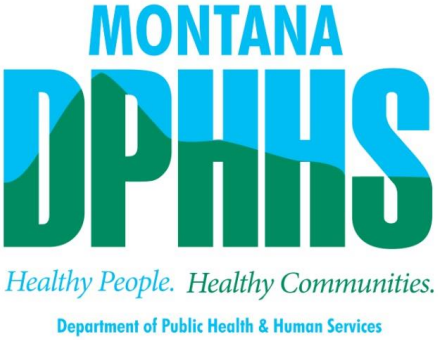
MONTANA CENTRAL TUMOR REGISTRY ABSTRACTING MANUAL 2016

For use with the TUMOR REGISTRY ABSTRACT FORM TR-003 Revised 8/10

Montana Central Tumor Registry
Department of Public Health and Human Services
Public Health and Safety Division
PO Box 202952
Helena, MT 59620
406 . 444 . 6786



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PREFACE

Construction of this manual is modeled from the Facility Oncology Registry Data Standards 2010 (FORDS). Implementation of this manual will be required with cancer cases diagnosed on or after January 1, 2010. FORDS has been written to ensure that cancer registry data support the meaningful evaluation of patient diagnosis and treatment and that these data are collected with standardized quality control mechanisms.

Required fields are either required by the Montana Central Tumor Registry law (Duty to Report Tumors 50-15-703), Administrative Rules of Montana (37.8.1801 – 37.8.1808), Public Law 102-515 (Cancer Registries Amendment Act), or NPCR Required Status Table under cooperative agreement with the Centers for Disease Control and Prevention, PA 02060, National Program of Cancer Registries (cooperative agreement number U58/DP000765).

PURPOSE

Central cancer registries are organizations that collect, store, analyze, and interpret cancer data on people who are diagnosed and/or treated for cancer in population-based areas. The primary objective of the MCTR is to analyze the incidence, mortality, survival, and the changing frequency of cancer in Montana residents. Analysis is possible with complete case, complete data, timely and quality data reporting.

CASEFINDING

Casefinding is the method of locating all eligible cancer cases and retrieving the required information on all patients diagnosed with or treated for cancer who are to be included in the MCTR. Casefinding will identify both new cases and cases already entered. Active casefinding (involves the registrar retrieving all source documents) is recommended for identifying reportable cases. Reportable cases could easily be missed with passive casefinding as non-registry staff are not familiar with reporting criteria and terminology. For example, non-registry staff could miss the collection of cases with terms that may not sound cancerous (such as linitis plastica or Waldenstrom's macroglobulinemia).

A procedure for obtaining complete and relevant data on all cancer patients with a reportable tumor should be established. The following casefinding sources may identify possible cancer cases:

- Pathology reports (histology, cytology, autopsy, bone marrow, hematology)
- Medical Record Disease Index
- History and Physical
- Consultation Notes
- Progress Notes
- Discharge Summary
- Daily admissions and discharges
- Notes from physician's offices
- Diagnostic Imaging reports (X-ray, MRI, CAT scans)
- Surgery schedule
- Medical oncology logs
- Radiation oncology logs

These sources should be checked thoroughly and periodically to ensure that all cancer patients receiving inpatient or outpatient services from the hospital are included in the registry.

REFERENCE DATE

The reference date is the start date after which all eligible cases must be included in the tumor registry. The Montana Legislature established Montana's reference date as January 1, 1979.

REPORTABLE LIST

According to the Administrative Rules of Montana (37.8.1801), the following tumors are to be submitted for reporting. Hospitals are required to submit reportable cancer cases to the MCTR within six months after the patient's discharge date. The list is based on those cases which are categorized as malignant, in-situ, or benign (for types listed below) by the International Classification of Diseases for Oncology.

A. All malignant neoplasms (including in-situ) (behavior code 2 or 3)

EXCEPTION: Basal Cell Carcinoma (BCC) or Squamous Cell Carcinoma (SCC) of skin (C44._).

NOTE: BCC and SCC of the labia (C51.0-C51.1), vagina (C52.9), vulva (C51.9), clitoris (C51.2), penis (C60.1-C60.9), scrotum (C63.2), prepuce (C60.0), and anus (C21.0) must be included. Carcinoma in-situ of the cervix (CIS), intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III) are reportable because of their in-situ classification. These cases are not required by the Commission on Cancer but are not excluded in the Montana Law or Administrative Rules 37.8.1801 and must be reported.

B. All benign tumors of the brain (behavior code 0 or 1)

INCLUDES: meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of the CNS (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2), and pineal gland (C75.3)

C. All carcinoid tumors (malignant, benign, and NOS)

D. Ambiguous Terms (*with indication of reportable cancer*) without additional information

- **Apparent(ly)**
- **Appears**
- **Comparable with**
- **Compatible with**
- **Consistent with**
- **Favor(s)**
- **Malignant appearing**
- **Most likely**
- **Presumed**
- **Probable**
- **Suspect(ed)**
- **Suspicious (for)**
- **Typical (of)**
- **Neoplasm or Tumor for C70.0-C72.9, C75.1-C75.3**

Exception: If a cytology is reported as *suspicious*, do not interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Examples of reportable ambiguous terms:

1. Chest x-ray states *consistent with carcinoma* of the right upper lobe of the lung. The patient refused further work-up or treatment.
2. Mammogram documents *suspicious for malignancy*.
3. CT of brain *suspicious for neoplasm*. Neoplasm is reportable for C70.0-C72.9, C75.1-C75.3.

Examples of non-reportable ambiguous terms:

1. Chest x-ray states *consistent with neoplasm* of left upper lobe of lung. While "consistent with" can indicate a problem, "neoplasm" without indication of malignancy is not reportable except for non-malignant primary intracranial and CNS tumors.
2. Mammogram notes p*ossible carcinoma* of the breast. "Possible" is not on the reportable list.
3. Mammogram notes *suspicious* density. While "suspicious" can indicate a problem, "density" is not indicative of cancer.

Non-analytic cases are required to be reported to the Montana Central Tumor Registry.

Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only and do not constitute a diagnosis.

Reportable ICD-9-CM and ICD-10-CM Codes (review for reportability)

ICD-9-CM Code	ICD-10-CM Code	Description
042	B20	AIDS (*review for AIDS-related malignancies*)
140.0 – 172.9 174.0 – 209.36 209.7	C00.0 – C43.9, C45.0 – C96.9	Malignant neoplasms **except 173.0 - 173.9 or C44.00 – C44.99**
209.00 - 209.69	D3Aa._	Carcinoid tumors (any behavior) and neuroendocrine tumor (malignant only)
225.0 - 225.9	D32.0 – D33.9	Benign neoplasms of brain and spinal cord
227.3 - 227.4	D35.2, D35.3	Benign neoplasm of pituitary gland, pineal body, and other intracranial endocrine-related structures
228.02	D18.02	Hemangioma of intracranial structures
228.1	D18.1	Lymphangioma (of brain, nervous system, and reportable endocrine glands only)
230.0 - 234.9	D00.0 – D09.9	Carcinoma in-situ except **232.0 - 232.9**
236.0	D39.0	Stromal endometriosis (8931/3 per ICD-O-3)
237.0 - 237.9	D42.0 – D42.9, D43.0 – D43.9, D44.3 – D44.5	Neoplasm of uncertain behavior of endocrine glands and nervous system **except 237.2 - 237.4**
238.4	D45	Polycythemia vera (9950/3)
238.6	D47.0 – D47.9	Solitary plasmacytoma (9731/3), extramedullary plasmacytoma (9734/3)
238.71 – 238.79	D46.0 – D47.9	Other lymphatic and hematopoietic diseases
239.6-239.7	D49.6	Neoplasms of unspecified behavior of brain and other parts of nervous system
273.2	C88.2	Gamma heavy chain disease (9762/3); Franklin's disease (9762/3)
273.3	C88.0	Waldenstrom's macroglobulinemia (9761/3)
277.89	C96.5, C96.6	Other specified disorders of metabolism. Reportable terms include Hand-Schuller-Christian disease; histiocytosis (acute) (chronic); histiocytosis X (chronic)
285.3	D64.81	Anemia due to antineoplastic chemotherapy
288.3	D72.1	Hypereosinophilic syndrome (9964/3). Diagnosis must be "hypereosonophilic syndrome" to be reportable
288.4	D76.1 – D76.3	Hemophagocytic syndrome (histiocytic syndromes)
289.6	D45	Familial polycythemia (synonym for polycythemia vera)
289.83	D75.81	Chronic Myelofibrosis (NOS) (9961/3),
338.3	G89.3	Neoplasm-related pain (acute) (chronic); Cancer associated pain; Pain due to malignancy
511.81	J91.0	Malignant pleural effusion
789.51	R18.0	Malignant ascites
990	T66	Effects of radiation, unspecified (radiation sickness)
V10.00 - V10.9	Z85.0_ - Z85.8_	Personal history of malignancy (*review for recurrence, subsequent cancers, and/or subsequent tx*)
V58.0-V58.12	Z51.0, Z51.1_	Encounter or admission for radiotherapy, chemotherapy, or immunotherapy (*review for reportability*)
V66.1-V66.2	Z51.89	Convalescence following radiotherapy or chemotherapy (*review for reportability*)
V67.1-V67.2	Z08	Follow-up exam following radiotherapy or chemotherapy (*review for reportability*)
V86.0 - V86.1	Z17	Estrogen receptor positive or negative status [ER + / ER -]
E873.2	Y63.2	Failure in dosage, overdose of radiation in therapy (radiation sickness)
E879.2	Y84.2	Adverse effect of radiation therapy
E930.7	None	Adverse effect of antineoplastic antibiotics
E933.1	None	Adverse effect of antineoplastic and immunosuppressive drugs

Non-Reportable Cancers

A. Patients with a history of malignancy who are clinically free of disease when seen at your facility.
B. Patients with skin cancer that do not meet the histology requirements in the Reportable List.
C. Patients diagnosed with a probable carcinoma and subsequently ruled out (see list of Ambiguous Terms).
   Example: A patient was diagnosed with probable lung carcinoma in June 1995 and a biopsy performed in July 1995 revealed no evidence of cancer.
D. Patients who receive transient care to avoid interrupting a course of therapy started elsewhere.
   Example: A patient who lives in Idaho is visiting and receives scheduled chemotherapy started in Idaho.
E. Out-of-state patients with a history of or evidence of cancer who are not receiving cancer treatment or are seen for an unrelated medical condition.

QUALITY CONTROL

Accuracy and consistency are essential in tumor registry reporting. A computerized tumor registry should conduct minimal data quality checks. This includes visual review of abstracts and computerized edit checks on each abstract prior to submission to the MCTR. The MCTR will perform quality assurance tasks upon receipt of abstracts from each reporting institution. Review procedures may include visual review of abstracts, review of accession register and abstracts, and periodic re-abstracting of cases. The reporting facility will be required to resolve incomplete, incorrect, or inconsistent data upon MCTR query.

FOLLOW-UP

Annual follow-up of patients is an important cancer registry function. The MCTR conducts yearly lifetime follow-up on all reported cases. Follow-up is based on the date of last contact and is delinquent (lost) if no contact has been made within 15 months after the date of last follow-up information. Cases that are lost-to-follow-up (delinquent) should remain in the follow-up process until follow-up information is obtained.

Follow-up data must include the date(s) and type(s) of treatment for cancer, the site(s) of distant metastasis, date and type of recurrence, subsequent treatment for progressive disease or recurrence, the site and histology of any subsequent primary, the date of last contact, the patient's current physician, and the status of the patient and the cancer.

CONFIDENTIALITY

All data concerning cancer patients is held in strict confidence by the MCTR. Confidentiality is of paramount importance; the privacy of patients, physicians, and hospitals is strictly maintained. As it is elsewhere, confidentiality is an issue of increasing concern to cancer registries. The policy of the MCTR does not release any patient identifying information to third parties. Data is released only in statistically summarized form so that individual patients, hospitals, or physicians cannot be identified. Further, statistically summarized information is released only to individuals or organizations who are qualified to perform and interpret data analyses and who employ safeguards against any unauthorized disclosure.

PROCEDURE MANUAL

Tumor registries should maintain a complete, up-to-date procedure manual that documents each phase of its operations. A procedure manual is a valuable and necessary tool used to organize and maintain an effective, efficient program. When adhered to, this manual will ensure a smooth operation with consistent and accurate abstracting, systematic and continuous follow-up, and complete and timely reporting.

The procedure manual should contain:

- The objectives of the cancer registry
- Job descriptions and specifications of registry positions
- Case eligibility criteria
- The reportable list
- Procedures for casefinding, maintaining and using a suspense file, and accessioning

- A description of the registry filing system
- Documentation of data collection methods, including principles of abstracting, detailed definitions for each data item, references used for coding systems, if applicable, and staging systems used
- Follow-up procedures
- Documentation of quality control procedures
- A description of reporting mechanisms
- Policy statements about confidentiality and release of information

DATE OF FIRST CONTACT

The *Date of First Contact* is the date of the facility's first inpatient or outpatient contact with the patient for diagnosis or treatment of the cancer. Usually, the *Date of First Contact* is the date of admission for diagnosis or for treatment. If the patient was admitted for non-cancer-related reasons, the *Date of First Contact* is the date the cancer was first suspected during the hospitalization. If the patient's diagnosis or treatment is as an outpatient of the facility, the *Date of First Contact* is the date the patient first appeared at the facility for that purpose.

If the state or regional registry requires pathology-only cases to be abstracted and reported, the *Date of First Contact* is the date the specimen was collected.

UNIQUE PATIENT IDENTIFIERS

Accession Number and *Sequence Number* uniquely identify the patient and the tumor. Each cancer patient in a registry is assigned a unique accession number, and each primary diagnosed for that patient is assigned a sequence number. The accession number never changes.

- Accession numbers are never reassigned, even if a patient is removed from the registry.
- The sequence number is the sequence of all tumors over a lifetime of a patient and is counted throughout the patient's lifetime.
- A registry may contain a single abstract for a patient with a sequence number of 02, because the first tumor had been either diagnosed and treated elsewhere or diagnosed and/or treated before the facility's reference date. Because of differences in requirements, however, it is still possible for two registries with dissimilar eligibility requirements (for example, a facility registry and a state central registry) to assign different sequence numbers to the same tumor, even though the sequence number codes and instructions applied are the same.

NATIONAL PROVIDER IDENTIFIER

The National Provider Identifier (NPI) is a unique identification number for health care providers that was implemented in 2007 and 2008 by the Centers for Medicare and Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008. Individual item descriptions in this manual should be reviewed for specific coding instructions.

CANCER IDENTIFICATION

Follow the instructions in the ICD-O-3 section, "Coding Guidelines for Topography and Morphology" (ICD-O-3 pp. 19-42) to code *Primary Site*, *Histology*, *Behavior Code*, and *Grade/Differentiation*.

MULTIPLE PRIMARIES

The most recent **SEER Multiple Primary and Histology Coding Rules** contain site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, and malignant and nonmalignant brain primaries. A separate set of rules addresses the specific and general rules for all other sites. The multiple primary rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology and coding instructions.

The **SEER Multiple Primary and Histology Coding Rules** do not apply to hematopoietic and lymphoid tumors. Use the **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** and the **Hematopoietic and Lymphoid Neoplasms Database** to code hematopoietic primaries (lymphoma and leukemia M9590-9989) diagnosed on January 1, 2010 or later. Use the tables in Appendix A only for hematopoietic and lymphoid cases diagnosed prior to 2010. Primary site and timing are not applicable for determining whether these malignancies represent one or more primaries.

Paired Organ Sites

A list of paired organ sites can be found earlier in this section with the coding instructions for *Laterality*. Refer to the **SEER Multiple Primary and Histology Coding Rules** to determine whether involvement of paired sites should be coded as one or two primaries.

REVISING THE ORIGINAL DIAGNOSIS

Data are gathered from multiple sources using the most recent and complete information available. Over time, the patient's records may contain new information such as tests, scans, and consults. Change the primary site, laterality, histology, and stage as the information becomes more complete. If the primary site is changed, it may also be necessary to revise site-specific staging and treatment codes. There is no time limit for making revisions that give better information about the original diagnosis or stage. However, if staging information is updated, it is important to adhere to the timing requirements for the respective staging system. Most cases that require revision are unknown primaries.

Examples:

1) The institution clinically diagnoses a patient with carcinomatosis. The registry enters the case as an unknown primary (C80.9), carcinoma, NOS (8010/3), stage of disease unknown. Nine months later, a paracentesis shows serous cystadenocarcinoma. The physician says that the patient has an ovarian primary. Change the primary site to ovary (C56.9), histology to serous cystadenocarcinoma (8441/3), and diagnostic confirmation to positive cytologic study, no positive histology (code 2). If enough information is available that meets the AJCC timing requirements for staging, change the stage from not applicable (88) to the appropriate staging basis, TNM elements, and stage group, or to unknown. Update the Collaborative Staging input items and rerun the derivation program.

2) A physician may decide that a previously clinically diagnosed malignancy is a benign lesion. The patient is referred from a nursing home to the facility. The chest x-ray shows a cavitary lesion in the right lung. The family requests that the patient undergo no additional workup or treatment. Discharge diagnosis is "probable carcinoma of right lung". The registrar abstracts a lung primary (C34.9). Two years later a chest x-ray shows an unchanged lesion. The physician documents "lung cancer ruled out". Delete the case from the registry. Adjust the sequence number(s) of any other primaries the patient may have. Do not reuse the accession number.

AMBIGUOUS TERMINOLOGY

If the wording in the patient record is ambiguous with respect to tumor spread, use the following guidelines.

List of Ambiguous Terms Describing Tumor Spread

Terms that Constitute Tumor Involvement/Extension	
Adherent	Into
Apparent	Onto
Compatible with	Out onto
Consistent with	Probable
Encroaching upon	Suspect
Fixation, fixed	Suspicious
Induration	To

OUTCOMES

The outcomes data items describe the known clinical and vital status of the patient. Follow-up information is obtained at least annually for all living *Class of Case* 10-22 patients included in a cancer registry's database. Recorded follow-up data should reflect the most recent information available to the registry that originates from reported patient hospitalizations, known patient readmissions, contact with the patient's physician, and/or direct contact with the patient.

While the patient is alive, be sure that contact information is kept current. In addition to the treatment and recurrence items, these include:

- Current Street Address
- Current City
- Current State
- Current Zip Code
- Telephone
- Date of Last Contact

Once the patient's death has been recorded, no further follow-up is performed.

IN UTERO DIAGNOSIS AND TREATMENT

Beginning in 2009, diagnosis and treatment dates for a fetus prior to birth are to be assigned the actual date of the event. In the past, those dates were set by the rule to the date the baby was born. The exact date may be used for cases diagnosed prior to 2009.

EMBOLIZATION

The term embolization refers to the intentional blocking of an artery or vein. The mechanism and the reason for embolization determine how and whether it is to be recorded.

Chemoembolization is a procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time. Code chemoembolization as *Chemotherapy* when embolizing agent(s) is a chemotherapeutic drug(s) or when the term *chemoembolization* is used with no reference to the agent. Use *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) to determine whether the drugs used are classified as chemotherapeutic agents. Also code as *Chemotherapy* when the patient has primary or metastatic cancer in the liver and the only information about embolization is a statement that the patient had chemoembolization, tumor embolization, or embolization of the tumor in the liver. However, if alcohol is specified as the embolizing agent, even in the liver, code the treatment as *Other Treatment*.

Radioembolization is embolization combined with injection of small radioactive beads or coils into an organ or tumor. Code *Radiation Modality* as brachytherapy when tumor embolization is performed using a radioactive agent or radioactive seeds.

Embolization is coded as *Other Treatment* (code 1) if the embolizing agent is alcohol, or if the embolized site is other than the liver and the only information in the record is that the patient was given “embolization” with no reference to the agent.

Do not code pre-surgical embolization of hypervascular tumors with particles, coils, or alcohol. These pre-surgical embolizations are typically performed to make the resection of the primary tumor easier. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

TUMOR REGISTRY LAW
TITLE 50. HEALTH AND SAFETY
CHAPTER 15. VITAL STATISTICS

Part 7. Tumor Registry

50-15-701. Short title. This part may be cited as the "Tumor Registry Act".

