

Florida Cancer Data System



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Data Acquisition Manual 2016



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- Commission on Cancer/American College of Surgeons (COC/ACoS)

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FLORIDA CANCER DATA SYSTEM

PREFACE

In 1978, the Department of Health and Rehabilitative Services, now known as the Florida Department of Health, contracted with the Sylvester Comprehensive Cancer Center/University of Miami School of Medicine to implement and maintain the Florida Cancer Data System (FCDS). FCDS has been operational and collecting incidence data on cancer cases seen in Florida hospitals on or after January 1, 1981. Ambulatory diagnostic/treatment centers and pathology laboratories began cancer case reporting with patients seen on or after July 1, 1997. Dermatologists began actively reporting cases January 1, 2011. Urologists, Medical Oncologists, and Hematology/Oncologists began reporting patients seen on or after January 1, 2013. Additional specialty physician reporting is expected in the future.

Cancer reporting to FCDS is mandated by Florida statutes. All cancer cases seen in any health facility licensed under Florida Statute Section 395 or Section 408.07 must be reported to FCDS according to Florida Statutes Section 385.202. This includes all hospitals, ambulatory diagnostic and treatment centers, clinical laboratories and physicians' offices.

Currently, FCDS processes over 200,000 cancer case abstracts each year. When these cases are unduplicated, there are approximately 120,000 newly diagnosed incidence cancer cases per year. Currently, the FCDS database contains approximately 3,500,000 cases.

The 2016 edition of the FCDS Data Acquisition Manual (DAM) is compatible with national standards. These standards are created and endorsed by the Center for Disease Control and Prevention/National Program of Cancer Registries (CDC/NPCR), the North American Association of Central Cancer Registries (NAACCR), the National Cancer Institute/Surveillance Epidemiology & End Results Program (NCI/SEER), and the Commission on Cancer/American College of Surgeons (COC/ACoS)

CONFIDENTIALITY

According to Florida Statute 381, Public Health: General Provisions, "Information submitted in reports required by this section is confidential, exempt from the provisions of s.119.07 (1), and is to be made public only when necessary to public health. A report so submitted is not a violation of the confidential relationship between practitioner and patient."

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) became law April 14, 2001. While most organizations had two full years until April 14, 2003 to comply, questions regarding how this new law impacts cancer reporting continues to arise. The North American Association of Central Cancer Registries (NAACCR) has provided materials that address these questions. As you will see, HIPAA regulations only impact current state cancer reporting procedures. Specifically,

HIPAA allows for the reporting of identifiable cancer data to public health entities. Because the Florida Cancer Data System falls under the definition of a public health entity, HIPAA allows your facility to continue to report data to us in compliance with state law. Written informed consent from each cancer patient reported to public health entities is not required under HIPAA; rather hospitals must simply document that reporting has occurred.

FCDS continues to adhere to all Florida Statutes and Department of Health guidelines, and follow strict security measures to assure patient and institutional confidentiality.

IMMUNITY FROM LIABILITY

No institution or individual complying with Florida statutes 385.202, 405.01, 381.0031, and Florida State Administrative Code(may not have latest update) Rules 64D-3.004 and 64D3.034 shall be civilly or criminally liable for divulging information or providing materials to the statewide registry as required by the law.

FLORIDA STATE LAW

Title XXIX

**PUBLIC
HEALTH**

Chapter 381

Public Health: General Provisions

381.0031 Report of diseases of public health significance to department.--

(1) Any practitioner licensed in this state to practice medicine, osteopathic medicine, chiropractic medicine, naturopathy, or veterinary medicine; any hospital licensed under part I of chapter 395; or any laboratory licensed under chapter 483 that diagnoses or suspects the existence of a disease of public health significance shall immediately report the fact to the Department of Health.

(2) Periodically the department shall issue a list of infectious or noninfectious diseases determined by it to be a threat to public health and therefore of significance to public health and shall furnish a copy of the list to the practitioners listed in subsection (1).

(3) Reports required by this section must be in accordance with methods specified by rule of the department.

(4) Information submitted in reports required by this section is confidential, exempt from the provisions of s. [119.07\(1\)](#), and is to be made public only when necessary to public health. A report so submitted is not a violation of the confidential relationship between practitioner and patient.

(5) The department may obtain and inspect copies of medical records, records of laboratory tests, and other medical-related information for reported cases of diseases of public health significance described in subsection (2). The department shall examine the records of a person who has a disease of public health significance only for purposes of preventing and eliminating outbreaks of disease and making epidemiological investigations of reported cases of diseases of public health significance, notwithstanding any other law to the contrary. Health care practitioners, licensed health care facilities, and laboratories shall allow the department to inspect and obtain copies of such medical records and medical-related information, notwithstanding any other law to the contrary. Release of medical records and medical-related information to the department by a health care practitioner, licensed health care facility, or laboratory, or by an authorized employee or agent thereof, does not constitute a violation of the confidentiality of patient records. A health care practitioner, health care facility, or laboratory, or any employee or agent thereof, may not be held liable in any manner for damages and is not subject to criminal penalties for providing patient records to the department as authorized by this section.

(6) The department may adopt rules related to reporting diseases of significance to public health, which must specify the information to be included in the report, who is required to report, the method and time period for reporting, requirements for enforcement, and required follow-up activities by the department which are necessary to protect public health.

This section does not affect s. [384.25](#).

History.--s. 2, ch. 29834, 1955; ss. 19, 35, ch. 69-106; s. 67, ch. 77-147; s. 4, ch. 89-311; s. 2, ch. 90-347; s. 15, ch. 91-297; s. 2, ch. 95-188; s. 184, ch. 96-406; s. 175, ch. 97-101; s. 4, ch. 98-151; s. 252, ch. 98-166; s. 8, ch. 2000-367.

Note.--Former s. 381.231.

385.202 Statewide cancer registry.--

(1) Each facility licensed under chapter 395 and each freestanding radiation therapy center as defined in s. [408.07](#) shall report to the Department of Health such information, specified by the department, by rule, which indicates diagnosis, stage of disease, medical history, laboratory data, tissue diagnosis, and radiation, surgical, or other methods of diagnosis or treatment for each cancer diagnosed or treated by the facility or center. Failure to comply with this requirement may be cause for registration or licensure suspension or revocation.

(2) The department shall establish, or cause to have established, by contract with a recognized medical organization in this state and its affiliated institutions, a statewide cancer registry program to ensure that cancer reports required under this section shall be maintained and available for use in the course of any study for the purpose of reducing morbidity or mortality; and no liability of any kind or character for damages or other relief shall arise or be enforced against any hospital by reason of having provided such information or material to the department.

(3) The department or a contractual designee operating the statewide cancer registry program required by this section shall use or publish said material only for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality, except that a summary of such studies may be released for general publication. Information which discloses or could lead to the disclosure of the identity of any person whose condition or treatment has been reported and studied shall be confidential and exempt from the provisions of s. [119.07](#)(1), except that:

(a) Release may be made with the written consent of all persons to whom the information applies;

(b) The department or a contractual designee may contact individuals for the purpose of epidemiologic investigation and monitoring, provided information that is confidential under this section is not further disclosed; or

(c) The department may exchange personal data with any other governmental agency or a contractual designee for the purpose of medical or scientific research, provided such governmental agency or contractual designee shall not further disclose information that is confidential under this section.

(4) Funds appropriated for this section shall be used for establishing, administering, compiling, processing, and providing biometric and statistical analyses to the reporting facilities. Funds may also be used to ensure the quality and accuracy of the information reported and to provide management information to the reporting facilities.

(5) The department may, by rule, classify facilities for purposes of reports made to the cancer registry and specify the content and frequency of the reports. In classifying facilities, the department shall exempt certain facilities from reporting cancer information that was previously reported to the department or retrieved from existing state reports made to the department or the Agency for Health Care Administration. The provisions of this section shall not apply to any facility whose primary function is to provide psychiatric care to its patients.

History.--ss. 2, 3, 4, 9, ch. 78-171; s. 5, ch. 82-213; s. 2, ch. 83-234; s. 96, ch. 86-220; s. 1, ch. 90-6; s. 3, ch. 95-188; s. 201, ch. 96-406; s. 190, ch. 97-101; s. 31, ch. 97-237; s. 24, ch. 99-397.

Note.--Former s. 381.3812.

CONFIDENTIALITY

Title XXIX

Chapter 405

PUBLIC HEALTH

Medical Information Available For Research

405.01 Release of medical information to certain study groups; exemption from liability.—

Any person, hospital, assisted living facility, hospice, sanatorium, nursing or rest home or other organization may provide information, interviews, reports, statements, memoranda, or other data relating to the condition and treatment of any person to research groups, governmental health agencies, medical associations and societies, and in-hospital medical staff committees, to be used in the course of any study for the purpose of reducing morbidity or mortality. No liability of any kind or character for damages or other relief shall arise or be enforced against any person or organization by reason of having provided such information or material, or by reason of having released or published the findings and conclusions of such groups to advance medical research and medical education, or by reason of having released or published generally a summary of such studies.

History.--s. 1, ch. 65-533; s. 19, ch. 90-344; s. 27, ch. 95-210.

Title XXIX

Chapter 405

PUBLIC HEALTH

Medical Information Available For Research

405.02 Limitation on publication of released information.—

Research groups, governmental health agencies, organized medical associations and societies, and in-hospital medical staff committees shall use or publish said material only for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality, except that a summary of such studies may be released by any such group for general publication.

History.--s. 2, ch. 65-533; s. 20, ch. 90-344; s. 244, ch. 96-406.

Title XXIX

Chapter 405

PUBLIC HEALTH

Medical Information Available For Research

405.03 Confidentiality.—

In all events, the identity of any person whose condition or treatment has been studied shall be confidential and exempt from the provisions of s. [119.07\(1\)](#).

History.--s. 3, ch. 65-533; s. 21, ch. 90-344; s. 245, ch. 96-406.

408.07 Definitions.—As used in this chapter, with exception of ss. 408.031-408.045, the term:

- (1) "Accepted" means that the agency has found that a report or data submitted by a health care facility or a health care provider contains all schedules and data required by the agency and has been prepared in the format specified by the agency, and otherwise conforms to applicable rule or Florida Hospital Uniform Reporting System manual requirements regarding reports in effect at the time such report was submitted, and the data are mathematical reasonable and accurate.
- (2) "Adjusted admission" means the sum of acute and intensive care admissions divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues. If a hospital reports only subacute admissions, then "adjusted admission" means the sum of subacute admissions divided by the ratio of total inpatient revenues to gross revenues.
- (3) "Agency" means the Agency for Health Care Administration.
- (4) "Alcohol or chemical dependency treatment center" means an organization licensed under chapter 397.
- (5) "Ambulatory care center" means an organization which employs or contracts with licensed health care professionals to provide diagnosis or treatment services predominantly on a walk-in basis and the organization holds itself out as providing care on a walk-in basis. Such an organization is not an ambulatory care center if it is wholly owned and operated by five or fewer health care providers.
- (6) "Ambulatory surgical center" means a facility licensed as an ambulatory surgical center under chapter 395.
- (7) "Audited actual data" means information contained within financial statements examined by an independent, Florida-licensed, certified public accountant in accordance with generally accepted auditing standards, but does not include data within a financial statement about which the certified public accountant does not express an opinion or issues a disclaimer.
- (8) "Birth center" means an organization licensed under s. 383.305.
- (9) "Cardiac catheterization laboratory" means a freestanding facility that employs or contracts with licensed health care professionals to provide diagnostic or therapeutic services for cardiac conditions such as cardiac catheterization or balloon angioplasty.
- (10) "Case mix" means a calculated index for each health care facility or health care provider, based on patient data, reflecting the relative costliness of the mix of cases to that facility or provider compared to a state or national mix of cases.
- (11) "Clinical laboratory" means a facility licensed under s. 483.091, excluding: any hospital laboratory defined under s. 483.041(6); any clinical laboratory operated by the state or a political subdivision of the state; any blood or tissue bank where the majority of revenues are received from the sale of blood or tissue and where blood, plasma, or tissue is procured from volunteer donors and donated, processed, stored, or distributed on a nonprofit basis; and any clinical laboratory which is wholly owned and operated by physicians who are licensed pursuant to chapter 458 or chapter 459 and who practice in the same group practice, and at which no clinical laboratory work is performed for patients referred by any health care provider who is not a member of that same group practice.
- (12) "Comprehensive rehabilitative hospital" or "rehabilitative hospital" means a hospital licensed by the agency as a specialty hospital as defined in s. 395.002; provided that the hospital provides a program of comprehensive medical rehabilitative services and is designed, equipped, organized, and operated solely to deliver comprehensive medical rehabilitative services, and further provided that all licensed beds in the hospital are classified as "comprehensive rehabilitative beds" pursuant to s. 395.003(4), and are not classified as "general beds."

- (13) "Consumer" means any person other than a person who administers health activities, is a member of the governing body of a health care facility, provides health services, has a fiduciary interest in a health facility or other health agency or its affiliated entities, or has a material financial interest in the rendering of health services.
- (14) "Continuing care facility" means a facility licensed under chapter 651.
- (15) "Critical access hospital" means a hospital that meets the definition of "critical access hospital" in s. 1861(mm) (1) of the Social Security Act and that is certified by the Secretary of Health and Human Services as a critical access hospital.
- (16) "Cross-subsidization" means that the revenues from one type of hospital service are sufficiently higher than the costs of providing such service as to offset some of the costs of providing another type of service in the hospital. Cross-subsidization results from the lack of a direct relationship between charges and the costs of providing a particular hospital service or type of service.
- (17) "Deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. For hospitals, such reductions include contractual adjustments; uncompensated care; administrative, courtesy, and policy discounts and adjustments; and other such revenue deductions, but also includes the offset of restricted donations and grants for indigent care.
- (18) "Diagnostic-imaging center" means a freestanding outpatient facility that provides specialized services for the diagnosis of a disease by examination and also provides radiological services. Such a facility is not a diagnostic-imaging center if it is wholly owned and operated by physicians who are licensed pursuant to chapter 458 or chapter 459 and who practice in the same group practice and no diagnostic-imaging work is performed at such facility for patients referred by any health care provider who is not a member of that same group practice.
- (19) "FHURS" means the Florida Hospital Uniform Reporting System developed by the agency.
- (20) "Freestanding" means that a health facility bills and receives revenue, which is not directly subject to the hospital assessment for the Public Medical Assistance Trust Fund as described in s. 395.701.
- (21) "Freestanding radiation therapy center" means a facility where treatment is provided through the use of radiation therapy machines that are registered under s. 404.22 and the provisions of the Florida Administrative Code implementing s. 404.22. Such a facility is not a freestanding radiation therapy center if it is wholly owned and operated by physicians licensed pursuant to chapter 458 or chapter 459 who practice within the specialty of diagnostic or therapeutic radiology.
- (22) "GRAA" means gross revenue per adjusted admission.
- (23) "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges, and other operating revenue. Gross revenues do not include contributions, donations, legacies, or bequests made to a hospital without restriction by the donors.
- (24) "Health care facility" means an ambulatory surgical center, a hospice, a nursing home, a hospital, a diagnostic-imaging center, a freestanding or hospital-based therapy center, a clinical laboratory, a home health agency, a cardiac catheterization laboratory, a medical equipment supplier, an alcohol or chemical dependency treatment center, a physical rehabilitation center, a lithotripsy center, an ambulatory care center, a birth center, or a nursing home component licensed under chapter 400 within a continuing care facility licensed under chapter 651.
- (25) "Health care provider" means a health care professional licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 463, chapter 464, chapter 465, chapter 466, part I, part III, part IV, part V, or part X of chapter 468, chapter 483, chapter 484, chapter 486, chapter 490, or chapter 491.
- (26) "Health care purchaser" means an employer in the state, other than a health care facility, health insurer, or health care provider, who provides health care coverage for her or his employees.

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- (27) "Health insurer" means any insurance company authorized to transact health insurance in the state, any insurance company authorized to transact health insurance or casualty insurance in the state that is offering a minimum premium plan or stop-loss coverage for any person or entity providing health care benefits, any self-insurance plan as defined in s. 624.031, any health maintenance organization authorized to transact business in the state pursuant to part I of chapter 641, any prepaid health clinic authorized to transact business in the state pursuant to part II of chapter 641, any multiple-employer welfare arrangement authorized to transact business in the state pursuant to ss. 624.436-624.45, or any fraternal benefit society providing health benefits to its members as authorized pursuant to chapter 632.
- (28) "Home health agency" means an organization licensed under part IV of chapter 400.
- (29) "Hospice" means an organization licensed under part VI of chapter 400.
- (30) "Hospital" means a health care institution licensed by the Agency for Health Care Administration as a hospital under chapter 395.
- (31) "Lithotripsy center" means a freestanding facility that employs or contracts with licensed health care professionals to provide diagnosis or treatment services using electro-hydraulic shock waves.
- (32) "Local health council" means the agency defined in s. 408.033.
- (33) "Market basket index" means the Florida hospital input price index (FHIPI), which is a statewide market basket index used to measure inflation in hospital input prices weighted for the Florida-specific experience which uses multistate regional and state-specific price measures, when available. The index shall be constructed in the same manner as the index employed by the Secretary of the United States Department of Health and Human Services for determining the inflation in hospital input prices for purposes of Medicare reimbursement.
- (34) "Medical equipment supplier" means an organization that provides medical equipment and supplies used by health care providers and health care facilities in the diagnosis or treatment of disease.
- (35) "Net revenue" means gross revenue minus deductions from revenue.
- (36) "New hospital" means a hospital in its initial year of operation as a licensed hospital and does not include any facility, which has been in existence as a licensed hospital, regardless of changes in ownership, for over 1 calendar year.
- (37) "Nursing home" means a facility licensed under s. 400.062 or, for resident level and financial data collection purposes only, any institution licensed under chapter 395 and which has a Medicare or Medicaid certified distinct part used for skilled nursing home care, but does not include a facility licensed under chapter 651.
- (38) "Operating expenses" means total expenses excluding income taxes.
- (39) "Other operating revenue" means all revenue generated from hospital operations other than revenue directly associated with patient care.
- (40) "Physical rehabilitation center" means an organization that employs or contracts with health care professionals licensed under part I or part III of chapter 468 or chapter 486 to provide speech, occupational, or physical therapy services on an outpatient or ambulatory basis.
- (41) "Prospective payment arrangement" means a financial agreement negotiated between a hospital and an insurer, health maintenance organization, preferred provider organization, or other third-party payor which contains, at a minimum, the elements provided for in s. 408.50.

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(42) "Rate of return" means the financial indicators used to determine or demonstrate reasonableness of the financial requirements of a hospital. Such indicators shall include, but not be limited to: return on assets, return on equity, total margin, and debt service coverage.

(43) "Rural hospital" means an acute care hospital licensed under chapter 395, having 100 or fewer licensed beds and an emergency room, and which is:

(a) The sole provider within a county with a population density of no greater than 100 persons per square mile;

(b) An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from another acute care hospital within the same county;

(c) A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer per square mile;

(d) A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this paragraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the State Center for Health Statistics at the Agency for Health Care Administration; or

(e) A hospital designated as a Critical Access Hospital by the Department of Health in accordance with federal regulations and state requirements.

Population densities used in this subsection must be based upon the most recently completed United States census.

(44) "Special study" means a nonrecurring data-gathering and analysis effort designed to aid the agency in meeting its responsibilities pursuant to this chapter.

(45) "Teaching hospital" means any Florida hospital officially affiliated with an accredited Florida medical school which exhibits activity in the area of graduate medical education as reflected by at least seven different graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education or the Council on Postdoctoral Training of the American Osteopathic Association and the presence of 100 or more full-time equivalent resident physicians. The Director of the Agency for Health Care Administration shall be responsible for determining which hospitals meet this definition.

History.--s. 71, ch. 92-33; s. 75, ch. 92-289; s. 13, ch. 93-129; s. 39, ch. 93-217; s. 17, ch. 95-144; s. 38, ch. 97-103; s. 2, ch. 98-14; s. 2, ch. 98-21; s. 14, ch. 98-89; s. 44, ch. 2000-153; s. 28, ch. 2000-163; s. 2, ch. 2000-227. ch. 2003-258; s. 5, ch. 2005-81; s. 77, ch. 2006-197; s. 10, ch. 2006-261.

Rule 64D-3.003

64D-3.003 Notification by Laboratories.

(1) Each laboratory director or designee in charge of a laboratory shall report, or cause to be reported evidence suggestive of or diagnostic of diseases or conditions listed in subsection 64D-3.002(1), F.A.C., from any specimen derived from a human body, or from an animal in the case of rabies or plague testing, to the county health department director or administrator or the State Health Officer or to either of their designated representatives. Such reports shall be made within 72 hours of recognition by telephone, or other electronic means, or in writing, except for certain specified diseases as indicated by a (T), which shall be reported immediately by telephone and followed by a written report. Exceptions to laboratory reporting as defined by this rule are provided for sexually transmitted diseases including AIDS, as indicated in Rule 64D-3.017, F.A.C.

(2) All reports of cancer identified by laboratories licensed under Chapter 483, F.S., shall be submitted to the Florida Cancer Data System within six (6) months of diagnosis.

(3) The State Health Officer shall periodically, but no less than annually, issue a listing of laboratory test results that are to be reported. The July 1999 "Reportable Laboratory Findings," incorporated by reference in this rule, shall be updated to reflect changes in technology and practice and may be obtained from the Department of Health, Bureau of Epidemiology, 4052 Bald Cypress Way, Bin A-12, Tallahassee, Florida 32399-1720.

(4) To allow follow-up of laboratory findings by the local county health department director/administrator or their designee, all specimens submitted for laboratory tests or examinations related to a disease or condition listed in subsection 64D-3.002(1), F.A.C., shall be accompanied by certain identifying information. In addition to the name and date of birth of the person from whom the specimen was obtained; the name, address and telephone number of the processing clinical laboratory; and the diagnostic test(s) performed, specimen type and result, the following information shall be provided:

(a) Address, telephone number, race, sex, and ethnicity of the person from whom the specimen was obtained or, if this is not available,

(b) Name, address and telephone number of the submitting physician, health care provider or other authorized person who submitted the specimen.

(5) The practitioner who first authorizes, orders, requests or submits a specimen shall be responsible for obtaining and providing the information required in (4) above at the time the specimen is sent to or received by the laboratory.

(6) Notification of test results shall be submitted by telephone, or other electronic means, or in writing on a form furnished by the laboratory. Reports shall be made within 72 hours of a test result. Any preliminary telephone communication must be followed up by a written report.

(7) If the laboratory that makes the positive finding received the specimen from another laboratory, the laboratory making the positive finding shall be responsible for reporting such results as defined in subsection 64D-3.003(1), F.A.C.

(8) In addition to the reporting requirements pursuant to subsection 64D-3.003(1), F.A.C., each laboratory that obtains

a human isolate of *Escherichia coli* O157:H7, or *Neisseria meningitidis* or *Haemophilus influenzae* from a sterile site

or *Staphylococcus aureus* with a vancomycin minimum inhibitory concentration (MIC) = or > 8 micrograms per milliliter from any site shall retain a subculture of the isolate on suitable media for at least six months after receipt of the specimen in the laboratory. In lieu of retaining this subculture, the laboratory is permitted to send the subculture to the Florida Department of Health State Central Laboratory, which will maintain a record indicating the date that these subcultures were submitted to the Central Laboratory.

(9) In addition to the reporting requirements pursuant to subsection 64D-3.003(1), F.A.C., each laboratory that makes a finding, or suggestive finding, of malaria or cyclospora parasites in a specimen of a patient shall retain a stained permanent slide for at least six months after receipt of the specimen in the laboratory. In lieu of retaining the slide(s), the laboratory may send such slide(s) to the State of Florida Department of Health Central Laboratory, which will maintain a record indicating the date that these specimens were submitted to the Central Laboratory.

(10) Each laboratory licensed to perform tests for any reportable disease or condition shall make its records for such diseases or conditions available for on-site inspection by the department or its authorized representatives.

(11) Persons submitting specimens for reportable laboratory tests to the Florida Department of Health, pursuant to subsection 64D-3.003(4), F.A.C., are required to supply the laboratories with sufficient information to comply with the provisions of this section.

Specific Authority 381.0011(13), 381.003(2), 381.0031(6), 384.33 FS. Law Implemented 381.0011, 381.003, 381.0031, 384.25 FS. History—New 12-29-77, Amended 6-7-82, Formerly 10D-3.66, Amended 2-26-92, 7-21-96, Formerly 10D-3.066, Amended 11-2-98, 7-5-99, 6-4-00, 6-9-03. *Repealed* 11-20-06...

Editorial Note: See 64D-3.031

Rule 64D-3.031

64D-3.031 Notification by Laboratories.

(1) Each person or designee who is in charge of a public, federal, private, military or hospital laboratory responsible for receiving the initial order to perform serologic, immunologic, microscopic, biochemical, molecular or cultural tests on specimens derived from a human body or an animal or for collecting the specimen shall report or cause to be reported any laboratory test suggestive of or diagnostic of diseases or conditions listed in the Table of Notifiable Diseases or Conditions, Rule 64D-3.029, F.A.C. per this rule.

(2) Receipt of a laboratory test order requesting the identification of reportable agents shall be considered by the laboratory as an indication of suspected diagnosis. However, laboratories need only to report suspected cases if indicated in the “suspect immediately” column under laboratories in the Table of Notifiable Diseases or Conditions, Rule 64D-3.029, F.A.C.

(3) To allow follow-up of laboratory findings suggestive of or diagnostic of diseases or conditions in the Table of Notifiable Diseases or Conditions, the form upon which the information will be reported shall be furnished by the laboratory that includes the following information:

(a) The Patient's:

1. First and last name, including middle initial;
2. Address including street city, state and zip code;
3. Phone number, including area code;
4. Date of birth;
5. Sex;
6. Race;
7. Ethnicity (specify if of Hispanic descent or not of Hispanic descent);
8. Pregnancy status if applicable;
9. Social Security number;

(b) The Laboratory

1. Name, address and telephone number of laboratory performing test;
2. Type of specimen (for example stool, urine, blood, mucus, etc.);
3. Date of specimen collection;
4. Site (for example cervix, eye, etc., if applicable);
5. Date of report;
6. Type of tests performed and results, including reference range, titer when quantitative procedures are performed, and including all available results on speciating, grouping or typing of organisms;
7. Submitting provider's name, address including street, city, zip code and telephone number, including area code.

(4) Laboratories located out of state, licensed under Part 1, Chapter 483, F.S., who collect specimens in Florida or who receive the initial order for testing from a practitioner, blood bank, plasmapheresis center or other health care provider located in Florida, shall report in the same way as if the findings had been made by a laboratory located in Florida.

(5) Upon the Department's implementation of its Electronic Laboratory Reporting System (ELR) for laboratory findings suggestive of or diagnostic of diseases or conditions, reports will be submitted electronically to the Department using Health Level Seven (HL7)

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version 2.3.1 format. The CDC Implementation Guide for Transmission of Laboratory-Based Reporting of Public Health Information using version 2.3.1 of the Health Level Seven (HL7) Standard Protocol, incorporated by reference, is available at the Department of Health, ELR Project, 4052 Bald Cypress Way, Bin A-12, Tallahassee, Florida 32399-1715.

(a) The Department's ELR System shall include:

1. The initial contact with the reporting laboratory;
2. A content review and testing of the laboratories' HL7 transmissions; and

Rule 64D-3.031

64D-3.031 Notification by Laboratories.

3. The transition from testing to production for the HL7 laboratory transmissions.

(b) The Department and laboratory will agree on a date of implementation

(c) Laboratories reporting electronically through ELR and the Department shall agree to a date that the transmission of findings suggestive of or diagnostic of diseases or conditions listed in the Table of Notifiable Disease or Conditions, Rule 64D-3.029 F.A.C., electronically in HL7 version 2.3.1 format to the Department is acceptable and considered good faith reporting and the laboratory will no longer be required to submit paper forms pursuant to 64D-3.031(3) F.A.C.

(d) The Department shall ensure access to the laboratory findings suggestive of or diagnostic of disease or conditions listed in the Table of Notifiable Diseases or Conditions to authorized representatives of the department.

(6) This section does not prohibit a laboratory from making a report by telephone, in writing, or facsimile to the county health department having jurisdiction for the area in which the office of the submitting practitioner or the patient's residence is located.

(7) In order to study disease incidence, each laboratory licensed to perform tests for any notifiable disease or condition shall report the test volume for each related diagnostic test performed for the notifiable diseases listed in 64D-3.029, F.A.C.

(a) Reports are to be filed annually on or before April 1 of each year to the Department electronically in a format agreed upon by the department and the laboratory with the following information:

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(1) Type of diagnostic test;

(2) Patient's date of birth;

(3) Patient's sex;

(4) Race;

(5) Ethnicity (specify if of Hispanic descent or not of Hispanic descent).

(8) Each laboratory licensed to perform tests for any reportable disease or condition shall make its records for such diseases or conditions available for on-site inspection by the Department or its authorized representatives.

Specific Authority 381.0011(7), 381.0011(13), 381.003(2), 381.0031(5), 381.0031(6), 384.33, 392.66 FS. Law Implemented 381.0011, 381.003, 381.0031, 384.25(1), 392.53(1) FS. History—New_____.

Editorial Note: History-New 12-29-77, Amended 6-7-82, Formerly 10D-3.66, Amended 2-26-92, 7-21-96, Formerly 10D-3.066, Amended 11-2-98, 7-5-99, 6-4-00, 6-9-03, 9-1-05, Formerly 64D3.003, 64D-3.017 & 64D-3.023

64D-3.034 Cancer Reporting.

64D-3.034 Cancer Reporting

(1) Reporting Requirements:

- a. Each facility and laboratory licensed under Chapters 395 and 483, and Section 408.07(20), F.S., respectively and practitioners licensed under Chapter 458, 459, 464, F.S., are required to report to the Florida Cancer Data System as required by Section 385.202, F.S., within six (6) months of each diagnosis and within six (6) months of the date of each treatment.
- b. Each facility shall submit each cancer case report electronically. Those facilities with fewer than 35 cancers annually requiring abstracting may submit paper copies or portions of the medical record, provided the copies contain all of the required information as per (1)(c).
- c. The data items, coding schemes, definitions, record layouts, and reporting procedures are to follow the guidance provided in the Florida Cancer Data System Data Acquisition Manual (2005, or current edition), incorporated by reference, available at <http://www.fcds.med.miami.edu/inc/downloads.shtml>.

(2) Notwithstanding (1), each facility, center, and laboratory that reports cancer cases to the Florida Cancer Data System shall make its records available for on-site review by the department or its authorized representatives.

Specific Authority 381.0011(13), 381.003(2), 381.0031(6), 384.33, 385.202(5), 392.66 FS. Law Implemented 381.0011, 381.003, 381.0031, 384.25, 385.202, 392.53 FS. History—New

Editorial Note: History—Formerly 10D-3.77, 10D-3.077, and 64D-3.006 (3) (5)...

64D-3.006

64D-3.006 Reports, Medical Facilities and Freestanding Radiation Therapy Centers.

(1) The chief administrative officer of each civilian facility licensed under Chapter 395, F.S., and freestanding radiation therapy centers, as defined in Section 408.07, F.S., shall (and the United States military and Veterans Administration hospitals are requested to) appoint an individual from the staff, hereinafter referred to as “reporting officer,” who shall be responsible for reporting cases or suspect cases of diseases on the notifiable disease list in persons admitted to, attended to, or residing in the facility (cf. Notification by Laboratories, Rule 64D-3.003, F.A.C.).

(2) Reporting of a case or suspected case of notifiable disease or condition by a facility or center fulfills the requirements of the licensed practitioner to report; however, it is the responsibility of the practitioner to ensure that the report is made as stipulated in Rule 64D-3.002, F.A.C. Reports shall be made within 72 hours of diagnosis. Special provisions for reporting sexually transmissible diseases, including HIV infection, are found in Rule 64D-3.016, F.A.C., and for cancer, in subsection 64D-3.006(3), F.A.C.

(3) Reporting of cancer cases by a licensed practitioner, a hospital facility licensed under Chapter 395, F.S., and freestanding radiation therapy centers, as defined in Section 408.07, F.S., to the Florida Cancer Data System as required by Section 385.202, F.S., shall be accomplished within six (6) months of the date of each diagnosis and within six (6) months of the date of each treatment.

(4) Florida Cancer Data System staff will provide each freestanding ambulatory surgical center with an annual list of cancer cases for which reports are required and allow three (3) months from the date of notification for submission of reports to the Florida Cancer Data System for each case on the list. This annual list will be generated by comparing the ambulatory patient data maintained by the Agency for Health Care Administration with the Florida Data System file for each calendar year. This comparison will be made each year after the Florida Cancer Data System file for each year is complete, including all hospital and pathology laboratory data expected for that year. The list sent to each freestanding ambulatory surgical center will contain only those records from the Agency for Health Care Administration ambulatory patient dataset or from cancer case data received from ambulatory centers that cannot be matched with any previously reported case.

(5) For reportable cancer cases, each facility licensed under chapter 395, F.S., and each freestanding radiation therapy center as defined in Section 408.07, F.S., shall electronically submit to the Florida Cancer Data System all available data items as specified in the Data Acquisition Manual and Confidential Abstract Report. Those facilities and centers with fewer than thirty-five (35) cancer cases annually requiring abstracting may submit to FCDS paper copies of portions of the case record that include all available information that is needed for abstracting by FCDS staff. The coding schemes, record layouts, and definitions for these items are those issued by the Florida Cancer Data System in its Data Acquisition Manual and Confidential Abstract Report, DOH Form 2029, dated July 1997, incorporated herein by reference. These documents are available from the Florida Department of Health, Bureau of Epidemiology, 4052 Bald Cypress Way, Bin A-12, Tallahassee, Florida 32399-1720.

Specific Authority 381.0011(13), 381.003(2), 381.0031(6), 384.33, 385.202(5), 392.66 FS. Law Implemented 381.0011, 381.003, 381.0031, 384.25, 385.202, 392.53 FS. History—New 12-29-77, Amended 6-7-82, Formerly 10D-3.77, Amended 2-26-92, 7-21-96, Formerly 10D-3.077, Amended 11-2-98, 7-5-99, 6-4-00.

PUBLIC LAW 107-260—OCT. 29, 2002 116 STAT. 1743

Public Law 107-260

107th Congress

An Act to amend the Public Health Service Act to provide for the collection of data on benign brain-related tumor through the national program of cancer registries.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Benign Brain Tumor Cancer Registries Amendment Act”.

SEC. 2. NATIONAL PROGRAM OF CANCER REGISTRIES; BENIGN BRAIN-RELATED TUMORS AS ADDITIONAL CATEGORY OF DATA COLLECTED.

- (a) In GENERAL—Section 399B of the Public Health Service Act (42 U.S.C. 280e), as redesignated by section 502 (2) (A) of Public Law

106-310 (114 Stat. 1115), is amended in subsection (a)—

- (1) by redesignating paragraphs (1) through (5) as subparagraphs (A) through (3), respectively, and indenting appropriately;

- (2) by striking “(a) IN GENERAL—The Secretary” and inserting the following:

- (a) IN GENERAL—

“(1) STATEWIDE CANCER REGISTRIES—The Secretary”;

- (3) in the matter preceding subparagraph (A) (as so redesignated). By striking “population-based” and all that follows through “data” and inserting the following: “population-based, statewide registries to collect, for each condition specified in paragraph (2)(A), data”; and

- (4) by adding at the end the following:

“(2) CANCER; BENIGN BRAIN-RELATED TUMORS—

“(A) IN GENERAL—For purposes of paragraph (1), the conditions referred to in this paragraph are the following:

“(i) Each form of in-situ and invasive cancer with the exception of basal cell and squamous cell carcinoma of the skin), including malignant brain-related tumors.

“(ii) Benign brain-related tumors

“(B) BRAIN-RELATED TUMOR—For purposes of subparagraph (A):

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“(i) The term ‘brain-related tumor’ means a listed primary tumor (whether malignant or benign) occurring in any of the following sites:’

“(I) The brain, meninges, spinal cord, cauda equina, a cranial nerve or nerves or any other part of the central nervous system.

“(II) The pituitary gland, pineal gland, or craniopharyngeal duct.

“(ii) The term ‘listed’, with respect to a primary tumor, means a primary tumor that is listed in the International Classification of Diseases for Oncology (commonly referred to as the ICD-O).

“(iii) The term ‘International Classification of Diseases for Oncology’ means a classification system that includes topography (site) information and histology (cell type information) developed by the World Health Organization, in collaboration with international centers, to promote international comparability in the collection, classification, processing and presentation of cancer statistics. The ICDO system is a supplement to the International Statistical Classification of Diseases and Related Health Problems (commonly known as the ICD) and is the standard coding system used by cancer registries worldwide. Such term includes any modification made to such system for purposes of the United States. Such term further includes any published classification system that is internationally recognized as a successor to the classification system referred to in the first sentence of this clause.

“(C) STATEWIDE CANCER REGISTRY—References in this section to cancer registries shall be considered to be references to registries described in this subsection.”

(b) APPLICABILITY—The amendments made by subsection (a) apply to grants under section 399B of the Public Health Service Act for fiscal year 2002 and subsequent fiscal years, except that, in the case of a State that received such a grant for fiscal year 2000, the Secretary of Health and Human Services may delay the applicability of such amendments to the State for not more than 12 months if the Secretary determines that compliance with such amendments requires the enactment of a statute by the State or the issuance of State regulations.

Approved October 29, 2002.

LEGISLATIVE HISTORY—s. 2558:
Congressional record, Vol. 148 (2002):
Aug. 1. considered and passed Senate.
Oct 10. considered and passed House.

SECTION I: GUIDELINES FOR CANCER DATA REPORTING

The Florida Cancer Data System (FCDS) is charged with maintaining a high quality database of useable, timely, complete and accurate cancer data for every reportable case of cancer diagnosed or treated in the state of Florida. The FCDS Data Acquisition Manual (FCDS DAM) includes guidelines and instructions for case identification, case eligibility (which cases must be reported to FCDS), abstracting and coding, and multiple appendices that are referenced throughout the manual. The manual only addresses data items that are required by FCDS and the Florida Department of Health to support Florida's statewide, population-based cancer registry. These guidelines have been established as a means to achieve and maintain this objective.

All reporting facilities, regardless of affiliation, **MUST** adhere to the following guidelines for cancer data reporting. The instructions and codes in this manual take precedence over all previous instructions/manuals.

It is the responsibility of both the reporting facility and the facility abstractor (contractor) to be familiar with and understand the content of the most current version of the FCDS Data Acquisition Manual and to update it upon receipt of any changes from FCDS. This responsibility exists without regard to whether or not case abstracting and reporting is being performed by an employee of the reporting facility or through some contractual arrangement with an independent abstracting agency or individual within or outside the state of Florida.

CONFIDENTIALITY - Patient information, personal health information, medical records and healthcare facility data are all confidential and continue to be a concern with regard to cancer and other disease reporting. Please do not fax or email patient information to FCDS. Also, please take care when discussing cases over the phone with FCDS staff.

DO NOT E-MAIL, FAX OR MAIL PATIENT INFORMATION (PHI) TO FCDS UNDER ANY CIRCUMSTANCES unless you are provided specific instructions for using our Secure Fax Service.

A. CASE ELIGIBILITY

Florida facilities are legislatively mandated to report any case of cancer meeting the Florida "cancer" definition, regardless of facility or network affiliation or Class of Case. FCDS requires complete abstracting of cancer cases that the Commission on Cancer/American College of Surgeons may not require.

If your facility participates in the diagnosis, staging, treatment, or continuing care of a patient during the first course of treatment, progression of disease or disease recurrence the case must be reported to FCDS. If any diagnostic, staging, or other evaluative studies are conducted at your facility (diagnostic imaging, re-biopsy, sentinel node biopsy, surgical resection or other staging or treatment, etc.) your facility must report the case regardless of the Class of Case.

Patients whose First Course of Therapy is "Active Surveillance" or "Watchful Waiting" must be reported as their cancer has not been treated by any means...it is only being followed. However, "NO TREATMENT" is a different treatment decision than "Watchful Waiting". Please be cautious when distinguishing the two cases.

"Consult-Only" cases *MAY* be an exception to reporting.

A "consult only" case is any case where the facility provides a second opinion or review of earlier studies **without additional testing at your facility**. A second opinion may include re-reading pathology slides or re-reading diagnostic imaging studies. If your facility does not perform any additional testing, the case may not be reportable to FCDS. However, if your facility does any additional testing for this or any other cancer and they have evidence of disease or are undergoing treatment for cancer, the case is reportable.

Exception 1: Patients undergoing planned first course or later course hormonal treatment for breast or prostate cancer that continue to demonstrate no active neoplasm should not be reported. Any other type of cancer or patient with active malignancy (any evidence of disease) must be reported.

Exception 2: Patients seen in an ambulatory care setting for “port-a-cath” placement where no chemotherapeutic or anti-neoplastic agent(s) is injected into the port do not need to be reported. However, many Florida healthcare facilities including Commission on Cancer/American College of Surgeons accredited cancer programs continue to report these cases voluntarily as part of monitoring the full continuum of patient care delivered under the care of the facility.

Please note that many types of drugs may be administered through a “port-a-cath” delivery system. The medical record and medication flow sheets **MUST** be reviewed and cannot include administration of any anti-neoplastic agent(s) through the port-a-cath for the case to meet this exclusion criterion. If any anti-neoplastic agent is administered at the reporting facility, either as an outpatient or inpatient, the case must be reported.

Note: Facilities may opt to abstract and report “port-a-cath” placement cases at their discretion.

1. Reportable Patients

All patients first seen at the reporting facility on or after January 1, 1981 (July 1, 1997 for free-standing/ambulatory surgery centers and freestanding radiation therapy centers), whether as an inpatient, outpatient or in an ambulatory care setting, who meet one or more of the following criteria must be reported:

- a) all patients with an active, malignant neoplasm (in-situ or invasive), whether being treated or not (includes active surveillance),
- b) all patients with an active, benign or borderline brain or central nervous system (CNS) tumor, diagnosed on or after 01/01/2004, whether being treated or not (includes active surveillance)
- c) all patients undergoing prophylactic, neoadjuvant, or adjuvant therapy for malignancy,
- d) all patients diagnosed at autopsy,
- e) all historical cases that meet FCDS reportability guidelines.

2. Not Reportable Patients

- a) patients seen only in consultation to provide a second opinion to confirm a diagnosis or a treatment plan (no additional testing can be performed at your facility or the case is reportable),
- b) patients in remission (NED) and not receiving prophylactic or adjuvant therapy,
- c) patients first seen at the reporting facility prior to January 1, 1981 (July 1, 1997 for free-standing centers) and returning after that date for the same primary malignant neoplasm,
- d) patients who receive transient care to avoid interrupting a course of therapy started elsewhere.

3. Reportable Neoplasms

Determination of whether or not a given primary neoplasm is reportable is made by reference to the morphology and behavior codes of the *International Classification of Diseases for Oncology* including any approved updates or errata published by WHO and approved by NAACCR for ICD-O-3. Three newly reportable conditions were introduced with the *2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*. Please refer to the most current version of the Hematopoietic Database and Manual for complete reporting instructions.

An online version of ICD-O-3 is available on the WHO International Agency for Research on Cancer (IARC) website: <http://codes.iarc.fr/>. This useful online tool should be used with the following notes:

- The online version of ICD-O-3 is referred to as ICD-O-3.1 as it includes the 2011 updates and any previous errata to ICD-O-3 that have been published since 2000.
- For solid tumors – DO USE the original publication, ICD-O-3 (2000), only.
- For solid tumors – DO NOT USE the ICD-O-3.1 (2011) codes for solid tumors (non-

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hematopoietic, non-lymphoid), as the new codes have not been approved for implementation in the United States and/or Canada as yet.

- For non-solid tumors, use the histology rules in the Hematopoietic and Lymphoid Database. The database already includes the 2011 Heme/Lymph Histology Code Updates.
- Please refer the Appendix R (NAACCR Guidelines for ICD-O-3 Update Implementation) for the complete list of ICD-O-3 code changes effective 1/1/2015 and the complete 2011 Updates.

- a) **In Situ and Invasive Cancers** - FCDS includes primary malignancies which are in situ and/or invasive. Therefore, any cancer with an ICD-O behavior code of /2 (in situ) or /3 (malignant) is reportable to FCDS (**except** carcinoma in situ of the cervix, carcinoma in situ of the prostate, CIN III, and PIN III). Cancers with benign or borderline behavior are discussed elsewhere in this section.

If a tumor with an ICD-O behavior code of /0 or /1 is determined to be in-situ or invasive by the manner in which it is behaving (in malignant fashion), or by a pathologist, the case is reportable.

- Anal Intraepithelial Neoplasia (AIN III)** is reportable to FCDS and should be included in casefinding activities. This non-invasive neoplasm of the anus or anal canal (C21.0-C21.1) is not the same as SCC of perianal skin (C44.5). It is important to distinguish between true anal cancers and skin of anus neoplasms. Neoplasms of the skin of anus (perianal skin) are not reportable, even if they extend into the anal canal. **AIN III** of the perianal skin is not reportable to FCDS.
- Laryngeal Intraepithelial Neoplasia (LIN III)** is reportable to FCDS and should be included in casefinding activities.
- Vaginal Intraepithelial Neoplasia (VAIN III)** is reportable to FCDS and should be included in casefinding activities.
- Vulvar Intraepithelial Neoplasia (VIN III)** is reportable to FCDS and should be included in casefinding activities.
- Pancreatic Intraepithelial Neoplasia (PAIN III)** is reportable to FCDS (histology 8148/2) and should be included in casefinding activities.
- *Glandular Intraepithelial Neoplasia, Grade III/High Grade Glandular Dysplasia** is reportable as adenocarcinoma in situ of the esophagus with histology code 8148/2.
- In Utero Diagnosis and Treatment** – beginning in 2009, diagnosis and treatment dates for a fetus prior to birth are to be assigned the actual date of the event. In the past, those dates were set by rule to the date the baby was born. The exact date may be used for cases diagnosed prior to 2009 and must be used for cases diagnosed 1/1/2009 and later.
- New terminology may be used by your local pathologist** to describe malignant or in situ neoplasms (i.e. well differentiated neuroendocrine neoplasm). When this occurs the neoplasm is reportable to FCDS.

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***Note 1:** AJCC TNM Manual, 7th edition states for Esophageal Cancers: “High grade dysplasia includes all non-invasive neoplastic epithelia that was formerly called carcinoma in situ, a diagnosis that is no longer used for columnar mucosae anywhere in the gastrointestinal tract.” Therefore, all high grade/severe dysplasia of esophagus are reportable as carcinoma in situ.

***Note 2:** AJCC TNM Manual, 7th edition states for Colon Cancers: “The terms ‘high grade dysplasia’ and ‘severe dysplasia’ may be used as synonymous for in situ adenocarcinoma and in situ carcinoma. These cases should be assigned a pTis.” It is necessary to contact your pathologist and/or cancer committee to determine if s/he applies this definition to all colon cancers. If so, high grade/severe dysplasia of any colon site is reportable as adenocarcinoma in situ (8140/2).

- b) **Specified malignant neoplasms of the skin;** dermatofibrosarcoma protuberans, Kaposi sarcoma, malignant melanoma, Merkel cell carcinoma, mycosis fungoides, sebaceous adenocarcinoma, and sweat gland adenocarcinoma **are reportable conditions.**
- c) **Gastro-intestinal stromal tumor (GIST) and thymoma** are often non-malignant. However, they must be abstracted and assigned a Behavior Code of /3 if they are noted to have multiple foci, metastasis, or positive lymph nodes or there is other evidence of malignancy noted by surgeon, pathologist, or during clinical workup following initial diagnosis.
- d) **Chronic Lymphocytic Leukemia** patients may exhibit clinical remission (no symptoms) but are never totally free of disease. Physicians may even state these patients are “in remission”. However, these cases should be reported to FCDS, regardless of physician-stated remission status.
- e) **Basal and squamous skin cancers in genital sites (histology codes 8000-8110) are reportable.**

“Genital Sites” include the following anatomic locations:

- | | | |
|------------------------------|-------------------------|------------------------------|
| C51.0 - C51.1 – Labia | C51.2 - Clitoris | C51.8 - C51.9 - Vulva |
| C52.9 - Vagina | C60.0 - Prepuce | C60.9 - Penis |
| C63.2 - Scrotum | | |

- f) **Carcinoid Tumor of Appendix Diagnosis Date 1/1/2015 forward is a Reportable Malignancy**
- g) **Clarification for Reporting /2 and /3 Pancreatic Neoplasms** - The classification and reporting of tumors of the pancreas can be confusing in part due to the latest terminology associated with tumors arising in the pancreas, and complicated by the mixed nature of benign, borderline, in-situ and invasive neoplasms and various histologic subtypes associated with pancreatic neoplasms. In 2010 the World Health Organization (WHO) published the latest WHO Classification of Tumors of the Pancreas. ALL in-situ and invasive (malignant) neoplasms of the pancreas are reportable to FCDS. However, some reportable neoplasms are associated with terminology registrars may not immediately recognize as reportable malignancy.

Reportable	ICD-O-3	Description
Yes	****/2	All Histologies with Behavior Code of /2 (in-situ)
Yes	****/3	All Histologies with Behavior Code of /3 (invasive)
Yes	8440/3	Cystadenocarcinoma of the pancreas
Yes	8150/3	Cystic Pancreatic Endocrine Neoplasm (CPEN)
Yes	8500/3	Infiltrating Duct Carcinoma of the pancreas
Yes	8503/2	Intraductal Oncocytic Papillary Neoplasm (IOPN) of the pancreas
Yes	8453/2	Intraductal Papillary Mucinous Neoplasms (IPNM) of the pancreas

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Reportable	ICD-O-3	Description
Yes	8453/3	Intraductal Papillary Mucinous Neoplasm (IPNM) with invasive carcinoma
Yes	8503/2	Intraductal Tubule-Papillary Neoplasm (ITPN) of the pancreas
Yes	8503/3	Intraductal Tubule-Papillary Neoplasm (ITPN) with invasive carcinoma
Yes	8470/2	Mucinous Cystic Neoplasm (MCN) of the pancreas with high-grade dysplasia
Yes	8470/2	Non-invasive Mucinous Cystic Neoplasm (MCN) of the pancreas with high-grade dysplasia
Yes	8470/2	Mucinous Cystadenocarcinoma, non-invasive (MCN)
Yes	8470/3	Mucinous Cystadenocarcinoma of the pancreas
Yes	8470/3	Mucinous Cystic Neoplasm (MCN) of the pancreas with invasive carcinoma
Yes	8246/3	Neuroendocrine Carcinoma of the pancreas
Yes	8240/3	Neuroendocrine Tumor, Grade 1 (NET GR1) of the pancreas
Yes	8249/3	Neuroendocrine Tumor, Grade 2 (NET GR2) of the pancreas
Yes	8471/3	Papillary Mucinous Cystadenocarcinoma of the pancreas
Yes	8452/3	Solid Pseudo-Papillary Neoplasm (SPN) of the pancreas
Yes	8552/3*	Mixed acinar-ductal carcinoma
Yes	8163/2*	Papillary neoplasm, pancreatobiliary-type, with high grade intraepithelial neoplasia
Yes	8163/3*	Pancreatobiliary-type carcinoma
No	n/a	Histologies with Behavior Code of /0 (benign)
No	n/a	Histologies with Behavior Code of /1 (borderline)
No	n/a	Serous cystadenomas, solid and cystic papillary (Hamoudi) tumors, lympho-epithelial cysts and simple cysts are all benign and not reportable
* New histology codes not yet implemented in the U.S. are still reportable – use histology 8500 or 8140		
References: 2010 WHO Classification of Tumours of the Pancreas; Pathologe. 2011 Nov;32 Suppl 2:332-6. doi: 10.1007/s00292-011-1515-2; Ann Surg. 2004 May; 239(5): 651–659), 2011 ICD-O-3 Updates, 2015 SEER Program Coding and Staging Manual, and NCI SEER Ask A SEER Registrar.		

- d) **Benign and Borderline Cancers** - **Benign and borderline primary intracranial and central nervous system (CNS) tumors with a behavior code of /0 or /1 in ICD-O-3** are reportable as of 01/01/2004. This includes benign and borderline tumors of intracranial glands (pituitary gland, pineal gland, and tumors of the craniopharyngeal duct), meningioma, and tumors of cranial nerves. If the patient has a history of benign and/or borderline intracranial and/or central nervous system (CNS) tumor that was diagnosed prior to 1/1/2004 the case should not be reported to FCDS as a “history of cancer” and should not be sequenced.

CDC published a reference manual in 2004 entitled, “Data Collection of Primary Central Nervous System Tumors.” The manual is available free of charge in PDF format on the CDC NPCR Website at <http://www.cdc.gov/npcr/pdf/btr/braintumorguide.pdf>. This document and ICD-O-3 are the primary references when determining case reportability for primary brain and CNS tumors.

If the diagnoses date of a benign or borderline brain and CNS tumor is unknown and the admission date is 01/01/2004 or later, the case is reportable.

If the patient has a history of benign and/or borderline intracranial and/or central nervous system (CNS) tumor that was diagnosed prior to 1/1/2004 the case should not be reported to FCDS as a “history of cancer” and should not be sequenced.

Benign and borderline neoplasms of the cranial bones (C41.0) are not reportable.

- h) **Pilocytic/Juvenile astrocytoma is reportable; code the histology and behavior code 9421/3.**
- i) **Table of Anatomic (Primary) Sites for Reportable Benign and Borderline Tumors of Intra-cranial and other central nervous system tumors.**

Anatomic Intracranial and CNS Sites for Reportable Benign / Borderline Tumors		
General Term	Anatomic Site	ICD-O-3 Code
Meninges	Cerebral meninges	C700
	Spinal meninges	C701
	Meninges, NOS	C709
Brain	Cerebrum	C710
	Frontal lobe	C711
	Temporal lobe	C712
	Parietal lobe	C713
	Occipital lobe	C714
	Ventricle, NOS	C715
	Cerebellum, NOS	C716
	Brain stem	C717
	Overlapping lesion of brain	C718
	Brain, NOS	C719
Spinal cord, cranial nerves, and other parts of the central nervous system	Spinal cord	C720
	Cauda equine	C721
	Olfactory nerve	C722
	Optic nerve	C723
	Acoustic nerve	C724
	Cranial nerve, NOS	C725
	Overlapping lesion of brain and central nervous system	C728
	Nervous system, NOS	C729
Pituitary gland, craniopharyngeal duct and pineal gland	Pituitary gland	C751
	Craniopharyngeal duct	C752
	Pineal gland	C753

4. Not Reportable Neoplasms

- a) **Primary skin tumors (C44.) with histology codes 8000-8110**

Skin Cancers - Basal cell carcinoma and squamous cell carcinoma of non-genital skin sites are common malignancies. These tumors are not to be reported to FCDS, regardless of stage. All other malignant tumors of the skin must be reported including but not limited to malignant melanoma, Merkel cell carcinoma, lymphoma of skin, and other non-squamous and non-basal cell skin cancers. Only the following malignant neoplasms of the skin (C44.0-C44.9) are not reportable:

M 8000 – M 8005	Neoplasm, malignant, NOS of the skin
M 8010 – M 8046	Epithelial carcinoma, NOS of the skin
M 8050 – M 8084	Papillary and squamous cell neoplasm of the skin
M 8090 – M 8110	Basal cell carcinoma of the skin

- b) **AIN III (8077/2) of the Perianal Skin (C44.5) is not reportable.**
- c) **AIN III of anus or anal canal (C21.0- C21.1) is reportable to FCDS.**
- d) **BIRADS 4 or BIRADS 5 on Mammography without biopsy to confirm cancer is not reportable to FCDS.** BIRADS 4 and BIRADS 5 are diagnostic imaging designations for highly suspicious for malignancy and malignancy on imaging. If only the mammography report is available stating BIRADS 4 or BIRADS 5, this is not enough information to abstract and report the case to FCDS.

5) Reporting Multiple Primary Tumors - Single versus Multiple Primaries

Operational rules are needed to ensure consistency in reporting multiple primary neoplasms. Basic factors include the anatomic site of origin of the neoplasm, the date of diagnosis, the histologic type of each neoplasm, the behavior of the neoplasm, and laterality. Please consult the attending physician if questions arise regarding the number of primary tumors.

In general, if there is a difference in the primary site where the neoplasm originates, it is fairly easy to determine whether it is a single or multiple primaries, regardless of dates of detection or differences in histology. Likewise, if there is a clear-cut difference in histology, other data such as the primary site and the date of detection are not essential to make this determination. Standardized rules have been developed and published to assist the registrar in making single versus multiple primary decisions.

2007 Multiple Primary and Histology Coding Rules for Solid Tumors

The *2007 Multiple Primary and Histology Coding Rules* for solid tumors contain site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, and malignant and nonmalignant brain primaries. A separate set of rules addresses the specific and general rules for all other solid tumor sites. And, a special set of rules has been written for hematopoietic and lymphoid neoplasms. The multiple primary rules guide and standardize the process of determining the number of primary tumors or abstracts to be created. The histology rules contain detailed histology coding instructions. Registrars must refer to the *2007 Multiple Primary and Histology Coding Rules* for general and cancer site-specific instructions. More information on these rules can be found on the NCI SEER website at <http://seer.cancer.gov/tools/mphrules/index.html>

2015 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Rules and Heme DB

The *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the accompanying Hematopoietic Database replaced the February 2001 Single Versus Subsequent Primaries of Lymphatic and Hematopoietic Disease rules and foldout table. An on-line version of the new rules and database is available at: <http://seer.cancer.gov/seertools/hemelymph>. A desktop version is available for download at <http://seer.cancer.gov/tools/heme/>. Please be sure to use the most current version as these rules and codes replace all previous versions.

DO NOT USE ICD-O-3 to code any histology 9590-9992. Use the Heme Manual and Database.

6) Clarification of Reporting Requirements

a) Malignant Neoplasms/Benign tumors

A patient is considered to have a benign, borderline, or malignant neoplasm when so indicated by a recognized medical practitioner. In determining a diagnosis of cancer, a positive pathology report takes precedence over all other reports or statements. Many benign and borderline neoplasms of the brain and central nervous system are diagnosed based upon diagnostic imaging, only (CT, PET, MRI, etc.). Other cancers may be diagnosed by alternate means such as direct visualization (without biopsy) or a diagnosis may be based upon clinical evidence, alone. The data item "Diagnostic Confirmation" is used to identify the method of diagnosis for each case. The codes are to be used in a hierarchical order in most cases. In the absence of a positive pathology report, all information in the record must be assessed to determine whether or not the case is reportable and to identify the method used to establish (confirm) the diagnosis.

b) Clinically Diagnosed Cases Are Reportable

In the absence of a histologic or cytologic confirmation of a reportable cancer, accession a case based on the **clinical diagnosis** (when a recognized medical practitioner says the patient has a cancer or carcinoma or when the patient is undergoing treatment for cancer that may not have been histologically or otherwise confirmed). A clinical diagnosis may be recorded as part of the final diagnosis on the face sheet or other parts of the medical record. See Note and Exceptions below.

Note: A pathology report normally takes precedence over a clinical diagnosis. If the patient has a negative biopsy, the case would not be reported.

Exception 1: If the physician treats a patient for cancer in spite of the negative biopsy, abstract and report the case.

Exception 2: If enough time has passed that it is reasonable to assume that the physician has seen the negative pathology, but the clinician continues to call this a reportable disease, accession the case. A reasonable amount of time would be equal to or greater than 6 months.

c) Ambiguous Terminology

As part of the registry case-finding activities, all diagnostic reports should be reviewed to confirm whether a case is reportable. This includes pathology reports, bone marrow biopsy reports, autopsy reports, diagnostic imaging reports, and results from medical testing. If the terminology describing the diagnostic assessment is ambiguous, use the following guidelines to determine whether a particular case should be abstracted and reported to FCDS. Words or phrases that appear to be synonyms of these terms do not constitute a diagnosis. For example, “likely” alone does not constitute a diagnosis.

In the absence of more definitive evidence, the following modifying terms, when applied to a neoplasm, should be interpreted as diagnostic of cancer:

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

* use of the terms “neoplasm” and “tumor” begin with cases diagnosed 1/1/2004 and later and are to be used in conjunction with nonmalignant (benign or borderline ICD-O-3 behavior codes /0 or /1) primary intracranial and central nervous systems, only (C70.0-C72.9, C75.1-C75.3).

“While ‘consistent with’ can indicate involvement, ‘neoplasm’ without specification of malignancy is not diagnostic except for non-malignant primary intracranial and central nervous system tumors.”

Exception: If cytology is reported as “suspicious,” abstract the case only if a positive biopsy or a physician’s clinical impression of cancer supports the cytology findings.

Examples of Diagnostic Terms:

Example 1: The inpatient discharge summary documents a chest x-ray *consistent with carcinoma* of the right upper lobe. The patient refused further work-up or treatment. *Consistent with carcinoma* is indicative of cancer.

Example 2: The mammogram report states *suspicious for malignancy*. *Suspicious for malignancy* is indicative of cancer.

Ambiguous Terms That Do Not Constitute a Diagnosis *without additional information*

The following modifying terms, when applied to a malignancy, should NOT be considered diagnostic of cancer without additional information such as treatment for cancer.

Cannot be ruled out possible	questionable suggests	equivocal potentially malignant	rule out worrisome
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Positive molecular marker or cytogenetic testing in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only and do not constitute a diagnosis.

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

- If an **ambiguous term(s) precede** a word that is **synonymous** with an in situ or invasive tumor (e.g.: cancer, carcinoma, malignant neoplasm, non-invasive cancer, etc.) the case is reportable. Abstract and report the case

Example: The pathology report says: Prostate biopsy with markedly abnormal cells that are typical of adenocarcinoma.” Abstract and report the case.

Negative Example: The final diagnosis on the outpatient report reads: Rule out leukemia. Do not abstract or report the case. **Do** track that you reviewed the record and deemed the case not reportable. Be sure to include the reason the case is not reportable to FCDS so you do not have to re-review the case during the annual AHCA casefinding audit.

- **Discrepancies:** If one section of the medical record(s) uses a reportable term such as “apparently” and another section of the medical record(s) uses a term that is not on the reportable list, accept the reportable term and abstract the case.

Exception: Do not abstract a case based on *suspicious* cytology, alone. The case is to be abstracted only if proven by *positive cytology or other diagnostic method* including a physician’s clinical diagnosis. See the data item Diagnostic Confirmation for methods of diagnosis.

Note: If the **word or an equivalent term does not appear** on the reportable list or is not a form of a word on the reportable list, the term is not diagnostic of cancer. Do not report the case. Forms of the word are such as: “Favored” rather than Favor(s); “appeared to be” rather than appears. Do not substitute synonyms such as “supposed” for presumed or “equal” for comparable.

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

Note: If the ambiguous diagnosis is **proven to be not reportable** by biopsy, cytology, or physician’s statement (cancer was ruled out as diagnosis), **do not report** the case.

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

Benign and borderline primary intracranial and CNS tumors

- Use the “Ambiguous Terms that are Reportable” list to identify benign and borderline primary intracranial and CNS tumors that are reportable.
- If any of the reportable **ambiguous terms precede** either the word “**tumor**” or the word “**neoplasm**,” the case is reportable. Abstract and report the case.

Example: The mass on the CT scan is consistent with pituitary tumor. Abstract and report the case.

- **Discrepancies:** If one section of the medical record(s) uses a reportable term such as “apparently” and another section of the medical record(s) uses a term that is not on the reportable list, accept the reportable term, abstract and report the case.
- **NOTE: Glomus Jugulare Tumors and Carotid Body Tumors** are head and neck cancers (tumors of the blood vessels of the neck) not intracranial neoplasms and are “**not reportable**”.

Exception: Do not abstract a case based only on suspicious cytology without additional confirmation of the presence of disease. The case is abstracted and reported if proven by positive cytology or other diagnostic methods including a physician's clinical diagnosis. See the data item Diagnostic Confirmation for methods of diagnosis.

Note: If the **word or an equivalent term does not appear** on the reportable list or is not a form of a word on the reportable list, the term is not diagnostic of cancer. Do not abstract the case. Forms of the word are such as: "Favored" rather than Favor(s); "appeared to be" rather than appears. Do not substitute synonyms such as "supposed" for presumed or "equal" for comparable.

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

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

d) Outpatient/Ambulatory Care Only Cases

There must be sufficient documentation in the medical chart (positive radiology report, positive pathology report, physician statement, etc.) that definitively establishes that the patient either has active malignancy and/or is currently undergoing therapy for malignancy. If insufficient documentation exists in the medical chart, do not abstract the case.

e) Non-Analytic Cases

The American College of Surgeons/Commission on Cancer does not require accredited facilities to abstract non-analytic cases. However, FCDS does require the collection and reporting of ALL cases that meet the FCDS reporting requirements, regardless of Class of Case.

f) Historical Cases

The American College of Surgeons/Commission on Cancer does not require accredited facilities to abstract historical cases. However, FCDS does require the collection and reporting of certain historical cancers even when the patient has no evidence the historical cancer is "active".

Patients diagnosed with any cancer during their lifetime are many times more likely to develop new cancers. It is important for researchers to know the number and types of any and all cancers each patient has had during his/her lifetime in order to effectively research and evaluate cancer incidence.

If a patient has had at least one primary reportable neoplasm that is currently active or under treatment, all other primary reportable neoplasms the patient has ever had (active or inactive), regardless of the date of diagnosis, must be reported. Each case of cancer must be abstracted and reported separately.

Information about the previous (historical) primary(s) may be sketchy. The abstractor should attempt to complete an abstract with as much information as is available in the medical record.

