SECTION II: GENERAL ABSTRACTING INSTRUCTIONS

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It is the responsibility of every abstractor to know the content of the *FCDS Data Acquisition Manual (DAM)* and to update it upon receipt of any change from FCDS. Should you need training in cancer registry data collection, please visit the FCDS Learning Management System and consider taking the FCDS Abstracting Basics Course to gain a better understanding of the skills and training required to meet FCDS abstracting requirements and the national standards used when abstracting and coding cancer cases.

This manual is intended to explain in detail each data item required for Florida Cancer Data System (FCDS) case reporting. It should be used as the primary information resource for any data item that must be coded and documented in accordance with Florida cancer reporting rules and statutes. Descriptions are only intended to provide sufficient detail to achieve consensus in submitting the required data. In no way does this manual imply any restriction on the type or degree of detail information collected, classified or studied within any healthcare facility-based cancer registry. Special Use Fields are available as needed.

Basic Rules:

1) Always refer to the *FCDS Data Acquisition Manual* when completing an abstract.

2) Always submit a separate abstract for each reportable primary neoplasm identified.

3) Use leading zeros when necessary to right justify.

4) Text is required to adequately justify ALL coded values and to document supplemental information such as patient and family history of malignancy. Data items MUST be well documented in text field(s); specifically, Place of Diagnosis, Physical Exam, X-rays and Scans, Scopes and Diagnostic Tools, Surgical Procedures and Findings, Laboratory and Pathology (including: Dates of Specimen Collection, Primary Site, Histology, Behavior and Grade), and the Collaborative Stage data items including both core items and site specific factors. Treatment information MUST also be documented in the text fields, particularly if the treatment is non-standard or the case is non-analytic or historical. Dates should be included within text in each section to provide a chronology of events, imaging, lab tests, surgeries, and other treatments.

   Please refer to Appendix L of this manual for specific documentation instructions and examples.

Basic Rules For Date Fields:

1) Dates are transmitted in a format widely accepted outside of the registry setting. The format is CCYYMMDD. However, this does not necessarily mean that the way dates are entered into your registry software has changed. Software providers are the primary resource for information about fields in their own systems. Only valid portions of any date are to be transmitted. For each date field, there is an associated date flag item. The date flag fields will be used to record the reason why a date is not known.

2) In the absence of a definitive Date of Diagnosis, the best approximation is acceptable and preferred to coding the month and/or year as unknown. If the only information available for the Date of Diagnosis is the year, it is suggested that you use June 15 for the month and day, plus the year indicated. Also, if the only information given is month and year for the Date of Diagnosis, approximate the day by using 15.
Example: Patient was diagnosed April 2000; use 2000/04/15 as the Date of Diagnosis.

REGISTRY INFORMATION

The Registry Information section of the abstract includes the data items that identify the reporting facility, the case, the date of first contact or admission, the abstractor and the date abstracted.

Data Items Included In This Section

NAACCR Item Number	Item Name
540	Reporting Facility
550	Accession Number- Hosp
560	Sequence Number – Hospital
580	Date of First Contact
581	Date of First Contact Flag
2300	Medical Record Number
2090	Date Case Completed/Date Abstracted
570	Abstracted By (Cancer Abstractor Code)
500	Type of Reporting Source

REPORTING FACILITY   NAACCR ITEM #540

Identifies the facility reporting the case. This is a four-digit FCDS-assigned Facility Number. See Appendix A for hospital, surgery center, and free-standing radiation therapy center Facility Numbers.

The Reporting Facility (NACCR Item #540), Accession Number (NAACCR Item #550), and Sequence Number (NAACCR Item #560) uniquely identify the facility, patient, and tumor(s). Each cancer patient in a facility is assigned a unique accession number, and each primary tumor diagnosed for that patient is assigned a sequence number to differentiate between primary cancers for the patient accessioned. See individual data item descriptions and coding instructions for more information on each data item noted.

Coding Instructions
1. Enter the four-digit FCDS-assigned Facility Number from Appendix A.
2. The FCDS Facility Number is not the same as the FORDS Facility ID Number (FIN).
3. Each facility participating in a shared or network cancer registry must use the unique respective facility number unless the registry has been approved/designated an umbrella organization by FCDS.
4. Cases must be abstracted and reported separately for each facility according to Florida statute unless otherwise designated.
5. The four-digit reporting facility number must be right justified.

ACCESSION NUMBER- HOSP   NAACCR ITEM #550

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

The Reporting Facility (NACCR Item #540), Accession Number (NAACCR Item #550), and Sequence Number (NAACCR Item #560) uniquely identify the facility, patient, and tumor(s). Each cancer patient in a facility is assigned a unique accession number, and each primary tumor diagnosed for that patient is assigned a sequence number to differentiate between primary cancers for the patient accessioned. See individual data item descriptions and coding instructions for more information on each data item noted.

Enter the nine-digit Accession Number as assigned by the reporting facility.

Format: The first four digits of the Accession Number specify the year in which the patient first had contact with the reporting facility in the format CCYY. The last five digits are the sequential/numeric order in which the registry entered the case into the database.

Each patient receives only one accession number from your facility for a lifetime, regardless of the facility "reference date," number of primary cancers reported, or alternate numbering assignment. Accession numbers are never reassigned, even if a patient is removed from your facility registry.

When a patient is deleted from the database, **do not** re-use the accession number for another patient.

Multiple primary reportable malignant neoplasms in one patient are designated by successive sequence numbers. Therefore, when submitting abstracts for multiple primary neoplasms for one patient at the same time, use the same FCDS accession number for every cancer reported.

SEQUENCE NUMBER-HOSPITAL   NAACCR ITEM #560

Enter the two-digit sequence number that corresponds to this primary tumor. This data item records the

chronological appearance of each reportable primary malignant and non-malignant neoplasm over the entire lifetime of the person, regardless of where they were diagnosed or treated.

The Reporting Facility (NACCR Item #540), Accession Number (NAACCR Item #550), and Sequence Number (NAACCR Item #560) uniquely identify the facility, patient, and tumor(s). Each cancer patient in a facility is assigned a unique accession number, and each primary tumor diagnosed for that patient is assigned a sequence number to differentiate between primary cancers for the patient accessioned. See individual data item descriptions and coding instructions for more information on each data item noted.

Codes 00–35 indicate neoplasms of in situ or malignant behavior (behavior equals 2 or 3).

A solitary reportable malignant neoplasm is not part of a sequence; therefore, enter **00** to indicate the lack of sequence.

If a patient was previously reported as sequence 00 and has since developed a subsequent reportable malignant neoplasm, the sequence should be designated by the appropriate number, 02, 03, etc. The original 00 will be changed to 01 automatically in the FCDS files.

If two or more independent primary malignant neoplasms are diagnosed simultaneously, the lowest sequence number should be assigned to the malignancy with the worst prognosis.

Codes 60–88 indicate neoplasms of non-malignant behavior (behavior equals 0 or 1).

A solitary reportable non-malignant neoplasm is not part of a sequence; therefore, enter 60 to indicate the lack of sequence.

If a patient was previously reported as sequence 60 and has since developed a subsequent reportable non-malignant neoplasm, the sequence should be designated by the appropriate number, 62, 63, etc. The original 60 will be changed to 61 automatically in the FCDS files.

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.

A re-evaluation of all related sequence numbers is required whenever an additional neoplasm is identified

Code	Description
00	One Malignant Primary Only
01	First of two or more malignant primaries
02	Second of two or more malignant primaries
03	Third of three or more malignant primaries
60	One non-malignant primary
61	First of two or more non-malignant primaries
62	Second of two or more non-malignant primaries

DATE OF FIRST CONTACT   NAACCR ITEM #580

Enter the year, month, and day (CCYYMMDD) of the patient's first contact with the reporting facility for the diagnosis and/or treatment of the tumor, whether as an inpatient or an outpatient for diagnosis and/or first course treatment. The date may represent the date of an outpatient visit for a biopsy, x-ray, scan, or laboratory test, the date of admission to the facility, or the date of a pathology specimen that was collected

as part of surgical resection or biopsy performed during a long-term in-patient admission.

When a diagnosis of cancer is made during a patient's long-term stay for another condition, the date the patient was first examined for the cancer-related problem should be used as the Date of First Contact. If the case was initially diagnosed at autopsy, the Date of Death should be used as the Date of First Contact as well as for the Date of Diagnosis.

An error is issued if the Date of First Contact precedes the Date of Diagnosis by more than thirty days.

DATE OF FIRST CONTACT FLAG   NAACCR ITEM #581

This flag explains why there is no appropriate value in the corresponding date field, Date of 1st Contact.

Coding Instructions
1. Leave this item blank if *Date of First Contact* (NAACCR Item #580) has a full or partial date recorded.
2. Code 12 if the *Date of First Contact* cannot be determined at all.

Code	Description
12	A proper value is applicable but not known (that is, the date of first contact is unknown).
(blank)	A valid date value is provided in item *Date of First Contact* (NAACCR Item #580).

MEDICAL RECORD NUMBER   NAACCR ITEM #2300

Enter the patient's 11-digit Medical Record Number used by the facility to identify the patient. Use leading zeros when necessary to right justify. Do not use special characters in this field (i.e. *, -, /). If the patient has no Medical Record Number you may indicate the casefinding source as follows or you may enter any facility identification number that will be helpful in locating the record at any future date:

0000000OUT – Outpatient	00000000XRT – Radiation Therapy
00000CLINIC – Clinic	000000CHEMO – Chemotherapy
000000000NA – Unknown	000000000MD – Physician Office
000000000SU – 1-day surgery clinic	

DATE CASE COMPLETED/DATE ABSTRACTED   NAACCR ITEM #2090

Enter the Date the case is being abstracted. The format for all dates is numeric (CCYYMMDD).

Unknown date is not acceptable in this field.

PLEASE DO NOT SUBMIT INCOMPLETE CASES TO FCDS.

ABSTRACTED BY   NAACCR ITEM #570

Enter the three-digit FCDS Abstractor Code of the person abstracting this case. Each abstractor that submits cases to FCDS must have her/his own unique FCDS Abstractor Code. And, all abstracts submitted must have an approved and valid (current) FCDS Abstractor Code in this field. Validation of the FCDS Abstractor Code is part of the FCDS EDITS process, therefore, if any Abstractor Code is

incorrect, invalid or expired, the batch will fail edits at the time of batch upload or record entry.

The FCDS Abstractor Code should never be shared with other abstractors.

Please refer to Section I of this manual for more information on the FCDS Abstractor Code requirement.

TYPE OF REPORTING SOURCE   **NAACCR ITEM #500**

Enter the Type of Reporting Source code that identifies the source of information used to abstract the case.

Code	Description
1	Hospital Inpatient; managed health plans with comprehensive, unified medical records
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
3	Laboratory only (hospital-affiliated or independent)
4	Physician's Office/Private Medical Practitioner (LMD)
5	Nursing/Convalescent Home/Hospice
6	Autopsy Only
7	Death Certificate Only (DCO) - FCDS Use Only
8	Other hospital outpatient units/surgery centers

Definitions

Managed health plan: HMO or other health plan (e.g. Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally (in a unit record) and is available to the abstractor.

Physician office: Examinations, tests and limited surgical procedures may be performed in a physician office. If called a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

Serial record: The office or facility stores information separately for each patient encounter.

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

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

When multiple source documents are used to abstract a case, use the following priority order to assign a code for Type of Reporting Source: Priority order of codes 1, 2, 8, 4, 3, 5, 6, 7.

Code	Label	Source Documents	Priority

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

Code	Label	Source Documents	Priority
		surgery, radiation or oncology clinic	
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)	• Facilities with serial record (not a unit record) • Radiation treatment centers • Medical oncology centers (hospital affiliated or independent) There were no source documents from code 1.	2
3	Laboratory Only (hospital-affiliated or independent	• Laboratory with serial record (not a unit record) There were no source documents from codes 1, 2, 8, or 4.	5
4	Physician's Office/Private Medical Practitioner	• Physician's office that is NOT an HMO or large multi-specialty physician group practice. There were no source documents from codes 1, 2 or 8	4
5	Nursing/Convalescent Home/Hospice	• Nursing or convalescent home or a hospice. There were no source documents from codes 1, 2, 8, 4, or 3.	6
6	Autopsy Only	• Autopsy The cancer was first diagnosed on autopsy. There are no source documents from codes 1, 2, 8, 4, 3 or 5.	7
7	Death Certificate Only	Death certificate is the only source of information; follow-back activities did not identify source documents from codes 1, 2, 8, 4, 3, 5 or 6. If another source document is subsequently identified, the Type of Reporting Source code must be changed to the appropriate code in the range of 1, 2, 8, 4, 3 or 6	
8	Other hospital outpatient units/surgery centers	• Other hospital outpatient units/surgery centers. Includes, but not limited to, outpatient surgery and nuclear medicine services. There are no source documents from codes 1 or 2.	3

PATIENT DEMOGRAPHICS

The Patient Demographics section of the abstract includes the set of data items used to describe personal information about an individual patient. When grouped, these data can be used to study how cancer rates differ by geographic location, as well as what groups are at a higher risk of certain types of cancer. Much of the information in this section is confidential in nature and can be used to identify individual patients. Care must be taken at all times to assure patient confidentiality when reporting cases.

Data Items Included in this section:

NAACCR Item Number	Item Name
2230	Name – Last
2240	Name – First
2250	Name – Middle
2280	Name – Alias
2390	Name - Maiden
2320	Social Security Number
240	Date of Birth
241	Date of Birth Flag
252	Birthplace State
254	Birthplace Country
220	Sex
160	Race 1
161	Race 2
162	Race 3
163	Race 4
164	Race 5
190	Spanish/Hispanic Origin
150	Marital Status
1300	Height at Diagnosis (inches)
1300	Weight at Diagnosis (lbs.)
1300	Tobacco Use – Cigarette
1300	Tobacco Use – OthSmoke
1300	Tobacco Use – SmokelessTob
1300	Tobacco Use – NOS
2335	Addr at DX - Supplemental
2330	Addr at DX – No &Street
70	Addr at DX – City
80	Addr at DX – State
102	Addr at DX – Country
100	Addr at DX – Postal Code
90	County at DX
2350	Addr Current – No & Street
1810	Addr Current – City
1820	Addr Current – State
1832	Addr Current – Country
1830	Addr Current – Postal Code
1840	County--Current
2360	Telephone Current
630	Primary Payer at DX
2460	Physician – Managing
2465	NPI – Managing Physician
2475	NPI – Following Physician
2485	NPI – Primary Surgeon
2495	NPI – Physician #3 (Radiation Oncologist)
2505	NPI – Physician #4 (Medical Oncologist)
310	Text – Usual Occupation
320	Text – Usual Industry

NAME – LAST   **NAACCR ITEM #2230**

Enter the patient's full last name. Blanks, spaces, hyphens, and apostrophe marks are allowed. However, FCDS software will strip off these special characters during upload to the FCDS database.

*Example:*Mc Donald is entered McDonald. O'Hara is entered OHara.

NAME – FIRST   **NAACCR ITEM #2240**

Enter the patient's full first name with no special characters (e.g., no periods). Do not enter the patient's middle initial in this field. If you encounter an EDIT failure that the Patient Name does not match from a previously submitted neoplasm, contact your Field Coordinator to correct any Demographic EDITS including Name EDITS prior to submission.

NAME – MIDDLE   **NAACCR ITEM #2250**

Enter the patient's middle name or middle initial with no special characters (e.g., no periods). If the patient does not have a middle name or if the middle name is unknown, leave this field blank.

NAME – ALIAS   **NAACCR ITEM #2280**

Enter the patient's alternate name or "AKA" (also known as), if known. You may also enter postscripts in this field such as "Junior", "Senior", etc. Note that the maiden name is entered in Name-Maiden field.

NAME – MAIDEN   **NAACCR ITEM #2390**

For patients who are or have been married, enter the patient's maiden name with no special characters (e.g., no periods). If the patient does not have a maiden name, if no information is available, or if this field is not applicable (patient is a male), leave this field blank. If the patient has a hyphenated name, you may put the name that precedes the hyphen in this field. Example: Green-Moss; enter Green.

SOCIAL SECURITY NUMBER   **NAACCR ITEM #2320**

Enter the patient's complete nine-digit Social Security Number. Partial Social Security Numbers (last 4-digits or last 6-digits) and billing-system-generated proxy Social Security Numbers are not allowed. If you are unable to access the patient social security number through your electronic medical record (EMR) you must work with your in-house IT security and records access contacts to ensure you can see this item.

The Social Security Number is entered without dashes and without a letter suffix.

If the patient's Social Security Number is unknown, not applicable or incomplete, enter 999999999.

Social Security Numbers can be obtained from the patient's Medicare information. The Medicare number and Social Security Number are often the same.

Medicare numbers with an "A" suffix indicate the Social Security Number is the patient's number.

Medicare numbers with a "B" or "D" suffix indicate the Social Security Number belongs to someone other than the patient (i.e., spouse) and should NOT be used.

DATE OF BIRTH   **NAACCR ITEM #240**

Identifies the date of birth of the patient. **Coding Instructions**
1. 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.
2. For *in utero* diagnosis and treatment, record the actual date of birth.
3. If only the patient age is available, calculate the year of birth from age and the year of diagnosis and
4. 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).
5. If month is unknown, the day is coded unknown. If the year cannot be determined, the day and month are both coded unknown.
6. If the date of birth cannot be determined at all, record the reason in *Date of Birth Flag* (NAACCR Item #241)

DATE OF BIRTH FLAG   **NAACCR ITEM #241**

This flag explains why there is no appropriate value in the corresponding date field, *Date of Birth.*

Coding Instructions
1. Leave this item blank if *Date of Birth* (NAACCR Item #240) has a full or partial date recorded.
2. Code 12 if the *Date of Birth* cannot be determined at all.

Code	Description
12	A proper value is applicable but not known (that is, the date of first contact is unknown).
(blank)	A valid date value is provided in item *Date of Birth* (NAACCR Item #240).

BIRTHPLACE STATE   **NAACCR ITEM #252**

Enter the two-character United States Postal Service abbreviation (Appendix B) for the state, commonwealth, U.S. possession; or Canadian province/territory in which the patient was born.

Do not use State Code XX, YY, or ZZ for Canadian-born patients or patients born in a US Territory, US Possession, or while deployed out of the United States as part of the military or other federal service.

If the patient has multiple primaries, the state of birth is the same for each tumor.

