newly formatted diskette or a new CD. A diskette will hold 245 records in current transmission format. If you have more than 245 records to transmit, you must use software to compress the data into a ZIP archive or use multiple diskettes or a CD.

2. Prepare Backup - Prepare and verify a backup of all records transmitted. Maintain this backup at your facility until you receive confirmation the records were accepted by the VCR.

3. Label the Media - If using a diskette, remove the old label before a new label is applied. Record the following information on the label using a felt tip pen:

   a) File name of the output Transmit File using the following rules:

      1. The file name can be up to eight (8) characters long. In addition, you can include an extension up to three (3) characters long.

      2. The file name is not case sensitive; it does not matter whether you use upper case or lower case letters.

      3. The name can contain letters, numbers, special characters, and spaces.

      *Exception*: Do not use back slash (\), slash (/), colon (:), exponent (_), question mark (?), double quotes (“), less than (<), greater than (>), or end ().

   b) Your facility name and VCR ID number

   b) Number of records being transmitted

   c) Date you are transmitting the records

4. Complete a VCR Submission Form for Each Media Submitted - See *VCR Manual Part One, VCR Submission Form*.

5. Prepare Mailer - Place media in a protective mailer. Address the mailer with the VCR's address (See *VCR Manual Part One, Where to Report*) and your facility's address as the return address. This will ensure proper identification if the media becomes separated from the rest of the shipment.

6. Prepare the Shipment for Mailing - Place mailer, VCR Submission Form, Transmit List, and corrections (if applicable) in an envelope.

**WHEN TO REPORT**

## Transmission Date

Reporting facilities must mail shipments/transmit files by the 5th of every month. If the 5th falls on a weekend or holiday, shipments must be mailed/transmitted on the last working day before the 5th.

## Timeliness of Reporting

1. 180 Days - The VCR requires 90% of abstracts submitted by reporting facilities to be received by the VCR within 180 days from *Date of Diagnosis*.

2. Year End Deadline - The first working day in July is the deadline for submitting all reportable cases from the previous year. The months of May and June should be used to perform quality assurance procedures to ensure all cases have been identified and reported. These cases may fall into the 10% over 180 days. This is expected and acceptable. The timeliness requirement was established at 90% to provide a cushion of 10% to encourage late reporting of missed cases to assure reporting completeness.

## Long-Term Hospitalizations

When patients are hospitalized for a period of six (6) months or longer, records should be submitted 180 days from Date of Admission/1st Contact. Enter the current date in the Date of Discharge field. Date of Discharge may not be left blank and the exact Date of Discharge should be submitted later as a change. See *VCR Manual Part One, Changing Information*.

**WHERE TO REPORT**

## Mailing Instructions

1. Mail to - Virginia Cancer Registry
Virginia Department of Health
109 Governor St 10th Floor
Richmond VA 23219

2. Record the name of your facility and three or four digit VCR I.D.# in the upper left hand corner of the envelope prior to mailing shipments to the VCR.

3. Do not place media directly in VCR envelope without a protective mailer. Damaged media will be returned without being processed.

## DOCUMENT RETENTION

There is no statute governing how long copies of the yearly Accession Lists must be kept. Retention for at least five years is strongly recommended by the VCR; however, if space is limited, maintaining copies until your facility has had a VCR Quality Assessment Review for that year would be an acceptable alternative.

## FACILITY CONTACT PERSON FOR VCR

One person at each reporting facility is designated as the VCR contact person. This person is the primary contact for all correspondence and routine communication with the facility. Each facility designates the VCR contact person such as the cancer registrar, supervisor, or director.

To maintain proper communication, inform the VCR of any changes in the contact person at your facility by sending a letter to the address listed in *VCR Manual Part One, Where to Report* or calling (804) 764-7860.

## TRAININGS

The VCR conducts trainings throughout the year to provide specific information on VCR reporting requirements and data collection. Trainings are free of charge. See *VCR Manual Part Four, Quality Control: VCR, Trainings.*

Announcements listing dates and locations of trainings are mailed to VCR contacts periodically. If interested in attending a training, refer to the announcement or call the VCR.

## VCR PHONE NUMBERS

If you have any questions regarding the VCR, contact us at the central number: 1-804-864-7873 or:

| | | | |
|---|---|---|---|
| Region 1 | Northwest Virginia | Tina Hall | 1-804-864-7864 |
| Region 2 | Northern Virginia | Michael Bowman, CTR | 1-804-864-7856 |
| Region 3 | Southwest Virginia | Dianne Collins, CTR | 1-804-864-7857 |
| Region 4 | Central Virginia | James Newton | 1-804-864-7859 |
| Region 5 | Tidewater | Michael Peyton, CTR | 1-804-864-7885 |
| Quality Assurance Coordinator | | Bonita Bryant, CTR | 1-804-864-7860 |
| Statistical Analysis Coordinator | | Carolyn Halbert, MA, MPH | 1-804-864-7861 |
| Training Coordinator | | Jayne Holubowsky, CTR | 1-804-864-7873 |

# PART TWO:
# CASEFINDING

**CASEFINDING**

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

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

## Reportable Conditions

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

1. List of Reportable Conditions - *VCR Manual Appendix D* provides documentation of all conditions reportable to the VCR. It is structured alphabetically by the main histologic term.

2. ICD-9-CM Codes - *VCR Manual Part One, Reportable Codes* provides a list of ICD-9-CM codes used to identify reportable diagnoses.

## Casefinding Sources

The second step in establishing effective casefinding procedures is to identify all areas in the facility where these reportable conditions are either diagnosed or treated and the sources for casefinding in each area. The Health Information Management (HIM) Department and Pathology Department must be included as casefinding sources by all facilities; the remaining sources listed below should be included as applicable. Copies of reports forwarded for review to the person responsible for reporting to the VCR serve as a pending or tickler file to cross-reference with medical records flagged in the HIM Department.

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

1. Health Information Management Department (HIM)

    a. Chart Assembler/Coder/Analyst - All records with a diagnosis included in *VCR Manual Appendix D* or *ICD-9-CM Codes* listed in *VCR Manual Part One, Reportable Codes* should be flagged for the person responsible for VCR reporting.

    b. Disease Index - Records assigned an ICD-9-CM code included on the list provided in *VCR Manual Part One, Reportable Codes* should be reviewed to identify reportable cases. In addition to casefinding, the disease index should also be used as a quality control measure to make sure all reportable diagnoses have been submitted. See also *VCR Manual Part Four, Quality Control: Reporting Facilities.*

**CASEFINDING**

c. Transcription - All discharge summaries with a reportable condition in the final diagnosis and operative reports bearing a post-operative reportable diagnosis should be copied and forwarded to the person responsible for reporting to VCR.

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

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

   b. Cytology - All cytology reports should be reviewed for a malignant diagnosis and, when identified, a copy forwarded to the person responsible for VCR reporting. An alternative would be to review a log of positive or abnormal cytologies.

   c. Hematology - Peripheral blood reports should be reviewed for a diagnosis of malignancy and, when identified, a copy forwarded to the person responsible for VCR reporting. Bone Marrow - All bone marrow reports should be reviewed for a diagnosis of malignancy and, when identified, a copy forwarded to the person responsible for VCR reporting.

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

3. Outpatient Departments

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

   b. Emergency Room (ER) - Pathology and cytology reports from procedures performed in the ER should be screened and reported if a reportable diagnosis is made or if the patient expires with a history of a reportable disease.

4. Oncology Services

   a. Radiation Therapy - Radiation therapy records, appointment logs, or patient rosters must be reviewed. If reporting criteria are met, cases must be submitted to the VCR. Patients diagnosed elsewhere but treated at your facility must be reported.

   b. Medical Oncology/Chemotherapy - Chemotherapy records, appointment logs, or patient rosters must be reviewed. If reporting criteria are met, cases must be submitted to the VCR. Patients diagnosed elsewhere but treated at your facility must be reported.\

**CASEFINDING**

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

## Completeness of Casefinding

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

## Most Effective Casefinding Procedure

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

1. Flag all inpatient and outpatient medical records with an ICD-9-CM diagnosis code as listed in *VCR Manual Part One, Reportable Codes.*

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

3. Review records, appointment logs, or rosters of patients seen in the chemotherapy, radiation therapy, and any other area where reportable conditions are diagnosed or treated.

4. Review the ICD-9-CM disease index monthly to identify reportable diagnoses.

5. Perform quality control procedures to assure all reportable cases were identified and reported to the VCR.

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# PART THREE:
# DATA ITEM INSTRUCTIONS

**GENERAL INFORMATION**

## Data Item Completion

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

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

## Recording Unknown or Not Applicable Information

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

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

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

3. Unknown/Not Applicable, Blank- Since information for the following required data items may be unknown or not applicable, they are the only data items that may be left blank as specified in the data item instructions in this section:

    - *Name - Suffix*
    - *Name - Middle*
    - *Name - Maiden*
    - *Name - Alias*
    - *Text - Usual Occupation for age < 14*
    - *Text - Usual Industry for age < 14*
    - *Place of Diagnosis when patient is diagnosed at reporting facility*
    - *Accession Number for Non-registry hospitals*

**GENERAL INFORMATION**

## Recording Dates

1. Date Format- All date fields are numeric and contain eight (8) characters formatted as MMDDCCYY. The first two digits record the month, the third and fourth digits record the day and the last four digits record the century and year. Single digit months, days, and years must be preceded with a zero in the first space.

   *Example:* Record January 1, 2007 as:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 0 | 1 | 0 | 1 | 2 | 0 | 0 | 7 |

2. Allowable Values –

| **Month** | | **Day** | **Year** |
|---|---|---|---|
| 01 January | 08 August | 01 | Use four-digit year |
| 02 February | 09 September | 02 | 9999 Year unknown* |
| 03 March | 10 October | 03 | |
| 04 April | 11 November | … | |
| 05 May | 12 December | … | |
| 06 June | 99 Month unknown* | 31 | |
| 07 July | | 99 Day unknown* | |

* Unknown (99 or 9999) is not valid for certain date fields; see "*Unknown Dates, Exceptions,*" below.

3. Actual Dates- The following fields must contain the actual month, day, century, and year. They may not contain 99 in any part of the date field, and they may not be approximated.
   1. *Date of 1st Contact*
   2. *Date of Inpatient Adm*
   3. *Date of Inpatient Disch*
   4. *Date of Last Contact*
   5. *Date Case Completed**
   6. *Date Case Last Changed**
   7. *Date Case Report Exported**

   * These dates are usually entered automatically by the cancer registry software programs.

## GENERAL INFORMATION

4. Approximating Dates- If the exact date is unknown, use guidelines below to estimate dates from descriptive terms for the following fields:

   - *Birth Date*
   - *Date of Diagnosis*
   - *RX Date--Surgery*
   - *RX Date--Radiation*
   - *RX Date--Systemic*
   - *RX Date--Other*
   - *Date of 1st Crs RX—COC*

   a. Approximating Month**:** Use the following guidelines to estimate month from descriptive terms:

      1. Code 'spring of' to April (04)
      2. Code 'summer' or 'middle of year' to July (07)
      3. Code 'fall' or 'autumn' to October (10)
      4. For 'winter of', try to determine whether the physician means the first of the year or the end of the year and code January (01) or December (12) as appropriate.
      5. Code 'early in year' to January (01)
      6. Code 'late in year' to December (12)
      7. Use whatever information is available to calculate the month, such as ‘7 months ago’.
      8. If a descriptive term is not included in this guideline or if there are no descriptive terms available, code as unknown (99). Do not enter fictitious dates or default values.

   b. Approximating Year**:** Use the following guidelines to estimate year from descriptive terms:

      1. Code 'a couple of years' to two years earlier.
      2. Code 'a few years' to three years earlier.
      3. Use whatever information is available to calculate the year, such as ‘7 years ago’.
      4. If a descriptive term is not included in this guideline or if there are no descriptive terms available, code as unknown (9999). Do not enter fictitious dates or default values.

   c. Approximating Day**:** No approximation of day is acceptable. If day is unknown, enter 99 in the appropriate position in the date field for dates where this is acceptable. Do not enter fictitious days or default values.

5. Unknown Dates- If the month, day, century, or year is unknown with no information to calculate, enter 99 in the appropriate position in the date field. See list of date fields that cannot contain 99 under *Exact (or actual) Dates*.

6. Fictitious Dates- If any part of a date is unknown and there is no description or guideline to approximate a date for fields where this is acceptable, enter 99. Do not enter fictitious dates or default values such as 15 for unknown day or 0101 followed by a known year when month and day are unknown. Because fictitious dates or default values cannot be differentiated from exact dates when comparing dates reported by different facilities, incorrect dates may be chosen over exact dates during the record consolidation process. Fictitious dates also harm the scientific integrity of the data.

**GENERAL INFORMATION**

7. Summary of Acceptable Entries for Date Fields**:**

| Date Fields | Approximation or 99 Acceptable | Actual Date Only |
|---|---|---|
| Birth Date | X | |
| Date of 1st Contact | | X |
| Date of Inpatient Adm | | X |
| Date of Inpatient Disch | | X |
| Date of Diagnosis | X | |
| RX Date – Surgery | X | |
| RX Date – Radiation | X | |
| RX Date – Systemic | X | |
| RX Date – Other | X | |
| Date of 1st Crs RX – CoC | X | |
| Date of Last Contact | | X |
| Date Case Completed | | X |
| Date Case Last Changed | | X |
| Date Case Report Exported | | X |

## Ill-defined Sites

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

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

**GENERAL INFORMATION**

## Hematopoietic, reticuloendothelial, immunoproliferative, and myeloproliferative diseases

Throughout the VCR Manual, "hematopoietic, reticuloendothelial, immunoproliferative, and myeloproliferative diseases" are referenced and often have special rules. Below is a listing of the primary sites and histologies included in these diseases:

| | |
|---|---|
| C42.0 | Blood |
| C42.1 | Bone marrow |
| C42.3 | Reticuloendothelial system |
| C42.4 | Hematopoietic system |
| 9731/9734 | Plasmacytoma |
| 9732 | Multiple myeloma |
| 9733 | Plasma cell leukemia |
| 9740-9742 | Mast cell tumors |
| 9750/9754 | Malignant histiocytosis |
| 9755 | Histiocytic sarcoma |
| 9756 | Langerhans cell sarcoma |
| 9760 | Immunoproliferative disease, NOS |
| 9761 | Waldenstrom macroglobulinemia |
| 9762 | Heavy chain disease |
| 9764 | Immunoproliferative small intestinal disease (Mediterranean lymphoma) |
| 9800-9820, 9826, 9831-9920, 9940-9948 | Leukemias |
| 9930 | Myeloid sarcoma |
| 9931 | Acute panmyelosis with fibrosis |
| 9950 | Polycythemia vera |
| 9960 | Chronic myeloproliferative disorder |
| 9961 | Myelosclerosis with myeloid metaplasia |
| 9962 | Essential thrombocythemia |
| 9963 | Chronic neutrophilic leukemia |
| 9964 | Hypereosinophilic syndrome |
| 9980-9985 | Refractory anemias |
| 9986 | Myelodysplastic syndrome with 5q deletion syndrome |
| 9987 | Therapy-related myelodysplastic syndrome, NOS |
| 9989 | Myelodysplastic syndrome, NOS |

**GENERAL INFORMATION**

## Questions

If you have any questions regarding completion of VCR required data items:

1. Refer to the appropriate section of the VCR Manual for detailed instructional information regarding completion of the data item in question.

2. Call your VCR Cancer Surveillance Specialist at the following numbers:

| | | |
|---|---|---|
| i. | Michael Bowman, CTR | (804) 864-7856 |
| ii. | Michael Peyton, CTR | (804) 864-7885 |
| iii. | James Newton | (804) 864-7859 |
| iv. | Tina Hall | (804) 864-7864 |
| v. | Dianne Collins, CTR | (804) 864-7857 |
| vi. | Bonita Bryant, CTR | (804) 864-7860 |
| vii. | Jayne Holubowsky, CTR | (804) 864-7873 |

3. Make a copy of the pertinent parts of the medical record; attach a note to the record in question.

**NAME - LAST**

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

## Recording Name – Last

1. Spaces- Do not record spaces or apostrophes in the last name

   *Examples:* Mc Donald is recorded as McDonald.
   O'Hara is recorded as OHara

2. 25 Characters- If the last name is more than 25 characters, enter only the first 25.

3. Hyphenated Names are allowed. No other special characters are allowed.

   *Example:* The last name is Green-Moss. Record as Green-Moss.

4. Change To Name- This data item should be updated on the hospital abstract if the last name changes and the change must be submitted to the VCR. See *VCR Manual Part One, Changing Information*.

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

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

**NAME - SUFFIX**

Record the patient's name suffix.

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

## Recording Name-Suffix

1. Punctuation- Do not use any punctuation.

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

3. Suggested Abbreviation –

| Title | Abbreviation |
|---|---|
| Doctor | MD, PhD |
| Junior | Jr |
| Senior | Sr |
| Third | III |
| Fourth | IV |

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

   *Example:* The patient's name is John C. Smith III, MD. Record the III.

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

**NAME – FIRST**

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

## Recording Name-First

1. Spaces- Do not record spaces in the first name.

   *Example:* Mary Jane is entered as MaryJane.

2. 14 characters- If the first name is more than 14 characters, enter only the first 14.

3. Punctuation- Do not use any punctuation.

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

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

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

**NAME – MIDDLE**

Record the patient's middle name.

## Recording Name-Middle

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

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

3. Punctuation- Do not use any punctuation.

**NAME – MAIDEN**

Record the maiden name of female patients who are or have been married. This item is useful for matching multiple records on the same patient.

## Recording Name-Maiden

1. Hyphens are allowed.

   *Example:* The last name is Green-Moss. Record as Green-Moss.

2. Unknown Or Not Applicable- Leave this data item blank if the patient does not have a maiden name, information is not available, or it is not applicable to the patient as in the case of a male. Do not record *not applicable*, *n/a* or *unknown*.

**NAME – ALIAS**

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

## Recording Name-Alias

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

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

**GUIDELINES FOR RECORDING PATIENT ADDRESS**

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

## Rules for Persons Without Apparent Residences:

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

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

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

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

    1. Incarcerated persons

    2. Persons in nursing, convalescent, and rest homes

    3. Persons in homes, schools, hospitals, or wards for the physically disabled, mentally retarded, or mentally ill

    4. Long-term residents of other hospitals, such as Veterans Administration (VA) hospitals

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

**ADDR AT DX - NO & STREET**

Record the number and street address of the patient's usual residence at the time the tumor was initially diagnosed. Patient address is used to provide census tract and other geocodes for incidence statistics and epidemiologic research. The VCR uses geocoding software for automated assignment of geocodes. To increase the rate of automated geocoding, improve the quality of residence data, and enhance the specificity of residence information available for research, addresses must conform to the following format rules.

## Recording Addr At Dx - No & Street

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

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

   *Example:* 103 First Avenue should be recorded as 103 FIRST AVENUE

3. Multiple Tumors- If the patient has multiple tumors, the address may be different for each primary.

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

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

6. Do Not Update this data item if the patient's address changes over time. See *VCR Manual Part Three, Guidelines For Recording Patient Address* for detailed residency rules.

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

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

   b. Pound signs- The use of pound signs (#) to designate address units should be avoided whenever possible. The preferred notation is as follows:

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

   If a pound sign is used, there must be a space between the pound sign and secondary number (e.g., 425 FLOWER BLVD # 72).

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

**ADDR AT DX - NO & STREET, continued**

8. Abbreviations: Enter complete street names without abbreviation. Abbreviate only directional prefixes, directional suffixes and street type suffixes as included on the following VCR list, *Standardized Abbreviations for Street Address.* Use of abbreviations for these terms will enable the entire street address to be recorded.

   *Examples:* 101 W PINE ST RICHMOND 23234 is in Chesterfield County
   101 W PINE WAY RICHMOND 23234 is in Richmond City

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

   *Example:* Address: P.O. Box 20, 221 Springfield Rd
   Record as: 221 SPRINGFIELD RD

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

    *Example:* Address: RD2 35 Sycamore St
    Record as: 35 SYCAMORE ST when it is known that 35 is the street number

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

    *Example:* Address: Apartment F at 321 Knollwood Dr.
    Record *Addr at DX-No and Street* as: 321 KNOLLWOOD DR
    Record *Address at DX- Supplemental* as: APT F

12. Intersections: Use one of the following formats when an intersection is used in place of a street number:

    SMITH AND JONES ST (not Sts or Streets)
    SMITH ST AND JONES ST
    SMITH AT JONES

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

    *Example:* Address: Oak Nursing Home, 1530 Elm Ave
    Record *Addr at DX-No and Street* as: 1530 ELM AVE
    Record *Address at DX- Supplemental* as: OAK NURSING HOME

## VCR STANDARD ABBREVIATIONS FOR STREET ADDRESS

### Directional Prefix or Suffix Abbreviations

| Prefix/Suffix | Abb |
|---|---|
| North | N |
| South | S |

| Prefix/Suffix | Abb |
|---|---|
| East | E |
| West | W |

| Prefix/Suffix | Abb |
|---|---|
| Northeast | NE |
| Northwest | NW |

| Prefix/Suffix | Abb |
|---|---|
| Southeast | SE |
| Southwest | SW |

### Street Prefix Abbreviations

| Prefix | Abb |
|---|---|
| Avenue | AV,AVE |
| Boulevard | BLVD |
| Calle | CLL |
| Caminito | CMT |

| Prefix | Abb |
|---|---|
| Camino | CMN |
| Circulo | CIR |
| Corte | CT |
| Drive | DR |

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

| Prefix | Abb |
|---|---|
| Via | VIA |
| Vista | VISTA |
| | |
| | |

### Street Suffix Abbreviations

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

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

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

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

**ADDR AT DX-SUPPLEMENTL**
**(Address At Diagnosis – Supplemental)**

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

## Recording Addr at Dx – Supplemental

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

2. Do Not Update this data item if the patient's address changes over time. See *VCR Manual Part Three, Guidelines For Recording Patient Address* for detailed residency rules.

**ADDR AT DX – CITY**
**(Address At Diagnosis – City/Town)**

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

## Recording Addr at DX-City

1. Do Not Update this data item if the patient's address changes over time. Changing this data item would destroy its usefulness. See *VCR Manual Part Three, Guidelines For Recording Patient Address* for detailed residency rules.

2. Rural area- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.

3. Punctuation- Do not use punctuation, special characters, or abbreviations.

4. Capital Letters- The use of capital letters is preferred.

5. Multiple Tumors- If the patient has multiple tumors, the address may be different for each primary.

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

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

**ADDR AT DX - STATE**

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

## Recording Addr at DX-State

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

2. Do Not Update this data item if the patient's address changes over time. Changing this data item would destroy its usefulness. See *VCR Manual Part Three, Guidelines for Recording Patient Address* for detailed residency rules.

3. Abbreviations- Only abbreviations on the following three tables are acceptable.

## Abbreviations - US States & Possessions

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

**ADDR AT DX – STATE, continued**

Abbreviations – Other US Possessions

| US Possession | | US Possession | |
|---|---|---|---|
| American Samoa | AS | Marshall Islands | MH |
| Guam | GU | Outlying Islands | UM |
| Puerto Rico | PR | APO/FPO Armed Services America | AA |
| Virgin Islands | VI | APO/FPO Armed Services Europe | AE |
| Palau | PW | APO/FPO Armed Services Pacific | AP |
| Micronesia | FM | | |

Abbreviations – Canadian Provinces

| Province | | Province | |
|---|---|---|---|
| Alberta | AB | Nunavut | NU |
| British Columbia | BC | Ontario | ON |
| Manitoba | MB | Prince Edward Island | PE |
| New Brunswick | NB | Quebec | QC |
| Newfoundland/Labrador | NL | Saskatchewan | SK |
| Northwest Territories | NT | Yukon | YT |
| Nova Scotia | NS | | |

Abbreviations – Other

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

The address is part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies. Do not update this data item if the patient's address changes over time – changing this data item would destroy its usefulness. See *VCR Manual Part Three, Guidelines for Recording Patient Address* for detailed residency rules.

**ADDR AT DX - POSTAL CODE**

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

*Example:* The extended postal code 60611-2797 is recorded as 606112797.

## Recording Addr At DX- Postal Code

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

   *Example:* When only five digits, 60611, are available, record 60611_ _ _ _.

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

3. Hyphens- Do not record hyphens.

4. Do Not Update this data item if patient's address changes over time. Changing this data item would destroy its usefulness. See *VCR Manual Part Three, Guidelines for Recording Patient Address* for detailed residency rules.

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

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

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

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

## Codes and Definitions

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

## Special Instructions

Registry Hospitals- If less than 9 digits are available left justify and follow by blanks.

**COUNTY AT DX**
**(Residence At Diagnosis – County)**

Record the county of the patient's usual residence when the tumor was diagnosed.

## Recording County At Dx

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

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

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

4. Outside of Virginia- If the patient resides in a state other than Virginia, in Canada, or in a US possession, the specific county is not required and should be coded to 998.

5. FIPS Codes- Record the county at diagnosis using county codes issued by the Bureau of Standards in the Federal Information Processing Standards (FIPS). The FIPS codes for Virginia counties are listed in *VCR Manual Appendix F, Federal Information Processing Standards (FIPS)* and are generally incorporated into abstracting software.

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

    1. SEER Geo-Codes- Record the three digit country code in which the patient resided at diagnosis using *VCR Manual Appendix G, SEER Geo-Codes*. These codes are generally incorporated into abstracting software.

    2. Country unknown- Record 999 when the country of residence is unknown.

## Additional Codes and Definitions

In addition to the FIPS and Geo-codes, the following codes are acceptable:

| Code | Definition |
|---|---|
| 998 | Patient resides outside of Virginia |
| 999 | Unknown county/country |

**AGE AT DIAGNOSIS**

Record the patient's age at his/her last birthday before diagnosis.

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

## Recording Age At Diagnosis

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

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

3. Date of Diagnosis Unknown- Use 999 if the date of diagnosis is unknown.

## Special Instructions

Age must be documented in the PE Text field.

**BIRTH DATE**

Record the patient's date of birth

## Recording Birth Date

1. Date Format- Record date in month, day, year format (MMDDCCYY). Record the month in the first two spaces, the day in the third and fourth spaces, and the year in the last four spaces. A zero must precede single-digit months and days. See *VCR Manual, Part Three, General Instructions* for allowable values.

   *Example:* Record June 30, 1906 as 06301906.

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

   *Example 1:* The patient is 60 years old when diagnosed on June 15, 1996. The medical record does not have a birth date. Record unknown month (99) and day (99). Estimate the year as 1936 (99991936).

   *Example 2:* Record the patient's date of birth as 99991927 when the medical record contains only the year of birth (1927).

3. Calculating Date of Birth- If date of birth is unavailable, but the year of diagnosis and age are known, calculate approximate date of birth. Use 99999999 only if the age at diagnosis is also unknown.

4. Unknown Month, Day and/or Year- If date is not known, record 99999999. If only part of the date is known, record what is known and enter approximations for month and/or year if descriptions are available or 99 for what is unknown. No approximation of day is acceptable. Refer to *VCR Manual, Part Three: Data Item Instructions, General Information, Dates* for instructions regarding Approximating Dates and Unknown Dates. Fictitious dates or default values are not acceptable to be entered for month, day, or year.

**BIRTH PLACE**

Record the patient's place of birth.

## Recording Birth Place

### Born in the United States

1. State of Birth- If the patient was born in the United States, record the state of birth.

2. SEER Geo-codes- Record the patient's place of birth using the *VCR Manual Appendix G, SEER Geo-Codes*. These codes include states of the United States as well as foreign countries.

   a. Specific Code- Use the most specific code possible.

   b. Software- These codes are generally incorporated in abstracting software.

   c. Original Codes- At the time SEER assigned geo-codes in the 1970's, the United States owned or controlled islands in the Pacific. Many of these islands are now independent. Some are controlled by countries other than the United States. The original codes are used for these islands to preserve historic information. The names have been annotated to show the new political designation. The alphabetic list displays the correct code.

3. Unknown State- If the state is unknown, record 000.

### Born Outside the United States

1. Country of Birth- If patient was born outside the United States, enter the country of birth.

2. SEER Geo-codes- Record the three digit country code using *VCR Manual Appendix G, SEER Geo-Codes*.

3. Unknown Country- If the country is unknown, record *998*.

### Birth Place Unavailable

Information unavailable- Record *999* when place of birth is unavailable.

## Additional Codes and Definitions

In addition to the SEER Geo-codes, the following codes are acceptable:

| Code | Definition |
|---|---|
| 998 | Place of birth outside of the United States, country unknown |
| 999 | Place of birth unknown |

**SOCIAL SECURITY NUMBER**

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

## Recording Social Security Number

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

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

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

   a. First three digits cannot = 000 or 666

   b. Fourth and Fifth digits cannot = 00

   c. Last four digits cannot = 0000

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

4. Correction- If a correction is made to the Social Security Number, a change sheet must be submitted to the VCR. See *VCR Manual Part One, Changing Information*.

**SEX**

Record the patient's sex.

## Codes and Definitions

| Code | Definition |
|---|---|
| 1 | Male |
| 2 | Female |
| 3 | Other (Hermaphrodite) |
| 4 | Transsexual |
| 9 | Not stated/Unknown |

## Special Instructions

1. Sex must be documented in the PE Text field
2. Codes of 3 or 4 requires documentation in the PE Text field

**SPANISH/HISPANIC ORIGIN**

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

## Codes and Definitions

| Code | Definition |
|---|---|
| 0 | Non-Spanish, Non-Hispanic |
| 1 | Mexican (includes Chicano) |
| 2 | Puerto Rican |
| 3 | Cuban |
| 4 | South or Central American (except Brazil) |
| 5 | Other specified Spanish/Hispanic origin (includes European) |
| 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 category of 1 – 5) |
| 7 | Spanish surname only (the only evidence of the person's Hispanic origin is surname or maiden name and there is no contrary evidence that the person is not Hispanic |
| 8 | Dominican Republic |
| 9 | Unknown whether Spanish or not |

## Recording Spanish/Hispanic Origin

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

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

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

4. Information Not Available- If this information is not available, reference ***"A Toolkit for Collecting Race, Ethnicity, and Primary Language Information From Patients"*** which was developed by the Health Research Educational Trust providing guidance on how to collect this information during patient registration. This resource is available at the following link and should be shared with personnel responsible for patient registration throughout your facilities:

   www.hretdisparities.org/hretdisparities/index.jsp.

**RACE**
**RACE 1, RACE 2, RACE 3, RACE 4, RACE 5**

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

## Codes and Definitions

| Code | Definition | Code | Definition |
|---|---|---|---|
| 01 | White | 21 | Chamorran |
| 02 | Black | 22 | Guamanian, NOS |
| 03 | American Indian, Aleutian, Eskimo | 25 | Polynesian, NOS |
| 04 | Chinese | 26 | Tahitian |
| 05 | Japanese | 27 | Samoan |
| 06 | Filipino | 28 | Tongan |
| 07 | Hawaiian | 30 | Melanesian, NOS |
| 08 | Korean | 31 | Fiji Islander |
| 09 | Asian Indian, Pakistani | 32 | New Guinean |
| 10 | Vietnamese | 88 | No further race documented (Do **Not** use in Race 1) |
| 11 | Laotian | 96 | Other Asian, includes Asian NOS, & Oriental NOS |
| 12 | Hmong | 97 | Pacific Islander, NOS |
| 13 | Kampuchean, includes Khmer & Cambodian | 98 | Other |
| 14 | Thai | 99 | Unknown |
| 20 | Micronesian | | |

## Recording Race

### Single Race

1. <u>One Race</u>- If only one race is reported for the patient, in Race 1 enter the race code and in Race 2 through Race 5, enter 88.

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

   *Example 1:* If the patient's race is listed as white, in Race 1 enter 01 and in Race 2 through Race 5 enter 88. Do not code 01 in Race 1 signifying one parent and 01 again in Race 2 for other parent.

   *Example 2*: A patient was born in Mexico of Mexican parentage. Code Race 1 as 01 and Race 2 through Race 5 as 88.

**RACE, continued**
**RACE 1, RACE 2, RACE 3, RACE 4, RACE 5**

## Multiple Races

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

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

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

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

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

   *Example:* Patient is described as Japanese and Hawaiian. Code Race 1 as 07, Hawaiian, Race 2 as 05 Japanese, and Race 3 through Race 5 as 88.

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

   *Example:* Patient is stated to be Vietnamese and Black. Code Race 1 as 10 Vietnamese, Race 2 as 02 Black, and Race 3 through Race 5 as 88.

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

   *Example:* The patient is described as Asian-American with Korean parents. Code race as 08 Korean because it is more specific than 96 Asian, NOS. Code Race 2 through 5 as 88.

## No Race Stated

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

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

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

**RACE, continued**
**RACE 1, RACE 2, RACE 3, RACE 4, RACE 5**

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

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

### Race-Specific Guidelines

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

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

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

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

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

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

### Use of Code 88 (No further race documented)

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

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

### Use of Code 99 (Unknown)

1. If the patient's race is unknown, enter 99 in Race 1 through Race 5.

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

## Special Instructions

Race must be recorded in the PE Text field. If race is unknown, it should be recorded as such in the text field.

### Reference

***"A Toolkit for Collecting Race, Ethnicity, and Primary Language Information form Patients"*** is a reference developed by the Health Research Educational Trust providing guidance on how to collect this information during patient registration. This resource is available at the following link and should be shared with personnel responsible for patient registration throughout your facilities:

www.hretdisparities.org/hretdisparities/index.jsp.

**MARITAL STATUS AT DX**

Record the patient's marital status when the tumor was diagnosed.

## Codes and Definitions

| Code | Definition |
|---|---|
| 1 | Single (never married) |
| 2 | Married (including common law) |
| 3 | Separated |
| 4 | Divorced |
| 5 | Widowed |
| 9 | Unknown |

## Recording Marital Status at DX

1. Do not change patient's marital status if it changes over time.

2. Under the Age of 15- If a patient is younger than 15 years of age and marital status is unknown, assume he/she is single and code 1.

**PRIMARY PAYER AT DIAGNOSIS**

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

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

## Codes and Definitions

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

**PRIMARY PAYER AT DIAGNOSIS, Continued**

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

## Recording Primary Payer at Diagnosis

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

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

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

**TEXT - USUAL OCCUPATION**

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

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

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

## Recording Text-Usual Occupation

1. Retired- **Do not record retired.**

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

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

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

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

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

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

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

**TEXT - USUAL INDUSTRY**

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

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

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

## Recording Text-Usual Industry

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

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

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

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

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

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

**MEDICAL RECORD NUMBER**

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

## Recording Medical Record Number

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

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

   *Example:* Medical record number 811234 would be recorded

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | 8 | 1 | 1 | 2 | 3 | 4 |

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

   *Examples:* Radiation Therapy

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | R | T |

   One-day surgery clinic

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | S | U |

4. Unknown- If the medical record number is unknown, record

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | U | N | K |

## COMORBIDITIES AND COMPLICATIONS # 1 (Secondary Diagnoses)

Record the patient's preexisting 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.

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 evaluation patient survival and other outcomes. Complications may be related to quality of care.

**Recording Comorbidities and Complications**

1. Secondary diagnoses must be reported for patients that have inpatient hospitalizations at your facility.
   a. Report the ICD-9-CM codes for up to 10 comorbid conditions or complications

      Note: For comorbid conditions (ICD-9-CM codes 001 – 139.8 and 240 – 999.9) there is an assumed decimal point between the 3rd and 4th characters

      *Example 1:* COPD, ICD-9-CM code 496, record 496000

      *Example 2:* Type I diabetes mellitus, ICD-9-CM code 250.01, record 25001

      *Example 3:* Hypertension, ICD-9-CM code 401, record 40100

      Note: For complications (ICD-9-CM "E" codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters

      *Example 1:* The patient was inadvertently exposed to an overdose of external beam radiation, ICD-9-CM code E873.2, record E8732

      *Example 2:* The patient with colon cancer underwent surgical resection and subsequently experiences an anastomotic leak, ICD-9-CM code E930.0, record E9300

      *Example 3:* The patient has a personal history of breast cancer, ICD-9-CM code V10.3, record V1030

2. Secondary diagnoses should be reported for patients receiving outpatient care or treated in oncology clinics at your facility when available

3. Consult the patient record for the discharge abstract. Secondary diagnoses are found on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available.

4. Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded in the billing department at your facility

**COMORBIDITIES AND COMPLICATIONS # 1, continued**
**(Secondary Diagnoses)**

5. Report the secondary diagnoses for this cancer using the following priority rules:

   a. Surgically treated patients:
      i. Following the most definitive surgery of the primary site
      ii. Following other non-primary site surgeries

   b. Non-surgically treated patients:
      i. Following the first treatment encounter/episode

   c. In cases of non-treatment:
      i. Following the last diagnostic/evaluative encounter

6. If the data item *Readmission To the Same Hospital Within 30 Days of Surgical Discharge* is coded to 1, 2, or 3, then use available *Comorbidities and Complications* data items to record E codes appearing on the "readmission: discharge abstract

7. **Do not** record any neoplasms (ICD-9-CM codes 140 – 239.9) listed as secondary diagnoses for this data item

8. **Do not** record causes of injury and poisoning unrelated to the patient's medical care (ICD-9-CM codes E800 – E86939, E880 – E929.9, or E950 – E999)

9. **Do not** record the following factors influencing health status and contact with heath services (ICD-9-CM codes V01-V07.1, V07.4-V09.91, V16-V21.9, V23.2-V25.3, V2535-V43289, V46-V50.4, or V20.8-V83.89)

10. If no secondary diagnoses were documented, then code 00000 in this data item, and leave the remaining "Comorbidities and Complications" data items blank

11. If fewer than 10 secondary diagnoses are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" data items blank

## COMORBIDITIES AND COMPLICATIONS # 2 (Secondary Diagnoses)

Record the patient's preexisting 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.

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 evaluation patient survival and other outcomes. Complications may be related to quality of care.

**Recording Comorbidities and Complications**

1. If only one comorbid condition or complication is listed, then leave this data item blank

2. If only two comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank

## COMORBIDITIES AND COMPLICATIONS # 3 (Secondary Diagnoses)

Record the patient's preexisting 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.

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 evaluation patient survival and other outcomes. Complications may be related to quality of care.

**Recording Comorbidities and Complications**

1. If fewer than three comorbid conditions or complications are listed, then leave this data item blank

2. If only three comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank

## COMORBIDITIES AND COMPLICATIONS # 4
## (Secondary Diagnoses)

Record the patient's preexisting 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.

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 evaluation patient survival and other outcomes. Complications may be related to quality of care.

**Recording Comorbidities and Complications**

1. If fewer than four comorbid conditions or complications are listed, then leave this data item blank

2. If only four comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank

## COMORBIDITIES AND COMPLICATIONS # 5 (Secondary Diagnoses)

Record the patient's preexisting 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.

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 evaluation patient survival and other outcomes. Complications may be related to quality of care.

**Recording Comorbidities and Complications**

1. If fewer than five comorbid conditions or complications are listed, then leave this data item blank

2. If only five comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank

## COMORBIDITIES AND COMPLICATIONS # 6 (Secondary Diagnoses)

Record the patient's preexisting 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.

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 evaluation patient survival and other outcomes. Complications may be related to quality of care.

**Recording Comorbidities and Complications**

1. If fewer than six comorbid conditions or complications are listed, then leave this data item blank

2. If only six comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank

## COMORBIDITIES AND COMPLICATIONS # 7 (Secondary Diagnoses)

Record the patient's preexisting 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.

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 evaluation patient survival and other outcomes. Complications may be related to quality of care.

**Recording Comorbidities and Complications**

1. If fewer than seven comorbid conditions or complications are listed, then leave this data item blank

2. If only seven comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank

## COMORBIDITIES AND COMPLICATIONS # 8
## (Secondary Diagnoses)

Record the patient's preexisting 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.

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 evaluation patient survival and other outcomes. Complications may be related to quality of care.

**Recording Comorbidities and Complications**

1. If fewer than eight comorbid conditions or complications are listed, then leave this data item blank

2. If only eight comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank

## COMORBIDITIES AND COMPLICATIONS # 9 (Secondary Diagnoses)

Record the patient's preexisting 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.

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 evaluation patient survival and other outcomes. Complications may be related to quality of care.

**Recording Comorbidities and Complications**

1. If fewer than nine comorbid conditions or complications are listed, then leave this data item blank

2. If only nine comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank

## COMORBIDITIES AND COMPLICATIONS # 10 (Secondary Diagnoses)

Record the patient's preexisting 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.

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 evaluation patient survival and other outcomes. Complications may be related to quality of care.

**Recording Comorbidities and Complications**

1. <u>If fewer than 10 comorbid conditions or complications are listed,</u> then leave this data item blank

**ACCESSION NUMBER - HOSP**
**(Registry Accession Number)**

Record the registry accession number assigned by your facility.

## Recording Accession Number-Hosp

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

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

   *Example:* A patient is diagnosed at the reporting institution in 2003. The first four digits of the registry accession number are 2003. This is the 33rd patient accessioned in 2003, making the last five digits of the registry accession number 00033. The full registry accession number is 200300033.

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

## Special Instructions

1. Registry Hospitals- For more detailed instructions on assigning registry accession number, refer to *ACOS COC Facility Oncology Registry Data Standards (FORDS)*.

**SEQUENCE NUMBER - HOSPITAL**

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

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

## Sequence Numbers for Malignant or In Situ Primaries

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

## Sequence Numbers for Non-Malignant Tumors

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

## Recording Sequence Number

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

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

   *Example*: In January 2001, the registry assigns sequence number 00 to a patient with malignant melanoma. The patient develops a second primary cancer of the lung in July 2002. Assign sequence number 02 to the second cancer (lung). Change the sequence number of the first cancer (malignant melanoma) to 01.

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

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

**SEQUENCE NUMBER - HOSPITAL, continued**

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

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

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

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

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

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

6. In Situ Tumor Followed by an Invasive Cancer- If an in situ tumor is followed by an invasive cancer in the same site more than two months apart, report as two primaries even if stated to be a recurrence. The invasive primary should be reported with the date of the invasive diagnosis. Assign sequence numbers to both primaries with the in situ cancer being the first of the two. Refer to the *Multiple Primary and Histology Coding Rules* for more specific information by site.

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

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

8. Newly reportable conditions- If the patient has a condition that was diagnosed prior to the condition being reportable do not count that condition when assigning sequence number.

   *Example*: A patient was diagnosed with refractory anemia on June 25, 1999 (not reportable until 2001) and then was later diagnosed with acute myelogenous leukemia on March 21, 2003 at your facility. Abstract only the acute myelogenous leukemia and assign a Sequence Number of 00.

**SEQUENCE NUMBER - HOSPITAL, continued**

9. Unaccessioned tumor- Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence.

10. Considered Recurrence- The following sites/histologies are single primaries. Any reappearance of the original disease is documented as a recurrence. Assign a sequence number to the first disease occurrence. Do not assign another sequence number to any subsequent occurrences.

    - Invasive transitional and papillary transitional cell carcinomas (8120-8130) of the bladder
    - Invasive adenocarcinoma (8140) of the prostate
    - Kaposi sarcoma (9140/3) regardless of primary site
    - Non-malignant brain and CNS tumors of the same histology, same site, and same laterality.

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

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

13. Fictitious Sequence Numbers - Do not enter fictitious sequence numbers. Fictitious sequence numbers harm the scientific integrity of the data.

**CLASS OF CASE**

Record class of case based on reference date. For hospitals with hospital based cancer registries, use your registry's reference date. For non-registry hospitals, use January 1, 1990 as the reference date. (See *VCR Manual Part One, Reference Date*)

## Codes and Definitions

| Code | Definition |
|---|---|
| 0 | Diagnosis at the reporting facility and all of the first course of treatment was performed elsewhere or the decision not to treat was made at another facility. Cases include:<br><br>• Patients who choose to be treated elsewhere.<br>• Patients who are referred elsewhere for treatment.<br><br>*Example:* Patient enters the reporting facility with dizziness and receives a workup. Results are positive for multiple metastatic deposits in both lobes of the brain and mass in the right upper lobe of the lung. The patient is discharged to hospital B for treatment with a diagnosis of lung cancer with metastasis to the brain. |
| 1 | Diagnosis at the reporting facility and all or part of first course of treatment was performed at the reporting facility. Cases include:<br><br>• Patients diagnosed at the reporting facility:<br>  o whose treatment plan is either not to treat or watchful waiting.<br>  o who refuse treatment.<br>  o who are not treatable or who were given palliative care only due to age, advanced disease, or other medical conditions.<br>  o for whom it is unknown whether treatment was recommended or administered.<br>  o for whom treatment was recommended, but it is unknown whether it was administered.<br>  o who received all or part of their first course of treatment in a staff physician's office. "Staff physician" refers to any medical staff with admitting privileges at the reporting facility.<br>• Patients diagnosed at a staff physician's office who receive their first course of treatment at the reporting facility.<br><br>*Example:* Patient is admitted with hemoptysis. Workup reveals right upper lobe mass. Biopsy is positive for adenocarcinoma. The patient undergoes surgery followed by radiation therapy at the same facility. |
| 2 | Diagnosis elsewhere, and all or part of the first course of treatment was performed at the reporting facility.<br><br>*Example:* Patient was diagnosed and had surgery at another facility for primary breast cancer. The patient then comes to your facility for radiation therapy.<br><br>*Note:* If patient is a Class of Case 2, Date of Diagnosis should not equal Date of 1st Contact. |

**CLASS OF CASE, continued**

| Code | Definition |
|---|---|
| 3 | Diagnosis and all of the first course of treatment was performed elsewhere. Presents at your facility with recurrence or persistent disease. Presents at your facility, diagnosed and expires with no treatment. Cases include:<br><br>• Patients treated at the reporting facility for whom no information on first course of treatment is available<br>• Patients for whom the accessioning facility developed a treatment plan or provided "second opinion" services, but the diagnosis and treatment was provided elsewhere.<br>• Patients treated for recurrence or progression for a previously diagnosed malignancy<br><br>*Example:* Patient was diagnosed and treated for primary bladder cancer four years prior to admission. Patient is then admitted to your facility for cystectomy for recurrent bladder cancer.<br><br>*Note:* If patient is a Class of Case 3, Date of Diagnosis should not equal Date of 1st Contact. |
| 4<br>**These cases are NOT REPORT-ABLE to VCR** | Diagnosis and/or first course of treatment was performed at the reporting facility prior to the reference date of the registry. Cases include:<br><br>• Patients for whom the reporting facility manages or treats a recurrence or progression of disease after the reference date.<br>• Patients for whom it is unknown whether the reporting facility delivered the first course of treatment prior to the reference date.<br><br>*Example:* Patient was diagnosed prior to 1990 with breast cancer and is now admitted to your facility for pain management from widespread metastasis of the original breast cancer. |
| 5 | Diagnosed at autopsy<br><br>*Example:* Patient dies at home, but autopsy performed at reporting facility. There was no previous knowledge or suspicion of cancer. |
| 7 | Pathology report only. Patient does not enter the reporting facility at any time for diagnosis or treatment. This category excludes tumors diagnosed at autopsy.<br><br>*Example:* Hospital pathology department received a tissue sample for evaluation which was positive for malignant melanoma. The lesion was excised in the doctor's office and the patient never visited the hospital. |
| 8 | Diagnosis was established by death certificate only. *Used by VCR only.* |
| 9 | Unknown. Use only under VCR guidelines when sufficient detail for determining Class of Case is not stated in patient record. Use when unknown if previously diagnosed, unknown if previously treated, or when patient was previously diagnosed but date of diagnosis is unknown.<br><br>*Example:* Patient is admitted for a TURP for recurrent bladder cancer. It is unknown when the original cancer was diagnosed. |

**CLASS OF CASE, continued**

## Analytic and Non-analytic Cases

Class of Case shows the role the reporting institution played in the patient's diagnosis or treatment. Class of case codes are further categorized into analytic and non-analytic categories to reflect where the initial diagnosis or treatment occurred. Both analytic and non-analytic cases are reportable to the VCR.

1. Analytic Cases (Class of Case 0, 1, and 2) - Analytic cases include those that were first diagnosed and/or received all or part of their first course of treatment at the reporting institution.

2. Non-analytic Cases (Class of Case 3, 5, 7, 8, and 9) – Non-analytic cases include those referred to the reporting institution for recurrence or subsequent therapy. They were first diagnosed and received all of their first course of treatment at another institution or if the patient expires with a history of cancer. Non-analytic cases also include cases diagnosed at autopsy and pathology report only cases.

**CASEFINDING SOURCE**

Record 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.

This data item will help facilities in prioritizing their casefinding activities. It provides more detail than "Type of Reporting Source."

## Codes and Definitions

### Case first identified at a reporting facility:

| Code | Definition |
|---|---|
| 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, code 23; includes nuclear medicine) |
| 27 | Tumor Board |
| 28 | Hospital Rehabilitation Service or Clinic |
| 29 | Other Hospital Source (including clinic, NOS or outpatient department, NOS) |

**CASEFINDING SOURCE, continued**

**Case first identified by source other than a reporting facility covered in codes 10-29:**

| Code | Definition |
|---|---|
| 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)<br>*Note:* This includes cases reported as a result of reconciliation and quality assessments reviews (audits) |
| 99 | Unknown |

## Recording Casefinding Source

1. Cases First Identified at the Reporting Facility- Record the source where the tumor was first identified during routine casefinding procedures using the codes under 'Case first identified at a reporting facility'. Code the earliest source (based on patient or specimen contact at the facility) of identifying information.

   *Example*: A reportable case is identified while reviewing pathology reports during routine casefinding. Code *Casefinding Source* to 20 Pathology Department Review.

2. Cases Identified by Source Other Than a Reporting Facility Covered in the Codes Above- If the tumor was first identified by a source other than the reporting facility, select the most appropriate code to identify the source from the list of codes under 'Case First Identified by Source Other Than a Reporting Facility Covered in the Codes Above'. One specific use of these codes will be to indicate previously unreported tumors identified as a result of quality control procedures conducted by the VCR (e.g. reconciliation, audit, death clearance).

   *Example:* During VCR reconciliation, a tumor on the list of cases to be reconciled is determined to be reportable. The facility abstracts the case and enters code 95.

**TYPE OF REPORTING SOURCE**

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

## Codes and Definitions

| Code | Definition |
|---|---|
| 1 | Hospital inpatient, hospital outpatient, clinic |
| 2 | Radiation Treatment Centers or Medical Oncology Centers (independent) |
| 3 | Laboratory only (hospital or private), POP |
| 6 | Autopsy Only |
| 7 | Death certificate only **(VCR use only)** |
| 8 | Other hospital outpatient units/surgery centers (independent) |

## Recording Type of Reporting Source

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

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

**DATE OF 1ST CONTACT**

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

## Recording Date of 1st Contact

1. Date Format- Record date in month, day, year format (MMDDCCYY). Record the month in the first two spaces, the day in the third and fourth spaces, and the year in the last four spaces. A zero must precede single-digit months and days. See *VCR Manual, Part Three, General Instructions* for allowable values

   *Example:* Record June 30, 2007 as 06302007.

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

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

4. Never Leave Blank- This data item can never be blank and can never be zero filled.

5. **Report actual date only. Unknown (99) or approximation of month, day, century, or year is not acceptable when reporting to the VCR. Fictitious dates or default values are also not acceptable.**

6. Readmission for a Newly Reportable Condition- When a patient is readmitted on or after January 1, 2001 for a condition not previously required to be reported, the Date of 1st Contact is the earliest date on or after January 1, 2001 the patient was seen at the reporting institution. (Registry hospitals see also *Special Instructions*.)

   *Example:* The patient was diagnosed with a colon primary in 1980. The patient came to the reporting facility in 1999 for treatment. The case was not reportable in 1999 due to the date of diagnosis being prior to January 1, 1990. The patient returns to the reporting facility for cancer treatment on March 23, 2007. The case is now reportable with a Date of 1st Contact of 03232007.

7. Earlier than Date of Inpatient Discharge- The Date of 1st Contact must be earlier than the date of inpatient discharge.

   *Example 1*: The patient is seen as an outpatient for a colonoscopy with a positive biopsy on October 6, 2007. He is admitted to the hospital from October 10, 2007 to October 15, 2007 for surgery. The Date of 1st Contact is 10062007.

   *Example 2*: The patient is admitted from August 23, 2007 to August 27, 2007 for shortness of breath. On August 25, 2007 the patient has a lung biopsy, which is diagnostic of cancer. The Date of 1st Contact is 08232007.

**DATE OF 1ST CONTACT, continued**

8. Admission Unrelated to Cancer- If a patient is admitted for other reasons not related to cancer, use the diagnosis date as the date of first contact.

   *Example*: Patient is admitted for a reason unrelated to cancer on 1/15/2007 and 1/17/2007 is incidentally diagnosed with cancer, the *Date of 1st Contact* is 01172007.

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

   *Example*: Patient undergoes a biopsy in a physician's office on September 8, 2007. The pathology specimen was sent to your facility and was read as malignant melanoma. The patient enters your facility on September 14, 2007 for a wide excision. The Date of 1st Contact is 09142007.

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

    *Example:* The patient has an outpatient mammogram on April 10, 2003 that is suspicious for cancer. The patient returns for a biopsy that is diagnostic of cancer on April 17, 2003. This case would be reportable at the time of the biopsy with a Date of 1st Contact of 04102003.

**INSTITUTION REFERRED FROM**

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

## Recording Institution Referred From

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

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

3. Not Referred- Code 0000000000 if the patient was not referred to the reporting institution from another institution. *Institution Referred From* for Private Outpatient Specimens (POP) is coded to 0000000000.

4. Referring Facility- Use the codes in your current selection of facility ID numbers (FIN), i.e., Commission on Cancer (COC) codes, to identify the facility from which the patient was referred. This field is 10 characters. For facilities with seven-digit FINs assigned by the COC before January 1, 2001, the coded FIN will consist of three leading zeros followed by the full seven-digit number, e.g., 0006231234. For facilities with eight-digit FINs assigned by COC after January 1, 2001, the coded FIN will consist of two leading zeroes, followed by the full eight-digit number, e.g., 0010000000. *Note:* Most abstracting software including AbstractPlus will automatically zero-fill these remaining spaces when the selection is made from a table of facility codes.

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

6. List of FINs- A complete list of FINs is available on the American College of Surgeons web site at:

   *http://www.facs.org/*

## NPI - INSTITUTION REFERRED FROM

Record the NPI number of the facility from which the patient was referred.

The NPI is a unique identification number. It is equivalent to *Facility Referred From.* Both are required during a period of transition.

**Recording NPI – Institution Referred From**

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

2. Format- The NPI number is a 10-digit number, beginning with a 2 for facilities

3. NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008 and later

    a. NPI may be blank for cases diagnosed on or before December 31, 2007

    b. Check with the registry, billing, or health information departments of the facility to determine the NPI

**FOLLOWING PHYSICIAN**

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

## Recording Following Physician

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

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

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

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

**NPI - FOLLOWING PHYSICIAN**

Record the NPI for the physician currently responsible for the patient's medical care.

## Recording NPI - Following Physician

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

2. Format- The NPI number is a 10-digit number, beginning with a 1 for an individual provider

3. Change this data item when patient follow up becomes the responsibility of another physician

4. NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008 and later

    a. NPI may be blank for cases diagnosed on or before December 31, 2007

    b. Check with the registry, billing, or health information departments of the facility to determine the NPI

**DATE OF DIAGNOSIS**

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

## Recording Date of Diagnosis

1. Date Format- Record the date in month, day, year format (MMDDCCYY). Record the month in the first two spaces, the day in the third and fourth spaces, and the year in the last four spaces. A zero must precede single-digit months and days. See *VCR Manual, Part Three, General Instructions* for allowable values.

   *Example:* Record June 30, 2007 as 06302007

2. Date Reportable- Use the earliest Date of Diagnosis whether clinically or histologically confirmed.

   *Example 1*: The patient was diagnosed with stromal endometriosis August 24, 2001. The patient presents to the reporting institution for treatment of the stromal endometriosis on November 5, 2001. This case would be reportable with a Date of Diagnosis of 08242001.

   *Example 2*: The patient has a history of breast cancer diagnosed September 10, 1988. The patient now presents to the reporting institution with metastasis from the breast. This case would be reportable with a Date of Diagnosis of 09101988.

3. Unknown Month, Day and/or Year of Diagnosis- If the original Date of Diagnosis is not known, record 99999999. If only part of the date is known, record what is known and enter approximation for month and/or year if descriptions are available or 99 for what is unknown. Approximation of day is acceptable. Refer to *VCR Manual, Part Three: Data Item Instructions, General Information, Dates* for instructions regarding Approximating Dates and Unknown Dates. Fictitious dates or default values are not acceptable to be entered for month, day, or year.

   *Note for registry hospitals*: According to reporting requirements of the ACOS Commission on Cancer, when a patient is diagnosed elsewhere prior to entering the reporting facility and the Date of Diagnosis is unknown, the hospital should record the date the patient was first seen at the reporting facility as the Date of Diagnosis. This is not the practice of the VCR; these cases must be reported to the VCR with an unknown Date of Diagnosis (99999999).

   *Example 1*: The patient has a history of breast cancer. The patient presents to the reporting facility July 5, 2007 and receives Tamoxifen for breast cancer. The original Date of Diagnosis is unknown. The correct Date of Diagnosis is 99999999.

   *Example 2:* Patient receives palliative treatment for breast cancer diagnosed in June 2007. The correct Date of Diagnosis is 06992007. Do not record 06152007 where 15 is a default value for day.

   *Example 3:* Documentation in the patient's record from a June 2007 admission indicates the patient was diagnosed 'last year'. The correct Date of Diagnosis is 99992006. Do not record 01012006 where 0101 are default values for month and day.

**DATE OF DIAGNOSIS, continued**

*Example 4:* Patient is admitted on January 15, 2007 with severe flank pain with history of lung cancer diagnosed five years ago. The correct Date of Diagnosis is 9999200. Do not record 99999999 when descriptive information can be used to approximate the year.

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

   *Example 1:* A March 12, 2002 mammogram reveals a mass in the upper-outer quadrant of a patient's right breast compatible with carcinoma. On March 20, 2002, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma. Date of Diagnosis is 03122002.

   *Example 2:* A physician notes a prostate nodule possible for cancer during a May 12, 2003 physical exam. On June 15, 2003 a needle biopsy of the prostate histologically confirms adenocarcinoma. Date of Diagnosis is 06152003 because "possible for cancer" does not constitute a reportable diagnosis.

5. Earlier date- If the physician states, in retrospect, the patient had a reportable condition at an earlier date, use the earlier date as the Date of Diagnosis.

   *Example*: A patient has a total abdominal hysterectomy for endometriosis in January 2000. The patient is admitted to the hospital with abdominal pain in November 2002. An omental biopsy shows metastatic cystadenocarcinoma. Pathologists re-review the 2000 hysterectomy specimen. They identify an area of cystadenocarcinoma in the left ovary. Date of Diagnosis is 01992000.

6. Non-reportable conditions, that transforms into a reportable condition- If a patient is diagnosed with a non-reportable condition that later transforms into a reportable condition, record the date the patient was diagnosed with the reportable condition.

   *Example*: The patient was diagnosed with myelodysplastic syndrome on May 1, 2000 (not reportable until 2001) and it transforms into acute myelogenous leukemia on June 15, 2002. Abstract as acute myelogenous leukemia with a Date of Diagnosis of 06152002.

7. Diagnosed at Autopsy- The date of death is the Date of Diagnosis for a case diagnosed at autopsy.

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

**PRIMARY SITE**

This data item records the topography code for the primary site of the cancer/tumor condition being reported using ICD-O-3 or ICD-O-2 (*International Classification of Diseases for Oncology, Third or Second Edition* published by the World Health Organization).

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

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

3. Cases with Unknown *Date of Diagnosis*- If the *Date of Diagnosis* is unknown and cannot be estimated, the *Date of 1st Contact* should be used to determine the correct coding manual to use. Code according to ICD-O-3 when the *Date of 1st Contact* is on or after January 1, 2001. Code according to ICD-O-2 when the *Date of 1st Contact* is prior to January 1, 2001. Newly reportable conditions for 2001 and 2004 are not reportable when Date of Diagnosis is unknown.

## Coding Primary Site

1. Registry Hospitals- Registry hospitals must provide ICD-O topography codes for primary site on each case submitted to the VCR. Refer to the *FORDS Manual, Revised for 2007* at the following link for guidelines:

   http://www.facs.org/cancer/coc/fordsmanual.html

2. Non-registry Hospitals- Non-registry hospitals do not provide ICD-O topography codes for cases submitted to the VCR. VCR staff assigns ICD-O topography codes using the information recorded by hospital personnel in the data item *Text-Primary Site Title* (See *VCR Manual Part Three, Data Item Instructions, Text-Primary Site Title*).

## Determining Primary Site

1. Use all information available in the medical record for determining primary site. Operative reports, oncology consults and pathology reports will help in determining the correct primary site. If you cannot make this determination, consult a physician. You may also submit the abstract to the VCR with appropriate documentation in text fields, copies of health record documentation if necessary and a note on the submission form requesting assistance. Your VCR Cancer Surveillance Specialist will review the case and respond to you.

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

   *Example 1:* The wrist contains several tissue types; skin, bone, soft tissue

   *Example 2:* The large intestine is divided as follows:

| | |
|---|---|
| cecum | splenic flexure of colon |
| ascending colon | descending colon |
| hepatic flexure of colon | sigmoid colon |
| transverse colon | rectosigmoid colon |

**PRIMARY SITE, continued**

3. Hematopoietic Diseases- Primary site is bone marrow (C42.1) for the following hematopoietic diseases:
   Leukemia, with exceptions
   Multiple myeloma
   Polycythemia vera
   Refractory anemia
   Chronic myeloproliferative disease
   Myelosclerosis with myeloid metaplasia
   Essential/idiopathic thrombocythemia
   Myelodysplastic syndromes

   ***Exception*:** Myeloid sarcoma is a leukemic deposit in an organ or tissue and the primary site should be the site of origin.

4. Lymphoma- Lymphomas may arise in lymph nodes, lymphatic tissue such as tonsils, spleen, Waldeyer ring, or thymus, and extranodal sites. Distinguishing between nodal and extranodal origin is important because extranodal lymphomas may have a better prognosis. Do not record the biopsy site as the primary site unless it has been confirmed as the primary site; do not record a metastatic site as the primary site.

   Lymphomas may be present in both an extralymphatic organ and at least one lymph node chain. Carefully identify the origin of the tumor. Record the primary site as the extranodal organ or the lymph nodes as directed by the managing physician.

   Primary site for lymphoma should be determined and documented as follows:

   a. Single Lymph Node Chain- The primary site is the specific lymph node chain (C77._).

      *Example:* The primary site for a lymphoma involving only the inguinal lymph nodes is inguinal lymph nodes (C77.4).

   b. Multiple Lymph Node Chains- The primary site for a lymphoma involving multiple lymph node regions should list the nodal regions involved in the *Text-Primary Site Title* field and be coded to C77.8.

      *Example:* The primary site for a lymphoma involving cervical, axillary, and inguinal lymph nodes is lymph nodes of multiple regions (C77.8).

   c. Lymphatic tissue- The primary site for lymphomas arising in lymphatic tissue is the site of origin (tonsil C09._, spleen C42.2, Waldeyer ring C14.2, or thymus C37.9).

   d. Extranodal lymphomas- Extranodal lymphomas arise from lymphatic cells in organs such as intestine or stomach. The primary site for extranodal lymphomas is the organ of origin.

      *Example 1:* The primary site for lymphoma of the stomach is stomach (C16._).

      *Example 2:* The primary site for **mycosis fungoides** and **cutaneous lymphoma** is skin (C44._).

**PRIMARY SITE, continued**

e. Region- The primary site for a lymphoma in a mass identified as *retroperitoneal*, *inguinal*, or *mesenteric* with no specific information to indicate what tissue is involved should be recorded as lymph nodes, NOS.

*Example:* The primary site for a retroperitoneal lymphoma, NOS is lymph nodes, NOS (C77.9).

f. Unknown Primary, No Indication of Extranodal Origin- The primary site is lymph nodes NOS (C77.9) when:

1) The primary site cannot be determined and there is no indication of extranodal origin.

2) A patient has disseminated lymphoma and a primary site is unknown or not specified.

3) Bone marrow metastases are present and the primary site is unknown or not specified.

g. Unknown Primary, Extranodal Origin Suspected- The primary site is *Unknown* (C80.9) when no site is indicated for a lymphoma and **it is suspected to be of extranodal origin.**

*Example:* The primary site for a lymphoma involving the brain and lung with no lymph node involvement is *Unknown* (C80.9).

5. B-Cell Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma

a. Diagnosis Only in Tissue- The primary site is the tissue involved, usually the lymph node, if the diagnosis is made only in tissue other than bone marrow or blood.

b. Diagnosis in Both Blood or Bone Marrow and Other Tissue- The primary site is the tissue involved, usually the lymph node, if diagnosed in both blood or bone marrow and other tissue.

c. Diagnosis Only in Blood or Bone Marrow- The primary site is bone marrow if diagnosed in only the blood or bone marrow.

d. Basis of Diagnosis is Unknown- The primary site is bone marrow if the basis of the diagnosis is unknown.

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

7. Kaposi Sarcoma- The primary site for Kaposi Sarcoma is the site in which it arises. The primary site is *skin NOS* (C44.9) if the Kaposi Sarcoma arises simultaneously in the skin and another site and the primary site is not identified.

8. Waldenstrom Macroglobulinemia- The primary site is *blood* (C42.0).

**PRIMARY SITE, continued**

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

    a. Melanoma with unknown primary, record primary site as *skin NOS* (C44.9).

    b. Lymphoma with unknown primary, refer to Lymphomas described on previous page.

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

    d. Sarcoma with unknown primary, record primary site as *soft tissue NOS* (C49.9)

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

## Text

Text to support this data item must be recorded in the specific text field. See *VCR Manual Part Three, Data Item Instructions, Text-Primary Site Title.* For registry hospitals, this text field is used by the VCR to validate ICD-O topography and laterality codes reported; for non-registry hospitals, this text field is used to assign the ICD-O topography codes and validate laterality.

**LATERALITY**

Record appropriate laterality code. Laterality refers to a side of the body. It applies to the primary site only.

## Codes and Definitions

| Code | Definition |
|---|---|
| 0 | Not a paired organ |
| 1 | Right: origin of primary |
| 2 | Left: origin of primary |
| 3 | Only one side involved, right or left origin unspecified |
| 4 | Bilateral involvement, side of origin unknown, stated to be a single primary.<br><br>*Including:*<br><br>Both ovaries simultaneously involved with a single histology<br>Bilateral retinoblastomas<br>Bilateral Wilms tumors |
| 9 | Paired site, but lateral origin unknown; midline tumor |

## Recording Laterality

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

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

3. Listing of Paired Sites

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

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

   c. Exclusions should be coded to "0."