History: En. Sec. 1, Ch. 354, L. 1981.

50-15-702. Definitions. As used in this part, the following definitions apply:

(1) "Department" means the department of public health and human services provided for in 2-15-2201.

(2) "Health care practitioner" means a person licensed pursuant to Title 37, chapter 3, to practice medicine or pursuant to Title 37, chapter 4, to practice dentistry.

(3) "Hospital" means a facility that provides, by or under the supervision of licensed physicians, services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick persons.

(4) "Medical services" means diagnosis or treatment of illness in a human being by or under the supervision of a health care practitioner.

History: En. Sec. 2, Ch. 354, L. 1981; amd. Sec. 106, Ch. 418, L. 1995; amd. Sec. 283, Ch. 546, L. 1995; amd. Sec. 1, Ch. 101, L. 1997.

50-15-703. Duty to report tumors. The following persons or entities shall report to the department on forms provided by the department all medical and personal information as specified in rules of the department and laboratory results pertaining to the treatment and condition of a person with a reportable tumor:

(1) a hospital that provides medical services relating to the tumor;

(2) a clinical laboratory, as defined in 50-5-101, that is not owned or operated by a hospital and that provides laboratory services relating to the tumor; and

(3) a health care practitioner or health care facility, not covered by subsection (1) or (2), providing medical services relating to the tumor.

History: En. Sec. 3, Ch. 354, L. 1981; amd. Sec. 1, Ch. 12, L. 1985; amd. Sec. 2, Ch. 101, L. 1997.

50-15-704. Confidentiality. Information received by the department pursuant to this part may not be released unless:

(1) it is in statistical, nonidentifiable form;

(2) the provisions of Title 50, chapter 16, part 6, are satisfied;

(3) the release or transfer is to a person or organization that is qualified to perform data processing or data analysis and that has safeguards against unauthorized disclosure of that information;

(4) the release or transfer is to a central tumor registry of another state and is of information concerning a person who is residing in that state; or

(5) the release is to a health care practitioner or health care facility that is providing or has provided medical services to a person who has or has had a reportable tumor.

History: En. Sec. 4, Ch. 354, L. 1981; amd. Sec. 27, Ch. 632, L. 1987; amd. Sec. 3, Ch. 101, L. 1997.

50-15-705. Tumor registry. The department shall maintain a registry containing the names of all persons reported to it and all other information submitted to the department concerning those persons pursuant to 50-15-703.

History: En. Sec. 5, Ch. 354, L. 1981.

50-15-706. Rules. The department may adopt rules implementing this part, including:

(1) the types of tumors that are reportable; and

(2) the information on each patient having a reportable tumor that must be submitted to the department.

History: En. Sec. 6, Ch. 354, L. 1981.

50-15-707 through 50-15-709 reserved. 50-15-710. Immunity from liability. A person other than the department may not be held liable in a civil or criminal action for complying with the reporting requirements of 50-15-703 or for lawfully using information provided by the tumor registry in a manner that does not violate the Tumor Registry Act.

History: En. Sec. 4, Ch. 101, L. 1997.

data.opi.mt.gov/bills/mca/50/15/50-15-701.htm

37.8.1801 **DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES RECORDS AND STATISTICS**

Subchapter 18

Tumor Registry

37.8.1801 REPORTABLE TUMORS

(1) The following tumors are designated as reportable:

(a) malignant neoplasm, with the exception of a basal or squamous carcinoma of the skin;

(b) skin cancer of the labia, vulva, penis or scrotum;

(c) benign tumor of the brain, including a:

(i) meningioma (cerebral meninges);

(ii) pinealoma (pineal gland); or

(iii) adenoma (pituitary gland);

(d) carcinoid tumor, whether malignant, benign or not otherwise specified (NOS).

(2) A benign tumor other than one of those listed in (1) may be reported to the department for inclusion in the tumor registry if prior approval has been obtained from the Department of Public Health and Human Services, Public Health and Safety Division, Montana Central Tumor Registry, 1400 Broadway, PO Box 202951, Helena, MT 59620-2951.

(3) A tumor which is otherwise reportable, but has been diagnosed and recorded using the words "apparently", "appears", "comparable with", "compatible with", "consistent with", "favors", "malignant appearing", "most likely", "presumed", "probable", "suspected", "suspicious", or "typical of" with reference to that tumor is considered reportable.

(4) In order for the department to maintain current reporting, hospitals and physicians shall submit to the department information on reportable tumors within six months from the first inpatient or outpatient date that the patient was seen with cancer; independent laboratories shall submit to the department information on reportable tumors within six months from the date the laboratory service associated with the tumor was rendered.

History: 50-15-706, MCA; IMP , 50-15-703, MCA; NEW , 1982 MAR p. 391, Eff. 2/26/82; AMD , 1985 MAR p. 1857, Eff. 11/30/85; AMD , 1988 MAR p. 726, Eff. 4/15/88; TRANS , from DHES, 1997 MAR p. 1460; AMD , 2003 MAR p. 2441, Eff. 10/31/03; AMD , 2009 MAR p. 87, Eff. 1/30/09.

37.8.1802 REQUIRED RECORDS, INITIAL ADMISSION AND TREATMENT

(1) Whenever a hospital initially provides medical services to any patient relating to a tumor designated as reportable by ARM 37.8.1801, it must collect, record, and make available to the department the following information about that patient:

(a) name and current physical address of patient;

(b) patient's physical address at time of diagnosis;

(c) social security number;

(d) name of spouse, if any;

(e) phone number;
(f) race, Hispanic origin if applicable, sex, and marital status;
(g) age at diagnosis, place of birth, and month, day, and year of birth;
(h) name, address, and phone number of friend or relative to act as contact, plus relationship of that contact to patient;
(i) date and place of initial diagnosis;
(j) primary site of tumor (paired organ);
(k) sequence of primary tumors if more than one;
(l) other primary tumors;
(m) method of confirming diagnosis;
(n) histology, including dates, place, histologic type and slide number;
(o) summary staging, including whether in situ, localized, regional, distant or unstaged, with no information, or whether AJCC or TNM staging is utilized, and, if so, the findings of this staging;
(p) description of tumor and its spread, if any, including size in centimeters, number of positive nodes, number of nodes examined and site of distant metastases;
(q) procedures done to diagnose or stage tumors including dates, procedures, and results (such as physical exams, scopes, x-rays, scans, or lab tests);
(r) cumulative summary of all therapy directed at the subject tumor, including:
(i) date of therapy;
(ii) specific type of surgery or radiation therapy, if any, and details of chemical, hormonal, or other kinds of treatment; and
(iii) if no therapy given, reason for lack of therapy.
(s) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence, or recurring, or status unknown;
(t) if recurrence of tumor, date, type, and distant sites of first recurrence;
(u) names of physicians primarily and secondarily responsible for follow up;
(v) date of each follow up;
(w) if patient has died, date of death, place, cause, and whether autopsy performed;
(x) primary payer at diagnosis;
(y) usual occupation and industry; and
(z) tobacco and alcohol use history.

History: 50-15-706, MCA; IMP , 50-15-703, MCA; NEW , 1982 MAR p. 391, Eff. 2/26/82; TRANS , from DHES, 1997 MAR p. 1460; AMD , 2003 MAR p. 2441, Eff. 10/31/03; AMD , 2009 MAR p. 87, Eff. 1/30/09.

37.8.1803 REQUIRED RECORDS, FOLLOW UP

(1) Whenever a patient for whom information has been provided to the tumor registry is admitted to the hospital providing the information on an inpatient or outpatient basis for further treatment related to the tumor for which original registration in the tumor registry was made, the hospital must keep on file the following information:
(a) patient's name, noting any change from previous records;
(b) any paired organ involvement, noting sequence;
(c) subsequent histology, including dates, place, histology type, slide number and procedure;

(d) date, type of procedure and findings of any surgery or other exploratory measure;

(e) date and type of any administration of radiation;

(f) date of any administration of hormones, chemotherapy, immunotherapy or any other kind of treatment;

(g) date of death and/or last follow up;

(h) if death has occurred, the place, cause and whether an autopsy was performed;

(i) if an autopsy was performed, its findings pertaining to cancer;

(j) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence, or has recurred, or status is unknown;

(k) if recurrence of tumor, date, type, and distant sites of first recurrence; and

(l) names of those physicians primarily and secondarily responsible for follow up treatment.

History: 50-15-706, MCA; IMP , 50-15-703, MCA; NEW , 1982 MAR p. 391, Eff. 2/26/82; TRANS , from DHES, 1997 MAR p. 1460; AMD , 2003 MAR p. 2441, Eff. 10/31/03; AMD , 2009 MAR p. 87, Eff. 1/30/09.

Rules 37.8.1804 through 37.8.1807 reserved

37.8.1808 REQUIRED RECORDS, INDEPENDENT CLINICAL LABORATORIES

(1) Whenever a clinical laboratory which is not owned or operated by a hospital provides laboratory services for any patient relating to a tumor designated as reportable by ARM 37.8.1801, it must collect, record, and make available to the department the following information about that patient:

(a) name and current address of patient;

(b) patient's address at time of diagnosis;

(c) social security number;

(d) name of spouse, if any;

(e) race, sex, and marital status;

(f) age at diagnosis, month, day, and year of birth;

(g) date and place of initial diagnosis;

(h) primary site of tumor (paired organ);

(i) sequence of primary tumors, if more than one;

(j) method of confirming diagnosis;

(k) histology, including dates, place, histologic type, and slide number;

(l) summary staging, including whether in situ, localized, regional, distant or unstaged, with no information, or whether AJCC or TNM staging is utilized, and, if so, the findings of the staging;

(m) description of tumor and its spread, if any, including size in centimeters, number of positive nodes, number of nodes examined, and site of distant metastasis;

(n) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence, or recurring, or status unknown; and

(o) names of physicians primarily and secondarily responsible for follow up.

History: 50-15-706, MCA; IMP , 50-15-703, MCA; NEW , 1985 MAR p. 1857, Eff. 11/30/85; TRANS , from DHES, 1997 MAR p. 1460; AMD , 2003 MAR p. 2441, Eff. 10/31/03; AMD , 2009 MAR p. 87, Eff. 1/30/09.

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Patient Information

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Reporting Hospital

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Hospital (Reporting Facility)	540			Required

Description
Reporting Hospital identifies the facility reporting the case.

Rationale
Each facility is unique. The reporting hospital is essential to monitor data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Instructions for Coding
- Contact the MCTR if unsure how to complete this field.

Abstracted By

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	570	3		Required

Description
Abstracted By records the name of the individual abstracting the case.

Rationale
This item can be used for quality control and management in multi-staffed registries.

Instructions for Coding
- Record the first and last name of the abstractor.

Date Abstracted

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2090	8		Required

Description
Date Abstracted identifies the date the case is abstracted. This date will not change if the case is modified or updated.

Rationale
The date is recorded to measure timeliness of reporting.

Instructions for Coding
- Record the date the case is abstracted.

Facility

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Hospital (Reporting Facility)	540	3	04/07	Required

Description
Facility # identifies the facility reporting the case.

Rationale
Each facility's identification number is unique. The number is essential to monitor data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Instructions for Coding
- Contact the MCTR if unsure how to complete this field.

Montana Reporting Facilities

Hospitals

Number	NPI Number	ACoS Number	Facility Name	City
403	1568629764	6810010	Community Hospital of Anaconda	Anaconda
411	1316965346	6810013	Fallon Medical Complex	Baker
458	1730129305	6810005	Big Sandy Medical Center	Big Sandy
412	1265478291	6810020	Billings Clinic	Billings
413	1083655997	6810030	St. Vincent Healthcare	Billings
407	1720079619	6810040	Bozeman Deaconess Hospital	Bozeman
400	1528037215	6810055	St. James Healthcare	Butte
414	1497754782	6810085	Liberty Medical Center	Chester
415	1083602205	6810095	Teton Medical Center	Choteau
409	1054388387	6810100	Stillwater Community Hospital	Columbus
416	1467445049	6810110	Pondera Medical Center	Conrad
417	1598874232	6810123	Roosevelt Memorial Medical Center	Culbertson
418	1831143080	6810125	Northern Rockies Medical Center	Cut Bank
419	1275560617	6810129	Powell County Memorial Hospital	Deer Lodge
420	1326042078	6810135	Barrett Hospital and Healthcare	Dillon
421	1760531404	6810150	Dahl Memorial Healthcare Association	Ekalaka
405	1740223882	6810155	Madison Valley Hospital Association	Ennis
422	1023066081	6810160	Rosebud Healthcare Center	Forsyth
423	1356332266	6810170	Missouri River Medical Center	Fort Benton
424	1689685323	6810190	Frances Mahon Deaconess Hospital	Glasgow
425	1376552893	6810220	Glendive Medical Center	Glendive
427	1881650737	6810245	Benefis Hospital/Sletten Cancer Institute	Great Falls
480	1801897780	10000701	Great Falls Clinic	Great Falls
429	1659475846	6810260	Marcus Daly Memorial Hospital	Hamilton
430	1891713533	6810272	Big Horn County Memorial Hospital	Hardin
431	1073687406	6810285	Wheatland Memorial Healthcare	Harlowton
432	1427059070	6810290	Northern Montana Hospital	Havre
434	1710152277	6810330	St. Peter's Hospital	Helena
477	1417945627	6810360	Kalispell Regional Medical Center	Kalispell
438	1790798387	6810380	Central Montana Medical Center	Lewistown
439	1952312050	6810390	St. John's Lutheran Hospital	Libby
408	1245222306	6810395	Livingston Memorial Hospital	Livingston
440	1255476388	6810405	Phillips County Hospital	Malta
441	1548292220	6810410	Holy Rosary Healthcare	Miles City
443	1396711396	6810415	Community Medical Center	Missoula
445	1023032588	6810225	St. Patrick Hospital	Missoula

Number	NPI Number	ACoS Number	Facility Name	City
402	1922073907	6810440	Granite County Medical Center	Philipsburg
471	1265547939	6810445	Clark Fork Valley Hospital	Plains
446	1467452102	6810450	Sheridan Memorial Hospital Association	Plentywood
447	1821184888	6810460	St. Joseph Medical Center	Polson
448	1396766903	6810465	Northeast Montana Health Services	Poplar
410	1336119338	6810477	Beartooth Hospital & Health Center	Red Lodge
467	1336213446	6810481	St. Luke Community Hospital	Ronan
449	1386751196	6810485	Roundup Memorial Healthcare	Roundup
451	1346224391	6810505	Daniels Memorial Hospital	Scobey
468	1497742415	6819070	Marias Medical Center	Shelby
469	1083710651	6819075	Ruby Valley Hospital	Sheridan
452	1285719161	6810510	Sidney Health Center	Sidney
470	1093809196	6819080	Mineral Community Hospital	Superior
404	1447245857	6810530	Broadwater Health Center	Townsend
454	1396710851	6810550	North Valley Hospital	Whitefish
457	1811102270	6819100	Mountainview Medical Center	White Sulphur Springs
455	1821016536	6810560	Northeast Montana Health Services	Wolf Point

VA Hospitals

Number	NPI Number	ACoS Number	Facility Name	City
463	1457546384	6810180	Montana VAMC	Fort Harrison

Indian Health Services

Number			Facility Name	City
478	1861409955	6810050	Blackfeet Indian Health Services	Browning
462	1235302142	6810120	Crow IHS Hospital	Crow Agency
464	1942367842	6810280	Fort Belknap IHS Hospital	Harlem
474	1972694602	9999999	Fort Peck IHS Poplar Health Services	Poplar

Radiation Centers

Number	NPI Number	ACoS Number	Facility Name	City
490	1902871544	6813498	Northern Rockies Radiation Oncology Center	Billings

Pathology Laboratories

Number	NPI Number	ACoS Number	Facility Name	City
498	1790787935	9999999	Yellowstone Pathology Institute	Billings
493	1669597266	9999999	Northern Plains Pathology	Great Falls
495	1740364017	9999999	Western Montana Clinic	Missoula

Physicians

Number	NPI Number	ACoS Number	Facility Name	City
200	1760485619	9999999	Tallman Dermatology	Billings
202	1003900457	9999999	Advanced Dermatology	Butte
208	1720073596	9999999	Dermatology Office of Great Falls	Great Falls
210	1003902909	9999999	Helena Dermatology	Helena
212	1497896229	9999999	Associated Dermatology of Helena	Helena
204	1114093846	9999999	Dermatology Associates of Kalispell	Kalispell

Accession Number

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	550	9	01/04, 01/10	Required

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

Rationale
This data item protects the identity of the patient and allows cases to be identified on a local, state, and national level.

Instructions for Coding
- 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.
- When a patient is deleted from the database, do not reuse the accession number for another patient.
- The first four numbers specify the year (of first contact with cancer) and the last five numbers are the numeric order in which the patient was entered into the registry database.
- Numeric gaps are allowed in accession numbers.
- A patient's accession number is never reassigned.
- If a patient is first accessioned into the registry, then the registry later changes its reference date and the patient is subsequently accessioned into the registry with a new primary, use the original accession number associated with the patient and code the data item *Sequence Number* appropriately.

Examples:

Code	Reason
200300033	Patient enters the hospital in 2003 and is diagnosed with breast cancer. The patient is the 33rd patient accessioned in 2003.
200300033	A patient with the accession number 200300033 for a breast primary returns to the hospital with a subsequent colon primary in 2004. The accession number will remain the same. *Sequence Number* will reflect this primary.
200300010	Patient is diagnosed in November 2002, at another facility enters the reporting facility in January 2003, and is the tenth case accessioned in 2003.
200300012	Patient is diagnosed in staff physician office in December 2002 enters the reporting facility in January 2003, and is the 12th case accessioned in 2003.
199100067	Patient enters the hospital in 1991, and is diagnosed with prostate cancer. The registry later sets a new reference date of January 1, 1997. The same patient presents with a diagnosis of lymphoma in 2005. *Sequence Number* will distinguish this primary.
200300001	First patient diagnosed/treated and entered into the registry database for 2003.
200300999	999th patient diagnosed/treated and entered into the registry database for 2003.
200401504	1504th patient diagnosed/treated and entered into the registry database for 2004.

Sequence Number

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	560	2	09/04, 09/06, 04/07, 01/10	Required

Description
Sequence Number indicates the sequence of reportable malignant and non-malignant neoplasms over the lifetime of the patient.

Rationale
This data item is used to distinguish among cases having the same accession numbers, to select patients with only one malignant primary tumor for certain follow-up studies, and to analyze factors involved in the development of multiple tumors.

Instructions for Coding
- Codes 00-59 and 99 indicate neoplasms of malignant or in-situ behavior (behavior code 2 or 3).
- Codes 60-88 indicate neoplasms of non-malignant behavior (behavior code 0 or 1) and malignant neoplasms that the MCTR has defined as reportable that the CoC does not require (carcinoma in-situ of the cervix (CIS), intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III)).
- Code 00 only if the patient has a single malignant primary. If the patient develops a subsequent malignant or in-situ primary tumor, change the code for the first tumor from 00 to 01, and number the subsequent tumors sequentially.
- Code 60 only if the patient has a single non-malignant primary or reportable neoplasm that the MCTR has defined as reportable that the CoC does not require (see list above). If the patient develops a subsequent non-malignant primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent non-malignant primaries sequentially.
- 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.
- 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.
- Any tumor in the patient's past which is reportable or reportable-by-agreement at the time the current tumor is diagnosed must be taken into account when sequencing subsequently accessioned tumors. However, do not reassign sequence numbers if one of those tumors becomes non-reportable later.
- Sequence numbers should be reassigned if the facility learns later of an un-accessioned tumor that would affect the sequence.