This data item in combination with BIRTHPLACE COUNTRY is a modification of the historical data item Birthplace [250].

BIRTHPLACE COUNTRY   **NAACCR ITEM #254**

Enter the three-character International Organization for Standardization (ISO) Country Code abbreviation

(Appendix B) for the country in which the patient was born.

If the patient has multiple primaries, the country of birth must be the same for each tumor.

This data item in combination with BIRTHPLACE STATE is a modification of the historical data item Birthplace [250].

Please refer to Appendix B for specific Country Codes.

Note: The Custom Codes below should be used with caution as they are non-specific and may lead to edit errors. Only use these non-specific codes when more specific information is not available but you know the continent of origin.

Custom Codes – May be for historic or future use
ZZN North America NOS
ZZC Central American NOS
ZZS South America NOS
ZZP Pacific NOS
ZZE Europe NOS
ZZF Africa NOS
ZZA Asia NOS
ZZX Non-US NOS
ZZU Unknown

Custom Codes – FOR HISTORIC USE ONLY
XNI North American Islands
XCB Other Caribbean Islands
XEN England, Channel Islands, Isle of Man
XSC Scandinavia
XGR Germanic Countries
XSL Slavic Countries
XCZ Czechoslovakia (former)
XYG Yugoslavia (former)
XUM Ukraine and Moldova
XNF North Africa
XSD Sudanese Countries
XWF West Africa
XSF South Africa
XEF East Africa
XIF African Islands
XET Ethiopia and Eritrea
XAP Arabian Peninsula
XIS Israel and Palestine
XCR Caucasian Republics of former USSR
XOR Other Asian Republics of former USSR
XSE Southeast Asia
XMS Malaysia, Singapore, Brunei
XCH China, NOS
XML Melanesian Islands
XMC Micronesian Islands
XPL Polynesian Islands

SEX   **NAACCR ITEM #220**

Enter the appropriate Sex code.

Code	Description
1	Male
2	Female
3	Other (Hermaphrodite)
4	Transsexual
9	Unknown/not stated

RACE 1, RACE 2- 5   **NAACCR ITEMS 160, 161, 162, 163, 164**

Item Name	NAACCR Item #
Race 1	160
Race 2	161
Race 3	162
Race 4	163
Race 5	164

Refer to the **Race Coding Instructions** Supplement and to Appendix D (**Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics**) for guidance.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutia, Alaskan Native or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
		31	Fiji Islanders
10	Vietnamese	32	New Guinean
11	Laotian	96	Other Asian, including Asian, NOS and Oriental, NOS
12	Hmong	97	Pacific Islander, NOS
13	Kampuchean	98	Other
14	Thai	99	Unknown
15	Asian Indian or Pakistani, NOS		
16	Asian Indian		
17	Pakistani		

SPANISH/ HISPANIC ORIGIN   **NAACCR ITEM #190**

Enter the patient's designated Spanish or Hispanic origin. This term identifies persons of Spanish/ Hispanic surname or ethnicity. (See Appendix E for a list of Spanish surnames and for instructions for using the list to determine ethnicity) Accurate determination of Hispanic ethnicity is important for purposes for calculating cancer rates for Hispanics. All records for a patient should contain the same code.

Persons of Spanish or Hispanic origin may be of any race, but these categories are generally not used for Native American, Filipinos, etc., who may have Spanish names. The use of code 9 is discouraged. If the medical record does not indicate Hispanic ethnicity and the name does not appear in Appendix E, code 0 non-Hispanic.

If a patient has a Hispanic name but there is reason to believe they are not Hispanic (e.g. the patient is Filipino, or the patient is a woman known to be non-Hispanic who has a Hispanic married name) the code in this field should be 0, Non-Spanish, Non- Hispanic.

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

MARITAL STATUS   **NAACCR ITEM #150**

Enter the patient's Marital Status at the time of diagnosis of the primary being reported. If the patient has multiple primaries, marital status may be different for each primary. If a patient is younger than 15 years of age, assume he/she is single and code 1.

Code	Description
1	Single (never married)
2	Married (including common law)
3	Separated
4	Divorced
5	Widowed
6	Unmarried or Domestic Partner (same sex or opposite sex, registered or unregistered)
9	Unknown

HEIGHT AT DIAGNOSIS   NAACCR ITEM #1300

Enter the patient's height at the time of diagnosis for all sites in inches. Historical cases may not have this information available. Different tumors for the same patient may have different values. Therefore, height at DX should be collected from source records once for each cancer. Height should be taken from the Nursing Interview Guide, Flow Chart, or Vital Stats section from the patient's hospital medical record or physician office record.

See Appendix J for converting feet to inches.

Coding Instructions

Code height as 2 digit numbers and measured in inches (note that 1 foot=12 inches).

Code "98" for 98 inches or greater.

Code "99" for unknown height.

Code "99" for historical cases.

All inches values should be rounded to the nearest whole number; values with decimal place x .5 and greater should be rounded up (e.g., 62.5 inches would be 63 inches).

The height entered should be that listed at or around the time of diagnosis. If no height was listed on the date of diagnosis, please use the height recorded on the date closest to the date of diagnosis and before treatment was started.

You can use the following on-line conversion calculator: http://manuelsweb.com/in_cm.htm
If you have trouble opening this link from this file, copy and paste the address into your browser.

WEIGHT AT DIAGNOSIS   NAACCR ITEM #1300

Enter the patient's weight at the time of diagnosis for all sites. Historical cases may not have this information available. Different tumors for the same patient may have different values. It should be collected from source records once for each cancer.

See Appendix -KJ for converting kilograms to pounds.

Coding Instructions

Code weight as 3 digit numbers and measured in pounds (note that 1 kg = 2.2 pounds).

Code "999" for unknown weight.

Code "999" for historical cases.

All pound values should be rounded to the nearest whole number; values with decimal place x.5 and greater should be rounded up (e.g., 155.5 pounds would be 156 pounds).

Patients with a weight of less than 100 pounds should be recorded with a leading 0.

TOBACCO USE   **NAACCR ITEM #1300**

Records the patient's past or current use of tobacco. Tobacco use should be recorded from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats or Nursing Assessment section, or other available source from the patient's hospital medical record or physician office record.

The collection of Tobacco Use will be divided into three types of tobacco products and when tobacco use is indicated, but type is not specified:

- **TobaccoUseCigarette** -Cigarette smoking
- **TobaccoUseOtherSmoke** - Smoking tobacco products other than cigarettes (e.g., pipes, cigars, kreteks)
- **TobaccoUseSmokeless** - Smokeless tobacco products (e.g, chewing tobacco, snuff, etc.)
- **TobaccoUseNOS** - Tobacco, NOS

Codes	Description
0	Never used
1	Current user
2	Former user, quit within one year of the date of diagnosis
3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated/no smoking specifics provided

If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than "Never used." If the medical record indicates "None," use 0 ("Never Used").

ADDR AT DX – SUPPLEMENTAL   **NAACCR ITEM #2335**

Enter the name of the place where the patient lived at the time of diagnosis, such as, a nursing home, or the name of an apartment complex.

The Supplemental address field is to be used to record the name of a place, not an address.

For example, "WEST WOOD RETIREMENT HOME" would be entered in the Supplemental Address field and it is not acceptable in the standard address fields.

This field may also be used to record if the patient is homeless, a transient patient, or a foreign resident.

ADDR at DX – NO & STREET   **NAACCR ITEM #2330**

Enter the number and street or the rural mailing address of the patient's residence at the time of diagnosis, including apartment number. Leave blanks between numbers and words. If the patient has multiple primaries, the address may be different for subsequent primaries. Do not abbreviate street names.

If the patient is a resident of the United States, the address must be a properly formed USPS street address. Following is a list of acceptable spellings:

"RR" is acceptable—no RURAL ROUTE, STAR ROUTE or RURAL DELIVERY
"HCR" is acceptable—no HC or HIGHWAY CONTRACT
"PO BOX" is acceptable—no POB or POST OFFICE BOX
"HOMELESS" is not allowed
"GENERAL DELIVERY" is acceptable

Enter "UNKNOWN" if the patient's address at diagnosis is not known.
"UNKNOWN" is acceptable—no UNK or UK. The word "UNKNOWN" must be spelled out.

For analytic cases the address at diagnosis will usually be the patient's current address.

For non-analytic cases, the address at diagnosis may not be the patient's current address. Review of the patient's medical record may reveal information regarding the patient's residence at the time of diagnosis. This information may be limited to city or state, but may include the actual street address in some instances. Any information available should be entered in the appropriate address field.

Avoid the use of post office box number and rural routes whenever possible. Do not use a temporary address. The Census Bureau definition of residence is "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."

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

Persons with No Usual Residence (transients, homeless): Use the street 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 children below college level are residents of their parents' home.

Persons in Custodial Care Facilities: The Census Bureau states "Persons under formally authorized, supervised care or custody" are residents of the facility.

Persons in the Armed Forces and on Maritime Ships: Members of the armed forces are residents of the installation area. Use the stated street address for military personnel and their family. Military personnel may use the installation street 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 detailed rules.

ADDR at DX – CITY   NAACCR ITEM #70

Enter the name of the city or town in which the patient resides at the time of diagnosis. If the patient resides in a rural area, record the name of the city used in their mailing address. If the patient has multiple primaries, the city of residence may be different for each primary. If the name of the city or town is not known at the time of diagnosis enter "UNKNOWN". Do not abbreviate.

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

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

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

Persons in Custodial Care Facilities: The Census Bureau states "Persons under formally authorized, supervised care or custody" are residents of the facility.

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

The Census Bureau has detailed residency rules for Navy personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for detailed rules.

ADDR at DX – STATE   **NAACCR ITEM #80**

USPS abbreviation for the state, territory, commonwealth, U.S. possession, or Canada Post abbreviation for the Canadian province/territory in which the patient resides at the time the reportable tumor is diagnosed.

If the patient has multiple primaries, the state of residence may be different for each tumor.

Codes (in addition to USPS abbreviations)

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

FCDS Address field requirements:

Address At Dx - State	Class of Case	Address Status	County	Zip Code
FL	00-30,34-43	Full Address Required	Valid FL	Valid FL
FL	31-33	Full Address allowed but Unknown is permitted	Valid FL,999	Valid FL,99999
Non-FL exclude XX,YY,ZZ, US Possessions and Canada	00-14,34,35,38,40,41,42	Full Known Address Required	998	State Zip
Non-FL exclude XX,YY,ZZ, US Possessions and Canada	20-33,36-37,43	Full Address allowed but Unknown is permitted	998	State Zip, 99999
XX,YY	00-99	Unknown Permitted	998	88888
ZZ	00-99	Unknown Permitted	999	99999

US Possessions and Canada	00-99	Unknown Permitted	998	99999

ADDR at DX – COUNTRY   NAACCR ITEM #102

Enter the three-character International Organization for Standardization (ISO) Country Code abbreviation (Appendix B) for the country in which the patient was living at the time of diagnosis.

If the patient has multiple primaries, the address at diagnosis may be different for each tumor/abstract.

Please refer to Appendix B for specific Country Codes.

Note: The Custom Codes below should be used with caution as they are non-specific and may lead to edit errors. Only use these non-specific codes when more specific information is not available but you know the continent of origin.

Custom Codes – May be for historic or future use ZZN North America NOS
ZZC Central American NOS
ZZS South America NOS
ZZP Pacific NOS
ZZE Europe NOS
ZZF Africa NOS
ZZA Asia NOS
ZZX Non-US NOS
ZZU Unknown

Custom Codes – FOR HISTORIC USE ONLY
XNI North American Islands
XCB Other Caribbean Islands
XEN England, Channel Islands, Isle of Man
XSC Scandinavia
XGR Germanic Countries
XSL Slavic Countries
XCZ Czechoslovakia (former)
XYG Yugoslavia (former)
XUM Ukraine and Moldova
XNF North Africa
XSD Sudanese Countries
XWF West Africa
XSF South Africa
XEF East Africa
XIF African Islands
XET Ethiopia and Eritrea
XAP Arabian Peninsula
XIS Israel and Palestine
XCR Caucasian Republics of former USSR
XOR Other Asian Republics of former USSR
XSE Southeast Asia
XMS Malaysia, Singapore, Brunei
XCH China, NOS
XML Melanesian Islands

XMC Micronesian Islands
XPL Polynesian Islands

ADDR at DX – POSTAL CODE   NAACCR ITEM #100

For Canadian residents, use 999999999. If using the FCDS IDEA Upload program only, Canadian valid Zip codes (ANANAN format) will be replaced with 999999999 at time of upload. For Single Entry users, Canadian residents must have 999999999 in the Zip code.

Current Zip (Postal) Code and postal directories are available from the National Information Data Center, PO Box 96523, Washington, DC 200900-6523 or call (301) 287-2347. Most major cities have a telephone listing, which you may call for Zip (Postal) Code information. Many mailing address look-up services are also available on the Internet, including
http://www.usps.com/ncsc/lookups/lookup_zip+4.html.

COUNTY at DX   NAACCR ITEM #90

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

FCDS only allows Florida County Codes. If any residence is out of Florida, the county code must be 998 or 999.

Codes (in addition to FIPS)

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

999   COUNTY UNKNOWN

Use code 998 for Canadian residents.

FCDS Address field requirements:

Address At Dx - State	Class of Case	Address Status	County	Zip Code
FL	00-30,34-43	Full Address Required	Valid FL	Valid FL
FL	31-33	Full Address allowed but Unknown is permitted	Valid FL,999	Valid FL,99999
Non-FL exclude XX,YY,ZZ,US Possessions and Canada	00-14,34,35,38,40,41,42	Full Known Address Required	998	State Zip
Non-FL exclude XX,YY,ZZ,US Possessions and Canada	20-33,36-37,43	Full Address allowed but Unknown is permitted	998	State Zip, 99999

XX,YY	00-99	Unknown Permitted	998	88888
ZZ	00-99	Unknown Permitted	999	99999
Canada and US Possessions	00-99	Unknown Permitted	998	99999

ADDR CURRENT – NO & STREET   NAACCR ITEM #2350

Enter the address number & street of the patient's current and usual residence. Leave a blank between numbers and words.

The Census Bureau definition of residence is "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."

Do not abbreviate street names.

If the patient has multiple primaries, the address may be different for subsequent primaries.
Avoid the use of post office box numbers and rural routes whenever possible. Do not use a temporary address.

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

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

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

Persons in Custodial Care Facilities: The Census Bureau states "Persons under formally authorized, supervised care or custody" are residents of the facility.

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

The Census Bureau has detailed residency rules for Navy personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for detailed rules.

ADDR CURRENT – CITY   NAACCR ITEM #1810

Enter the name of the city or town of the patient's current and usual residence. If the patient resides in a rural area, record the name of the city used in their mailing address.

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

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

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

Persons in Custodial Care Facilities: The Census Bureau states "Persons under formally authorized, supervised care or custody" are residents of the facility.

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

The Census Bureau has detailed residency rules for Navy personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for detailed rules.

ADDR CURRENT – STATE   **NAACCR ITEM #1820**

USPS abbreviation for the state, territory, commonwealth, U.S. possession, or Canada Post abbreviation for the Canadian province/territory of the patient's current usual residence. If the patient has multiple tumors, the
current state of residence should be the same for all tumors.

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

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

FCDS Address field requirements:

Address Current - State	Class of Case	Address Status	County	Zip Code
FL	00-99	Full Known Address Required	Valid FL	Valid FL
Non-FL exclude XX,YY,ZZ, US Possessions and Canada	00-99	Full Known Address Required	998	State Zip
XX,YY	00-99	Unknown Permitted	998	88888
ZZ (NOT ALLOWED)				
US Possessions and Canada	00-99	Unknown Permitted	998	99999

ADDR CURRENT – COUNTRY   **NAACCR ITEM #1832**

Enter the three-character International Organization for Standardization (ISO) Country Code abbreviation (Appendix B) for the country in which the patient was living at the time of last known contact.

If the patient has multiple primaries, the current address at diagnosis is the same for each tumor/abstract.

Please refer to Appendix B for specific Country Codes.

Note: The Custom Codes below should be used with caution as they are non-specific and may lead to edit errors. Only use these non-specific codes when more specific information is not available but you know the continent of origin.

Custom Codes – May be for historic or future use
ZZN North America NOS
ZZC Central American NOS
ZZS South America NOS
ZZP Pacific NOS
ZZE Europe NOS
ZZF Africa NOS
ZZA Asia NOS
ZZX Non-US NOS
ZZU Unknown

Custom Codes – FOR HISTORIC USE ONLY
XNI North American Islands
XCB Other Caribbean Islands
XEN England, Channel Islands, Isle of Man
XSC Scandinavia
XGR Germanic Countries
XSL Slavic Countries
XCZ Czechoslovakia (former)
XYG Yugoslavia (former)
XUM Ukraine and Moldova
XNF North Africa
XSD Sudanese Countries
XWF West Africa
XSF South Africa
XEF East Africa
XIF African Islands
XET Ethiopia and Eritrea
XAP Arabian Peninsula
XIS Israel and Palestine
XCR Caucasian Republics of former USSR
XOR Other Asian Republics of former USSR
XSE Southeast Asia
XMS Malaysia, Singapore, Brunei
XCH China, NOS
XML Melanesian Islands
XMC Micronesian Islands
XPL Polynesian Islands

ADDR CURRENT – POSTAL CODE   **NAACCR ITEM #1830**

For United States residents, enter either the 5-digit or the extended 9-digit Zip code. When the 9-digit extended Zip code is not available, enter the 5-digit Zip code followed by zeros.

For residents of countries other than the United States, U.S. possessions or territories, or Canada enter

888888888.

For Canadian residents, enter 999999999. If using the FCDS IDEA Upload program only, Canadian valid Zip codes (ANANAN format) will be replaced with 999999999 at time of upload. For Single Entry users, Canadian residents must have 999999999 in the Zip code.

Current Zip (Postal) Code and postal directories are available from the National Information Data Center, PO Box 96523, Washington, DC 200900-6523 or call (301) 287-2347. Most major cities have a telephone listing, which you may call for Zip (Postal) Code information. Many mailing address look-up services are also available on the Internet, including http://www.usps.com/ncsc/lookups/lookup_zip+4.html.

COUNTY – CURRENT   NAACCR ITEM #1840

Code for county of patient's current residence. For U.S. residents, standard codes are those of the FIPS publication – *Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas.* Florida FIPS County Codes can be found in Appendix B.

FCDS only allows Florida FIPS County Codes. If any residence is out of Florida, the county code must be 998 or 999.