**LATERALITY, continued**

| PAIRED SITE | ICD-O CODE |
|---|---|
| Acoustic nerve (excluding diagnoses prior to 2004)* | C72.4 |
| Adrenal gland | C74.0-C74.9 |
| Breast | C50.0-C50.9 |
| Carotid body | C75.4 |
| Cerebral Meninges, NOS (excluding diagnoses prior to 2004)* | C70.0 |
| Cerebrum (excluding diagnoses prior to 2004)* | C71.0 |
| Connective, subcutaneous, and other soft tissues of lower limb and hip | C49.2 |
| Connective, subcutaneous, and other soft tissues of upper limb and shoulder | C49.1 |
| Cranial nerve, NOS (excluding diagnoses prior to 2004)* | C72.5 |
| Epididymis | C63.0 |
| Eye and lacrimal gland | C69.0-C69.9 |
| Fallopian tube | C57.0 |
| Frontal lobe (excluding diagnoses prior to 2004)* | C71.1 |
| Frontal sinus | C31.2 |
| Kidney, NOS | C64.9 |
| Long bones of lower limb | C40.2 |
| Long bones of upper limb and scapula | C40.0 |
| Lung | C34.1-C34.9 |
| Main bronchus (excluding carina, code to “0”) | C34.0 |
| Maxillary sinus | C31.0 |
| Middle Ear | C30.1 |
| Nasal cavity (excluding nasal cartilage and nasal septum, code to “0”) | C30.0 |
| Occipital lobe (excluding diagnoses prior to 2004)* | C71.4 |
| Olfactory nerve (excluding diagnoses prior to 2004)* | C72.2 |
| Optic nerve (excluding diagnoses prior to 2004)* | C72.3 |
| Ovary | C56.9 |
| Parietal lobe (excluding diagnoses prior to 2004)* | C71.3 |
| Parotid gland | C07.9 |
| Pelvic bones (excluding sacrum, coccyx, and symphysis, code to “0”) | C41.4 |
| Peripheral nerves and autonomic nervous system of lower limb and hip | C47.2 |
| Peripheral nerves and autonomic nervous system of upper limb and shoulder | C47.1 |
| Pleura | C38.4 |

**LATERALITY, continued**

| PAIRED SITE | ICD-O CODE |
|---|---|
| Renal Pelvis | C65.9 |
| Rib and clavicle (excluding sternum, code to “0”) | C41.3 |
| Short bones of lower limb | C40.3 |
| Short bones of upper limb | C40.1 |
| Skin of eyelid | C44.1 |
| Skin of external ear | C44.2 |
| Skin of lower limb and hip | C44.7 |
| Skin of other and unspecified parts of face (midline, code to “9”) | C44.3 |
| Skin of trunk (midline, code to “9”) | C44.5 |
| Skin of upper limb and shoulder | C44.6 |
| Spermatic cord | C63.1 |
| Sublingual gland | C08.1 |
| Submandibular gland | C08.0 |
| Temporal lobe (excluding diagnoses prior to 2004)* | C71.2 |
| Testis | C62.0-C62.9 |
| Tonsillar fossa | C09.0 |
| Tonsillar pillar | C09.1 |
| Tonsil, NOS | C09.9 |
| Tonsil, Overlapping | C09.8 |
| Ureter | C66.9 |

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

## Text

Text to support this data item must be recorded in the specific text field. See *VCR Manual Part Three, Data Item Instructions, Text-Primary Site Title.*

**HISTOLOGIC TYPE**

This data item records the code for histologic type of the cancer/tumor being reported using ICD-O-3 or ICD-O-2 (*International Classification of Diseases for Oncology, Third* or *Second Edition* published by the World Health Organization).

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

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

3. Cases With Unknown *Date of Diagnosis*- If the *Date of Diagnosis* is unknown and cannot be estimated, the *Date of 1st Contact* should be used to determine the correct coding manual to use. Code according to ICD-O-3 when the *Date of 1st Contact* is on or after January 1, 2001. Code according to ICD-O-2 when the *Date of 1st Contact* is prior to January 1, 2001. Newly reportable conditions for 2001 and 2004 are not reportable when Date of Diagnosis is unknown.

## Coding Histology

3. Registry Hospitals- Registry hospitals must provide ICD-O codes for histologic type for each case submitted to the VCR. Refer to the *FORDS Manual, Revised for 2007* at the following link for guidelines:

   http://www.facs.org/cancer/coc/fordsmanual.html

4. Non-Registry Hospitals- Non-registry hospitals do not provide ICD-O histology codes for cases submitted to the VCR. VCR staff assigns ICD-O histology codes using the information recorded in the data items *Text-DX Proc-Path* and *Text-Histology Title* (*VCR Manual Part Three, Data Item Instructions, Text-DX Proc-Path* and *Text-Histology Title*).

## Determining Histology

1. Best description of the diagnosis- Always use the final diagnosis. Morphology can be based on histologic or clinical findings. Histology refers to identifying the types of cells involved. Identifying cell types is important because various histologic types have different growth rates and different prognoses.

2. Review all pathology reports. Determine the histology by using the complete final pathologic diagnosis including all comments and addenda. Use the SEER 2007 Multiple Primary and Histology Coding Rules when coding histology for all reportable solid malignant tumors.

   *Example 1:* Final pathologic diagnosis is *non-small cell carcinoma, most likely adenocarcinoma.* The phrase *most likely adenocarcinoma* is an important component of the complete histologic diagnosis and impacts the proper ICD-O code assignment. Code to adenocarcinoma, 8140

   *Example 2*: Final pathologic diagnosis is *B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma in cervical lymph nodes.* The complete histologic diagnosis is *B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma in cervical lymph nodes.* All terms associated with both the leukemia and lymphoma diagnoses as well as the tissue and clinical information used for diagnosis are needed to determine whether the diagnosis should be coded as a leukemia or lymphoma, either 9823 or 9670.

**HISTOLOGIC TYPE, continued**

*Example 3*: Final pathologic diagnosis is *adenocarcinoma of the lung vs. mesothelioma.* The diagnosis on the discharge summary was *mesothelioma.* The complete histologic diagnosis is *mesothelioma,* code 9050.

*Example 4:* Final pathologic diagnosis is *meningioma of the temporal dura*. The histologic diagnosis is *meningioma,* code 9530/0.

***Exception*:** At times the final diagnosis is *Not Otherwise Specified* (carcinoma, NOS; melanoma, NOS; sarcoma, NOS; lymphoma, NOS; or malignant tumor, NOS). Use the histology from the addenda or comment if it identifies a more specific histologic type such as adenocarcinoma, amelanotic melanoma or spindle cell sarcoma.

*Example:* Final pathologic diagnosis is *ductal carcinoma, NOS* of the breast. Comment states the histology is *ductal carcinoma, mucinous type* of the breast. The histologic type is *ductal carcinoma, mucinous type,* code 8523.

3. Specimens from definitive cancer-directed surgery- Reports based on specimens from definitive cancer directed surgery are usually the most explicit

***Exception***: When the biopsy removes the entire tumor. *Example*: The pathology report from a skin biopsy identifies *superficial spreading malignant melanoma*. At wide excision, no residual tumor was found. The histologic type is *superficial spreading malignant melanoma*.

4. Absence of pathologic confirmation- In the absence of pathologic confirmation, use the final diagnosis

*Note:* Cancer, NOS (8000/3) and carcinoma, NOS (8010/3) are not interchangeable. If the physician says the patient has carcinoma, record carcinoma, NOS (8010/3). If the physician only says cancer, do not assume it is carcinoma, but record as cancer, NOS (8000/3).

## Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-DX Proc-Path* and *Text-Histology Title.* For registry hospitals, these text fields are used by the VCR to validate ICD-O histology codes reported; for non-registry hospitals, these text fields are used to assign the ICD-O histology codes.

**BEHAVIOR**

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

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

2. Cases Diagnosed prior to January 1, 2001- Coded according to ICD-O-2.

3. Cases With Unknown *Date of Diagnosis*- If the *Date of Diagnosis* is unknown and cannot be estimated, the *Date of 1st Contact* should be used to determine the correct coding manual to use. Code according toICD-O-3 when the *Date of 1st Contact* is on or after January 1, 2001. Code according to ICD-O-2 when the *Date of 1st Contact* is prior to January 1, 2001.

## Coding Behavior

1. Registry Hospitals- Registry hospitals must provide ICD-O codes for behavior on each case submitted to the VCR. Refer to the *FORDS Manual* at the following link for guidelines:

   http://www.facs.org/cancer/coc/fordsmanual.html

2. Non-registry Hospitals- Non-registry hospitals do not provide ICD-O behavior codes for cases submitted to the VCR. VCR staff assigns ICD-O behavior codes using the information recorded in the data items *Text-DX Proc -Path* and *Text-Histology Title* (See *VCR Manual Part Three, Data Item Instructions, Text-DX Proc -Path* and *Text-Histology Title*).

## Determining Behavior

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

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

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

3. Reportable Benign and Borderline Behaviors- Primary intracranial and central nervous system tumors with a behavior code of /0 or /1 (benign and borderline or "non-malignant") are reportable regardless of histologic type for the sites listed below.

- Meninges (C70.0 - C70.9)
- Brain (C71.0 - C71.9)
- Spinal Cord (C72.0)
- Cauda equina (C72.1)
- Cranial nerves (C72.2 - C72.5)
- Other CNS (C72.8, C72.9)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)

**BEHAVIOR, continued**

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

- *Adenocarcinoma in an adenomatous polyp with no invasion of stalk*
- *Bowen's disease*
- *Clark's level 1 for melanoma (limited to epithelium)*
- *Comedocarcinoma, noninfiltrating*
- *Confined to epithelium*
- *Hutchinson's melanotic freckle, NOS*
- *Intracystic, noninfiltrating*
- *Intraductal*
- *Intraepidermal, NOS*
- *Intraepithelial, NOS*
- *Involvement up to but not including the basement membrane*
- *Lentigo maligna*
- *Lobular neoplasia, grade III (LN3)*
- *Lobular, noninfiltrating*
- *Noninfiltrating*
- *Noninvasive*
- *No stromal involvement*
- *Papillary, noninfiltrating or intraductal*
- *Precancerous melanosis*
- *Pre-invasive*
- *Queyrat's erythroplasia*
- *Stage 0*
- *Vaginal epithelial neoplasia, grade 3 (VAIN III)*
- *Vulvar epithelial neoplasia, grade 3 (VIN III)*

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

*Example:* The pathology report reads *intraductal carcinoma* (8500/2) *with focal areas of invasion.* The phrase *with focal areas of invasion* is an important component in determining behavior and impacts the proper ICD-O code assignment. The histologic type must include the invasive component, *intraductal carcinoma with focal areas of invasion* (8500/3).

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

   a. Obtain a statement from your pathologists that outlines the terminology policy of their department.

   b. Submit the statement to the appropriate medical staff committee for approval. Registry hospitals would normally submit the statement to the Cancer Committee.

   c. Document a policy that states colon sites diagnosed with severe dysplasia and/or high grade dysplasia will be abstracted as carcinoma in-situ.

   d. Add the policy to your Policy and Procedure Manual attaching the approved statement from your pathologists.

   e. Forward a copy of the policy and statement to the VCR to keep on permanent file.

**BEHAVIOR, continued**

f. Abstract all colon cases diagnosed with severe dysplasia and/or high grade dysplasia as carcinoma in-situ. In the text for each case, document the final pathologic diagnosis along with the statement "in-situ per pathologist".

## Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-DX Proc-Path* and *Text-Histology Title.* For registry hospitals, these text fields are used by the VCR to validate ICD-O behavior codes reported; for non-registry hospitals, these text fields are used to assign the ICD-O behavior codes.

**GRADE**

This data item records the code for grade or differentiation of the cancer/tumor being reported using ICD-O-3 or ICD-O-2 (*International Classification of Diseases for Oncology, Third* or *Second Edition* published by the World Health Organization).

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

2. Cases Diagnosed prior to January 1, 2001- Coded according to ICD-O-2.

3. Cases With Unknown Date of Diagnosis- If *Date of Diagnosis* is unknown and cannot be estimated, *Date of 1st Contact* should be used to determine correct coding manual to use. Code according to ICD-O-3 when *Date of 1st Contact* is on or after January 1, 2001. Code according to ICD-O-2 when *Date of 1st Contact* is prior to January 1, 2001.

## Coding Grade

1. Registry Hospitals- Registry hospitals must provide ICD-O grade codes for each case submitted to the VCR. Refer to the *FORDS Manual, Revised for 2007* at the following link for guidelines:

   http://www.facs.org/cancer/coc/fordsmanual.html

2. Non-registry Hospitals- Non-registry hospitals do not provide ICD-O grade codes for cases submitted to the VCR. VCR staff assign ICD-O grade codes using the information recorded in the data item *Text-DX Proc-Path* and *Text-Histology Title* (See *VCR Manual Part Three, Data Item Instructions, Text-DX Proc - Path* and *Text-Histology Title*).

## Codes and Definitions

| Code | Definition |
|---|---|
| 1 | *Grade I* - Well differentiated, differentiated NOS |
| 2 | *Grade II* - Moderately differentiated, moderately well differentiated, intermediate differentiation |
| 3 | *Grade III* - Poorly differentiated, dedifferentiated |
| 4 | *Grade IV* - Undifferentiated, anaplastic |
| 5 | *T Cell* - For lymphomas and leukemias only, T cell, T precursor |
| 6 | *B Cell* - For lymphomas and leukemias only, B cell, Pre B, B precursor |
| 7 | *Null Cell* - For lymphomas and leukemias only, null cell, non T, non B |
| 8 | *N K Cell* - For lymphomas and leukemias only, Natural killer cell |
| 9 | *Grade Unknown* - Grade/cell type not determined, not stated, not applicable |

**GRADE, continued**

## Determining Grade/Differentiation

The grade or differentiation of the tumor describes the resemblance to normal tissue. Well differentiated (Grade I) is the most like normal tissue. As the grade gets higher, the tumor is progressively less like normal tissue.

1. Final Pathologic Diagnosis- Use the grade or differentiation stated in the final pathologic diagnosis. If the grade or differentiation is not stated in the final pathologic diagnosis, use the information from the microscopic description or comments.

   *Example:* Microscopic description is *moderately differentiated squamous cell carcinoma with poorly differentiated areas*. Final pathologic diagnosis is *moderately differentiated squamous cell carcinoma*. The grade is *moderately differentiated* (2).

2. Two Different Grades- If a diagnosis indicates two different grades or degrees of differentiation, use the numerically higher grade or differentiation. Always use the higher grade/differentiation, even if it does not represent the majority of the lesion.

   *Example:* Final pathologic diagnosis is m*oderately to poorly differentiated carcinoma.* The grade is *poorly differentiated* (3).

3. Biopsy vs. Resection –

   a. If a needle biopsy or incisional biopsy of a primary site has a differentiation given and the excision or resection does not, use the information from the needle/incisional biopsy.

   b. If there is a difference between the grade given for a biopsy of the primary site and the grade given for the resected specimen, use the higher grade.

4. Grade from Primary Tumor- Use the grade or differentiation from the pathologic examination of the primary tumor, not from metastatic sites. If the primary site is unknown, the grade/differentiation is unknown (9).

5. In Situ vs. Invasive- Record the grade for in situ lesions if the information is available. If a tumor contains both in situ and invasive components, the grade of the invasive tumor takes precedence over any reported grade of the non invasive tumor.

6. Central Nervous System Tumors- The WHO (World Health Organization) grading system is used to estimate prognosis and for the purpose of AJCC (American Joint Committee on Cancer) staging if the pathologist does not state the grade of the tumor. This grading is not the same as the differentiation or grade code and should not be used as such. Use terms such as low grade or anaplastic rather than using the reported WHO grade. In many cases there will be no verbal description of the grade or differentiation and these cases must be given an unknown grade.

   a. Astrocytomas- If no grade is given for astrocytomas, then code 9 (unknown).

   b. Glioblastoma multiforme- If no grade is given for glioblastoma multiforme, then code 9 (unknown).

**GRADE, continued**

7. Lymphomas and Leukemias, Designation of T-cell, B-cell, Null Cell, or NK Cell- Codes 5-8 define T cell or B cell origin for leukemias and lymphomas only.

   a. T cell, B cell, null cell, or NK cell classification have precedence over grading or differentiation.

   b. High, Low and Intermediate Grade- Do not use "high grade," "low grade," or "intermediate grade" descriptions for lymphomas as a basis for differentiation. These terms are categories in the Working Formulation of lymphoma diagnoses and do not relate to the grade.

8. Grading of Non-Histologically Proven Malignancies- It may be possible to establish the grade of a tumor through Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) when there is no tissue diagnosis. Brain tumors, which are one of the few sites you can grade without histologic confirmation, can be graded using these methods.

9. Variation in Usual Terms-When there is variation in the usual terms for degree of differentiation, use the following conversions:

| CODE | GRADE | TERMINOLOGY |
|---|---|---|
| 2 | I-II | Low grade, partially well differentiated |
| 3 | II-III | Medium grade, intermediate grade |
| | III | Moderately undifferentiated, relatively undifferentiated |
| 4 | III-IV | High grade |

10. Three-grade System- Usually tumor grade is described as I/IV or 1/4 which means grade one in a four grade system. Occasionally a three-grade system is used. If the grade is written II/III or 2/3, this is a Grade 2 of a three-grade system. Use following conversions:

| CODE | DOCUMENTED AS |
|---|---|
| 2 | I/III or 1/3 |
| 3 | II/III or 2/3 |
| 4 | III/III or 3/3 |

11. Different Descriptions for Grade- If the grade of a specimen is described using more than one grading system, report the tumor grade using the following priority order:

    a. Terminology (differentiation: well, moderately, poorly, moderately-well, etc.)

    b. Histologic Grade (Grade I, Grade II, Grade III, Grade IV)

    c. Nuclear Grade

    ***Exceptions:*** Prostate, Breast, and Kidney have different priority orders because of additional schemes used to describe grade. Use the site-specific priority lists for each of these sites.

**GRADE, continued**

12. Prostate- Prostate cancers are usually graded using Gleason's score or pattern. Gleason's grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern (the pattern occupying greater than 50% of the cancer) is indicated by the first number of the Gleason's grade and the secondary pattern is indicated by the second number. These two numbers are added together to create a score, ranging from 2 to 10.

    a. Only one number- If the pathologist gives only one number less than 5 without indication if a score or a pattern, assume it describes the pattern. If only one number is given and it is greater than 5, assume it is the score. If there are two numbers, assume they refer to two patterns and add them to get score.

    b. Conversion Table- Use following conversion when the reports give only the Gleason's score (2-10) or Gleason's pattern (1-5):

| CODE | SCORE (sum of primary & secondary patterns) | PATTERN | GRADING |
|---|---|---|---|
| 1 | 2,3,4 | 1,2 | I Well differentiated |
| 2 | 5,6 | 3 | II Moderately differentiated |
| 3 | 7,8,9,10 | 4,5 | III Poorly differentiated |

    c. Priority Order- For prostate cancers, report the tumor grade using the following priority order:

        1) Gleason Grade (the sum of the patterns)

        2) Terminology (differentiation: well, moderately, poorly, moderately-well, etc.)

        3) Histologic Grade (Grade I, Grade II, Grade III, Grade IV)

        4) Nuclear Grade

13. Breast- The differentiation of a breast tumor may be described using Bloom-Richardson (BR) grading system (aka Scarff-Bloom-Richardson, modified Bloom-Richardson (BR), SBR Grading, Elston-Ellis modification of Bloom-Richardson grading system, Nottingham grade, Nottingham modifications of Bloom-Richardson grading system).

    a. Morphologic features- The Bloom-Richardson grading scheme is based on three morphologic features of invasive breast cancers. The features are:

        1) degree of tumor tubule formation

        2) tumor mitotic activity

        3) nuclear pleomorphism of tumor cells (nuclear grade)

    b. Bloom-Richardson score- To obtain the final Bloom-Richardson score, add score from tubule formation plus number of mitotic score, plus score from nuclear pleomorphism. Seven possible scores are condensed into three BR grades. The three grades then translate into well differentiated (BR low grade), moderately differentiated (BR intermediate grade), and poorly differentiated (BR high grade).

**GRADE, continued**

c. Conversion Table- Use the following conversion table when the reports give only the Bloom-Richardson score.

| CODE | BR SCORE | BR GRADE | NUCLEAR GRADE | TERMINOLOGY | HISTOLOGIC GRADE |
|---|---|---|---|---|---|
| 1 | 3-5 | Low | 1/3; 1/2 | Well differentiated | I/III; 1/3 |
| 2 | 6, 7 | Intermediate | 2/3 | Moderately differentiated | II/III; 2/3 |
| 3 | 8, 9 | High | 2/2; 3/3 | Poorly differentiated | III/III; 3/3 |

d. Priority Order- Use grade or differentiation information from the breast pathology report in the following priority order:

1) Bloom-Richardson scores (ranges 3-9 convert to grade)
2) Bloom-Richardson grade (low, intermediate, high)
3) Nuclear Grade only
4) Terminology (differentiation: well, moderately, poorly, moderately-well, etc.)
5) Histologic Grade (Grade I, Grade II, Grade III, Grade IV)

14. Kidney Priority Order-For kidney cancers, report the tumor grade in the following priority order:

a. Fuhrman Grade
b. Nuclear Grade
c. Terminology (differentiation: well, moderately)
d. Histologic Grade (Grade I, Grade II )

*Note:* These prioritization rules do not apply to Wilms tumor (8960). Use the general rules for coding grade for Wilms tumor.

## Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-DX Proc-Path* and *Text-Histology Title.* For registry hospitals, these text fields are used by the VCR to validate ICD-O grade codes reported; for non-registry hospitals, these text fields are used to assign the ICD-O grade codes.

## DIAGNOSTIC CONFIRMATION

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

## Codes and Definitions

| Code | Definition |
|---|---|
| **Microscopically Confirmed** | |
| 1 | *Positive histology.* Microscopic diagnosis based on tissue specimens from biopsy, frozen section, surgery, autopsy, or dilatation and curettage. Bone marrow biopsy and bone marrow aspiration. Hematologic confirmation of leukemia (peripheral blood smear). |
| 2 | *Positive cytology, no positive histology.* Cytologic diagnosis based on microscopic examination of cells as contrasted with tissues. Fine-needle aspiration (FNA) is frequently used to obtain a cytologic specimen. Cells may be removed from exudate, secretions, or washings from tissue. (e.g., Sputum smears, bronchial brushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical and vaginal smears.) Cytology also includes paraffin-block specimens from concentrated spinal, pleural, or peritoneal fluid. |
| 4 | *Positive microscopic confirmation, method not specified.* The record is reported as microscopically confirmed but no information is provided about the method (histology or cytology). |
| **Not Microscopically Confirmed** | |
| 5 | *Positive laboratory test/marker study.* A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. This includes alpha-fetoprotein for liver cancer and abnormal electrophoretic spike for multiple myeloma. Elevated PSA is nondiagnostic of cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5. |
| 6 | *Direct visualization without microscopic confirmation.* Use this code only in the absence of positive histology or cytology. Diagnosis made at surgical exploration or by endoscopy (colposcope, mediastinoscope, laparoscope). Autopsy only record (only information is from gross autopsy report). |
| 7 | *Radiography and other imaging techniques without microscopic confirmation.* Use this code only in the absence of positive histology or cytology. Diagnosed by radiology, including ultrasound, computerized (axial) tomography (CT or CAT scans) and magnetic resonance imaging (MRI). |
| 8 | *Clinical diagnosis only (other than 5, 6, or 7).* Use this code only in the absence of positive histology or cytology. Records diagnosed by clinical methods not mentioned previously. |
| **Confirmation Unknown** | |
| 9 | *Unknown whether or not microscopically confirmed.* Death-certificate-only records (VCR use only). Method of confirmation is unknown. |

**DIAGNOSTIC CONFIRMATION, continued**

## Recording Diagnostic Confirmation

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

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

   *Example:* A patient is admitted on 11/28/2003. A chest x-ray dated 12/1/2003 diagnoses a probable lung cancer. The patient refuses a diagnostic workup. The registry codes the diagnostic confirmation to radiography (7). The patient consents to a lymph node biopsy on 2/3/2004. The biopsy confirms small cell carcinoma. Change the diagnostic confirmation code to positive histology (1).

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

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

   b. Bone marrow specimens (aspiration and biopsy)

   c. For leukemia only, positive hematologic findings including peripheral blood smears, CBCs and WBCs

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

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

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

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

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

   *Example 1*: The presence of alpha-fetoprotein for liver cancer

   *Example 2:* An abnormal electrophoretic spike for multiple myeloma or Waldenstrom macroglobulinemia.

   *Example 3:* If the workup for a prostate cancer patient is limited to a highly elevated PSA and the physician diagnoses and/or treats the patient based only on that PSA, code the diagnostic confirmation to 5.

**DIAGNOSTIC CONFIRMATION, continued**

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

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

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

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

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

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

## Text

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

## AMBIGUOUS TERMINOLGOY DIAGNOSIS

Record the terminology used to describe the diagnosis.

### Codes and Definitions

| Code | Definition |
|---|---|
| 0 | Conclusive term(s): Diagnosis based on a definitive statement of malignancy within two months of the original diagnosis |
| 1 | Ambiguous term(s) only: Diagnosis based on ambiguous terminology within two months of initial diagnosis (diagnosis from a pathology report, cytology report, or radiology report or in the medical record. Update to 2 id a definitive diagnosis is made fore than 2 months later |
| 2 | Conclusive cancer diagnosis, by any method, more than two months following an initial diagnosis based on ambiguous terminology |
| 9 | Unknown if diagnosis was based on ambiguous terminology |

### Recording Ambiguous Terminology Diagnosis

1. Cases diagnosed on or before December 31, 2006 – leave blank

2. Cases diagnosed after December 31, 2006

   a. Code 0 applies to all diagnostic methods except cytology
      *Example 1:* Pathology report stated adenocarcinoma in TURP chips. No prior diagnosis based on ambiguous terminology

      *Example 2:* Mammogram suspicious for ductal carcinoma in situ. Pathology from lumpectomy two weeks later confirmed ductal carcinoma in situ

   b. Code 1 applies to cases that contain ambiguous terms describing a cytology diagnosis
      *Example 1:* MRI of chest shows a malignant appearing lesion in the right upper lobe of lung. Patient refused further work-up or treatment

      *Example 2:* Patient with an elevated PSA is admitted for TRUS. Pathology from biopsy states, "prostatic chips

   c. Code 2 cases are those that were originally diagnosed based only on ambiguous terminology; then, more than two months after the initial diagnosis, a conclusive diagnosis was made by any diagnostic method including, but not limited to, clinical diagnosis, cytology, pathology, or autopsy.
      *Example 1:* Biopsy of thyroid reads, "most likely thyroid cancer." Three months later, a biopsy is positive for papillary follicular cancer. Initially the case would have been coded 1 (ambiguous terminology only). Because of the conclusive term in the subsequent biopsy, the code is changed to 2.

   d. Code 9 if it is unknown if the diagnosis was based on ambiguous terminology.
      *Example 1:* Discharge summary states the patient has adenocarcinoma of the prostate. No other information available

Refer to *Part One: Reporting Requirements, Reportable Conditions, Ambiguous Terminology* for terms that constitute a diagnosis of cancer

## DATE OF CONCLUSIVE DIAGNOSIS

Record the date when a conclusive cancer diagnosis (based on definitive statement of malignancy) is made following an initial diagnosis that was based only on ambiguous terminology. The date of the conclusive diagnosis must be more than two months following the initial (ambiguous terminology only) diagnosis.

If the date of conclusive diagnosis is within two months following the initial (ambiguous terminology only) diagnosis, the case does not meet the criteria for ambiguous terminology only.

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

### Recording Date of Conclusive Diagnosis

1. The date must be greater than two months from the date of initial diagnosis.

   a. Date Format- Record the date in month, day, year format (MMDDCCYY). Record the month in the first two spaces, the day in the third and fourth spaces, and the year in the last four spaces. A zero must precede single-digit months and days. See *VCR Manual, Part Three, General Instructions* for allowable values.

   *Example:* Record June 30, 2007 as 06302007

2. Record the date a conclusive diagnosis was made based on a definitive statement of malignancy.

3. Leave blank for cases diagnosed on or before December 31, 2006.

4. Allowable values:

| **Month** | | **Day** | **Year** |
|---|---|---|---|
| 01 January | 08 August | 01 | Use four-digit year |
| 02 February | 09 September | 02 | 9999 Year unknown |
| 03 March | 10 October | 03 | |
| 04 April | 11 November | … | |
| 05 May | 12 December | … | |
| 06 June | 99 Month unknown | 31 | |
| 07 July | | 99 Day unknown | |

**DATE OF CONCLUSIVE DIAGNOSIS, continued**

| Code | Definition |
|---|---|
| 00000000 | No conclusive diagnosis made; the only diagnosis was made by ambiguous terminology.<br><br>*Example:* CT of chest 09/12/2007 states suspicious for lung cancer. No further work-up or treatment |
| MMDDCCYY | The date the conclusive cancer diagnosis is made at least 2 months after an initial diagnosis based on ambiguous terminology.<br><br>*Example:* Pathology report for the case above dated 12/30/2007 states "small cell carcinoma of the left lower lobe, lung." Changed from 00000000 to 12302007 based on pathology report 2 or more months after the initial diagnosis made with ambiguous terminology. |
| 88888888 | Not applicable; initial diagnosis made by definitive terminology.<br><br>*Example:* Patient diagnosed with non-Hodgkin lymphoma. |
| 99999999 | Unknown date; unknown if diagnosis based on ambiguous terminology.<br><br>*Example 1:* Consult report states, "patient had TURP for adenocarcinoma in 2007;" code to 99992007.<br><br>*Example 2:* Discharge summary states patient has prostate cancer; no other diagnostic or treatment information available; code to 99999999. |
| (leave blank) | Patient was diagnosed on or before December 31, 2006<br><br>*Example:* Patient had mastectomy at another facility 11/29/2006. Seen at reporting facility in 2007 for radiation therapy. |

## DATE OF MULTIPLE TUMORS

Record the date the patient is diagnosed with multiple or subsequent reportable tumor(s) reported as a single primary. Multiple tumors must have the same histologic group as the original tumor and must be located in the same organ or primary site as the original tumor, using the primary site and histology coding rules.

### Recording Date of Multiple Tumors

1. Record the date the patient is diagnosed with synchronous multiple tumors abstracted as a single primary.

2. Record the *Date of Initial Diagnosis* as the *Date of Multiple Tumors* when reportable tumors are abstracted as a single primary at the time of initial diagnosis.

3. The *Date of Multiple Tumors* must occur within the time specified by the *SEER 2007 Multiple Primary and Histology Coding* Rules following the site-specific rules, when available.

4. Allowable values:

| **Month** | | **Day** | **Year** |
|---|---|---|---|
| 01 January | 08 August | 01 | Use four-digit year |
| 02 February | 09 September | 02 | 9999 Year unknown |
| 03 March | 10 October | 03 | |
| 04 April | 11 November | … | |
| 05 May | 12 December | … | |
| 06 June | 99 Month unknown | 31 | |
| 07 July | | 99 Day unknown | |

## DATE OF MULTIPLE TUMORS, continued

| Code | Definition |
|---|---|
| 00000000 | Single tumor<br><br>*Example:* Pathology from colon resection: 2 cm adenocarcinoma of the ascending colon. No other tumor is mentioned. |
| MMDDCCYY | The date that multiple tumors from the same primary are identified.<br><br>*Example 1:* 05/21/2007: Mastectomy, patient has multiple tumor: a 2 cm infiltrating ductal carcinoma in the lower inner quadrant and a 1 cm infiltrating ductal carcinoma in the upper inner quadrant of the left breast; code to 05212007<br><br>*Example 2:* Results from 4/13/2007 TURB pathology report shows papillary transitional cell carcinoma present in tissue from the bladder neck, dome and posterior wall. Using the bladder, renal pelvis, and ureter multiple primary rules, these tumors are accessioned as a single primary; code to 04132007 |
| 88888888 | Information on multiple tumors is not applicable for this site.<br><br>*Example:* Biopsy of multiple lymph nodes shows B cell lymphoma. |
| 99999999 | Unknown date.<br><br>*Example 1:* Patient is seen at reporting facility for palliative care following treatment for multiple colon tumors. No other information is available |
| (leave blank) | Patient was diagnosed on or before December 31, 2006<br><br>*Example:* Patient was diagnosed at another facility 12/27/2006 and seen at reporting facility for surgery 1/10/2007. |

## MULTIPLE TUMORS REPORTED AS ONE PRIMARY
(Mult Tum Rept as One Prim)

Record multiple tumors reported as a single tumor.

This identifies cases with multiple tumors that are abstracted as a single primary using the multiple primary rules. Multiple tumors may individually exhibit in situ, invasive or any combination of in situ and invasive behaviors. Multiple intracranial and central nervous system tumors may individually exhibit benign, borderline, or a combination of these behaviors.

1. Cases diagnosed on or before December 31, 2006 - leave blank

2. Cases diagnosed after December 31, 2006:

   a. Multiple tumors found in the same organ or in a single primary site may occur at the time of initial diagnosis or within the time specified by the SEER 2007 Multiple Primary and Histology Coding Rules.

   b. The data item does not apply to metastatic tumors

   c. Data will be collected at the time of initial case abstract or within one year of the initial diagnosis

   d. When a physician states that there are two or more primaries, but for surveillance purposes, the case is reported as a single primary.

   e. Use 88, not applicable for:
      1) Leukemia (M9800 – M9949)
      2) Lymphoma (M9590 – M9729)
      3) Immunoproliferative disease (M9760 – M9769)
      4) Unknown primaries (C80.9)

### CODES AND DEFINITIONS

| CODE | DEFINITION |
|---|---|
| 00 | Single tumor. Includes single tumor with both in situ and invasive components |
| 10 | At least two benign tumors in the same organ or primary (Behavior = 0) |
| 11 | At least two borderline tumors in the same organ/primary site (Behavior = 1) |
| 12 | At least one benign **AND** at least one borderline tumor in the same organ/primary site |
| 20 | At least two in situ tumors in the same organ/primary (Behavior = 2) |
| 30 | One or more in situ tumor(s) **AND** one or more invasive tumor(s) in the same organ/primary site |
| 31 | One or more polyps with either in situ carcinoma or invasive carcinoma **AND** one or more frank adenocarcinoma(s) in the same segment of the colon, rectosigmoid, and/or rectum |
| 32 | Diagnosis of Familial Polyposis (FAP) **AND** carcinoma (in situ or invasive) is present in at least one of the polyps |
| 40 | At least two invasive tumors in the same organ (Behavior = 3) |
| 80 | Multiple tumors present in the same organ/primary site, unknown if in situ or invasive |
| 88 | Information on multiple tumors is not applicable for this site |
| 99 | Unknown if multiple tumors, death certificate only cases |

## MULTIPLICTY COUNTER

Record the number of tumors (multiplicity) reported as a single primary.

Patients with multiple tumors reported as a single primary for surveillance purposes may have a worse prognosis and 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.

| Code | Definition |
|---|---|
| 01 | One tumor only<br><br>*Example 1:* Pathology from colon resection shows a 3cm adenocarcinoma in the ascending colon<br>*Example 2:* Pathology from colon resection shows a 3cm adenocarcinoma in the ascending colon. Biopsy of liver shows a solitary metastatic lesion compatible with a colon primary. |
| 02 | Two tumors present<br><br>*Example:* The patient has a 2 cm infiltrating ductal carcinoma in the lower inner quadrant of the left breast and a 1 cm infiltrating ductal carcinoma in the upper outer quadrant of the left breast. |
| 03 | Three tumors present<br><br>*Example:* CT of chest shows two lesions in the left lung and a single lesion in the right lung. Biopsy of the right lung lesion shows adenocarcinoma. No further work-up is performed. Using the multiple primary rules for lung, the case is abstracted as a single primary and the multiplicity counter is 3. |
| 04 – 87 | Four through eighty-seven or more tumors present |
| 88 | Information on multiple tumors not applicable for this site<br><br>*Example:* Patient is diagnosed with non-Hodgkin lymphoma |
| 99 | Multiple tumors present, unknown how many<br><br>*Example:* Pathology report for TURB mentions multiple bladder tumors. Pathology report states papillary transitional cell carcinoma present in tissue from bladder neck, dome, and posterior wall. |
| (leave blank) | Patient was diagnosed on or before December 31, 2006<br><br>*Example:* Pathology report from a 12/30/2006 colonoscopy states patient has 2 lesions in the ascending colon. |

**MULTIPLICTY COUNTER, continued**

### Coding Instructions Multiplicity Counter

1. Use the multiple primary coding rules for the specific site to determine whether the tumors are a single or multiple primaries.

2. Code the number of tumors being abstracted as a single primary.

3. Do NOT count metastasis.

4. Use code 01 when:
   a. There is a single primary tumor in the primary site being abstracted.

   b. There is a single tumor with separate foci of tumor.

   c. It is unknown if there is a single tumor or multiple tumors

   d. And the multiple primary rules instructed you to default to a single tumor

5. Use code 88 for:
   a. Leukemia (M9800 – M9949)

   b. Lymphoma (M9590 – M9769)

   c. Immunoproliferative disease (M9760 – M9769)

   d. Unknown primary (C80.9)

6. Use code 99 when:
   a. The original pathology report is not available and the documentation does not specify whether there was a single tumor or multiple tumors in the primary site

   b. The tumor is described as multifocal or multicentric

   c. The tumor is described as diffuse

   d. The operative or pathology report describes multiple tumors but does not give an exact number

7. Leave blank for cases diagnosed on or before December 31, 2006

**GUIDELINES FOR RECORDING COLLABORATIVE STAGE**

## The Collaborative Staging (CS) System

The Collaborative Staging (CS) System is a group of 15 data items designed to provide a single uniform set of codes and rules for collection of extent of disease and stage information to meet the needs of all organizations.

CS provides for the collection of a common set of data items from which the three major staging systems, SEER Summary Stage, American Joint Committee on Cancer (AJCC), and SEER 10-digit EOD, can be derived by computer algorithm. The CS data items capture the facts regarding the extent and spread of the disease in a consistent manner with the details regarding the extension saved in the data set then used to assign the stage to a group or category. The manual is available at the following website:

http://www.cancerstaging.org/cstage/manuals.html

## Effective Date

CS must be used for cases diagnosed on or after January 1, 2004. It is not to be used for cases diagnosed prior to that date; cases diagnosed prior to January 1, 2004 should be coded to the system in effect at the time of diagnosis as indicated below.

1. Date of Diagnosis 2001 to 2003- Stage cases diagnosed between January 1, 2001 and December 31, 2003 according to SEER Summary Stage 2000 and leave CS items and SEER Summary Stage 1977 blank.

2. Date of Diagnosis prior to 2001- Stage cases diagnosed prior to January 1, 2001 according to SEER Summary Stage 1977 and leave CS Items and SEER Summary 2000 blank.

3. Unknown Date of Diagnosis- Stage cases with unknown Date of Diagnosis (99999999) according to Date of 1st Contact. If the Date of 1st Contact is on or after January 1, 2004, code the CS data items. If Date of 1st Contact is prior to January 1, 2004, stage according to the appropriate SEER Summary Stage 77 or 2000 guidelines.

## How Collaborative Staging Works

CS is a site-specific coding system. CS codes are defined for every site and histology combination. Depending on the site or histology, the coding schema and instructions will vary. For each reportable case, the CS data items specific to that cancer are extracted from the medical record and coded in the Collaborative Staging System fields. What happens after data collection is complete differs for registry and non-registry hospitals:

1. Registry Hospitals- When CS data collection is complete, the registrar activates the computer algorithms to derive the values for the items in the TNM system and Summary Stage (both 1977 and 2000). The derived data items, assigned to specific "derived" fields, will be incorporated into the hospital registry database.

2. Non-Registry Hospitals- Non-registry hospitals are required to supply supporting documentation for the coding of Collaborative Staging.

**GUIDELINES FOR RECORDING COLLABORATIVE STAGE, continued**

## Understanding TNM and AJCC Definitions

Instructions for completing CS data items quite often refer to AJCC (TNM) staging principles. The following AJCC definitions are included to assist in interpreting these instructions.

1. Clinical and Pathologic Staging- AJCC TNM staging is based on clinical, operative, and pathologic assessment of the extent of disease. The staging basis is determined by the point of evaluation.

    a. Clinical staging is based on evidence acquired after the staging workup is completed but before any definitive treatment has begun. Evaluation is based on information from the physical exam, imaging, endoscopy evaluations, biopsy and surgical exploration. Clinical stage is assigned prior to any cancer-directed treatment and is not changed on the basis of subsequent information. Clinical staging ends if a decision is made not to treat the patient. The clinical stage is essential to selecting and evaluating primary therapy. When applicable guidelines are provided on the site-specific schema pages in the *CS Manual*.

    b. Pathologic staging is assigned after the resection of the primary tumor and analysis of the surgical specimen. It uses evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination. The pathologic stage provides additional precise data used for estimating prognosis and calculating end results. Most sites also require the removal and examination of regional lymph nodes. When applicable guidelines are provided on the site-specific schema pages in the *CS Manual*.

2. T, N, M- The AJCC staging scheme is based on the evaluation of the **T, N,** and **M** components.

    a. The **T** element designates the size and invasiveness of the primary tumor. The numerical value increases with tumor size and extent of invasiveness. A small lesion confined to the organ of origin would be coded as T1; larger tumor size or deeper extension into adjacent structures, tissues, capsules, or ligaments as T2; larger tumor size or extension beyond the organ of origin but confined to the region, T3; and a massive lesion or one that directly invades another organ or viscera, major nerves, arteries, or bone, T4.

    b. The **N** component designates the presence or absence of tumor in the regional nodes. In some sites there is an increasing numerical valued based on size, fixation, or capsular invasion. In other sites, numerical value is based on multiple node involvement or number of locations and the regional lymph nodes.

    c. The **M** component identifies the presence or absence of distant metastases, including lymph nodes that are not regional.

**GUIDELINES FOR RECORDING COLLABORATIVE STAGE, continued**

## Collaborative Staging Manual and Coding Instructions (*CS Manual*)

The complete instructions and site-specific defined codes are documented in the *Collaborative Staging and Coding Instructions (CS Manual)* in two parts:

1. Part I- provides general instructions and instructions and codes for generic (non site-specific) items.

2. Part II- contains site-specific instructions and codes.

## General CS Guidelines

Site-specific codes and instructions are referred to as schema. While some schemas are based on primary site and some on histologic type (such as melanoma and lymphoma), the schemas are referred to as site-specific for the sake of brevity. These schemas are documented in the *Collaborative Staging Manual and Coding Instructions (CS Manual), Part II.*

The following points, taken from the *CS Manual,* provide overall guidelines to consider when completing CS data items.

1. Timing of CS Data Collection- The data collected for CS are limited to:

   1) all information gathered through completion of surgery(ies) in first course of treatment or

   2) all information available within four months of the date of diagnosis in the absence of disease progression. Disease progression is defined as further direct extension or distant metastasis known to have developed after diagnosis was established.

   3) whichever is ***longer***

2. Microscopic Confirmation- CS is collected on all cases regardless of whether they are microscopically confirmed. Cases not microscopically confirmed should be coded from the schema for the site/histology the physician considers most likely to be the primary.

3. All Sites/Histologies- CS is collected on all sites/histologies.

4. All Histologies- All schemas apply to all histologies unless otherwise noted.

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

6. Highest Code- For each field, code the highest applicable number. The codes are ordered in a hierarchy so increasing numbers generally indicate increasing degrees of tumor involvement.

   ***Exception:*** Codes for Unknown, Not Applicable, and NOS categories such as Localized, NOS do not take priority over more specific codes with lower numbers.

**GUIDELINES FOR RECORDING COLLABORATIVE STAGE, continued**

7. Clinical and Operative/Pathological Assessment- For the fields CS Tumor Size, CS Extension, CS Lymph Nodes, and CS Mets at DX, CS records the greatest extent of disease based on combined clinical and operative/pathological assessment.

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

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

.

8. Operative/Pathology Information vs. Clinical Information- When a patient does not receive preoperative treatment and the operative/pathology information disproves the clinical information, use the operative/pathology information.

9. Preoperative Treatment- When a patient receives preoperative treatment, the greatest extent of disease prior to the beginning of treatment should be recorded.

    a. Preoperative (or neoadjuvant) treatment is defined as systemic (chemotherapy, hormone therapy, or immunotherapy) treatment or radiation therapy that is administered as an attempt to shrink the tumor, improve resectability, or control symptoms before the patient undergoes surgery.

    b. Refer to CS data item-specific descriptions for instructions when post-operative disease is more extensive despite neoadjuvant treatment.

10. Disease Progression- Metastasis known to have developed after the initial extent of disease was established (disease progression) should be excluded when determining the farthest extent of disease at the time of diagnosis.

11. Autopsy Reports- Autopsy reports are used in coding CS in the same way as pathology reports, applying the same rules for inclusion and exclusion.

12. None vs. Unknown

    a. Inaccessible primary sites- Cancers of certain primary sites are not easily examined by palpation, observation, physical examination, or other clinical methods. These 'inaccessible' primary sites include, but are not limited to, bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri and ovary.

        1) Negative regional lymph nodes- A new coding rule in the Collaborative Staging System applies to these inaccessible sites, primarily for localized or early stage cancers. The Collaborative Staging System allows data collectors to record regional lymph nodes as negative (based on clinical evaluation) rather than unknown when there is no mention of regional lymph node involvement in physical examination, pre-treatment diagnostic testing or surgical exploration, and patient receives what would be usual treatment to primary site (treatment appropriate to stage of disease as determined by physician).

**GUIDELINES FOR RECORDING COLLABORATIVE STAGE, continued**

2) No distant metastasis- This new coding guideline also permits data collectors to record distant metastasis clinically as none rather than unknown (again, based on clinical evaluation) when the clinician proceeds with usual treatment of the primary site, since this action presumes there are no distant metastasis that would otherwise change the treatment approach.

3) Codes for Unknown- The codes for unknown information can and should be used when there is reasonable doubt the tumor is no longer localized.

*Example:* When there is clinical evidence a prostate cancer has penetrated through the capsule into the surrounding tissues (regional direct extension) and regional lymph node involvement is not mentioned, it would be correct to code lymph node involvement and metastases at diagnosis as unknown in the absence of any specific information regarding nodes or distant metastases.

b. Accessible primary sites- For accessible primary sites that can be observed, palpated or examined without instruments, such as breast, oral cavity, skin, salivary gland, thyroid, and other organs, there should be some description of the regional lymph node status. A statement such as "remainder of examination negative" is sufficient to code regional lymph nodes as clinically negative.

13. Use of Physician TNM Staging- If the only description of extent of disease is in terms of T (tumor), N (node), and M (metastasis), assign CS codes in appropriate field that corresponds to TNM information. If there is a discrepancy between documentation in medical record and physician's assignment of TNM, the documentation takes precedence.

14. Definitions of Adjacent Tissues, Structures, and Organs-

a. Adjacent connective tissue- Some Collaborative Staging System schemas for ill-defined or nonspecific sites in the *CS Manual* contain a code for adjacent connective tissue, which is defined here as unnamed tissues that immediately surround an organ or structure containing a primary cancer. Use this code when a tumor has invaded past the outer border (capsule, serosa, or other edge) of the primary organ into the organ's surrounding supportive structures but has not invaded into larger structures or adjacent organs. The structures identified in ICD-O-3 as connective tissue include the following**:**

| | | |
|---|---|---|
| adipose tissue | fatty tissue | skeletal muscle |
| aponeuroses | fibrous tissue | subcutaneous tissue |
| arteries | ganglia | synovia |
| blood vessels | ligaments | tendons |
| bursa | lymphatic channels (not nodes) | tendon sheaths |
| connective tissue, NOS | muscle | veins |
| fascia | nerves | vessels, NOS |

In general, these tissues do not have specific names. These tissues form the framework of many organs, provide support to hold organs in place, bind tissues and organs together, and serve as storage sites for nutrients. Blood, cartilage and bone are sometimes considered connective tissues, but in the *CS Manual* they are listed separately.

**GUIDELINES FOR RECORDING COLLABORATIVE STAGE, continued**

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

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

## Recording CS Data Items

Use the following steps to assist in properly coding CS data items:

1. Identify Primary Site and Histology- Read the medical record carefully to identify the primary site and histology. While reviewing the record, make mental notes about the tissues and lymph nodes that are involved by the tumor.

2. Choose the Correct Coding Schema- Most CS schemas apply to cases defined by their primary site. A few of the schemas apply to cases defined by their histologic type. Schemas by histologic type take precedence over the schema by site.

   a. Histology-Specific Coding Schemas - Use Histology-Specific coding schemas if histology is any one of the following:

      - Melanoma (8720-8790)*
      - Kaposi's sarcoma (9140)
      - Retinoblastoma (9510-9514)
      - Lymphoma (9590-9699 and 9702-9729)
      - Mycosis Fungoides (9700-9701)
      - Hematopoietic and reticuloendothelial system (9731-9989)

      *Melanomas are further broken down by primary site code, as follows:

      1. Malignant melanoma of the skin, vulva, penis and scrotum
      2. Malignant melanoma of conjunctiva
      3. Malignant melanoma of iris and ciliary body
      4. Malignant melanoma of choroid
      5. Malignant melanoma of other eye

   b. Primary Site Coding Schemas- If the histology is not listed above, use the schema for the primary site.

**GUIDELINES FOR RECORDING COLLABORATIVE STAGE, continued**

3. Verify Schema- Each schema clearly states the applicable primary sites and histologies at the beginning of the schema. Verify you are in the correct chapter by confirming the site/histology is in the list at the beginning of the schema.

   *Note:* The appropriate site or histology schema to use for coding surgical treatment(s) may be different from the site or histology schema used for coding the CS data items. *Example*: An extra lymphatic lymphoma of the stomach treated surgically would use the lymphoma schema for CS but surgery would be coded using the stomach codes for surgery to primary site.

4. Assign CS Codes- Once you have confirmed you are in the proper schema, begin assigning codes for the 15 CS data items as described in the data item-specific pages. Be sure to read the notes and follow the site/histology-specific instructions at the beginning of each item.

5. Text- Record text in the appropriate text fields to justify all 15 CS data items.

## CS Data Items

The following table lists the CS data items required to be reported to the VCR.

| Data Item | Description |
|---|---|
| CS Tumor Size* | Code to describe tumor size |
| CS Extension* | Code to describe how far the tumor has spread directly |
| CS Tumor Size/Ext Eval | Code to describe how the farthest tumor spread was determined |
| CS Lymph Nodes* | Code to describe whether regional lymph nodes are involved |
| CS Reg Lymph Nodes Eval | Code to describe how the farthest lymph node spread was determined |
| Regional Lymph Nodes Positive | Number of positive regional lymph nodes from the pathology report |
| Regional Lymph Nodes Examined | Number of regional lymph nodes examined by the pathologist |
| CS Mets at DX* | Code to describe the farthest distant metastasis (including distant lymph nodes) |
| CS Mets Eval | Code to describe how the distant metastasis was determined |
| CS Site-Specific Factors (SSF) 1-6* | Codes to describe site-specific prognostic information. See details in the following table. |

*Indicates items that have site-specific variations for some codes.

**GUIDELINES FOR RECORDING COLLABORATIVE STAGE, continued**

## Site Specific Factors (SSF) Used for Primary Site/Histology Schemas

Some schemas require prognostic information not required for most sites. *CS Site-Specific Factors 1-6* are designed to collect that information. The schemas that make use of one or more site-specific factors are identified in the table below.

| SSF | Site/Histologies Where Used | | |
|---|---|---|---|
| 1 | Head and neck* | mycosis fungoides | melanoma/iris and ciliary body |
| | colon | breast | retinoblastoma |
| | rectum | ovary | brain |
| | liver | placenta | other CNS |
| | pleura | prostate | thyroid |
| | melanoma | testis | other endocrine |
| | | melanoma/conjunctiva | Kaposi's sarcoma |
| | | melanoma/choroid | lymphoma |
| 2 | Head and neck*, liver, melanoma, breast, prostate, testis, lymphoma | | |
| 3 | Head and neck*, melanoma, breast, prostate, testis, lymphoma | | |
| 4 | Head and neck*, melanoma, breast, prostate, testis | | |
| 5 | Head and neck*, breast, prostate, testis | | |
| 6 | Head and neck*, breast, prostate | | |

* Head and neck includes the following schemas: upper lip; lower lip; other lip; base of tongue; anterior tongue; upper gum; lower gum and retromolar trigone; other gum; floor of mouth; hard palate; soft palate/uvula; other mouth; buccal mucosa; parotid gland; submandibular gland; other salivary glands; oropharynx; anterior surface of epiglottis; nasopharynx; pyriform sinus/hypopharynx; other pharynx; nasal cavity; middle ear; maxillary sinus; ethmoid sinus; other sinus; glottic larynx; supraglottic larynx; subglottic larynx; other larynx

## CS Data Item Descriptions, Instructions, and Schemas

A description and instructions for completing each of the 15 CS data items have been compiled on the following *VCR Manual* data item pages. This information is consistent with instructions documented in the *FORDS (Facility Oncology Registry Data Standards) Manual* used by Registry Hospitals and the *CS Manual.*

To determine the correct codes for each of the CS items, refer to the schemas documented in the CS Manual, Part II.

**CS TUMOR SIZE**

Record the largest dimension or diameter of the **primary tumor**.

## Recording CS Tumor Size

1. Site/Histology-Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 1.0* (*CS Manual*) for additional information.

2. Record In Millimeters- Tumor size must be recorded in millimeters.

   a. To convert centimeters to millimeters, multiply the dimension by 10.

   *Example*: Mammogram shows 2.5 cm breast tumor. Code as 025 (2.5 cm x 10 = 25 mm)

   b. Tenths of millimeters - If tumor size is given in tenths of millimeters, record size as 001 if largest dimension of tumor is between 0.1 and 0.9 mm.

   *Example*: Prostate needle biopsy shows 0.6 mm carcinoma. Round up six-tenths of mm to 1.0 mm and code as 001

3. Priority Order- Record tumor size information in the following order:

   a. Pathology Report- Record tumor size from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.

   *Example:* Thyroidectomy specimen yields 8 mm carcinoma. Code 008.

   b. Preoperative treatment- If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the largest size of tumor prior to treatment.

   *Example*: Patient has a 2.2 cm mass in oropharynx; needle aspiration of mass confirms squamous cell carcinoma. Patient receives chemotherapy. Pathologic size of tumor after total resection is 0.8 cm. Code 022

   c. No response to neoadjuvant treatment- In the infrequent event the tumor does not respond to neoadjuvant treatment and is larger after preoperative treatment as determined by the operative or pathology report, code the largest size.

   d. Imaging/radiographic techniques - Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but it should be taken as low priority, just above a physical exam.

   *Example*: CT of chest shows 4 cm mass in RUL. Code 040

   e. Difference in reported tumor size- If there is a difference in reported tumor size among imaging and radiographic techniques, record the largest size of tumor reported in the record.

**CS TUMOR SIZE, continued**

4. No Size Given- Record the exact size of the primary tumor for all sites/histologies except those for which it is stated to be not applicable. Code 999 if no size is given.

5. Primary Tumor- Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis. However, if the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

6. Largest Dimension- Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

   *Example*: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Code 051.

7. Multi-focal- If a malignancy is multi-focal and you have a tumor size for more than one focus, record the size of the largest tumor if the pathologist does not add the tumor sizes together.

8. Invasive/in situ -
   a. Invasive component- Record the size of the invasive component, if given. If both an in situ and an invasive component are present, and the invasive component is measured, record the size of the invasive component even if it is smaller.

   *Example:* Tumor is mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive. Code 014.

   b. Breast primary- If the size of the invasive component is ***not*** given; record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

   *Example*: Duct carcinoma in situ covering a 1.9 cm area with focal areas of invasive ductal carcinoma. Code 019.

   c. Entirely in situ- For purely in situ lesions, code the size as stated.

9. Microscopic Residual Tumor- does not affect overall tumor size.

10. Pieces and Chips- Do not add pieces or chips together to create a whole. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size.

11. Residual Tumor- If an excisional biopsy is performed and residual tumor at the time of the resection of the primary is found to be larger than the excisional biopsy, code the size of the residual tumor.

12. Incisional Biopsy- Code tumor size 999 for an incisional needle biopsy. An incisional needle biopsy may remove an entire tumor. In this event, the tumor size may be recorded.

13. Melanoma- Record tumor size (lateral dimension) for malignant melanoma. Depth of invasion is coded in a site-specific factor.

**CS TUMOR SIZE, continued**

14. Special codes- Tumor dimension is to be recorded for all schemas, except as follows:

    a. Code 998- The descriptions in code 998 take precedence over any mention of size.

       Code 998 is used only for the following sites:

       - Esophagus- Entire circumference
       - Stomach- Diffuse, widespread—¾ or more, linitis plastica
       - Colorectal- Familial/multiple polyposis
       - Lung and main stem bronchus- Diffuse, entire lobe or lung
       - Breast carcinoma- Diffuse

    b. Code 990- should be used when no gross tumor is seen and tumor is only identified microscopically.

    *Example:* Diagnosis of severe dysplasia with focal areas of microinvasion of the cervix. Code 990.

    ***Note:*** The terms microscopic focus, microfocus, and microinvasion are **not** the same as [macroscopic] foci or focus. A macroscopic focus or foci indicates a very small or isolated area, pinpoint, or spot of tumor that may be visible grossly. Only tumor identified microscopically should be coded 990.

    c. Codes 991 through 995 are non-specific size. If a specific size is given, code the more precise size in the range 001–989.

    d. Code 888- For the following diagnoses and/or primary sites, size is not applicable. Record as code 888.

    - Hematopoietic Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms (See *VCR Manual, Part Three, General Information* for a listing of these conditions.)

    - Hodgkin and non-Hodgkin Lymphoma (959-972 except 9700/3 & 9701/3)

15. Determining Descriptive Tumor Size- Refer to *CS Manual, Part One, Appendix I* for additional guidelines for recording size based on various descriptions.

## Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-Path, Text-DX Proc-X-ray/Scans, Text-DX Proc-OP, and Text-DX Proc-Scopes*.

**CS EXTENSION**

Record any 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*.

## Recording CS Extension

1. Site/Histology-Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 1.0* (*CS Manual*) for additional information.

2. Farthest Extension- Code the farthest documented extension of the primary tumor.

3. Discontinuous Metastases- Do not include discontinuous metastases to distant sites which are coded in *CS Mets at Dx* except for ovary and corpus uteri.

4. Priority Order- Record extension information in the following order:

   a. Pathology report- Record extension from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.

   b. Preoperative treatment- If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the farthest extension, prior to treatment (clinically).

      *Example*: Patient has rectal mass firmly attached to pelvic wall (extension code 60). Patient undergoes preoperative radiation therapy. The pathology report from the low anterior resection shows residual tumor outside the rectum in perimuscular tissue (extension code 40). Code extension as 60, because the preoperative treatment apparently "shrank" the tumor away from the pelvic wall.

   c. No response to neoadjuvant treatment- In the infrequent event the tumor does not respond to neoadjuvant treatment and is more extensive after preoperative treatment as determined by the operative or pathology report, code the farthest extension.

      *Example 1:* Patient found to have an obstructing central lung tumor very close to the main stem bronchus (extension code 20). Patient undergoes six weeks of intensive chemotherapy. At thoracotomy, tumor was observed directly extending into trachea (extension code 70). Code extension as 70, because the tumor was noted to be more extensive after the preoperative treatment.

      *Example 2*: Patient has a 5.5 cm hard, moveable mass in the right breast (extension code 10) and receives preoperative chemotherapy. The pathology report from the modified radical mastectomy shows residual 2.8 cm mass with infiltration of the deep subcutaneous tissues over the mass (extension code 20). Code extension as 20, because although the chemotherapy "shrank" the tumor, the residual tumor was found to be more extensive than the clinical presentation.

**CS EXTENSION, continued**

d. Imaging/radiographic techniques- Information on extent of disease from imaging/radiographic techniques can be used to code extension when there is no more specific extension information from a pathology or operative report.

e. Organ not included in schema- If an involved organ or tissue is not mentioned in the schema, approximate the location and code by comparing it with listed organs or tissues in the same anatomic area.

f. Contiguous extension- With the exception of corpus uteri and ovary, all codes represent contiguous (direct) extension of tumor from the site of origin to the organ/structure/tissue represented in the code.

*Example:* Carcinoma of the prostate with extension to pubic bone would be coded 60. Carcinoma of the prostate with metastases to thoracic spine would be coded in CS Extension to the appropriate code for tumor extension and the metastases to the thoracic spine would be coded in the CS Mets at Dx field.

5. Ambiguous Terminology- Determination of the cancer stage is both a subjective and objective assessment of how far the cancer has spread. Sometimes the clinician is hesitant to commit to a definite statement that a particular organ or tissue is involved by the cancer and uses what data collectors refer to as "ambiguous terminology." Refer to the following lists for terms that do and do not constitute tumor involvement or extension:

a. Terms that constitute tumor involvement:

- Adherent
- Apparent(ly)
- Appears to
- Comparable with
- Compatible with
- Consistent with
- Contiguous with
- Continuous with
- Encroaching upon*
- Extension to, into, onto, out onto
- Features of
- Fixation to another structure**
- Fixed**
- Impending perforation of
- Impinging upon
- Impose/imposing upon
- Incipient invasion
- Induration
- Infringe/infringing
- Into*
- Intrude
- Invasion to, into, onto, out onto
- Most likely
- Onto*
- Overstep
- Presumed
- Probable
- Protruding into (unless encapsulated)
- Suspected
- Suspicious
- To*
- Up to

* interpreted as involvement whether the description is clinical or pathological
** interpreted as involvement of other organ or tissue

**CS EXTENSION, continued**

b. Terms that do not constitute involvement:

- Abuts
- Approaching
- Approximates
- Attached
- Cannot be excluded
- Cannot be ruled out
- Efface/effacing/ effacement
- Encased/encasing
- Encompass(ed)
- Entrapped
- Equivocal
- Extension to without invasion/involvement of
- Kiss/kissing
- Matted(except for lymph nodes)
- Possible
- Questionable
- Reaching
- Rule out
- Suggests
- Very close to
- Worrisome

c. Terms not listed- These lists can generally be used to interpret the intent of the physician; however, if individual clinicians use these terms differently, the physician's definitions and choice of therapy should be recognized. If a term used in a diagnostic statement is not listed below, consult the physician to determine the intent of the statement.

6. TNM Information

a. Incomplete information- If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the T category stated by the physician.

b. Physician's statement- If the only indication of extension in the record is the physician's statement of a T category from the TNM staging system or a stage from a site-specific staging system, such as Dukes' C, record the numerically lowest equivalent extension code for that T category.

7. Distant Metastases must be coded in *CS Mets at Dx.*

8. Nodal or Metastatic Involvement- Do not code *CS Extension* as in situ if there is any evidence of nodal or metastatic involvement; use the code for 'Localized, NOS' if there is no better information.

9. Residual Disease/Positive Margins- The presence of microscopic residual disease or positive tumor margins does not increase the extension code.

## Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-Path, Text-DX Proc-PE, Text-DX Proc-X-ray/Scans, Text-DX Proc-OP,* and *Text-DX Proc-Scopes.*

**CS TUMOR SIZE/EXT EVAL**

Record how the codes for *CS Tumor Size* and *CS Extension* were determined, based on the diagnostic methods employed.

*Example:* Patient has a chest x-ray showing an isolated 4 cm tumor in the right upper lobe. Patient opts for radiation therapy. Use code 0.

## Recording CS Tumor Size/Ext Eval

1. Site/Histology-Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 1.0* (*CS Manual*) for additional information.

2. Farthest Extension or Size of Tumor- Select the code that documents the report or procedure from which the information about the farthest extension or size of the primary tumor was obtained. This may not be the numerically highest Eval code.

   *Example*: Fine needle aspiration biopsy (Eval code 1) confirms adenocarcinoma of prostate. CT scan of pelvis (Eval code 0) shows tumor extension through the prostatic capsule into adjacent connective tissues. Code CS Tumor Size/Ext Eval as 0 because the CT scan showed more extensive tumor than the biopsy.

3. Basis of *CS Extension*- For primary sites/histologies listed in Table 5 in the General Instructions of *CS Manual*, *Part One* code this data item on basis of *CS Extension* only.

4. Basis of *CS Tumor Size* and *CS Extension*- For primary sites listed on Table 4 in the General Instructions of the *CS Manual*, *Part One* select the code that best explains how the information in both *CS Tumor Size* **and** *CS Extension* data items were determined.

   a. Difference in evaluation codes- If there is a difference between how the tumor size and the extension were determined, select the evaluation code that reflects what method diagnosed the furthest involvement.

      *Example:* Tumor size for a breast cancer biopsy is 020. There is ulceration of the skin noted during the physical exam. Use code 0; the evaluation is based on physical examination, since the ulceration information from the physical examination indicates further involvement.

   b. No surgery- If the patient had no surgery, code 0, 1, or 9.

      *Example 1:* Colon cancer with colonoscopy and biopsy confirming cancer. Code as 1.

      *Example 2*: Endoscopies for cervix or bladder would be coded as 1 in this field.

      ***Exception*:** Lung cancer with mediastinoscopy showing direct extension into mediastinum. Use code 1.

**CS TUMOR SIZE/EXT EVAL, continued**

c. Surgery, followed by other treatments- If the patient had surgery followed by other treatment(s) use code 3 or 9.

d. Size or extension greater after treatment- If the size or extension of the tumor was greater after presurgical treatment than before treatment, use code 6.

e. Basis for neoadjuvant therapy- If the size or extension of the tumor determined prior to treatment was the basis for neoadjuvant therapy, use code 5.

f. Autopsy/diagnosis known before death- If the patient had an autopsy and the diagnosis was known or suspected prior to death, use code 2.

g. Autopsy/diagnosis not known before death- If the patient had an autopsy and the malignancy was not known or suspected prior to death, use code 8.

5. Not Applicable- For sites/histologies listed on Table 6 in General Instructions of the *CS Manual, Part One* this field is coded to 9, "Not applicable."

6. Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography, lymphography, angiography, scintigraphy (nuclear scans), ultrasonography, magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

7. Observation at Surgery- Code 1 also includes observations at surgery, such as an exploratory laparotomy in which cancer is identified, where further tumor extension is not biopsied.

8. Code 3- Use code 3 for a biopsy of tumor extension that meets the requirements for pathologic staging basis. Pathologic staging requirements vary by site. Refer to the *CS Manual, Part II*, for more detailed instructions by site.

   *Example*: Colon cancer with colonoscopy and biopsy confirming cancer. Use code 1. The biopsy does not meet the criteria for pathologic staging.

**CS LYMPH NODES**

Record the code to identify the regional lymph nodes involved with cancer at the time of diagnosis.

## Recording CS Lymph Nodes

1. Site/Histology Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 1.0* (*CS Manual*) for additional information.

2. Farthest From the Primary Site- Record the specific regional lymph node chain farthest from the primary site that is involved by tumor either clinically or pathologically.

   a. Record highest applicable code- Regional lymph nodes are listed for each site/histology. In general, the regional lymph nodes in the chain closest to the primary site have the lower codes. Nodes farther away from the primary or in farther lymph node chains have higher codes. Record the highest applicable code.

      *Example*: Peribronchial lymph nodes are positive on fine needle aspiration biopsy. Contralateral mediastinal mass noted on CT scan but not biopsied. Patient chooses radiation therapy as primary treatment. Use the code for contralateral mediastinal lymph node involvement as it is higher than the code for peribronchial lymph nodes.