Malignant or In-situ

Code	Definition
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
…	
59	Fifty-ninth of 59 or more independent malignant or in-situ primaries
99	Unknown number of malignant or in-situ primaries

Benign or Reportable-by-Agreement

Code	Definition
60	Only one non-malignant primary or in-situ case required by MCTR listed above
61	First of two or more independent non-malignant primaries or in-situ case required by MCTR listed above
62	Second of two or more independent non-malignant primaries or in-situ case required by MCTR listed above
…	
…	(Consecutive number of non-malignant primaries) or in-situ case required by MCTR listed above
…	
87	Twenty-seventh of twenty-seven independent non-malignant primaries or in-situ case required by MCTR listed above
88	Unspecified number of neoplasms in this category

Examples:

Code	Reason
00	A patient with no history of previous cancer is diagnosed with in-situ breast carcinoma June 13, 2003.
01	The sequence number is changed when the patient with an in-situ breast carcinoma diagnosed on June 13, 2003, is diagnosed with a subsequent melanoma on August 30, 2003.
02	Sequence number assigned to the melanoma diagnosed on August 30, 2003, following a breast cancer in-situ diagnosed on June 13, 2003.
04	A nursing home patient is admitted to a hospital for first course surgery for a colon adenocarcinoma. The patient has a prior history of three malignant cancers of the type the registry is required to accession, though the patient was not seen for these cancers at the hospital. No sequence numbers 01, 02, or 03 are accessioned for this patient.
60	The sequence number assigned to a benign brain tumor diagnosed on November 1, 2005, following a breast carcinoma diagnosed on June 13, 2003, and a melanoma diagnosed on August 30, 2003.
63	Carcinoma in-situ of the cervix (CIN III) is diagnosed by the facility in 2003 and accessioned as sequence 60. A benign brain tumor was diagnosed and treated elsewhere in 2002; patient comes to the facility with a second independent benign brain tumor in 2004. Unaccessioned earlier brain tumor is counted as sequence 61, CIN III is re-sequenced to 62, and second benign brain tumor is assigned sequence 63.

Date of First Contact

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Date First Seen	580	8	01/04, 09/06, 01/10	Required

Description
Date of First Contact is the date of the facility's first inpatient or outpatient contact with the patient for diagnosis or treatment of the cancer. Usually, the *Date of First Contact* is the date of admission for diagnosis or for treatment. \\

Rationale
This data item can be used to measure the time between first contact and the date that the case was abstracted. It can also be used to measure the length of time between the first contact and treatment for quality of care reports.

Instructions for Coding
- Record the date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or treatment of a reportable tumor. The date may be the date of an outpatient visit for a biopsy, X-ray, or laboratory test, or the date a pathology specimen was collected at the hospital
- If this is an autopsy-only or death certificate-only case, then use the date of death.
- When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility.

Examples:

Code	Reason
02122008	A patient has an outpatient mammography that is suspicious for malignancy on February 12, 2008, and subsequently undergoes an excisional biopsy or radical surgical procedure on February 14, 2008
09142009	Patient undergoes a biopsy in a physician's office on September 8, 2009. The pathology specimen was sent to the reporting facility and was read as malignant melanoma. The patient enters that same reporting facility on September 14, 2009 for wide re-excision.
12072010	Patient has an MRI of the brain on December 7, 2010 for symptoms including severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery on December 19 removes all gross tumor..
04992003	If information is limited to the description "Spring, 2003".
07992003	If information is limited to the description "The middle of the year, 2003".
10992003	If information is limited to the description "Fall, 2003".
12992003 or 01992004	If information is limited to the description "Winter", try to determine if this means the beginning or the end of the year.

Medical Record Number

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Chart Number	2300	11		Required

Description
Records the medical record number usually assigned by the reporting facility's health information management (HIM) department.

Rationale
This number identifies the patient within a reporting facility. It can be used to reference a patient record and it helps to identify multiple reports on the same patient.

Instructions for Coding
- Record the medical record number.
- When a patient enters a military hospital as a family member of a military sponsor, do not code the patient's relationship to the military sponsor in this field.

Last Name

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Name – Last	2230	40	01/10	Required

Description
Identifies the last name of the patient.

Rationale
This data item is used by hospitals as a patient identifier.

Instructions for Coding
- Truncate name if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed.
- Do not use other punctuation.
- Do not leave blank; code as unknown if the patient's last name is unknown.
- This field may be updated, if the last name changes.

First Name

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Name – First	2240	40	01/10	Required

Description
Identifies the first name of the patient.

Rationale
This data item is used by hospitals to differentiate between patients with the same last name.

Instructions for Coding
- Truncate name if more than 40 letters long. Do not use punctuation.

Middle Name

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Name – Middle	2250	40	01/10	Required

Description
Identifies the middle name or middle initial of the patient.

Rationale
This data item helps to distinguish between patients with identical first and last names.

Instructions for Coding
- Truncate the name if more than 40 letters long. Record the middle initial if the complete name is not provided. Do not use punctuation.

Maiden Name

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Name – Maiden	2390	40	01/10	Required

Description
Identifies the maiden name of the patient.

Rationale
Maiden name may be useful in matching multiple records for the same patient.

Instructions for Coding
- Truncate the name if more than 15 letters long. Do not use punctuation.
- Leave blank if unknown or patient was never married.

Alias

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Name – Alias	2280	40	01/10	Required

Description
Identifies the alias or nickname of the patient.

Rationale
This item is useful for matching multiple records on the same patient.

Instructions for Coding
- If the patient uses only a last name alias, record the last name alias followed by a blank space and the real first name.
- If the patient uses an alias for the first name, record the last name followed by a blank space and the alias name.
- If the patient uses an alias for the first and last name, record the last name alias followed by a blank space and the first name alias.
- Leave the field blank if the patient has no alias.

Primary Payer

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	630	2	07/06, 01/10	Required

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

Rationale
This item is used in financial analysis and as an indicator for quality and outcome analyses. 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 hospital.

Instructions for Coding
- If the patient is diagnosed at the reporting facility, record the payer at the time of diagnosis.
- If the patient is diagnosed elsewhere or the payer at the time of diagnosis is not known, record the payer when the patient is initially admitted for treatment.
- Record the type of insurance reported on the patient's admission page.
- If more than one payer or insurance carrier is listed on the patient's admission page, record the first.
- If the patient's payer or insurance carrier changes, do not change the initially recorded code.

Patient Address

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
				Required

Patient Address and Residency Rules

The patient's address at diagnosis is the patient's place of residence at the time of original diagnosis. It does not change if the patient moves. If the patient has more than one primary tumor, the address at diagnosis may be different for each primary.

The current address initially is the patient's residence at the time the patient was first seen at the accessioning facility for this primary. The current address is updated if the patient moves. If the patient has more than one primary tumor, the current address should be the same for each primary.

Normally a residence is the home named by the patient. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with the rules of the Census Bureau whenever possible. The registry can 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 case carefully.

Rules for Persons with Ambiguous Residences

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

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

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

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

- Incarcerated persons
- Persons in nursing, convalescent, and rest homes
- Persons in homes, schools, hospitals, or wards for the physically disabled, mentally retarded, or mentally ill.
- Long-term residents of other hospitals, such as Veterans Affairs (VA) hospitals.

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 families. Military personnel may use the installation address or the surrounding community's address. The Census Bureau has detailed residency rules for Navy personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for the detailed rules.

Street Address at DX

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Patient Address at Diagnosis Addr at DX – No & Street	2330	60	01/10	Required

Description
Identifies the patient's address (number and street) at the time of diagnosis.

Rationale
The address is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies. Physical address allows a central registry to assign latitude and longitude to patient addresses and gives the ability to map each location. Accurate geographic information allows a central registry to monitor cancer trends to watch for possible patterns that could be the first hint of an environmental or other geographic focus of increased cancer risk.

Instructions for Coding
- Record the physical address (number and street address or the rural mailing address) of the patient's usual residence when the tumor was diagnosed.
- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at *http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf*.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to:

  - AVE (avenue)
  - BLVD (boulevard)
  - CIR (circle)
  - CT (court)
  - DR (drive)
  - PLZ (plaza)
  - PARK (park)
  - PKWY (parkway)
  - RD (road)
  - SQ (square)
  - ST (street)
  - APT (apartment)
  - BLDG (building)
  - FL (floor)
  - STE (suite)
  - UNIT (unit)
  - RM (room)
  - DEPT (department)
  - N (north)
  - NE (northeast)
  - NW (northwest)
  - S (south)
  - SE (southeast)
  - SW (southwest)
  - E (east)
  - W (west)

  A complete list of recognized street abbreviations is provided in *Appendix C of USPS Pub 28*.
- Punctuation is normally limited to periods (i.e., 39.2 RD), slashes for fractional addresses (i.e., 101 ½ MAIN ST), and hyphens when a hyphen carries meaning (i.e., 289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (i.e., 425 FLOWER BLVD # 72).
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not update this data item if the patient's address changes.
- See "Residency Rules" on page 41 for further instructions.

Code	Definition
103 FIRST AVE SW APT 102	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
UNKNOWN	If the patient's address is unknown, enter UNKNOWN.

City

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Addr at DX – City or Town	70	50	01/10	Required

Description
Identifies the name of the city or town in which the patient resides at the time the tumor is diagnosed and treated.

Rationale
The city or town is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Instructions for Coding
- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.
- If the patient has multiple malignancies, the city or town may be different for subsequent primaries.
- Do not update this data item if the patient's city or town of residence changes.
- See "Residency Rules" on page 41 for further instructions.

County

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	90	3	01/04, 09/06, 01/10	Required

Description
Identifies the county of the patient's residence at the time the reportable tumor is diagnosed.

Rationale
This data item may be used for epidemiological purposes. For example, to measure the cancer incidence in a particular geographic area.

Instructions for Coding

- For U.S. residents, use codes issued by the Federal Information Processing Standards (FIPS) publication, *Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas*. This publication is available in a reference library or can be accessed on the Internet through the U.S. EPA's Envirofacts Data Warehouse and Applications Web site at *http://www.epa.gov/.*
- If the patient has multiple tumors, the county codes may be different for each tumor.
- If the patient is a non-U.S. resident and is coded XX in State at Diagnosis, then code the patient's country of residence in this space.
- For country codes, see the current version of *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary*, *(http://www.naaccr.org).*
- Do not update this data item if the patient's county of residence changes.

Montana County Codes:

Label	Label	Label
Beaverhead	Granite	Powell
Big Horn	Hill	Prairie
Blaine	Jefferson	Ravalli
Broadwater	Judith Basin	Richland
Carbon	Lake	Roosevelt
Carter	Lewis & Clark	Rosebud
Cascade	Liberty	Sanders
Chouteau	Lincoln	Sheridan
Custer	McCone	Silver Bow
Daniels	Madison	Stillwater
Dawson	Meagher	Sweetgrass
Deer Lodge	Mineral	Teton
Fallon	Missoula	Toole
Fergus	Musselshell	Treasure
Flathead	Park	Valley
Gallatin	Petroleum	Wheatland
Garfield	Phillips	Wibaux
Glacier	Pondera	Yellowstone
Golden Valley	Powder River	

State

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Addr at DX – State	80	2	01/04, 09/06, 01/10	Required

Description
Identifies the patient's state of residence at the time of diagnosis.

Rationale
The state of residence is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Instructions for Coding
- Use U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province or territory in which the patient resides at the time the tumor is diagnosed and treated.
- If the patient has multiple tumors, the state of residence may be different for subsequent primaries.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
- Do not update this data item if the patient's state of residence changes.

Common abbreviations (refer to the Zip Code directory for further listings)

State		State		State	
Alabama	AL	Massachusetts	MA	Tennessee	TN
Alaska	AK	Michigan	MI	Texas	TX
Arizona	AZ	Minnesota	MN	Utah	UT
Arkansas	AR	Mississippi	MS	Vermont	VT
California	CA	Missouri	MO	Virginia	VA
Colorado	CO	Montana	MT	Washington	WA
Connecticut	CT	Nebraska	NE	West Virginia	VW
Delaware	DE	Nevada	NV	Wisconsin	WI
District of Columbia	DC	New Hampshire	NH	Wyoming	WY
Florida	FL	New Jersey	NJ	United States, state unk	US
Georgia	GA	New Mexico	NM	American Samoa	AS
Hawaii	HI	New York	NY	Guam	GU
Idaho	ID	North Carolina	NC	Puerto Rico	PR
Illinois	IL	North Dakota	ND	Virgin Islands	VI
Indiana	IN	Ohio	OH	Palau	PW
Iowa	IA	Oklahoma	OK	Micronesia	FM
Kansas	KS	Oregon	OR	Marshall Islands	MH
Kentucky	KY	Pennsylvania	PA	Outlying Islands	UM
Louisiana	LA	Rhode Island	RI	APO/FPO Armed Services America	AA
Maine	ME	South Carolina	SC	APO/FPO Armed Services Europe	AE
Maryland	MD	South Dakota	SD	APO/FPO Armed Services Pacific	AP

The following are abbreviations for Canadian provinces and territories:

Province/Territory		Province/Territory	
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NL	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS	Canada, province unknown	CD

Zip Code

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Addr at DX – Postal (Zip) Code	100	9	01/04	Required

Description
Identifies the postal code of the patient's address at diagnosis.

Rationale
The postal code 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.

Instructions for Coding
- For U.S. residents, record the patient's nine-digit extended postal code at the time of diagnosis and treatment.
- For Canadian residents, record the six-character postal code.
- When available, record the postal code for other countries.
- If the patient has multiple malignancies, the postal code may be different for subsequent primaries.
- Do not update this data item if the patient's postal code changes.
- See "Residency Rules" on page 41 for further instructions.

Montana Zip Codes:

City	County	Zip	City	County	Zip
Absarokee	Stillwater	59001	Acton	Yellowstone	59002
Alberton	Mineral	59820	Alder	Madison	59710
Alzada	Carter	59311	Anaconda	Deer Lodge	59711
Angela	Rosebud	59312	Antelope	Sheridan	59211
Arlee	Lake	59821	Ashland	Rosebud	59003
Augusta	Lewis & Clark	59410	Avon	Powell	59713
Babb	Glacier	59411	Bainville	Roosevelt	59212
Baker	Fallon	59313	Ballantine	Yellowstone	59006
Basin	Jefferson	59631	Bearcreek	Carbon	59007
Belfry	Carbon	59008	Belgrade	Gallatin	59714
Belt	Cascade	59412	Biddle	Powder River	59314
Big Arm	Lake	59910	Bigfork	Flathead	59911
Bighorn	Treasure	59010	Big Sandy	Chouteau	59520
Big Sky	Gallatin	59716	Big Timber	Sweet Grass	59011
Billings	Yellowstone	59101	Billings	Yellowstone	59102
Billings	Yellowstone	59103	Billings	Yellowstone	59104
Billings	Yellowstone	59105	Billings	Yellowstone	59106
Billings	Yellowstone	59107	Billings	Yellowstone	59108
Birney	Rosebud	59012	Black Eagle	Cascade	59414
Bloomfield	Dawson	59315	Bonner	Missoula	59823
Boulder	Jefferson	59632	Box Elder	Hill	59521
Boyd	Carbon	59013	Boyes	Carter	59316
Bozeman	Gallatin	59715	MSU Bozeman	Gallatin	59717
Bozeman	Gallatin	59718	Bozeman	Gallatin	59719
Bozeman	Gallatin	59771	Bozeman	Gallatin	59772
Bozeman	Gallatin	59773	Brady	Pondera	59416
Bridger	Carbon	59014	Broadus	Powder River	59317
Broadview	Yellowstone	59015	Brockton	Roosevelt	59213
Brockway	McCone	59214	Browning	Glacier	59417
Brusett	Garfield	59318	Buffalo	Fergus	59418
Busby	Big Horn	59016	Butte	Silver Bow	59701
Butte	Silver Bow	59702	Butte	Silver Bow	59703
Butte	Silver Bow	59750	Bynum	Teton	59419
Cameron	Madison	59720	Canyon Creek	Lewis & Clark	59633
Capitol	Carter	59319	Cardwell	Jefferson	59721
Carter	Chouteau	59420	Cascade	Cascade	59421
Cat Creek	Petroleum	59087	Charlo	Lake	59824
Chester	Liberty	59522	Chinook	Blaine	59523
Choteau	Teton	59422	Circle	McCone	59215
Clancy	Jefferson	59634	Clinton	Missoula	59825
Clyde Park	Park	59018	Coffee Creek	Fergus	59424
Cohagen	Garfield	59322	Colstrip	Rosebud	59323
Columbia Falls	Flathead	59912	Columbus	Stillwater	59019
Condon	Missoula	59826	Conner	Ravalli	59827
Conrad	Pondera	59425	Cooke City	Park	59020
Coram	Flathead	59913	Corvallis	Ravalli	59828
Corwin Springs	Park	59030	Craig	Lewis & Clark	59648
Crane	Richland	59217	Creston	Flathead	59902
Crow Agency	Big Horn	59022	Culbertson	Roosevelt	59218
Custer	Yellowstone	59024	Cut Bank	Glacier	59427
Dagmar	Sheridan	59219	Darby	Ravalli	59829
Dayton	Lake	59914	De Borgia	Mineral	59830
Decker	Big Horn	59025	Deer Lodge	Powell	59722

City	County	Zip	City	County	Zip
Dell	Beaverhead	59724	Denton	Fergus	59430
Dillon	Beaverhead	59725	Divide	Silver Bow	59727
Dixon	Sanders	59831	Dodson	Phillips	59524
Drummond	Granite	59832	Dupuyer	Pondera	59432
Dutton	Teton	59433	East Glacier	Glacier	59434
East Helena	Lewis & Clark	59635	Edgar	Carbon	59026
Ekalaka	Carter	59324	Elliston	Powell	59728
Elmo	Lake	59915	Emigrant	Park	59027
Ennis	Madison	59729	Essex	Flathead	59916
Ethridge	Toole	59435	Eureka	Lincoln	59917
Evergreen	Flathead	59901	Fairfield	Teton	59436
Fairview	Richland	59221	Fallon	Prairie	59326
Fishtail	Stillwater	59028	Flaxville	Daniels	59222
Florence	Ravalli	59833	Floweree	Chouteau	59440
Forestgrove	Fergus	59441	Forsyth	Rosebud	59327
Fort Benton	Chouteau	59442	Fort Harrison	Lewis & Clark	59636
Fort Peck	Valley	59223	Fort Shaw	Cascade	59443
Fort Smith	Big Horn	59035	Fortine	Lincoln	59918
Four Buttes	Daniels	59263	Frazer	Valley	59225
Frenchtown	Missoula	59834	Froid	Roosevelt	59226
Fromberg	Carbon	59029	Galata	Toole	59444
Gallatin Gateway	Gallatin	59730	Gardiner	Park	59030
Garneill	Fergus	59445	Garrison	Powell	59731
Garryowen	Big Horn	59031	Geraldine	Chouteau	59446
Geyser	Judith Basin	59447	Gildford	Hill	59525
Glasgow	Valley	59230	Glen	Beaverhead	59732
Glendive	Dawson	59330	Glentana	Valley	59240
Gold Creek	Powell	59733	Grantsdale	Ravalli	59835
Grass Range	Fergus	59032	Great Falls	Cascade	59401
Great Falls	Cascade	59402	Great Falls	Cascade	59403
Great Falls	Cascade	59404	Great Falls	Cascade	59405
Great Falls	Cascade	59406	Greenough	Missoula	59836
Greycliff	Sweet Grass	59033	Hall	Granite	59837
Hamilton	Ravalli	59840	Hammond	Carter	59332
Hardin	Big Horn	59034	Harlem	Blaine	59526
Harlowton	Wheatland	59036	Harrison	Madison	59735
Hathaway	Rosebud	59333	Haugan	Mineral	59842
Havre	Hill	59501	Hays	Blaine	59527
Heart Butte	Pondera	59448	Helena	Lewis & Clark	59601
Helena	Lewis & Clark	59602	Helena	Lewis & Clark	59604
Helena	Lewis & Clark	59620	Helena	Lewis & Clark	59624
Helena	Lewis & Clark	59626	Helmville	Powell	59843
Heron	Sanders	59844	Highwood	Chouteau	59450
Hilger	Fergus	59451	Hingham	Hill	59528
Hinsdale	Valley	59241	Hobson	Judith Basin	59452
Hogeland	Blaine	59529	Homestead	Roosevelt	59242
Hot Springs	Sanders	59845	Hungry Horse	Flathead	59919
Huntley	Yellowstone	59037	Huson	Missoula	59846
Hysham	Treasure	59038	Ingomar	Rosebud	59039
Inverness	Hill	59530	Ismay	Custer	59336
Jackson	Beaverhead	59736	Jefferson City	Jefferson	59638
Joliet	Carbon	59041	Joplin	Liberty	59531
Jordan	Garfield	59337	Judith Gap	Wheatland	59453
Kalispell	Flathead	59901	Kalispell	Flathead	59902
Kalispell	Flathead	59903	Kalispell	Flathead	59904