If the patient does not have any reportable neoplasms, active or under treatment, no other primary neoplasms the patient has ever had need to be reported.

See Section I-C Abstracting Historical Cases Optional Minimal Dataset for guidelines regarding the abstracting of historical cases in an abbreviated format. **NOTE: DO NOT INCLUDE OBSOLETE CODES** of any kind when reporting historical cases regardless of method for reporting these cases (Minimal Historical Grid or Full Abstract). This includes obsolete histology codes (do not include), obsolete treatment codes (do not include), obsolete staging system or stage code(s), etc. Abstract these cases according to current standards.

g) Multi-Facility Reporting (shared cases)

FCDS requires that any cancer case that meets FCDS case reporting requirements must be submitted by every facility providing services to the patient. Therefore, facilities that are members of shared, combined or joint cancer registries and/or cancer programs must report each cancer case seen in each facility separately unless approved to do so by the Florida Department of Health and FCDS.

h) Responsibility for Reporting

It is the responsibility of the custodian of the medical record or the facility that is administering care to report the case to FCDS. FCDS reviews the Agency for Health Care Administration (AHCA) cancer patient data annually as a retrospective quality control completeness audit. The AHCA database provides an after-the-fact case finding mechanism; ensuring cancer cases that have been reported to AHCA are also included in the FCDS database.

i) Annual Reporting Deadline – June 30th

The June 30th Deadline is an annual milestone for cancer reporting in Florida. Florida law requires that all cancer cases diagnosed/treated for cancer, having a cancer-related health visit while undergoing cancer treatment, or having any evidence of disease at the time of encounter must be abstracted and transmitted to FCDS within 6 months of the date of first encounter for cancer.

FCDS reinforces the 6-month reporting standard with a June 30th Deadline each year.

Reporting Compliance and Data Quality Reports are run following the annual June 30th Deadline.

Facilities not in compliance with the 6-month reporting rule will be notified by FCDS of the delinquency. Each facility will be asked to develop a remedial plan to bring the facility back into compliance with state statutes. The plan must also include a statement indicating how the facility plans to stay in compliance once the current reporting year has been completed and compliance has been reached for the year in question.

If no action is taken or delinquency continues, FCDS will notify the Florida Department of Health that the facility is non-compliant and further action will be taken. Any remediation or other action plan must be approved by the Florida Department of Health and FCDS. FCDS will monitor the plan.

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Table A: NAACCR Layout Version 16: Comparison of Reportable Cancers: FCDS, CoC, and NPCR.

	FCDS	CoC	NPCR
Reportable Diagnoses	1. Behavior code of 2 or 3 in ICD-O-3 (includes LIN III, VIN III, VAIN III, AIN III). 2. Non-malignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in the Table: Primary Site Codes for Non-Malignant Primary Intracranial and Central Nervous System Tumors.	1. Behavior code of 2 or 3 in ICD-O-3; or, for 2010 and later diagnoses, behavior code 3 according to the <i>WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues</i> (2008). 2. Non-malignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in the Table: Primary Site Codes for Non-Malignant Primary Intracranial and Central Nervous System Tumors.	1. Behavior code of 2 or 3 in ICD-O-3 (includes VIN III, VAIN III, AIN III); or, for 2010 and later diagnoses, behavior code 3 according to the <i>WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues</i> (2008). 2. Non-malignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in the Table: Primary Site Codes for Non-Malignant Primary Intracranial and Central Nervous System Tumors.
Exceptions (not reportable)	1. Skin cancers (C44_) with histologies 8000-8110. 2. CIS of the cervix and CIN III 3. PIN III (after 1/1/2001).	1. Skin cancers (C44_) with histology 8000-8110 (after 1/1/2003); prior to that date, AJCC stage groups 2-4 in this group were reportable. 2. CIS of the cervix and CIN III (after 1/1/96). 3. PIN III (after 1/1/96). 4. VIN III (after 1/1/96). 5. VAIN III (after 1/1/96). 6. AIN (after 1/1/96).	1. Skin cancers (C44_) with histologies 8000-8005, 8010-8046, 8050-8084, 8090-8110. 2. CIS of the cervix and CIN III. 3. PIN III (after 1/1/2001).
Historical Neoplasm	If a patient has at least one primary reportable neoplasm which is active or under treatment, all other primary reportable neoplasms the patient has ever had (active or inactive), regardless of the date of diagnosis, must be reported.	Not included unless patient has evidence of this neoplasm (active disease).	Not included unless patient has evidence of this neoplasm (active disease).
Multiple Primary Rules	2007 Multiple Primary and Histology Coding Rules (most recent version)	2007 Multiple Primary and Histology Coding Rules (most recent version)	2007 Multiple Primary and Histology Coding Rules (most recent version)
Hematopoietic and Lymphoid Neoplasm Rules	2014 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Database (current version)	2014 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Database (current version)	2014 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Database (current version)
Ambiguous Terminology Considered as Diagnostic of Cancer	apparent(ly) appears comparable with compatible with consistent with favors malignant appearing most likely presumed probable suspect(ed) suspicious (for) typical of Exception: if the cytology is reported as “suspicious” and neither a positive biopsy nor a physician’s clinical impression supports the cytology findings, do not treat as diagnosis of cancer.	apparent(ly) appears comparable with compatible with consistent with favors malignant appearing most likely presumed probable suspect(ed) suspicious (for) typical of Exception: if the cytology is reported as “suspicious” and neither a positive biopsy nor a physician’s clinical impression supports the cytology findings, do not treat as diagnosis of cancer.	apparent(ly) appears comparable with compatible with consistent with favors malignant appearing most likely presumed probable suspect(ed) suspicious (for) typical of Exception: if the cytology is reported as “suspicious” and neither a positive biopsy nor a physician’s clinical impression supports the cytology findings, do not treat as diagnosis of cancer.
Ambiguous Terminology NOT Considered as Diagnostic of Cancer	cannot be ruled out equivocal possible potentially malignant questionable rule out suggests worrisome	cannot be ruled out equivocal possible potentially malignant questionable rule out suggests worrisome	cannot be ruled out equivocal possible potentially malignant questionable rule out suggests worrisome

* Juvenile astrocytoma is reported as **9421/3**.

** Do not substitute synonyms such as “supposed” for “presumed” or “equal” for “comparable.” Do not substitute “likely” for “most likely.” Use only the exact words on the list.

Table 3. Primary Site Codes for Non-Malignant Primary Intracranial and Central Nervous System Tumors (non-malignant primary intracranial and central nervous system tumors with a behavior code of 0 or 1 [benign/borderline] are reportable regardless of histologic type for these topography codes). The CDC Brain Tumor Guide entitled, “*Data Collection of Primary Central Nervous System Tumors*” is available for reference @ <http://www.cdc.gov/cancer/npcr/pdf/btr/braintumorguide.pdf>

Reference Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Sixteenth Edition Version 15 – Chapter III: Standards for Tumor Inclusion and Reportability

Topography	
Codes	Description
C70.0	Meninges
C70.1	Cerebral Meninges
C70.9	Spinal meninges Meninges, NOS
C71.0	Brain
C71.1	Cerebrum
C71.2	Frontal lobe
C71.3	Temporal lobe
C71.4	Parietal lobe
C71.5	Occipital lobe
C71.6	Ventricle, NOS
C71.7	Cerebellum, NOS
C71.8	Brain stem
C71.9	Overlapping lesion of brain Brain, NOS
C72.0	Spinal Cord, Cranial Nerves, and Other Parts of the Central Nervous System
C72.1	Spinal cord
C72.2	Spinal cord
C72.3	Cauda equina
C72.4	Olfactory nerve
C72.5	Optic nerve
C72.8	Acoustic nerve
C72.9	Cranial nerve, NOS Overlapping lesion of brain and central nervous system Nervous system, NOS
C75.1	Other Endocrine Glands and Related
C75.2	Structures
C75.3	Pituitary gland Craniopharyngeal duct Pineal gland

B. CASEFINDING

Casefinding is the method used to identify new cancer cases, inpatient or outpatient. All facilities are responsible for complete casefinding for all patients seen at your facility regardless of type of service. It is important that the following multiple sources in the hospital be searched to keep missed reportable cases to a minimum. The procedure outlined below should be adapted to each individual facility:

1. **HIM/Medical Record Disease Indices** or Unified Billing System Report (Inpatient and outpatient, including inpatient hospice)
2. **Pathology Reports** (biopsy specimen reports, surgical specimen reports, bone marrow biopsy, needle biopsy, cytology, autopsy, addenda, consultation reports, etc.)
3. **Radiation Therapy** Department (patient logs and/or billing reports)
4. **Infusion Center** (patient logs and/or billing reports)
5. **Outpatient Departments** (including cancer specialty clinics, chemotherapy clinics, infusion centers, day surgery, emergency room, medical oncology logs, etc.)
6. **Diagnostic Imaging** (Radiology) Department (MRI, CT scan, PET scan, x-ray, mammogram, etc.)

1. HIM/Medical Record Disease Index/Unified Billing System Report

Every patient record with a reportable ICD-10-CM code (see Current Casefinding List) must be reviewed to determine whether or not the case meets FCDS criteria for case reporting. It is essential that all patient service areas be included in these reports. The FCDS Casefinding Lists have been pared down to only include diagnoses of active disease. Therefore, most cases on your list will need to be abstracted and reported.

ICD-10-CM and ICD-10-PCS were adopted as the U.S. standard on 10/1/2015. ICD-10-CM Casefinding List is included in this and previous FCDS DAM documents. Please ensure your facility IT staff has been given a copy of the ICD-10-CM list to avoid interruption in casefinding for the last quarter of calendar year 2015.

Upon review, if a patient is found not to have a malignancy as coded by the HIM/Medical Record or Billing Department or does not meet FCDS criteria for case reporting, the name should be added to the facility's "Not Reportable List." The list may be substituted with the facility "suspense" file based on available vendor tools.

The "Not Reportable List" is useful when FCDS is conducts casefinding audits based on AHCA data. Some facilities will save a "Not Reportable List" as an electronic file embedded within their software such as a "suspense" case and should include comments that the registrar reviewed the medical record and determined that the case does not meet reportable criteria. The "suspense" case should include documentation as to why the facility will not report the case either in text and/or using the FCDS AHCA Disposition Codes below.

Code	Description
1	Reportable-Missed Case-Case to be Abstracted & Reported by Facility
2	N/R - Tumor was Not Malignant - Behavior = 0 or 1
3	N/R - NonReportable Skin Cancer - Site=C44.* and Morph = 8000 to 8110
4	N/R - No Evidence of Cancer at This Time - NED
5	N/R - Consultation Only
6	N/R - Cancer Not Proven - Equivocal
7	Case Previously Reported to FCDS by this Facility
8	N/R - Outpatient Record with No Active Cancer Documented in Record
9	N/R - Insitu Cancer of Cervix or CIN III
10	N/R - Other
11	Reportable-Case Abstracted BUT Not found in FCDS files - Abst Requested
12	N/R - No Cancer Mentioned in Medical Record
13	Skins we elected not to FB since most of them turn out N/R
14	N/R - Hematopoietic Diseases Dx Prior to 2001
15	N/R - Case DX Prior to FCDS Reference Date - Same Cancer/Same Facility
16	N/R - Benign or Borderline Brain/CNS Tumor Dx Prior to 2004
20	Unknown if Reportable - No Record of this Patient at this Facility
21	Unknown if Reportable - Lost Medical Record
30	Unknown if Reportable - No Follow-Back Ever Returned by this Facility
40	N/R - Special Case - Other
50	Hospice Case - Not A Hospital
51	Transitional Care Center - Not A Hospital

2. Pathology Reports

ALL ANATOMIC (SURGICAL) PATHOLOGY REPORTS (including reports from biopsy specimen, surgical resection specimen, bone marrow biopsy, needle biopsy and fine needle aspiration biopsy, diagnostic hematology, cytology and autopsy reports and all addenda) for inpatients, outpatients and ambulatory care patients MUST be reviewed to determine whether or not a case is reportable.

Pathology Reports MUST also be submitted electronically to FCDS under the FCDS E-Pathology Reporting Program.

Since most cancer patients have a biopsy or operative resection performed, nearly all of the reportable cases can be identified by pathology reports alone. Check with your pathology department to see if the department information system can be used to facilitate the review of these reports.

Pathology reports must also be reviewed within each reporting facility at least annually to insure that no cases have been missed by the reporting facility.

3. Radiation Therapy Department

New patient registration rosters and radiation therapy summaries are excellent casefinding sources for patients treated with radiation. Unified Billing System Reports also can be used to identify these cases.

4. Outpatient Departments

New patient registration rosters for single-day surgery departments, oncology-related service areas (specialty clinics, chemotherapy clinics, infusion centers, day surgery, and other ambulatory care), outpatient departments (including outpatient diagnostic radiology and laboratory service areas) and emergency rooms are additional casefinding sources for patients seen only in an ambulatory care setting. Unified Billing System Reports also can be used to identify these cases.

5. Diagnostic Imaging (Radiology) Department

New patient registration rosters for patients receiving diagnostic imaging services (x-ray, CT scan, PET scan, MRI, or other imaging) are an excellent source for identifying new cancer cases.

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ICD-9-CM CASEFINDING LIST FOR REPORTABLE TUMORS – Jan-Sept 2015

The following ICD-9-CM list is to be used to identify all reportable tumors. Some ICD-9-CM codes may include conditions that are not malignant or otherwise not reportable. These records should be reviewed and assessed individually to verify whether or not they are reportable to FCDS. No Optional Codes are included.

ICD-9-CM	Description
140.00-209.36	Malignant neoplasms (excluding skin 173.0-173.9)
209.70-209.79	Secondary neuroendocrine tumors
225.0-225.9	Benign neoplasm of brain and spinal cord neoplasm
227.3-227.4	Benign neoplasm of pituitary gland, pineal body, and intracranial endocrine-related structures
228.02	Hemangioma; of intracranial structures
228.1	Lymphangioma, any site brain, other parts of CNS
230.0-234.9	Carcinoma in situ (exclude: skin, cervix and prostate– 232.0-232.9, 233.1, 233.4)
237.0-237.1, 237.5, 237.6, 237.9	Neoplasm of uncertain behavior (borderline) of intracranial endocrine glands, brain and CNS
238.4	Polycythemia vera (9950/3)
239.6-239.7	Neoplasms of unspecified nature Brain and CNS
273.3	Waldenstrom macroglobulinemia (9761/3)
511.81	Malignant pleural effusion (code first malignant neoplasm if known)
789.51	Malignant ascites (code the first malignant neoplasm if known)
V58.0	Encounter for radiotherapy
V58.1	Encounter for chemotherapy and immunotherapy
V58.11	Antineoplastic Chemotherapy
V58.12	Antineoplastic Immunotherapy

ICD-10-CM CASEFINDING LIST FOR REPORTABLE TUMORS – Oct 1, 2015 and later encounters

The following ICD-10-CM list is to be used to identify all reportable tumors. Some ICD-10-CM codes may contain conditions that are not malignant or otherwise not reportable. These records should be reviewed and assessed individually to verify whether or not they are reportable to FCDS. See Appendix O for a complete set of individual codes required.

ICD-10-CM	Description
C00._ - C43._	Malignant neoplasms
C4A._	Merkel Cell Carcinoma
C45._ - C96._	Malignant neoplasms
D00._ - D09._	Carcinoma in situ (exclude: skin, cervix and prostate– D04._, D06._ and D07.5)
D18.02	Hemangioma; of intracranial structures
D18.1	Lymphangioma, any site brain, other parts of CNS
D32._	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33._	Benign neoplasm of brain and other parts of central nervous system
D35.2, D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42._, D43._	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3-D44.5	Neoplasm of uncertain behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3)
D46._	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D47.1	Chronic myeloproliferative disease (9960, 9963)
D47.3	Essential (hemorrhagic) thrombocytopenia (9962)
D47.4	Osteomyelofibrosis (9961)
D47.Z_	Other specified neoplasm of uncertain/unknown behavior of lymphoid, hematopoietic (9965, 9966, 9967, 9971, 9975, 9987)
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960, 9970, 9931)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
J91.0	Malignant Pleural Effusion
R18.0	Malignant ascites
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.11	Encounter for antineoplastic chemotherapy
Z51.12	Encounter for antineoplastic immunotherapy

C. ABSTRACTING**1. Personnel Requirements – Abstractor Training and FCDS Abstractor Code**

Abstractor Training: Trained personnel must perform abstracting. FCDS provides basic incidence abstracting training via web-based modules free of charge and available 24 hours a day, 7 days a week. The 20 modules constitute one “course” in the FCDS Learning Management System. The 20 modules include over 1000 slides with sound overlay, practice exercises, and quizzes to monitor progress. The entire course takes from 40-80 hours to complete, depending on individual knowledge level at the start of the course. It is highly recommended that each student enter the course with a strong understanding of human anatomy and medical terminology. Modules are available at <http://fcdsmoodle.med.miami.edu/>.

Other training is available through SEER*Training, SEER*Educate, the Commission on Cancer, the American Joint Committee on Cancer, the National Cancer Registrars Association (NCRA), the Florida Cancer Registrars Association (FCRA), and the North American Association of Central Cancer Registries (NAACCR).

FCDS Abstractor Code: Every registrar/abstractor planning to work in the State of Florida is required to obtain an individual FCDS Abstractor Code. This code is assigned by FCDS to persons who successfully pass the FCDS Abstractor Code On-Line Examination, regardless of certification by NCRA as a CTR, experience in the registry industry, or other factors. As of January 1, 2013 any individual planning to acquire a New FCDS Abstractor Code or planning to renew an Existing FCDS Abstractor Code must take and pass the FCDS Abstractor Code Exam.

The FCDS Abstractor Code Requirement has been FCDS Policy for many years and applies to every cancer registrar working in the state of Florida (CTR or non-CTR, Florida resident or out-of-state contractor, regardless of number of years’ experience). FCDS will not accept cases from individuals without an Active/Current FCDS Abstractor Code.

While the FCDS Abstractor Code Requirement Policy remains unchanged, the FCDS Abstractor Code Exam is a new tool introduced to help FCDS expedite FCDS Abstractor Code approvals, renewals, and monitoring. Exams are short (15-20 multiple choice or T/F questions) with a variable mix of content questions weighted differently depending on whether this is an exam for a New FCDS Abstractor Code or Renewal of an existing FCDS Abstractor Code.

Questions are electronically selected at random from a pool of more than 350 questions covering 5 major topic areas. No two exams will be alike.

The 5 topic areas include;

- General Abstracting Knowledge
- Primary Site/Histology/Grade
- Stage at Diagnosis
- Latest Rule Changes
- Treatment and Survival

Standard References Used for Testing

- FCDS DAM (current version)
- ICD-O-3 (including errata and updates)
- MPH Rules for Solid Tumors (current)
- MPH Rules/Database for Hematopoietic/Lymphoid Neoplasms (current)
- Collaborative Stage Data Collection System – Lab Tests, Tumor Markers, SSF Notes
- AJCC Cancer Staging Manual, 7th edition
- SEER Summary Staging Manual 2000

- SEER*Rx (current)
- SEER Self-Instruction Manuals (basics)
 - ◊ Book 2 – Cancer Characteristics
 - ◊ Book 3 – Tumor Registrar Vocabulary: Composition of Medical Terms
 - ◊ Book 4 – Human Anatomy as Related to Tumor Formation

WHO NEEDS TO TAKE THE FCDS ABTRACTOR CODE EXAM?

- ✓ Individuals hoping to acquire a NEW FCDS Abtractor Code will need to take the New FCDS Abtractor Code Exam.
- ✓ If an individual's FCDS Abtractor Code has been expired for greater than 2 years, the individual must re-apply and take and pass the New FCDS Abtractor Code Exam.

WHO NEEDS TO TAKE THE FCDS ABTRACTOR CODE RENEWAL EXAM?

- ✓ Individuals with an ACTIVE (not yet expired) FCDS Abtractor Code will be required to take and pass the FCDS Abtractor Code Renewal Exam once their code has expired.
- ✓ Individuals with an EXPIRED FCDS Abtractor Code will be required to take the FCDS Abtractor Code Renewal Exam each year in order to keep their FCDS Abtractor Code current and to renew their individual FCDS Abtractor Code, annually.

2. Case Abstracting Requirements – Timeliness

Individual cases **must be abstracted no later than six months** after the date of first contact with the reporting facility. The only exceptions to this reporting timeline are the free-standing ambulatory surgical centers who are reporting under the Ambulatory Centers Cancer Reporting Program.

Cases may be abstracted earlier than six months after the date of first contact, but only if the required information regarding first course of therapy is available and complete.

DO NOT SEND INCOMPLETE RQRS (Rapid Quality Reporting System) CASES TO FCDS.

All cases meeting the reporting requirements outlined in Section I.A must be abstracted following the guidelines set forth in Section II of this document. Questions regarding the interpretation of individual data items should be referred to the FCDS office.

Note: The ACoS CoC changed CoC Cancer Program Standard 5.2 (abstracting timeliness) on 1/1/2014. This is a change for CoC Cancer Program Accreditation (only) and does not change the Florida 6-month reporting requirement or the FCDS June 30th Deadline.

Why? Florida Statute requires that cases be completely abstracted (all information must be included regarding the diagnosis, staging, first course of treatment, cancer progression or recurrence) within 6-months of first patient encounter for cancer at your facility.

Do not send FCDS partial abstracts for ACoS CoC Rapid Quality Reporting System (RQRS).

Note: The CoC FORDS Manual instructs registrars from CoC Programs that the data item "Date Case Completed" should not be filled in until the case has been completed and all data required have been abstracted/coded.

The case is "pending completion" until all first course treatment has been investigated and documented in the original abstract sent to FCDS and the final abstract that is sent to the NCDB.

All abstracts are required to pass the FCDS EDITS metafile.

3. Not Reportable List

A list of cases reviewed but not reported to FCDS (not reportable list) should be maintained by each reporting facility either in electronic or other format. This can be as part of your abstracting software maintained in your “suspense” file or in a separate document with easy access. A sample form is included at the end of this Section. Any patient encounter that appears on a facility casefinding list that does not meet the reporting requirements outlined in Section I should be recorded on the “Not Reportable List” with an explanation as to why the case will not be reported. FCDS suggests you also include the FCDS Disposition Code associated with the reason not reported to facilitate your annual AHCA Follow-Back activities.

The list should include the patient’s name, social security number, medical record number, date of birth, ICD-9-CM or ICD-10-CM code, admission date, and disposition code or reason they were not reported. The list may be kept in a paper notebook, spreadsheet, vendor software suspense file, or in any other easily accessible format. You may use the FCDS form or you may create your own.

Casefinding audits are performed periodically at every reporting facility as well as through annual case matching with the Florida Agency for Health Care Administration (AHCA) data files to assure completeness of reporting. The not reportable list will expedite resolution of cases that show up as ‘missed cases’ during these casefinding audits. Missed Cases Are Late Reported Cases – always.

Failure to keep the list will result in FCDS requesting that the reporting facility pull each ‘missed case’ record again and review whether or not it should have been reported to FCDS. An explanation must then be submitted to FCDS detailing any reason any case will not be reported to FCDS or the case must be abstracted and reported to FCDS.

FCDS Disposition Codes may be included in the file as reference for reason the case is not reportable.

Code	Description
1	Reportable-Missed Case-Case to be Abstracted & Reported by Facility
2	N/R - Tumor was Not Malignant - Behavior = 0 or 1
3	N/R - NonReportable Skin Cancer - Site=C44.* and Morph = 8000 to 8110
4	N/R - No Evidence of Cancer at This Time - NED
5	N/R - Consultation Only
6	N/R - Cancer Not Proven - Equivocal
7	Case Previously Reported to FCDS by this Facility
8	N/R - Outpatient Record with No Active Cancer Documented in Record
9	N/R - Insitu Cancer of Cervix or CIN III
10	N/R - Other
11	Reportable-Case Abstracted BUT Not found in FCDS files - Abst Requested
12	N/R - No Cancer Mentioned in Medical Record
13	Skins we elected not to FB since most of them turn out N/R
14	N/R - Hematopoietic Diseases Dx Prior to 2001
15	N/R - Case DX Prior to FCDS Reference Date - Same Cancer/Same Facility
16	N/R - Benign or Borderline Brain/CNS Tumor Dx Prior to 2004
20	Unknown if Reportable - No Record of this Patient at this Facility
21	Unknown if Reportable - Lost Medical Record
30	Unknown if Reportable - No Follow-Back Ever Returned by this Facility
40	N/R - Special Case - Other
50	Hospice Case - Not A Hospital
51	Transitional Care Center - Not A Hospital

4. Abstracting Non-Analytic and Historical Cases

Although the Commission on Cancer/American College of Surgeons (COC/ACoS) does not require accredited facilities to abstract non-analytic or historical cases, a population-based cancer registry such as FCDS must record ALL cancers meeting the FCDS reporting requirements, regardless of class of case, place of diagnosis or date of diagnosis. These cases require the same attention to detail and text as with any CoC “analytic” type case (abstracted and quality reviewed with the same rigorous data quality and documentation expectation). Include chronologic information about the cancer as available.

FCDS realizes that much of the information about the original diagnosis, staging and treatment of non-analytic and historical cancers may be unavailable or incomplete. The abstractor should attempt to complete each abstract with as much information as is available in the medical record.

- a. The following morphology codes are reportable as historical cases if they were diagnosed prior to 1/1/01 and the patient has another active reportable neoplasm. These neoplasms were historically reported with behavior /1 (borderline malignancy). They were changed to behavior /3 (malignant) when ICD-O-3 was released in 2001. This change in reporting rules is consistent with ICD-O-3.

8931/3	9960/3	9981/3	9989/3
9393/3	9961/3	9982/3	
9538/3	9962/3	9983/3	
9950/3	9980/3	9984/3	

If a patient diagnosed with any of the above hematopoietic disease morphology codes prior to 01/01/2001 undergoes transformation to another hematopoietic disease before 01/01/2010, enter the case into the registry using the histology and behavior (malignant) diagnosed on or after 01/01/2001 with the 2001 or later diagnosis date.

If the diagnosis date of a hematopoietic disease is unknown and the admission date is 01/01/2001 or later, the case is reportable using ICD-O-3 reporting criteria. Please refer to the FCDS Rules for Reporting Hematopoietic Diseases in Section II for specific instructions on reporting hematopoietic diseases.

- b. Benign and borderline brain and central nervous system tumors are reportable even if they were diagnosed prior to 1/1/04 and the patient has another active reportable neoplasm.
- c. Squamous Intraepithelial Neoplasia Grade III of vulva, vagina, and anus are reportable as historical cases, even if they were diagnosed prior to 01/01/2001, and the patient has another active reportable neoplasm.

5. Abstracting Historical Cases Optional Minimal Dataset

Historical case refers to a primary reportable neoplasm (malignant or benign/borderline brain/CNS tumors) that it is not active (no evidence of disease) and currently not receiving any treatment AND the patient is seen at the reporting facility for another cancer/benign reportable neoplasm that is active and/or undergoing treatment.

DUPLICATE CASE SUBMISSIONS (CASES PREVIOUSLY SENT TO FCDS) ARE OFTEN PROBLEMATIC WITH HISTORICAL CASE SUBMISSIONS. ALWAYS REFERENCE AND USE THE FACILITY ALPHA LISTING WITH A REFERENCE DATE OF 1/1/1981 AS THE PRIMARY ACCESSION REGISTER FOR EACH FACILITY, REGARDLESS OF A COC REFERENCE DATE.

There are two methods for reporting a Historical Case:

FCDS will accept historical cases reported as full abstracts or reported using the minimal dataset.

DO NOT INCLUDE OBSOLETE CODES of any kind when reporting historical cases regardless of method for reporting these cases (Minimal Historical Grid or Full Abstract). This includes obsolete histology codes (do not include), obsolete treatment codes (do not include), obsolete staging system or stage code(s), etc. Abstract cases according to the current coding standard.

- a. For every abstract submitted, the record layout will allow for the entry of up to five (5) historical cases. The fields required for each of the five cases include:

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1. Sequence Number
 2. Diagnosis Date
 3. Primary Site (ICD-O-3)
 4. Histology (ICD-O-3)
 5. Behavior (ICD-O-3)
 6. Laterality
 7. State of Residence at Diagnosis (State Abbreviation)
 8. County of Residence at Diagnosis (FIPS County Code)
 9. CS SSF 25 - Discriminator
- b. These fields will be edited at time of transmission and will include Sequence Number and Diagnosis Date edit checks as well as State and County edit checks.
 - c. **These fields should ONLY be used when abstracting a historical case with insufficient information.**
 - d. **A complete abstract MUST be reported to FCDS for cases with sufficient information in the patient's medical record or when the patient has evidence of the historical cancer at the time of patient encounter (persistent disease, progression of disease or disease recurrence – patient with evidence of this cancer at the time of patient encounter).**
 - e. REMEMBER, the minimal dataset only applies to Class of Case 33 Historical Cases with insufficient information. All other Non-Analytical cases, including Class of Case 33 historical cases with sufficient information REQUIRE a full abstract be reported to FCDS.
 - f. Historical Cases should not include Unknown Primary Cancers (C80.9 or C76.*).
 - g. Quality Control for these cases will be increased and documentation supporting the minimal dataset may need to be provided.
6. Reporting Historical Cases in the State Specific fields

DUPLICATE CASE SUBMISSIONS (CASES PREVIOUSLY SENT TO FCDS) ARE OFTEN PROBLEMATIC WITH HISTORICAL CASE SUBMISSIONS. ALWAYS REFERENCE AND USE THE FACILITY ALPHA LISTING WITH A REFERENCE DATE OF 1/1/1981 AS THE PRIMARY ACCESSION REGISTER FOR EACH FACILITY, REGARDLESS OF A COC REFERENCE DATE.

- a. Historical information must be completed starting with the eight fields in HISTORY1. Every additional historical case would use the next sequential group of eight fields (i.e. HISTORY2 through HISTORY5). No gaps in the groups can exist.

Examples:

One Historical Case – MUST use Historical #1 group of nine fields.

Two Historical Cases – MUST use Historical #1 and Historical #2 groups of nine fields.

In the example of Two Historical cases, if Historical #1 and Historical #3 groups of nine fields are populated, than abstract will not be accepted due to a gap in Historical #2 group.

- b. When a particular group is selected (Historical #1), all nine fields must be filled.

Historical date must be completed in accordance with the current standards. If any of these fields are left blank, then the abstract and possibly the entire batch will be rejected.

Examples:

Historical #1: Sequence Number,

Historical #1: Dx Date,

Historical #1: Primary Site,

Historical #1: Histology,

Historical #1: Behavior,
Historical #1: Laterality,
Historical #1: Dx State Abbreviation,
Historical #1: Dx County FIPS
Historical #1: CS SSF25 Discriminator

Once these historical groupings pass structure check edits, a full abstract will be generated from the data provided. The derived Historical abstracts will be subject to our full set of edit checks. If any failures exist, the abstract and batch will be rejected.

DO NOT INCLUDE OBSOLETE CODES of any kind when reporting historical cases regardless of method for reporting these cases (Minimal Historical Grid or Full Abstract). This includes obsolete histology codes (do not include), obsolete treatment codes (do not include), obsolete staging system or stage code(s), etc. Abstract cases according to current coding standard.

7. Annual Reporting Deadline – June 30th

The June 30th Deadline is an annual milestone for cancer reporting in Florida. Florida law requires that all cancer cases diagnosed/treated for cancer, having a cancer-related health visit while undergoing cancer treatment, or having any evidence of disease at the time of encounter must be abstracted and transmitted to FCDS within 6 months of the date of first encounter for cancer. FCDS reinforces the 6-month reporting standard with a June 30th Deadline each year.

Compliance and Data Quality Reports are run following the annual June 30th Deadline.

Facilities not in compliance with the 6-month reporting rule will be notified by FCDS of the delinquency. Each facility will be asked to develop a remedial plan to bring the facility back into compliance with state statutes with a plan to remain in compliance. If no action is taken or delinquency continues, FCDS will notify the Florida Department of Health that the facility is non-compliant and further action will be taken. Any remediation or other action plan must be approved by the Florida Department of Health and FCDS. FCDS will monitor the plan.

8. Required/Recommended Desktop References – paper and/or electronic – current version

REQUIRED DESKTOP REFERENCES

REQUIRED REFERENCE	ORDERING INFORMATION
Current FCDS Data Acquisition Manual	FCDS, Florida Cancer Data System PO Box 016960 (D4-11) Miami, FL 33101 http://fcds.med.miami.edu/inc/downloads.shtml
<i>International Classification of Diseases for Oncology, 3rd ed. Geneva, World Health Organization: 2000, including three published errata and the 2011 ICD-O-3 Update</i>	The World Health Organization WHO Publications Center USA; 49 Sheridan Avenue; Albany, NY 12210 ISBN 9241545348 Order Number 11503350 http://www.who.int/classifications/icd/en/index.html
Current Multiple Primary and Histology Coding Rules for Solid Tumors	National Cancer Institute, SEER Program, Bethesda, MD Johnson CH, Peace S, Adamo P, et al. National Cancer Institute, Surveillance, Epidemiology and End Results Program. Bethesda, MD: 2007 http://seer.cancer.gov/registrars

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Current Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Hematopoietic Database (desktop or web-based versions available)	Download latest version from the National Cancer Institute, SEER Program, Bethesda, MD http://seer.cancer.gov/registrars
<i>AJCC Cancer Staging Manual</i> , 7th ed. American Joint Committee on Cancer, Chicago IL. Springer: 2009	Edge, S.B.; Byrd, D.R.; Compton, C.C.; Fritz, A.G.; Greene, F.L.; Trotti, A. (Eds.) 7th ed. 2010, 2010, X, 646 p. 130 illus. With CD-ROM. Softcover, ISBN 978-0-387-88440-0 http://www.springer.com/
<i>SEER Summary Staging Manual 2000</i> , including 4 published Errata (2001, 2002, 2012 and 2015)	Download e-version (no printed versions available) National Cancer Institute, SEER Program, Bethesda, MD http://seer.cancer.gov/registrars
Current SEER*Rx – Interactive Drug Database	National Cancer Institute, Surveillance, Epidemiology and End Results Program, Bethesda MD. Available for download at http://seer.cancer.gov/registrars/

RECOMMENDED DESK REFERENCES

RECOMMENDED BOOK	ORDERING INFORMATION
<i>Facility Oncology Registry Data Standards (FORDS)</i> , current edition	American College of Surgeons (ACS) 55 East Erie Street Chicago, IL 60611-2797 http://www.facs.org/cancer/coc/
<i>CA: A Cancer Journal for Clinicians</i>	Lippincott Williams & Wilkins Publishers P.O. Box 1600 Hagerstown, MD 21741-9910 301-223-2300 (Voice) http://caonline.amcancersoc.org/
<i>Cancer Principles and Practice of Oncology</i> , 9 th edition	Lippincott Williams & Wilkins Publishers 227 East Washington Square Philadelphia, PA 19106-3780 ISBN-10: 1451105452
<i>Cancer Registry Management Principles & Practice for Hospitals and Central Registries</i> , 3rd Edition, 2011	Kendall/Hunt Publishing Company 4050 Westmark Drive, PO Box 1840 Dubuque, IA 52004-1840 1-(800) 228-0810 www.kendallhunt.com/ncra ISBN 978-0-7575-6900-5
<i>American Cancer Society Textbook of Clinical Oncology</i>	American Cancer Society Vermont Division, Inc. 13 Loomis Street Montpelier, VT 05602 1-800-227-2345; 1-800-ACS-2345 http://www.cancer.org

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<p><i>Registry Plus Online Help</i></p>	<p>Download the free desktop reference, <i>Registry Plus Online Help</i> at http://www.cdc.gov/cancer/npcr <i>Online Help</i> is an interactive tool that incorporates many of the references above and is maintained by the CDC. The <i>Registry Plus Online Help</i> application includes fully indexed versions of the FORDS Manual, Collaborative Stage, and Multiple Primary and Histology Coding manuals as well as the NAACCR Data Dictionary, the SEER Coding Manual and the ICD-O-3.</p>
<p>NAACCR <i>Standards for Cancer Registries Volume II: Data Standards and Data Dictionary</i>, current edition</p>	<p>North American Association of Central Cancer Registries, Inc. (NAACCR) 2121 West White Oaks Drive, Suite B Springfield, Illinois 62704-7412 Phone: (217) 698-0800 Fax: (217) 698-0188 http://www.naaccr.org</p>
<p>SEER <i>Self Instructional Manuals 1-4, 7; Book 1 – Objectives and Functions of a Tumor Registry (1999)</i> <i>Book 2 – Cancer Characteristics and Selection of Cases(1991)</i> <i>Book 3 – Tumor Registrar Vocabulary: The Composition of Medical Terms (1992)</i> <i>Book 4 – Human Anatomy as Related to Tumor Formation (1995)</i> <i>Book 7 - Statistics/Epidemiology for Cancer Registries(1994)</i></p>	<p>National Cancer Institute Publications Ordering Service P.O. Box 24128, Baltimore, MD 21227, 301-330-7968 To order by phone, contact 1-800-4-CANCER and select the option to order publications. You may use our online Publications Locator at http://www.cancer.gov/publications</p> <p>The <i>SEER Program Coding and Staging Manual</i> can be downloaded and they are available in both PDF and ZIP formats. http://seer.cancer.gov/registrars</p> <p>http://www.seer.cancer.gov/registrars/ / See order for SEER publications http://seer.cancer.gov/publications/</p> <p><i>SEER Program: Instructional Manuals on CD-ROM</i></p> <p>Historical Staging and Coding Manuals on CD-ROM</p>
<p>SEER <i>Program Code Manual</i>, current edition Order SEER Publications Online-order form SEER publications available in hardcopy include reports and monographs, coding manuals, self-instructional manuals for tumor registrars, and ICD conversion materials</p>	<p>National Cancer Institute Publications Ordering Service P.O. Box 24128, Baltimore, MD 21227, 301-330-7968 http://www.cancer.gov/publications</p> <p>http://seer.cancer.gov/tools/codingmanuals/index.html</p>
<p>CDC <i>Data Collection of Primary Central Nervous System Tumors, National Program of Cancer Registries Training Materials</i> , 2004</p>	<p>Cancer for Disease Control and Prevention (CDC) National Program of Cancer Registries 4770 Buford Hwy, NE, Mail Stop K-53 Atlanta, GA 30042 -3717 Phone: 1(888) 842-6355 Fax: (770) 488-4760 http://www.cdc.gov/cancer/npcr/training/btr/</p>

D. DATA TRANSMISSION (Batched Records or Single Case Entry plus Edits/Corrections/QC)

ALL CASES MUST BE TRANSMITTED TO FCDS ELECTRONICALLY using FCDS secure information and data sharing portal: the FCDS IDEA, and in accordance with all FCDS Data

Submission Policies and Procedures. See Appendix Q for FAQs on the FCDS IDEA.

RELEASE OF INFORMATION – FCDS will not release any patient information directly to any contractor due to liability and confidentiality issues regarding contractual agreements not involving FCDS. Furthermore, new guidelines set forth under HIPAA (Health Insurance Portability and Accountability Act) have introduced additional restrictions regarding releasing and re-releasing patient information under many circumstances. FCDS understands that this policy may present some challenges to some contractors. Any contract between a healthcare facility and a private contractor where FCDS is not a party to the contract cannot include allowances for FCDS to release patient information to anyone other than the reporting facility.

Contractors must make arrangements with their clients (facilities) to forward any FCDS correspondence that includes patient information to them (contractor). This includes, but is not limited to edit discrepancies, quality control inquiries, verification of patient information, death certificate notification, AHCA casefinding audits, etc. Any discrepancies or omissions that are discovered after an abstract has been transmitted and processed will be posted to FCDS IDEA for review and/or correction. A *SAMPLE* FCDS Discrepancy Journal is provided at the end of this Section.

As a courtesy, FCDS will make every attempt to inform contractors of outgoing edits, quality control inquiries, verification of patient information, death certificate notification, AHCA casefinding audits, etc. However, the contractor and the reporting facility are ultimately responsible for assuring these reports and inquiries reach the contractor through appropriate channels.

CONFIDENTIALITY - Patient information, personal health information, medical records and healthcare facility data are all confidential and continue to be a concern with regard to cancer and other disease reporting. Please do not fax or email patient information to FCDS. Also, please take care when discussing cases over the phone with FCDS staff.

DO NOT E-MAIL, FAX OR MAIL PATIENT INFORMATION (PHI) TO FCDS UNDER ANY CIRCUMSTANCES unless you are provided specific instructions for using our Secure Fax Service.

CONFIDENTIAL INFORMATION includes any HIPAA-defined Protected Health Information.

PHI information in the healthcare includes:

- Patient name, address including street, city, county, zip code and equivalent geo codes,
- Name of relatives,
- Name of employers,
- All elements of date pertaining to patient (ex-admission, discharge and birthdate)
- Telephone numbers
- Fax numbers
- Electronic email addresses
- Social Security number, medical record number,
- Health plan beneficiary number,
- Account number
- Certificate and license number,
- Any vehicle or other device serial number
- Web Universal Resource Locator (URL)
- Internet Protocol (IP) address number
- Finger or voice prints
- Photographic images

1. Quarterly Reporting

FCDS REQUIRES THAT FACILITIES TRANSMIT DATA AT LEAST QUARTERLY.

MONTHLY DATA SUBMISSION IS RECOMMENDED FOR LARGE FACILITIES (facilities reporting over 500 cases/year).

DO NOT SEND INCOMPLETE RQRS (Rapid Quality Reporting System) CASES TO FCDS.**2. Electronic Submissions**Record Layout

All data must be submitted in the current NAACCR Version transfer record layout. The FCDS field positions and field lengths are standardized using the NAACCR transfer record layout, data definitions and data exchange guidelines. All fields identified as Core ('C') must be filled using valid codes. Any field identified as Optional ('O') may be submitted to FCDS as optional.

3. Receipt on Upload

An Upload Receipt is generated after the upload is successfully transmitted.

4. Data Acceptance Policy – FCDS EDITS

Batch submissions will be edited immediately upon upload using the standard FCDS EDITS metafile. This metafile is published on the FCDS website and is available for use by software vendors and other interested parties who wish to run edits prior to data submission.

Each record must pass all inter and intra-item edits before acceptance by FCDS.

Records that require a NAACCR edit override (FORCE) will pass the edit check process and will be accepted. However, upon review at FCDS it may be determined the case does not meet the criteria for edit override (FORCE) and a Correction may be made to the case. Information about corrections to cases will be returned to the facility so you can correct your database as well.

For the cases requiring an edit override or Force, FCDS staff will review submitted text to determine if sufficient information has been provided to override the edit in question. If the information provided in text is insufficient, the reporting facility will have two weeks from the time of case transmission to send FCDS the appropriate information from the path report, discharge summary, or other source to support the code(s) assigned. The FCDS Quality Control Staff will use the documentation provided to validate the coding and set the relevant override flag(s).

E. PSYCHIATRIC, MILITARY AND VETERANS ADMINISTRATION FACILITIES

United States military and Veterans Administration healthcare facilities are requested to report cancer under Rule 64D-3.006 of the Florida Administrative Code. While these institutions are not mandated to report, FCDS encourages them to voluntarily report their cancer cases in order to provide complete cancer incidence in Florida.

F. AMBULATORY SURGERY CENTERS

In July 1997, the Florida legislature amended state cancer reporting legislation to include cancer case reporting by ambulatory patient care facilities. The Florida Department of Health and FCDS agreed that in order to ease the burden of reporting by ambulatory centers FCDS would take on the responsibility of cancer case identification, the critical first step in the reporting of cancer cases.

Administrative Options for Reporting for Ambulatory Surgical Centers:

1. Facilities with a History of Reporting – Several ambulatory surgical centers already voluntarily report complete cancer cases to FCDS. Reporting by these facilities will continue as in the past. The FCDS notification of cases for cancer reporting for these facilities will actually be a quality

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control exercise. Cases identified through the notification process will be considered 'Missed Cases' and will need to be reported in a timely manner.

2. Annual reporting through the FCDS Notification of Cases (Annual AHCA Audit) - The AHCA discharge data from the surgical centers is matched with the complete FCDS Master-file database regardless of the type of cancer or the date of discharge. Records are matched on Social Security Number, Date of Birth, Sex, Race and County of Residence. Each AHCA record that does not match with a case in the FCDS Master-file is identified on the AHCA Unmatched Cancer Records Request listing for reporting.
3. Unmatched Ambulatory Surgery Center Cases are posted to the FCDS IDEA. Cases must be reviewed for reportability and abstracted using FCDS IDEA Single Entry. If the case is "not reportable" the appropriate AHCA Disposition Code must be entered in FCDS IDEA to explain why the facility will not report the case.

Code	Description
1	Reportable-Missed Case-Case to be Abstracted & Reported by Facility
2	N/R - Tumor was Not Malignant - Behavior = 0 or 1
3	N/R - NonReportable Skin Cancer - Site=C44.* and Morph = 8000 to 8110
4	N/R - No Evidence of Cancer at This Time - NED
5	N/R - Consultation Only
6	N/R - Cancer Not Proven - Equivocal
7	Case Previously Reported to FCDS by this Facility
8	N/R - Outpatient Record with No Active Cancer Documented in Record
9	N/R - Insitu Cancer of Cervix or CIN III
10	N/R - Other
11	Reportable-Case Abstracted BUT Not found in FCDS files - Abst Requested
12	N/R - No Cancer Mentioned in Medical Record
13	Skins we elected not to FB since most of them turn out N/R
14	N/R - Hematopoietic Diseases Dx Prior to 2001
15	N/R - Case DX Prior to FCDS Reference Date - Same Cancer/Same Facility
16	N/R - Benign or Borderline Brain/CNS Tumor Dx Prior to 2004
20	Unknown if Reportable - No Record of this Patient at this Facility
21	Unknown if Reportable - Lost Medical Record
30	Unknown if Reportable - No Follow-Back Ever Returned by this Facility
40	N/R - Special Case - Other
50	Hospice Case - Not A Hospital
51	Transitional Care Center - Not A Hospital

G. FREE-STANDING RADIATION THERAPY CENTERS

Those facilities that do not voluntarily report full cancer abstracts to FCDS will have to upload minimal data on all cancer patient encounters for casefinding using the FCDS IDEA. FCDS will match the cancer records identified by each facility against the FCDS Master file. Each record that does not match with a case in the FCDS Master file will be identified for reporting.

H. PRIVATE PHYSICIAN OFFICES

Practitioners licensed under Chapters 458, 459, 464, F.S., are required to report to the Florida Cancer Data System as required by Section 385.202, F.S., within six (6) months of each diagnosis and within six (6) months of the date of each treatment. Each physician office shall submit each cancer case report electronically. FCDS currently requires physician office (claims) reporting from medical oncology, hematology, urology, and other physician practices. Dermatology practices report under the Dermatology Reporting Module (abbreviated reporting mechanism designed to report skin cancers).

I. CLINICAL LABORATORY CANCER IDENTIFICATION PROGRAM

Every anatomic pathology laboratory that reads biopsy specimens and/or surgical resection specimens collected from patient encounters within the state of Florida MUST electronically submit the specified data for every malignant cancer case. This includes ALL hospital labs and ALL non-hospital labs.

Complete information, reporting specifications and pathology lab case report record layout can be found on the FCDS website at <http://fcds.med.miami.edu>. Each pathology laboratory has multiple submission choices; generating a tab delimited file from their existing database, using the web-based software provided by FCDS, generating an HL7 formatted file for download or generating an HL7 formatted file for transmission using PHINMS. Click on the PATH LAB icon then scroll down to the Path Labs File Layout. The document describes in detail the various formats that are acceptable to FCDS. The rest of the PATH LAB page includes important information for reference, including; the NAACCR/FCDS cancer terms, SNOMED codes and ICD-9 code files you should use to filter and select only the lab records that identify cancer as specified in these standard files.

J. FCDS RESPONSIBILITIES

1. Data Acquisition

In order to support the data acquisition aspect of the statewide registry, FCDS will:

- a. Provide manuals, which specifically define data collection and reporting requirements,
- b. Provide a data collection tool(s) and user manual(s) for electronic/web-based data submission,
- c. Train facility staff and interested parties in incidence data collection via FCDS sponsored training programs (NAACCR Webinars), FCDS web-based training modules, teleconferences, FCDS web broadcasts or recorded educational events and programs. All FCDS-originated training materials and web broadcasts are recorded and available free on the FCDS website.
- d. Provide specific routine reports to verify data submission and resolve data discrepancies.

2. Training and Education

FCDS develops, teaches, and supports a full range of Education and Training Options including:

- o FCDS educational web broadcasts are organized up to 6 times a year or as needed.
- o The FCDS On-Line web based Abstractor Training Course consisting of 20 modules and 1000 informational slides with voice-over recordings and testing is available on the FCDS website.
- o FCDS hosts 12 NAACCR Educational Webinars at 7 host sites around the state each year.
- o Additional resources are available and advertised through the FCDS Memo and via blast e-mail.

3. Quality Control

The primary objective of the Florida Cancer Data System (FCDS) is to maintain a high quality database of useable, timely, complete and accurate data for every case of cancer identified in the state of Florida.

- a. Completeness is the extent to which all required cases have been reported to FCDS.

Completeness is assessed using:

- i. Historical data from facilities
 - ii. On-Site or Remote Access Casefinding Audits
 - iii. Annual Linkage to Florida's Agency for Health Care Administration statewide patient encounter files – AHCA Casefinding Audits (AHCA Match)
 - iv. Annual Linkage to Florida's Bureau of Vital Statistics statewide death files - Mortality Casefinding Audits (Death Certificate Notifications)
- b. Accuracy is the extent to which the data submitted have been correctly coded and match the information contained in the medical record. Accuracy encompasses correct interpretation and application of coding rules and guidelines, identifies data entry and data submission errors and evaluates case correctness.

Accuracy is assessed using:

- i. FCDS Abstractor Code Testing
 - ii. FCDS Abstractor Code Annual Renewal Testing
 - iii. Field-Item, Inter-Item and Intra-Item Data Edits
 - iv. QC Visual Review Sampling of Every 25th Record
 - v. On-Site Re-Abstracting Audits
 - vi. Remote Access Re-Abstracting Audits
 - vii. Mail-In Re-Abstracting Audits
 - viii. FCDS Management Reports
- c. **Timeliness** involves how quickly each reporting facility submits cases to FCDS once a patient enters the health care system. The standard set forth by NAACCR, CDC/NPCR, ACOS/COC and FCDS is 95% of all new reportable cancer cases seen at any facility must be abstracted, submitted and any corrections for edit failures be completed within 6 months from the date of service. 100% of cases must be submitted by June 30 of any given year.

Timeliness is assessed using:

- i. Admissions by Facility Report
- ii. Facility Timeliness Report

FCDS Data Quality/Quality Control Program Components

1. On-Site and/or Remote Access Casefinding Audits

The FCDS Quality Control staff will periodically perform review of casefinding procedures by auditing the casefinding sources within each facility. This may be done in-person at the facility or may be completed remotely utilizing a variety of facility-generated data streams matched to the FCDS files. Names identified will be compared to the FCDS Master File by the auditor. The registrar at the facility will be asked to review their “Not Reportable List” and identify the reason for any case(s) found by the auditor that were not abstracted. Medical records for cases not found in the FCDS Master File or on the “Not Reportable List” will have to be reviewed by the facility abstractor.

If any case is found to meet the cancer reporting requirements outlined in Section I, the case must be abstracted and reported to FCDS. For any case found that does not meet the cancer reporting requirements outlined in Section I, an explanation must be submitted to FCDS detailing the reason it will not be reported.

2. FCDS/Agency for Health Care Administration (AHCA) Casefinding Audits

FCDS staff will perform annual matching of the FCDS Master File to the Florida Agency for Health Care Administration (AHCA) files for both inpatient and outpatient/ambulatory patient encounters. FCDS will provide the reporting facility with an electronic list of Unmatched AHCA Cases (cases that appear in the AHCA files but have no matching record in the FCDS Master File) available on the FCDS website.

Consolidated AHCA and Vital Statistics Follow-Back (Casefinding Audits).

The Consolidated AHCA and Vital Statistics Follow-Back will be available via FCDS IDEA following the June 30 Reporting Deadline.

The facility abstractor then must compare the list of Unmatched AHCA Cases to the facility “Not Reportable List”. Cases that appear on the Unmatched AHCA Cases listing but do not appear on the “Not Reportable List” will need to be reviewed by the facility abstractor. Upon review, if any case is found to meet the cancer reporting requirements outlined in Section I,

SECTION I: GUIDELINES FOR CANCER DATA REPORTING

the case must be abstracted and reported to FCDS. These cases are a priority reporting item and must be abstracted as soon as possible. Please reference the AHCA Disposition Codes List for “reason not reported to FCDS”.

Code	Description
1	Reportable-Missed Case-Case to be Abstracted & Reported by Facility
2	N/R - Tumor was Not Malignant - Behavior = 0 or 1
3	N/R - NonReportable Skin Cancer - Site=C44.* and Morph = 8000 to 8110
4	N/R - No Evidence of Cancer at This Time - NED
5	N/R - Consultation Only
6	N/R - Cancer Not Proven - Equivocal
7	Case Previously Reported to FCDS by this Facility
8	N/R - Outpatient Record with No Active Cancer Documented in Record
9	N/R - In situ Cancer of Cervix or CIN III
10	N/R - Other
11	Reportable-Case Abstracted BUT Not found in FCDS files - Abst Requested
12	N/R - No Cancer Mentioned in Medical Record
13	Skins we elected not to FB since most of them turn out N/R
14	N/R - Hematopoietic Diseases Dx Prior to 2001
15	N/R - Case DX Prior to FCDS Reference Date - Same Cancer/Same Facility
16	N/R - Benign or Borderline Brain/CNS Tumor Dx Prior to 2004
20	Unknown if Reportable - No Record of this Patient at this Facility
21	Unknown if Reportable - Lost Medical Record
30	Unknown if Reportable - No Follow-Back Ever Returned by this Facility
40	N/R - Special Case - Other
50	Hospice Case - Not A Hospital
51	Transitional Care Center - Not A Hospital

3. FCDS/Bureau of Vital Statistics Casefinding Audits (Death Clearance Audit)

FCDS staff will perform annual matching of the FCDS Master File to the Florida Bureau of Vital Statistics death files. FCDS will provide the reporting facility with a list of unmatched Vital Statistics cases (deaths) that show the place of death as the reporting facility.

Consolidated Vital Statistics and AHCA Follow-Back (Casefinding Audits).

The Integrated Vital Statistics and AHCA Follow-Back will be available via FCDS IDEA following the June 30 Reporting Deadline.

The facility abstractor will need to research these cases to determine if the patient did expire at the facility and whether or not the case meets the cancer reporting requirements. If any case is found to meet the reporting requirements, the case must be abstracted and reported to FCDS. For each case that will not be reported to FCDS or did not expire at the reporting facility, FCDS requires a brief statement be submitted that sufficiently explains why the case will not be reported. Please reference the Death Clearance Disposition Codes Listing below for “reason not reported to FCDS”.

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Code	Description
0	Pending Follow Back
1	Missed Case - Case Abstracted & Reported by Facility
2	N/R - Tumor was Not Malignant - Behavior = 0 or 1
3	N/R - NonReportable Skin Cancer - Site=C44.* and Morph = 8000 to 8110
4	N/R - No Evidence of Cancer at This Time - NED
5	N/R - Consultation Only
6	N/R - Cancer Not Proven - Equivocal
7	Case Previously Reported to FCDS by this Facility
8	N/R - Outpatient Record with No Active Cancer Documented in Record
9	N/R - Insitu Cancer of Cervix or CIN III, VIN III, VAIN III, PIN III
10	N/R - Other
11	Case Abstracted by Facility but Not found in FCDS Masterfile
12	N/R - No Mention of Cancer in Medical Record
13	This follow-back code no longer valid
14	N/R - Non-Reportable Myeloproliferative Disease - Dx Prior to 2001
15	N/R - Case DX Prior to FCDS Reference Date - Same Cancer/Same Facility
16	N/R - Benign or Borderline Brain/CNS Tumor Dx Prior to 2004
20	Unknown if Reportable - No Record of this Patient at this Facility
21	Unknown if Reportable - Lost Medical Record
30	Unknown if Reportable - No Follow-Back Info ever Returned by Facility
40	N/R - Special Case - Other
41	This Vital Statistics Record Matches an AHCA Record- For FCDS Use Only
50	Hospice Case - Not A Hospital
51	Transitional Care Center - Not A Hospital
52	Not A Hospital, NOS
53	Closed Facility - No Records Available
54	Nursing Home Death or Residence Death, Not A Hospital Death
55	DCO Replaced by Non-DCO- For FCDS Use Only
56	Report Source 7 or 8 is corrected and does not link back to proper Pt.
57	Demographic information changed. Death Certificate linkage was lost.

4. FCDS EDITS Metafile includes Field-Item, Inter-Item and Intra-Item Data Edits

FCDS uses a standard EDITS Metafile that has been modified to meet Florida requirements. The FCDS EDITS Metafile can be found on the FCDS website as well as a master listing of changes by date. FCDS EDITS include data edits to validate codes, crosscheck related data items and records and check for blank fields. The Florida specific data edits were created for all Florida only fields as well as for common abstracting errors identified through re-abstracting audits. Edits are reviewed as needed (monthly). New edits are added as needed.

5. QC Visual Review Sampling of Every 25th Record

FCDS Quality Control staff visually reviews at least one in every 25th record submitted by each reporting facility. The Quality Control Visual Review is designed to facilitate visual editing of abstracted data. It allows a trained eye to detect inconsistent coding that electronic edit checks cannot identify; it is a tool to identify deficiencies in abstractors' understanding of abstracting concepts, data definitions and coding selections that may require additional training. The QC Abstract Review Case Selection Process is fully automated and randomly selects one of every 25th record processed, which accounts for 4% of cases being visually reviewed for accuracy. Each case selected is placed in a QC file ready for visual review by the FCDS QC staff. Records with discrepant data must be resolved by the reporting facilities through FCDS IDEA by making return comments on each case (agree/disagree/add documentation to support original coding/other rationale). The case is then reviewed again by FCDS QC staff (different staff than the original FCDS Reviewer) and a final decision is made based on all information available.

This three-step process provides the registry every opportunity to rebut identified “errors” or “deficiencies” in the abstract by having three CTR or CTR-eligible staff review each case and provide documented input to what they interpret from the documentation provided in the original abstract. This process also serves as an educational tool for new and experienced registrars regarding where they have deficiencies in their abstracting tool kit and what they should be doing when abstracting specific cases by providing comment on a case-by-case basis.

Registry Managers should always share results with staff member responsible for the original abstract. Otherwise, they will continue to make the same error without knowledge they are

doing something incorrectly, inconsistently, or out of synch with national reporting standards and guidelines.

6. On-Site or Remote Access Re-Abstracting Audits

The FCDS Quality Control staff and/or outside contract agents working on behalf of FCDS will perform on-site or remote access review of abstracting procedures by auditing individual reports and/or entire medical records of cases previously submitted to FCDS. The data validation or re-abstracting audit serves to verify that coded data submitted to FCDS can be validated when compared to original source documents at the hospital or central registry level. Discrepant data are followed back to the originating institution for clarification.

Reconciliation of the Re-abstracting Audit: Key data items will be evaluated and any discrepancy noted between the auditor's findings and the original abstract findings will be returned to the facility for reconciliation. If the auditor's findings are disputed, documentation must be submitted to clarify the originally abstracted codes.

These audits allow assessment with regard to standardized interpretation of data definitions, coding rules and guidelines, policies and procedures and serve to identify areas that may require further education and training.

7. Remote Access Re-Abstracting Audits

FCDS may substitute On-Site Re-Abstracting Audits with Remote Access Re-Abstracting Audits. Should FCDS decide to perform Remote Online audits, facilities will be asked to make available pertinent reports from medical records and/or other data sources to FCDS for review or FCDS will utilize existing source documents used in routine reporting.

8. FCDS Abstractor Code Policy

Every registrar/abstractor planning to work in the State of Florida is required to obtain an individual FCDS Abstractor Code. This code is assigned by FCDS to persons who successfully pass the FCDS Abstractor Code On-Line Examination, regardless of certification by NCRA as a CTR, experience in the registry industry, or other factors. As of January 1, 2013, any individual planning to acquire a New FCDS Abstractor Code or planning to Renew an Existing FCDS Abstractor Code must take and pass the FCDS Abstractor Code Exam. Registration for testing and real-time on-line testing can be found on the FCDS website.

The FCDS Abstractor Code Requirement has been FCDS Policy for many years and applies to every cancer registrar working in the state of Florida (CTR or non-CTR, Florida resident or out-of-state contractor, regardless of number of years' experience). FCDS will not accept cases from individuals without an Active/Current FCDS Abstractor Code.

While the FCDS Abstractor Code Requirement Policy remains unchanged, the FCDS Abstractor Code Exam is a tool introduced to help FCDS expedite FCDS Abstractor Code approvals, renewals, and monitoring. Exams are short (15-20 multiple choice or T/F questions) with a variable mix of content questions weighted differently depending on whether this is an exam for a New FCDS Abstractor Code or Renewal of an existing FCDS Abstractor Code.

Questions are electronically selected at random from a pool of nearly 350 questions covering 5 major topic areas. No two exams will be alike.

The 5 topic areas include;

- General Abstracting Knowledge
- Primary Site/Histology/Grade
- Stage at Diagnosis
- Latest Rule Changes
- Treatment and Survival

Standard References Used for Testing

- FCDS DAM (current version)
- ICD-O-3 (including errata and updates)
- MPH Rules for Solid Tumors (current)
- MPH Rules/Database for Hematopoietic/Lymphoid Neoplasms (current)
- Collaborative Stage Data Collection System - Lab Tests, Tumor Markers, SSF Notes
- AJCC Cancer Staging Manual, 7th edition
- SEER Summary Staging Manual 2000
- SEER*Rx (current)
- SEER Self-Instruction Manuals (basics)
 - ◇ Book 2 – Cancer Characteristics
 - ◇ Book 3 – Tumor Registrar Vocabulary: Composition of Medical Terms
 - ◇ Book 4 – Human Anatomy as Related to Tumor Formation

WHO NEEDS TO TAKE THE FCDS ABTRACTOR CODE EXAM?

- ✓ Individuals hoping to acquire a NEW FCDS Abtractor Code will need to take the New FCDS Abtractor Code Exam.
- ✓ If an individual's FCDS Abtractor Code has been expired for greater than 2 years, the individual must re-apply and take and pass the New FCDS Abtractor Code Exam.

WHO NEEDS TO TAKE THE FCDS ABTRACTOR CODE RENEWAL EXAM?

- ✓ Individuals with an ACTIVE (not yet expired) FCDS Abtractor Code will be required to take and pass the FCDS Abtractor Code Renewal Exam once their code has expired.
- ✓ Individuals with an EXPIRED FCDS Abtractor Code will be required to take the FCDS Abtractor Code Renewal Exam each year in order to keep their FCDS Abtractor Code current and to renew their individual FCDS Abtractor Code, annually.
- Registrars will be required to navigate, use and apply standard cancer registry desk and electronic desktop or web-based references and resources to pass the examination.
- References used include but are not limited to: Current FCDS DAM, Current MPH Rules for both Solid Tumors and Hematopoietic and Lymphoid Neoplasms, Collaborative Stage Data Collection Rules and Schema including Site Specific Factors, SEER*Rx, the Hematopoietic Database and SEER Self Instructional Manuals including Books 2, 3, 4.
- Examinations are timed with a maximum of 1 hour allowed to take the annual renewal exam (15 Q&A) and 2 hours allowed for initial exam (20 Q&A).
- The registrar will be given two opportunities to successfully pass the examination with a score of 80% or greater.
- If the registrar fails twice, s/he must wait at least one week to take the examination again. Registrars should not abstract cancer cases between failed exams.

SECTION I: GUIDELINES FOR CANCER DATA REPORTING

- Abstractors who successfully pass the examination will be assigned a Florida Cancer Data System Abstractor Code. Codes are renewed annually.
- NEVER share your abstractor code or your code may be suspended or revoked.

Before taking the exam, please read through and become familiar with the FCDS DAM to ensure you understand all of the Florida abstracting and data collection requirements. The current version FCDS DAM can be found on our website, <http://fcds.med.miami.edu>. There are a few Florida-specific requirements critical to complete reporting in Florida that many out-of-state registrars miss – reporting of non-analytic cases and all sequences for historical cancers.

FCDS monitors use of individual codes and is alert to the practice of sharing abstractor codes for new staff, temporary staff, and even permanent staff.

Please be secure with your abstractor code, abstracted data, personal information, and all confidential materials.

A breach of confidentiality and/or of protected personal health information or PHI, also known as a HIPAA Violation, may result in substantial civil monetary penalties (up to \$1.5 million in a single calendar year) and/or criminal penalties of up to 10 years in federal prison.

Personal Health Information (PHI) includes:

- Patient name, address including street, city, county, zip code and equivalent geo codes,
- Name of relatives,
- Name of employers,
- All elements of date pertaining to patient (ex-admission, discharge and birthdate)
- Telephone numbers
- Fax numbers
- Electronic email addresses
- Social Security number, medical record number,
- Health plan beneficiary number,
- Account number
- Certificate and license number,
- Any vehicle or other device serial number
- Web Universal Resource Locator (URL)
- Internet Protocol (IP) address number
- Finger or voice prints
- Photographic images

9. Admissions by Facilities Report

FCDS Data Acquisition staff will review the Admissions by Facilities Report (an internal FCDS report) on a regular basis. This report makes a comparison of observed to expected numbers of cases reported by each facility for any time period requested. The report is based on a five-year historical summary of cases reported to FCDS by each facility. The ratio of observed to expected is reported as a percent of completeness. Either FCDS Staff or a representative of the Department of Health will notify facilities that have not reported the expected number of cases. These same data are included in the Quarterly Activity Report.