      ***Exception*:** The higher codes for 'Regional lymph nodes, NOS'; 'Lymph nodes, NOS'; 'Stated as N1, no other information'; 'Stated as N2a, no other information', and so forth, should only be used when there is no available information as to the name(s) of the regional nodes involved.

   b. Pathology report- Record involved regional lymph nodes from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery or if the treatment has no effect on the lymph nodes.

   c. Clinical vs. Pathological- If there is a discrepancy between clinical information and pathologic information about the same lymph nodes, the pathologic information takes precedence, if no preoperative treatment was administered.

      *Example:* Axillary lymphadenopathy stated as "suspicious for involvement" noted on physical exam. After axillary dissection, all lymph nodes are negative. Code CS Lymph Nodes as 0, no regional lymph node involvement.

   d. For inaccessible sites, primarily for localized or early stage cancers- Record regional lymph nodes as negative rather than unknown (based on clinical evaluation) when there is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing or surgical exploration, and the patient receives what would be usual treatment to the primary site (see the *VCR Manual, Part Three, Collaborative Stage, General CS Guidelines* for further discussion).

   e. Direct extension- If there is direct extension of the primary tumor into a regional lymph node, record the involved node in this data item.

**CS LYMPH NODES, continued**

f. Preoperative treatment- If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, the clinical status of the lymph nodes takes precedence.

*Example*: Patient has a hard matted mass in the axilla (code 50) and a needle biopsy of the breast that confirms ductal carcinoma. Patient receives three months of chemotherapy. The pathology report from the modified radical mastectomy shows only scar tissue in the axilla with no involvement of axillary lymph nodes (Negative, code 00). Use code 50 because the chemotherapy apparently "sterilized" the lymph nodes.

g. No response to neoadjuvant treatment- In the infrequent event clinically involved regional lymph nodes do not respond to neoadjuvant treatment and are more extensively involved after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code CS Reg Nodes Eval as 6, based on pathology/operative report after treatment.

*Example:* Patient has needle biopsy-proven prostate cancer with no mention of involved lymph nodes on physical examination (Negative, code 00). He receives Lupron while deciding whether to undergo a radical prostatectomy. At the time of surgery, a laparoscopic pelvic node biopsy is reported to show metastases (Regional nodes involved, code 10) to lymph nodes and the prostatectomy is canceled. Code CS Lymph Nodes as 10 because the preoperative treatment (Lupron) had no effect on the lymph nodes.

3. In Situ- Code 00 for lymph node involvement when the *CS Extension* is coded in situ, even if no lymph nodes are removed, since "in situ" by definition means noninvasive.

4. Solid Tumors

a. Terms

1) The terms "fixed" or "matted" and "mass in the hilum, mediastinum, retroperitoneum, and/or mesentery" (with no specific information as to tissue involved) are considered involvement of lymph nodes.

2) Any other terms such as "palpable," "enlarged," "visible swelling," "shotty," or "lymphadenopathy" should be ignored unless there is a statement of involvement by the physician.

***Exception:*** The terms "adenopathy", "enlargement", and "mass in the hilum or mediastinum" should be coded as involvement for lung primaries

3) The terms "homolateral," "ipsilateral," and "same side" are used interchangeably.

b. Lymphomas- For lymphomas, *any* mention of lymph nodes is indicative of involvement.

**CS LYMPH NODES, continued**

c. Unidentified nodes- Any unidentified nodes included with the resected primary site specimen are to be coded as "Regional lymph nodes, NOS".

d. Lymph Nodes, NOS- Where more specific categories are provided, the codes for "Regional lymph nodes, NOS" and "Lymph nodes, NOS" should be used *only* after an exhaustive search for more specific information.

5. Size of Regional Lymph Nodes

a. Pathology report- When size of involved regional lymph nodes is required, code from pathology report, if available.

b. Size of metastasis- Code the size of the metastasis, not the entire node, unless otherwise stated in site-specific schemas. The size of the metastasis within the lymph node can be inferred if the size for the entire node falls within one of the codes.

*Example*: A single involved node 1.5 cm in size can be coded to ‘Single lymph node < 2 cm’ because the metastasis cannot be larger than 1.5 cm.

6. TNM information

a. Physician's statement- If the only indication of lymph node involvement in the record is the physician’s statement of an N category from the TNM staging system or a stage from a site-specific staging system, such as Dukes’ C, record the numerically lowest equivalent *CS Lymph Nodes* code.

b. Discrepancy between information- If there is a discrepancy between documentation in the medical record and the physician’s assignment of TNM, the documentation takes precedence. Cases of this type should be discussed with the physician who assigned the TNM.

c. Incomplete information- If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, lymph node involvement may be inferred from the N category stated by the physician.

7. For Colon, Rectosigmoid and Rectum Primaries, if there is a statement about tumor nodule(s) in the pericolic or perirectal fat, use the following guidelines for coding regional lymph node involvement:

a. Smooth contour- Code as regional lymph node involvement if the nodule has a smooth contour.

b. Irregular contour- Code as tumor extension if the nodule has an irregular contour.

**CS LYMPH NODES, continued**

## Coding Regional Lymph Nodes for Head and Neck Sites

For head and neck sites, regional lymph node information is coded in several fields. The CS Lymph Nodes field contains information about the nodes involved, their number and laterality. Site-Specific Factors 1 and 2 are used to code the size of involved lymph nodes and the presence of extracapsular extension. Site-Specific Factors 3 through 6 are used to code the presence or absence of lymph node involvement in each of 7 different levels and other groups. The definitions of the levels are the same for all applicable head and neck sites. One digit is used to represent lymph nodes of a single level, with the three digits of Site-Specific Factor 3 representing lymph nodes of, respectively, Levels IIII; the digits of Site-Specific Factor 4 representing lymph nodes of Levels IV and V and the retropharyngeal nodes; the digits of Site-Specific Factor 5 representing lymph nodes of Levels VI and VII and the facial nodes; and the digits of Site-Specific Factor 6 representing the remaining Other groups. In each digit, a code 1 means *Yes, the nodes are involved*.

*Example:* A carcinoma of the base of tongue involves bilateral submandibular nodes and left upper, mid, and lower jugular nodes, the largest measuring 4 cm. There is no extracapsular extension. These are level I, II, III, and IV lymph nodes according to AJCC definitions. CS Lymph Nodes is coded 40 (bilateral or contralateral nodes). Site-Specific Factor 1 is coded 040 indicating the largest size. Site-Specific Factor 2 is coded 000 for no extracapsular extension. Site-Specific Factor 3 is coded 111, to show that levels I, II, and III are involved. Site-Specific Factor 4 is coded 100 to show that level IV is involved. Site-Specific Factors 5 and 6 are each coded 000, since no other nodes are involved.

### Unknown

In Site-Specific Factors 3-6 for lymph node levels, use code 9 only when it is unknown if lymph nodes are involved. Within each of the Site-Specific Factors 3-6, do not code 9 in some positions and 0 or 1 in other positions. If specific information is available about the positive or negative status of some but not all nodes in any one level or group, assume that the rest of the nodes in the same Site-Specific Factor are negative and code accordingly.

*Example*: Laryngeal biopsy with squamous cell carcinoma, no other information available. CS Lymph Nodes is coded 99. Site-Specific factors 1-6 are each coded 999, since no information is available regarding lymph node involvement.

### NOS

When the only information available is “Regional nodes, NOS” or “Cervical nodes, NOS” or “Internal jugular lymph nodes, NOS” or “Lymph nodes, NOS,” code 0 in all digits of Site-Specific Factors 3-6.

*Example:* Patient diagnosed elsewhere with carcinoma of oropharynx with cervical lymph node involvement. No other information available. CS Lymph Nodes is coded 50 (regional nodes, NOS, not stated if ipsilateral, bilateral, or contralateral, or if single or multiple). Site-specific Factors 1 and 2 are each coded 999. Site-Specific Factors 3-6 are each coded 000.

**CS LYMPH NODES, continued**

## Definitions of Levels for Head and Neck Sites

The definitions of the levels and the lymph node chains included in each level are as follows:

**Level I** contains the submental and submandibular triangles bounded by the anterior and posterior bellies of the digastric muscle, and the hyoid bone inferiorly, and the body of the mandible superiorly.

| | | |
|---|---|---|
| Submandibular | Submaxillary | Submental |

**Level II** contains the upper jugular lymph nodes and extends from the level of the skull base superiorly to the hyoid bone inferiorly.

| | | |
|---|---|---|
| Jugulodigastric (subdigastric) | Upper deep cervical | Upper jugular |

**Level III** contains the middle jugular lymph nodes from the hyoid bone superiorly to the level of the lower border of the cricoid cartilage inferiorly.

| | |
|---|---|
| Middle deep cervical | Mid-jugular |

**Level IV** contains the lower jugular lymph nodes from the level of the cricoid cartilage superiorly to the clavicle inferiorly.

| | | |
|---|---|---|
| Jugulo-omohyoid (supraomohyoid) | Lower deep cervical | Lower jugular |

**Level V** contains the lymph nodes in the posterior triangle bounded by the anterior border of the trapezius muscle posteriorly, the posterior border of the sternocleidomastoid muscle anteriorly, and the clavicle inferiorly. For descriptive purposes, Level V may be further subdivided into upper, middle, and lower levels corresponding to the superior and inferior planes that define Levels II, III, and IV.

Posterior cervical
Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower, corresponding to the levels that define upper, middle, and lower jugular nodes)

**Level VI** contains the lymph nodes of the anterior central compartment from the hyoid bone superiorly to the suprasternal notch inferiorly. On each side, the lateral boundary is formed by the medial border of the carotid sheath.

| | | |
|---|---|---|
| Anterior deep cervical | Paratracheal | Pretracheal |
| Laterotracheal | Prelaryngeal (Delphian) | Recurrent laryngeal |
| Paralaryngeal | | |

**Level VII** contains the lymph nodes inferior to the suprasternal notch in the superior mediastinum.

Upper mediastinal

**CS LYMPH NODES, continued**

### Other groups

Buccinator (facial)
Nasolabial
Parapharyngeal
Periparotid and intraparotid
Preauricular
Retropharyngeal
Sub-occipital

## Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-Path, Text-DX Proc-PE, Text-DX Proc-X-ray/Scans, Text-DX Proc-OP,* and *Text-DX Proc-Scopes.*

**CS REG NODES EVAL**

Record how the code for *CS Lymph Nodes* was determined, based on the diagnostic methods employed.

## Recording CS Reg Nodes Eval

1. Site/Histology-Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 1.0* (*CS Manual*) for additional information.

2. Farthest Involvement- Select the code that documents the report or procedure from which the information about the farthest involved regional lymph nodes was obtained; this may not be the numerically highest eval code.

   *Example:* Modified radical neck dissection for hypopharyngeal cancer shows one lower jugular node involved (*CS Reg LN* code 10, eval code 3). Physical exam shows hard, matted scalene (transverse cervical) node presumed to contain metastasis (*CS Reg LN* code 32, eval code 0). Code this data item 0 since the scalene node involvement was determined clinically rather than by examination of tissue.

3. Sites/Histologies On Table 6- Code 9 may be used for this data item for sites/histologies listed on Table 6 in the General Instructions of the *CS Manual, Part One*.

4. Best Code- Select the code that best explains how the information for *CS Lymph Nodes* was determined.

   a. No removal of lymph nodes- If the patient had no removal of lymph node(s) use code 0, 1, or 9.

   *Example 1:* Prostate cancer with laparoscopic lymph node biopsy showing involved nodes; radical prostatectomy canceled. Code CS Reg Node Eval as 3.

   *Example 2*: Lung cancer with CT scan or MRI showing involved contralateral mediastinal nodes. Code CS Reg Node Eval as 0.

   b. Removal followed by other treatment- If the patient had removal of lymph node(s) surgery followed by other treatment(s) use code 3 or 9.

   c. Preoperative treatment- If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, the clinical status of lymph nodes takes precedence (code 5).

   d. Basis of neoadjuvant therapy- If the size, number or extension of regional lymph node involvement determined prior to treatment was the basis for neoadjuvant therapy, use code 5. However, if more extensive tumor is determined during lymph node examination after neoadjuvant therapy, use code 6.

   e. Involvement greater after surgery- If the size, number, or extension of regional lymph node involvement was greater after treatment than before treatment, use code 3 or 6.

**CS REG NODES EVAL, continued**

f. Autopsy/diagnosis known before death- If the patient had an autopsy and the diagnosis was known or suspected prior to death, use code 2.

g. Autopsy/diagnosis not known before death- If the patient had an autopsy and the malignancy was not known or suspected prior to death, use code 8.

5. Imaging Studies- Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography, lymphography, angiography, scintigraphy (nuclear scans), ultrasonography, magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

6. Pathologic Stage- If the lymph node procedure meets the requirements for the pathologic staging basis of regional lymph nodes use code 3. Pathologic staging requirements vary by site. Refer to the *Collaborative Staging Manual and Coding Instructions Part II*, for more detailed instructions by site.

   *Example:* Prostate cancer with laparoscopic lymph node biopsy showing involved nodes; radical prostatectomy canceled. Code this data item 3. Staging algorithm would identify information as pathologic (p). A positive biopsy of one or more regional lymph nodes is sufficient to meet the pathologic staging basis for prostate cancer.

7. Observation at Surgery- Code 1 also includes observations at surgery, such as an exploratory laparotomy in which cancer is identified, where regional lymph nodes are not biopsied.

**REGIONAL NODES POSITIVE**
(EODNodPos)

Record the exact number of regional lymph nodes examined by the pathologist and found to contain metastases.

## Recording Regional Nodes Positive

1. Site/Histology-Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 1.03.00* (*CS Manual*) for additional information.

2. In situ and Invasive- Rules for coding Regional Nodes Positive are the same for both in situ and invasive cases.

3. Distant Lymph Nodes- Only record information about regional lymph nodes in this data item. Involved distant lymph nodes should be coded in *CS Mets at Dx*

4. Pathology Information Only - This data item is based on pathology information only.

5. No Lymph Nodes Removed- If no lymph nodes were removed for examination, or if a lymph node drainage area was removed, but no lymph nodes were found, code 98.

6. Total Number Positive- Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.

    a. Count is cumulative- The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

    b. Preoperative treatment- This item is to be recorded regardless of whether the patient received preoperative treatment.

7. Aspiration/Biopsy/Sample/Dissection- Any combination of positive aspirated, biopsied, sampled or dissected lymph nodes is coded 97 if the number of involved nodes cannot be determined on the basis of cytology or histology.

8. For the following primary sites and histologies, Regional Nodes Positive, is always coded 99:

    - Brain and Cerebral Meninges (C70.0, C71.0-C71.9)
    - Hematopoietic, Reticuloendothelial, Immunoproliferative & Myeloproliferative Neoplasms (see *VCR Manual, Part Three, General Information* for a list of these conditions)
    - Hodgkin and non-Hodgkin Lymphoma (except 9700/3 and 9701/3)
    - Other Parts of Central Nervous System (C70.1, C70.9, C72.0-C72.5, C72.8-C72.9)
    - Other and Ill-Defined Primary Sites (see *VCR Manual, Part Three, General Information* for a list of these sites)
    - Placenta (C58.9)
    - Unknown Primary (C80.9)

**REGIONAL NODES POSITIVE, continued**
(EODNodPos)

## Text

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

**REGIONAL NODES EXAMINED**
(EODNodExam)

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

## Recording Regional Nodes Examined

1. Site/Histology-Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 1.0* (*CS Manual*) for additional information.

2. In situ and Invasive- Rules for coding Regional Nodes Examined are the same for both in situ and invasive cases.

3. Distant Lymph Nodes- Only record information about *regional* lymph nodes in this data item. Involved distant lymph nodes should be coded in *CS Mets at Dx*.

4. Pathology Information Only - This data item is based on pathology information only.

5. No Lymph Nodes Removed- If no lymph nodes were removed for examination, or if a lymph node drainage area was removed, but no lymph nodes were found, code 00.

6. Unknown if Lymph Nodes Removed- If it is unknown whether nodes were removed or examined, code as 99.

7. Total Number- Record the total number of regional lymph nodes removed and examined by the pathologist.

    a. Count is cumulative- The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

    b. Aspiration and removal- If lymph nodes are aspirated and other lymph nodes are removed, code to 98.

    c. Preoperative treatment- This data item is to be recorded regardless of whether the patient received preoperative treatment.

8. Biopsy- If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, code 96.

9. For the following primary sites and histologies, Regional Nodes Examined, is always coded 99:
    - Brain and Cerebral Meninges (C70.0, C71.0-C71.9)
    - Hematopoietic, Reticuloendothelial, Immunoproliferative & Myeloproliferative Neoplasms (see *VCR Manual, Part Three, General Information* for a list of these conditions)
    - Hodgkin and non-Hodgkin Lymphoma (except 9700/3 and 9701/3)
    - Other Parts of Central Nervous System (C70.1, C70.9, C72.0-C72.5, C72.8-C72.9)
    - Other and Ill-Defined Primary Sites (see *VCR Manual, Part Three, General Information* for a list of these sites)
    - Placenta (C58.9)
    - Unknown Primary (C80.9)

**REGIONAL NODES EXAMINED, continued**
(EODNodExam)

## Text

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

**CS METS AT DX**

Record the code that identifies the distant site(s) of metastatic involvement at time of diagnosis.

## Recording CS Mets at DX

1. Site/Histology-Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 1.0* (*CS Manual*) for additional information.

2. Highest Code- Assign the highest applicable code for metastasis at diagnosis, whether the determination was clinical or pathological and whether or not the patient had any preoperative systemic therapy.

3. Progression of Disease- Metastasis known to have developed after the extent of disease was established (also referred to as progression of disease) should not be recorded in this data item.

4. None vs. Unknown- Use code 00 (none), rather than code 99 (unknown), when the physician proceeds with standard treatment of the primary site for localized or early stage, since this action presumes that there are no distant metastasis that would otherwise alter the treatment approach.

5. Reasonable Doubt- Code 99 can and should be used in situations where there is reasonable doubt the tumor is no longer localized and there is no documentation of distant metastasis.

6. TNM Information- If the only indication of extension in the record is the physician's statement of an M category from the TNM staging system or a stage from a site-specific staging system, such as Dukes' D, record the numerically lowest equivalent extension code for that M category. In most cases, this will be 40, 'Distant metastasis, NOS.'

## Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-Path, Text-DX Proc-X-ray/Scans, Text-DX Proc-OP,* and *Text-DX Proc-Scopes.*

**CS METS EVAL**

Record how the code for *CS Mets at Dx* was determined based on the diagnostic methods employed.

## Recording CS Mets Eval

1. Site/Histology-Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 1.0* (*CS Manual*) for additional information.

2. Farthest Involvement- Select the CS Mets Eval code that documents the report or procedure from which the information about metastatic involvement farthest from the primary site was obtained; this may not be the numerically highest eval code.

3. Table 6 of *CS Manual*- Code 9 may be used for primary sites/histologies listed on Table 6 of the *CS Manual*.

4. Select the code that best explains how the information in *CS Mets at Dx* was determined.

   a. No examination of metastatic tissue- If the patient had no examination of metastatic tissue use code 0, 1, or 9.

   *Example:* Lung cancer with endoscopy of contralateral lung showing involvement of contralateral mainstem bronchus. Code this data item 1.

   b. Negative pathology report- If the patient had removal of presumed metastatic tissue (even though the pathology report was negative), use code 3.

   c. Farthest from primary- Code the method of evaluation for the site(s) farthest from the primary.

   *Example*: Colon cancer patient has CT scan showing normal lungs. During the resection, the surgeon palpates the liver and finds it to be normal. Code this field as 0, since the CT scan shows that potential metastatic sites outside the surgical field are negative.

   d. Autopsy/diagnosis known before death- Code 2 if the patient had an autopsy and the diagnosis was known or suspected prior to death.

   e. Autopsy/diagnosed not known before death- Code 8 if the patient had an autopsy and the malignancy was not known or suspected prior to death.

5. Preoperative Treatment- If biopsies taken after pre-operative treatment are negative for metastasis and clinical evidence of metastasis remains, use code 5.

6. Clinical Evidence of Metastasis- If the patient has biopsies of some metastases while others are visible only on imaging, use code 6 to indicate if, after preoperative treatment, the biopsy is negative for metastasis but there is still evidence of clinical metastasis.

**CS METS EVAL, continued**

7. Imaging Studies- Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography, lymphography, angiography, scintigraphy (nuclear scans), ultrasonography, magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

   *Example:* Patient has diagnosis of colon cancer by biopsy. CT scan shows liver metastasis. Code this data item 0.

8. Pathologic Staging- Any positive biopsy or resection of distant metastasis meets the requirement for pathologic staging basis and should be coded to CS Mets Eval code 3. Pathologic staging requirements vary by site. Refer to the *CS Manual, Part II*, for more detailed instructions by site.

   *Example:* Prostate cancer with enlarged scalene node confirmed as cancer on needle biopsy. Code this data item 3, since there was biopsy of the metastatic site.

9. Observations at Surgery- Code 1 also includes observations at surgery, such as exploration at the time of resection, where distant metastasis is not biopsied.

**CS SITE-SPECIFIC FACTOR 1**

Record site-specific additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

## Recording CS Site-Specific Factor 1

1. Site/Histology-Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.

2. No Site/Histology-Specific Factor for a Schema- Code 888 if there is no site/histology-specific factor for a schema.

3. Primary Sites/Histologies for Site-Specific Factor 1- The following primary sites/histologies use *Site-Specific Factor 1* to code information. See the site-specific schemas for acceptable codes and their definitions.

| Site/Histology | Factor |
|---|---|
| Head and neck* | Size of Lymph Nodes |
| Colon | Carcinoembryonic Antigen (CEA) |
| Rectosigmoid, rectum | Carcinoembryonic Antigen (CEA) |
| Liver | Alpha Fetoprotein (AFP) |
| Pleura | Pleural Effusion |
| Malignant Melanoma of Skin, Vulva, Penis, Scrotum | Measured Thickness (Depth), Breslow's Measurement |
| Mycosis Fungoides | Peripheral Blood Involvement |
| Breast | Estrogen Receptor Assay (ERA) |
| Ovary | Carbohydrate Antigen 125 (CA-125) |
| Placenta | Prognostic Scoring Index |
| Prostate | Prostatic Specific Antigen (PSA) Lab Value |
| Testis | Alpha Fetoprotein (AFP) |
| Malignant Melanoma of Conjunctiva | Measured Thickness (Depth), Breslow's Measurement |
| Malignant Melanoma of Choroid | Measured Thickness (Depth), Breslow's Measurement |
| Malignant Melanoma of Iris and Ciliary Body | Measured Thickness (Depth), Breslow's Measurement |
| Retinoblastoma | Extension evaluated at Enucleation |
| Brain | WHO Grade |
| Other CNS | WHO Grade |
| Thyroid | Solitary vs. Multifocal |
| Other Endocrine | WHO Grade |
| Kaposi Sarcoma | Associated with HIV/AIDS |
| Lymphoma | Associated with HIV/AIDS |

*Refer to *VCR Manual, Part Three, Guidelines for Recording Collaborative Stage, Site-Specific Factors* for a list of head and neck schemas.

**CS SITE-SPECIFIC FACTOR 1, continued**

4. Test Not Performed- When there is a statement in the record that a test was not performed code to 000.

5. No Report of Lab Test- If there is no report of a lab test in the patient record code to 999.

6. Kaposi Sarcoma- For Kaposi sarcoma, if AIDS status is not documented, use code 999 (Unknown), rather than 002 (Not Present).

## Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-Path, Text-DX Proc-PE, Text-DX Proc-X-ray/Scans, Text-DX Proc-OP,* and *Text-DX Proc-Scopes.*

**CS SITE-SPECIFIC FACTOR 2**

Record site-specific additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

## Recording CS Site-Specific Factor 2

1. Site/Histology-Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.

2. No Site/Histology-Specific Factor for a Schema- Code 888 if there is no site/histology-specific factor for a schema.

3. Primary Sites/Histologies for Site-Specific Factor 2- The following primary sites/histologies use *Site-Specific Factor 2* to code information. See the site-specific schemas for acceptable codes and their definitions.

| Site/Histology | Factor |
|---|---|
| Head and neck* | Extracapsular Extension, Lymph Nodes for Head and Neck |
| Liver | Fibrosis Score |
| Malignant Melanoma of Skin, Vulva, Penis, Scrotum | Ulceration |
| Breast | Progesterone Receptor Assay (PRA) |
| Prostate | Prostatic Specific Antigen (PSA) |
| Testis | Human Chorionic Gonadotropin (HCG) |
| Hodgkin Lymphoma and Non-Hodgkin Lymphoma | Symptoms at Diagnosis |

* Refer to *VCR Manual, Part Three, Guidelines for Recording Collaborative Stage, Site-Specific Factors* for a list of head and neck schemas.

4. Test Not Performed- When there is a statement in the record that a test was not performed code to 000.

5. No Report of Lab Test- If there is no report of a lab test in the patient record code to 999.

6. Malignant Melanoma- For malignant melanoma of skin, if ulceration is not mentioned in the pathology report, code 000.

## Text

Text to support this data item must be recorded in the specific text fields. See VCR Manual Part Three, Data Item Instructions, *Text-Path, Text-DX Proc-PE, Text-DX Proc-X-ray/Scans, Text-DX Proc-OP,* and *Text-DX Proc-Scopes*.

**CS SITE-SPECIFIC FACTOR 3**

Record site-specific additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

## Recording CS Site-Specific Factor 3

1. Site/Histology-Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.

2. No Site/Histology-Specific Factor for a Schema- Code 888 if there is no site/histology-specific factor for a schema.

3. Primary Sites/Histologies for Site-Specific Factor 3- The following primary sites/histologies use *Site-Specific Factor 3* to code information. See the site-specific schemas for acceptable codes and their definitions.

| Site/Histology | Factor |
|---|---|
| Head and neck* | Levels I-III, Lymph Nodes of Head and Neck |
| Malignant Melanoma of Skin, Vulva, Penis, Scrotum | Clinical Status of Lymph Node Mets |
| Breast | Number of Positive Ipsilateral Axillary Lymph Nodes |
| Prostate | CS Extension - Pathologic Extension |
| Testis | LDH (Lactate Dehydrogenase) |
| Lymphoma | International Prognostic Index (IPI) Score |

* Refer to *VCR Manual, Part Three, Guidelines for Recording Collaborative Stage, Site-Specific Factors* for a list of head and neck schemas.

4. Test Not Performed- Code 000 when there is a statement in the record that a test was not performed.

5. No Report of Lab Test- Code 999 if there is no report of a lab test in the patient record.

6. Lymphoma- For the lymphomas, if the IPI score is not stated in the record, code 999. It is not necessary to calculate the IPI score from other information in the record.

7. For Head and Neck Sites Only**:**

   a. Unknown if lymph nodes are involved- Use code 9 only when it is unknown if lymph nodes are involved. Within the Site-Specific Factors, do not code 9 in some positions and 0 or 1 in other positions. If specific information is available about the positive or negative status of some but not all nodes in any one level or group, assume that the rest of the nodes in the same Site-Specific Factor are negative and code accordingly.

   b. "Regional nodes, NOS" - When the only information available is "Regional nodes, NOS" or "Cervical nodes, NOS" or "Internal jugular lymph nodes, NOS" or "Lymph nodes, NOS," code 0 in all digits of Site-Specific Factors 3-6.

**CS SITE-SPECIFIC FACTOR 3, continued**

c. See "Coding Regional Lymph Nodes for Head and Neck Sites" under CS Lymph Nodes for further information about the regional nodes of the head and neck, including definitions of the levels.

## Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-Path, Text-DX Proc-PE, Text-DX Proc-X-ray/Scans, Text-DX Proc-OP,* and *Text-DX Proc-Scopes.*

**CS SITE-SPECIFIC FACTOR 4**

Record site-specific additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

## Recording CS Site-Specific Factor 4

1. Site/Histology-Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.

2. No Site/Histology-Specific Factor for a Schema- Code 888 if there is no site/histology-specific factor for a schema.

3. Primary Sites/Histologies for Site-Specific Factor 4- The following primary sites/histologies use *Site-Specific Factor 4* to code information. See the site-specific schemas for acceptable codes and their definitions.

| Site/Histology | Factor |
|---|---|
| Head and neck* | Levels IV-V, Lymph Nodes of Head and Neck |
| Malignant Melanoma of Skin, Vulva, Penis, Scrotum | Lactate Dehydrogenase (LDH) |
| Breast | Immunohistochemistry (IHC) of Regional Lymph Nodes |
| Prostate | Prostatic Apex Involvement |
| Testis | Radical Orchiectomy Performed |

   1. Refer to *VCR Manual, Part Three, Guidelines for Recording Collaborative Stage, Site-Specific Factors* for a list of head and neck schemas.

4. Test Not Performed- Code 000 when there is a statement in the record that a test was not performed.

5. No Report of Lab Test- Code 999 if there is no report of a lab test in the patient record.

6. For Head and Neck Sites Only**:**

   a. Unknown if lymph nodes are involved- Use code 9 only when it is unknown if lymph nodes are involved. Within the Site-Specific Factors, do not code 9 in some positions and 0 or 1 in other positions. If specific information is available about the positive or negative status of some but not all nodes in any one level or group, assume that the rest of the nodes in the same Site-Specific Factor are negative and code accordingly.

   b. "Regional nodes, NOS" - When the only information available is "Regional nodes, NOS" or "Cervical nodes, NOS" or "Internal jugular lymph nodes, NOS" or "Lymph nodes, NOS," code 0 in all digits of Site-Specific Factors 3-6.

   c. See "Coding Regional Lymph Nodes for Head and Neck Sites" under CS Lymph Nodes for further information about the regional nodes of the head and neck, including definitions of the levels.

**CS SITE-SPECIFIC FACTOR 4, continued**

## Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-Path, Text-DX Proc-PE, Text-DX Proc-X-ray/Scans, Text-DX Proc-OP,* and *Text-DX Proc-Scopes.*

**CS SITE-SPECIFIC FACTOR 5**

Record site-specific additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

## Recording CS Site-Specific Factor 5

1. Site/Histology-Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.

2. No Site/Histology-Specific Factor for a Schema- Code 888 if there is no site/histology-specific factor for a schema.

3. Primary Sites/Histologies for Site-Specific Factor 4- The following primary sites/histologies use *Site-Specific Factor 4* to code information. See the site-specific schemas for acceptable codes and their definitions.

| Site/Histology | Factor |
|---|---|
| Head and neck* | Levels VI-VII, Lymph Nodes of Head and Neck |
| Breast | Molecular Studies of Regional Lymph Nodes |
| Prostate | Gleason Primary and Secondary Patterns |
| Testis | Size of Metastasis in Lymph Nodes |

2. Refer to *VCR Manual, Part Three, Guidelines for Recording Collaborative Stage, Site-Specific Factors* for a list of head and neck schemas.

7. Test Not Performed- Code 000 when there is a statement in the record that a test was not performed.

8. No Report of Lab Test- Code 999 if there is no report of a lab test in the patient record.

9. For Head and Neck Sites Only**:**

   a. Unknown if lymph nodes are involved- Use code 9 only when it is unknown if lymph nodes are involved. Within the Site-Specific Factors, do not code 9 in some positions and 0 or 1 in other positions. If specific information is available about the positive or negative status of some but not all nodes in any one level or group, assume that the rest of the nodes in the same Site-Specific Factor are negative and code accordingly.

   b. "Regional nodes, NOS" - When the only information available is "Regional nodes, NOS" or "Cervical nodes, NOS" or "Internal jugular lymph nodes, NOS" or "Lymph nodes, NOS," code 0 in all digits of Site-Specific Factors 3-6.

   c. See "Coding Regional Lymph Nodes for Head and Neck Sites" under CS Lymph Nodes for further information about the regional nodes of the head and neck, including definitions of the levels.

**CS SITE-SPECIFIC FACTOR 5, continued**

## Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-Path, Text-DX Proc-PE, Text-DX Proc-X-ray/Scans, Text-DX Proc-OP,* and *Text-DX Proc-Scopes.*

**CS SITE-SPECIFIC FACTOR 6**

Record site-specific additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

## Recording CS Site-Specific Factor 6

1. Site/Histology-Specific Instructions- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.

2. No Site/Histology-Specific Factor for a Schema- Code 888 if there is no site/histology-specific factor for a schema.

3. Primary Sites/Histologies for Site-Specific Factor 4- The following primary sites/histologies use *Site-Specific Factor 4* to code information. See the site-specific schemas for acceptable codes and their definitions.

| Site/Histology | Factor |
|---|---|
| Head and neck* | Parapharyngeal, Parotid, Preauricular, and Sub-Occipital Lymph Nodes, Lymph Nodes for Head and Neck |
| Breast | Size of Tumor--Invasive Component |
| Prostate | Gleason Score |

   1. Refer to *VCR Manual, Part Three, Guidelines for Recording Collaborative Stage, Site-Specific Factors* for a list of head and neck schemas.

4. Test Not Performed- Code 000 when there is a statement in the record that a test was not performed.

5. No Report of Lab Test- Code 999 if there is no report of a lab test in the patient record.

6. For Head and Neck Sites Only**:**

   a. Unknown if lymph nodes are involved- Use code 9 only when it is unknown if lymph nodes are involved. Within the Site-Specific Factors, do not code 9 in some positions and 0 or 1 in other positions. If specific information is available about the positive or negative status of some but not all nodes in any one level or group, assume that the rest of the nodes in the same Site-Specific Factor are negative and code accordingly.

   b. "Regional nodes, NOS" - When the only information available is "Regional nodes, NOS" or "Cervical nodes, NOS" or "Internal jugular lymph nodes, NOS" or "Lymph nodes, NOS," code 0 in all digits of Site-Specific Factors 3-6.

   c. See "Coding Regional Lymph Nodes for Head and Neck Sites" under CS Lymph Nodes for further information about the regional nodes of the head and neck, including definitions of the levels.

**CS SITE-SPECIFIC FACTOR 6, continued**

## Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-Path, Text-DX Proc-PE, Text-DX Proc-X-ray/Scans, Text-DX Proc-OP,* and *Text-DX Proc-Scopes.*

**SEER SUMMARY STAGE**

Record the SEER Summary Stage at diagnosis in the appropriate Summary Stage field according to SEER Summary Stage 2000 (SS2000) or SEER Summary Staging 1977 (SS77*)* based on *Date of Diagnosis*. See also *VCR Manual Part Three, Guidelines for Recording SEER Summary Stage.*

## Cases Diagnosed On or After January 1, 2004

1. SS2000 and SS1977 must be left blank.

2. All Collaborative Stage data items must be completed. See *VCR Manual, Part Three, Collaborative Stage Guidelines*.

## Cases Diagnosed Between January 1, 2001 and December 31, 2003.

1. SS2000 - Use *SEER Summary Stage Manual 2000* to code Summary Stage.

2. Time Rule - Summary Stage should include all information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.

## Cases Diagnosed Prior to January 1, 2001

1. SS77 - Use *SEER Summary Stage Guide 1977* to code Summary Stage.

2. Time Rule - Summary Stage is limited to all information available within two months of the date of initial diagnosis.

   ***Exception*:** Summary Stage for prostate primaries is limited to all information available within the first four months of diagnosis.

**Cases with Unknown *Date of Diagnosis*** - If specific information regarding the spread of the cancer at the time of diagnosis is known use the following guidelines:

1. If *Date of 1st Contact* is between January 1, 2001 and December 31, 2003, use SS2000.

2. If *Date of 1st Contact* is prior to January 1, 2001, use SS77.

3. If staging information at diagnosis is not known, stage as *Unknown*, 9.

**Guidelines for Recording SEER Summary Stage** can be found on pages 2-24 of the *SEER Summary Stage Manual 2000.*

**SEER SUMMARY STAGE, continued**

## Codes and Definitions

| Code | Definition |
|---|---|
| 0 | *In Situ. In situ* means "in place". An *in situ* diagnosis means the cancer has not penetrated the basement membrane of the tissue and there is no stromal invasion. An *in situ* diagnosis can only be made microscopically because a pathologist must identify the basement membrane and determine it has not been penetrated. Organs and tissues that have no epithelial layer cannot be staged as *in situ* since they do not have a basement membrane. Therefore, carcinomas and melanomas are the only types of cancer that can be classified as *In situ*, code 0. Sarcomas are never described as *in situ*. Pathologists may also describe *in situ* cancer as *non-invasive, preinvasive, non-infiltrating, intra-epithelial, Stage 0, intraductal, intracystic, no stromal invasion,* and *no penetration below the basement membrane.* |
| 1 | *Localized.* A localized cancer is a malignancy limited to the organ of origin; it has spread no farther than the organ in which it started. The lesion does not extend beyond the outer limits of the primary organ, and there is no evidence of metastasis anywhere else in the body. A tumor can be widely invasive or even show metastases within the organ itself and still be considered *confined to organ of origin* or *localized*. It is important to know and recognize the names of different structures within the organ (such as lamina propria, myometrium, muscularis) so a description of invasion or involvement of these structures will not be interpreted as regional spread. |
| 2 – 5 | *Regional.* A tumor is considered regional when it has extended beyond the limits of the organ of origin and there is no evidence of distant metastasis. Cancer becomes regional when there is the potential for spread by more than one lymphatic or vascular supply route. Codes 2 through 5 reflect the subcategories of this stage. |
| 2 | *Regional by Direct Extension Only.* Invasion of the tumor is through the entire wall of the organ of origin into surrounding organs and/or adjacent tissues. Secondary sites may be described as having tumor *on the surface* rather than *in the organ.* This stage is not valid for lymphoma staging. |
| 3 | *Regional Lymph Nodes Involved Only.* Lymph nodes are involved by tumor. There is tumor invasion of the walls of lymphatics where cells can travel through lymphatic vessels to nearby lymph nodes where they are filtered out and begin to grow in the nodes. This stage is not valid for lymphoma staging. |
| 4 | *Regional by Both Direct Extension and Lymph Node Involvement.* The tumor has extended beyond the limits of the primary site by a combination of direct extension and lymph node involvement. This stage is not valid for lymphoma staging. |
| 5 | *Regional, NOS* (Not Otherwise Specified). The tumor has extended beyond the limits of the primary site with no evidence of distant metastases but it is unclear whether the tissues are involved by direct extension or lymph nodes. Use this category for staging Non-Hodgkin and Hodgkin lymphoma of more than one lymph node chain on the same side of the diaphragm. |

**SEER SUMMARY STAGE, continued**

| Code | Definition |
|---|---|
| 7 | *Distant Site(s)/Node(s) Involved.* Distant metastases are tumor cells that have broken away from the primary tumor, have traveled to other parts of the body, and have begun to grow at the new location. Distant stage is also called *remote, diffuse, disseminated, metastatic,* or *secondary disease*. In most cases there is no continuous trail of tumor cells between the primary site and the distant site.<br><br>Cancer cells can travel from the primary site in any of four ways:<br>a. Extension - Extension from primary organ beyond adjacent tissue into next organ e.g., from the lung through the pleura into bone or nerve<br>b. Lymph Channels - Travel in lymph channels beyond the first (regional) drainage area. Tumor cells can be filtered, trapped and begin to grow in any lymph nodes in the body.<br>c. Blood - Hematogenous or blood-borne metastases. Invasion of blood vessels within the primary tumor (veins are more susceptible to invasion than thicker-walled arteries) allows escape of tumor cells or tumor emboli which are transported through the blood stream to another part of the body where it lodges in a capillary to arteriole. At that point the tumor penetrates the vessel wall and grows back into the surrounding tissue.<br>d. Body Fluids - Spread through fluids in a body cavity, e.g., malignant cells rupture the surface of the primary tumor and are released into the thoracic or peritoneal cavity. They float in the fluid and can land on and begin to grow on any tissue reached by the fluid. This type of spread is called implantation or seeding metastases.<br><br>Common sites of distant spread are liver, lung, brain, bones, but they are not listed specifically for each staging scheme. These organs receive blood flow from all parts of the body and thus are a target for distant metastases. However, if the primary site is adjacent to the liver, lung, brain, or bone, it is important to review the summary staging scheme for the primary site to assure the stage is not regional by direct extension. |
| 9 | *Unknown if Extension or Metastases* (Unstaged, Unknown, or Unspecified). This category is used when sufficient evidence is not available to adequately assign a stage at diagnosis such as:<br>a. Biopsy Only - Only an incisional biopsy is performed and there is no supporting clinical information<br>b. Refuses - Patient refuses a diagnostic or treatment procedure<br>c. Limited Workup - There is limited workup due to patient's age or contraindicating condition(s) or patient expires before workup completed.<br>d. Transferred - Patient is transferred to another facility for further diagnosis and treatment.<br>e. Unknown or Ill-Defined Primary - When the primary site is unknown or ill-defined.<br>f. Unknown Extent at Diagnosis - Patient is seen at your facility after initial diagnosis and first course of treatment and stage at diagnosis in not known. |

## Text

Text to support this data item must be recorded in the specific text fields. Positive and negative findings describing how far the cancer has spread from the organ of origin and the corresponding dates of the findings must be recorded in the appropriate *Text-DX* fields as described in *VCR Manual Part Three, Data Item Instructions.* Text to justify the Summary Stage code must be recorded in the field *Text-Staging* as described in *VCR Manual Part Three, Data Item Instructions.*

**GUIDELINES FOR RECORDING FIRST COURSE OF TREATMENT**

First course of treatment includes all methods of cancer-directed therapy recorded in the treatment plan and administered to the patient before disease progression or recurrence. Never code treatment unless you know it has actually been administered at your facility or any other facility; record as None, 00 or 0.

No therapy is a treatment option (the patient refused therapy, the family/guardian refused therapy, the patient expired before therapy started, or the physician recommended no therapy). Therefore, first course of treatment may be no treatment. Use the date the decision was made not to treat as *Date of 1st Crs Rx*.

All modalities of treatment are included regardless of sequence or degree of completion of any component method.

## Treatment Plan

A treatment plan describes the cancer-directed treatment intended to modify, control, remove or destroy proliferating cancer cells. The documentation confirming a treatment plan may be fragmented. It is frequently found in several different sources, e.g., medical or clinic records, consultation reports, and outpatient records. All cancer-directed therapies specified in the physician(s) treatment plan are a part of the first course of treatment. When a treatment plan is not available or unclear, consult a physician.

A discharge plan may contain part or all of the treatment plan.

A treatment plan may specify one or more modalities of therapy (surgery, radiation, chemotherapy, hormone therapy, immunotherapy, or other therapy). A treatment "regimen" may include combinations of concurrent or adjuvant therapies.

*Example:* A patient had a transurethral resection diagnostic of bladder cancer. Resection was followed by Cobalt-60 radiation, ileal loop diversion, and a complete cystectomy with node dissection. Code as follows:

| Data Item | Treatment Code |
|---|---|
| Cancer-directed surgery | 50 - Complete cystectomy |
| Radiation Regional RX Modality | 22- Cobalt-60 radiation |
| Chemotherapy | 00 - None |
| Hormone Therapy | 00 - None |
| Immunotherapy | 00 - None |
| Other treatment | 0 - No other cancer-directed therapy |

**GUIDELINES FOR RECORDING FIRST COURSE OF TREATMENT, continued**

## Guidelines for Determining *First Course of Treatment*

First course of treatment includes all cancer-directed therapy planned and administered by the physician(s) during or after the first diagnosis of cancer. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more.

## Time Period Rules for First Course of Treatment for Malignancies except Leukemias (in order of precedence).

1. If there is a documented, planned first course of treatment, first course ends at the completion of this treatment plan, regardless of the duration of the treatment plan.

2. If the patient is treated according to a facility's standards of practice (established protocol), first course ends at the completion of the treatment.

3. If there is no documented treatment plan, established protocol, or management guidelines, and consultation with a physician is not possible, use the principle: "initial treatment must begin within four months of the date of initial diagnosis."

4. If the patient refuses all treatment modalities, then changes his/her mind and the treatment is initiated, consult a physician to determine if this is part of first course of treatment.

## Special Rules for Leukemias

The first course of definitive treatment is related to the first *remission* as follows:

1. If a remission, complete or partial, is achieved during the first course of therapy for the leukemic process, include:

    - All definitive therapy considered as *remission-inducing* for the first remission.

    - All definitive therapy considered as *remission-maintaining* for the first remission (maintenance chemotherapy or irradiation to the central nervous system).

    - Disregard all treatment administered to the patient after the relapse of the first remission.

2. If no remission is attained during the first course of therapy, record all treatment attempted to induce the remission. Disregard all treatment administered to the patient as a subsequent attempt to induce remission.

## Watchful Waiting

If a treatment plan is given for symptoms/disease progression after period of *watchful waiting*, this treatment is not considered part of first course. For example, if physician and patient choose a *wait and watch* approach to prostate cancer and the patient becomes symptomatic, consider the symptoms to be an indication the disease has progressed and any further treatment is not part of first course.

**GUIDELINES FOR RECORDING FIRST COURSE OF TREATMENT, continued**

## Treatment Failure

Treatment failure or disease progression may prompt the physician to stop therapy before the full course has been completed. Any therapy administered after the discontinuation of first course must be considered as secondary or subsequent treatment.

## Treatment for Recurrence or Progression

Treatment for recurrence or progression of disease includes all cancer-directed therapies administered after the first course of treatment is complete.

If the patient does not respond or if the disease progresses, a physician may stop the first course of treatment before it is complete. Therapy administered after the first course ends is not recorded as first course of treatment.

## Non Cancer-Directed Treatment

Non cancer-directed treatments prolong the patient's life, alleviate pain, make the patient comfortable, or prepare the patient for cancer-directed therapy. They are not meant to destroy or control the tumor or delay the spread of disease. Non cancer-directed procedures include diagnostic tests and supportive care (treatments designed to relieve symptoms and minimize the effects of the cancer). Surgical procedures performed to diagnose/stage disease (exploratory) or for relief of symptoms (palliative) are non cancer-directed surgery. **Non cancer-directed therapies should not be coded as treatment.**

*Examples of non cancer-directed therapies include:*

Diagnostic procedures:
- Incisional biopsies
- Exploratory procedures/surgery with or without biopsies, such as celiotomy, laparotomy, cystotomy, nephrotomy, gastrotomy, thoracotomy
- Brushings, washings, aspiration of cells, and hematologic findings (peripheral blood smears) are not surgical procedures.

Palliative procedures:
- Colostomy
- Nephrostomy
- Esophagostomy
- Tracheostomy
- Gastrostomy

Supportive care/relieving symptoms:
- Pain medication
- Oxygen
- Antibiotics administered for an associated infection
- Intravenous therapy to maintain fluid or nutritional balance
- Laser therapy directed at relieving symptoms

**GUIDELINES FOR RECORDING FIRST COURSE OF TREATMENT, continued**

***Exception:*** Treatment for hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue". See *VCR Manual, Part Three, RX Summ-Other).*

## Cancer-Directed Treatment

Cancer-directed treatment is tumor directed, and its purpose is to modify, control, remove, or destroy primary or metastatic cancer tissue. Physicians administer the therapy(ies) to remove or minimize the size of tumor or to delay the spread of disease. Record all cancer-directed therapy administered to the patient. For complete treatment information, record therapies given in other institutions and failed treatments (the patient did not respond).

*Example 1:* A patient is diagnosed with stage IV small cell carcinoma of the lung. The treatment plan recommends radiation to shrink the metastatic tumor and alleviate the pain caused by rib metastases. The reporting institution delivers beam radiation. The data item *Rad--Reg RX Modality* is coded 22, beam radiation, NOS.

*Example 2*: A patient with breast cancer enters the reporting institution for a lumpectomy. The physician's treatment plan specifies radiation therapy to the breast following surgery. It is unknown if the patient had radiation. Code the data item *RX Summ - Surg Prim Site* to a partial or less than total mastectomy (22). Record the data item *Rad--Regional RX Modality* as (00), none. If additional follow-up information reveals the patient did receive radiation, change to the appropriate radiation code.

**RX SUMM - SURG PRIM SITE**
**(Surgery to Primary Site)**

Record the most invasive, definitive cancer-directed procedure performed to the primary site as part of the first course of treatment at the reporting institution and other institutions.

Cancer-directed surgery modifies, controls, removes, or destroys proliferating cancer tissue.

## Recording Surgery to Primary Site

1. An excisional biopsy is cancer-directed surgery.

   *Example:* The surgeon states the procedure is an excisional biopsy, but the pathology report shows microscopic involvement of the margins. Record the code for an excisional biopsy as *Rx Summ - Surg Prim Site*.

   *Note:* Biopsies that remove all gross tumor or leave only microscopic margins should be coded to surgery of the primary site.

2. If no cancer-directed surgery was performed, code to 00.

3. If it is unknown if cancer-directed surgery was performed, code to 99.

4. Best Information- Use the best information in the operative/pathology reports to determine the operative procedure. Do not depend on the name of the procedure since it may be incomplete. If the operative report is unclear as to what was excised or if there is a discrepancy between the operative and pathology reports, use the pathology report, unless there is reason to doubt its accuracy.

5. Site-Specific Surgery Codes- Refer to *VCR Manual Appendix I* for surgical codes.

   a. Hierarchy-For codes 00 through 79, the descriptions of the surgical procedures are hierarchical. Last-listed responses take precedence over earlier-listed responses. (regardless of code or numeric value). Code 98 takes precedence over all other codes values.

      - Codes 10 through 18 are site-specific descriptions of tumor-destruction procedures that do not produce a pathologic specimen.

      - Codes 20 through 80 are site-specific descriptions of resection procedures.

   b. Numeric Code Sequence- To the extent possible, codes and their definitions are the same as those assigned in *VCR Manual 2001*. As a result of added and modified codes however, the numeric code sequence may deviate from the order in which descriptions of the surgical procedures are listed.

**RX SUMM - SURG PRIM SITE, continued**
**(Surgery to Primary Site)**

*Example:* A rectosigmoid primary surgically treated by polypectomy with electrocautery, which is listed after polypectomy alone, is coded 22.

20 Local tumor excision, NOS
26 Polypectomy
27 Excisional biopsy
Combination of 20 or 26-27 WITH
21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation

c. Special Code 98 applies to specific tumors that cannot be clearly defined in terms of primary or nonprimary site. Surgical Procedure of Primary Site should be coded 98 for *Unknown and Ill-defined Primary Sites and Hematopoietic/ Reticuloendothelial/ Immunoproliferative/Myeloproliferative Disease (*See *VCR Manual, Part Three, General Information* for a list of these sites and conditions). The item *RX Summ--Surg Oth Reg/Dis Site* is used to indicate whether surgery was performed for these tumors.

6. Total Resection- If a surgical procedure removes the remaining portion of an organ which had been partially resected previously for any condition, code as total removal of the organ. If none of the primary organ remains, the code should indicate this is the case.

*Example 1:* Resection of a stomach which had been partially excised previously is coded as total removal of stomach.

*Example 2*: Removal of a cervical stump is coded as total removal of uterus.

*Example 3*: Lobectomy of a lung with a previous wedge resection is coded as total removal of lobe.

7. Biopsies that remove all of the tumor and/or leave only microscopic margins are to be coded in this item.

8. Extranodal Lymphomas- Surgery for extranodal lymphomas should be recorded using the scheme for the extranodal site.

*Example:* Use the scheme for the stomach to record a gastrectomy for a primary lymphoma of the stomach.

9. Surgery for Multiple Primaries- If multiple primaries are treated by a single surgical event, code the appropriate surgical items for each primary.

*Example 1:* If a total abdominal hysterectomy was done for a patient with two primaries, one of the cervix and one of the endometrium, code each as having had a total abdominal hysterectomy.

**RX SUMM - SURG PRIM SITE, continued**
**(Surgery to Primary Site)**

*Example 2*: If a total colectomy was done for a patient with multiple primaries in several segments of the colon, code total colectomy for each of the primary segments.

10. Regional tissue or organs- Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted in the *VCR Manual, Appendix I.*

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery.*

## Special Instructions

1. Registry Hospitals - If you can record multiple surgical procedures in your registry software, make sure the data item transmitted to the VCR as *RX Summ - Surg Prim Site* reflects the most extensive code.

**RX DATE - SURGERY**
**(Date Of First Surgical Procedure)**

Record the earliest date on which the patient had cancer-directed surgery for this primary or metastatic site. This includes *RX Summ-Surg Prim Site, RX Summ-Scope Reg LN Surg, and RX Summ-Surg Oth Reg/Dis.*

## Recording RX Date-Surgery

1. Date Format- Record the date of cancer-directed surgery in month, day, year format (MMDDCCYY). Record the month in the first two spaces, the day in the third and fourth spaces, and the year in the last four spaces. A zero must precede single-digit months and days. See *VCR Manual Part Three, General Instructions* for allowable values.

2. No Surgery of Primary Site- This data item may contain a date even when surgery to the primary site equals 00 (none).

   *Example*: Patient has excision of a brain lesion on January 15, 2003; final pathology diagnosis is metastatic lung carcinoma. Patient refuses further work-up.

   *RX Summ - Surg Prim Site* code = 00
   *RX Date - Surgery* = 01152003
   *RX Summ - Surg Oth Reg/Dis* = 4

3. Collecting the dates for each treatment modality allows sequencing of multiple treatments and aids evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

4. Special Codes -

   a. Code 00000000- When no cancer-directed surgery is performed and for autopsy-only records.

   b. Code 99999999- When it is unknown if any cancer-directed surgery was performed, the date is unknown, or if the record was identified by death certificate only.

   c. Exact Date Unavailable- If the exact date of cancer-directed surgery is not available, record a approximate date. Refer to *VCR Manual Part Three, General Information*.

## Special Instructions

1. Registry Hospitals- If you can record multiple surgery dates, make sure the data item transmitted to the VCR *as RX Date-Surgery* reflects the earliest date of cancer-directed surgery.

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery.*

**RX SUMM - SCOPE REG LN SURG**
**(Scope of Regional Lymph Node Surgery)**

Record the code for the type of surgery to regional lymph nodes performed as first course of treatment. This includes treatment given at all facilities as part of the first course of treatment.

## Codes and Definitions

| Code | Definition |
|---|---|
| 0 | *None*- No regional lymph node surgery. No lymph nodes found in pathologic specimen. Diagnosed at autopsy. |
| 1 | *Biopsy or aspiration of regional lymph node, NOS* - Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease. |
| 2 | *Sentinel lymph node biopsy*- Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor. |
| 3 | *Number of regional nodes removed unknown or not stated; regional lymph nodes removed, NOS*- Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel node biopsy. |
| 4 | *1–3 regional lymph nodes removed*- Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy. |
| 5 | *4 or more regional lymph nodes removed*- Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy. |
| 6 | *Sentinel node biopsy and code 3, 4,or 5 at same time, or timing not stated*- Code 2 was performed in a single surgical event with code 3, 4, or 5. Or, code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record. |
| 7 | *Sentinel node biopsy and code 3, 4, or 5 at different times*- Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5. |
| 9 | *Unknown or not applicable*- It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease. |

**RX SUMM - SCOPE REG LN SURG, continued**
**(Scope of Regional Lymph Node Surgery)**

## Recording Scope of Regional Lymph Node Surgery

1. Regional Lymph Node List - Refer to *VCR Manual Appendix I* for site-specific regional lymph node listings. All other nodes not listed are considered distant sites and must be coded in the data item *RX Summ - Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s).*

2. Aspiration, biopsy or removal of lymph nodes- Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease.

3. Minimum number- There is no minimum number of nodes that must be removed; code to the farthest regional lymph nodes removed regardless of involvement with disease (e.g., the biopsy of contralateral lung lymph nodes).

4. Hierarchy- Codes 0-7 are hierarchical. Code the procedure that is numerically higher

5. Meninges, brain, spinal cord, cranial nerves and other parts of the central nervous system- For primaries of the meninges, brain, spinal cord, cranial nerves and other parts of the central nervous system (C70.0-C70.9, C71.0-C71.9, C72.0-C72.9), code to 9.

6. Lymphoma- For lymphomas with a lymph node primary site, code 9. For extranodal lymphomas, refer to the site-specific codes for the primary site.

7. Unknown or ill defined primary site or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease, code to 9. See *VCR Manual, Part Three, General Information* for a list of these sites and conditions.

8. No regional lymph nodes- This data item may not be blank. If no regional lymph nodes were removed or no surgery was performed, record 0.

   *Example 1:* Aspiration of regional lymph node of a pharynx primary to confirm histology of widely metastatic disease is coded to 1.

   *Example 2*: A patient with a breast primary has a sentinel lymph node biopsy of the right axilla, followed by right axillary lymph node dissection during the same surgical event, code to 6.

## Special Instructions

1. Registry Hospitals - If you can record multiple surgical procedures in your registry software, make sure the data item transmitted to the VCR as *RX Summ - Scope Reg LN Surg* reflects most extensive code.

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery.*

**RX SUMM - SURG OTH REG/DIS**
**(Surgery to Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s))**

Record the code for the type of surgery to sites other than the primary site and regional lymph nodes, performed as part of the first course of treatment. This includes treatment given at all facilities as part of the first course of treatment.

This data item describes the removal of tissues and organs other than the primary tumor or organ of origin. This data item is for all procedures that do not meet the definition of *RX Summ- Surgery of Primary Site* or *RX Summ - Scope of Regional Lymph Node Surgery*.

## Codes and Definitions

| Code | Definition |
|---|---|
| 0 | *None,* No surgical procedure of nonprimary site was performed.<br>Diagnosed at autopsy. |
| 1 | *Nonprimary surgical procedure performed*- Nonprimary surgical resection to other site(s), unknown if the site(s) is regional or distant. |
| 2 | *Nonprimary surgical procedure to other regional sites*- Resection of regional site. |
| 3 | *Nonprimary surgical procedure to distant lymph node(s)*-Resection of distant lymph node(s). |
| 4 | *Nonprimary surgical procedure to distant site*- Resection of distant site. |
| 5 | *Combination of codes*- Any combination of surgical procedures 2, 3, or 4. |
| 9 | *Unknown*- It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only. |

## Recording Surgery to Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)

1. Hierarchy- The codes are hierarchical. Code the procedure that is numerically higher in this data item.

2. Suspicion of malignancy- Code the removal of non-primary tissue the surgeon suspected was involved with the malignancy even if the pathology is negative.

3. Unknown or ill-defined primary sites or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease- Assign code 1 if any surgical procedure is performed to treat these cases. See *VCR Manual, Part Three, General Information* for a list of these sites and conditions.

   *Example*: Surgical biopsy of metastatic lesion from liver; unknown primary is coded to 1.

**RX SUMM - SURG OTH REG/DIS, continued**
**(Surgery to Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s))**

4. Incidental removal- Do not code the incidental removal of tissue. Incidental is defined as tissue removed for reasons other than the malignancy.

   *Example:* The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon is not coded therefore, this case would be coded to 0.

5. No surgery- This data item may not be blank. If there was no surgery to other regional sites, distant sites or distant lymph nodes, record 0.

## Special Instructions

1. Registry Hospitals - If you can record multiple surgical procedures in your registry software, make sure the data item transmitted to the VCR as *RX Summ - Surg Oth Reg/Dis* reflects the most extensive (numerically highest) code.

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery.*

**REASON FOR NO SURGERY**
**(Reason No Surgery of the Primary Site)**

Record the reason for no Surgery of Primary Site. Codes 1-9 are valid only when *RX Summ - Surg Prim Site* is coded 00.

## Codes and Definitions

| Code | Definition |
|---|---|
| 0 | Surgery of the primary site was performed. |
| 1 | Surgery of the primary site was not performed because it was not part of the planned first course treatment. |
| 2 | Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.) |
| 5 | Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery. |
| 6 | Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in patient record. |
| 7 | Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record. |
| 8 | Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended. |
| 9 | It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only. |

## Recording Reason for No Surgery

1. No surgery in plan- Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include surgery of the primary site, or if the option of "no treatment" was accepted by the patient.

2. If *Surgical Procedure of Primary Site* is coded 98, code *Reason for No Surgery* to 1.

3. Patient refused- If the patient refused recommended surgical treatment, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended, code to 7.

**REASON FOR NO SURGERY, continued**
**(Reason No Surgery of the Primary Site)**

4. Unknown treatment- If the treatment plan offered multiple choices, but it is unknown which treatment, if any, was provided, code to 9.

   *Example 1:* A patient with a primary tumor of the liver is not recommended for surgery due to advanced cirrhosis, code to 2.

   *Example 2:* A patient is referred to another facility for recommended surgical resection of a gastric carcinoma, but further information from the facility to which the patient was referred is not available, code to 8.

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery.*

**RAD- REGIONAL RX MODALITY**
**(Radiation Regional Treatment Modality)**

Record the dominant modality of radiation therapy used to deliver the most clinically significant regional dose to the primary volume of interest during the first course of treatment.

## Codes and Definitions

| Code | Definition |
|---|---|
| 00 | *No radiation treatment* - Radiation therapy was not administered to the patient. Diagnosis at autopsy |
| 20 | *External beam, NOS*- The treatment is known to be by external beam, but there is insufficient information to determine the specific modality. |
| 21 | *Orthovoltage*- External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV). |
| 22 | *Cobalt-60, Cesium-137*- External beam therapy using a machine containing either a Cobalt- 60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51. |
| 23 | *Photons (2–5 MV)*- External beam therapy using a photon producing machine with a beam energy in the range of 2–5 MV. |
| 24 | *Photons (6–10 MV)*- External beam therapy using a photon producing machine with a beam energy in the range of 6–10 MV. |
| 25 | *Photons (11–19 MV)*- External beam therapy using a photon producing machine with a beam energy in the range of 11–19 MV. |
| 26 | *Photons (>19 MV)*- External beam therapy using a photon producing machine with a beam energy of more than 19 MV. |
| 27 | *Photons (mixed energies)*- External beam therapy using more than one energy over the course of treatment. |
| 28 | *Electrons*- Treatment delivered by electron beam. |
| 29 | *Photons and electrons mixed*- Treatment delivered using a combination of photon and electron beams. |
| 30 | *Neutrons, with or without photons/electrons*- Treatment delivered using neutron beam. |
| 31 | *IMRT* - Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record. |
| 32 | *Conformal or 3-D therapy*- An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record. |
| 40 | *Protons*- Treatment delivered using proton therapy. |
| 41 | *Stereotactic radiosurgery, NOS*-Treatment delivered using stereotactic radiosurgery, type not specified in patient record. |
| 42 | *Linac radiosurgery* - Treatment categorized as using stereotactic technique delivered with a linear accelerator. |
| 43 | *Gamma Knife*- Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine. |

**RAD- REGIONAL RX MODALITY, continued**
**(Radiation Regional Treatment Modality)**

| Code | Definition |
|---|---|
| 50 | *Brachytherapy, NOS*- Brachytherapy, interstitial implants, molds, seeds, needles, or Intracavitary applicators of radioactive materials not otherwise specified. |
| 51 | *Brachytherapy, Intracavitary, LDR*- Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator). |
| 52 | *Brachytherapy, Intracavitary, HDR*- Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes. |
| 53 | *Brachytherapy, Interstitial, LDR*- Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources. |
| 54 | *Brachytherapy, Interstitial, HDR*- Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources. |
| 55 | *Radium*- Infrequently used for low dose rate (LDR) interstitial and Intracavitary therapy. |
| 60 | *Radioisotopes, NOS*- Iodine-131, Phosphorus-32, etc. |
| 61 | *Strontium-89* -Treatment primarily by intravenous routes for bone metastases. |
| 62 | *Strontium-90* |
| 80* | *Combination modality, specified**- Combination of external beam radiation and either radioactive implants or radioisotopes* **This is a converted code and should not be coded for cases diagnosed on or after 1/1/2003.** |
| 85* | *Combination modality, NOS**- Combination of radiation treatment modalities not specified in code 80.* **This is a converted code and should not be coded for cases diagnosed on or after 1/1/2003.** |
| 98 | *Other, NOS* -Radiation therapy administered, but the treatment modality is not specified or is unknown. |
| 99 | *Unknown* - It is unknown whether radiation therapy was administered. Death certificate only |

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* For cases diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation administered to the patient as part or all of the first course of therapy. Codes 80 and 85 describe specific converted descriptions of radiation therapy and should not be used to record regional radiation for cases diagnosed on or after January 1, 2003.

**RAD- REGIONAL RX MODALITY, continued**
**(Radiation Regional Treatment Modality)**

## Recording Radiation Regional Treatment Modality

1. Finding radiation information- Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.

2. Regional vs. Boost- Radiation treatment is frequently delivered in two or more phases which can be summarized as "regional" and "boost" treatments.

   a. Regional Radiation is directed at the cancer site and a larger area of surrounding tissue.

   b. Boost Radiation is a supplemental radiation dose targeted directly to the tumor site (or site of the original tumor). It is provided to a smaller area within the same volume as regional, in order to enhance the effect of the regional treatment.

   The VCR only requires Regional Radiation to be reported.

3. Only one modality delivered- If only one radiation treatment modality is delivered to a patient and it is not specified as either regional or boost treatment, assume it is regional treatment and code accordingly.

4. Multiple radiation modalities- In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality.

5. Boost Treatment- In some circumstances, the boost treatment may precede the regional treatment.

6. Terms- For purposes of this data item, photons and x-rays are equivalent.

   *Example 1:* Patient receives 15 MV external pelvic treatment to 4,500 cGy for cervical carcinoma, and then receives two Fletcher intracavitary implants is coded to 25.

   *Example 2*: A patient with carcinoma of the parotid receives daily treatments of which 60% are delivered by 15 MV photons and 40% of the dose is delivered by 16 MV electrons is coded to 29.

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Radiation (Beam) or RX Text - Radiation Other.*

**RX DATE - RADIATION**
**(Date Radiation Started)**

Record the date radiation started.

## Recording RX Date- Radiation

1. Date Format- Record the date in month, day, year format (MMDDCCYY). Record the month in the first two spaces, the day in the third and fourth spaces, and the year in the last four spaces. A zero must precede single-digit months and days. See *VCR Manual Part Three, General Instructions* for allowable values.

   *Example:* Record December 15, 2006 as 12152006.

2. Collecting dates for each treatment- modality allows sequencing of multiple treatments and evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

3. Special Codes

   a. Code 00000000-When no radiation therapy is administered, or a case is identified only at autopsy.

   b. Code 88888888- When 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.

   c. Code 99999999- When it is unknown if any radiation therapy was administered, the date is unknown, or if the record was identified only from death certificate information.

   *d.* Exact date unavailable- If the exact date radiation started is not available, record an approximate date, refer to *VCR Manual Part Three, General Information.*

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Radiation (Beam)* or *RX Text - Radiation Other*.

**RX SUMM- SURG/RAD SEQ**
**(Radiation/Surgery Sequence)**

Record the sequencing of radiation and surgical procedures given as part of first course of treatment.