Codes (in addition to FIPS)

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

999   COUNTY UNKNOWN

Use code 998 for Canadian residents.

FCDS Address field requirements:

Address Current - State	Class of Case	Address Status	County	Zip Code
FL	00-99	Full Known Address Required	Valid FL	Valid FL
Non-FL exclude XX,YY,ZZ, US Possessions and Canada	00-99	Full Known Address Required	998	State Zip
XX,YY	00-99	Unknown Permitted	998	88888
ZZ (NOT ALLOWED)				
Canada and US Possessions	00-99	Unknown Permitted	998	99999

TELEPHONE CURRENT   NAACCR ITEM #2360

Enter the current telephone number with area code for the patient. Do not enter dashes or spaces.

0000000000   Patient does not have a telephone
9999999999   Telephone number unavailable or unknown

PRIMARY PAYER at DX   NAACCR ITEM #630

Enter the Primary Payer code that corresponds to the patient's primary method of payment or medical insurance coverage at the time of initial diagnosis and/or treatment. If more than one payer or insurance carrier is listed on the patient's admission page record the first.

Code	Label	Description
01	Not Insured	Patient has no insurance and is declared a charity write-off
02	Not Insured, self-pay	Patient has no insurance and is declared responsible for charges.
10	Insurance, NOS	Type of insurance unknown or other than the type listed in codes **20, 21, 31, 35, 60-68.**
20	Private Insurance: Managed care, HMO, PPO	Patient has insurance with a managed care provider health maintenance organization [HMO] preferred provider organization [PPO]
21	Private Insurance: Fee-for-Service	An insurance plan that does not have negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.
31	Medicaid	State government-administered insurance for persons who are uninsured below the poverty level, or covered under entitlement programs. Medicaid other than described in code 35.
35	Medicaid administered through a Managed Care plan	State government-administered insurance through a managed care plan. State government insurance that is administered through a commercial managed care plan such as an HMO or PPO for persons who are uninsured, below the poverty level, or covered under entitlement programs
60	Medicare/Medicare, NOS	Federal government funded insurance for persons who are 62 years of age or older, or are chronically disabled (social security insurance eligible). Not described in codes 61, 62, or 63.
61	Medicare with supplement, NOS	Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare. State government administered Medicaid insurance with Federal Medicare supplement.
62	Medicare administered through a Managed Care plan	Patient is enrolled in Medicare through a Managed Care plan (e.g. HMO or PPO). The Managed Care plan pays for all incurred costs. Federal government insurance for persons who are retired or disabled.
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare. Medicare with supplement. Patient has Medicare and another insurance to pay costs not covered by Medicare
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with State Medicaid administered supplement. Patient has Medicare and another insurance to pay costs not covered by Medicare
65	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a

Code	Label	Description
		military treatment facility to military personnel, retirees, and their dependents. Formally CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).
66	Military	Military personnel or their dependents who are treated in a military facility
67	Veterans Affairs	Veterans who are treated in Veterans Affairs facilities
68	Indian/Public Health Service	Patient who receives care at an Indian Health Service facility, a Public Health Service facility or at another facility, and the medical costs are reimbursed by the Indian Health Service or the Public Health Service.
99	Insurance status unknown	It is unknown from the patient's medical record whether or not the patient is insured.

PHYSICIAN – MANAGING   NAACCR ITEM #2460

Enter the appropriate identifying code for the managing or attending physician who has responsibility for the patient at the reporting facility. Generally, each facility assigns their own coding scheme to physicians on staff. If the physician is no longer on staff, enter the FCDS facility number or enter the physician's last name. Use leading zeros when necessary to right justify.

NPI – MANAGING PHYSICIAN   NAACCR ITEM #2465

Identifies the physician who is responsible for the overall management of the patient during diagnosis And/or treatment of this cancer. You may search for NPI standard provider ID numbers at
https://nppes.cms.hhs.gov/nppes/npiregistrysearch.do?subaction=reset&searchtype=ind

Coding Instructions
• Record the 10-digit NPI for the physician responsible for managing the patient's care.
• Check with the billing or health information departments to determine the physician's NPI or search at https://nppes.cms.hhs.gov/NPPES/NPIRegistrySearch.do?subAction=reset&searchType=ind.
• NPI should be recorded as available.
• NPI may be left blank.

Blanks are allowed in this field when data are not available. FCDS encourages all registries and vendors to attempt to identify, capture and code all data items, including the "as available" and the 5 "NPI-Physician" data items. However, FCDS recognizes these items may not be available or may not be applicable to all cases.

Code	Definition
(fill Spaces)	10-digit NPI number for the managing physician.
(leave blank)	NPI for the managing physician is unknown or not available.

NPI – FOLLOWING PHYSICIAN   NAACCR ITEM #2475

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

Coding Instructions
• Record the 10-digit NPI for the physician currently responsible for the patient's medical care.
• Check with the billing or health information departments to determine the physician's NPI or search
  at https://nppes.cms.hhs.gov/NPPES/NPIRegistrySearch.do?subAction=reset&searchType=ind.
• NPI should be recorded as available.
• NPI may be left blank.

Blanks are allowed in this field when data are not available. FCDS encourages all registries and vendors
to attempt to identify, capture and code all data items, including the "as available" and the 5 "NPI-
Physician" data items. However, FCDS recognizes these items may not be available or may not be
applicable to all cases.

Code	Definition
(fill Spaces)	10-digit NPI number for the following physician.
(leave blank)	NPI for the following physician is unknown or not available.

NPI – PRIMARY SURGEON   NAACCR ITEM #2485

Identifies the physician who performed the most definitive surgical procedure.

Coding Instructions
• Record the 10-digit NPI for the physician who performed the most definitive surgical procedure.
• Check with the billing or health information departments to determine the physician's NPI or
search at https://nppes.cms.hhs.gov/NPPES/NPIRegistrySearch.do?subAction=reset&searchType=ind.
• NPI should be recorded as available for all cases diagnosed January 1, 2008, and later.
• NPI may be left blank.

Blanks are allowed in this field when data are not available. FCDS encourages all registries and vendors
to attempt to identify, capture and code all data items, including the "as available" and the 5 "NPI-
Physician" data items. However, FCDS recognizes these items may not be available or may not be
applicable to all cases.

Code	Definition
(fill Spaces)	10-digit NPI number for the primary surgeon.
(leave blank)	The patient did not have surgery. NPI for the primary surgeon is unknown or not available. The physician who performed the surgical procedure was not a surgeon (for example, general practitioner).

NPI – PHYSICIAN #3 – (RADIATION ONCOLOGIST)   NAACCR ITEM #2495
Records the NPI for a physician involved in the care of the patient. It is recommended that this item
identify the physician who performed the most definitive radiation therapy.

Coding Instructions
• Record the 10-digit NPI for the physician.
• Check with the billing or health information departments to determine the physician's NPI or search
  at https://nppes.cms.hhs.gov/NPPES/NPIRegistrySearch.do?subAction=reset&searchType=ind.
• NPI should be recorded as available.

• NPI may be left blank.

Blanks are allowed in this field when data are not available. FCDS encourages all registries and vendors to attempt to identify, capture and code all data items, including the "as available" and the 5 "NPI-Physician" data items. However, FCDS recognizes these items may not be available or may not be applicable to all cases.

Code	Definition
(fill Spaces)	10-digit NPI number for the primary radiation oncologist.
(leave blank)	NPI for the primary radiation oncologist is unknown or not available.

NPI – PHYSICIAN #4 (MEDICAL ONCOLOGIST)   NAACCR ITEM #2505

Records the NPI for a physician involved in the care of the patient. It is recommended that this data item identify the physician who gives the most definitive systemic therapy.

Coding Instructions
• Record the 10-digit NPI for the physician.
• Check with the billing or health information departments to determine the physician's NPI or search
   at https://nppes.cms.hhs.gov/NPPES/NPIRegistrySearch.do?subAction=reset&searchType=ind.
• NPI should be recorded as available.
• NPI may be left blank.

Blanks are allowed in this field when data are not available. FCDS encourages all registries and vendors to attempt to identify, capture and code all data items, including the "as available" and the 5 "NPI-Physician" data items. However, FCDS recognizes these items may not be available or may not be applicable to all cases.

Code	Definition
(fill Spaces)	10-digit NPI number for the primary medical oncologist.
(leave blank)	NPI for the primary medical oncologist is unknown or not available.

TEXT – USUAL OCCUPATION   NAACCR ITEM #310

Enter sufficient text to document the patient's usual occupation, also known as the type of job or kind of work performed during most of the patient's working life before diagnosis of cancer. Occupation is the type of job the patient was engaged in for the longest time prior to a cancer diagnosis. It is not necessarily the highest paid job nor is it the job considered the most prestigious, but the one that accounted for the greatest number of working years. Example: Registered nurse

"Retired" is not an occupation. Do not enter "retired" when the only information available is that the patient is retired. When all the information available is "retired" enter "unknown" in this field.

Do enter "Unknown" when no information is available.

If the patient has never worked, record "never worked" as the Usual Occupation.

If the patient was a housewife/househusband and also worked outside the home during 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 of the home for most of his/her adult life, record "housewife" or househusband."

The reference guide, "A Cancer Registrar's Guide to Collecting Industry and Occupation", DHHS (NIOSH) Publication No. 2011-173, is available free of charge in PDF format from CDC and NIOSH at http://www.cdc.gov/niosh/docs/2011-173/pdfs/2011-173.pdf and includes Tips on capturing these data.

TEXT – USUAL INDUSTRY   NAACCR ITEM #320

Industry is the type of business or industry where the patient worked in his or her usual occupation. Example: Healthcare. Industry is a broader term than occupation. It encompasses the environment in which the occupation took place. Enter sufficient text to document the patient's usual occupation.

Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry, that performs more than one of these components. If the face sheet identifies the employer, and the chart does not specify the industry, enter the name of the employer instead of the industry.

The reference guide, "A Cancer Registrar's Guide to Collecting Industry and Occupation", DHHS (NIOSH) Publication No. 2011-173, is available free of charge in PDF format from CDC and NIOSH at http://www.cdc.gov/niosh/docs/2011-173/pdfs/2011-173.pdf and includes Tips on capturing these data.

TUMOR INFORMATION

The Tumor Information section includes the set of data items used to describe the cancer or tumor being reported. It includes when and where the cancer was first diagnosed, the anatomic location and type of cancer, staging   and other descriptive information used to characterize the cancer at the time of diagnosis.

Data Items Included in This Chapter

NAACCR Item Number	Item Name
390	Date of Diagnosis
391	Date of Diagnosis Flag
2690	Text – Place of Diagnosis
610	Class of Case
490	Diagnostic Confirmation
400	Primary Site
410	Laterality
522	Histologic Type ICD-O-3
523	Behavior ICD-O-3
440	Grade/Differentiation/Immunophenotype
1182	Lymph-Vascular Invasion
2580	Text- Primary Site Title
2590	Text- Histology Title

DATE OF INITIAL DIAGNOSIS   **NAACCR ITEM #390**

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

An error is issued of the Date of First Contact precedes the Date of Diagnosis by more than thirty days.

Coding Instructions

1. Use the first date of diagnosis whether clinically or histologically established.

2. When diagnostic imaging or other test confirms a diagnosis (including when the diagnosis uses one of the "Ambiguous Terms" defined in Section I), the date of diagnosis is the date of the first diagnosis, whether on imaging, confirmatory test, or biopsy/resection.

3. If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis.

4. Refer to the list of "Ambiguous Terms" in Section I for language that represents a diagnosis of cancer. This list should be used for both clinical and pathological first confirmation of cancer.

5. The date of death is the date of diagnosis for a *Class of Case* (NAACCR Item #610) 38 (diagnosed at autopsy). However, if the patient is suspected of having cancer prior to death and autopsy and the autopsy simply confirms the presence of malignancy, the date of the first diagnosis should be used and the patient would not have been diagnosed at autopsy, but rather by whatever other means the criteria for cancer might have been met prior to death.

6. For patients diagnosed prior to the date of first contact with the reporting facility, record the date of diagnosis as given in the medical record. This can usually be found in the patient history or a consultation report. If a date is not recorded:

    a. and if the patient was seen at the reporting facility within one month of the diagnosis then the date of first contact may be used as the date of diagnosis.

    b. and if the date of the first cancer-directed therapy or treatment is known then the date of the first cancer-directed therapy or treatment may be used as the date of diagnosis.

7. In the absence of a definitive diagnosis date for patient diagnosed at the reporting facility:

    a. the date of first contact may be entered as the date of diagnosis, or

    b. the date of first cancer-directed therapy may be recorded as the date of diagnosis.

8. When a diagnosis of cancer is made during the patient's long-term stay for another condition, adjust the date of first contact as outlined under Date of First Contact.

9. If the only information is "Spring of," "Middle of the year," "Fall," approximate these as April, July, and October, respectively. For "Winter of," it is important to determine whether the beginning of the year or the end of the year is meant before approximating the month.

10. If the only information is "recently," the date of diagnosis should be estimated as one month prior to month and year of admission. You may estimate the day as the 15th of the month.

11. If the only information is "several months ago," the date of diagnosis should be estimated as three months prior to the month and year of admission. You may estimate the day as the 15th of the month.

12. If the year of diagnosis cannot be identified, it must be approximated. In that instance, the month and day are unknown.

13. Use the actual date of diagnosis for an in utero diagnosis (For cases diagnosed before January 1, 2009, assign the date of birth).

DATE OF DIAGNOSIS FLAG   NAACCR ITEM# 391

This flag explains why there is no appropriate value in the corresponding date field, Date of Diagnosis [390].

Code	Description
12	A proper value is applicable but not known (that is, the date of diagnosis is unknown).
(blank)	A valid date value is provided in item Date of Diagnosis (NAACCR Item #390) or the date was not expected to have been transmitted

TEXT – PLACE OF DIAGNOSIS   NAACCR ITEM #2690

Enter text information about the facility, city, state, or county where the diagnosis was made, even if at your facility. If the patient was diagnosed in a physician's office, please enter the physician's name and any other identifying information.

Text is needed to justify the codes selected for the related data item(s) and to allow for the recording of information that is not coded at all. Text is also used for quality control and for special studies.

Text information should be retrieved from the medical record and should not be generated electronically from coded values.

CLASS OF CASE   NAACCR ITEM #610

The Class of Case reflects the facility's role in managing the cancer, whether the cancer is required to be reported by CoC, and whether the case was diagnosed after the program's Reference Date.
Enter the appropriate Class of Case. Use the code from the accompanying table which best describes the level of involvement by the reporting facility with the initial diagnosis and treatment of the reported cancer.

- Code 00 applies only when it is known the patient went elsewhere for treatment. If it is not known that the patient actually went somewhere else, code *Class of Case* 10.

- A staff physician (codes 10-12, 41) is a physician who is employed by the reporting facility, under contract with it, or a physician who has routine practice privileges there. Treatment provided in a staff physician's office is provided "elsewhere". That is because care given in a physician's office is not within the hospital's realm of responsibility.

- If the hospital has purchased a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved are staff physicians or not, as with any other physician.

- "In-transit" care is care given to a patient who is temporarily away from the patient's usual practitioner for continuity of care. If these cases are abstracted, they are *Class of Case* 31. If a patient begins first course radiation or chemotherapy elsewhere and continues at the reporting facility, and the care is not in-transit, then the case is analytic (*Class of Case* 21).

Analytic Classes of Case	
Initial diagnosis at reporting facility	
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10	Initial diagnosis at the reporting facility or in a staff physician's office AND part or all of first course Treatment or a decision not to treat was at the reporting facility, NOS.
	If it is **not known** that the patient actually **went somewhere else,** code *Class of Case* 10
11	Initial diagnosis in staff physician's office AND part of first course treatment was done at the reporting facility
12	Initial diagnosis in staff physician's office AND all first course treatment or a decision not to treat was done at the reporting facility
13	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.

Analytic Classes of Case	
Initial diagnosis at reporting facility	
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility
Initial diagnosis elsewhere	
20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility
Non-Analytic Classes of Case	
Patient appears in person at reporting facility	
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only) NOTE: The 2010 FORDS Manual changed the definition Class of Case = 30 the CoC added a new component to what previously had been "consult only." The addition is for cases where the facility is part of the "staging workup after initial diagnosis elsewhere." These cases are "analytic" to FCDS and in Florida a "consult only" case only refers to a case where the facility provides a second opinion without additional testing.
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (**active disease**)

33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (**disease not active**)
34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility
35	Case diagnosed before program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility
36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37	Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death
Patient does not appear in person at reporting facility	
40	Diagnosis AND all first course treatment given at the same staff physician's office
41	Diagnosis and all first course treatment given in two or more different staff physician offices
Non-Analytic Classes of Case	
Patient appears in person at reporting facility	
42	Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43	Pathology or other lab specimens only
49	Death certificate only
99	Non-analytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).

DIAGNOSTIC CONFIRMATION   NAACCR ITEM #490

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

Coding Instructions for Solid Tumors (all tumors *except* ICD-O-3 Histology Codes M9590-9992)
1. The codes are in **priority order**; code 1 has the highest priority. Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods. This data item must be changed to the lower (higher priority) code if a more definitive method confirms the diagnosis *at any time during* the course of the disease.

2. Code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy or D&C or from aspiration of biopsy of bone marrow specimens. Code 1 is the preferred coding for Fine Needle Aspiration (FNA).

3. Code 2 when the microscopic diagnosis is based on cytologic examination of *cells* such as sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.

4. Code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer.

5. Code 6 when the diagnosis is based only on the surgeon's operative report from a surgical exploration or endoscopy or from gross autopsy findings in the absence of tissue or cytological findings.

Codes Solid Tumors (all tumors *except* ICD-O-3 Histology Codes M9590-9992)

Code	Description	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. Examples include alpha-fetoprotein for liver cancer and abnormal electrophoretic spike for multiple myeloma. Elevated PSA is not diagnostic of cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only, other than 5, 6 or 7	The malignancy was reported by the physician in the medical record.
9	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 nonanalytic).

Coding Instructions for <u>Hematopoietic or Lymphoid Neoplasms</u> (ICD-O-3 Histology Codes M9590-9992)
1. 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.

2. Code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, or autopsy or bone marrow specimens from aspiration or biopsy.

3. For leukemia only, code 1 when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear. Do not use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow, or blood.

4. Code 2 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.

5. Code 3 when there is a histology positive for cancer AND positive immunophenotyping and/or positive genetic testing results. Do not use code 3 for neoplasms diagnosed prior to January 1, 2010.