10. Facility Timeliness Report

FCDS Data Acquisition staff will review the Facility Timeliness Report on a regular basis.

This report shows the average amount of time (in days) that it takes the reporting facility to submit a case to FCDS. It specifically; 1) calculates the difference between the date the reporting facility had the first contact with the patient and the date the case was abstracted, 2) calculates the difference between the date the case was abstracted and the date the case entered the FCDS Master File, and 3) calculates the difference between the date the reporting facility first had contact with the patient and the date the case entered the FCDS Master File. The time between the date the reporting facility had contact with the patient and the date the case entered the FCDS Master File should be 180 days or less. These same data are included in the Quarterly Activity Report (see Section Forms).

11. Other Quality Control Studies and Audits

FCDS Quality Control staff will run quarterly reports to help identify areas of concern regarding reporting by individual facilities. These quarterly reports will be used to identify trends in case reporting that may need to be addressed at a facility or at the state level. For example, if a facility reports that 95% of their prostate cases are "unstaged" at the time of first contact with their facility there may be a problem with the abstractor's understanding how to correctly interpret the field 'FCDS Stage at First Contact' and/or how to code it correctly. Similar analyses will be conducted for individual abstractors within the facility. The FCDS Quality Control staff will perform ad-hoc inquiries to the FCDS Master File when data requests are made. Any unusual data will be reviewed, and facility-abstracting staff may be requested to review individual cases to confirm the reporting of certain data items.

12. Facility Evaluation Report

The report is a graphical and numerical representation of the performance of a reporting facility over a given time period, detailing the three principles of data appraisal: Timeliness, Completeness and Accuracy.

13. FCDS Data Quality Indicator Report (DQIR)

The FCDS Data Quality Indicator Report is designed to provide feedback to registries on the completeness of case abstracts by examining the frequency of coding "unknown" or "ill-defined" values in key analytic data items. Data must meet rigorous national quality standards to be included in local, regional, state, and national cancer rates, reports to Congress, numerous surveillance-related publications and for registry certification.

The percent of "unknown" and "ill-defined" values is an indicator used in ranking Florida's overall data quality and completeness of case reporting and is used when comparing Florida data to other states for overall data validity and reliability. These data are also early indicators of problem areas and areas where FCDS and local registries can improve upon cancer reporting as data are available. The report includes the Florida state and National distribution of "unknown" value used for comparison. The report uses data from analytic cases only

Note: This report is a scaled down model of a similar report the CDC National Program of Cancer Registries (NPCR) provides to Florida and each NPCR state as an assessment of our state-wide data.

4. Data Requests

Filing the appropriate FCDS and DOH forms is required for data requests. The forms are available on the FCDS website (<http://fcds.med.miami.edu/inc/datarequest.shtml>)

Requests for special reports involving release of personal identifiers will be reviewed by a data use

committee of DOH for cost effectiveness, research worthiness, and to ensure patient confidentiality.

In general, most requests for data fall into five categories: CD's with raw non-confidential data, statistical/tabular data, confidential data, data linkages, and data for investigation of potential cancer clusters. There are specific procedures for data release based on the category of request and associated fees. All data requests, regardless of the nature of the request, must be submitted to FCDS in writing.

Reporting facility data is considered confidential data. When requesting facility specific data (data other than that submitted from your facility), please mail the data request form along with original cover letters from all concerned facilities on their facility letterhead to FCDS. It is the requestors responsibility to obtain permission for data release from each of the medical facilities of interest prior to making the data request. Keep in mind that all applicable fees apply. The exception to the above rule is when requesting data submitted from the originating institution. Each reporting facility has an annual \$300 credit, which can be applied to data requests only with regard to data submitted from their institution. Requests should be submitted in writing on facility letterhead and signed by the supervisor or the administrator listed in the FCDS database. If the data is to be sent to a third party, this request should be specified in the letter.

Data are extracted from two main files: the master file and the commercial file. The master file is a data file containing all cancer records that have successfully passed the SEER (Surveillance Epidemiology and End Results, National Cancer Institute program) and FCDS standard edit checks. This file is continually updated as new records are received. The commercial file is a 'snapshot' of the master- file at the exact moment it is created; therefore it remains static while the master-file is dynamic. Depending on the nature of the request, FCDS will determine from which file to extract the data. Generally, the commercial file is used to fill requests for incidence data because the data are relatively static and menu rates are calculated from this file. For a complete list of data items available, please refer to FCDS data items list document. Data on the website uses the commercial file.

Availability of Data by Type, Media, Format, and Data Request Fees and Billing Procedures

1) Data CD's

FCDS provides three raw data CD's: a Public Use CD and two versions of the Confidential CD. *Please note these are flat files in a fixed layout, (approximately 2 million records each year) therefore you will need some type of software to read in the data and analyze it (i.e. SAS, SPSS, SQL).*

FCDS will fill data requests for data CD's within 20 business days once the application has been approved and payment has been received by FCDS.

- a. The *Public Use CD* is available without charge to anyone requesting FCDS data. The Public Use CD contains county level case data for all sites, with many of the demographic variables collapsed into aggregate groups, i.e. age, race, marital status, etc. The application form along with the variable list for the Public Use CD are available under the "Data Request" link on the FCDS web site <http://fcds.med.miami.edu>. Please download the application and follow the submission instructions.
- b. The two versions of the *Confidential CD* are: 1) The Limited Confidential CD which contains no geocoded data, and 2) the Full Confidential CD containing geocoded data. Both Confidential CDs are void of any personal identifiers (name, address, date of birth, and social security number). The only difference between the CDs is that one contains geocodes, the other does not. FCDS approval is required for release of the Limited Confidential CD. The application process for the Full Confidential CD requires DOH IRB approval prior to release. Both Confidential CDs are available only to recognized academic, research, and governmental institutions. There is a charge for both versions of the Confidential CD. Please see the Fees and Billing Procedure section of this document for information on these charges. The application forms for the Confidential CDs are available online under the "Data Request" link on the FCDS web site <http://fcds.med.miami.edu> .

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If you would like to request one of the CDs please download this document and follow the submission instructions. In addition, if applying for the Full Confidential CD, please note as stated above you will need to fill out the DOH IRB form as well. This form is available within the "Procedure Guide for studies that utilize FCDS for patient identification and contact" document under the "Data Request" link of our website. Further information on the DOH IRB application process and timeline can be found at <http://www.doh.state.fl.us/execstaff/irb/index.html>.

For questions, please contact:

Florida Department of Health
Bureau of Epidemiology
Cancer Registry
Re: Confidential Data Request
4052 Bald Cypress Way, Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 245-4401
Fax: (850) 922-9299

The data on the CDs are updated when necessary, with the most recent year being added as it becomes available. FCDS will **fill data requests** for data CDs **within 20 business days** once the application has been approved and payment has been received by FCDS.

2) Statistical/Tabular Data (All non-CD requests for Data)

All requests for non-confidential statistical/tabular data must be received in writing, please use the form titled "Data Request Form (for statistical and tabular data)" found under the Data Requests link on the FCDS web site <http://fcds.med.miami.edu>. This type of data request can be approved directly by FCDS.

The basic rule of thumb is that as long as the tabulation cannot either directly or indirectly identify any patient, the data may be released. In an effort to protect the indirect identification of the patient, the "rule of ten" is applied; this rule suppresses any cell containing fewer than 10 cases. Tabulated data may be released at or above the county code level with a count of 10 or greater; for counts less than 10 or data below the county level; approval will be required from the Department of Health.

Because each request is unique, FCDS staff will discuss the project with the requestor to verify the type of data required and determine if the system is capable of producing the required data and to determine approximately how long it will take to fill the request. Based on this information, an estimate of the cost is provided. Then the applicant will need to submit the request in writing. FCDS staff may contact the requestor as needed to discuss and clarify additional details of the request.

FCDS will fill data requests for statistical/tabular data within 20 business days once the request has been finalized and the cost has been approved.

3) Confidential Data

All requests for confidential data (any data that can directly identify a patient) must be sent to the Florida Department of Health (DOH) for approval using both the DOH Bureau of Epidemiology and the DOH Institutional Review Board (IRB). Please refer to the *Procedure Guide for Studies that Utilize the Florida Cancer Data System Data for Patient Identification and Contact* for application materials and submission requirements. The Procedure Guide can be found at <http://fcds.med.miami.edu/inc/datarequest.shtml>. Further information on the DOH IRB application process and timeline can be found at <http://www.doh.state.fl.us/execstaff/irb/index.html>

For questions, please contact:

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Cancer Registry
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Tallahassee, FL 32399-1720
Telephone: (850) 245-4401
Fax: (850) 922-9299

Once approval has been received from **both** the DOH Bureau of Epidemiology and DOH IRB, FCDS staff will then begin to work directly with the researcher. FCDS will not begin work on the project until we have received all of the necessary approval and paperwork directly from the DOH Bureau of Epidemiology. Only those data items (variables) specified in the *Application for Research Use of the Florida Cancer Data System* will be extracted. FCDS will fill confidential data requests within 6 weeks time once the request and cost have been approved.

Please note that approval for confidential data through Florida Department of Health can take anywhere from 8 weeks to 18 months, depending on complexity and thoroughness of the request of the application. Please plan accordingly.

4) Data Linkage

A data linkage project is a request that involves linking FCDS data to external or internal data sets. The preliminary steps involving linkages are identical to those of confidential data requests. (Please refer to the confidential data requests section above).

Fields used in the linkage must be consistent in both data sets. The researcher should send FCDS the data in a fixed length ASCII file with the proper record layout and format. (Refer to Data Linkage Record Layout document). Any deviations from the record layout or format will require extra work and will be charged to the requestor according to the fee schedule. (Refer to Fees and Billing Procedure below).

FCDS will fill data linkage requests within 6 weeks following approval of the request and fees.

5) Cancer Cluster Data

Requests for information regarding potential cancer clusters should be directed to the County Health Department. If necessary, staff at the County Health Department will contact the appropriate division at the central office of the Florida Department of Health for assistance.

6) Fees and Billing Procedure

Each reporting facility has an annual \$200 credit, which can be applied to data requests only with regard to data submitted from their institution. Requests should be submitted in writing on company letterhead. If the data is to be sent to a third party, this request should be specified in the letter.

The billing procedure for the Confidential CDs is as follow: once payment and supporting documentation are received, the CD is mailed out. For all other data requests, an invoice will be mailed (via email or postal service) along with the results of the data request or linkage.

Most requests generate a fee. The FCDS does not receive additional funding to perform special, ad-hoc data analysis; therefore actual costs are passed on to the applicant.

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The fees are as follows:

- Public use CD - No Charge
- Minimum charge - \$150.00
- Statistical analysis/programming/data coordination - \$150.00 per hour
- Limited Confidential CD without geocodes - \$500.00
- Full Confidential CD with geocodes - \$1,000
- Data Linkage:

Sliding scale: <10,000	\$3,000
10,000 – 24,999	\$2,500 fee plus .05 cents per record
25,000 – 49,999	\$3,000 fee plus .03 cents per record
50,000 – 99,999	\$3,500 fee plus .02 cents per record
100,000 – 249,999	\$4,000 fee plus .015 cents per record
250,000+	\$5,000 fee plus .011 cents per record
- Geocoded & Patient Contact lists

Sliding scale: <10,000	\$1,500
10,000 – 24,999	\$2,000
25,000 – 49,999	\$2,500
50,000 – 99,999	\$3,000
100,000 – 249,999	\$3,500
250,000+	\$4,000

Subsequent listing (without changes to format, layout, or variables) will be charged 50 percent of the sliding scale fee for the number of records extracted. For example, subsequent request for another 30,000 patient listing would be $2500 \times .50 = \$1,250$.

- Overnight mailing - actual cost

Data linkage fees are charged for those projects involving the matching of an outside data source to the Florida Cancer Data System database. Please contact FCDS directly to discuss fields and the associated record layout. A copy of the required record layout is available under the “Data Request” link on the FCDS web site <http://fcds.med.miami.edu>.

Data coordination fees apply to all data linkage projects; they involve manually reviewing possible matches and correcting for any deviations in field length or variable formats.

Please contact FCDS prior to submitting a written request to discuss the analysis/data extraction and to obtain an estimate of any fees.

Additional information such as published resources and statistics are available on the FCDS website: <http://fcds.med.miami.edu/inc/statistics.shtml>

If a data request does not fall into any of the above categories please contact us at 1-800-906-3034 or 305-243-4600.

All media requests should be directed to Irv Kokol of the FL DOH Office of Communications at 850- 245-4111.

FCDS maintains a list of all published articles using FCDS Data. Please provide information on any scientific publications resulting from a data request.

K. FCDS MANAGEMENT REPORTS

FCDS Quarterly Activity Status Report

This report summarizes the FCDS file activity for each facility on a quarterly basis. Every facility

should have some file activity during every quarter of the year. The report documents information about the number and quality of cases submitted during the previous quarter, timeliness of reporting, and also provides an annual incidence and completeness summary, which compares observed-to-expected numbers of cases reported for the year. (See Forms Section)

FCDS Data Quality Indicator Report

This report is a scaled down model of a similar report the CDC National Program of Cancer Registries (NPCR) provides to Florida and each NPCR state as an assessment of state-wide data. The report reflects 5 years of data and examines the frequency of assignment of “unknown” or “ill-defined” values to key analysis variables over the course of the five-year period with comparison to national.

The percent of “unknown” and “ill-defined” values in certain variables is a data quality indicator used to rank Florida’s overall data quality and completeness of the data for each case reported and is used when comparing Florida data to other states for overall data reliability. These data are also indicators of problem areas where FCDS and local registries can improve upon cancer reporting as data are available.

Annual AHCA Unmatched Report

The AHCA Unmatched Report and subsequent follow-back procedures are used to assess casefinding completeness at the facility level.

Consolidated AHCA and Vital Statistics Follow-Back Reports (Casefinding Audits).

Consolidated AHCA and Vital Statistics Follow-Back Reports will be available via FCDS IDEA following the June 30 Reporting Deadline.

Annual Bureau of Vital Statistics Unmatched Report

FCDS staff will perform annual matching of the FCDS Master File to the Florida Bureau of Vital Statistics death files. FCDS will provide the reporting facility with a list of unmatched Vital Statistics cases (deaths) that show the place of death as the reporting facility.

Consolidated Vital Statistics and AHCA Follow-Back Reports (Casefinding Audits).

Consolidated Reports Vital Statistics and AHCA Follow-Back Reports will be available via FCDS IDEA following the June 30 Reporting Deadline.

FCDS EDITS Master List

This is a listing of all FCDS edits included in the latest FCDS EDITS Metafile and includes the edit number, edit category, and edit message. The current list can be found under Downloads on the FCDS website. This list is updated regularly and can be found on the FCDS Website under Downloads.

L. AWARDS

Jean Byers Memorial Award for Excellence in Cancer Registration

Pat Strait Award for Excellence in Cancer Registry Abstracting – The Pat Strait Award for Excellence in Cancer Registry Abstracting is awarded to individuals who contribute to a facility achieving the annual Jean Byers Memorial Award.

Criteria for receipt of the Jean Byers Award and the Pat Strait Award are based on a standard set of criteria that meet or exceed the completeness, timeliness and accuracy requirements determined by

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FCDS and CDC. The criteria may change between years, depending on annual reporting conditions but generally are a factor of a combination of successful data quality metrics including; Reporting Deadline, percent of missed cases as determined using AHCA and Vital Statistics Matching and Follow-Back Results (missed cases cannot exceed 10% of the facility's annual caseload), and other established data quality indicator metrics.

M. FCDS GENERAL MAILING INSTRUCTIONS:

DO NOT MAIL ANY MATERIALS CONTAINING PERSONAL HEALTH INFORMATION

In order to protect and properly handle all packages FCDS is making the following recommendations:

1. We ask that if you are mailing a package to FCDS use Federal Express, UPS, Airborne Express or any other type of courier service.

- a. The FCDS street address below must be used for courier packages:

FCDS
University of Miami School of Medicine
1550 NW 10 AVE
Room 410
Miami, FL 33136

Include the following text on a separate header page in the package.

- b. Always request a signature upon delivery.
 - c. Make sure that the addressee at FCDS knows that she/he is to expect a package.
 - d. Track the package to ensure that it has reached its destination. You may want to explore the e-mail tracking and notification features that the courier of choice offers.
2. **For non-confidential information**, if using US Postal Service, which may include Express mail, Priority mail, and Certified mail, you must use the FCDS PO Box address below:

FCDS
University of Miami School of Medicine
PO BOX 016960 (D4-11)
Miami, FL 33101

3. All shipments must adhere to the [FCDS Confidential Information Security Policy](#).

N. CALENDAR/FORMS/TEMPLATES/SAMPLE REPORTS

- FCDS Annual Reporting Calendar
- FCDS 2016 Abstract Form - Sample
- FCDS Discrepancy Journal - Sample
- Not Reportable List - Template
- FCDS Quarterly Activity Status Report – Sample
- FCDS Data Quality Indicator Report - Sample

**FCDS 2016 Reporting Calendar
FCDS Recurring Deadlines**

Patient Encounter for Cancer	Case Should Be Reported
January 2016	July 2016
February 2016	August 2016
March 2016	September 2016
April 2016	October 2016
May 2016	November 2016
June 2016	December 2016
July 2016	January 2017
August 2016	February 2017
September 2016	March 2017
October 2016	April 2017
November 2016	May 2017
December 2016	June 2017

RECURRING DEADLINES		
Monthly	FC Review/Inquiry	Cases with FC Review Inquiry or correction(s) must be reviewed and responded to monthly
Monthly	QC Review/Inquiry	Cases with QC Review Inquiry or correction(s) must be reviewed and responded to monthly
June 30	Annual Reporting Deadline	All cases from previous calendar year must be reported to FCDS on or before June 30 th each year
October 15	Consolidated Follow-Back Deadline	All unmatched cases from the combined AHCA and Vital Records Death Match must be resolved 7/15-10/15 each year
Varies	FAPTP Follow-Back Deadline	All unmatched cases from FAPTP must be resolved each year



TUMOR INFORMATION

Class of Case

- 00 10 11 12 13 14 20 21 22 30 31 32
- 33 34 35 36 37 38 40 41 42 43 49 99

Diagnostic Confirmation

- 1 Histology 2 Cytology 3 Histo/Immuno and/or Gene Studies **Only for Hematopoietic or Lymphoid Neoplasms** 4 Micro, NOS 5 Lab test/marker study
- 6 Dir. Visual 7 Radiography 8 Clinical 9 Unknown

Date of Initial DX - - Place of DX _____

Primary Site Text Title _____ Histology Text Title _____

Primary Site C ____ Histology Behavior Grade/Differentiation/Immunophenotype

Laterality 0 None 1 Right 2 Left 3 Unilat 4 Bilat 5 Paired site: Midline Tumor 9 Unk

Lymph Vascular Invasion 0 Absent/not identified 1 Present/Identified 8 N/A 9 Unk

Height at DX (inches) |__|__|__|__|

Weight at DX (lbs) |__|__|__|__|

Tobacco Use Cigarette |__|

Tobacco Use Smokeless |__|

Tobacco Use Other Smoke |__|

Tobacco Use NOS |__|

SEER SUMMARY STAGE 2000 |__| Benign/Borderline |__| In-Situ |__| Localized |__| Regional (3, 4, or 5) |__| Distant

Summary Tumor Size |__|__|__|__|

Regional Nodes Positive |__|__|

Regional Nodes Examined |__|__|

TNM Clinical Descriptor ____

TNM Pathologic Descriptor ____

Clinical T ____ N ____ M ____

Pathologic T ____ N ____ M ____

Clinical Stage/Prognostic Group ____

Pathologic Stage/Prognostic Group ____

CS Site-Specific Factor 1 |__|__|__|__|

CS Site-Specific Factor 9 |__|__|__|__|

CS Site-Specific Factor 17 |__|__|__|__|

CS Site-Specific Factor 2 |__|__|__|__|

CS Site-Specific Factor 10 |__|__|__|__|

CS Site-Specific Factor 18 |__|__|__|__|

CS Site-Specific Factor 3 |__|__|__|__|

CS Site-Specific Factor 11 |__|__|__|__|

CS Site-Specific Factor 19 |__|__|__|__|

CS Site-Specific Factor 4 |__|__|__|__|

CS Site-Specific Factor 12 |__|__|__|__|

CS Site-Specific Factor 20 |__|__|__|__|

CS Site-Specific Factor 5 |__|__|__|__|

CS Site-Specific Factor 13 |__|__|__|__|

CS Site-Specific Factor 21 |__|__|__|__|

CS Site-Specific Factor 6 |__|__|__|__|

CS Site-Specific Factor 14 |__|__|__|__|

CS Site-Specific Factor 22 |__|__|__|__|

CS Site-Specific Factor 7 |__|__|__|__|

CS Site-Specific Factor 15 |__|__|__|__|

CS Site-Specific Factor 23 |__|__|__|__|

CS Site-Specific Factor 8 |__|__|__|__|

CS Site-Specific Factor 16 |__|__|__|__|

CS Site-Specific Factor 24 |__|__|__|__|



Text – Dx Procedures – Physical Exam

RX Text - Surgery

Text – Dx Procedures – X-ray/Scans

RX Text – Radiation (Beam)

Text – Dx Procedures – Scopes

RX Text – Radiation (Other)

Text – Dx Procedures – Lab Tests

RX Text - Chemotherapy

Text – Dx Procedures – Operative Report

RX Text - Hormone

Text – Dx Procedures – Pathology Report

RX Text - BRM

RX Text - Other

Text – Staging

REMARKS



FOLLOW-UP

Vital Status 0 Dead 1 Alive

Cancer Status 1 NED 2 Evidence of Disease 9 Unknown

Date of Last Contact | | | | | - | - | | | |

Date of last Contact Flag: Blank 12 Event occurred but Date UNK

NPI Physician Managing

| | | | | | | | | | | |

NPI Physician Follow-Up

| | | | | | | | | | | |

NPI Physician – Primary Surgery

| | | | | | | | | | | |

NPI Physician 3 – Radiation Oncologist

| | | | | | | | | | | |

NPI Physician 4 – Medical Oncologist

| | | | | | | | | | | |



Discrepancy Journal

2/22/2013 11:36:16 AM

Page: 1 of 1

Medical Facility:		Region: 2	Option: 4						
Abs	Accession	Seq	Abstract Type	Patient Name	Recipient	Site	DX Date	Initials	N8G
		Medical Record #:		SSN:	DOB:				

Error:390 Force:N If Regional Nodes Positive = 01-97, then CS Lymph Nodes cannot = 000

Discrepant Data: Edit: CS Lymph Nodes, Regional Nodes Positive (CS)
 E:0390: If Regional Nodes Positive = 01-97, then CS Lymph Nodes cannot = 000

Primary Site (540)	{C502}
Histologic Type ICD-O-3 (550)	{8500}
Behavior Code ICD-O-3 (554)	{3}
Regional Nodes Positive (914)	{12}
CS Lymph Nodes (992)	{000}
CS Site-Specific Factor25 (1075)	{988}

Error:776 Force:N A discrepancy exist between the Regional Nodes Examined and Regional Nodes Positive data items.

Discrepant Data: Edit: CS Reg Nodes Ex, Pos, Site, Hist ICDO3, Rept(FCDS)
 E:0776: Conflict between Regional Nodes Examined {04} and Regional Nodes Positive {12}

M:Schema: Breast

Primary Site (540)	{C502}
Histologic Type ICD-O-3 (550)	{8500}
Behavior Code ICD-O-3 (554)	{3}
Date of Diagnosis (530)	{Y:2011 M:05 D:20}
Type of Reporting Source (563)	{0}
Regional Nodes Examined (916)	{04}
Regional Nodes Positive (914)	{12}
CS Site-Specific Factor25 (1075)	{988}
CS Version Input Current (1161)	{020430}
CS Extension (988)	{100}

Date

Florida Cancer Data System Quarterly Cancer Case Reporting Status Report

This Quarterly Cancer Case Reporting Status Report is divided in two sections: a Quarterly Activity Summary and an Annual Case Submission Summary. This report is used as a preliminary indication of the completeness, timeliness, and quality of your data.

Quarterly Activity Summary

The Quarterly Activity Summary reflects the file activity and the cases submitted by your facility for the time period specified above.

New Data Submitted:

Total number of cases electronically submitted for this quarter

Total number of *good* cases: *(cases requiring no changes)*

Total number of *forced* cases: *(exceptional cases requiring overrides of standard data edits following validation of the data submitted)*

File Activity:

Total number of *deleted* cases: *(cases deleted due to duplicate record submission; cases that do not meet the FCDS reporting requirements; cases diagnosed prior to the FCDS 1981 reference date)*

Total number of cases in the *pending* file: *(cases that failed one or more standard data edits during this and any previous quarters and remain in the pending file awaiting data validation)*

Annual Case Submission Summary

The Annual Case Summary reflects all cases submitted by your facility for the past four years. The fifth year displayed is the current reporting year. A two-year average (excluding current year data) is the base from which the Expected Completeness Percentage is calculated.

Admission Year/Case Count	Average # Cases Reported =	
2016		
2015		<u>% Complete for</u>
2014		<u>Reporting Year</u>
2013	Actual	Expected
2012		

Please review this report in detail. If you have any questions or would like additional information please you're your Field Coordinator at (305) 243-4600. Thank you for your cooperation in providing timely and quality data to the FCDS.

FCDS Data Quality Indicator Report

The Florida Cancer Data System (FCDS) is charged with providing the highest quality data available in annual cancer surveillance reporting to the Florida Department of Health and the CDC National Program of Cancer Registries (NPCR). Data must meet rigorous standards to be included in local, regional, state, and national cancer rates, reports to Congress, and various cancer surveillance-related publications. This report is a scaled down model of a similar report the CDC National Program of Cancer Registries (NPCR) provides to Florida and each NPCR state as an assessment of our state-wide data.

The FCDS Data Quality Indicator Report reflects 5 year comparison data as in sample below showing 2010-2014 Diagnosis Year data and examines the frequency of assignment of “unknown” or “ill-defined” values to key analysis variables over the course of the five-year period with comparison to national.

The percent of “unknown” and “ill-defined” values in certain variables is a data quality indicator used to rank Florida’s overall data quality and completeness of the data for each case reported and is used when comparing Florida data to other states for overall data reliability. These data are also indicators of problem areas where FCDS and local registries can improve upon cancer reporting as data are available. Goals have been established nationally by NPCR or by FCDS.

Florida Cancer Data System - Facility Data Quality Indicator Report (DQIR) for 2016										
Analytic cases ¹ (extracted 2/23/2016)										
Goals	2014		2013		2012		2011		2010	
	Facility %	Florida Facilities %	Facility %	Florida Facilities %	Facility %	Florida Facilities %	Facility %	Florida Facilities %	Facility %	Florida Facilities %
Total Analytic Cases	1,280	110,557	1,274	114,341	1,189	112,997	1,185	112,308	1,212	111,793
Demographics										
Sex										
Sex Unknown (9)	0.00%	0.02%	0.00%	0.03%	0.00%	0.03%	0.00%	0.02%	0.00%	0.01%
Race										
Race Other, NOS (98)	0.00%	1.42%	0.00%	1.25%	0.00%	1.15%	0.00%	1.06%	0.00%	1.08%
Race Unknown (99)	0.00%	1.71%	0.07%	0.94%	0.08%	0.71%	0.08%	0.72%	0.16%	0.83%
Ethnicity										
Ethnicity Unknown (9)	0.07%	0.76%	0.31%	0.65%	0.16%	0.66%	0.42%	0.97%	0.33%	0.96%
Date of Birth										
Birth Year Unknown	0.46%	0.10%	0.31%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Birth Month Unknown	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Birth Day Unknown	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Primary Payer at DX										
Primary Payer Unknown (99)	0.23%	1.10%	0.47%	1.05%	0.00%	1.00%	0.08%	1.10%	0.82%	1.41%
Marital Status at DX										
Marital Status Unknown (9)	0.31%	2.36%	0.15%	1.96%	0.25%	2.14%	0.33%	2.10%	0.24%	2.50%
Social Security Number										
Missing/Impossible SSN ²	0.94%	3.86%	1.66%	3.37%	1.56%	2.38%	0.74%	1.99%	1.36%	1.82%
Address at DX										
Ungeocodable (Certainty 9) ³	0.00%	0.00%	0.08%	0.03%	0.64%	0.97%	0.18%	0.50%	1.36%	1.12%
PO Boxes (Certainty 5) ³	3.52%	1.89%	2.54%	2.12%	1.10%	1.20%	2.03%	1.78%	1.54%	1.20%
Tumor Characteristics										
Diagnostic Confirmation										
Not Microscopically Confirmed (5-8)	1.71%	0.27%	3.76%	0.35%	3.20%	0.42%	1.68%	0.46%	1.81%	0.49%
DX Method Unknown (9)	0.00%	0.31%	0.00%	0.21%	0.00%	0.17%	0.00%	0.18%	0.00%	0.10%
Topography										
Other/Ill-Defined Sites (C76x)	0.00%	0.01%	0.00%	0.01%	0.00%	0.01%	0.00%	0.02%	0.16%	0.03%
Unknown Primary Site (C809)	1.48%	1.74%	1.57%	1.87%	1.66%	1.85%	2.02%	1.95%	1.48%	1.94%
Histology/Grade										
Morphology Non-specific (8000-8005)	1.09%	1.87%	1.49%	2.00%	1.26%	2.10%	1.09%	1.95%	1.07%	1.98%
*Grade Unknown (excludes C80.9)	34.84%	35.21%	37.75%	36.89%	33.72%	36.71%	30.17%	34.00%	30.44%	34.67%
Stage										
Derived/Summary Stage=2000 Unknown (9)	2.57%	5.09%	3.21%	5.36%	3.53%	5.77%	4.97%	6.12%	3.71%	6.18%

¹ Analytic according to FCDS (class of case: 0 - 22 or 34 - 42)

² 999999999, 123456789, 111111111, 222222222, 333333333, 444444444, 555555555, 666666666, 777777777, 888888888, 000000000, 773000000, 997654321

³ Percentages based on analytic cases of Florida residents at time of DX only.

SECTION II: GENERAL ABSTRACTING INSTRUCTIONS

SECTION II: GENERAL ABSTRACTING INSTRUCTIONS

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

<u>NAACCR Item Number</u>	<u>Item Name</u>
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 (NAACCR 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 (NAACCR 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 (NAACCR 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 <i>Date of First Contact</i> (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:

00000000OUT – Outpatient

00000000XRT – Radiation Therapy

000000CLINIC – 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.

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.

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	<ul style="list-style-type: none"> Hospital inpatient ; Includes outpatient services of HMOs and large multi-specialty physician group practices with unit record. <ul style="list-style-type: none"> Offices/facilities with unit record HMO physician office or group HMO affiliated free-standing laboratory, surgery, radiation or oncology clinic 	1
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)	<ul style="list-style-type: none"> Facilities with serial record (not a unit record) Radiation treatment centers Medical oncology centers (hospital affiliated or independent) <p>There were no source documents from code 1.</p>	2
3	Laboratory Only (hospital-affiliated or independent)	<ul style="list-style-type: none"> Laboratory with serial record (not a unit record) <p>There were no source documents from codes 1, 2, 8, or 4.</p>	5
4	Physician's Office/Private Medical Practitioner	<ul style="list-style-type: none"> Physician's office that is NOT an HMO or large multi-specialty physician group practice. <p>There were no source documents from codes 1, 2 or 8</p>	4
5	Nursing/Convalescent Home/Hospice	<ul style="list-style-type: none"> Nursing or convalescent home or a hospice. <p>There were no source documents from codes 1, 2, 8, 4, or 3.</p>	6
6	Autopsy Only	<ul style="list-style-type: none"> Autopsy <p>The cancer was first diagnosed on autopsy.</p> <p>There are no source documents from codes 1, 2, 8, 4, 3 or 5.</p>	7
7	Death Certificate Only	<p>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</p>	
8	Other hospital outpatient units/surgery centers	<ul style="list-style-type: none"> Other hospital outpatient units/surgery centers. Includes, but not limited to, outpatient surgery and nuclear medicine services. <p>There are no source documents from codes 1 or 2.</p>	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:

<u>NAACCR Item Number</u>	<u>Item Name</u>
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 – Codes Updated
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****APPENDIX Q - FLORIDA DEPARTMENT OF HEALTH LETTER TO FLORIDA REPORTING FACILITIES ON FLORIDA SOCIAL SECURITY NUMBER REQUIREMENT ON ALL CASES.**

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 <i>Date of Birth</i> (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 ISO Country Codes.

SEX**NAACCR ITEM #220**

Enter the appropriate Sex code.

Code	Description
1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
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://manuelswb.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.

Refer to Appendix B for specific ISO Country Codes.

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.

Refer to Appendix B for specific ISO Country Codes.

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 88888888.

For Canadian residents, enter 99999999. If using the FCDS IDEA Upload program only, Canadian valid Zip codes (ANANAN format) will be replaced with 99999999 at time of upload. For Single Entry users, Canadian residents must have 99999999 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/nsc/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.

Code	Label	Description
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 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

Code	Label	Description
		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

<u>NAACCR Item Number</u>	<u>Item Name</u>
390	Date of Diagnosis
391	Date of Diagnosis Flag
2690	Text – Place of Diagnosis
610	Class of Case
490	Diagnostic Confirmation
400	Primary Site
2580	Text- Primary Site Title
410	Laterality
522	Histologic Type ICD-O-3
2590	Text- Histology Title
523	Behavior ICD-O-3
440	Grade/Differentiation/Immunophenotype
756	Tumor Size Summary - NEW
820	Regional Lymph Nodes Positive
830	Regional Lymph Nodes Examined
1182	Lymph-Vascular Invasion

SEER RESOURCE: 2015 Coding and Staging Manual - Appendix C: Site-Specific Coding Modules

Appendix C of the 2015 SEER Coding and Staging Manual brings together the site-specific instructions needed to abstract a case, facilitating efficiency and accuracy. The site-specific coding modules include SEER coding guidelines; equivalent terms, definitions, tables, charts and illustrations; multiple primary rules; histology coding rules; stage coding instructions and surgery of primary site codes. Some modules include site-specific coding guidelines. The goal is to have stand-alone modules for major anatomic sites.

<http://seer.cancer.gov/manuals/2015/appendixc.html>

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 if the Date of First Contact precedes the Date of Diagnosis by more than thirty days.

Positive tumor markers alone are not diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis – never the date of positive tumor marker.

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	
<i>Initial diagnosis at reporting facility</i>	
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 <i>Class of Case 10</i>
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	
<i>Initial diagnosis at reporting facility</i>	
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility
<i>Initial diagnosis elsewhere</i>	
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	
<i>Patient appears in person at reporting facility</i>	
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
	<i>Patient does not appear in person at reporting facility</i>
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	
	<i>Patient appears in person at reporting facility</i>
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. To date there is not a single laboratory test that can be used to confirm any patient has evidence of cancer without diagnostic imaging and/or biopsy to support the diagnosis. This code should be used sparingly if at all. **DO NOT USE THIS CODE.**
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.

Code	Description	Definition
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 **Hematopoietic or Lymphoid Neoplasms (ICD-O-3 Histology Codes M9590-9992)**

- There is no priority hierarchy for coding *Diagnostic Confirmation* for hematopoietic and lymphoid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing. See the *Hematopoietic Database (DB)* for information on the definitive diagnostic confirmation for specific types of tumors.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- Code 8 when the case was diagnosed by any clinical method that cannot be coded as 6 or 7.
- 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).

Code	Description	Definition
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.
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

- Record the ICD-O-3 topography code for the site of origin.
- Consult the physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.
- Topography codes are indicated by a “C” preceding the three-digit code number. Do not record the decimal point.
- 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.
- 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:

- o C02.8 Overlapping lesion of tongue
 - o C08.8 Overlapping lesion of major salivary glands
 - o 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 identified 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

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.

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

ICD-O-3	SITES
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
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 autonomic 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)

ICD-O-3	SITES
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 the histologic type from the *International Classification of Diseases for Oncology* or *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*.

Site-Associated/Site-Related Codes: Some histology/behavior terms in ICD-O-3 have a related or associated primary site code in parenthesis next to the histology code; for example Hepatoma (C220).

- Use the site code suggested by ICD-O-3 when the primary site is the same as the site code suggested or when the primary site is unknown but the histology is known.
- Code the site as documented in the medical record and ignore the suggested ICD-O-3 code when a primary site is specified in the medical record and there is no evidence of neoplasm in the suggested site.

2011 UPDATE TO ICD-O-3: In 2011 the World Health Organization released the third errata to the ICD-O-3 which included updated histology codes, new histology codes, updated behavior codes, and more. North America has been managing these updates in a step-wise roll-out taking place in 2014-2017. The full scope of WHO 2011 ICD-O-3 Updates is covered in **Appendix R** of this manual and should be followed closely.

Heme/Lymph Histology: 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) including any published errata that have been implemented as of 1/1/2016.

DO NOT USE ICD-O-3 to code any histology 9590 or greater (refer to the Hematopoietic Database).

TEXT – HISTOLOGY TITLE

NAACCR ITEM #2590

Enter the histologic type, behavior, and grade of the tumor being reported. Do not use vendor-driven auto-coding of the histologic type, behavior, or grade of the tumor in this field. Enter free text.

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 and ICD-O-3 Updates. 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
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

Code	Label	Description
		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.

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/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.

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.

NEW -- TUMOR SIZE SUMMARY

NAACCR ITEM #756

This data item records the most accurate measurement in millimeters of a solid primary tumor, usually measured on the surgical resection specimen. This NEW for 2016 tumor size replaces CS Tumor Size.

Tumor size is one indication of the extent of disease the time of diagnosis. It is used frequently by both clinicians and researchers to assess cancer screening efforts and initial treatment options and variations. Tumor size that is independent of stage is also useful for quality assurance efforts.

CODING INSTRUCTIONS

1. All measurements should be in millimeters (mm).
2. Size measured on the surgical resection specimen, when surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered.

3. If neoadjuvant (preoperative) therapy followed by surgery, do not record the size of the pathologic specimen. Code the largest size of tumor prior to neoadjuvant (preoperative) treatment; if unknown code size as 999.
4. If no surgical resection, then largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures prior to any other form of treatment.
5. Priority of imaging/radiographic techniques: Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but it should be taken as low priority, over a physical exam.
6. Tumor size discrepancies among imaging and radiographic reports: If there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies which imaging is most accurate, record the largest size in the record, regardless of which imaging technique reports it.
7. Record the size of the invasive component, if given.
8. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.
9. Record the size as stated for purely in situ lesions.
10. Disregard microscopic residual or positive surgical margins when coding tumor size.
11. Do not add the size of pieces or chips together to create a whole.
12. Multifocal/multicentric tumors: If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor or if all of the tumors are in situ, code the size of the largest in situ tumor.
13. Document the information to support coded tumor size in the appropriate text field of the abstract.

Code	Description
000	No mass/tumor found
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2mm-988mm)
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
998	<p>SITE-SPECIFIC CODES</p> <p>Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: Colon (C18.0, C18.2-C18.9) and/or Rectosigmoid and Rectum (C19.9, C20.9)</p> <p>If no size is documented:</p> <p>Circumferential: Esophagus (C15.0 C15.5, C15.8 C15.9)</p>

	Diffuse; widespread: 3/4s or more; linitis plastica: Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9) Diffuse, entire lung or NOS: Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9) Diffuse: Breast (C50.0 C50.6, C50.8 C50.9)
999	Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed; Not applicable

REGIONAL LYMPH NODES POSITIVE**NAACCR ITEM #820**

Records the exact number of regional nodes examined by the pathologist and found to contain metastases. This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient. When no lymph nodes are examined by a pathologist, Regional Lymph Nodes Positive MUST = 98 (No Nodes Examined). When only Isolated Tumor Cells are identified by immunohistochemistry test within lymph node the lymph node is not counted as positive. There are not enough cancer cells in the node to treat as positive node.

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

REGIONAL LYMPH NODES EXAMINED**NAACCR ITEM #830**

Records the total number of regional lymph nodes that were removed and examined by the pathologist. This data item serves as a quality measure of the pathologic and surgical evaluation and treatment of the patient.

Codes

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

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 as an indicator of prognosis.

NOTE: Only invasive solid tumors can have lymph vascular invasion or LVI. Per CAP, "if there really is LVI, then this tumor isn't an in-situ tumor. It is a sampling issue, or possibly the lymphatic invasion could be coming from an invasive carcinoma in another location. Non-Invasive Tumors that exhibit LVI should be staged and treated as invasive neoplasm. The invasive tumor may have been missed in the pathologic sampling or LVI may be present in lymphatic spaces without stromal invasion and associated with carcinoma in situ. This is a rare and unusual situation that is extremely unlikely to occur."

- 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.
- 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

CANCER STAGING INFORMATION AND REQUIREMENTS

SEER SUMMARY STAGE 2000: Direct-Assignment of SEER Summary Stage using the SEER Summary Stage 2000 Manual is required for all cases abstracted and reported to FCDS.

AJCC TNM CANCER STAGING: Direct-Assignment of both clinical and pathologic AJCC TNM Cancer Staging is required for all cases diagnosed and reported to FCDS 1/1/2016 and forward.

Required AJCC TNM Cancer Staging Data Items (Cancers diagnosed 1/1/2016 and forward)

Clinical T (NAACCR Item # 940)

Clinical N (NAACCR Item #950)

Clinical M (NAACCR Item #960)

Clinical Stage Group (NAACCR Item #970)

Clinical Stage (Prefix/Suffix) Descriptor (NAACCR Item #980)

TNM Clinical – Staged By (NAACCR Item#990)

Pathologic T (NAACCR Item #880)

Pathologic N (NAACCR Item #890)

Pathologic M (NAACCR Item #900)

Pathologic Stage Group (NAACCR Item #910)

Pathologic Stage (Prefix/Suffix) Descriptor (NAACCR Item #920)

TNM Pathologic – Staged By (NAACCR Item #930)

TNM Edition Number (NAACCR Item #1060)

COLLABORATIVE STAGE DATA COLLECTION SYSTEM (CSv2): Direct-Assignment of Core CS Data Items is required for all cases diagnosed before 1/1/2016 and seen at your facility for continuation of initial course of treatment or with evidence of recurrence or progression of cancer not previously reported to FCDS. This includes “non-analytic” cases with evidence of cancer.

NOTE: Minimal Historical Cases (historical cancers with no evidence of the historical cancer – but having a new primary cancer diagnosis or undergoing treatment for a different primary cancer) are not required to have the Core CS Data Items coded. However, the minimal historical case will be required to have a SEER Summary Stage 2000 assigned and entered in the “historical grid” that is sent to FCDS.

Required Core CS Data Items (Cancers diagnosed before 1/1/2016)

- *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: CS Site-Specific Factors 1-25 are required for all cancers with an exception made for Minimal Historical Cases. See Appendix H for schema-specific SSF requirements.

SEER SUMMARY STAGE 2000 – Required for ALL Cancers

You MUST refer to the *SEER Summary Staging Manual 2000* for site-specific coding instructions. This information can be found online at <http://seer.cancer.gov/tools/ssm/>.

SEER Summary Stage is based on a combination of pathologic, operative and clinical assessments. Gross observations at surgery are particularly important when all malignant tissue is not removed. In the event of a discrepancy between pathology and operative reports concerning excised tissue, priority is given to the pathology report.

SEER Summary Stage 2000 is based on all information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.

Enter the SEER Summary Stage 2000 at the time of initial Diagnosis or treatment of the reportable tumor using the *SEER Summary Staging Manual 2000*.

Stage Codes for All Primaries except Lymph Nodes and Lymphoid Tissue, Kaposi Sarcoma, Sezary Disease, and Hematopoietic:

CODES	DEFINITIONS
0	<i>in situ</i>
1	Local
2	Regional/Direct Extension
3	Regional/Nodes Only
4	Regional/Direct Extension & Nodes
5	Regional, NOS
7*	Distant/Systemic Disease
8**	Benign/Borderline Brain Tumor
9***	Unknown, Unstaged, Not Applicable, NED, Historical Case, Unknown Primary

*The following malignancies must have summary stage at diagnosis = **7**.

- Leukemia
- Plasma Cell Myeloma
- Reticuloendotheliosis
- Letterer-Siwe Disease
- Myelodysplastic Syndrome

** all benign/borderline brain and central nervous system tumors stage = **8**

***all unknown primaries (C80.9) must have summary stage at diagnosis = **9**.

NOTE: For Stage Code for Lymph Nodes and Lymphoid Tissue, Kaposi Sarcoma, Sezary Disease, and Hematopoietic refer to *SEER Summary Manual 2000*.

AJCC TNM CANCER STAGING – Required for cancers diagnosed 1/1/2016 forward

Registrars MUST USE AND REFERENCE the 7th edition of the AJCC Cancer Staging Manual when assigning and coding T, N, M Categories and Stage Group. Site-Specific Rules apply to most cases.

AJCC CANCER STAGING MANUAL, 7th edition @ <http://www.springer.com/medicine> (est. \$65.00)
Springer (publisher) ISBN: 978-0-387-88440-0 @ <http://www.springer.com/us/book/9780387884400>

AJCC TNM Staging Curriculum for Cancer Registrars – FREE Self-Instruction for AJCC Staging @ <http://cancerstaging.org/CSE/Registrar> includes basic instructions for cancer staging:

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 items.

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:

<u>NAACCR Item Number</u>	<u>Item Name</u>
940	Clinical T
950	Clinical N
960	Clinical M
970	Clinical Stage Group
980	Clinical Stage (Prefix/Suffix) Descriptor
*990	*TNM Clinical – Staged By (expanded field size and definitions)
880	Pathologic T
890	Pathologic N
900	Pathologic M
910	Pathologic Stage Group
920	Pathologic Stage (Prefix/Suffix) Descriptor
*930	*TNM Pathologic – Staged By (expanded field size and definitions)
106 1060	TNM Edition Number

New AJCC T, N, and M Categories to be Implemented in 2016:

The primary considerations when assigning AJCC staging classifications are timeframe and criteria. The clinical staging (or classification) timeframe includes information obtained from the time of diagnosis throughout the diagnostic workup and ends at the initiation of definitive treatment. Within the clinical staging timeframe, criteria include physical exam, imaging, endoscopies, and diagnostic biopsies. It is important to emphasize that the mere existence of a pathology report that includes microscopic assessment does not exclude it from the clinical staging criteria. If the assessment was a part of the diagnostic workup, it has occurred within the clinical timeframe and can be used for clinical staging.

The pathologic staging/classification timeframe includes information obtained from the moment of diagnosis and throughout the diagnostic workup (i.e., all information from clinical classification), the operative findings and pathology report from the definitive surgery. Within the pathologic staging timeframe, criteria include all of the clinical staging criteria, operative findings from the surgeon, and the pathology report for the resected specimen. Observations from the surgeon in the operative findings that are not accompanied by a biopsy are included in the pathologic staging criteria (e.g., observation of extension without a tissue sample for pathologic review). Similarly, involvement found on imaging is considered in the pathologic staging criteria even in the absence of tissue biopsy.

According to the AJCC manual and trainings, the appropriate T, N, and M categories should be assigned based on the NEW 2016 T, N, M Category Codes described later in this section of the DAM. This may entail allowing, for example, the pathologic staging M category to be properly assigned as cM1.

The new categories have been generated by adding the prefixes of ‘c’ and ‘p’ to existing valid clinical and pathologic T, N, and M categories respectively, and by modifying, adding, and deleting specific existing categories newly prefixed with a ‘c’ or ‘p’. For example, the addition of pTis to the clinical classification T category will enable its use for in situ patients in accordance with the AJCC rules (an in situ diagnosis cannot be made on imaging alone).

Expanded for 2016 – NEW * TNM “Staged By” Codes

00 Not staged

10 Physician, NOS, or physician type not specified in codes 11-15

11 Surgeon

12 Radiation Oncologist

13 Medical Oncologist

14 Pathologist

15 Multiple Physicians; tumor board, etc.

20 Cancer registrar

30 Cancer registrar and physician

40 Nurse, physician assistant, or other non-physician medical staff

50 Staging assigned at another facility

60 Staging by Central Registry

88 Case is not eligible for staging

99 Staged but unknown who assigned stage

2016 T, N, M Category Codes – ALLOWABLE CODES FOR AJCC T, N, and M Category Items

Clinical T – Primary Tumor*

Code	Definition
< BLANK >	Not recorded
cX	cTX
c0	cT0
pA	pTa
pIS	pTis
pISU	pTispu
pISD	pTispd
c1MI	cT1mi, pT1 mic
c1	cT1
c1A	cT1a
c1A1	cT1a1
c1A2	cT1a2

Code	Definition
c1B	cT1b
c1B1	cT1b1
c1B2	cT1b2
c1C	cT1c
c1D	cT1d
c2	cT2
c2A	cT2a
c2A1	cT2a1
c2A2	cT2a2
c2B	cT2b
c2C	cT2c
c2D	cT2d

Code	Definition
c3	cT3
c3A	cT3a
c3B	cT3b
c3C	cT3c
c3D	cT3d
c4	cT4
c4A	cT4a
c4B	cT4b
c4C	cT4c
c4D	cT4d
c4E	cT4e
88	Not applicable

***Note:** See the individual schemas/TNM chapters for the specific T (sub)categories used.

Clinical N – Regional lymph nodes*

Code	Definition
< BLANK >	Not recorded
cX	cNX
c0	cN0
c0A	cN0a
c0B	cN0b
c1	cN1
c1A	cN1a
c1B	cN1b
c1C	cN1c

Code	Definition
c2	cN2
c2A	cN2a
c2B	cN2b
c2C	cN2c
c3	cN3
c3A	cN3a
c3B	cN3b
c3C	cN3c
c4	cN4
88	Not applicable

***Note:** See the individual schemas/TNM chapters for the specific N (sub)categories used.

Clinical M – Distant metastasis*

Code	Definition
< BLANK >	Not recorded
c0	cM0
c0I+	cM0(i+)
c1	cM1
c1A	cM1a
c1B	cM1b
c1C	cM1c
c1D	cM1d
c1E	cM1e
p1	pM1
p1A	pM1a
p1B	pM1b
p1C	pM1c
p1D	pM1d
p1E	pM1e
88	Not applicable

***Note:** See the individual schemas/TNM chapters for the specific M (sub)categories used.

Clinical Stage Group

Code	Definition
0	Stage 0
0A	Stage 0A
0IS*	Stage 0is
1	Stage I
1A	Stage IA
1A1	Stage IA1
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1B2	Stage IB2
1C	Stage IC

Code	Definition
1S	Stage IS
2	Stage II
2A	Stage IIA
2A1	Stage IIA1
2A2	Stage IIA2
2B	Stage IIB
2C	Stage IIC
3	Stage III
3A	Stage IIIA
3B	Stage IIIB
3C	Stage IIIC

Code	Definition
3C1	Stage IIIC1
3C2	Stage IIIC2
4	Stage IV
4A	Stage IVA
4A1	Stage IVA1
4A2	Stage IVA2
4B	Stage IVB
4C	Stage IVC
0C	Occult
88	Not applicable
99	Unknown
0C	Occult (Lung)

***Applicable for Renal Pelvis/Ureter, Bladder and Urethra**

Pathologic T – Primary Tumor*

Code	Definition
< BLANK >	Not recorded
pX	pTX
p0	pT0
pA	pTa
pIS	pTis
pISU	pTispu
pISD	pTispd
p1MI	pT1mi, pT1 mic
p1	pT1
p1A	pT1a
p1A1	pT1a1
p1A2	pT1a2

Code	Definition
p1B	pT1b
p1B1	pT1b1
p1B2	pT1b2
p1C	pT1c
p1D	pT1d
p2	pT2
p2A	pT2a
p2A1	pT2a1
p2A2	pT2a2
p2B	pT2b
p2C	pT2c
p2D	pT2d

Code	Definition
p3	pT3
p3A	pT3a
p3B	pT3b
p3C	pT3c
p3D	pT3d
p4	pT4
p4A	pT4a
p4B	pT4b
p4C	pT4c
p4D	pT4d
p4E	pT4e
88	Not applicable

***Note:** See the individual schemas/TNM chapters for the specific T (sub)categories used.

Pathologic N – Regional lymph nodes*

Code	Definition
< BLANK >	Not recorded
pX	pNX
c0	cN0
p0	pN0
p0I-	pN0i-
p0I+	pN0i+
p0M-	pN0m-
p0M+	pN0m+
p1MI	pN1mi
p0A	pN0a
p0B	pN0b
p1	pN1
p1A	pN1a

Code	Definition
p1B	pN1b
p1C	pN1c
p2	pN2
p2A	pN2a
p2B	pN2b
p2C	pN2c
p3	pN3
p3A	pN3a
p3B	pN3b
p3C	pN3c
p4	pN4
88	Not applicable

***Note:** See the individual schemas/TNM chapters for the specific N (sub)categories used.

Pathologic N Classification	Description of Pathologic N including ITCs
pN0	No regional lymph node metastasis histologically, no examination for isolated tumor cells (ITCs)
pN0(i-)	No regional lymph node metastasis histologically, negative morphological findings for ITC
pN0(i+)	No regional lymph node metastasis histologically, positive morphological findings for ITC
pN0(mol-)	No regional lymph node metastasis histologically, negative non-morphological findings for ITC
pN0(mol+)	No regional lymph node metastasis histologically, positive non-morphological findings for ITC

Pathologic M – Distant metastasis*

Code	Definition
< BLANK >	Not recorded
c0	cM0
c0I+	cM0(i+)
p1	pM1
p1A	pM1a
p1B	pM1b
p1C	pM1c
p1D	pM1d
p1E	pM1e
c1	cM1
c1A	cM1a
c1B	cM1b
c1C	cM1c
c1D	cM1d
c1E	cM1e
88	Not applicable

**Note: See the individual schemas/TNM chapters for the specific M (sub)categories used.*

Pathologic Stage Group

Code	Definition
0	Stage 0
0A	Stage 0A
0IS*	Stage 0is
1	Stage I
1A	Stage IA
1A1	Stage IA1
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1B2	Stage IB2
1C	Stage IC

Code	Definition
1S	Stage IS
2	Stage II
2A	Stage IIA
2A1	Stage IIA1
2A2	Stage IIA2
2B	Stage IIB
2C	Stage IIC
3	Stage III
3A	Stage IIIA
3B	Stage IIIB
3C	Stage IIIC

Code	Definition
3C1	Stage IIIC1
3C2	Stage IIIC2
4	Stage IV
4A	Stage IVA
4A1	Stage IVA1
4A2	Stage IVA2
4B	Stage IVB
4C	Stage IVC
OC	Occult
88	Not applicable
99	Unknown
OC	Occult (Lung)

**Applicable for Renal Pelvis/Ureter, Bladder and Urethra*

TNM Clinical Descriptor**NAACCR Item 980**

Identifies the AJCC clinical stage (prefix/suffix) descriptor as recorded by the physician. AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

Codes

- 0 None
- 1 E (Extranodal, lymphomas only)
- 2 S (Spleen, lymphomas only)
- 3 M (Multiple primary tumors in a single site)
- 5 E & S (Extranodal and spleen, lymphomas only)
- 9 Unknown, not stated in patient record

TNM Pathologic Descriptor**NAACCR Item 920**

Identifies the AJCC pathologic stage (prefix/suffix) descriptor as recorded by the physician. AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

Codes

- 0 None
- 1 E (Extranodal, lymphomas only)
- 2 S (Spleen, lymphomas only)
- 3 M (Multiple primary tumors in a single site)
- 4 Y (Classification during or after initial multimodality therapy) – pathologic staging only
- 5 E & S (Extranodal and spleen, lymphomas only)
- 6 M & Y (Multiple primary tumors and initial multimodality therapy)
- 9 Unknown, not stated in patient record

COLLABORATIVE STAGE DATA COLLECTION SYSTEM (CSv2)

- **CS Site Specific Factors are Required for all cancers**
- **CS Core Items are Required for cancers diagnosed before 1/1/2016**
- **(exception - Historical Cancer with No Evidence of Disease)**

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.

The following CS “core” 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 are required for collection based on the site specific schema selection. See Appendix H for a complete of site-specific SSF requirements for 2016 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/>

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

SEER RESOURCE: 2015 Coding and Staging Manual - Appendix C: Site-Specific Coding Modules

Appendix C of the 2015 SEER Coding and Staging Manual brings together the site-specific instructions needed to abstract a case, facilitating efficiency and accuracy. The site-specific coding modules include SEER coding guidelines; equivalent terms, definitions, tables, charts and illustrations; multiple primary rules; histology coding rules; stage coding instructions and surgery of primary site codes. Some modules include site-specific coding guidelines. The goal is to have stand-alone modules for major anatomic sites.

<http://seer.cancer.gov/manuals/2015/appendixc.html>

Data Items Included In This Section:

<u>NAACCR Item Number</u>	<u>Item Name</u>
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
3170	Rx Date – Date of Most Definitive Surgical Procedure
3171	Rx Date – Date Most Definitive Surgery Flag
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
2620	Rx Text – Radiation (Beam)
2630	Rx Text – Radiation Other
1639	Rx Summ – Systemic Surg Seq
1390	Rx Summ – Chemo
1220	Rx Date – Chemo
1221	Rx Date—Chemo Flag
2640	Rx Text – Chemo
1400	Rx Summ – Hormone
1230	Rx Date – Hormone
1231	Rx Date—Hormone Flag
2650	Rx Text – Hormone

1410	Rx Summ – BRM/Immunotherapy
1240	Rx Date – BRM/Immunotherapy
1241	Rx Date—BRM Flag
2660	Rx Text – BRM
1420	Rx Summ – Other
1250	Rx Date – Other
1251	Rx Date—Other Flag
2670	Rx Text – Other
3250	Rx Summ – Transplnt/Endocr
1285	Rx Summ--Treatment Status

DEFINITION OF FIRST COURSE OF TREATMENT

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence.

“Active surveillance” is a form of planned treatment for some patients; its use is coded in the RX Summ – Treatment Status item.

“No therapy” is different than “active surveillance.” “No therapy” or “No treatment” is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given. If the patient refuses all treatment, code “patient refused” (Code 7 or 87) for all treatment modalities.

Maintenance therapy given as part of the first course of planned therapy (example: maintenance chemo for leukemia) is part of the planned first course treatment. Patients receiving maintenance therapy are analytic cases for the state and for facility.

TREATMENT PLAN

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

- A discharge plan must be part of the patient record in a JCAHO-accredited hospital and may contain all or only part of the full treatment plan for any given patient.
- All therapies specified in the physician(s) treatment plan(s) are a part of the first course of treatment if they are actually administered to the patient.
- An established protocol or accepted treatment management guideline for the type of cancer an individual is receiving treatment may also be used as a treatment plan when available. These may also be referred to as treatment guidelines. Treatment guidelines may be local to your institution, protocol-specific, or may be published national guidelines such as the NCCN Treatment Guidelines.
- If there is no treatment plan, established treatment protocol, or treatment management guidelines (local or national), and a consultation with a physician advisor is not possible, use the principle: “initial treatment must begin within four months of the date of initial diagnosis.”

DEFINITION OF NON-CANCER DIRECTED THERAPY

Patients receiving treatment for supportive care (non-curative treatment) and/or palliative care ARE required to be reported to FCDS. Patients receiving supportive/palliative care enter your facility with evidence of their cancer (evidence of disease on admission). While the treatment may not cure the patient, the patient does have evidence of cancer and may be given cancer-directed treatment, but with the intent of supporting the patient or alleviating symptoms...not to cure the patient of their cancer.

Non-cancer directed treatment refers to any treatment designed to 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, palliative care, 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.

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 or published national 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

Active Surveillance – See Watchful Waiting

Ablation of the primary tumor: Ablation is the treatment of and removal of a part of [biological tissue](#) (primary tumor), traditionally by [surgery](#) but more recently using a wide variety of techniques, the newest of which is to use a catheter to target the tumor for ablation which improves outcome and reduces effects on surrounding tissues. These techniques provide minimally invasive treatment to a primary tumor for early stage disease or can be used for local control of metastatic tumor that might bleed or cause other symptoms in patients with advanced disease and can be used for a wide variety of cancers in many locations.

Electrocautery was the first type of ablation used to vaporize tumors in the bladder for example when TURBT was performed – it is still used today. But, today they call it radiofrequency ablation rather than electrocautery when it is the technique used to destroy tumor.

Thermal techniques are generally classified as “ablative” and include radiofrequency, laser, microwave, cryotherapy, and high intensity focused ultrasound.

Ablative techniques do not effect a lot of the surrounding tissue and can be an alternative to surgery for more and more types of cancers. Typical tumors where ablation is a viable option include lung, bladder,

kidney, liver, and skin cancers.

- Surface ablation of the [skin](#) ([dermabrasion](#) or resurfacing because it induces [regeneration](#)) often uses chemicals (which cause peeling) or is done by lasers.
- Cryoablation uses extreme cold to freeze then thaw then repeat to destroy tumor because the repeated freezing and thawing produces tumor necrosis or kills the tumor...and a new technique, the ice ball is being used for cryoablation – the frozen tumor falls off like a frozen wart when it is treated with extreme cold.
- Laser ablation uses either high or low frequency laser light to destroy tumor and can be very exact in treating small tumors or hard to reach tumors.
- Microwave and Radiofrequency Ablation use thermal techniques to heat the tumor similar to electrocautery but using microwave and radiofrequency waves.
- PDT – photodynamic therapy is a type of laser ablation
- High-intensity Focused Ultrasound – Uses Sound Waves to create heat

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.

Embolization (of primary tumor and/or metastasis)

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. “Embolization” is a procedure performed to create an embolus, a blocked or hardened blood vessel, and is used to shut down blood flow and blood supply to the primary tumor or to metastasis. Embolization can include injection of a chemical like alcohol or a chemo agent to sclerose or harden key blood vessel(s) and may even trap chemo behind the embolus; or can be performed by injecting a foreign material or substance like coils or radioactive beads to block the artery and prevent any blood flow to the tumor.

Embolization may follow tumor ablation using RFA or other techniques to further treat the tumor or metastases – code both if this is the case.

Types of Embolization Include:

- Chemo-Embolization – Uses Chemotherapy Agent(s) – TACE (transcatheter arterial chemoembolization) is an image-guided, minimally invasive procedure for the delivery of chemotherapeutic drugs directly to the tumor. Code as chemotherapy when the embolizing agent(s) is a chemotherapeutic drug(s). Use SEER*RX to determine whether the drugs used are classified as chemotherapeutic agents. Do Not Code the method of delivery.
- Alcohol-Embolization – Uses Alcohol
- Radioactive Beads/Spheres
- Artificial Embolus – plastic or metal coils, foam, other plugs
- Treatment Code Will Depend on Type of Embolization

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 Yttrium 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.

Palliative Care: Palliative care is provided to prolong the patient’s life by controlling symptoms, to alleviate persistent pain, or to make the patient comfortable. Palliative care provided to relieve symptoms may include surgery, radiation therapy, Systemic therapy (chemotherapy, hormonal therapy, or other systemic agents), and/or other pain management therapy. Patients receiving palliative care are reportable to FCDS. This treatment may or may not be coded as part of first course of therapy.

Radiation Therapy: Radiation therapy uses high-energy radiation to shrink tumors and kill cancer cells. X-rays, gamma rays, and charged particles are types of radiation used for cancer treatment. The radiation may be delivered by a machine outside the body (external-beam radiation therapy), or it may come from radioactive material placed in the body near cancer cells (internal radiation therapy, also called brachytherapy). Systemic radiation therapy uses radioactive substances, such as radioactive iodine, that travel in the blood to kill cancer cells. Radiation therapy is sometimes given with curative intent (that is, with the hope that the treatment will cure a cancer, either by eliminating a tumor, preventing cancer recurrence, or both). In such cases, radiation therapy may be used alone or in combination with surgery, chemotherapy, or both. Radiation therapy may also be given with palliative intent. Palliative treatments are not intended to cure. Instead, they relieve symptoms and reduce the suffering caused by cancer.

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.

Surgery: First course surgery items describe the most definitive type of surgical treatment the patient received from any facility, when it was performed, and its efficacy. When no surgical treatment is given, the reason is recorded. Please be sure to attribute where each procedure was performed, whether it was at your facility or at another facility and if at another facility, note where if known. Multiple surgical treatment data items exist to describe the extent of surgical resection directed at the primary tumor, regional lymphatics, and/or other distant locations from the primary tumor. It is also important to record when no surgery is performed, when other treatments precede surgery (neoadjuvant) and what, where, and when each surgical procedure is performed – to the best of your ability.

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.

Systemic Therapy: Systemic therapy encompasses the treatment modalities captured by the data items chemotherapy, hormone therapy, and immunotherapy. These may be given alone or in combination and may include bone marrow or stem cell transplant procedure following completion of systemic treatments. Systemic therapies are often delivered in treatment cycles, either alone or in combination with other agents. If a patient has an adverse reaction to one or more of the agents, the physician may decide to change one or more of the agents to better accommodate the clinical status of the patient. When this occurs and the replacement agent is in the same treatment category as the original agent, there is no change in the original treatment plan and all therapy should be coded. However, if the agent changes class of drugs or the entire protocol is changed, or if the patient exhibits progression of disease while being treated with the initial agent(s), any new agent(s) would not be included as part of the first course of treatment but should be documented in the abstract as subsequent therapy. Note that systemic agents may be administered using a variety of routes including IV administration, oral administration, intrathecal administration (directly into the cerebrospinal canal), intraperitoneal/intrapleural/intrapericardial agents may be directly injected into the peritoneal space, pleural space, or pericardial space, and using other means.