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

## Codes and Definitions

| Code | Definition |
|---|---|
| 0 | *No radiation therapy and/or surgical procedures*- No radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node (s). Diagnosed at autopsy.<br><br>*Example*: Due to other medical conditions surgery was not performed. |
| 2 | *Radiation therapy before surgery*- Radiation therapy given before surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).<br><br>*Example*: A patient has a large lung lesion and received radiation therapy prior to resection. |
| 3 | *Radiation therapy after surgery*- Radiation therapy given after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).<br><br>*Example*: A patient received a wedge resection of a right breast mass with axillary lymph node dissection followed by radiation to the right breast. |
| 4 | *Radiation therapy both before and after surgery*- Radiation therapy given before and after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).<br><br>*Example*: Preoperative radiation was given to a large, bulky vulvar lesion and was followed by lymph node dissection. This was then followed by radiation therapy to treat positive lymph nodes. |
| 5 | *Intraoperative radiation therapy*- Intraoperative therapy given during surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).<br><br>*Example*: A cone biopsy of the cervix is followed by intracavitary implant for IIIB cervical carcinoma. |

**RX SUMM- SURG/RAD SEQ, continued**
**(Radiation/Surgery Sequence)**

| Code | Definition |
|---|---|
| 6 | *Intraoperative radiation therapy with other therapy administered before or after surgery*- Intraoperative radiation therapy given during surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node (s) with other radiation administered before or after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).<br><br>*Example*: Stage IV vaginal carcinoma was treated with 5,000 cGy to the pelvis followed by a lymph node dissection and 2,500 cGy of intracavitary brachytherapy. |
| 9 | *Sequence unknown*- Administration of radiation therapy and surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record.<br><br>It is unknown if radiation therapy was administered and/or it is unknown if surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed.<br><br>Death Certificate only.<br><br>*Example:* An unknown primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. |

## Recording RX Summ-Surg/Rad Seq

1. Surgical procedures include RX Summ- Surg Prim Site (surgery of the primary site); RX Summ- Scope LN Surg (scope of regional lymph node surgery); RX Summ- Surg Oth Reg/Dis (surgery to other regional site, distant site, or distant lymph node)

2. No surgery- If all surgery procedures listed above are coded to 0, then this item should be coded to 0.

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery, RX Text - Radiation (Beam) and RX Text - Radiation Other.*

**RX SUMM - CHEMO**
**(Chemotherapy)**

Record the type of chemotherapy administered as first course of treatment at your institution and at all other institutions. If chemotherapy was not administered, then this item records the reason it was not administered to the patient. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

## Codes and Definitions

| Code | Definition |
|---|---|
| 00 | None- chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy. |
| 01 | Chemotherapy NOS- Chemotherapy administered as first course therapy, but the type and number of agents is not documented in patient record. |
| 02 | Single-agent chemotherapy administered as first course therapy<br>. |
| 03 | Multiagent chemotherapy administered as first course therapy. |
| 82 | Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age). |
| 85 | Chemotherapy was not administered because the patient died prior to planned or recommended therapy. |
| 86 | Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record. |
| 87 | Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record. |
| 88 | Chemotherapy was recommended, but it is unknown if it was administered. |
| 99 | It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record.<br><br>Death certificate only |

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**RX SUMM - CHEMO, continued**
**(Chemotherapy)**

## Recording Chemotherapy

1. Chemotherapy not usually given for this condition- If chemotherapy was not administered to the patient, and it is known it is not usually administered for this stage of cancer or type of condition, code to 00.

2. Patient did not select chemotherapy- If the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy, code to 00.

3. Chemotherapy usually given for this condition- If it is known chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

4. Patient refused- If the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended, code to 87.

5. Unknown- If it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered, code to 99.

6. Change to regimen- If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (See *VCR Manual, Part Three, Chemotherapy Group Classifications*) than the original agent, the new regimen represents the start of subsequent therapy, and *only the original agent or regimen is recorded as first course therapy*.

   *Example:* The physician documents a multimodality treatment plan that includes a combination regimen of chemotherapy. Velban is one of the drugs in the chemotherapy regimen. After two cycles of chemotherapy, the physician says the Velban will be replaced with Oncovin and the chemotherapy will continue as planned. This is a continuation of the planned first course of therapy since they are in the same group.

7. List of chemotherapeutic agents- Use *SEER RX* to determine if a drug is a chemotherapy agent. *SEER RX* is an interactive antineoplastic drug data base and it can be downloaded from this website:

   http://seer.cancer.gov/tools/seerrx/

   Note: According to the standard set by *SEER RX*, **Herceptin** and **Interleukin** are considered chemotherapy drugs, not immunotherapy.

**RX SUMM - CHEMO, continued**
**(Chemotherapy)**

## Methods of Administration

| Method | Definition |
|---|---|
| Intravenous (IV) Infusion | A small plastic needle is inserted into a vein. Chemotherapy flows from the IV bag/bottle, through the needle and catheter into the bloodstream. |
| Orally | Medication taken in the form of either a pill or liquid taken by mouth. |
| Intrathecal | Administered directly into the cerebrospinal fluid through a lumbar puncture needle into an implanted access device (e.g., Ommaya reservoir). |
| Pleural/pericardial | Injected directly into pleural or pericardial space to control malignant effusions. |
| Intraperitoneal | Injected into the peritoneal cavity. |
| Hepatic artery | Injected into a catheter inserted into artery that supplies blood to liver. |

## Clarification of Terms

| Term | Definition |
|---|---|
| Adjuvant chemotherapy | Chemotherapy given after other methods have destroyed the clinically detectable cancer cells. Chemotherapy given to destroy micrometastases (undetectable cancer cells). The intent is to prevent or delay a recurrence.<br><br>*Example:* The patient has breast cancer with positive nodes. The patient is clinically free of disease after a modified radical mastectomy. The patient is treated with adjuvant chemotherapy to prevent or delay disease recurrence. |
| Multimodality therapy<br>Combined modality therapy<br>Concurrent therapy | Chemotherapy given before, during, or after other treatment modalities (surgery, radiation) as a part of the treatment plan. |
| Neo-adjuvant therapy | Given prior to surgical resection or radiation therapy to reduce the bulk of a locally advanced primary cancer.<br><br>*Example*: A patient with locally advanced breast cancer receives chemotherapy to reduce tumor size. Chemotherapy is followed by a modified radical mastectomy. |
| Treatment cycles | Chemotherapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more chemotherapy drugs. The interval of a treatment cycle varies and chemotherapy may be administered for several weeks or several years. |

**RX SUMM - CHEMO, continued**
**(Chemotherapy)**

## Chemotherapy Group Classifications

| Group | Subgroup | Example |
|---|---|---|
| Alkylating agents | Nitrogen mustard | Mechlorethamine (Mutagens), phenylalanine mustard (Memphians), chlorambucil (leukeran), cyclophosphamide (Cytoxan) |
| | Ethylenimine derivatives | Triethylene-thiophosphoramide (Thio-TEPA) |
| | Alkyl sulfonates | Busulfan (Myleran) |
| | Nitrosoureas | Carmustine (Lomustine) |
| | Triazines | DTIC (Dacarbazine) |
| Antimetabolites | Folic acid analogues | Methotrexate (Amethopterin, MTX) |
| | Pyrimidine analogues | 5-fluorouracil (5-FU) |
| | Purine analogues | 6-mercaptopurine (6-MP) |
| Natural products | Anti-tumor | Dactinomycin (Actinomycin D), doxorubicin (Adriamycin), daunorubicin (Daunomycin), bleomycin (Blenoxane), mitomycin C (Mutamycin) |
| | Plant alkaloids | Vinblastine (Velban, VBL), vincristine (Oncovin, VCR) |
| | Enzymes | l-asparaginase (Elspar) |
| Miscellaneous | | Cis-diammine dichloroplatinum II (Cisplatin), hydroxyurea (Hydrea), procarbazine (Matulane) |

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Chemo.*

**RX SUMM - HORMONE**
**(Hormone Therapy)**

Record the type of hormone therapy the patient received as a part of first course of treatment at your institution and all other institutions. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Hormone therapy achieves its effect on cancer tissue through change of the hormone balance. Included are the administration of hormones, agents acting via hormonal mechanisms, antihormones, and steroids.

## Codes and Definitions

| Code | Definition |
|---|---|
| 00 | None, hormone therapy was not part of the planned first course of therapy.<br>Diagnosed at autopsy. |
| 01 | Hormone therapy administered as first course therapy. |
| 82 | Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age). |
| 85 | Hormone therapy was not administered because the patient died prior to planned or recommended therapy. |
| 86 | Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record. |
| 87 | Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record. |
| 88 | Hormone therapy was recommended, but it is unknown if it was administered. |
| 99 | It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only |

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**RX SUMM - HORMONE, continued**
**(Hormone Therapy)**

## Recording Hormone Therapy

1. All sites (primary and metastatic)- Hormones, agents acting via hormonal mechanisms, and antihormones (cancer-directed only) are to be coded for all sites (primary and metastatic).

2. Prednisone

   a. Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

   b. Do not code prednisone as hormone therapy when it is administered for reasons other than cancer treatment.

   *Example 1:* A patient has advanced lung cancer with metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormone therapy.

   *Example 2:* A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Do not code the prednisone as hormone therapy.

3. Hormone replacement therapy- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.

   *Example:* Patients with breast cancer may be treated with aminoglutethimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. These patients must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (Florinef) as a replacement therapy. Code Rx Summ- Hormone to 00, None.

4. Hormone therapy not usually given for this condition- If hormone therapy was not administered to the patient, and it is known it is not usually administered for this type and stage of cancer, code to 00.

5. Patient selected treatment option without hormone therapy- If the treatment plan offered multiple options, and the patient selected treatment that did not include hormone therapy, code to 00.

6. Thyroid replacement therapy- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.

7. Hormone therapy usually given for this condition- If it is known hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

8. Patient refused- If the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended, code to 87.

**RX SUMM - HORMONE, continued**
**(Hormone Therapy)**

9. Unknown- If it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered, code to 99.

10. List of hormonal agents- Use *SEER RX* to determine if a drug is a hormonal agent. *SEER RX* is an interactive antineoplastic drug data base and it can be downloaded from this website:

    http://seer.cancer.gov/tools/seerrx/

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Hormone.*

**RX SUMM - BRM**
**(Immunotherapy)**

Record the immunotherapy (biological response modifier, BRM) the patient received as a part of first course of treatment at the reporting institution and all other institutions. If immunotherapy was not administered, then this item records the reason it was not administered to the patient. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells.

## Codes and Definitions

| Code | Definition |
|---|---|
| 00 | None, immunotherapy was not part of the planned first course of therapy.<br>Diagnosed at autopsy. |
| 01 | Immunotherapy administered as first course therapy. |
| 82 | Immunotherapy was not recommended/administered because it was contra-indicated due to patient risk factors (i.e., comorbid conditions, advanced age). |
| 85 | Immunotherapy was not administered because the patient died prior to planned or recommended therapy. |
| 86 | Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record. |
| 87 | Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record. |
| 88 | Immunotherapy was recommended, but it is unknown if it was administered. |
| 99 | It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only. |

## Recording Immunotherapy

1. Immunotherapy not usually given for this condition- If immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer, code to 00.

2. Patient selected treatment option without immunotherapy- If the treatment plan offered multiple options, and the patient selected treatment that did not include immunotherapy, code to 00.

**RX SUMM - BRM, continued**
**(Immunotherapy)**

3. Immunotherapy usually given for this condition- If it is known immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

4. Patient refused- If the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended, code to 87.

5. Unknown- If it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered, code to 99.

6. List of Immunotherapy agents- Use *SEER RX* to determine if a drug is an immunotherapy agent. *SEER RX* is an interactive antineoplastic drug data base and it can be downloaded from this website:

   http://seer.cancer.gov/tools/seerrx/

7. Immunotherapy includes:

| | | |
|---|---|---|
| Allogeneic cells | Levamisole | Vaccine therapy |
| BCG | MVE - 2 | Virus therapy |
| Interferon | Pyran copolymer | |
| LAK cells | Thymosin | |

Note: According to the standard set by *SEER RX*, **Herceptin** and **Interleukin** are considered chemotherapy drugs, not immunotherapy.

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - BRM.*

**RX SUMM- TRANSPLNT/ENDROCR**
**(Hematologic Transplant and Endocrine Procedures)**

Record the systemic therapeutic *procedures* administered as part of the first course of treatment at this and all other facilities. If none of these *procedures* were administered, then this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

## Codes and Definitions

| Code | Definition |
|---|---|
| 00 | No transplant procedure or endocrine therapy was administered as part of first course therapy. Diagnosed at autopsy. |
| 10 | A bone marrow transplant procedure was administered, but the type was not specified. |
| 11 | Bone marrow transplant- autologous. |
| 12 | Bone marrow transplant- allogeneic. |
| 20 | Stem cell harvest and infusion. |
| 30 | Endocrine surgery and/or endocrine radiation therapy. |
| 40 | Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20.) |
| 82 | Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age). |
| 85 | Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy. |
| 86 | Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record. |
| 87 | Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record. |
| 88 | Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered. |
| 99 | It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record.<br>Death certificate only. |

**RX SUMM- TRANSPLNT/ENDROCR, continued**
**(Hematologic Transplant and Endocrine Procedures)**

## Recording Hematologic Transplant and Endocrine Procedures

1. Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.

2. Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation.

3. Endocrine irradiation and/or endocrine surgery

    1. Procedures that suppress the naturally occurring hormonal activity of the patient and thus alter or effect the long-term control of the cancer's growth.

    2. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.

4. These procedures are not usually administered for this condition- Code 00 if a transplant or endocrine procedure was not administered to the patient, and it is known these procedures are not usually administered for this type and stage of cancer.

5. Patient selected treatment option that did not include one of these procedures- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include a transplant or endocrine procedure.

6. These procedures are usually administered for this condition- If it is known a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to patient, use code 82, 85, 86, or 87 to record reason why it was not.

7. Patient refused- If the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended, code to 87.

8. Unknown- If it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered, code to 99.

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery.*

**RX DATE - SYSTEMIC**
**(Date Systemic Therapy Started)**

Record the date of initiation for systemic therapy that is part of the first course of treatment.

## Recording Rx Date – Systemic

1. Date Format- Record the date in month, day, year format (MMDDCCYY). Record the month in the first two spaces, the day in the third and fourth spaces, and the year in the last four spaces. A zero must precede single-digit months and days. See *VCR Manual Part Three, General Instructions* for allowable values

2. Systemic therapy includes the administration of chemotherapy agents, hormonal agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy.

3. First or Earliest Date- Record the first or earliest date on which systemic therapy was administered. Systemic therapy includes *Chemotherapy*, *Hormone Therapy*, *Immunotherapy*, and *Hematologic Transplant and Endocrine Procedures.*

   *Example:* Record December 15, 2006 as 12152006.

4. Collecting dates for each treatment modality allows sequencing of multiple treatments and evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

5. Special Codes

   a. Code 00000000- When no systemic therapy is administered. Records diagnosed at autopsy.

   b. Code 88888888- When 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.

   c. Code 99999999- When it is unknown if any systemic therapy was administered, the date is unknown, or if the record was identified only from death certificate information.

   d. Exact Date Unavailable- If the exact date the systemic therapy started is not available, record an approximate date. Refer to *VCR Manual Part Three, General Information.*

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text- Chemotherapy, Hormone or BRM.*

**RX SUMM - SYSTEMIC SUR SEQ**
**(Systemic/Surgery Sequence)**

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

## Codes and Definitions

| Code | Definition |
|---|---|
| 0 | *No systemic therapy and/or surgical procedures*- No systemic therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s). Diagnosed at autopsy.<br><br>*Example*: Due to other medical conditions surgery was not performed. |
| 2 | *Systemic therapy before surgery*- Systemic therapy given before surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).<br><br>*Example*: A patient with prostate cancer received hormone therapy prior to radical prostatectomy. |
| 3 | *Systemic therapy after surgery*- Systemic therapy given after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).<br><br>*Example*: A patient underwent a colon resection followed by a 5-FU based chemotherapy regimen. |
| 4 | *Systemic therapy both before and after surgery*- Systemic therapy given before and after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).<br><br>*Example*: A patient with breast cancer receives pre-operative chemotherapy followed by postoperative Tamoxifen. |
| 5 | *Intraoperative systemic therapy*- Intraoperative systemic therapy given during surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).<br><br>*Example*: Patient with an intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity |

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**RX SUMM - SYSTEMIC SUR SEQ, continued**
**(Systemic/Surgery Sequence)**

| Code | Definition |
|---|---|
| 6 | *Intraoperative systemic therapy with other therapy administered before or after surgery*- Intraoperative systemic therapy given during surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node (s) with other systemic therapy administered before or after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).<br><br>*Example*: Patient with metastatic colon cancer receives intraoperative chemotherapy to the liver and postoperative 5-FU and leucovorin with irinotecan. |
| 9 | *Sequence unknown*- Administration of systemic therapy and surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record.<br><br>It is unknown if systemic therapy was administered and/or it is unknown if surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed.<br><br>Death Certificate only.<br><br>*Example:* An unknown primary of the head and neck was treated with surgery and chemotherapy prior to admission, but the sequence is unknown. |

## Recording RX Summ-Systemic Sur Seq

1. Surgical procedures include RX Summ- Surg Prim Site (surgery of the primary site); RX Summ- Scope LN Surg (scope of regional lymph node surgery); RX Summ- Surg Oth Reg/Dis (surgery to other regional site, distant site, or distant lymph node)

2. No surgery- If all surgery procedures listed above are coded to 0, then this item should be coded to 0.

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery, RX Text -Chemo, RX Text - BRM, and RX Text -Hormone.*

**RX SUMM - OTHER**
**(Other Cancer-Directed Therapy)**

Record other cancer-directed therapy received by the patient as part of the first course of treatment at the reporting institution and all other institutions. Other treatment includes therapies designed to modify or control the cancer cells that are not defined in *Surgery, Radiation,* or *Systemic Therapy* fields.

## Codes and Definitions

| Code | Definition |
|---|---|
| 0 | None- All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy. |
| 1 | Other- Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases (see next page). |
| 2 | Other-Experimental- This code is not defined. It may be used to record participation in institution based clinical trials. |
| 3 | Other-Double Blind- A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken. |
| 6 | Other-Unproven Cancer treatments administered by nonmedical personnel. |
| 7 | Refusal- Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record. |
| 8 | Recommended; unknown if administered- Other treatment was recommended, but it is unknown whether it was administered. |
| 9 | Unknown- It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only. |

**RX SUMM - OTHER, continued**
**(Other Cancer-Directed Therapy)**

## Recording Other Treatment

1. Hematopoietic diseases- Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Such treatments include phlebotomy, transfusions, and aspirin, and should be coded 1.

   a. Phlebotomy may be called blood removal, blood letting, or venisection.

   b. Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.

   c. Aspirin (also known as ASA, acetylsalicylic acid, or by a brand name) is used as a treatment for essential thrombocythemia. Record ONLY aspirin therapy to thin the blood for symptomatic control of thrombocythemia.

      To determine whether aspirin is administered for pain, cardiovascular protection, or thinning of platelets in the blood, use the following general guideline:

      - Pain control is approximately 325–1000 mg every 3–4 hours.
      - Cardiovascular protection starts at about 160 mg/day.
      - Aspirin treatment for essential thrombocythemia is low dose, approximately 70-100 mg/day.

2. Ancillary Drugs- Do not code ancillary drugs in this field. There is no coding scheme for ancillary drugs.

   *Examples:* Aredia, Allopurinol, G-CSF (growth stimulating factors), Epogen, Nupogen/Neupogen, Leucovorin

   *Note:* This is a partial list. See *SEER RX* to determine if a drug is an ancillary drug. *SEER RX* is an interactive antineoplastic drug data base and it can be downloaded from this website:

   http://seer.cancer.gov/tools/seerrx/

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Other*.

**RX DATE - OTHER**
**(Date Other Treatment)**

Record the date other treatment started.

## Recording RX Date- Other

1. Date Format- Record date in month, day, year format (MMDDCCYY). Record the month in the first two spaces, the day in the third and fourth spaces, and the year in the last four spaces. A zero must precede single-digit months and days. See *VCR Manual Part Three, General Instructions* for allowable values.

   *Example:* Record December 15, 2006 as 12152006.

2. Collecting dates for each treatment modality allows sequencing of multiple treatments and evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

3. Special Codes

   a. Code 00000000- When no other treatment is administered and for records diagnosed at autopsy.

   b. Code 99999999- When it is unknown if any other treatment was administered, the date is unknown, or if the record was identified only from death certificate information.

   c. Exact date unavailable- If the exact date other treatment started is not available, record an approximate date. Refer to *VCR Manual Part Three, General Information*.

## Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Other*.

**DATE OF 1ST CRS RX - COC**
**(Date of First Course of Treatment)**

Record the date of first course treatment. This is the date of initiation of the first cancer-directed therapy for the cancer being reported

## Recording Date of 1st CRS RX- COC

1. Date Format- Record date in month, day, year format (MMDDCCYY). Record the month in the first two spaces, the day in the third and fourth spaces, and the year in the last four spaces. A zero must precede single-digit months and days. See *VCR Manual Part Three, General Instructions* for allowable values.

   *Example:* Record December 15, 2006 as 12152006.

2. Earliest Date- Record the earliest of the following dates: *RX Date- Surgery, RX Date- Radiation, RX Date- Systemic*, or RX *Date- Other*.

3. Physician Decides Not to Treat- If the physician decides not to treat the patient, record the date of this decision as the Date of 1st Crs Rx. The physician may decide not to treat the patient because of comorbid conditions, advanced disease, or because the accepted management of the cancer is to observe until the disease progresses or until the patient becomes symptomatic.

   *Example:* On February 12, 2006 the physician says a low-stage prostate cancer patient will be observed until the Prostatic Specific Antigen (PSA) level starts to rise. Enter 02122006 as the date of first course treatment.

4. Patient Refuses Treatment- If the patient refuses treatment, record the date of this decision as the Date of 1st Crs Rx. If the patient is diagnosed at the reporting facility and no further information is available record the date the patient was last seen at the reporting institution.

5. Incisional Biopsy- Do not record the date of incisional, core or fine needle biopsy as the Date of 1st CRS RX-COC.

6. Special Codes

   a. Code 00000000- When the patient is diagnosed at autopsy.

   b. Code 99999999- If unknown if any cancer-directed treatment was administered, date is unknown, or if record was identified only by death certificate (VCR use only).

      *Example*: A patient was diagnosed at your facility by an incisional biopsy on March 17, 2005 and did not return to the your facility and the physician lost contact. Enter 99999999.

   c. Exact date unavailable- If the exact date treatment started is not available, record an approximate date. Refer to *VCR Manual Part Three, General Information*.

**DATE OF LAST CONTACT**

Record the date of last contact.

## Recording Date of Last Contact

1. Date Format- Record date in month, day and year format (MMDDCCYY). Record the month in the first two spaces, the day in the third and fourth spaces, and the year in the last four spaces. A zero must precede single-digit months and days. See *VCR Manual Part Three, General Instructions* for allowable values.

2. Report actual date only- Unknown (99) or approximation of month, day, century, or year is not acceptable when reporting to the VCR. Fictitious dates or default values are also not acceptable.

   ***Exception***: If a patient is known to have expired after discharge from your facility, the month and/or day may be reported as 99 if the exact month and/or day is not known.

3. Inpatient Admission- If the last contact with a patient is an inpatient admission, record the date of discharge.

4. Outpatient Visit- If the last contact with the patient was an outpatient visit, record the outpatient date.

5. Treatment After Discharge- If the patient receives treatment after discharge record the date of the treatment.

   *Example*: The patient is admitted on November 1, 2006 and is discharged on November 3, 2003 and then starts his radiation treatment on December 1, 2006. The date of last contact is 12012006.

6. Patient Deceased- If the patient is deceased, record the date of death.

   *Note*: *Date of Last Contact* does not have to be submitted as a change or update if the patient is readmitted or expires after the initial record was submitted.

**VITAL STATUS**

Record the appropriate code for the patient's vital status as of the date recorded in data item *Date of Last Contact*. Use the most accurate information available.

## Codes and Definitions

| Code | Definition |
|---|---|
| 0 | Dead |
| 1 | Alive |

*Note*: Vital Status does not have to be submitted as a change or update if the patient expires after the initial record was submitted. The VCR periodically matches records on the VCR database against Virginia death certificate files. As a result of this match, the VCR will send to each hospital a list of its reported patients who have expired.

**REPORTING HOSPITAL**

Record the reporting facility identification (ID) number as described under special instructions below.

## Special Instructions

1. Registry Hospitals - Record the ID number assigned to your facility by the American College of Surgeons, Commission on Cancer.

**ABSTRACTED BY**

Record the initials of the individual completing the abstract.

## Special Instructions

1. Registry Hospitals - Record the initials or assigned code of the individual who abstracted this record. Do not code the data entry person unless that person is also the abstractor.

**GUIDELINES FOR REPORTING TEXT**

## Text Requirements

The VCR requires all records to include text information to support specified fields. The purpose of text is quality control. Text is used to validate data items, verify potential errors identified through standard edits, document clarifications, determine multiple primaries, and reconcile data item discrepancies when the same patient is submitted by several facilities. Defensive abstracting, as this documentation is often called, is an absolute necessity for quality data.

Cancer abstracting software must include specific fields designed to document text as defined by NAACCR fields. These fields must be transmitted to the VCR in addition to the other required data items when electronic shipments are prepared.

## Completion of Text Fields

Text should be complete but concise. The text fields must summarize all cancer information recorded in the medical record. Text must be completed for primary site, laterality, histology, grade, and collaborative stage or summary stage on every record. Text should be completed for pathology and other diagnostic and treatment text fields as appropriate for studies performed and treatment provided. If information is missing from the record, state that it is missing. The text fields should be used to document information that will support the accuracy of data so anyone reviewing the abstract will be able to justify the coded information.

## Amount of Text

Quality of text is more important than amount or quantity of text. The most useful text is brief, concise, and addresses pertinent issues. Often it is necessary to use abbreviations to provide adequate descriptions within the limited size of the text fields. Use standard medical abbreviations whenever possible. Refer to *VCR Manual Appendix J* for a list of VCR acceptable abbreviations. Include dates (month, day, and year) when appropriate.

Note the maximum field lengths for each text field. These lengths indicate how many characters will be transmitted to the VCR. Since your abstracting software may provide you with more characters in each of these fields, make sure the most **important information is documented at the beginning** of the text field. 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. Do not include irrelevant information. Do not repeat information from other text fields.

**TEXT-DX PROC-PE**
**Maximum Field Length - 200 characters**

Record text information from the history/physical examination that supports the diagnosis and history of the tumor as applicable.

## Source Records*:*

The history/physical examination findings may be found in, but are not limited to, the following source records:

- History and Physical Report
- Consultation Reports
- Progress Notes

## Suggestions for Text:

- Date of physical exam.
- Age, sex, race/ethnicity.
- History that relates to cancer diagnosis.
- Primary site.
- Histology (if diagnosis prior to this admission).
- Tumor location.
- Tumor size.
- Palpable lymph nodes.
- Record positive and negative clinical findings. Record positive results first.
- Impression (when stated and pertains to cancer diagnosis).
- Treatment plan.

*Examples:*

1. 5 cm mass palpated in UOQ rt breast
2. Abdominal pain, constipation
3. Enlarged lymph node in neck, fatigue
4. 35 year old white male with unexplained 30 lb weight loss.

**TEXT-DX PROC-X-RAY/SCAN**
**Maximum Field Length - 250 characters**

Record text information from diagnostic imaging reports as applicable. Document both positive and negative findings and the date(s) of the imaging result(s).

## Source Records:

The diagnostic imaging findings may be found in, but are not limited to, the following source records:

- All Diagnostic X-ray reports including mammograms and CT scans
- History and Physical Report
- Consultation Reports
- Discharge Summary

## Suggestions for Text:

- Date(s) of X-ray/Scan(s).
- Age, sex, race/ethnicity (when given).
- Primary site.
- Histology (if given).
- Tumor location.
- Tumor size.
- Lymph nodes.
- Record positive and negative clinical findings. Record positive results first.
- Distant disease or metastasis.

*Examples:*

1. 01/15/07 mammo-2 cm mass in UOQ rt breast; 01/16/07 normal CXR
2. 01/15/07 CT-abd-large mass in sigmoid colon with possible extension into pericolic fat; 01/16/07 negative bone scan
3. 01/15/07 CT-abd-diffuse adenopathy involving the retroperitoneal, periaortic, and inguinal LN
4. 1/15/07 MRI glioblastoma multiforme, WHO grade III

**TEXT-DX PROC-SCOPES**
**Maximum Field Length - 250 characters**

Record text information from endoscopic examinations as applicable. Document both positive and negative findings and the date(s) of the scope(s).

## Source Records:

The endoscopic examination findings may be found in, but are not limited to, the following source records:

- Endoscopy Reports (i.e. Bronchoscopy, Colonoscopy, Laryngoscopy, Esophagoscopy)
- History and Physical Report
- Discharge Summary
- Consultation Reports

## Suggestions for Text:

- Date(s) of endoscopic exam(s).
- Primary site.
- Histology (if given).
- Tumor location.
- Tumor size.
- Lymph nodes.
- Record positive and negative clinical findings. Record positive results first.

*Examples:*

1. Sigmoidoscopy 2/15/04-Extrinsic compression of sigmoid most likely secondary to mass
2. Sigmoidoscopy 2/15/04-Ulcerated lesion found in rectosigmoid with invasion through the serosa
3. EGD 2/1/04-5 cm constricting mass in lower esophagus with metastasis to the cervical lymph nodes

**TEXT-DX PROC-LAB TESTS**
**Maximum Field Length - 250 characters**

Record information from laboratory tests or marker studies other than cytology/histopathology that are clinically diagnostic of cancer as applicable. Document pertinent positive and negative findings and the result(s) and date(s) of these test(s).

## Source Records:

The laboratory examination findings may be found in, but are not limited to, the following source records:

- Laboratory Reports
- History and Physical Reports
- Consultation Reports

## Suggestions for Text:

- Type of laboratory test/tissue specimen(s).
- Record both positive and negative findings. Record positive test results first.
- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Date(s) of laboratory test(s).
- Tumor markers included, but are not limited to:
    - Breast Cancer: Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu.
    - Prostate Cancer: Prostatic Specific Antigen (PSA).
    - Testicular Cancer: Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH).

*Examples:*

1. 1/15/04 ER/PR studies positive
2. 1/15/04 CEA = 10.4
3. 2/01/04 Elevated WBC

**TEXT-DX PROC-OP**
**Maximum Field Length - 250 characters**

Record text information from operative reports that support the diagnosis as applicable. Document both positive and negative findings and the date(s) of the procedure(s).

## Source Records:

The operative findings may be found in, but are not limited to, the following source records:

- Operative Reports
- Consultation Reports

## Suggestions for Text:

- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived.
- Number of lymph nodes removed.
- Size of tumor removed.
- Documentation of residual tumor.
- Evidence of invasion of surrounding areas.

*Examples:*

1. MRM 2/1/04-Firm 3 cm mass excised from rt UOQ
2. Hemicolectomy 2/15/04-No metastatic nodules noted in liver
3. Exp Lap 2/1/04-Tumor arising from ileum and enlarged spleen consistent with lymphoma
4. Mastectomy 2/22/04- 3 out of 12 lymph nodes found to have metastasis

**TEXT-DX PROC-PATH**
**Maximum Field Length - 250 characters**

Record text from cytology and histopathology reports to support the final pathologic diagnosis. Include all descriptive terms from the histology or cytology report to describe the specific diagnosis including nouns, adjectives, and phrases. Also include differential diagnoses, documentation to support unusual site/histology combinations, notes, comments, addenda, and results of consults and second opinions. Record the final diagnosis from slide reviews if applicable.

Either *Text-Histology Title* or *Text-Dx Proc-Path* must be completed on each record. Information to support the exact diagnosis has to appear in one of these two fields. *Text-Histology Title* is a 40 character field generally used to record clinical or other non pathologic diagnoses; *Text-Dx Proc-Path* is a 250 character field generally used to record histologically and cytologically confirmed diagnoses from pathology reports.

This field should also include text to support multiple primaries diagnosed simultaneously and discrepancies between pathology reports. For example, if a definitive surgery pathology report has a more specific or differing diagnosis than the biopsy report, document the physician's final diagnosis. Include text to clarify site and/or histology information for cases discussed at Cancer Conference, especially if the site was unknown.

## Terminology

If the reporting facility considers the terminology of severe dysplasia or high grade dysplasia of the colon as synonymous with carcinoma in-situ, follow the procedure described in *VCR Manual Part Three, Behavior*. Include text in this field to support the final pathologic diagnosis along with the statement "in-situ per pathologist". If any colon cases diagnosed with severe dysplasia and/or high grade dysplasia are submitted to the VCR without the text documentation "in-situ per pathologist", the cases will either not be entered in the VCR database or they will be deleted since the terminology alone is not reportable.

Mixed or multiple histologies may have documentation of various phrases describing the tumor. When documenting the description of the tissue, include the terminology type in the description. These terms are important because they impact the ICD-O code assignment.

- **Principal Tumor Type** - Phrases such as "predominantly" and "with features of" are often used to identify the principal tumor type. Use this information when recording text to support the histologic diagnosis.

- **Non-Principal Tumor Type** - The phrases "with foci of", "areas of" or "elements of" do not describe the majority of the tumor. These terms should be included in text even though they are not used to code the histologic type.

## Source Records*:*

The pathology findings may be found in, but are not limited to, the following source records:

- Pathology and Cytology Reports
- Slide Consultation Reports
- Autopsy Reports

**TEXT-DX PROC-PATH, continued**
**Maximum Field Length - 250 characters**

## Suggestions for Text:

- Date(s) of procedure(s).
- Type of tissue specimen(s).
- Tumor type and grade (include all modifying adjectives (i.e., predominantly, with features of, with foci of, elements of, etc.).
- Gross tumor size.
- Extent of tumor spread.
- Involvement of 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.

*Examples:*

1. Poorly diff infiltrating duct and tubular carcinoma
2. Thyroidectomy specimen yields 8mm mass in RUL
3. Stains positive for mucin producing adenocarcinoma
4. Transitional cell Ca with foci of squamous differentiation
5. Negative bone marrow
6. Tumor directly extends into the trachea
7. 2 out of 10 peribronchial lymph nodes examined are positive on biopsy
8. Positive brain metastasis
9. Meningioma, WHO grade I

**TEXT-PRIMARY SITE TITLE**
**Maximum Field Length - 40 characters**

Record text describing the primary site including subsite information. Always document laterality when the site is paired. Refer to the listing of Paired Sites in *VCR Manual Part Three, Laterality. Text-Primary Site Title* must be completed on each record.

## Source Records:

The primary site and laterality may be found in, but are not limited to, the following source records:

- Pathology Report
- Operative Report
- Xrays/Scans
- Discharge Summary
- Consultation Reports

## Suggestions for Text:

- Include information on the location of the primary site of the tumor.
- Include available information on tumor laterality.

*Examples:*

1. Rt breast, UOQ
2. Sigmoid Colon
3. Cervical and Inguinal LNs
4. R Frontal Lobe of Brain

**TEXT-HISTOLOGY TITLE**
**Maximum Field Length - 40 characters**

Record text to support the patient's final diagnosis: clinical, other non pathologic diagnosis, or histologic diagnosis including cell type, behavior, and grade.

Either *Text-Histology Title* or *Text-Dx Proc-Path* must be completed on each record. Information to support the exact diagnosis has to appear in one of these two fields. *Text-Histology Title* is a 40 character field generally used to record clinical or other non pathologic diagnoses; *Text-Dx Proc-Path* is a 250 character field generally used to record histologically and cytologically confirmed diagnoses from pathology reports.

## Source Records*:*

The histologic diagnosis may be found in, but is not limited to, the following source records:

- Pathology and Cytology Reports
- History and Physical Report
- Discharge Summary
- Consultation Reports
- Slide Consultation Reports

## Suggestions for Text:

- Information on histologic type and behavior.
- Information on differentiation from scoring systems such as Gleason's Score, Bloom-Richardson, Grade, etc.

*Examples:*

1. Ductal Ca w/ lobular features, well diff
2. Moderately to poorly diff Adenoca
3. Diffuse large B-cell lymphoma
4. Cancer

**TEXT-STAGING**
**Maximum Field Length - 300 characters**

Record text to support any Collaborative Stage data items not already supported in other text fields (see *VCR Manual Part Three, Data Item Instructions, Collaborative Stage*). This field can also be used to continue Collaborative Stage text from another field.

*Example*: The only information available is the TNM stage, record *Physician stated this case is a T1N1MO*.

Record text information to support the Summary Stage code assigned according to *SEER Summary Stage 2000* (SS2000) or *SEER Summary Stage 1977* (SS77) when applicable (see *VCR Manual Part Three, Data Item Instructions, SEER Summary Stage*). Document the extension of the disease that justifies the Summary Stage based on imaging studies, lab tests, scopes, and operative procedures performed. Also include both positive and negative findings and appropriate dates not already recorded in other *Text-DX* fields. If information is not sufficient to support a specific Summary Stage code, record *unknown* in this field.

## Source Records:

Information to determine Collaborative Stage data items and Summary Stage may be found in, but is not limited to, the following reports:

- Pathology Reports
- Operative procedures
- X-Rays/Scans
- Scopes
- Lab Tests
- Discharge Summary
- Consultations

## Suggestions for Text:

- Date(s) of procedure(s), including clinical procedures that provided information for assigning stage.
- Organs involved by direct extension.
- Size of tumor.
- Status of margins.
- Number and sites of positive lymph nodes.
- Site(s) of distant metastasis.
- Physician’s comments.

**TEXT-STAGING, continued**
**Maximum Field Length - 300 characters**

*Examples:*

1. Work up and initial treatment for prostate primary included lung scan, bone scan, and CT/Pelvis. Based on these procedures, the Summary Stage is determined to be *Distant,* code 7. Document the following in the appropriate text fields:

   *Text-Dx Proc-X-ray/Scan:* Bone Scan 1/15/07-mets to pelvis; Lung scan 1/20/07 no evidence of metastatic disease; CT/Pelvis-1/15/07-positive iliac adenopathy

   *Text-Staging:* Pelvic bone mets

2. Diagnosis of lymphoma and workup included CT scans and a bone marrow biopsy. Based on these procedures, the Summary Stage is determined to be *Regional NOS*, code Document the following in the appropriate text fields:

   *Text-Dx Proc-X-ray/Scan:* CT scans 1/15/74-mediastinal and axillary LN suspicious for lymphoma, no pelvic or retroperitoneal adenopathy

   *Text-Dx Proc-Path:* Bone marrow 2/01/07 negative

   *Text-Staging:* Multiple LN regions above diaphragm

3. If the only documentation is that the patient was diagnosed two years ago and now is admitted in January 2007 for treatment of recently discovered bone metastases, record:

   *Text-Staging:* unknown at initial dx, bone mets 1/07

**RX TEXT-SURGERY**
**Maximum Field Length - 150 characters**

Record all surgical procedures, including dates, performed as first course of treatment as applicable. Surgical procedures used to treat regional lymph nodes and other regional and/or distant sites as first course of treatment should be documented. If applicable, text should also be included to describe the number of regional lymph nodes examined as part of the first course of treatment.

## Source Records:

The surgical procedure information may be found in, but is not limited to, the following source records:

- Operative Reports
- Discharge Summary
- Consultation Reports
- History and Physical Report

## Suggestions for Text:

- Date of each procedure
- Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites
- Lymph nodes removed
- Regional tissues removed
- Metastatic sites
- Facility where each procedure was performed
- Record positive and negative findings; record positive findings first

*Examples:*

1. 01/15/07 Rt lumpectomy; 1/25/07 Rt MRM with LND (10 LN removed)
2. 01/15/07 Rt hemicolectomy with LND (12 LN removed) & wedge resection of liver
3. 01/15/07 Excision of cervical LN

**RX TEXT-RADIATION (BEAM)**
**Maximum Field Length - 150 characters**

Record all beam radiation, including dates, given as first course of treatment as applicable.

## Source Records:

The radiation information may be found in, but is not limited to, the following source records:

- Radiation Records or treatment letters
- Discharge Summary
- Consultation Reports

## Suggestions for Text:

- Date when radiation treatment began
- Where treatment was given (e.g., at this facility, at another facility)
- Type(s) of beam radiation (e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities)
- Other treatment information (e.g., patient discontinued after five treatments; unknown if radiation was given)

*Examples:*

1. Began 01/15/04, 6000 cGy, 30fx
2. Radiation planned, patient refused
3. None

**RX TEXT-RADIATION OTHER**
**Maximum Field Length - 150 characters**

Record all other radiation, including dates, given as first course of treatment as applicable.

## Source Records*:*

The other radiation treatment may be found in, but is not limited to, the following source records:

- Radiation logbooks or treatment letters
- Discharge Summary
- Consultation Reports

## Suggestions for Text:

- Date treatment was started
- Where treatment was given (e.g., at this facility, at another facility)
- Type(s) of non-beam radiation (e.g., High Dose rate brachytherapy, seed implant, Radioisotopes [I-131])
- Other treatment information (e.g., unknown if radiation was given)

*Examples:*

1. None
2. 01/15/04 Brachytherapy
3. 01/15/04 Iodine-131 at Cancer Radiation Center

**RX TEXT-CHEMO**
**Maximum Field Length - 200 characters**

Record all chemotherapy, including dates, administered as first course of treatment as applicable.

## Source Records*:*

The chemotherapy treatment information may be found in, but is not limited to, the following source records:

- Chemotherapy logbooks or treatment letters
- Discharge Summary
- Consultation Reports
- History and Physical Report

## Suggestions for Text:

- Date when chemotherapy began
- Where treatment was given (e.g., at this facility, at another facility)
- Type of chemotherapy (e.g., name of agent(s) or protocol)
- Other treatment information (e.g., treatment cycle incomplete, unknown if chemotherapy was given)

*Examples:*

1. 01/15/07 Cisplatin & VP16 started, failed after 3 mths; Carboplatin & Taxol started
2. 01/15/07 5 FU started
3. 01/15/07 CHOP started at Cancer Treatment Center.

**RX TEXT-HORMONE**
**Maximum Field Length - 200 characters**

Record all hormone therapy, including dates, administered as first course of treatment as applicable.

## Source Records:

The hormone therapy information may be found in, but is not limited to, the following source records:

- Discharge Summary
- Consultation Reports
- History and Physical Report

## Suggestions for Text:

- Date treatment was started
- Where treatment was given (e.g., at this facility, at another facility)
- Type of hormone or antihormone (e.g., Tamoxifen)
- Type of endocrine surgery or radiation (e.g., orchiectomy)
- Other treatment information (e.g., treatment cycle incomplete; unknown if hormones were given)

*Examples:*

1. 01/15/07 Tamoxifen prescription given to pt; unknown if filled
2. 01/15/07 Prednisone started as part of CHOP regimen

**RX TEXT-BRM**
**Maximum Field Length - 100 characters**

Record biological-response modifier treatment, including dates, administered as first course of therapy for cancer as applicable. This is also referred to as immunotherapy.

## Source Records:

The biological-response modifier treatment information may be found in, but is not limited to, the following source records:

- Discharge Summary
- Consultation Reports
- History and Physical Report

## Suggestions for Text:

- When treatment was given (e.g., at this facility; at another facility)
- Type of BRM agent (e.g., Interferon, BCG)
- BRM procedures (e.g., bone marrow transplant, stem cell transplant)
- Other treatment information (e.g., treatment cycle incomplete; unknown if BRM was given)

*Examples:*

1. 01/15/07 Levamisole started
2. 01/15/07 Stem cell transplant done at University Hospital.
3. 01/15/07 Interferon started

**RX TEXT-OTHER**
**Maximum Field Length - 100 characters**

Record all other treatment, including dates, performed as first course of treatment as applicable.

## Source Records:

Other treatment may be found in, but is not limited to, the following source records:

- Discharge Summary
- Consultation Reports
- History and Physical Reports

## Suggestions for Text:

- Date treatment was started
- Where treatment was given (e.g., at this facility, at another facility)
- Type of other treatment (e.g., blinded clinical trial, hyperthermia)
- Other treatment information (e.g., treatment cycle incomplete; unknown if other treatment was given)

*Examples:*

1. 01/15/04 hyperbaric oxygen started at General Hospital
2. 01/15/04 PUVA
3. None

**TEXT-REMARKS**
**Maximum Field Length - 350 characters**

- Record text information not elsewhere provided for or as an overflow from other text fields. The following information should be included in this field as applicable to the case:

- Document the site, laterality if applicable, histology, and date of diagnosis for all known previous primaries.

- Document text to explain any unusual or potentially questionable entry on the abstract. This will reduce the need to re-pull medical records at a later date.

- Document text to note particular issues or clarifications that were resolved prior to completion of the abstract. For example, clarifications made with a physician through quality assurance studies.

## Source Records*:*

Information for this field may be found in, but is not limited to, the following source records:

- History and Physical Report
- Pathology Reports
- Discharge Summary
- Consultation Reports
- Cancer Conference Documentation

## Suggestions for Text:

- Personal history of cancer.
- Comorbidities.
- Information on sequence numbers if a person was diagnosed with another cancer out-of-state or before the registry's reference date.
- Justification for unusual site/histology combinations.

*Examples:*

1. Simultaneous tumors: mucinous adenoCA of sigmoid invading pericolic fat, 2/15 + LN and adenoCA of cecum with lamina propria invasion
2. Primary site determined at Cancer Conference upon review of clinical presentation and diagnostic evaluation
3. Hx of thyroid cancer diagnosed in 1992 in New York.
4. Hx of benign meningioma 2003

**PLACE OF DIAGNOSIS**
**Maximum Field Length - 50 characters**

Record text to indicate the facility, city, state or country where the diagnosis was made. This data item is required only when the patient was not diagnosed at the reporting facility.

## Source Records*:*

Information for this field may be found in, but is not limited to, the following source records:

- Admission record
- History and Physical Report
- Consultation Reports

## Suggestions for Text:

- Record the complete name of the hospital or the physician office where the diagnosis occurred. The initials of the hospital are not adequate.

- For out-of-state residents and facilities, include the city and state where the medical facility is located.

*Examples*:

1. University General Hospital, Anytown, MD
2. Medical Center of London, England

## HIV/AIDS

Record whether the patient has HIV/AIDS.

| CODE | DEFINITION |
|---|---|
| 0 | No evidence of HIV/AIDS diagnosis |
| 1 | Evidence of HIV/AIDS diagnosis |
| 9 | Unknown if any HIV/AIDS diagnosis |

## DIOXIN EXPOSURE

Record whether the patient has had dioxin (agent orange) exposure.

| CODE | DEFINITION |
|---|---|
| 0 | No evidence of dioxin exposure |
| 1 | Evidence of dioxin exposure |
| 9 | Unknown if any dioxin exposure |

## VIETNAM VETERAN

Record the patients' Vietnam service status.

| CODE | DEFINITION |
|---|---|
| 0 | Patient is not a Vietnam veteran |
| 1 | Patient is a Vietnam veteran |
| 9 | Unknown if the patient is a Vietnam veteran |

## TOBACCO HISTORY

Record the patient's history of tobacco use.

| CODE | DEFINITION |
|---|---|
| 0 | Never used |
| 1 | Cigarette smoker, current |
| 2 | Cigar/pipe smoker, current |
| 3 | Snuff/chew/smokeless, current |
| 4 | Combination use, current |
| 5 | Previous use |
| 9 | Unknown |

## NUMBER OF YEARS SMOKED

Record the number of years the patient smoked.

| | |
|---|---|
| 00 | Not applicable |
| 01 | Patient smoked one year |
| 02 | Patient smoked two years |
| … | Record the actual number of years the patient smoked |
| 99 | Unknown number of years smoking |

## ALCOHOL HISTORY

Record the patient's alcohol use

| CODE | DEFINITION |
|---|---|
| 0 | No alcohol use |
| 1 | Patient uses alcohol |
| 9 | Unknown if patient uses alcohol |

## FAMILY HISTORY

Record whether the patient has a family history of any cancer.

| CODE | DEFINITION |
|---|---|
| 0 | No family history of cancer |
| 1 | Positive family history of cancer |
| 9 | Unknown if patient has a family history of cancer |

## BREAST MAMMOGRAM

Record the result of the patient's mammogram; for BREAST primary cancers only.

| CODE | DEFINITION |
|---|---|
| 0 | Mammogram NOT DONE |
| 1 | Mammogram indicative of cancer |
| 2 | Mammogram shows no indication of cancer |
| 3 | Mammogram was borderline, unable to determine if positive or negative |
| 8 | Ordered but results are unknown |
| 9 | Unknown if test was ordered |

## BREAST - S-phase

Record the S-phase as documented in the pathology report; for BREAST primary cancers only

| CODE | DEFINITION |
|---|---|
| 0 | S-phase NOT DONE |
| 1 | Result elevated |
| 2 | Result normal |
| 8 | Ordered but results are unknown |
| 9 | Unknown if test was ordered |

## BREAST - DNA PLOIDY

Record the DNA ploidy as documented in the pathology report; for BREAST primary cancers only.

| CODE | DEFINITION |
|---|---|
| 0 | Ploidy NOT DONE |
| 1 | Aneuploid |
| 2 | Diploid |
| 8 | Ordered but results are unknown |
| 9 | Unknown if test was ordered |

**SYSTEM CODES**
**(Electronic Reporting Hospitals Only)**

System codes reflect types of coding systems used, record processing dates, and other information regarding how the data were collected. These codes are required to be transmitted on cases submitted electronically. System codes are added to cases submitted on the VCR Report Form at the time of data entry at the VCR.

1. Registry Hospitals- Registry hospitals using commercial or hospital-developed software are responsible for making sure the correct system codes are submitted. Since most are computer generated, the registrar must communicate problems in complying with VCR code requirements to software vendors or facility Information Systems personnel.

## Required Codes and Definitions

| VCR Required Data Item | NAACCR Item # | VCR Specific Instructions |
|---|---|---|
| Record Type | 0 | Must always contain "**A**" for *Full case abstract type, including text data item;* length=5966. |
| Registry Type | 30 | Allowable codes: "**2**" for central registry or hospital consortium (not population based); and "**3**" for single hospital/freestanding center. |
| FIN Coding System | 35 | Must always contain "**2**" for COC FIN 10-digit codes. |
| NAACCR Record Version | 50 | Must always contain "**B**" for 2003 version (Version V11). |
| Race Coding Sys—Current | 170 | Must always contain "**6**" indicating 2000+ SEER & COC. |
| Site Coding Sys—Current | 450 | Cases diagnosed on or after 01/1/2001 must always contain "**5**" for ICD-O-3; cases diagnosed before 1/1/2001 must always contain "**4**" for ICD-O-2; cases with an unknown *Date of Diagnosis* (99999999) and *Date of 1st Contact* on or after 01/01/2001 must always contain **"5"** for ICD-O-3; cases with an unknown *Date of Diagnosis* (99999999) and *Date of 1st Contact* prior to 01/01/2001 must always contain **"4"** for ICD-O-2. |
| Morph Coding Sys—Current | 470 | Cases diagnosed on or after 01/1/2001 must always contain "**7**" for ICD-O-3; cases diagnosed before 1/1/2001 must always contain "**6**" for ICD-O-2 plus REAL and FAB codes; cases with an unknown *Date of Diagnosis* (99999999) and *Date of 1st Contact* on or after 01/01/2001 must always contain **"7"** for ICD-O-3; cases with an unknown *Date of Diagnosis* (99999999) and *Date of 1st Contact* prior to 01/01/2001 must always contain **"6"** for ICD-O-2 plus REAL and FAB codes. |
| RX Coding Sys—Current | 1460 | Must always contain "**06**" for *Treatment data coded according to FORDS.* |

**SYSTEM CODES, continued**
**(Electronic Reporting Hospitals Only)**

## Required Codes and Definitions, continued

| VCR Required Data Item | NAACCR Item # | VCR Specific Instructions |
|---|---|---|
| Date Case Completed | 2090 | Must contain the date abstract first passed all edits applied. 99 is not acceptable in any portion of the date. |
| Date Case Last Changed | 2100 | Contains the latest date the case was modified after completion at the reporting facility. |
| Date Case Report Exported | 2110 | Must contain the date the reporting facility exported the electronic abstract to a file for transmission to the central registry. 99 is not acceptable in any portion of the date. |
| ICD-O-3 Conversion Flag | 2116 | Cases diagnosed on or after 1/1/2001 must contain "**0**" for *Primary site and morphology originally coded in ICD-O-3.* |
| COC Coding Sys—Current | 2140 | Cases diagnosed on or after 1/1/2003 must contain "**08**" for *FORDS.* Cases diagnosed prior to 1/1/2003 must contain "**07**" for *ROADS and 1998 supplement.* |
| Vendor Name | 2170 | *Commercial Software*: name and version number must always be included; *Hospital-Developed Software*: must always enter "HOSP" for name followed by version number or month/year system was developed or last modified; *AbstractPlus*: will contain name and version number as specified by the VCR. |

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# PART FOUR:
# QUALITY CONTROL

# QUALITY CONTROL

The purpose of cancer data collection varies with the type and goals of the registry. The primary goal of hospital-based cancer registries is the improvement of patient care, and the primary goal of non-registry hospitals is to provide data to the central cancer registry. The primary objective of the central or population-based incidence registries is the determination of cancer rates and trends in the population. Whether data are reported to the Virginia Cancer Registry (VCR) or reported by the VCR, there is a universal need for the data collected in any type of registry to be of the highest quality.

Quality can be defined as fitness for use. To assure data are of sufficient quality for use in meeting registry goals, quality control must be an integral component of the data collection system. Quality control involves the systematic execution of a carefully planned set of activities to monitor data quality and take appropriate action to positively affect future quality.

Activities and procedures to assure data quality should focus on three areas: completeness, accuracy and timeliness. Completeness refers to both case ascertainment and data collection; completeness is achieved when all cases are found and all the necessary data are collected for each case. Accuracy refers to how well the abstracted data reflect the patient's diagnosis and treatment. Timeliness measures how the abstracting and reporting process are accomplished according to an expected schedule.

Evaluation of completeness, accuracy, and timeliness is the first step in quality control. To be effective, the registry's quality control plan must also involve a continuous loop of monitoring, communication, and feedback.

The following two sections describe various strategies used by reporting facilities and the VCR to assure data are as complete, accurate and timely as possible. The activities described for reporting facilities will enhance compliance with VCR reporting standards. Since communication and feedback are essential to the success of any quality control program, the major quality control procedures used by the VCR are described in order for hospital contacts to more fully understand the rationale for VCR requirements as well as verbal and written requests and questions made by the VCR.

**QUALITY CONTROL: REPORTING FACILITIES**

Reporting facilities must insure cancer data collected and submitted to the VCR are complete, accurate, and timely. Although some facilities may incorporate additional activities to assure quality, at a minimum, all facilities must include the following procedures to meet VCR reporting requirements and standards.

## Completeness

1. Casefinding Sources - All areas where cancer patients are diagnosed or treated must be included in the casefinding system. This includes outpatient treatment areas, e.g., Radiation Therapy, Chemotherapy, Same Day Surgery Units, and the Emergency Room. Review of pathology reports, including private outpatient specimens and autopsy reports, must be included in casefinding.

2. Disease Index - Review of a Disease Index should be performed to verify all reportable cases are submitted to the VCR. If performed monthly, this review will simplify the annual reconciliation procedure (See *VCR Manual Part Four, Quality Control: VCR*) and aid in timeliness of reporting.

3. Transmission Verification - Facilities should check completeness of transmissions as follows:

   a. Check Totals: Verify the number of cases transmitted equals the number received by the VCR as indicated on the report entitled, *Confirmation of Records Received by the Virginia Cancer Registry* , which is the report facilities receive back after the VCR has processed a shipment. Resolve the discrepancies or contact your VCR Field Representative.

   b. Maintain Listings: : Keep in the facility's Policy and Procedure manual a copy of all *Confirmation of Records Received by the Virginia Cancer Registry* reports, as verification of records received by the VCR. Retention for at least five years is strongly recommended; however, if space is limited, maintaining copies until your facility has had a VCR Quality Assessment Review for that specific year would be an acceptable alternative.

   c. Compare Listings: Compare the names on the *Accession List* report, a report periodically provided by the VCR in order to reconcile the accession year, against your transmitted list, generated based upon the same criterion. If there are differences in the lists, resolve the discrepancies or contact your VCR Field Representative. Submit any missed cases identified by this process.

4. Required Fields - All data items required by the VCR must be submitted for each record. For a listing of these items, refer to *VCR Manual Appendix K, Required Data Set for Reporting Facilities.* Entries for each required data item must include specific demographic, diagnostic and treatment information that accurately reflects what is documented in the health record.

**QUALITY CONTROL: REPORTING FACILITIES, continued**

## Accuracy

1. Text Fields - The *Required Data Set for Reporting Facilities* includes text fields (See *VCR Manual Appendix K, Required Data Set for Reporting Facilities*). The reason for requiring text is to enhance data accuracy. These fields give hospitals the ability to convey information to validate data items, document clarifications, reconcile data item discrepancies, support unusual site/histology combinations, provide history of previous cancers/reportable tumors, and explain any unusual or potentially questionable entry on the abstract. Required text information must be recorded in the designated text fields. (See also *VCR Manual Part Three, Data Item Instructions, Guidelines for Reporting Text).*

2. Computer Edits - Computer edits should be an integral component of any electronic abstracting system. These edits should check for completion of all required fields, allowable values and ranges, and interfield consistency. Edit checks should be performed on each completed abstract. Abstracts should be re-edited if any changes are made.

3. Visual Editing - The completed abstract should be visually reviewed to identify errors not detectable by the computer. Inconsistencies among data items could be identified when comparing text to coded items, e.g., stage coded to local with text indicating lymph node involvement.

4. Physician Input - Physicians should serve as resources to the abstractor. They should be consulted when questions arise during abstracting. Physician input may assist in identifying a primary site or provide clarification of conflicting statements or reports in the health record. Documentation of the physician input should be included in the text to support abstracted data.

**QUALITY CONTROL: REPORTING FACILITIES, continued**

## Timeliness

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

2. VCR Deadline - The first working day in July is the deadline for submitting all reportable cases seen at the reporting facility during the previous year.

3. VCR Reporting Schedule - This schedule should be followed to assure abstracts are received by the VCR within the required 180 days.

| Cases with a Date of Inpatient Disch/Date of 1st Contact in: | Mail on or before the 5th of: |
|---|---|
| January | June of same year |
| February | July of same year |
| March | August of same year |
| April | September of same year |
| May | October of same year |
| June | November of same year |
| July | December of same year |
| August | January of following year |
| September | February of following year |
| October | March of following year |
| November | April of following year |
| December | May** of following year |

*Example 1:* All cases with a Date of Inpatient Disch/Date of 1st Contact on or between January 1 and January 31, 2007 must be received on or before June 5, 2007.

*Example 2*: All cases with a Date of Inpatient Disch/Date of 1st Contact on or between December 1 and December 31, 2007 should be received on or before May 5, 2008

** The VCR deadline has not changed. The weeks between May 5th and July 5th should be used to perform Quality Assurance procedures to ensure all cases for the year have been identified and reported. These cases may fall into the 10% over 180 days. This is expected and acceptable.

*Note:* This schedule should be used by reporting facilities as a guideline to assess timeliness of reporting but will not be used by the VCR to determine exact timeliness rates for reporting facilities. Reports provided by the VCR will show specific timeliness rates based on the number of days from *Date of Inpatient Disch* or *Date of 1st Contact* and the date the abstract was received by the VCR.

**QUALITY CONTROL: REPORTING FACILITIES, continued**

4. Incomplete and Suspense Cases - At a registry hospital, after identifying a potential case for the registry from a casefinding source, cases unable to be completely abstracted may be placed in an electronic suspense file. A system should be in place to monitor these cases so they are completed and reported to the VCR in a timely manner. A case will not export out of AbstractPlus if it is incomplete.

5. Method to Assure Timeliness - Review the Disease Index monthly using the reporting schedule as a guide to verify all reportable cases have been submitted within the 180-day timeframe.

**QUALITY CONTROL: VCR**

Quality control activities are conducted by the VCR to assure data in the central registry are complete, accurate, and timely. These activities fall into three categories: 1) internal procedures as data are processed, 2) on-site quality assessment reviews, and 3) trainings conducted by VCR staff or in conjunction with other organizations. These three major aspects of the VCR quality control program are described below.

## Internal Quality Control Procedures

The quality control procedures described below are performed by the VCR routinely to enhance the quality of cancer data in the central cancer registry.

1. Completeness

   a. VCR Reporting Sources - The VCR establishes reporting from sources required to report and reporting through state data exchange agreements to assure all reportable cases are received. The VCR reporting sources (See *VCR Manual Part One, Reporting Requirements, VCR Reporting Sources)* include the following:

      - Acute Care Hospitals
      - Laboratories
      - Non Hospital Sources
      - States with Data Exchange Agreements

   b. Non-Reporting - All hospitals are required to submit on or before the 5th of every month or the last working day before the 5th if the 5th falls on a weekend or holiday. A listing of hospitals that have not submitted for two consecutive months is generated monthly at the VCR. A VCR Cancer Surveillance Specialist contacts hospitals appearing on this list and appropriate action is taken.

**QUALITY CONTROL: VCR continued**

c. Reconciliation - An annual comparison is made of each hospital's Disease Index with the VCR database to assure all cases have been reported. Each hospital receives a listing of cases identified as not being reported to the VCR with instructions to review each record to determine if the case is reportable. Cases missed, but now identified, must be reported. Cases that are not reportable must have justification documented on the listing explaining why the case is not reportable. Missed cases and listings must be returned to the VCR by the specified deadline.

d. Death Clearance - The VCR conducts a Death Clearance procedure annually. This process involves identifying Virginia Death Certificates with a reportable cause of death and matching them to the VCR files. Non-matched death certificates are potentially missed cases. Hospital contacts receive a listing of non-matched patients who expired at their hospital to determine if they were reportable. Missed cases must be reported. Cases that were not reportable must have justification documented on the listing. Missed cases and listings must be returned to the VCR by a specified deadline. At the conclusion of this process, the remaining non-matched cases are reviewed and may be abstracted at the VCR from the death certificates and defined as Death Certificate Only (DCO) cases. A DCO percentage (the number of DCO cases divided by the total number of incidence cases for that year) is computed. The VCR DCO percentage is measured against the North American Association of Central Cancer Registries (NAACCR) DCO standard, which states a registry should have fewer than 5% DCO's in a given year of incidence cases.

2. Accuracy

a. Computer Edits - Computer edits are performed on 100% of abstracts and consolidated records. The VCR utilizes a combination of North American Association of Central Cancer Registries (NAACCR), Surveillance, Epidemiology and End Results Reporting Program (SEER), National Program of Cancer Registries (NPCR), and Commission on Cancer (COC) edits from the NAACCR metafile with VCR-developed edits added. These edits check for completion of all required fields, allowable ranges, allowable values, and interfield consistency. They check for invalid entries such as impossible site/histology combinations or flag unusual entries for review. VCR Cancer Surveillance Specialists follow-up with hospital contacts and provide feedback on errors found.

b. Visual Editing - Records are reviewed for consistency between coded data items and text documentation. This type of review is performed to detect discrepancies not detectable by the computer. VCR Cancer Surveillance Specialists provide hospital contacts with feedback on these reviews.

c. Electronic Reporting Approvals - An approval process is required for facilities newly reporting electronically, new contacts, hospital software changes, and updated North American Association of Central Cancer Registries (NAACCR) formats. (See *VCR Manual Appendix C, Electronic Reporting* for detailed instructions.) Hospital shipments are monitored and VCR Cancer Surveillance Specialists provide feedback to hospital contacts until acceptable accuracy is achieved.

d. Unknown Values - The frequency of *"unknown"* or code for unknown in data items, such as age at diagnosis, sex, race, state, and county is monitored and follow-up is performed to eliminate as many unknowns as possible. Virginia cancer reporting regulations that the Virginia Board of Health establishes requires personally identifying information.

**QUALITY CONTROL: VCR, continued**

e. Resolution of Duplicates - To assure accuracy of incidence statistics, an incidence file containing all cases for a specified time period is created and a report is generated listing all cases alphabetically by last name. Cases with the same name are identified. Those determined to be the same person are then reviewed manually to determine whether they represent multiple primaries or duplications. While cases determined to be duplicates are deleted from the file, source records are retained and attached to the appropriate tumor in the VCR database.

3. Timeliness

a. VCR Timeliness Standard - At least 90% of the records must be received by the VCR within 180 days from *Date of Inpatient Disch* if an inpatient or *Date of 1st Contact* if an outpatient.

b. Closeout Deadline -The first working day closest to July 5th is the deadline for submitting all reportable cases diagnosed/treated in the prior year.

c. Closeout Notification - Hospitals are notified annually of the closeout deadline and requested to notify the VCR when they anticipate closing out. Failure to meet the July deadline results in referral of the hospital to the Department of Health, Bureau of Facility Licensure and Certification.

## On-Site Quality Assessment Review

Quality Assessment Reviews are routinely conducted at hospitals. Hospitals are scheduled for a review when certain criteria are met, such as unsatisfactory results from previous review, inability to perform annual reconciliation, reporting problems, and time lapse since last review. The reviews are designed to determine the quality of reporting to the VCR. During the review, casefinding completeness, data quality and timeliness of reporting are evaluated by VCR Cancer Surveillance Specialists.

1. Notification of Quality Assessment Review- Hospitals receive a scheduling letter one month prior to the date of review. The scheduling letter includes:

a. Date and time of the review

b. *Hospital Index Verification* list of patients included on the hospital's Disease Index not reported to the VCR (Index from previous year's reconciliation is used)

c. Request to have autopsy reports from the year being reviewed available the day of the review

d. *Data Quality Evaluation* list of randomly selected cases reported to the VCR within the last twelve months that will be reabstracted by a VCR Cancer Surveillance Specialist

e. Request for private area with adequate work space for the VCR Cancer Surveillance Specialist

*Note:* If a hospital did not submit a Disease Index during the reconciliation procedure, it will receive the scheduling letter two months prior to the review. The hospital has three weeks from the date of the letter to submit a Disease Index to the VCR.

## QUALITY CONTROL: VCR, continued

2. Hospital Preparation for a Quality Assessment Review- Hospitals must have the following available the day of the review:

   a. Health records for the patients on the *Hospital Index Verification* list. The patient's complete health record must be pulled including all inpatient and outpatient records.

   b. Autopsy reports for the year being reviewed.

   c. Health records and copies of corresponding abstracts for all the cases on the *Data Quality Evaluation* list. All admissions used to abstract the case must be pulled. *Note*: Additional health records may be requested on the day of review.

3. On Site Review Process- The VCR Cancer Surveillance Specialists will evaluate the following during their visit:

   a. Casefinding Completeness- The first component of the quality assessment review is the casefinding audit. The audit is a review and evaluation of the effectiveness of a facility's casefinding mechanisms used in submitting reportable cases to the VCR. The objective of the audit is to determine whether all reportable records are being identified and submitted to the VCR to insure VCR data accurately reflect cancer incidence in Virginia.

      The VCR Cancer Surveillance Specialist reviews the health records (and/or cancer registry files, if applicable) from the *Hospital Index Verification* list to determine if these records are reportable and to identify any weaknesses or trends in a hospital's casefinding procedures. The autopsy reports are reviewed to insure all autopsy reports with a reportable condition have been reported to the VCR, including incidental findings.

      If not included in the Disease Index, pathology, cytology, autopsy, chemotherapy, radiation therapy, and other outpatient clinic information and related health records are reviewed to insure the reporting of eligible records from these sources.