6. Code 5 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.

7. Code 6 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.

8. Code 8 when the case was diagnosed by any clinical method that cannot be coded as 6 or 7.

9. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion 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.

Codes Hematopoietic or Lymphoid Neoplasms (ICD-O-3 Histology Codes M9590-9992)

Code	Description	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
3	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 to refine or confirm a specific diagnosis. For example, bone marrow examination is positive for acute myeloid leukemia. (9861/3) Genetic testing shows AML with inv(16)(p13.1q22) (9871/3).
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer.

Code	Description	Definition
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only, other than 5, 6 or 7	The malignancy was reported by the physician in the medical record.
9	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 nonanalytic).

PRIMARY SITE   **NAACCR ITEM#400**

Enter the topography code for the site of origin of the primary tumor from the *International Classification of Diseases for Oncology* (ICD-O-3). The terms primary site, site and topography are used synonymously.

Coding Instructions
1. Record the ICD-O-3 topography code for the site of origin.

2. Consult the physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.

3. Topography codes are indicated by a "C" preceding the three-digit code number. Do not record the decimal point.

4. Follow the Coding Instructions in ICD-O-3 and in the current *SEER Multiple Primary and Histology Coding Rules* to assign site for solid tumors.

5. 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 (M-9590-9992) and to determine whether multiple conditions represent one or more tumors to be abstracted for cases diagnosed on or after January 1, 2010.

6. Use subcategory 8 for single tumors that overlap the boundaries of two or more sub-sites and the point of origin is not known.

7. Use subcategory 9 for multiple tumors that originate in different subsites of one organ.

Specific Tissues with Ill-Defined Sites
1. Avoid use of C76._ codes. If any of the following histologies appears only with an ill-defined site description (e.g., "abdominal" or "arm"), code it to the tissue in which such tumors arise rather than the ill-defined region (C76._) of the body, which contains multiple tissues.)

2. Use the alphabetic index in ICD-O-3 to assign the most specific site if only a general location is specified in the record.

3. Head and Neck cancers can be challenging when it comes to identifying the primary site. The surgeon, pathologist, radiologist or clinician may generalize the topography to "head and neck" without stating an actual anatomic site for the primary tumor. And, it is not uncommon for the patient to present with positive cervical nodes (neck nodes) without evidence of a primary tumor.

The SEER Multiple Primary and Histology Coding Rules instruct abstractors to use ICD-O-3 topography codes C02.8, C08.8 or C14.8 when the primary site is stated to be "head and neck" but no primary tumor is identified or when the term "head and neck" is used to describe primary. These neoplasms are treated as head and neck primary cancers, not unknown primary cancers.

When the point of origin **cannot be determined**, use a topography code for overlapping sites:
- C02.8 Overlapping lesion of tongue
- C08.8 Overlapping lesion of major salivary glands
- C14.8 Overlapping lesion of lip, oral cavity, and pharynx.

4. Use the table below to assign primary site when the only information available is the histologic type of tumor and the patient has metastatic disease without an identifiable primary site. The primary site is presumed to be the NOS or "not otherwise specified" primary site code when the histology is known but for which no primary can be found. Do not code these cases to C80.9.

Histologic Type Codes	Histologic Types	Preferred Site Codes for Ill-Defined Primary Sites
8720-8790	Melanoma	C44._, Skin
8800-8811, 8813-8830, 8840-8921, 9040-9044	Sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	C49._, Connective, Subcutaneous and Other Soft Tissues
8990-8991	Mesenchymoma	C49._, Connective Subcutaneous and Other Soft Tissues
8940-8941	Mixed tumor, salivary gland type	C07._, for Parotid Gland; C08._, for Other and Unspecified Major Salivary glands
9120-9170	Blood vessels tumors, Lymphatic vessel tumors	C49._, Connective Subcutaneous and other Soft tissues
9240-9252	Mesenchymal chondrosarcoma and giant cell tumors	C40._, C41._ for bone and cartilage C49._, Connective, Subcutaneous, and Other Soft tissues
9580-9582	Granular cell tumor and alveolar soft part sarcoma	C49._, Connective, Subcutaneous and Other Soft Tissues

IMPOSSIBLE PRIMARY SITE/HISTOLOGY COMBINATIONS

Combinations of some primary sites and histologies are designated as impossible because the combination is biologically impossible, i.e., the particular form of cancer does not arise in the specified site.

It will often be useful to check medical references or to discuss specific problem cases with the registry's medical advisors. The suggestions below are a starting point for analyzing an impossible site/morphology combination, but are not a substitute for a medical decision. Reference to the original medical record will be required.

1. Retroperitoneum/Peritoneum and Melanomas: If melanoma is identifies in peritoneal or retroperitoneal tissue, it is almost certainly metastatic to that site. Try to identify the primary site of the melanoma. If no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

2. Nasal Cavity/Middle Ear/Accessory Sinuses and Osteosarcomas: Osteosarcomas arise in bone, and the specified site code in ICD-O-3 is C40._ or C41._. Osteosarcomas arising in the areas of the nose, middle ear, and sinuses should be assumed to have arisen in the bone of the skull and their primary site coded C41.0.

3. Pleura/Mediastinum and Carcinomas or Melanomas: If a carcinoma or melanoma is identified in the pleura or mediastinum, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma or melanoma. For a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

4. Peripheral Nerves/Connective Tissue and Carcinomas or Melanomas: If a carcinoma or melanoma is identified in peripheral nerves or connective tissue, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma or melanoma. For a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

5. Meninges/Brain/Other CNS and Carcinomas: If a carcinoma is identified in the brain, meninges, or other central nervous system, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma. Check that the tumor is indeed a carcinoma and not "Cancer" or "Malignancy" which would be coded 8000/3. If it is a carcinoma and no primary can be determined, code "Unknown primary site", C80.9.

6. Bone and Carcinomas or Melanomas: If a carcinoma or melanoma is defined in the pleura or mediastinum, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma or melanoma. For a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

7. Ill-defined Sites and Various Histologies: Some histologic types are by convention more appropriately coded to a code representing the tissue in which such tumors arise rather than the ill-defined region of the body, which contains multiple tissues. The table below shows for the histologic types addressed in this edit which site should be used instead of an ill-defined site in the range C76.0-C76.8.
(See 2007 Multiple Primary and Histology Coding Rules)

IMPOSSIBLE PRIMARY SITE/HISTOLOGY COMBINATIONS

SITE	HISTOLOGY
C480-C488 Retroperitoneum and peritoneum	8720-8790 Melanomas
C300 Nasal Cavity C301 Middle ear C310-C319 Accessory sinuses	9250-9342 Osteosarcoma (Giant cell Ewing's odontogenic)
C381-C388 Pleura and mediastinum	8010-8245 8247-8671 8940-8941 8720-8790 Melanomas
C470-C479 Peripheral nerves C490-C499 Connective tissue	8010-8671 Carcinomas 8940-8941 8720-8790 Melanomas
C700-C709 Meninges C710-C719 Brain C720-C729 Other central nervous system	8010-8671 Carcinomas 8940-8941
C400-C419 Bone	8010-8060 Carcinoma (except squamous cell) 8075-8671 8940-8941 8720-8790 Melanomas
C760-C768 Ill-defined Sites	8720-8790 Melanoma 8800-8811 Sarcoma except myeloid sarcoma 8813-8830 Fibromatous neoplasms 8840-8921 Fibrosarcoma 9040-9044 Dermatofibrosarcoma 8990-8991 mesenchymoma 8940-8941 Mixed tumor, salivary gland type 9120-9170 Blood vessel tumor lymphatic vessel tumor 9240-9252 Mesenchymal chondrosarcoma, and giant cell tumors 9540-9560 Nerve Sheath tumor 9580-9582 Granular cell tumor and alveolar soft part sarcoma

LATERALITY   **NAACCR ITEM #410**

Laterality 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.   It 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. "Midline" in this context refers to the point where the "right" and "left" sides of paired organs come into direct contact and a tumor forms at that point. Most paired sites cannot develop midline tumors. For example, skin of the trunk can have a midline tumor, but the breasts cannot.

Coding Instructions

1. Code laterality for all paired sites. (See Section One for additional information.)

2. For the sites C300, C340, C413, C414, the laterality can be coded 04, or 9.

3. Do not code metastatic sites as bilateral involvement.

4. Where the right and left sides of paired sites (for C441-C443, C445-C447, C700, C710-C714, and

C722-C725 ONLY) are contiguous (come into contact) and the lesion is at the point of contact of the right and left sides, use code 5, midline. Most paired sites cannot develop midline tumors. For example, skin of the trunk can have a midline tumor, but the breasts can not

5. Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites 0.

Code	Description
0	Organ is not a paired site.
1	Origin of primary is right.
2	Origin of primary is left.
3	Only one side involved, right or left origin unspecified. For in situ cases, if laterality unknown use '3'
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastoma, bilateral Wilms tumor. A bilateral laterality (4) should be assigned when there are multiple nodules in both lungs
5	Paired site: midline tumor ONLY for C441-C443, C445-C447, C700, C710-C714, and C722-C725
9	Paired site, but no information concerning laterality.

PRIMARY SITES REQUIRING LATERALITY

ICD-O-3	SITES
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1 – C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bones of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum)
C41.4	Pelvic bones ("excluding" not in the sacrum, coccyx and symphysis pubis)
C44.1	Skin of eyelid
C44.2	Skin of external ear

ICD-O-3	SITES
C44.3	Skin of other and unspecified parts of face (midline code "9")
C44.5	Skin or trunk (midline code "9")
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and automatic nervous system of upper limb shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous and other soft tissues of lower limb and hip
C50.0 – C 50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0 – C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0 – C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges, NOS (excluding diagnoses prior to 2004)
C71.0	Cerebrum (excluding diagnoses prior to 2004)
C71.1	Frontal lobe (excluding diagnoses prior to 2004)
C71.2	Temporal lobe (excluding diagnoses prior to 2004)
C71.3	Parietal lobe (excluding diagnoses prior to 2004)
C71.4	Occipital lobe (excluding diagnoses prior to 2004)
C72.2	Olfactory nerve (excluding diagnoses prior to 2004)
C72.3	Optic nerve (excluding diagnoses prior to 2004)
C72.4	Acoustic nerve (excluding diagnoses prior to 2004)
C72.5	Cranial nerve, NOS (excluding diagnoses prior to 2004)
C74.0 – C74.9	Adrenal gland
C75.4	Carotid body

HISTOLOGIC TYPE ICD-O-3   NAACCR ITEM #522

Histologic Type identifies the microscopic anatomy of cells, is a basis for staging and the determination of treatment options, and affects the prognosis and course of the disease. Enter the histology code associated with tie histologic type from the *International Classification of Diseases for Oncology* or *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual.*

The standard references for histology coding is the *Multiple Primary and Histology Coding Rules,* the *current Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual,* the Hematopoietic Database, and the *International Classification of Diseases for Oncology,* Third Edition (ICD-O-3). DO NOT USE ICD-O-3 to code any histology 9590 or greater (refer to the Hematopoietic Database).

BEHAVIOR ICD-O-3   **NAACCR ITEM #523**

Enter the behavior that best describes the tumor. The fifth digit of the morphology code listed in the *International Classification of Diseases for Oncology,* 2000, Third Edition (ICD-O-3), pages 27-28, 66 which appears after the slash (/) is the behavior code. If the only specimen was from a metastatic site, code the histologic type of the metastatic site and code **3** for the Behavior code.

Use behavior code 3 if any invasion is present, no matter how limited.
• Code 3 if any *malignant* invasion is present, no matter how limited.
• Code 3 if any *malignant* metastasis to nodes or tissue beyond the primary is present.
• If the specimen is from a metastatic site, code the histology of the metastatic site and code 3 for behavior.

Code	Label	Description
0	Benign	Benign (Reportable for intracranial and CNS sites only)
1	Borderline	Uncertain whether benign or malignant Borderline malignancy Low malignant potential Uncertain malignant potential (Reportable for intracranial and CNS sites only)
2	Insitu and/or carcinoma insitu	Carcinoma in situ; Intraepithelial; Noninfiltrating; Noninvasive

Code	Label	Description
2	Synonymous with Insitu adopted from the SEER Program Coding and Staging Manual 2011, Page 72	AIN III (C211) Behavior code '2' Bowen disease (not reportable for C440-C449) Clark level I for melanoma (limited to epithelium) 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, noninfiltrating (C50_) Noninfiltrating Noninvasive No stromal invasion/involvement Papillary, noninfiltrating or intraductal Precancerous melanosis (C44_) Queyrat erythroplasia (C60_) Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria) VAIN III (C529) VIN III (C51_)
3	Invasive	Malignant, primary site (invasive) or Microinvasive

For example Intraductal carcinoma (8500/2) with focal areas of invasion code behavior of 3.

Note: The ICD-O-3 behavior code for juvenile astrocytoma (9421/1) is coded as 3 by agreement of North American registry standard-setters. Refer to "Case Eligibility" in Section One for information.

GRADE   NAACCR ITEM #440

New Grade Coding Instructions were published for cases diagnosed 1/1/2014 and forward. Below are excerpts from the Consensus Technical Working Group "Instructions for Coding Grade 2014+." The complete set of instructions is included in Appendix N of this manual.

Coding Grade/Cell Indicator for Hematopoietic and Lymphoid Neoplasms

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

Grade codes for hematopoietic and lymphoid neoplasms

1. Determine the histology based on the current Hematopoietic and Lymphoid Neoplasm Manual [http://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules/].

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

Terminology	Grade Code
T-cell; T-precursor	5
B-Cell; Pre-B; B-precursor	6
Null cell; Non T-non B	7
NK cell (natural killer cell)	8

Coding Grade/Differentiation for Solid Tumors

Grade, Differentiation (Codes 1, 2, 3, 4, 9) - Pathologic examination determines the grade, or degree of differentiation, of the tumor. For these cancers, the grade is a measurement of how closely the tumor cells resemble the parent tissue (organ of origin). Well-differentiated tumor cells closely resemble the tissue from the organ of origin. Poorly differentiated and undifferentiated tumor cells are disorganized and abnormal looking; they bear little (poorly differentiated) or no (undifferentiated) resemblance to the tissue from the organ of origin. These similarities/differences may be based on pattern (architecture), cytology, nuclear (or nuclear) features, or a combination of these elements, depending upon the grading system that is used. Some grading systems use only pattern, for example Gleason grading in prostate. Others use only a nuclear grade (usually size, amount of chromatin, degree of irregularity, and mitotic activity). Fuhrman's grade for kidney is based only on nuclear features. Most systems use a combination of pattern and cytologic and nuclear features; for example Nottingham's for breast combines numbers for pattern, nuclear size and shape, and mitotic activity. The information from this data item is useful for determining prognosis and treatment.

Pathologists describe the tumor grade using three systems or formats:
1. Two levels of similarity; also called a two-grade system
2. Three levels of similarity; also called a three-grade system (code according to "Coding for solid tumors."
   a. Grade I, well
   b. Grade II, moderately
   c. Grade III, poorly (undifferentiated carcinoma is usually separated from this system, since "poorly" bears some, albeit little, similarity to the host tissue, while "undifferentiated" has none, e.g. Undifferentiated carcinoma).
3. Four levels of similarity; also called a four-grade system. The four-grade system describes the tumor as a. Grade I; also called well-differentiated
   a. Grade II; also called moderately differentiated
   b. Grade III; also called poorly differentiated
   c. Grade IV; also called undifferentiated or anaplastic

Coding Grade/Differentiation for Solid Tumors

1. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code grade based on information prior to neoadjuvant therapy even if grade is unknown.

2. Code the grade from the primary tumor only.
   a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site.
   b. If primary site is unknown, code grade to 9.

3. Code the grade shown below (6th digit) for specific histologic terms that implies a grade.

   Carcinoma, undifferentiated (8020/34)
   Carcinoma, anaplastic (8021/34)
   Follicular adenocarcinoma, well differentiated (8331/31)
   Thymic carcinoma, well differentiated (8585/31)
   Sertoli-Leydig cell tumor, poorly differentiated (8631/33)
   Sertoli-Leydig cell tumor, poorly differentiated with heterologous elements (8634/33)
   Undifferentiated sarcoma (8805/34)
   Liposarcoma, well differentiated (8851/31)
   Seminoma, anaplastic (9062/34)
   Malignant teratoma, undifferentiated (9082/34)
   Malignant teratoma, intermediate type (9083/32)
   Intraosseous osteosarcoma, well differentiated (9187/31)
   Astrocytoma, anaplastic (9401/34)
   Oligodendroglioma, anaplastic (9451/34)
   Retinoblastoma, differentiated (9511/31)
   Retinoblastoma, undifferentiated (9512/34)

4. In situ and/or combined in situ/invasive components:
   a. If a grade is given for an in situ tumor, code it. Do NOT code grade for dysplasia such as high grade dysplasia.
   b. If there are both in situ and invasive components, code only the grade for the invasive portion even if its grade is unknown.

5. If there is more than one grade, code the highest grade within the applicable system. Code the highest grade even if it is only a focus. Code grade in the following priority order using the first applicable system:
   a. special grade systems for the sites listed in Coding for Solid Tumors #6
   b. differentiation: use Coding for Solid Tumors #7: 2-, 3-, or 4- grade system
   c. nuclear grade: use Coding for Solid Tumors #7: 2-, 3-, or 4- grade system
   d. If it isn't clear whether it is a differentiation or nuclear grade and a 2-, 3-, or 4- grade system was used, code it.
   e. Terminology (use Coding for Solid Tumors #8)

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

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

Please see Appendix N for complete **2014 Grade System Rules** update.

LYMPH-VASCULAR INVASION   NAACCR ITEM #1182

Lymph-vascular invasion or LVI indicates the presence or absence of tumor cells in small lymphatic channels (not lymph nodes) or small blood vessels within the primary tumor or in the surrounding tissues of the primary site as noted microscopically by the pathologist. When a neoplasm shows the presence of lymph-vascular invasion, tumor cells have broken free of the primary tumor and now have the ability to float throughout the body. Therefore, lymph-vascular invasion may be used an indicator of prognosis**.**

Benign, borderline and in-situ neoplasms cannot have lymphatic or vascular invasion by definition. When any invasion is present, the neoplasm is classified as malignant with behavior = 3.