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.

DEFINITIONS OF FIRST COURSE OF TREATMENT - Leukemia And Hematopoietic Diseases

Adopted from the FORDS Manual 2015

LEUKEMIA

The first course of treatment includes all therapies planned and administered by the physician(s) during the first diagnosis of leukemia. Record all remission-inducing or remission-maintaining therapy as the first course of treatment. Treatment regimens often include multiple modes of therapy. The administration of these therapies can span up to a year or longer.

A patient may relapse after achieving a first remission. All therapy administered after a relapse is not counted as first course of treatment. It is referred to as secondary or subsequent therapy.

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 is 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, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, 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/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease*. Code **98** for the following sites:

a. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease

1. Primary sites: C42.0, C42.1, C42.3, or C42.4 AND
2. Histologies: 9750, 9760-9764, 9820-9822, 9826, 9831-9920, 9931-9964, 9980-9989

b. Unknown or ill-defined sites (C76.0-C76.8, C80.9)

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.

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 sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes is most frequently encountered. For all other sites, non-sentinel regional node dissections are typical, and codes 2, 6 and 7 are infrequently used.

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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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 <i>Regional Lymph Nodes</i>

			<i>Examined</i> (NAACCR Item #830) and <i>Regional Lymph Nodes Positive</i> (NAACCR Item #820).
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	<ul style="list-style-type: none"> 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). 	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	<ul style="list-style-type: none"> 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. 	
5	4 or more regional lymph nodes removed	<ul style="list-style-type: none"> 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). 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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.

		<p>SLNBx only.</p> <ul style="list-style-type: none"> • 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. 	
7	Sentinel node biopsy and code 3,4, or 5 at different times	<ul style="list-style-type: none"> • 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 pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only. 	
9	9 Unknown or not	<ul style="list-style-type: none"> • 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 <i>Surgery of Primary Site</i> [NAACCR Item #1290]). Review surgically treated cases coded 9 in <i>Scope of Regional/ Lymph Node Surgery</i> 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 <i>distant lymph node(s)</i>
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 OF FIRST SURGICAL PROCEDURE

NAACCR ITEM #1200

Records the earliest date on which any first course surgical procedure was performed. This could be the date of first biopsy (FNA, core, incisional or excisional) or date of resection if not preceded by biopsy.

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.

The date in this item may be the same as that in *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170), if the patient received only one surgical procedure and it was a resection of the primary site.

RX DATE OF FIRST SURGICAL PROCEDURE 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 <i>RX Date--Surgery of First Surgical Procedure</i> (NAACCR item #1200).

DATE MOST DEFINITIVE SURG RESECTION**NAACCR ITEM # 3170**

Records the date of the most definitive (most extensive) surgical procedure of the primary site that was performed as part of the first course of treatment.

This item is used to measure the lag time between diagnosis and the most definitive surgery of the primary site and to evaluate treatment efficacy.

Coding Instructions

- Record the date on which the surgery described by surgical procedure of primary site (NAACCR Item #1290) was performed at this or any facility.

The date in this item may be the same as that in *Date of First Surgical Procedure* (NAACCR Item #1200), if the patient received only one surgical procedure and it was a resection of the primary site.

RX DATE OF MOST DEFINITIVE SURGERY FLAG**NAACCR ITEM #3171**

This flag explains why there is no appropriate value in the corresponding date field, *RX Date of Most Definitive Surgical Resection of Primary Site* (NAACCR Item #3170).

Coding Instructions

- Leave this item blank if *RX Date of Most Definitive Surgical Resection of Primary Site* (NAACCR Item #3170) has a full or partial date recorded.
- Code 12 if the *RX Date of Most Definitive Surgical Resection of Primary Site* cannot be determined, but the patient did receive first course surgery.
- Code 10 if it is unknown whether any surgery was performed.
- Code 11 if no surgical procedure was performed.

- 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 <i>Date of Most Definitive Surgical Resection of Primary Site</i> (NAACCR Item #3170).

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

- Assign **code 0** when Surgery of Primary Site is coded in the range of 10-90 (the patient did have surgery of primary site).
- Assign a code in the **range of 1-8** if Surgery of Primary Site is coded 00 or 98.
- Assign **code 1**
 - If RX Summ—Surg Prim Site (NAACCR Item #1290) is coded 98.
 - 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. Active Surveillance or 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 TEXT – SURGERY**NAACCR ITEM #2610**

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

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	<u>None</u> No radiation therapy was administered.
1	<u>Beam radiation</u> X-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, intra-operative radiation and stereotactic radiosurgery (gamma knife and proton beam).

Code	Description
2	<u>Radioactive implants</u> Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials
3	<u>Radioisotopes</u> Internal use of radioactive isotopes (iodine-131 or phosphorus-32) Can be administered orally, intracavitary, or by intravenous injection.
4	<u>Combinations of beam radiation, with radioactive implants, or radioisotopes</u> (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	<u>Radiation therapy, NOS (method or source not specified)</u> Radiation was administered, but the method or source is not documented (radiation therapy, NOS)
7	<u>Patient or patient's guardian refused</u>
8	<u>Radiation therapy recommended, unknown if administered</u> A physician recommended radiation therapy or referred the patient for a radiation therapy consult, follow-up does not confirm that therapy was received
9	<u>Unknown if radiation therapy administered</u> 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).
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	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

Code	Label	Definition
	administered before or after surgery	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 if 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
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).

Code	Label	Definition
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt- 60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.
23	Photons (2—5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2—5 MV.
24	Photons (6—10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6—10 MV.
25	Photons (11—19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11—19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
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).

Code	Label	Definition
52	Brachytherapy, Intracavitary, HDR	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
80*	Combination modality, specified*	Combination of external beam radiation and either radioactive implants or radioisotopes*
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 <i>Date Radiation Ended</i> (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 TEXT--RADIATION (BEAM)

NAACCR ITEM #2620

Enter the types of beam radiation administered to the patient as part of first course of therapy. Include dates and chronology of care. 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. Include dates and chronology of care. 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-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 <i>RX Date Chemotherapy</i> (NAACCR Item #1220). Case was diagnosed between 2003 and 2009 and the facility did not record <i>RX Date Chemotherapy</i> (NAACCR Item #1220) at that time.

RX TEXT—CHEMO**NAACCR ITEM #2640**

Enter the documentation regarding chemotherapy treatment of the tumor being reported. Include dates and chronology of care. 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 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 papillary 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 <i>RX Date Hormone</i> (NAACCR Item #1230). Case was diagnosed between 2003 and 2009 and the facility did not record <i>RX Date Hormone</i> (NAACCR Item #1230) at that time.

RX TEXT—HORMONE**NAACCR ITEM #2650**

Enter the documentation regarding the hormone treatment of the tumor being reported. Include dates and chronology of care. 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

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 <i>RX Date BRM/Immunotherapy</i> (NAACCR Item #1240). Case was diagnosed between 2003 and 2009 and the facility did not record <i>RX Date BRM/Immunotherapy</i> (NAACCR Item #1240) at that time.

RX TEXT—BRM**NAACCR ITEM #2660**

Enter the documentation regarding the biological response modifiers or immunotherapy treatments of the tumor being reported. Include dates and chronology of care. 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 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 other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to

Code	Label	Description
	other systemic therapy administered before or after surgery	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
40	Combination of endocrine surgery and/or radiation with a transplant procedure (combination of codes 30 and 10, 11, 12 or 20).

Code	Description
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.

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. There is no reason to suspect that the patient would have had other therapy.
 - c. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include other therapy.
 - d. Patient elects to pursue no treatment following the discussion of other therapy. Discussion does not equal a recommendation.
 - e. Only information available is that the patient was referred for consideration of other therapy. Referral does not equal a recommendation.
 - f. 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	<u>ALTERNATIVE SYSTEMS</u>
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
<u>MANUAL HEALING</u>	Magnetoiresonance Spectroscopy
Acupressure	Diet, Nutrition, Lifestyle
Biofield Therapeutics	Changes In Lifestyle
Massage Therapy	Diet
Reflexology	Gerson Therapy
Zone Therapy	Macrobiotics
MIND/BODY CONTROL	Megavitamins
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. <i>Examples:</i> 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 not 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).
15	Information is not available at this time, but it is expected that it will be available later
(blank)	A valid date value is provided in item <i>Date Other Treatment Started</i> (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: ALL Stage Items including ALL Site-Specific Factors MUST have Text Documentation.

The use of standard abbreviations in documentation and diagnostic text is acceptable. However, FCDS must be able to understand use of standard abbreviations to clarify and validate coded data.

Refer to Appendix C for the latest list of standard abbreviations.

CAUTION: Use of Non-Standard Abbreviations

- **Non-Standard Abbreviations may have multiple interpretations and should not be used.**
- **Do not customize abbreviations or overuse abbreviations to the point where the information has no meaning or context.**

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.

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. Include dates and chronology of care. 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. Include dates and chronology of care. 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. Include dates and chronology of care. 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. Include dates and chronology of care.

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. Include dates and chronology of care to ensure tumor markers are consistent with timeline of care.

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 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. Include dates and chronology of care. 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. Include dates and chronology of care. 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. Include dates and chronology of care. See Appendix L

RX TEXT – SURGERY**NAACCR ITEM #2610**

Enter information describing the surgical procedure(s) performed as part of first course of therapy. Include dates and chronology of care. 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. Include dates and chronology of care. 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. Include dates and chronology of care. 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. Include dates and chronology of care. 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. Include dates and chronology of care. 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. Include dates and chronology of care. 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. Include dates and chronology of care. 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. Include dates and chronology of care. 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

<u>NAACCR Item Number</u>	<u>Item Name</u>
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 <i>Date of Last Contact or Death</i> (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

APPENDIX A

**FLORIDA HEALTHCARE FACILITIES
CURRENTLY REPORTING TO FCDS**

**Includes:
HOSPITALS
FREE-STANDING SURGICAL CENTERS,
RADIATION THERAPY CENTERS**

**Does NOT Include:
Dermatologist in Private Practice
Urologist in Private Practice
Hematologist in Private Practice
Medical Oncologist in Private Practice**

APPENDIX A – HOSPITAL LISTING – FCDS FACILITY NUMBER ORDER

FACILITY	HOSPITAL NAME	OPTION	CITY
1100	SHANDS UNIVERSITY OF FLORIDA	4	GAINESVILLE
1103	NF/SG VETERAN HEALTHCARE SYSTEM	6	GAINESVILLE
1170	N FLORIDA REGIONAL MEDICAL CENTER	4	GAINESVILLE
1205	BAKER COUNTY MEDICAL SERVICE INC	0	MACCLENNY
1300	GULF COAST MEDICAL CENTER	4	PANAMA CITY
1306	BAY MEDICAL CENTER	4	PANAMA CITY
1405	SHANDS STARKE REGIONAL MEDICAL CTR	4	STARKE
1505	CAPE CANAVERAL HOSPITAL	4	COCOA BEACH
1506	PARRISH MEDICAL CENTER	4	TITUSVILLE
1508	PALM BAY HOSPITAL	4	PALM BAY
1510	VIERA HOSPITAL	4	VIERA
1521	45TH MEDICAL GROUP 45MDSS SGSACT	7	PATRICK AIR FORCE BASE
1546	HOLMES REGIONAL MEDICAL CENTER	4	MELBOURNE
1547	WUESTHOFF MEDICAL CENTER- ROCKLEDGE	4	ROCKLEDGE
1548	WUESTHOFF MEDICAL CENTER MELBOURNE	4	MELBOURNE
1601	WESTSIDE REGIONAL MED CTR	4	PLANTATION
1602	MEMORIAL REGIONAL HOSPITAL SOUTH	2	HOLLYWOOD
1605	BROWARD HEALTH	4	FORT LAUDERDALE
1606	MEMORIAL REGIONAL CANCER CENTER	4	HOLLYWOOD
1607	NORTH BROWARD MEDICAL CENTER	4	DEERFIELD BEACH
1609	IMPERIAL POINT MEDICAL CENTER	2	FORT LAUDERDALE
1610	MEMORIAL HOSPITAL PEMBROKE	2	PEMBROKE PINES
1636	HOLY CROSS HOSPITAL	4	FORT LAUDERDALE
1645	CORAL SPRINGS MEDICAL CENTER	2	CORAL SPRINGS
1647	CLEVELAND CLINIC HOSPITAL	4	WESTON
1649	MEMORIAL HOSPITAL MIRAMAR	2	MIRAMAR
1671	KINDRED HOSP S FL HOLLYWOOD	0	HOLLYWOOD
1673	KINDRED FT LAUDERDALE	0	FORT LAUDERDALE
1676	PLANTATION GENERAL HOSP	4	PLANTATION
1681	NORTHWEST MEDICAL CENTER	2	MARGATE
1686	FLORIDA MEDICAL CENTER	2	FORT LAUDERDALE
1687	UNIVERSITY MEDICAL CENTER	2	TAMARAC
1688	MEMORIAL HOSPITAL WEST	4	PEMBROKE PINES
1690	HOLLYWOOD PAVILION	8	HOLLYWOOD
1705	CALHOUN LIBERTY HOSPITAL	0	BLOUNTSTOWN
1800	FAWCETT MEMORIAL HOSPITAL	2	PORT CHARLOTTE
1836	PEACE RIVER REGIONAL MEDICAL CENTER	3	PORT CHARLOTTE
1846	CHARLOTTE REGIONAL MEDICAL CENTER	2	PUNTA GORDA
1900	SEVEN RIVERS REGIONAL MEDICAL CTR	2	CRYSTAL RIVER
1905	CITRUS MEMORIAL HOSPITAL	2	INVERNESS
2000	ORANGE PARK MEDICAL CENTER	4	ORANGE PARK
2090	KINDRED HOSPITAL NORTH FLORIDA	0	GREEN COVE SPRINGS

APPENDIX A – HOSPITAL LISTING – FCDS FACILITY NUMBER ORDER

FACILITY	HOSPITAL NAME	OPTION	CITY
2130	PHYSICIANS REG MED CTR-PINE RIDGE	2	NAPLES
2140	PHYSICIANS REG MEDICAL CTR COLLIER	2	NAPLES
2146	NCH HEALTHCARE SYSTEM	4	NAPLES
2150	NORTH COLLIER HOSPITAL	4	NAPLES
2190	THE WILLOUGH AT NAPLES	8	NAPLES
2205	SHANDS LAKE SHORE REGIONAL MED CTR	4	LAKE CITY
2226	ORLANDO VA MEDICAL CENTER	6	LAKE CITY
2246	LAKE CITY MEDICAL CENTER	2	LAKE CITY
2302	JACKSON SOUTH COMMUNITY CENTER	4	MIAMI
2304	AVENTURA HOSP AND COMP CANCER CTR	4	AVENTURA
2305	JAMES M JACKSON MEMORIAL HOSPITAL	4	MIAMI
2306	HOMESTEAD HOSPITAL	4	HOMESTEAD
2307	WEST KENDALL BAPTIST HOSPITAL	3	MIAMI
2310	ANNE BATES LEACH EYE HOSPITAL	4	MIAMI
2321	U S AIR FORCE HOSPITAL	7	HOMESTEAD
2326	MIAMI V A MEDICAL CENTER	6	MIAMI
2336	BAPTIST HOSPITAL OF MIAMI	4	MIAMI
2338	MERCY HOSPITAL	2	MIAMI
2346	KINDRED HOSP S FL CORAL GABLES	0	CORAL GABLES
2347	UNIVERSITY OF MIAMI HOSPITAL	4	MIAMI
2348	DOCTORS HOSPITAL	2	CORAL GABLES
2349	HIALEAH HOSPITAL	2	HIALEAH
2351	MOUNT SINAI MEDICAL CENTER	4	MIAMI BEACH
2353	NORTH SHORE MEDICAL CENTER	4	MIAMI
2356	PALM SPRINGS GENERAL HOSPITAL	2	HIALEAH
2358	KENDALL MEDICAL CENTER	2	MIAMI
2359	MIAMI CHILDRENS HOSPITAL	2	MIAMI
2372	U OF MIAMI HOSPITAL CLINICS	4	MIAMI
2374	JACKSON NORTH MEDICAL CENTER	2	NORTH MIAMI BEACH
2376	SOUTH MIAMI HOSPITAL	4	SOUTH MIAMI
2377	WESTCHESTER GENERAL HOSPITAL	2	MIAMI
2378	CORAL GABLES HOSPITAL	2	CORAL GABLES
2379	LARKIN COMMUNITY HOSPITAL	2	SOUTH MIAMI
2383	PALMETTO GENERAL HOSPITAL	3	HIALEAH
2405	DESOTO MEMORIAL HOSPITAL	2	ARCADIA
2605	BAPTIST MEDICAL CENTER BEACHES	4	JACKSONVILLE BEACH
2606	SHANDS JACKSONVILLE MEDICAL CENTER	4	JACKSONVILLE
2621	NAVAL HOSPITAL JAX TUMOR REGISTRY	7	JACKSONVILLE
2636	BAPTIST REGIONAL CANCER CENTER-JAX	4	JACKSONVILLE
2638	ST VINCENTS MEDICAL CENTER	4	JACKSONVILLE
2640	BAPTIST MEDICAL CENTER SOUTH	4	JACKSONVILLE
2647	NEMOURS CHILDRENS HOSPITAL	2	ORLANDO

APPENDIX A – HOSPITAL LISTING – FCDS FACILITY NUMBER ORDER

FACILITY	HOSPITAL NAME	OPTION	CITY
2648	MEMORIAL HOSPITAL JACKSONVILLE	4	JACKSONVILLE
2650	MAYO CLINIC HOSPITAL	4	JACKSONVILLE
2651	SPECIALTY HOSPITAL JACKSONVILLE	0	JACKSONVILLE
2660	ST. LUKE-ST VINCENT'S HEALTHCARE	4	JACKSONVILLE
2672	WOLFSON CHILDRENS HOSP NCC	4	JACKSONVILLE
2700	WEST FLORIDA HOSPITAL	4	PENSACOLA
2705	UNIVERSITY HOSPITAL AND CLINIC	8	PENSACOLA
2721	NAVAL HOSPITAL OF PENSACOLA	7	PENSACOLA
2736	BAPTIST HOSPITAL OF PENSACOLA	4	PENSACOLA
2738	SACRED HEART CANCER CENTER	4	PENSACOLA
2870	FLORIDA HOSPITAL - FLAGLER	4	PALM COAST
2905	GEORGE E WEEMS MEMORIAL HOSPITAL	0	APALACHICOLA
3000	FLORIDA STATE HOSPITAL	8	CHATTAHOOCHEE
3300	SACRED HEART HOSPITAL ON THE GULF	3	PORT SAINT JOE
3505	FLORIDA HOSPITAL WAUCHULA	2	WAUCHULA
3605	HENDRY REGIONAL MEDICAL CENTER	0	CLEWISTON
3701	OAK HILL HOSPITAL	4	BROOKSVILLE
3705	BAYFRONT HEALTH BROOKSVILLE	2	BROOKSVILLE
3715	SPRING HILL REGIONAL HOSPITAL	2	SPRING HILL
3805	HIGHLANDS REGIONAL MEDICAL CENTER	2	SEBRING
3836	FLORIDA HOSPITAL HEARTLAND DIVISION	2	SEBRING
3890	FLORIDA HOSPITAL LAKE PLACID	2	LAKE PLACID
3901	TAMPA VA HOSPITAL	6	TAMPA
3903	BRANDON REGIONAL HOSPITAL	4	BRANDON
3906	TAMPA GENERAL HOSPITAL	3	TAMPA
3907	FLORIDA HOSPITAL TAMPA	4	TAMPA
3908	SHRINERS HOSPITALS FOR CHILDREN	3	TAMPA
3910	ST. JOSEPH'S HOSPITAL-SOUTH	4	RIVERVIEW
3921	U S AIR FORCE REGIONAL HOSPITAL	7	MACDILL AFB
3932	H LEE MOFFITT CANCER CENTER	4	TAMPA
3936	ST JOSEPHS HOSPITAL NORTH	4	LUTZ
3937	ST JOSEPH HOSPITAL	4	TAMPA
3938	SOUTH FLORIDA BAPTIST HOSPITAL	2	PLANT CITY
3947	KINDRED HOSPITAL CENTRAL TAMPA	2	TAMPA
3973	FLORIDA HOSPITAL CARROLLWOOD	4	TAMPA
3974	KINDRED HOSPITAL BAY AREA TAMPA	2	TAMPA
3977	MEMORIAL HOSPITAL OF TAMPA	2	TAMPA
3978	TAMPA COMMUNITY HOSPITAL	2	TAMPA
3988	SOUTH BAY HOSPITAL	2	SUN CITY CENTER
4005	DOCTORS MEMORIAL HOSPITAL - BONIFAY	0	BONIFAY
4105	INDIAN RIVER MEMORIAL HOSPITAL	4	VERO BEACH
4170	SEBASTIAN RIVER MEDICAL CENTER	2	SEBASTIAN

APPENDIX A – HOSPITAL LISTING – FCDS FACILITY NUMBER ORDER

FACILITY	HOSPITAL NAME	OPTION	CITY
4205	CAMPBELLTON GRACEVILLE HOSPITAL	0	GRACEVILLE
4206	JACKSON HOSPITAL	2	MARIANNA
4516	LEESBURG REGIONAL MEDICAL CENTER	4	LEESBURG
4546	SOUTH LAKE HOSPITAL	3	CLERMONT
4547	FLORIDA HOSPITAL WATERMAN	4	TAVARES
4601	CAPE CORAL HOSPITAL	4	CAPE CORAL
4605	LEE MEMORIAL HEALTH SYSTEM	4	FT MYERS
4645	REG CANCER CTR GULF COAST HOSPITAL	2	FT MYERS
4647	LEHIGH REGIONAL MEDICAL CENTER	2	LEHIGH ACRES
4690	LEE MEMORIAL HOSPITAL HEALTHPARK	4	FT MYERS
4705	TALLAHASSEE MEMORIAL HEALTHCARE	4	TALLAHASSEE
4770	CAPITAL REGIONAL MEDICAL CENTER	2	TALLAHASSEE
4816	TRICOUNTY HOSPITAL	0	WILLISTON
5005	MADISON COUNTY MEMORIAL HOSPITAL	0	MADISON
5100	BLAKE MEDICAL CENTER	4	BRADENTON
5105	MANATEE MEMORIAL HOSP	4	BRADENTON
5110	LAKEWOOD RANCH MEDICAL CENTER	4	BRADENTON
5200	OCALA REGIONAL MEDICAL CENTER	4	OCALA
5202	WEST MARION COMMUNITY HOSPITAL	4	OCALA
5203	ST VINCENTS MED CTR CLAY COUNTY	3	MIDDLEBURG
5205	MUNROE REGIONAL PATH	4	OCALA
5207	KINDRED HOSPITAL OCALA	0	OCALA
5346	MARTIN MEMORIAL MEDICAL CENTER	4	STUART
5390	MARTIN MEMORIAL HOSPITAL SOUTH	4	STUART
5406	LOWER KEYS MEDICAL CENTER	2	KEY WEST
5446	FISHERMENS HOSPITAL	2	MARATHON
5471	MARINERS HOSPITAL	2	TAVERNIER
5490	LOWER KEYS MEDICAL CENTER	8	KEY WEST
5505	BAPTIST MEDICAL CENTER NASSAU	2	FERNANDINA BEACH
5606	TWIN CITIES HOSPITAL	3	NICEVILLE
5607	NORTH OKALOOSA MEDICAL CENTER	3	CRESTVIEW
5610	SACRED HEART HOSP EMERALD COAST	2	MIRAMAR BEACH
5621	96 MEDICAL GROUP SGSAH	7	EGLIN AFB
5670	FORT WALTON BEACH MED CTR	2	FORT WALTON BEACH
5705	RAULERSON HOSPITAL	2	OKEECHOBEE
5805	FLORIDA HOSPITAL APOPKA	4	APOPK
5806	HEALTH CENTRAL	2	OCOEE
5836	FLORIDA HOSPITAL CANCER INST SOUTH	4	ORLANDO
5848	UF HEALTH CANCER CENTER AT ORLANDO	4	ORLANDO
5849	FLORIDA HOSPITAL EAST ORLANDO	4	ORLANDO
5850	WINTER PARK MEMORIAL HOSPITAL	4	WINTER PARK
5851	ORLANDO REGIONAL MEDICAL CENTER	4	ORLANDO

APPENDIX A – HOSPITAL LISTING – FCDS FACILITY NUMBER ORDER

FACILITY	HOSPITAL NAME	OPTION	CITY
5852	DR P PHILLIPS HOSPITAL	4	ORLANDO
5890	WINTER PARK PAVILION	8	WINTER PARK
5891	ARNOLD PALMER MEDICAL CENTER	4	ORLANDO
5900	POINCIANA MEDICAL CENTER	4	KISSIMMEE
5936	ST CLOUD REGIONAL MEDICAL CENTER	4	ST CLOUD
5967	OSCEOLA REGIONAL MEDICAL CENTER	4	KISSIMMEE
5969	CELEBRATION HEALTH FL HOSPITAL	4	CELEBRATION
5970	FLORIDA HOSPITAL KISSIMMEE	4	KISSIMMEE
6001	WEST PALM HOSPITAL	4	WEST PALM BEACH
6003	DELRAY MEDICAL CENTER	3	DELRAY BEACH
6005	BETHESDA MEMORIAL HOSPITAL	4	BOYNTON BEACH
6007	LAKESIDE MEDICAL CENTER	3	BELLE GLADE
6008	BETHESDA HOSPITAL WEST	4	BOYNTON BEACH
6026	WEST PALM BEACH V A MED CTR	6	WEST PALM BEACH
6036	ST MARYS MEDICAL CENTER	4	WEST PALM BEACH
6045	WEST BOCA MEDICAL CENTER	2	BOCA RATON
6046	BOCA RATON REGIONAL HOSPITAL	4	BOCA RATON
6047	GOOD SAMARITAN MEDICAL CENTER	4	WEST PALM BEACH
6048	JFK MEDICAL CENTER	4	ATLANTIS
6068	WELLINGTON REGIONAL MEDICAL CENTER	4	WEST PALM BEACH
6069	PALMS WEST HOSPITAL	2	LOXAHATCHEE
6070	PALM BEACH GARDENS MEDICAL CENTER	2	PALM BEACH GARDENS
6074	JUPITER MEDICAL CENTER	4	JUPITER
6104	FLORIDA HOSPITAL WESLEY CHAPEL	5	WESLEY CHAPEL
6105	FLORIDA HOSPITAL ZEPHYRHILLS	2	ZEPHYRHILLS
6106	NORTH BAY HOSPITAL	4	NEW PORT RICHEY
6170	MEDICAL CENTER OF TRINITY	2	NEW PORT RICHEY
6171	BAYFRONT HEALTH, DADE CITY	2	DADE CITY
6172	REGIONAL MED CENTER BAYONET POINT	4	HUDSON
6201	NORTHSIDE HOSP HEART INSTITUTE	2	ST PETERSBURG
6203	EDWARD WHITE HOSPITAL	2	ST PETERSBURG
6205	FLORIDA HOSPITAL NORTH PINELLAS	2	TARPON SPRINGS
6206	LARGO MEDICAL CENTER	4	LARGO
6226	BAY PINES V A MEDICAL CENTER	6	BAY PINES
6246	ALL CHILDRENS HOSPITAL	2	ST PETERSBURG
6248	BAYFRONT MEDICAL CENTER	2	ST PETERSBURG
6249	MEASE DUNEDIN HOSPITAL	4	DUNEDIN
6250	MORTON PLANT HOSPITAL	4	CLEARWATER
6251	ST ANTHONY HOSPITAL	4	ST PETERSBURG
6252	LARGO MEDICAL CENTER OF INDIAN ROCK	8	LARGO
6273	PALMS OF PASADENA HOSPITAL	2	ST PETERSBURG
6274	ST PETERSBURG GENERAL HOSPITAL	2	ST PETERSBURG

APPENDIX A – HOSPITAL LISTING – FCDS FACILITY NUMBER ORDER

FACILITY	HOSPITAL NAME	OPTION	CITY
6278	MEASE COUNTRYSIDE HOSPITAL	4	SAFETY HARBOR
6290	KINDRED HOSP BAY AREA ST PETERSBURG	2	ST PETERSBURG
6305	LAKELAND REGIONAL MEDICAL CENTER	4	LAKELAND
6346	BARTOW REGIONAL MEDICAL CENTER	2	BARTOW
6347	HEART OF FLORIDA HOSPITAL	2	DAVENPORT
6348	LAKE WALES HOSPITAL	2	LAKE WALES
6349	WINTER HAVEN HOSPITAL	4	WINTER HAVEN
6390	WINTER HAVEN HOSPITAL REGENCY	4	WINTER HAVEN
6446	PUTNAM COMMUNITY MEDICAL CTR	2	PALATKA
6570	FLAGLER HOSPITAL	3	ST AUGUSTINE
6600	COLUMBIA LAWNWOOD REGIONAL MED CTR	2	FORT PIERCE
6646	TRADITION MEDICAL CENTER	4	PT ST LUCIE
6647	ST LUCIE MEDICAL CENTER	3	PORT ST LUCIE
6690	SAVANNAS HOSPITAL	8	PORT ST LUCIE
6704	GULF BREEZE HOSPITAL	4	GULF BREEZE
6705	JAY HOSPITAL	2	JAY
6707	SANTA ROSA MEDICAL CENTER	2	MILTON
6805	SARASOTA MEMORIAL HOSPITAL	4	SARASOTA
6810	ENGLEWOOD COMMUNITY HOSPITAL	4	ENGLEWOOD
6815	COMPLEXCARE AT RIDGELAKE	0	SARASOTA
6846	VENICE REGIONAL MEDICAL CENTER	4	VENICE
6870	DOCTORS HOSPITAL	3	SARASOTA
6905	CENTRAL FLORIDA REGIONAL HOSPITAL	4	SANFORD
6910	ORLANDO REGIONAL SOUTH SEMINOLE HOS	4	LONGWOOD
6936	FLORIDA HOSPITAL ALTAMONTE	4	ALTAMONTE SPRINGS
7005	VILLAGES REGIONAL HOSPITAL	2	THE VILLAGES
7105	SHANDS LIVE OAK REGIONAL MED CTR	4	LIVE OAK
7205	DOCTORS MEMORIAL HOSPITAL	2	PERRY
7305	LAKE BUTLER HOSPITAL HAND SURG. CTR	0	LAKE BUTLER
7405	BERT FISH MEDICAL CENTER	3	NEW SMYRNA BEACH
7406	HALIFAX HOSPITAL MEDICAL CENTER	4	DAYTONA BEACH
7407	FLORIDA HOSPITAL DELAND	4	DELAND
7446	FLORIDA HOSPITAL FISH MEMORIAL	2	ORANGE CITY
7447	MEMORIAL HOSPITAL ORMOND BEACH	4	ORMOND BEACH
7448	FLORIDA HOSPITAL MEMORIAL MED CTR	4	DAYTONA BEACH
7605	HEALTHMARK REGIONAL MEDICAL CENTER	0	DE FUNIAK SPRINGS
7705	NW FLORIDA COMMUNITY HOSPITAL	0	CHIPLEY
7706	KINDRED PALM BEACHES	2	RIVIERA BEACH
7707	MANATEE MEMORIAL HOSPITAL	5	BRADENTON
7708	KINDRED HOSPITAL MELBOURNE	2	MELBOURNE
9084	HALIFAX MEDICAL CENTER-PORT ORANGE	4	PORT ORANGE

APPENDIX A – SURGICAL CENTERS – FCDS FACILITY NUMBER ORDER

FACILITY	SURGERY CENTER NAME	OPTION	CITY
8000	AYERS SURGERY CENTER	S	GAINESVILLE
8001	EYE SURGICENTER	S	GAINESVILLE
8002	N FLORIDA REGIONAL MEDICAL CENTER	T	GAINESVILLE
8004	MULLIS EYE INSTITUTE INC	S	PANAMA CITY
8005	NORTHWEST FLORIDA GASTROENTEROLOGY	S	PANAMA CITY
8006	NORTHWEST FLORIDA SURGERY CENTER	T	PANAMA CITY
8007	AMBULATORY SURGICAL CARE	T	MERRITT ISLAND
8008	ASC OF BREVARD	S	MELBOURNE
8009	BREVARD SURGERY CENTER	S	MELBOURNE
8010	MERRITT ISLAND SURGERY CENTER	T	MERRITT ISLAND
8012	MEMORIAL SAME DAY WEST	S	PEMBROKE PINES
8013	ATLANTIC SURGICAL CENTER	S	POMPANO BEACH
8014	CLEVELAND CLINIC OF FLORIDA	S	WESTON
8015	EYE CARE AND SURGERY CENTER	S	FT LAUDERDALE
8016	FOUNDATION FOR ADVANCED EYE CARE	S	SUNRISE
8017	MEMORIAL SAME DAY EAST	S	HOLLYWOOD
8019	OUTPATIENT SURGICAL SERVICES	S	PLANTATION
8020	SURGERY CTR AT CORAL SPRING	S	CORAL SPRINGS
8021	RAND SURGICAL PAVILLION CORPORATION	S	POMPANO BEACH
8023	HARBORSIDE SURGERY CENTER	T	PUNTA GORDA
8024	ST LUCIES OUTPATIENT SURGERY CENTER	S	PORT CHARLOTTE
8025	HEALTHSOUTH CITRUS SURGERY CENTER	T	LECANTO
8026	CITRUS ENDOSCOPY AND SURGERY CENTER	T	CRYSTAL RIVER
8027	ORANGE PARK SURGERY CENTER	T	ORANGE PARK
8029	COLLIER SURGERY CTR	T	NAPLES
8030	GASKINS EYE CARE AND SURGERY CENTER	S	NAPLES
8031	MONTGOMERY EYE CENTER	S	NAPLES
8032	NAPLES DAY SURGERY SOUTH	S	NAPLES
8033	NAPLES DAY SURGERY NORTH	S	NAPLES
8034	NEWGATE SURGERY CENTER INC	S	NAPLES
8035	ENDOSCOPY CENTER OF NAPLES	S	NAPLES
8036	AMBULATORY SURGICAL CTR	S	MIAMI
8037	THE SURGERY CENTER OF CORAL GABLES	S	MIAMI
8038	CORAL VIEW SURGERY CENTER	S	MIAMI
8040	HIALEAH AMBULATORY CARE CENTER	S	HIALEAH
8042	MIAMI EYE CENTER	S	MIAMI
8043	SANTA LUCIA SURG CTR-MIAMI VISION	S	CORAL GABLES
8044	COLUMBIA N MIAMI BCH SURGERY CTR	S	NORTH MIAMI
8047	SURGICAL PARK CENTER LTD	S	MIAMI
8048	THE MIAMI ASC, LP	T	MIAMI
8049	REED CENTER FOR AMB UROLOGICAL SURG	S	BAY HARBOR ISLAND
8050	VENTURE AMBULATORY SURGICAL CENTER	S	N MIAMI BEACH

APPENDIX A – SURGICAL CENTERS – FCDS FACILITY NUMBER ORDER

FACILITY	SURGERY CENTER NAME	OPTION	CITY
8051	JACKSONVILLE SURGERY CENTER	T	JACKSONVILLE
8052	MAYO OUTPATIENT SURGERY CENTER	S	JACKSONVILLE
8053	NORTH FL EYE CLINIC SURGICENTER	S	JACKSONVILLE
8054	COLUMBIA PARKSIDE SURG CTR JAX	T	JACKSONVILLE
8055	RIVERSIDE PARK SURGICENTER	S	JACKSONVILLE
8056	SAMUEL WELLS SURGI CENTER	S	JACKSONVILLE
8059	UNIVERSITY OF FLORIDA FACULTY CLINI	S	JACKSONVILLE
8060	CORDOVA AMBULATORY SURGICAL CENTER	S	PENSACOLA
8061	MEDICAL CTR CLINC AMB SURG CTR	T	PENSACOLA
8062	NORTH FLORIDA SURGERY CENTER	S	PENSACOLA
8063	FOREST OAKS AMB SURG CTR	S	SPRING HILL
8064	ALL SAINTS SURGERY CENTER	T	BROOKSVILLE
8065	SUNCOAST SURGERY CTR OF HERNANDO	S	SPRING HILL
8068	SURGICAL CTR OF CENTRAL FL	S	SEBRING
8069	AMBULATORY SURGERY CENTER	S	TAMPA
8070	BRANDON SURGERY CENTER	S	BRANDON
8071	TAMPA BAY SURGERY CENTER	S	TAMPA
8072	CENTER FOR SPECIALIZED SURGERY	S	TAMPA
8073	ST JOSEPH'S SAME DAY SURGERY CTR	S	TAMPA
8074	TAMPA EYE & SPECIALTY SURGERY CTR	S	TAMPA
8075	TAMPA OUTPATIENT SURGICAL FACILITY	S	TAMPA
8076	USF ENDOSCOPY CTR TAMPA FL	S	TAMPA
8077	FL EYE INSTITUTE SURGICENTER INC	S	VERO BEACH
8078	HEALTHSOUTH INDIAN RIVER SURG CTR	S	VERO BEACH
8079	VERO EYE CENTER	S	VERO BEACH
8081	LAKE SURGERY AND ENDOSCOPY CENTER	T	LEESBURG
8082	LEESBURG REG AMB SURG CTR	S	LEESBURG
8083	MID FLORIDA EYES SURGERY CENTER	T	MOUNT DORA
8084	BARKLEY SURGICENTER INC	T	FT MYERS
8087	DERMATOLOGICAL AND COSMETIC SURGERY	S	FT MYERS
8088	EYE SURGERY AND LASER CENTER	S	CAPE CORAL
8089	LIFELINE ENDOSCOPY CENTER	S	CAPE CORAL
8091	LEE ISLAND COAST SURGERY CENTER	S	FT MYERS
8092	SW FL INST OF AMBULATORY SURGICTR	S	FT MYERS
8093	SW FL ENDOSCOPY CENTER	S	FT MYERS
8094	SURGI AND LASER CTR OF SW FL	S	FT MYERS
8095	SURGICARE CENTER	T	FT MYERS
8096	CENTER FOR DIGESTIVE HEALTH	T	FT MYERS
8097	ALPHA AMBULATORY SURGERY CENTER	S	TALLAHASSEE
8100	TALLAHASSEE ENDOSCOPY CENTER	S	TALLAHASSEE
8101	TALLAHASSEE OUTPATIENT SURGERY CENT	S	TALLAHASSEE
8102	TALLAHASSEE SINGLE DAY SURGERY CENT	T	TALLAHASSEE

APPENDIX A – SURGICAL CENTERS – FCDS FACILITY NUMBER ORDER

FACILITY	SURGERY CENTER NAME	OPTION	CITY
8103	WEST FLORIDA SURGERY CTR	S	BRADENTON
8104	CORTEZ FOOT SURGERY CENTER	S	BRADENTON
8105	EYE ASSOCIATES SURGERY CENTER	T	BRADENTON
8106	GULF COAST SURGERY CENTER	T	BRADENTON
8107	MANATEE ENDOSCOPY CENTER	S	BRADENTON
8108	CENTRAL FLORIDA EYE INSTITUTE	S	OCALA
8109	ENDOSCOPY CENTER OF OCALA INC	T	OCALA
8110	SURGERY CENTER OF OCALA	T	OCALA
8111	OCALA SPECIALTY SURGERY CENTER LLC	S	OCALA
8113	SURGERY CENTER OF STUART	T	STUART
8114	EMERALD COAST SURG CTR	T	FT WALTON BEACH
8115	AMBULATORY ANKLE AND FOOT CTR OF FL	S	ORLANDO
8116	CENTRAL FL SURGICAL CENTER	T	OCOE
8117	CLEVELAND CLINIC NAPLES	S	NAPLES
8119	OAKWATER SURGICAL CENTER	S	ORLANDO
8120	HEALTHSOUTH ORLANDO CTR OPD SURG	T	ORLANDO
8121	PHYSICIANS SURGICAL CARE CENTER	S	WINTER PARK
8122	SAME DAY SURGI CENTER OF ORLANDO	S	ORLANDO
8123	SURGICAL LICENSED WARD	T	ORLANDO
8124	UNIVERSITY SURGICAL CENTER	T	WINTER PARK
8125	UROLOGICAL AMBULATORY SURGERY CTR	T	ORLANDO
8126	WINTER PARK AMBULATORY SURGERY CTR	S	WINTER PARK
8127	KISSIMMEE SURGERY CENTER	T	KISSIMMEE
8128	DOCTORS SURGERY CTR/LEVIN EYE CTR	T	KISSIMMEE
8130	BOCA RATON OUTPATIENT SURG & LASER	T	BOCA RATON
8131	DELRAY OUTPATIENT SURG AND LASER	S	DELRAY BEACH
8132	INTRACOASTAL OPD SURGICAL CTR	S	WEST PALM BEACH
8133	KIMMEL OUTPATIENT SURGICAL CENTER	S	WEST PALM BEACH
8134	PALM BEACH OUTPATIENT SURGICAL CTR	S	LAKE WORTH
8135	N COUNTY SURGICTR PLM BCH	S	PALM BEACH GARDEN
8137	PALM BEACH EYE CLINIC	S	WEST PLAM BEACH
8138	PALM BEACH LAKES SURGERY CENTER	S	WEST PALM BEACH
8140	PRESIDENTIAL EYE SURGICENTER	S	WEST PALM BEACH
8141	JUPITER EYE CENTER	S	JUPITER
8142	BOYNTON BEACH ASC LLC	T	BOYTON BEACH
8143	OUTPATIENT CENTER OF BOYNTON BCH	T	BOYTON BEACH
8144	NEW PORT RICHEY SURG CTR AT TRINITY	S	TRINITY
8145	FLORIDA MEDICAL CLINIC PA	T	ZEPHYRHILLS
8146	PASCO SURGERY CENTER	S	ZEPHYRHILLS
8147	HOLIDAY SURGERY CENTER	S	HOLIDAY
8148	MEDICAL DEVELOP CORP OF PASCO CTY	S	HUDSON
8150	SEVEN SPRINGS SURGERY CENTER INC	S	NEW PORT RICHEY

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FACILITY	SURGERY CENTER NAME	OPTION	CITY
8151	SUNCOAST EYE CENTER	S	HUDSON
8152	SUNCOAST SKIN SURGERY CLINIC	S	NEW PORT RICHEY
8153	MEADOW LANE SURGERY CENTER	S	NEW PORT RICHEY
8154	BAY AREA ENDOSCOPY CENTER	S	ST PETERSBURG
8155	BAYFRONT MED PLAZA SAMEDAY SURGERY	S	ST PETERSBURG
8156	CLEARWATER ENDOSCOPY CENTER	S	CLEARWATER
8157	BELLEAIR SURGERY CTR	T	CLEARWATER
8158	COUNTRYSIDE SURGERY CENTER	T	CLEARWATER
8159	WEST BAY SURGERY CENTER	T	LARGO
8163	ST LUKES CATARACT CENTER	S	TARPON SPRINGS
8164	SUNCOAST MEDICAL CLINIC, LLC	S	ST PETERSBURG
8165	HEALTHSOUTH ST PETERSBURG SURG CTR	S	ST PETERSBURG
8166	SUNCOAST MED CLINIC, LLC ENDOSCOPY	S	ST PETERSBURG
8168	CENTRAL FLORIDA SURGI CENTER	T	LAKELAND
8169	CENTRAL FLORIDA SURGICENTER	S	LAKELAND
8170	EYE SURGERY AND LASER CENTER OF MID	T	WINTER HAVEN
8171	AESTHETIC PLASTIC SURGERY CENTER	T	VENICE
8172	CAPE SURGERY CENTER	T	SARASOTA
8173	CENTER FOR ADVANCED EYE SURGERY LP	S	SARASOTA
8175	EYE CENTER OF FLORIDA	S	VENICE
8176	BON SECOURS VENICE HEALTHPK SURGERY	S	VENICE
8178	SURGERY CENTER AT ST ANDREWS	S	VENICE
8179	SURGICARE CTR OF VENICE INC	S	VENICE
8181	FLORIDA EYE CLINIC ASC	S	ALTAMONTE SPRINGS
8182	FL SURGERY CTR ALTAMONTE	T	ALTAMONTE SPRINGS
8183	ST AUGUSTINE ENDOSCOPY CENTER	T	ST AUGUSTINE
8184	SURGERY CENTER OF FORT PIERCE	T	FORT PIERCE
8185	DAY SURGERY INC	S	PORT ST LUCIE
8186	TREASURE COAST COSMETIC SURGERY CEN	S	PORT ST LUCIE
8187	AMBULATORY SUR CTR OF CENTRAL FL	S	DELAND
8188	ATLANTIC SURGERY CENTER	S	DAYTONA
8190	DELAND SURGERY CENTER	T	DELAND
8191	NEW SMYRNA BCH AMBULATORY CARE CTR	S	NEW SMYRNA BEACH
8192	OFFICE OF DR RICHARD JABLONSKI	S	ORMOND BEACH
8194	PHYSICIANS AMBULATORY SURGERY CTR	T	ORMOND BEACH
8195	SUNRISE SURGICAL CENTER	S	DAYTONA BEACH
8196	VOLUSIA ENDOSCOPY CENTER	T	ORMOND BEACH
8197	TOTAL BACK CARE CENTER	T	NAPLES
8198	PLAZA SURGERY CENTER	T	JACKSONVILLE
8199	ENDOSCOPY CTR OF PENSACOLA	S	PENSACOLA
8201	BRADENTON SURGERY CENTER	S	BRADENTON
8202	THE OCALA EYE SURGERY CENTER	S	OCALA

APPENDIX A – SURGICAL CENTERS – FCDS FACILITY NUMBER ORDER

FACILITY	SURGERY CENTER NAME	OPTION	CITY
8203	CENTER FOR SPECIAL SURGERY	T	ST PETERSBURG
8205	TRINITY SURGERY CENTER	T	NEW PORT RICHEY
8206	TREASURE COAST CTR FOR SURGERY	S	STUART
8207	GALLOWAY SURGICAL CTR	S	MIAMI`
8208	RIVERSIDE SURGERY CENTER	S	SEBASTIAN
8209	BETHESDA OUTPATIENT SURGERY CENTER	S	BOYNTON BEACH
8210	COLUMBIA DOCTORS SAME DAY SURG	T	SARASOTA
8211	NORTHPOINT SURGERY AND LASER CENTER	T	WEST PALM BEACH
8212	GULFSHORE ENDOSCOPY CTR INC	S	NAPLES
8213	HEALTHSOUTH MELBOURNE SURG CTR	T	MELBOURNE
8214	LAKELAND SURG AND DIAGNOSTIC CTR	S	LAKELAND
8215	THE FACIAL PLASTIC SURGERY CENTER	S	NAPLES
8216	MEDICAL ARTS SURGICAL CENTER	S	MIAMI
8217	MEDICAL PARTNERS SURGERY CTR	S	JACKSONVILLE
8219	BERAJA CLIN LASER AND SURGER CTR	T	CORAL GABLES
8220	WATERS EDGE SURGERY CENTER	S	STUART
8221	ORLANDO SURGERY CTR LTD	S	ORLANDO
8222	SEVEN RIVERS COMMUNITY HOSPITAL ASC	S	CRYSTAL RIVER
8223	DIGESTIVE DISEASE ASSOCIATES	S	CLEARWATER
8224	SURGERY CTR OF NORTH FL INC	S	GAINESVILLE
8227	HERNANDO ENDOSCOPY AND SURGERY CTR	S	BROOKSVILLE
8228	LEAGUE AGAINST CANCER INC	S	MIAMI
8229	ST LUCIE SURGERY CENTER	S	PORT ST LUCIE
8230	SURGERY CENTER OF STUART	S	STUART
8231	HEALTHSOUTH CRESTVIEW SURGERY CTR	S	XX
8234	NORTH FLORIDA SURGERY CTR LAKE CITY	T	LAKE CITY
8236	BEVERLY HILLS SURGERY CENTER, INC	S	BEVERLY HILLS
8237	LASER AND SURG CTR THE PALM BEACHES	S	PALM BEACH GARDENS
8239	SURGERY CENTER OF MELBOURNE	S	MELBOURNE
8240	PLASTIC SURGERY CENTER OF LAKE CTY	S	TAVARES
8241	SOUTHERN SURGERY CENTER	S	LAKE CITY
8242	RIVERWALK AMBULATORY SURGERY CENTER	S	FT MYERS
8243	SURGERY CENTER OF SARASOTA	S	SARASOTA
8244	THE PALMETTO SURGERY CENTER	S	HIALEAH
8245	HEALTH CENTRAL SURGERY CENTER	S	OCOEE
8246	LAKESIDE SURGERY CENTER	T	ORLANDO
8247	ST AUGUSTINE SURGERY CENTER	T	SAINT AUGUSTINE
8249	WINTER HAVEN AMB SURGICAL CENTER	T	WINTER HAVEN
8250	PHYSICIANS DAY SURGERY CENTER INC	T	NAPLES
8251	CITRUS UROLOGY CENTER INC	S	LECANTO
8252	FLORIDA COASTAL SURGERY CENTER	S	NAPLES
8253	INTERVENTIONAL THERAPEUTICS INC	S	PENSACOLA

APPENDIX A – SURGICAL CENTERS – FCDS FACILITY NUMBER ORDER

FACILITY	SURGERY CENTER NAME	OPTION	CITY
8254	OUTPATIENT PLASTIC SURGERY CENTER	S	PALM SPRINGS
8255	MNH SURGICAL CENTER INC	T	MAITLAND
8256	ROSATO PLASTIC SURGERY CENTER	S	VERO BEACH
8257	MORTON PLANT BARDMOOR SURG CTR	S	LARGO
8258	MAYO CLINIC JACKSONVILLE ASC FOR GI	S	JACKSONVILLE
8259	SURGERY CENTER OF CORAL GABLES LLC	S	CORAL GABLES
8260	SURGIKID OF FLORIDA INC	S	TAMPA
8261	OUTPATIENT SURGERY CENTER OF BOCA	S	BOCA RATON
8262	MIAMI HAND CENTER	S	MIAMI
8263	SOUTHEASTERN SURGERY CENTER	T	TALLAHASSEE
8264	LAKE WORTH SURGICAL CENTER	S	LAKE WORTH
8265	UNIVERSITY EYE SURGERY CENTER	S	FORT MYERS
8266	SURGERY CENTER OF OKEECHOBEE INC	T	OKEECHOBEE
8268	PHYSICIANS OUTPATIENT SURGERY CTR	T	FT LAUDERDALE
8269	MELBOURNE SAME DAY SURGERY	S	MELBOURNE
8270	NORTH FLORIDA ENDOSCOPY CENTER	S	GAINESVILLE
8271	CORAL SPRINGS SURGICAL CENTER	T	CORAL SPRINGS
8272	JACKSONVILLE CENTER FOR ENDOSCOPY	T	JACKSONVILLE
8274	WESTON OUTPATIENT SURGICAL CENTER	S	WESTON
8275	FLORIDA ENDOSCOPY SURGERY CENTER	S	BROOKSVILLE
8276	ORTHOPAEDIC SURGERY CENTER	S	GAINESVILLE
8277	GULF COAST ENDOSCOPY CENTER SOUTH	S	FORT MYERS
8278	SURGERY CENTER OF WESTON	S	WESTON
8279	C MED INC	S	CLEARWATER
8280	SURGERY CENTER OF FT LAUDERDALE	S	LAUDERDALE LAKES
8281	TOTAL EYE CARE SURGERY CENTER INC	S	LEESBURG
8282	ARMENIA SURGERY CENTER	S	TAMPA
8283	SUNCOAST SURGERY CENTER	T	FORT MYERS
8284	THE LASER AND SURGERY CENTER	S	PANAMA CITY
8285	BAPTIST MEDICAL PARK ASC LLC	S	PENSACOLA
8286	MANATEE SURGICAL CENTER INC	S	BRADENTON
8287	SARASOTA PLASTIC SURGERY CENTER INC	S	SARASOTA
8288	ST LUCIE SURGICAL CENTER	S	FORT PIERCE
8289	LASER AND SURGICAL SVCS	S	SARASOTA
8290	SUNCOAST ENDOSCOPY CENTER	T	IVERNESS
8291	DIGESTIVE DISEASE ENDOSCOPY CENTER	T	TAMARAC
8292	BAYVIEW SURGERY CENTER	S	SARASOTA
8293	COASTAL MEDICAL CENTER	S	SARASOTA
8294	SUMMERLIN BEND SURGERY CENTER LLP	T	FORT MYERS
8295	GULF COAST ENDOSCOPY CTR OF VENICE	S	VENICE
8296	BONITA COMMUNITY HEALTH CENTER	T	BONITA SPRINGS
8297	ENDOSCOPY SURGERY OUTPATIENT CTR	T	LADY LAKE

APPENDIX A – SURGICAL CENTERS – FCDS FACILITY NUMBER ORDER

FACILITY	SURGERY CENTER NAME	OPTION	CITY
8298	JACKSONVILLE BEACH SURGERY CENTER	T	JACKSONVILLE BEACH
8299	CENTER FOR GASTROINTESTINAL	T	WEST PALM BEACH
8300	SURGERY CTR OF SW FLORIDA INC	S	FORT MYERS
8301	NORTH MIAMI BEACH SURGICAL CENTER	S	MIAMI
8302	WATERSIDE AMB SURGICAL CTR INC	T	WEST PALM BEACH
8303	FL MEDICAL CLINIC PA AMB SUR CTR	T	TAMPA
8304	SURGICAL CENTER FOR EXCELLENCE	S	PANAMA CITY
8305	CITRUS SURGICAL CENTER	S	ORLANDO
8306	MELBOURNE GI CENTER	S	MELBOURNE
8307	CHARLOTTE ENDOSCOPY SURGERY CENTER	T	PORT CHARLOTTE
8308	COLLIER ENDOSCOPY AND SURGERY CTR	S	NAPLES
8309	THE GABLES SURGICAL CENTER	S	MIAMI
8310	FL ORTHOPEDIC INSTITUTE SURGERY CTR	T	TEMPLE TERRACE
8311	MEDICAL SPECIALTY PROCEDURES	T	VERO BEACH
8312	VERO BEACH SURGERY CTR, LLC	S	VERO BEACH
8313	LASER AND SURGERY CENTER	S	OCALA
8314	PADDOCK PARK SURGERY CENTER	S	OCALA
8315	DESTIN SURGERY CENTER	S	DESTIN
8316	CENTER FOR DIGESTIVE ENDOSCOPY	S	ORLANDO
8317	KISSIMMEE ENDOSCOPY CENTER	S	KISSIMMEE
8318	JUPITER OUTPATIENT SURGERY CTR	T	JUPITER
8319	PALMS WELLINGTON SURGICAL CENTER	T	ROYAL PALM BEACH
8321	WEST COAST ENDOSCOPY CTR	S	CLEARWATER
8322	NORTH PINEALLAS SURGERY CENTER	S	DENEDIN
8323	ST MICHAEL'S SURGERY CTR	S	LARGO
8324	ADVANCED AMBULATORY SURGERY CENTER	S	ALTAMONTE SPRINGS
8325	NATURE COAST REG. SURGERY CENTER	S	PERRY
8326	SURGERY CTR AT POINT WEST	S	BRADENTON
8327	OLD MOULTRIE SURG CTR INC	T	ST AUGUSTINE
8328	PROMENADES SURGERY CENTER LC	S	PORT CHARLOTTE
8329	PALM ENDOSCOPY CTR INC	S	ALTAMONTE SPRINGS
8330	GLADIOLUS SURGERY CENTER	T	FT MYERS
8331	ORLANDO OPHTHALMOLOGY SURG CTR LLC	T	ORLANDO
8332	SUNCOAST ENDOSCOPY OF SARASOTA LLC	S	SARASOTA
8333	KENDALL ENDOSCOPY AND SURGERY CTR	T	MIAMI
8334	GROVE PLACE SURGERY CENTER LLC	S	VERO BEACH
8335	HEALTHSOUTH SURG CTR OF AVENTURA	T	AVENTURA
8336	GABLES SURGERY CENTER	T	MIAMI
8337	SURGERY CENTER OFVOLUSIA LLC	T	PORT ORANGE
8338	SURGICAL CTR OF THE TREASURE COAST	T	PORT ST LUCIE
8339	JAX CTR FOR ENDOSCOPY SOUTHSIDE	T	JACKSONVILLE
8340	PONTE VEDRA AMBULATORY SURG CTR	S	PONTE VEDRA BCH

APPENDIX A – SURGICAL CENTERS – FCDS FACILITY NUMBER ORDER

FACILITY	SURGERY CENTER NAME	OPTION	CITY
8341	TAMPA BAY SPECIALITY SURGICAL CTR	T	PINELLAS PARK
8342	CENTER FOR ENDOSCOPY	T	SARASOTA
8343	TAMPA BAY REGIONAL SURG CTR	S	LARGO
8344	INTERCOASTAL MED GRP AMB SURG CTR	S	SARASOTA
8345	LASER AND SURG CTR OF THE PALM BCH	T	WEST PALM BEACH
8346	SPECIALISTS IN UROLOGY SURG CTR LLC	S	NAPLES
8347	PANAMA CITY SURGERY CENTER	T	PANAMA CITY
8348	LIVE OAK ENDOSCOPY CTR LLC	T	VERO BEACH
8350	LARGO AMBULATORY SURG CTR	S	LARGO
8351	SOUTH TAMPA SURGERY CENTER	S	TAMPA
8352	PALM SURGERY CENTER LLC	S	W PALM BEACH
8354	SURGERY ENDOSCOPY CENTER LLC	S	SEBRING
8355	SURGERY CENTER SACRED HEART MED PK	S	DESTIN
8356	MARION ENDOSCOPY AND SURG INST	S	OCALA
8357	BAYSIDE AMBULATORY CENTER	S	MIAMI
8358	PONTE VEDRA SURGERY CENTER	S	PONTE VEDRA BCH
8359	SURGERY CENTER AT JENSEN BEACH LLC	T	JENSEN BEACH
8360	ATLANTIS OUTPATIENT CENTER LLC	S	LAKE WORTH
8361	SOUTH LAKE HOSPITAL SURGERY CENTER	T	CLERMONT
8362	ST ANTHONY PHYSICIANS SURGERY CTR	S	ST PETERSBERG
8363	TWIN LAKES SURGERY CENTER	T	DAYTONA BCH
8364	SURGERY CENTER AT WELLINGTON	S	W PALM BEACH
8365	LAKE MARY SURGERY CENTER	S	LAKE MARY
8366	VILLAGES ENDOSCOPY & SURGICAL CTR	S	SUMMERFIELD
8367	BAYONET POINT SURG AND ENDO CTR	S	HUDSON
8368	TAMPA BAY SURGERY CTR MIDTOWN	S	TAMPA
8369	WEBSTER SURGICAL CENTER	S	TALLAHASSEE
8370	GULFCOAST SURGERY CENTER INC	S	SARASOTA
8371	CLAY SURGERY CENTER	S	ORANGE PARK
8372	MIAMI SURGERY CENTER	S	MIAMI
8373	EYE SURGERY CENTER OF ST AUGUSTINE	S	ST AUGUSTINE
8374	S FLORIDA AMBULATORY SURGICAL CTR	S	MIAMI
8375	PARK PLACE SURGERY CENTER LLC	S	MAITLAND
8376	MILLENIA SURGERY CENTER LLC	S	ORLANDO
8377	PEDIATRIC SURGERY CENTERS LLC	S	TAMPA
8378	SEVEN HILLS SURGERY CENTER	T	TALLAHASSEE
8379	EYE SURGERY & LASER CTR OF SEBRING	S	SEBRING
8380	DOCTORS OUTPATIENT SURGERY CTR	T	NAPLES
8381	MEDICAL ARTS SURGERY CTR OF S MIAMI	S	MIAMI
8382	TAMPA BAY ENDOSCOPY CENTER	S	TAMPA
8383	SURGERY CTR OF LAKELAND HILLS BLVD	S	XXX
8384	PT ORANGE ENDOSCOPY & SURGERY CTR	T	PORT ORANGE

APPENDIX A – SURGICAL CENTERS – FCDS FACILITY NUMBER ORDER

FACILITY	SURGERY CENTER NAME	OPTION	CITY
8385	SPACE COAST ENDOSCOPY CENTER	T	ROCKLEDGE
8386	SOUTH BROWARD ENDOSCOPY CENTER	S	HOLLYWOOD
8387	GRIFFIN ROAD CAMPUS OF LSDC LLP	S	LAKELAND
8388	ALLIANCE SURGICAL CENTER	S	LAKE MARY
8389	OUTPATIENT CENTER OF DELRAY	T	DELRAY BEACH
8390	CAPE CORAL ENDOSCOPY AND SURGERY	S	CAPE CORAL
8391	ORTHOPEDIC SURG CTR OF CLEARWATER	S	CLEARWATER
8392	SARASOTA AMBULATORY SURG CTR LTD	S	SARASOTA
8393	CLERMONT AMULATORY SURG CTR LLLP	S	CLERMONT
8394	OUTPATIENT SURG CTR OF ST AUGUSTINE	S	ST AUGUSTINE
8395	EYE INSTITUTE SURGERY CENTER LLC	S	MELBOURNE
8396	BRANDON AMBULATORY SURGERY CENTER	S	BRANDON
8397	DAY SURGERY CENTER	S	WINTER HAVEN
8398	COASTAL SURGERY CENTER LLC	S	JACKSONVILLE
8399	PALMS WEST SURGICENTER	S	LOXAHATCHEE
8400	GULF POINTE SURGERY CENTER	T	PORT CHARLOTTE
8401	SOUTH PALM AMBULATORY SURGERY CTR	T	BOCA RATON
8402	RIVERWALK ENDOSCOPY CENTER LLC	S	FT MYERS
8403	MURDOCK AMBULATORY SURGERY CENTER	S	PT CHARLOTTE
8404	GULF BREEZE ENDOSCOPY	S	GULF BREEZE
8405	COURTENAY SAME DAY SURGERY CENTER	T	MERRITT ISLAND
8406	ST PETERSBURG ENDOSCOPY CENTER LLC	S	ST PETERSBURG
8407	CENTRAL FL ENDOSCOPY AND SURG INST	S	OCALA
8408	NAPLES EYE SURGERY CENTER, LLC	S	NAPLES
8409	HALLANDALE OUTPATIENT SURGICAL CTR	S	HALLANDALE
8410	ADVANCED EYE SURGERY CENTER	S	VERO BEACH
8411	SOUTHPOINT SURGERY CENTER LLC	S	JACKSONVILLE
8412	PARKCREEK SURGERY CENTER	T	COCONUT CREEK
8413	TOMOKA SURGERY CENTER LLC	S	ORMOND BEACH
8414	LASER & OUTPATIENT SURGERY CENTER	S	GAINESVILLE
8415	MIAMI LAKES SURGERY CENTER, LTD	T	MIAMI LAKES
8416	BASCOM PALMER SURGERY CENTER	S	PALM BEACH GARDENS
8417	SOUTH COUNTY OUTPATIENT SURGERY CTR	S	DELRAY BEACH
8418	HALLANDALE OUTPATIENT SURGICAL CTR	S	ZEPHYRHILLS
8419	CTR OF SURGICAL EXCELLENCE VENICE	S	VENICE
8420	NEW TAMPA SURGERY CENTER	S	WESLEY CHAPEL
8421	AMBULATORY SURG CTR OF BOCA RATON	S	BOCA RATON
8422	PASADENA SURGERY CENTER	S	SAINT PETERSBURG
8423	BAY AREA PHYSICIANS SURGERY CENTER	S	RIVERVIEW
8424	FLEMING ISLAND SURGERY CENTER	T	FLEMING ISLAND
8425	ST MARK'S SURGICAL CENTER, LLC	S	FORT MYERS
8426	ANDREWS INSTITUTE ASC LLC	S	GULF BREEZE