      The results of the casefinding audit are defined in terms of a completeness rate. The completeness rate indicates the percentage of reportable records submitted by the hospital to the VCR. The VCR acceptable completeness rate is 97 to 100%.

   b. Data Quality- The second component of the quality assessment review is a reabstracting study to evaluate data quality. Reabstracting compares the information in the health record to the previously abstracted data to determine the accuracy and completeness of the data. The VCR Cancer Surveillance Specialist reabstracts the cases on the Data Quality Evaluation list to identify any inaccurate information or misunderstandings of reporting guidelines.

      The results of the reabstracting study are defined in terms of an accuracy rate. The accuracy rate indicates the percentage of data items reported correctly. The VCR standard for data quality is an accuracy rate of 97 to 100%.

**QUALITY CONTROL: VCR, continued**

c. Timeliness**-** The third component of the quality assessment review is timeliness of reporting. For the VCR to provide timely statistics and reports, facilities must submit data in a timely manner.

   The timeliness standard established by the VCR to monitor hospital reporting requires at least 90% of the hospital's records be received by the VCR within 180 days from *Date of Inpatient Disch* if an inpatient or *Date of 1st Contact* if an outpatient. To evaluate timeliness, the VCR Cancer Surveillance Specialist uses reports generated by the VCR and assessment of cases currently being abstracted based on the reporting schedule (See *VCR Manual, Quality Control, VCR Reporting Schedule*).

d. Summation- At the conclusion of the review, the VCR Cancer Surveillance Specialist discusses findings and recommendations with appropriate hospital personnel during a summation conference. This provides the VCR Cancer Surveillance Specialist the opportunity to provide feedback relative to areas of compliance and concern. It also enables hospital personnel to be aware of the results of the review and ask questions regarding the findings and recommendations.

e. Quality Assessment Review Report-The VCR sends a written report documenting findings, problems, recommendations, and rates to the hospital. A listing of missed records identified as reportable to the VCR and a listing of data items requiring correction are included in the report.

f. Reporting Review Deficiencies- Hospital staff must submit the missed records and corrections to the VCR within 30 days of when they receive the report.

g. Tracking Results- Upon completion of the Quality Assessment Review Report, completeness and accuracy rates by year review performed are entered into a tracking system at the VCR. This information provides a concise summary of review results for use in determining a hospital's performance over time and in identifying hospitals requiring more intense follow up.

## Trainings

Education is an important part of quality control. In addition to providing feedback to contacts regarding quality assessment reviews, visual reviews and edit checks, the VCR offers trainings throughout the year. These trainings provide specific information on state reporting requirements and cancer data collection. For more information about training opportunities currently being offered, contact your VCR Cancer Surveillance Specialist.

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# APPENDIX A:
# CODE OF VIRGINIA

**Sections from the *Code of Virginia* related to reporting cancer to the Virginia Cancer Registry**

The entire *Code* can be accessed at:

http://www.virginia.gov/cmsportal2/government_4096/codes_and_laws.html

**§ 32.1-70. Information from hospitals, clinics, certain laboratories and physicians supplied to Commissioner; statewide cancer registry.**

A. Each hospital, clinic and independent pathology laboratory shall make available to the Commissioner or his agents information on patients having malignant tumors or cancers. A physician shall report information on patients having cancers unless he has determined that a hospital, clinic or in-state pathology laboratory has reported the information. This reporting requirement shall not apply to basal and squamous cell carcinoma of the skin. Such information shall include the name, address, sex, race, diagnosis and any other pertinent identifying information regarding each such patient and shall include information regarding possible exposure to Agent Orange or other defoliants through their development, testing or use or through service in the Vietnam War. Each hospital, clinic, independent pathology laboratory, or physician shall provide other available clinical information as defined by the Board of Health.

B. From such information the Commissioner shall establish and maintain a statewide cancer registry. The purpose of the statewide cancer registry shall include but not be limited to:

1. Determining means of improving the diagnosis and treatment of cancer patients.
2. Determining the need for and means of providing better long-term, follow-up care of cancer patients.
   2a. Conducting epidemiological analyses of the incidence, prevalence, survival, and risk factors associated with the occurrence of cancer in Virginia.
3. Collecting data to evaluate the possible carcinogenic effects of environmental hazards including exposure to dioxin and the defoliant, Agent Orange.
4. Improving rehabilitative programs for cancer patients.
5. Assisting in the training of hospital personnel.
6. Determining other needs of cancer patients and health personnel.

**§ 32.1-70.2. Collection of cancer case information by the Commissioner.**

A. Using such funds as may be appropriated therefore, the Commissioner or his designee may perform on-site data collection of the records of patients having malignant tumors or cancers at those consenting hospitals, clinics, independent pathology laboratories and physician offices required to report information of such patients pursuant to the reporting requirements of § 32.1-70, in order to ensure the completeness and accuracy of the statewide cancer registry.

B. The selection criteria for determining which consenting hospitals, clinics, independent pathology laboratories and physician offices may be subject to on-site data collection under the provisions of this section shall include, but shall not be limited to: (i) expected annual number of cancer case reports, (ii) historical completeness and accuracy of reporting rates, and (iii) whether the facility maintains its own cancer registry.

C. The Board of Health shall promulgate regulations necessary to implement the provisions of this section.

**§ 32.1-71. Confidential nature of information supplied; publication; reciprocal data-sharing agreements.**

A. The Commissioner and all persons to whom information is submitted in accordance with § 32.1-70 shall keep such information confidential. Except as authorized by the Commissioner in accordance with the provisions of § 32.1-41, no release of any such information shall be made except in the form of statistical or other studies which do not identify individual cases.

B. The Commissioner may enter into reciprocal data-sharing agreements with other cancer registries for the exchange of information. Upon the provision of satisfactory assurances for the preservation of the confidentiality of such information, patient-identifying information may be exchanged with other cancer registries which have entered into reciprocal data-sharing agreements with the Commissioner.

**§ 32.1-71.01. Penalties for unauthorized use of statewide cancer registry.**

In addition to the remedies provided in § 32.1-27, any person who uses, discloses or releases data maintained in the statewide cancer registry in violation of § 32.1-71 shall be subject, in the discretion of the court, to a civil penalty not to exceed $25,000 for each violation, which shall be paid to the general fund.

**§ 32.1-71.02. Notification of cancer patients of statewide cancer registry reporting.**

A. Any physician diagnosing a malignant tumor or cancer shall, at such time and in such manner as considered appropriate by such physician, notify each patient whose name and record abstract is required to be reported to the statewide cancer registry pursuant to § 32.1-70 that personal identifying information about him has been included in the registry as required by law. Any physician required to so notify a patient that personal identifying information about him has been included in the cancer registry may, when, in the opinion of the physician, such notice would be injurious to the patient's health or well-being, provide the required notice to the patient's authorized representative or next of kin in lieu of notifying the patient.

B. Upon request to the statewide cancer registry, the patient whose personal identifying information has been submitted to such registry shall have a right to know the identity of the reporter of his information to such registry.

**§ 32.1-40. Authority of Commissioner to examine medical records.**

Every practitioner of the healing arts and every person in charge of any medical care facility shall permit the Commissioner or his designee to examine and review any medical records which he has in his possession or to which he has access upon request of the Commissioner or his designee in the course of investigation, research or studies of diseases or deaths of public health importance. No such practitioner or person shall be liable in any action at law for permitting such examination and review.

**§ 32.1-41. Anonymity of patients and practitioners to be preserved in use of medical records.**

The Commissioner or his designee shall preserve the anonymity of each patient and practitioner of the healing arts whose records are examined pursuant to § 32.1-40 except that the Commissioner, in his sole discretion, may divulge the identity of such patients and practitioners if pertinent to an investigation, research or study. Any person to whom such identities are divulged shall preserve their anonymity.

**§ 32.1-27. Penalties, injunctions, civil penalties and charges for violations.**

A. Any person willfully violating or refusing, failing or neglecting to comply with any regulation or order of the Board or Commissioner or any provision of this title shall be guilty of a Class 1 misdemeanor unless a different penalty is specified.

B. Any person violating or failing, neglecting, or refusing to obey any lawful regulation or order of the Board or Commissioner or any provision of this title may be compelled in a proceeding instituted in an appropriate court by the Board or Commissioner to obey such regulation, order or provision of this title and to comply therewith by injunction, mandamus, or other appropriate remedy or, pursuant to § 32.1-27.1, imposition of a civil penalty or appointment of a receiver.

C. Without limiting the remedies which may be obtained in subsection B of this section, any person violating or failing, neglecting or refusing to obey any injunction, mandamus or other remedy obtained pursuant to subsection B shall be subject, in the discretion of the court, to a civil penalty not to exceed $25,000 for each violation, which shall be paid to the general fund, except that civil penalties for environmental pollution shall be paid into the state treasury and credited to the Water Supply Assistance Grant Fund created pursuant to § 32.1-171.2. Each day of violation shall constitute a separate offense.

D. With the consent of any person who has violated or failed, neglected or refused to obey any regulation or order of the Board or Commissioner or any provision of this title, the Board may provide, in an order issued by the Board against such person, for the payment of civil charges for past violations in specific sums, not to exceed the limits specified in § 32.1-27.1 and subsection C of this section. Such civil charges shall be instead of any appropriate civil penalty which could be imposed under § 32.1-27.1 and subsection C of this section.

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# APPENDIX B:
# REGULATIONS FOR DISEASE REPORTING AND CONTROL

# STATE BOARD OF HEALTH

## PART I

## DEFINITIONS

**12 VAC 5-90-10. Definitions.**

"Cancer" means all carcinomas, sarcomas, melanomas, leukemias, and lymphomas, excluding localized basal and squamous cell carcinomas of the skin, except for lesions of the mucous membranes.

## PART VIII

## CANCER REPORTING

**12 VAC 5-90-150. Authority**

Article 9 (§ 32.1-70 et seq.) of Title 32.1 of the *Code of Virginia* authorized the establishment of a statewide cancer registry.

**12 VAC5-90-160. Reportable Cancers and Tumors.**

Clinically or pathologically diagnosed cancers, as defined in 12 CAC 5-90-10, and benign brain and central nervous system tumors shall be reported to the Virginia Cancer Registry in the department. Carcinoma of the cervix is not reportable.

**12 VAC 5-90-170. Those Required to Report.**

Any person in charge of a medical care facility, clinic, or independent pathology laboratory which diagnoses or treats cancer patients is required to report. Physicians are required to report cases of cancer in those instances when it has been determined that a medical care facility, clinic or in-state pathology laboratory has not reported. Any person making such report shall be immune from liability as provided by § 32.1-38 of the *Code of Virginia*.

**12 VAC 5-90-180. Report Contents and Procedures.**

Each report shall include the patient's name, address (including county or independent city of residence), age, date of birth, sex, date of diagnosis, date of admission or first contact, primary site of caner, histology (including type, behavior, and grade), basis of diagnosis, social security number, laterality, stage, treatment, recurrence information (when applicable), name of reporting facility, vital status, cause of death (when applicable), date of last contact, history of tobacco and alcohol use, and history of service in Vietnam and exposure to dioxin-containing compounds, when applicable.

Reporting shall be by electronic means where possible. Output file formats shall conform to the most recent version of the North American Association of Central Cancer Registries' (NAACCR) standard data file layout. Facilities without electronic reporting means and physicians shall submit the required information on the Virginia Cancer Registry Reporting Form. A copy of the pathology report(s) should accompany each completed reporting form, when available. Medical care facilities and clinics reporting via the reporting form should also submit a copy of the admission form and discharge summary.

**12 VAC 5-90-180. Report Contents and Procedures (continued).**

Reports shall be made within six months of the diagnosis of cancer and submitted to the Virginia Cancer Registry on a monthly basis. Cancer programs conduction annual follow-up on patients shall submit follow-up data monthly in an electronic format approved by the Virginia Cancer Registry.

The entire regulations document is available online at:

http://www.vdh.state.va.us/epi/regs.pdf

# APPENDIX C:
# ELECTRONIC REPORTING

**ELECTRONIC REPORTING INSTRUCTIONS**

## Definition of Electronic Reporting

Electronic reporting is the submission of reportable cases to the Virginia Cancer Registry (VCR) on diskette or other specified electronic medium using commercial, hospital-developed or AbstractPlus software. Written approval from the VCR is required to report electronically.

## Who Reports Electronically

1. Registry Hospitals - Hospitals with cancer registries functioning as an integral component of a hospital cancer program are required to electronically report cases included in their registry using commercial or hospital-developed software when all approval criteria are met.

## Initiating Electronic Reporting

To initiate the approval process for electronic reporting, the hospital shall first contact their VCR Cancer Surveillance Specialist. The Cancer Surveillance Specialist will provide a worksheet containing questions specific to the type of data collection currently being performed, either registry hospital or non registry hospital. The worksheet must be completed by appropriate hospital personnel and returned to the Cancer Surveillance Specialist. The Cancer Surveillance Specialist will review the electronic reporting specifications and the approval process with the hospital contact as described below.

## Electronic Reporting Specifications

Hospitals must meet the following specifications before submitting a trial shipment to the VCR for evaluation:

1. Required Data Items - All data items required by the VCR must be transmitted electronically for each record submitted. A listing of the VCR Required Data Set is included in *VCR Manual Appendix K* Specific instructions for completion of each item are described in the *VCR Manual Part Three*.

2. Record Format - The VCR-required version of the NAACCR (North American Association of Central Cancer Registries) Data Exchange Record Format must be used for electronic reporting.

3. File Configuration - Files must be submitted in an ASCII text format, fixed length with no delimiters between fields. Both a carriage return and a line feed must be used to designate the end of each record.

## ELECTRONIC REPORTING INSTRUCTIONS

4. Medium for Electronic Transmission - Data must be submitted via email, on 3½" diskettes or Compact Discs (CDs) supplied by the facility. Diskettes and CDs are not returned after processing. Files must be checked for viruses prior to sending to the VCR. If a virus is detected by the VCR, the shipment will be returned unprocessed.

5. Backup - A backup file of all records must be maintained by the reporting facility until the VCR indicated there were no problems reading the file.

6. Text Information - The VCR requires all electronically-reported records to include text information in designated text fields to support codes and to describe pertinent diagnostic and treatment findings. Text information in electronic form replaces the requirement for supportive paper documentation. The purpose of text information is quality control. Text is used to validate data items, verify potential errors identified through standard edits, document explanations and clarifications, determine multiple primaries, and reconcile data item discrepancies when the same patient is submitted by several facilities. Defensive abstracting, as text information is often called, is an absolute necessity for quality data. Refer to the *VCR Manual Part Three* for text guidelines and requirements.

7. Edits - Standard data checks and cross-checks should be run and errors corrected prior to electronic transmission of the records to the VCR. Hospitals should work with their software vendors to ensure3 the version of edits used is compatible with the current NAACCR data exchange file format.

8. Blank Fields - Edits must be in place to flag required fields left blank in error. Blank fields must be completed before records are transmitted to the VCR.

9. Transmit List - With each file, a hard copy listing of all records being transmitted in the file must be sent to the VCR. This transmit list must contain at least the patient's name, tumor registry number, primary site, and diagnosis date.

10. Records Not Included in Hospital Registry (Registry Hospitals only) - Records reportable to the VCR but not included in the hospital cancer registry must still be reported electronically to the VCR.

11. Submit Records Only Once - Records transmitted electronically must be submitted only once, even if corrections or follow-up information are added to the file. The only time more than one record for the same patient is transmitted is for multiple primary cancers/reportable tumors. To eliminate duplicate cases, a flag must be included in the software that will not allow the same primary to be submitted more than once. If a duplicate record is transmitted in error, draw a line through the record on the transmit list and mark *delete.* The VCR will delete these records before they are added to VCR files.

12. Corrections - Corrections may not be transmitted electronically even if the registry software provides this capability. To correct records previously reported to the VCR, follow the instructions provided in *VCR Manual Part One, Changing/Deleting Information.*

**ELECTRONIC REPORTING INSTRUCTIONS**

## Responsibility for Electronic Reporting Specifications

Responsibility for making appropriate software changes to meet the above specifications is dependent upon the type of software used by the facility as follows:

1. Commercial Cancer Registry Software - The software vendor is responsible for enabling the facility to meet all electronic reporting specifications.

2. Hospital-Developed Cancer Registry Software - The hospital Information Systems Department is responsible for enabling the facility to meet all electronic reporting specifications.

## Approval for Electronic Reporting

Hospitals must receive written approval from the VCR before records may be reported electronically on a monthly basis. Approval is based on review by the VCR of data reported electronically in the trial shipment against specified paper documentation. The trial shipment is evaluated for compliance to electronic reporting specifications, format, data quality, and completion of text fields. Written feedback is provided and problem areas must be corrected. Additional trial shipments may be requested until all aspects of the evaluation are satisfactory.

In addition to initiating electronic reporting in a registry or non registry hospital, this approval process is also used to evaluate data in previously-approved facilities when there is a new VCR contact, new software, updated reporting format, and for periodic quality control monitoring. See *VCR Manual Part Four, Quality Control: VCR.*

## Electronic Reporting Approval Process

The steps required for approval of electronic reporting are as follows:

1. Trial Shipment - After all electronic reporting specifications have been met and records have been abstracted into the software, a trial shipment shall be prepared and submitted to the VCR for evaluation. The following must be included in the trial shipment:

    a. Electronic File - The electronic file must be submitted on diskette, CD, or secure website and contain actual records not previously submitted to the VCR. The number of records depends on the type of reporting hospital, registry or non registry:

        - Registry Hospital - 20 records of various primary sites.

**ELECTRONIC REPORTING INSTRUCTIONS**

b. Paper Abstracts - An abstract from your software must be printed for each record on the trial shipment. All VCR required data items including text to support diagnostic findings, primary site, laterality, histology, behavior, grade, summary stage, and treatment must be printed on each abstract.

c. Copies of Supportive Documentation - Copies of supportive documentation from the medical record including pathology report, discharge summary, operative report, consultations, progress notes, radiology reports, and admission record must be included for each record on the electronic file. Paper documentation is used to verify the accuracy of required data fields reported in the electronic record.

2. Evaluation - The trial shipment is evaluated by the VCR for compliance to electronic reporting specifications, format, data quality, and completion of text fields. Hospitals may continue to abstract cases into their software system while the VCR is reviewing the trial shipment; however, no additional cases shall be submitted to the VCR until feedback is received on the current trial shipment.

3. Feedback - The VCR Cancer Surveillance Specialist will provide written feedback to the hospital contact to convey the results of the review. Errors and/or data items needing clarification will be identified and must be corrected or addressed in the trial shipment and for cases completed while the trial shipment was being reviewed. Additional trial shipments may be requested to resolve problems identified during evaluation(s).

4. Approval - When all aspects of the evaluation are acceptable, written approval for electronic reporting will be sent to the hospital contact. Approved hospitals do not have to send paper abstracts and supporting paper documentation with electronic files.

## Records Accessioned by the VCR

After records are accepted and processed by the VCR, a report titled *Records Accessioned by the Virginia Cancer Registry* that lists records received by the VCR from that shipment. This listing should be reviewed carefully and promptly as described in *VCR Manual Part Four, Transmission Verification.* All listings should be kept as verification of records reported to the VCR.

## When to Report

Trial shipments must be mailed as soon as the requested number of cases is complete and ready to transmit. Mailing files on the first working day of every month applies only after the facility receives final electronic reporting approval.

## How to Report

Electronic shipments for submission to the VCR should be prepared according to the instructions documented in *VCR Manual Part One, How to Report.*

# APPENDIX D:
# REPORTABLE CONDITIONS

**REPORTABLE CONDITIONS**

This *List of Reportable Conditions* provides documentation of all conditions reportable to the Virginia Cancer Registry (VCR). It is structured alphabetically by the main histologic term. Qualifiers and/or adjectives associated with the main term are included only if needed to specify when the condition is reportable. The abbreviation "NOS" means "Not Otherwise Specified."

## Determining Reportable Conditions Using Histologic Terms

Conditions are to be reported if the diagnosis includes the terms cancer, carcinoma, malignant**,** and lymphoma**.** Most leukemias and sarcomas are reportable except as noted as exclusions on the listing. Other reportable conditions not containing these terms (i.e., refractory anemia, stromal endometriosis, Ewing tumor, carcinofibroma) are also included in this listing.

All primary intracranial and central nervous system (CNS) tumors are reportable. This includes benign, malignant and borderline tumors for the following sites:

Intracranial and Central Nervous System Sites

- Meninges (C70.0 - C70.9)
- Brain (C71.0 - C71.9)
- Spinal Cord (C72.0)
- Cauda equina (C72.1)
- Cranial nerves (C72.2 - C72.5)
- Other CNS (C72.8, C72.9)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)

## Determining Reportable Conditions Using *ICD-O* Behavior Codes

All cases with a behavior code of /**2** (in situ) or /**3** (malignant) in the *International Classification of Diseases for Oncology* (*ICD-O*), are reportable neoplasms. In addition, juvenile or pilocytic astrocytoma with a behavior code of /**1** (uncertain/borderline) in *ICD-O, Third Edition* is also reportable using a behavior code of /**3**.

*Note:* If a pathologist verifies a neoplasm with an ICD-O behavior code of /0 (benign) or /1 (uncertain) as "in situ" or "malignant", these cases are reportable.

Cases diagnosed with primary intracranial and central nervous system tumors with a behavior code of **/0** or **/1** (benign and borderline or "non-malignant") regardless of histologic type for sites listed above under *Intracranial and Central Nervous System Sites* are reportable.

**REPORTABLE CONDITIONS**

## Exclusions

Conditions that are not to be reported to the VCR if the diagnosis includes:

- Cancers primary to the skin (C44.0-C44.9) with the following histologies:
  - ☞ Neoplasms, malignant, NOS of the skin
  - ☞ Epithelial carcinomas of the skin
  - ☞ Squamous cell carcinomas (SCC) of the skin
  - ☞ Basal cell carcinomas (BCC) of the skin

  *Note:* These lesions are reportable for squamous and basal cell cancers originating in mucoepidermoid sites: lip, anus, vulva, vagina, penis or scrotum (*ICD-O* codes C00.0-C00.9, C21.0, C51.0-C51.9, C52.9, C60.0-60.9 & C63.2).

- Cervical intraepithelial neoplasia (CIN)

- Prostatic intraepithelial neoplasia (PIN)

- The following conditions are only reportable if diagnosed **prior to January 1, 2001**:

  - ☞ Cystadenoma
    mucinous, borderline malignancy
    papillary, borderline malignancy
    papillary mucinous, borderline malignancy
    papillary pseudomucinous, borderline malignancy
    papillary serous, borderline malignancy
    pseudomucinous, borderline malignancy
    serous, borderline malignancy

  - ☞ Tumor
    mucinous, of low malignant potential
    papillary mucinous, of low malignant potential
    papillary serous, of low malignant potential
    serous, NOS, of low malignant potential
    serous, papillary, of low malignant potential

## Legend for List of Reportable Conditions

Use this legend to interpret special designations used on the following list of currently reportable conditions:

- ➢ **Bold Print-** Benign and borderline behaviors of these conditions are only reportable if the primary site is listed under *Intracranial and Central Nervous System Sites* on page 1 of *Appendix D*

- ➢ (Single asterisk)- Not reportable if primary to skin as specified under Exclusions
.
- ➢ ** (Double asterisk)- Reportable only if the date of diagnosis is on or after January 1, 2001.

## REPORTABLE CONDITIONS

Adamantinoma (long bones, malignant, tibial only)
Adenoacanthoma
Adenocarcinofibroma**
Adenocarcinoma
Adenofibroma (malignant endometrioid only)
**Adenoma**
Adenosarcoma
AIN III (anal intraepithelial neoplasia, grade III)**
Ameloblastoma (malignant only)
Androblastoma (malignant only)
Anemia, refractory**
Angioendotheliomatosis
**Angiolipoma**
Angiomyosarcoma
Angiosarcoma
Argentaffinoma (malignant only)
Arrhenoblastoma (malignant only)
Astroblastoma
**Astrocytoma**
Astroglioma
Blastoma
Cancer*
Carcinoid (exclude tumor of appendix, strumal, argentaffin tumor NOS, enterochromaffin-like cell NOS, and tubular)
Carcinofibroma**
Carcinoma*
Carcinomatosis*
Carcinosarcoma
CASTLE (Carcinoma showing thymus-like element)**
Chloroma
Cholangiocarcinoma
Chondroblastoma (malignant only)
Chondrosarcoma
Chordoma
Choriocarcinoma
Chorioepithelioma
Chorionepithelioma
Class IV cytology
Class V cytology
Comedocarcinoma
CPNET (central primitive neuroectodermal, NOS)**
**Craniopharyngioma**
Cylindroma (exclude eccrine dermal, and skin)
Cyst, dermoid (with malignant transformation only or with secondary tumor******, **NOS**)
Cystadenocarcinofibroma**
Cystadenocarcinoma
Cystadenofibroma (malignant endometrioid only)
Cystosarcoma phyllodes (malignant only)
Cytopenia, refractory with multilineage dysplasia******
Dermatofibrosarcoma
Diktyoma (malignant only)**
DIN III (ductal intraepithelial neoplasia, grade III)**
Disease - include only:
- alpha heavy chain
- Bowen*
- Di Guglielmo
- Franklin
- gamma heavy chain
- Heavy chain NOS**
- Hodgkin
- immunoproliferative (NOS and small intestinal only)
- Letterer-Siwe
- mast cell, systemic tissue
- Mu heavy chain**
- Myeloproliferative, chronic**
- Paget* (exclude of bone)
- Sezar

Disorder, myeloproliferative, chronic**
Disorder, primary cutaneous CD30+ T-cell lymphoproliferative**
Dysgerminoma
Ectomesenchymoma**
Endometriosis, stromal**
Enteroglucagonoma (malignant only)**
Ependymoblastoma
**Ependymoma**
Epithelioma* (NOS, basal cell, malignant, and squamous cell only)
Erythremia (acute and chronic only)
Erythroleukemia

See page 2 of *Appendix D* for legend of special designations.

## REPORTABLE CONDITIONS

Erythroplasia, Queyrat*
Esthesioneuroblastoma
Esthesioneurocytoma
Esthesioneuroepithelioma
Fibrochondrosarcoma
Fibrodentinosarcoma**
Fibroepithelioma, of Pinkus type or NOS*/**
**Fibrolipoma**
Fibroliposarcoma
**Fibroma, NOS**
Fibromyxosarcoma
Fibro-odontosarcoma**
Fibrosarcoma
Fibroxanthoma (malignant only)
**Gangliocytoma**
**Ganglioglioma (**anaplastic****)**
Ganglioneuroblastoma
**Ganglioneuroma**
Gastrinoma (malignant only)
Gemistocytoma
Germinoma
GIST-Gastrointestinal stromal tumor (malignant only)**
Glioblastoma
**Gliofibroma**
Glioma, astrocytic, malignant, NOS, **chordoid, subependymal**
Gliomatosis cerebri
Gliosarcoma
Glomangiosarcoma
Glucagonoma (malignant only)
Granuloma (Hodgkin only)
**Hemangioblastoma**
**Hemangioendothelioma**
**Hemangioma**
**Hemangiopericytoma**
Hemangiosarcoma
Hepatoblastoma
Hepatocarcinoma
Hepatocholangiocarcinoma
Hepatoma (exclude benign)
Hidradenocarcinoma**
Hidradenoma (malignant only)**
Histiocytoma (malignant fibrous only)
Histiocytosis (malignant, and acute progressive X only)
Histiocytosis, Langerhans cell, disseminated or generalized**
Hutchinson melanotic freckle (melanoma in only)
Hypernephroma
Immunocytoma
Insulinoma (malignant only)
LCIS, NOS (lobular carcinoma in situ)**
**Leiomyoma (NOS)**
**Leiomyomatosis (NOS)**
Leiomyosarcoma
Lentigo maligna
Leukemia (exclude granular lymphocytic)
Linitis plastica
**Lipoma (atypical or NOS)**
Liposarcoma (exclude well differentiated liposarcoma, superficial)
LN III, LN3 (of breast also called lobular neoplasia, grade 3 only)
Lymphangioendothelioma (malignant only)
Lymphangiosarcoma
Lymphoblastoma
Lymphoepithelioma*
Lymphoma
Lymphosarcoma
Macroglobulinemia, Waldenstrom
Malignancy*
Malignant*
Mastocytoma (malignant only)
Mastocytosis (malignant only)
Medulloblastoma
Medulloepithelioma
Medullomyoblastoma
**Melanocytosis, diffuse**
**Melanocytoma, meningeal**
Melanoma (exclude juvenile)
Melanomatosis, meningeal**
Melanosis (precancerous only)
**Meningioma** (anaplastic, papillary, rhabdoid**)
**Meningiomatosis (NOS)**
Mesenchymoma (malignant only)
Mesonephroma (exclude benign)
Mesothelioma (exclude benign and cystic)

See page 2 of *Appendix D* for legend of special designations.

## REPORTABLE CONDITIONS

**Metaplasia, agnogenic myeloid****
Microglioma
MPNST, NOS (malignant peripheral nerve sheath tumor)**
Mycosis fungoides
Myelofibrosis (acute, chronic idiopathic, with myeloid metaplasia** or as a result of myeloproliferative disease** only)
Myeloma
Myelomatosis
Myelosclerosis (megakaryocytic, acute, malignant or with myeloid metaplasia)**
Myelosis
Myoblastoma (malignant granular cell only)
Myoepithelioma (malignant only)**
Myosarcoma
Myosis, stromal NOS or endolymphatic stromal**
Myxoliposarcoma
Myxosarcoma
Neoplasia, ductal intraepithelial, grade 3 (of breast – also called DIN III)**
Neoplasia, intratubular germ cell**
Neoplasia, lobular, grade 3 only of breast (also called LN III, LN3)
Neoplasia, squamous** intraepithelial, grade 3 (of anus**, vulva and vagina only- also called, AIN III**, VIN III and VAIN III)
**Neoplasm**
Nephroblastoma
Nephroma (exclude mesoblastic)
**Neurilemmoma**
Neurilemmosarcoma
**Neurinomatosis**
Neuroblastoma
**Neurocytoma** (olfactory**)
Neuroepithelioma
**Neurofibroma**
**Neurofibromatosis (NOS)**
Neurofibrosarcoma
**Neuroma (NOS)**
Neurosarcoma
**Neurothekeoma**
Nevus (malignant blue only)
Odontosarcoma
Oligoastrocytoma, mixed
Oligodendroblastoma
Oligodendroglioma
Orchioblastoma
Osteochondrosarcoma
Osteoclastoma (malignant only)
Osteofibrosarcoma
Osteosarcoma
Pancreatoblastoma
Panmyelosis, acute only
**Papilloma**
Papulosis, lymphomatoid**
**Paraganglioma**
Paragranuloma, Hodgkin
Perineural MPNST**
**Perineurioma (**malignant**)**
Pheochromoblastoma
Pheochromocytoma (malignant only)
Pilomatrixoma* (malignant only)
**Pinealoma (NOS)**
Pineoblastoma
**Pineocytoma**
Plasmacytoma
PNET (primitive neuroectodermal tumor)**
Pneumoblastoma
Polycythemia (proliferative, rubra vera, or vera)**
Polyembryoma
Polyposis (malignant lymphomatous only)
Porocarcinoma**
Poroma, eccrine (malignant only)**
PPNET (peripheral primitive neuroectodermal tumor)**
Preleukemia**
**Prolactinoma**
Pseudomyxoma peritonei
Queyrat erythroplasia*
Reticuloendotheliosis
Reticulosarcoma
Reticulosis (histiocytic medullary, malignant, pagetoid** and polymorphic only)
**Rhabdomyoma (NOS)**
Rhabdomyosarcoma
Rhabdosarcoma
Sarcoma (exclude well diff liposarcoma, superficial)

See page 2 of *Appendix D* for legend of special designations.

## REPORTABLE CONDITIONS

Sarcomatosis (meningeal only)
Schwannoma (malignant only)
Seminoma
SETTLE (spindle epithelial tumor with thymus-like element)**
Somatostatinoma (malignant only)**
Spermatocytoma
Spiradenoma (malignant only)**
Spongioblastoma (polar or malignant **only)****
Spongioneuroblastoma
Stromatosis, endometrial**
Struma (malignant ovarii and Wuchernde Langhans only)
**Subependymoma**
Sympathicoblastoma
Syndrome,
- 5q deletion with myelodysplastic syndrome**
  - Hypereosinophilic**
- Myelodysplastic**
  - NOS**
  - with 5q deletion syndrome**
  - therapy-related, NOS**
  - therapy-related, alkylating agent related**
  - therapy-related, epidopophyllotoxin related**
  - Preleukemic**
  - Sezary

Synovioma (NOS and malignant only)
Syringoma chondroid, (malignant only)**
Teratoblastoma, malignant
Teratocarcinoma
**Teratoma**
Thecoma (malignant only)
Thrombocythemia (essential, essential hemorrhagic, idiopathic, or idiopathic hemorrhagic)**
Thymoma (malignant or type C** only)
Tumor - include only:
- adenocarcinoid
- adrenal cortical (malignant only)
- alpha cell (malignant only)
- Askin
- Bednar
- beta cell (malignant only)

Tumor - include only *cont*:
- Brenner (malignant only)
- Burkitt
- carcinoid, NOS (except of appendix)
- carcinoid (malignant only)
- **cells**
- desmoplastic small round cell
- **dysembryoplastic neuroepithelial**
- embolus*
- endodermal sinus
- **epithelial***
- Ewing
- **fibrous, solitary** (malignant**)
- follicular dendritic cell**
- fusiform cell type* (malignant only)
- G cell (malignant only)
- gastrin cell (malignant only)**
- gastrointestinal stromal (malignant only)**
- germ cell
- giant cell (malignant only)
- glomus (malignant only)**
- **granular cell**
- granulosa cell (malignant or sarcomatoid** only)
- Grawitz
- interstitial cell (malignant only)
- intravascular bronchial alveolar**
- Klatskin
- Krukenberg
- Leydig cell (malignant only)
- malignant* (any type**)
- Mast cell (malignant only)
- Merkel cell
- mesenchymal (malignant only)
- mesodermal, mixed
- metastatic*
- mixed pineal**
- mixed salivary gland type (malignant only)
- mucocarcinoid
- Mullerian mixed
- neuroectodermal (exclude melanotic)
- nonencapsulating sclerosing
- odontogenic (malignant only)

See page 2 of *Appendix D* for legend of special designations.

## REPORTABLE CONDITIONS

Tumor - include only *cont*:
- olfactory, neurogenic
- Pancoast
- peripheral neuroectodermal or peripheral primitive neuroectodermal, NOS**
- peripheral nerve sheath (malignant)**
- phyllodes (malignant only)
- pineal parenchymal of intermediate differentiation**
- Pinkus***/****
- plasma cell
- polyvesicular vitelline
- primitive neuroectodermal
- rhabdoid, NOS**
- rhabdoid/teratoid, atypical**
- round cell, desmoplastic, small**
- Schminke
- secondary*
- Sertoli-Leydig cell (poorly differentiated, with heterologous elements, sarcomatoid, malignant)**
- sinus, endodermal
- small cell type* (malignant only)
- **smooth muscle (NOS)**
- **soft tissue**
- spindle cell type* (malignant only)
- spindle epithelial with thymus-like element or thymus-like differentiation**
- steroid cell (malignant only)**
- sweat gland (malignant only)
- teratoid/rhabdoid, atypical**
- transitional pineal**
- triton, malignant
- trophoblastic, epithelioid**
- vitelline, polyvesicular
- Wilm
- yolk sac

Ulcer, rodent*
VAIN III (vaginal intraepithelial neoplasia, grade 3)
VIN III (vulvar intraepithelial neoplasia, grade 3)
Vipoma (malignant only)**
Xanthoastrocytoma, pleomorphic

See page 2 of *Appendix D* for legend of special designations.

# APPENDIX E:
# MULTIPLE PRIMARY DETERMINATION

# MULTIPLE PRIMARY DETERMINATION

For all cases diagnosed January 1, 2007 and later, the *2007 Multiple Primary and Histology Coding Rules* (MP/H) should be utilized. MP/H represent the first site-specific multiple primary and histology rules developed to promote consistent and standardized coding. Physician guidance by specialty pathologists and clinicians was integral to the review and revision process. Regular consultation with the editors of ICD-O-3 clarified ICD-O-3 codes and ensured the new rules accurately reflect the ICD-O-3 editors' intent and purpose.

The 2007 MP/H rules include site specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, and malignant brain. A separate set of rules addresses the specific and general rules for malignant solid tumors originating in all other sites. The multiple primary rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions. For example, there are instructions and guidance for identifying histologic lineages, differentiating between general (NOS) terms and specific histologic types, and correctly assigning mixed and combination codes.

## Determining Multiple Primaries for Solid Malignant Tumors – diagnosis dated January 1, 2007 and later

### A. General Instructions

1. Use the MP/H rules to determine the number of reportable primaries. Do NOT use these rules to determine case reportability, stage or grade

2. The 2007 MP/H rules **replace all previous** multiple primary and histology coding **rules.**

3. The rules are **effective** for cases **diagnosed January 1, 2007** and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.

4. Read the **General instructions** and the **site-specific Equivalent Terms and Definitions** before using the multiple primary rules.

5. The MP/H rules are available in three formats: flowchart, text, and matrix. The **rules are identical,** only the formats differ. Use the rules in the format that is easiest for you to follow.

6. **Do not use** a physician's statement to decide whether the patient has a recurrence of a previous cancer or a new primary. Use the multiple primary rules as written **unless a pathologist compares** the present tumor to the "original" tumor and states that this tumor is a recurrence of cancer from the previous primary.

7. Use the Determining Multiple Primaries: hematopoietic Primaries (lymphoma and leukemia rules and table "Definitions of Single and Subsequent Primaries for Hematologic Malignancies" to determine single versus multiple primaries for lymphoma and leukemia cases.

**MULTIPLE PRIMARY DETERMINATION**

## B. How to use the MP/H Rules

1. Use the **Multiple Primary** rules to **make a decision on the number of primary malignancies** to be abstracted for reportable solid malignant tumors.

2. Use the **site-specific rules** for the following sites:
   a. Brain, malignant (intracranial and CNS)
   b. Breast
   c. Colon
   d. Head and Neck
   e. Kidney
   f. Lung
   g. Malignant Melanoma of the Skin
   h. Renal pelvis, ureter, bladder and other urinary

3. Use the **Other Site rules** for solid malignant tumors that occur in primary sites not covered by the site-specific rules.

4. Each module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors) is an independent, complete set of coding rules. To determine which set of rules to use:
   a. Where there is no tumor in the primary site, only metastatic lesions are present:
      i. Use the primary site documented by a physician and use the multiple primary and histology coding rules for that primary site
      ii. If no primary is documented, code the primary site as unknown and use the general multiple primary and histology coding rules. Use the "Unknown if Single or Multiple Tumors" module to determine multiple primaries and the "Single Tumor" module for coding histology.

   b. To choose the appropriate module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors):
      i. Use the multiple primary and histology coding rules for the primary site
      ii. Determine the number of tumors:
         a.) Do not count metastatic lesions
         b.) When the tumor is only described a multicentric or multifocal and the number of tumors is not mentioned, use the "Unknown if Single or Multiple Tumors" module
         c.) When there is a tumor or tumors with separate microscopic foci, ignore the separate microscopic foci and use the "Single Tumor" or "Multiple Tumor" modules as appropriate
         d.) When the patient has a single tumor, use the "Single Tumor" module
         e.) If there are multiple tumors, use the "Multiple Tumor" module

   c. See the Equivalent Terms and Definitions for Head and Neck for guidance in coding the primary site
   d. Use the primary site documented by the physician on the medical record

**MULTIPLE PRIMARY DETERMINATION**

5. If a **single primary,** prepare **one abstract**

6. If there are **multiple primaries,** prepare **two or more abstracts**

7. Rules are in hierarchical order within each module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors). Use the first rule that applies and **STOP**

The MP/H Rules is available online at :
http://seer.cancer.gov/tools/mphrules/download.html

## Determining Multiple Primaries for Solid Malignant Tumors – diagnosis prior to January 1, 2007

## More Than One Malignant Cancer

If more than one primary malignant cancer is diagnosed, a separate report must be submitted for each primary. The VCR, like most central registries in the United States, follows the rules of the Surveillance, Epidemiology and End Results (SEER) Program for determination of multiple primary cancers. The reference information contained in this section is taken from the *SEER Program Code Manual, Third Edition, January 1998*.

The determination of how many primary cancers a patient has is, of course, a medical decision, but operational rules are needed in order to ensure consistency of reporting by all participants. Basic factors include the site of origin, the date of diagnosis, the histologic type, the behavior of the neoplasm (i.e., in situ versus malignant), and laterality.

In general, if there is a difference in the site where the cancer originates, it is fairly easy to determine whether it is a separate primary, regardless of dates of diagnosis and differences in histology.

Likewise, if there is a clear-cut difference in histology, other data such as site and time of diagnosis are not essential. In some neoplasms, however, one must be careful since different histologic terms are used, for example, *leukemic phase of* or *converting to*, to describe progressive stages of the same disease process.

## More than One Nonmalignant Intracranial or Central Nervous System Tumor

If more than one primary nonmalignant intracranial or central nervous system tumor is diagnosed, a separate report must be submitted for each primary. The VCR, like most central registries in the United States, follows the rules for determination of multiple non-malignant primary tumors prepared by the North American Association of Central Cancer Registries (NAACCR) Registry Operations Committee Benign Brain Tumor Subcommittee.

**MULTIPLE PRIMARY DETERMINATION**

The natural biology of nonmalignant tumors is that of expansive, localized growth with common local recurrences, and uncommon or unusual metastasis. Nonmalignant brain tumors confine themselves to one location, their site of origin, and thus any new nonmalignant brain tumor would represent a new tumor. Therefore, if multiple nonmalignant tumors of the same histology are identified in different locations they should be considered separate primaries. Nonmalignant tumors of the same histology, same site, and same side will recur in the same location. If they recur, even after 20 years, they are still the same tumor.

## More Than One Lymphatic or Hematopoietic Disease

Cancer registrars are often faced with multiple pathology reports in patients with hematologic malignancies, and the diagnoses reported may require different morphology codes. This is due in part to the fact that a more intensive diagnostic study may yield a more specific diagnosis, and in part due to the natural histories of hematopoietic diseases, which may progress from one diagnosis into another. The PCR, like most central registries in the United States, follows the rules of the Surveillance, Epidemiology and End Results (SEER) Program for determination of multiple lymphatic and hematopoietic diseases. The reference information contained in this section is taken from the *SEER Program Code Manual, Third Edition, January 1998.*

**MULTIPLE PRIMARY DETERMINATION**

## Determination Rules

This appendix contains multiple primary determination rules for the following:

1. Non-Malignant Intracranial and Central Nervous System Primaries refer to pages E-E.

2. Lymphatic and Hematopoietic Diseases refer to pages E-E.

**MULTIPLE PRIMARY DETERMINATION**
**NONMALIGNANT INTRACRANIAL AND CENTRAL NERVOUS SYSTEM (CNS)**

## INTRACRANIAL AND CENTRAL NERVOUS SYSTEM TUMORS

This section includes benign and borderline tumors for the following sites:

- Meninges (C70.0 - C70.9)
- Brain (C71.0 - C71.9)
- Spinal Cord (C72.0)
- Cauda equina (C72.1)
- Cranial nerves (C72.2 - C72.5)
- Other CNS (C72.8, C72.9)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)

## DEFINITIONS

1. **Non-malignant**: behavior code of /0 or /1.

2. **Same Site-** Each 4-digit subcategory as delineated in ICD-O-3 is considered to be separate sites. Therefore, to be the same site it must be exactly the same.

   ***Exception**:* 4-digit NOS site code (Meninges, NOS (C70.9), Brain, NOS (C71.9), Nervous System, NOS (C72.9)) with specific 4-digit site code in same rubric

   *Example:* Meninges, NOS (C70.9) with spinal meninges (C70.1) is the same site.

3. **Different site-** Each 4-digit subcategory as delineated in ICD-O-3 is considered to be a separate site.

   *Example*: Frontal lobe (C71.1) and Temporal lobe (C71.2) are different sites.

   ***Exception**:* 4-digit NOS site code (Meninges, NOS (C70.9), Brain, NOS (C71.9), Nervous System, NOS (C72.9)) with specific 4-digit site code in same rubric

   *Example*: Brain Stem (C71.7) with intracranial site, NOS (C71.9) is the same site.

4. **Same histology-** Use the table on page E/# in priority order:

   1. If both histologies are in the same histologic group, then they are the same histology*

      *Example:* A diagnosis of *subependymoma* (9383/1) followed by a diagnosis of *choroids glioma* (9444/1) would be considered the same histology.

   2. If a histology has the same first 3 digits as any histology in the table on page E/#, then they are the same histology*

      *Example*: A diagnosis of *ganglioglioma* (**950**5) followed by a diagnosis of *pacinian tumor* (**950**7) would be considered the same histology.

**MULTIPLE PRIMARY DETERMINATION**
**NONMALIGNANT INTRACRANIAL AND CENTRAL NERVOUS SYSTEM (CNS)**

3. If both histologies have the same first 3 digits but neither are in the table on page E/12, then they are the same histology

   *Example*: A diagnosis of a teratoma, NOS (**908**0) followed by a diagnosis of a dermoid cyst (**908**4) would be considered the same histology.

   ***Note:** If two histologies are in the same group in the table on page E/12, code the one with the earliest diagnosis date or the more specific histology.

***Exception*:** If one of the diagnoses is a non-specific term and the other is more specific (both in the same group), use the more specific diagnosis.

*Example*: A patient has a diagnosis of choroids plexus papilloma, NOS (9390/0) which is non-specific term and is subsequently diagnosed with atypical choroid plexus papilloma (9390/1) a more specific histology, report as atypical choroid plexus papilloma.

**5. Different histology**- Use the table on page E/#.

1. If both histologies are the same at the 3 digit level but are in 2 different histologic groups in the table on page E/14, then they are different histologies.

   *Example*: A diagnosis of gliofibroma, (**944**2) followed by a diagnosis of choroids glioma (**944**4) would be considered two different histologies.

2. If histologies are different at the 3 digit level and are not in same group in the table on page E/#, then they are different histologies.

   *Example*: A diagnosis of papillary ependymoma, NOS (9393) followed by a diagnosis of gliofibroma (9442) would be considered two different histologies.

3. If histologies are different at the 3 digit level and neither are in the table on page E/12, then they are different histologies

   *Example*: A diagnosis of ganglioneuroma (9490) followed by a diagnosis of pilocytic astrocytoma (9421) would be considered two different histologies.

## MULTIPLE PRIMARY DETERMINATION
## NONMALIGNANT INTRACRANIAL AND CENTRAL NERVOUS SYSTEM (CNS)

| Histologic Groupings To Determine Same Histology For Non-Malignant Brain Tumors | |
|---|---|
| Choroid plexus neoplasms | 9390/0 choroid plexus papilloma<br>9390/1 atypical choroids plexus papilloma |
| Ependymomas | 9383 subependymoma<br>9394 myxopapilliary ependymoma<br>9444 chordoid glioma |
| Neuronal and neuronal-glial neoplasms | 9384 subependymal giant cell astrocytoma 9412 desmoplastic infantile astrocytoma<br>9413 dysembryoplastic neroepithelial tumor 9442 gliofibroma<br>9505/1 ganglioglioma<br>9506 central neurocytoma Neurofibromas 9540/0 neurofibroma, NOS<br>9540/1 neurofibromatosis, NOS (includes Von Recklinghausen disease except of bone)<br>9541 melanotic neurofibroma<br>9550 plexiform neurofibroma<br>9560/0 neurilemoma, NOS, Schwannoma, NOS, acoustic neuroma |
| Neurinomatosis | 9560/1 neurinomatosis |
| Neurothekeoma | 9562 neurothekeoma |
| Neuroma | 9570 neuroma, NOS |
| Perineurioma, NOS | 9571/0 perineurioma, NOS |

6. **Timing-** 2-month timing rule does not apply. Nonmalignant tumors may recur in the same location. If they recur, even after many years, they are still the same tumor.

7. **Laterality:**

   a. **Single side (SS)**: involves only one side of sites listed in *PCR Manual, Part Three, Laterality.*

   b. **Both sides (BS)**: involves both sides of sites listed in *PCR Manual, Part Three, Laterality.*

   c. **Laterality unknown (LX)**: Site does not have laterality coded or laterality is not known for site.

**MULTIPLE PRIMARY DETERMINATION**
**NONMALIGNANT INTRACRANIAL AND CENTRAL NERVOUS SYSTEM (CNS)**

# GENERAL RULES FOR DETERMINING MULTIPLE PRIMARIES FOR NONMALIGNANT INTRACRANIAL AND CENTRAL ERVOUS SYSTEM TUMORS.

**1. Multiple lesions in which <u>all are non-malignant</u> tumors**

**a. Different Sites**- If different sites, then separate primaries

*Example:* Patient has a benign cerebral meningioma, NOS over the left parietal lobe. The patient is subsequently diagnosed with a benign spinal meningioma, NOS. Because these tumors are located in different subsites they are considered **separate** primary tumors.

**b. Different Histologies**- If different histologies, then separate primaries

**c. Same Site/Same Histology**- If same site and same histology*:

1. and **laterality is same side**, **one side is unknown or not applicable**, then single primary
2. and **laterality is both sides**, then separate primaries

*Example*: Patient has a benign cerebral meningioma, NOS over the left parietal lobe. The patient is subsequently diagnosed with a benign cerebral meningioma, NOS on the right side of the brain. Because these tumors are located on different sides of the brain they are considered **separate** primary tumors.

*** Note**: If two histologies are in the same group in the table on page E/12, code the one with the earliest diagnosis date or the more specific histology

**2. Multiple tumors in which one is non-malignant and the other is a malignant lesion**

**a. Non-malignant tumor followed by malignant tumor**: separate primaries regardless of timing

**b. Malignant tumor followed by a non-malignant tumor**: separate primaries regardless of timing

**Note:** For malignant intracranial and central nervous system tumors, follow rules and definitions on pages E-E.

**MULTIPLE PRIMARY DETERMINATION**
**LYMPHATIC/HEMATOPOIETIC**

# GUIDELINES FOR DETERMINING MULTIPLE PRIMARIES FOR LYMPHATIC AND HEMATOPOIETIC DISEASES

1. **Lymphoma and Leukemia Terminology -** *Lymphoma* is a general term for hematopoietic solid malignancies of the lymphoid series. *Leukemia* is a general term for liquid malignancies of either the lymphoid or the myeloid series. While it is recognized some malignancies occur predominantly (or even exclusively) in liquid or solid form, because so many malignancies can potentially arise as either leukemias or lymphomas (or both), all hematopoietic malignancies are assumed to have this potential.

2. **Lymphoid and Myeloid Series -** Malignancies of the lymphoid series are considered to be different from those of the myeloid series. Therefore a lymphoid malignancy arising after diagnosis of a myeloid malignancy (or myelodysplastic or myeloproliferative disorder) would be considered a subsequent (new) primary; however, a myeloid malignancy diagnosed after a previous myeloid malignancy would not count as a subsequent primary. Histiocytic malignancies are considered different from both lymphoid and myeloid malignancies.

3. **Hodgkin and Non-Hodgkin Lymphoma -** Hodgkin lymphoma is considered to be different from non-Hodgkin lymphoma (NHL). Among the NHLs, B-cell malignancies are considered different from T-cell/NK cell malignancies. Therefore, a B-cell malignancy arising later in the course of a patient previously diagnosed with a T-cell malignancy would be considered a subsequent primary; however, a T-cell malignancy diagnosed later in the same patient would not be considered a subsequent primary.

4. **Sequence of Diagnosis -** The sequence of diagnosis affects whether a diagnosis represents a subsequent primary. In some cases, the order of occurrence of the two diagnoses being compared is a factor in the decision whether the second diagnosis is a new primary.

**MULTIPLE PRIMARY DETERMINATION**
**LYMPHATIC/HEMATOPOIETIC**

# RULES FOR DETERMINING MULTIPLE PRIMARIES FOR LYMPHATIC AND HEMATOPOIETIC DISEASES

1. **The topography (site) is to be disregarded in determining multiple primaries of lymphatic and hematopoietic diseases**.

2. **The interval between diagnoses is not to enter into the decision.**

   *Example*: A lymphocytic lymphoma (9670/3) diagnosed in March 1999 and an unspecified non-Hodgkin lymphoma (9591/3) diagnosed in April 2001 would be considered one primary, a lymphocytic lymphoma diagnosed March 1999 (the earlier diagnosis).

## Lymphatic and Hematopoietic Disease Tables: ICD-O-3 and ICD-O-2

The ICD-O-3 (*International Classification of Diseases for Oncology, Third Edition)* and ICD-O-2 (*Second Edition)* tables are used to determine multiple primaries of lymphatic and hematopoietic diseases. The ICDO-3 table is to be used with diagnoses on or after January 1, 2001 and when the first diagnosis was made prior to 2001 and the second diagnosis was made on or after January 1, 2001. The ICD-O-2 table is to be used when both diagnoses were made prior to January 1, 2001.

The ICD-O-3 version of the hematopoietic primaries table is very different from the ICD-O-2 version in both format and medical understanding of these diseases. For example, a first diagnosis of leukemia and later diagnosis of lymphoma in the same patient may be considered two primaries in one version and one primary in the other version. As a result, the two tables may not be used interchangeably.

# Instructions for Using the ICD-O-3 and ICD-O-2 Lymphatic and Hematopoietic Disease Tables

1. **If both lymphatic/hematopoietic diseases are diagnosed on or after January 1, 2001**, use the ICD-O-3 table of this Appendix.

2. **If the first diagnosis was prior to 2001 and the second diagnosis was on or after January 1, 2001**, use the ICD-O-3 table.

3. **If both diagnoses are prior to January 1, 2001**, use the ICD-O-2 table of this Appendix.

# MULTIPLE PRIMARY DETERMINATION LYMPHATIC/HEMATOPOIETIC

## 4. Use of Tables By Registry and Non Registry Hospitals

**a. Registry Hospitals -** To use both the ICD-O-3 and ICD-O-2 Lymphatic/Hematopoietic tables, first assign the proper ICD-O morphology code then follow instructions below for using the table. The ICD-O-3 table and the *Complete Diagnostic Terms for Table (based on ICD-O-3)* display only the ICD-O-3 primary (boldfaced) term associated with the code. Refer to the ICD-O-3 for a complete list of terms. If you are unsure of a decision as to single or multiple primary, call the PCR or abstract the case as a new primary and submit to the PCR with a note of explanation included in *Text-Remarks.*

**c. Non-Registry Hospitals** - Since Non-Registry Hospitals do not assign ICD-O codes, use the terminology in the pathologic diagnosis to locate the correct multiple primary decision. If a term does not appear on the tables or if you are unsure of the decision, call the PCR or abstract the case as a new primary and submit to the PCR with a note of explanation included on the abstract.

**5. Using the ICD-O-3 Table**- To use this table, locate the first morphology code/diagnosis in rows 1through 52. Then locate the second morphology code/diagnosis in columns 1 through 52. In the cell at the intersection of the first diagnosis row and the second diagnosis column, a "S" symbol indicates the two diagnoses are most likely the same disease process (prepare/update a single abstract), and a "D" indicates they are most likely different disease processes (prepare more than one abstract).

***Note:*** If one of the two diagnoses is an NOS (not otherwise specified) term and the other is more specific and determined to be the same disease process, report the more specific diagnosis regardless of the sequence. Be sure to report the earlier date of diagnosis. For example, if a diagnosis of non-Hodgkin lymphoma NOS is followed by a diagnosis of follicular lymphoma, report the morphology as follicular lymphoma and use the date of diagnosis from the non-Hodgkin lymphoma.

**6. Using the ICD-O-2 Table**- To use this table, locate the first morphology code/diagnosis in the left column of the table, then locate the second morphology code/diagnosis in the other columns. If the second primary appears in the middle column, the two diagnoses are usually considered two separate primaries. If the second diagnosis appears in the right-hand column, then the two diagnoses are usually considered one primary. Select the disease mentioned in the first column unless there is an indication in the right-hand column to do otherwise. If the pathology report specifically states differently, use the pathology report.

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# ICD-O-3 TABLE

# SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATPOIETIC DIESASE

## Both diseases diagnosed on or after 01/01/2001

## or

## First diagnosis made prior to 2001 and second diagnosis made on or after 01/01/2001

| February 28, 2001<br>PAGE 1<br>SECOND DX ACROSS<br>FIRST DX DOWN | | 1. **9590** Malig lymphoma, NOS | 2. **9591** NHL, NOS | 3. **9596** Compos HD/NHL | 4. **9650-9667** Hodgkin lymphoma | 5. **9670-9671** ML, sm B lymphoma | 6. **9673** Mantle cell lymphoma | 7. **9675-9684** ML, diff lg B-cell | 8. **9687** Burkitt lymphoma | 9. **9689,9699** Marg zn, B-cel lymphoma | 10. **9690-9698** Follic ymphoma |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Malignant lymphoma, NOS | 9590 | **S** | S | S | S | S | S | S | S | S | S |
| 2. NHL, NOS | 9591 | S | **S** | D | D | S | S | S | S | S | S |
| 3. Composite HD/NHL | 9596 | S | S | **S** | S | S | S | S | S | S | S |
| 4. Hodgkin lymphoma | 9650-9667 | S | D | D | **S** | D | D | D | D | D | D |
| 5. ML, small B lymphocytic | 9670-9671 | S | S | D | D | **S** | D | D | D | D | D |
| 6. Mantle cell lymphoma | 9673 | S | S | D | D | D | **S** | D | D | D | D |
| 7. ML, diffuse, large B-cell | 9675-9684 | S | S | D | D | S | D | **S** | S | D | S |
| 8. Burkitt lymphoma | 9687 | S | S | D | D | D | D | D | **S** | D | D |
| 9. Marg zone, B-cell lymphoma | 9689, 9699 | S | S | D | D | D | D | D | D | **S** | D |
| 10.Follicular lymphoma | 9690-9698 | S | S | D | D | D | D | S | D | D | **S** |
| 11.Mycos fung, Sezary disease | 9700-9701 | S | S | D | D | D | D | D | D | D | D |
| 12.T/NK-cell NHL | 9702-9719 | S | S | D | D | D | D | D | D | D | D |
| 13.Precurs lym'blas lymph NOS | 9727 | S | S | D | D | D | D | D | D | D | D |
| 14.Precur lym'blas lymph B-cell | 9728 | S | S | D | D | D | D | D | D | D | D |
| 15.Precur lym'blas lymph T-cell | 9729 | S | S | D | D | D | D | D | D | D | D |
| 16.Plasma cell tumors | 9731-9734 | D | D | D | D | D | D | D | D | D | D |
| 17.Mast cell tumors | 9740-9742 | D | D | D | D | D | D | D | D | D | D |
| 18.Histiocyt/Langerhans cell | 9750-9756 | D | D | D | D | D | D | D | D | D | D |
| 19.Dendritic cell sarcoma | 9757-9758 | S | S | D | D | D | D | D | D | D | D |
| 20.Immunoprolif disease, NOS | 9760 | S | S | D | D | S | D | S | D | D | D |
| 21.Waldenstrom macroglob | 9761 | S | S | D | D | S | D | S | D | D | D |
| 22.Heavy chain disease, NOS | 9762 | S | S | D | D | D | D | D | D | D | D |
| 23.Immun sm intest disease | 9764 | S | S | D | D | D | D | D | D | D | D |
| 24.Leuk/Acute leuk, NOS | 9800-9801 | S | S | D | D | D | D | D | S | D | D |
| 25.Acute biphenotypic leukem | 9805 | S | S | D | D | S | S | S | S | S | S |
| 26.Lymphocytic leukem, NOS | 9820 | S | S | D | D | D | D | D | S | D | S |
| 27.BCLL/SLL | 9823 | S | S | D | D | S | D | S | D | D | D |
| 28.Burkitt cell leukemia | 9826 | S | S | D | D | D | D | D | S | D | D |
| 29.Adult T-cell leuk/lymph | 9827 | S | S | D | D | D | D | D | D | D | D |
| 30.Prolym'cyt leuk, NOS | 9832 | D | D | D | D | S | D | D | D | D | D |
| 31.Prolym'cyt leuk, B-cell | 9833 | D | D | D | D | S | D | D | D | D | D |
| 32.Prolym'cyt leuk, T-cell | 9834 | D | D | D | D | D | D | D | D | D | D |
| 33.Precurs lym'cyt leuk, NOS | 9835 | S | S | D | D | D | D | D | D | D | D |
| 34.Precurs B-cell leuk | 9836 | S | S | D | D | D | D | D | D | D | D |
| 35.Precurs T-cell leuk | 9837 | S | S | D | D | D | D | D | D | D | D |
| 36.Myeloid leukemias | 9840-9910 | D | D | D | D | D | D | D | D | D | D |
| 37.Therapy related AML | 9920 | D | D | D | D | D | D | D | D | D | D |
| 38.Myeloid sarcoma | 9930 | D | D | D | D | D | D | D | D | D | D |
| 39.Acute panmyelosis | 9931 | D | D | D | D | D | D | D | D | D | D |
| 40.Hairy cell leukemia | 9940 | D | D | D | D | D | D | D | D | D | D |
| 41.Chron myelomonocyt leuk | 9945 | D | D | D | D | D | D | D | D | D | D |
| 42.Juvenile myelomonocy leuk | 9946 | D | D | D | D | D | D | D | D | D | D |
| 43.NK-cell leukemia | 9948 | S | S | D | D | D | D | D | D | D | D |
| 44.Polycythemia vera | 9950 | D | D | D | D | D | D | D | D | D | D |
| 45.Chron myeloprolif disease | 9960 | D | D | D | D | D | D | D | D | D | D |
| 46.Myelosclerosis | 9961 | D | D | D | D | D | D | D | D | D | D |
| 47.Essen thrombocythem | 9962 | D | D | D | D | D | D | D | D | D | D |
| 48.Chron neutrophilic leukemia | 9963 | D | D | D | D | D | D | D | D | D | D |
| 49.Hypereosinophilic syndrome | 9964 | D | D | D | D | D | D | D | D | D | D |
| 50.Refractory anemias | 9980-9986 | D | D | D | D | D | D | D | D | D | D |
| 51.Therapy related MDS | 9987 | D | D | D | D | D | D | D | D | D | D |
| 52.Myelodysplastic syndr, NOS | 9989 | D | D | D | D | D | D | D | D | D | D |
| Codes: S--one primary only; D--presumably a subsequent primary | | | | | | | | | | | |

| February 28, 2001<br>PAGE 2<br><br>SECOND DX ACROSS<br><br>FIRST DX DOWN | | 11. **9700-9701** MF Sezary dz | 12. **9702-9719** T/NK-cell lymphoma | 13. **9727** Precur lym'blas lym, NOS | 14. **9728** Precur lym'blas lym B-cell | 15. **9729** Precur lym'blas ly T-cell | 16. **9731-9734** Plasma cell tumors | 17. **9740-9742** Mast cell tumors | 18. **9750-9756** histiocytos; LCH | 19. **9757-9758** Dendritic cell sarc | 20. **9760** Immunoprolif dz |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Malignant lymphoma, NOS | 9590 | S | S | S | S | S | S | S | S | S | S |
| 2. NHL, NOS | 9591 | S | S | S | S | S | D | D | D | S | S |
| 3. Composite HD/NHL | 9596 | S | S | S | S | S | D | D | D | D | S |
| 4. Hodgkin lymphoma | 9650-9667 | D | D | D | D | D | D | D | D | D | D |
| 5. ML, small B lymphocytic | 9670-9671 | D | D | D | D | D | D | D | D | D | D |
| 6. Mantle cell lymphoma | 9673 | D | D | D | D | D | D | D | D | D | D |
| 7. ML, diffuse, large B-cell | 9675-9684 | D | D | D | D | D | D | D | D | D | S |
| 8. Burkitt lymphoma | 9687 | D | D | D | D | D | D | D | D | D | D |
| 9. Marg zone, B-cell lymphoma | 9689, 9699 | D | D | D | D | D | D | D | D | D | D |
| 10.Follicular lymphoma | 9690-9698 | D | D | D | D | D | D | D | D | D | D |
| 11.Mycos fung, Sezary disease | 9700-9701 | **S** | D | D | D | D | D | D | D | D | D |
| 12.T/NK-cell NHL | 9702-9719 | D | **S** | D | D | D | D | D | D | D | S |
| 13.Precurs lym'blas lymph NOS | 9727 | D | D | **S** | S | S | D | D | D | D | D |
| 14.Precur lym'blas lymph B-cell | 9728 | D | D | S | **S** | D | D | D | D | D | D |
| 15.Precur lym'blas lymph T-cell | 9729 | D | D | S | D | **S** | D | D | D | D | D |
| 16.Plasma cell tumors | 9731-9734 | D | D | D | D | D | **S** | D | D | D | D |
| 17.Mast cell tumors | 9740-9742 | D | D | D | D | D | D | **S** | D | D | D |
| 18.Histiocyt/Langerhans cell | 9750-9756 | D | D | D | D | D | D | D | **S** | D | D |
| 19.Dendritic cell sarcoma | 9757-9758 | D | D | D | D | D | D | D | D | **S** | D |
| 20.Immunoprolif disease, NOS | 9760 | D | D | D | D | D | S | D | D | D | **S** |
| 21.Waldenstrom macroglob | 9761 | D | D | D | D | D | D | D | D | D | S |
| 22.Heavy chain disease, NOS | 9762 | D | D | D | D | D | D | D | D | D | S |
| 23.Immun sm intest disease | 9764 | D | D | D | D | D | S | D | D | D | S |
| 24.Leuk/Acute leuk, NOS | 9800-9801 | D | S | S | S | S | D | D | D | D | D |
| 25.Acute biphenotypic leukem | 9805 | S | S | S | S | S | D | D | D | D | D |
| 26.Lymphocytic leukem, NOS | 9820 | S | S | S | S | S | D | D | D | D | S |
| 27.BCLL/SLL | 9823 | D | D | D | D | D | D | D | D | D | S` |
| 28.Burkitt cell leukemia | 9826 | D | D | D | D | D | D | D | D | D | D |
| 29.Adult T-cell leuk/lymph | 9827 | D | D | D | D | D | D | D | D | D | D |
| 30.Prolym'cyt leuk, NOS | 9832 | D | D | D | D | D | D | D | D | D | D |
| 31.Prolym'cyt leuk, B-cell | 9833 | D | D | D | D | D | D | D | D | D | D |
| 32.Prolym'cyt leuk, T-cell | 9834 | D | D | D | D | D | D | D | D | D | D |
| 33.Precurs lym'cyt leuk, NOS | 9835 | D | D | D | D | D | D | D | D | D | D |
| 34.Precurs B-cell leuk | 9836 | D | D | S | S | S | D | D | D | D | D |
| 35.Precurs T-cell leuk | 9837 | D | D | S | S | D | D | D | D | D | D |
| 36.Myeloid leukemias | 9840-9910 | D | D | D | D | D | D | D | D | D | D |
| 37.Therapy related AML | 9920 | D | D | D | D | D | D | D | D | D | D |
| 38.Myeloid sarcoma | 9930 | D | D | D | D | D | D | D | D | D | D |
| 39.Acute panmyelosis | 9931 | D | D | D | D | D | D | D | D | D | D |
| 40.Hairy cell leukemia | 9940 | D | D | D | D | D | D | D | D | D | D |
| 41.Chron myelomonocyt leuk | 9945 | D | D | D | D | D | D | D | D | D | D |
| 42.Juvenile myelomonocy leuk | 9946 | D | D | D | D | D | D | D | D | D | D |
| 43.NK-cell leukemia | 9948 | D | S | D | D | D | D | D | D | D | D |
| 44.Polycythemia vera | 9950 | D | D | D | D | D | D | D | D | D | D |
| 45.Chron myeloprolif disease | 9960 | D | D | D | D | D | D | D | D | D | D |
| 46.Myelosclerosis | 9961 | D | D | D | D | D | D | D | D | D | D |
| 47.Essen thrombocythem | 9962 | D | D | D | D | D | D | D | D | D | D |
| 48.Chron neutrophilic leukemia | 9963 | D | D | D | D | D | D | D | D | D | D |
| 49.Hypereosinophilic syndrome | 9964 | D | D | D | D | D | D | D | D | D | D |
| 50.Refractory anemias | 9980-9986 | D | D | D | D | D | D | D | D | D | D |
| 51.Therapy related MDS | 9987 | D | D | D | D | D | D | D | D | D | D |
| 52.Myelodysplastic syndr, NOS | 9989 | D | D | D | D | D | D | D | D | D | D |
| Codes: S--one primary only; D--presumably a subsequent primary | | | | | | | | | | | |