Lymphoid and myeloid neoplasms (neoplasms that originate in the lymphatic system, bone marrow, or in circulating blood) cannot have lymphatic or vascular invasion. Only solid tumors may have LVI.

Lymphatic invasion is not the same as involvement of regional lymph nodes.

Lymph-vascular invasion does not include perineural invasion.

Coding Instructions
1. The primary source of this information is the pathology report or a physician's statement.
2. **Use code 0 when behavior = 0, 1, or 2 (ALL benign, borderline, and in-situ neoplasms)**
3. Use code 0 when the pathology report states that no lymph-vascular invasion was identified.
4. Use code 1 when lymph-vascular is identified anywhere in a primary tumor specimen.
5. **Use code 8 when histology = 9590-9992 (ALL lymphoid and myeloid neoplasms).**
6. Use code 9 if the pathology report indicates that the presence of lymph-vascular invasion could not be determined or when no information is available in the pathology report or medical record.
7. **Use code 9 when no tissue from the primary site was examined (invasive solid tumors only).**

Code	Description
0	Behavior = 0, 1, or 2 (benign, borderline or in-situ neoplasm)
0	Lymph-vascular invasion not present (absent)/not identified
1	LVI Present/Identified
8	Histology = 9590-9992 (lymphoid or myeloid neoplasm)
9	LVI Unknown, Indeterminate, Not Stated, or no tissue from primary site was examined

TEXT- PRIMARY SITE TITLE   NAACCR ITEM #2580
Enter the location of the primary site of the tumor being reported. Include available information on tumor laterality. Do not use vendor-driven auto-coding of primary site title in this field. Enter free text.

TEXT – HISTOLOGY TITLE   NAACCR ITEM #2590
Enter the histologic type, behavior, and grade of the tumor being reported. Do not use vendor-drive auto-coding of the histologic type, behavior, or grade of the tumor in this field. Enter free text.

COLLABORATIVE STAGE DATA COLLECTION SYSTEM (CSv2)

Collaborative Staging (CS) is to be used for all cases regardless of date of diagnosis until 12/31/2015. For Collaborative Staging, registrars code discrete pieces of information once and the CS computer algorithm derives the values for the 6th and 7th editions of the AJCC Cancer Staging Manual T, N, M, and Stage Group, and descriptors, as well as Summary Stage 1977 and Summary Stage 2000. 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.

FCDS will collect all the required CS fields in accordance with the latest version of CS, currently version 02.05, and necessary to derive AJCC TNM Staging 6th and 7th edition and SEER Summary Stage 2000. This includes CS data collection for all schemas and schema discriminator (SSF25) for applicable sites consistent with CDC NPCR and the Florida Department of Health requirements.

The following CS data items are to be coded for all schemas. Items with an asterisk (*) have site-specific variations for some codes.

CS Tumor Size (NAACCR Item #2800) *
CS Extension (NAACCR Item #2810) *
CS Tumor Size/Ext Eval (NAACCR Item #2820)
CS Lymph Nodes (NAACCR Item #2830) *
CS Reg Lymph Nodes Eval (NAACCR Item #2840)
Regional Lymph Nodes Examined (NAACCR Item #830)
Regional Lymph Nodes Positive (NAACCR Item #820)
CS Mets at DX (NAACCR Item #2850) *
CS Mets Eval (NAACCR Item #2860)

CS Site-Specific Factors 1-25 is required for collection based on the site specific schema selection. See Appendix H for a complete of site-specific SSF requirements for 2012 or go to http://fcds.med.miami.edu/inc/downloads.shtml to see all site specific schemas and their required Site-Specific Factors. This spreadsheet is subject to change based on AJCC CSv2 revisions.

Coding CS Data Items
The complete instructions and site-histology defined codes are available in the current version of
Collaborative Stage Data Collection System http://www.cancerstaging.org/cstage/

AJCC TNM CANCER STAGING SYSTEM

2014-2015 Transition Years Requirement: The AJCC TNM Cancer Staging data itmes may be left blank or may be reported as "Optional" for cancers diagnosed, treated, or otherwise reported to FCDS 1/1/2014-12/31/2015. Only registries with CoC Accreditation can submit the "Optional" TNM fields. AJCC TNM staging requires use of the *AJCC Cancer Staging Manua*l, 7th edition for all TNM items.

2016 Requirement: AJCC TNM staging requires use of the *AJCC Cancer Staging Manua*l, 7th edition for all cancers diagnosed, treated, or otherwise reported to FCDS beginning 1/1/2016.

The AJCC TNM Cancer Staging System is based on the clinical, operative, and pathologic assessment of the anatomic extent of disease at the time of initial cancer diagnosis and is used to make appropriate treatment decisions, determine prognosis, and measure end results.

Rules for Staging and Definitions of T, N, M (clinical and pathologic) may vary across primary site. You MUST refer to the current *AJCC Cancer Staging Manual* to code AJCC TNM Stage data item.

Use the rules in the current *AJCC Cancer Staging Manual* to assign AJCC T, N, M and Stage Group values. The following general rules apply to AJCCTNM staging for all cancer sites.

- *Clinical Staging* includes any information obtained about the extent of cancer before initiation of definitive treatment (surgery, systemic or radiation therapy, active surveillance, or palliative care) or within four months after the date of diagnosis, whichever is *shorter*, as long as the cancer has not clearly progressed during that time frame.

- *Pathologic Staging* includes any information obtained about the extent of cancer through completion of definitive surgery as part of first course treatment or identified within four months after the date of diagnosis, whichever is *longer*, as long as there is no systemic or radiation therapy initiated or the cancer has not clearly progressed during that time frame.

Data Items Included in this Section:

NAACCR Item Number	Item Name
940	Clinical T
950	Clinical N
960	Clinical M
970	Clinical Stage Group
980	Clinical Stage (Prefix/Suffix) Descriptor
990	TNM Clinical – Staged By
880	Pathologic T
890	Pathologic N
900	Pathologic M
910	Pathologic Stage Group
920	Pathologic Stage (Prefix/Suffix) Descriptor
930	TNM Pathologic – Staged By
1060	TNM Edition Number

Coding AJCC TNM Cancer Staging Data Items
The complete coding instructions and site-histology defined criteria for assigning individual T, N, and M elements and the Stage Group (clinical and pathologic) are available in the current version of *AJCC Cancer Staging Manual.* Go to http://www.cancerstaging.org for ordering information.

TREATMENT INFORMATION

The Treatment Information section includes the set of data items used to describe how the cancer or tumor was treated. FCDS only collects the "First Course of Treatment." This concept is described and reinforced throughout the chapter.

Cancers can be treated using many different means including surgery, radiation therapy, chemotherapy, hormones, biological response modifiers and even unconventional or unproven methods. Within each of these broad categories of treatments are many finer designations of specific treatment types. This section helps to categorize cancer directed therapies by type and specific method.

Three important sub-sections are included at the beginning of this section to help orient the abstractor with regard to concept and terminology used throughout this section.
-        Definition of Cancer Directed Therapy
-        Definition of "First Course of Treatment"
-        General Coding Instructions Site Specific Surgery

Data Items Included In This Section:

NAACCR Item Number	Item Name
1290	Rx Summ – Surg Prim Site
1201	Rx Date—Surgery Flag
1292	Rx Summ – Scope Regional Lymph Node Surgery
1294	Rx Summ – Surgery of Oth Reg/Dis
1200	Date of First Surgical Procedure
1340	Reason for No Surgery
1360	Rx Summ – Radiation
1380	Rx Summ – Surg/Rad Seq
1570	Rad – Regional RX Modality
1210	Rx Date – Radiation
1211	Rx Date—Radiation Flag
1430	Reason for No Radiation
1639	Rx Summ – Systemic Surg Seq
1390	Rx Summ – Chemo
1220	Rx Date – Chemo
1221	Rx Date—Chemo Flag
1400	Rx Summ – Hormone
1230	Rx Date – Hormone
1231	Rx Date—Hormone Flag
1410	Rx Summ – BRM/Immunotherapy
1240	Rx Date – BRM/Immunotherapy
1241	Rx Date—BRM Flag
1420	Rx Summ – Other
1250	Rx Date – Other
1251	Rx Date—Other Flag
3250	Rx Summ – Transplnt/Endocr
1285	RX Summ--Treatment Status
2620	RX Text – Radiation (Beam)
2630	RX Text – Radiation Other
2640	RX Text – Chemo
2650	RX Text – Hormone
2660	RX Text – BRM
2670	RX Text – Other

DEFINITION OF CANCER-DIRECTED THERAPY

The concept of definitive treatment is limited to procedures directed toward cancer tissues whether of the primary site or metastases. If a specific therapy normally affects, controls, changes, removes, or destroys cancer tissue, it is classified as definitive treatment even if it cannot be considered curative for a particular patient in view of the extent of disease, incompleteness of treatment, lack of apparent response, size of dose, operative mortality, or other criteria.

Cancer treatment involves medical procedures to destroy, modify, control, or remove primary, regional, or metastatic cancer tissue. The goals of cancer treatment include eradicating known tumors entirely, preventing the recurrence or spread of the primary cancer, and relieving symptoms if all reasonable curative approaches have been exhausted. Decisions concerning how to treat a particular cancer are based on many factors. The primary goal is to choose an approach that will remove the tumor, rid the body of wandering cancer cells, and prevent a recurrence.

Any treatment that is given to modify, control, remove or destroy primary or metastatic cancer tissue is cancer directed treatment. The type of treatment is meant to remove a tumor or minimize the size of tumor or delay the spread of disease.

To ensure complete and accurate treatment data, terms such as "first course of treatment" and "treatment for recurrence or progression" should be defined. For cancer registrars, it is necessary to distinguish cancer-directed treatment from non-cancer directed treatment, which are recorded differently in cancer data fields.

First course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. In cancer treatment data registration, the data of the first course treatment is the month, day, and year of the first cancer-directed treatment that is administered.

DEFINITION OF NON-CANCER DIRECTED THERAPY

Non-cancer directed treatment refers to any treatment designed to prepare the patient for cancer-directed treatment, prolong a patient's life, alleviate pain, or make the patient comfortable. Non-cancer directed treatments are not meant to destroy the tumor, control the tumor, or delay the spread of disease. These treatments include diagnostic test and supportive care.

If a patient receives ONLY symptomatic or supportive therapy, this is classified as "non cancer directed therapy."

The term "palliative" may be used in different context: (a) as meaning non-curative and (b) as meaning the alleviation of symptoms. Thus, some treatments termed palliative fall within the definition of cancer directed treatment and some treat the patient but not the cancer. For example, radiation therapy to bony metastases is considered cancer directed treatment because in addition to alleviating pain, the radiation also kills cancer cells in the bone.

Palliative care description: This treatment qualifies the patient as analytic if it is given as part of the planned first course of treatment.

definition of first course of treatment - All Diseases (Including Benign And Borderline Intracranial & CNS Tumors) Except Leukemia And Hematopoietic Diseases

Time period for First Course of Treatment (in order of precedence)

1. If there is a documented, planned first course of treatment, first course ends at the completion of this treatment plan, regardless of the duration of the treatment plan.

2. If the patient is treated according to a facility's standard of practice, first course ends at the completion of the treatment.

3. If there is no documentation of a planned first course of treatment or standard of practice, first course of treatment includes all treatment received before disease progression or treatment failure. If it is undocumented whether there is disease progression/treatment failure and the treatment in question begins more than one year after diagnosis, assume that the treatment is not part of first course.

4. If a patient refuses all treatment modalities and does not change his/her mind within a reasonable time frame, or if the physician opts not to treat the patient, record that there was no treatment in the first course.

DEFINITIONS

Cancer tissue: Proliferating malignant cells; an area of active production of malignant cells. Cancer tissue includes primary tumor and metastatic sites where cancer tissue grows. Cells in fluid such as pleural fluid or ascitic fluid are not "cancer tissue" because the cells do not grow and proliferate in the fluid.

Disease recurrence: The patient must have had a disease-free interval or remission (the cancer was not clinically evident). Following a disease-free interval, there is documentation that the initial/original tumor gave rise to the later tumor.

Surgical Procedure: Any surgical procedure coded in the fields Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional or Distant Sites.

Treatment: Procedures that destroy or modify primary (primary site) or secondary (metastatic).cancer tissue.

Treatment failure: The treatment modalities did not destroy or modify the cancer cells. The tumor either became larger (disease progression) or stayed the same size after treatment.

Watchful waiting: A treatment option for patients with slow, indolent diseases, such as prostate cancer and chronic lymphocytic leukemia (CLL). The physician closely monitors the patient and delays treatment until the patient becomes symptomatic or there are other signs of disease progression, such as rising PSA. If treatment is given for symptoms/disease progression after a period of "watchful waiting," this treatment is not considered part of first course. For example, if a physician and patient choose a "wait and watch" approach to prostate cancer or chronic lymphocytic leukemia and the patient becomes symptomatic, consider the symptoms to be an indication that the disease has progressed and that any further treatment is not part of first course.

Coding Instructions

1. When physician decides to do watchful waiting for a patient who has prostate cancer, the first course of therapy is no treatment. Code all of the treatment fields to 00, not done. When the disease progresses and the patient is symptomatic; any prescribed treatment is second course.

2. When the patient refuses treatment the first course of therapy is no treatment. Code the treatment fields to refused. If the patient later changes his/her mind and decides to have the prescribed treatment code:

    a. Code the treatment as first course of therapy if it has been less than one year since the cancer was diagnosed and there has been no documented disease progression.

    b. Code the treatment as second course of therapy if it has been more than one year since the original cancer was diagnosed or if there has been documented disease progression.

    c. Code all treatment that was started and administered.

       Example: The patient completed only the first dose of a planned 30 day chemotherapy regimen. Code chemotherapy as administered.

3. If a patient has multiple primaries and the treatment given for one primary also affects/treats the other primary, code the treatment for both primary sites.

    Example 1: The patient had prostate and bladder cancer. The bladder cancer was treated with a TURB. The prostate cancer was treated with radiation to the prostate and pelvis. The pelvic radiation includes the regional lymph nodes for the bladder. Code the radiation as treatment for both the bladder and prostate cases.

    Example 2: The patient had a hysterectomy for ovarian cancer. The pathology report reveals a previously unsuspected microinvasive cancer of the cervix. Code the hysterectomy as surgical treatment for both the ovarian and cervix primaries.

4. If a patient has multiple primaries and the treatment given affects only one of the primaries, code the treatments only on the site that is affected.

    Example: The patient has colon and tonsil primaries. The colon cancer is treated with a hemicolectomy and the tonsil primary is treated with radiation to the tonsil and regional nodes. Do not code the radiation for the colon. Do not code the hemicolectomy for the tonsil.

5. If a patient is diagnosed with an unknown primary, code the treatment given as first course even if the correct primary is identified later.

    Example: The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Hormonal treatment is started. Code the chemotherapy as first course of treatment. The hormone therapy is second course.

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 the 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.

If alcohol is specified as the embolizing agent, even in the liver, code the treatment as Other Therapy.

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 such as Ytrium 90. Do not code as radioisotope, code as brachytherapy. Embolization is coded as Other Therapy (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 presurgical 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.

DEFINITIONS OF FIRST COURSE OF TREATMENT - Leukemia And Hematopoietic Diseases
Adopted from the SEER Program Coding and Staging Manual 2004 Edition

LEUKEMIA

Leukemia is grouped or typed by how quickly the disease develops and gets worse. Chronic leukemia gets worse slowly. Acute leukemia gets worse quickly.

Leukemia are also grouped by the type of white blood cell that is affected. The groupings are: lymphoid leukemia and myeloid leukemia.

DEFINITIONS

Consolidation: Repetitive cycles of chemotherapy given immediately after the remission.

Induction: Initial intensive course of chemotherapy.

Maintenance: Chemotherapy given for a period of months or years to maintain remission.

"Maintenance treatment given as part of the first course of planned treatment (for example, for leukemia) is first course treatment, and cases receiving that treatment are analytic."

Remission: The bone marrow is normocellular with less than 5% blasts, there are no signs or symptoms of the disease, no signs or symptoms of central nervous system leukemia or other extramedullary infiltration, and all of the following laboratory values are within normal limits: white blood cell count and differential, hematocrit/hemoglobin level, and platelet count.

Treatment for leukemia is divided into three phases:

1. Remission induction (chemotherapy and/or biologic response modifiers)
2. CNS prophylaxis or consolidation (irradiation to brain, chemotherapy)
3. Remission continuation or maintenance (chemotherapy or bone marrow transplants).

Coding First Course of Therapy for Leukemia and Hematopoietic Diseases:

When precise information permits, the first course of definitive treatment is to be related to the first "remission" as follows. If a patient has a partial or complete remission during the first course of therapy:

- Code all therapy that is "remission-inducing" as first course. All definitive therapy considered as "remission-inducing" for the first remission.
- Code all therapy that is "consolidation" as first course.
- Code all therapy that is "remission-maintaining" as first course.

All definitive therapy considered as "remission-maintaining" for the first remission, i.e., maintenance chemotherapy, or irradiation to the central nervous system.

Note: Do not record treatment given after the patient relapses (is no longer in remission).

Some patients do not have a remission.

A change in the treatment plan indicates a failure to induce remission. If the patient does not have a remission:

- Record the treatment given in an attempt to induce remission.
- Do not record treatment administered after the change in treatment plan.

OTHER HEMATOPOIETIC

Record all treatments as described above. The following treatments are coded as "other" in Other Treatment even though they do not "modify, control, remove, or destroy proliferating cancer tissue."

Aspirin (also known as ASA, acetylsalicylic acid, or by a brand name) is coded as a treatment for essential thrombocythemia - ONLY. **DO NOT CODE aspirin as "other treatment" for any site EXCEPT Essential Thrombocythemia.**

Only record aspirin therapy for essential thrombocythemia when it is given to thin the blood for symptomatic control. Use the following guidelines to determine whether aspirin is administered for thinning of blood for thrombocythemia rather than for pain control or cardiovascular protection:

- Aspirin treatment for essential thrombocythemia is low dose, approximately 70-100 mg/day
- The dosage for pain control is approximately 325-1000 mg every 3-4 hours.
- Cardiovascular protection starts at about 160 mg/day.