APPENDIX A – SURGICAL CENTERS – FCDS FACILITY NUMBER ORDER

FACILITY	SURGERY CENTER NAME	OPTION	CITY
8427	SPECIALISTS IN UROLOGY SURGERY CENT	S	BONITA SPRINGS
8428	PACE AMBULATORY SURGERY CENTER	S	PACE
8429	BLUE SPRINGS SURGERY CENTER	S	ORANGE CITY
8430	CAPITAL CITY SURGICAL CENTER LLC	S	TALLAHASSEE
8431	SAND LAKE SURGERY CENTER	S	ORLANDO
8432	PEDIATRIC SURGERY CTR - ODESSA LLC	S	ODESSA
8433	RMG IVF SURGERY CENTER INC	S	TAMPA
8434	PLAZA SURGERY CENTER II	S	JACKSONVILLE
8435	TLC OUTPATIENT SURG AND LASER CTR	S	LADY LAKE
8436	CELEBRATION SURGERY CENTER, LLC.	S	KISSIMMEE
8437	AMELIA ISLAND SURGERY CENTER	S	FERNANDINA BEACH
8438	LAKE ENDOSCOPY CENTER	S	SUMMERFIELD
8439	MICROSPINE SURG CTR DEFUNIAK SPRING	S	DEFUNIAK SPRINGS
8440	SURGICAL SPECIALISTS ASC	S	FORT WALTON BEACH
8441	PREMIER ENDOSCOPY CENTER	S	NAPLES
8442	SURGERY CENTER OF KEY WEST	S	KEY WEST
8443	ORANGE CITY SURGERY CENTER	S	ORANGE CITY
8444	TAKE SHAPE SURGERY CENTER, LLC	S	PLANTATION
8445	PUTNAM AMBULATORY SURGERY CENTER	S	PALATKA
8446	USF HEALTH ENDOSCOPY AND SURG CTR	S	TAMPA
8447	SANCTUARY SURGICAL CENTRE	S	BOCA RATON
8448	CARILLON SURGERY CENTER	S	ST PETERSBURG
8449	PONTE VEDRA BEACH SURGERY CENTER	S	PONTE VEDRA BEACH
8450	CENTER ONE SURGERY CENTER	S	JACKSONVILLE
8451	SURGICARE OF MIRAMAR	S	MIRAMAR
8452	BREVARD SPECIALTY SURGERY CTR, LLC	S	MELBOURNE
8453	PARK CENTER FOR PROCEDURES	S	FORT MYERS
8454	CORAL RIDGE OUTPATIENT CENTER	S	OAKLAND PARK
8455	ADVANCED SURGERY CENTER	S	LAKE WORTH
8456	UNIVERSITY INTERVENTIONAL CENTER	S	PENSACOLA
8457	GULF COMPREHENSIVE SURGERY CENTER	S	ENGLEWOOD
8458	SARASOTA PHYSICANS SURGICAL CENTER	S	SARASOTA
8459	DOWNTOWN SURGERY CENTER	S	ORLANDO
8460	SURGERY CENTER OF THE VILLAGES LLC	S	SUMMERFIELD
8461	SEASCAPE SURGERY CENTER	S	TAMPA
8462	SURGICAL CENTER AT SUN N LAKE LLC	S	SEBRING
8463	RIVERWALK AMBULATORY SURGERY CENTER	S	BRADENTON
8464	TREASURE COAST SURGICAL CENTER	S	FORT PIERCE
8465	SURGERY CTR AT POINTE WEST EAST CTR	S	BRADENTON
8466	SPACE COAST SURGERY CENTER LLLP	S	MERRITT ISLAND
8470	EYE SURGERY CENTER OF NORTH FLORIDA	S	JACKSONVILLE
8471	SURGERY CENTER AT DUVAL	S	DORAL

APPENDIX A – SURGICAL CENTERS – FCDS FACILITY NUMBER ORDER

FACILITY	SURGERY CENTER NAME	OPTION	CITY
8472	CRANE CREEK SURGERY CENTER	S	MELBOURNE
8473	WESTCHASE SURGERY CENTER	S	TAMPA
8474	ATLANTIC SURGERY AND LASER CENTER	S	MELBOURNE
8475	PACAYA BAY SURGERY CENTER	S	FORT MYERS
8476	SURGERY CENTER OF MOUNT DORA	S	MOUNT DORA
8477	CARILLON SURGERY CENTER	S	SAINT PETERSBURG
8478	BROWARD SPECIALTY SURGICAL CENTER	S	HOLLYWOOD
8479	CAPE HEALTH SURGERY CENTER	S	CAPE CORAL
8480	INDIAN RIVER SURGERY CENTER	S	VERO BEACH
8481	KEY BISCAYNE SURGERY CENTER	S	KEY BISCAYNE
8482	GALLOWAY SURGERY CENTER	S	MIAMI
8483	SAFETY HARBOR SURGERY CENTER LLC	S	CLEARWATER
8484	SPEC IN UROLOGY SURG CTR FT MYERS	S	FT MYERS
8485	TITUSVILLE CTR SURGICAL EXCELLENCE	S	TITUSVILLE
8486	SPECIALISTS IN UROLOGY FT. MYERS	S	NAPLES
8487	CTR FOR SPECIALIZED SURG FT MYERS	S	FORT MYERS
8488	RIVERSIDE ENDOSCOPY CENTER LLC	S	JACKSONVILLE
8489	ENDO SURGICAL CENTER OF FLORIDA	S	ORLANDO
8490	GULFSTREAM AMBULATORY SURGERY CTR	S	CORAL SPRINGS
8491	AESTHETIC SURGERY CTR OF WINTER PK	S	WINTER PARK
8492	MAITLAND SURGERY CENTER	S	MAITLAND
8493	SURGERY CENTER OF MID FLORIDA	S	OCALA
8494	SURGICARE OF MIRAMAR	S	MIRAMAR
8495	BLUE WATER SURGERY CENTER	S	PORT SAINT LUCIE
8496	PREMIER SURGICAL CENTER LLC	S	TAVARES
8497	LASER SPINE SURGICAL CENTER	S	TAMPA
8498	APOLLO SURGERY CENTER LLC	S	WEST MELBOURNE
8499	ADVANCE SURGERY CENTER OF SARASOTA	S	SARASOTA
8501	BAPTIST ENDOSCOPY CTR CORAL SPRINGS	S	CORAL SPRINGS
8502	SURGCENTER PINELLAS	S	LARGO
8503	ENDO SURGICAL CTR OF FLORIDA	S	ORLANDO
8504	RED HILLS SURGICAL CENTER	S	TALLAHASSEE
8506	ORLANDO ORTHOPAEDIC OUTPT SURG CTR	S	ORLANDO
8507	EYE SPECIALISTS LASER AND SURG CTR	S	FORT MYERS

APPENDIX A – FREE STANDING RADIATION THERAPY CENTERS – FCDS FACILITY NUMBER ORDER

FACILITY	RADIATION CENTER NAME	OPTION	CITY
7390	N FLORIDA RECEPTION AND MED CTR	R	LAKE BUTLER
8467	SOUTH FL RADIATION ONCO-BOCA RATON	R	BOCA RATON
8468	SFRO AT PORT ST LUCIE	R	PT. ST. LUCIE
8469	RADIOLOGICAL INST OF THE VILLAGES	R	THE VILLAGES
8602	FLORIDA CANCER AFILIATES	R	PANAMA CITY
8603	AMERICAN CANCER TREATMENT CENTER	R	ROCKLEDGE
8604	CANCER CARE CENTERS OF BREVARD	R	MELBOURNE
8605	CANCER CARE CTRS OF MERRITT ISLAND	R	MERRITT ISLAND
8607	RADIATION THERAPY CENTER OF BREVARD	R	ROCKLEDGE
8609	CORAL SPRINGS RTX REGIONAL CENTER	R	CORAL SPRINGS
8610	SOUTH FLORIDA RADIOTHERAPY CTR	R	PLANTATION
8613	CHARLOTTE CO RADIATION THERAPY REG	R	PORT CHARLOTTE
8614	21ST CENTURY ONCOLOGY BEVERLY HILLS	R	BEVERLY HILLS
8616	ROBERT BOISSONEAULT LECANTO	R	LECANTO
8617	21ST CENTURY ONCOLOGY ORANGE PARK	R	ORANGE PARK
8626	FLORIDA CANCER SPECIALISTS	R	SPRING HILL
8627	FLORIDA CANCER AFILIATES	R	BROOKSVILLE
8629	21ST CENTURY ONCOLOGY SEBRING	R	SEBRING
8632	TAMPA BAY RADIATION ONCOLOGY	R	BRANDON
8633	TAMPA BAY RADIATION ONCOLOGY	R	SUN CITY CENTER
8635	INTERCOMMUNITY CANCER CENTER	R	LEESBURG
8637	CAPE CORAL RADIATION THERAPY CENTER	R	CAPE CORAL
8639	RADIATION THERAPY REGIONAL CENTER	R	FT MYERS
8640	21ST CENTURY ONC BRADENTON WEST	R	BRADENTON
8641	21ST CENTURY ONC BRADENTON EAST	R	BRADENTON
8642	ROBERT BOISSONEAULT ASSOC OCALA	R	OCALA
8643	21ST CENTRUY ONC. KEY WEST	R	KEY WEST
8653	PALM BEACH CANCER INSTITUTE	R	WEST PALM BEACH
8654	FLORIDA CANCER AFILIATES	R	HUDSON
8655	FLORIDA CANCER SPECIALISTS	R	NEW PORT RICHEY
8656	FLORIDA CANCER SPECIALISTS	R	ZEPHYRHILLS
8657	FLORIDA CANCER SPECIALISTS	R	HUDSON
8658	PASCO PINELLAS CANCER CENTER	R	HOLIDAY
8663	TAMPA BAY ONCOLOGY CENTER	R	LARGO
8666	21ST CENTURY ONCOLOGY PALATKA	R	PALATKA
8668	PORTER RADIATION ONCOLOGY SARASOTA	R	SARASOTA
8669	PORTER RADIATION ONCOLOGY VENICE	R	VENICE
8671	21ST CENTURY ONC ST. AUGUSTINE	R	ST AUGUSTINE
8672	NORTH COLLIER REG RADATION CENTER	R	NAPLES
8675	PORTER RADIATION ONCOLOGY ENGLEWOOD	R	ENGLEWOOD
8676	ROBERTBOISSONEAULT ONC INST TIMER	R	OCALA
8680	SARASOTA RAD THERAPY REG CTR	R	SARASOTA

APPENDIX A – FREE STANDING RADIATION THERAPY CENTERS – FCDS FACILITY NUMBER ORDER

FACILITY	RADIATION CENTER NAME	OPTION	CITY
8682	CANCER CARE CENTER OF SEBASTIAN	R	SEBASTIAN
8683	RAD THER CTR OF BREVARD TITUSVILLE	R	ROCKLEDGE
8685	AMERICAN CANC TREATMENT TITUSVILLE	R	TITUSVILLE
8687	21ST CENTURY ONC JACKSONVILLE BEACH	R	JACKSONVILLE BEACH
8691	ACKERMAN CANCER ONCOLOGY	R	JACKSONVILLE
8693	HYDE PARK CANCER CENTER TAMPA	R	TAMPA
8694	PLANT CITY CANCER TREATMENT CTR	R	PLANT CITY
8696	CAPITAL CANCER CENTER	R	TALLAHASSEE
8698	BIG LAKE CANCER CENTER	R	OKEECHOBEE
8699	MID FLORIDA RADIATION ONCOLOGY ASSO	R	FORT PIERCE
8701	ACKERMAN CANCER CENTER	R	FERNANDINA BEACH
8702	WATSON CLINIC LLP	R	LAKELAND
8703	BARDMOOR CANCER CENTER	R	LARGO
8704	ROBERT BOISSONEAULT ONC INST	R	VILLAGES
8705	OSCEOLA CANCER CENTER	R	KISSIMMEE
8706	S FL RADIATION ONCOLOGY BOCA WEST	R	BOCA RATON
8707	21ST CENTURY ONCOLOGY OCALA	R	OCALA
8709	LAKELAND REGIONAL CANCER CENTER	R	LAKELAND
8710	DATTOLI CANCER CENTER	R	SARASOTA
8711	CENTRAL FL CANCER INST	R	DAVENPORT
8712	FORT WALTON BEACH RADIATION CTR	R	FORT WALTON BEACH
8713	COMMUNITY CANCER CTR OF NORTH FL	R	GAINESVILLE
8715	21ST CENTURY ONC BONITA SPRINGS	R	BONITA SPRINGS
8718	21ST CENTURY ONC LEHIGH ACRES	R	LEHIGH ACRES
8719	21ST CENTURY ONCOLOGY JACKSONVILLE	R	JACKSONVILLE
8720	HEALTH FIRST CANCER SVCS MELBOURNE	R	MELBOURNE
8721	21ST CENTURY ONCOLOGY CRO	R	CRESTVIEW
8722	21ST CENTURY ONCOLOGY DESTIN	R	SANTA ROSA BEACH
8723	COUNTRYSIDE CANCER CENTER	R	CLEARWATER
8724	BAY REGIONAL CANCER CENTER	R	PANAMA CITY
8725	TAMPA BAY RADIATION ONCOLOGY	R	TAMPA
8726	DORAL ONCOLOGY CENTER	R	MIAMI
8727	WATSON CLINIC CANCER & RESEARCH CTR	R	LAKELAND
8730	CANCER CARE CTR OF BREVARD WUESTOFF	R	MELBOURNE
8733	COMMUNITY CANCER CTR OF LAKE CITY	R	LAKE CITY
8736	BOYNTON BEACH RADIATION ONCOLOGY	R	BOYNTON BEACH
8738	CYBERKNIFE CENTER OF MIAMI	R	MIAMI
8739	SFRO AT HOLLYWOOD	R	HOLLYWOOD
8741	CENTRAL FLORIDA CANCER INSTITUTE	R	LAKE WALES
8745	P BCH CANCER INST CTR RAD THERAPY	R	WEST PALM BEACH
8747	SOUTH FLORIDA RADIATION ONCOLOGY	R	PALM BEACH GARDENS
8748	21ST CENTURY ONCOLOGY AVENTURA	R	AVENTURA

APPENDIX A – FREE STANDING RADIATION THERAPY CENTERS – FCDS FACILITY NUMBER ORDER

FACILITY	RADIATION CENTER NAME	OPTION	CITY
8750	21ST CENTURY ONCOLOGY	R	NAPLES
8752	21ST CENTURY ONCOLOGY JACKSONVILLE	R	JACKSONVILLE
8753	AVENTURA COMPREHENSIVE CANCER CTR	R	AVENTURA
8755	INTERCOMMUNITY CANCER INSTITUTE	R	CLERMONT
8756	INTERCOMMUNITY CANCER CTR LADY LAKE	R	LADY LAKE
8757	21ST CENTURY ONC LAKEWOOD RANCH	R	BRADENTON
8758	SFRO AT FORT PIERCE	R	FT PIERCE
8759	NEW MILLENNIUM CYBERKNIFE	R	BRANDON
8760	CYBERKNIFE CENTER OF TAMPA BAY	R	TAMPA
8761	CENTRAL FLORIDA CANCER INSTITUTE	R	WINTER HAVEN
8762	UROLOGY SPECIALIST OF WEST FLORIDA	R	CLEARWATER
8763	21ST CENTURY ONC LEE CANCER CTR	R	FORT MYERS
8766	21ST CENTURY ONCOLOGY	R	NAPLES
8767	N FL CANCER CTR LAKE CITY LLC	R	LAKE CITY
8768	WELLSPRING ONCOLOGY	R	PINELLAS PARK
8769	SAND LAKE CANCER CENTER	R	ORLANDO
8770	SFRO AT COCONUT CREEK	R	COCONUT CREEK
8773	SFRO VERO BEACH	R	VERO BEACH
8774	TERK ONCOLOGY SOUTH POINT CANCER CT	R	JACKSONVILLE
8775	TAMPA BAY RADIATION ONCOLOGY, PA	R	TAMPA
8776	21ST CENTURY ONC - PEMBROKE PINES	R	PEMBROKE PINES
8777	S FL RADIATION ONC AT PALOMINO PARK	R	WELLINGTON
8778	S FL RADIATION ONC AT STUART	R	STUART
8780	SOUTH FLORIDA RADIATION ONC JUPITER	R	JUPITER
8781	LAKWOOD RANCH ONCOLOGY CENTER	R	BRADENTON
8782	21ST CENTURY ONC BROWARD GENERAL	R	FT. LAUDERDALE
8783	21ST CENTURY ONC NORTH BROWARD HOSP	R	DEERFIELD BEACH
8784	UNIV OF FL PROTON THERAPY INST	R	JACKSONVILLE
8785	FLORIDA CANCER AFFILIATES	R	NEW PORT RICHEY
8786	ADVANCE PROSTATE CANCER INSTITUTE	R	OXFORD
8789	SPECIALISTS IN UROLOGY - NAPLES	R	NAPLES
8790	WINTER PARK CANCER CENTER	R	WINTER PARK
8792	SFRO AT LITTLE HAVANA	R	MIAMI
8793	SFRO AT BETHESDA HEALTH CITY	R	BOYNTON BEACH
8794	SFRO AT FLORIDA MEDICAL CENTER	R	LAUDERDALE LAKES
8795	SFRO AT WELLINGTON MED. CTR	R	WELLINGTON
8796	SPACE COAST MEDICAL ASSOCIATES LLP	R	TITUSVILLE
8797	SPACE COAST MEDICAL ASSOCIATES LLP	R	VIERA
8798	INNOVATIVE CANCER INSTITUTE, LLC	R	MIAMI
8799	SFRO AT PALMETTO GENERAL	R	HIALEAH
8800	SFRO AT JACKSON SOUTH	R	MIAMI
8801	CLERMONT ONCOLOGY CENTER LLC	R	CLERMONT

APPENDIX A – FREE STANDING RADIATION THERAPY CENTERS – FCDS FACILITY NUMBER ORDER

FACILITY	RADIATION CENTER NAME	OPTION	CITY
8802	SFRO AT GOOD SAMARITAN WPB	R	WEST PALM BEACH
8803	SFM KENDALL	R	MIAMI
8804	FL CANCER SPECIALIST, TAMPA CTR	R	TAMPA
8805	FL CANCER SPECIALIST, LARGO CTR	R	LARGO
9940	WOODLANDS MEDICAL SPECIALISTS	R	PENSACOLA

APPENDIX B

UPDATED - International Organization for Standardization (ISO) Country Codes

United States Postal Service (USPS) State Abbreviation Codes

United States Territory and Possessions Abbreviation Codes

Canadian Province and Territory Abbreviation Codes

Florida Federal Information Processing Standards (FIPS) County Codes

APPENDIX B
International Organization for Standardization (ISO) Country Codes – Code Order

Code	Label
ABW	Aruba
AFG	Afghanistan
AGO	Angola
AGO	Cabinda
AGO	Principe
AIA	Anguilla
ALA	Aland Islands
ALB	Albania
AND	Andorra
ARE	United Arab Emirates
ARG	Argentina
ARM	Armenia
ASM	American Samoa
ASM	Samoa, American
ATA	Antarctica
ATF	French Southern Territories
ATG	Antigua and Barbuda
ATG	Barbuda
AUS	Australia
AUS	Australian New Guinea
AUT	Austria
AZE	Azerbaijan
BDI	Burundi
BDI	Urundi
BEL	Belgium
BEN	Benin
BES	Bonaire, Saint Eustatius and Saba
BES	Saba
BES	Saint Eustatius
BES	St. Eustatius
BFA	Burkina Faso
BGD	Bangladesh
BGD	East Pakistan
BGR	Bulgaria
BHR	Bahrain
BHS	Bahamas
BIH	Bosnia and Herzegovina
BIH	Herzegovina
BLM	St. Barthelemy
BLR	Belarus

APPENDIX B
International Organization for Standardization (ISO) Country Codes – Code Order

Code	Label
BLR	Byelorus
BLR	Byelorussian S.S.R.
BLR	Russia, White
BLR	White Russia
BLZ	Belize
BLZ	British Honduras
BLZ	Honduras, British
BMU	Bermuda
BND	Brunei Darussalam
BOL	Bolivia
BRA	Brazil
BRB	Barbados
BRN	Brunei
BTN	Bhutan
BVT	Bouvet Island
BWA	Botswana
CAF	Central African Republic
CAN	Canada
CCK	Cocos (Keeling) Islands
CCK	Keeling Islands
CHE	Switzerland
CHL	Chile
CHN	China
CHN	China, Peoples Republic of
CHN	Peoples Republic of China
CHN	Tibet
CIV	Cote d'Ivoire
CIV	Ivory Coast
CMR	Cameroon
COD	Congo, Democratic Republic of
COD	Zaire
COG	Congo
COK	Cook Islands
COL	Colombia
COM	Comoros
CPV	Cape Verde
CRI	Costa Rica
CSK	Czechoslovakia (former) [Pre-2013 cases only]
CUB	Cuba
CUW	Curacao

APPENDIX B
International Organization for Standardization (ISO) Country Codes – Code Order

Code	Label
CXR	Christmas Island
CYM	Cayman Islands
CYP	Cyprus
CZE	Czech Republic
DEU	Germany
DJI	Djibouti
DMA	Dominica
DNK	Denmark
DOM	Dominican Republic
DZA	Algeria
ECU	Ecuador
EGY	Egypt
ENG	England
ERI	Eritrea
ESH	Sahara, Western
ESH	Western Sahara
ESP	Balearic Islands
ESP	Canary Islands
ESP	Spain
EST	Estonia
ETH	Ethiopia
FIN	Finland
FJI	Fiji
FLK	Falkland Islands
FLK	Malvinas
FRA	Corsica
FRA	France
FRO	Faroe Islands
FSM	Federated States of Micronesia
FSM	Micronesia, Federated States of
FSM	Micronesia, NOS
GAB	Gabon
GBR	Great Britain
GBR	United Kingdom
GEO	Georgia [country]
GGY	Guernsey
GHA	Ghana
GIB	Gibraltar
GIN	Guinea
GLP	Guadeloupe

APPENDIX B
International Organization for Standardization (ISO) Country Codes – Code Order

Code	Label
GMB	Gambia
GNB	Guinea Bissau
GNQ	Equatorial Guinea
GNQ	Guinea, Equatorial
GRC	Greece
GRD	Grenada
GRL	Greenland
GTM	Guatemala
GUF	French Guiana
GUF	Guiana, French
GUM	Guam
GUY	British Guiana
GUY	Guiana, British
GUY	Guyana
HKG	Hong Kong
HMD	Heard Island and McDonald Islands
HND	Honduras
HRV	Croatia
HTI	Haiti
HUN	Hungary
IDN	Indonesia
IMN	Isle of Man
IND	India
IND	Sikkim
IOT	British Indian Ocean Territory
IRL	Eire
IRL	Ireland
IRL	Ireland, Republic of
IRN	Iran
IRQ	Iraq
ISL	Iceland
ISR	Israel
ITA	Italy
JAM	Jamaica
JEY	Jersey
JOR	Jordan
JPN	Japan
JPN	Nampo-Shoto, Southern
JPN	Ryukyu Islands
KAZ	Kazakhstan

APPENDIX B
International Organization for Standardization (ISO) Country Codes – Code Order

Code	Label
KEN	Kenya
KGZ	Kyrgyzstan
KHM	Cambodia
KIR	Gilbert Islands
KIR	Kiribati
KIR	Line Islands, Southern
KIR	Southern Line Islands
KNA	St. Kitts and Nevis
KOR	Korea, NOS
KOR	Korea, South
KOR	South Korea
KWT	Kuwait
LAO	Laos
LBN	Lebanon
LBR	Liberia
LBY	Libya
LCA	St. Lucia
LIE	Liechtenstein
LKA	Ceylon
LKA	Sri Lanka
LSO	Lesotho
LTU	Lithuania
LUX	Luxembourg
LVA	Latvia
MAC	Macao
MAC	Macau
MAF	Saint-Martin
MAF	St. Martin
MAR	Morocco
MCO	Monaco
MDA	Moldova
MDG	Madagascar
MDG	Malagasy Republic
MDV	Maldives
MEX	Mexico
MHL	Marshall Islands
MKD	Macedonia
MLI	Mali
MLT	Malta
MMR	Burma

APPENDIX B
International Organization for Standardization (ISO) Country Codes – Code Order

Code	Label
MMR	Myanmar
MNE	Montenegro
MNG	Mongolia
MNP	Mariana Islands, Northern
MNP	Northern Mariana Islands
MOZ	Mozambique
MRT	Mauritania
MSR	Montserrat
MTQ	Martinique
MUS	Mauritius
MWI	Malawi
MWI	Nyasaland
MYS	Malaysia
MYT	Mayotte
NAM	Namibia
NCL	New Caledonia
NER	Niger
NFK	Norfolk Island
NGA	Nigeria
NIC	Nicaragua
NIR	Ireland, Northern
NIR	Northern Ireland
NIR	Ulster
NIU	Niue
NLD	Netherlands
NOR	Norway
NPL	Nepal
NRU	Nauru
NZL	New Zealand
OMN	Oman
PAK	Pakistan
PAK	West Pakistan
PAN	Canal Zone
PAN	Panama
PCN	Pitcairn Islands
PER	Peru
PHL	Philippines
PLW	Palau
PNG	Papua New Guinea
POL	Poland

APPENDIX B
International Organization for Standardization (ISO) Country Codes – Code Order

Code	Label
PRI	Puerto Rico
PRK	Korea, North
PRK	North Korea
PRT	Azores
PRT	Madeira Islands
PRT	Portugal
PRY	Paraguay
PSE	Occupied Palestine Territory
PSE	Palestine Territory, Occupied
PYF	French Polynesia
PYF	Polynesia, French
QAT	Qatar
REU	Réunion
ROU	Romania
RUS	Russia
RWA	Ruanda
RWA	Rwanda
SAU	Saudi Arabia
SCT	Scotland
SDN	Sudan
SEN	Senegal
SGP	Singapore
SGS	South Georgia and the South Sandwich Islands
SHN	St. Helena
SJM	Svalbard and Jan Mayen
SLB	Solomon Islands
SLE	Sierra Leone
SLV	El Salvador
SMR	San Marino
SOM	Somalia
SPM	Miquelon
SPM	St. Pierre and Miquelon
SRB	Serbia
SSD	South Sudan
SSD	Sudan, South
STP	Sao Tome and Principe
SUR	Suriname
SVK	Slovakia
SVN	Slovenia
SWE	Sweden

APPENDIX B
International Organization for Standardization (ISO) Country Codes – Code Order

Code	Label
SWZ	Swaziland
SYC	Seychelles
SYR	Syria
TCA	Caicos Islands
TCA	Turks and Caicos
TCA	Turks Islands
TCD	Chad
TGO	Togo
THA	Thailand
TJK	Tajikistan
TKL	Tokelau
TKM	Turkmenistan
TLS	East Timor
TLS	Timor, East
TLS	Timor-Leste
TON	Tonga
TTO	Tobago
TTO	Trinidad and Tobago
TUN	Tunisia
TUR	Turkey
TUV	Ellice Islands
TUV	Tuvalu
TWN	China, Republic of (Taiwan)
TWN	Republic of China (Taiwan)
TWN	Taiwan
TZA	Tanzania
UGA	Uganda
UKR	Ukraine
UMI	Johnston Atoll
UMI	Midway Islands
UMI	Swan Islands
UMI	U.S. Minor Outlying Islands
UMI	Wake Island
URY	Uruguay
USA	Armed Forces Americas
USA	Armed Forces Canada, Europe, Middle East, Africa
USA	Armed Forces Pacific
USA	United States
UZB	Uzbekistan
VAT	Vatican City

APPENDIX B
International Organization for Standardization (ISO) Country Codes – Code Order

Code	Label
VCT	Grenadines
VCT	St. Vincent and the Grenadines
VEN	Venezuela
VGB	British Virgin Islands
VGB	Virgin Islands, British
VIR	U.S. Virgin Islands
VIR	Virgin Islands, U.S.
VNM	Vietnam
VUT	Vanuatu
WLF	Wallis and Futuna
WLS	Wales
WSM	Samoa
WSM	Samoa, Western
XAP	Arabian Peninsula [Pre-2013 cases only]
XCB	Other Caribbean Islands [Pre-2013 cases only]
XCH	China, NOS [Pre-2013 cases only]
XCR	Caucasian Republics of the USSR [Pre-2013 cases only]
XCZ	Czechoslovakia (former) [Pre-2013 cases only]
XEF	East Africa [Pre-2013 cases only]
XEN	England, Channel Islands, Isle of Man [Pre-2013 cases only]
XET	Ethiopia (Abyssinia), Eritrea [Pre-2013 cases only]
XGR	Germanic Countries [Pre-2013 cases only]
XIF	African Coastal Islands (prev. in South Africa, NOS) [Pre-2013 cases only]
XIS	Israel and former Jewish Palestine [Pre-2013 cases only]
XMC	Micronesian Islands [Pre-2013 cases only]
XML	Melanesian Islands, Solomon Islands [Pre-2013 cases only]
XMS	Malaysia, Singapore, Brunei [Pre-2013 cases only]
XNF	North Africa [Pre-2013 cases only]
XNI	North American Islands [Pre-2013 cases only]
XOR	Other Asian Republics of the USSR [Pre-2013 cases only]
XPL	Polynesian Islands [Pre-2013 cases only]
XSC	Scandinavia [Pre-2013 cases only]
XSD	Sudanese Countries [Pre-2013 cases only]
XSE	Indochina [Pre-2013 cases only]
XSE	Southeast Asia [Pre-2013 cases only]
XSF	Rep.of South Africa,Botswana Lesotho,Namibia,Swaziland[Pre-2013 cases only]
XSF	South Africa, NOS [Pre-2013 cases only]
XSL	Slavic Countries [Pre-2013 cases only]
XUM	Ukraine and Moldavia [Pre-2013 cases only]
XWF	Other West African Countries [Pre-2013 cases only]

APPENDIX B
International Organization for Standardization (ISO) Country Codes – Code Order

Code	Label
XWF	West Africa, NOS (French Africa, NOS) [Pre-2013 cases only]
YEM	Yemen
YUG	Yugoslavia (former) [Pre-2013 cases only]
ZAF	Republic of South Africa
ZAF	South Africa, Republic of
ZMB	Zambia
ZWE	Zimbabwe
ZZA	Asia, NOS
ZZC	Central America, NOS
ZZE	Europe, NOS
ZZF	Africa, NOS
ZZN	North America, NOS
ZZP	Pacific, NOS
ZZS	South America, NOS
ZZU	Latin America, NOS
ZZU	Unknown
ZZX	Non-U.S./Canada, NOS
ZZX	Not U.S. or Canada, but no other information

APPENDIX B**International Organization for Standardization (ISO) Country Codes – Country Order**

Code	Label
AFG	Afghanistan
ZZF	Africa, NOS
XIF	African Coastal Islands (prev. in South Africa, NOS) [Pre-2013 cases only]
ALA	Aland Islands
ALB	Albania
DZA	Algeria
ASM	American Samoa
AND	Andorra
AGO	Angola
AIA	Anguilla
ATA	Antarctica
ATG	Antigua and Barbuda
XAP	Arabian Peninsula [Pre-2013 cases only]
ARG	Argentina
USA	Armed Forces Americas
USA	Armed Forces Canada, Europe, Middle East, Africa
USA	Armed Forces Pacific
ARM	Armenia
ABW	Aruba
ZZA	Asia, NOS
AUS	Australia
AUS	Australian New Guinea
AUT	Austria
AZE	Azerbaijan
PRT	Azores
BHS	Bahamas
BHR	Bahrain
ESP	Balearic Islands
BGD	Bangladesh
BRB	Barbados
ATG	Barbuda
BLR	Belarus
BEL	Belgium
BLZ	Belize
BEN	Benin
BMU	Bermuda
BTN	Bhutan
BOL	Bolivia
BES	Bonaire, Saint Eustatius and Saba
BIH	Bosnia and Herzegovina

APPENDIX B**International Organization for Standardization (ISO) Country Codes – Country Order**

Code	Label
BWA	Botswana
BVT	Bouvet Island
BRA	Brazil
GUY	British Guiana
BLZ	British Honduras
IOT	British Indian Ocean Territory
VGB	British Virgin Islands
BRN	Brunei
BND	Brunei Darussalam
BGR	Bulgaria
BFA	Burkina Faso
MMR	Burma
BDI	Burundi
BLR	Byelorussia
BLR	Byelorussian S.S.R.
AGO	Cabinda
TCA	Caicos Islands
KHM	Cambodia
CMR	Cameroon
CAN	Canada
PAN	Canal Zone
ESP	Canary Islands
CPV	Cape Verde
XCR	Caucasian Republics of the USSR [Pre-2013 cases only]
CYM	Cayman Islands
CAF	Central African Republic
ZZC	Central America, NOS
LKA	Ceylon
TCD	Chad
CHL	Chile
CHN	China
XCH	China, NOS [Pre-2013 cases only]
CHN	China, Peoples Republic of
TWN	China, Republic of (Taiwan)
CXR	Christmas Island
CCK	Cocos (Keeling) Islands
COL	Colombia
COM	Comoros
COG	Congo
COD	Congo, Democratic Republic of

APPENDIX B**International Organization for Standardization (ISO) Country Codes – Country Order**

Code	Label
COK	Cook Islands
FRA	Corsica
CRI	Costa Rica
CIV	Cote d'Ivoire
HRV	Croatia
CUB	Cuba
CUW	Curacao
CYP	Cyprus
CZE	Czech Republic
CSK	Czechoslovakia (former) [Pre-2013 cases only]
DNK	Denmark
DJI	Djibouti
DMA	Dominica
DOM	Dominican Republic
XEF	East Africa [Pre-2013 cases only]
BGD	East Pakistan
TLS	East Timor
ECU	Ecuador
EGY	Egypt
IRL	Eire
SLV	El Salvador
TUV	Ellice Islands
ENG	England
XEN	England, Channel Islands, Isle of Man [Pre-2013 cases only]
GNQ	Equatorial Guinea
ERI	Eritrea
EST	Estonia
ETH	Ethiopia
XET	Ethiopia (Abyssinia), Eritrea [Pre-2013 cases only]
ZZE	Europe, NOS
FLK	Falkland Islands
FRO	Faroe Islands
FSM	Federated States of Micronesia
FJI	Fiji
FIN	Finland
FRA	France
GUF	French Guiana
PYF	French Polynesia
ATF	French Southern Territories
GAB	Gabon

APPENDIX B**International Organization for Standardization (ISO) Country Codes – Country Order**

Code	Label
GMB	Gambia
GEO	Georgia [country]
XGR	Germanic Countries [Pre-2013 cases only]
DEU	Germany
GHA	Ghana
GIB	Gibraltar
KIR	Gilbert Islands
GBR	Great Britain
GRC	Greece
GRL	Greenland
GRD	Grenada
VCT	Grenadines
GLP	Guadeloupe
GUM	Guam
GTM	Guatemala
GGY	Guernsey
GUY	Guiana, British
GUF	Guiana, French
GIN	Guinea
GNB	Guinea Bissau
GNQ	Guinea, Equatorial
GUY	Guyana
HTI	Haiti
HMD	Heard Island and McDonald Islands
BIH	Herzegovina
HND	Honduras
BLZ	Honduras, British
HKG	Hong Kong
HUN	Hungary
ISL	Iceland
IND	India
XSE	Indochina [Pre-2013 cases only]
IDN	Indonesia
IRN	Iran
IRQ	Iraq
IRL	Ireland
NIR	Ireland, Northern
IRL	Ireland, Republic of
IMN	Isle of Man
ISR	Israel

APPENDIX B**International Organization for Standardization (ISO) Country Codes – Country Order**

Code	Label
XIS	Israel and former Jewish Palestine [Pre-2013 cases only]
ITA	Italy
CIV	Ivory Coast
JAM	Jamaica
JPN	Japan
JEY	Jersey
UMI	Johnston Atoll
JOR	Jordan
KAZ	Kazakhstan
CCK	Keeling Islands
KEN	Kenya
KIR	Kiribati
PRK	Korea, North
KOR	Korea, NOS
KOR	Korea, South
KWT	Kuwait
KGZ	Kyrgyzstan
LAO	Laos
ZZU	Latin America, NOS
LVA	Latvia
LBN	Lebanon
LSO	Lesotho
LBR	Liberia
LBY	Libya
LIE	Liechtenstein
KIR	Line Islands, Southern
LTU	Lithuania
LUX	Luxembourg
MAC	Macao
MAC	Macau
MKD	Macedonia
MDG	Madagascar
PRT	Madeira Islands
MDG	Malagasy Republic
MWI	Malawi
MYS	Malaysia
XMS	Malaysia, Singapore, Brunei [Pre-2013 cases only]
MDV	Maldives
MLI	Mali
MLT	Malta

APPENDIX B**International Organization for Standardization (ISO) Country Codes – Country Order**

Code	Label
FLK	Malvinas
MNP	Mariana Islands, Northern
MHL	Marshall Islands
MTQ	Martinique
MRT	Mauritania
MUS	Mauritius
MYT	Mayotte
XML	Melanesian Islands, Solomon Islands [Pre-2013 cases only]
MEX	Mexico
FSM	Micronesia, Federated States of
FSM	Micronesia, NOS
XMC	Micronesian Islands [Pre-2013 cases only]
UMI	Midway Islands
SPM	Miquelon
MDA	Moldova
MCO	Monaco
MNG	Mongolia
MNE	Montenegro
MSR	Montserrat
MAR	Morocco
MOZ	Mozambique
MMR	Myanmar
NAM	Namibia
JPN	Nampo-Shoto, Southern
NRU	Nauru
NPL	Nepal
NLD	Netherlands
NCL	New Caledonia
NZL	New Zealand
NIC	Nicaragua
NER	Niger
NGA	Nigeria
NIU	Niue
ZZX	Non-U.S./Canada, NOS
NFK	Norfolk Island
XNF	North Africa [Pre-2013 cases only]
ZZN	North America, NOS
XNI	North American Islands [Pre-2013 cases only]
PRK	North Korea
NIR	Northern Ireland

APPENDIX B
International Organization for Standardization (ISO) Country Codes – Country Order

Code	Label
MNP	Northern Mariana Islands
NOR	Norway
ZZX	Not U.S. or Canada, but no other information
MWI	Nyasaland
PSE	Occupied Palestine Territory
OMN	Oman
XOR	Other Asian Republics of the USSR [Pre-2013 cases only]
XCB	Other Caribbean Islands [Pre-2013 cases only]
XWF	Other West African Countries [Pre-2013 cases only]
ZZP	Pacific, NOS
PAK	Pakistan
PLW	Palau
PSE	Palestine Territory, Occupied
PAN	Panama
PNG	Papua New Guinea
PRY	Paraguay
CHN	Peoples Republic of China
PER	Peru
PHL	Philippines
PCN	Pitcairn Islands
POL	Poland
PYF	Polynesia, French
XPL	Polynesian Islands [Pre-2013 cases only]
PRT	Portugal
AGO	Principe
PRI	Puerto Rico
QAT	Qatar
XSF	Rep.of South Africa,Botswana Lesotho,Namibia,Swaziland[Pre-2013 cases only]
TWN	Republic of China (Taiwan)
ZAF	Republic of South Africa
REU	Réunion
ROU	Romania
RWA	Ruanda
RUS	Russia
BLR	Russia, White
RWA	Rwanda
JPN	Ryukyu Islands
BES	Saba
ESH	Sahara, Western
BES	Saint Eustatius

APPENDIX B**International Organization for Standardization (ISO) Country Codes – Country Order**

Code	Label
WSM	Samoa
ASM	Samoa, American
WSM	Samoa, Western
SMR	San Marino
STP	Sao Tome and Principe
SAU	Saudi Arabia
XSC	Scandinavia [Pre-2013 cases only]
SCT	Scotland
SEN	Senegal
SRB	Serbia
SYC	Seychelles
SLE	Sierra Leone
IND	Sikkim
SGP	Singapore
SXM	Saint-Martin
XSL	Slavic Countries [Pre-2013 cases only]
SVK	Slovakia
SVN	Slovenia
SLB	Solomon Islands
SOM	Somalia
XSF	South Africa, NOS [Pre-2013 cases only]
ZAF	South Africa, Republic of
ZZS	South America, NOS
SGS	South Georgia and the South Sandwich Islands
KOR	South Korea
SSD	South Sudan
XSE	Southeast Asia [Pre-2013 cases only]
KIR	Southern Line Islands
ESP	Spain
LKA	Sri Lanka
BLM	St. Barthelemy
BES	St. Eustatius
SHN	St. Helena
KNA	St. Kitts and Nevis
LCA	St. Lucia
SXM	St. Martin
SPM	St. Pierre and Miquelon
VCT	St. Vincent and the Grenadines
SDN	Sudan
SSD	Sudan, South

APPENDIX B**International Organization for Standardization (ISO) Country Codes – Country Order**

Code	Label
XSD	Sudanese Countries [Pre-2013 cases only]
SUR	Suriname
SJM	Svalbard and Jan Mayen
UMI	Swan Islands
SWZ	Swaziland
SWE	Sweden
CHE	Switzerland
SYR	Syria
TWN	Taiwan
TJK	Tajikistan
TZA	Tanzania
THA	Thailand
CHN	Tibet
TLS	Timor, East
TLS	Timor-Leste
TTO	Tobago
TGO	Togo
TKL	Tokelau
TON	Tonga
TTO	Trinidad and Tobago
TUN	Tunisia
TUR	Turkey
TKM	Turkmenistan
TCA	Turks and Caicos
TCA	Turks Islands
TUV	Tuvalu
UMI	U.S. Minor Outlying Islands
VIR	U.S. Virgin Islands
UGA	Uganda
UKR	Ukraine
XUM	Ukraine and Moldavia [Pre-2013 cases only]
NIR	Ulster
ARE	United Arab Emirates
GBR	United Kingdom
USA	United States
ZZU	Unknown
URY	Uruguay
BDI	Urundi
UZB	Uzbekistan
VUT	Vanuatu

APPENDIX B

International Organization for Standardization (ISO) Country Codes – Country Order

Code	Label
VAT	Vatican City
VEN	Venezuela
VNM	Vietnam
VGB	Virgin Islands, British
VIR	Virgin Islands, U.S.
UMI	Wake Island
WLS	Wales
WLF	Wallis and Futuna
XWF	West Africa, NOS (French Africa, NOS) [Pre-2013 cases only]
PAK	West Pakistan
ESH	Western Sahara
BLR	White Russia
YEM	Yemen
YUG	Yugoslavia (former) [Pre-2013 cases only]
COD	Zaire
ZMB	Zambia
ZWE	Zimbabwe

APPENDIX B
United States Postal Service State Abbreviation Codes
Canadian Province Abbreviation Codes
United States Territory Abbreviation Codes

NAME	STATE/PROVINCE CODE	COUNTRY CODE
Alabama	AL	USA
Alaska	AK	USA
Alberta	AB	CAN
American Samoa	AS	ASM
Arizona	AZ	USA
Arkansas	AR	USA
Armed Forces Americas	AA	USA
Armed Forces Canada, Europe, Middle East, Africa	AE	USA
Armed Forces Pacific	AP	USA
British Columbia	BC	CAN
California	CA	USA
Canada, NOS	CD	CAN
Colorado	CO	USA
Connecticut	CT	USA
Delaware	DE	USA
District of Columbia	DC	USA
Florida	FL	USA
Georgia	GA	USA
Guam	GU	GUM
Hawaii	HI	USA
Idaho	ID	USA
Illinois	IL	USA
Indiana	IN	USA
Iowa	IA	USA
Johnston Atoll	UM	UMI
Kansas	KS	USA
Kentucky	KY	USA
Louisiana	LA	USA
Maine	ME	USA
Manitoba	MB	CAN
Mariana Islands (Trust Territory of Pacific Islands)	MP	MNP
Marshall Islands (Trust Territory Pacific Islands)	MH	MHL
Maryland	MD	USA
Massachusetts	MA	USA
Michigan	MI	USA
Micronesia (Fed States of) (Caroline, Trust Terr of Pacific)	FM	FSM
Midway Islands	UM	UMI
Minnesota	MN	USA
Mississippi	MS	USA
Missouri	MO	USA
Montana	MT	USA
Nebraska	NE	USA
Nevada	NV	USA
New Brunswick	NB	CAN

APPENDIX B
United States Postal Service State Abbreviation Codes
Canadian Province Abbreviation Codes
United States Territory Abbreviation Codes

NAME	STATE/PROVINCE CODE	COUNTRY CODE
New Hampshire	NH	USA
New Jersey	NJ	USA
New Mexico	NM	USA
New York	NY	USA
Newfoundland, Labrador	NL	CAN
North American Islands	ZZ	XNI
North Carolina	NC	USA
North Dakota	ND	USA
Northwest Territories	NT	CAN
Northwest Territories, Yukon Territory	YN	CAN
Nova Scotia	NS	CAN
Nunavut	NU	CAN
Ohio	OH	USA
Oklahoma	OK	USA
Ontario	ON	CAN
Oregon	OR	USA
Palau (Trust Territory of Pacific Islands)	PW	PLW
Pennsylvania	PA	USA
Prince Edward Island	PE	CAN
Puerto Rico	PR	PRI
Quebec	QC	CAN
Rhode Island	RI	USA
Saskatchewan	SK	CAN
South Carolina	SC	USA
South Dakota	SD	USA
Swan Islands	UM	UMI
Tennessee	TN	USA
Texas	TX	USA
U.S. Virgin Islands	VI	VIR
United States, NOS	US	USA
Unknown Residence	ZZ	ZZU
Utah	UT	USA
Vermont	VT	USA
Virginia	VA	USA
Wake Island	UM	UMI
Washington	WA	USA
West Virginia	WV	USA
Wisconsin	WI	USA
Wyoming	WY	USA
Yukon Territory	YT	CAN

Note 1: State Code XX should not be used if patient is from US or Canada

Note 2: State Code YY should not be used if patient is from US or Canada

Note 3: State Code ZZ should be known for residents of US or Canada with unknown address

APPENDIX B
Federal Information Processing Standards (FIPS) County Codes for FLORIDA

County Name	FIPS Code
ALACHUA	001
BAKER	003
BAY	005
BRADFORD	007
BREVARD	009
BROWARD	011
CALHOUN	013
CHARLOTTE	015
CITRUS	017
CLAY	019
COLLIER	021
COLUMBIA	023
DESOTO	027
DIXIE	029
DUVAL	031
ESCAMBIA	033
FLAGLER	035
FRANKLIN	037
GADSDEN	039
GILCHRIST	041
GLADES	043
GULF	045
HAMILTON	047
HARDEE	049
HENDRY	051
HERNANDO	053
HIGHLANDS	055
HILLSBOROUGH	057
HOLMES	059
INDIAN RIVER	061
JACKSON	063
JEFFERSON	065
LAFAYETTE	067
LAKE	069
LEE	071
LEON	073
LEVY	075
LIBERTY	077
MADISON	079
MANATEE	081

County Name	FIPS Code
MARION	083
MARTIN	085
MIAMI-DADE	086
MONROE	087
NASSAU	089
OKALOOSA	091
OKEECHOBEE	093
ORANGE	095
OSCEOLA	097
PALM BEACH	099
PASCO	101
PINELLAS	103
POLK	105
PUTNAM	107
SANTA ROSA	113
SARASOTA	115
SEMINOLE	117
ST. JOHNS	109
ST. LUCIE	111
SUMTER	119
SUWANNEE	121
TAYLOR	123
UNION	125
VOLUSIA	127
WAKULLA	129
WALTON	131
WASHINGTON	133
UNKNOWN	999

APPENDIX C

UPDATED - BREAST CANCER PROFILE - ER/PR/HER2 PROGNOSTIC FACTORS

SEER PROGRAM CODING AND STAGING MANUAL 2015 LINK TO CODING GUIDELINES FOR SPECIFIED SITES

GLOSSARY OF COMMON TERMS

NEW – 2016 NAACCR RECOMMENDED STANDARD ABBREVIATIONS – NEW
NAACCR Recommended Abbreviations consist of almost 500 terms with recommended abbreviations.

ABBREVIATION/SYMBOL ORDERED BY TERM/WORD TERM/WORD ORDERED BY ABBREVIATION/SYMBOL

Abbreviations often are used by cancer abstractors to shorten the written narratives entered into text fields. However, abbreviations can generate confusion, because abbreviations may vary among different institutions and even between different specialties within the same institution. To be useful, an abbreviation must be clearly understood by any individual who encounters it. Consequently, the use of abbreviations is a useful abstracting practice only if universally recognized abbreviations are used.

These lists are to be used as a primary reference by the cancer abstractor, to help abstract necessary information into a limited number of text fields for storage and transmission of cancer information. Terms included in the lists are limited to those that are commonly utilized when abstracting cancer information.

When abstracting into text fields, the use of abbreviations should be limited to those that appear on these lists whenever practical. Listings are not exhaustive, but the most commonly used terms were included.

Please note that although abbreviations are presented in uppercase, either upper- or lowercase may be utilized when entering abbreviations within abstraction software.

The listings were compiled from abbreviation lists from SEER Book 3, the NAACCR Pathology Committee, the Veterans Administration, Dr. Jay Piccirillo's comorbid conditions training materials, the Florida Cancer Data System, and the California Cancer Registry.

ER/PR/HER2

What are estrogen receptors (ER)?

Estrogen receptors are a group of proteins found inside cells. These protein receptors are activated by the hormone estrogen. The hormone estrogen binds to the receptors inside the cells and may cause the cells to grow.

ER negative cancer cells do not need estrogen to grow, and usually do not stop growing when treated with hormones that block estrogen from binding.

ER positive cancer cells may need estrogen to grow, and may stop growing or die when treated with substances that block the binding and actions of estrogen such as hormones (Tamoxifen) or aromatase inhibitors (Arimidex, Aromasin, or Femara).

What is a progesterone receptor (PR)?

A progesterone receptor is another type of protein receptor found inside cells. This protein receptor is activated by the hormone progesterone. The hormone progesterone binds to the receptor inside the cells and may cause cells to grow.

PR negative cancer cells do not need progesterone to grow, and usually do not stop growing when treated with hormones that block progesterone from binding.

PR positive cancer cells need progesterone to grow and will usually stop growing when treated with hormones that block progesterone from binding such as hormones (Tamoxifen) or aromatase inhibitors (Arimidex, Aromasin, or Femara).

Pre-menopausal women with ER/PR positive cancers are usually treated with Tamoxifen for 5 years, regardless of nodal status or other prognostic factors such as HER2 status.

Post-menopausal women are usually treated with an aromatase inhibitor rather than Tamoxifen, regardless of nodal status or other prognostic factors such as HER2 status.

What is HER2/neu?

HER2/neu is a protein involved in normal cell growth and may be found in some types of cancer cells. These protein receptors may also be referred to as tyrosine kinase receptors or human epidermal growth factor receptors.

HER2 positive cancers have an abundance of the protein HER2/neu on their surface. When too much of this protein is present, cells may grow more quickly and are more likely to spread to other parts of the body. Herceptin is a drug that is used to treat HER2-positive cancers (breast, stomach, other) when there is an overexpression of HER2 on cancer cells surfaces.

HER2 testing guidelines and techniques continue to evolve as do the guidelines for interpretation of results. In 2013 the College of American Pathologists (CAP) working with the American Society of Clinical Oncology (ASCO) published updated guidelines for HER2 Testing. The new guidelines clarified test, retest, interpretation and other factors changing cut-off points for positive/negative results among other clarifications providing a better set of patient safety criteria as well as improved clarification of testing/re-testing criteria and results interpretation.

Favorable Prognostic Factors ER/PR/HER2

- ✓ Estrogen Receptor (ER) **positive** is a favorable prognostic factor.
 - Hormonal Therapy should be considered in 1st course treatment planning for premenopausal women
 - Aromatase Inhibitor Therapy should be considered in 1st course treatment planning for post-menopausal women.
- ✓ Progesterone Receptor (PR) **positive** is a favorable prognostic factor.
 - Hormonal Therapy should be considered in 1st course treatment planning.

APPENDIX C

- Aromatase Inhibitor Therapy should be considered in 1st course treatment planning for postmenopausal women.
- ✓ **Single Receptor positive** tumors (ER+ only or PR+ only) do exist but are rare with an unfavorable prognosis
 - These tumors are often large in size, are of high grade, are often HER2+, and are often lymph node +
 - Single Receptor positive tumors are usually NOT treated with Hormonal Therapy or Aromatase Inhibitors
- ✓ Human Epidermal growth factor Receptor 2 (HER2) **positive** is a favorable prognostic factor.
 - Herceptin (trastuzumab) or Tykerb (lapatinib) should be included as part of 1st course treatment plan

Unfavorable Prognostic Factors ER, PR, HER2

- Estrogen Receptor (ER) **negative** is an unfavorable prognostic factor.
 - Hormonal Therapy/Aromatase Inhibitor Therapy usually NOT included as part of 1st course treatment plan
- Progesterone Receptor (PR) **negative** is an unfavorable prognostic factor.
 - Hormonal Therapy/Aromatase Inhibitor Therapy usually NOT included as part of 1st course treatment plan
- **Single Receptor negative** tumors (ER- only or PR- only) do exist but are rare with an unfavorable prognosis
 - These tumors are often large in size, are of high grade, are often HER2+, and are often lymph node +
 - Single Receptor negative tumors are usually NOT treated with Hormonal Therapy or Aromatase Inhibitors
- Human Epidermal growth factor Receptor 2 (HER2) **negative** is an unfavorable prognostic factor.
 - Herceptin (trastuzumab) or Tykerb (lapatinib) usually NOT included as part of 1st course treatment plan
- **Triple Negative Breast Cancer** (ER neg/PR neg/HER2 neg) is a **very unfavorable** prognostic combination.

2014 ASCO and CAP Reporting guidelines: ASCO and the CAP have issued recommendations for reporting the results of immunohistochemical assays for ER and PgR (Table 1).⁵ Studies using both IHC and the ligand binding assay suggest that patients with higher hormone receptor levels have a higher probability of response to hormonal therapy, but expression as low as 1% positive staining has been associated with clinical response. As a result, the guidelines recommend classifying all cases with at least 1% positive cells as receptor positive.⁵ For patients with low ER expression (1% to 10% weakly positive cells), the decision on endocrine therapy should be based on an analysis of its risks and potential benefits.

Table 1. Reporting Results of Estrogen Receptor (ER) and Progesterone Receptor (PgR) Testing

Result	Criteria	Comments
Positive	Immunoreactive tumor cells present (≥1%)	The percentage of immunoreactive cells may be determined by visual estimation or quantitation. Quantitation can be provided by reporting the percentage of positive cells or by a scoring system, such as the Allred score or H score.
Negative	<1% immunoreactive tumor cells present	

Older Testing Methods included the reporting of a % of cells with a range of nuclear positivity with accompanying interpretation (positive, negative, borderline). **2014 CAP guidelines eliminated borderline results.** ER/PR are now reported as being either Negative or Positive (See Table 1 above). **Positive results are now ≥1%.**

Test	Value Range	Negative	Borderline	Positive
ER Proportion Score	0%-100%	<5%	5%–19%	≥20%
ER Intensity Score	None, weak, intermediate, strong	None, weak	intermediate	Strong
PR Proportion Score	0%-100%	<5%	5%–19%	≥20%
PR Intensity Score	None, weak, intermediate, strong	None, weak	intermediate	Strong
HER2 by IHC	0, 1+, 2+, 3+	0, 1+	2+	3+
HER2 by FISH	Ratio 1.00-9.79 (note decimal point)	≤ 1.8	1.80-2.20	≥ 2.00
HER2 by CISH	Ratio 1.00-9.79 (note decimal point)	≤ 1.8	1.80-2.20	≥ 2.00
HER2 by unknown	No value given	Stated by MD	Stated by MD	Stated by MD
Test Not Mentioned in Medical Record - Code as Not Done (998) or Unknown if Done (999)				

SEER RESOURCE: 2015 Coding and Staging Manual - Appendix C: Site-Specific Coding Modules

Appendix C of the 2015 SEER Coding and Staging Manual brings together the site-specific instructions needed to abstract a case, facilitating efficiency and accuracy. The site-specific coding modules include SEER coding guidelines; equivalent terms, definitions, tables, charts and illustrations; multiple primary rules; histology coding rules; stage coding instructions and surgery of primary site codes. Some modules include site-specific coding guidelines. The goal is to have stand-alone modules for major anatomic sites.

<http://seer.cancer.gov/manuals/2015/appendixc.html>

<ul style="list-style-type: none"> ⊕ Oral Cavity ⊕ Parotid, Other and Unspecified Glands ⊕ Pharynx, Tonsil, Oropharynx, Hypopharynx, Pyriform Sinus ⊕ Esophagus ⊕ Stomach ⊕ Small Intestine ⊕ Colon ⊕ Rectosigmoid, Rectum ⊕ Anus ⊕ Liver, Intrahepatic Bile Ducts ⊕ Gallbladder, Extrahepatic Bile Ducts, Ampulla of Vater ⊕ Pancreas ⊕ Other Digestive ⊕ Nasal Cavity, Middle Ear ⊕ Sinuses ⊕ Larynx ⊕ Trachea ⊕ Lung ⊕ Heart, Mediastinum, Pleura ⊕ Bones, Joints, Cartilage ⊕ Skin ⊕ Melanoma ⊕ Mycosis Fungoides, Sezary Disease ⊕ Nerves, Nervous System, Soft Tissues ⊕ Retroperitoneum, Peritoneum 	<ul style="list-style-type: none"> ⊕ Breast ⊕ Vulva, Vagina ⊕ Cervix Uteri ⊕ Corpus Uteri, Uterus, NOS ⊕ Ovary ⊕ Fallopian Tube, Ligaments, Adnexa ⊕ Other and Unspecified Female Genital Organs, Placenta ⊕ Penis ⊕ Prostate ⊕ Testis ⊕ Other and Unspecified male Genital Organs ⊕ Kidney ⊕ Renal Pelvis, Ureter ⊕ Bladder ⊕ Urethra, Other Urinary ⊕ Eye ⊕ Brain, Central Nervous System, Malignant ⊕ Brain, Central Nervous System, Benign and Borderline ⊕ Thyroid ⊕ Thymus, Adrenal and Other Endocrine Glands ⊕ Kaposi Sarcoma ⊕ Lymphoma ⊕ Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloid ⊕ Other and Unknown Sites
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GLOSSARY OF COMMON TERMS

Abstract - A succinct synopsis of pertinent information gleaned from the patient record. Every abstract should reflect the diagnosis and first course of therapy for each cancer diagnosis in any patient. In general, an abstract represents the first four to twelve months of the patient's cancer experience. Completeness, consistency and attention to detail are very important. Please take care when abstracting each cancer case.

Active Surveillance/Watchful Waiting - No therapy is also a first course of therapy treatment option. If a physician or patient elects to undergo simple observation (as is often the case with prostate cancer) and later receives a TURP or hormonal therapy, the first course of therapy is No Therapy. The abstract should reflect that no therapy was administered for the first course.

Adjuvant - Systemic therapy and/or radiation therapy that is given after other methods have destroyed the clinically detectable cancer cells. This therapy is given to destroy micrometastases (undetectable cancer cells). The intent is to prevent or delay a recurrence.

Analytic Case - Any case of cancer where the reporting facility is involved in the diagnosis and/or evaluation of the diagnosis and/or the evaluation of the extent of cancer spread at the time of diagnosis and/or the administration of all or any part of the first course of therapy.

Cancer Directed Therapy - Any treatment that is given to modify, control, remove or destroy primary or metastatic cancer tissue. The treatment is meant to remove or minimize the size of tumor or delay the spread of disease.

Clinical Stage or Clinical Classification – This is a point in time, not specific types of exams or procedures. The clinical (stage) classification encompasses all information from the diagnostic workup. This is from the moment of diagnosis until just before the first treatment.

Concurrent Therapy - Different types of therapies that are administered at the same time.

Consultation - Services rendered by a facility to confirm a diagnosis or treatment plan. Examples include: Pathology review of slides that have been previously read by another pathology physician or department; Radiation therapy planning without radiation therapy services administered; Specialty testing performed to confirm a diagnosis or extent of disease where the testing is not available elsewhere.

End-Results Registry - A cancer registry that performs all of the necessary functions required by the Commission on Cancer/American College of Surgeons for cancer program accreditation.

Federal Information Processing Standards (FIPS) – Standard codes for U.S. counties taken from the publication “Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas.”

First Course of Therapy or Treatment - All methods of therapy that are included in the original treatment plan, including neo-adjuvant, concurrent, prophylactic, palliative, and adjuvant therapies. Generally, the first course of therapy is completed during the first four months after a patient's diagnosis with cancer. The first course of therapy can extend beyond one year after initial diagnosis.

No therapy is also a first course of therapy treatment option. If a physician or patient elects to undergo simple observation (as is often the case with prostate cancer) and later receives a TURP or hormonal therapy, the first course of therapy is No Therapy. The abstract should reflect that no therapy was administered for the first course.

Historical Case - A case of cancer that is not active or receiving therapy (NED, remission) that must be reported to accompany a case of cancer for the same patient that is active or receiving therapy.

Incidence Registry - A cancer registry that performs minimal cancer reporting as required in order to calculate cancer incidence rates for a defined geographic region and/or meet state reporting requirements.

NED - No Evidence of Disease

Neo-Adjuvant - Systemic therapy and/or radiation therapy that is given prior to surgical resection to reduce the bulk of a locally advanced primary cancer. Definitive surgery must be performed to complete the loop. Systemic therapy may consist of chemotherapy, immunotherapy, or hormone therapy.

Non-Analytic Case - Any case of cancer where the reporting facility is not involved with the diagnosis and/or the first course of therapy but, the patient is seen at the reporting facility with evidence of active cancer, and/or is actively receiving therapy for cancer, and/or is diagnosed with cancer at the time an autopsy is performed.

Non-Cancer Directed Therapy - Any treatment that is designed to prepare a patient for cancer-directed therapy, prolong a patient's life, alleviate pain or make the patient comfortable. Non-cancer directed therapies are not meant to destroy or control the tumor or delay the spread of disease. These therapies include diagnostic tests and supportive care.

Palliative - Treatment that is given primarily for the purpose of pain control. Palliative therapy is non-curative. Any benefits of the treatment are considered secondary contributions to the patient's quality of life.

Pathologic Stage or Pathologic Classification – This is a point in time, not specific types of procedures. The pathologic (stage) classification encompasses all information from the diagnostic workup, the surgical (operative) evaluation, and the pathologist's review of the resected specimen, from the moment of diagnosis THROUGH the surgical resection.

Prophylactic - Radiation therapy that is administered for the purpose of preventing the development of symptoms in a setting in which clinical evidence indicates that problems are likely to develop if treatment is not administered.

Remission - Cancer that is no longer detectable by any testing or evaluation means. This term is most often used for leukemia cases.

Reportable Case - Any cancer case that meets reporting requirements as outlined in Section I.