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SECOND DX ACROSS

FIRST DX DOWN

| | | 21. **9671** Waldenstrom | 22. **9762** Heavy Chain dz | 23. **9764** Imm sm intest dz | 24. **9800-9801** Leuk/ acute leuk, NOS | 25. **9805** Acute biphenotypic leuk | 26. **9820** Lymphocytic leukemia, NOS | 27. **9823** BCLL/SLL | 28. **9826** Burkitt leukemia | 29. **9827** Adult T-cell leukemia/lymph | 30. **9832** Prolymphocyt leukemia, NOS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Malignant lymphoma, NOS | 9590 | S | S | S | S | S | S | S | S | S | S |
| 2. NHL, NOS | 9591 | S | S | S | S | S | S | S | S | S | D |
| 3. Composite HD/NHL | 9596 | S | S | S | S | D | S | S | S | S | D |
| 4. Hodgkin lymphoma | 9650-9667 | D | D | D | D | D | D | D | D | D | D |
| 5. ML, small B lymphocytic | 9670-9671 | S | D | D | D | S | S | S | D | D | S |
| 6. Mantle cell lymphoma | 9673 | D | D | D | D | S | D | D | D | D | D |
| 7. ML, diffuse, large B-cell | 9675-9684 | S | S | S | D | S | S | S | D | D | S |
| 8. Burkitt lymphoma | 9687 | D | D | D | S | S | S | D | S | D | D |
| 9. Marg zone, B-cell lymphoma | 9689, 9699 | D | D | D | D | S | D | D | D | D | D |
| 10.Follicular lymphoma | 9690-9698 | D | D | D | D | S | D | D | D | D | D |
| 11.Mycos fung, Sezary disease | 9700-9701 | D | D | D | D | S | S | D | D | D | D |
| 12.T/NK-cell NHL | 9702-9719 | D | D | D | D | S | S | D | D | D | D |
| 13.Precurs lym'blas lymph NOS | 9727 | D | D | D | S | S | S | D | D | D | D |
| 14.Precur lym'blas lymph B-cell | 9728 | D | D | D | S | S | S | D | D | D | D |
| 15.Precur lym'blas lymph T-cell | 9729 | D | D | D | S | S | S | D | D | D | D |
| 16.Plasma cell tumors | 9731-9734 | D | D | D | D | D | D | D | D | D | D |
| 17.Mast cell tumors | 9740-9742 | D | D | D | D | D | D | D | D | D | D |
| 18.Histiocyt/Langerhans cell | 9750-9756 | D | D | D | D | D | D | D | D | D | D |
| 19.Dendritic cell sarcoma | 9757-9758 | D | D | D | D | D | D | D | D | D | D |
| 20.Immunoprolif disease, NOS | 9760 | S | S | S | D | D | D | D | D | D | D |
| 21.Waldenstrom macroglob | 9761 | **S** | D | D | D | D | S | S | D | D | D |
| 22.Heavy chain disease, NOS | 9762 | D | **S** | S | D | D | S | S | D | D | D |
| 23.Immun sm intest disease | 9764 | D | S | **S** | D | D | D | D | D | D | D |
| 24.Leuk/Acute leuk, NOS | 9800-9801 | D | D | D | **S** | S | S | D | S | S | D |
| 25.Acute biphenotypic leukem | 9805 | D | D | D | S | **S** | S | S | S | S | S |
| 26.Lymphocytic leukem, NOS | 9820 | S | S | D | S | S | **S** | S | S | S | S |
| 27.BCLL/SLL | 9823 | D | D | D | D | S | S | **S** | D | D | S |
| 28.Burkitt cell leukemia | 9826 | D | D | D | S | S | S | D | **S** | D | D |
| 29.Adult T-cell leuk/lymph | 9827 | D | D | D | D | S | S | D | D | **S** | D |
| 30.Prolym'cyt leuk, NOS | 9832 | D | D | D | D | S | S | S | D | D | **S** |
| 31.Prolym'cyt leuk, B-cell | 9833 | D | D | D | D | S | S | S | D | D | S |
| 32.Prolym'cyt leuk, T-cell | 9834 | D | D | D | D | S | S | D | D | S | S |
| 33.Precurs lym'cyt leuk, NOS | 9835 | D | D | D | S | S | S | D | D | D | D |
| 34.Precurs B-cell leuk | 9836 | D | D | D | S | S | S | D | D | D | D |
| 35.Precurs T-cell leuk | 9837 | D | D | D | S | S | S | D | D | D | D |
| 36.Myeloid leukemias | 9840-9910 | D | D | D | S | S | D | D | D | D | D |
| 37.Therapy related AML | 9920 | D | D | D | S | S | D | D | D | D | D |
| 38.Myeloid sarcoma | 9930 | D | D | D | S | S | D | D | D | D | D |
| 39.Acute panmyelosis | 9931 | D | D | D | S | S | D | D | D | D | D |
| 40.Hairy cell leukemia | 9940 | D | D | D | S | S | D | D | D | D | D |
| 41.Chron myelomonocyt leuk | 9945 | D | D | D | S | S | D | D | D | D | D |
| 42.Juvenile myelomonocy leuk | 9946 | D | D | D | S | S | D | D | D | D | D |
| 43.NK-cell leukemia | 9948 | D | D | D | S | S | D | D | D | D | D |
| 44.Polycythemia vera | 9950 | D | D | D | S | S | D | D | D | D | D |
| 45.Chron myeloprolif disease | 9960 | D | D | D | S | S | D | D | D | D | D |
| 46.Myelosclerosis | 9961 | D | D | D | S | S | D | D | D | D | D |
| 47.Essen thrombocythem | 9962 | D | D | D | S | D | D | D | D | D | D |
| 48.Chron neutrophilic leukemia | 9963 | D | D | D | S | D | D | D | D | D | D |
| 49.Hypereosinophilic syndrome | 9964 | D | D | D | S | D | D | D | D | D | D |
| 50.Refractory anemias | 9980-9986 | D | D | D | S | S | D | D | D | D | D |
| 51.Therapy related MDS | 9987 | D | D | D | S | S | D | D | D | D | D |
| 52.Myelodysplastic syndr, NOS | 9989 | D | D | D | S | S | D | D | D | D | D |

Codes: S--one primary only; D--presumably a subsequent primary

| February 28, 2001<br>PAGE 4<br><br>SECOND DX ACROSS<br><br>FIRST DX DOWN | | 31. **9833** Prolymph leuk, B-cell | 32. **9834** Prolympho leuk, T-cell | 33. **9835** Precurs lymph leuk,NOS | 34. **9836** Precurs leuk, B-cell | 35. **9837** Precurs leuk, T-cell | 36. **9840-9910** Myel leukemias | 37. **99520** Therapy related AML | 38. **9930** Myeloid sarcoma | 39. **9931** Acute panmyelosis | 40. **9940** Hairy cell leukemia | 41. **9945** Chronic myelomono leuk |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Malignant lymphoma, NOS | 9590 | S | S | S | S | S | S | S | S | S | S | S |
| 2. NHL, NOS | 9591 | D | D | S | S | S | D | D | D | D | D | D |
| 3. Composite HD/NHL | 9596 | D | D | S | S | S | D | D | D | D | D | D |
| 4. Hodgkin lymphoma | 9650-9667 | D | D | D | D | D | D | D | D | D | D | D |
| 5. ML, small B lymphocytic | 9670-9671 | S | D | D | D | D | D | D | D | D | D | D |
| 6. Mantle cell lymphoma | 9673 | D | D | D | D | D | D | D | D | D | D | D |
| 7. ML, diffuse, large B-cell | 9675-9684 | S | D | D | D | D | D | D | D | D | D | D |
| 8. Burkitt lymphoma | 9687 | D | D | D | D | D | D | D | D | D | D | D |
| 9. Marg zone, B-cell lymphoma | 9689, 9699 | D | D | D | D | D | D | D | D | D | D | D |
| 10.Follicular lymphoma | 9690-9698 | D | D | D | D | D | D | D | D | D | D | D |
| 11.Mycos fung, Sezary disease | 9700-9701 | D | D | D | D | D | D | D | D | D | D | D |
| 12.T/NK-cell NHL | 9702-9719 | D | D | D | D | D | D | D | D | D | D | D |
| 13.Precurs lym'blas lymph NOS | 9727 | D | D | S | S | S | D | D | D | D | D | D |
| 14.Precur lym'blas lymph B-cell | 9728 | D | D | S | S | D | D | D | D | D | D | D |
| 15.Precur lym'blas lymph T-cell | 9729 | D | D | S | D | S | D | D | D | D | D | D |
| 16.Plasma cell tumors | 9731-9734 | D | D | D | D | D | D | D | D | D | D | D |
| 17.Mast cell tumors | 9740-9742 | D | D | D | D | D | D | D | D | D | D | D |
| 18.Histiocyt/Langerhans cell | 9750-9756 | D | D | D | D | D | D | D | D | D | D | D |
| 19.Dendritic cell sarcoma | 9757-9758 | D | D | D | D | D | D | D | D | D | D | D |
| 20.Immunoprolif disease, NOS | 9760 | D | D | D | D | D | D | D | D | D | D | D |
| 21.Waldenstrom macroglob | 9761 | D | D | D | D | D | D | D | D | D | D | D |
| 22.Heavy chain disease, NOS | 9762 | D | D | D | D | D | D | D | D | D | D | D |
| 23.Immun sm intest disease | 9764 | D | D | D | D | D | D | D | D | D | D | D |
| 24.Leuk/Acute leuk, NOS | 9800-9801 | D | D | S | S | S | S | S | S | D | D | S |
| 25.Acute biphenotypic leukem | 9805 | S | S | S | S | S | S | S | S | S | S | S |
| 26.Lymphocytic leukem, NOS | 9820 | S | S | S | S | S | D | D | D | D | S | D |
| 27.BCLL/SLL | 9823 | S | D | D | D | D | D | D | D | D | D | D |
| 28.Burkitt cell leukemia | 9826 | D | D | D | D | D | D | D | D | D | D | D |
| 29.Adult T-cell leuk/lymph | 9827 | D | D | D | D | D | D | D | D | D | D | D |
| 30.Prolym'cyt leuk, NOS | 9832 | S | S | D | D | D | D | D | D | D | D | D |
| 31.Prolym'cyt leuk, B-cell | 9833 | **S** | D | D | D | D | D | D | D | D | D | D |
| 32.Prolym'cyt leuk, T-cell | 9834 | D | **S** | D | D | D | D | D | D | D | D | D |
| 33.Precurs lym'cyt leuk, NOS | 9835 | D | D | **S** | S | S | D | D | D | D | D | D |
| 34.Precurs B-cell leuk | 9836 | D | D | S | **S** | D | D | D | D | D | D | D |
| 35.Precurs T-cell leuk | 9837 | D | D | S | D | **S** | D | D | D | D | D | D |
| 36.Myeloid leukemias | 9840-9910 | D | D | D | D | D | **S** | S | S | S | D | S |
| 37.Therapy related AML | 9920 | D | D | D | D | D | S | **S** | S | S | D | S |
| 38.Myeloid sarcoma | 9930 | D | D | D | D | D | S | S | **S** | S | D | S |
| 39.Acute panmyelosis | 9931 | D | D | D | D | D | S | S | S | **S** | D | S |
| 40.Hairy cell leukemia | 9940 | D | D | D | D | D | D | D | D | D | **S** | D |
| 41.Chron myelomonocyt leuk | 9945 | D | D | D | D | D | S | S | S | S | D | **S** |
| 42.Juvenile myelomonocy leuk | 9946 | D | D | D | D | D | S | S | S | S | D | S |
| 43.NK-cell leukemia | 9948 | D | D | D | D | D | D | D | D | D | D | D |
| 44.Polycythemia vera | 9950 | D | D | D | D | D | D | D | D | D | D | D |
| 45.Chron myeloprolif disease | 9960 | D | D | D | D | D | S | S | S | S | D | S |
| 46.Myelosclerosis | 9961 | D | D | D | D | D | S | S | S | S | D | S |
| 47.Essen thrombocythem | 9962 | D | D | D | D | D | S | S | S | S | D | S |
| 48.Chron neutrophilic leukemia | 9963 | D | D | D | D | D | S | S | S | S | D | S |
| 49.Hypereosinophilic syndrome | 9964 | D | D | D | D | D | S | S | S | S | D | S |
| 50.Refractory anemias | 9980-9986 | D | D | D | D | D | S | S | S | S | D | S |
| 51.Therapy related MDS | 9987 | D | D | D | D | D | S | S | S | S | D | S |
| 52.Myelodysplastic syndr, NOS | 9989 | D | D | D | D | D | S | S | S | S | D | S |
| Codes: S--one primary only; D--presumably a subsequent primary | | | | | | | | | | | | |

| February 28, 2001<br>PAGE 5<br>SECOND DX ACROSS<br>FIRST DX DOWN | | 42. **9946** Juv myelomono leuk | 43. **9948** NK-cell leukemia | 44. **9950** Polycythemia vera | 45. **9960** Chronic myeloprolifer dz | 46. **9961** Myelosclerosis | 47. **9962** Essential thrombocythemia | 48. **9963** Chr neutrophil leukemia | 49. **9964** Hypereosin syndrome | 50. **9980-9986** Refract anemias | 51. **9987** therapy rel MDS | 52. **9989** Myelodyspl |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Malignant lymphoma, NOS | 9590 | S | S | D | D | D | D | D | D | D | D | D |
| 2. NHL, NOS | 9591 | D | D | D | D | D | D | D | D | D | D | D |
| 3. Composite HD/NHL | 9596 | D | D | D | D | D | D | D | D | D | D | D |
| 4. Hodgkin lymphoma | 9650-9667 | D | D | D | D | D | D | D | D | D | D | D |
| 5. ML, small B lymphocytic | 9670-9671 | D | D | D | D | D | D | D | D | D | D | D |
| 6. Mantle cell lymphoma | 9673 | D | D | D | D | D | D | D | D | D | D | D |
| 7. ML, diffuse, large B-cell | 9675-9684 | D | D | D | D | D | D | D | D | D | D | D |
| 8. Burkitt lymphoma | 9687 | D | D | D | D | D | D | D | D | D | D | D |
| 9. Marg zone, B-cell lymphoma | 9689, 9699 | D | D | D | D | D | D | D | D | D | D | D |
| 10.Follicular lymphoma | 9690-9698 | D | D | D | D | D | D | D | D | D | D | D |
| 11.Mycos fung, Sezary disease | 9700-9701 | D | D | D | D | D | D | D | D | D | D | D |
| 12.T/NK-cell NHL | 9702-9719 | D | D | D | D | D | D | D | D | D | D | D |
| 13.Precurs lym'blas lymph NOS | 9727 | D | D | D | D | D | D | D | D | D | D | D |
| 14.Precur lym'blas lymph B-cell | 9728 | D | D | D | D | D | D | D | D | D | D | D |
| 15.Precur lym'blas lymph T-cell | 9729 | D | D | D | D | D | D | D | D | D | D | D |
| 16.Plasma cell tumors | 9731-9734 | D | D | D | D | D | D | D | D | D | D | D |
| 17.Mast cell tumors | 9740-9742 | D | D | D | D | D | D | D | D | D | D | D |
| 18.Histiocyt/Langerhans cell | 9750-9756 | D | D | D | D | D | D | D | D | D | D | D |
| 19.Dendritic cell sarcoma | 9757-9758 | D | D | D | D | D | D | D | D | D | D | D |
| 20.Immunoprolif disease, NOS | 9760 | D | D | D | D | D | D | D | D | D | D | D |
| 21.Waldenstrom macroglob | 9761 | D | D | D | D | D | D | D | D | D | D | D |
| 22.Heavy chain disease, NOS | 9762 | D | D | D | D | D | D | D | D | D | D | D |
| 23.Immun sm intest disease | 9764 | D | D | D | D | D | D | D | D | D | D | D |
| 24.Leuk/Acute leuk, NOS | 9800-9801 | S | D | D | S | S | D | S | S | D | S | S |
| 25.Acute biphenotypic leukem | 9805 | S | S | D | S | S | D | D | D | S | S | S |
| 26.Lymphocytic leukem, NOS | 9820 | D | S | D | D | D | D | D | D | D | D | D |
| 27.BCLL/SLL | 9823 | D | D | D | D | D | D | D | D | D | D | D |
| 28.Burkitt cell leukemia | 9826 | D | D | D | D | D | D | D | D | D | D | D |
| 29.Adult T-cell leuk/lymph | 9827 | D | D | D | D | D | D | D | D | D | D | D |
| 30.Prolym'cyt leuk, NOS | 9832 | D | D | D | D | D | D | D | D | D | D | D |
| 31.Prolym'cyt leuk, B-cell | 9833 | D | D | D | D | D | D | D | D | D | D | D |
| 32.Prolym'cyt leuk, T-cell | 9834 | D | D | D | D | D | D | D | D | D | D | D |
| 33.Precurs lym'cyt leuk, NOS | 9835 | D | D | D | D | D | D | D | D | D | D | D |
| 34.Precurs B-cell leuk | 9836 | D | D | D | D | D | D | D | D | D | D | D |
| 35.Precurs T-cell leuk | 9837 | D | D | D | D | D | D | D | D | D | D | D |
| 36.Myeloid leukemias | 9840-9910 | S | D | D | S | S | S | S | S | D | S | S |
| 37.Therapy related AML | 9920 | S | D | D | D | S | D | D | D | D | S | S |
| 38.Myeloid sarcoma | 9930 | S | D | D | S | S | S | S | D | D | S | S |
| 39.Acute panmyelosis | 9931 | S | D | D | D | S | D | D | D | D | S | S |
| 40.Hairy cell leukemia | 9940 | D | D | D | D | D | D | D | D | D | D | D |
| 41.Chron myelomonocyt leuk | 9945 | S | D | D | S | S | D | S | D | D | S | S |
| 42.Juvenile myelomonocy leuk | 9946 | **S** | D | D | D | S | D | D | D | D | S | S |
| 43.NK-cell leukemia | 9948 | D | **S** | D | D | D | D | D | D | D | D | D |
| 44.Polycythemia vera | 9950 | D | D | **S** | S | S | D | D | D | D | D | D |
| 45.Chron myeloprolif disease | 9960 | D | D | D | **S** | S | S | S | D | D | D | D |
| 46.Myelosclerosis | 9961 | S | D | D | S | **S** | S | S | D | D | S | S |
| 47.Essen thrombocythem | 9962 | D | D | D | S | S | **S** | S | D | D | D | D |
| 48.Chron neutrophilic leukemia | 9963 | D | D | D | S | S | S | **S** | D | D | D | D |
| 49.Hypereosinophilic syndrome | 9964 | S | D | D | S | S | D | D | **S** | D | D | D |
| 50.Refractory anemias | 9980-9986 | S | D | D | S | S | D | D | D | **S** | S | S |
| 51.Therapy related MDS | 9987 | S | D | D | S | S | D | D | D | S | **S** | S |
| 52.Myelodysplastic syndr, NOS | 9989 | A | D | D | S | S | D | D | D | S | S | **S** |
| Codes: S--one primary only; D--presumably a subsequent primary | | | | | | | | | | | | |

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# APPENDIX F:
# FEDERAL INFORMATION PROCESSING STANDARDS (FIPS) COUNTY CODES FOR VIRGINIA

Federal Information Processing Standards Publication, Counties and Equivalent Entities of the United States, its Possessions, and Associated Areas. US Department of Commerce, National Institute of Standards and Technology, Gaithersburg, MD, August 31, 1990

## FIPS COUNTY CODES FOR VIRGINIA

| | |
|---|---|
| 001 | Accomack |
| 003 | Albemarle |
| 005 | Alleghany |
| 007 | Amelia |
| 009 | Amherst |
| 011 | Appomattox |
| 013 | Arlington |
| 015 | Augusta |
| 017 | Bath |
| 019 | Bedford |
| 021 | Bland |
| 023 | Botetourt |
| 025 | Brunswick |
| 027 | Buchanan |
| 029 | Buckingham |
| 031 | Campbell |
| 033 | Caroline |
| 035 | Carroll |
| 036 | Charles City |
| 037 | Charlotte |
| 041 | Chesterfield |
| 043 | Clarke |
| 045 | Craig |
| 047 | Culpepper |
| 049 | Cumberland |
| 051 | Dickenson |
| 053 | Dinwiddie |
| 057 | Essex |
| 059 | Fairfax |
| 061 | Fauquier |
| 063 | Floyd |
| 065 | Fluvanna |
| 067 | Franklin |
| 069 | Frederick |
| 071 | Giles |
| 073 | Gloucester |
| 075 | Goochland |
| 077 | Grayson |
| 079 | Greene |
| 081 | Greensville |
| 083 | Halifax |
| 085 | Hanover |
| 087 | Henrico |
| 089 | Henry |
| 091 | Highland |
| 093 | Isle of Wight |
| 095 | James City |
| 097 | King and Queen |
| 099 | King George |
| 101 | King William |
| 103 | Lancaster |
| 105 | Lee |
| 107 | Loudoun |
| 109 | Louisa |
| 111 | Lunenburg |
| 113 | Madison |
| 115 | Mathews |
| 117 | Mecklenburg |
| 119 | Middlesex |
| 121 | Montgomery |
| 125 | Nelson |
| 127 | New Kent |
| 131 | Northampton |
| 133 | Northumberland |
| 135 | Nottoway |
| 137 | Orange |
| 139 | Page |
| 141 | Patrick |
| 143 | Pittsylvania |
| 145 | Powhatan |
| 147 | Prince Edward |
| 149 | Prince George |
| 153 | Prince William |
| 155 | Pulaski |
| 157 | Rappahannock |
| 159 | Richmond |
| 161 | Roanoke |
| 163 | Rockbridge |
| 165 | Rockingham |
| 167 | Russell |
| 173 | Smyth |
| 175 | Southampton |
| 177 | Spotsylvania |
| 179 | Stafford |
| 181 | Surry |
| 183 | Sussex |
| 185 | Tazewell |
| 187 | Warren |
| 191 | Washington |
| 193 | Westmoreland |
| 195 | Wise |
| 197 | Wythe |
| 199 | York |

# APPENDIX G:
# SEER GEOCODES

## For Coding Place of Birth and Place of Death

# SEER GEOCODES

## CONTINENTAL UNITED STATES AND HAWAII

000 United States

001 New England States
- 002 Maine
- 003 New Hampshire
- 004 Vermont
- 005 Massachusetts
- 006 Rhode Island
- 007 Connecticut
- 008 New Jersey

010 North Mid-Atlantic States
- 011 New York
- 014 Pennsylvania
- 017 Delaware

020 South Mid-Atlantic States
- 021 Maryland
- 022 District of Columbia
- 023 Virginia
- 024 West Virginia
- 025 North Carolina
- 026 South Carolina

030 Southeastern States
- 031 Tennessee
- 033 Georgia
- 035 Florida
- 037 Alabama
- 039 Mississippi

040 North Central States
- 041 Michigan
- 043 Ohio
- 045 Indiana
- 047 Kentucky

050 Northern Midwest States
- 051 Wisconsin
- 052 Minnesota
- 053 Iowa
- 054 North Dakota
- 055 South Dakota
- 056 Montana

060 Central Midwest States
- 061 Illinois
- 063 Missouri
- 065 Kansas
- 067 Nebraska

070 Southern Midwest States
- 071 Arkansas
- 073 Louisiana
- 075 Oklahoma
- 077 Texas

080 Mountain States
- 081 Idaho
- 082 Wyoming
- 083 Colorado
- 084 Utah
- 085 Nevada
- 086 New Mexico
- 087 Arizona

090 Pacific Coast States
- 091 Alaska
- 093 Washington
- 095 Oregon
- 097 California
- 099 Hawaii

# SEER GEOCODES

## UNITED STATES POSSESSIONS

When SEER geocodes were originally assigned during the 1970s, the United States owned or controlled islands in the Pacific. Since then many of these islands have either been given their independence or had control turned over to another country. In order to maintain consistent information over time, these islands are still to be coded to the original codes. Earlier designations are listed in parentheses.

100 Atlantic/Caribbean Area
- 101 Puerto Rico
- 102 US Virgin Islands
- 109 Other Atlantic/Caribbean Area

110 Canal Zone

120 Pacific Area
- 121 American Samoa
- 122 Kiribati (Canton and Enderbury Islands Southern Line Islands, Phoenix Islands)
- 123 Micronesia [Federated States of] (Caroline Islands, Trust Territory of Pacific Islands)
- 124 Cook Islands (New Zealand)
- 125 Tuvalu (Ellice Islands)
- 126 Guam
- 127 Johnston Atoll
- 129 Mariana Islands (Trust Territory of Pacific Islands
  Northern Mariana Islands

- 131 Marshall Islands (Trust Territory of Pacific Islands)
- 132 Midway Islands
- 133 Nampo-Shoto, Southern
- 134 Ryukyu Islands (Japan)
- 135 Swan Islands
- 136 Tokelau Islands (New Zealand)
- 137 Wake Island

- 139 Palau (Trust Territory of Pacific Islands)

# SEER GEOCODES

## NORTH AND SOUTH AMERICA, EXCLUSIVE OF THE UNITED STATES AND ITS POSSESSIONS

210 Greenland

220 Canada
- 221 Maritime Provinces
  - Labrador
  - New Brunswick
  - Newfoundland
  - Nova Scotia
  - Prince Edward Island
- 222 Quebec
- 223 Ontario
- 224 Prairie Provinces
  - Alberta
  - Manitoba
  - Saskatchewan
- 225 Northwest Territories
  - Yukon Territory
- 226 British Columbia
- 227 Nunavut (Nunavut became an official Territory of Canada on April 1, 1999)

230 Mexico

240 North American Islands
- 241 Cuba
- 242 Haiti
- 243 Dominican Republic
- 245 Other Caribbean Islands
  - Anguilla
  - Antigua and Barbuda
  - Antilles, NOS
  - Aruba
  - Barbados
  - British Virgin Islands
  - British West Indies, NOS
  - Caribbean, NOS
  - Cayman Islands
  - Curacao
  - Dominica
  - French West Indies
  - Grenada
  - Grenadines, The
  - Guadeloupe
  - Leeward Islands, NOS
  - Martinique
  - Montserrat
  - Netherlands Antilles
  - St Christopher-Nevis
  - St Kitts
  - St Lucia
  - St Vincent and The Grenadines
  - Trinidad and Tobago
  - Turks Islands Antilles, NOS
  - West Indies, NOS
  - Windward Islands, NOS
- 246 Bermuda
- 247 Bahamas, The
- 249 St Pierre and Miquelon

250 Central America
- 251 Guatemala
- 252 Belize (British Honduras)
- 253 Honduras
- 254 El Salvador
- 255 Nicaragua
- 256 Costa Rica
- 257 Panama

260 North America, NOS

265 Latin America, NOS

## SEER GEOCODES

### NORTH AND SOUTH AMERICA, EXCLUSIVE OF THE UNITED STATES AND ITS POSSESSIONS, continued

300 South America, NOS
- 311 Columbia
- 321 Venezuela
- 331 Guyana (British Guiana)
- 332 Suriname (Dutch Guiana)
  - Netherlands Guiana
- 333 French Guiana
- 341 Brazil
- 345 Ecuador
  - Galapagos Islands
- 351Peru
- 355 Bolivia
- 361 Chile
- 365 Argentina
- 371 Paraguay
- 375 Uruguay

380 South American Islands
- 381 Falkland Islands

# SEER GEOCODES

## EUROPE

*Former or alternative names are in parenthesis*

Europe, NOS (See code 499)*

400 United Kingdom, NOS
- 401 England
  - Channel Islands
  - Guernsey
  - Isle of man
  - Jersey
- 402 Wales
- 403 Scotland
  - Orkney Islands
  - Shetland Islands
- 404 Northern Ireland (Ulster)

410 Ireland (Eire)
- Ireland, NOS
- Republic of Ireland

420 Scandinavia
- Lapland, NOS
- 421 Iceland
- 423 Norway
  - Svalbard
- 425 Denmark
  - Faroe (Faeroe) Islands
- 427 Sweden
- 429 Finland

430 Germanic Countries
- 431 Germany
  - East Germany including East Berlin
  - West Germany including West Berlin
  - Federal Republic of Germany
  - German Democratic Republic
  - Germany, East
  - Germany, Federal Republic of
  - Germany, West
- 432 Netherlands
  - Holland
- 433 Belgium
- 434 Luxembourg
- 435 Switzerland
- 436 Austria
- 437 Liechtenstein

440 Romance-language Countries
- 441 France
  - Corsica
  - Monaco
- 443 Spain
  - Andorra
  - Balearic Islands
  - Canary Islands

**Effective cases diagnosed 01/01/1992 & later*

- 445 Portugal
  - Azores
  - Cape Verde Islands
  - Madeira Islands
- 447 Italy
  - San Marino
  - Sardinia
  - Sicily
  - Vatican City (Holy See)
- 449 Romania

450 Slavic Countries
- 451 Poland
- 452 (former)Czechoslovakia region
  - Bohemia
  - Czech Republic
  - Moravia
  - Slovak Republic
  - Slovakia
- 453 (former)Yugoslavia region
  - Bosnia-Herzegovina
  - Croatia
  - Dalmatia
  - Jugoslavia
  - Macedonia
  - Montenegro
  - Serbia
  - Slavonia
  - Slovenia

## SEER GEOCODES

**EUROPE,** continued

454 Bulgaria
455 Russia
Russian Federation (former) USSR
Russia, NOS (Russian SFSR)
456 Ukraine and Moldova (Bessarabia)
Moldavia (Moldavian SSR)
(Ukrainian SSR)
457 Belarus
(Byelorussian SSR)
(White Russia)
458 Estonia (Estonian SSR)
459 Latvia (Latvian SSR)
461 Lithuania (Lithuanian SSR)
463 Baltic Republic(s), NOS
(Baltic States, NOS)

470 Other Mainland Europe
471 Greece
Crete
475 Hungary
481 Albania
485 Gibraltar

490 Other Mediterranean Islands
491 Malta
495 Cyprus

499 Europe, NOS*
Central Europe, NOS
Eastern Europe, NOS
Northern Europe, NOS
Southern Europe, NOS
Western Europe, NOS

**Effective cases diagnosed 01/01/1992 & later*

**AFRICA**

500 Africa, NOS
Central Africa, NOS
Equatorial Africa, NOS

510 North Africa, NOS
511 Morocco
513 Algeria
515 Tunisia
517 Libya
(Cyrenaica)
(Tripoli)
(Tripolitania)
519 Egypt (United Arab Republic)

520 Sudanese Countries
Burkina Faso (Upper Volta)
Chad
Mali
Mauritania
Niger
Sudan (Anglo-Egyptian Sudan)
Western (Spanish) Sahara

530 West Africa
French West Africa, NOS
531 Nigeria
539 Other West African Countries
Benin (Dahomey)
Cameroon (Kameroon)
Central African Republic (French Equatorial Africa)
Cote d'Ivoire (Ivory Coast)
Congo (Congo-Brazzaville, French Congo)
Equatorial Guinea (Spanish Guinea) (Bioko [Fernando Poo] Rio Muni)
Gabon
Gambia, The
Ghana
Guinea
Guinea Bissau (Portuguese Guinea)
Liberia
Senegal
Sierra Leone
Togo

## SEER GEOCODES

540 South Africa
- 541 Zaire (Congo-Leopoldville, Belgian Congo, Congo Kinshasa)
- 543 Angola (Sao Tome, Principe, Cabinda)
- 545 Republic of South Africa (Bophuthatswana, Cape Colony, Ciskei, Natal, Free State [Orange Free State], Transkei, Transvaal, Venda)
  - Botswana (Bechuanaland)
  - Lesotho (Basutoland)
  - Namibia (South West Africa)
  - Swaziland
  - Union of South Africa
- 547 Zimbabwe (Rhodesia, Southern Rhodesia)
- 549 Zambia (Northern Rhodesia)
- 551 Malawi (Nayasaland)
- 553 Mozambique
- 555 Madagascar (Malagasy Republic)

571 East Africa
- 571 Tanzania (Tanganyika, Tanzanyika, Zanzibar)
- 573 Uganda
- 575 Kenya
- 577 Rwnada (Ruanda)
- 579 Burundi (Urundi)
- 581 Somalia (Somali Republic, Somaliland)
- 583 Djibouti (French Territory of the Afars and Issas, French Somaliland)
- 585 Ethiopia (Abyssinia)
  - Eritrea

580 African Costal Islands (prev included in 540)
- Comoros
- Mauritius
- Mayotte
- Reunion
- St Helena
- Seychelles

**ASIA**

600 Asia, NOS *

610 Near East
- Mesopotamia, NOS
- 611 Turkey Anatolia
  - Armenia (Turkey)
  - Asia Minor, NOS

620 Asian Arab Countries
- Iraq-Saudi Arabia Neutral Zone
- 621 Syria
- 623 Lebanon
- 625 Jordan (Trans-Jordan, former Arab Palestine)
- 627 Iraq
- 629 Arabian Peninsula
  - Bahrain
  - Kuwait
  - Oman
  - Muscat
  - Persian Gulf States, NOS
  - Qatar
  - Saudi Arabia
  - United Arab Emirates
  - (Trucial States)
  - Yemen (Aden, People's Democratic Republic of Yemen, Southern Yemen)
- 631 Israel and former Jewish Palestine
  - Gaza
  - Palestine (Palestinian National Authority - PNA)
  - West Bank
- 633 Caucasian Republics of the former USSR
  - Armenia
  - Azerbaijan (Nagorno-Karabakh)
  - Georgia
- 634 Other Asian Republics of the former USSR
  - Kazakhstan (Kazakh SSR)
  - Kyrgyzstan (Kirghiz SSR, Kyrgyz)
  - Tajikistan (Tadzhik SSR)
  - Turkmenistan (Turkmen SSR)
  - Uzbekistan (Uzbek SSR)
- 637 Iran (Persia)
- 638 Afghanistan
- 639 Pakistan (West Pakistan)
- 640 Mid-East Asia, NOS
  - Maldives

## SEER GEOCODES

641 India
Andaman Islands
643 Nepal
Bhutan
Sikkim
645 Bangladesh (East Pakistan)
647 Sri Lanka (Ceylon)
649 Myanmar (Burma)

650 Southeast Asia
651 Thailand (Siam)

660 Indochina
661 Laos
663 Cambodia
Kampuchea
665 Vietnam (Tonkin, Annam, Cochin China)
671 Malaysia
Brunei
Malay Peninsula
North Borneo
Singapore
673 Indonesia (Dutch East Indies)
Borneo
Java
New Guinea, except Australian & North East Sumatra
675 Philippines (Philippine Islands)

680 East Asia
681 China, NOS
682 China (People's Republic of China)
683 Hong Kong
684 Taiwan (Formosa, Republic of China)
685 Tibet
686 Macao (Macau)
691 Mongolia
693 Japan
695 Korea
North Korea
South Korea

### AUSTRALIA AND OCEANIA

711 Australia
Cartier Islands
Cocos (Keeling) Islands
New Guinea, Australian
New Guinea, North East
Norfolk Island
Papau New Guinea

715 New Zealand
Niue

720 Pacific Islands ~
Oceania, NOS
Polynesia, NOS
721 Melanesian Islands
Fiji
Futuna
New Hebrides
Solomon Islands
Vanuatu
Wallis
723 Micronesian Islands ~
Christmas Island
Nauru
725 Polynesian Islands ~
French Polynesia
New Caledonia
Pitcairn Islands
Samoa, Western
Tonga
Western Samoa
750 Antarctica

*~ Except possessions of the USA*

### PLACE OF BIRTH UNKNOWN

998 Place of Birth stated not to be in the United States, but no other information available
999 Place of Birth unknown

## SEER GEOCODES – Alphabetic Listing

**A**

585 Abyssinia
629 Aden
583 Afars and Issas
638 Afghanistan
500 Africa
570 Africa, East
510 Africa, North
540 Africa, South
545 Africa, South West
530 Africa, West
580 African Coastal Islands (previously included in 540)
037 Alabama
091 Alaska
481 Albania
224 Alberta
513 Algeria
250 America, Central
260 America, North (use more specific term if possible)
300 America, South
121 American Samoa
611 Anatolia
641 Andaman Islands
443 Andorra
543 Angola
245 Anguilla
665 Annam
750 Antarctica
245 Antigua
245 Antilles, NOS
245 Antilles, Netherlands
625 Arab Palestine
629 Arabia, Saudi
629 Arabian Peninsula
365 Argentina
087 Arizona
071 Arkansas
633 Armenia (U.S.S.R.)
611 Armenia (Turkey)
245 Aruba
600 Asia, NOS
680 Asia, East
640 Asia, Mid-East
610 Asia Minor, NOS
610 Asia, Near-East
650 Asia, Southeast
620 Asian Arab countries
634 Asian Republics of the former U.S.S.R.
109 Atlantic/Caribbean area, other U.S. possessions
100 Atlantic/Caribbean area, U.S. possessions
711 Australia
711 Australian New Guinea
436 Austria
633 Azerbaijan
633 Azerbaizhan S.S.R.
445 Azores

**B**

247 Bahamas
629 Bahrain
443 Balearic Islands
463 Baltic Republic, NOS
463 Baltic States, NOS
645 Bangladesh
245 Barbados
245 Barbuda
545 Basutoland
431 Bavaria
545 Bechuanaland
457 Belarus
541 Belgian Congo
433 Belgium
252 Belize
539 Benin
246 Bermuda
456 Bessarabia
643 Bhutan
539 Bioko (Fernando Poo)
452 Bohemia
355 Bolivia
545 Bophuthatswana
673 Borneo
453 Bosnia-Herzegovina
545 Botswana
341 Brazil
226 British Columbia
331 British Guiana
252 British Honduras

## SEER GEOCODES – Alphabetic Listing

245 British Virgin Islands
245 British West Indies, NOS
671 Brunei
454 Bulgaria
520 Burkina Faso (Upper Volta)
649 Burma (see Myanmar)
579 Burundi
457 Byelorussian S.S.R.

**C**

401 Channel Islands (British)
361 Chile
681 China, NOS
665 China, Cochin
682 China, People's Republic of
684 China, Republic of
723 Christmas Island
545 Ciskel
665 Cochin China
711 Cocos (Keeling) Islands
311 Columbia
083 Colorado
580 Comoros
226 Columbia, British
022 Columbia, District of
539 Congo-Brazzaville
541 Congo-Leopoldville
541 Congo, Belgian
539 Congo, French
007 Connecticut
124 Cook
441 Corsica
256 Costa Rica
539 Cote d'Ivoire (Ivory Coast)
471 Crete
453 Croatia
241 Cuba
245 Curacao
495 Cyprus
517 Cryonic
452 Czechoslovakia
452 Czech Republic

**D**

539 Dahomey
453 Dalmatia
017 Delaware
425 Denmark
022 District of Columbia
583 Djibouti
449 Dobruja
245 Dominica
243 Dominican Republic
673 Dutch East Indies
332 Dutch Guiana

**E**

570 East Africa
680 East Asia
431 East Germany
673 East Indies, Dutch
645 East Pakistan
499 Eastern Europe, NOS
345 Ecuador
519 Egypt
410 Eire
254 El Salvador
125 Ellice Islands
122 Enderbury Islands
401 England
500 Equatorial Africa, NOS
539 Equatorial Guinea (Spanish Guinea)
585 Eritrea
458 Estonia
458 Estonian S.S.R. (Estonia)
585 Ethiopia
499 Europe, NOS
470 Europe, other mainland

**F**

420 Faroe
381 Falkland
431 Federal
539 Fernando
721 Fiji
429 Finland
035 Florida

## SEER GEOCODES – Alphabetic Listing

| | |
|---|---|
| 684 | Formosa |
| 721 | Fortuna |
| 441 | France |
| 545 | Free State (Orange Free State) |
| 539 | French Congo |
| 333 | French Guiana |
| 725 | French Polynesia |
| 583 | French Somaliland |
| 530 | French West Africa, NOS |
| 245 | French West Indies |

**G**

| | |
|---|---|
| 539 | Gabon |
| 345 | Galapagos Islands |
| 539 | Gambia |
| 631 | Gaza Strip |
| 033 | Georgia (USA) |
| 633 | Georgia (USSR) |
| 430 | Germanic countries |
| 431 | German Democratic Republic |
| 431 | Germany |
| 431 | Germany, East |
| 431 | Germany, Federal Republic of |
| 431 | Germany, West |
| 539 | Ghana |
| 485 | Gibraltar |
| 122 | Gilbert Islands |
| 471 | Greece |
| 210 | Greenland |
| 245 | Grenada |
| 245 | Grenadines, The |
| 245 | Guadeloupe |
| 126 | Guam |
| 251 | Guatemala |
| 401 | Guernsey |
| 331 | Guiana, British |
| 332 | Guiana, Dutch |
| 333 | Guiana, French |
| 539 | Guinea |
| 539 | Guinea-Bissau (Portuguese Guinea) |
| 539 | Guinea, Equatorial |
| --- | Guinea, New (see New Guinea) |
| 539 | Guinea, Portuguese |
| 331 | Guyana |

**H**

| | |
|---|---|
| 242 | Haiti |
| 099 | Hawaii |
| 432 | Holland |
| 253 | Honduras |
| 252 | Honduras, British |
| 683 | Hong |
| 475 | Hungary |

**I**

| | |
|---|---|
| 421 | Iceland |
| 081 | Idaho |
| 061 | Illinois |
| 641 | India |
| 045 | Indiana |
| 673 | Indies, Dutch East |
| 660 | Indochina |
| 673 | Indonesia |
| 053 | Iowa |
| 637 | Iran |
| 627 | Iraq |
| 620 | Iraq-Saudi Arabian Neutral Zone |
| 410 | Ireland (Erie) |
| 404 | Ireland, Northern |
| 410 | Ireland, NOS |
| 410 | Ireland, Republic of |
| 401 | Isle of Man |
| 631 | Israel |
| 583 | Issas |
| 447 | Italy |
| 539 | Ivory Coast |

**J**

| | |
|---|---|
| 244 | Jamaica |
| 423 | Jan Mayen |
| 693 | Japan |
| 673 | Java |
| 401 | Jersey |
| 631 | Jewish Palestine |
| 127 | Johnston Atoll |
| 625 | Jordan |
| 244 | Jamaica |
| 453 | Jugoslavia |

## SEER GEOCODES – Alphabetic Listing

**K**

539 Kameroon
663 Kampuchea
065 Kansas
634 Kazakh SSR
634 Kazakhstan
047 Kentucky
575 Kenya
634 Kirghiz SSR
122 Kiribati
695 Korea
695 Korea, North
695 Korea, South
629 Kuwait
634 Kyrgystan
634 Kyrgyz

**L**

221 Labrador
661 Laos
420 Lapland, NOS
265 Latin America, NOS
459 Latvia
459 Latvian SSR (Latvia)
623 Lebanon
245 Leeward Islands, NOS
545 Lesotho
539 Liberia
517 Libya
437 Liechtenstein
122 Line Islands, Southern
461 Lithuania
461 Lithuanian SSR (Lithuania)
073 Louisiana
434 Luxembourg

**M**

686 Macao
686 Macau
453 Macedonia
555 Madagascar
445 Madeira Islands
002 Maine
555 Malagasy Republic
551 Malawi
671 Malay Peninsula
671 Malaysia
640 Maldives
520 Mali
491 Malta
224 Manitoba
129 Mariana Islands
221 Maritime Provinces, Canada
131 Marshall Islands
245 Martinique
021 Maryland
005 Massachusetts
520 Mauritania
580 Mauritius
580 Mayotte
490 Mediterranean
721 Melanesian
610 Mesopotamia,
230 Mexico
041 Michigan
123 Micronesian Islands [Federated States of] (Caroline Islands, Trust Territory of Pacific Islands)
723 Micronesian Islands (except possessions of the USA)
640 Mid-East Asia
132 Midway Islands
052 Minnesota
249 Miquelon
039 Mississippi
063 Missouri
456 Moldavia
456 Moldavian SSR
456 Moldova
441 Monaco
691 Mongolia
056 Montana
453 Montenegro
245 Montserrat
452 Moravia
511 Morocco
080 Mountain States
553 Mozambique
629 Muscat
649 Myanmar

## SEER GEOCODES – Alphabetic Listing

**N**

| | |
|---|---|
| 545 | Namibia |
| 133 | Nampo-shoto, Southern |
| 545 | Natal |
| 723 | Nauru |
| 610 | Near-East Asia |
| 067 | Nebraska |
| 643 | Nepal |
| 432 | Netherlands |
| 245 | Netherlands Antilles |
| 332 | Netherlands Guiana |
| 085 | Nevada |
| 245 | Nevis |
| 221 | New Brunswick |
| 724 | New Caledonia |
| 001 | New England |
| 673 | New Guinea, except Australian and North East |
| 711 | New Guinea, Australian |
| 711 | New Guinea, North East |
| 003 | New Hampshire |
| 721 | New Hebrides |
| 008 | New Jersey |
| 086 | New Mexico |
| 011 | New York |
| 715 | New Zealand |
| 221 | Newfoundland |
| 255 | Nicaragua |
| 520 | Niger |
| 531 | Nigeria |
| 715 | Niue |
| 711 | Norfolk Island |
| 510 | North Africa, NOS |
| 260 | North America, NOS (use more specific Term if possible) |
| 240 | North American Islands |
| 671 | North Borneo (Malaysia) |
| 025 | North Carolina |
| 040 | North Central States |
| 054 | North Dakota |
| 711 | North East New Guinea |
| 695 | North Korea |
| 010 | North Mid-Atlantic States |
| 499 | Northern Europe, NOS |
| 404 | Northern Ireland |
| 129 | Northern Mariana Islands |
| 050 | Northern Midwest States |
| 549 | Northern Rhodesia |
| 225 | Northwest Territories (Canada) |
| 423 | Norway |
| 998 | Not United States, NOS |
| 221 | Nova Scotia |
| 227 | Nunavut |
| 551 | Nyasaland |

**O**

| | |
|---|---|
| 043 | Ohio |
| 075 | Oklahoma |
| 629 | Oman |
| 223 | Ontario |
| 545 | Orange Free State |
| 095 | Oregon |
| 403 | Orkney |

**P**

| | |
|---|---|
| 120 | Pacific area, US Possessions |
| 090 | Pacific Coast States |
| 720 | Pacific Islands |
| 123 | Pacific Islands, Trust Territory of the (code to Specific islands if possible) |
| 639 | Pakistan |
| 645 | Pakistan, East |
| 639 | Pakistan, West |
| 139 | Palau (Trust Territory of the Pacific Islands) |
| 625 | Palestine, Arab |
| 631 | Palestine, Jewish |
| 631 | Palestine, NOS |
| 631 | Palestinian National Authority – PNA |
| 257 | Panama |
| 711 | Papua New Guinea |
| 371 | Paraguay |
| 014 | Pennsylvania |
| 629 | People's Democratic Republic of Yemen |
| 682 | People's Republic of China |
| 637 | Persia |
| 629 | Persian Gulf States, NOS |
| 351 | Peru |
| 675 | Philippine Islands |
| 675 | Philippines |

## SEER GEOCODES – Alphabetic Listing

| | |
|---|---|
| 725 | Pitcairn |
| 451 | Poland |
| 725 | Polynesian |
| 445 | Portugal |
| 539 | Portuguese |
| 224 | Prairie |
| 221 | Prince |
| 543 | Principe |
| 101 | Puerto |

**Q**

| | |
|---|---|
| 629 | Qatar |
| 222 | Quebec |

**R**

| | |
|---|---|
| 684 | Republic of China |
| 545 | Republic of South Africa |
| 580 | Reunion |
| 006 | Rhode Island |
| 547 | Rhodesia |
| 549 | Rhodesia, Northern |
| 547 | Rhodesia, Southern |
| 539 | Rio Muni |
| 440 | Romance-language countries |
| 449 | Romania |
| 449 | Roumania |
| 577 | Ruanda |
| 449 | Rumania |
| 455 | Russia, NOS |
| 455 | Russian, SFSR |
| 457 | Russian, White |
| 455 | Russian Federation (former USSR) |
| 577 | Rwanda |
| 134 | Ryukyu Islands |

**S**

| | |
|---|---|
| 520 | Sahara, Western |
| 121 | Samoa, American |
| 725 | Samoa, Western |
| 245 | St. Christopher-Nevis |
| 580 | St. Helena |
| 245 | St. Kitts (see St Christopher-Nevis) |
| 245 | St. Lucia |
| 249 | St. Pierre |
| 245 | St. Vincent |
| 447 | San Marino |
| 543 | Sao Tome |
| 447 | Sardinia |
| 224 | Saskatchewan |
| 629 | Saudi Arabia |
| 420 | Scandinavia |
| 403 | Scotland |
| 539 | Senegal |
| 453 | Serbia |
| 580 | Seychelles |
| 403 | Shetland Islands |
| 651 | Siam |
| 447 | Sicily |
| 539 | Sierra Leone |
| 643 | Sikkim |
| 671 | Singapore |
| 450 | Slavic countries |
| 453 | Slavonia |
| 452 | Slovak Republics |
| 452 | Slovakia |
| 453 | Slovenia |
| 721 | Solomon Islands |
| 581 | Somali Republic |
| 581 | Somalia |
| 581 | Somaliland |
| 583 | Somaliland, French |
| 540 | South Africa |
| 545 | South Africa, Republic of |
| 545 | South Africa, Union of |
| 300 | South America |
| 380 | South American Islands |
| 026 | South Carolina |
| 055 | South Dakota |
| 695 | South Korea |
| 020 | South Mid-Atlantic States |
| 545 | South West Africa |
| 650 | Southeast Asia |
| 030 | Southeastern States |
| 499 | Southern Europe, NOS |
| 122 | Southern Line Islands |
| 070 | Southern Midwest States |
| 133 | Southern Nampo-shoto |
| 547 | Southern Rhodesia |
| 629 | Southern Yemen |

## SEER GEOCODES – Alphabetic Listing

| | |
|---|---|
| --- | Soviet Union (see individual republics) |
| 443 | Spain |
| 520 | Spanish Sahara |
| 647 | Sri Lanka |
| 520 | Sudan (Anglo-Egyptian Sudan) |
| 520 | Sudanese countries |
| 673 | Sumatra |
| 332 | Suriname |
| 423 | Svalbard |
| 135 | Swan Islands |
| 545 | Swaziland |
| 427 | Sweden |
| 435 | Switzerland |
| 621 | Syria |

**T**

| | |
|---|---|
| 634 | Tadzhik SSR |
| 684 | Taiwan |
| 634 | Tajikistan |
| 571 | Tanzania |
| 571 | Tanganyika |
| 571 | Tanzanyika |
| 031 | Tennessee |
| 077 | Texas |
| 651 | Thailand (Siam) |
| 685 | Tibet |
| 245 | Tobago |
| 539 | Togo |
| 136 | Tokelau Islands |
| 725 | Tonga |
| 665 | Tonkin |
| 625 | Trans-Jordan |
| 545 | Transkei |
| 545 | Transvaal |
| 449 | Transylvania |
| 245 | Trinidad |
| 517 | Tripoli |
| 517 | Tripolitania |
| 629 | Trucial States |
| 515 | Tunisia |
| 611 | Turkey |
| 634 | Turkmen SSR |
| 634 | Turkmenistan |
| 245 | Turks Islands |
| 125 | Tuvalu |

**U**

| | |
|---|---|
| 573 | Uganda |
| 456 | Ukraine |
| 456 | Ukrainian SSR |
| 404 | Ulster |
| 545 | Union of South Africa |
| --- | Union of Soviet Socialist Republics (USSR) (see individual republics) |
| 629 | United Arab Emirates |
| 519 | United Arab Republic |
| 400 | United Kingdom |
| 000 | United States |
| 102 | U.S. Virgin Islands |
| 999 | Unknown |
| 520 | Upper Volta |
| 375 | Uruguay |
| 579 | Urundi |
| 084 | Utah |
| 634 | Uzbekistan |
| 634 | Uzbek, SSR |

**V**

| | |
|---|---|
| 721 | Vanuatu |
| 447 | Vatican City |
| 545 | Venda |
| 321 | Venezuela |
| 004 | Vermont |
| 665 | Vietnam |
| 245 | Virgin Islands (British) |
| 102 | Virgin (US) |
| 023 | Virginia |

**W**

| | |
|---|---|
| 137 | Wake Island |
| 402 | Wales |
| 449 | Wallachia |
| 721 | Wallis |
| 093 | Washington (state) |
| 022 | Washington DC |
| 530 | West Africa, NOS |
| 539 | West African countries, other |
| 631 | West Bank |
| 431 | West Germany |

## SEER GEOCODES – Alphabetic Listing

| | |
|---|---|
| 245 | West Indies, NOS (see also individual islands) |
| 639 | West Pakistan |
| 024 | West Virginia |
| 499 | Western Europe, NOS |
| 520 | Western Sahara |
| 725 | Western Samoa |
| 457 | White Russia |
| 245 | Windward Islands |
| 051 | Wisconsin |
| 082 | Wyoming |

**Y**

| | |
|---|---|
| 629 | Yemen |
| 629 | Yemen, People's Democratic Republic of |
| 453 | Yugoslavia (former Yugoslavia region) |
| 225 | Yukon Territory |

**Z**

| | |
|---|---|
| 541 | Zaire |
| 549 | Zambia |
| 571 | Zanzibar |
| 547 | Zimbabwe |

# APPENDIX H:
# SEER SUMMARY STAGING MANUAL 2000

Please insert a copy of the SEER Summary Staging Manual 2000.

It is downloadable at:

*http://seer.cancer.gov/tools/ssm/*

# APPENDIX I:
# SURGICAL CODES

# Alphabetical Index by Primary Site for Surgical Codes

| Primary Site | *ICD-O* Code(s) | *Appendix I* Page # |
|---|---|---|
| Accessory sinuses | C31.0-C31.9 | 77 |
| Adnexa of eye | C69.0-C69.9 | 77 |
| Adrenal gland | C74.0-C74.9 | 77 |
| Anal canal and anus | C21.0-C21.8 | 29 |
| Anus and anal canal | C21.0-C21.8 | 29 |
| Articular cartilage, bones, & joints of limbs & other & unspecified sites | C40.0-C41.9 | 41 |
| Autonomic nervous system and peripheral nerves | C47.0-C47.9 | 41 |
| Biliary tract, other, and unspecified parts of | C24.0-C24.9 | 77 |
| Bladder | C67.0-C67.9 | 68 |
| Blood | C42.0 | 39 |
| Bone marrow | C42.1 | 39 |
| Bones, joints, and articular cartilage of limbs and other and unspecified sites | C40.0-C41.9 | 41 |
| Brain | C71.0-C71.9 | 71 |
| Breast | C50.0-C50.9 | 50 |
| Bronchus and lung | C34.0-C34.9 3 | 37 |
| Cervix uteri | C53.0-C53.9 | 53 |
| Central Nervous System (CNS) parts, other, spinal cord, and cranial nerves | C72.0-C72.9 | 71 |
| Colon | C18.0-C18.9 | 20 |
| Connective, subcutaneous, and other soft tissues | C49.0-C49.9 | 41 |
| Corpus uteri | C54.0-C55.9 | 56 |
| Cranial nerves, spinal cord, and other CNS parts | C72.0-C72.9 | 71 |
| Digestive organs, other, and ill-defined digestive organs | C26.0-C26.9 | 77 |
| Ear, middle | C30.1 | 77 |
| Endocrine glands, other, and related structures | C75.0-C75.9 | 77 |
| Esophagus | C15.0-C15.9 | 15 |
| Eye and adnexa of eye | C69.0-C69.9 | 77 |
| Gallbladder | C23.9 | 77 |
| Gastrointestinal tract, NOS | C26.9 | 77 |
| Genital organs, female, other, and unspecified organs | C57.0-C57.9 | 77 |
| Genital organs, male, other, and unspecified organs | C63.0-C63.9 | 77 |
| Gum | C03.0-C03.9 | 6 |
| Heart | C38.0 | 77 |
| Heart, mediastinum, and pleura, overlapping lesion of | C38.8 | 77 |
| Hematopoietic Diseases | C42.0-C42.4 | 39 |
| Hypopharynx | C13.0-C13.9 | 13 |
| Ill-defined primary | C76.0-C76.8 | 85 |
| Immunoproliferative Diseases | C42.0-C42.4 | 39 |
| Intestinal tract, NOS | C26.0 | 77 |
| Intrahepatic bile ducts | C22.1 | 31 |
| Intrathoracic organs and respiratory system, other, and ill-defined sites | C39.0-C39.9 | 77 |
| Joints, bones, & articular cartilage of limbs & other & unspecified sites | C40.0-C41.9 | 41 |
| Kidney | C64.9 | 66 |

| Primary Site | ICD-O Code(s) | Appendix I Page # |
|---|---|---|
| Larynx | C32.0-C32.9 | 35 |
| Lip | C00.0-C00.9 | 6 |
| Oral cavity, and pharynx, other, and ill-defined sites in | C14.2-C14.8 | 77 |
| Liver | C22.0 | 31 |
| Lung and bronchus | C34.0-C34.9 | 37 |
| Lymph nodes | C77.0-C77.9 | 75 |
| Mediastinum | C38.1-C38.3 | 77 |
| Mediastinum, heart, and pleura, overlapping lesion of | C38.8 | 77 |
| Meninges | C70.0-C70.9 | 71 |
| Mouth, floor of | C04.0-C04.9 | 6 |
| Mouth, other, and unspecified parts of | C06.0-C06.9 | 6 |
| Myeloproliferative Disorders | C42.1 | 39 |
| Nasal cavity | C30.0 | 77 |
| Nasopharynx | C11.0-C11.9 | 13 |
| Oral cavity | C00.0-C06.9 | 6 |
| Oral cavity and pharynx, other and ill-defined sites of | C14.2-C14.8 | 77 |
| Oropharynx | C10.0-C10.9 | 13 |
| Ovary | C56.9 | 59 |
| Palate | C05.0-C05.9 | 6 |
| Pancreas | C25.0-C25.9 | 33 |
| Parotid gland | C07.9 | 10 |
| Penis | C60.0-C60.9 | 77 |
| Peripheral nerves and autonomic nervous system | C47.0-C47.9 | 41 |
| Peritoneum | C48.1-C48.2 | 77 |
| Peritoneum and retroperitoneum, overlapping lesion of | C48.8 | 77 |
| Pharynx, oral cavity, other and ill-defined sites of | C14.2-C14.8 | 77 |
| Pharynx, NOS | C14.0 | 13 |
| Placenta | C58.9 | 77 |
| Pleura, heart, mediastinum, overlapping lesion of | C38.8 | 77 |
| Pleura, NOS | C38.4 | 77 |
| Prostate gland | C61.9 | 62 |
| Pyriform sinus | C12.9 | 13 |
| Rectosigmoid junction | C19.9 | 23 |
| Rectum | C20.9 2 | 6 |
| Renal pelvis | C65.9 | 66 |
| Respiratory system and intrathoracic organs, other, and ill-defined sites within | C39.0-C39.9 | 77 |
| Reticuloendothelial System | C42.3 | 39 |
| Retroperitoneum | C48.0 | 77 |
| Retroperitoneum and peritoneum, overlapping lesion of | C48.8 | 77 |
| Salivary glands, major; other, and unspecified glands | C08.0-C08.9 | 10 |
| Skin | C44.0-C44.9 | 47 |
| Small intestine | C17.0-C17.9 | 77 |
| Soft tissues, other, and connective and subcutaneous tissues | C49.0-C49.9 | 41 |
| Spinal cord, cranial nerves, and other CNS parts | C72.0-C72.9 | 71 |
| Spleen | C42.2 | 45 |

| **Primary Site** | ***ICD-O* Code(s)** | ***Appendix I* Page #** |
|---|---|---|
| Stomach | C16.0-C16.9 | 17 |
| Subcutaneous, connective, and other soft tissues | C49.0-C49.9 | 41 |
| Testis | C62.0-C62.9 | 64 |
| Thymus | C37.9 | 77 |
| Thyroid gland | C73.9 | 73 |
| Tongue, base of | C01.9 | 6 |
| Tongue, other, and unspecified parts of | C02.0-C02.9 | 6 |
| Tonsil | C09.0-C09.9 | 13 |
| Trachea | C33.9 | 77 |
| Unknown primary site | C80.9 | 85 |
| Ureter | C66.9 | 66 |
| Urinary bladder | C67.0-C67.9 | 68 |
| Urinary organs, other and unspecified organs | C68.0-C68.9 | 77 |
| Uterus, NOS | C55.9 | 56 |
| Vagina | C52.9 | 77 |
| Vulva | C51.0-C51.9 | 77 |

**ORAL CAVITY**
**Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9, Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9, Other Parts of Mouth C06.0-C06.9**
(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

- 10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

**No specimen sent to pathology from surgical events 10–14.**

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

**Specimen sent to pathology from surgical events 20–27**.

30 Wide excision, NOS

**Code 30 includes**:
Hemiglossectomy
Partial glossectomy

40 Radical excision of tumor, NOS
- 41 Radical excision of tumor ONLY
- 42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
- 43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

**Codes 40–43 include**:
Total glossectomy
Radical glossectomy

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

## ORAL CAVITY
## Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9, Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9, Other Parts of Mouth C06.0-C06.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES

**Cheek (Buccal) Mucosa, Vestibule**

- Cervical, NOS
- Facial: Buccinator (buccal)
  - Nasolabial
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Parotid, NOS:
  - Infra-auricular
  - Preauricular

**Floor of Mouth**

- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
      - Middle
      - Upper, NOS:
        - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Sublingual

**Gum**

- Cervical, NOS
- Facial, NOS:
  - Buccinator (buccal)
  - Nasolabial
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS: Jugulodigastric (subdigastric)

**ORAL CAVITY**
**Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9, Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9, Other Parts of Mouth C06.0-C06.9**
(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES (continued)

**Gum (continued)**
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Retropharyngeal **for upper gum**

**Hard Palate**
- Buccinator
- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Retropharyngeal

**Lip**
- Cervical, NOS
- Facial, NOS
  - Buccinator (buccal) **for upper lip**
  - Nasolabial **for upper lip**
- Internal jugular, NOS
- Deep cervical, NOS
  - Lower, NOS
    - Jugulo-omohyoid (supraomohyoid)
  - Middle
  - Upper, NOS
    - Jugulodigastric (subdigastric)
- Mandibular **for lower lip:**
  - Submandibular (submaxillary)
  - Submental
- Parotid:
  - Infra-auricular **for upper lip**
  - Preauricular **for upper lip**

**ORAL CAVITY**
**Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9, Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9, Other Parts of Mouth C06.0-C06.9**
(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES (continued)

**Other parts of mouth**
- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Posterior triangle/supraclavicular

**Soft Palate, Uvula**
- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Retropharyngeal

**Tongue**
- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Sublingual

# PAROTID AND OTHER UNSPECIFIED GLANDS
# Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

**No specimen sent to pathology from surgical events 10–14**.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

**Specimen sent to pathology from surgical events 20–27**.

30 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS
- 31 Facial nerve spared
- 32 Facial nerve sacrificed
- 33 Superficial lobe ONLY
  - 34 Facial nerve spared
  - 35 Facial nerve sacrificed
- 36 Deep lobe (Total)
  - 37 Facial nerve spared
  - 38 Facial nerve sacrificed

40 Total parotidectomy, NOS; total removal of major salivary gland, NOS
- 41 Facial nerve spared
- 42 Facial nerve sacrificed

50 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
- 51 WITHOUT removal of temporal bone
- 52 WITH removal of temporal bone
- 53 WITH removal of overlying skin (requires graft or flap coverage)

80 Parotidectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# PAROTID AND OTHER UNSPECIFIED GLANDS
# Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES

**All sites**

- Cervical, NOS for **parotid gland and other major salivary glands**
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Retropharyngeal

**Parotid gland**

- Parotid node(s):
  - Infra-auricular
  - Intraparotid
  - Preauricular

**Submandibular**

- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)

# PHARYNX
# Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9, Pyriform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

**No specimen sent to pathology from surgical events 10–15**.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision
28 Stripping
**Specimens sent to pathology from surgical events 20–28**.