Phlebotomy (also known as blood removal, blood letting, or venesection) is coded as treatment for polycythemia vera - ONLY. **DO NOT CODE phlebotomy as "other treatment" for any condition EXCEPT Polycythemia Vera.**

Transfusions may include whole blood, RBCs, platelets, plateletphoresis, fresh frozen plasma (FFP), plasmaphoresis, and cryoprecipitate. **DO NOT CODE transfusion as "other treatment" for any site.**

GENERAL CODING INSTRUCTIONS SITE-SPECIFIC SURGERY

1. Refer to **Appendix F** for site-specific surgery codes.

2. Once it is determined that cancer-directed surgery was performed, use the best information in the operative/pathology reports to determine the operative procedure. Do not depend on the name of the procedure since it may be incomplete.

3. If the operative report is unclear regarding what was excised or if there is a discrepancy between the operative and pathology reports, use the pathology report, unless there is a reason to doubt its accuracy.

4. If a surgical procedure removes the remaining portion of an organ, which had been partially resected previously for any condition, code as total removal of the organ.

5. A date field is also included to document the first date of any surgery performed.

6. If there is no indication anywhere in the patient's medical record that surgery was either planned or performed enter Surgery Rx Summary as 00 – No Surgical Procedure.

7. There is no need to code any non-cancer-directed surgery performed (i.e., the patient had only a biopsy, exploratory or bypass surgery without resection of the primary or metastatic tumor).

8. If multiple primaries are excised at the same time, code the appropriate surgery for each site.

For example:
1. If a total abdominal hysterectomy was done for a patient with two primaries, one of the cervix and one of the endometrium, code each as having had a total abdominal hysterectomy.

2. If a total colectomy was done for a patient with multiple primaries in several segments of the colon, code total colectomy for each of the primary segments. Ignore the surgical approach when coding procedures. Ignore the surgical margins when coding procedures. Ignore the use of laser if used only for the initial incision.

3. Surgical procedures performed solely for the purpose of establishing a diagnosis/stage or for the relief of symptoms, and procedures such as brushings, washings, and aspiration of cells as well as hematologic findings (peripheral blood smears) are not considered cancer therapy.

4. Surgery for extranodal lymphomas should be coded using the schema for the extranodal site.

    For example:
    A lymphoma of the stomach is to be coded using the schema for stomach.
    Record the most invasive, extensive surgical procedure performed during the first course of therapy (whether or   not it was performed at your facility).

RX SUMM – SURG PRIM SITE   NAACCR ITEM #1290

Record surgery of the primary site for all cases using the Site-Specific Surgery Codes found in **Appendix F**. Surgery to remove regional tissue or organs is coded in this field only if the tissue or organs are removed with the primary site in an en bloc resection. An en bloc resection is the removal of organs in one piece at one time.

Code the most invasive surgical procedure for the primary site.

Code	Label	Description
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10-19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to Appendix F for the correct site-specific code for the procedure.
20-80	Site-specific codes; resection	Refer to Appendix F for the correct site-specific code for the procedure.
90	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Site-specific codes; special	Special code. Refer to Appendix F for the correct site-specific code for the procedure.
99	Unknown	Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

Coding Instructions

1. Code **00** if no surgery is performed on the primary site or if case was diagnosed at autopsy, and would not be otherwise coded to **98**.

2. Use the site-specific coding scheme corresponding to the coded primary site.

3. Code the most **invasive, extensive, or definitive** surgery if the patient has multiple surgical

procedures of the primary site even if there is no tumor found in the pathologic specimen. The codes in the range of **00-80** are **listed** in hierarchical but not necessarily numerical order. When more than one surgical procedure is performed, code the procedure listed furthest down the list within the codes 10-80.
Example: Patient has a needle biopsy of prostate that is positive for adenocarcinoma. The patient chooses to have a radical prostatectomy. The pathologic examination of the prostatectomy specimen shows no residual tumor. Code the radical prostatectomy.

*Example***:** Patient has a colonoscopy with removal of a polyp in the sigmoid colon. The pathology report identifies carcinoma extending into the stalk ("Surgery of Primary Site" code **27**). A week later, the patient has a hemicolectomy ("Surgery of Primary Site" code **40**). Code the hemicolectomy since it is the most invasive, definitive surgery and has the numerically higher code

4. Code an **excisional biopsy,** even when documented as **incisional**, when:
a.   All disease is removed (**margins free**) OR
b.   All gross disease is removed and there is only **microscopic residual at the margin**

Note: Do not code an excisional biopsy when there is *macroscopic residual* disease

5. Code **80** or **90** only when there is no specific information about the surgery.

6. Code **total removal of the primary site** when a previous procedure resected a portion of the site and the current surgery removed the rest of the organ. The previous procedure may have been cancer directed or non-cancer directed surgery.

7. Code the removal of regional or distant **tissue/organs** when they are resected in continuity with the primary site (**en bloc**). Specimens from an en bloc resection may be submitted to pathology separately.

Example: Code an en bloc removal when the patient has a hysterectomy and an omentectomy.

8. Code surgery for extra-lymphatic lymphoma using the site-specific surgery coding scheme (not lymph node scheme) for the primary site.

9. Code **98** takes precedence over code 00 and should be coded for any tumor characterized by the specific sites and/or histologies identified in the site-specific code instructions (Appendix F) for *Unknown and Ill-Defined Primary Sites and Hematopoietic/Reticuloenthelial/Immunoproliferative/ Myeloproliferative Disease*. Code **98** for the following sites:

a. Primary sites
      1. Brain (C700-C709) OR
      2. Spinal cord (C710-C719) OR
      3. Cranial nerves and other parts of the central nervous system (C720-C729)
b. Lymphoma with primary site in lymph nodes (C770-C779) AND histology
      1. 9590-9596 OR
      2. 9650-9719 OR
      3. 9727-9729
c. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease
      1. Primary sites: C420, C421, C423, or C424 AND
      2. Histologies: 9750, 9760-9764, 9820-9822, 9826, 9831-9920, 9931-9964, 9980-9989
      3. Unknown or ill-defined sites (C760-C768, C809)

10. Assign **code 99** for death certificate only (DCO) cases

SITE-SPECIFIC CANCER-DIRECTED SURGERY CODES

Use the site-specific surgical procedure codes in Appendix F in this manual for the following primary sites. Use the "ALL OTHER SITES" general surgery codes in Appendix F for sites not listed in the table.

Code	Site
C00.0-C06.9	Lip and oral cavity
C07.9-C08.9	Parotid and other unspecified salivary glands
C09.0-C14.0	Pharynx
C15.0-C15.9	Esophagus
C16.0-C16.9	Stomach
C18.0-C18.9	Colon
C19.9	Rectosigmoid
C20.9	Rectum
C21.0-C21.8	Anus
C22.0-C22.1	Liver and intrahepatic bile ducts
C25.0-C25.9	Pancreas
C32.0-C32.9	Larynx
C34.0-C34.9	Lung
C42.0, C42.1, C42.3, C42.4	Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease
C40.0-C41.9 C47.0-C47.9 C49.0-C49.9	Bones, joints & articular cartilage; peripheral nerves and autonomic nervous system; connective, subcutaneous and other soft tissue
C42.2	Spleen
C44.0-C44.9	Skin
C50.0-C50.9	Breast
C53.0-C53.9	Cervix uteri
C54.0-C55.9	Corpus uteri
C56.9	Ovary
C61.9	Prostate
C62.0-C62.9	Testis
C64.9-C66.9	Kidney, Renal pelvis and Ureter
C67.0-C76.9	Bladder
C70.0-C72.9	Brain and Other Parts of Central Nervous System
C73.9	Thyroid gland
C77.0-C77.9	Lymph nodes
C76.0-C76.8, C80.9	Ill Defined Primary Sites and Unknown Primary

NOTE: Surgery for extranodal lymphomas should be coded using the schema for the extranodal site. Surgeries for all other primary cancers not listed above should be coded using the general surgery code schema for All Other Sites at the end of Appendix F.

RX SUMM – SCOPE REG LN SUR   **NAACCR ITEM #1292**

This field describes the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

Revised Coding Directives for Implementation January 1, 2012
The following instructions should be applied to all surgically treated cases for all types of cancers. The treatment of breast and skin cancer is where the distinction between sentinel1ymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes is most frequently encountered. For all other sites, non-sentinel regional node dissections are typical, and codes 2, 6 and 7 are infrequently used.

Code	Label	General Instructions Applying to ALL Sites	Additional Notes Specific for Breast (C50.x)
0	No regional lymph node surgery	No regional lymph node surgery.	
1	Biopsy or aspiration of regional lymph node(s)	Review the operative report of to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed. If additional procedures were performed on the lymph nodes, use the appropriate code 2-7.	Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report of to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7.
2	Sentinel Lymph Node Biopsy	• The operative report states that a SLNBx was performed. • Code 2 SLNBx when the operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination. • When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. Code this as a SLNBx (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.	• If a relatively large number of lymph nodes, more than 5, are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an axillary lymph node dissection (ALND). • Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. Review the operative report to confirm that an axillary incision was made and a node exploration was conducted. Patients undergoing SLNBx who fail to map will often undergo ALND. Code these cases as 2 if no ALND was performed, or 6 when ALND was performed during the same operative event Enter the appropriate number of nodes examined and positive in the data items *Regional Lymph Nodes Examined* (NAACCR Item #830) and *Regional Lymph Nodes Positive* (NAACCR Item

			#820).
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	• The operative report states that a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure). • Code 3 (Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS). Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7). • Code 4 (1-3 regional lymph nodes removed) should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only. • Code 5 (4 or more regional lymph nodes removed). If a relatively small number of nodes was examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes was examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7).	Generally, ALND removes at least 7~9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same procedure (code 6 or 7).
4	1-3 regional lymph nodes removed		
5	4 or more regional lymph nodes removed		

		• Infrequently, a SNLBx is attempted and the patient	
6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated	• SNLBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known • Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only. • Infrequently, a SNLBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection.) When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6.	• Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed.
7	Sentinel node biopsy and code 3,4, or 5 at different times	•SNLBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events. • Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. •If relatively few nodes are pathological1y examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.	
9	9 Unknown or not	• The status of regional lymph node evaluation should be known for surgically-treated cases (i.e., cases coded 19-90 in the applicable data item *Surgery of Primary Site* [NAACCR Item #1290]). Review surgically treated cases coded 9 in *Scope of Regional/ Lymph Node Surgery* to confirm the code.	

General Instructions
Use the operative report as the primary sources document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), or a more extensive dissection of regional lymph nodes, or a combination of both SNLBx and regional lymph node dissection. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these 2 procedures. Do not use the number of lymph nodes removed

and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.

Coding Instructions

1. Code **0** when regional lymph node removal procedure was not performed.

2. Code 0 if there is no indication anywhere in the patient's medical record that regional lymph node surgery was either planned or performed.

3. Codes **1-7** are hierarchical. Code the procedure that is numerically higher.

4. The regional lymph node surgical procedure(s) may be done to diagnose cancer, stage the disease, or as part of the initial treatment. Record all surgical procedures that remove, biopsy, or aspirate regional lymph node(s) whether or not there were any surgical procedures of the primary site.
Example: Patient has a sentinel node biopsy of a single lymph node. Assign code 2 (Sentinel lymph node biopsy [only]).

5. The Scope of Regional Lymph Node field is cumulative; add the number of all of the lymph nodes removed during each surgical procedure performed as part of the first course of treatment.

Example: Patient has a positive cervical node biopsy. The pathology report from a subsequent node dissection identifies three cervical nodes. Assign code 5 (4 or more regional lymph nodes removed).

6. If the operative report lists a lymph node dissection, but no nodes were found by the pathologist, code the Scope of Regional Lymph Node Surgery to 0 (No lymph nodes removed)

7. If the patient has two primaries with common regional lymph nodes, code the removal of regional nodes for both primaries.

Example: Patient has a cystoprostatectomy and pelvic lymph node dissection for bladder cancer. Pathology identifies prostate cancer as well as the bladder cancer and 4/21 nodes positive for metastatic adenocarcinoma. Code Scope of Regional Lymph Node Surgery to 5 (4 or more regional lymph nodes removed) for both primaries.

7. Code Scope **9** for:

a. Primary sites
*   Brain (C700-C709) OR
*   Spinal cord (C710-C719) OR
*   Cranial nerves and other parts of the central nervous system (C720-C729)

b. Lymphoma with primary site in lymph nodes (C770-C779) AND histology:

   Histologies: 9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971

c. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease

*   Primary sites: C420, C421, C423, or C424 AND
*   Histologies: 9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992

- Unknown or ill-defined sites (C760-C768, C809)

RX SUMM – SURG OTH REG/DIS   NAACCR ITEM #1294

Enter the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site. This field is for all procedures that do not meet the definitions of Surgery of Primary Site. The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Coding Instructions

Code 0 if there is no indication anywhere in the patient's medical record that surgical resection of distant lymph node(s) and/or regional/distant tissue or organs was either planned or performed.

Code the highest numerical code that describes the surgical resection of distant lymph node(s) and/or regional/distant tissue or organs.

Example: A patient has an excisional biopsy of a hard palate lesion that is removed from the roof of the mouth and a resection of a metastatic lung nodule during the same surgical event. Code the resection of the lung nodule as **3** (distant site).

Code the removal of non-primary tissue that was removed because the surgeon suspected it was involved with the malignancy even if the pathology is negative.

Do not code the incidental removal of tissue. Incidental is defined as tissue removed for reason other than the malignancy.

Example: During a colon resection, the surgeon noted that the patient had cholelithiasis and removed the gall bladder. Do not code removal of the gall bladder.

Code	Label	Description
0	None	No surgical procedure of nonprimary site was performed. Diagnosed as autopsy.
1	Nonprimary surgical procedure performed	Nonprimary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.
2	Nonprimary surgical procedure to other regional sites	Resection of regional site.
3	Nonprimary surgical procedure to distant lymph node(s)	Resection of *distant lymph node(s)*
4	Nonprimary surgical procedure to distant site	Resection of distant site.
5	Combination of codes **2**, **3**, or **4**	Any combination of surgical procedures **2**, **3**, or **4**.
9	Unknown	It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only.

RX DATE—SURGERY   NAACCR ITEM #1200

Records the earliest date on which any first course surgical procedure was performed.

Coding Instructions
Record the date of the first surgical procedure of the types coded as *RX Summ—Surg Prim Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Surgical Procedure/Other Site* (NAACCR Item #1294) performed at this or any facility.

RX DATE—SURGERY FLAG   NAACCR ITEM #1201

This flag explains why there is no appropriate value in the corresponding date field, *RX Date --Surgery* (NAACCR Item #1200).

Coding Instructions
1. Leave this item blank if *RX Date-- Surgery* (NAACCR Item #1200) has a full or partial date recorded.
2. Code 12 if the *RX Date-- Surgery* cannot be determined, but the patient did receive first course surgery.
3. Code 10 if it is unknown whether any surgery was performed.
4. Code 11 if no surgical procedure was performed.
5. Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed)
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item RX *Date--Surgery of First Surgical Procedure* (NAACCR item #1200).

REASON FOR NO SURGERY   NAACCR ITEM #1340

Reason for No Surgery code refers to item Rx Summ-Surg Prim Site.

Code	Description
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first-course treatment.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first-course of therapy. No reason was

	noted in patient record.
7	Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only.

Coding Instructions

1. Assign **code 0** when Surgery of Primary Site is coded in the range of 10-90 (the patient did have surgery of primary site).

2. Assign a code in the **range of 1-8** if Surgery of Primary Site is coded 00 or 98.

3. Assign **code 1**

   a. If RX Summ—Surg Prim Site (NAACCR Item #1290) is coded 98.

   b. There is no information in the patient's medical record about surgery AND It is known that surgery is not usually performed for this type and/or stage of cancer OR There is no reason to suspect that the patient would have had surgery of primary site.

   c. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include surgery of the primary site Patient elects to pursue no treatment following the discussion of radiation treatment. Discussion does not equal a recommendation.

   d. Only information available is that the patient was referred to a surgeon. Referral does not equal a recommendation.

   e. Watchful waiting (prostate)

   f. Patient diagnosed at autopsy

4. Assign **code 6**

   a. When it is known that surgery was recommended AND

   b. It is known that surgery was not performed AND

   c. There is no documentation explaining why surgery was not done.

5. Assign **code 7** (refused) if the patient refused recommended surgery, or made a blanket statement that he/she refused all treatment.

6. Assign **code 8** (unknown) if the treatment plan offered surgery, but it is unknown if the patient actually had the surgery.

7. Assign **code 9**

   a. When there is no documentation that surgery was recommended or performed

   b. Death certificate only.

c. Autopsy only.

RX SUMM – RADIATION   NAACCR ITEM #1360

Enter the type of radiation therapy that the patient received, as part of the first course of treatment. This field records radiation administered to the primary site or any metastatic site. Record radiation delivered at your facility as well as radiation done in all other facilities regardless of source, field being treated, or intent of treatment (curative or palliative).

Code	Description
0	None No radiation therapy was administered.
1	Beam radiation X-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, intra-operative radiation and stereotactic radiosurgery (gamma knife and proton beam).
2	Radioactive implants Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials
3	Radioisotopes Internal use of radioactive isotopes (iodine-131 or phosphorus-32) Can be administered orally, intracavitary, or by intravenous injection.
4	**Combinations of beam radiation, with radioactive implants, or radioisotopes (combination of 1 with 2 and/or 3)** The patient was treated with a combination of beam radiation and at least one of the two methods described by codes **2** and **3**.
5	**Radiation therapy, NOS (method or source not specified)** Radiation was administered, but the method or source is not documented (radiation therapy, NOS)
7	**Patient or patient's guardian refused**
8	**Radiation therapy recommended, unknown if administered** A physician recommended radiation therapy or referred the patient for a radiation therapy consult, follow-up does not confirm that therapy was received
9	**Unknown if radiation therapy administered** No confirmation if radiation therapy was recommended or performed (frequently non-analytic cases). Unknown if radiation therapy administered.

Coding Instructions
1. Assign **code 0**

   a. There is no information in the patient's medical record about radiation AND It is known that radiation is not usually performed for this type and/or stage of cancer OR there is no reason to suspect that the patient would have had radiation.

   b. If there is no indication anywhere in the medical record that radiation was either planned or performed enter Rx Summ Radiation as 0 – None or No radiation therapy was administered..

   c. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include radiation.

d. Patient elects to pursue no treatment following the discussion of radiation treatment.

e. Discussion does not equal a recommendation.

f. Only information available is that the patient was referred to a radiation oncologist. Referral does not equal a recommendation.

g. Watchful waiting (prostate)

h. Patient diagnosed at autopsy

2. Assign **code 1** for beam radiation directed to cancer tissue. The source of the beam radiation is not used for coding purposes. Sources may include, but are not limited to: X-ray, Cobalt, linear accelerator, neutron beam, betatron, spray radiation, stereotactic radiosurgery such as gamma knife and proton beam.