City	County	Zip	City	County	Zip
Kevin	Toole	59454	Kila	Flathead	59920
Kinsey	Custer	59338	Kremlin	Hill	59532
Lake McDonald	Flathead	59921	Lakeside	Flathead	59922
Lambert	Richland	59243	Lame Deer	Rosebud	59043
Larslan	Valley	59244	Laurel	Yellowstone	59044
Lavina	Golden Valley	59046	Ledger	Pondera	59456
Lewistown	Fergus	59457	Libby	Lincoln	59923
Lima	Beaverhead	59739	Lincoln	Lewis & Clark	59639
Lindsay	Dawson	59339	Livingston	Park	59047
Lloyd	Blaine	59535	Lodge Grass	Big Horn	59050
Lolo	Missoula	59847	Loma	Chouteau	59460
Lonepine	Sanders	59848	Loring	Phillips	59537
Lothair	Liberty	59461	Lothair	Toole	59474
Lustre	Valley	59225	Luther	Carbon	59068
Malmstrom AFB	Cascade	59402	Malta	Phillips	59538
Manhattan	Gallatin	59741	Marion	Flathead	59925
Martin City	Flathead	59926	Martinsdale	Meagher	59053
Marysville	Lewis & Clark	59640	McAllister	Madison	59740
McCabe	Roosevelt	59245	McLeod	Sweet Grass	59052
Medicine Lake	Sheridan	59247	Melrose	Silver Bow	59743
Melstone	Musselshell	59054	Melville	Sweet Grass	59055
Mildred	Prairie	59341	Miles City	Custer	59301
Mill Iron	Carter	59324	Milltown	Missoula	59851
Missoula	Missoula	59801	Missoula	Missoula	59802
Missoula	Missoula	59803	Missoula	Missoula	59804
Missoula	Missoula	59806	Missoula	Missoula	59807
Missoula	Missoula	59808	Moccasin	Judith Basin	59462
Moiese	Lake	59824	Molt	Stillwater	59057
Monarch	Cascade	59463	Montana City	Jefferson	59634
Moore	Fergus	59464	Mosby	Garfield	59058
Musselshell	Musselshell	59059	Nashua	Valley	59248
Neihart	Cascade	59465	Niarada	Sanders	59845
Norris	Madison	59745	Noxon	Sanders	59853
Nye	Stillwater	59061	Oilmont	Toole	59466
Olive	Powder River	59343	Olney	Flathead	59927
Opheim	Valley	59250	Otter	Powder River	59062
Outlook	Sheridan	59252	Ovando	Powell	59854
Pablo	Lake	59855	Paradise	Sanders	59856
Park City	Stillwater	59063	Peerless	Daniels	59253
Pendroy	Teton	59467	Phillipsburg	Granite	59858
Pinesdale	Ravalli	59841	Plains	Sanders	59859
Plentywood	Sheridan	59254	Plevna	Fallon	59344
Polaris	Beaverhead	59746	Polebridge	Flathead	59928
Polson	Lake	59860	Pompeys Pillar	Yellowstone	59064
Pony	Madison	59747	Poplar	Roosevelt	59255
Powderville	Powder River	59345	Power	Teton	59468
Pray	Park	59065	Proctor	Lake	59914
Proctor	Lake	59929	Pryor	Big Horn	59066
Radersburg	Broadwater	59641	Ramsay	Silver Bow	59748
Rapelje	Stillwater	59067	Ravalli	Lake	59863
Raymond	Sheridan	59256	Raynesford	Judith Basin	59469
Red Lodge	Carbon	59068	Redstone	Sheridan	59257
Reedpoint	Stillwater	59069	Reserve	Sheridan	59258
Rexford	Lincoln	59930	Richey	Dawson	59259
Richland	Valley	59260	Ringling	Meagher	59642

City	County	Zip	City	County	Zip
Roberts	Carbon	59070	Rollins	Lake	59931
Ronan	Lake	59864	Roscoe	Carbon	59071
Rosebud	Rosebud	59347	Roundup	Musselshell	59072
Roy	Fergus	59471	Rudyard	Hill	59540
Ryegate	Golden Valley	59074	Saco	Phillips	59261
Saint Ignatius	Lake	59865	Saint Marie	Valley	59231
Saint Mary	Glacier	59417	Saint Regis	Mineral	59866
Saint Xavier	Big Horn	59075	Saltese	Mineral	59867
Sand Coulee	Cascade	59472	Sand Springs	Garfield	59077
Sanders	Treasure	59076	Sanders	Treasure	59038
Santa Rita	Glacier	59473	Savage	Richland	59262
Scobey	Daniels	59263	Seeley Lake	Missoula	59868
Shawmut	Wheatland	59078	Shelby	Toole	59474
Shepherd	Yellowstone	59079	Sheridan	Madison	59749
Shonkin	Chouteau	59450	Sidney	Richland	59270
Silesia	Carbon	59041	Silver Gate	Park	59081
Silver Star	Madison	59751	Simms	Cascade	59477
Somers	Flathead	59932	Sonnette	Powder River	59348
Springdale	Park	59082	Stanford	Judith Basin	59479
Stevensville	Ravalli	59870	Stockett	Cascade	59480
Stryker	Lincoln	59933	Sula	Ravalli	59871
Sumatra	Rosebud	59083	Sun River	Cascade	59483
Sunburst	Toole	59482	Superior	Mineral	59872
Swan Lake	Flathead	59911	Sweetgrass	Toole	59484
Teigen	Petroleum	59084	Terry	Prairie	59349
Thompson Falls	Sanders	59873	Three Forks	Gallatin	59752
Toston	Broadwater	59643	Townsend	Broadwater	59644
Trego	Lincoln	59934	Trout Creek	Sanders	59874
Troy	Lincoln	59935	Turner	Blaine	59542
Twin Bridges	Madison	59754	Twodot	Wheatland	59085
Ulm	Cascade	59485	Valier	Pondera	59486
Vandalia	Valley	59273	Vaughn	Cascade	59487
Victor	Ravalli	59875	Vida	McCone	59274
Virginia City	Madison	59755	Volborg	Custer	59351
Walkerville	Silver Bow	59701	Warmsprings	Deer Lodge	59756
Westby	Sheridan	59275	West Glacier	Flathead	59936
West Yellowstone	Gallatin	59758	Whitefish	Flathead	59937
Whitehall	Jefferson	59759	Wht Sulphur Spr	Meagher	59645
Whitetail	Daniels	59276	Whitlash	Liberty	59545
Wibaux	Wibaux	59353	Willard	Fallon	59354
Willow Creek	Gallatin	59760	Wilsall	Park	59086
Winifred	Fergus	59489	Winnett	Petroleum	59087
Winston	Broadwater	59647	Wisdom	Beaverhead	59761
Wise River	Beaverhead	59762	Wolf Creek	Lewis & Clark	59648
Wolf Point	Roosevelt	59201	Worden	Yellowstone	59088
Wyola	Big Horn	59089	Yellowtail	Big Horn	59035
Zortman	Phillips	59546	Zurich	Blaine	59547

Social Security Number

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2320	9		Required

Description
Records the patient's Social Security number.

Rationale
This data item can be used to identify patients with similar names.

Instructions for Coding
- Record the patient's Social Security number.
- A patient's Medicare claim number may not always be identical to the person's Social Security number.
- Record Social Security numbers that end with a "B" or "D" as 999999999. The patient receives benefits under the spouse's number and this is the spouse's Social Security number.

Date of Birth

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Birthdate	240	8	01/10	Required

Description
Identifies the date of birth of the patient.

Rationale
This data item is useful for patient identification. It is also useful when analyzing tumors according to age cohort.

Instructions for Coding
- Record the patient's date of birth as indicated in the patient record. For single-digit day or month, record with a lead 0 (for example, September is 09). Use the full four-digit year for year.
- For *in utero* diagnosis and treatment, record the actual date of birth. It will follow one or both dates for those events.
- If only the patient age is available, calculate the year of birth from age and the year of diagnosis and leave day and month of birth unknown (for example, a 60 year old patient diagnosed in 2010 is calculated to have been born in 1950).
- If month is unknown, the day is coded unknown. If the year cannot be determined, the day and month are both coded unknown.

Facility Referred From

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Institution Referred From	2410	10	01/09	Optional

Description
Identifies the facility that referred the patient to the reporting facility.

Rationale
This number is used to document and monitor referral patterns.

Instructions for Coding
- Record the facility name and city the patient was referred from.

Facility Referred To

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Institution Referred To	2420	10	01/09	Optional

Description
Identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

Rationale
This number is used to document and monitor referral patterns.

Instructions for Coding
- Record the facility and city the patient was referred to.

Race

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	160	2	01/04, 01/09, 01/10	Required

Description
Identifies the primary race of the person.

Rationale
Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Instructions for Coding
- Additional races should also be recorded.
- "Race" is analyzed with *Spanish/Hispanic Origin*. Both items must be recorded.
- All tumors for the same patient should have the same race.

Record	**Record**
White	Micronesian, NOS
Black	Chamorran
American Indian, Aleutian, or Eskimo	Guamanian, NOS
Chinese	Polynesian, NOS
Japanese	Tahitian
Filipino	Samoan
Hawaiian	Tongan
Korean	Melanesian, NOS
Vietnamese	Fiji Islander
Laotian	New Guinean
Hmong	Other Asian, including Asian, NOS and Oriental, NOS
Kampuchean (Cambodian)	Pacific Islander, NOS
Thai	Other
Asian Indian or Pakistani, NOS	Unknown
Asian Indian	
Pakistani	

Spanish/Hispanic Origin

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Ethnicity	190	1	09/04	Required

Description
Identifies persons of Spanish or Hispanic origin.

Rationale
This code is used by hospitals and central registries to identify whether or not the person should be classified as "Hispanic" for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the 01 (White category) or *Race 1* through *Race 5*.

Instructions for Coding
- Persons of Spanish or Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.
- Record Non-Spanish or non-Hispanic for Portuguese and Brazilian persons.
- If the patient has multiple tumors, all records should have the same code.

Record
Non-Spanish; non-Hispanic
Mexican (includes Chicano)
Puerto Rican
Cuban
South or Central American (except Brazil)
Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
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 other category of 1-5)
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)
Dominican Republic (for use with patients who were diagnosed with cancer on January 1, 2005, or later)
Unknown whether Spanish or not; not stated in patient record

Sex

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Gender	220	1		Required

Description
Identifies the sex of the patient.

Rationale
This data item is used to compare cancer rates and outcomes by site. The same sex code should appear in each medical record for a patient with multiple tumors.

Instructions for Coding
- Record the patient's sex as indicated in the medical record.

Record
Male
Female
Other (hermaphrodite)
Transsexual
Not stated in patient record

Age at Diagnosis

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	230	3		Required

Description
Records the age of the patient at his or her birthday before diagnosis.

Rationale
This data item is useful for patient identification. It may also be useful when analyzing tumors according to specific patient age.

Instructions for Coding
- If the patient has multiple primaries, then the age at diagnosis may be different for subsequent primaries.

Code	Definition
0	Less than one year old.
1	One year old, but less than two years old.
2	Two years old.
…	Show actual age in years.
120	One hundred twenty years old.
999	Unknown age.

Marital Status

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	150	1		Required

Description
Identifies the patient's marital status at diagnosis.

Rationale
This data item is used to evaluate marital status and identify those at risk for certain cancers.

Instructions for Coding
- Code the patient's marital status at diagnosis for each primary tumor.
- If the patient has more than one primary tumor, the marital status may be different for each.
- Marital status should not be modified or updated if the patient's marital status changes after diagnosis.
- If a patient is under 15 years of age, assume he/she is single.

Record
Single (never married)
Married (including common law)
Separated
Divorced
Widowed
Unknown

Spouse/Parent Name

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Name – Spouse/Parent	2290	60	01/10	Required

Description
Identifies the patient's spouse or parent.

Rationale
This data item is used to confirm marital status and to aid in follow-up of the patient.

Instructions for Coding
- Record the patient's spouse's name if the patient is married.
- Record the patient's parent's name if the patient is unmarried or is still a child.

Place of Birth

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Birthplace	250	3	01/04, 09/06	Required

Description
Records the patient's place of birth.

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

Instructions for Coding
- Record the two-digit state abbreviation, Canadian province or territory, or record country.

Common Abbreviations:

State		State		State	
Alabama	AL	Massachusetts	MA	Tennessee	TN
Alaska	AK	Michigan	MI	Texas	TX
Arizona	AZ	Minnesota	MN	Utah	UT
Arkansas	AR	Mississippi	MS	Vermont	VT
California	CA	Missouri	MO	Virginia	VA
Colorado	CO	Montana	MT	Washington	WA
Connecticut	CT	Nebraska	NE	West Virginia	VW
Delaware	DE	Nevada	NV	Wisconsin	WI
District of Columbia	DC	New Hampshire	NH	Wyoming	WY
Florida	FL	New Jersey	NJ	United States, state unk	US
Georgia	GA	New Mexico	NM	American Samoa	AS
Hawaii	HI	New York	NY	Guam	GU
Idaho	ID	North Carolina	NC	Puerto Rico	PR
Illinois	IL	North Dakota	ND	Virgin Islands	VI
Indiana	IN	Ohio	OH	Palau	PW
Iowa	IA	Oklahoma	OK	Micronesia	FM
Kansas	KS	Oregon	OR	Marshall Islands	MH
Kentucky	KY	Pennsylvania	PA	Outlying Islands	UM
Louisiana	LA	Rhode Island	RI	APO/FPO Armed Services America	AA
Maine	ME	South Carolina	SC	APO/FPO Armed Services Europe	AE
Maryland	MD	South Dakota	SD	APO/FPO Armed Services Pacific	AP

The following are abbreviations for Canadian provinces and territories:

Province/Territory		Province/Territory	
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NL	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS	Canada, province unknown	CD

Telephone Number

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2360	11		Required

Description
Records the current telephone number with area code for the patient and describes who the phone number belongs to.

Rationale
This data item may be used by the hospital registry to contact the patient for follow-up.

Instructions for Coding
- The telephone number should be the current number with area code of the patient.
- Update this data item if the patient's telephone number changes.

Tobacco History

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Smoking History	340	1	01/09	Required

Description
Identifies the patient's past or current use of tobacco.

Rationale
This data item is used to evaluate if previous or present tobacco use may have caused a higher risk of cancer.

Instructions for Coding
- Record the type of tobacco.
- Record if the tobacco use is current or past use.

Record
Never used
Cigarette smoker, current
Cigar/pipe smoker, current
Snuff/chew/smokeless, current
Combination use, current
Previous use
Unknown

Alcohol History

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	350	1	01/09	Required

Description
Indicates the patient's past or current consumption of alcoholic beverages.

Rationale
This data item is used to evaluate if previous or present alcohol use have caused a higher risk of cancer.

Instructions for Coding
- Record current or past history of alcohol use.

Record
No history of alcohol use
Current use of alcohol
Past history of alcohol use, does not currently use
Alcohol usage unknown

Usual Occupation

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – Usual Occupation	310	100	01/10	Required

Description
Usual Occupation describes information about the patient's usual occupation, also known as usual type of job or work.

Rationale
Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies occupational groups in which cancer screening or prevention activities may be beneficial. This data item applies only to patients who are age 14 years or older at the time of diagnosis.

Instructions for Coding
- Record the patient's usual occupation (i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor). Do not record "retired".
- If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any known occupation.
- Update this field if better information is obtained as to the usual occupation of the patient. However, it is not the responsibility of the registrar to update abstracts with information provided on death certificates.
- If the patient was a housewife/househusband and also worked outside the home most of his/her adult life, record the usual occupation outside of the home. If the patient was a housewife/househusband and did not work outside the home for most of his/her adult life, record "housewife" or "househusband".
- If the patient was not a student or housewife and never worked, record "never worked" as the usual occupation.
- If no information is available, record "unknown".
- Spell out acronyms of occupations; do not just record the acronym. For example, spell out Registered Nurse rather than RN.

Usual Industry

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – Usual Industry	320	100	01/10	Required

Description
Usual Industry describes information about the patient's usual industry; also known as usual kind of business/industry.

Rationale
Used to identify new work-related health hazards, serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial. This data item applies only to patients who are age 14 years or older at the time of diagnosis.

Instructions for Coding
- 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.
- Be sure to distinguish among "manufacturing", "wholesale", "retail", and "service" components of an industry which performs more than one of these components.
- If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient 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, a central registry may be able to use the employer name and city/town to determine the type of activity conducted at that location
- If current or most recent occupation, rather than usual occupation was recorded, record the patient's current or most recent business/industry.
- Update this field if better information is obtained as to the usual industry of the patient. However, it is not the responsibility of the registrar to update abstracts with industry information provided on death certificates.
- There should be an entry for "usual industry" if any occupation is recorded. If no information is available regarding industry in which the reported occupation was carried out, record "unknown".
- Spell out acronyms of industry/company; do not just record the acronym. For example, spell out Department of Public Health and Human Services rather than DPHHS.
- Describe the company if the name of the company is not in itself descriptive. For example, describe "Sam's" as "Sam's Exxon Gas Station".

Follow-Up Contact - Name

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2394	60	01/10	Required

Description
Identifies a contact person available for contact if the patient is unavailable. First and last name, in natural order, of a person, other than the patient or a physician, who can be contacted to obtain follow-up information for the patient.

Rationale
Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Instructions for Coding
- Record the name of a contact person other than the patient's spouse or physician.

Follow-Up Contact - Relationship

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
		25		Required

Description
Identifies the contact person's relationship to the patient.

Rationale
Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Instructions for Coding
- Record the relationship of the contact person (e.g., son, daughter, friend, mother, father, neighbor).

Follow-Up Contact - No & Street

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2392	60	01/10	Required

Description
Identifies the street address of the contact person.

Rationale
Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Instructions for Coding
- Record the number and street address or the rural mailing address of the contact person's usual residence.
- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at *http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf*.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to:

  - AVE (avenue)
  - BLVD (boulevard)
  - CIR (circle)
  - CT (court)
  - DR (drive)
  - PLZ (plaza)
  - PARK (park)
  - PKWY (parkway)
  - RD (road)
  - SQ (square)
  - ST (street)
  - APT (apartment)
  - BLDG (building)
  - FL (floor)
  - STE (suite)
  - UNIT (unit)
  - RM (room)
  - DEPT (department)
  - N (north)
  - NE (northeast)
  - NW (northwest)
  - S (south)
  - SE (southeast)
  - SW (southwest)
  - E (east)
  - W (west)

  A complete list of recognized street abbreviations is provided in *Appendix C of USPS Pub 28*.
- Punctuation is normally limited to periods (i.e., 39.2 RD), slashes for fractional addresses (i.e., 101 ½ MAIN ST), and hyphens when a hyphen carries meaning (i.e., 289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (i.e., 425 FLOWER BLVD # 72).
- See "Residency Rules" on page 41 for further instructions.

Code	Definition
103 FIRST AVE SW APT 102	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
UNKNOWN	If the contact person's address is unknown, enter UNKNOWN.

Follow-Up Contact - City

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1842	50	01/10	Required

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

Rationale
Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Instructions for Coding
- Record the name of the city or town used in the contact person's mailing address.
- See "Residency Rules" in on page 41 for further instructions.

Follow-Up Contact - State

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1844	2		Required

Description
USPS abbreviation for the state (including U.S. territories, commonwealths, or possessions), or Canada Post abbreviation for the Canadian province/territory of the follow-up contact's current usual residence. If the patient has multiple tumors, the follow-up contact state should be the same for all tumors.

Rationale
Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Instructions for Coding
- U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory in which the contact person resides.
- If the contact person is a foreign resident, then code either XX or YY depending on the circumstance.