30 Pharyngectomy, NOS
- 31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
- 32 Total pharyngectomy

40 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)
- 41 WITH Laryngectomy (laryngopharyngectomy)
- 42 WITH bone
- 43 WITH both 41 and 42

50 Radical pharyngectomy (includes total mandibular resection), NOS
- 51 WITHOUT laryngectomy
- 52 WITH laryngectomy

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

## PHARYNX
## Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9, Pyriform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES

**Nasopharynx**
- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Retropharyngeal
- Spinal accessory (posterior cervical)

**Pyriform Sinus, Hypopharynx, Laryngopharynx**
- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Parapharyngeal
- Paratracheal
  - Recurrent pharyngeal nerve chain
- Prelaryngeal
  - Delphian node
- Retropharyngeal

**Pharynx, NOS**
- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Parapharyngeal

**PHARYNX**
**Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9, Pyriform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0**
(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES (Continued)

**Pharynx, NOS (continued)**
- Paratracheal
  - Recurrent pharyngeal nerve chain
- Prelaryngeal
  - Delphian node
- Retropharyngeal

**Tonsil, Oropharynx**
- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Retropharyngeal

# ESOPHAGUS
# C15.0-C15.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

**No specimen sent to pathology from surgical events 10–14**.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

**Specimen sent to pathology from surgical events 20–27**.

30 Partial esophagectomy

40 Total esophagectomy, NOS

50 Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
- 51 WITH laryngectomy
- 52 WITH gastrectomy, NOS
- 53 Partial gastrectomy
- 54 Total gastrectomy
- 55 Combination of 51 WITH any of 52–54

80 Esophagectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# ESOPHAGUS
# C15.0-C15.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES

**Cervical Esophagus**
- Cervical, NOS:
  - Anterior deep cervical (laterotracheal) (recurrent laryngeal)
  - Internal jugular, NOS:
    - Deep cervical, NOS:
      - Upper, NOS:
        - Jugulodigastric (subdigastric)
      - Lower, NOS
- Peri-/paraesophageal (upper and lower)
- Scalene (inferior deep cervical)
- Supraclavicular (transverse cervical) Peri-/paraesophageal

**Intrathoracic, lower (abdominal) Esophagus**
- Left gastric (superior gastric):
  - Cardiac (cardial)
  - Lesser curvature
  - Perigastric, NOS
- Peri-/paraesophageal
- Posterior mediastinal (tracheoesophageal)
- Subcarinal

**Intrathoracic, upper thoracic or middle, Esophagus:**
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Intrabronchial:
  - Carinal (tracheobronchial) (tracheal bifurcation)
  - Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)
  - Peritracheal
- Left gastric (superior gastric):
  - Cardiac (cardial)
  - Lesser curvature
  - Perigastric, NOS
- Mediastinal Posterior (tracheoesophageal) and superior
- Peri-/paraesophageal (upper and lower)
- Subcarinal

# STOMACH
# C16.0-C16.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

**No specimen sent to pathology from surgical events 10–14**.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

**Specimen sent to pathology from surgical events 20–27**.

30 Gastrectomy, NOS (partial, subtotal, hemi-)
- 31 Antrectomy, lower (distal-less than 40% of stomach)***
- 32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
- 33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

**Code 30 includes:**

Partial gastrectomy, including a sleeve resection of the stomach
Billroth I: anastomosis to duodenum (duodenostomy)
Billroth II: anastomosis to jejunum (jejunostomy)

40 Near-total or total gastrectomy, NOS
- 41 Near-total gastrectomy
- 42 Total gastrectomy

**A total gastrectomy may follow a previous partial resection of the stomach**.

50 Gastrectomy, NOS WITH removal of a portion of esophagus
- 51 Partial or subtotal gastrectomy
- 52 Near total or total gastrectomy

**Codes 50–52 are used for gastrectomy resection when only portions of esophagus are included in procedure**.

# STOMACH
# C16.0-C16.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE (continued)

**Codes**

60 Gastrectomy with a resection in continuity with the resection of other organs, NOS***
- 61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***
- 62 Near total or total gastrectomy, in continuity with the resection of other organs***
- 63 Radical gastrectomy, in continuity with the resection of other organs***

**Codes 60–63 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection**.

80 Gastrectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included

# STOMACH
# C16.0-C16.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES

**Gastroesophageal Junction**
- Celiac
- Diaphragmatic
- Left gastric
- Lower esophageal
- Pericardial

**Stomach**
- Celiac
- Hepatic
- Left gastric (superior gastric), NOS:
  - Cardial
  - Cardioesophageal
  - Gastric, left
  - Gastropancreatic, left
  - Lesser curvature
  - Lesser omentum
  - Paracardial
- Pancreaticosplenic (pancreaticolienal)
- Perigastric, NOS
- Peripancreatic
- Right gastric (inferior gastric), NOS:
  - Gastrocolic
  - Gastroduodenal
  - Gastroepiploic (gastro-omental), right or NOS
  - Gastrohepatic
  - Greater curvature
  - Greater omental
  - Infrapyloric
  - Pancreaticoduodenal
  - Pyloric, NOS:
    - Infrapyloric (subpyloric)
    - Suprapyloric
- Splenic (lienal), NOS:
  - Gastroepiploic (gastro-omental), left
  - Splenic Hilar

**COLON**
**C18.0-C18.9**
(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE

**Code** removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site.*

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

**No specimen sent to pathology from surgical events 10–14**.

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy, NOS
- 28 Polypectomy-endoscopic
- 29 Polypectomy-surgical excision

Any combination of 20 or 26–29 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

**Specimen sent to pathology from surgical events 20–29**.

30 Partial colectomy, segmental resection
- 32 Plus resection of contiguous organ; example: small bowel, bladder

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)
- 41 Plus resection of contiguous organ; example: small bowel, bladder

50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)
- 51 Plus resection of contiguous organ; example: small bowel, bladder

60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
- 61 Plus resection of contiguous organ; example: small bowel, bladder

**COLON**
**C18.0-C18.9**
(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE (continued)

**Codes**

70 Colectomy or coloproctotectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)

**Code 70 includes:** Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

80 Colectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**COLON**
**C18.0-C18.9**
(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES

**All colon subsites**:
- Colic, NOS
- Epicolic (adjacent to bowel wall)
- Mesenteric, NOS
- Paracolic/pericolic
- Nodule(s) in pericolic fat

**Ascending colon:**
- Ileocolic
- Middle colic
- Right colic

**Cecum and Appendix**:
- Cecal, NOS
  - Anterior (prececal)
  - Posterior (retrocecal)
- Ileocolic
- Right colic

**Descending colon**:
- Inferior mesenteric
- Left colic
- Sigmoid

**Sigmoid**:
- Inferior mesenteric
- Sigmoidal (sigmoid mesenteric)
- Superior hemorrhoidal
- Superior rectal

**Transverse colon and flexures**:
- Inferior mesenteric **for splenic flexure only**
- Left colic **for splenic flexure only**
- Middle colic
- Right colic **for hepatic flexure only**

# RECTOSIGMOID
# C19.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE

**Code** removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site*.

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

**No specimen sent to pathology from surgical events 10–14**.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

**Specimen sent to pathology from surgical events 20–27**.

30 Wedge or segmental resection; partial proctosigmoidectomy, NOS
- 31 Plus resection of contiguous organs; example: small bowel, bladder

**Procedures coded 30 include, but are not limited to**:
- Anterior resection
- Hartmann operation
- Low anterior resection (LAR)
- Partial colectomy, NOS
- Rectosigmoidectomy, NOS
- Sigmoidectomy

40 Pull through WITH sphincter preservation (colo-anal anastomosis)

50 Total proctectomy

51 Total colectomy

55 Total colectomy WITH ileostomy, NOS
- 56 Ileorectal reconstruction
- 57 Total colectomy WITH other pouch; example: Koch pouch

# RECTOSIGMOID
# C19.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE (continued)

**Codes**

60 Total proctocolectomy, NOS
  65 Total proctocolectomy WITH ileostomy, NOS
  66 Total proctocolectomy WITH ileostomy and pouch
  **Removal of the colon from cecum to the rectosigmoid or a portion of the rectum**.

70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration

80 Colectomy, NOS; Proctectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# RECTOSIGMOID
# C19.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES

Colic, NOS
    Left colic
Hemorrhoidal, superior or middle
Inferior mesenteric
Mesenteric, NOS
Paracolic/pericolic
Paravertebral
Perirectal
Rectal
Sigmoidal (sigmoid mesenteric)
Superior rectal

# RECTUM
# C20.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE

**Code** removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site.*

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

**No specimen sent to pathology from surgical events 10-14**.

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 28 Curette and fulguration

**Specimen sent to pathology from surgical events 20–28**.

30 Wedge or segmental resection; partial proctectomy, NOS

**Procedures coded 30 include, but are not limited to**:
- Anterior resection
- Hartmann's operation
- Low anterior resection (LAR)
- Transsacral Rectosigmoidectomy

40 Pull through WITH sphincter preservation (coloanal anastomosis)

50 Total proctectomy

**Procedure coded 50 includes, but is not limited to**:
- Abdominoperineal resection (Miles Procedure)

60 Total proctocolectomy, NOS

70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration

80 Proctectomy, NOS

**RECTUM**
**C20.9**
(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE (continued)

**Codes**

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# RECTUM
# C20.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES

Hemorrhoidal, superior, middle or inferior
Inferior mesenteric
Internal iliac (hypogastric), NOS:
    Obturator
Mesenteric, NOS
Perirectal
Rectal
Sacral, NOS:
    Lateral (laterosacral)
    Middle sacral (promontorial) (Gerota's node)
    Presacral
Sigmoidal (sigmoid mesenteric)

# ANUS
# C21.0-C21.8

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal Ablation

**No specimen sent to pathology from surgical events 10–15**.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

**Specimen sent to pathology from surgical events 20–27**.

60 Abdominal perineal resection, NOS (APR; Miles procedure)
- 61 APR and sentinel node excision
- 62 APR and unilateral inguinal lymph node dissection
- 63 APR and bilateral inguinal lymph node dissection

**The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery*.**

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# ANUS
# C21.0-C21.8

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES

Anorectal
    Inferior hemorrhoidal
Internal iliac (hypogastric), NOS: **for anus and anal canal:**
    Obturator **for anus and anal canal**
Lateral sacral (laterosacral)
Paravertebral
Perirectal
Superficial inguinal (femoral) **for anus and anal canal**

# LIVER AND INTRAHEPATIC BILE DUCTS
# C22.0-C22.1

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Alcohol (Percutaneous Ethanol Injection-PEI)
- 16 Heat-Radio-frequency ablation (RFA)
- 17 Other (ultrasound, acetic acid)

**No specimen sent to pathology from surgical events 10–17**.

20 Wedge or segmental resection, NOS
- 21 Wedge resection
- 22 Segmental resection, NOS
  - 23 One
  - 24 Two
  - 25 Three
  - 26 Segmental resection AND local tumor destruction

**Specimen sent to pathology from surgical events 20–26**.

30 Lobectomy, NOS
- 36 Right lobectomy
- 37 Left lobectomy
- 38 Lobectomy AND local tumor destruction

50 Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe)
- 51 Right lobectomy
- 52 Left lobectomy
- 59 Extended lobectomy AND local tumor destruction

60 Hepatectomy, NOS
- 61 Total hepatectomy and transplant

65 Excision of a bile duct (for an intra-hepatic bile duct primary only)
- 66 Excision of a bile duct PLUS partial hepatectomy

75 Bile duct and hepatectomy WITH transplant

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# LIVER AND INTRAHEPATIC BILE DUCTS
# C22.0-C22.1

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES

Caval
Hepatic, NOS:
- Hepatic artery
- Hepatic pedicle
- Inferior vena cava
- Porta hepatis (portal) (hilar) [in hilus of liver]

Hepatoduodenal ligament
Periportal

# PANCREAS
# C25.0-C25.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

25 Local excision of tumor, NOS

30 Partial pancreatectomy, NOS; example: distal

35 Local or partial pancreatectomy and duodenectomy
- 36 WITHOUT distal/partial gastrectomy
- 37 WITH partial gastrectomy (Whipple)

40 Total pancreatectomy

60 Total pancreatectomy and subtotal gastrectomy or duodenectomy

70 Extended pancreatoduodenectomy

80 Pancreatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# PANCREAS
# C25.0-C25.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES

Celiac
Hepatic
Infrapyloric (subpyloric)
Lateral aortic (lumbar)
Pancreaticosplenic (pancreaticolienal)
Peripancreatic, NOS:
- Anterior, NOS:
  - Anterior pancreaticoduodenal
  - Anterior proximal mesenteric
  - Pyloric
- Inferior to the head and body of pancreas
- Posterior, NOS:
  - Pericholedochal (common bile duct)
  - Posterior pancreaticoduodenal
  - Posterior proximal mesentery
- Superior to the head and body of pancreas

Pyloric
Retroperitoneal
Splenic (lienal):
- Gastroepiploic (gastro-omental), left
- Splenic hilum
- Suprapancreatic

Superior mesenteric

# LARYNX
# C32.0-C32.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

**No specimen sent to pathology from surgical events 10–15**.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

- 25 Laser excision
- 28 Stripping

**Specimen sent to pathology from surgical events 20–28**.

30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy, NOS
- 31 Vertical laryngectomy
- 32 Anterior commissure laryngectomy
- 33 Supraglottic laryngectomy

40 Total or radical laryngectomy, NOS
- 41 Total laryngectomy ONLY
- 42 Radical laryngectomy ONLY

50 Pharyngolaryngectomy

80 Laryngectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# LARYNX
# C32.0-C32.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES

Anterior deep cervical (laterotracheal) (recurrent laryngeal):
- Paralaryngeal
- Paratracheal
- Prelaryngeal:
  - Delphian node
- Pretracheal

Cervical, NOS
Internal jugular, NOS:
- Deep cervical, NOS:
  - Lower, NOS:
    - Jugulo-omohyoid (supraomohyoid)
  - Middle
  - Upper, NOS:
    - Jugulodigastric (subdigastric)

Mandibular, NOS:
- Submandibular (submaxillary)
- Submental

Retropharyngeal

# LUNG
# C34.0-C34.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
**Unknown whether a specimen was sent to pathology for surgical events coded 19**

15 Local tumor destruction, NOS
12 Laser ablation or cryosurgery
13 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
**No specimen sent to pathology from surgical events 12–13 and 15**.

20 Excision or resection of less than one lobe, NOS
23 Excision, NOS
24 Laser excision
25 Bronchial sleeve resection ONLY
21 Wedge resection
22 Segmental resection, including lingulectomy
**Specimen sent to pathology from surgical events 20–25**.

30 Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)
33 Lobectomy WITH mediastinal lymph node dissection
**The lymph node dissection should be coded under *Scope of Regional Lymph Node Surgery.***

45 Lobe or bilobectomy extended, NOS
46 WITH chest wall
47 WITH pericardium
48 WITH diaphragm

55 Pneumonectomy, NOS
56 WITH mediastinal lymph node dissection (radical pneumonectomy)
**The mediastinal lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery.***

65 Extended pneumonectomy
66 Extended pneumonectomy plus pleura or diaphragm

70 Extended radical pneumonectomy
**The mediastinal lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery.***

80 Resection of lung, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**LUNG**
**C34.0-C34.9**
(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

## REGIONAL LYMPH NODES

Aortic [above diaphragm], NOS:
- Peri-/para-aortic, NOS:
  - Ascending aorta (phrenic)
- Subaortic (aortico-pulmonary window )

Bronchial
Carinal (tracheobronchial) (tracheal bifurcation)
Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)
Intrapulmonary, NOS:
- Interlobar
- Lobar
- Segmental
- Subsegmental

Intrathoracic
Mediastinal, NOS:
- Anterior
- Posterior (tracheoesophageal)

Pericardial
Peri-/parabronchial
Peri-/paraesophageal
Peri-/paratracheal, NOS:
- Azygos (lower peritracheal)

Pre- and retrotracheal, NOS:
- Precarinal

Pulmonary ligament
Scalene
Subcarinal
Supraclavicular

## HEMATOPOIETIC/RETICULOENDOTHELIAL/IMMUNOPROLIFERATIVE/ MYELOPROLIFERATIVE DISEASE C42.0, C42.1, C42.3, C42.4 (with any histology) or M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989 (with any site)

| | |
|---|---|
| C42.0 | Blood |
| C42.1 | Bone marrow |
| C42.3 | Reticuloendothelial system |
| C42.4 | Hematopoietic system |
| 9750 | Malignant histiocytosis |
| 9760 | Immunoproliferative disease, NOS |
| 9761 | Waldenstrom macroglobulinemia |
| 9763 | Heavy chain disease |
| 9764 | Immunoproliferative small intestinal disease (Mediterranean lymphoma) |
| 9800-9820, 9826, 9831-9920, 9940-9948 | Leukemias |
| 9931 | Acute panmyelosis with fibrosis |
| 9950 | Polycythemia vera |
| 9960 | Chronic myeloproliferative disorder |
| 9961 | Myelosclerosis with myeloid metaplasia |
| 9962 | Essential thrombocythemia |
| 9963 | Chronic neutrophilic leukemia |
| 9964 | Hypereosinophilic syndrome |
| 9980-9985 | Refractory anemias |
| 9986 | Myelodysplastic syndrome with 5q deletion syndrome |
| 9987 | Therapy-related myelodysplastic syndrome, NOS |
| 9989 | Myelodysplastic syndrome, NOS |

## SURGERY OF PRIMARY SITE

**Code**

98 All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment.

**Surgical procedures for hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative primaries are to be recorded using the data item *Surgical Procedure/Other Site.***

**HEMATOPOIETIC/RETICULOENDOTHELIAL/IMMUNOPROLIFERATIVE/ MYELOPROLIFERATIVE DISEASE**
**C42.0, C42.1, C42.3, C42.4 (with any histology) or**
**M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989**
**(with any site)**

## REGIONAL LYMPH NODES

Not applicable. Code 9 for Scope Regional Lymph Node Surgery.

# BONES, JOINTS, AND ARTICULAR CARTILAGE C40.0-C41.9
# PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C47.0-C47.9
# CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES C49.0-C49.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
**Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).**

15 Local tumor destruction
**No specimen sent to pathology from surgical event 15.**

25 Local excision

26 Partial resection
**Specimen sent to pathology from surgical events 25–26.**

30 Radical excision or resection of lesion WITH limb salvage

40 Amputation of limb
- 41 Partial amputation of limb
- 42 Total amputation of limb

50 Major amputation, NOS
- 51 Forequarter, including scapula
- 52 Hindquarter, including ilium/hip bone
- 53 Hemipelvectomy, NOS
- 54 Internal hemipelvectomy

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**BONES, JOINTS, AND ARTICULAR CARTILAGE C40.0-C41.9**
**PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C47.0-C47.9**
**CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES C49.0-C49.9**
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

Regional lymph node metastasis from bone tumors is extremely rare.

**Abdomen**:
- Celiac
- Iliac
- Para-aortic

**Arm/shoulder:**
- Axillary
- Epitrochlear **for hand/forearm**
- Spinal accessory (posterior cervical) **for shoulder**

**Head and neck** :
- All head and neck subsites:
  - Cervical, NOS
- Eyelid/canthus:
  - Facial, NOS:
    - Buccinator (buccal)
    - Nasolabial
  - Mandibular, NOS:
    - Submandibular (submaxillary)
    - Submental
  - Parotid, NOS:
    - Infra-auricular
- External ear/auditory canal:
  - Mastoid (post-/retro-auricular)
  - Preauricular
- Face, Other (cheek, chin, forehead, jaw, nose and temple):
  - Facial, NOS:
    - Buccinator (buccal)
    - Nasolabial
  - Mandibular, NOS:
    - Submandibular (submaxillary)
    - Submental
  - Parotid, NOS:
    - Infra-auricular
    - Preauricular

**BONES, JOINTS, AND ARTICULAR CARTILAGE C40.0-C41.9**
**PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C47.0-C47.9**
**CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES C49.0-C49.9**
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES (continued)

**Head and neck (continued)** :

- Lip:
  - Facial, NOS:
    - Buccinator (buccal)
    - Nasolabial
  - Mandibular, NOS:
    - Submandibular (submaxillary)
    - Submental
  - Parotid, NOS:
  - Infra-auricular
  - Preauricular
- Neck:
  - Axillary
  - Mandibular, NOS:
    - Submental
  - Mastoid (post-/retro-auricular)
  - Parotid, NOS:
    - Infra-auricular
    - Preauricular
  - Spinal accessory (posterior cervical)
    - Supraclavicular (transverse cervical)
- Scalp:
  - Mastoid (post-/retro-auricular)
  - Parotid, NOS:
    - Infra-auricular
    - Preauricular
  - Spinal accessory (posterior cervical)

**Leg/hip:**

- Popliteal **for heel and calf**
- Superficial inguinal (femoral)

**Pelvis**:

- Deep inguinal, NOS:
  - Node of Cloquet or Rosenmuller (highest deep inguinal)
- Superficial inguinal (femoral)

**Thorax**:

- Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)
- Mediastinal

**BONES, JOINTS, AND ARTICULAR CARTILAGE C40.0-C41.9**
**PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C47.0-C47.9**
**CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES C49.0-C49.9**
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES (continued)

**Trunk, lower:**
Superficial inguinal (femoral)

**Trunk, upper:**
Axillary
Cervical
Internal mammary
Supraclavicular (transverse cervical)

# SPLEEN
# C42.2

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
**Unknown whether a specimen was sent to pathology for surgical events coded 19 principally for cases diagnosed prior to January 1, 2003).**

21 Partial splenectomy

22 Total splenectomy

80 Splenectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# SPLEEN
# C42.2

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

Not applicable.

Code 9 for Scope Regional Lymph Node Surgery.

**SKIN**
**C44.0-C44.9**
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

**No specimen sent to pathology from surgical events 10–14**.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

**Specimen sent to pathology from surgical events 20–27**.

30 Biopsy of primary tumor followed by a gross excision of the lesion (does not have to be done under the same anesthesia)
- 31 Shave biopsy followed by a gross excision of the lesion
- 32 Punch biopsy followed by a gross excision of the lesion
- 33 Incisional biopsy followed by a gross excision of the lesion
- 34 Mohs surgery, NOS
- 35 Mohs with 1-cm margin or less
- 36 Mohs with more than 1-cm margin

45 Wide excision or reexcision of lesion or minor (local) amputation with margins more than 1 cm, NOS. Margins MUST be microscopically negative.
- 46 WITH margins more than 1 cm and less than or equal to 2 cm
- 47 WITH margins greater than 2 cm

**If the excision does not have microscopically negative margins greater than 1 cm, use the appropriate code, 20-36.**

60 Major amputation

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**SKIN**
**C44.0-C44.9**
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

**Arm/shoulder:**
- Axillary
- Epitrochlear **for hand/forearm**
- Spinal accessory (posterior cervical) **for shoulder**

**Head and neck** :
- All head and neck subsites:
  - Cervical, NOS

- External ear/auditory canal:
  - Mastoid (post-/retro-auricular)
  - Preauricular

- Face, Other (cheek, chin, forehead, jaw, nose and temple):
  - Facial, NOS:
    - Buccinator (buccal)
    - Nasolabial
  - Mandibular, NOS:
    - Submandibular (submaxillary)
    - Submental
  - Parotid, NOS:
    - Infra-auricular
    - Preauricular
- Lip:
  - Facial, NOS:
    - Buccinator (buccal)
    - Nasolabial
  - Mandibular, NOS:
    - Submandibular (submaxillary)
    - Submental
  - Parotid, NOS:
    - Infra-auricular
    - Preauricular
- Neck:
  - Axillary
  - Mandibular, NOS:
    - Submental
  - Mastoid (post-/retro-auricular)
  - Parotid, NOS:
  - Infra-auricular
  - Preauricular
- Spinal accessory (posterior cervical)
  - Supraclavicular (transverse cervical)

**SKIN**
**C44.0-C44.9**
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES (continued)

**Head and neck (continued)** :
- Scalp:
  - Mastoid (post-/retro-auricular)
  - Parotid, NOS:
    - Infra-auricular
    - Preauricular
  - Spinal accessory (posterior cervical)

**Leg/hip:**
- Popliteal **for heel and calf**
- Superficial inguinal (femoral)

**Lower trunk:**
- Superficial inguinal (femoral)

**Upper trunk:**
- Axillary
- Cervical
- Internal mammary
- Supraclavicular (transverse cervical)

# BREAST
# C50.0-C50.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS
**No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).**

20 Partial mastectomy, NOS; less than total mastectomy, NOS
- 21 Partial mastectomy WITH nipple resection
- 22 Lumpectomy or excisional biopsy
- 23 Reexcision of the biopsy site for gross or microscopic residual disease
- 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

**Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.**

30 Subcutaneous mastectomy
**A subcutaneous mastectomy is the removal of breast tissue without the nipple and areolar complex or overlying skin.**

40 Total (simple) mastectomy
- 41 WITHOUT removal of uninvolved contralateral breast
- 43 Reconstruction NOS
  - 44 Tissue
  - 45 Implant
  - 46 Combined (Tissue and Implant)
- 42 WITH removal of uninvolved contralateral breast

47 Reconstruction NOS
- 48 Tissue
- 49 Implant
- 75 Combined (Tissue and Implant)

**A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done.**

**For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site.***

**If contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.**

**BREAST**
**C50.0-C50.9**
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE (continued)

**Codes**

50 Modified radical mastectomy
- 51 WITHOUT removal of uninvolved contralateral breast
- 53 Reconstruction, NOS
  - 54 Tissue
  - 55 Implant
  - 56 Combined (Tissue and Implant)
- 52 WITH removal of uninvolved contralateral breast
  - 57 Reconstruction, NOS
  - 58 Tissue
  - 59 Implant
  - 63 Combined (Tissue and Implant)

**Removal of all breast tissue, nipple, areolar complex, and variable amounts of breast skin in continuity with axilla. Specimen may or may not include portion of pectoralis major muscle.**

**If contralateral breast reveals a second primary, it is abstracted separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.**

**For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site.***

60 Radical mastectomy, NOS
- 61 WITHOUT removal of uninvolved contralateral breast
  - 64 Reconstruction, NOS
  - 65 Tissue
  - 66 Implant
  - 67 Combined (Tissue and Implant)
- 62 WITH removal of uninvolved contralateral breast
  - 68 Reconstruction, NOS
  - 69 Tissue
  - 73 Implant
  - 74 Combined (Tissue and Implant)

70 Extended radical mastectomy
- 71 WITHOUT removal of uninvolved contralateral breast
- 72 WITH removal of uninvolved contralateral breast

80 Mastectomy, NOS\

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**BREAST**
**C50.0-C50.9**
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

Axillary, NOS:
- Level I (low) (superficial), NOS [adjacent to tail of breast]:
  - Anterior (pectoral)
  - Lateral (brachial)
  - Posterior (subscapular)
- Level II (mid-level) (central), NOS:
  - Interpectoral (Rotter's)
- Level III (high) (deep), NOS:
  - Apical (subclavian)
  - Axillary vein

Infraclavicular (ipsilateral) (subclavicular)
Internal mammary (parasternal)
Intramammary
Subclavicular
Supraclavicular- lymph nodes in the supraclavicular fossa, a triangle defined by the omohyoid muscle and tendon (lateral and superior border), the internal jugular vein (medial border), and the clavicle and subclavian vein (lower border). Adjacent lymph nodes outside this triangle are considered to lower cervical and therefore are distant nodes.
Transpectoral

**CERVIX UTERI**
**C53.0-C53.9**
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Laser ablation
- 17 Thermal ablation

**No specimen sent to pathology from surgical events 10–17**.

20 Local tumor excision, NOS
- 26 Excisional biopsy, NOS
- 27 Cone biopsy
- 24 Cone biopsy WITH gross excision of lesion
- 29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27 or 29 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision
- 25 Dilatation and curettage; endocervical curettage (for in situ only)
- 28 Loop electrocautery excision procedure (LEEP)

**Specimen sent to pathology from surgical events 20–29**.

30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries
**Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.**

40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary
**Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff**.

50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 51 Modified radical hysterectomy
- 52 Extended hysterectomy
- 53 Radical hysterectomy; Wertheim procedure
- 54 Extended radical hysterectomy

60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
- 61 WITHOUT removal of tubes and ovaries
- 62 WITH removal of tubes and ovaries

# CERVIX UTERI
# C53.0-C53.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE (continued)

**Codes**

70 Pelvic exenteration
71 Anterior exenteration
**Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.**

72 Posterior exenteration
**Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes**.

73 Total exenteration
**Includes removal of all pelvic contents and pelvic lymph nodes.**

74 Extended exenteration
**Includes pelvic blood vessels or bony pelvis**.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# CERVIX UTERI
# C53.0-C53.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

Iliac, NOS:
- Common
- External
- Internal (hypogastric), NOS:
  - Obturator

Paracervical
Parametrial
Pelvic, NOS
Sacral, NOS:
- Lateral (laterosacral)
- Middle (promontorial) (Gerota's node)
- Presacral

Uterosacral

# CORPUS UTERI
# C54.0-C55.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
**Unknown whether a specimen was sent to pathology for surgical events coded 19**

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Thermal ablation

**No specimen sent to pathology from surgical events 10–16**.

20 Local tumor excision, NOS; simple excision, NOS
- 24 Excisional biopsy
- 25 Polypectomy
- 26 Myomectomy

Any combination of 20 or 24–26 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

**Specimen sent to pathology from surgical events 20–26.**

30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies).
- 31 WITHOUT tube(s) and ovary(ies)
- 32 WITH tube(s) and ovary(ies)

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)
**Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff**.

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)
**Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.**

60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 61 Modified radical hysterectomy
- 62 Extended hysterectomy
- 63 Radical hysterectomy; Wertheim procedure
- 64 Extended radical hysterectomy

65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)
- 66 WITHOUT removal of tube(s) and ovary(ies)
- 67 WITH removal of tube(s) and ovary(ies)

**CORPUS UTERI**
**C54.0-C55.9**
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE (continued)

**Codes**

75 Pelvic exenteration

76 Anterior exenteration
**Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.**

77 Posterior exenteration
**Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.**

78 Total exenteration
**Includes removal of all pelvic contents and pelvic lymph nodes.**

79 Extended exenteration
**Includes pelvic blood vessels or bony pelvis**.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# CORPUS UTERI
# C54.0-C55.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

Aortic, NOS:
- Lateral (lumbar)
- Para-aortic
- Periaortic

Iliac:
- Common
- External
- Internal (hypogastric), NOS:
  - Obturator

Paracervical
Parametrial
Pelvic, NOS
Sacral, NOS:
- Lateral (laterosacral)
- Middle (promontorial) (Gerota's node)
- Presacral

Uterosacral

# OVARY
# C56.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

17 Local tumor destruction, NOS
**No specimen sent to pathology from surgical event 17**.

25 Total removal of tumor or (single) ovary, NOS
26 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
27 WITHOUT hysterectomy
28 WITH hysterectomy
**Specimen sent to pathology from surgical events 25–28**.

35 Unilateral (salpingo-)oophorectomy; unknown if hysterectomy done
36 WITHOUT hysterectomy
37 WITH hysterectomy

50 Bilateral (salpingo-)oophorectomy; unknown if hysterectomy done
51 WITHOUT hysterectomy
52 WITH hysterectomy

55 Unilateral or bilateral (salpingo-)oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done
56 WITHOUT hysterectomy
57 WITH hysterectomy

60 Debulking; cytoreductive surgery, NOS
61 WITH colon (including appendix) and/or small intestine resection (not incidental)
62 WITH partial resection of urinary tract (not incidental)
63 Combination of 61 and 62
**Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.**

70 Pelvic exenteration, NOS
71 Anterior exenteration
**Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.**

72 Posterior exenteration
**Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.**

73 Total exenteration
**Includes removal of all pelvic contents and pelvic lymph nodes.**

74 Extended exenteration
**Includes pelvic blood vessels or bony pelvis**

**OVARY**
**C56.9**
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE (continued)

**Codes**

80 (Salpingo-)oophorectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# OVARY
# C56.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

Aortic, NOS:
- Lateral (lumbar)
- Para-aortic
- Periaortic

Iliac, NOS:
- Common
- External
- Internal (hypogastric), NOS:
  - Obturator

Inguinal
Lateral sacral (laterosacral)
Pelvic, NOS
Retroperitoneal, NOS
Sacral

# PROSTATE
# C61.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Do not code** an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item *Hematologic Transplant and Endocrine Procedures.*

**Codes**

00 None; no surgery of primary site; autopsy ONLY

18 Local tumor destruction or excision, NOS

19 Transurethral resection (TURP), NOS
**Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19**

10 Local tumor destruction, NOS
- 14 Cryoprostatectomy
- 15 Laser ablation
- 16 Hyperthermia
- 17 Other method of local tumor destruction

**No specimen sent to pathology from surgical events 10–17**.

20 Local tumor excision, NOS
- 21 Transurethral resection (TURP), NOS
- 22 TURP—cancer is incidental finding during surgery for benign disease
- 23 TURP—patient has suspected/known cancer

Any combination of 20–23 WITH
- 24 Cryosurgery
- 25 Laser
- 26 Hyperthermia

**Specimen sent to pathology from surgical events 20–26**.

30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

50 Radical prostatectomy, NOS; total prostatectomy, NOS
**Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.**

70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
**Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy**.

80 Prostatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# PROSTATE
# C61.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

Iliac, NOS:
- External
- Internal (hypogastric), NOS:
  - Obturator

Pelvic, NOS
Periprostatic
- Sacral, NOS:
- Lateral (laterosacral)

Middle (promontorial) (Gerota's node)
Presacral

# TESTIS
# C62.0-C62.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

12 Local tumor destruction, NOS
**No specimen sent to pathology from surgical event 12**.

20 Local or partial excision of testicle
**Specimen sent to pathology from surgical event 20**.

30 Excision of testicle WITHOUT cord

40 Excision of testicle WITH cord/or cord not mentioned (radical orchiectomy)

80 Orchiectomy, NOS (unspecified whether partial or total testicle removed)

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# TESTIS
# C62.0-C62.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

Aortic, NOS
- Lateral (lumbar)
- Para-aortic
- Periaortic
- Preaortic
- Retroaortic

Pericaval, NOS
- Interaortocaval
- Paracaval
- Precaval

Retrocaval
Pelvic, NOS
Retroperitoneal, NOS
Spermatic vein

# KIDNEY, RENAL PELVIS, AND URETER
# Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal ablation

**No specimen sent to pathology from this surgical event 10–15**.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

**Specimen sent to pathology from surgical events 20–27**.

30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)

**Procedures coded 30 include, but are not limited to**:
Segmental resection; Wedge resection

40 Complete/total/simple nephrectomy—for kidney parenchyma
Nephroureterectomy
**Includes bladder cuff for renal pelvis or ureter**.

50 Radical nephrectomy
**May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter**.

70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with the resection of other organ(s) (colon, bladder)
**The other organs, such as colon or bladder, may be partially or totally removed**.

80 Nephrectomy, NOS; Ureterectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# KIDNEY, RENAL PELVIS, AND URETER
# Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

**Kidney**

- Aortic, NOS:
  - Lateral (lumbar)
  - Para-aortic
  - Periaortic
- Paracaval
- Renal hilar
- Retroperitoneal, NOS

**Renal Pelvis**

- Aortic, NOS:
  - Lateral (lumbar)
  - Para-aortic
  - Periaortic
- Paracaval
- Renal hilar
- Retroperitoneal, NOS

**Ureter**

- Iliac, NOS:
- Common
- External
- Internal (hypogastric), NOS:
  - Obturator
- Lateral aortic (lumbar)
- Paracaval
- Pelvic, NOS
- Periureteral
- Renal hilar
- Retroperitoneal, NOS

# BLADDER
# C67.0-C67.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Intravesical therapy
- 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy

**No specimen sent to pathology from surgical events 10–16**.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

**Specimen sent to pathology from surgical events 20–27**.

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Radical cystectomy (male only)
- 61 Radical cystectomy PLUS ileal conduit
- 62 Radical cystectomy PLUS continent reservoir or pouch, NOS
- 63 Radical cystectomy PLUS abdominal pouch (cutaneous)
- 64 Radical cystectomy PLUS in situ pouch (orthotopic)

70 Pelvic exenteration, NOS
- 71 Radical cystectomy (female only); anterior exenteration

**A radical cystectomy in a female includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra.**
- 72 Posterior exenteration
- 73 Total exenteration

**Includes removal of all pelvic contents and pelvic lymph nodes.**

**The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery*.**

# BLADDER
# C67.0-C67.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE (continued)

**Codes**

74 Extended exenteration
**Includes pelvic blood vessels or bony pelvis**.

80 Cystectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# BLADDER
# C67.0-C67.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

Iliac, NOS:
- External
- Internal (hypogastric), NOS:
  - Obturator

Pelvic, NOS
Perivesical
Sacral, NOS
- Lateral (laterosacral)
- Middle (promontorial) (Gerota's node)
- Presacral

# BRAIN
# Meninges C70.0-C70.9, Brain C71.0-C71.9, Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C72.0-C72.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Do not code** laminectomies for spinal cord primaries.

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Tumor destruction, NOS
**No specimen sent to pathology from surgical event 10.**

**Do not record stereotactic radiosurgery as tumor destruction. It should be recorded in the radiation treatment items.**

20 Local excision (biopsy) of lesion or mass
**Specimen sent to pathology from surgical event 20**.

40 Partial resection

55 Gross total resection

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**BRAIN**
**Meninges C70.0-C70.9, Brain C71.0-C71.9, Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C72.0-C72.9**
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

Not applicable.

Code 9 for Scope of Regional Lymph Node Surgery.

# THYROID
# C73.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

13 Local tumor destruction, NOS
**No specimen sent to pathology from surgical event 13**.

25 Removal of less than a lobe, NOS
- 26 Local surgical excision
- 27 Removal of a partial lobe ONLY

**Specimen sent to pathology from surgical events 25–27**.

20 Lobectomy and/or isthmectomy
- 21 Lobectomy ONLY
- 22 Isthmectomy ONLY
- 23 Lobectomy WITH isthmus

30 Removal of a lobe and partial removal of the contralateral lobe

40 Subtotal or near total thyroidectomy

50 Total thyroidectomy

80 Thyroidectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# THYROID
# C73.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

Anterior deep cervical (laterotracheal) (recurrent laryngeal):
- Paralaryngeal
- Paratracheal
- Prelaryngeal:
  - Delphian node
- Pretracheal

Cervical, NOS
Internal jugular, NOS:
- Deep cervical, NOS:
  - Lower, NOS:
    - Jugulo-omohyoid (supraomohyoid)
  - Middle

Mediastinal, NOS
- Posterior mediastinal (tracheoesophageal)
- Upper anterior mediastinal

Retropharyngeal
Spinal accessory (posterior cervical)
Submandibular
Submental
Supraclavicular (transverse cervical)

# LYMPH NODES
# C77.0-C77.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
**Unknown whether a specimen was sent to pathology for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003).**

15 Local tumor destruction, NOS
**No specimen sent to pathology from surgical event 15**.

25 Local tumor excision, NOS
**Less than a full chain, includes an excisional biopsy of a single lymph node**.

30 Lymph node dissection, NOS
- 31 One chain
- 32 Two or more chains

40 Lymph node dissection, NOS PLUS splenectomy
- 41 One chain
- 42 Two or more chains

50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
- 51 One chain
- 52 Two or more chains

60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy. (Includes staging laparotomy for lymphoma.)
- 61 One chain
- 62 Two or more chains

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

# LYMPH NODES
# C77.0-C77.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

Not applicable.

Code 9 for Scope of Regional Lymph Node Surgery.

**ALL OTHER SITES**
**C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9**
(Except for unknown and ill-defined sites and M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

**No specimen sent to pathology from surgical events 10–14.**

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

**Specimen sent to pathology from surgical events 20–27**.

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation
- 41 Total enucleation (for eye surgery only)

50 Surgery stated to be “debulking”

60 Radical surgery
**Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.**

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

## ALL OTHER SITES

**C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9**

(Except for unknown and ill-defined sites and M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

**Accessory Sinuses (maxillary sinus, ethmoid sinus, frontal sinus, sphenoid sinus)**
- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Retropharyngeal

**Adrenal gland**
- Retroperitoneal

**Ampulla of Vater**
- Celiac
- Hepatic
- Infrapyloric (subpyloric)
- Lateral aortic (lumbar)
- Node of the foramen of Winslow (epiploic) (omental)
- Pancreaticoduodenal
- Peripancreatic
- Periportal
- Proximal mesenteric
- Pyloric
- Retroperitoneal
- Superior mesenteric

- Lymph Nodes:
  - Anterior to ampulla of Vater
  - Inferior to ampulla of Vater
  - Posterior to ampulla of Vater
  - Superior to ampulla of Vater

Endocrine Glands, other and related structures (parathyroid gland, pituitary gland, craniopharyngeal duct, pineal gland, carotid body, aortic body, endocrine gland, NOS)
- Cervical **for carotid body and parathyroid only**
- Mediastinal **for aortic body and thymus only**

- Not applicable, for the following sites:
  - Craniopharyngeal duct (C75.2); Pituitary gland (C75.1); Pineal gland (C75.3)

**ALL OTHER SITES**
**C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9**
(Except for unknown and ill-defined sites and M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES (continued)

**Epididymis, Spermatic cord, Scrotum, NOS, Other specified parts of male genital organs, overlapping lesion of male genital organs, Male genital organs, NOS**
- Iliac, NOS:
  - External
  - Internal (hypogastric), NOS: Obturator
- Inguinal, NOS:
  - Deep, NOS
    - Node of Cloquet or Rosenmuller (highest deep inguinal)
  - Superficial inguinal (femoral)
- Pelvic, NOS

**Extrahepatic bile duct**
- Cystic duct (Calot's node)
- Node of the foramen of Winslow (epiploic) (omental)
- Pancreaticoduodenal
- Pericholedochal (common bile duct)
- Periduodenal
- Peripancreatic (near head of pancreas only)
- Periportal
- Porta hepatis (portal) (hilar) [in hilus of liver]

**Eye and Adnexa**
- Cervical
- Mandibular, NOS:
  - Submandibular (submaxillary)
- Parotid, NOS:
  - Infra-auricular; Preauricular

**Female Genital Organs (fallopian tube, broad ligament, round ligament, parametrium, uterine adnexa)**
- Aortic, NOS
  - Lateral (lumbar); Para-aortic; Periaortic
- Iliac, NOS:
  - Common
  - External
  - Internal (hypogastric), NOS: Obturator
- Inguinal
- Lateral sacral (laterosacral)
- Pelvic, NOS
- Presacral
- Retroperitoneal, NOS

**ALL OTHER SITES**
**C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9**
(Except for unknown and ill-defined sites and M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES (continued)

**Gallbladder, Overlapping lesion of biliary tract and biliary tract, NOS**
- Celiac
- Cystic duct (Calot's node)
- Node of the foramen of Winslow (epiploic) (omental)
- Pancreaticoduodenal
- Pericholedochal (common bile duct)
- Periduodenal
- Peripancreatic (near head of pancreas only)
- Periportal
- Porta hepatis (portal) (hilar) [in hilus of liver]
- Superior mesenteric

**Heart and Mediastinum**
- Aortic [above diaphragm], NOS:
  - Peri/para-aortic, NOS:
    - Ascending aorta (phrenic)
  - Subaortic (aortico-pulmonary window)
- Carinal (tracheobronchial) (tracheal bifurcation)
- Mediastinal, NOS: Anterior; Posterior (tracheoesophageal)
- Pericardial
- Peri/paraesophageal
- Peri/paratracheal, NOS:
  - Azygos (lower peritracheal)
- Pre- and retrotracheal, NOS: Precarinal
- Pulmonary ligament
- Subcarinal

**Intestinal Tract, NOS, Overlapping lesion of digestive system, Gastrointestinal tract, NOS**
- Intra-abdominal
- Paracaval
- Pelvic
- Subdiaphragmatic

**Male Genital Organs (prepuce, glans penis, body of penis, penis, NOS)**
- Iliac, NOS
  - External
  - Internal (hypogastric), NOS: Obturator
- Inguinal:
  - Deep, NOS: Node of Cloquet or Rosenmuller (highest deep inguinal)
  - Superficial (femoral)
- Pelvic, NOS

**ALL OTHER SITES**
**C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9**
(Except for unknown and ill-defined sites and M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES (continued)

**Nasal Cavity and Middle Ear**
- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Upper, NOS: Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Mastoid (post-/retro-auricular) **for middle ear**
- Retropharyngeal

**Placenta**
- Aortic, NOS: Lateral (lumbar)
  - Para-aortic
  - Peri-aortic
- Iliac, NOS: Common
  - External
  - Internal (hypogastric), NOS: Obturator
- Parametrial
- Pelvic, NOS
- Sacral: Lateral (laterosacral)
  - Middle (promontorial) (Gerota's node)
  - Presacral
  - Uterosacral

**Pleura**
Aortic [above diaphragm], NOS: Peri/para-aortic, NOS: Ascending aorta (phrenic)
Subaortic (aortico-pulmonary window)
Carinal (tracheobronchial) (tracheal bifurcation)
Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)
Internal Mammary
Intrapulmonary, NOS: Interlobar, Lobar, Segmental, Subsegmental
Intrathoracic
Mediastinal, NOS: Anterior and Posterior (tracheoesophageal)
Pericardial
Peri/parabronchial
Peri/paraesophageal
Peri/paratracheal, NOS: Azygos (lower peritracheal)
Pre- and retrotracheal, NOS: Precarinal
Pulmonary ligament
Scalene
Subcarinal
Supraclavicular

**ALL OTHER SITES**
**C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9**
(Except for unknown and ill-defined sites and M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES (continued)

**Respiratory System and Intrathoracic Organs, Other and Ill-defined Sites**

- Aortic [above diaphragm], NOS:
  - Peri/para-aortic, NOS:
    - Ascending aorta (phrenic)
  - Subaortic (aortico-pulmonary window)
- Carinal (tracheobronchial) (tracheal bifurcation)
- Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)
- Intrapulmonary, NOS:
  - Interlobar
  - Lobar
  - Segmental
  - Subsegmental
- Mediastinal, NOS:
  - Anterior & Posterior (tracheoesophageal)
- Pericardial
- Peri/parabronchial
- Peri/paraesophageal
- Peri/paratracheal, NOS:
  - Azygos (lower peritracheal)
- Pre-and retrotracheal, NOS:
  - Precarinal
- Pulmonary ligament
- Subcarinal

**Retroperitoneum and Peritoneum**

- Intra-abdominal
- Paracaval
- Pelvic
- Subdiaphragmatic

**Small Intestine**

- Pericholedochal (common bile duct)
- Superior mesenteric

**Duodenum:**

- Duodenal
- Gastroduodenal
- Hepatic
- Infrapyloric (subpyloric)
- Pancreaticoduodenal
- Pericholedochal
- Pyloric
- Superior mesenteric

**ALL OTHER SITES**
**C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9**
(Except for unknown and ill-defined sites and M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES (continued)

**Small Intestine (continued)**
- **Jejunum and Ileum**:
  - Ileocolic **for terminal ileum only**
  - Mesenteric, NOS
  - Posterior cecal (retrocecal) **for terminal ileum only**
  - Superior mesenteric

**Thymus**
- Mediastinal

**Trachea**
- Mediastinal, NOS
  - Posterior (tracheoesophageal)
- Paratracheal
- Pretracheal
- Tracheal, NOS

**Urinary organs, other and unspecified (urethra, paraurethral gland)**
- Iliac, NOS
  - Common
  - External
  - Internal (hypogastric), NOS: Obturator
- Inguinal:
  - Deep, NOS:
    - Node of Cloquet or Rosenmuller (highest deep inguinal)
  - Superficial (femoral)
- Pelvic, NOS
- Presacral
- Sacral, NOS

**Vagina**
- **All parts of vagina**:
  - Pelvic lymph nodes:
    - Iliac, NOS:
      - Common
      - External
      - Internal (hypogastric), NOS: Obturator
    - Inguinal
    - Middle sacral (promontorial) (Gerota's node)
    - Pelvic, NOS

- **Lower third of vagina**:
  - Ipsilateral or bilateral:
    - Inguinal, NOS: Superficial (femoral)

**ALL OTHER SITES**
**C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9**
(Except for unknown and ill-defined sites and M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES (continued)

**Vagina (continued)**
- **Upper two-thirds of vagina**:
  - Illiac, NOS:
    - External
    - Internal (hypogastric)
      - Orturator
  - Pelvic, NOS

**Vulva**
- Inguinal, NOS:
  - Deep, NOS:
    - Node of Cloquet or Rosenmuller (highest deep inguinal)
- Superficial (femoral)

**Waldeyer ring and Overlapping lesion of lip, oral cavity and pharynx**
- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Parapharyngeal
- Paratracheal
  - Recurrent pharyngeal nerve chain
- Prelaryngeal
  - Delphian node
- Retropharyngeal

# UNKNOWN AND ILL-DEFINED PRIMARY SITES
# C76.0-C76.8, C80.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## SURGERY OF PRIMARY SITE

**Code**

98 All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

**Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item *Surgical Procedure/Other Site.***

# UNKNOWN AND ILL-DEFINED PRIMARY SITES C76.0-C76.8, C80.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

## REGIONAL LYMPH NODES

**Other and ill-defined sites**

Not applicable.

Code 9 for Scope Regional Lymph Node Surgery.

**Unknown Primary Site**

Not applicable.

Code 9 for Scope Regional Lymph Node Surgery.

# APPENDIX J:
# ABBREVIATIONS AND SYMBOLS

# ABBREVIATIONS

The VCR requires all cases to include text information to support specific coded fields. Complete and descriptive text is vital to the quality control efforts of the VCR. Often it is necessary to use abbreviations to provide adequate descriptions within the limited size of the text fields. However, a reader may interpret many standard medical abbreviations differently. The VCR will rely on the attached abbreviation list to indicate how VCR staff will interpret the abbreviation when its use is unclear. It is a combination of the North American Association of Central Cancer Registries (NAACCR)'s *Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Tenth Edition; Version 11 -- Appendix G: Recommended Abbreviations for Abstractors.*

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

The listings are not exhaustive, but many of the most commonly used terms were included. Abbreviations for chemotherapy drugs and/or regimens are not included. For short names and acronyms of antineoplastic drugs, consult the SEER Program *Self Instructional Manual for Tumor Registrars: Book 8-Antineoplastic Drugs, Third Edition or SEER RX* at http://seer.cancer.gov/tools/seerrx/.

Please note that although abbreviations are presented in uppercase, either upper- or lowercase may be utilized when entering abbreviations within abstraction software. When abstracting into text fields, the use of abbreviations should be limited to those that appear on these lists whenever practical. Abbreviations and symbols should be used carefully.

The abbreviations list does not include an abbreviation for the word **cancer**. While the abbreviation "CA" is often used in the medical record to mean either the term **cancer** or **carcinoma**, it should be used in text reported to the VCR to indicate the histologic term of carcinoma. This distinction is very important when verifying histologic coding for cancer, NOS (8000/3) and carcinoma, NOS (8010/3).

This appendix contains two tables for abbreviations, one in term order and one in abbreviation order.

# ABBREVIATIONS

## ORDERED BY WORD/TERM

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Abdomen (abdominal) | ABD |
| Abdominal hysterectomy | ABD HYST |
| Abdominal perineal (Abdominoperineal) | AP |
| Abdominoperineal resection | APR |
| Abnormal | ABN |
| Abnormal liver function test | ALFT |
| Above | ^ |
| Above knee (amputation) | AK(A) |
| Absent/Absence | ABS |
| Abstract/Abstracted | ABST |
| Achilles tendon reflex | ATR |
| Acid phosphatase | ACID PHOS |
| Acquired Immune Deficiency Syndrome | AIDS |
| Acral lentiginous melanoma | ALM |
| Activities of daily living | ADL |
| Acute erythroleukemia | AEL |
| Acute granulocytic leukemia | AGL |
| Acute leukemia | AL |
| Acute lymphocytic leukemia | ALL |
| Acute megakaryoblastic leukemia | AMEGL |
| Acute myeloblastic leukemia | AMBL |
| Acute myelogenous leukemia | AML |
| Acute myelomonocytic leukemia | AMML |
| Acute myocardial infarction | AMI |
| Acute promyelocytic leukemia | APL |
| Acute renal failure | ARF |
| Acute Respiratory Distress (Disease) Syndrome | ARDS |
| Acute tubular necrosis | ATN |
| Acute undifferentiated leukemia | AUL |
| Adenocarcinoma | ADENOCA, ACA |
| Adenosine triphosphate | ATP |
| Adjacent | ADJ |
| Admission/Admit | ADM |
| Adrenal cortex | AC |
| Adrenal cortical hormone | ACH |
| Adrenocorticotrophic hormone | ACTH |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Adult T-cell leukemia | ATL |
| Adult T-cell leukemia/lymphoma | ATLL |
| Adult-onset Diabetes Mellitus | AODM |
| Affirmative | AFF |
| Against medical advice | AMA |
| AIDS-related condition (complex) | ARC |
| AIDS-related disease | ARD |
| Air contrast barium enema | ACBE |
| Albumin | ALB |
| Alcohol | ETOH |
| Alkaline phosphatase | ALK PHOS |
| Alpha chain disease | ACD |
| Alpha-fetoprotein | AFP |
| Also known as | AKA |
| Alternate | ALT |
| Ambulatory | AMB |
| Amount | AMT |
| Amputation | AMP |
| Amyotrophic lateral sclerosis | ALS |
| Anal intraepithelial neoplasia, grade III | AIN III |
| Anaplastic | ANAP |
| And | & |
| Angioblastic immunoblastic lymphadenopathy | AIL |
| Angiography/Angiogram | ANGIO |
| Anterior | ANT |
| Anteroposterior | AP |
| Antidiuretic hormone | ADH |
| Antigen | AG |
| Aortic stenosis | A-STEN |
| Apparently | APPL'Y |
| Appendix | APP |
| Approximately | APPROX |
| Arrhythmia | ARRHY |
| Arterial blood gases | ABG |
| Arteriosclerosis/Arteriosclerotic | AS |
| Arteriosclerotic cardiovascular disease | ASCVD |
| Arteriosclerotic heart disease | ASHD |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Arteriosclerotic Peripheral Vascular Disease | ASPVD |
| Arteriovenous | AV |
| Arteriovenous malformation | AVM |
| Artery (ial) | ART |
| As soon as possible | ASAP |
| Ascending | ASC |
| Ascending colon | A-COLON |
| Aspiration | ASP |
| Aspiration biopsy cytology | ABC |
| Aspirin, Acetylsalicylic acid | ASA |
| At | @ |
| Atrial fibrillation | A FIB |
| Atrial flutter | A FLUTTER |
| Atrial premature complexes | APC |
| Atrial stenosis/insufficiency/incompetence | AI |
| Auscultation & percussion | A&P |
| Autoimmune hemolytic anemia | AIHA |
| Autologous bone marrow | ABM |
| Autologous bone marrow transplantation | ABMT |
| Autonomic nervous system | ANS |
| Autopsy | AUT |
| Average | AVG |
| Axilla(ry) | AX |
| Bacillus Calmette-Guerin | BCG |
| Barium | BA |
| Barium enema | BE |
| Barium swallow | BAS |
| Bartholin's, Urethral & Skene's | BUS |
| Basal cell carcinoma | BCC |
| Before noon | AM |
| Below knee (amputation) | BK(A) |
| Benign prostatic hypertrophy/hyperplasia | BPH |
| Bilateral | BIL |
| Bilateral hilar lymphadenopathy | BHL |
| Bilateral lower lobes | BLL |
| Bilateral pelvic lymph node dissection | BPLND |
| Bilateral salpingo-oophorectomy | BSO |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Bile duct | BD |
| Biological response modifier | BRM |
| Biopsy | BX |
| Bipolar affective disorder | BAD |
| Black female | B/F |
| Black male | B/M |
| Bladder outlet obstruction | BOO |
| Bladder tumor | BT |
| Blood pressure | BP |
| Blood urea nitrogen | BUN |
| Blood volume | BV |
| Bone Marrow | BM |
| Bone marrow aspirate | BMA |
| Bone marrow biopsy | BMBX |
| Bone Marrow Transplant | BMT |
| Bowel Movement | BM |
| Bowel sounds | BS |
| Breast self examination | BSE |
| Breath sounds | BRS |
| Bright red blood | BRB |
| Bright red blood per rectum | BRBPR |
| Bronchial lymph node | BLN |
| Bronchoalveolar washing | BAW |
| Bronchogenic carcinoma | BGCA |
| Burkitt lymphoma | BL |
| Calcium | CA |
| Capsule (s) | CAP(S) |
| Carcinoembryonic antigen | CEA |
| Carcinoma | CA |
| Carcinoma *in situ* | CIS |
| Carcinoma unknown primary | CUP |
| Cardioesophageal junction | CEJ |
| Cardiovascular disease | CVD |
| CAT/CT scan/Computerized axial tomography | CT |
| Ceased to breath | CTB |
| Centigram | CGM |
| Centigray | CGY |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Centimeter | CM |
| Central nervous system | CNS |
| Cerebrospinal fluid | CSF |
| Cerebrovascular accident | CVA |
| Cervical intraepithelial neoplasia | CIN |
| Cervical intraepithelial neoplasia, grade III | CIN III |
| Cervical spine | C-SPINE |
| Cervical vertebrae | C1-C7 |
| Cervix | CX |
| Change | CHG |
| Chemotherapy | CHEMO |
| Chest X-ray | CXR |
| Chief complaint | C/C |
| Cholecystectomy | CHOLE |
| Chronic | CHR |
| Chronic granulocytic leukemia | CGL |
| Chronic leukemia | CL |
| Chronic lymphocytic leukemia | CLL |
| Chronic lymphosarcoma leukemia | CLSL |
| Chronic myelodysplastic syndrome | CMS |
| Chronic myeloid (myelocytic) leukemia | CML |
| Chronic myelomonocytic leukemia | CMML |
| Chronic obstructive lung disease | COLD |
| Chronic obstructive pulmonary disease | COPD |
| Chronic renal failure | CRF |
| Chronic ulcerative colitis | CUC |
| Cigarettes | CIG |
| Clear | CLR |
| Clinical tumor, nodes, metastases | CTNM |
| Cobalt 60 | CO60 |
| Collaborative stage | CS |
| Colon, Ascending | A-COLON |
| Colon, Descending | D-COLON |
| Colon, Sigmoid | SIG-COLON |
| Colon, Transverse | TRANS-COLON |
| Colony-stimulating factor | C-SF |
| Common bile duct | CBD |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Complaint (-ning) of | C/O |
| Complete blood count | CBC |
| Complete continuous remission | CCR |
| Computerized axial tomography scan | CT, CAT |
| Congenital heart disease | CHD |
| Congestive heart failure | CHF |
| Consistent with | C/W |
| Continue/continuous | CONT |
| Contralateral | CONTRA |
| Coronary artery bypass graft | CABG |
| Coronary artery disease | CAD |
| Coronary care unit | CCU |
| Cubic centimeter | CC |
| Curie | CU |
| Cutaneous | CUT |
| Cutaneous T-cell lymphoma | CTCL |
| Cystic fibrosis | CF |
| Cystoscopy | CYSTO |
| Cytology | CYTO |
| Date of birth | DOB |
| Date of death | DOD |
| Dead on arrival | DOA |
| Debridement | DEB |
| Decrease(d) | DECR |
| Deep tendon reflex | DTR |
| Deep vein thrombosis | DVT |
| Deoxyribonucleic acid | DNA |
| Dermatofibrosarcoma protuberans | DFSP |
| Dermatology | DERM |
| Descending | DESC |
| Descending colon | D-COLON |
| Diabetes mellitus | DM |
| Diagnosis | DX |
| Diagnostic laparoscopy | DL |
| Diameter | DIAM |
| Died of other causes | DOC |
| Died with disease | DWD |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Diethylstilbestrol | DES |
| Differentiated/differential | DIFF |
| Digital rectal examination | DRE |
| Dilatation and curettage | D&C |
| Direct extension | DE |
| Discharge | DISCH |
| Discontinue(d) | DC |
| Disease | DZ |
| Disease free interval | DFI |
| Disseminated | DISSEM |
| Disseminated intravascular coagulopathy | DIC |
| Distant metastases | DM |
| Doctor | DR |
| Ductal carcinoma *in situ* | DCIS |
| Dyspnea on exertion | DOE |
| Ears, nose, and throat | ENT |
| Electrocardiogram | ECG/EKG |
| Electroencephalogram | EEG |
| Electromyogram | EMG |
| Emergency room | ER |
| Endoscopic retrograde cholangiopancreatography | ERCP |
| Enlarged | ENLGD |
| Equal(s) | = |
| Esophagogastro-duodenoscopy | EGD |
| Esophagus | ESO |
| Estrogen receptor assay | ERA |
| Evaluation | EVAL |
| Every | Q |
| Every day | QD |
| Examination | EXAM |
| Examination under anesthesia | EUA |
| Excision/excised | EXC(D) |
| Expired | EXP |
| Exploratory | EXPL |
| Exploratory laparotomy | EXPL LAP |
| Extend/extension | EXT |
| Extended care facility | ECF |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| External | EX |
| Extremity | EXTR |
| Eyes, ears, nose and throat | EENT |
| Family history | FHX |
| Family medical history | FMH |
| Fever of unknown origin | FUO |
| Fine needle aspiration | FNA |
| Fine needle aspiration biopsy | FNAB |
| Fingerbreadth | FB |
| Flexible sigmoidoscopy | FLEX SIG |
| Floor of mouth | FOM |
| Fluid | FL |
| Fluoroscopy | FLURO |
| Follow-up | FU |
| For example | E.G |
| Fracture | FX |
| French-American-British | FAB |
| Frequent/Frequency | FREQ |
| Frozen section | FS |
| Full thickness skin graft | FTSG |
| Gallbladder | GB |
| Gastroesophageal | GE |
| Gastroesophageal reflux disease | GERD |
| Gastrointestinal | GI |
| General/Generalized | GEN |
| Genitourinary | GU |
| Grade | GR |
| Gram | GM |
| Greater/Greater than | > |
| Gynecology | GYN |
| Head, eyes, ears, nose, throat | HEENT |
| Hematocrit | HCT |
| Hematology | HEMO |
| Hemoglobin | HGB |
| Hepatitis A (virus) | HAV |
| Hepatitis B (virus) | HBV |
| Hepatitis C (virus) | HCV |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Hepatitis D (virus) | HDV |
| Hepatocellular carcinoma | HCC |
| Hepatosplenomegaly | HSM |
| History | HX |
| History and physical | H&P |
| History of | H/O |
| History of present illness | HPI |
| Hodgkin disease | HD |
| Hormone | HORM |
| Hospital | HOSP |
| Hour/Hours | HR(S) |
| Human chorionic gonadotropin | HCG |
| Human Immunodeficiency Virus | HIV |
| Human Papilloma Virus | HPV |
| Human T-Lymphotrophic Virus, (Type III) | HTLV |
| Hypertension | HTN |
| Hypertensive cardiovascular disease | HCVD |
| Hypertensive vascular disease | HVD |
| Hysterectomy | HYST |
| Idiopathic hypertrophic subaortic stenosis | IHSS |
| Idiopathic thrombocytopenia | ITP |
| Immunoglobulin | IG |
| Immunohistochemical | IHC |
| Impression | IMP |
| Inch | IN |
| Incision & drainage | I&D |
| Includes/Including | INCL |
| Increase(d) | INCR |
| Inferior | INF |
| Inferior vena cava | IVC |
| Infiltrating | INFILT |
| Inflammatory bowel disease | IBD |
| Inpatient | IP |
| Insulin-dependent diabetes mellitus | IDDM |
| Intensive care unit | ICU |
| Intercostal margin | ICM |
| Intercostal space | ICS |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Intermittent positive pressure breathing | IPPB |
| Internal | INT |
| Internal mammary artery | IMA |
| Interstitial lung disease | ILD |
| Intra abdominal | IAB |
| Intramuscular | IM |
| Intrathecal | IT |
| Intravenous | IV |
| Intravenous cholangiogram | IVCA |
| Intravenous pyelogram | IVP |
| Invade(s)/invading/invasion | INV |
| Involve(s)/involvement/involving | INVL |
| Iodine | I |
| Ipsilateral | IPSI |
| Irregular | IRREG |
| Joule | J |
| Jugular venous distention | JVD |
| Junction | JCT, JX |
| Juvenile rheumatic arthritis | JRA |
| Kaposi sarcoma | KS |
| Kidneys, ureters, bladder | KUB |
| Kilogram | KG |
| Kilovolt | KV |
| Laboratory | LAB |
| Lactic dehydrogenase | LDH |
| Laparotomy | LAP |
| Large | LRG |
| Large bowel resection | LBR |
| Large cleaved cell | LCC |
| Last menstrual period | LMP |
| Lateral | LAT |
| Left | LT |
| Left breast biopsy | LBBX |
| Left bundle branch block | LBBB |
| Left costal margin | LCM |
| Left eye | OS |
| Left lower extremity | LLE |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Left lower lobe | LLL |
| Left lower quadrant | LLQ |
| Left salpingo-oophorectomy | LSO |
| Left upper extremity | LUE |
| Left upper lobe | LUL |
| Left upper outer quadrant | LUOQ |
| Left upper quadrant | LUQ |
| Left ureteral orifice | LUO |
| Less/Less than | < |
| Licensed practical nurse | LPN |
| Linear accelerator | LINAC |
| Liver, kidney, spleen | LKS |
| Liver, kidney, spleen, bladder | LKSB |
| Liver/spleen scan | LS SCAN |
| Lobular carcinoma in situ | LCIS |
| Lobular in situ | LIS |
| Lobular neoplasia, grade 2 | LN2 |
| Long Term Care Facility | LTCF |
| Lower extremity | LE |
| Lower inner quadrant | LIQ |
| Lower outer quadrant | LOQ |
| Lower right quadrant | LRQ |
| Lumbar puncture | LP |
| Lumbar spine | L-SPINE |
| Lumbar vertebra | L1-L5 |
| Lumbosacral | LS |
| Lupus erythematosus | LUP ERYTH |
| Lymph node biopsy | LNBX |
| Lymph node dissection | LND |
| Lymph node resection | LNR |
| Lymph node(s) | LN(S) |
| Lymphadenopathy-associated virus | LAV |
| Lymphangiography/lymphangiogram | LAG |
| Macrophage colony-stimulating factor | M-CSF |
| Magnetic resonance cholangiopancreatography | MRCP |
| Magnetic resonance imaging | MRI |
| Main stem bronchus | MSB |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Malignant | MALIG |
| Malignant carcinoid syndrome | MCS |
| Malignant fibrous histiocytoma | MFH |
| Mandible/mandibular | MAND |
| Mastectomy | MAST, MX |
| Maximum | MAX |
| Medical center | MC |
| Medical history | MHX |
| Medication | MED |
| Melanoma associated antigen | MAA |
| Metastatic/Metastasis | METS |
| Methicillin Resistant Staphylococcus Aureus | MRSA |
| Microgram | MCG |
| Microscopic | MICRO |
| Midclavicular line | MCL |
| Middle | MID |
| Middle lobe | ML |
| Millicurie (hours) | MC(H) |
| Milligram (hours) | MG(H) |
| Milliliter | ML |
| Millimeter | MM |
| Million electron volts | MEV |
| Minimum | MIN |
| Minus | - |
| Minute | MIN |
| Mitral valve prolapse | MVP |
| Mixed combined immunodeficiency | MCID |
| Mixed connective tissue disease | MCTD |
| Moderate (ly) | MOD |
| Moderately differentiated | MD, MOD DIFF |
| Modified radical mastectomy | MRM |
| Monoclonal antibody | MC-AB, MCAB, MAB, MOAB |
| More/More than | > |
| Multifocal arterial tachycardia | MAT |
| Multifocal premature ventricular contraction | MPVC |
| Multiple | MULT |
| Multiple myeloma | MM |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Multiple sclerosis | MS |
| Myasthenia gravis | MG |
| Myelodysplasia/myelodysplastic syndrome | MDS |
| Myeloproliferative disease | MPD |
| Myocardial infarction | MI |
| Natural killer | NK |
| Nausea and vomiting | N&V |
| Neck vein distention | NVD |
| Needle biopsy | NBX |
| Needle liver biopsy | NLBX |
| Negative | NEG, - |
| Neoplasm | NEOPL |
| Neoplasm embryonic antigen | NEA |
| Nephrectomy | NX |
| Nerves, Cranial 1-12 | N-I - N-XII |
| Neurology | NEURO |
| No acute/active disease | NAD |
| No evidence of disease | NED |
| No evidence of recurrence | NER |
| No significant findings | NSF |
| Nodular & diffuse lymphoma | NDL |
| Non small cell carcinoma | NSCCA |
| Non-Hodgkin malignant lymphoma | NHML |
| Non-Hodgkin lymphoma | NHL |
| Non-small cell lung cancer | NSCLC |
| Normal | NL |
| Not applicable | NA |
| Not elsewhere classified/classifiable | NEC |
| Not otherwise specified | NOS |
| Not recorded | NR |
| Number | # |
| Nursing home | NH |
| Obstetrics | OB |
| Obstructed (-ing, -ion) | OBST |
| Occult primary malignancy | OPM |
| Oncology | ONC |
| Operating room | OR |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Operation | OP |
| Operative report | OP RPT |
| Organic brain syndrome | OBS |
| Orthopedics | ORTHO |
| Otology | OTO |
| Ounce | OZ |
| Outpatient | OP |
| Outpatient surgery | OPS |
| Packs per day | PPD |
| Palpated (-able) | PALP |
| Papanicolaou smear | PAP |
| Papillary | PAP |
| Past/personal (medical) history | PMH |
| Pathologic tumor, nodes, metastases | PTNM |
| Pathology | PATH |
| Patient | PT |
| Pediatrics | PEDS |
| Pelvic inflammatory disease | PID |
| Peptic ulcer disease | PUD |
| Percussion and auscultation | P&A |
| Percutaneous | PERC |
| Percutaneous transhepatic cholecystogram | PTC |
| Peripheral vascular disease | PVD |
| Phosphorus 32 | P32 |
| Physical examination | PE |
| Physiotherapy/Physical therapy | PT |
| Plasma cell leukemia | PCL |
| Platelets | PLT |
| Plus | + |
| Polycythemia vera | PCV |
| Poorly differentiated | PD, POOR DIFF |
| Positive | POS, + |
| Positron emission tomography | PET |
| Possible | POSS |
| Posterior | POST |
| Posteroanterior | PA |
| Postoperative (-ly) | POST OP |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Pound(s) | LB(S), # |
| Premature atrial contraction | PAC |
| Preoperative (-ly) | PRE OP |
| Prescription | RX |
| Present illness | PI |
| Previous | PREV |
| Primary medical physician | PMP |
| Primitive neuroectodermal tumor | PNET |
| Prior to admission | PTA |
| Probable (-ly) | PROB |
| Proctoscopy | PROCTO |
| Progesterone receptor assay | PRA |
| Prolymphocyctic leukemia | PLL |
| Prostatic intraepithelial neoplasia | PIN |
| Prostatic intraepithelial neoplasia, grade III | PIN III |
| Prostatic specific antigen | PSA |
| Pulmonary | PULM |
| Pulmonary artery | PULM ART |
| Quadrant | QUAD |
| Radiation absorbed dose | RAD |
| Radiation therapy | RT |
| Radical neck dissection | RND |
| Radioactive iodine | RAI |
| Radioimmunoassay | RIA |
| Received | REC'D |
| Red blood cells (count) | RBC |
| Regarding | RE |
| Regional medical center R | MC |
| Regular | REG |
| Regular sinus rhythm | RSR |
| Resection (ed) | RESEC |
| Respiratory | RESPIR, RESP |
| Review of outside films | ROF |
| Review of outside slides | ROS |
| Rheumatic heart disease | RHD |
| Rheumatoid arthritis | RA |
| Right | RT |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Right breast biopsy | RBBX |
| Right bundle branch block | RBBB |
| Right costal margin | RCM |
| Right eye | OD |
| Right inner quadrant | RIQ |
| Right lower extremity | RLE |
| Right lower lobe | RLL |
| Right lower quadrant | RLQ |
| Right middle lobe | RML |
| Right outer quadrant | ROQ |
| Right salpingo-oophorectomy | RSO |
| Right upper extremity | RUE |
| Right upper lobe | RUL |
| Right upper quadrant | RUQ |
| Right ureteral orifice | RUO |
| Rule out | R/O |
| Sacral spine | S-SPINE |
| Sacral vertebra | S1-S5 |
| Salpingo-oophorectomy | SO |
| Sarcoma | SARC |
| Satisfactory | SATIS |
| Sequential multiple analysis | SMA |
| Serum glutamic oxaloacetic transaminase | SGOT |
| Serum glutamic pyruvic transaminase | SGPT |
| Severe combined immunodeficiency syndrome | SCID |
| Short(ness) of breath | SOB |
| Sick sinus syndrome | SSS |
| Sigmoid colon | SIG COLON |
| Skilled nursing facility | SNF |
| Small | SM |
| Small bowel | SB |
| Small bowel obstruction | SBO |
| Small bowel resection | SBR |
| Small cell lung carcinoma | SCLC |
| Specimen | SPEC |
| Spine, Cervical | C-SPINE |
| Spine, Lumbar | L-SPINE |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Spine, Sacral | S-SPINE |
| Spine, Thoracic | T-SPINE |
| Split thickness skin graft | STSG |
| Squamous | SQ |
| Squamous cell carcinoma | SCC |
| Status post | S/P |
| Subcutaneous | SUBQ |
| Summary stage | SS |
| Superior vena cava | SVC |
| Surgery/Surgical | SURG |
| Suspicious/suspected | SUSP |
| Symptoms | SX |
| Syndrome of inappropriate ADH | SIADH |
| Systemic lupus erythematosus | SLE |
| T-cell acute lymphoblastic leukemia | T-ALL |
| T-cell chronic lymphatic leukemia | T-CLL |
| Thoracic spine | T-SPINE |
| Thrombotic thrombocytopenia purpura | TTP |
| Times | X |
| Total abdominal hysterectomy | TAH |
| Total abdominal hysterectomy- bilateral salpingo-oophorectomy | TAH-BSO |
| Total axial (lymph) node irradiation | TANI |
| Total parenteral nutrition | TPN |
| Total vaginal hysterectomy | TVH |
| Transbronchial biopsy | TBBX |
| Transient ischemic attack | TIA |
| Transitional cell carcinoma | TCC |
| Transrectal ultrasound | TRUS |
| Transrectal ultrasound of prostate | TRUSP |
| Transurethral resection | TUR |
| Transurethral resection bladder | TURB |
| Transurethral resection bladder tumor | TURBT |
| Transurethral resection prostate | TURP |
| Transverse colon | TRANS-COLON |
| Transverse rectus abdominous myocutaneous | TRAM |
| Treatment | TX |
| True vocal cord | TVC |
| Tumor size | TS |