Treatment - See Treatment Section

APPENDIX C**2016 NAACCR RECOMMENDED ABBREVIATION LIST
ORDERED BY WORD/TERM(S)**

WORD/TERM(S)	ABBREVIATION/SYMBOL
Abdomen (abdominal)	ABD
Abdomen/Pelvis	A/P
Abdominal perineal	AP
Abnormal	ABN or ABNL
Above	^
Above knee (amputation)	AK(A)
Absent/Absence	ABS
Abstract/Abstracted	ABST
Achilles tendon reflex	ATR
Acid phosphatase	ACID PHOS
Acquired Immune Deficiency Syndrome	AIDS
Activities of daily living	ADL
Acute granulocytic leukemia	AGL
Acute lymphocytic leukemia	ALL
Acute myelogenous leukemia	AML
Acute myocardial infarction	AMI
Acute renal failure	ARF
Acute Respiratory Distress (Disease) Syndrome	ARDS
Acute tubular necrosis	ATN
Adenocarcinoma	ADENOCA or ADENO
Adenopathy	ADENOP
Adenosine triphosphate	ATP
Adjacent	ADJ
Admission/Admit	ADM
Adrenal cortex	AC
Adrenal cortical hormone	ACH
Adrenocorticotrophic hormone	ACTH
Adult-onset Diabetes Mellitus	AODM

APPENDIX C

C-7

WORD/TERM(S)	ABBREVIATION/SYMBOL
Adverse drug reaction	ADR
Affirmative	AFF
African American	AA
Against medical advice	AMA
AIDS-related condition (complex)	ARC
AIDS-related disease	ARD
Air contrast barium enema	ACBE
Albumin	ALB
Alcohol	ETOH
Alkaline phosphatase	ALK PHOS
Alpha-fetoprotein	AFP
Also known as	AKA
Ambulatory	AMB
Amount	AMT
Amputation	AMP
Amyotrophic lateral sclerosis	ALS
Anal intraepithelial neoplasia, grade III	AIN III
Anaplastic	ANAP
And	&
Angiography/Angiogram	ANGIO
Anterior	ANT
Anteroposterior	A-P
Antibiotics	ABX
Antibody	AB
Antidiuretic hormone	ADH
Antigen	AG
Aortic stenosis	A-STEN
Apparently	APPL'Y
Appendix	APP
Approximately	≈
Aromatase inhibitor	AI
Arrhythmia	ARRHY
Arterial blood gases	ABG
Arteriosclerotic cardiovascular disease	ASCVD
Arteriosclerotic heart disease	ASHD
Arteriosclerotic Peripheral Vascular Disease	ASPVD

APPENDIX C

WORD/TERM(S)	ABBREVIATION/SYMBOL
Arteriosclerosis/Arteriosclerotic	AS
Arteriovenous	AV
Arteriovenous malformation	AVM
Artery (ial)	ART
As soon as possible	ASAP
Ascending colon	A-COLON
Aspiration	ASP
Aspirin, Acetylsalicylic acid	ASA
Associated	ASSOC
At	@
Atrial fibrillation	A FIB
Atrial flutter	A FLUTTER
Atrial premature complexes	APC
Atrial stenosis/insufficiency/incompetence	AI
Auscultation & percussion	A&P
Autoimmune hemolytic anemia	AIHA
Autonomic nervous system	ANS
Autopsy	AUT
Average	AVG
Axilla(ry)	AX
Axillary Lymph Node Dissection	AXLND or ALND
Bacillus Calmette-Guerin	BCG
Barium	BA
Barium enema	BE
Bartholin's, Urethral & Skene's	BUS
Basal cell carcinoma	BCC
Base of tongue	BOT
Before noon	AM
Below knee (amputation)	BK(A)
Benign prostatic hypertrophy/hyperplasia	BPH
Bilateral	BIL or B/L

APPENDIX C

C-9

WORD/TERM(S)	ABBREVIATION/SYMBOL
Bilateral salpingo-oophorectomy	BSO
Bile duct	BD
Biological response modifier	BRM
Biopsy	BX
Bipolar affective disorder	BAD
Black female	B/F or BF
Black male	B/M or BM
Bladder tumor	BT
Blood pressure	BP
Blood urea nitrogen	BUN
Blood volume	BV
Bloom-Richardson	BR
Body mass index	BMI
Body surface area	BSA
Bone marrow	BM
Bone marrow biopsy	BMBX
Bone marrow transplant	BMT
Bone scan	BSC
Bowel movement	BM
Brachytherapy	BRACHY
Brain tumor	BT
Breast cancer susceptibility gene	BRCA 1 and BRCA 2
Bright red blood per rectum	BRBPR
Brother	BRO
Calcification(s)	CA ⁺⁺ or CALC(s)
Calcium	CA
Cancer	SPELL OUT; DO NOT ABBREVIATE
Cancer Antigen 125	CA 125
Capsule (s)	CAP(S)
Carbohydrate Antigen 19-9	CA 19-9
Carcinoembryonic antigen	CEA
Carcinoma	CA
Carcinoma <i>in situ</i>	CIS
Cardiovascular disease	CVD
CAT/CT scan/Computerized axial tomography	CT

APPENDIX C

WORD/TERM(S)	ABBREVIATION/SYMBOL
Centigray	CGY
Centimeter	CM
Centimeters from nipple	CFN
Central nervous system	CNS
Cerebrospinal fluid	CSF
Cerebrovascular accident	CVA
Cervical intraepithelial neoplasia	CIN
Cervical intraepithelial neoplasia, grade III	CIN III or CIN 3
Cervical spine	C-SPINE
Cervical vertebrae	C1-C7
Change	CHG
Chemotherapy	CHEMO
Chest, abdomen, pelvis	C/A/P
Chest X-ray	CXR
Chief complaint	CC
Chromogenic in situ hybridization	CISH
Chronic	CHR
Chronic granulocytic leukemia	CGL
Chronic lymphocytic leukemia	CLL
Chronic myeloid (myelocytic) leukemia	CML
Chronic obstructive lung disease	COLD
Chronic obstructive pulmonary disease	COPD
Chronic renal failure	CRF
Chronic ulcerative colitis	CUC
Cigarettes	CIG
Circulating tumor cells	CTC
Circumferential resection margin	CRM
Clear	CLR
Cobalt 60	CO60
Collaborative stage	CS
Colon, Ascending	A-COLON
Colon, Descending	D-COLON
Colon, Sigmoid	SIG COLON or S-COLON
Colon, Transverse	TRANS-COLON or T-COLON

APPENDIX C

C-11

WORD/TERM(S)	ABBREVIATION/SYMBOL
Colony-stimulating factor	C-SF
Complaint (-ning) of	C/O
Complete blood count	CBC
Congenital heart disease	CHD
Congestive heart failure	CHF
Consistent with	C/W
Continue/continuous	CONT
Contralateral	CONTRA
Coronary artery bypass graft	CABG
Coronary artery disease	CAD
Coronary care unit	CCU
centimeter	CM
Cystic fibrosis	CF
Cystoscopy	CYSTO
Cytology	CYTO
Date of birth	DOB
Date of death	DOD
Dead on arrival	DOA
Decrease(d)	DECR
Deep tendon reflex	DTR
Deep vein thrombosis	DVT
Degenerative joint disease	DJD
Deoxyribonucleic acid	DNA
Dermatology	DERM
Descending colon	D-COLON
Diabetes mellitus	DM
Diagnosis	DX
Diameter	DIAM
Diethylstilbestrol	DES
Differentiated/differential	DIFF
Differential diagnosis	DDX
Digital rectal examination	DRE
Dilatation and curettage	D&C
Discharge	DISCH or D/C

APPENDIX C

WORD/TERM(S)	ABBREVIATION/SYMBOL
Discontinue(d)	DC
Disease	DZ
Disseminated intravascular coagulopathy	DIC
Disseminated tumor cells	DTC
Don't/Doesn't know	DK
Ductal carcinoma <i>in situ</i>	DCIS
Due to	D/T
Dyspnea on exertion	DOE
Ears, nose, and throat	ENT
Electrocardiogram	ECG/EKG
Electroencephalogram	EEG
Electromyogram	EMG
Electron volt	EV
Elevated	ELEV or ^
Emergency department	ED
Emergency room	ER
End stage renal disease	ESRD
Endoscopic retrograde cholangiopancreatography	ERCP
Enlarged	ENLGD or ENL
Epidermal growth factor receptor	EGFR
Equal(s)	=
Esophagogastro-duodenoscopy	EGD
Estrogen receptor (assay)	ER, ERA
Evaluation	EVAL
Every	Q
Every day	QD
Evidence of	E/O
Exam under anesthesia	EUA
Examination	EXAM
Excision/excised	EXC(D)
Expired	EXP
Exploratory	EXPL
Exploratory laparotomy	EXPL LAP or EXP LAP

APPENDIX C

C-13

WORD/TERM(S)	ABBREVIATION/SYMBOL
Extend/extension	EXT
External beam radiotherapy	EBRT
External radiation therapy	XRT
Eye, ear, nose, throat	EENT
Familial adenomatous polyposis	FAP
Family History	FHX
Fever of unknown origin	FUO
Fine needle aspiration	FNA
Fine needle aspiration biopsy	FNAB
Floor of mouth	FOM
Flow cytometry	FLOW CYTO
Fluid	FL
Fluorescence in situ hybridization	FISH
Fluoroscopy	FLURO
Follicular lymphoma international prognostic index	FLIPI
Follow-up	FU
For example	E.G.
Fraction(s)	FX(s)
Fracture	FX
Frequent/Frequency	FREQ
Frozen section	FS
Full thickness skin graft	FTSG
Gallbladder	GB
Gastroesophageal	GE
Gastroesophageal reflux disease	GERD
Gastrointestinal	GI
Gastrointestinal stromal tumors	GIST
General/Generalized	GEN
Genitourinary	GU
Grade	GR
Gray	GY
Greater/Greater than	>
Gynecology	GYN
Hematocrit	HCT

APPENDIX C

WORD/TERM(S)	ABBREVIATION/SYMBOL
Hematology/Oncology (ist)	HEM/ONC
Hematoxylin and Eosin	H&E
Hemoglobin	HGB
Hemoglobin and hematocrit	H/H
Hepatitis A (virus)	HAV or HEP A
Hepatitis B (virus)	HBV or HEP B
Hepatitis C (virus)	HCV or HEP C
Hepatitis D (virus)	HDV or HEP D
Hepatosplenomegaly	HSM
High dose rate	HDR
High grade squamous intraepithelial lesion	HGSIL
Hispanic female	HF
Hispanic male	HM
History	HX
History and physical	H&P
History of	H/O
History of present illness	HPI
Hormone	HORM
Hormone replacement therapy	HRT
Hospital	HOSP
Hour/Hours	HR(S)
Human chorionic gonadotropin	HCG
Human epidermal growth factor receptor 2	HER2
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymphotropic Virus, (Type III)	HTLV
Hypertension	HTN
Hypertensive cardiovascular disease	HCVD
Hypertensive vascular disease	HVD
Hysterectomy	HYST
Idiopathic hypertrophic subaortic stenosis	IHSS
Idiopathic thrombocytopenia	ITP
Immunoglobulin	IG
Immunohistochemical	IHC

APPENDIX C

C-15

WORD/TERM(S)	ABBREVIATION/SYMBOL
Impression	IMP
Incision & drainage	I&D
Includes/Including	INCL
Increase(d)	INCR
Inferior	INF
Inferior vena cava	IVC
Infiltrating	INFILT or INFIL
Infiltrating/invasive ductal carcinoma	IDC
Inflammatory bowel disease	IBD
Inpatient	IP or INPT
Insulin-dependent diabetes mellitus	IDDM
Intensity modulated radiation therapy	IMRT
Intensive care unit	ICU
Intercostal margin	ICM
Intercostal space	ICS
Intermittent positive pressure breathing	IPPB
Internal	INT
International prognostic index (for lymphoma)	IPI
International prognostic score	IPS
Interstitial lung disease	ILD
Intracavitary brachytherapy	ICB
Intramuscular	IM
Intraperitoneal	IP
Intrathecal	IT
Intravenous	IV
Intravenous cholangiogram	IVCA
Intravenous pyelogram	IVP
Invade(s)/invading/invasion	INV
Involve(s)/involvement/involving	INVL
Iodine 131	I-131
Ipsilateral	IPSI
Irregular	IRREG
Isolated tumor cells	ITC
Janus kinase 2	JAK2
Jugular venous distention	JVD
Juvenile rheumatic arthritis	JRA

APPENDIX C

WORD/TERM(S)	ABBREVIATION/SYMBOL
Kaposi sarcoma	KS
Kidneys, ureters, bladder	KUB
Kilogram	KG
Kilovolt	KV
Laboratory	LAB
Lactic dehydrogenase	LDH
Laparotomy	LAP
Large	LRG
Laryngeal intraepithelial neoplasia	LIN
Last menstrual period	LMP
Lateral	LAT
Left	LT
Left bundle branch block	LBBB
Left costal margin	LCM
Left lower extremity	LLE
Left lower lobe	LLL
Left lower quadrant	LLQ
Left salpingo-oophorectomy	LSO
Left upper extremity	LUE
Left upper lobe	LUL
Left upper outer quadrant	LUOQ
Left upper quadrant	LUQ
Less/Less than	<
Licensed practical nurse	LPN
Linear accelerator	LINAC
Liver function test	LFT
Liver/spleen scan	LS SCAN
Lobular carcinoma in situ	LCIS
Low dose rate	LDR
Lower extremity	LE
Lower inner quadrant	LIQ
Lower outer quadrant	LOQ

APPENDIX C

C-17

WORD/TERM(S)	ABBREVIATION/SYMBOL
Lumbar spine	L-SPINE
Lumbar vertebra	L1-L5
Lumbosacral	LS
Lupus erythematosus	SLE
Lymph node(s)	LN(S)
Lymph node dissection	LND
Lymphadenopathy	LAD or LAN
Lymphadenopathy-associated virus	LAV
Lymph/vascular invasion	LVI
Macrophage colony-stimulating factor	M-CSF
Magnetic resonance cholangiopancreatography	MRCP
Magnetic resonance imaging	MRI
Main stem bronchus	MSB
Malignant/malignancy	MALIG or MAL
Malignant melanoma	SPELL OUT; DO NOT ABBREVIATE
Mammogram	MMG or MAMMO
Mandible/mandibular	MAND
Maternal grandfather	MGF
Maternal grandmother	MGM
Maximum	MAX
Medical center	MC
Medical Oncology (ist)	MED ONC
Medication	MED
Megavolt	MV
Melanoma in situ	MIS
Metastatic/Metastasis	METS
Methicillin Resistant Staphylococcus Aureus	MRSA
Microgram	MCG
Microsatellite instability	MSI
Microscopic	MICRO

APPENDIX C

WORD/TERM(S)	ABBREVIATION/SYMBOL
Middle lobe	ML
Millicurie (hours)	MC(H)
Milligram (hours)	MG(H)
Milliliter	ML
Millimeter	MM
Million electron volts	MEV
Minimally invasive breast biopsy	MIBB
Minimum	MIN
Minus	-
Minute	MIN
Mitral valve prolapse	MVP
Mixed combined immunodeficiency	MCID
Mixed connective tissue disease	MCTD
Moderate (ly)	MOD
Moderately differentiated	MD, MOD DIFF or M/DIFF
Modified radical mastectomy	MRM
Monoclonal gammopathy of uncertain significance	MGUS
Month(s)	MO(S)
More/More than	>
Mucinous cystic neoplasm	MCN
Multifocal atrial tachycardia	MAT
Multifocal premature ventricular contraction	MPVC
Multiple	MULT
Multiple sclerosis	MS
Multiple myeloma	SPELL OUT; DO NOT ABBREVIATE
Myasthenia gravis	MG
Myelodysplastic syndrome	MDS
Myocardial infarction	MI
Nausea and vomiting, nausea/vomiting	N&V or N/V
Neck vein distention	NVD
Negative	NEG
Negative	-
Neoplasm	NEOPL
Neuroendocrine tumor	NET

APPENDIX C

C-19

WORD/TERM(S)	ABBREVIATION/SYMBOL
Neurology	NEURO
No evidence	NE
No evidence of disease	NED
No significant findings	NSF
Non-Hodgkin lymphoma	NHL
Non insulin dependent diabetes mellitus	NIDDM
Non small cell carcinoma	NSCCA
Non small cell lung carcinoma	NSCLC
Normal	NL or NML or NORM
Not applicable	NA or N/A
Not elsewhere classified	NEC
Not otherwise specified	NOS
Not recorded	NR
Not reportable	NR
Number	#
Nursing home	NH
Obstetrics	OB
Obstructed (-ing, -ion)	OBST
Oncology (ist)	ONC
Operating room	OR
Operative report	OP RPT
Organic brain syndrome	OBS
Orthopedics	ORTHO
Otology	OTO
Ounce	OZ
Outpatient	OP or OUTPT
Pack years	PY
Packs per day	PPD
Palpated (-able)	PALP
Papanicolaou smear	PAP
Papillary	PAP
Papillary transitional cell carcinoma	PTCC
Past/personal (medical) history	PMH
Paternal grandfather	PGF

APPENDIX C

WORD/TERM(S)	ABBREVIATION/SYMBOL
Paternal grandmother	PGM
Pathology	PATH
Patient	PT
Pediatrics	PEDS
Pelvic inflammatory disease	PID
Peptic ulcer disease	PUD
Per rectum	PR
Percutaneous	PERC
Percutaneous transhepatic cholecystogram	PTC
Performance Status	PS
Peripheral blood stem cell transplant	PBSCT
Peripheral nervous system	PNS
Peripheral vascular disease	PVD
Phosphorus 32	P32
Physical examination	PE
Physiotherapy/Physical therapy	PT
Platelets	PLT
Plus	+
Polycythemia vera	P VERA or PCV
Poorly differentiated	PD, POOR DIFF or P/DIFF
Positive	POS
Positive	+
Positron emission tomography	PET
Possible	POSS
Posterior	POST
Postoperative (-ly)	POST OP
Pound(s)	LB(S)
Pound(s)	#
Premature atrial contraction	PAC
Preoperative (-ly)	PRE OP
Prescription	RX
Previous	PREV
Primary care physician	PCP

APPENDIX C

C-21

WORD/TERM(S)	ABBREVIATION/SYMBOL
Primary medical physician	PMP
Prior to admission	PTA
Probable (-ly)	PROB
Proctoscopy	PROCTO
Progesterone receptor (assay)	PR, PRA
Prostatic intraepithelial neoplasia, grade III	PIN III or PIN 3
Prostatic specific antigen	PSA
Pulmonary	PULM
Quadrant	QUAD
Radiation absorbed dose	RAD
Radiation Oncology	RAD ONC or RONC
Radiation therapy	RT or XRT
Radical retropubic prostatectomy	RRP
Radioactive iodine	RAI
Radioactive iodine uptake	RAIU
Radioimmunoassay	RIA
Received	REC'D
Recommend	REC
Red blood cells (count)	RBC
Refractory anemia	RA
Refractory anemia with excess blasts	RAEB
Regarding	RE
Regional	REG
Regional medical center	RMC
Regular	REG
Regular sinus rhythm	RSR
Renal cell carcinoma	RCC
Resection (ed)	RESEC
Reticulum cell sarcoma	RCS
Review of outside films	ROF
Review of outside slides	ROS
Rheumatic heart disease	RHD
Rheumatoid arthritis	RA
Right	RT

APPENDIX C

WORD/TERM(S)	ABBREVIATION/SYMBOL
Right bundle branch block	RBBB
Right costal margin	RCM
Right inner quadrant	RIQ
Right lower extremity	RLE
Right lower lobe	RLL
Right lower quadrant	RLQ
Right middle lobe	RML
Right outer quadrant	ROQ
Right salpingo-oophorectomy	RSO
Right upper extremity	RUE
Right upper lobe	RUL
Right upper quadrant	RUQ
Robotic assisted laparoscopy	RAL
Robotic assisted radical prostatectomy	RARP
Rule out	R/O
Sacral spine	S-SPINE
Sacral vertebra	S1-S5
Salpingo-oophorectomy	SO
Satisfactory	SATIS
Sentinel lymph node	SLN
Sentinel lymph node biopsy	SLNBX
Serum Chromogranin A	CGA
Serum glutamic oxaloacetic transaminase	SGOT
Serum glutamic pyruvic transaminase	SGPT
Serum protein electrophoresis	SPEP
Severe combined immunodeficiency syndrome	SCID
Short(ness) of breath	SOB
Sick sinus syndrome	SSS
Sigmoid colon	SIG COLON or S-COLON
Small	SM
Small bowel	SB
Small cell carcinoma	Small Cell CA
Small lymphocytic lymphoma	SLL
Social History	SH or SHX

APPENDIX C

C-23

WORD/TERM(S)	ABBREVIATION/SYMBOL
Specimen	SPEC
Spine, Cervical	C-SPINE
Spine, Lumbar	L-SPINE
Spine, Sacral	S-SPINE
Spine, Thoracic	T-SPINE
Split thickness skin graft	STSG
Squamous	SQ
Squamous cell carcinoma	SQCC – not SCC
Squamous intraepithelial neoplasia	SIN III
Status post	S/P
Stem cell transplant	SCT
Subcutaneous	SUBCU or SUBQ
Suggestive	SUGG
Summary stage	SS
Superior vena cava	SVC
Supraclavicular	SCV
Supraclavicular fossa	SCF
Surgery/Surgical	SURG
Suspicious/suspected	SUSP
Stem cell transplant	SCT
Symptoms	SX
Syndrome of inappropriate ADH	SIADH
Systemic lupus erythematosus	SLE
Thoracic spine	T-SPINE
Thoracic vertebra	T1 – T12
Thrombotic thrombocytopenia purpura	TTP
Times	X
Tobacco	TOB
Total abdominal hysterectomy	TAH
Total abdominal hysterectomy- bilateral salpingo-oophorectomy	TAH-BSO
Total vaginal hysterectomy	TVH
Transient ischemic attack	TIA
Transitional cell carcinoma	TCC
Transrectal ultrasound	TRUS
Transurethral resection	TUR

APPENDIX C

WORD/TERM(S)	ABBREVIATION/SYMBOL
Transurethral resection bladder	TURB
Transurethral resection prostate	TURP
Transverse colon	TRANS-COLON or T-COLON
Treatment	TX
True vocal cord	TVC
Tuberculosis	TB
Tumor board	TB
Tumor, node, metastasis	TNM
Tumor size	TS
Twice a day (daily)	BID
Ultrasound	US
Undifferentiated	UNDIFF
Unknown	UNK
Upper extremity	UE
Upper gastrointestinal (series)	UGI
Upper inner quadrant	UIQ
Upper outer quadrant	UOQ
Upper respiratory infection	URI
Urinary tract infection	UTI
Vagina/Vaginal	VAG
Vaginal hysterectomy	VAG HYST
Vaginal intraepithelial neoplasia (grade III)	VAIN III or VAIN 3
Vertical growth phase	VGP
Vertical growth rate	VGR
Vital signs	VS
Vulvar intraepithelial neoplasia (grade III)	VIN III or VIN 3
Week(s)	WK(S)
Weight	WT
Weight loss	WL
Well differentiated	WD, WELL DIFF or W/DIFF
White blood cells (count)	WBC
White female	W/F or WF

APPENDIX C

C-25

WORD/TERM(S)	ABBREVIATION/SYMBOL
White male	W/M or WM
With	W/
Within normal limits	WNL
Without	W/O
Wolff-Parkinson-White syndrome	WPW
Work-up	W/U
Xray	XR
Year(s)	YR(S)
Year old	YO or Y/O

APPENDIX C**2016 NAACCR RECOMMENDED ABBREVIATION LIST
ORDERED BY ABBREVIATION/SYMBOL**

ABBREVIATION/SYMBOL	WORD/TERM(S)
ABD	Abdomen (abdominal)
A/P	Abdomen/Pelvis
AP	Abdominal perineal
ABN or ABNL	Abnormal
^	Above
AK(A)	Above knee (amputation)
ABS	Absent/Absence
ABST	Abstract/Abstracted
ATR	Achilles tendon reflex
ACID PHOS	Acid phosphatase
AIDS	Acquired Immune Deficiency Syndrome
ADL	Activities of daily living
AGL	Acute granulocytic leukemia
ALL	Acute lymphocytic leukemia
AML	Acute myelogenous leukemia
AMI	Acute myocardial infarction
ARF	Acute renal failure
ARDS	Acute Respiratory Distress (Disease) Syndrome
ATN	Acute tubular necrosis
ADENOCA or ADENO	Adenocarcinoma
ADENOP	Adenopathy
ATP	Adenosine triphosphate
ADJ	Adjacent
ADM	Admission/Admit
AC	Adrenal cortex
ACH	Adrenal cortical hormone
ACTH	Adrenocorticotrophic hormone
AODM	Adult-onset Diabetes Mellitus

APPENDIX C

C-27

ABBREVIATION/SYMBOL	WORD/TERM(S)
ADR	Adverse drug reaction
AFF	Affirmative
AA	African American
AMA	Against medical advice
ARC	AIDS-related condition (complex)
ARD	AIDS-related disease
ACBE	Air contrast barium enema
ALB	Albumin
ETOH	Alcohol
ALK PHOS	Alkaline phosphatase
AFP	Alpha-fetoprotein
AKA	Also known as
AMB	Ambulatory
AMT	Amount
AMP	Amputation
ALS	Amyotrophic lateral sclerosis
AIN III	Anal intraepithelial neoplasia, grade III
ANAP	Anaplastic
&	And
ANGIO	Angiography/Angiogram
ANT	Anterior
A-P	Anteroposterior
ABX	Antibiotics
AB	Antibody
ADH	Antidiuretic hormone
AG	Antigen
A-STEN	Aortic stenosis
APPL'Y	Apparently
APP	Appendix
≈	Approximately
AI	Aromatase inhibitor
ARRHY	Arrhythmia
ABG	Arterial blood gases
ASCVD	Arteriosclerotic cardiovascular disease
ASHD	Arteriosclerotic heart disease
ASPVD	Arteriosclerotic Peripheral Vascular Disease

APPENDIX C

ABBREVIATION/SYMBOL	WORD/TERM(S)
AS	Arteriosclerosis/Arteriosclerotic
AV	Arteriovenous
AVM	Arteriovenous malformation
ART	Artery (ial)
ASAP	As soon as possible
A-COLON	Ascending colon
ASP	Aspiration
ASA	Aspirin, Acetylsalicylic acid
ASSOC	Associated
@	At
A FIB	Atrial fibrillation
A FLUTTER	Atrial flutter
APC	Atrial premature complexes
AI	Atrial stenosis/insufficiency/incompetence
A&P	Auscultation & percussion
AIHA	Autoimmune hemolytic anemia
ANS	Autonomic nervous system
AUT	Autopsy
AVG	Average
AX	Axilla(ry)
AXLND or ALND	Axillary Lymph Node Dissection
BCG	Bacillus Calmette-Guerin
BA	Barium
BE	Barium enema
BUS	Bartholin's, Urethral & Skene's
BCC	Basal cell carcinoma
BOT	Base of tongue
AM	Before noon
BK(A)	Below knee (amputation)
BPH	Benign prostatic hypertrophy/hyperplasia
BIL or B/L	Bilateral

APPENDIX C

C-29

ABBREVIATION/SYMBOL	WORD/TERM(S)
BSO	Bilateral salpingo-oophorectomy
BD	Bile duct
BRM	Biological response modifier
BX	Biopsy
BAD	Bipolar affective disorder
B/F or BF	Black female
B/M or BM	Black male
BT	Bladder tumor
BP	Blood pressure
BUN	Blood urea nitrogen
BV	Blood volume
BR	Bloom-Richardson
BMI	Body mass index
BSA	Body surface area
BM	Bone marrow
BMBX	Bone marrow biopsy
BMT	Bone marrow transplant
BSC	Bone scan
BM	Bowel movement
BRACHY	Brachytherapy
BT	Brain tumor
BRCA 1 and BRCA 2	Breast cancer susceptibility gene
BRBPR	Bright red blood per rectum
BRO	Brother
CA++ or CALC(s)	Calcification(s)
CA	Calcium
SPELL OUT; DO NOT ABBREVIATE	Cancer
CA 125	Cancer Antigen 125
CAP(S)	Capsule (s)
CA 19-9	Carbohydrate Antigen 19-9
CEA	Carcinoembryonic antigen
CA	Carcinoma
CIS	Carcinoma <i>in situ</i>
CVD	Cardiovascular disease
CT	CAT/CT scan/Computerized axial tomography

APPENDIX C

ABBREVIATION/SYMBOL	WORD/TERM(S)
CGY	Centigray
CM	Centimeter
CFN	Centimeters from nipple
CNS	Central nervous system
CSF	Cerebrospinal fluid
CVA	Cerebrovascular accident
CIN	Cervical intraepithelial neoplasia
CIN III or CIN 3	Cervical intraepithelial neoplasia, grade III
C-SPINE	Cervical spine
C1-C7	Cervical vertebrae
CHG	Change
CHEMO	Chemotherapy
C/A/P	Chest, abdomen, pelvis
CXR	Chest X-ray
CC	Chief complaint
CISH	Chromogenic in situ hybridization
CHR	Chronic
CGL	Chronic granulocytic leukemia
CLL	Chronic lymphocytic leukemia
CML	Chronic myeloid (myelocytic) leukemia
COLD	Chronic obstructive lung disease
COPD	Chronic obstructive pulmonary disease
CRF	Chronic renal failure
CUC	Chronic ulcerative colitis
CIG	Cigarettes
CTC	Circulating tumor cells
CRM	Circumferential resection margin
CLR	Clear
CO60	Cobalt 60
CS	Collaborative stage
A-COLON	Colon, Ascending
D-COLON	Colon, Descending
SIG COLON or S-COLON	Colon, Sigmoid
TRANS-COLON or T-COLON	Colon, Transverse

APPENDIX C

C-31

ABBREVIATION/SYMBOL	WORD/TERM(S)
C-SF	Colony-stimulating factor
C/O	Complaint (-ning) of
CBC	Complete blood count
CHD	Congenital heart disease
CHF	Congestive heart failure
C/W	Consistent with
CONT	Continue/continuous
CONTRA	Contralateral
CABG	Coronary artery bypass graft
CAD	Coronary artery disease
CCU	Coronary care unit
CM	centimeter
CF	Cystic fibrosis
CYSTO	Cystoscopy
CYTO	Cytology
DOB	Date of birth
DOD	Date of death
DOA	Dead on arrival
DECR	Decrease(d)
DTR	Deep tendon reflex
DVT	Deep vein thrombosis
DJD	Degenerative joint disease
DNA	Deoxyribonucleic acid
DERM	Dermatology
D-COLON	Descending colon
DM	Diabetes mellitus
DX	Diagnosis
DIAM	Diameter
DES	Diethylstilbestrol
DIFF	Differentiated/differential
DDX	Differential diagnosis
DRE	Digital rectal examination
D&C	Dilatation and curettage
DISCH or D/C	Discharge

APPENDIX C

ABBREVIATION/SYMBOL	WORD/TERM(S)
DC	Discontinue(d)
DZ	Disease
DIC	Disseminated intravascular coagulopathy
DTC	Disseminated tumor cells
DK	Don't/Doesn't know
DCIS	Ductal carcinoma <i>in situ</i>
D/T	Due to
DOE	Dyspnea on exertion
ENT	Ears, nose, and throat
ECG/EKG	Electrocardiogram
EEG	Electroencephalogram
EMG	Electromyogram
EV	Electron volt
ELEV or ^	Elevated
ED	Emergency department
ER	Emergency room
ESRD	End stage renal disease
ERCP	Endoscopic retrograde cholangiopancreatography
ENLGD or ENL	Enlarged
EGFR	Epidermal growth factor receptor
=	Equal(s)
EGD	Esophagogastro-duodenoscopy
ER, ERA	Estrogen receptor (assay)
EVAL	Evaluation
Q	Every
QD	Every day
E/O	Evidence of
EUA	Exam under anesthesia
EXAM	Examination
EXC(D)	Excision/excised
EXP	Expired
EXPL	Exploratory
EXPL LAP or EXP LAP	Exploratory laparotomy

APPENDIX C

C-33

ABBREVIATION/SYMBOL	WORD/TERM(S)
EXT	Extend/extension
EBRT	External beam radiotherapy
XRT	External radiation therapy
EENT	Eye, ear, nose, throat
FAP	Familial adenomatous polyposis
FHX	Family History
FUO	Fever of unknown origin
FNA	Fine needle aspiration
FNAB	Fine needle aspiration biopsy
FOM	Floor of mouth
FLOW CYTO	Flow cytometry
FL	Fluid
FISH	Fluorescence in situ hybridization
FLURO	Fluoroscopy
FLIPI	Follicular lymphoma international prognostic index
FU	Follow-up
E.G.	For example
FX(s)	Fraction(s)
FX	Fracture
FREQ	Frequent/Frequency
FS	Frozen section
FTSG	Full thickness skin graft
GB	Gallbladder
GE	Gastroesophageal
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GIST	Gastrointestinal stromal tumors
GEN	General/Generalized
GU	Genitourinary
GR	Grade
GY	Gray
>	Greater/Greater than
GYN	Gynecology
HCT	Hematocrit

APPENDIX C

ABBREVIATION/SYMBOL	WORD/TERM(S)
HEM/ONC	Hematology/Oncology (ist)
H&E	Hematoxylin and Eosin
HGB	Hemoglobin
H/H	Hemoglobin and hematocrit
HAV or HEP A	Hepatitis A (virus)
HBV or HEP B	Hepatitis B (virus)
HCV or HEP C	Hepatitis C (virus)
HDV or HEP D	Hepatitis D (virus)
HSM	Hepatosplenomegaly
HDR	High dose rate
HGSIL	High grade squamous intraepithelial lesion
HF	Hispanic female
HM	Hispanic male
HX	History
H&P	History and physical
H/O	History of
HPI	History of present illness
HORM	Hormone
HRT	Hormone replacement therapy
HOSP	Hospital
HR(S)	Hour/Hours
HCG	Human chorionic gonadotropin
HER2	Human epidermal growth factor receptor 2
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HTLV	Human T-Lymphotropic Virus, (Type III)
HTN	Hypertension
HCVD	Hypertensive cardiovascular disease
HVD	Hypertensive vascular disease
HYST	Hysterectomy
IHSS	Idiopathic hypertrophic subaortic stenosis
ITP	Idiopathic thrombocytopenia
IG	Immunoglobulin
IHC	Immunohistochemical

APPENDIX C

C-35

ABBREVIATION/SYMBOL	WORD/TERM(S)
IMP	Impression
I&D	Incision & drainage
INCL	Includes/Including
INCR	Increase(d)
INF	Inferior
IVC	Inferior vena cava
INFILT or INFIL	Infiltrating
IDC	Infiltrating/invasive ductal carcinoma
IBD	Inflammatory bowel disease
IP or INPT	Inpatient
IDDM	Insulin-dependent diabetes mellitus
IMRT	Intensity modulated radiation therapy
ICU	Intensive care unit
ICM	Intercostal margin
ICS	Intercostal space
IPPB	Intermittent positive pressure breathing
INT	Internal
IPI	International prognostic index (for lymphoma)
IPS	International prognostic score
ILD	Interstitial lung disease
ICB	Intracavitary brachytherapy
IM	Intramuscular
IP	Intraperitoneal
IT	Intrathecal
IV	Intravenous
IVCA	Intravenous cholangiogram
IVP	Intravenous pyelogram
INV	Invade(s)/invading/invasion
INVL	Involve(s)/involvement/involving
I-131	Iodine 131
IPSI	Ipsilateral
IRREG	Irregular
ITC	Isolated tumor cells
JAK2	Janus kinase 2
JVD	Jugular venous distention
JRA	Juvenile rheumatic arthritis

APPENDIX C

ABBREVIATION/SYMBOL	WORD/TERM(S)
KS	Kaposi sarcoma
KUB	Kidneys, ureters, bladder
KG	Kilogram
KV	Kilovolt
LAB	Laboratory
LDH	Lactic dehydrogenase
LAP	Laparotomy
LRG	Large
LIN	Laryngeal intraepithelial neoplasia
LMP	Last menstrual period
LAT	Lateral
LT	Left
LBBB	Left bundle branch block
LCM	Left costal margin
LLE	Left lower extremity
LLL	Left lower lobe
LLQ	Left lower quadrant
LSO	Left salpingo-oophorectomy
LUE	Left upper extremity
LUL	Left upper lobe
LUOQ	Left upper outer quadrant
LUQ	Left upper quadrant
<	Less/Less than
LPN	Licensed practical nurse
LINAC	Linear accelerator
LFT	Liver function test
LS SCAN	Liver/spleen scan
LCIS	Lobular carcinoma in situ
LDR	Low dose rate
LE	Lower extremity
LIQ	Lower inner quadrant
LOQ	Lower outer quadrant

APPENDIX C

C-37

ABBREVIATION/SYMBOL	WORD/TERM(S)
L-SPINE	Lumbar spine
L1-L5	Lumbar vertebra
LS	Lumbosacral
SLE	Lupus erythematosus
LN(S)	Lymph node(s)
LND	Lymph node dissection
LAD or LAN	Lymphadenopathy
LAV	Lymphadenopathy-associated virus
LVI	Lymph/vascular invasion
M-CSF	Macrophage colony-stimulating factor
MRCP	Magnetic resonance cholangiopancreatography
MRI	Magnetic resonance imaging
MSB	Main stem bronchus
MALIG or MAL	Malignant/malignancy
SPELL OUT; DO NOT ABBREVIATE	Malignant melanoma
MMG or MAMMO	Mammogram
MAND	Mandible/mandibular
MGF	Maternal grandfather
MGM	Maternal grandmother
MAX	Maximum
MC	Medical center
MED ONC	Medical Oncology (ist)
MED	Medication
MV	Megavolt
MIS	Melanoma in situ
METS	Metastatic/Metastasis
MRSA	Methicillin Resistant Staphylococcus Aureus
MCG	Microgram
MSI	Microsatellite instability
MICRO	Microscopic

APPENDIX C

ABBREVIATION/SYMBOL	WORD/TERM(S)
ML	Middle lobe
MC(H)	Millicurie (hours)
MG(H)	Milligram (hours)
ML	Milliliter
MM	Millimeter
MEV	Million electron volts
MIBB	Minimally invasive breast biopsy
MIN	Minimum
-	Minus
MIN	Minute
MVP	Mitral valve prolapse
MCID	Mixed combined immunodeficiency
MCTD	Mixed connective tissue disease
MOD	Moderate (ly)
MD, MOD DIFF or M/DIFF	Moderately differentiated
MRM	Modified radical mastectomy
MGUS	Monoclonal gammopathy of uncertain significance
MO(S)	Month(s)
>	More/More than
MCN	Mucinous cystic neoplasm
MAT	Multifocal atrial tachycardia
MPVC	Multifocal premature ventricular contraction
MULT	Multiple
MS	Multiple sclerosis
SPELL OUT; DO NOT ABBREVIATE	Multiple myeloma
MG	Myasthenia gravis
MDS	Myelodysplastic syndrome
MI	Myocardial infarction
N&V or N/V	Nausea and vomiting, nausea/vomiting
NVD	Neck vein distention
NEG	Negative
-	Negative
NEOPL	Neoplasm
NET	Neuroendocrine tumor

APPENDIX C

C-39

ABBREVIATION/SYMBOL	WORD/TERM(S)
NEURO	Neurology
NE	No evidence
NED	No evidence of disease
NSF	No significant findings
NHL	Non-Hodgkin lymphoma
NIDDM	Non insulin dependent diabetes mellitus
NSSCA	Non small cell carcinoma
NSCLC	Non small cell lung carcinoma
NL or NML or NORM	Normal
NA or N/A	Not applicable
NEC	Not elsewhere classified
NOS	Not otherwise specified
NR	Not recorded
NR	Not reportable
#	Number
NH	Nursing home
OB	Obstetrics
OBST	Obstructed (-ing, -ion)
ONC	Oncology (ist)
OR	Operating room
OP RPT	Operative report
OBS	Organic brain syndrome
ORTHO	Orthopedics
OTO	Otology
OZ	Ounce
OP or OUTPT	Outpatient
PY	Pack years
PPD	Packs per day
PALP	Palpated (-able)
PAP	Papanicolaou smear
PAP	Papillary
PTCC	Papillary transitional cell carcinoma
PMH	Past/personal (medical) history
PGF	Paternal grandfather

APPENDIX C

ABBREVIATION/SYMBOL	WORD/TERM(S)
PGM	Paternal grandmother
PATH	Pathology
PT	Patient
PEDS	Pediatrics
PID	Pelvic inflammatory disease
PUD	Peptic ulcer disease
PR	Per rectum
PERC	Percutaneous
PTC	Percutaneous transhepatic cholecystogram
PS	Performance Status
PBSCT	Peripheral blood stem cell transplant
PNS	Peripheral nervous system
PVD	Peripheral vascular disease
P32	Phosphorus 32
PE	Physical examination
PT	Physiotherapy/Physical therapy
PLT	Platelets
+	Plus
P VERA or PCV	Polycythemia vera
PD, POOR DIFF or P/DIFF	Poorly differentiated
POS	Positive
+	Positive
PET	Positron emission tomography
POSS	Possible
POST	Posterior
POST OP	Postoperative (-ly)
LB(S)	Pound(s)
#	Pound(s)
PAC	Premature atrial contraction
PRE OP	Preoperative (-ly)
RX	Prescription
PREV	Previous
PCP	Primary care physician

APPENDIX C

C-41

ABBREVIATION/SYMBOL	WORD/TERM(S)
PMP	Primary medical physician
PTA	Prior to admission
PROB	Probable (-ly)
PROCTO	Proctoscopy
PR, PRA	Progesterone receptor (assay)
PIN III or PIN 3	Prostatic intraepithelial neoplasia, grade III
PSA	Prostatic specific antigen
PULM	Pulmonary
QUAD	Quadrant
RAD	Radiation absorbed dose
RAD ONC or RONC	Radiation Oncology
RT or XRT	Radiation therapy
RRP	Radical retropubic prostatectomy
RAI	Radioactive iodine
RAIU	Radioactive iodine uptake
RIA	Radioimmunoassay
REC'D	Received
REC	Recommend
RBC	Red blood cells (count)
RA	Refractory anemia
RAEB	Refractory anemia with excess blasts
RE	Regarding
REG	Regional
RMC	Regional medical center
REG	Regular
RSR	Regular sinus rhythm
RCC	Renal cell carcinoma
RESEC	Resection (ed)
RCS	Reticulum cell sarcoma
ROF	Review of outside films
ROS	Review of outside slides
RHD	Rheumatic heart disease
RA	Rheumatoid arthritis
RT	Right

APPENDIX C

ABBREVIATION/SYMBOL	WORD/TERM(S)
RBBB	Right bundle branch block
RCM	Right costal margin
RIQ	Right inner quadrant
RLE	Right lower extremity
RLL	Right lower lobe
RLQ	Right lower quadrant
RML	Right middle lobe
ROQ	Right outer quadrant
RSO	Right salpingo-oophorectomy
RUE	Right upper extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
RAL	Robotic assisted laparoscopy
RARP	Robotic assisted radical prostatectomy
R/O	Rule out
S-SPINE	Sacral spine
S1-S5	Sacral vertebra
SO	Salpingo-oophorectomy
SATIS	Satisfactory
SLN	Sentinel lymph node
SLNBX	Sentinel lymph node biopsy
CGA	Serum Chromogranin A
SGOT	Serum glutamic oxaloacetic transaminase
SGPT	Serum glutamic pyruvic transaminase
SPEP	Serum protein electrophoresis
SCID	Severe combined immunodeficiency syndrome
SOB	Short(ness) of breath
SSS	Sick sinus syndrome
SIG COLON or S-COLON	Sigmoid colon
SM	Small
SB	Small bowel
Small Cell CA – not SCC	Small cell carcinoma
SLL	Small lymphocytic lymphoma
SH or SHX	Social History

APPENDIX C

C-43

ABBREVIATION/SYMBOL	WORD/TERM(S)
SPEC	Specimen
C-SPINE	Spine, Cervical
L-SPINE	Spine, Lumbar
S-SPINE	Spine, Sacral
T-SPINE	Spine, Thoracic
STSG	Split thickness skin graft
SQ	Squamous
SQCC – not SCC	Squamous cell carcinoma
SIN III	Squamous intraepithelial neoplasia
S/P	Status post
SCT	Stem cell transplant
SUBCU or SUBQ	Subcutaneous
SUGG	Suggestive
SS	Summary stage
SVC	Superior vena cava
SCV	Supraclavicular
SCF	Supraclavicular fossa
SURG	Surgery/Surgical
SUSP	Suspicious/suspected
SCT	Stem cell transplant
SX	Symptoms
SIADH	Syndrome of inappropriate ADH
SLE	Systemic lupus erythematosus
T-SPINE	Thoracic spine
T1 – T12	Thoracic vertebra
TTP	Thrombotic thrombocytopenia purpura
X	Times
TOB	Tobacco
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy- bilateral salpingo-oophorectomy
TVH	Total vaginal hysterectomy
TIA	Transient ischemic attack
TCC	Transitional cell carcinoma
TRUS	Transrectal ultrasound
TUR	Transurethral resection

APPENDIX C

ABBREVIATION/SYMBOL	WORD/TERM(S)
TURB	Transurethral resection bladder
TURP	Transurethral resection prostate
TRANS-COLON or T-COLON	Transverse colon
TX	Treatment
TVC	True vocal cord
TB	Tuberculosis
TB	Tumor board
TNM	Tumor, node, metastasis
TS	Tumor size
BID	Twice a day (daily)
US	Ultrasound
UNDIFF	Undifferentiated
UNK	Unknown
UE	Upper extremity
UGI	Upper gastrointestinal (series)
UIQ	Upper inner quadrant
UOQ	Upper outer quadrant
URI	Upper respiratory infection
UTI	Urinary tract infection
VAG	Vagina/Vaginal
VAG HYST	Vaginal hysterectomy
VAIN III or VAIN 3	Vaginal intraepithelial neoplasia (grade III)
VGP	Vertical growth phase
VGR	Vertical growth rate
VS	Vital signs
VIN III or VIN 3	Vulvar intraepithelial neoplasia (grade III)
WK(S)	Week(s)
WT	Weight
WL	Weight loss
WD, WELL DIFF or W/DIFF	Well differentiated
WBC	White blood cells (count)
W/F or WF	White female

APPENDIX C

C-45

ABBREVIATION/SYMBOL	WORD/TERM(S)
W/M or WM	White male
W/	With
WNL	Within normal limits
W/O	Without
WPW	Wolff-Parkinson-White syndrome
W/U	Work-up
XR	Xray
YR(S)	Year(s)
YO or Y/O	Year old

APPENDIX C**2015 NAACCR RECOMMENDED ABBREVIATION LIST
CONTEXT-SENSITIVE ABBREVIATIONS**

ABBREVIATION/SYMBOL	WORD/TERM(S)
AP	Anteroposterior
AP	Abdominal perineal
BM	Bone marrow
BM	Bowel movement
CA	Calcium
CA	Carcinoma
MIN	Minimum
MIN	Minute
ML	Milliliter
ML	Middle lobe
MM	Millimeter
MM	Multiple myeloma
PAP	Papillary
PAP	Papanicolaou smear
PT	Patient
PT	Physiotherapy/Physical therapy
RT	Right
RT	Radiation therapy

APPENDIX D

RACE CODING INSTRUCTIONS

AND

**RACE AND NATIONALITY DESCRIPTIONS
FROM THE 2000 CENSUS AND BUREAU OF VITAL STATISTICS**

**RACE AND NATIONALITY DESCRIPTIONS
ALPHABETIC INDEX**

Race Coding Instructions
Adopted from SEER Coding and Staging Manual 2004

1. Code the primary race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5. The five race fields allow for the coding of multiple races consistent with the Census 2000. Rules 2 - 8 further specify how to code Race 1, Race 2, Race 3, Race 4 and Race 5.
2. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white in the next race field.
3. If a person's race is a combination of Hawaiian and any other race(s), code Race 1 as 07 Hawaiian and code the other races in Race 2, Race 3, Race 4, and Race 5 as appropriate.

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

4. If the person is not Hawaiian, code Race 1 to the first stated non-white race (02-98).

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

Note: in the following scenarios, only the race code referred to in the example is coded. For cases diagnosed after January 1, 2000, all race fields must be coded.

5. The fields Place of Birth, Race, Marital Status, Name, Maiden Name, and Hispanic Origin are inter-related. Use the following guidelines in priority order:
 - a. Code the patient's stated race, if possible. Refer to Appendix "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" for guidance.

Example 1: Patient is stated to be Japanese. Code as 05 Japanese.

Example 2: Patient is stated to be German-Irish. Code as 01 White.

Example 3: Patient is described as Arabian. Code as 01 White.

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

Example 4: The person's race is recorded as Asian and the place of birth is recorded as Japan. Code race as 05 Japanese because it is more specific than 96 Asian, NOS.

Example 5: The person describes himself as an Asian-American born in Laos. Code race as 11 Laotian because it is more specific than 96 Asian, NOS.

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

Example: The patient is described as Asian-American with Korean parents. Code race as 08 Korean because it is more specific than 96 Asian [-American].

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

Example 1: Patient described as a black female. Code as 02 Black.

Example 2: Patient describes herself as multi-racial (nothing more specific) and nursing notes say "African-American." Code as 02 Black.

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

8. If race is unknown or not stated in the medical record and birth place is recorded, in some cases race may be inferred from the nationality. Refer to the Appendix entitled "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" to identify nationalities from which race codes may be inferred.

Example 1: Record states: "this native of Portugal..." Code race as 01 White per the Appendix.

Example 2: Record states: "this patient was Nigerian..." Code race as 02 Black per the Appendix.

Exception: If the patient's name is incongruous with the race inferred on the basis of nationality, code Race 1 through Race 5 as 99, Unknown.

Example 1: Patient's name is Siddhartha Rao and birthplace is listed as England. Code Race 1 through Race 5 as 99 Unknown.

Example 2: Patient's name is Ping Chen and birthplace is Ethiopia. Code Race 1 through Race 5 as 99 Unknown.

9. Use of patient name in determining race:
 - a. Do not code race from name alone, especially for females with no maiden name given.
 - b. In general, a name may be an indicator of a racial group, but should not be taken as the only indicator of race.

- c. A patient name may be used to identify a more specific race code.

Example 1: Race reported as Asian, name is Hatsu Mashimoto. Code race as 05 Japanese.

Example 2: Birthplace is reported as Guatemala and name is Jose Chuicol [name is identified as Mayan]. Code race as 03 Native American

- d. A patient name may be used to infer Spanish ethnicity or place of birth, but a Spanish name alone (without a statement about race or place of birth) cannot be used to determine the race code. Refer to ethnicity guidelines for further information.

Example: Alice Gomez is a native of Indiana (implied birthplace: United States). Code Race 1 through Race 5 as 99 Unknown, because nothing is known about her race...

10. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do NOT code a patient stated to be Hispanic or Latino as 98 Other Race in Race 1 and 88 in Race 2 through Race 5.

Example: Sabrina Fitzsimmons is a native of Brazil. Code race as 01 White per Appendix.

11. When the race is recorded as Negro or African-American, code race as 02 Black.
12. Code 03 should be used for any person stated to be Native American or [western hemisphere] Indian, whether from North, Central, South, or Latin America. For Central, South, or Latin American Indians, see additional ethnicity coding guidelines under Spanish Surname or Origin.
13. Death certificate information may be used to supplement ante mortem race information only when race is coded unknown in the patient record or when the death certificate information is more specific.

Example 1: In the cancer record Race 1 through Race 5 are coded as 99 Unknown. The death certificate states race as black. Change cancer record for Race 1 to 02 Black and Race 2 through Race 5 to 88.

Example 2: Race 1 is coded in the cancer record as 96 Asian. Death certificate gives birthplace as China. Change Race 1 in the cancer record to 04 Chinese and code Race 2 through Race 5 as 88.

**RACE AND NATIONALITY DESCRIPTIONS
FROM THE 2000 CENSUS AND BUREAU OF VITAL STATISTICS**

Note: Use these lists only when race is not stated but other information is provided in the medical record.

References:

1. *"Race and Ethnicity Code Set, Version 1.0," Centers for Disease Control and Prevention, March 2000.*
2. *"Instruction manual, part 4: Classification And Coding Instructions For Death Records, 1999-2001," Division of Vital Statistics, National Center for Health Statistics, undated*

Key

- † Use this code unless patient is stated to be Native American (Indian)
- * Terms listed in reference 2, above.
- ‡ Description of religious affiliation rather than stated nationality or ethnicity; should be used with caution when determining appropriate race code.

CODE 01 WHITE

Afghan, Afghanistani
Afrikaner
Albanian
Algerian*
Amish*
Anglo-Saxon*
Arab, Arabian
Argentinian*†
Armenian
Assyrian
Australian*
Austrian*
Azores*
Basque*
Bavarian*
Bolivian*†
Bozniak/Bosnian
Brava/Bravo*
Brazilian†
Bulgarian
Cajun
Californio
Canadian*
Caucasian*
Central American†
Chechnyan
Chicano*
Chilean†
Colombian*†
Costa Rican*†
Creole*
Croat/Croatian
Crucian*
Cuban (unless specified as Black)*
Cypriot
Czechoslovakian*
Eastern European
Ebian*

Ecuadorian*†
Egyptian
English
English-French*
English-Irish*
European*
Finnish*
French
French Canadian*
Georgian*
German
Greek*
Guatemalan†
Gypsy*
Hebrew*‡
Herzegovenian
Hispanic*
Honduran†
Hungarian*
Iranian, Iran
Iraqi
Irish
Islamic*‡
Israeli
Italian
Jordanian*
Kurd/Kurdish
Kuwaitian*
Ladina/Ladino*
Latin American*†
Latino
Latvian*
Lebanese
Libyan*
Lithuanian*
Maltese*
Marshenese*
Mauritian*
Moroccan*
Mediterranean*
Mexican†
Middle Eastern
Moroccan*
Moslem*‡
Muslim*
Near Easterner
Nicaraguan†
Nordic*
North African
Norwegian*
Other Arab

Palestinian
Panamanian†
Paraguayan†
Parsi*
Persian*
Peruvian*†
Polish
Portuguese*
Puerto Rican (unless specified as Black)
Romanian*
Rumanian
Russian*
Salvadoran†
Saudi Arabian*
Scandinavian*
Scottish, Scotch
Semitic*‡
Serbian*
Servian*
Shi'ite‡
Sicilian*
Slavic, Slovakian*
South American†
Spanish*, Spaniard
Sunni*‡
Swedish*
Syrian
Tunisian*
Turkish, Turk*
Ukrainian*
United Arab Emirati
Uruguayan†
Venezuelan*†
Welsh*
White
Yemenite*
Yugoslavian*
Zoroastrian*

CODE 02 BLACK OR AFRICAN AMERICAN

African
African American
Afro-American
Bahamian
Barbadian
Bilalian*
Black
Botswana
Cape Verdean*
Dominica Islander (unless specified as White)
Dominican/Dominican Republic (unless specified as White)

Eritrean*
Ethiopian
Ghanian*
Haitian
Hamitic*
Jamaican
Kenyan*
Liberian
Malawian*
Mugandan*
Namibian
Nassau*
Negro
Nigerian
Nigritian
Nubian*
Other African
Santo Domingo*
Seychelloise*
Sudanese*
Tanzanian*
Tobagoan
Togolese*
Trinidadian
West Indian
Zairean

CODE 03 AMERICAN INDIAN AND ALASKA NATIVE

(see separate list of tribes)

Alaska Native
Aleut
American Indian
Central American Indian
Eskimo
Meso American Indian
Mexican American Indian
South American Indian
Spanish American Indian

ASIAN RACE CODES

<u>Code</u>	<u>Definition</u>
96	Amerasian
16	Asian Indian
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
96	Asian
96	Asiatic
96	Bangladeshi
96	Bhutanese
96	Bornean
96	Bruneian
96	Burmese
13	Cambodian
96	Celebesian
96	Ceram
96	Ceylonese
04	Chinese
96	Eurasian
06	Filipino
12	Hmong
96	Indo-Chinese
96	Indonesian
05	Iwo Jiman
05	Japanese
96	Javanese
13	Kampuchean
08	Korean
11	Laotian
96	Maldivian
96	Madagascar
96	Malaysian
96	Mongolian
96	Montagnard
96	Nepalese
05	Okinawan
96	Oriental
96	Other Asian
17	Pakistani
96	Sikkimese
96	Singaporean
96	Sri Lankan
96	Sumatran
04	Taiwanese
14	Thai
96	Tibetan
10	Vietnamese
96	Whello
96	Yello

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER CODES

<u>Code</u>	<u>Definition</u>
20	Bikinian
20	Carolinian
21	Chamorro
20	Chuukese
25	Cook Islander
20	Eniwetok, Enewetak
31	Fijian
22	Guamanian
07	Hawaiian
20	Kirabati
20	Kosraean
20	Kwajalein
97	Maori
20	Mariana Islander
20	Marshallese
30	Melanesian
20	Micronesian, NOS
07	Native Hawaiian
97	Nauruan
30	New Caledonian
30	New Hebrides
97	Other Pacific Islander
97	Pacific Islander
20	Palauan
32	Papua New Guinean
07	Part Hawaiian
20	Pohnpeian
25	Polynesian
20	Ponapean
20	Saipanese
27	Samoan
30	Solomon Islander
26	Tahitian
20	Tarawan
20	Tinian
25	Tokelauan
28	Tongan
20	Trukese
25	Tuvaluan
30	Vanuatuan
20	Yapese

98 OTHER RACE, NOT ELSEWHERE CLASSIFIED

Do not use this code for Hispanic, Latino or Spanish, NOS.

OTHER RACE DESCRIPTIONS

Note 1: The following descriptions of ethnic origin cannot be coded to a specific race code. Look for other descriptions of race in the medical record. If no further information is available, code as 99 Unknown.

Aruba Islander
Azerbaijani
Belizean
Bermudan
Cayenne
Cayman Islander
Guyanese
Indian (not specified as Native American,
Eastern Indian, Northern, Central, or South
American Indian)
Mestizo
Morena
South African
Surinam
Tejano

Note 2: The following terms self-reported in the 2000 Census cannot be coded to a specific race code. Look for other descriptions of race in the medical record. If no further information is available, code as 99 Unknown.

Biracial
Interracial
Mixed
Multiethnic
Multinational
Multiracial

Indian Tribes of the United States, Canada and Mexico (Race Code 03)

Source: National Center for Health Statistics: Appendix C, Instruction Manual, part 4: Classification and Coding Instructions For Death Records, 1999-2001.

Abnaki
Absentee-Shawnee
Acoma
Ak Chin
Alabama-Coushatt Tribes of Texas
Alsea
Apache
Arapaho
Arikara
Assiniboin
Atacapa
Athapaskan
Atsina
Aztec
Bear River

Beaver
Bella Coola
Beothuk
Blackfoot
Boold Piegan
Blue Lake
Brotherton
Caddo
Cakchiquel-Ienca
Calapooya
Carrier
Catawba
Cattaraugus
Cayuga
Cayuse
Chasta Costa
Chehalis
Chemehuevi
Cherokee
Chetco
Cheyenne
Cheyenne River Sioux
Chickahominy
Chickasaw
Chinook
Chipewyan
Chippewa
Chippewa-Ojibwa
Chiricahua Apache
Chitimacha
Choctaw
Chol
Chontal
Chorti
Chuckchansi
Chumash
Clallam
Clatsop
Clackamas
Clear Lake
Coast Salish
Cochimi
Cochiti
Cocopa
Coeur D'Alene Tribe of Idaho
Cocopah
Columbia
Colville
Comox
Comanche
Concow

Conquille
Coushatta
Covelo
Cow Creek
Cowichan
Cowlitz
Coyotero Apache
Cree
Creek
Crow
Crow Creek Sioux
Dakota
Delaware
Diegueno
Digger
Dog Rib
Duckwater
Eskimo
Euchi
Eyak
Flathead
Fort Hall Res. Tribe of Idaho
French Indian
Gabrieleno
Galice Creek
Gay Head
Gosiute
Gros Ventre
Haida
Han
Hare
Hat Creek
Hawasupai
Hidatsa
Hoh
Hoopa
Hopi
Houma
Hualapai
Huastec
Humboldt Bay
Hupa
Huron
Illinois
Ingalik
Iowa
Iroquois
Isleta
Jemez
Joshua
Juaneno

Jicarilla Apache
Kaibah
Kalispel
Kanosh Band of Paiutes
Kansa
Karankawa
Karok
Kaska
Kaw
Kawai
Keresan Pueblos
Kern River
Kichai
Kickapoo
Kiowa
Kiowa Apache
Kitamat
Klamath
Klikitat
Koasati
Kootenai Tribe of Idaho
Kusa
Kutchin
Kutenai
Kwakiutl
Lac Courte Dreille
Laguna
Lakmuit
Lipan Apache
Lower Brule Sioux
Luiseno
Lummi
Maidu
Makah
Malecite
Mandan
Maricopa
Mary's River
Mashpee
Mattaponi
Maya
Mayo
Mdewakanton Sioux
Menominee
Menomini
Mequendodon
Mescalero Apache
Miami
Micmac
Mission Indians
Missouri

Miwok
Mixe
Mixtec
Modoc
Mohave
Mohawk
Mohegan
Molala
Monachi
Mono
Montagnais
Montauk
Muckleshoot
Munsee
Nambe
Namsemond
Nanticoke
Narragansett
Naskapi
Natchez
Navaho
Navajo
Nez Perce
Niantic
Nipmuck
Nisenan-Patwin
Nisqually
Nomelaki
Nooksak
Nootka
Northern Paiute
Oglala Sioux
Okanogan
Omaha
Oneida
Onondaga
Opata
Opato
Osage
Oto
Otoe
Otomi
Ottawa
Ozette
Paiute
Pamunkey
Panamint
Papago
Passamaquoddy
Patwin
Pawnee

Pen d'Oreille
Penobscot
Peoria
Pequot
Picuris
Pima
Pit River
Pojoaque
Pomo
Ponca
Poosepatuck
Potawatomi
Potomac
Powhatan
Pueblos
Puyallup
Quapaw
Quechan
Quileute
Quinaielt
Quinault
Rappahannock
Rogue River
Rosebud Sioux
Sac and Fox
Saginaw
Salish
Sandia
San Felipe
San Ildefonso
San Juan
San Lorenzo
San Luis Obispo
San Luiseno
Sanpoil
Sanpoil Nespelem
Sant'ana
Santa Barbara
Santa Clara
Santa Ynez
Santee
Santee Sioux
Santiam
Sauk and Fox
Scaticook
Sekane
Seminole
Seneca
Seri
Shasta
Shawnee

Shinnecock
Shivwits Band of Paiutes
Shoshone
Shoshone-Bannock
Shuswap
Siouans
Sioux
Sisseton
Sisseton-Wahpeton Sioux
Siuslaw
Skagit Suiattle
Skokomish
Slave
Smith River
Snake
Snohomish
Snoqualmi
Songish Southern Paiute
Squaxin
Stockbridge
Sumo-Mosquito
Suquamish
Swinomish
Taimskin
Tanana
Tanoan Pueblos
Taos
Tarahumare
Tarascan
Tawakoni
Tejon
Tenino or Warm Springs
Tesuque
Teton
Teton Sioux
Tillamook
Timucua
Thlinget
Tolowa
Tonawanda
Tonkawa
Tonto Apache
Topinish
Totonac
Tsimshian
Tulalip
Tule River Indians
Tunica
Tuscarora
Tututni
Umatilla

Umpqua
Upper Chinook
Ute
Waca
Waicuri-Pericue
Wailaki
Walapai
Walla Walla
Wampanoag
Wapato
Warm Springs
Wasco
Washo
Washoe
Western Apache
Western Shoshone
Whilkut
Wichita
Wikchamni
Wind River Shoshone
Winnebago
Wintu
Wintun
Wishram
Wyandotte
Xicaque
Yahooskin
Yakima
Yamel
Yana
Yankton
Yanktonnais Sioux
Yaqui
Yaquina
Yavapai
Yawilmani
Yellow Knife
Yerington Paiute
Yokuts
Yokuts-Mono
Yomba Shoshone
Yuchi
Yuki
Yuma
Yurok
Zacatec
Zapotec
Zia
Zoque
Zuni

**RACE AND NATIONALITY DESCRIPTIONS
ALPHABETIC INDEX**

A

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03 Absentee -Shawnee
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01 Afghan, Afghanistani
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02 African American
01 Afrikaner
02 Afro-American
03 Ak Chin
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Tribes of Texas
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01 Albanian
03 Aleut
01 Algerian*
03 Alsea
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01 Amish*
01 Anglo-Saxon*
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03 Arapaho
01 Argentinian*†
03 Arikara
01 Armenian
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96 Asiatic
03 Assiniboin
01 Assyrian
03 Atacapa
03 Athapaskan
03 Atsina
01 Australian*
01 Austrian*
01 Azores*
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B

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96 Bangladeshi
02 Barbadian
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01 Bozniak/Bosnian
01 Brava/Bravo*
01 Brazilian
03 Brotherton
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C

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03 Cherokee
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03 Chickahominy
03 Chickasaw
01 Chilean†

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- 01 Cuban (unless specified as Black)*
- 01 Cypriot
- 01 Czechoslovak -ian*

D

- 03 Dakota
- 03 Delaware
- 03 Diegueno
- 03 Digger
- 03 Dog Rib
- 02 Dominica Islander
(unless specified as White)
- 02 Dominican/Dominican Republic (unless specified as White)
- 03 Duckwater

E

- 01 Eastern European
- 01 Ebian*
- 01 Ecuadorian*†
- 01 Egyptian
- 01 English
- 01 English-French*
- 01 English-Irish*
- 20 Eniwetok, Enewetak
- 02 Eritrean*
- 03 Eskimo
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- 01 European*
- 03 Eyak

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- 03 French Indian

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03 Gosiute
01 Greek*
03 Gros Ventre
22 Guamanian
01 Guatemalan†
01 Gypsy*

H

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03 Han
03 Hare
03 Hat Creek
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03 Hawasupai
01 Hebrew*‡
01 Herzegovenian
03 Hidatsa
01 Hispanic*
12 Hmong
03 Hoh
01 Honduran†
03 Hoopa
03 Hopi
03 Houma
03 Hualapai
03 Huastec
03 Humboldt Bay
01 Hungarian*
03 Hupa
03 Huron

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01 Irish
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01 Jordanian*
03 Joshua
03 Juaneno

K

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03 Kanosh Band of
Paiutes
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03 Karankawa
03 Karok
03 Kaska
03 Kaw
03 Kawai
02 Kenyan*
03 Keresan Pueblos
03 Kern River
03 Kichai
03 Kickapoo
03 Kiowa
03 Kiowa Apache
20 Kirabati
03 Kitamat
03 Klamath
03 Klikitat
03 Koasati
03 Kootenai Tribe of
Idaho
08 Korean
20 Kosraean
01 Kurd/Kurdish
03 Kusa
03 Kutchin
03 Kutenai
01 Kuwaitian*
20 Kwajalein
03 Kwakiutl

L

03 Lac Courte Dreille
01 Ladina/Ladino*
03 Laguna
03 Lakmuit
11 Laotian
01 Latin American*†
01 Latino/Latina
01 Latvian*
01 Lebanese
02 Liberian
01 Libyan*
03 Lipan Apache
01 Lithuanian*
03 Lower Brule Sioux
03 Luiseno
03 Lummi

M

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03 Maidu
03 Makah
02 Malawian*
96 Malaysian
96 Maldivian
03 Malecite
01 Maltese*
03 Mandan
97 Maori
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03 Maricopa
20 Marshallese
01 Marshenese*
03 Mary's River
03 Mashpee
03 Mattaponi
01 Mauritian*
03 Maya
03 Mayo
03 Mdewakanton Sioux
01 Mediterranean*
30 Melanesian
03 Menominee
03 Menomini
03 Mequendodon
03 Mescalero Apache
03 Meso American Indian
01 Mexican†
03 Mexican American
 Indian
03 Miami
03 Micmac

20 Micronesian, NOS
 01 Middle Eastern
 03 Mission Indians
 03 Missouri
 03 Miwok
 03 Mixe
 03 Mixtec
 03 Modoc
 03 Mohave
 03 Mohawk
 03 Mohegan
 03 Molala
 03 Monachi
 96 Mongolian
 03 Mono
 03 Montagnais
 96 Montagnard
 03 Montauk
 01 Moroccan*
 01 Moroccan*
 01 Moslem*†
 03 Muckleshoot
 02 Mugandan*
 03 Munsee
 01 Muslim*†

N

03 Nambe
 02 Namibian
 03 Namsemond
 03 Nanticoke
 03 Narragansett
 03 Naskapi
 02 Nassau*
 03 Natchez
 07 Native Hawaiian
 97 Nauruan
 03 Navaho
 03 Navajo
 01 Near Easterner
 02 Negro
 96 Nepalese
 30 New Caledonian
 30 New Hebrides
 03 Nez Perce
 03 Niantic
 01 Nicaraguan†
 02 Nigerian
 02 Nigritian
 03 Nipmuck
 03 Nisenan-Patwin
 03 Nisqually

03 Nomelaki
03 Nooksak
03 Nootka
01 Nordic*
01 North African
03 Northern Paiute
01 Norwegian*
02 Nubian*

O

03 Oglala Sioux
03 Okanogan
05 Okinawan
03 Omaha
03 Oneida
03 Onondaga
03 Opata
03 Opato
96 Oriental
03 Osage
02 Other African
01 Other Arab
96 Other Asian
97 Other Pacific Islander
98 Other race, not
elsewhere classified
03 Oto
03 Otoe
03 Otomi
03 Ottawa
03 Ozette

P

97 Pacific Islander
03 Paiute
17 Pakistani
20 Palauan
01 Palestinian
03 Pamunkey
01 Panamanian†
03 Panamint
03 Papago
32 Papua New Guinean
01 Paraguayan†
01 Parsi*
07 Part Hawaiian
03 Passamaquoddy
03 Patwin
03 Pawnee
03 Pen d'Oreille
03 Penobscot
03 Peoria

03 Pequot
01 Persian*
01 Peruvian*†
03 Picuris
03 Pima
03 Pit River
20 Pohnpeian
03 Pojoaque
01 Polish
25 Polynesian
03 Pomo
20 Ponapean
03 Ponca
03 Poosepatuck
01 Portuguese*
03 Potawatomi
03 Potomac
03 Powhatan
03 Pueblos
01 Puerto Rican (unless
specified as Black)
03 Puyallup

Q

03 Quapaw
03 Quechan
03 Quileute
03 Quinaietl
03 Quinault

R

03 Rappahannock
03 Rogue River
01 Romanian*
03 Rosebud Sioux
01 Rumanian
01 Russian*

S

03 Sac and Fox
03 Saginaw
20 Saipanese
03 Salish
01 Salvadoran†
27 Samoan
03 San Felipe
03 San Ildefonso
03 San Juan
03 San Lorenzo
03 San Luis Obispo
03 San Luiseno
03 Sandia

03 Sanpoil
 03 Sanpoil Nespelem
 03 Santa Barbara
 03 Santa Clara
 03 Santa Ynez
 03 Sant'ana
 03 Santee
 03 Santee Sioux
 03 Santiam
 02 Santo Domingo*
 01 Saudi Arabian*
 03 Sauk and Fox
 01 Scandanavian*
 03 Scaticook
 01 Scottish, Scotch
 03 Sekane
 03 Seminole
 01 Semitic*‡
 03 Seneca
 01 Serbian*
 03 Seri
 01 Servian*
 02 Seychelloise*
 03 Shasta
 03 Shawnee
 01 Shi'ite‡
 03 Shinnecock
 03 Shivwits Band of
 Paiutes
 03 Shoshone
 03 Shoshone-Bannock
 03 Shuswap
 01 Sicilian*
 96 Sikkimese
 96 Singaporean
 03 Siouans
 03 Sioux
 03 Sisseton
 03 Sisseton -Wahpeton
 Sioux
 03 Siuslaw
 03 Skagit Suiattle
 03 Skokomish
 03 Slave
 01 Slavic, Slovakian*
 03 Smith River
 03 Snake
 03 Snohomish
 03 Snoqualmi
 30 Solomon Islander
 03 Songish Southern
 Paiute

01 South American
 03 South American Indian
 03 Spanish American
 Indian
 01 Spanish*, Spaniard
 03 Squaxin
 96 Sri Lankan
 03 Stockbridge
 02 Sudanese*
 96 Sumatran
 03 Sumo-Mosquito
 01 Sunni*‡
 03 Suquamish
 01 Swedish*
 03 Swinomish
 01 Syrian

T

26 Tahitian
 03 Taimskin
 04 Taiwanese
 03 Tanana
 03 Tanoan Pueblos
 02 Tanzanian*
 03 Taos
 03 Tarahumare
 03 Tarascan
 20 Tarawan
 03 Tawakoni
 03 Tejon
 03 Tenino or Warm
 Springs
 03 Tesuque
 03 Teton
 03 Teton Sioux
 14 Thai
 03 Thlinget
 96 Tibetan
 03 Tillamook
 03 Timucua
 20 Tinian
 02 Tobagoan
 02 Togolese*
 25 Tokelauan
 03 Tolowa
 03 Tonawanda
 28 Tongan
 03 Tonkawa
 03 Tonto Apache
 03 Topinish
 03 Totonac
 02 Trinidadian

20 Trukese
03 Tsimshian
03 Tulalip
03 Tule River Indians
03 Tunica
01 Tunisian*
01 Turkish, Turk*
03 Tuscarora
03 Tututni
25 Tuvaluan

U

01 Ukrainian*
03 Umatilla
03 Umpqua
01 United Arab Emirati
03 Upper Chinook
01 Uruguayan†
03 Ute

V

30 Vanuatuan
01 Venezuelan*†
10 Vietnamese

W

03 Waca
03 Waicuri-Pericue
03 Wailaki
03 Walapai
03 Walla Walla
03 Wampanoag
03 Wapato
03 Warm Springs
03 Wasco
03 Washo
03 Washoe
01 Welsh*
02 West Indian
03 Western Apache
03 Western Shoshone
96 Whello
03 Whilkut
01 White
03 Wichita
03 Wikchamni
03 Wind River Shoshone
03 Winnebago
03 Wintu
03 Wintun
03 Wishram
03 Wyandotte

X

03 Xicaque

Y

03 Yahooskin

03 Yakima

03 Yamel

03 Yana

03 Yankton

03 Yanktonnais Sioux

20 Yapese

03 Yaqui

03 Yaquina

03 Yavapai

03 Yawilmani

96 Yello

03 Yellow Knife

01 Yemenite*

03 Yerington Paiute

03 Yokuts

03 Yokuts-Mono

03 Yomba Shoshone

03 Yuchi

01 Yugoslavian*

03 Yuki

03 Yuma

03 Yurok

Z

03 Zacatec

02 Zairean

03 Zapotec

03 Zia

03 Zoque

01 Zoroastrian*‡

03 Zuni

Note: The following terms cannot be coded to a specific race code. Look for other descriptions of race in the medical record. If no further information is available, code as 99 Unknown.