Common abbreviations

State		State		State	
Alabama	AL	Massachusetts	MA	Tennessee	TN
Alaska	AK	Michigan	MI	Texas	TX
Arizona	AZ	Minnesota	MN	Utah	UT
Arkansas	AR	Mississippi	MS	Vermont	VT
California	CA	Missouri	MO	Virginia	VA
Colorado	CO	Montana	MT	Washington	WA
Connecticut	CT	Nebraska	NE	West Virginia	VW
Delaware	DE	Nevada	NV	Wisconsin	WI
District of Columbia	DC	New Hampshire	NH	Wyoming	WY
Florida	FL	New Jersey	NJ	United States	US
Georgia	GA	New Mexico	NM	American Samoa	AS
Hawaii	HI	New York	NY	Guam	GU
Idaho	ID	North Carolina	NC	Puerto Rico	PR
Illinois	IL	North Dakota	ND	Virgin Islands	VI
Indiana	IN	Ohio	OH	Palau	PW
Iowa	IA	Oklahoma	OK	Micronesia	FM
Kansas	KS	Oregon	OR	Marshall Islands	MH
Kentucky	KY	Pennsylvania	PA	Outlying Islands	UM
Louisiana	LA	Rhode Island	RI	APO/FPO Armed Services America	AA
Maine	ME	South Carolina	SC	APO/FPO Armed Services Europe	AE
Maryland	MD	South Dakota	SD	APO/FPO Armed Services Pacific	AP

The following are abbreviations for Canadian provinces and territories:

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

Follow-Up Contact – Zip Code

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1846	9		Required

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

Rationale
Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Instructions for Coding
- For U.S. residents, record the contact person's nine-digit extended postal code.
- For Canadian residents, record the six-character postal code.
- When available, record the postal code for other countries.
- See "Residency Rules" on page 41 for further instructions.

Follow-Up Contact - Telephone Number

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
		10		Required

Description
Identifies the phone number of the contact person.

Rationale
Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Instructions for Coding
- Record the phone number of the contact person with the area code.

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Cancer Information

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Date of Diagnosis

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Diagnosis Date	390	8	09/04, 01/09, 01/10	Required

Description
Records the date of initial diagnosis by a physician for the tumor being reported.

Rationale
The timing for staging and treatment of cancer begins with the date of initial diagnosis for cancer.

Instructions for Coding
- Use the first date of diagnosis whether clinically or histologically confirmed.
- If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis.
- Use the date treatment was started as the date of diagnosis if the patient receives a first course of treatment before a definitive diagnosis.
- Refer to the list of "Ambiguous Terms" on page 13 for language that represents a diagnosis of cancer.
- The date of death is the date of diagnosis for cases diagnosed at autopsy or death certificate only.
- Use the actual date of diagnosis for an *in utero* diagnosis, for cases diagnosed on January 1, 2009 or later. For cases diagnosed before January 1, 2009, assign the date of birth.
- If the year of diagnosis cannot be identified, it must be approximated. In that instance, the month and date are unknown.

Examples:

Code	Reason
06302005	June 30, 2005
03122005	A March 12, 2005 mammogram reveals a mass in the upper-outer quadrant of a patient's right breast compatible with a carcinoma. On March 20, 2005, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma.
05122003	A physician notes a prostate nodule that is suspicious for cancer during a May 12, 2003 physical examination. On June 15, 2003, an ultrasound guided needle biopsy of the prostate provides Histologic confirmation of adenocarcinoma.
01992004	A patient has a total abdominal hysterectomy for endometriosis in January 2004. The patient is admitted to the hospital with abdominal pain and distention in November 2005. A laparoscopy with omental biopsy shows metastatic cystadenocarcinoma. Pathologists review the 2004 hysterectomy specimen. They identify an area of cystadenocarcinoma in the left ovary.
09992005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description "Spring, 2003".
07992003	If information is limited to the description "The middle of the year, 2003".
10992003	If information is limited to the description "Fall, 2003".
12992003 or 01992004	If information is limited to the description "Winter", try to determine if this means the beginning or the end of the year. Code January or December as indicated.

Primary Site

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	400			Required

Description
Identifies the primary site.

Rationale
Primary Site is a basis for staging and determination of treatment options. If also affects the prognosis and course of the disease.

Instructions for Coding
- Record the site of origin.
- Consult the physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.
- Follow the Instructions for Coding in ICD-O-3, pages 20-40 and in the current *Multiple Primary and Histology Coding Rules* to assign site for solid tumors.
- Follow the instructions in *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic and Lymphoid Neoplasms Database (hematopoietic DB) for assigning site for lymphomas, leukemia and other hematopoietic neoplasms.

Laterality

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Paired Organ	410	1	01/04, 01/10	Required

Description
Identifies the side of a paired organ or the side of the body on which the reportable tumor originated. This applies to the primary site only.

Rationale
Laterality supplements staging and extent of disease information and defines the number of primaries involved.

Instructions for Coding
- Code laterality for all paired sites (see list of paired organs on the following page).
- Do not code metastatic sites as bilateral involvement.
- Code midline lesions 5.
- Non-paired sites may be coded right or left, if appropriate.

Record
Organ is not a paired site.
Origin of primary is right.
Origin of primary is left.
Only one side involved, right or left origin not specified.
Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously with a single histology; bilateral retinoblastomas; bilateral Wilms tumors
Paired site: midline tumor.
Paired site, but no information concerning laterality.

Laterality must be recorded for the following paired organs as 1-5 or 9. Organs that are not paired, for which you have not recorded right or left laterality, are coded 0. Midline origins are coded 5. This code is new for 2010, and it may be used retrospectively for cases diagnosed prior to 2010.

Site
Parotid gland
Submandibular gland
Sublingual gland
Tonsillar fossa
Tonsillar pillar
Overlapping lesion of tonsil
Tonsil, NOS
Nasal cavity (excluding nasal cartilage and nasal septum)
Middle ear
Maxillary sinus
Frontal sinus
Main bronchus(excluding carina)
Lung
Pleura
Long bones of upper limb and scapula
Short bones of upper limb
Long bones of lower limb
Short bones of lower limb
Rib and clavicle (excluding sternum)
Pelvic bones (excluding sacrum, coccyx, and symphysis pubis)
Skin of eyelid
Skin of external ear
Skin of other and unspecified parts of face
Skin of trunk
Skin of upper limb and shoulder
Skin of lower limb and hip
Peripheral nerves and autonomic nervous system of upper limb and shoulder
Peripheral nerves and autonomic nervous system of lower limb and hip
Connective, subcutaneous, and other soft tissues of upper limb and shoulder
Connective, subcutaneous, and other soft tissues of lower limb and hip
Breast
Ovary
Fallopian tube
Testis
Epididymis
Spermatic cord
Kidney, NOS
Renal pelvis
Ureter
Eye and lacrimal gland
Cerebral meninges, NOS
Cerebrum and Frontal lobe
Temporal, Parietal, and Occipital lobes
Olfactory, Optic, Acoustic, and Cranial nerves, NOS
Adrenal gland
Carotid body

Other Primary Tumors

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – Other Primary Tumors		90		Required

Description
Text area for documentation of information regarding other primary tumors the patient may have.

Rationale
Identification of other tumors may affect the sequence.

Instructions for Coding

- Document the information regarding other tumors the patient may have or had in the past.

For example:

01 = adenoca of cervix, 1957, not submitted
01 = oat cell carcinoma of lung, 1996, submitted

Place of Diagnosis

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – Place of Diagnosis	2690	60	01/10	Required

Description
Text area for manual documentation of the facility, physician office, city, state, or county where the diagnosis was made.

Rationale
Place of Diagnosis is necessary for case consolidation with cases that are reported from multiple sources and provides information to record class of case.

Instructions for Coding
- Place an X in the appropriate box.
- Use the Other category to record a physician name, address, city, or state where diagnosis took place.

Diagnostic Confirmation

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	490	1	01/04, 01/10	Required

Description
Records the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history.

Rationale
This item is an indicator of the precision of diagnosis. The percentage of solid tumors that are clinically diagnosed only is an indication of whether casefinding is including sources outside of pathology reports. Full incidence calculations must include both clinically and pathologically confirmed cases.

Instructions for Coding Solid Tumors (all tumors except M9590-9992)

- This is a hierarchical schema to identify how the malignancy was determined – from histologic confirmation being most precise to unknown being the least. Histologic confirmation is the highest determination and takes precedence.
- This data item must be changed to the highest on the list if a more definitive method confirms the diagnosis at any time during the course of the disease.
- Record Histology for positive hematologic findings and bone marrow specimens for leukemia, including peripheral blood smears and aspiration biopsies.
- Record Cytology for positive brushings, washings, cell aspiration, and hematologic findings (except for leukemia).

Codes for Solid Tumors

Check	Definition
Positive histology	Histologic confirmation (tissue microscopically examined).
Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
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 not diagnostic of cancer.
Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
Clinical diagnosis only (other than 5, 6, or 7)	The malignancy was reported by the physician in the medical record.
Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually non-analytic).

Instructions for Coding Hematopoietic or Lymphoid Tumors (9590-9992)

- There is no priority hierarchy for coding diagnostic Confirmation for hematopoietic and lymphoid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing. See the *Hematopoietic Database (DB)* for information on the definitive diagnostic confirmation for specific types of tumors.
- Mark Histology when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, or autopsy or bone marrow specimens from aspiration or biopsy.
- For leukemia only, mark histology when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear. Do not use histology if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow, or blood.
- Mark cytology when the microscopic diagnosis is based on cytologic examination of *cells* (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.
- Mark histology when there is a histology positive for cancer AND positive immunophenotyping and/or positive genetic testing results.
- Mark lab test when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer, but no positive histologic confirmation.
- Mark visual when the diagnosis is based only on the surgeon's report from a surgical exploration or endoscopy or from gross autopsy findings without tissue or cytological findings.
- Mark clinical when the case was diagnosed by any clinical method that cannot be marked as visual or xray. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of excluding where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.

Check	Definition
Positive histology	Histologic confirmation (tissue microscopically examined).
Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
Positive histology PLUS • Positive immunophenotyping AND/OR • Positive genetic studies	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results. For example, bone marrow examination is positive for acute myeloid leukemia (9861/3). Genetic testing shows AML with inv(16)(p13.1q22) (9871/3).
Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer.
Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
Clinical diagnosis only (other than 5, 6, or 7)	The malignancy was reported by the physician in the medical record.
Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually non-analytic).

Diagnostic Summary

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
				Required

Description
Diagnostic Summary documents information from physical evaluation, pathology, scopes, x-rays/scans, and lab tests.

Rationale
Information documented in the Diagnostic Summary substantiates the patient's cancer diagnosis. The MCTR uses information provided in Diagnostic Summary to code class of case, date of first contact, sequence, date of diagnosis, primary site, place of diagnosis, diagnostic confirmation, histology, grade, behavior, and stage.

Instructions for Coding
- Review and record results from all reports related to the diagnosis even if results are negative.
- Approved abbreviations should be used (listed in Appendix B).

Physical Exam

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – DX Proc – PE	2520	1,000	01/10	Required

Description
Physical Evaluation describes the history and physical examination about the history of the current tumor and the clinical description of this tumor.

Rationale
Physical evaluation provides verification of date of first contact, diagnosis date, age, race, Hispanic origin, sex, primary site, laterality, histology, sequence number, and staging.

Instructions for Coding
- Approved abbreviations should be used (listed in Appendix B).

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
- Treatment plan

Pathology

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – DX Proc – Path	2570	1,000	01/10	Required

Description
Pathology section should describe dates, procedures, slide #, facility, specimen results, histology, grade, behavior, tumor size, extent of spread, surgical margins, lymph nodes involved and examined.

Rationale
Pathologic information indicates primary site, histologic type, grade, extent of disease, etc.

Instructions for Coding
- Approved abbreviations should be used (listed in Appendix B).

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

Histology

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Morphology	522	4	09/06, 01/10	Required

Description
Histology identifies the microscopic anatomy of cells.

Rationale
Histology is a basis for staging and the determination of treatment options. It also affects the prognosis and course of the disease.

Instructions for Coding
- Review and document relevant information from all pathology reports.
- Cancer and carcinoma are not interchangeable; document what physician states.
- Include all modifying adjectives (i.e., predominantly, with features of, with foci of, elements of).
- Use the Multiple Primary and Histology Coding Rules to determine whether the patient has a single or multiple primaries before recording information.
- Record histology for different primaries in separate abstracts.
- Record positive and negative clinical findings; record positive results first
- Approved abbreviations should be used (listed in Appendix B)

Behavior

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	523	1	01/04, 01/10	Required

Description
Records the behavior of the tumor being reported. The fifth digit of the morphology code is the behavior code.

Rationale
The behavior code is used by pathologists to describe whether the tissue samples are benign (0), borderline (1), in-situ (2), or invasive (3).

Instructions for Coding
- Record information on reportable tumors with descriptions of behavior including benign, borderline, in-situ, or malignant.
- If any invasion is present, no matter how limited, the cancer is considered malignant.
- If the specimen is from a metastatic site, record the histology of the metastatic site and behavior is malignant.
- Approved abbreviations should be used (listed in Appendix B).

Type	Definition
Benign	Benign
Borderline	Uncertain whether benign or malignant
	Borderline malignancy
	Low malignant potential
	Uncertain malignant potential
In-situ and/or carcinoma in-situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk
	Clark level 1 for melanoma (limited to epithelium)
	Comedocarcinoma, noninfiltrating (C50.-)
Synonymous with in-situ	Confined to epithelium
	Hutchinson melanotic freckle, NOS (C44.-)
	Intracystic, non-infiltrating
	Intraductal
	Intraepidermal, NOS
	Intraepithelial, NOS
	Involvement up to, but not including the basement membrane
	Lentigo maligna (C44.-)
	Lobular neoplasia (C50.-)
	Lobular, non-infiltrating (C50.-)
	Non-infiltrating
	Noninvasive
	No stromal involvement
	Papillary, non-infiltrating or intraductal
	Precancerous melanosis (C44.-)
	Queyrat erythroplasia (C60.-)
Invasive	Invasive or microinvasive

Grade

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	440	1	09/04, 01/09, 01/10	Required

Description
Grade describes the tumor's resemblance to normal tissue. Well differentiated (Grade I) is the most like normal tissue, and undifferentiated (Grade IV) is the least like normal tissue. Grades 5-8 define particular cell lines for lymphomas and leukemias.

Rationale
This data item is useful for prognosis.

Instructions for Coding
- Record grade from all pathology reports.
- If the grade is not stated in the final pathologic diagnosis, use the information from the microscopic description or comments.
- When there is no tissue diagnosis, it may be possible to establish grade through magnetic resonance imaging (MRI) or positron emission tomography (PET). When available, record grade based on findings from these reports.
- For sites other than breast, prostate, and kidney, code the tumor grade using the following priority order: 1) terminology; 2) histologic grade; 3) nuclear grade.
- For **breast** cancers, code the tumor grade using the following priority order: 1) Bloom-Richardson (Nottingham) Scores; 2) Bloom-Richardson Grade; 3) Nuclear Grade; 4) Terminology; and 5) Histologic Grade.
- For **kidney** cancers, code the tumor grade using the following priority rules: 1) Fuhrman Grade; 2) Nuclear Grade; 3) Terminology (well differentiated, moderately differentiated); and 4) Histologic Grade. These prioritization rules do not apply to Wilm's tumor (M-8960).
- For **prostate** cancers, code the tumor grade according to the following priority order: 1) Gleason Score (this is the sum of the patterns, e.g., if the pattern is 2+4 the score is 6); 2) Terminology; 3) Histologic Grade; and 4) Nuclear Grade (obsolete).

Code	Grade/Cell	Label
1	Grade I, 1, i	Well differentiated; differentiated, NOS
2	Grade II, 2, ii I/III or 1/3	Moderately differentiated; moderately well differentiated; intermediate differentiation
3	Grade III, 3, iii II/III or 2/3	Poorly differentiated; dedifferentiated
4	Grade IV, 4, iv III/III or 3/3	Undifferentiated; Anaplastic
For Lymphomas and Leukemias		
5		T cell; T-precursor
6		B cell; pre-B; B-precursor
7		Null cell; non T-non B
8		NK (natural killer) cell (effective with diagnosis 1/1/95 and after)
For Use in All Histologies		
9		Cell type not determined, not stated or not applicable; unknown primaries; high grade dysplasia (adenocarcinoma in-situ)

The instructions for coding grade and differentiation are found in the "Morphology" section of the ICD-O-3 "Coding Guidelines for Topography and Morphology" (ICD-O-3 pages 30-34).

For sites other than breast, prostate, and kidney, code the tumor grade using the following priority order: 1) terminology; 2) histologic grade; 3) nuclear grade.

The grade of a tumor, including brain, can be established through magnetic resonance imaging (MRI) or positron emission tomography (PET) when there is no tissue diagnosis.

For primary tumors of the brain and spinal cord (C71.0 – C72.9) do not record the WHO grade as the tumor *Grade/Differentiation*; record the WHO grade in the data item *CS Site-Specific Factor 1*. Grade astrocytomas (M-9383, 9484, 9400, 9401, 9410-9412, 9420, 9421) according to ICD-O-3 rules: I (well differentiated), Code 1; II (intermediate differentiation), Code 2; III (poorly differentiated), Code 3; IV (anaplastic), Code 4. Do not automatically code glioblastoma multiforme as Grade IV if no grade is given, code 9 (unknown).

Some primary sites are routinely assigned a grade other than *Grade/Differentiation* that is defined by the ICD-O-3. For the *Grade/Differentiation* item, it is necessary to convert from these systems to Grade/Differentiation as described in the following sections.

Coding Two-grade Systems

Two grade systems apply to colon, rectosigmoid junction, rectum (C18.0-C20.9), and heart (C38.0). Code these sites using a two-grade system; Low Grade (2) or High Grade (4). If the grade is listed as 1/2 or as Low Grade, then code 2. If the grade is listed as 2/2 or as High Grade, then code 4.

Code	Terminology	Histologic Grade
2	Low Grade	1/2
4	High Grade	2/2

Coding Three-grade Systems

Three grade systems apply to peritoneum (C48.1, C48.2), breast (C50.0-C50.9), endometrium (C54.1), fallopian tube (C57.0), prostate (C61.9), kidney (C64.9), and brain and spinal cord (C71.0-C72.9). For sites other than breast, prostate, and kidney, code the tumor grade using the following priority order: (1) Terminology; (2) Histologic Grade; and (3) Nuclear Grade as shown in the table below.

Code	Terminology	Histologic Grade	Nuclear Grade
2	Low grade, well to moderately differentiated	I/III or 1/3	1/3, 1/2
3	Medium grade, moderately undifferentiated, relatively undifferentiated	II/III or 2/3	2/3
4	High grade, poorly differentiated to undifferentiated	III/III or 3/3	2/2, 3/3

Breast (C50.0-C50.9)

For breast cancers, code the tumor grade using the following priority order: (1) Bloom-Richardson (Nottingham) Scores; (2) Bloom-Richardson Grade; (3) Nuclear Grade; (4) Terminology; and (5) Histologic Grade as shown in the table below.

Code	Bloom-Richardson (Nottingham) Scores	Bloom-Richardson Grade	Nuclear Grade	Terminology	Histologic Grade
1	3-5 points	Low grade	1/3, 1/2	Well differentiated	I/III or 1/3
2	6, 7 points	Intermediate grade	2/3	Moderately differentiated	II/III or 2/3
3	8, 9 points	High grade	2/2, 3/3	Poorly differentiated	III/III or 3/3

Kidney (C64.9)

For kidney cancers, code the tumor grade using the following priority rules: (1) Fuhrman Grade; (2) Nuclear Grade; (3) Terminology (well differentiated, moderately differentiated); and (4) Histologic Grade. These prioritization rules do not apply to Wilm's tumor (M-8960).

Prostate (C61.9)

For prostate cancers, code the tumor grade using the table below according to the following priority order: (1) Gleason Score (this is the sum of the patterns, e.g., if the pattern is 2+4 the score is 6); (2) Terminology; (3) Histologic Grade; and (4) Nuclear Grade (obsolete).