## ABBREVIATIONS

| WORD/TERM (S) | ABBREVIATION/SYMBOL |
|---|---|
| Tumor, node, metastasis | TNM |
| Twice a day (daily) | BID |
| Ultrasound | US |
| Undetermined | UNDET |
| Undetermined origin | UDO |
| Undifferentiated | UNDIFF |
| Unilateral salpingo-oophorectomy | USO |
| Unknown | UNK |
| Upper extremity | UE |
| Upper gastrointestinal (series) | UGI |
| Upper inner quadrant | UIQ |
| Upper outer quadrant | UOQ |
| Upper respiratory infection | URI |
| Upper right quadrant | URQ |
| Urinary tract infection | UTI |
| Vagina/Vaginal | VAG |
| Vaginal hysterectomy | VAG HYST |
| Vaginal intraepithelial neoplasia | VAIN |
| Vaginal intraepithelial neoplasia (grade III) | VAIN III |
| Vascular | VASC |
| Versus | VS |
| Vulvar intraepithelial neoplasia | VIN |
| Vulvar intraepithelial neoplasia (grade III) | VIN III |
| Well differentiated | WD, WELL DIFF |
| White blood cells (count) | WBC |
| White female | W/F |
| White male | W/M |
| Will follow (in) office | WF-O |
| Wilms (tumor), aniridia, genitourinary (abnormalities), and (mental) | WAGR |
| With | W/ |
| Within normal limits | WNL |
| Without | W/O |
| Wolff-Parkinson-White Syndrome | WPW |
| Work-up | W/U |
| Xray | XR |
| Year | YR |
| Yolk Sac Tumor | YST |

# ABBREVIATIONS

## ORDER BY ABBREVIATION

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| A FIB | Atrial fibrillation |
| A FLUTTER | Atrial flutter |
| A&P | Auscultation & percussion |
| ABC | Aspiration biopsy cytology |
| ABD | Abdomen (abdominal) |
| ABD HYST | Abdominal hysterectomy |
| ABG | Arterial blood gases |
| ABM | Autologous bone marrow |
| ABMT | Autologous bone marrow transplantation |
| ABN | Abnormal |
| ABS | Absent/Absence |
| ABST | Abstract/Abstracted |
| AC | Adrenal cortex |
| ACA | Adenocarcinoma |
| ACBE | Air contrast barium enema |
| ACD | Alpha chain disease |
| ACH | Adrenal cortical hormone |
| ACID PHOS | Acid phosphatase |
| A-COLON | Ascending colon |
| ACTH | Adrenocorticotrophic hormone |
| ADENOCA, ACA | Adenocarcinoma |
| ADH | Antidiuretic hormone |
| ADH SIADH | Syndrome of inappropriate |
| ADJ | Adjacent |
| ADL | Activities of daily living |
| ADM | Admission/Admit |
| AEL | Acute erythroleukemia |
| AFF | Affirmative |
| AFP | Alpha-fetoprotein |
| AG | Antigen |
| AGL | Acute granulocytic leukemia |
| AI | Atrial stenosis/insufficiency/incompetence |
| AIDS | Acquired Immune Deficiency Syndrome |
| AIHA | Autoimmune hemolytic anemia |
| AIL | Angioblastic immunoblastic lymphadenopathy |
| AIN III | Anal intraepithelial neoplasia, grade III |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| AK(A) | Above knee (amputation) |
| AKA | Also known as |
| AL | Acute leukemia |
| ALB | Albumin |
| ALFT | Abnormal liver function test |
| ALK PHOS | Alkaline phosphatase |
| ALL | Acute lymphocytic leukemia |
| ALM | Acral lentiginous melanoma |
| ALS | Amyotrophic lateral sclerosis |
| ALT | Alternate |
| AM | Before noon |
| AMA | Against medical advice |
| AMB | Ambulatory |
| AMBL | Acute myeloblastic leukemia |
| AMEGL | Acute megakaryoblastic leukemia |
| AMI | Acute myocardial infarction |
| AML | Acute myelogenous leukemia |
| AMML | Acute myelomonocytic leukemia |
| AMP | Amputation |
| AMT | Amount |
| ANAP | Anaplastic |
| ANGIO | Angiography/Angiogram |
| ANS | Autonomic nervous system |
| ANT | Anterior |
| AODM | Adult-onset Diabetes Mellitus |
| AP | Abdominal perineal (Abdominoperineal) |
| AP | Anteroposterior |
| APC | Atrial premature complexes |
| APL | Acute promyelocytic leukemia |
| APP | Appendix |
| APPL'Y | Apparently |
| APPROX | Approximately |
| APR | Abdominoperineal resection |
| ARC | AIDS-related condition (complex) |
| ARD | AIDS-related disease |
| ARDS | Acute Respiratory Distress (Disease) Syndrome |
| ARF | Acute renal failure |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| ARRHY | Arrhythmia |
| ART | Artery (ial) |
| AS | Arteriosclerosis/Arteriosclerotic |
| ASA | Aspirin, Acetylsalicylic acid |
| ASAP | As soon as possible |
| ASC | Ascending |
| ASCVD | Arteriosclerotic cardiovascular disease |
| ASHD | Arteriosclerotic heart disease |
| ASP | Aspiration |
| ASPVD | Arteriosclerotic Peripheral Vascular Disease |
| A-STEN | Aortic stenosis |
| ATL | Adult T-cell leukemia |
| ATLL | Adult T-cell leukemia/lymphoma |
| ATN | Acute tubular necrosis |
| ATP | Adenosine triphosphate |
| ATR | Achilles tendon reflex |
| AUL | Acute undifferentiated leukemia |
| AUT | Autopsy |
| AV | Arteriovenous |
| AVG | Average |
| AVM | Arteriovenous malformation |
| AX | Axilla(ry) |
| B/F | Black female |
| B/M | Black male |
| BA | Barium |
| BAD | Bipolar affective disorder |
| BAS | Barium swallow |
| BAW | Bronchoalveolar washing |
| BCC | Basal cell carcinoma |
| BCG | Bacillus Calmette-Guerin |
| BD | Bile duct |
| BE | Barium enema |
| BGCA | Bronchogenic carcinoma |
| BHL | Bilateral hilar lymphadenopathy |
| BID | Twice a day (daily) |
| BIL | Bilateral |
| BK(A) | Below knee (amputation) |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| BKA | Below knee amputation |
| BL | Burkitt lymphoma |
| BLL | Bilateral lower lobes |
| BLN | Bronchial lymph node |
| BM | Bone Marrow |
| BM | Bowel Movement |
| BMA | Bone marrow aspirate |
| BMBX | Bone marrow biopsy |
| BMT | Bone Marrow Transplant |
| BOO | Bladder outlet obstruction |
| BP | Blood pressure |
| BPH | Benign prostatic hypertrophy/hyperplasia |
| BPLND | Bilateral pelvic lymph node dissection |
| BRB | Bright red blood |
| BRBPR | Bright red blood per rectum |
| BRM | Biological response modifier |
| BRS | Breath sounds |
| BS | Bowel sounds |
| BSE | Breast self examination |
| BSO | Bilateral salpingo-oophorectomy |
| BT | Bladder tumor |
| BUN | Blood urea nitrogen |
| BUS | Bartholin's, Urethral & Skene's |
| BV | Blood volume |
| BX | Biopsy |
| C/C | Chief complaint |
| C/O | Complaint (-ning) of |
| C/W | Consistent with |
| C1-C7 | Cervical vertebrae |
| CA | Calcium |
| CA | Carcinoma |
| CABG | Coronary artery bypass graft |
| CAD | Coronary artery disease |
| CAP(S) | Capsule (s) |
| CBC | Complete blood count |
| CBD | Common bile duct |
| CC | Cubic centimeter |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| CCR | Complete continuous remission |
| CCU | Coronary care unit |
| CEA | Carcinoembryonic antigen |
| CEJ | Cardioesophageal junction |
| CF | Cystic fibrosis |
| CGL | Chronic granulocytic leukemia |
| CGM | Centigram |
| CGY | Centigray |
| CHD | Congenital heart disease |
| CHEMO | Chemotherapy |
| CHF | Congestive heart failure |
| CHG | Change |
| CHOLE | Cholecystectomy |
| CHR | Chronic |
| CIG | Cigarettes |
| CIN | Cervical intraepithelial neoplasia |
| CIN III | Cervical intraepithelial neoplasia, grade III |
| CIS | Carcinoma *in situ* |
| CL | Chronic leukemia |
| CLL | Chronic lymphocytic leukemia |
| CLR | Clear |
| CLSL | Chronic lymphosarcoma leukemia |
| CM | Centimeter |
| CML | Chronic myeloid (myelocytic) leukemia |
| CMML | Chronic myelomonocytic leukemia |
| CMS | Chronic myelodysplastic syndrome |
| CNS | Central nervous system |
| CO60 | Cobalt 60 |
| COLD | Chronic obstructive lung disease |
| CONT | Continue/continuous |
| CONTRA | Contralateral |
| COPD | Chronic obstructive pulmonary disease |
| CRF | Chronic renal failure |
| CS | Collaborative stage |
| CSF | Cerebrospinal fluid |
| C-SF | Colony-stimulating factor |
| C-SPINE | Cervical spine |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| CT | CAT/CT scan/Computerized axial tomography |
| CT, CAT | Computerized axial tomography scan |
| CTB | Ceased to breath |
| CTCL | Cutaneous T-cell lymphoma |
| CTNM | Clinical tumor, nodes, metastases |
| CU | Curie |
| CUC | Chronic ulcerative colitis |
| CUP | Carcinoma unknown primary |
| CUT | Cutaneous |
| CVA | Cerebrovascular accident |
| CVD | Cardiovascular disease |
| CX | Cervix |
| CXR | Chest X-ray |
| CYSTO | Cystoscopy |
| CYTO | Cytology |
| D&C | Dilatation and curettage |
| DC | Discontinue(d) |
| DCIS | Ductal carcinoma *in situ* |
| D-COLON | Descending colon |
| DE | Direct extension |
| DEB | Debridement |
| DECR | Decrease(d) |
| DERM | Dermatology |
| DES | Diethylstilbestrol |
| DESC | Descending |
| DFI | Disease free interval |
| DFSP | Dermatofibrosarcoma protuberans |
| DIAM | Diameter |
| DIC | Disseminated intravascular coagulopathy |
| DIFF | Differentiated/differential |
| DISCH | Discharge |
| DISSEM | Disseminated |
| DL | Diagnostic laparoscopy |
| DM | Diabetes mellitus |
| DM | Distant metastases |
| DNA | Deoxyribonucleic acid |
| DOA | Dead on arrival |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| DOB | Date of birth |
| DOC | Died of other causes |
| DOD | Date of death |
| DOE | Dyspnea on exertion |
| DR | Doctor |
| DRE | Digital rectal examination |
| DTR | Deep tendon reflex |
| DVT | Deep vein thrombosis |
| DWD | Died with disease |
| DX | Diagnosis |
| DZ | Disease |
| E.G | For example |
| ECF | Extended care facility |
| ECG/EKG | Electrocardiogram |
| EEG | Electroencephalogram |
| EENT | Eyes, ears, nose and throat |
| EGD | Esophagogastro-duodenoscopy |
| EMG | Electromyogram |
| ENLGD | Enlarged |
| ENT | Ears, nose, and throat |
| ER | Emergency room |
| ERA | Estrogen receptor assay |
| ERCP | Endoscopic retrograde cholangiopancreatography |
| ESO | Esophagus |
| ETOH | Alcohol |
| EUA | Examination under anesthesia |
| EVAL | Evaluation |
| EX | External |
| EXAM | Examination |
| EXC(D) | Excision/excised |
| EXP | Expired |
| EXPL | Exploratory |
| EXPL LAP | Exploratory laparotomy |
| EXT | Extend/extension |
| EXTR | Extremity |
| FAB | French-American-British |
| FB | Fingerbreadth |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| FHX | Family history |
| FL | Fluid |
| FLEX SIG | Flexible sigmoidoscopy |
| FLURO | Fluoroscopy |
| FMH | Family medical history |
| FNA | Fine needle aspiration |
| FNAB | Fine needle aspiration biopsy |
| FOM | Floor of mouth |
| FREQ | Frequent/Frequency |
| FS | Frozen section |
| FTSG | Full thickness skin graft |
| FU | Follow-up |
| FUO | Fever of unknown origin |
| FX | Fracture |
| GB | Gallbladder |
| GE | Gastroesophageal |
| GEN | General/Generalized |
| GERD | Gastroesophageal reflux disease |
| GI | Gastrointestinal |
| GM | Gram |
| GR | Grade |
| GU | Genitourinary |
| GYN | Gynecology |
| H&P | History and physical |
| H/O | History of |
| HAV | Hepatitis A (virus) |
| HBV | Hepatitis B (virus) |
| HCC | Hepatocellular carcinoma |
| HCG | Human chorionic gonadotropin |
| HCT | Hematocrit |
| HCV | Hepatitis C (virus) |
| HCVD | Hypertensive cardiovascular disease |
| HD | Hodgkin disease |
| HDV | Hepatitis D (virus) |
| HEENT | Head, eyes, ears, nose, throat |
| HEMO | Hematology |
| HGB | Hemoglobin |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| HIV | Human Immunodeficiency Virus |
| HORM | Hormone |
| HOSP | Hospital |
| HPI | History of present illness |
| HPV | Human Papilloma Virus |
| HR(S) | Hour/Hours |
| HSM | Hepatosplenomegaly |
| HTLV | Human T-Lymphotrophic Virus, (Type III) |
| HTN | Hypertension |
| HVD | Hypertensive vascular disease |
| HX | History |
| HYST | Hysterectomy |
| I | Iodine |
| I&D | Incision & drainage |
| IAB | Intra abdominal |
| IBD | Inflammatory bowel disease |
| ICM | Intercostal margin |
| ICS | Intercostal space |
| ICU | Intensive care unit |
| IDDM | Insulin-dependent diabetes mellitus |
| IG | Immunoglobulin |
| IHC | Immunohistochemical |
| IHSS | Idiopathic hypertrophic subaortic stenosis |
| ILD | Interstitial lung disease |
| IM | Intramuscular |
| IMA | Internal mammary artery |
| IMP | Impression |
| IN | Inch |
| INCL | Includes/Including |
| INCR | Increase(d) |
| INF | Inferior |
| INFILT | Infiltrating |
| INT | Internal |
| INV | Invade(s)/invading/invasion |
| INVL | Involve(s)/involvement/involving |
| IP | Inpatient |
| IPPB | Intermittent positive pressure breathing |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| IPSI | Ipsilateral |
| IRREG | Irregular |
| IT | Intrathecal |
| ITP | Idiopathic thrombocytopenia |
| IV | Intravenous |
| IVC | Inferior vena cava |
| IVCA | Intravenous cholangiogram |
| IVP | Intravenous pyelogram |
| J | Joule |
| JCT | Junction |
| JRA | Juvenile rheumatic arthritis |
| JVD | Jugular venous distention |
| JX | Junction |
| KG | Kilogram |
| KS | Kaposi sarcoma |
| KUB | Kidneys, ureters, bladder |
| KV | Kilovolt |
| L1-L5 | Lumbar vertebra |
| LAB | Laboratory |
| LAG | Lymphangiography/lymphangiogram |
| LAP | Laparotomy |
| LAT | Lateral |
| LAV | Lymphadenopathy-associated virus |
| LB(S) | Pound(s) |
| LBBB | Left bundle branch block |
| LBBX | Left breast biopsy |
| LBR | Large bowel resection |
| LCC | Large cleaved cell |
| LCIS | Lobular carcinoma in situ |
| LCM | Left costal margin |
| LDH | Lactic dehydrogenase |
| LE | Lower extremity |
| LINAC | Linear accelerator |
| LIQ | Lower inner quadrant |
| LIS | Lobular in situ |
| LKS | Liver, kidney, spleen |
| LKSB | Liver, kidney, spleen, bladder |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| LLE | Left lower extremity |
| LLL | Left lower lobe |
| LLQ | Left lower quadrant |
| LMP | Last menstrual period |
| LN(S) | Lymph node(s) |
| LN2 | Lobular neoplasia, grade 2 |
| LNBX | Lymph node biopsy |
| LND | Lymph node dissection |
| LNR | Lymph node resection |
| LOQ | Lower outer quadrant |
| LP | Lumbar puncture |
| LPN | Licensed practical nurse |
| LRG | Large |
| LRQ | Lower right quadrant |
| LS | Lumbosacral |
| LS SCAN | Liver/spleen scan |
| LSO | Left salpingo-oophorectomy |
| L-SPINE | Lumbar spine |
| LT | Left |
| LTCF | Long Term Care Facility |
| LUE | Left upper extremity |
| LUL | Left upper lobe |
| LUO | Left ureteral orifice |
| LUOQ | Left upper outer quadrant |
| LUP ERYTH | Lupus erythematosus |
| LUQ | Left upper quadrant |
| MAA | Melanoma associated antigen |
| MAB | Monoclonal antibody |
| MALIG | Malignant |
| MAND | Mandible/mandibular |
| MAST | Mastectomy |
| MAT | Multifocal arterial tachycardia |
| MAX | Maximum |
| MC | Medical center |
| MC(H) | Millicurie (hours) |
| MC-AB, MCAB | Monoclonal antibody |
| MCG | Microgram |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| MCID | Mixed combined immunodeficiency |
| MCL | Midclavicular line |
| MCS | Malignant carcinoid syndrome |
| M-CSF | Macrophage colony-stimulating factor |
| MCTD | Mixed connective tissue disease |
| MD | Moderately differentiated |
| MDS | Myelodysplasia/myelodysplastic syndrome |
| MED | Medication |
| MED | Medicine |
| METS | Metastatic/Metastasis |
| MEV | Million electron volts |
| MFH | Malignant fibrous histiocytoma |
| MG | Myasthenia gravis |
| MG(H) | Milligram (hours) |
| MHX | Medical history |
| MI | Myocardial infarction |
| MICRO | Microscopic |
| MID | Middle |
| MIN | Minimum |
| MIN | Minute |
| ML | Middle lobe |
| ML | Milliliter |
| MM | Millimeter |
| MM | Multiple myeloma |
| MOAB | Monoclonal antibody |
| MOD | Moderate (ly) |
| MOD DIFF | Moderately differentiated |
| MPD | Myeloproliferative disease |
| MPVC | Multifocal premature ventricular contraction |
| MRCP | Magnetic resonance cholangiopancreatography |
| MRI | Magnetic resonance imaging |
| MRM | Modified radical mastectomy |
| MRSA | Methicillin Resistant Staphylococcus Aureus |
| MS | Multiple sclerosis |
| MSB | Main stem bronchus |
| MULT | Multiple |
| MVP | Mitral valve prolapse |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| MX | Mastectomy |
| N&V | Nausea and vomiting |
| NA | Not applicable |
| NAD | No acute/active disease |
| NBX | Needle biopsy |
| NDL | Nodular & diffuse lymphoma |
| NEA | Neoplasm embryonic antigen |
| NEC | Not elsewhere classified/classifiable |
| NED | No evidence of disease |
| NEG | Negative |
| NEOPL | Neoplasm |
| NER | No evidence of recurrence |
| NEURO | Neurology |
| NH | Nursing home |
| NHL | Non-Hodgkin lymphoma |
| NHML | Non-Hodgkin malignant lymphoma |
| N-I - N-XII | Nerves, Cranial 1-12 |
| NK | Natural killer |
| NL | Normal |
| NLBX | Needle liver biopsy |
| NOS | Not otherwise specified |
| NR | Not recorded |
| NSCCA | Non small cell carcinoma |
| NSCLC | Non-small cell lung cancer |
| NSF | No significant findings |
| NVD | Neck vein distention |
| NX | Nephrectomy |
| OB | Obstetrics |
| OBS | Organic brain syndrome |
| OBST | Obstructed (-ing, -ion) |
| OD | Right eye |
| ONC | Oncology |
| OP | Operation |
| OP | Outpatient |
| OP RPT | Operative report |
| OPM | Occult primary malignancy |
| OPS | Outpatient surgery |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| OR | Operating room |
| ORTHO | Orthopedics |
| OS | Left eye |
| OTO | Otology |
| OZ | Ounce |
| P&A | Percussion and auscultation |
| P32 | Phosphorus 32 |
| PA | Posteroanterior |
| PAC | Premature atrial contraction |
| PALP | Palpated (-able) |
| PAP | Papanicolaou smear |
| PAP | Papillary |
| PATH | Pathology |
| PCL | Plasma cell leukemia |
| PCV | Polycythemia vera |
| PD | Poorly differentiated |
| PE | Physical examination |
| PEDS | Pediatrics |
| PERC | Percutaneous |
| PET | Positron emission tomography |
| PI | Present illness |
| PID | Pelvic inflammatory disease |
| PIN | Prostatic intraepithelial neoplasia |
| PIN III | Prostatic intraepithelial neoplasia, grade III |
| PLL | Prolymphocyctic leukemia |
| PLT | Platelets |
| PMH | Past/personal (medical) history |
| PMP | Primary medical physician |
| PNET | Primitive neuroectodermal tumor |
| POOR DIFF | Poorly differentiated |
| POS | Positive |
| POSS | Possible |
| POST | Posterior |
| POST OP | Postoperative (-ly) |
| PPD | Packs per day |
| PRA | Progesterone receptor assay |
| PRE OP | Preoperative (-ly) |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| PREV | Previous |
| PROB | Probable (-ly) |
| PROCTO | Proctoscopy |
| PSA | Prostatic specific antigen |
| PT | Patient |
| PT | Physiotherapy/Physical therapy |
| PTA | Prior to admission |
| PTC | Percutaneous transhepatic cholecystogram |
| PTNM | Pathologic tumor, nodes, metastases |
| PUD | Peptic ulcer disease |
| PULM | Pulmonary |
| PULM ART | Pulmonary artery |
| PVD | Peripheral vascular disease |
| Q | Every |
| QD | Every day |
| QUAD | Quadrant |
| R/O | Rule out |
| RA | Rheumatoid arthritis |
| RAD | Radiation absorbed dose |
| RAI | Radioactive iodine |
| RBBB | Right bundle branch block |
| RBBX | Right breast biopsy |
| RBC | Red blood cells (count) |
| RCM | Right costal margin |
| RE | Regarding |
| REC'D | Received |
| REG | Regular |
| RESEC | Resection (ed) |
| RESP | Respiratory |
| RESPIR | Respiratory |
| RHD | Rheumatic heart disease |
| RIA | Radioimmunoassay |
| RIQ | Right inner quadrant |
| RLE | Right lower extremity |
| RLL | Right lower lobe |
| RLQ | Right lower quadrant |
| RMC | Regional medical center |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| RML | Right middle lobe |
| RND | Radical neck dissection |
| ROF | Review of outside films |
| ROQ | Right outer quadrant |
| ROS | Review of outside slides |
| RSO | Right salpingo-oophorectomy |
| RSR | Regular sinus rhythm |
| RT | Radiation therapy |
| RT | Right |
| RUE | Right upper extremity |
| RUL | Right upper lobe |
| RUO | Right ureteral orifice |
| RUQ | Right upper quadrant |
| RX | Prescription |
| S/P | Status post |
| S1-S5 | Sacral vertebra |
| SARC | Sarcoma |
| SATIS | Satisfactory |
| SB | Small bowel |
| SBO | Small bowel obstruction |
| SBR | Small bowel resection |
| SCC | Squamous cell carcinoma |
| SCID | Severe combined immunodeficiency syndrome |
| SCLC | Small cell lung carcinoma |
| SGOT | Serum glutamic oxaloacetic transaminase |
| SGPT | Serum glutamic pyruvic transaminase |
| SIG COLON | Sigmoid colon |
| SLE | Systemic lupus erythematosus |
| SM | Small |
| SMA | Sequential multiple analysis |
| SNF | Skilled nursing facility |
| SO | Salpingo-oophorectomy |
| SOB | Short(ness) of breath |
| SPEC | Specimen |
| SQ | Squamous |
| SS | Summary stage |
| S-SPINE | Sacral spine |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| SSS | Sick sinus syndrome |
| STSG | Split thickness skin graft |
| SUBQ | Subcutaneous |
| SURG | Surgery/Surgical |
| SUSP | Suspicious/suspected |
| SVC | Superior vena cava |
| SX | Symptoms |
| TAH | Total abdominal hysterectomy |
| TAH-BSO | Total abdominal hysterectomy- bilateral salpingo-oophorectomy |
| T-ALL | T-cell acute lymphoblastic leukemia |
| TANI | Total axial (lymph) node irradiation |
| TBBX | Transbronchial biopsy |
| TCC | Transitional cell carcinoma |
| T-CLL | T-cell chronic lymphatic leukemia |
| TIA | Transient ischemic attack |
| TNM | Tumor, node, metastasis |
| TPN | Total parenteral nutrition |
| TRAM | Transverse rectus abdominous myocutaneous |
| TRANS-COLON | Transverse colon |
| TRUS | Transrectal ultrasound |
| TRUSP | Transrectal ultrasound of prostate |
| TS | Tumor size |
| T-SPINE | Thoracic spine |
| TTP | Thromboticthrombocytopenia purpura |
| TUR | Transurethral resection |
| TURB | Transurethral resection bladder |
| TURBT | Transurethral resection bladder tumor |
| TURP | Transurethral resection prostate |
| TVC | True vocal cord |
| TVH | Total vaginal hysterectomy |
| TX | Treatment |
| UDO | Undetermined origin |
| UE | Upper extremity |
| UGI | Upper gastrointestinal (series) |
| UIQ | Upper inner quadrant |
| UNDET | Undetermined |
| UNDIFF | Undifferentiated |

## ABBREVIATIONS

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| UNK | Unknown |
| UOQ | Upper outer quadrant |
| URI | Upper respiratory infection |
| URQ | Upper right quadrant |
| US | Ultrasound |
| USO | Unilateral salpingo-oophorectomy |
| UTI | Urinary tract infection |
| VAG | Vagina/Vaginal |
| VAG HYST | Vaginal hysterectomy |
| VAIN | Vaginal intraepithelial neoplasia |
| VAIN III | Vaginal intraepithelial neoplasia (grade III) |
| VASC | Vascular |
| VIN | Vulvar intraepithelial neoplasia |
| VIN III | Vulvar intraepithelial neoplasia (grade III) |
| VS | Versus |
| W/ | With |
| W/F | White female W/F |
| W/M | White male |
| W/O | Without |
| W/U | Work-up |
| WAGR | Wilms (tumor), aniridia, genitourinary (abnormalities), and (mental) |
| WBC | White blood cells (count) |
| WD | Well differentiated |
| WELL DIFF | Well differentiated |
| WF-O | Will follow (in) office |
| WNL | Within normal limits |
| WPW | Wolff-Parkinson-White syndrome |
| XR | Xray |
| YR | Year |
| YST | Yolk Sac Tumor |

# ABBREVIATIONS

## CONTEXT-SENSITIVE ABBREVIATIONS

When using these abbreviations make sure the meaning of the abbreviation is readily apparent in the context in which it is used.

| ABBREVIATION | WORD/TERM(S) |
|---|---|
| AP | Anteroposterior |
| | Abdominal perineal |
| BM | Bone marrow |
| | Bowel movement |
| CA | Calcium |
| | Carcinoma |
| DM | Diabetes mellitus |
| | Distant metastases |
| MIN | Minimum |
| | Minute |
| ML | Milliliter |
| | Middle lobe |
| MM | Millimeter |
| | Multiple myeloma |
| OP | Operation |
| | Outpatient |
| PAP | Papillary |
| | Papanicolaou smear |
| PT | Patient |
| | Physiotherapy/Physical therapy |
| RT | Right |
| | Radiation therapy |

# ABBREVIATIONS

## SYMBOLS

| SYMBOL | WORD/TERM (S) |
|---|---|
| - | Minus |
| # | Number |
| & | And |
| @ | At |
| ^ | Above |
| + | Plus, Positive |
| < | Less/Less than |
| = | Equal(s) |
| > | Greater/Greater than, More/more than |
| X | Times |

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# APPENDIX K:
# REQUIRED DATA SET
# FOR REPORTING FACILITIES

# Required Data Set for Reporting Facilities (Effective 1/1/2008)

| VCR Required Data Items | Field Length | NAACCR Item # |
|---|---|---|
| Patient Identification | | |
| Accession Number | 9 | 550 |
| Sequence Number | 2 | 560 |
| Medical Record Number | 11 | 2300 |
| Social Security Number | 9 | 2320 |
| Military Medical Record Number Suffix | 2 | 2310 |
| Last Name | 25 | 2230 |
| First Name | 14 | 2240 |
| Middle Name (Middle Initial) | 14 | 2250 |
| Patient Address (# and Street) at Diagnosis | 40 | 2330 |
| Patient Address at Diagnosis – Supplemental | 40 | 2335 |
| City/Town at Diagnosis (City or Town | 20 | 70 |
| State at Diagnosis (State) | 2 | 80 |
| Postal Code at Diagnosis (Zip Code) | 9 | 100 |
| County at Diagnosis | 3 | 90 |
| Patient Address (Number & Street) Current | 40 | 2350 |
| Patient Address Current – Supplemental | 40 | 2355 |
| City/Town – Current | 20 | 1810 |
| State – Current | 2 | 1820 |
| Postal Code – Current (Zip Code) | 9 | 1830 |
| Telephone | 10 | 2360 |
| Place of Birth | 3 | 250 |
| Date of Birth | 8 | 240 |
| Age at Diagnosis | 3 | 230 |
| Marital Status | 1 | 150 |
| Race 1 | 2 | 160 |
| Race 2 | 2 | 161 |
| Race 3 | 2 | 162 |
| Race 4 | 2 | 163 |
| Race 5 | 2 | 164 |
| Spanish Origin – All Sources (Spanish/Hispanic Origin) | 1 | 190 |
| Sex | 1 | 220 |
| Text – Usual Occupation | 40 | 310 |
| Text – Usual Industry | 40 | 320 |
| Primary Payer at Diagnosis | 2 | 630 |
| Comorbidities & Complications #1 (Secondary Diagnosis) | 5 | 3110 |
| Comorbidities & Complications #2 (Secondary Diagnosis) | 5 | 3120 |
| Comorbidities & Complications #3 (Secondary Diagnosis) | 5 | 3130 |
| Comorbidities & Complications #4 (Secondary Diagnosis) | 5 | 3140 |
| Comorbidities & Complications #5 (Secondary Diagnosis) | 5 | 3150 |
| Comorbidities & Complications #6 (Secondary Diagnosis) | 5 | 3160 |
| Comorbidities & Complications #7 (Secondary Diagnosis) | 5 | 3161 |
| Comorbidities & Complications #8 (Secondary Diagnosis) | 5 | 3162 |
| Comorbidities & Complications #9 (Secondary Diagnosis) | 5 | 3163 |
| Comorbidities & Complications #10 (Secondary Diagnosis) | 5 | 3164 |

**Bold**= Added 1/1/2007

# Required Data Set for Reporting Facilities
# (Effective 1/1/2008)

| VCR Required Data Items | Field Length | NAACCR Item # |
|---|---|---|
| Tobacco History | 1 | 340 |
| Alcohol History | 1 | 350 |
| Family History of Cancer | 1 | 360 |
| **NPI – Managing Physician** | **10** | **2465** |
| Following Physician (Follow up Physician) | 8 | 2470 |
| **NPI – Following Physician** | **10** | **2475** |
| Primary Surgeon | 8 | 2480 |
| **NPI – Primary Physician** | **10** | **2485** |
| Physician #3 (Other Physician/Radiation Oncologist) | 8 | 2490 |
| **NPI – Physician # 3 (Radiation Oncologist)** | **10** | **2495** |
| Physician #4 (Other Physician/Medical Oncologist) | 8 | 2500 |
| **NPI – Physician #4 (Medical Oncologist)** | **10** | **2505** |
| Cancer Identification | | |
| Class of Case | 1 | 610 |
| Facility Referred From | 10 | 2410 |
| **NPI – Institution Referred From** | **10** | **2415** |
| Facility Referred To | 10 | 2420 |
| **NPI – Institution Referred To** | **10** | **2425** |
| Date of Initial Diagnosis | 8 | 390 |
| Primary Site | 4 | 400 |
| Text – Primary Site Title | 40 | 2580 |
| Laterality | 1 | 410 |
| Histology | 4 | 522 |
| Text – Histology Title | 40 | 2590 |
| Behavior Code | 1 | 523 |
| Grade/Differentiation | 1 | 440 |
| Histologic Confirmation | 1 | 490 |
| **Ambiguous Terminology Diagnosis** | **1** | **442** |
| **Date of Conclusive Diagnosis** | **8** | **443** |
| **Date of Multiple Tumors** | **8** | **2290** |
| **Multiple Tumors Reported as One Primary** | **2** | **444** |
| **Multiplicity Counter** | **2** | **446** |
| Tumor Size | 3 | 780 |
| Regional Lymph Nodes Examined | 2 | 830 |
| Regional Lymph Nodes Positive | 2 | 820 |
| Stage of Disease at Diagnosis | | |
| Date of Surgical Diagnostic and Staging Procedure | 8 | 1280 |
| Surgical Diagnostic and Staging Procedure | 2 | 1350 |
| Surgical Diagnostic and Staging Procedure at This Facility | 2 | 740 |
| Clinical T | 2 | 940 |
| Clinical N | 2 | 950 |
| Clinical M | 2 | 960 |
| Clinical Stage Group | 2 | 970 |

**Bold**= Added 1/1/2007

# Required Data Set for Reporting Facilities (Effective 1/1/2008)

| VCR Required Data Items | Field Length | NAACCR Item # |
|---|---|---|
| Stage of Disease at Diagnosis - continued | | |
| Clinical Stage (Prefix/Suffix) Descriptor | 1 | 980 |
| Staged By (Clinical Stage) | 1 | 990 |
| Pathologic T | 2 | 880 |
| Pathologic N | 2 | 890 |
| Pathologic M | 2 | 900 |
| Pathologic Stage Group | 2 | 910 |
| Pathologic Stage (Prefix/Suffix) Descriptor | 1 | 920 |
| Staged By (Pathologic Stage) | 1 | 930 |
| SEER Summary Stage 2000 | 1 | 759 |
| Collaborative Stage: | | |
| CS Tumor Size | 3 | 2800 |
| CS Extension | 2 | 2810 |
| CS Tumor Size/Ext Eval | 1 | 2820 |
| CS Lymph Nodes | 2 | 2830 |
| CS Reg Nodes Eval | 1 | 2840 |
| CS Mets at DX | 2 | 2850 |
| CS Mets Eval | 2 | 2860 |
| CS Site Specific Factor 1 | 3 | 2880 |
| CS Site Specific Factor 2 | 3 | 2890 |
| CS Site Specific Factor 3 | 3 | 2900 |
| CS Site Specific Factor 4 | 3 | 2910 |
| CS Site Specific Factor 5 | 3 | 2920 |
| CS Site Specific Factor 6 | 3 | 2930 |
| Derived AJCC T | 2 | 2940 |
| Derived AJCC T Descriptor | 1 | 2950 |
| Derived AJCC N | 2 | 2960 |
| Derived AJCC N Descriptor | 1 | 2970 |
| Derived AJCC M | 2 | 2980 |
| Derived AJCC M Descriptor | 1 | 2990 |
| Derived AJCC Stage Group | 2 | 3000 |
| Derived SS1977 | 1 | 3010 |
| Derived SS2000 | 1 | 3020 |
| Text: | | |
| Dx Procedures – Lab Tests | 250 | 2550 |
| Dx Procedures – Op Procedures | 250 | 2560 |
| Dx Procedures – Pathology | 250 | 2570 |
| Dx Procedures – PE | 200 | 2520 |
| Dx Procedures – X-Rays/Scans | 250 | 2530 |
| Dx Procedures – Place of Diagnosis | 50 | 2690 |
| Dx Procedures – Remarks | 350 | 2680 |
| First Course of Treatment | | |
| Date of First Course of Treatment | 8 | 1270 |
| Date of First Surgical Procedure | 8 | 1200 |

**Bold**= Added 1/1/2007

# Required Data Set for Reporting Facilities
# (Effective 1/1/2008)

| VCR Required Data Items | Field Length | NAACCR Item # |
|---|---|---|
| Date of Most Definitive Surgical Resection of Primary Site | 8 | 3170 |
| Surgical Procedure of Primary Site | 2 | 1290 |
| Surgical Procedure of Primary Site At This Facility | 2 | 670 |
| Scope of Regional Lymph Node Surgery | 1 | 1292 |
| Surgical Procedure/Other Site | 1 | 1294 |
| Scope of Regional Lymph Node Surgery At This Facility | 1 | 672 |
| Surgical Procedure/Other Site at This Facility | 1 | 674 |
| Date of Surgical Discharge | 8 | 3180 |
| Readmission to the Same Hospital Within 30 Days of Surgical Discharge | 1 | 3190 |
| Surgical Procedure/Other Site | 1 | 1294 |
| Reason for No Surgery of Primary Site | 1 | 1340 |
| Date Radiation Started | 8 | 1210 |
| Location of Radiation Treatment | 1 | 1550 |
| Radiation Treatment Volume | 2 | 1540 |
| Regional Treatment Modality | 2 | 1570 |
| Regional Dose: cGy | 5 | 1510 |
| Boost Treatment Modality | 2 | 3200 |
| Boost Dose: cGy | 5 | 3210 |
| Number of Treatments to This Volume | 2 | 1520 |
| Radiation/Surgery Sequence | 1 | 1380 |
| Date Radiation Ended | 8 | 3220 |
| Reason for No Radiation | 1 | 1430 |
| Date Systemic Therapy Started | 8 | 3230 |
| Chemotherapy | 2 | 1390 |
| Chemotherapy at This Facility | 2 | 700 |
| Hormone Therapy (Hormone/Steroid Therapy) | 2 | 1400 |
| Hormone Therapy at This Facility (Hormone/Steroid Therapy) | 2 | 710 |
| Immunotherapy | 2 | 1410 |
| Immunotherapy at This Facility | 2 | 720 |
| Hematologic Transplant and Endocrine Procedures | 2 | 3250 |
| Systemic/Surgery Sequence | 1 | 1639 |
| Date Other Treatment Started | 8 | 1250 |
| Other Treatment | 1 | 1420 |
| Other Treatment at This Facility | 1 | 730 |
| Palliative Care (Palliative Procedure) | 1 | 3270 |
| Palliative Care at This Facility (Palliative Procedure at This Facility) | 1 | 3280 |
| RX Text: | | |
| Surgery | 150 | 2610 |
| Radiation – Beam | 150 | 2620 |

**Bold**= Added 1/1/2007

# Required Data Set for Reporting Facilities (Effective 1/1/2008)

| VCR Required Data Items | Field Length | NAACCR Item # |
|---|---|---|
| First Course of Treatment (continued) | | |
| RX Text (continued): | | |
| Radiation – Other | 150 | 2630 |
| Chemotherapy | 200 | 2640 |
| Hormone | 200 | 2650 |
| BRM | 100 | 2660 |
| Other | 100 | 2670 |
| Outcomes | | |
| Date of First Recurrence | 8 | 1860 |
| Type of First Recurrence | 2 | 1880 |
| Date of Last Contact or Death | 8 | 1750 |
| Vital Status | 1 | 1760 |
| Following Registry | 10 | 2440 |
| **NPI – Following Registry** | **10** | **2445** |
| Follow up Source | 1 | 1790 |
| Next Follow up Source | 1 | 1800 |
| Case Administration | | |
| Abstracted By | 3 | 570 |
| Facility Identification Number (FIN) | 10 | 540 |
| **NPI – Reporting Facility** | **10** | **545** |
| Archive FIN | 10 | 3100 |
| **NPI – Archive FIN** | **10** | **3105** |
| Override ACSN/CLASS/SEQ | 1 | 1985 |
| Override HOSPSEQ/DXCONF | 1 | 1986 |
| Override COC – SITE/TYPE | 1 | 1987 |
| Override HOSPSEQ/SITE | 1 | 1988 |
| Override SITE/TNM-STAGE GROUP | 1 | 1989 |
| Override AGE/SITE/MORPH | 1 | 1990 |
| Override SURG/DXCONF | 1 | 2020 |
| Override SITE/TYPE | 1 | 2030 |
| Override HISTOLOGY | 1 | 2040 |
| Override LEUK,LYMPHOMA | 1 | 2070 |
| Override SITE/BEHAVIOR | 1 | 2071 |
| Override SITE/LAT/MORPH | 1 | 2074 |
| CoC Coding System – Current | 2 | 2140 |
| CoC Coding System – Original | 2 | 2150 |
| Race Coding System – Current | 1 | 170 |
| Race Coding System – Original | 1 | 180 |
| Site Coding System – Current | 1 | 450 |
| Site Coding System – Original | 1 | 460 |
| Morphology Coding System – Current | 1 | 470 |
| Morphology Coding System - Original | 1 | 480 |
| ICD-O-2 Conversion Flag | 1 | 1980 |

**Bold**= Added 1/1/2007

# Required Data Set for Reporting Facilities
# (Effective 1/1/2008)

| VCR Required Data Items | Field Length | NAACCR Item # |
|---|---|---|
| Case Administration – continued | | |
| ICD-O-3 Conversion Flag | 1 | 2116 |
| TNM Edition Number | 2 | 1060 |
| ICD Revision Comorbidities and Complications | 1 | 3165 |
| RX Coding System – Current | 2 | 1460 |
| Derived AJCC – Flag | 1 | 3030 |
| Derived SS1977 – Flag | 1 | 3040 |
| Derived SS2000 – Flag | 1 | 3050 |
| CS Version First | 6 | 2935 |
| CS Version Latest | 6 | 2936 |
| NAACCR Record Version | 1 | 50 |
| Vendor Name | 10 | 2170 |
| Date Case Completed | 8 | 2090 |
| Date Case Report Exported | 8 | 2110 |
| Virginia State Specific | | |
| HIV/AIDS | 1 | 2220 |
| Dioxin Exposure | 1 | 2220 |
| Vietnam Veteran | 1 | 2220 |
| Tobacco History | 1 | 2220 |
| Number of Years Smoked | 1 | 2220 |
| Alcohol History | 1 | 2220 |
| Family History | 1 | 2220 |
| Breast Mammogram | 1 | 2220 |
| Breast S-phase | 1 | 2220 |
| Breast DNA Ploidy | 1 | 2220 |
| Colon CEA | 1 | 2220 |
| Ovary CA-125 | 1 | 2220 |
| Prostate PSA | 1 | 2220 |

**Bold**= Added 1/1/2007

# APPENDIX L:
# REPORTING FACILITY NUMBERS

# Alphabetic Facility Listing

| Corp. | Facility Name | Region |
|---|---|---|
| | Advanced Dermatology of Charlottesville | 1 Northwest |
| | Affiliated Dermatologists-VA | 4 Central |
| | Affiliated Potomac Urology | 2 North |
| | Alabama Statewide Cancer Registry | 0 Out of State |
| | Alberto A. Gorges, MD | 2 North |
| Inova | Alexandria Hospital | 2 North |
| | Alexandria Urological Associates | 2 North |
| Columbia | Alleghany Regional Hospital | 3 Southwest |
| Bon Secours | Ambulatory Surgery Center at VA Beach | 5 East |
| | Arlington Fairfax Hematology | 2 North |
| | Associates in Dermatology, Inc. | 5 East |
| | Associates in Radiation Oncology, P.C. | 2 North |
| | Atlantic Dermatology Associates, P.C. | 5 East |
| | Augusta Medical Center | 1 Northwest |
| | Avenues Dermatology | 4 Central |
| | Bartolozzi Magalski & Kim | 2 North |
| | Bath County Community Hospital | 1 Northwest |
| Sentara | Bayside Hospital | 5 East |
| Carilion | Bedford Community Hospital | 3 Southwest |
| | Belmont Medical Center | 1 Northwest |
| | Blue Ridge Surgery Center | 3 Southwest |
| | Bluefield Family Medicine | 3 Southwest |
| | Bon Secours Health Center at Harbour View | 5 East |
| | Bon Secours Mary Immaculate Hospital | 5 East |
| | Bone Marrow Transplant Unit | 4 Central |
| | Bostwick Laboratories, Inc. | 4 Central |
| | Breast Care Specialists | 3 Southwest |
| | Buchanan General Hospital | 3 Southwest |
| | Cancer Center of New River | 3 Southwest |
| | Cancer Center of the Piedmont | 3 Southwest |
| | Cancer Center of VA | 5 East |
| | Cancer Center of Virginia | 1 Northwest |
| | Cancer Center-Bedford County | 3 Southwest |
| | Cancer Outreach Assoc. | 3 Southwest |

| Corp. | Facility Name | Region |
|---|---|---|
| Sentara | Careplex Hospital | 5 East |
| | Carilion Brambleton Ambulatory Surgical Center | 3 Southwest |
| | Carilion Cancer Center of Western VA | 3 Southwest |
| | Carilion Gyn Oncology Assoc. | 3 Southwest |
| | Carilion Medical Center | 3 Southwest |
| | Carilion Pediatric Oncology | 3 Southwest |
| | Carolina B. Longa MD | 5 East |
| | Carroll-Pinto, Inc. | 5 East |
| | Cataract and Refractive Surgery Center | 4 Central |
| | CBL Path, Inc. | 0 Out of State |
| | Center for Radiation Oncology | 3 Southwest |
| | Center for Surgical Excellence | 3 Southwest |
| | Centra Health | 3 Southwest |
| | Central VA Radiation | 1 Northwest |
| | Central Virginia Gynecologic | 4 Central |
| | Central Virginia Training Center | 3 Southwest |
| | Chase City Family Practice | 4 Central |
| | Chesapeake General Hospital | 5 East |
| | Children's Hospital of the King's Daughters | 5 East |
| | Children's Hospital of the King's Daughters Health and Surgery Center | 5 East |
| | Children's Specialty Group | 5 East |
| | Chippenham Hospital (merged into CJW) | 4 Central |
| HCA | CJW Medical Center (Chippenham Campus) | 4 Central |
| | Claypool Hill Clinic | 3 Southwest |
| | Clinch Co. Community Health Center (closed) | 3 Southwest |
| HCA | Clinch Valley Medical Center | 3 Southwest |
| | Colon & Rectal Specialists, Ltd. | 4 Central |
| | Commonwealth Cancer Institute | 4 Central |
| | Commonwealth Dermatology | 4 Central |
| | Commonwealth Gynecologic | 4 Central |
| | Commonwealth Surgeons Ltd. | 4 Central |
| | Community Memorial Healthcenter | 4 Central |
| | Community Physicians | 4 Central |
| | Countryside Ambulatory Surgery Center | 2 North |
| | Culpeper Regional Hospital | 1 Northwest |

| Corp. | Facility Name | Region |
|---|---|---|
| | Danville Dermatology Associates | 3 Southwest |
| | Danville Hematology Inc. | 3 Southwest |
| | Danville Regional Cancer Center | 3 Southwest |
| | Danville Urology Clinic | 3 Southwest |
| | Delta Hematology/Oncology | 5 East |
| | Delta Hematology/Oncology | 5 East |
| Bon Secours | DePaul Medical Center | 5 East |
| | Dermatology Associates of McLean, Ltd. | 2 North |
| | Dermatology Associates of Virginia, P.C. | 4 Central |
| | Dermatology Associates of Virginia, P.C. | 4 Central |
| | Dermatology Associates of Virginia, P.C. | 4 Central |
| | Dermatology Associates of Virginia, P.C. | 4 Central |
| | Dermatology Associates, Inc. | 1 Northwest |
| | Dermatology Center, P.C., The | 2 North |
| | Dermatology, Inc. of Va. Beach | 5 East |
| | Dewitt Army Community Hospital | 2 North |
| | Dickenson Community Hospital | 3 Southwest |
| | Doctors Surgery Center-Williamsburg, L.L.C. | 5 East |
| | Dominion Pathology Laboratories | 5 East |
| | Dr. Piatt Dermatology | 1 Northwest |
| | East Rockingham Health Center | 0 Out of State |
| | Eastern Shore Physicians & Surgeons | 5 East |
| | Eastern Shore Physicians Inc. | 5 East |
| Inova | Fair Oaks Hospital | 2 North |
| Inova | Fairfax Hospital | 2 North |
| | Fairfax Medical Lab | 2 North |
| | Fairfax Pathology Associates, LTD | 2 North |
| | Fairfax Radiology Center | 2 North |
| | Fairfax Surgical Center | 2 North |
| | Fairfax-Prince William Hematology | 2 North |
| | Falls Church Medical Center | 2 North |
| | Family Health Care Associates | 3 Southwest |
| | Family Health Care Associates | 3 Southwest |
| | Family Medical Care, Inc. | 3 Southwest |
| | Fauquier Hospital, Inc. | 1 Northwest |

| Corp | Facility Name | Region |
|---|---|---|
| Carilion | Franklin Memorial Hospital | 3 Southwest |
| | Fredericksburg Ambulatory Surgery Center, LLC | 1 Northwest |
| | Fredericksburg Oncology Inc. | 1 Northwest |
| | Fridling and Sawchuk | 2 North |
| | Front Royal Family Practice | 1 Northwest |
| | Gastroenterology Associates of Northern Virginia | 2 North |
| | Gastroenterology Center of VA, PLLC | 2 North |
| | George M. Kemp, MD | 5 East |
| | GI Pathology Partners, PLLC | 0 Out of State |
| Carilion | Giles Memorial Hospital | 3 Southwest |
| | Greenberg & Perdahl Services | 2 North |
| | GYN Oncology of SW VA | 3 Southwest |
| | Halifax Regional Hospital | 4 Central |
| | Hampton Rd. Surgical Specialist | 5 East |
| | Hanover Outpatient Surgery Center, LP | 4 Central |
| | Hardy & Hart | 2 North |
| | Hematology & Oncology Division | 4 Central |
| | Hematology & Oncology Practice | 4 Central |
| | Hematology Oncology Assoc. | 5 East |
| | Hematology Oncology Assoc. | 5 East |
| | Hematology Oncology Assoc. | 5 East |
| | Hematology Oncology Assoc. Inc. | 1 Northwest |
| | Hematology-Oncology Assoc. Ltd. | 2 North |
| | Henrico Doctors' Hospital - Forest Campus | 4 Central |
| HCA | Henrico Doctor's Hospital - Parham | 4 Central |
| | Highland Pathology | 3 Southwest |
| | Hope Hematology Oncology | 1 Northwest |
| | Hunter Holmes McGuire VAMC | 4 Central |
| Inova | Inova Surgery Center | 2 North |
| | Jackson Laboratories, Inc. | 1 Northwest |
| | James J. Stark, MD | 5 East |
| Columbia | John Randolph Medical Center | 4 Central |
| | Johns Radiation Oncology | 4 Central |
| | Johnston Memorial Hospital | 3 Southwest |
| | Joseph Buchino, M.D. | 2 North |

| Corp | Facility Name | Region |
|---|---|---|
| | Kaiser Permanente | 0 Out of State |
| | Kaiser Permanente Falls Church Ambulatory Surgery Center | 2 North |
| | Kenner Army Community Hospital | 4 Central |
| Kindred Health Care | Kindred Hospital Richmond | 4 Central |
| | Lab Corp. of America - Burlington | 0 Out of State |
| | Lab Corp. of America - Chesapeake | 5 East |
| | Lab Corp. of America - Herndon | 2 North |
| | Lab Corp. of America - Research Triangle | 0 Out of State |
| | Lab Corp. of America - Richmond | 4 Central |
| | Lakeview Medical Center | 5 East |
| | Lakewood Pathology Associates | 0 Out of State |
| | Langley AFB | 5 East |
| | Lee County Health Department | 3 Southwest |
| | Lee Regional Medical Center | 3 Southwest |
| Sentara | Leigh Memorial Hospital | 5 East |
| HCA | Lewis-Gale Regional Cancer Center | 3 Southwest |
| Inova | Loudoun Cancer Care Center | 2 North |
| | Loudoun Radiation Oncology | 2 North |
| | Loudoun Radiation Oncology | 2 North |
| Sentara | Louise Obici Memorial Hospital | 5 East |
| | Lynchburg General (merged Centra Health) | 3 Southwest |
| | Lynchburg Hematology-Oncology | 3 Southwest |
| | Martha Davis Cancer Center | 5 East |
| | Martha Jefferson Hospital | 1 Northwest |
| | Martha Jefferson Outpatient Surgery Center, LLC | 1 Northwest |
| | Mary Immaculate Ambulatory Surgery Center | 5 East |
| | Mary Washington Hospital | 1 Northwest |
| Bon Secours | Maryview Medical Center | 5 East |
| | Massey Cancer Center | 4 Central |
| | McDonald Army Community Hospital | 5 East |
| | Medical Oncology & Hematology | 2 North |
| | Medical Oncology & Hematology | 2 North |
| | Medical Specialists | 1 Northwest |
| | Memorial Ambulatory Surgery Center, LLC | 4 Central |

| Corp | Facility Name | Region |
|---|---|---|
| Bon Secours | Memorial Regional Medical Center | 4 Central |
| | Michael L. Smith, Inc. | 1 Northwest |
| | Mid-Atlantic Pathology Services, Inc. | 2 North |
| | Mid-Atlantic Urology | 2 North |
| | Mid-Rivers Cancer Center | 5 East |
| HCA | Montgomery Regional Hospital | 3 Southwest |
| | Monument Radiology, PC | 4 Central |
| Inova | Mount Vernon Hospital | 2 North |
| | Mountain View Regional Medical Center | 3 Southwest |
| | National Health Care of Bristol | 3 Southwest |
| | Naval Regional Medical Center - Portsmouth | 5 East |
| Carilion | New River Valley Medical Center | 3 Southwest |
| | New River Valley Surgery Center | 3 Southwest |
| Sentara | Norfolk General Hospital | 5 East |
| | Northern Neck Surgical Service | 5 East |
| | Northern VA Pelvic Surgery | 2 North |
| | Northern Virginia Oncology GRP | 2 North |
| | Norton Community Hospital | 3 Southwest |
| | Oncology & Hematology Assoc. | 3 Southwest |
| | Oncology & Hematology Assoc. | 1 Northwest |
| | Oncology & Hematology Assoc. | 3 Southwest |
| | Oncology & Hematology Assoc. | 3 Southwest |
| | Oncology & Hematology Assoc. | 3 Southwest |
| | Oncology & Hematology Assoc. | 3 Southwest |
| | Oncology & Hematology Assoc. | 3 Southwest |
| | Oncology Associates | 5 East |
| | Oncology Center of Virginia | 4 Central |
| | Oncology/Hematology-Loudoun | 2 North |
| | OUR Lab | 0 Out of State |
| | Oyster Point Dermatology, Inc. | 5 East |
| | Page Memorial Hospital | 1 Northwest |
| | Pariser Dermatology Specialists, Ltd. | 5 East |
| | Pathology Consultants of Central Virginia | 3 Southwest |
| HCA | Pathology Services of Southwest VA, P.C. | 3 Southwest |

| Corp | Facility Name | Region |
|---|---|---|
| | Patrick Community Hospital | 3 Southwest |
| | Peninsula Cancer Institute | 5 East |
| | Peninsula Surgery Center | 5 East |
| | Piedmont Day Surgery Center, Inc. | 3 Southwest |
| | Piedmont Laboratories | 3 Southwest |
| | Piedmont Medical Laboratory | 1 Northwest |
| | Potomac Ambulatory Surgery Center, L.L.C. | 2 North |
| | Potomac Hospital | 2 North |
| | Potomac Radiation Oncology Center | 2 North |
| | Pratt Medical Center | 1 Northwest |
| | Premier Health Care Assoc. | 4 Central |
| | Prince William Dermatology, PC | 2 North |
| | Prince William Hospital | 2 North |
| | Prince William Surgery Center | 2 North |
| HCA | Pulaski Community Hospital | 3 Southwest |
| | Pulmonary Medicine of Va. Beach | 5 East |
| | Quest Diagnostics | 5 East |
| | Quest Diagnostics - Atlanta | 0 Out of State |
| | Quest Diagnostics - Nichols Institute | 2 North |
| | Radiation Oncology | 2 North |
| | Radiation Oncology | 2 North |
| | Radiation Oncology Assoc. | 2 North |
| | Radiation Oncology Assoc. Inc. | 3 Southwest |
| | Rappahannock General Hospital | 5 East |
| | Ravenel Oncology Center | 3 Southwest |
| | Regional Surgical Services, LLC | 3 Southwest |
| Columbia | Reston Hospital Center | 2 North |
| | Reston Surgery Center | 2 North |
| HCA | Retreat Hospital | 4 Central |
| | Richard R. Andrews, M.D. | 5 East |
| Bon Secours | Richmond Community Hospital | 4 Central |
| | Richmond Derm. & Laser Specialists, PC | 4 Central |
| | Richmond Radiation Oncology Center | 4 Central |
| | Riverside - Tappahannock Hospital | 5 East |
| | Riverside Middle Peninsula Cancer Center | 5 East |
| | Riverside Regional Medical Center | 5 East |

| Corp | Facility Name | Region |
|---|---|---|
| | Riverside Walter Reed Hosp.- Gloucester | 5 East |
| | Roanoke Ambulatory Surgery Center | 3 Southwest |
| | Robert M. Weinacker, MD | 3 Southwest |
| | Roche Labs Alexandria (closed) | 8 In state other |
| | Rockingham Dermatology, P.C. | 1 Northwest |
| | Rockingham Memorial Hospital | 1 Northwest |
| CHS | Russell County Medical Center | 3 Southwest |
| | Salem Jefferson Surgical Clinic Inc. | 3 Southwest |
| | Scott County Health Department | 3 Southwest |
| | Selma Medical Associates | 1 Northwest |
| | Sentara Leigh Ambulatory Surgery Center | 5 East |
| | Sentara Williamsburg Community Outpatient Care Center | 5 East |
| | Shelly Hoover | 4 Central |
| | Shenandoah County Memorial Hospital | 1 Northwest |
| | Shenandoah Oncology Assoc. | 1 Northwest |
| | Shore Memorial Hospital | 5 East |
| | Skin Cancer Outpatient Surgical Hospital | 2 North |
| | Smyth County Community Hospital | 3 Southwest |
| CHS | Southampton Memorial Hospital | 5 East |
| CHS | Southern Virginia Regional Medical Center | 5 East |
| | Southside Community Hospital | 4 Central |
| CHS | Southside Regional Medical Center | 4 Central |
| Wellmont | Southwest Virginia Regional Cancer Center | 3 Southwest |
| Bon Secours | St. Francis Medical Center | 4 Central |
| | St. Francis Surgery Center | 4 Central |
| Bon Secours | St. Mary's Hospital - Richmond | 4 Central |
| | State Medical Examiner | 4 Central |
| Carilion | Stonewall Jackson Hospital | 1 Northwest |
| | Stony Point Surgery Center | 4 Central |
| | Surgery Center of Central Virginia | 3 Southwest |
| | Surgery Center of Chesapeake, LLC | 5 East |
| | Surgery Center of Lynchburg | 3 Southwest |
| | Surgical Oncology | 4 Central |
| | Surgi-Center of Central Virginia, Inc. | 1 Northwest |

| Corp | Facility Name | Region |
|---|---|---|
| | Tazewell Community Hospital | 3 Southwest |
| | The Skin Cancer Surgery Center | 2 North |
| | Thomas M. O'Neill, M.D. | 2 North |
| | Tidewater Dermatopathology Service | 5 East |
| | Tidewater Surgical Specialists | 5 East |
| | Tierney W. Andrew, MD | 4 Central |
| | Tuckahoe Surgery Center | 4 Central |
| | Twin County Regional Hospital | 3 Southwest |
| | University of Virginia | 1 Northwest |
| | University of Virginia Health System | 1 Northwest |
| | URO - Radiation Prostate Institute | 2 North |
| | Urology Associates of New River Valley | |
| | Urology Associates of the Piedmont | 1 Northwest |
| | Urology of Virginia, P.C. | 5 East |
| | Urosurgical Center of Richmond-Monument | 4 Central |
| | VA Biotechnical Labs | 3 Southwest |
| | VA Oncology Assoc. | 5 East |
| | VCU School of Dentistry | 4 Central |
| | Veterans Administration Medical Center (Hampton) | 5 East |
| | Veterans Administration Medical Center (Salem) | 3 Southwest |
| | Virginia Beach Ambulatory Surgery Center | 5 East |
| Sentara | Virginia Beach General Hospital | 5 East |
| | Virginia Breast Center | 4 Central |
| | Virginia Cancer Institute | 4 Central |
| | Virginia Commonwealth University--Medical Campus | 4 Central |
| | Virginia Hematology & Oncology | 2 North |
| | Virginia Hematology Oncology | 5 East |
| | Virginia Hospital Center Arlington | 2 North |
| | Virginia Oncology Associates | 5 East |
| | Virginia Oncology Associates | 5 East |
| | Virginia Oncology Care | 3 Southwest |
| | Virginia Pathology Services, P.C. | 2 North |
| | Virginia Physicians Inc. - Laboratory | 4 Central |
| | Virginia Surgery Center, L.L.C. | 5 East |
| | Virginia Urology Center Laboratory | 4 Central |

| Corp | Facility Name | Region |
|---|---|---|
| | Washington Pathology Services | 2 North |
| | Wellmont Lonesome Pine Hospital | 3 Southwest |
| | West End Hematology and Medical Oncology, Inc. | 4 Central |
| | West End Surgical Corp. | 4 Central |
| | William C. Reha, M.D. | 2 North |
| | Williamsburg Radiation Therapy Center | 5 East |
| Sentara | Williamsburg Regional Medical Center | 5 East |
| | Williamsburg Surgery | 5 East |
| | Winchester Medical Center | 1 Northwest |
| | Wise County Health Department | 3 Southwest |
| | Wythe County Community Hospital | 3 Southwest |