3. Assign **code 2** when the radiation is delivered by interstitial implant, molds, seeds, needles or intracavitary applicators. The radioactive material used in implants includes, but is not limited to: cesium, radium, radon, radioactive gold, and iodine.

4. Assign **code 3** when radioactive isotopes are given orally, intracavitary or by intravenous injection. Radioactive isotopes include but are not limited to: I-131 or P-32.

5. If the patient has multiple radiation types, code the dominant type (the greatest dose of radiation).

6. Assign **code 9** when there is no documentation that radiation was recommended or performed Death certificate only.

RX SUMM--SURG/RAD SEQ   NAACCR ITEM #1380

Codes for the sequencing of radiation and surgery given as part of the first course of treatment.

Coding Instructions
1. Surgical procedures include *RX Summ—Surg Prim Site* (NAACCR Item #1290); *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292); *Surgical Procedure/Other Site* (NAACCR Item #1294). If all of these procedures are coded 0, then this item should be coded 0.
2. If the patient received both radiation therapy and any one or a combination of the following surgical procedures: *RX Summ—Surg Prim Site, Regional Lymph Node Surgery,* or *Surgical Procedure/Other Site,* then code this item 2—9, as appropriate.

Code	Label	Definition
0	No radiation therapy and/or surgical procedures	No radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery. Diagnosed at autopsy.
2	Radiation therapy before surgery	Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).

Code	Label	Definition
4	Radiation therapy both before and after surgery	Radiation therapy given before and after any surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
7	Surgery both before and after surgery	Radiation was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown	Administration of radiation therapy and surgery to primary site, scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is unknown is radiation therapy was administered and/or it is unknown if surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed.

RAD--REGIONAL RX MODALITY   NAACCR ITEM #1570

Records the dominant modality of radiation therapy used to deliver the clinically most significant regional dose to the primary volume of interest during the first course of treatment.

Coding Instructions
Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.

In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality.

Note that in some circumstances the boost treatment may precede the regional treatment.
- For purposes of this data item, photons and x-rays are equivalent.
- Code IMRT or conformal 3D whenever either is explicitly mentioned.
- **Code radioembolization as brachytherapy.**
- Code 00 A patient was treated for mycosis fungoides with PUVA (psoralen and long-wave ultraviolet radiation). Code this treatment as *Other Treatment* (NAACCR Item #1420, code 1.

Code	Label	Definition

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt- 60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.
23	Photons *(2—5* MV)	External beam therapy using a photon producing machine with a beam energy in the range of *2—5* MV.
24	Photons (6—10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6—10 MV.
25	Photons (11—19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11—19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.

Code	Label	Definition
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles (radioembolization), or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, Intracavitary, LDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavitary, HDR	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-l 31, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
80*	Combination modality, specified*	Combination of external beam radiation and either radioactive implants or radioisotopes*
85*	Combination modality, NOS*	Combination of radiation treatment modalities not specified in code 80.*
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	Radiation therapy administered, treatment volume unknown or not stated in the patient record; it is unknown whether radiation therapy was administered. Death certificate only.

Note: For cases diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation administered to the patient as part or all of the first course of therapy. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to *Vol. II, ROADS,* and *DAM* rules and **should not** be used to record regional radiation for cases diagnosed on or later than January 1, 2003.

RX DATE RADIATION   **NAACCR ITEM #1210**

Records the date on which radiation therapy began at any facility that is part of the first course of treatment.

Coding Instructions
1. If you know that radiation therapy was performed as a part of the first course of therapy, but do not know the exact date the therapy was initiated, estimate the date therapy was initiated.
2. The date when treatment started will typically be found in the radiation oncologist's summary letter for the first course of treatment.
3. The *RX Date–Radiation Flag* (NAACCR ITEM #1211) is used to explain why RX *Date Radiation* is not known.

RX DATE—RADIATION FLAG   NAACCR ITEM #1211

This flag explains why there is no appropriate value in the corresponding date field, *RX Date-- Radiation* (NAACCR Item #1210).

Coding Instructions
1. Leave this item blank if *RX Date-- Radiation* (NAACCR Item #1210) has a full or partial date recorded.
2. Code 12 if the *RX Date-- Radiation* cannot be determined, but the patient did receive first course radiation.
3. Code 10 if it is unknown whether any radiation was given.
4. Code 11 if no radiation is planned or given.
5. Code 15 if radiation is planned, but has not yet started and the start date is not yet available.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any radiation was given).
11	No proper value is applicable in this context (for example, no radiation was administered).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, radiation was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, radiation therapy had begun at the time of the most recent follow-up but was not yet completed).
(blank)	A valid date value is provided in item *Date Radiation Ended* (NAACCR Item #3200).

REASON FOR NO RADIATION   NAACCR ITEM #1430

Reason for No Radiation identifies why radiation therapy was not provided to the patient and distinguishes a physician's not recommending this therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan.

Coding Instructions
• If *Regional Treatment Modality* (NAACCR Item #1570) is coded 00, then record the reason based on

documentation in patient record.

• Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include radiation therapy.

• Code 7 if the patient refused recommended radiation therapy, made a blanket refusal of all recommended

treatment, or refused all treatment before any was recommended.

• Code 8 if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.

• Code 8 to indicate referral to a radiation oncologist was made and the registry should follow to determine

whether radiation was administered. If follow-up to the specialist or facility determines the patient was never there and no other documentation can be found, code 1.

• Cases coded 8 should be followed and updated to a more definitive code as appropriate.

• Code 9 if the treatment plan offered multiple options, but it is unknown which treatment, if any, was provided.

Code	Definition
0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first course treatment.
2	Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation etc.).
5	Radiation therapy was not administered because the patient died prior to planned or recommended therapy.
6	Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.
7	Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Radiation therapy was recommended, but it is unknown whether it was administered.
9	It is unknown if radiation therapy was recommended or administered. Death certificate and autopsy cases only.

RX-SUMM-CHEMO   **NAACCR ITEM #1390**

Records the type of chemotherapy administered as first course treatment at this and all other facilities. If chemotherapy was not administered, then this item records the reason it was not administered to the patient.

Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Enter the type of chemotherapy administered during the first course of therapy.

Coding Instructions
1. Code 00 if there is no indication anywhere in the patient's medical record that chemotherapy was either planned or administered.

2. Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.

3. Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy.

4. Codes 82, 85, 86, 87 if it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

5. Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

6. Code 88 if chemotherapy was planned, but not started at the time of the most recent follow-up.

7. Code 99 if unknown if chemotherapy   was recommended or administered.

8. Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved.

9. If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy, and *only the original agent or regimen is recorded as first course therapy*.

10. Only the agent, not the method of administration, is to be considered in coding.

11. Combination chemotherapy containing prednisone (a hormone) should be coded in this field by counting the number of chemotherapy agents in the combination (excluding prednisone).

12. Refer to the *SEER*Rx Interactive Drug Database* (*http://seer.cancer.gov/*) for a list of chemotherapeutic agents.

Code	Description
00	None, chemotherapy was not part of the first course of therapy; not customary therapy for this cancer
01	Chemotherapy, NOS
02	Chemotherapy, single agent
03	Chemotherapy, multiple agents (combination regimen)
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.).
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered; it was recommended by the patient's physician, but was not

	administered as part of first-course therapy. No reason was noted in the patient record.
87	Chemotherapy was not administered; the patient's physician recommended it, but this treatment was refused by the patient, the patient's family member, or patient's guardian. The refusal was noted in the patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered
99	Unknown if chemotherapy was recommended or administered because it is not stated in patient medical record; death certificate – only cases

RX DATE – CHEMO   NAACCR ITEM #1220

Records the date of initiation of chemotherapy that is part of the first course of treatment.

Coding Instructions
1. Enter the date chemotherapy was initiated that is part of the first course of treatment.
2. The *RX Date–Chemo Flag* (NAACCR Item #1221) is used to explain why *RX Date Chemotherapy* is not a known date.

RX DATE—CHEMO FLAG   NAACCR ITEM #1221

This flag explains why there is no appropriate value in the corresponding date field, RX *Date Chemotherapy* (NAACCR Item #1220).

Coding Instructions
1. Leave this item blank if *RX Date Chemotherapy* (NAACCR Item #1220) has a full or partial date recorded.
2. Code 12 if the *RX Date Chemotherapy* cannot be determined, but the patient did receive first course chemotherapy.
3. Code 10 if it is unknown whether any chemotherapy was given.
4. Code 11 if no chemotherapy is planned or given.
5. Code 15 if chemotherapy is planned, but not yet started. Follow this patient for chemotherapy and update this item, *RX Date Chemotherapy*, and the relevant chemotherapy items.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any chemotherapy was given)..
11	No proper value is applicable in this context (for example, no chemotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, chemotherapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, chemotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item *RX Date Chemotherapy* (NAACCR Item #1220). Case was diagnosed between 2003 and 2009 and the facility did not record *RX Date*

	Chemotherapy(NAACCR Item #1220) at that time.

RX SUMM – HORMONE   NAACCR ITEM #1400

Records the type of hormone therapy administered as first course treatment at this and all other facilities. If hormone therapy was not administered, then this item records the reason it was not administered to the patient.

Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth.

It is not usually used as a curative measure.

Hormones are divided into 3 categories: 1. Hormones, 2. Antihormones, 3. Adrenocorticotrophic agents

Code	Description
00	None, hormone therapy was not part of the planned first course of therapy; not usually administered for this type and/or stage of cancer; diagnosed at autopsy only.
01	Hormone therapy administered as first course therapy.
82	Hormone therapy was not recommended/administered because it was contra indicated due to patient risk factors (comorbid conditions, advanced age, etc.).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Coding Instructions
1. Assign **code 00** when
   a) There is no information in the patient's medical record that hormone therapy was either planned or administered
   b) There is no reason to suspect that the patient would have had hormone therapy
   c) If the treatment plan offered multiple treatment options and the patient selected treatment that
   d) did not include hormone therapy
   e) Patient elects to pursue no treatment following the discussion of hormone therapy treatment.
   f) Only information available is that the patient was referred to an oncologist. Referral does not
   g) equal a recommendation.
   h) Watchful waiting (prostate)
   i) Patient diagnosed at autopsy

2. Assign **code 99**
   a) Death certificate only.
   b) Some types of cancer **thrive and proliferate because** of **hormones** (estrogen, progesterone and testosterone) that naturally occur in the body. These types of cancer may be treated by an **antihormone** or by the surgical removal/radiation of the organ(s) that produce the hormone, such as the testes and ovaries. **Surgical removal** of **organs** for hormone manipulation is not coded in this data item. Code these procedures in the data field Hematologic Transplant and Endocrine Procedures.
   c) Other types of cancers are **slowed** or **suppressed** by **hormones**. These cancers are treated by administering hormones.
   Example 1: Endometrial cancer may be treated with progesterone. Code all administration of progesterone to patients with endometrial cancer in this field. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer.

   Example 2: **Follicular** and **papillar**y cancers of the **thyroid** are often treated with thyroid hormone to suppress serum thyroid-stimulating hormone (TSH). If a patient with papillary and/or follicular cancer of the thyroid is given a thyroid hormone, code the treatment in this field.

   Code the hormonal agent given as part of combination chemotherapy, e.g. MOPP, COPP whether it affects the cancer cells or not.

   Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of hormonal agents

RX DATE – HORMONE   NAACCR ITEM #1230

Records the date of initiation of hormone therapy that is part of the first course of treatment.

Coding Instructions
Record the first or earliest date on which hormone therapy was administered by any facility. This date corresponds to administration of the agents coded in *RX Summ Hormone* (NAACCR Item #1390).

RX DATE—HORMONE FLAG   NAACCR ITEM #1231

This flag explains why there is no appropriate value in the corresponding date field, *RX Date Hormone* (NAACCR Item #1230).

Coding Instructions
1. Leave this item blank if *RX Date Hormone* (NAACCR Item #1230) has a full or partial date recorded.
2. Code 12 if the *RX Date Hormone* cannot be determined, but the patient did receive first course hormone therapy.
3. Code 10 if it is unknown whether any hormone therapy was given.
4. Code 11 if no hormone therapy is planned or given.
5. Code 15 if hormone therapy is planned, but not yet started. Follow this patient for hormone therapy and update this item, *RX Date Hormone*, and the relevant hormone therapy items.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any hormone therapy was given).
11	No proper value is applicable in this context (for example, no hormone therapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, hormone therapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, hormone therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item *RX Date Hormone* (NAACCR Item #1230). Case was diagnosed between 2003 and 2009 and the facility did not record *RX Date Hormone* (NAACCR Item #1230) at that time.

RX SUMM – BRM/IMMUNOTHERAPY   NAACCR ITEM #1410

Records the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of treatment. Immunotherapy (biological response modifier) consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells.

Types of immunotherapy

Cancer Vaccines: Cancer vaccines are still in the experimental phase and are not coded in this data item. They may be coded in the field Other Therapy. Currently clinical trials use cancer vaccines for brain, breast, colon, kidney, lung, melanoma and ovary.

Interferons: Interferons belong to a group of proteins called cytokines. They are produced naturally by the white blood cells in the body. Interferon-alpha is able to slow tumor growth directly as well as activate the immune system. It is used for a number of cancers including multiple myeloma, chronic myelogenous leukemia (CML), hairy cell leukemia, and malignant melanoma.

Interleukins (IL-2) are often used to treat kidney cancer and melanoma.

Monoclonal Antibodies: Monoclonal antibodies are produced in a laboratory. The artificial antibodies are injected into the patient to seek out and disrupt cancer cell activities and to enhance the immune response against the cancer. For example, Rituximab (Rituxan) may be used for non-Hodgkin lymphoma, and trastuzumab (Herceptin) may be used for certain breast cancers.

Coding Instructions
1. Assign code 00
   a. When there is no information in the patient's medical record that immunotherapy was either planned or administered
   b. There is no reason to suspect that the patient would have had immunotherapy.
   c. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include immunotherapy.
   d. Patient elects to pursue no treatment following the discussion of immunotherapy. Discussion does not equal a recommendation.
   e. Only information available is that the patient was referred to an oncologist. Referral does not equal a recommendation.

      f.   Watchful waiting (prostate)

      g.   Patient diagnosed at autopsy

2. Assign code 87
    a. If the patient refused recommended immunotherapy.
    b. If the patient made a blanket refusal of all recommended treatment.
3. Assign code 99 if the patient refused all treatment before any was recommended.
    a. Death certificate only.

Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of immunotherapeutic agents.

Code	Description
00	None, Immunotherapy was not part of the first course of therapy; not customary therapy for this cancer
01	Immunotherapy
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered; it was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was noted in the patient record.
87	Immunotherapy was not administered; the patient's physician recommended it, but the patient, the patient's family member, or the patient's guardian refused this treatment. The refusal was noted in the patient's records
88	Immunotherapy was recommended, but it is unknown if it was administered
99	It is unknown if Immunotherapy was recommended or administered because it is not stated in patient record; death certificate-only cases.

RX DATE – BRM/IMMUNOTHERAPY   NAACCR ITEM #1240

Records the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of treatment.

Coding Instructions
1. Enter the date the biologic response modifier/immunotherapy was initiated that is part of the first course of treatment.
2. The *RX Date–BRM Flag* (NAACCR Item #1241) is used to explain why *RX Date BRM/Immunotherapy* is not a known date

RX DATE- BRM FLAG   NAACCR ITEM #1241

This flag explains why there is no appropriate value in the corresponding date field, *RX Date BRM/Immunotherapy* (NAACCR Item #1240).

Coding Instructions
1. Leave this item blank if *RX Date BRM/Immunotherapy* (NAACCR Item #1240) has a full or partial date recorded.
2. Code 12 if the *RX Date BRM/Immunotherapy* cannot be determined, but the patient did receive first course immunotherapy or a biologic response modifier.
3. Code 10 if it is unknown whether any immunotherapy or a biologic response modifier was given.

4. Code 11 if no immunotherapy or biologic response modifier is planned or given.
5. Code 15 if immunotherapy or a biologic response modifier is planned, but not yet started.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any immunotherapy was given).
11	No proper value is applicable in this context (for example, no immunotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, immunotherapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, immunotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item *RX Date BRM/Immunotherapy* (NAACCR Item #1240). Case was diagnosed between 2003 and 2009 and the facility did not record *RX Date BRM/Immunotherapy* (NAACCR Item #1240) at that time.

RX SUMM—SYSTEMIC / SUR SEQ   NAACCR ITEM #1639

Records the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment.

Coding Instructions
1. Enter the sequencing of systemic therapy (RX Summ-Chemo [1390], RX Summ-Hormone [1400], and RX Summ-Transplnt/Endocr [3250]) and surgical procedures given as part of the first course of treatment.
2. If none of the following surgical procedures was performed: RX Summ- SurgPrim Site(NAACCR Item #1290), RX Summ--Scope Reg LN Sur (NAACCR Item #1292), RX Summ--Surg Oth Reg/Dis (NAACCR Item #1294), then this item should be coded 0.

3. If the patient received both systemic therapy and any one or a combination of the following surgical procedures: RX Summ--Surg Prim Site (NAACCR Item #1290), RX Summ--Scope Reg LN Sur (NAACCR Item #1292), or RX Summ--Surg Oth Reg/Dis (NAACCR Item #1294), then code this item 2—9, as appropriate.

Code	Label	Description
0	No systemic therapy and/or surgical procedures	No systemic therapy was given; and/or no surgical procedure of primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery was performed. Diagnosed at autopsy.
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
4	Systemic therapy both before and after surgery	Systemic therapy was given before and after any surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
5	Intraoperative systemic therapy	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to

Code	Label	Description
		other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with other systemic therapy administered before or after surgery	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) with other systemic therapy administered before or after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
7	Surgery both before and after systemic therapy	Systemic therapy both before and after radiation", defined as Systemic therapy was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown	Administration of systemic therapy and surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is unknown if systemic therapy was administered and/or it is unknown if surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed.

RX SUMM – TRANSPLNT/ENDOCR   NAACCR ITEM #3250

Identifies systemic therapeutic *procedures* administered as part of the first course of treatment at this and all other facilities. If none of these *procedures* were administered, then this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

Definitions:

Bone marrow transplant (BMT): Procedure used to restore stem cells that were destroyed by chemotherapy and/or radiation. Replacing the stem cells allows the patient to undergo higher doses of chemotherapy.