Code	Gleason's Score (sum of primary and secondary patterns)	Terminology	Histologic Grade
1	2, 3, 4	Well differentiated	I
2	5, 6	Moderately differentiated	II
3	7, 8, 9, 10	Poorly differentiated	III

Tumor Grade and AJCC Staging

The *AJCC Cancer Staging Manual* may state that specific histologies are to be considered a specific grade. Follow AJCC instructions when assigning stage only. Follow ICD-O-3 rules and rules in this section for assigning a grade to tumors recorded in your abstract. The specialized grades described in the *AJCC Cancer Staging Manual* are recorded directly as Collaborative Staging items.

Scopes

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – DX Proc – Scopes	2540	1,000	01/10	Required

Description
Scopes document endoscopic examinations that provide information for staging and treatment.

Rationale
Scopes provide verification of diagnosis date, diagnostic confirmation, primary site, laterality, histology, and staging.

Instructions for Coding
- Approved abbreviations should be used (listed in Appendix B).

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

X-Ray/Scans

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – DX Proc – X-ray/Scan	2530	1,000	01/10	Required

Description
X-rays or scans describe all X-rays, scans, and/or other imaging examinations that provide information about staging.

Rationale
X-rays and scans provide verification of diagnosis date, diagnostic confirmation, primary site, laterality, histology, and staging.

Instructions for Coding
- Approved abbreviations should be used (listed in Appendix B).

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

Lab Tests

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – DX Proc – Lab Tests	2550	1,000	01/10	Required

Description
Lab tests describe information from laboratory examinations other than cytology or histopathology.

Rationale
Lab tests provide verification of diagnosis date, diagnostic confirmation, primary site, grade, laterality, histology, and staging.

Instructions for Coding
- Approved abbreviations should be used (listed in Appendix B).

Suggestions for text:
- Type of laboratory test/tissue specimen(s)
- Record positive and negative clinical findings; record positive 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)

Surgical Margins

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – Surgical Margins	1320	1	01/10	Recommended

Description
Surgical Margin records the final status of the surgical margins after resection of the primary tumor.

Rationale
This data item serves as a quality measure for pathology reports and is used for staging, and may be a prognostic factor in recurrence.

Instructions for Coding
- Record the margin status as it appears in the pathology report.
- Approved abbreviations should be used (listed in Appendix B).

Example	Definition
No residual tumor	All margins are grossly and microscopically negative.
Residual tumor, NOS	Involvement is indicated, but not otherwise specified.
Microscopic residual tumor	Cannot be seen by the naked eye.
Macroscopic residual tumor	Gross tumor of the primary site which is visible to the naked eye.
Margins not evaluable	Cannot be assessed (indeterminate).
No primary site surgery	No surgical procedure of the primary site. Diagnosed at autopsy.
Unknown or not applicable	If is unknown whether a surgical procedure to the primary site 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.

Collaborative Staging

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2800	3	09/06, 01/09, 01/10	Required

Description
Collaborative Staging was designed for registrar use. It relieves registrars from the necessity of staging a single case according to more than one staging system. It avoids the problems that can occur when it is necessary to consider multiple pieces of information simultaneously to assign a single code. For Collaborative Staging, registrars code discrete pieces of information once and the CS computer algorithm derives the values for AJCC T, N, M, and Stage Group, Summary Stage 1977, and Summary Stage 2000. The derived stage codes are ideally suited for data analysis because of the consistency that can be obtained with objectively-recorded, identically-processed data items.

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

Instructions for Recording
- Code the tumor size in the *Size of Tumor* item.
- Code how far the tumor has spread directly in the *Extension* item.
- Code the number of positive regional lymph nodes from the pathology report in the *No. of Positive Regional Nodes* item.
- Code the number of regional lymph nodes examined by the pathologist in the *No. of Regional Lymph Nodes Examined* item.
- Code the farthest distant metastasis (including distant lymph nodes) in the *Sites of Distant Metastases* item.

How Collaborative Staging Works

Collaborative Staging was designed for registrar use. It relieves registrars from the necessity of staging a single case according to more than one staging system. It avoids the problems that can occur when it is necessary to consider multiple pieces of information simultaneously to assign a single code. For Collaborative Staging, registrars code discrete pieces of information once and the CS computer algorithm derives the values for AJCC 6th and 7th editions of the **AJCC Cancer Staging Manual** T, N, M, and Stage Group, Summary Stage 1977, and Summary Stage 2000. The derived stage codes are ideally suited for data analysis because of the consistency that can be obtained with objectively-recorded, identically-processed data items.

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

The following CS data items are coded by the registrar. Items with an asterisk (*) have site-specific variations for some codes.

- *CS Tumor Size**
- *CS Extension**
- *CS Tumor Size/Ext Eval*
- *CS Lymph Nodes**
- *CS Reg Lymph Nodes Eval*
- *Regional Lymph Nodes Examined*
- *Regional Lymph Nodes Positive*
- *CS Mets at DX **
- *CS Mets at DX – Bone*
- *CS Mets at DX – Brain*
- *CS Mets at DX – Liver*
- *CS Mets at DX – Lung*
- *CS Mets Eval*
- *CS Site-Specific Factors 1-25*, for some sites*

The CS algorithm produces the output items listed below. The derived AJCC items are separate from the physician-coded items; and the derived Summary Stage items are separate from the manually-coded items collected by the CoC in the past. The derived items must never be manually altered.

- *Derived AJCC-6 and AJCC-7 T*
- *Derived AJCC-6 and AJCC-7 T Descriptor*
- *Derived AJCC-6 and AJCC-7 N*
- *Derived AJCC-6 and AJCC-7 N Descriptor*
- *Derived AJCC-6 and AJCC-7 M*
- *Derived AJCC-6 and AJCC-7 M Descriptor*
- *Derived AJCC-6 and AJCC-7 Stage Group*
- *Derived SS1977*
- *Derived SS2000*

All derived items are assigned a "storage value", which is stored in the computer and used for data transmission and analysis, and an associated "display value" which is displayed on the computer screen or in printed reports. The display values (for example, "N3c") were designed to be familiar and readily interpretable to registrars and physicians.

Like the AJCC and Summary Stage codes that are derived from it, CS is a site-specific staging system. The CS algorithm uses tumor site and histology to determine which CS schema to apply. Collaborative Staging codes are defined for every site and histology combination. The *AJCC Cancer Staging Manual* does not cover all sites, and some histologies are excluded from sites with an AJCC coding scheme. When the CS algorithm processes a site-histology combination that does not have an applicable AJCC code, it assigns the display string "NA" for "Not applicable." A blank display string for a derived item means the CS algorithm was not run for the case.

Coding CS Items

The complete instructions and site-histology defined codes are available in the current version of **Collaborative Stage Data Collection System**.

See the definitions for the Site Specific Factors in this manual for the requirements for staging for cases diagnosed in 2010. This list is likely to change in future years.

Using CS Derived Values

Some differences in the ways that the CS algorithm operates and how the AJCC stage assignment rules are made can result in differences between the derived values for some patients and the direct-coded stages. The differences of most interest to registrars are those that might explain discrepancies between the derived AJCC T, N, M and Stage Group values and the values recorded for the same cases by physicians.

As a "best stage" system, CS makes use of the most complete information available to stage the tumor. The *AJCC Cancer Staging Manual* distinguishes between clinical staging, based on information available prior to primary treatment, and pathologic staging, based on information gathered as a product of the treatment process (particularly surgery). It also has specific rules governing how the components gathered at different times in the process may be combined. The CS algorithm derives a clinical (c) or pathologic (p) descriptor for each of the T, N and M stage components based on the source of information used to validate the most extensive spread of the tumor, and uses the components to derive a stage group without reference to the value of the descriptors. Some derived stage groups may involve combinations that are neither clinical nor pathologic according to AJCC rules, so a case that is unstageable for a physician applying AJCC rules may be assigned a Derived AJCC Stage Group value by the CS algorithm. Other cases may involve combinations that do not match either the physician-assigned clinical stage or the pathologic stage.

Tumor Size

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2800	3	09/06, 01/09, 01/10	Required

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

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

Instructions for Coding
- Record tumor size information in the following order:
  - Record tumor size from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.
  - If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the largest size of tumor whether prior to or following treatment.
  - 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.
  - If there is a difference in reported tumor size among imaging and radiographic techniques, record the largest size of tumor reported in the record.
- 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.
  - 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.
  - Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.
  - 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.
  - **Additional rule for breast primaries**: If the size of the invasive component is ***not*** given, record the size of the entire tumor from the surgical report, pathology report, radiology report, or clinical examination.
  - For purely in-situ lesions, code the size as stated.
  - Microscopic residual tumor does not affect overall tumor size.
  - 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.
  - Record tumor size 999 for an incisional needle biopsy. On rare occasions, an incisional needle biopsy may remove an entire tumor. In this event, the tumor size may be recorded.
  - Record tumor size (lateral dimension) for malignant melanoma. Depth of invasion is coded in a site-specific factor.

- Special codes
  - Tumor dimension is to be recorded for all schemas, except as noted below.
  - The descriptions in code 998 take precedence over any mention of size. Code 998 is used only for the following sites:
    Esophagus (C15.0-C15.5, C15.8-C15.9): Entire circumference
    Stomach (C16.0-C16.6, C16.8-C16.9): Diffuse, widespread – ¾ or more, linitis plastica
    Colorectal (M-8220/8221 with /2 or /3): Familial/multiple polyposis
    Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9): Diffuse, entire lobe of lung
    Breast (C50.0-C50.6, C50.8-C50.9): Inflammatory carcinoma; Diffuse, widespread – ¾ or more of breast.
  - Code 990 should be used when no gross tumor is seen and tumor is only identified microscopically. ***Note:*** The terms microscopic focus, microfocus, and microinvasion are **not** the same as [macroscopic] focal or focus. A macroscopic focus of 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.
  - Codes 991 through 995 are non-specific size descriptions that, for some sites, are used to determine a T category. If a specific size is given, code the more precise size in the range 001-989.
  - See the individual site/histology schemas for further information and definitions.

Note: For the following diagnoses and/or primary sites, size is not applicable. Record as code 888.

- Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
  (M-9731-9734, 9740-9742, 9750-9758, 9760-9762, 9764-9769, 9800-9801, 9805, 9820, 9823, 9826-9827, 9831-9837, 9840, 9860-9861, 9863, 9866-9867, 9870-9876, 9891, 9895-9897, 9910, 9920, 9930-9931, 9940, 9945-9946, 9948, 9950, 9960-9964, 9965-9992)
- Hodgkin and non-Hodgkin Lymphoma
  (M-959_-972 Except 9700/3 and 9701/3)
- Unknown and Ill-Defined Primary Sites
  (C42.0-C42.4, C76.0-C76.5, C76.7-C76.8, C77.0-C77.5, C77.8-C77.9, C80.9; ***Note***: For C42._ and C77._, other than hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin Lymphomas as listed above, and Kaposi sarcoma 9140/3)

Code	Definition
000	Indicates no mass or no tumor found; for example, when a tumor of a stated primary site is not found, but the tumor has metastasized
001-988	Exact size in millimeters
989	989 millimeters or larger
990	Microscopic focus of foci only; no size of focus is given
991	Described as less than 1 cm
992	Described as less than 2 cm; greater than 1 cm; or, between 1 cm and 2 cm
993	Described as less than 3 cm; greater than 2 cm; or, between 2 cm and 3 cm
994	Described as less than 4 cm; greater than 3 cm; or, between 3 cm and 4 cm
995	Described as less than 5 cm; greater than 4 cm; or, between 4 cm and 5 cm
	SITE/HISTOLOGY-SPECIFIC CODES
999	Unknown; size not stated; not stated in patient record

Examples:

Code	Reason
001	Prostate needle biopsy shows 0.6 mm carcinoma (*round up six-tenths of mm*).
008	Thyroidectomy specimen yields 8 mm carcinoma.
014	Tumor is mixed in-situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive.
019	Duct carcinoma in-situ covering a 1.9 cm area with focal areas of invasive ductal carcinoma.
022	Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives courses of neoadjuvant combination chemotherapy. Pathologic size of tumor after total resection is 0.8 cm.
023	Infiltrating duct carcinoma with extensive in-situ component; total size 2.3 cm.
028	Chest x-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm.
033	A 3.3 cm tumor is 33 millimeters.
040	CT of chest shows 4 cm mass in RUL.
051	Tumor is described as 2.4 x 5.1 x 1.8 cm in size.
990	Cervix conization: severe dysplasia with focal areas of microinvasion. Code tumor size as microscopic focus, no size given.
999	Ovary specimen: extensive cystic disease with focal areas of tumor seeding. Disregard “focal” and code tumor size to unknown.

Describe Size

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
				Required

Description
Describe Size documents information about the size of tumor.

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

Instructions for Coding
- Approved abbreviations should be used (listed in Appendix B).
- If information is missing from the record, state that it is missing.

Suggestions for text:
- Size of tumor with measurements and description of what report the information was located

Extension

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2810	3	09/06, 01/09, 01/10	Required

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

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

Instructions for Coding
- Code the farthest documented extension of the primary tumor. Do not include discontinuous metastases to distant sites which are coded in *CS Mets at Dx* except for ovary and corpus uteri.
- Record extension in the following order:
  - Record extension from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.
  - If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the farthest extension, whether it was identified clinically prior to treatment or pathologically following treatment.
  - 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.
  - 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.
  - With the exception of corpus uteri and ovary, all codes represent continuous (direct) extension of tumor from the site of origin to the organ/structure/tissue represented in the code.
- Refer to the Ambiguous Terminology for terms that constitute tumor involvement or extension.
- 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.
- 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.
- Some site or histology schemas include designations such as T1, NOS; T2, NOS; Localized, NOS; and other non-specific categories. The NOS is added when there is further breakdown of the category into subsets (such as T1a, T1b, T1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as T1 NOS" when the appropriate subset (e.g., T1a or T1b) cannot be determined.
- Distant metastases must be coded in *CS Mets at Dx*.
- 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.
- The presence of microscopic residual disease or positive tumor margins does not increase the extension code.

Regional Lymph Nodes Positive

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	820	2	01/04, 09/06, 01/10	Required

Description
Number of Positive Regional Lymph Nodes records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases.

Rationale
This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient.

Instructions for Recording
- Only record information about regional lymph nodes in this data item. Involved distant lymph nodes should be coded in *Sites of Distant Metastases*.
- This item is based on pathology information only. 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.
- Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.
  - 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.
  - This item is to be recorded regardless of whether the patient received preoperative treatment.
- 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.
- Code 99 for the following primary sites and histologies:
  - Placenta (C58.9)
  - Brain and cerebral meninges (C70.0, C71.0-C71.9)
  - Other Parts of Central Nervous System (C70.1, C70.9, C72.0-C72.5, C72.8-C72.9)
  - Hodgkin and non-Hodgkin Lymphomas (M-959-972 except 9700/3 and 9701/3)
  - Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms (M-9731-9734, 9740-9742, 9750-9758, 9760-9762, 9764-9679, 9800-9801, 9805, 9820, 9823, 9826-9827, 9831-9837, 9840, 9860-9861, 9863, 9866-9867, 9870-9876, 9891, 9895-9897, 9910, 9920, 9930-9931, 9940, 9945-9946, 9948, 9950, 9960-9964, 9965-9992)
  - Unknown and Ill-Defined Primary Sites (C42.0-C42.4, C76.0-C76.5, C76.7-C76.8, C77.0-C77.5, C77.8-C77.9, C80.9; Note: for C42._ and C77._, other than hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin Lymphomas as listed above, and Kaposi sarcoma 9140/3)

Code	Description
00	All nodes examined are negative.
01-89	1-89 nodes are positive. (Code exact number of positive nodes).
90	90 or more nodes are positive.
95	Positive aspiration or core biopsy of lymph node(s) was performed.
97	Positive nodes are documented, but the number is unspecified.
98	No nodes were examined.
99	It is unknown whether nodes are positive; not applicable; not stated in patient record.

Regional Lymph Nodes Examined

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	830	2	01/04, 09/06, 01/10	Required

Description
Number of Regional Lymph Nodes Examined records the total number of regional lymph nodes that were removed and examined by the pathologist.

Rationale
This data item is a quality measure of the pathologic and surgical evaluation and treatment of the patient.

Instructions for Recording
- Only record information about regional lymph nodes in this data item. Involved distant lymph nodes should be coded in *Sites of Distant Metastases*.
- This item is based on pathology information only. 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.
- Record the total number of regional lymph nodes removed and examined by the pathologist.
  - 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.
  - Code 98 if the lymph nodes are aspirated and other lymph nodes are removed.
  - This item is to be recorded regardless of whether the patient received preoperative treatment.
- 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.
- Code 99 for the following primary sites and histologies:
  - Placenta (C58.9)
  - Brain and cerebral meninges (C70.0, C71.0-C71.9)
  - Other Parts of Central Nervous System (C70.1, C70.9, C72.0-C72.5, C72.8-C72.9)
  - Hodgkin and non-Hodgkin Lymphomas (M-959-972 except 9700/3 and 9701/3)
  - Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms (M-9731-9734, 9740-9742, 9750-9758, 9760-9762, 9764-9679, 9800-9801, 9805, 9820, 9823, 9826-9827, 9831-9837, 9840, 9860-9861, 9863, 9866-9867, 9870-9876, 9891, 9895-9897, 9910, 9920, 9930-9931, 9940, 9945-9946, 9948, 9950, 9960-9964, 9965-9992)
  - Unknown and Ill-Defined Primary Sites (C42.0-C42.4, C76.0-C76.5, C76.7-C76.8, C77.0-C77.5, C77.8-C77.9, C80.9; Note: for C42._ and C77._, other than hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin Lymphomas as listed above, and Kaposi sarcoma 9140/3)

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

Sites of Distant Metastases

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2850	2	09/06, 01/09, 01/10	Required

Description
Sites of Distant Metastases records site(s) of distant metastasis at initial diagnosis.

Rationale
This data item is used to document sites of distant metastasis and verify or confirm stage at diagnosis. The presence of metastatic disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes.

Instructions for Recording
- Code only the site(s) of distant metastasis identified during initial diagnosis and workup. Do not update this field over the course of the patient's disease.
- Use the AJCC Manual for Staging of Cancer or the SEER Summary Staging Guide to determine if sites are distant.
- Do not code any sites of regional or local metastasis.
- If there are more than three sites of distant metastasis, code three of the sites.
- Record a 0 if there are no distant metastases.
- Record a 9 if carcinomatosis is present, for disseminated disease, leukemias, and if the site is unknown.
- Do not code specific metastatic sites for unknown primaries (C80.9).

Examples
None
Peritoneum, includes positive ascitic fluid
Lung, including the visceral pleura
Pleura, includes positive pleural fluid
Liver
Bone
Central Nervous System, includes brain and spinal cord
Skin
Lymph nodes (distant only)
Other, generalized, carcinomatosis, disseminated, not specified, unknown

Substantiate Stage

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
				Required

Description
Substantiate Stage documents information about staging decisions.

Rationale
Documentation about staging decisions is heavily utilized for quality control and special studies. Text is needed to justify coded values and document supplemental information not generally included in coded values.

Instructions for Recording

Suggestions for text:
- Clinical procedures that provided information for assigning stage
- Organs involved by direct extension
- Status of margins
- Physician's comments

SEER Summary Staging

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	759	1	09/04, 01/09	Required

Description
Provides a site-specific description of the extent of disease at diagnosis.

Rationale
SEER Summary Stage 2000 is used by the CoC to describe disease spread at diagnosis for cancers with no AJCC TNM staging schema. It is a prognostic factor used in the analysis of patient care and outcomes.

Instructions for Recording
- Record the SEER Summary Stage code for all cases that do not have a defined AJCC staging schema.
- Refer to the SEER Summary Staging Manual 2000 for site-specific coding instructions. This information can be found on the Internet at http://www.seer.cancer.gov/tools/ssm//.

Stage	Definition
In-situ	Not progressed through the basement membrane of the organ involved (non-invasive).
Localized	A localized cancer is limited to the site of origin. There may be progression through the basement membrane but not beyond the walls of the organ involved. There is no evidence of metastasis elsewhere in the body.
Regional by direct extension (DE)	A regional cancer extends beyond the limits of the organ of origin into surrounding organs or tissues by direct extension.
Regional to lymph nodes (LN)	A regional cancer extends beyond the limits of the organ of origin into regional lymph nodes by metastasis.
Regional by DE and LN	A regional cancer extends beyond the limits of the organ of origin into surrounding organs or tissues by direct extension and regional lymph nodes.
Regional, NOS	Stage is regional, but is not otherwise specified.
Distant/systemic disease	A distant cancer has direct extension beyond adjacent organs or tissues or metastases to distant site(s) or distant lymph node(s).
Unknown	Unstaged, unknown, or unspecified; death certificate only.