Aruba Islander
Azerbaijani
Belizean
Bermudan
Biracial
Cayenne
Cayman Islander
Guyanese
Indian (not specified as
Native American, Eastern
Indian, Northern, Central, or
South American Indian)
Interracial
Mestizo
Mixed
Morena
Multiethnic
Multinational
Multiracial
South African
Surinam
Tejano

Appendix E

CENSUS LIST OF SPANISH SURNAMES

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

ABAD	ABELLEIRA	ABREO	ACETY	AFANADOR
ABADIA	ABELLERA	ABREU	ACEUEDO	AFRE
ABADIANO	ABENDANO	ABREUS	ACEVDO	AGADO
ABADIAS	ABERASTURI	ABREUT	ACEVEDA	AGALA
ABADILLA	ABERASTURIA	ABREV	ACEVEDO	AGANZA
ABADIN	ABERGEL	ABREW	ACEVES	AGAPITO
ABAIGAR	ABESADA	ABREYO	ACEVEZ	AGETOS
ABAJO	ABETE	ABRICA	ACEVIDO	AGIRRE
ABALLE	ABEYTA	ABRIGO	ACHA	AGON
ABALO	ABEYTTA	ABRIL	ACHEZ	AGOSTO
ABALOS	ABIEGA	ABRIOL	ACHON	AGRA
ABAONZA	ABILA	ABUIN	ACIDO	AGRAIT
ABARCA	ABILES	ABUNDES	ACIN	AGRAMONTE
ABARCO	ABILEZ	ABUNDEZ	ACOB	AGRAS
ABAROA	ABIN	ABUNDIS	ACOSTA	AGRAZ
ABARQUEZ	ABINA	ABUNDIZ	ACOSTA	AGREDA
ABARTA	ABIO	ABUNDO	ACUESTA	AGREDANO
ABARZUA	ABIOL	ABURTO	ACUNA	AGREGADO
ABASCAL	ABISLAIMAN	ABURTIN	ACUSTA	AGRONT
ABASTA	ABITTA	ACABA	ADAME	AGUABELLA
ABASTAS	ABITU	ACABEO	ADAMES	AGUADO
ABASTO	ABITUA	ACARON	ADAMEZ	AGUALLO
ABALUNZA	ABLANEDO	ACASTA	ADAN	AGUANO
ABAURREA	ABOGADO	ACOSTA	ADANZA	AGUARISTI
ABAY	ABOITE	ACCOSTA	ADARGO	AGUAS
ABAYA	ABOITES	ACCUAR	ADARGO	AGUASVIVAS
ABBADIE	ABOLLA	ACEBAL	ADAROS	AGUAYYA
ABDALA	ABONCE	ACEBEDO	ADAUUTO	AGUAYO
ABEA	ABORLLELE	ACEBO	ADELO	AGUDELO
ABEITA	ABOY	ACED	ADONA	AGUDO
ABEIRA	ABOYTES	ACEDO	ADORNO	AGUEDA
ABELAIRAS	ABRAHANTE	ACEITUNO	ADRIASOLA	AGUEDA
ABELAR	ABRAHANTES	ACENCIO	ADROVER	AGUELAR
ABELDANO	ABRAJAN	ACENEDO	ADROVET	AGUERA
ABELED	ABRANTE	ACERA	ADUNA	AGUERO
ABELLA	ABREA	ACEREDO	ADVINCULA	AGUEROS
ABELLAN	ABREGO	ACERETO	AEDO	AGUERRE
		ACERO	AFAN	AGUERREBERE

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

AGUERRIA	AGUON	ALAMILLO	ALBARENGA	ALCANIZ
AGUET	AGURRIES	ALAMO	ALBAREZ	ALCANTA
AGUIGUI	AGURTO	ALAMOS	ALBARICO	ALCANTAR
AGUILA	AGUSTI	ALANIS	ALBARRACIN	ALCANTARA
AGUILAR	AGVILAR	ALANIZ	ALBARRAN	ALCANTARO
AGUILER	AHEDO	ALANSO	ALBEAR	ALCANTOR
AGUILERA	AHIN	ALANZO	ALBELO	ALCARAS
AGUILES	AHUERO	ALAUINES	ALBERCA	ALCARAZ
AGUILLAR	AHUMADA	ALAUINEZ	ALBERIO	ALCAREZ
AGUILLEN	AIBAR	ALARCO	ALBERRO	ALCASAS
AGUILLERA	AINSA	ALARCON	ALBERTORIO	ALCAYDE
AGUILLON	AINZ	ALARD	ALBERU	ALCAZAR
AGUILO	AINZA	ALARDE	ALBEZ	ALCE
AGUILON	AIRA	ALARDIN	ALBIAR	ALCEDO
AGUIJOR	AISA	ALARI	ALBIDRES	ALCERRECA
AGUILOS	AISO	ALARICO	ALBIDREZ	ALCIBAR
AGUILU	AISPURO	ALARID	ALBILLAR	ALCIVAR
AGUILUZ	AIZPURU	ALARY	ALBINES	ALCOBER
AGUINAGA	AJUNTAS	ALAS	ALBIOL	ALCOCER
AGUINIGA	AJURIA	ALATORRE	ALBISO	ALCOCES
AGUINO	ALABADO	ALATRISTE	ALBITRE	ALCOLA
AGUINS	ALACAN	ALAVA	ALBIZO	ALCOLEA
AGUIRE	ALACAR	ALAVARADO	ALBIZU	ALCON
AGUIRRA	ALADRO	ALAVARDO	ALBO	ALCONTAR
AGUIRRE	ALAEZ	ALAYA	ALBONIGA	ALCORTA
AGUIRRECHU	ALAFA	ALAYETO	ALBOR	ALCOSER
AGUIRREGAVIRIA	ALAFFA	ALAYO	ALBORNOZ	ALCOSET
AGUIRRES	ALAGA	ALAYON	ALBORS	ALCOVER
AGUIRREZABAL	ALAGO	ALBA	ALBUERNE	ALCOZAR
AGULAR	ALAMAN	ALBACETE	ALBUJAR	ALCOZER
AGULIAR	ALAMANO	ALBALADEJO	ALBURQUERQUE	ALCUDIA
AGULLES	ALAMANZA	ALBALATE	ALCADE	ALDABA
AGULLO	ALAMARES	ALBALOS	ALCAIDA	ALDABE
AGUNDES	ALAMBAR	ALBANA	ALCAIDE	ALDACO
AGUNDEZ	ALAMEDA	ALBANDOZ	ALCALA	ALDAHONDO
AGUNDIS	ALAMIA	ALBANEZ	ALCALAN	ALDAMA
AGUNDIZ	ALAMILLA	ALBAREDA	ALCALDE	ALDANA

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

ALDAPA	ALEMANY	ALINAYA	ALMAREZ	ALMUNINA
ALDAPE	ALEMAR	ALIPAZ	ALMARZA	ALOMA
ALDARONDO	ALEN	ALIRE	ALMAZAN	ALOMAR
ALDAS	ALENCASTRO	ALIRES	ALMEDA	ALONA
ALDASORO	ALBQUIN	ALIREZ	ALMEDINA	ALONSO
ALDAVA	ALERS	ALLADICE	ALMEJO	ALONZO
ALDAVE	ALERTE	ALLADO	ALMENA	ALOY
ALDAYA	ALEVEDO	ALLALA	ALMENAR	ALOYO
ALDAZ	ALEXANDRINO	ALLANDE	ALMENARA	ALPIZAR
ALDAZABAL	ALFALLA	ALLARID	ALMENARES	ALPUCHE
ALDEBOT	ALFARA	ALLEGANZA	ALMENDARES	ALPUIN
ALDECOA	ALFARD	ALLEGUE	ALMENDAREZ	ALQUICIRA
ALDECOCEA	ALFARO	ALLEGUEZ	ALMENDARIZ	ALSINA
ALDEIS	ALFASSA	ALLENDE	ALMENDRAL	ALTAGRACIA
ALDEREGUIA	ALFAU	ALLENEGUI	ALMENDRAS	ALTAMIRA
ALDERETE	ALPEREZ	ALLESANDRO	ALMENDRAS	ALTAMIRANO
ALDERETTE	ALPONSECA	ALLONGO	ALMENGOR	ALTARRIBA
ALDERTE	ALPONSO	ALLOZA	ALMERA	ALTENES
ALDRETE	ALPONZO	ALMA	ALMERAZ	ALTIMIRANO
ALDUEN	ALFRIDO	ALMADA	ALMERIA	ALTONAGA
ALDUENDA	ALGARA	ALMADO	ALMESTICA	ALTOSINO
ALEANTAR	ALGARIN	ALMADOVA	ALMEYDA	ALTRECHE
ALEBIS	ALGARRA	ALMAGER	ALMEZQUITA	ALTUBE
ALEDO	ALGAVYA	ALMAGNER	ALMIRALL	ALTUNA
ALEGADO	ALGEA	ALMAGRO	ALMIRUDIS	ALTUR
ALEGRE	ALGECIRAS	ALMAGUER	ALMODOBAR	ALTUR
ALEGRET	ALGORA	ALMANCE	ALMODOBAR	ALTURET
ALEGRIA	ALGORRI	ALMANANCE	ALMODOUAR	ALTUZARRA
ALEJANDRE	ALGORTA	ALMANSA	ALMODOVA	ALVAREZ
ALEJANDRES	ALGUACIL	ALMANZA	ALMODOVAR	ALUIZO
ALEJANDREZ	ALGUESEVA	ALMANZAN	ALMOGABAR	ALUSTIZA
ALEJANDRO	ALLAGA	ALMANZAR	ALMOGUERA	ALUYON
ALEJO	ALICANTE	ALMANZO	ALMOINA	ALVA
ALEJOS	ALICCA	ALMAQUER	ALMONACID	ALVANADO
ALELUNAS	ALICEA	ALMARAS	ALMONDOVAR	ALVARA
ALEMAN	ALICIA	ALMARAZ	ALMONTE	ALVARADA
ALEMANIA	ALJIA	ALMARES	ALMONTES	ALVARADO
			ALMORA	ALVARAZ

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

ALVARDEZ	ALZALDE	AMEZCUA	ANDABLO	ANGLADE
ALVARDO	ALZATE	AMEZOLA	ANDALON	ANGLERO
ALVAREDO	ALZINA	AMEZQUITA	ANDALUZ	ANGOCO
ALVARENGA	ALZOLA	AMEZUA	ANDASOLA	ANGON
ALVARES	ALZUGARAY	AMIAL	ANDAVAZO	ANGUEIRA
ALVAREZ	ALZURI	AMIEIRO	ANDAVEVERDE	ANGUERA
ALVARIDO	AMABISCA	AMIEVA	ANDAZOLA	ANGUIANO
ALVARINO	AMADOR	AMIGO	ANDEREZ	ANGUINO
ALVARODO	AMAGO	AMILL	ANDIARENA	ANGUITA
ALVARRAN	AMALBERT	AMIRA	ANDINA	ANGULO
ALVARY	AMALLA	AMIRES	ANDINO	ANIAS
ALVEAR	AMARGOS	AMOR	ANDOLLO	ANIBARRO
ALVELAIS	AMARILLA	AMORES	ANDRACA	ANILLO
ALVELO	RIOSILLAS	AMOROS	ANDRADA	ANIZ
ALVERADO	AMARO	AMOROZ	ANDRADE	ANORGA
ALVERANGA	AMAVISCA	AMOSTEGUI	ANDRADES	ANQUIANO
ALVERES	AMAVIZCA	AMOZURRUTIA	ANDRADO	ANSALDUA
ALVEREZ	AMAYA	AMPARAN	ANDREOLAS	ANSALMO
ALVERIO	AMBE	AMPARANO	ANDREU	ANSISO
ALVERO	AMBEGUIA	AMPARO	ANDREZ	ANSOATEGUI
ALVEZ	AMBERT	AMPUDIA	ANDRIAL	ANSOLABEHERE
ALVIAR	AMBIA	AMPUERO	ANDRINO	ANSURES
ALVIDRES	AMBRIS	ANADON	ANDUAGA	ANTA
ALVIDREZ	AMBRIZ	ANALCO	ANDUEZA	ANTABLIN
ALVILLAR	AMEJORADO	ANALLA	ANDUIZA	ANTELO
ALVIRA	AMELY	ANAMOSA	ANDUJA	ANTEQUERA
ALVIRDE	AMENABAR	ANASAGASTI	ANDUJAL	ANTIGUA
ALVIREZ	AMENEDO	ANAYA	ANDUJAR	ANTILLON
ALVISO	AMENGUAL	ANAZAGASTY	ANDUJO	ANTIMO
ALVITRE	AMESCUA	ANCHANDO	ANDUYO	ANTOLIN
ALVIZAR	AMESGUITA	ANCHIA	ANDUZE	ANTOLINEZ
ALVIZO	AMESOLA	ANCHIETA	ANEIRO	ANTOMARCHY
ALVIZU	AMESQUA	ANCHONDO	ANEIROS	ANTONETTY
ALVO	AMESQUITA	ANCHUNDIA	ANEL	ANTOPIA
ALVORADO	AMESTI	ANCIRA	ANERO	ANTRILLO
ALZA	AMESTOY	ANCISO	ANGELES	ANTU
ALZAGA	AMEZAGA	ANDA	ANGLADA	ANTUNA

**APPENDIX E
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ANTUNANO	AQUILERA	ARANAS	ARBELO	ARCHUNDIA
ANTUNEZ	AQUILES	ARANAZ	ARBESU	ARCHUTETA
ANZALDA	AQUILLAR	ARANCIBIA	ARBIDE	ARCHVLETA
ANZALDO	AQUIN	ARANDA	ARBISO	ARCIA
ANZALDUA	AQUINAGA	ARANDIA	ARBIZO	ARCIAGA
ANZAR	AQUINES	ARANDO	ARBIZU	ARCIBA
ANZARA	AQUIRE	ARANDULES	ARBOLAEZ	ARCIDES
ANZARDO	ARA	ARANEGUI	ARBOLAY	ARCIGA
ANZELDE	ARABALO	ARANETA	ARBOLEDA	ARCILA
ANZORENA	ARABI	ARANGO	ARBOLEYA	ARCINAS
ANZUA	ARABITG	ARANGUA	ARBONA	ARCINIAGA
ANZUALDA	ARACENA	ARANGUIZ	ARBUCIAS	ARCINIEGA
ANZUETO	ARACHE	ARANGURE	ARBURUA	ARCINO
ANZULES	ARADILLAS	ARANGUREN	ARCA	ARCIZO
ANZURES	ARAGO	ARANIBAR	ARCACHA	ARCOS
APABLASA	ARAGON	ARANJON	ARCADIA	ARCOVERDE
APADACA	ARAGONES	ARANO	ARCARAZO	ARCULETA
APAEZ	ARAGONEZ	ARANZA	ARCAS	ARDAIZ
APALATEGUI	ARAGUAS	ARANZAZU	ARCAUTE	ARDANAZ
APALATEGUI	ARAGUNDI	ARANZUBIA	ARCAY	ARDANZ
APARICIO	ARAGUS	ARAOZ	ARCAZA	ARDANZ
APELLANIZ	ARAGUZ	ARAQUE	ARCE	ARDAVIN
APEZTEGUIA	ARAIN	ARATER	ARCEGA	ARDIGO
APODACA	ARAIN	ARAUIGO	ARCELAY	ARDILLA
APODOCA	ARAIZ	ARAUUS	ARCELO	ARDILLA
APOLINAR	ARAIZA	ARAUUSA	ARCELONA	ARDOIS
APONTE	ARAMAYO	ARAUUX	ARCENTALES	ARDON
APORTELA	ARAMBEL	ARAUZ	ARCEO	AREA
APRATO	ARAMBUL	ARAUZA	ARCHE	AREAN
APRICIO	ARAMBULA	ARAVENA	ARCHIBEQUE	AREAS
APUAN	ARAMBULO	ARAVIO	ARCHILA	AREBALO
AQUAYO	ARAMBURO	ARAYA	ARCHILLA	AREBALOS
AQUERO	ARAMBURU	ARAYATA	ARCHULETA	ARECES
AQUEVEQUE	ARAMENDIA	ARBALLO	ARCHULETO	ARECHAGA
AQUIAR	ARAN	ARBELAEZ	ARCHULETTA	ARECHAVALETA
AQUILAR	ARANA	ARBELBIDE	ARCHULTA	ARECHE
	ARANALDE	ARBELLO	ARCHUNDE	ARECHIGA

**APPENDIX E
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ARREAGA	ARRIETTA	ARTEA	ARZA	ASPILLAGA
ARREALA	ARRIGA	ARTEAGA	ARZABAL	ASPIRAS
ARREAZOLA	ARRILLAGA	ARTEAGO	ARZABALLA	ASPRA
ARREBOLA	ARRIOLA	ARTECHE	ARZAGA	ASPURIA
ARRECHE	ARRIQUIDEZ	ARTECONA	ARZAGOTTIA	ASPURO
ARRECHEA	ARRISOLA	ARTEGA	ARZAMENDI	ASPURU
ARREDENDO	ARRITOLA	ARTEGO	ARZAPALO	ASSEO
ARREDONDA	ARRIVILLAGA	ARTELLAN	ARZATE	ASSIS
ARREDONDO	ARRIZOLA	ARTERO	ARZAVE	ASTACIO
ARREGUI	ARRIZON	ARTESONA	ARZENO	ASTENCIO
ARREGUIN	ARROCENA	ARTETA	ARZOLA	ASTENGO
ARREGUY	ARROJAS	ARTIAGA	ARZON	ASTIAZARAN
ARRELLANO	ARROJO	ARTIDIELLO	ARZU	ASTIZ
ARRELLIN	ARROLLADO	ARTIEDA	ARZUAGA	ASTOL
ARRENDO	ARROLLO	ARTIGA	ASAD	ASTORGA
ARRENDONDO	ARRONA	ARTIGAS	ASCANO	ASTRAN
ARRENQUIN	ARRONDO	ARTIGO	ASCAR	ASTUDILLO
ARREOLA	ARRONGE	ARTILES	ASCARATE	ASTURIAS
ARREQUIBE	ARRONIZ	ARTIME	ASCARRUNZ	ASUA
ARREQUIN	ARRONTE	ARTIZ	ASCENCIO	ASUEGA
ARRESTOY	ARROYA	ARTOLA	ASCENCION	ASUNSOLO
ARRETCHE	ARROYAS	ARTOLOZAGA	ASCENSIO	ASURMENDI
ARREY	ARROYAVE	ARTURET	ASCUNCE	ASUSTA
ARREYGUE	ARROYO	ARTUZ	ASEBEDO	ATALA
ARREZOLA	ARROYOS	ARUCA	ASENCIO	ATANACIO
ARRIAGA	ARROZ	ARUFE	ASENCION	ATANCIO
ARRIAGO	ARRUE	ARUIZU	ASENIO	ATAYDE
ARRIARAN	ARRUFAT	ARUJO	ASENSIO	ATECA
ARRIASOLA	ARSATE	ARUS	ASEO	ATEHORTUA
ARRIAZA	ARSOLA	ARUZ	ASEVEDO	ATENCIO
ARRIAZOLA	ARSUAGA	ARVALLO	ASEVES	ATTENZA
ARRIBA	ARTACHE	ARVAYO	ASIS	ATTENZO
ARRIBAS	ARTALEJO	ARVELO	ASOMOZA	ATILANO
ARRIERA	ARTAU	ARVISU	ASPETIA	ATILES
ARRIERO	ARTAUD	ARVIZA	ASPERIN	ATONDO
ARRIETA	ARTAVIA	ARVIZO	ASPEYTTIA	ATRA
ARRIETE	ARTAZA	ARVIZU	ASPIAZU	ATRIO

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

ATTENCIO	AVITUA	AZOCA	BADILLA	BAJE
ATUCHA	AYABARRENO	AZOCAR	BADILLO	BAJO
AUCES	AYALA	AZOFRA	BADIO	BALADES
AUDELO	AYALLA	AZOR	BADIOLA	BALADEZ
AUFFANT	AYALO	AZOY	BAELLA	BALADO
AUGILAR	AYAN	AZPEITIA	BAELLO	BALADRON
AUILA	AYARZAGOITIA	AZPIAZU	BAENA	BALAEZ
AUILES	AYBAR	AZPIRI	BAERGA	BALAGIA
AULET	AYCART	AZPIROZ	BAESA	BALAGOT
AUMADA	AYENDE	AZUA	BAEZ	BALAGUE
AURIOLES	AYERBE	AZUARA	BAEZA	BALAGUER
AURRECOECHEA	AYERDI	AZUCENA	BAEZCRUZ	BALAGUERA
AUZA	AYERZA	AZUELA	BAGU	BALAIS
AVALA	AYES	AZUETA	BAGUE	BALAJADIA
AVALO	AYESTARAN	AZURDIA	BAGUER	BALANDRA
AVALOS	AYLLON	BABARAN	BAGUERO	BALANDRAN
AVALOSZ	AYMAT	BABIDA	BAGUES	BALANDRANO
AVARCA	AYMERICH	BABILONIA	BAGUEZ	BALANGA
AVECHUCO	AYOLA	BABIO	BAHADUJE	BALANON
AVECILLAS	AYON	BACA	BAHAMON	BALANZA
AVELAR	AYORA	BACALLAO	BAHAMONDE	BALAREZO
AVELLAN	AYOROA	BACARDI	BAHAMONDES	BALARIN
AVELLANAL	AYUSO	BACCA	BAHAMUNDI	BALART
AVELLANEDA	AZA	BACELIS	BAHENA	BALASQUIDE
AVELLANET	AZARES	BACERRA	BAIDA	BALBANEDA
AVENDANO	AZCANO	BACHICHA	BAIGEN	BALBAS
AVIGAEL	AZCARATE	BACILIO	BAILEZ	BALBASTRO
AVILA	AZCARRAGA	BACOS	BAILLERES	BALBIN
AVILAS	AZCARRETA	BACOSA	BAILON	BALBINA
AVILES	AZCOITIA	BADA	BAIRES	BALBOA
AVILEZ	AZCONA	BADAJOS	BAISA	BALBONA
AVILLAN	AZCUE	BADAJOSA	BAISDON	BALBONTIN
AVILUCEA	AZCUI	BADELLA	BAIZ	BALBUENA
AVINA	AZCUY	BADELLO	BAIZA	BALCACER
AVITA	AZIOS	BADIA	BAJADA	BALCAZAR
AVITEA	AZNAR	BADIAL	BAJANA	BALCAZAR
AVITIA	AZNAREZ	BADIAS	BAJANDAS	BALCELLS

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

BALCORTA	BALGOS	BALTAR	BAQUERIZO	BARCINAS
BALDARAMOS	BALIA	BALTASAR	BAQUERO	BARCON
BALDARRAMA	BALIDO	BALTAZAR	BAQUIRAN	BARCOS
BALDARRAMOS	BALINA	BALTIERRA	BARAGAN	BARDALES
BALDAZO	BALIZAN	BALTIERREZ	BARAGANA	BARDINAS
BALDELOMAR	BALLADARES	BALTODANO	BARAGAS	BARDISA
BALDENEGRO	BALLADAREZ	BALUIA	BARAHONA	BAREA
BALDEON	BALLAGAS	BALVANEDA	BARAJAS	BARED
BALDERA	BALLARDO	BALVERDE	BARAJOS	BARELA
BALDERAMA	BALLATE	BALZOLA	BARALT	BARELAS
BALDERAMOS	BALLEJO	BAMUELOS	BARANDA	BARENCO
BALDERAS	BALLEJOS	BANA	BARANDIARAN	BARENO
BALDERAZ	BALLERAS	BANAGA	BARASORDA	BARETTO
BALDEROS	BALLESTA	BANAGAS	BARAY	BAREZ
BALDERRAMA	BALLESTAS	BANALES	BARAZ	BARGARA
BALDERS	BALLESTE	BANANANDO	BARBA	BARGAS
BALDEVARONA	BALLESTER	BANARER	BARBACHANO	BARGOS
BALDEZ	BALLESTERAS	BANARES	BARBARENA	BARGUIARENA
BALDILEZ	BALLESTERO	BANCES	BARBASA	BARILLAS
BALDIT	BALLESTROS	BANGIELLA	BARBEITO	BARIN
BALDIVIA	BALLEZ	BANDAS	BARBERAN	BARINAS
BALDIVIEZ	BALLEZ	BANDERAS	BARBERENA	BARLOCO
BALDIZAN	BALLEZA	BANDIN	BARBOA	BARNACHEA
BALDIZON	BALLI	BANDURRAGA	BARBOLA	BARO
BALDOMERO	BALLINA	BANEGAS	BARBONTIN	BAROCIO
BALDONADO	BALLINAS	BANEZ	BARBOSA	BAROIAS
BALDOQUIN	BALLOTE	BANIQUED	BARCALA	BAROS
BALDOR	BALMACEDA	BANOS	BARCELO	BAROSELA
BALDOVINNO	BALMANA	BANREY	BARCELON	BAROZ
BALDOVINOS	BALMASEDA	BANUELAS	BARCENA	BARQUERA
BALDOZ	BALMORES	BANUELOS	BARCENAS	BARQUERO
BALDRICHE	BALOSSO	BANUET	BARCENES	BARQUET
BALEME	BALSA	BANVELOS	BARCENEZ	BARQUEZ
BALENCIA	BALSECA	BAO	BARCENILLA	BARQUIN
BALERIO	BALSEIRO	BAPTISTO	BARCIA	BARRAD
BALERO	BALSERA	BAQUEDANO	BARCIGALUPIA	BARRAGAN
BALESTERRI	BALSINDE	BAQUERA	BARCIMO	BARRAGAR

APPENDIX E
CENSUS LIST OF SPANISH SURNAMMES

BARRAGON	BARRIENTOS	BASALO	BATIZA	BEAZ
BARRAJAS	BARRIERA	BASALOVA	BATLLE	BECARIA
BARRAL	BARRIERO	BASANES	BATLLIA	BECERA
BARRALES	BARRIGA	BASANEZ	BATRES	BECERRA
BARRAMEDA	BARRILLAS	BASANO	BATREZ	BECEIRO
BARRANDEY	BARRIO	BASANTES	BATRIZ	BECENA
BARRANO	BARRIONUEVO	BASCON	BATULE	BECERA
BARRANTES	BARRIOS	BASCONCILLO	BAUSA	BECERRA
BARRAQUE	BARRO	BASCOY	BAUSTISTA	BECERRIL
BARRARA	BARROCAS	BASCUAS	BAUTA	BECERRO
BARRASA	BARRONA	BASDEO	BAUTISTA	BECHARA
BARRATACHEA	BARROSA	BASILLA	BAUZA	BECHO
BARRAZ	BARROSO	BASOCO	BAUZO	BECUAR
BARRAZA	BARROTERAN	BASORA	BAYANILLA	BEDIA
BARREDA	BARROZA	BASQUES	BAYARDO	BEDOLLA
BARREDO	BARROZO	BASQUEZ	BAYARENA	BEDOY
BARREGO	BARRUECO	BASTANCHURY	BAYAS	BEDOYA
BARREIRO	BARRUETA	BASTARDO	BAYCORA	BEGA
BARRENA	BARSENAS	BASTERRECHEA	BAYDES	BEGANO
BARRENECHE	BARTOLOME	BASTIDA	BAYLINA	BEGONA
BARRENECHEA	BARTOLOMEY	BASTIDAS	BAYLON	BEGUIRISTAIN
BARRENO	BARTUREN	BASTIDOS	BAYO	BEIRO
BARRERA	BARZA	BASUA	BAYON	BEISTEGUI
BARRERAGARCIA	BARZAGA	BASUALDO	BAYONA	BEITIA
BARRERAS	BARZANA	BASULTO	BAYRON	BEITRA
BARRERAZ	BARZILLA	BASURA	BAYUGA	BEJAR
BARRERO	BARZIZA	BASURCO	BAZA	BEJARAN
BARRETA	BARZOLA	BASURTO	BAZAIN	BEJARANO
BARRETO	BAS	BATALLA	BAZALDUA	BEJERANO
BARREZUETA	BASABE	BATALLAN	BAZAMAN	BEJINES
BARRIA	BASADRE	BATAN	BAZAN	BEJINEZ
BARRIAGA	BASAITES	BATANIDES	BAZAURE	BELA
BARRIAL	BASALDO	BATILLA	BAZUA	BELANCOURT
BARRIAS	BASALDU	BATINE	BAZURTO	BELANDRES
BARRIENTES	BASALDUA	BATIST	BEADA	BELARDE
BARRIENTEZ	BASALDUE	BATISTA	BEANES	BELARDES
BARRIENTO	BASALLO	BATIZ	BEAS	BELARDO

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

BELASQUEZ	BENAUIDES	BEVIDES	BERNAL	BERUIDES
BELASQUIDA	BENAVEDIZ	BEQUER	BERNALDEZ	BERZOZA
BELAUDE	BENAVENT	BERAIN	BERNALL	BESA
BELAUNZARAN	BENAVENTE	BERASATEGUI	BERNARDEZ	BESADA
BELAUSTEGUI	BENAVIDAS	BERAZA	BERNDES	BESARES
BELAYAL	BENAVIDES	BERBAN	BERNELL	BESCOS
BELCHEZ	BENAVIDEZ	BERBENA	BERNEZ	BESERRA
BELDEROL	BENAVIDOS	BERBER	BERNUDEZ	BESINAIZ
BELÉN	BENCOMO	BERBERENA	BEROIZ	BESTARD
BELÉNDEZ	BENCOSME	BERCEDONIS	BERONDA	BESTEIRO
BELETTE	BENDALIN	BERDEAL	BERRAYARZA	BESU
BELEZ	BENDAMIO	BERDECIA	BERRELES	BETANCE
BELIO	BENEGAS	BERDEJA	BERRELEZ	BETANCES
BELLAFLORES	BENEJAN	BERDEJO	BERRELLEZ	BETANCIS
BELLEZ	BENERO	BERDUGO	BERRELLEZA	BETANCCOURT
BELLIARD	BENESTANTE	BERDUSCO	BERRELEZA	BETANCCOURTH
BELLIDO	BENETEZ	BEREA	BERREYESA	BETANCUR
BELMAS	BENEVIDEZ	BEREAL	BERREYESA	BETANCURT
BELLOSO	BENGOA	BERENGUER	BERRIOS	BETETA
BELMARES	BENGOCHEA	BERENY	BERRIOZABAL	BETETA
BELMAREZ	BENIGUEZ	BERENY	BERRIZ	BETHENCOURT
BELMONTES	BENINE	BERGADO	BERROA	BETONCOURT
BELMONTES	BENIQUEZ	BERGARA	BERROCAL	BETRAN
BELMONTES	BENIQUEZ	BERGEZ	BERROCAL	BEXAR
BELMUDES	BENTES	BERGOLLA	BERROCALES	BEXAR
BELMUDES	BENTEZ	BERICOCHEA	BERRONES	BEZA
BELNAS	BENTO	BERICOCHEA	BERROS	BEZANILLA
BELOZ	BENITOA	BERIAN	BERROSPE	BEZARES
BELTRA	BENOVIDEZ	BERLANGA	BERROTERAN	BEZERRA
BELTRAN	BENOVIDEZ	BERLANGO	BERRU	BIANE
BELTRANENA	BENTA	BERMEA	BERRUECO	BIANES
BELTIRE	BENTANCOUR	BERMEJILLO	BERRUECO	BIANGEL
BELVADO	BENTANCOURT	BERMEJO	BERRUECOS	BIANGEL
BENABE	BENTANCUD	BERMEO	BERSOSA	BIAR
BENABE	BENTANCUR	BERMUDA	BERSOZA	BIASCOECHEA
BENABIDES	BENTURA	BERMUDES	BERTAINA	BIBIAN
BENADO	BENTUDIZ	BERMUDES	BERTOT	BIBIANO
BENALCAZAR	BENUN	BERMUDEZ	BERTRAN	BIBILONI
BENALLO	BENZAQUEN	BERMUNDEZ	BERUBEN	BICHARA
		BERNABE	BERUMEN	BIDABE

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

BIDAL	BLANCARTE	BOJORGUEZ	BOREGO	BOUCOURT
BIDART	BLANCAS	BOJORQUES	BORELA	BOULLON
BIDET	BLANCO	BOJORQUEZ	BORERO	BOUZA
BIDO	BLANCOCERDA	BOLADERES	BORGUEZ	BOUZAS
BIDOT	BLANES	BOLADO	BORJA	BOVADILLA
BIEDMA	BLANQUET	BOLANO	BORJAS	BOVEDA
BIELMA	BLANQUEZ	BOLANOS	BORJON	BOVES
BIENES	BLANQUIZ	BOLEDA	BORNIA	BRACAMONTE
BIERA	BLASQUEZ	BOLET	BORONDA	BRACAMONTES
BIGON	BLAYA	BOLIVAR	BORONDO	BRACAMONTEZ
BILANO	BLAZQUEZ	BOLOIX	BOROVAY	BRACERO
BILBAO	BLEA	BOLTARES	BORQUEZ	BRACEROS
BILBRAUT	BLONDET	BOLUFE	BORRAJO	BRACHO
BILLAFRANCO	BOADA	BOMBALIER	BORRAS	BRADOR
BILLALBA	BOADO	BONACHEA	BORRAYO	BRAMASCO
BILLALOBOS	BOBADILLA	BONAFONT	BORREGO	BRAMBILA
BILLESAS	BOBADILLO	BONAL	BORRER	BRAMBILL
BINAS	BOBE	BONALES	BORRERO	BRAN
BINELO	BOBEA	BONEFONT	BORRICO	BRANA
BINGOCHEA	BOBEDA	BONET	BORRIS	BRANCACHO
BINIMELIS	BOBELE	BONETA	BORROEL	BRANCACIO
BIRBA	BOBIAN	BONICHE	BORROTO	BRANDARIZ
BIRONDO	BOBILLO	BONILLA	BORRUEL	BRANUELAS
BIRRIEL	BOCACHICA	BONILLAS	BORUNDA	BRASSELERO
BIRRUETA	BOCANEGRA	BONILLO	BOSMENIER	BRASUEL
BISA	BOCARDIO	BONUZ	BOSQUE	BRAULIO
BISBAL	BOCHAS	BORAD	BOSQUES	BRAVO
BISCAILUZ	BODERO	BORBOA	BOSQUEZ	BREA
BISCAINO	BODIROGA	BORBOLLA	BOTANA	BRECEDA
BISCAYART	BOERAS	BORBON	BOTARD	BREIJO
BISTRAIN	BOEZ	BORDAGARAY	BOTAS	BREMA
BISUANO	BOFILL	BORDALLO	BOTELL	BRENES
BITELA	BOGARIN	BORDANO	BOTELLA	BRENLLA
BITHORN	BOHORQUEZ	BORDAYO	BOTELLO	BRETADO
BITOLAS	BOILES	BORDEGARAY	BOTERO	BRETO
BLADUELL	BOITES	BORDENAVE	BOTILLER	BRETOS
BLAJOS	BOJORGES	BORDOY	BOTILLO	BRIALES

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

BRIANO	BUBELA	BULERIN	BUSTABAD	CABAL
BRIAS	BUCETA	BULLAS	BUSTABADE	CABALEIRO
BRIEESCA	BUCIO	BULNES	BUSTAMANTE	CABALLA
BRIEESCAS	BUELNA	BULOS	BUSTAMANTES	CABALLER
BRICENO	BUENABAD	BULTRON	BUSTAMANTEZ	CABALLERO
BRIENO	BUENAFE	BURBANO	BUSTAMARTE	CABALLEROS
BRIEVA	BUENAVENTURA	BURBOA	BUSTAMENTE	CABALLES
BRIGNONI	BUENCONSEJO	BURCET	BUSTAMONTE	CABALLO
BRUALBA	BUENDEL	BURCIAGA	BUSTANANTE	CABAN
BRUIJL	BUENDIA	BURCIAGO	BUSTANANTE	CABANAS
BRILLANTES	BUENFIL	BURCOS	BUSTED	CABANELAS
BRINGAS	BUENO	BURDEOS	BUSTELO	CABANERO
BRINGUEZ	BUENROSTRO	BURGADO	BUSTEMANTE	CABANILLAS
BRIO	BUENROSTRO	BURGARA	BUSTILLO	CABANZON
BRIONES	BUENSUCESO	BURGENO	BUSTILLOS	CABARCAS
BRIONEZ	BUENTELLO	BURGOA	BUSTINZA	CABARCOS
BRISENO	BUENTEO	BURGOS	BUSTIO	CABARGA
BRISETA	BUENTEMPO	BURGUAN	BUSTO	CABASA
BRISEO	BUENTILLO	BURGUENO	BUSTOS	CABASIER
BRISUELA	BUERAS	BURGUETE	BUSTOZ	CABASOS
BRITO	BUERES	BURIEL	BUSUTIL	CABASSA
BRIZ	BUERGO	BURILLO	BUTANDA	CABASSO
BRIZAL	BUFANDA	BURTTICA	BUTERO	CABAZA
BRIZENO	BUGALLO	BURNEO	BUTRON	CABAZOS
BRIZO	BUGARIN	BURNIAS	BUTTANDA	CABEIRO
BRIZUELA	BUGAS	BURQUEZ	BUXEDA	CABEJE
BROCAS	BUGUES	BURRA	BUXO	CABELLERO
BROCHE	BUILES	BURRIEL	BUYON	CABELLO
BRONDO	BUILTRON	BURRIOLA	BUZANI	CABERA
BROTONS	BUTRAGO	BURROLA	BUZNEGO	CABERERA
BRUCELAS	BUTTRON	BURRON	BUZO	CABERRA
BRUCIAGA	BUTUREIDA	BURRUEL	CAAL	CABESUELA
BRUGUERA	BUTUREIRA	BURSIAGA	CAAMAL	CABEZA
BRUGUERAS	BUJAN	BURUATO	CAAMANO	CABEZADEBACA
BRUSUELAS	BUJANDA	BUSIGO	CAAMPUED	CABEZAS
BRUZOS	BUJANOS	BUSQUET	CABA	CABEZUDO
BUANTELLLO	BUJOSA	BUSQUETS	CABADA	CABEZUELA

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

CABIAS	CACHORA	CAJIGAL	CALEZ	CALZADA
CABIDO	CACHUA	CAJIGAS	CALIBO	CALZADIAS
CABIEDES	CACICEDO	CAJINA	CALIENES	CALZADILLA
CABIGAS	CADAHIA	CAJO	CALIX	CALZADILLAS
CABILLO	CADAVA	CAJUSTE	CALIXTO	CALZADO
CABLA	CADAVAL	CALABAZA	CALIXTRO	CALZIA
CABRALES	CADAVID	CALAFAT	CALIZ	CALZONCIN
CABRALEZ	CADAVIECO	CALAFELL	CALLADO	CAMACH
CABRANES	CADEMA	CALAMA	CALLANTA	CAMACHE
CABRE	CADENA	CALAMACO	CALLAVA	CAMACHO
CABREJA	CADENAS	CALAMARS	CALLAZO	CAMAMA
CABREJAS	CADENAZ	CALAMON	CALLE	CAMANCHO
CABREJOS	CADENGO	CALANA	CALLEIRO	CAMANEZ
CABRER	CADIerno	CALANCHE	CALLEJAS	CAMANO
CABRERA	CADILLA	CALANDRES	CALLEJO	CAMARAZA
CABRERAS	CADILLO	CALAS	CALLEJON	CAMARELLA
CABRERIZO	CADIS	CALATAYUD	CALLEJOS	CAMARENA
CABRERO	CADIZ	CALBILLO	CALLELLA	CAMARENO
CABRERRA	CADORNIGA	CALCADO	CALLEROS	CAMARERO
CABRET	CADRIEL	CALCANEO	CALLES	CAMARGO
CABREVA	CAGIGA	CALCANO	CALLEYRO	CAMARILLO
CABRIALES	CAGIGAL	CALCINES	CALLINICOS	CAMARO
CABRIELES	CAGIGAS	CALDA	CALLISTRO	CAMARON
CABRILES	CAGUIAS	CALDARON	CALOCA	CAMARRILLO
CABRILLO	CAHUE	CALDAS	CALOMARDE	CAMAYA
CABRILLOS	CAICEDO	CALDELAS	CALONGA	CAMAYD
CABRISAS	CAIGOY	CALDERA	CALONGE	CAMBA
CABRITO	CAILLAU	CALDERAS	CALONJE	CAMBALIZA
CABRON	CAINAS	CALDERILLA	CALSADA	CAMBERO
CABUENA	CAINZOS	CALDERIN	CALSADILLAS	CAMBEROS
CABUTO	CAJAR	CALDERO	CALVEIRO	CAMBIANICA
CACERAS	CAJAS	CALDERON	CALVERA	CAMBIS
CACERES	CAJEN	CALDEVILLA	CALVERO	CAMBLOL
CACEREZ	CAJERO	CALEJO	CALVES	CAMBO
CACHARRON	CAJIAO	CALENZANI	CALVET	CAMBON
CACHO	CAJIDE	CALERA	CALVILLO	CAMCHO
CACHON	CAJIGA	CALERO	CALVO	CAMEJO

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

CAMERENA	CAMUNEZ	CANDELERIA	CANTOYA	CARABAL
CAMERO	CANA	CANDIA	CANTRE	CARABALLO
CAMEZ	CANABA	CANDIAS	CANTRES	CARABALLOPEREZ
CAMILLO	CANABAL	CANEDA	CANTU	CARABANTES
CAMINA	CANABATE	CANEDO	CANTUA	CARABAY
CAMINAS	CANAHUATI	CANEGATA	CANTUTIERINA	CARABAZA
CAMINERO	CANAIDA	CANEIRO	CANUELAS	CARABELLA
CAMOCHO	CANALEJO	CANELA	CANZONA	CARABEO
CAMORODA	CANALES	CANELLAS	CAPABLANCA	CARABES
CAMPA	CANALEDZ	CANELLIS	CAPACETE	CARABEZ
CAMPACOS	CANALITA	CANELLO	CAPARRA	CARACENA
CAMPANERIA	CANALS	CANERO	CAPARROS	CARACHEO
CAMPANIONI	CANAMAR	CANES	CAPAS	CARACOSA
CAMPAS	CANAMERO	CANET	CAPATA	CARACOZA
CAMPAZ	CANAS	CANETE	CAPDEVILA	CARAJAL
CAMPERO	CANAVA	CANEZ	CAPELES	CARALT
CAMPILLO	CANAVVATI	CANGA	CAPELLAN	CARAMBOT
CAMPINS	CANAVERAL	CANGAS	CAPELO	CARAMEROS
CAMPIRANO	CANAYES	CANION	CAPERON	CARAMES
CAMPISTA	CANCEL	CANISALES	CAPESTANY	CARAMILLO
CAMPIZ	CANCELA	CANIZAL	CAPETILLO	CARANTA
CAMPOAMOR	CANCELO	CANIZALES	CARFALI	CARANZA
CAMPODONICA	CANCHE	CANIZALEZ	CARILLA	CARAPIA
CAMPOLLA	CANCHOLA	CANIZARES	CAPIN	CARARA
CAMPOMANES	CANCINO	CANIZAREZ	CAPIRO	CARASA
CAMPOREDONDO	CANCINOS	CANJURA	CAPISTRAN	CARASCO
CAMPPOS	CANCIO	CANLAS	CAPLANO	CARATACHEA
CAMPPOSAGRADO	CANDALES	CANO	CAPMANY	CARATAN
CAMPOVERDE	CANDANEDO	CANOVAS	CAPOTE	CARATTINI
CAMPOY	CANDANO	CANSECO	CAPRILES	CARAVACA
CAMPOZ	CANDANOSA	CANSINO	CAPRINE	CARAVAJAL
CAMPOZANO	CANDANOZA	CANTARERO	CAPUCHIN	CARAVANTES
CAMPUSANO	CANDELARI	CANTERO	CAPUCHINA	CARAVAYO
CAMPUZANO	CANDELARIA	CANTILLO	CAPUCHINO	CARAVEO
CAMUEIRAS	CANDELARIE	CANTORAN	CAQUIAS	CARAVES
CAMUNAS	CANDELARIO	CANTOS	CARABA	CARAZA
CAMUNES	CANDELAS	CANTOU	CARABAJAL	CARAZO

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

CARBA	CARDIEL	CARPINTERO	CARRETE	CARTAGENA
CARBAJAL	CARDINAS	CARPINTEYRO	CARRETERO	CARTAGO
CARBAJALES	CARDINEZ	CARPIO	CARRETO	CARTANA
CARBAJO	CARDONA	CARPZO	CARRIAGA	CARTAS
CARBALLAR	CARDONAS	CARRABALLO	CARRIAZO	CARTAYA
CARBALLEA	CARDOSA	CARRACEDO	CARRICA	CARUAJAL
CARBALLEIRA	CARDOVA	CARRADA	CARRICABURU	CARVAJAL
CARBALLIDO	CAREAGA	CARRADERO	CARRICARTE	CARVAJALES
CARBALLO	CARELA	CARRAL	CARRIDO	CARVAJALINO
CARBALLOSA	CARETA	CARRALEJO	CARRIEDO	CASABLANCA
CARBELLIDO	CARIAS	CARRALERO	CARRIJO	CASABO
CARBIA	CARIBE	CARRALES	CARRIL	CASADAS
CARBONEL	CARIDE	CARRALEZ	CARRILES	CASADES
CARBONELL	CARIDES	CARRAMAN	CARRILLA	CASADO
CARBOT	CARIELO	CARRANCA	CARRILLE	CASADOS
CARCACHE	CARIGA	CARRANCO	CARRILLO	CASAIS
CARCAMO	CARILLO	CARRANDI	CARRILO	CASAL
CARCANA	CARINGAL	CARRANSA	CARRIO	CASALES
CARCANAQUES	CARINHAS	CARRANZA	CARRION	CASALS
CARCANO	CARIRE	CARRASCO	CARRIQUE	CASAMAYOR
CARCAS	CARISALEZ	CARRASCOSA	CARRISAL	CASANAS
CARCELLERO	CARLA	CARRASGUILLO	CARRISALES	CASANDRA
CARDELLE	CARLETELLO	CARRASO	CARRISALEZ	CASANOVA
CARDELLES	CARLOS	CARRASQUILLA	CARRISOSA	CASANOVAS
CARDENA	CARMENATE	CARRASQUILLO	CARRISOZA	CASANUEVA
CARDENAL	CARMENATES	CARRATALA	CARRIZAL	CASARES
CARDENALES	CARMENATY	CARRAU	CARRIZALES	CASAREZ
CARDENAS	CARMOEGA	CARRAZANA	CARRIZALEZ	CASARIEGO
CARDENAZ	CARMONA	CARRAZCO	CARRIZO	CASARRUBIAS
CARDENES	CARNERA	CARREAGA	CARRIZOSA	CASAS
CARDENEZ	CARNERO	CARREDO	CARRIZOZA	CASASNOVAS
CARDENO	CARNICER	CARREJO	CARRODEGUAS	CASASOLA
CARDENOS	CARNICERO	CARRENO	CARROLA	CASASUS
CARDENOSA	CARO	CARREON	CARROSKUILLO	CASAUS
CARDENTEY	CARONADO	CARRERA	CARRSCO	CASAVANTES
CARDET	CAROPINO	CARRERAS	CARRUESCO	CASCANTE
CARDEZA	CARPENA	CARRERO	CARTAGEN	CASCON

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

CASCOS	CASTANADA	CASTIEL	CATALAN	CAYEROS
CASCUDO	CASTANARES	CASTILIO	CATALENA	CAYIAS
CASELAS	CASTANEADA	CASTILL	CATANACH	CAYON
CASELLAS	CASTANED	CASTILLA	CATANO	CAYUELA
CASERAS	CASTANEDA	CASTILLANOS	CATAQUET	CAYUSO
CASERES	CASTANEDO	CASTILLAS	CATASCA	CAZAMIAS
CASERMA	CASTANER	CASTILLEJA	CATASUS	CAZANAS
CASERO	CASTANIER	CASTILLEJO	CATEORA	CAZARES
CASERZA	CASTANIEITO	CASTILLEJOS	CATETE	CAZAREZ
CASES	CASTANO	CASTILLERO	CATOLICO	CAZARIN
CASIA	CASTANOLA	CASTILLO	CATZOELA	CAZON
CASIAN	CASTANON	CASTILLO	CAVAZOS	CDEBACA
CASIANO	CASTANOS	CASTILLO	CAUCE	CDEVACA
CASIAS	CASTANUELA	CASTILLO	CAUDALES	CEBADA
CASICA	CASTANY	CASTINEIRA	CAUDILES	CEBALLE
CASIELLES	CASTEJON	CASTINEIRAS	CAUDILLO	CEBALLES
CASILLA	CASTELA	CASTINEYRA	CAULA	CEBALLO
CASILLAN	CASTELAN	CASTORENA	CAUNDER	CEBALLOS
CASILLAS	CASTELANO	CASTORENO	CAUSO	CEBEY
CASILLOS	CASTELAO	CASTRA	CAVANAS	CEBOLLERO
CASINES	CASTELAR	CASTREJON	CAVASAS	CEBRERO
CASIQUE	CASTELAZO	CASTRELLON	CAVASOS	CEBREROS
CASQUITO	CASTELBLANCO	CASTRESANA	CAVAZ	CEBRIAN
CASIS	CASTELDEORO	CASTRILLO	CAVAZAS	CECENA
CASMERO	CASTELEIRO	CASTRILLO	CAVAZOS	CEDANO
CASORLA	CASTELLANAS	CASTRIZ	CAVAZOS	CEDENO
CASPARIS	CASTELLANES	CASTRO	CAVEDA	CEDILLO
CASPILLO	CASTELLANOS	CASTRODAD	CAVERO	CEDILLOS
CASSARE	CASTELLANOS	CASTROMAN	CAVEZA	CEDINO
CASSAS	CASTELLANOZ	CASTRON	CAVIEDES	CEDO
CASSIAS	CASTELLON	CASTROVERDE	CAVIEL	CEGARRA
CASSILLAS	CASTELLS	CASTRUITA	CAVLA	CEGUEDA
CASSINERIO	CASTELLVI	CASUL	CAVOS	CEIDE
CASSO	CASTELINAU	CASUSO	CAVOZOS	CEIJAS
CASTAIGNE	CASTELO	CATA	CAYADO	CEJA
CASTAN	CASTENADA	CATACALOS	CAYANAN	CEJAS
CASTANA	CASTENEDA	CATACHE	CAYCEDO	CEJO
	CASTIBLANCO	CATALA	CAYERE	CEJUDO

APPENDIX E
CENSUS LIST OF SPANISH SURNAMMES

CELA	CERECEDO	CHABERA	CHANONA	CHAVARRA
CELADA	CERECERES	CHABEZ	CHANTACA	CHAVARRI
CELADO	CERECEREZ	CHABOLLA	CHANTALA	CHAVARRIA
CELARDO	CERECERO	CHABOYA	CHANTRES	CHAVARRIAGA
CELAYA	CEREIJO	CHABRIER	CHAPA	CHAVARRO
CELAYETA	CEREZO	CHACA	CHAPARRO	CHAVECO
CELEDON	CERIN	CHACANACA	CHAPELA	CHAVERA
CELEIRO	CERMENO	CHACON	CHAPERO	CHAVERO
CELICEO	CERNA	CHADES	CHAPOY	CHAVEZ
CELIS	CERNAS	CHADEZ	CHAPPARO	CHAVIANO
CELIZ	CERNO	CHAFFINO	CHAPRALIS	CHAVIRA
CELORIO	CERNUDA	CHAFINO	CHAPRON	CHAVIRO
CENA	CERON	CHAGAS	CHARAFA	CHAVOLLA
CENDAN	CERPA	CHAGOLLA	CHARANZA	CHAVOYA
CENDEJAS	CERRILLO	CHAGOLLAN	CHARBA	CHAYRA
CENDOYA	CERRILLOS	CHAGOY	CHARBULA	CHAYRE
CENICEROS	CERRITOS	CHAGOYA	CHARCA	CHAYREZ
CENISEROS	CERROS	CHAGOYAN	CHARCAS	CHAZARO
CENISEROZ	CERTEZA	CHAGOYEN	CHARDON	CHAZARRETA
CENOZ	CERUANTES	CHAGRA	CHARFAUROS	CHECA
CENTELLAS	CERVANES	CHAGUACEDA	CHARNECO	CHECO
CENTENO	CERVANTE	CHAIDES	CHARO	CHEDA
CENTERO	CERVANTES	CHAIDEZ	CHARRES	CHEMALI
CENTURION	CERVANTEZ	CHAIRA	CHARRIA	CHENTE
CEPEDA	CERVENTES	CHAIREZ	CHARRIEZ	CHERENA
CEPEDES	CERVERA	CHALA	CHARRIN	CHERENE
CEPERO	CESANI	CHALAMBAGA	CHARRIS	CHERINO
CERABELLA	CESENA	CHALDU	CHARRO	CHERTA
CERALDE	CESIN	CHAMARTIN	CHARVEZ	CHESSANI
CERBANTES	CESPEDES	CHAMIZO	CHATON	CHEVANNES
CERBANTEZ	CESPEDEZ	CHAMORO	CHAUARRIA	CHEVARRIA
CERCADO	CESTERO	CHAMORRO	CHAVANA	CHEVAS
CERDA	CEVALLO	CHANDARLIS	CHAVANNA	CHEVERES
CERDEIRA	CEVALLOS	CHANES	CHAVARELA	CHEVEREZ
CERDEIRAS	CEVILLA	CHANEZ	CHAVARIA	CHEVEZ
CERECEDA	CEYANES	CHANGALA	CHAVARILLO	CHEVRES
CERECEDES	CHABARRIA	CHANO	CHAVARIN	CHIAGO

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

CHIAPA	CHUMACERO	CIRIA	COBARRUVIAS	COLLASO
CHICA	CHUMISO	CRIECCO	COBAS	COLLAZO
CHICAS	CHUPE	CRILO	COBELO	COLLOZO
CHICO	CHURBE	CIRIZA	COBEO	COLLS
CHICVARA	CHURRUCA	CIRLOS	COBIAN	COLMENAR
CHIDE	CIBERAY	CIRULI	COBIELLA	COLMENARES
CHIFALO	CIBRIAN	CISNER	COBIO	COLMENERO
CHIHUAHUA	CICERON	CISNERAS	COBO	COLOCHO
CHILIMIDOS	CICLIA	CISNEROS	COBOS	COLOCIO
CHIMAL	CID	CISNERO	COBREIRO	COLODRO
CHINANA	CIDDIO	CISNEROS	COCA	COLOMI
CHINCHILLA	CIEGO	CISNEROZ	COCIO	COLOMA
CHINEA	CIENA	CISTERNA	CODINA	COLOMAR
CHINO	CIENEGA	CIVEROLO	CODON	COLOMBANA
CHIONG	CIENEGAS	CLARA	CODORNIZ	COLOMBANI
CHIONO	CIENFUEGOS	CLARIT	COELLO	COLOMBERO
CHIOVARE	CIERRA	CLARO	COFINO	COLOME
CHIPPI	CIFRE	CLAROS	COFRESI	COLOMER
CHIPRES	CIFREDO	CLAROT	COIRA	COLOMES
CHIQUES	CIFUENTES	CLAUDIO	COLACION	COLOMINAS
CHIQUETE	CIGAR	CLAUSTRO	COLACO	COLOMO
CHIQUITO	CIGARROA	CLAVEL	COLARTE	COLON
CHIRIBOGA	CILLERO	CLAVELL	COLAS	COLONDRES
CHIRINO	CIMADEVILLA	CLAVELO	COLATO	COLONNETTA
CHIRINOS	CIMARRON	CLAVERAN	COLCA	COLONTORRES
CHOA	CIMENTAL	CLAVERIA	COLCHADO	COLORADO
CHOLICO	CINDO	CLAVERO	COLDERON	COLORBIO
CHOMAT	CINEUS	CLAVIJO	COLDIVAR	COLORE
CHOMORI	CINTA	CLEMENA	COLEGIO	COLORES
CHONO	CINTAS	CLERO	COLET	COLOROSO
CHOPERENA	CINTORA	CLIMENT	COLIMA	COLSA
CHORNA	CINTRA	COBA	COLINA	COLUDRO
CHOTO	CINTRON	COBALES	COLINDRES	COLUMBIE
CHOUZA	CIONCO	COBAR	COLIO	COLUNGA
CHOZA	CIPRES	COBARRUBIA	COLLADA	COMACHO
CHUCA	CIPRES	COBARRUBIAS	COLLADO	COMADURAN
CHUDALLA	CIREROL	COBARRUBIO	COLLANTES	COMAS
	CIRES			

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

COMBARRO	CONSTANTE	CORCHO	CORONEL	CORUGEDO
COMELLAS	CONSUEGRA	CORCINO	CORPAS	CORUJO
COMESANA	CONSUELO	CORCOLES	CORPION	CORVAN
COMESANAS	CONTADOR	CORCOVELOS	CORPORAN	CORVERA
COMON	CONTEMPRATO	CORDENIZ	CORPOS	CORVISON
COMORRE	CONTERAS	CORDERO	CORPUS	CORZA
COMPANIONI	CONTEREAS	CORDILLO	CORRADA	CORZO
COMPARAN	CONTERO	CORDOBA	CORRAL	COS
COMPARY	CONTIVAL	CORDOBES	CORRALEJO	COSCULLUELA
COMPEAN	CONTRARAS	CORDOLA	CORRALES	COSILLO
COMPIAN	CONTRÉAS	CORDONA	CORRALEZ	COSILLOS
COMPITO	CONTRERA	CORDOSO	CORRALIZA	COSIO
COMPOS	CONTRERAS	CORDOVA	CORRALLS	COSME
COMPTIS	CONTRERASS	CORDOVER	CORRCA	COSSIO
CONCEPCION	CONTRERAZ	CORDOVES	CORREA	COSSO
CONCEPTION	CONTRERES	CORDOVEZ	CORREDERA	COSTALES
CONCHA	CONTREROS	CORDOVI	CORREDOR	COSTELON
CONCHADO	CONTRERRAS	CORDOZA	CORREO	COSTILLA
CONCHAS	CONTRÉAS	COREANO	CORRES	COSTILLO
CONCHO	CONTESTANO	CORELLA	CORRETJER	COSTOSO
CONCHOLA	CONTRÉVAS	CORENTE	CORREU	CONSTRUBA
CONCHOS	COPADO	CORIA	CORRILLO	COTA
CONDADO	COPETILLO	CORIANO	CORRIPIO	COTARELO
CONDARCO	COPRIVIZA	CORIAT	CORRIZ	COTAYO
CONDE	COQUOZ	CORIZ	CORROS	COTELO
CONDENSA	CORA	CORMALIS	CORTADA	COTERA
CONEJERO	CORALES	CORNEJO	CORTAZA	COTERILLO
ONEJO	CORANADO	CORNEJOS	CORTAZAR	COTERO
CONESA	CORAZON	CORNIDE	CORTES	COTILLA
CONFORME	CORBALA	CORNIELL	CORTEZ	COTINOLA
CONRADO	CORBEA	CORNIER	CORTIJO	COTITTA
CONRRERAS	CORBELLA	CORODOVA	CORTINA	COTO
CONRIQUE	CORBERA	COROMINAS	CORTINAS	COTRINA
CONRIQUEZ	CORCES	CORONA	CORTINAZ	COTTES
CONS	CORCHADO	CORONADA	CORTINES	COTTO
CONSONERO	CORCHERO	CORONADO	CORTINEZ	COTULLA
CONSTANCIO	CORCHETE	CORONAS	CORTIZO	COUARRUBIAS