BMT Allogeneic: Receives bone marrow or stem cells from a donor.

BMT Autologous: Uses the patient's own bone marrow and/or stem cells. The tumor cells are filtered out and the purified blood and stem cells are returned to the patient.

Note: Used for breast cancer, lymphoma, leukemia, aplastic anemia, myeloma, germ cell tumors, ovarian cancer, and small cell lung cancer.

Conditioning: High-dose chemotherapy with or without radiation administered prior to transplants such as BMT and stem cell to kill cancer cells. This conditioning also destroys normal bone marrow cells so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the Chemotherapy field.

Hematopoietic Growth Factors: A group of substances that support hematopoietic (blood cell) colony formation. The group includes erythropoietin, interleukin-3, and colony-stimulating factors (CSFs). The growth-stimulating substances are ancillary drugs and not coded.

Non-Myeloablative Therapy: Uses immunosuppressive drugs pre- and post-transplant to ablate the bone marrow. These are not recorded as therapeutic agents.

Peripheral Blood Stem Cell Transplantation (PBSCT): Rescue that replaces stem cells after conditioning.

Rescue: Rescue is the actual BMT or stem cell transplant done after conditioning.

Stem Cells: Immature cells found in bone marrow, blood stream and umbilical cords. The stem cells mature into blood cells.

Coding Instructions

1. Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.
2. Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.
3. Endocrine irradiation and/or endocrine surgery are procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or affect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.
4. Code 00 if a transplant or endocrine procedure was not administered to the patient
5. Code 00 if there is no indication anywhere in the patient's medical record that a transplant or endocrine procedure was either planned or administered.
6. Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include a transplant or endocrine procedure.
7. If it is known that a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
8. Code 87 if the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
9. Code 88 if it is known that a physician recommended a hematologic transplant or endocrine procedure, but no further documentation is available yet to confirm its administration.
10. Code 88 to indicate referral to a specialist for hematologic transplant or endocrine procedures and the registry should follow the case. If follow-up to the specified specialist or facility determines the patient was never there, code 00.
11. Cases coded 88 should be followed to determine whether they were given a hematologic transplant or endocrine procedure or why not.
12. Code 99 if it is unknown whether a hematologic transplant and/or endocrine surgery/radiation was administered or recommended .

Code	Description
00	None, transplant procedure or endocrine therapy was not part of the first course of therapy; not customary therapy for this cancer
10	Bone marrow transplant, NOS. A bone marrow transplant procedure was administered, but the type was not specified
11	Bone marrow transplant – autologous
12	Bone marrow transplant – allogeneic
20	Stem cell harvest
30	Endocrine surgery and/or endocrine radiation therapy. Code only to be used for Primary Sites Breast and/or Prostate

Code	Description
40	Combination of endocrine surgery and/or radiation with a transplant procedure (combination of codes **30** and **10**, **11**, **12** or **20**).
82	Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered If a bone marrow or stem cell harvest was undertaken, but was not followed by a rescue or re-infusion as part of first course treatment
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record. Autopsy only cases.

RX SUMM – OTHER   **NAACCR ITEM #1420**

Enter any other cancer-directed therapy received by the patient as part of the first course of therapy. Record any other therapy administered at your facility and all other facilities.

Consult the most recent version of the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* for instructions for coding care of specific hematopoietic neoplasms in this item.

Other Treatment is rare. This data item will always generate an EDIT WARNING when code = 1 or 2. Warnings do not require EDIT Override or FORCE. If the case has other errors in addition to the warning the errors will need to be corrected prior to submission. Again, WARNINGS cannot be FORCEd.

The following explanations and definitions are quoted from the website for the National Center for Complementary and Alternative Medicine (NCCAM). Complementary and alternative medicine, as defined by NCCAM, is a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine. While some scientific evidence exists regarding some CAM therapies, for most there are key questions that are yet to be answered through well-designed scientific studies--questions such as whether they are safe and whether they work for the diseases or medical conditions for which they are used.

Complementary medicine is used **together with** conventional medicine. An example of a complementary therapy is using aromatherapy to help lessen a patient's discomfort following surgery.

Alternative medicine is used **in place of** conventional medicine. An example of an alternative therapy is using a special diet to treat cancer instead of undergoing surgery, radiation, or chemotherapy that has been recommended by a conventional doctor.

Coding Instructions
1. Assign **Code 0** when
    a. There is no indication anywhere in the patient's medical record that other therapy was either planned or administered
    b.
    c. There is no reason to suspect that the patient would have had other therapy.
    d. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include other therapy.
    e. Patient elects to pursue no treatment following the discussion of other therapy. Discussion does not equal a recommendation.
    f. Only information available is that the patient was referred for consideration of other therapy. Referral does not equal a recommendation.
    g. Patient diagnosed at autopsy

2. Assign **code 1**
    a. Hematopoietic treatments such as: phlebotomy for polycythemia vera or aspirin for essential thrombocythemia.
    b. Patient had cancer treatment that could not be assigned to the previous treatment fields (surgery, radiation, chemotherapy, immunotherapy, or systemic therapy).

3. Assign **Code 2** for any experimental or newly developed treatment that differs greatly from proven types of cancer therapy such as a clinical trial. *Note:* Hyperbaric oxygen has been used to treat cancer in clinical trials, but it is also used to promote tissue healing following head and neck surgeries. Do not code the administration of hyperbaric oxygen to promote healing as an experimental treatment.

4. Assign **code 3** when the patient is enrolled in a double blind clinical **trial**. When the trial is complete and the code is broken, review and recode the therapy.

5. Assign **code 6** for **unconventional** methods whether they are the single therapy or given in combination with conventional therapy. See below for more details.

6. Assign **code 8** When other therapy was recommended by the physician but there is no information that the treatment was given.

7. Assign **code 9**
    a. When there is no documentation that other therapy was recommended or performed
    b. Death certificate only.

Code 6
Use code 6 for unconventional methods (for example, laetrile) when they are given alone or in combination with cancer-directed treatment. Use code 6 for alternative and complementary therapies ONLY IF the patient receives no other type of treatment (for example, do not code megavitamins if the patient also received cancer-directed surgery). Code **6** includes but is not limited to:

UNCONVENTIONAL METHODS	ALTERNATIVE AND COMPLEMENTARY THERAPIES
Cancell	ALTERNATIVE SYSTEMS
Carnivora	Acupuncture
Glyoxylide	Ayurveda
Iscador	Environmental Medicine
Koch Synthetic Antitoxins	Homeopathic Medicine
Krebiozen	Natural Products
Laetrile	Native American, Latin American, Or
Malonide	Traditional Oriental Medicine
Parabenzoquinone	Bioelectromagnetic Applications
	Blue Light Treatment
ALTERNATIVE AND COMPLEMENTARY THERAPIES	Electroacupuncture
MANUAL HEALING	Magnetoresonance Spectroscopy
Acupressure	Diet, Nutrition, Lifestyle
Biofield Therapeutics	Changes In Lifestyle
Massage Therapy	Diet
Reflexology	Gerson Therapy
Zone Therapy	Macrobiotics
MIND/BODY CONTROL	Megavitimins
Biofeedback	Nutritional Supplements
Humor Therapy	Herbal Medicine
Meditation	Ginger
Relaxation Techniques	Ginkgo Biloba Extract
Yoga	Ginseng Root
PHARMACOLOGICAL AND BIOLOGICAL TREATMENTS	
Anti-Oxidizing Agents	
Cell Treatment	

Code	Description
0	No other cancer directed therapy except as coded elsewhere.
	Patient received no other cancer-directed therapy.
1	Other cancer-directed therapy – Other, Cancer-directed therapy that cannot be appropriately assigned to other specific treatment modalities. *Examples:* hyperbaric oxygen (as adjunct to cancer-directed treatment), or hyperthermia, PUVA, arterial block for renal cell carcinoma, and radio-frequency thermal ablation (hyperthermia). Embolization using alcohol as an embolization agent. Embolization for a site other than the liver where the embolizing agent is unknown.
2	Other experimental cancer-directed therapy (not included elsewhere)
	Includes any experimental or newly developed method or treatment differing greatly from proven types of cancer therapy. It may be used for institution-based clinical trials.
3	Other-Double-blind clinical trial, code not yet broken
	Patient is involved in a double blind clinical trial. Code the treatment actually administered when the double blind clinical trial code is broken. Do no code ancillary drugs in this field.
6	Unproven therapy (including laetrile, krebiozen, etc.)
	Unconventional treatments given by non-medical personnel.
7	Refusal, the patient or patient's guardian refused treatment that would have been coded as 1, 2, or 3.
8	Recommended; Other cancer-directed therapy recommended, unknown if administered
	Physician recommended other cancer-directed therapy but there is no indication in the record that the patient received the treatment.
9	Unknown if other cancer-directed therapy administered

RX DATE – OTHER   NAACCR ITEM #1250

Records the date on which other treatment began at any facility.

Coding Instructions
Enter the date any "other" therapy was initiated that is part of the first course of treatment.

RX DATE – OTHER FLAG   NAACCR ITEM #1251

This flag explains why there is no appropriate value in the corresponding date field, *RX Date Other* (NAACCR Item #1250).

Coding Instructions
1. Leave this item blank if *RX Date Other* (NAACCR Item #1250) has a full or partial date recorded.
2. Code 12 if the *RX Date Other* cannot be determined, but the patient did receive first course other treatment.
3. Code 10 if it is unknown whether any other treatment was given (*Other Treatment* [NAACCR Item #1420] is 9).
4. Code 11 if no other treatment is planned or given (*Other Treatment* [NAACCR Item #1420] is 0, 7 or 8).

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any Other Treatment was given).
11	No proper value is applicable in this context (for example, no Other Treatment given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, Other Treatment was given but the date is unknown).
(blank)	A valid date value is provided in item *Date Other Treatment Started* (NAACCR Item #1250).

RX SUMM – TREATMENT STATUS   **NAACCR ITEM #1285**

This data item summarizes whether the patient received any treatment or the tumor was under active surveillance.

Instructions for Coding
- This item may be left blank for cases diagnosed prior to 2010.
- Treatment given after a period of active surveillance is considered subsequent treatment and it not coded in this item.
- Use code 0 when treatment is refused or the physician decides not to treat for any reason such as the presence of comorbidities.

Code	Description
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment was given

TEXT- REQUIRED

The Text Required section includes the set of data items where documentation must be entered to verify complete and accurate coding. Please read the Introduction to Text Documentation which precedes this section to become familiar with FCDS text requirements. Text requirements are monitored by FCDS QC Review and through FCDS EDITS.

Please see Appendix L for specific text documentation requirements.

NOTE: Vendor insertion of auto text from coded data is NOT sufficient to meet the CDC/NPCR or FCDS requirements for text documentation. Registrars/Abstractors must know which text areas in their abstracting software will be submitted to FCDS. FCDS does not always know how or where vendors map your screen entry text to the FCDS required text fields.

The use of standard abbreviations in documentation and diagnostic text is acceptable.

Refer to Appendix C for standard abbreviations.

Data Items Included In This Section

NAACCR Item Number   Item Name

2520	Text – DX Procedures – Physical Exam
2530	Text – DX Procedures – X-Ray/Scans
2540	Text – DX Procedures – Scopes
2550	Text – DX Procedures – Lab Tests
2560	Text – DX Procedures – Operative Report
2570	Text – DX Procedures – Pathology Report
2580	Text – Primary Site Title
2590	Text – Histology Title
2600	Text – Staging
2610	RX Text – Surgery
2620	RX Text – Radiation (Beam)
2630	RX Text – Radiation Other
2640	RX Text – Chemo
2650	RX Text – Hormone
2660	RX Text – BRM
2670	RX Text – Other
2680	Text – Remarks
2690	Text – Place of Diagnosis

TEXT – DX PROC – PE   **NAACCR ITEM #2520**

Enter information from history and physical examinations. Information can include duration and type of symptoms, family history, location of tumor, etc. See Appendix L

TEXT – DX PROC – X-RAY/SCANS   **NAACCR ITEM #2530**

Enter information from diagnostic imaging reports, including X-rays, MRI and PET scans, ultrasound and other imaging studies. Both positive and negative exams are important. See Appendix L

TEXT – DX PROC – SCOPES   **NAACCR ITEM #2540**

Enter the text information from endoscopic examinations. Information can include visualization of tumor, location of tumor, etc. See Appendix L

TEXT – DX PROC – LAB TESTS   **NAACCR ITEM #2550**

Enter information from laboratory examination other than cytology or histopathology for the tumor being reported. Information can include tumor markers, serum and urine electrophoresis, special studies, etc.

Tumor Markers can be obtained from serum, Immunostaining, tissue and other specimens. They may be cancer-specific or more general involving markers for numerous cancer types. Some tumor marker examples include:

Breast Cancer: Progesterone Receptors Assays (PRA), Estrogen Receptor Assays (ERA), Her2/neu*
Prostate Cancer: Prostatic Specific Antigen (PSA)
Testicular Cancer: Human Chorionic Gonadotropin (hCG), Alpha Feto Protein (AFP)
Liver Cancer: Alpha Feto Protein (AFP)
Ovarian Cancer: CA-125
Other Markers Include: Carcinoembryonic antigen – CEA (Colorectal), CA-19-9, BRCA1 and numerous others

TEXT – DX PROC – OP   **NAACCR ITEM #2560**

Enter information from operative reports. Information from operative reports can include observations at surgery, tumor size, extent of involvement of primary or metastatic sites not surgically excised or biopsied and other information that may not be documented elsewhere. See Appendix L

TEXT – DX PROC – PATH   **NAACCR ITEM #2570**

Enter information from cytology and histopathology reports. Information from these reports can include tissue type, tumor size, extent of tumor spread, involvement of resection margins, tumor type, grade, behavior, lymph node status, metastatic involvement, etc. See Appendix L

TEXT – STAGING   NAACCR ITEM #2600

Enter staging information not already entered in the Text – DX Proc areas. Information can include a summary of all staging tests with overall stage as stated by physician(s), special considerations for staging, etc. See Appendix L

RX TEXT – SURGERY   NAACCR ITEM #2610

Enter information describing the surgical procedure(s) performed as part of first course of therapy. See Appendix L

RX TEXT--RADIATION (BEAM)   NAACCR ITEM #2620

Enter the types of beam radiation administered to the patient as part of first course of therapy. See Appendix L

Suggestion for text:
• Date when radiation treatment began
• Where treatment was given, e.g., at this facility, at another facility
• Other treatment information, e.g., patient discontinued after 5 treatments; unknown if radiation was given

RX TEXT--RADIATION OTHER   NAACCR ITEM #2630

Enter the types of non-beam radiation administered to the patient as part of first course of therapy. See Appendix L

Suggestion for text:
• Date treatment was started
• Where treatment was given, e.g., at this facility, at another facility
• Other treatment information, e.g., unknown if radiation was given

RX TEXT—CHEMO   NAACCR ITEM #2640

Enter the documentation regarding chemotherapy treatment of the tumor being reported. See Appendix L

Suggestion for text:
• Date when chemotherapy began
• Where treatment was given, e.g., at this facility, at another facility
• Type of chemotherapy, e.g., name of agent(s) or protocol
• Other treatment information, e.g., treatment cycle incomplete, unknown if chemotherapy was given

RX TEXT—HORMONE   **NAACCR ITEM #2650**

Enter the documentation regarding the hormone treatment of the tumor being reported. See Appendix L

Suggestion for text:
- Date treatment was started
- Where treatment was given, e.g., at this facility, at another facility
- Type of hormone or antihormone, e.g., Tamoxifen
- Type of endocrine surgery or radiation, e.g., orchiectomy
- Other treatment information, e.g., treatment cycle incomplete; unknown if hormones were given

RX TEXT—BRM   **NAACCR ITEM #2660**

Enter the documentation regarding the biological response modifiers or immunotherapy treatments of the tumor being reported. See Appendix L

Suggestion for text:
- When treatment was given, e.g., at this facility; at another facility
- Type of BRM agent, e.g., Interferon, BCG
- BRM procedures, e.g., bone marrow transplant, stem cell transplant
- Other treatment information, e.g., treatment cycle incomplete; unknown if BRM was given

RX TEXT--OTHER   **NAACCR ITEM #2670**

Enter the document documentation regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field. See Appendix L

Suggestion for text:
- Date treatment was started
- Where treatment was given, e.g., at this facility, at another facility
- Type of other treatment, e.g., blinded clinical trial, hyperthermia
- Other treatment information, e.g., treatment cycle incomplete; unknown if other treatment was given

TEXT – REMARKS   **NAACCR ITEM #2680**

Enter text information not elsewhere provided and for overflow from other text areas. See Appendix L

FOLLOW UP

The Follow Up section includes the set of data items used by the FCDS to monitor a facility's last contact with the patient at the time that the abstract was completed. FCDS does not require the collection of most of the data items pertaining to follow up. The FCDS required follow up data items are limited in scope; they mainly assist in performing limited survival analyses.

Data Items Included In This Section

NAACCR Item Number   Item Name
1750   Date of Last Contact
1751   Date of Last Contact Flag
1760   Vital Status
1770   Cancer Status

DATE OF LAST CONTACT   **NAACCR ITEM #1750**

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

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

DATE OF LAST CONTACT FLAG   **NAACCR ITEM #1751**

This flag explains why there is no appropriate value in the corresponding date field, *Date of Last Contact* (NAACCR Item #1750).

Coding Instructions
1. Leave this item blank if *Date of Last Contact* (NAACCR Item #1750) has a full or partial date recorded.
2. Code 12 if the *Date of Last Contact* cannot be determined.

Code	Description
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, the date of last contact is unknown).
(blank)	A valid date value is provided in item *Date of Last Contact or Death* (NAACCR Item #1750).

VITAL STATUS   **NAACCR ITEM # 1760**

Enter the patient's Vital Status as of the date entered in date of last contact.

Code	Description
0	Dead
1	Alive

CANCER STATUS   **NAACCR ITEM #1770**

Enter the cancer status that corresponds to the date of last contact. Cancer status is the absence or presence of cancer. It is coded independently for each primary. If a patient has multiple primaries, each record could have a different cancer status. If a patient has had surgical removal of the primary cancer and all other involved tissue and is felt to be free of cancer, cancer status should be coded 1 – No evidence of this cancer.

Code	Description
1	No evidence of this cancer
2	Evidence of this cancer
9	Unknown, indeterminate whether this cancer present, not stated in patient record