AJCC Staging

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
				Required

Description
AJCC TNM Stage is based on the clinical, operative, and pathologic assessment of the anatomic extent of disease and is used to make appropriate treatment decisions, determine prognosis, and measure end results. The following general rules apply to AJCC staging of all sites.

Rationale
The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Recording
- All cases should use the following time guidelines for evaluating stage: through first course of surgery or four months, whichever is longer.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.
- All cases should be confirmed microscopically for TNM classification (including clinical information). Rare cases that do not have biopsy or cytology of the tumor can be staged but should be analyzed separately and should not be included in survival analysis.
- Code the T, N, and M elements (clinical and pathologic) as recorded in the medical record.
- Code the AJCC Stage Group (clinical and pathologic); if no stage group was recorded by the appropriate person or persons, the registrar may enter stage group based on the components recorded.
- If a patient has multiple primaries, stage each primary independently.
- If the stage group cannot be determined from the recorded components, then record it as unknown.
- When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If, at a later time, the physician identifies which primary has metastasized, update the stage(s) as appropriate.

T
T evaluates the primary tumor (T) and reflects the tumor size and/or extension.

N
N identifies the absence of presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis/

M
M identifies the presence or absence of distant metastasis (M).

Stage Group
Stage Group identifies the anatomic extent of disease based on the T, N, and M elements.

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Treatment Information

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Cumulative Treatment Summary

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
				Required

Description
Cumulative Treatment Summary records information describing all treatment procedures performed as part of treatment. This includes experimental treatments (when the mechanism of action for a drug is unknown) and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field.

Rationale
Treatment data can be used to compare the efficacy of treatment options. Studies can be performed to evaluate effectiveness of treatment.

Instructions for Recording
- Approved abbreviations should be used (listed in Appendix B)
- If no treatment is given, record the date of the decision not to treat, the date of patient refusal, or the date the patient expired.

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. "No therapy" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given.

A treatment plan describes the type(s) of therapies intended to modify, control, remove, or destroy proliferating cancer cells. The documentation confirming a treatment plan may be found in several different sources; for example, medical or clinical records, consultation reports, and outpatient records.

- All therapies specified in the physician(s) treatment plan are a part of the first course of treatment if they are actually administered to the patient.
- A discharge plan must be part of the patient's record in a JCAHO-approved program and may contain part or all of the treatment plan.
- An established protocol or accepted management guidelines for the disease can be considered a treatment plan in the absence of other written documentation.
- If there is no treatment plan, established protocol, or management guidelines, and consultation with a physician advisor is not possible, use the principle: "initial treatment must begin within four months of the date of initial diagnosis".

Biopsy and Surgery

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
				Required

Description
Biopsy and surgery provides information for diagnosis and surgical procedures as part of treatment.

Rationale
Biopsy and surgery provides verification of place of diagnosis, diagnosis date, diagnostic confirmation, primary site, surgical treatment, regional lymph node involvement, sites of distant metastases, reasons for no treatment, margins, and staging. First course surgery items describe the most definitive type of surgical treatment the patient received from any facility, when it was performed, and its efficacy. When no surgical treatment is given, the reason is recorded. Major aspects of surgical care provided by the individual facility are also recorded so that hospital cancer programs can evaluate local patient care.

Instructions for Recording
- Approved abbreviations should be used (listed in Appendix B)

Suggestions for text:
- Date of each procedure
- Type(s) of surgical procedure(s), including biopsies, excisional biopsies and surgery to other and distant sites
- Lymph nodes removed
- Regional tissues removed
- Metastatic sites
- Facility where each procedure was performed
- Record positive and negative findings; record positive findings first
- Reason for no treatment

Radiation

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
				Required

Description
Radiation describes information about the treatment of the tumor being treated with radiation therapy.

Rationale
Radiation provides verification of place of treatment, date radiation started, type of radiation given, diagnosis date, diagnostic confirmation, primary site, and reasons for no treatment. To better reflect the contribution of radiation oncology to the treatment of cancer patients, these items record regional and boost treatment information.

Instructions for Recording
- Approved abbreviations should be used (listed in Appendix B)

Suggestions for text:
- Date when radiation treatment began and ended
- Where treatment was given (e.g., at this facility, at another facility, document facility if known)
- Bodily location of the radiation treatment
- Type of radiation (beam, radioactive implants, radioisotopes, radioembolization, combinations of radiation types, or unknown)
- Type(s) of beam radiation (e.g., Orthovoltage, Cobalt 60, Photons, Electrons, IMRT, Neutrons, Stereotactic radiosurgery, gamma knife, brachytherapy, strontium, MV X-rays, Mixed modalities, etc.)
- Number of treatments
- Other treatment information (e.g., patient discontinued after five treatments; unknown if radiation was given)
- Regional Dose cGy and Boost Dose cGy
- Reason for no treatment

Systemic Therapy

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
				Required

Description
Systemic therapy encompasses the treatment modalities captured by the items chemotherapy, hormone therapy, and immunotherapy. The descriptions and relationships among the items have been revised to separate the description of the administration of systemic agents or drugs from medical procedures which affect the hormonal or immunologic balance of the patient.

Rationale
Systemic therapy provides verification of place of treatment, date systemic therapy started, type of therapy given, diagnosis date, diagnostic confirmation, primary site, and reasons for no treatment.

Instructions for Recording
- Approved abbreviations should be used (listed in Appendix B)

Suggestions for text:
- Date systemic therapy (chemotherapy, hormone therapy, or immunotherapy) began and ended
- Where treatment was given (e.g., at this facility, at another facility)
- Type(s) of therapy (e.g., name of agent(s) or protocol)
- Other treatment information (e.g., treatment cycle incomplete, unknown if therapy was given)
- Reason for no treatment

Clarification of Systemic Therapy Terms	
Term	**Definition**
Chemotherapy	Cancer therapy that achieves its anti-tumor effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.
Hormone Therapy	Cancer therapy that achieves its anti-tumor effect through changes in hormonal balance. This includes the administration of hormones, agents acting via hormonal mechanisms, antihormones, and steroids.
Immunotherapy	Cancer therapy that achieves its anti-tumor effect by altering the immune system or changing the host's response to the tumor cells.
Endocrine Therapy	Cancer therapy that achieves its anti-tumor effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient and, therefore, alter or affect the long-term control of the cancer's growth.
Hematologic Transplants	Bone marrow or stem cell transplants performed to protect patients from myelosuppression or bone marrow ablation associated with the administration of high-dose chemotherapy or radiation therapy.

Use SEER*Rx to look up chemotherapeutic agents. The program is FREE and can be downloaded from http://www.seer.cancer.gov/seerrx. SEER*Rx has replaced the *Self-Instructional Manual for Tumor Registrars: Book 8 – Antineoplastic Drugs*, Third Edition.

Chemotherapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more chemotherapy drugs. If a patient has an adverse reaction, the managing physician may change one of the agents in a combination regimen. If the replacement agent belongs to the same group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) as the original agent, there is no change in the regimen. However, if the replacement agent is of a different group than the original agent, the new regimen represents the start of subsequent therapy, *only the original agent or regimen is recorded as first course therapy*.

Systemic agents may be administered by intravenous infusion or given orally. Other methods of administration include the following:

Method	Administration
Intrathecal	Administered directly into the cerebrospinal fluid through a lumbar puncture needle into an implanted access device (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 the artery that supplies blood to the liver.

Other Treatment

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
				Required

Description
Other therapy describes information about the treatment of the tumor being treated with non-traditional treatments. This treatment can't usually be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown) and blinded clinical trials.

Rationale
Other therapy provides verification of place of treatment, date Other therapy started, type of Other therapy given, diagnosis date, diagnostic confirmation, primary site, and reasons for no treatment.

Instructions for Recording
- Approved abbreviations should be used (listed in Appendix B)

Suggestions for text:
- Date treatment was started and ended
- Where treatment was given (e.g., at this facility, at another facility)
- Type of other treatment (e.g., blinded clinical trial, hyperthermia, and experimental therapy)
- Other treatment information (e.g., treatment cycle incomplete, unknown if other treatment was given)
- Reason for no treatment

Note that the treatment for reportable hematopoietic diseases can include supportive care, observation, or any treatment that does not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Supportive care and observation are not recorded in this data item, but for certain hematopoietic diseases that become reportable with publication of the ICD-O-3 (M9731/3–M9764/3, M9920/3–M9989/3) treatments such as phlebotomy, transfusions, and aspirin are defined below and should be coded 1.

- Phlebotomy may be called blood removal, blood letting, or venisection.
- Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.
- 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.

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Outcomes

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Date of Last Contact or Death

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Date Last Seen	1750	8	01/10	Required

Description
Records the date of last contact with the patient or the date of death.

Rationale
This information is used for patient follow-up and outcome studies.

Instructions for Coding
- Record the last date on which the patient was known to be alive or the date of death.
- If a patient has multiple primaries, all records should have the same date of last contact.

Vital Status

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Patient Status	1760	1		Required

Description
Records the vital status of the patient as the date entered in *Date of Last Contact or Death*.

Rationale
This information is used for patient follow-up and outcome studies.

Instructions for Coding
- This item is collected during the follow-up process with *Date of Last Contact or Death*.
- If a patient has multiple primaries, all records should have the same vital status.

Label
Dead
Alive

Cancer Status

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Tumor Status	1770	1	01/04	Required

Description
Records the presence or absence of clinical evidence of the patient's malignant or non-malignant tumor as the *Date of Last Contact or Death*.

Rationale
This information is used for patient follow-up and outcomes studies.

Instructions for Coding
- Cancer status is based on information from the patient's physician or other official source such as a death certificate.
- The patient's cancer status should be changed **only** if new information is received from the patient's physician or other official source. If information is obtained from the patient, a family member, or other non-physician, then cancer status is not updated.
- Cancer status changes if the patient has a recurrence or relapse.
- If a patient has multiple primaries, each primary could have a different cancer status.

Label
No evidence of this tumor
Evidence of this tumor
Unknown, indeterminate whether this tumor is present; not stated in patient record

Cause of Death

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Underlying Cause of Death	1910	4		Required

Description
Official cause of death as coded from the death certificate in valid ICD-10 codes. Central Registries obtain the official underlying cause of death from the Office of Vital Statistics.

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

Instructions for Coding
- Record unknown when death occurred and underlying cause of death from the death certificate is unavailable.

Autopsy

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1930	1		Required

Description
Code indicating whether or not an autopsy was performed.

Rationale
This field indicates if a patient had autopsy at death. Autopsy at death may affect the diagnostic confirmation of the tumor.

Instructions for Coding
- Leave blank if patient is alive.

Describe Place of Death

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – Describe Place of Death		25		Recommended

Description
Text to manually describe the facility, place, state, or country where the patient died and where the certificate of death is filed.

Rationale
This field also helps carry out death clearance. When a hospital reports a place of death, the information can help in death certificate matching. It can also signal an out-of-state death for which the death certificate is to be requested.

Instructions for Coding
- Describe in detail the place where the patient died (e.g., Montana Nursing Home, City, MT)

Recurrence Date - 1st

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1860	88	06/05, 01/10	Required

Description
Records the date of the first recurrence.

Rationale
This data item is used to measure the efficacy of the first course of treatment.

Instructions for Coding
- Record the date the physician diagnoses the first progression, metastasis, or recurrence of disease after a disease-free period.
- Reappearance of a tumor of the same histology in the same primary site during the time period defined by the SEER Multiple Primary and Histology Coding Rules does not constitute a recurrence.

Recurrence Type - 1st

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1880	2	06/05, 01/10	Required

Description
Identifies the type of first recurrence after a period of documented disease-free intermission or remission.

Rationale
This item is used to evaluate treatment efficacy and as a long-term prognostic factor.

Instructions for Coding
- Code the type of first recurrence. First recurrence may occur well after completion of the first course of treatment or after subsequent treatment.
- Reappearance of a tumor of the same histology in the same primary site during the time period defined by the SEER Multiple Primary and Histology Coding Rules does not constitute a recurrence.
- If the patient has never been disease-free, continue to track for disease-free status. This may occur after subsequent treatment has been completed.
- If the patient is disease-free, continue to track until a recurrence occurs. First recurrence may occur well after completion of the first course of treatment.
- Once a recurrence has been recorded, subsequent recurrences are NOT to be recorded.
- Organ or system of distant recurrence apply only if all first occurrences were in a single category. There may be multiple metastases (or "seeding") within the distant location.
- If there is more than one primary tumor and the physician is unable to decide which has recurred, code the recurrent disease for each tumor. If, at a later date, the recurrent primary is identified, revise the codes as appropriate.

Stage	Definition
In-situ	Not progressed through the basement membrane of the organ involved (non-invasive).
Localized	A localized cancer is limited to the site of origin. There may be progression through the basement membrane but not beyond the walls of the organ involved. There is no evidence of metastasis elsewhere in the body.
Regional by direct extension (DE)	A regional cancer extends beyond the limits of the organ of origin into surrounding organs or tissues by direct extension.
Regional to lymph nodes (LN)	A regional cancer extends beyond the limits of the organ of origin into regional lymph nodes by metastasis.
Regional by DE and LN	A regional cancer extends beyond the limits of the organ of origin into surrounding organs or tissues by direct extension and regional lymph nodes.
Regional, NOS	Stage is regional, but is not otherwise specified.
Distant/systemic disease	A distant cancer has direct extension beyond adjacent organs or tissues or metastases to distant site(s) or distant lymph node(s).
Unknown	Unstaged, unknown, or unspecified; death certificate only.

Describe Recurrence

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
				Required

Description
Describe Recurrence identifies the site or sites in which the tumor has recurred.

Rationale
This item is used to evaluate treatment efficacy and as a long-term prognostic factor.

Instructions for Recording
- Record the bodily site where recurrence has occurred.
- When carcinomatosis is present, distant sites are recorded unknown.

Comorbidities and Complications

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
				Recommended

Description
Comorbidities and Complications 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.

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

Instructions for Recording
- Secondary diagnoses must be reported for patients that have inpatient hospitalizations at your facility.
- Secondary diagnoses should be reported for patients receiving outpatient care or treated in oncology clinics at your facility when available.
- 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.
- Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility.
- Report the secondary diagnoses for this cancer using the following priority rules:
  - Surgically treated patients:
    a) following the most definitive surgery of the primary site
    b) following other non-primary site surgeries
  - Non-surgically treated patients:
    following the first treatment encounter/episode
  - In cases of non-treatment:
    following the last diagnostic/evaluative encounter
- **Do not** record any neoplasms (ICD-9-CM codes 140-239.9) listed as secondary diagnoses for this data item.
- **Do not** record causes of injury and poisoning unrelated to the patient's medical care (ICD-9-CM codes E800-E869.9, E880-E929.9, or E950-E999).
- **Do not** record the following factors influencing health status and contact with health services (ICD-9-CM codes V01-V07.1, V07.4-V09.91, V16-V21.9, V23.2-V25.3, V25.5-V43.89, V46-V50.4, or V50.8-V83.89).

Comorbidities are preexisting medical conditions or conditions that were present at the time the patient was diagnosed with this cancer (e.g., chronic conditions such as COPD, diabetes, and hypertension). Comorbid conditions are identified by ICD-9-CM codes 001-139.8 and 240-999.9.

Complications are conditions that occur during the hospital stay, while the patient is being treated for the cancer (e.g., postoperative urinary tract infection or pneumonia). Complications may also occur following the completion of therapy and be a cause for readmission to the hospital. Complications are identified by the ICD-9-CM "E" codes which classify environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects.

- Only "E" codes that describe adverse effects occurring during medical care are collected in this data item. They are represented by ICD-9-CM codes E870-E879.9 (misadventures to patients during surgical and medical care) and E930-E949.9 (drugs and medicinal and biologic substances causing adverse effects in therapeutic use).

Factors influencing the health status of patients are circumstances or problems that are not themselves a current illness of injury and are identified by the ICD-9-CM "V" codes (e.g., women receiving post menopausal hormone replacement therapy, or a history of malignant neoplasm).

- Only specific "V" codes which describe health characteristics are collected in this data item. They are represented by ICD-9-CM codes V07.2-V07.39 (prophylactic measures), V10-V15.9 (personal health history), V22.2-V23.1 (pregnancy), V25.4 (contraception), V44-V45.89 (artificial opening and other post surgical states), V50.41-V50.49 (prophylactic organ removal).
- Factors influencing the health status of patients are coded with the leading character "V", without the decimal point, and trailing zeros. Thus, V23.1 is coded as V2310.

Examples:

Code	Reason
49600	COPD (ICD-9-M code 496)
25001	Type 1 diabetes mellitus (ICD-9-CM code 250.01)
40100	Hypertension (ICD-9-CM code 401)
E8732	The patient was inadvertently exposed to an overdose of external beam radiation (ICD-9-CM code E873.2)
E8782	The patient with colon cancer underwent surgical resection and subsequently experienced an anastomotic leak (ICD-9-CM code E878.2)
E9300	During hospitalization, the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-9-CM code E930.0)
V1030	The patient has a personal history of breast cancer (ICD-9-CM code V10.3)

Physician - Surgeon

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Surgeon	2480	5		Required

Description
Surgeon records the physician who performed the most definitive surgical procedure.

Rationale
Administrative, physician, and service referral reports are based on this data item.

Instructions for Recording
- Once the registry has designated a primary surgeon for the patient, the information should not be changed or updated even if the patient receives care from another surgeon.
- Do not update this data item.

Physician - Follow-Up

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Following Physician	2470	5		Required

Description
Follow-Up Physician records the physician currently responsible for the patient's medical care.

Rationale
The following physician is the first contact for obtaining information on a patient's status and subsequent treatment. This information may be used for outcome studies.

Instructions for Recording
- Change this data item when patient follow-up becomes the responsibility of another physician.

Physician - Managing

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Managing Physician	2460	5		Required

Description
Managing Physician records another physician involved in the care of the patient.

Rationale
Administrative, physician, and service referral reports are based on this data item. It can also be used for follow-up purposes.

Physician – 3, 4

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2490	5	01/04, 01/10	Required

Description
Physician 3 and 4 records another physician involved in the care of the patient.

Rationale
Administrative, physician, and service referral reports are based on this data item. It can also be used for follow-up purposes.

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Appendix A

Subsequent Primaries Hematologic Malignancies

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CRITERIA FOR DETERMINING MULTIPLE PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

Use the table in this Appendix only for hematologic malignancies diagnosed prior to January 1, 2010. Beginning with diagnoses on January 1, 2010, use Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic and Lymphoid Neoplasm Database (Hematopoietic DB).

The following rules are to be used as a guide for identifying lymphomas and leukemias with second primaries. Note that the rules refer to general headings followed by the ICD-O morphology codes included in each heading. For specific terms such as "histiocytic," "diffuse," "nodular" and "granulocytic," check the ICD-O Alphabetic Index to determine into which general category a specific term falls. Complete instructions for determining subsequent primaries in lymphatic and hematopoietic diseases are available in both the SEER Program Code Manual 2004 and the FORDS.

***Note*:** *Different histologic terms are sometimes used to describe progressive stages or phases of the same disease process.*

Lymphoma Codes: Lymphomas present some unique coding difficulties because of the complexity of the classification and the variety of terminologies in use. The following rules will be helpful in choosing the correct ICD-O-3 code for the histologic type:

1. The current preferred terminology is the World Health Organization Classification of Tumors of the Hematopoietic and Lymphoid Tissues.
2. If this terminology is not what is stated in the diagnosis, the following guidelines from older classifications apply:
    a. When the terms "diffuse" and "nodular" (follicular) are both mentioned in a diagnosis, ignore the term "diffuse" in coding, because most nodular tumors progress to diffuse or have some diffuse aspects.
    b. If neither diffuse nor nodular (follicular) is mentioned, presume the lymphoma is diffuse.
    c. The terms lymphoma, malignant lymphoma, and non-Hodgkin's lymphoma may be used interchangeably.
    d. Avoid using non-specific or unclassified lymphoma terms if there are specific diagnoses that can be coded.
    e. Some terms have equivalent meanings, for example:
        i. Centroblastic = non-cleaved
        ii. Centrocytic = cleaved
        iii. Follicular = nodular
        iv. Histiocytic = large (cell)
        v. Lymphocytic = small (cell)
        vi. Mixed lymphocytic and histiocytic = mixed small and large (cell)
    f. When the term "mixed cellularity" is used with non-Hodgkin's lymphoma, it means mixed lymphocytic-histiocytic lymphoma.

DEFINITIONS OF SINGLE AND SUBSEQUENT PRIMARIES FOR HEMATOLOGIC MALIGNANCIES BASED ON ICD-O-3 REPORTABLE MALIGNANCIES, EFFECTIVE WITH DIAGNOSES 01/01/2001 – 12/31/2009

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 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 disease into another.

The following chart was prepared by Seer Program, NCI, and provided to aid the registrar in determining single versus subsequent primary.

The following guidelines are employed:

1. "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 that 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. 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 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 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. The sequence of diagnoses 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.

To use the table, assign the ICD-O-3 code to the first diagnosis and find the row containing that code. Assign the ICD-O-3 code for the second diagnosis and find the column containing that code. In the cell at the intersection of the first diagnosis row and the second diagnosis column, a **"**S" symbol indicates that the two diagnoses are most likely the **same** disease process (prepare/update a single abstract), and a **"**D" indicates that 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, code the more specific diagnosis regardless of the sequence. For example, if a diagnosis of non-Hodgkin lymphoma, NOS is followed by a diagnosis of follicular lymphoma, assign the morphology code for the follicular lymphoma*.

Note: *The table "Single versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases" 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 International Classification of Diseases, Third Edition (ICD-O-3) for a complete list of related terms and synonyms.*

Source: SEER Program, NCI

Complete Diagnostic Terms for Table (Based on ICD-O-3):

1.	9590	Malignant lymphoma, NOS
2.	9591	Malignant lymphoma, non-Hodgkin, NOS
3.	9596	Composite Hodgkin and non-Hodgkin lymphoma
4.	9650-9667	Hodgkin lymphoma (all subtypes)
5.	9670-9671	Malignant lymphoma, small B lymphocytic
6.	9673	Mantle cell lymphoma
7.	9675-9684	Malignant lymphoma, diffuse large B-cell
8.	9687	Burkitt lymphoma
9.	9689, 9699	Marginal zone B-cell lymphoma
10.	9690-9698	Follicular lymphoma
11.	9700-9701	Mycosis fungoides and Sezary syndrome
12.	9702-9719	T/NK-cell non-Hodgkin lymphoma
13.	9727	Precursor cell lymphoblastic lymphoma, NOS
14.	9728	Precursor B-cell lymphoblastic lymphoma
15.	9729	Precursor T-cell lymphoblastic lymphoma
16.	9731-9734	Plasma cell tumors
17.	9740-9742	Mast cell tumors
18.	9750-9756	Histiocytosis/Langerhans cell histiocytosis
19.	9757-9758	Dendritic cell sarcoma
20.	9760	Immunoproliferative disease, NOS
21.	9761	Waldenstrom macroglobulinemia
22.	9762	Heavy chain disease, NOS
23.	9764	Immunoproliferative small intestinal disease
24.	9800-9801	Leukemia, NOS/Acute leukemia, NOS
25.	9805	Acute biphenotypic leukemia
26.	9820	Lymphoid leukemia, NOS
27.	9823	B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma
28.	9826	Burkitt cell leukemia
29.	9827	Adult T-cell leukemia/lymphoma (HTLV-1 positive)
30.	9832	Prolymphocytic leukemia, NOS
31.	9833	Prolymphocytic leukemia, B-cell type
32.	9834	Prolymphocytic leukemia, T-cell type
33.	9835	Precursor cell lymphoblastic leukemia, NOS
34.	9836	Precursor B-cell lymphoblastic leukemia
35.	9837	Precursor T-cell lymphoblastic leukemia
36.	9840-9910	Myeloid leukemias
37.	9920	Therapy related acute myelogenous leukemia
38.	9930	Myeloid sarcoma
39.	9931	Acute panmyelosis with myelofibrosis
40.	9940	Hairy cell leukemia
41.	9945	Chronic myelomonocytic leukemia, NOS
42.	9946	Juvenile myelomonocytic leukemia
43.	9948	Aggressive NK-cell leukemia
44.	9950	Polycythemia vera
45.	9960	Chronic myeloproliferative disease, NOS
46.	9961	Myelosclerosis with myeloid metaplasia
47.	9962	Essential thrombocythemia
48.	9963	Chronic neutrophilic leukemia
49.	9964	Hypereosinophilic syndrome
50.	9980-9986	Refractory anemias
51.	9987	Therapy related myelodysplastic syndrome, NOS
52.	9989	Myelodysplastic syndrome, NOS

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 1 SECOND DX ACROSS 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, small B lymph	6. 9673 Mantle cell lymph	7. 9675-9684 ML, diff large B-cell	8. 9687 Burkitt lymphoma	9. 9689,9699 Marg zn, B-cl lym	10. 9690-9698 Follicular lymphoma
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	S	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. Precurs lym'blas lymph B-cell	9728	S	S	D	D	D	D	D	D	D	D
15. Precurs 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. Histiocytos/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

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 2 SECOND DX ACROSS FIRST DX DOWN		11. 9700-9701 MF, Sezary disease	12. 9702-9719 T/NK-cell lymphoma	13. 9727 Precurs lym'blas lymph NOS	14. 9728 Precurs lym'blas lymph B-cl	15. 9729 Precurs lym'blas lymph T-cl	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 dis
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. Precurs lym'blas lymph B-cell	9728	D	D	S	**S**	D	D	D	D	D	D
15. Precurs 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. Histiocytos/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	S	S	S	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	S	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	S	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

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 3 SECOND DX ACROSS FIRST DX DOWN		21. 9761 Waldenstrom	22. 9762 Heavy chain dis	23. 9764 Imm sm intest dis	24. 9800-9801 Leuk/Acu leuk NOS	25. 9805 Acute biphenotypic leuk	26. 9820 Lym'cyt leuk, NOS	27. 9823 BCLL/SLL	28. 9826 Burkitt leukemia	29. 9827 Adult T-cell leuk/lym	30. 9832 Prolym leuk, 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. Precurs lym'blas lymph B-cell	9728	D	D	D	S	S	S	D	D	D	D
15. Precurs 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. Histiocytos/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	S	D	D	D	D
44. Polycythemia vera	9950	D	D	D	S	D	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

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 4 SECOND DX ACROSS FIRST DX DOWN		31. 9833 Prolym leuk, B-cell	32. 9834 Prolym leuk, T-cell	33. 9835 Precurs leuk, NOS	34. 9836 Precurs leuk, B-cell	35. 9837 Precurs leuk, T-cell	36. 9840-9910 Myeloid leukemias	37. 9920 Therapy rel AML	38. 9930 Myeloid sarcoma	39. 9931 Acute panmyelosis	40. 9940 Hairy cell leukemia	41. 9945 Chr myelomono leu
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. Precurs lym'blas lymph B-cell	9728	D	D	S	S	D	D	D	D	D	D	D
15. Precurs 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. Histiocytos/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

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 5 SECOND DX ACROSS FIRST DX DOWN		42. 9946 Juv myelomono leu	43. 9948 NK-cell leukemia	44. 9950 Polycythemia vera	45. 9960 Chr myeloprolif dis	46. 9961 Myelosclerosis	47. 9962 Ess thrombocythem	48. 9963 Chr neutrophil leu	49. 9964 Hypereosin syndr	50. 9980-9986 Refract anemias	51. 9987 Therapy rel MDS	52. 9989 Myelodys syn NOS
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. Precurs lym'blas lymph B-cell	9728	D	D	D	D	D	D	D	D	D	D	D
15. Precurs 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. Histiocytos/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	S	D	D	S	S	D	D	D	S	S	**S**
Codes: S--one primary only; D--presumably a subsequent primary					SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov							

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Appendix B

Common Abbreviations

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Common Acceptable Abbreviations
(in order of terms)
2004

When abbreviating words in an address, refer to the address abbreviations in the MCTR Abstracting Manual or reference the USPS postal addressing standards at http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf

Abdomen	ABD	Autopsy	AUT
Abdominal Perineal	AP	Axilla(ry)	AX
Abnormal	ABN	Bacillus Calmette-Guerin	BCG
Above Knee Amputation	AK(A)	Barium	BA
Acid Phosphatase	ACID PHOS	Barium Enema	BE
Acquired Immunodeficiency Syndrome	AIDS	Bartholin's, Urethral, and Skene's Glands	BUS
Acute Granulocytic Leukemia	AGL	Below the Knee Amputation	BK(A)
Acute Lymphocytic Leukemia	ALL	Benign Prostatic Hypertrophy/Hyperplasia	BPH
Acute Myelogenous Leukemia	AML	Bilateral	BILAT
Adenocarcinoma	ADENOCA	Bilateral Salpingo-Oophorectomy	BSO
Adjacent	ADJ	Biological Response Modifier	BRM
Admission; Admit	ADM	Biopsy	BX, Bx
Against Medical Advice	AMA	Blood Urea Nitrogen	BUN
AIDS Related Complex	ARC	Bone Marrow	BM
Alcohol	ETOH	Bone Scan	BSC
Alkaline Phosphatase	ALK PHOS	Bowel Movement	BM
Alpha-fetoprotein	AFP	Bowel Sounds	BS
Also Known As	AKA	Breath Sounds	BS, BRS
Ambulatory	AMB	Bright Red Blood Per Rectum	BRB(PR)
Anal Intraepithelial Neoplasia	AIN	Cancer, Carcinoma	CA
Anaplastic	ANAP	Carcinoembryonic Antigen	CEA
Angiography	ANGIO	Carcinoma In-situ	CIS
Anterior	ANT	CAT Scan	CT, CT SC
Anteroposterior	AP	Centimeter	CM
Appendix	APP	Central Nervous System	CNS
Approximately	APPROX	Cerebrospinal Fluid	CSF
Arterial Blood Gas	ABG	Cervical Intraepithelial Neoplasia	CIN
Arteriosclerotic Cardiovascular Disease	ASCVD	Cervical Vertebra	C1-C7
Arteriosclerotic Heart Disease	ASHD	Cervix	CX
Arteriovenous	AV	Chemotherapy	CHEMO
Aspiration	ASP	Chest X-ray	CXR
Associated	ASSOC	Chief Complaint	CC
Auscultation & Percussion	A&P	Cholangiopancreatography	ERCP

Chronic Granulocytic Leukemia	CGL
Chronic Lymphocytic Leukemia	CLL
Chronic Myelogenous Leukemia	CML
Chronic Obstructive Pulmonary Disease	COPD
Cigarettes	CIG
Clear	CLR
Colon:	
Ascending Colon	ASC COLON
Descending Colon	DESC COLON
Sigmoid Colon	SIGM COLON
Transverse Colon	TRANS COLON
Complaining of	C/O
Complete Blood Count	CBC
Computerized Axial Tomography	CAT
Congestive Heart Failure	CHF
Consistent with	C/W
Continue	CONT
Coronary Artery Disease	CAD
Creatine Phosphokinase	CPK
Cubic Centimeter	CC
Cystoscopy	CYSTO
Cytology	CYTO
Cytomegalovirus	CMV
Date of Birth	DOB
Dead on Arrival	DOA
Decreased	DECR (or <)
Dermatology	DERM
Diabetes Mellitus	DM
Diagnosis	DX
Diameter	DIAM
Differentiated	DIFF
Dilation & Curettage	D&C
Discharge	DISCH
Discontinued	DISC
Disease	DZ, DIS
Disorder	D/O
Doctor	DR, MD
Dyspnea on Exertion	DOE
Ears, Nose & Throat	ENT
Electrocardiogram	EKG, ECG
Electroencephalogram	EEG
Electromyogram	EMG
Emergency Room	ER
Endoscopic Retrograde Cholangiopancreatography	ERCP
Esophagogastroduodenoscopy	EGD
Estrogen Receptor (Assay)	ERA
Evaluation	EVAL
Evidence	EVID
Examination	EXAM
Examination under Anesthesia	EUA
Excision	EXC
Exploratory Laparotomy	EXP LAP
Extend	EXT
Extended Care Facility	ECF
Extension	EXT
External	EXT
Extremity	EXT
Eyes, Ears, Nose & Throat	EENT
Family (Medical) History	FHx
Fever Unknown Origin	FUO
Follow-up	FU
Fracture	Fx
Gallbladder	GB
Gastroenterostomy	GE
Gastroesophageal	GE
Gastroesophageal Reflux Disease	GERD
Gastrointestinal	GI
Genitourinary	GU
Grade	GR
Gram	GM
Gynecology	GYN
Head, Eyes, Ears, Nose & Throat	HEENT
Hematocrit	HCT
Hemoglobin	HB, HGB
High Grade Prostatic Intra-epithelial Neoplasia	HGPIN
History	HX
History & Physical	H&P
History of	HO
History of Present Illness	HPI
Hormone	HORM
Hormone Replacement Therapy	HRT
Hospital	HOSP
Hour/Hours	HR, HRS
Human Chorionic Gonadotropin	HCG
Human Immunodeficiency Virus	HIV

Human Papilloma Virus	HPV
Human T-Lymphotrophic Virus Type III	HTLV-III
Hypertension	HTN
Hysterectomy	HYST
Immunoglobulin	Ig
Impression	IMP
Includes, Including	INCL
Increase	INCR (or >)
Inferior Vena Cava	IVC
Infiltrating	INFILT
Inpatient	IN-PT
Insulin-Dependent Diabetes Mellitus	IDDM
Intercostal Margin (space)	ICM(S)
Internal Mammary Artery	IMA
Intrathecal	IT
Intravenous	IV
Intravenous Pyelogram	IVP
Intravenous Urography	IVU
Iodine	I
Irregular	IRREG
Irritable Bowel Syndrome	IBS
Jugular Venous Distention	JVD
Kidneys, Ureter, Bladder	KUB
Kilogram	KG
Kilovolt	KV
Laboratory	LAB
Laparotomy	LAP
Large	LG
Last Menstrual Period	LMP
Lateral	LAT
Left	LT
Left Costal Margin	LCM
Left Lower Extremity	LLE
Left Lower Lobe	LLL
Left Lower Quadrant	LLQ
Left Middle Lobe	LML
Left Salpingo-oophorectomy	LSO
Left Upper Extremity	LUE
Left Upper Lobe	LUL
Left Upper Quadrant	LUQ
Liter	L
Liver, Kidney, Spleen (Bladder)	LKS(B)
Lower Extremity	LE
Lower Inner Quadrant	LIQ
Lower Outer Quadrant	LOQ
Lumbar Puncture	LP
Lumbar Vertebra	L1-L5
Lumbosacral	LS
Lymphadenopathy-Associated Virus	LAV
Lymph Node(s)	LN, LNS
Magnetic Resonance Imaging	MRI
Malignant	MALIG
Mandible	MAND
Mastectomy	MAST
Maxillary	MAX
Maximum	MAX
Medical Doctor	MD, DR
Medicine	MED
Metastatic, Metastasis	MET, METS
Microscopic	MICRO
Midclavicular Line	MCL
Middle Lobe	ML
Milliliter	ML
Millimeter	MM
Minimum	MIN
Mitral Valve Prolapse	MVP
Moderate	MOD
Moderately Differentiated	MD, MOD DIFF
Modified Radical Mastectomy	MRM
Month	MO
Nausea & Vomiting	N&V
Negative	NEG (or -)
Neurology	NEURO
No Evidence of Disease	NED
No Evidence of Metastatic Disease	NEMD
No Significant Findings	NSF
Normal	NL
Not Applicable	NA
Not Otherwise Specified	NOS
Not Recorded	NR
Nursing Home	NH
Obstructed(-ing,-ion)	OBST
Operating Room	OR
Operation	OP
Operative Report	OP RPT
Ounce	OZ

Outpatient	OP
Packs Per Day	PPD
Palpated(-able)	PALP
Papanicolaou Smear	PAP
Papillary	PAP
Past Medical History	PMH
Pathology	PATH
Patient	PT
Pelvic Inflammatory Disease	PID
Percussion & Auscultation	P&A
Percutaneous	PERC
Personal (Primary) Medical Doctor	PMD
Physical Examination	PE
Platelets	PLT
Poorly Differentiated	PD, POOR DIFF
Positive	POS (or +)
Positron Emission Tomography	PET
Possible	POSS
Posterior	POST
Posteroanterior	PA
Postoperative(-ly)	PO, POSTOP
Preoperative(-ly)	PREOP
Prescription	Rx
Present Illness	PID
Prior to Admission	PTA
Probable(-ly)	PROB
Progesterone Receptor (Assay)	PRA
Prostatic Intraepithelial Neoplasia	PIN
Prostatic Specific Antigen	PSA
Pulmonary	PULM
Radiation	RAD
Radiation Absorbed Dose	RAD
Radiation Therapy	RAD TX
Radical	RAD
Radioimmunoassay	RIA
Red Blood Cells	RBC
Resection	RESEC
Respiratory	RESP
Review of Systems	ROS
Right	RT
Right Costal Margin	RCM
Right Lower Extremity	RLE
Right Lower Lobe	RLL
Right Lower Quadrant	RLQ
Right Middle Lobe	RML
Right Salpingo-oophorectomy	RSO
Right Upper Extremity	RUE
Right Upper Lobe	RUL
Right Upper Quadrant	RUQ
Rule Out	R/O
Sacral Vertebra	S1-S5
Salpingo-oophorectomy	SO
Serum Glutamic Oxaloacetic Transaminase	SGOT
Serum Glutamic Pyruvic Transaminase	SGPT
Shortness of Breath	SOB
Signs & Symptoms	S/S
Skilled Nursing Facility	SNF
Small	SM, SML
Small Bowel	SB, SM BWL
Specimen	SPEC
Spine	
Cervical Spine	C-SPINE
Lumbar Spine	L-SPINE
Sacral Spine	S-SPINE
Thoracic Spine	T-SPINE
Split Thickness Skin Graft	STSG
Squamous	SQ, SQUAM
Squamous Cell Carcinoma	SCC, SCCA
Status Post	S/P
Subcutaneous	SUBQ, SQ
Superior Vena Cava	SVC
Surgery, Surgical	SURG
Symptoms	SX
Thoracic	T
Thoracic Vertebra	T1-T12
Total Abdominal Hysterectomy	TAH
Total Abdominal Hysterectomy-Bilateral Salpingo-oophorectomy	TAH-BSO
Total Parenteral Nutrition	TPN
Total Vaginal Hysterectomy	TVH
Toxic Multi-Nodular Goiter	TMNG
Transitional Cell Carcinoma	TCC
Transurethral Resection	TUR
Transurethral Resection Bladder (Tumor)	TURBT
Transurethral Resection of Prostate	TURP
Treatment	TX

Tumor Size	TS
Ultrasound	US
Undifferentiated	UNDIFF
Upper Extremity	UE
Upper Gastrointestinal	UGI
Upper Inner Quadrant	UIQ
Upper Outer Quadrant	UOQ
Vagina, Vaginal	VAG
Vaginal Hysterectomy	VAG HYST
Vaginal Intraepithelial Neoplasia	VAIN
Vascular	VASC
Veterans Administration	VA
Vulvar Intraepithelial Neoplasia	VIN
Well Differentiated	WD, WELL DIFF
White Blood Cells	WBC
With	W/
Within Normal Limits	WNL
Without	W/OUT, W/O
Work-up	W/U
X-ray	XR
X-ray Therapy	XRT
Year	YR
Year-Old	Y/O

Symbols

At	@
Comparison	/
Decrease, Less than	<
Equals	=
Increase, More than	>
Negative	-
Number*	#
Positive	+
Pounds**	#
Questionable	??
Times	X

* If it appears before a numeral.
** If it appears after a numeral.

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