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

COUCE	CRISTAN	CUBAS	CULTRERI	DALIPE
COUCEYRO	CRISTANCHO	CUBENAS	CUMBA	DALMAU
COUMPAROULES	CRISTERNA	CUBERO	CUMPIAN	DALMIDA
COUSO	CRISTIA	CUBIAS	CUMPIANO	DANACHE
COUTIN	CRISTIAN	CUBILLAS	CUNANAN	DANTUS
COUTINO	CRISTIN	CUBILLO	CUNES	DAPENA
COVERTIER	CRISTOBAL	CUBILLOS	CUNEZ	DARDANES
COVARRUBIA	CRISTOFOL	CUBIO	CUNI	DARDIZ
COVARRUBIAS	CRIXELL	CUBRIEL	CUNILL	DARDON
COVARRUBIAZ	CROSAS	CUCALON	CUNYUS	DARIAS
COVARRUBIO	CROZ	CUCUTA	CUPELES	DARNAUD
COVARRUVIAS	CRUANES	CUEBA	CUPRILL	DARQUEA
COVARRYBIAS	CRUANYAS	CUEBAS	CURA	DARRIBA
COVARUBIAS	CRUCES	CUELLAR	CURBELLO	DARUNA
COVAS	CRUCETA	CUELLA	CURBELO	DASTAS
COVIAN	CRUZ	CUELLAR	CURET	DATIL
COVILLO	CRUZADO	CUELLER	CURIEL	DAUBAR
COVIO	CRUZAT	CUELLO	CURRAIS	DAUILA
COVO	CRUZATA	CUEN	CURRAS	DAUSA
COVOS	CRUZCOSA	CUENCA	CURREA	DAUZ
COYA	CRUZCRUZ	CUENCO	CURZ	DAVALOS
COYAZO	CRUZON	CUENTAS	CUSCO	DAVILA
CRETOF	CRUZRODRIGUEZ	CUENTO	CUSTODIA	DAVILAS
CREMAR	CUADRA	CUERDO	CUSTODIO	DAVILLA
CREMATATA	CUADRADO	CUERO	CUTIE	DAVILLO
CRESPIN	CUADRAS	CUERVO	CUYA	DAZA
CRESPO	CUADRAZ	CUESTA	CUYAR	DCRUZ
CRIADO	CUADRO	CUESTAS	CUZA	DEAGEN
CRIBEIRO	CUADROS	CUETO	DABALOS	DEAGUERO
CRIOYOS	CUAN	CUEVA	DABILA	DEAGUILAR
CRISANTES	CUARA	CUEVAS	DACUMOS	DEAGUIRE
CRISANTO	CUARENTA	CUEVAZ	DAGNESSES	DEALBA
CRISANTOS	CUARON	CUEVOS	DAGO	DEALCALA
CRISOSTO	CUARTAS	CUILAN	DAGUERRE	DEALEJANDRO
CRISOSTOMO	CUASCUT	CUIN	DAGUILAR	DEALVA
CRISTALES	CUATE	CUIZON	DALAMA	DEALVAREZ
	CUBANO	CULEBRO	DALBOSCO	DEAMADOR

APPENDIX E
CENSUS LIST OF SPANISH SURNAMMES

DEANDA	DECAPRILES	DEESTRADA	DEHORTA	DELACOTERA
DEANDE	DECARDENAS	DEFALCON	DEHOSTOS	DELACRUZ
DEANDRES	DECASAS	DEFALLA	DEHOYAS	DELACUADRA
DEAQUERO	DECASO	DEFERIA	DEHOYOS	DELACUESTA
DEARAGON	DECASTANEDA	DEFERNANDEZ	DEIBARRA	DELACUEVA
DEARCE	DECASTILLO	DEFEX	DEIDA	DELACURZ
DEARCO	DECASTRO	DEFIESTA	DEIMES	DELAESPRIELLA
DEARCOS	DECENA	DEFIGUEROA	DEIRO	DELAFE
DEARELLANO	DECERDA	DEFILLO	DEISLA	DELAFUENTE
DEARIAS	DECERVANTES	DEFLORES	DEITA	DELAFUENTES
DEARMAS	DECESPEDES	DEFRESE	DEITURRONDO	DELAFUNTE
DEARO	DECHAVEZ	DEFRISCO	DEJARA	DELAGADILLO
DEARRIBA	DECHOUDENS	DEFUENTES	DEJAUREGUI	DELAGADO
DEARRILLAGA	DECIGA	DEGANI	DEJESU	DELAGARRIGUE
DEARROYO	DECLET	DEGARAY	DEJESUS	DELAGARZA
DEARTEAGA	DECOLLADO	DEGARCIA	DEJESUSGARCIA	DELAGDO
DEASES	DECOLON	DEGARZA	DEJESUSORTIZ	DELAGRANA
DEAVILA	DECONTRERAS	DEGELIA	DEJIMENEZ	DELAGUARDIA
DEAYALA	DECORDOBA	DEGOES	DEJORIA	DELAGUERRA
DEAZEVEDO	DECORDOVA	DEGOLLADO	DEJUAN	DELAGUILA
DEBACA	DECORO	DEGOMEZ	DELAARENA	DELAHERA
DEBARE	DECORONA	DEGONZALES	DELABARCA	DELAHERRAN
DEBARRA	DECORONADO	DEGONZALEZ	DELABARCENA	DELAHOYA
DEBATISTA	DECORSE	DEGRACIA	DELABARRERA	DELAHOZ
DEBATO	DECORTEZ	DEGUARA	DELABARZA	DELAHUERTA
DEBAYONA	DECOS	DEGUARDIA	DELABRA	DELAISLA
DEBESA	DECRISTINO	DEGUERRA	DEACABADA	DELAJARA
DEBONILLA	DECRUZ	DEGUERRERO	DELACAL	DEALASTRA
DEBRAS	DECUEVA	DEGUEVARA	DEACALLE	DEALCAZAR
DEBRAVO	DECUEVAS	DEGUIMERA	DEACAMARA	DEALLATA
DEBRUYAN	DEDELGADO	DEGUTIERREZ	DEACAMPA	DEALLAVE
DEBUENO	DEDIAZ	DEGUZMAN	DEACANAL	DEALLERA
DECABRAL	DEDIEGO	DEHARO	DEACERDA	DEALOZA
DECALDERON	DEDIOS	DEHERNANDEZ	DEACHICA	DELALTO
DECALLE	DEDOMINGUEZ	DEHERRERA	DEACONCEPCION	DELALUZ
DECAMACHO	DEDUARTE	DEHESA	DEACONCHA	DELAMADRID
DECANTU	DEESPARZA	DEHOMBRE	DEACORTE	DELAMANCHA

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

DELAMATA	DELARUA	DELCOLLADO	DELMENDO	DELPUESTO
DELAMAZA	DELASANTOS	DELCORRAL	DELMERCADO	DELRAZO
DELAMIELLA	DELASCASAS	DELCORRO	DELMORAL	DELREAL
DELAMERCED	DELASCUEVAS	DELCRISTO	DELMUNDO	DELREY
DELAMO	DELASERNA	DELCUETO	DELMURO	DELRICO
DELAMORA	DELASHERAS	DELCURTO	DELNODAL	DELRIEGO
DELAMORENA	DELASIERRA	DELDAGO	DELOA	DELRINCON
DELAMOTA	DELATEJA	DELEGANIS	DELOEN	DELRIO
DELANDA	DELATEJERA	DELEIJA	DELOERA	DELRISCO
DELANGEL	DELATOBA	DELEBON	DELOLMO	DELRIVERO
DELANOVAL	DELATORRE	DELERIO	DELOPEZ	DELRosal
DELANUEZ	DELATORRES	DELERME	DELORA	DELRosARIO
DELAO	DELATORRIENTE	DELESCAILLE	DELORO	DELSALTO
DELAOSA	DELATRINIDAD	DELEZA	DELOSADA	DELSOL
DELAOSSA	DELAUZ	DELFANTE	DELOSANGELES	DELTEIO
DELAPARRA	DELAVARA	DELFIERRO	DELOSANTOS	DELTIEMPO
DELAPASS	DELAVEGA	DELFIN	DELOSCOBOS	DELTORO
DELAPAZ	DELAVELLANO	DELFRANCIA	DELOSMONTEROS	DELUA
DELAPENA	DELAVICTORIA	DELGADA	DELOSPRADOS	DELUAO
DELAPEZA	DELAVINA	DELGADILL	DELOSREYES	DELUAN
DELAPIEDRA	DELAYA	DELGADILLO	DELOSRIOS	DELUNA
DELAPLATA	DELAZERDA	DELGADO	DELOSSANT	DELVAL
DELAPORTILLA	DELBARRIO	DELGADOD	DELOSSANTOS	DELVALLE
DELAPOZA	DELBLANCO	DELGADODEORAMA	DELOYA	DELVILLAR
DELAPRIDA	DELBOSQUE	S	DELOYOLA	DELVALLE
DELAPUENTE	DELBOSQUEZ	DELGIORGIO	DELOZA	DELVINO
DELARA	DELBOZQUE	DELGODO	DELOZADA	DEMACIAS
DELAREA	DELBREY	DELHARO	DELPALACIO	DEMALADE
DELAREZA	DELBUSTO	DELHIERRO	DELPALACIO	DEMARCHENA
DELARIOS	DELCADO	DELHIGOYO	DELPARADO	DEMARIN
DELARIVA	DELCALVO	DELIGANIS	DELPILAR	DEMARQUEZ
DELAROCA	DELCAMPILLO	DELIRA	DELPIN	DEMARRERO
DELAROCA	DELCAMPO	DELISEO	DELPINAL	DEMARTINEZ
DELAROSCHA	DELCAMPO	DELIZ	DELPINO	DEMATA
DELAROSA	DELCASTILLO	DELJUNCO	DELPORTILLO	DEMATAS
DELAROZA	DELCASTRO	DELLANO	DELPOSO	DEMATEO
DELARRA	DELCERRO	DELLANO	DELPOZO	DEMEDINA
DELARROYO	DELCID	DELMARGO	DELPRADO	DEMEIRE

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

DEMENA	DEORTIZ	DERODRIGUEZ	DESTRADA	DEYNES
DEMENDEZ	DEOSDADE	DERODRIQUEZ	DESUACIDO	DEZA
DEMENDOZA	DEOSORIO	DEROJAS	DETAPIA	DEZAMORA
DEMERCADO	DEOTERIS	DEROMERO	DETEJADA	DEZARA
DEMESA	DEOTERO	DEROSARIO	DETEVIS	DEZARRAGA
DEMIGUEL	DEPABLO	DEROZA	DETOLEDO	DEZAYAS
DEMIRANDA	DEPACHECO	DERRERA	DETORRES	DEZUNIGA
DEMOLINA	DEPACO	DERUBIO	DETRANALTES	DIACOS
DEMONTEBELLO	DEPADILLA	DERUEDA	DETTRES	DIAGO
DEMONTES	DEPARRA	DERUISA	DETRINIDAD	DIAMOS
DEMONTEVERDE	DEPAZ	DESABOTA	DEULLOA	DIASDELEON
DEMONTOYA	DEPEDRO	DESAENZ	DEVACA	DIAZ
DEMORALES	DEPENNA	DESALAS	DEVALDEZ	DIAZACEVEDO
DEMORENO	DEPEREZ	DESALAZAR	DEVALENCIA	DIAZCOLON
DEMOYA	DEPLATA	DESALERNOS	DEVALLE	DIAZCRUZ
DEMUNOZ	DEPONCE	DESALES	DEVALON	DIAZDEARCE
DEMURGA	DEPORTILLO	DESALINAS	DEVARA	DIAZDELCAMPO
DENA	DEPORTO	DESANCHEZ	DEVARGAS	DIAZDELCASTILLO
DENAVA	DEPORTOLA	DESANTIAGO	DEVARONA	DIAZDELEON
DENAVARRO	DEPOZO	DESANTIASGO	DEVASQUEZ	DIAZDEVILLEGAS
DENAVAS	DEPRAD	DESANTOS	DEVAZQUEZ	DIAZMEDINA
DENAVEJAR	DEPRADO	DESARACHO	DEVEGA	DIAZPIEDRA
DENECOCHEA	DEQUESADA	DESCALZO	DEVELASCO	DIAZRIVERA
DENIEVES	DEQUEVEDO	DESEVILLA	DEVELEZ	DIAZRODRIGUEZ
DENINA	DEQUINTANA	DESIERRA	DEVENCENTY	DIEGO
DENOGEAN	DEQUIROZ	DESIGA	DEVERA	DIEGUEZ
DENORIEGA	DERAMIREZ	DESOCARRAS	DEVIA	DIEPPA
DENUNEZ	DERAMOS	DESOCARRAZ	DEVIAN	DIEZ
DEOCA	DERAS	DESOLO	DEVICENTE	DIMAS
DEOCAMPO	DERENIA	DESOSA	DEVICTORIA	DIODONET
DEOCHOA	DEREYES	DESOTO	DEVILA	DIODOSIO
DEOLEO	DERIOS	DESOTOMAYOR	DEVILLAR	DIONES
DEOLIVIERA	DERIVAS	DESPANIA	DEVILLAR	DIOS
DEOLMO	DERIVERA	DESPLANTES	DEVILLEGAS	DIOSDADO
DEORO	DERMA	DESPUES	DEVOLIN	DIOSES
DEORTA	DEROBLES	DESRAVINES	DEYA	DIRECTO
DEORTEGA	DEROCA	DESSERO	DEYCAZA	DISARUFINO

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

ELIZARDO	ENCIZO	ERRO	ESCARENIO	ESCORIAZA
ELIZARRARAS	ENDARA	ERROA	ESCARENO	ESCORPISO
ELIZARRARAZ	ENDAYA	ESCABAR	ESCARIZ	ESCORZA
ELIZARRAS	ENDEMANO	ESCABEDO	ESCARPIO	ESCOTA
ELIZONDA	ENDOSO	ESCABI	ESCARRA	ESCOTO
ELIZONDO	ENGRACIO	ESCABIA	ESCARRAMAN	ESCOVADO
ELJAU	ENGUIDANOS	ESCAJEDA	ESCARREGA	ESCOVAR
ELORDUY	ENJADY	ESCALA	ESCARSEGA	ESCOVEDO
ELORREAGA	ENRIGUEZ	ESCALADA	ESCARSIGA	ESCOVER
ELORRIAGA	ENRIQUE	ESCALANTE	ESCARTIN	ESCRIBA
ELORZA	ENRIQUES	ESCALENTE	ESCARZAGA	ESCRIBANO
ELOSEGUI	ENRIQUEZ	ESCALERA	ESCARZEGA	ESCRICHE
ELOSUA	ENRRIQUEZ	ESCALET	ESCASENA	ESCUADRA
ELUGARDO	ENSENAT	ESCALLE	ESCADEL	ESCUDE
ELVIRA	EPIDENDIO	ESCALLON	ESCAPELL	ESCUDERO
ELYCIO	EQUIA	ESCALON	ESCATIOLA	ESCUETA
EMMANUELLI	EQUIHUA	ESCALONA	ESCAURIZA	ESCUJURI
EMMITE	ERAS	ESCALONTE	ESCOBADO	ESCUZIA
EMPASIS	ERASO	ESCAMILLA	ESCOBAL	ESGUERRA
EMPERADOR	ERAUSQUIN	ESCAMILLAS	ESCOBALES	ESPADA
EMPLEO	ERAZO	ESCAMILLO	ESCOBAR	ESPADAS
ENAMORADO	ERCHED	ESCANAME	ESCOBARETE	ESPALLAT
ENCALADA	ERCILLA	ESCANDELL	ESCOBEBE	ESPALIN
ENCALLADO	ERCILLO	ESCANDON	ESCOBEDA	ESPANA
ENCARNACION	ERDOZAIN	ESCANES	ESCOBEDO	ESPANO
ENCERRADO	EREBIA	ESCANIO	ESCOBER	ESPANOL
ENCHAUTEGUI	EREDIA	ESCANO	ESCOBIDO	ESPANOLA
ENCHINTON	ERES	ESCANUELA	ESCOBIO	ESPARAZA
ENCINA	EREVIA	ESCANUELAS	ESCOBOSA	ESPARRA
ENCINAS	ERIBES	ESCAPA	ESCOBOZA	ESPARSA
ENCINIA	ERIVES	ESCAPITA	ESCOCCHA	ESPARSEN
ENCINIAS	ERIVEZ	ESCAPULE	ESCODEDO	ESPARZ
ENCINIOS	EROLES	ESCAR	ESCOJIDO	ESPARZA
ENCINO	EROSA	ESCARCEGA	ESCOLAR	ESPEJEL
ENCINOSA	ERREA	ESCARCIDA	ESCOMILLA	ESPEJO
ENCISCO	ERRECA	ESCARCIGA	ESCONTRIAS	ESPELETA
ENCISO	ERRISURIZ	ESCARDA	ESCORCIA	ESPENDEZ

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

ESPENOSA	ESQUEDA	ESTEBANEZ	ESTRELLA	EZQUEDA
ESPEÑOZA	ESQUEDO	ESTEBES	ESTRELLAS	EZQUER
ESPERA	ESQUELL	ESTEBEZ	ESTRELLLO	EZQUERRA
ESPERANZA	ESQUENAZI	ESTEFAN	ESTREMERÁ	EZQUERRO
ESPERAS	ESQUER	ESTEFANI	ESTREMO	EZRATTY
ESPERICUETA	ESQUERA	ESTELA	ESTRINGEL	EZRRE
ESPERIQUETA	ESQUERDO	ESTENOZ	ESTRONZA	FABAL
ESPERO	ESQUERO	ESTEPA	ESTUDILLO	FABELA
ESPERON	ESQUERRA	ESTEPAN	ESTUPINAN	FABELO
ESPIGUL	ESQUERRE	ESTERAS	ETCHEBARREN	FABILA
ESPINA	ESQUEVEL	ESTERO	ETCHEBEHERE	FABRA
ESPINAL	ESQUIBAL	ESTEUDES	ETCHECHURY	FABREGAS
ESPINALES	ESQUIBEL	ESTEVA	ETCHEGARAY	FABREGAT
ESPINAR	ESQUIBIAS	ESTEVAN	ETCHEPARE	FABROS
ESPINDOLA	ESQUIERDO	ESTEVANE	ETCHEVERRIA	FABRYGEL
ESPINDULA	ESQUIJAROSA	ESTEVANES	ETCHEVERRY	FACIO
ESPINEIRA	ESQUIJARROSA	ESTEVANEZ	EUDAVE	FACUNDO
ESPINEL	ESQUILLANO	ESTEVEZ	EUFRACIO	FADRIQUE
ESPINELL	ESQUILIN	ESTEVEZ	EULATE	FAGET
ESPINET	ESQUINCA	ESTEVEZ	EURESTE	FAGOAGA
ESPINO	ESQUINEL	ESTEVIZ	EURESTI	FAGUNDO
ESPINOR	ESQUIVAL	ESTIEN	EURIOSTE	FAILA
ESPINOSA	ESQUIVEL	ESTIMBO	EUSEBIO	FAILDE
ESPINOZ	ESQUIVEZ	ESTOLANO	EUSTAQUIO	FAJARDO
ESPINOZA	ESQUIVIAS	ESTOLAS	EUZARRAGA	FALCHE
ESPIRICUETA	ESTABA	ESTOPELLAN	EVANGEL	FALCON
ESPIRITI	ESTABILLO	ESTOPINAN	EVANGELATOS	FALERO
ESPIRITU	ESTADA	ESTOQUE	EVARO	FALLEJO
ESPIVALETA	ESTADES	ESTORGA	EVIA	FALOMIR
ESPIVA	ESTALA	ESTRACA	EXIGA	FALQUEZ
ESPLANA	ESTAMPA	ESTRACÁ	EXINIA	FALTO
ESPONDA	ESTANOL	ESTRAD	EXPARZA	FALU
ESPRIU	ESTAPE	ESTRADA	EXPOSITO	FAMANIA
ESPRONCEDA	ESTAVILLA	ESTRADAS	EYLICIO	FAMILIA
ESPUDO	ESTAVILLO	ESTRADE	EYZAGUIRRE	FANDINO
ESPURVOA	ESTEBAN	ESTRADO	EZCURRA	FANEGO
ESQUEA	ESTEBANE	ESTRALLA	EZETA	FANGON

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

FANGONILLO	FEIGA	FERNENDEZ	FIGAROLA	FLECHA
FANJUL	FEIJOO	FERNIZ	FIGEROA	FLECHES
FARACH	FEITO	FERNIZA	FIGIROVA	FLEITAS
FARAGOZA	FELAN	FERRADAS	FIGOROA	FLEITES
FARFAN	FELANDO	FERRADAZ	FIGUEIRAS	FLEMATE
FARGA	FELIBERTY	FERRAEZ	FIGUERA	FLETE
FARGAS	FELICANO	FERRAJZ	FIGUERAS	FLETES
FARIAS	FELICIANO	FERRALES	FIGUERDA	FLOPES
FARILLAS	FELICITAS	FERRALEZ	FIGUEREDO	FLORATOS
FARINAS	FELICO	FERRANDES	FIGUERO	FLORENCIA
FARINOS	FELIPE	FERRANDIZ	FIGUERIA	FLORENCIO
FARIOS	FELISCIAN	FERRAS	FIGUERO	FLORES
FARPELLA	FELIU	FERRE	FIGUEROA	FLORESDDELGADO
FARRALES	FELIX	FERREGUR	FIGUEROLA	FLOREZ
FARRAY	FELIZ	FERREIRAS	FIGUERON	FLORIDO
FARRERA	FELPETO	FERREIRO	FIGUEROA	FLORIT
FARRIAS	FELUMERO	FERRER	FIGUEROSA	FLORITA
FARROS	FEMAT	FERRERAS	FIGUERRA	FLUXA
FARRULLA	FEMATH	FERRERIS	FIGUROA	FOJO
FAS	FEMATT	FERREYRA	FIGVEROA	FOLGAR
FAUDO	FENTANES	FERREYRO	FILGUEIRAS	FOLGUEIRA
FAUELA	FENTE	FERREZ	FILIZOLA	FOLGUEIRAS
FAUNI	FEO	FERRUA	FILLAS	FONALLEDAS
FAURA	FERAMISCO	FERRUSCA	FILOTEO	FONCERRADA
FAURIA	FERDIN	FESTEJO	FIMBRES	FONNEGRA
FAUSTINOS	FEREZ	FEYJOO	FIMBREZ	FONSECA
FAUSTO	FERIA	FIALLO	FINALES	FONT
FAVELA	FERMANDEZ	FIALLOS	FIOL	FONTAN
FAVELLA	FERMIN	FIDEL	FIQUEROA	FONTANES
FAVELO	FERNADEZ	FIEROVA	FIRA	FONTANET
FAVILA	FERNANDE	FIERRO	FIRPI	FONTANEY
FAYA	FERNANDEZ	FIERROS	FIUZA	FONTANEZ
FAZ	FERNANDEZCUETO	FIERROZ	FLACO	FONTANILLS
FEAL	FERNANDEZDECAST	FIESTAL	FLAMENCO	FONTANOZA
FEBLES	RO	FIGAL	FLANDES	FORTEBOA
FEBRE	FERNANDEZDELARA	FIGAREDO	FLANDEZ	FONTECHA
FEBRES	FERNANDO	FIGARELLA	FLAQUER	FONTELA

**APPENDIX E
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FONTENO	FRAIRE	FRESNEDO	FUMERO	GALAN
FONTCIELLA	FRAMIL	FRESNILLO	FUNCIA	GALARCE
FONTCOBA	FRANCA	FRESNO	FUNDORA	GALARRAGA
FORCELLEDO	FRANCISCA	FRESQUES	FUNES	GALARRETA
FORCEN	FRANCO	FRESQUEZ	FUNEZ	GALARSA
FORDIS	FRANCOS	FREYRE	FUNO	GALARTE
FORERO	FRANGUI	FREYTA	FUSANO	GALARZA
FORMANO	FRANJUL	FREYTES	FUSTE	GALARZE
FORMENT	FRANQUERO	FRIAS	FUSTER	GALAVEZ
FORMEZA	FRANQUEZ	FRIAZ	GABALDEN	GALAVIS
FORNARIS	FRANQUI	FRIETZE	GABALDON	GALAVIZ
FORNASERO	FRANQUIZ	FRIGOLA	GABANCHO	GALAZ
FORNOS	FRANSUA	FRISAN	GABASAN	GALBAN
FORNIS	FRANZOY	FROMETA	GABELA	GALCERAN
FORTANEL	FRAQUA	FRONDARINA	GABILONDO	GALDAMES
FORTEZ	FRASES	FRONTADO	GABINA	GALDAMEZ
FORTEZA	FRASQUILLO	FRONTTELLA	GABINO	GALDEANO
FORTIZ	FRATICELLI	FRONTERAS	GABRILEO	GALDOS
FORTUNO	FRAU	FROSTO	GABRILLO	GALDUROZ
FOYO	FRAUSTO	FRUGIA	GACHARNA	GALEANA
FRACISCO	FRAUSTRO	FRUTOS	GACHUPIN	GALEANO
FRADEJAS	FRAXEDAS	FRUTOZ	GADAL	GALENDEZ
FRADERA	FRAYO	FUENMAYOR	GADIA	GALERA
FRAGA	FRA YRE	FUENTAS	GAETAN	GALERIA
FRAGINALS	FREDELUCES	FUENTE	GAETAN	GALGUERA
FRAGO	FREGOSA	FUENTECILLA	GAFARE	GALI
FRAGOMENO	FREGOSO	FUENTEFRIA	GAGO	GALIANA
FRAGOSA	FREGOSO	FUENTES	GAHONA	GALICIA
FRAGOSO	FREGOZO	FUENTEZ	GAINZA	GALINANES
FRAGOZO	FREIJO	FUENTEZ	GAITAN	GALIND
FRAGUA	FREIRE	FUENZALIDA	GAITERO	GALINDA
FRAGUADA	FREIRIA	FUERO	GAITERO	GALINDEZ
FRAGUAS	FREIXAS	FUERTE	GAIVAN	GALINDO
FRAGUELA	FRENES	FUERTE	GAJARDO	GALINDRO
FRAGUIO	FRES	FUERTEZ	GAJATE	GALINZOGA
FRAIDE	FRESCAS	FUEYO	GALABEAS	GALIZ
FRAIDR	FRESCAZ	FULGENCIO	GALACHE	GALLAGA
FRAIJO	FRESNEDA	FULGUEIRA	GALAGARZA	

APPENDIX E
CENSUS LIST OF SPANISH SURNAMMES

GALLAGOS	GAMERO	GARATE	GARCIO	GARSA
GALLANES	GAMEROS	GARATEIX	GARDEA	GARSES
GALLARD	GAMEROZ	GARAVITO	GARDIA	GARTICA
GALLARDE	GAMEY	GARAY	GARDUNIO	GARVISO
GALLARDO	GAMEZ	GARAYALDE	GARDUNO	GARZA
GALLARETO	GAMINO	GARAYGORDOBIL	GARDUQUE	GARZACANTU
GALLART	GAMIO	GARAYUA	GAREJA	GARZAGARCIA
GALLARZA	GAMIZ	GARAYZAR	GARFIAS	GARZAGONGORA
GALLARZO	GAMONEDA	GARAZA	GARFIO	GARZAMARTINEZ
GALLASTEGUI	GANADONEGRO	GARBANI	GARGUENA	GARZAPENA
GALLEG	GANAN	GARBAYO	GARI	GARZARO
GALLEGAS	GANCEDO	GARBISO	GARIA	GARZES
GALLEGO	GANCERES	GARBIZO	GARIB	GARZON
GALLEGOES	GANDAR	GARCA	GARIBALDO	GARZONA
GALLEGOS	GANDARA	GARCED	GARIBAY	GARZORIA
GALLEGOZ	GANDARIA	GARCEL	GARIBY	GASCA
GALLEGUS	GANDARILLA	GARCELL	GARICA	GASCOT
GALLENO	GANDARILLAS	GARCEO	GARIFE	GASERO
GALLERAN	GANDIA	GARCERA	GARISPE	GASIO
GALLERITO	GANDON	GARCERAN	GARITA	GASPARDEALBA
GALLINAL	GANDORA	GARCES	GARITE	GASPORRA
GALLINAR	GANIVET	GARCEZ	GARIVAY	GASTELLO
GALLOR	GANUELAS	GARCIA	GARMENDIA	GASTELLUM
GALLOSA	GANUZA	GARCIACARDENAS	GARMENDIZ	GASTELO
GALMES	GANZALEZ	GARCIAGONZALEZ	GARMISA	GASTELUM
GALOFRE	GAONA	GARCIAGUERRERO	GARNICA	GASU
GALORZA	GARABAY	GARCIAGUZMAN	GARRANDES	GATAN
GALVAN	GARABITO	GARCIALOPEZ	GARRASTAZU	GATELL
GALVE	GARACOCHEA	GARCIAMARTINEZ	GARRIDO	GATICA
GALVES	GARAICOECHEA	GARCIAPENA	GARRIGA	GATO
GALVEZ	GARALDE	GARCIARIOS	GARRIGAS	GATSEOS
GAMA	GARAMENDI	GARCIAS	GARRIGO	GATTORNO
GAMALLO	GARAMILLO	GARCIAV	GARRIGOS	GAUBA
GAMARRA	GARANA	GARCIDUENAS	GARRIO	GAUCHAS
GAMAZA	GARANSUAY	GARCIGA	GARROBO	GAUCIN
GAMAZO	GARANZUAY	GARCILASO	GARROCHO	GAUD
GAMBOA	GARAT	GARCILAZO	GARROTE	GAUDIER

**APPENDIX E
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GAUNA	GELACIO	GINART	GOENAGA	GONZALEZHERNAN
GAUZENS	GELERA	GINARTE	GOICOCHEA	DEZ
GAVALDON	GELI	GINDRO	GOICOURIA	GONZALEZLEON
GAVALES	GELISTA	GINER	GOICURIA	GONZALEZSOTO
GAVAY	GELY	GINET	GOIRICELAYYA	GONZALO
GAVIA	GENAO	GINEZ	GOTIA	GONZALVEZ
GAVICA	GENDES	GINORI	GOLDEROS	GONZALVO
GAVIDIA	GENEL	GINORIO	GOMAR	GONZALZ
GAVILA	GENER	GINORIS	GOME	GONZAQUE
GAVILAN	GENERA	GINORY	GOMEZ	GONZELEZ
GAVILANES	GENESTA	GIRADO	GOMEZDEMOLINA	GONZELL
GAVILLA	GENINO	GIRALD	GOMEZTORRES	GONZLAES
GAVILLAN	GENIZ	GIRALDES	GOMEZTREJO	GONZLAEBZ
GAVINA	GENOVES	GIRALDEZ	GOMZALEZ	GONZLES
GAVINO	GERALDES	GIRALDO	GONALEZ	GONZLEZ
GAVIRA	GERALDINO	GIRALTO	GONAZLEZ	GONZOLES
GAVIRIA	GERALDO	GIRAU	GONDAR	GONZOLEZ
GAVITO	GERARDO	GIRAUDO	GONDRIZ	GORBEA
GAXIOLA	GERENA	GIRELA	GONEZ	GORDIANY
GAYA	GEREZ	GIRION	GONGALES	GORDILLO
GAYARRE	GERMENIS	GIRO	GONGALEZ	GORDILS
GAYO	GERMES	GIRON	GONGORA	GORDO
GAYOL	GERMONO	GIRONA	GONI	GORDOA
GAYOSO	GEROLAGA	GIRONELLA	GONSALE	GORENA
GAYOSSO	GERONES	GISBERT	GONSALES	GOROSAVE
GAYTAN	GERO	GISPERT	GONSALEZ	GOROSTIETA
GAZCA	GERUSA	GIZ	GONZABA	GOROSTIZA
GAZIVODA	GHIGLIOTTY	GLORIA	GONZAES	GOROZA
GAZOLAS	GIION	GOBEA	GONZAGUE	GORRAIZ
GAZTAMBIDE	GIL	GOCHEZ	GONZAL	GORRICO
GAZTELU	GILAS	GOCHICOA	GONZALAS	GORRINDO
GEA	GILBES	GODINA	GONZALE	GORRITA
GEADA	GILBUENA	GODINES	GONZALEA	GORRITZ
GEAGA	GILDELAMADRID	GODINET	GONZALES	GORRIZ
GEBARA	GIMENEZ	GODINEZ	GONZALEX	GORTAREZ
GEIGEL	GIMENO	GODOY	GONZALEZ	GORZELA
GELABERT	GIMINEZ	GOENA	GONZALEZDIAZ	GOSALVEZ

APPENDIX E
CENSUS LIST OF SPANISH SURNAMMES

GOTANDA	GRANADAS	GRUESO	GUARDARRAMOS	GUEREQUE
GOTAY	GRANADINO	GRULLON	GUARDERAS	GUERERO
GOTERA	GRANADO	GRUSMAN	GUARDIAN	GUERERRO
GOTIERREZ	GRANADOS	GUABA	GUARDIAS	GUERNICA
GOTOR	GRANADOZ	GUADA	GUARDIOLA	GUERRA
GOVANTES	GRANAS	GUADAGNIN	GUARENO	GUERREO
GOVEA	GRANDA	GUADALAJARA	GUARIS	GUERRER
GOVELLA	GRANDEZ	GUADALUPE	GUARJARDO	GUERRERO
GOYANES	GRANDIO	GUADAMUZ	GUARNERO	GUERRIDO
GOYCO	GRANDOS	GUADARAMA	GUARNEROS	GUERRIOS
GOYCOCHEA	GRANELA	GUADARRAMA	GUARTUCHE	GUERRO
GOYCOECHEA	GRANERO	GUADERRAMA	GUAS	GUERRRA
GOYCOOLEA	GRANIELA	GUADIAN	GUASCH	GUEVARA
GOYENECHÉ	GRANILLO	GUADIANA	GUASH	GUEVAREZ
GOYOS	GRANIS	GUADIANO	GUASP	GUEVARRA
GOYTIA	GRANIZO	GUADRON	GUAYANTE	GUEVERA
GOYZUETA	GRANJA	GUADA	GUAYDACAN	GUEVERRA
GOZMAN	GRATACOS	GUAJACA	GUDIEL	GUEZ
GRACIA	GRAULAU	GUAJARDO	GUDINO	GUIA
GRACIAN	GRAUPERA	GUAL	GUEBARA	GUIBOA
GRACIANI	GRAVERAN	GUALDARRAMA	GUECHO	GUICHO
GRACIANO	GRAZA	GUAMAN	GUEDE	GUIDERO
GRACIDA	GREIGO	GUANA	GUEDEA	GUIJARRO
GRADIAS	GRES	GUANAJUATO	GUEDES	GUIJOSA
GRADILLA	GRIEGO	GUANCHE	GUEDIN	GUILARTE
GRADILLAS	GRIHALVA	GUANGORENA	GUEIMUNDE	GUILBE
GRADISAR	GRIJALBA	GUANILL	GUEITS	GUILEZ
GRADO	GRIJALVA	GUANTE	GUEL	GUILAMA
GRAFALS	GRIJALVA	GUANTES	GUEL BENZU	GUILLEMARD
GRAGEDA	GRILLASCA	GUANTEZ	GUEL MES	GUILLEN
GRAIBE	GRILLIAS	GUAPO	GUEMES	GUILLENA
GRAJALES	GRIMALDO	GUARA	GUEMEZ	GUILLERMETY
GRAJEDA	GRISALES	GUARACHA	GUERA	GUILLERMO
GRAJERA	GROLON	GUARCH	GUERARA	GUINA
GRAJOLA	GRONA	GUARDADO	GUERCA	GUIRADO
GRAMAJO	GROSO	GUARDAMONDO	GUERENA	GUIRALES
GRANADA	GROVAS	GUARDARRAMA	GUERENO	GUIREMAND

**APPENDIX E
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GUIROLA	GURZI	HECHAVARRIA	HERNAEZ	HERVIS
GUISA	GUSMAN	HECHEVARRIA	HERNAIZ	HEVIA
GUISADO	GUSME	HEGUY	HERNAND	HEYSQUIERDO
GUISAO	GUSTAMANTE	HEL GUERA	HERNANDE	HIBARRA
GUISAR	GUSTAMENTE	HEL GUERO	HERNANDEL	HIDALGA
GUITANO	GUSTO	HEL GUEROS	HERNANDER	HIDALGO
GUTERREZ	GUTERREZ	HENANDEZ	HERNANDES	HIDALGOGATO
GUTTIAN	GUTIERES	HENAO	HERNANDEZ	HIDAS
GUTIERREZ	GUTIEREZ	HENARES	HERNANDEZCANTU	HIDROGO
GUTTRON	GUTTIEREZ	HENOJOSA	HERNANDEZORTIZ	HIERREZUELO
GUTTEREZ	GUTTIERR	HENRIGUEZ	HERNANDO	HIERRO
GUTTERREZ	GUTTIERRE	HENRIQUEZ	HERNANDORENA	HIGADERA
GUTTY	GUTTIERREA	HERALDEZ	HERNANDZ	HIGAREDA
GUIU	GUTTIERRER	HERANDEZ	HERNANEZ	HIGARES
GUIVAS	GUTTIERRER	HERAS	HERNANDEZ	HIGNOJOS
GUIZA	GUTTIERREZ	HERAZ	HERNENDEZ	HIGNOJOZ
GUIZADO	GUTTIERREZGARCIA	HERBELLO	HERONEMA	HIGUERA
GUIZAR	GUTTIERREZRIOS	HEREBIA	HERRADA	HIGUERAS
GUJARDO	GUTTIERRZ	HEREDERO	HERRADOR	HIGUERO
GULARTE	GUTTIERREZ	HEREDIA	HERRAN	HIGUEROS
GULBAS	GUTTEREZ	HEREIDA	HERRANZ	HILAR
GULDRIS	GUTTEREZ	HERENA	HERRARA	HILARIO
GULDRIZ	GUTTEREZ	HERERA	HERRARTE	HILERIO
GULIERREZ	GUTTIERREZ	HERERA	HERRERA	HINAJOSA
GUMA	GUTTIERREZ	HERETER	HERREA	HINAJOSA
GUNDIR	GUZMAN	HERIA	HERREION	HINESTROSA
GURARO	GUZMELI	HERIDIA	HERRENA	HINOJAS
GURELL	GUZMON	HERMANDEZ	HERRER	HINOJO
GURIDES	HACES	HERMANDEZ	HERRERA	HINOJOS
GUROLA	HAEDO	HERMIDA	HERRERAS	HINOJOSA
GURRERO	HANONO	HERMIDAS	HERRERIA	HINOJOSE
GURRIA	HARGITA	HERMIS	HERRERIAS	HINOJOSO
GURRIES	HARISPURU	HERMOCILLO	HERRERO	HINOJOZA
GURROLA	HARO	HERMOGENO	HERREROS	HINOSTRO
GURRUCHAGA	HAROS	HERMOSA	HERRERRA	HINOSTROSA
GURULE	HARVIER	HERMOSILLA	HERROZ	HINOSTROZA
GURVLE	HAYOS	HERMOSO	HERVAS	HINZO
	HECHANOVA	HERNADEZ	HERVELLA	HIPOLITO

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HIRALDO	HUANTE	HURTADO	IGLESIAS	INOCENCIO
HIRALES	HUANTES	HURTARTE	IGNACIO	INOSTROS
HIRALEZ	HUAPE	HYSQUIERDO	IGOA	INOSTROSA
HIRIGOYEN	HUARACHA	IANEZ	IGUALADA	INOSTROZA
HIRTADO	HUARTE	IANOS	IGUINA	INSAUSTI
HISQUIERDO	HUEDA	IBANES	ILARRAZA	INSERNI
HITA	HUERECA	IBANEZ	ILDEFONSO	INSIGNARES
HOGEDA	HUERENA	IBAR	ILHARREGUY	INSUA
HOJAS	HUERQUE	IBARBO	ILIZALITURRI	INSULAR
HOLGIN	HUERGAS	IBARGUENGOITIA	ILLAN	INSUNZA
HOLGUIN	HUERGO	IBARLUCEA	ILLANES	INSURRIAGA
HOLQUIN	HUERTA	IBARRA	ILLAS	INTERIAN
HOMAR	HUERTAS	IBARRIA	ILLERA	INTRIAGO
HOMS	HUERTAZ	IBARRONDO	ILLESCAS	INURRIGARRO
HONESTO	HUERTO	IBA VE	IMAS	INZUNZA
HONGOLA	HUERTO	IBA VEN	IMAZ	IPARRAGUIRRE
HONORIO	HUERTOS	IBERRA	INCHAURREGUI	IPINA
HONRADA	HUESCA	IBERRI	INCHAUSTEGUI	IQUINA
HORABUENA	HUESO	IBINARRIAGA	INCHAUSTI	IRACHETA
HORACIO	HUETE	IBOS	INCLAN	IRAGUI
HORCASITAS	HUEZO	IBUADO	INDART	IRAHETA
HORELICA	HUGUEZ	ICAMEN	INESTA	IRALA
HORMACHEA	HUICI	ICARDO	INESTROZA	IRAOLA
HORMAZA	HUICOCHEA	ICASIANO	INEZ	IRASTORZA
HORMAZABAL	HUIDOR	ICAZA	INFANTE	IRAZABAL
HORMILLA	HUIPE	ICEDO	INFANTES	IRAZOQUI
HORNEDO	HUISAR	ICHINAGA	INFANZON	IRIART
HORRUITINER	HUITRON	IDARRAGA	INFIESTA	IRIARTE
HORTA	HUIZAR	IDIAQUEZ	INGELMO	IRIBARREN
HOSTAS	HUMADA	IDIGORAS	INGRANDE	IRIBE
HOSTOS	HUMILDAD	IDOY	INGUANZO	IRIGARAY
HOYO	HURADO	IDROGO	INGUITO	IRIGONEGARAY
HOYOS	HURBINA	IDROVO	INIGO	IRIGOYEN
HOYUELA	HURIEGA	IGARAVIDEZ	INIGUES	IRIMIA
HUACUJA	HURON	IGARTUA	INIGUEZ	IRINEO
HUALDE	HURRIEGA	IGLECIAS	INIQUEZ	IRIONDO
HUAMAN	HURTADA	IGLESIA	INOA	IRIQUI

**APPENDIX E
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IRISARRI	ITULE	JAIMEZ	JAUREQUI	JORNACION
IRIYE	ITURBE	JAIRALA	JAUREZ	JORQUERA
IRIZAR	ITURBI	JALAMO	JAURGUI	JORQUEZ
IRIZARRI	ITURBIDE	JALLEO	JAURIGI	JORRIN
IRIZARRY	ITURMENDI	JALOMA	JAURIGUE	JOVE
IRIZARY	ITURRALDE	JALOMO	JAURIGUI	JOVELLANOS
IRIZZARY	ITURRASPE	JALTECO	JAURIQUE	JOVER
IRLAS	ITURREGUI	JANER	JAURIQUI	JOVET
IROZ	ITURRI	JANERO	JAURQUI	JOYA
IRIBARREN	ITURRIA	JAQUEZ	JAURRIETA	JUACHON
IRIZARRI	ITURRIAGA	JAQUIAS	JAVIER	JUAN
IRIZARRY	ITURRINO	JARA	JAVIERRE	JUANCHO
IRIZARY	ITURRIOZ	JARABA	JEMENTE	JUANERO
IRROBALI	IVANEZ	JARAMILLO	JEREZ	JUANES
IRUEGAS	IVARRA	JARAMILLA	JESUS	JUANES
IRUNGARAY	IXTA	JARAMILLO	JIMAREZ	JUANEZA
IRURETAGOYENA	IZA	JARDINES	JIMEMEZ	JUANICO
IRVEGAS	IZABAL	JARDINEZ	JIMENA	JUANITAS
ISAGUIRRE	IZAGUIRRE	JARERO	JIMENE	JUANA
ISAIS	IZAQUIRRE	JARMILLO	JIMENES	JUARBE
ISALZ	IZAR	JAROMILLO	JIMENEZ	JUARBE
ISALES	IZNAGA	JARQUEZ	JIMENIZ	JUARDO
ISARRARAS	IZQUIERDO	JARQUIN	JIMENO	JUARE
ISAS	IZURIETA	JARRIN	JIMENZ	JUAREGUI
ISASI	JACAS	JARRO	JIMINEZ	JUARES
ISERN	JACINTO	JASO	JINETE	JUAREZ
ISIAS	JACOBO	JASSO	JINEZ	JUARISTI
ISIDRON	JACOME	JATIVA	JINZO	JUARERRO
ISLA	JACOMINO	JAUUMA	JIRAU	JUARROS
ISLAS	JACOVO	JAUUME	JIRON	JUBELA
ISLAVA	JACQUEZ	JAUDNARENA	JOFRE	JUELLE
ISONA	JACUNDE	JAVNES	JOJOLA	JUEZ
ISORDIA	JADAR	JAVRE	JOMARRON	JUFIAR
ISQUIERDO	JALE	JAVREGUI	JORAMILLO	JULBE
ISUNZA	JALME	JAVREGUIBERRY	JORDANA	JULIA
ITHER	JAIMERENA	JAVREGUY	JORGANES	JUNCADELLA
ITUARTE	JAIMES	JAURENA	JORGE	JUNCAL

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JUNCO	LABRADO	LAGUER	LAMOSO	LAOS
JUNCOSA	LABRADOR	LAGUERUELA	LAMOURT	LAOSA
JUNEZ	LABUZAN	LAGUILLO	LAMOUTTE	LAPADURA
JUNGUERA	LACA	LAGUNA	LAMPARELLO	LAPARRA
JUNQUERA	LACALLE	LAGUNAS	LAMPEDUSA	LAPAZ
JURADO	LACARRA	LAGUNES	LAMPON	LAPENA
JURAEZ	LACASA	LAHOZ	LANAS	LAPICA
JURAHUI	LACASELLA	LAIJA	LANCARA	LAPIZ
JURDI	LACAYO	LAIJAS	LANCHA	LAPUERTA
JURE	LACEBAL	LAILES	LANDA	LAPUZ
JURI	LACEDONIA	LAINEZ	LANDAVASO	LARA
JURREZ	LACERA	LAISECA	LANDAVAZO	LARACUENTA
JUSAINO	LACHAPPA	LAIZ	LANDAVERDE	LARACUENTE
JUSINO	LACHICA	LAJARA	LANDAZURI	LARALDE
JUSTINIANI	LACHICO	LAJES	LANDEIRA	LARAN
JUSTINIANO	LACOMBA	LALLAVE	LANDERO	LARAS
JUSTIZ	LACOME	LALOMA	LANDEROS	LARDIZABAL
JUVER	LACONCHA	LALUEZA	LANDESTOY	LAREDO
JUVERA	LACRET	LALUZ	LANDETA	LARENA
LABADOR	LACRUE	LAMADRID	LANDEZ	LARENAS
LABADY	LACRUZ	LAMADRIZ	LANDIN	LARES
LABANDEIRA	LACSAMANA	LAMAS	LANDIVAR	LAREZ
LABARGA	LADAGA	LAMASA	LANDOL	LARIOS
LABARTA	LAFARGA	LAMATA	LANDRAU	LARIVA
LABASTIDA	LAFEBRE	LAMAZARES	LANDRIAN	LARIZ
LABASTILLA	LAFFONT	LAMBARDIA	LANDRON	LARRA
LABIO	LAFORTEZA	LAMBAREN	LANET	LARRACHE
LABIOSA	LAFUENTE	LAMBARENA	LANFRANCO	LARRAGA
LABISTE	LAFUENTES	LAMBARIA	LANGARA	LARRAGOITE
LABOCA	LAGAR	LAMBARRI	LANGARCIA	LARRAGOITY
LABORDA	LAGARDA	LAMBOY	LANGARICA	LARRAINZAR
LABORI	LAGARES	LAMEIRA	LANTIGUA	LARRALDE
LABORICO	LAGEYRE	LAMELA	LANUEZ	LARRAMENDI
LABORIN	LAGO	LAMELAS	LANUZA	LARRAN
LABOY	LAGOA	LAMIGUEIRO	LANZISERO	LARRANAGA
LABRA	LAGOMASINO	LAMORENA	LANZOT	LARRANGA
LABRADA	LAGRANA	LAMOSA	LAO	LARRASQUITO

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LARRASQUITU	LASOS	LAVIOS	LEDEZMA	LEONES
LARRAURI	LASSOS	LAVORICO	LEDO	LEONGUERRERO
LARRAYA	LASTRA	LAVORIN	LEDON	LEONIS
LARRAZ	LASTRE	LAYANA	LEGARDA	LEONOR
LARRAZABAL	LASTRES	LAYNA	LEGARRA	LEOS
LARRAZOLA	LATASA	LAZA	LEGARRETA	LEOZ
LARRAZOLO	LATIGO	LAZAGA	LEGARRETTA	LEPE
LARREA	LATONI	LAZALA	LEGASPE	LERA
LARREGUI	LATORRES	LAZALDE	LEGASPI	LERDO
LARRETA	LAUGIER	LAZANO	LEGORRETA	LERENA
LARREYNAGA	LAUREAN	LAZARIN	LEGOZA	LERET
LARRIBA	LAUREANO	LAZARINE	LEGRA	LERMA
LARRIBAS	LAUREDO	LAZARO	LEGUINA	LERMO
LARRINAGA	LAUREIRO	LAZARTE	LEIBA	LERNO
LARRINUA	LAUREL	LAZCANO	LEIBAS	LERO
LARRIVA	LAURELES	LAZCOS	LEIGON	LESA
LARRONDE	LAURIANO	LAZES	LEIJA	LESCANO
LARRONDO	LURIAS	LAZO	LEIMON	LESMES
LARROSA	LAURIDO	LAZODELAVEGA	LEIRA	LESPIER
LARROY	LAUSELL	LAZOS	LEIRO	LESPRON
LARRUA	LAUTERIO	LAZRINE	LEISA	LETAMENDI
LARRUBIA	LAUZARDO	LAZU	LEISECA	LETONA
LARTUNDO	LAUZURIQUE	LAZURTEGUI	LETTA	LETRIZ
LARZABAL	LAVANDEIRA	LEAL	LETTES	LEURA
LASA	LAVANDERA	LEANOS	LEIVA	LEV ALDO
LASAGA	LAVANDERO	LEBARIO	LEIVAS	LEVARIO
LASALDE	LAVANDERO	LEBRIO	LEIZAN	LEYBA
LASANTA	LAVASTIDA	LEBRON	LEIARZA	LEYBAS
LASAS	LAVAYEN	LECARO	LEIARZAR	LEYIA
LASAVIO	LAVEA	LECAROS	LELEVIER	LEYRA
LASCANO	LAVEAGA	LECEA	LEMES	LEYRO
LASCOR	LAVEGA	LECHON	LEMUS	LEYUA
LASCURAIN	LAVENDERA	LECHUGA	LEMUZ	LEYVA
LASERNA	LAVERGATA	LECTORA	LENERO	LEYVAS
LASES	LAVERNIA	LECUMBERRI	LENTE	LEZA
LASHERAS	LAVIADA	LECUSAY	LEODORO	LEZAJA
LASO	LAVILLA	LEDESMA	LEON	LEZAMA

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LEZANA	LINAREZ	LIZARRARAS	LLAVE	LLUIS
LEZCANO	LINEIRO	LIZARZABURU	LLAVERIAS	LLURIA
LIANO	LINERA	LIZASO	LLAVET	LLUVERAS
LIANOZ	LINERO	LIZASUAIN	LLAVONA	LOA
LIANZA	LINEROS	LIZCANO	LLENIN	LOAIZA
LIBOY	LIQUET	LLABRES	LLENZA	LOARTE
LIBRAN	LIQUEZ	LLACA	LLEO	LOAYZA
LIBREROS	LIRA	LLACER	LLEONART	LOBAINA
LICANO	LIRAALVARADO	LLADO	LLERA	LOBATO
LICEA	LIRANZO	LLAGOSTERA	LLERANDI	LOBATOS
LICEAGA	LIRES	LLAGUNO	LLERAS	LOBATOZ
LICERIO	LIRIANO	LLAMA	LLERENA	LOBERA
LICON	LIRIO	LLAMAS	LLERENAS	LODEIRO
LICONA	LISALDA	LLAMAZARES	LLEVERINO	LODEVICO
LICOR	LISALDE	LLAMBES	LLIBRE	LODOS
LICUDINE	LISAMA	LLAMEDO	LLINAS	LODOZA
LIENDO	LISARDO	LLAMES	LLITERAS	LOERA
LIERA	LISBOA	LLAMOSA	LLIZO	LOEZA
LIERAS	LISCANO	LLANA	LLOBERA	LOGOLUSO
LIERRA	LISEA	LLANAS	LLOBET	LOGRONO
LIEVANO	LISERA	LLANERA	LLOMPART	LOINAZ
LIEVANOS	LISERIO	LLANERAS	LLONA	LOIRA
LIGUES	LISOJO	LLANES	LLOPIS	LOJA
LIGUEZ	LIZA	LLANEZ	LLOPIZ	LOJERO
LIMARDO	LIZALDA	LLANIO	LLORCA	LOJO
LIMAS	LIZALDE	LLANO	LLOREDA	LOMANA
LIMIA	LIZAMA	LLANOS	LLORENS	LOMAYESVA
LIMON	LIZAN	LLANTADA	LLORENTE	LOMBANA
LIMONES	LIZANO	LLANTIN	LLORET	LOMBARDIA
LIMONEZ	LIZAOLA	LLANUSA	LLOREN	LOMBERA
LIMONTA	LIZARAGA	LLAPUR	LLOSA	LOMBRANA
LIMONTORRES	LIZARDE	LLARENA	LLOVERA	LOMBRANO
LIMOSNERO	LIZARDI	LLATA	LLOVERAS	LOMELI
LIMUEL	LIZARDO	LLAUGER	LLOVET	LOMELIN
LINAJE	LIZARRAGA	LLAURADO	LLOVIO	LOMELLIN
LINAN	LIZARRAGO	LLAURADOR	LLUBERES	LOMELY
LINARES	LIZARRALDE	LLAUSAS	LLUCH	LONA

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LONDONO	LORZA	LUCARIO	LUPIAN	MACHORRO
LONGORIA	LOSA	LUCATERO	LUPIANEZ	MACHUCA
LONGORIO	LOSADA	LUCATORTA	LUPIBA	MACIA
LONGOVIA	LOSADO	LUCENA	LUPRO	MACIAL
LONGUEVAN	LOSANA	LUCER	LUQUE	MACIAS
LONVELIN	LOSOYA	LUCERO	LUQUEZ	MACIAZ
LOPATEGUI	LOSTAUINAU	LUCIO	LUQUIN	MACIEL
LOPE	LOUATO	LUCO	LUQUIS	MACOTELA
LOPENA	LOUBRIEL	LUCOS	LURAS	MADA
LOPERA	LOURIDO	LUCRET	LUVIANO	MADALA
LOPERENA	LOUSTAUNAU	LUEBANO	LUYANDA	MADARIAGA
LOPETEGUI	LOVATO	LUENGAS	LUYANDO	MADERA
LOPEZ	LOVATON	LUENGO	LUZA	MADERIS
LOPEZCASTRO	LOVEIRA	LUEA	LUZANIA	MADERO
LOPEZMENDOZA	LOVERA	LUEBAS	LUZANILLA	MADIEDO
LOPEZRODRIGUEZ	LOVERAS	LUEVANO	LUZANO	MADOZ
LOPEZSANCHEZ	LOVILLE	LUEVANOS	LUZARDO	MADRAZO
LOPEZVEGA	LOVIO	LUEZA	LUZARRAGA	MADRIA
LOPOZ	LOYA	LUGARDO	LUZBET	MADRID
LOQUET	LOYNAZ	LUGARO	LUZUNARIS	MADRIGAL
LORA	LOYO	LUGO	LUZURIAGA	MADRIGALES
LORANCA	LOYOLA	LUGON	MACARAIG	MADRIGUAL
LORCA	LOZA	LUGONES	MACARDICAN	MADRIL
LOREDO	LOZADA	LUNA	MACARENO	MADRILES
LORENCES	LOZADO	LUIS	MACARON	MADRILL
LORENTE	LOZANA	LUITIN	MACAVINTA	MADRIZ
LORENZANA	LOZANO	LUIAN	MACAYA	MADRONA
LORERA	LOZEZ	LUIANO	MACAYAN	MADRUENO
LORETDDEMOLA	LOZOLLA	LUIARDO	MACDONADO	MADRUGA
LOREZ	LOZOYA	LUIO	MACEDA	MADRUANO
LORIDO	LUA	LUION	MACEIRA	MADUELL
LORIEGA	LUACES	LUMBRERA	MACEN	MADUENA
LORIGA	LUAN	LUMBRERAS	MACENA	MADUENO
LORIGO	LUAS	LUNA	MACEO	MADURO
LORONA	LUBE	LUNARES	MACEYRA	MAELIA
LORONO	LUBERTA	LUPERCIO	MACHICHE	MAES
LORTA	LUBIAN	LUPEZ	MACHIN	MAESE

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MAESO	MAINEZ	MALDONADO	MANDONADO	MANUZ
MAESTAS	MAIQUEZ	MALDONALDO	MANDUGARO	MANZANA
MAESTAZ	MAIRENA	MALDONDO	MANDUIAN	MANZANAL
MAESTES	MAISONAVE	MALDONODO	MANDUIANO	MANZANARES
MAESTOS	MAISONET	MALENDEZ	MANGOME	MANZANAREZ
MAESTRE	MAISTERRA	MALFAVON	MANGUAL	MANZANEDO
MAESTREY	MAITIA	MALIAROS	MANGUIA	MANZANERA
MAESTU	MAITO	MALIBRAN	MANICOM	MANZANERES
MAEVA	MAIZ	MALICAY	MANIQUIS	MANZANERO
MAEZ	MAJALCA	MALLANO	MANITO	MANZANET
MAGALDE	MAJANO	MALLEA	MANJARES	MANZANILLA
MAGALLAN	MAJARUCON	MALLOQUE	MANJAREZ	MANZANO
MAGALLANES	MAJENO	MALLORCA	MANJARRES	MANZUR
MAGALLANEZ	MAJIA	MALONADO	MANJARREZ	MAPALO
MAGALLON	MAJUL	MALONCON	MANOSA	MAPULA
MAGALONA	MAJUTA	MALOVE	MANQUERO	MAQUEDA
MAGANA	MALABANAN	MALPICA	MANQUEROS	MAQUEIRA
MAGANTE	MALABE	MALTES	MANRESA	MAQUINALEZ
MAGARINO	MALABEHAR	MALTOS	MANRIGUEZ	MAQUIVAR
MAGAZ	MALACARA	MALUIA	MANRIQUE	MARABOTTO
MAGDAEL	MALAGON	MALVAEZ	MANRIQUES	MARADIAGA
MAGDALANO	MALANA	MALVAREZ	MANRIQUEZ	MARALEZ
MAGDALENA	MALANCHE	MALVIDO	MANRRIQUE	MARANAN
MAGDALENO	MALANDRIS	MAMARADLO	MANRRIQUEZ	MARANON
MAGDIRILA	MALARIN	MANCEBO	MANSANALES	MARANTE
MAGENO	MALAUE	MANCERA	MANSANALEZ	MARANTOS
MAGLICA	MALAVE	MANCERO	MANSANARES	MARASCOLA
MAGLUTA	MALAVES	MANCHA	MANSANAREZ	MARATAS
MAGPAYO	MALAVET	MANCHACA	MANSILLA	MARAVEZ
MAGPURI	MALAVEZ	MANCHAN	MANSILLAS	MARAVILLA
MAGRINA	MALBAEZ	MANCHEGO	MANSITO	MARAVILLAS
MAGSOMBOL	MALBAS	MANCIAS	MANSO	MARAVILLO
MAGUREGUI	MALDANADO	MANCILLA	MANTECA	MARBAN
MAIMES	MALDENADO	MANCILLAS	MANTECON	MARCADIS
MAIMO	MALDOMADO	MANCINAS	MANTEROLA	MARCANO
MAINEGRA	MALDONA	MANCITO	MANTILLA	MARCELENO
MAINERO	MALDONADA	MANDADO	MANTINEZ	MARCELIN

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CENSUS LIST OF SPANISH SURNAMES**

MARCHA	MARINES	MARTIARENA	MASCARENAS	MATOS
MARCHAN	MARINEZ	MARTICORENA	MASCARENAS	MATOSO
MARCHANTE	MARIONA	MARTINDELCAMPO	MASCARENO	MATOZA
MARCHANY	MARISCAL	MARTINES	MASCARINAS	MATTILLO
MARCHECO	MARISTANY	MARTINETS	MASCARRO	MATURANA
MARCHENA	MARISY	MARTINEX	MASCORRO	MATURINO
MARCHIONDO	MARTINEZ	MARTINEZ	MASDEO	MATUTE
MARCIAL	MARLANO	MARTINEZDECASTR	MASDEU	MAULEON
MARCILLA	MARMOL	O	MASEDA	MAUNA
MARCILLO	MARMOLEJO	MARTINEZGARCIA	MASERO	MAUPOME
MARCOR	MARMOLEJOS	MARTINEZGONZALE	MASFERRER	MAURAS
MARCOS	MARONES	Z	MASIAS	MAUREL
MARDOMINGO	MARQUEZ	MARTINEZORTIZ	MASIEL	MAURICIO
MARDUENO	MARQUINA	MARTINEZRODRIGU	MASJUAN	MAURIES
MAREINA	MARQUIZ	EZ	MASPERO	MAURIZ
MARENCO	MARRASQUIN	MARTINIZ	MASPONS	MAUROSA
MARENTEZ	MARRENO	MARTIR	MASQUIDA	MAUROZA
MARENTEZ	MARRERO	MARTIRENA	MASSANA	MAYA
MAREQUE	MARRIAGA	MARTIZ	MASSANET	MAYAGOTIA
MARERO	MARRIETTA	MARTLARO	MASSAS	MAYANS
MARESMA	MARRODAN	MARTNEZ	MASSIATTE	MAYAS
MAREZ	MARROGUIN	MARTORELL	MASTACHE	MAYATE
MAREZ	MARROQUIN	MARTOS	MASTRAPA	MAYDON
MAREIL	MARRORO	MARUFFO	MASVIDAL	MAYEN
MARILENO	MARROZOS	MARUFO	MATA	MAYMI
MARGALLAN	MARROUFO	MARULANDA	MATAIYA	MAYNEZ
MARGARITO	MARRUFO	MARUNO	MATALLANA	MAYOL
MARGUEZ	MARRUGO	MARURI	MATALOBOS	MAYORA
MARIANES	MARRUJO	MARVEZ	MATAMOROS	MAYORAL
MARICHAL	MARSACH	MARXUACH	MATANZO	MAYORCA
MARICHALAR	MARSALIA	MARZAN	MATEAS	MAYORDOMO
MARIDUENA	MARSELLLOS	MARZOA	MATEO	MAYORGA
MARIN	MARTE	MARZOL	MATEOS	MAYORQUIN
MARINAS	MARTELON	MARZOVILLA	MATEU	MAYSONET
MARINELARENA	MARTENEZ	MAS	MATIAS	MAYTTIN
MARINERO	MARTES	MASCARDO	MATIENZO	MAYTORENA
	MARTEZ	MASCARENA	MATILLA	MAZA

APPENDIX E
CENSUS LIST OF SPANISH SURNAMMES

MAZARA	MEJA	MENA	MENDRIN	MERJIL
MAZARIEGO	MEJIAS	MENACHE	MENEDEZ	MERLA
MAZARIEGOS	MEJICO	MENACHO	MENENDEZ	MERLOS
MAZON	MEJIDO	MENCHACA	MENES	MERMEA
MAZORRA	MEJILLA	MENCHAEA	MENESES	MERMEJO
MAZPULE	MEJILLAS	MENCHAVEZ	MENEZ	MERMELLA
MAZQUIARAN	MEJORADA	MENCHEGO	MENJARES	MERODIO
MAZUCA	MEJORADO	MENCIA	MENJIVAR	MERONO
MAZUELOS	MELANDEZ	MENCIO	MENJUGA	MERU
MEASTAS	MELANO	MENCOS	MENOCAL	MERUELO
MEAVE	MELCHOR	MENDANA	MENOSCAL	MESA
MECADO	MELCON	MENDAROS	MENOUUD	MESEGUER
MECARTEA	MELCICIO	MENDEOLA	MENOYO	MESIA
MECENAS	MELENA	MENDEZ	MERA	MESIAS
MECHOSO	MELENCIANO	MENDIA	MERANCIO	MESILLAS
MEDEL	MELENDE	MENDIAS	MERAS	MESINAS
MEDELES	MELENDES	MENDIAZ	MERAZ	MESONERO
MEDELEZ	MELENDEZ	MENDIBLES	MERCAD	MESORANA
MEDELLIN	MELENDRES	MENDIBURO	MERCADA	MESQUIAS
MEDERO	MELENDREZ	MENDIBURU	MERCADAL	MESQUIT
MEDEROS	MELENEDEZ	MENDIETA	MERCADE	MESQUITA
MEDIANO	MELENEZ	MENDIETTA	MERCADER	MESQUITE
MEDIA VILLA	MELENUDO	MENDIGUTIA	MERCADO	MESQUITI
MEDINA	MELERO	MENDINE	MERCARDO	MESSARRA
MEDINAS	MELGAR	MENDIOLA	MERCED	MESSEGUER
MEDINILLA	MELGAREJO	MENDIOLEA	MERCEDES	MESTA
MEDIO	MELGARES	MENDIONDO	MERCHAIN	MESTAS
MEDIZ	MELGOSA	MENDITA	MERCHAN	MESTAZ
MEDOLA	MELGOZA	MENDIVEL	MERCODO	MESTRE
MEDRAN	MELIAN	MENDIVIL	MERCOLA	MESTRES
MEDRANO	MELIAS	MENDIZ	MERCONCHINI	MESTRIL
MEGARIZ	MELINDEZ	MENDIZABAL	MERELES	MEXIA
MEGUI	MELIOTA	MENDOSA	MERENDON	MEXICANO
MEJA	MELLADO	MENDOZ	MERENZ	MEZA
MEIRELES	MELLOCOTON	MENDOZA	MERGIL	MEZQUITA
MEIZOSO	MEMBRENO	MENDOZO	MERINO	MICAN
MEJA	MEMBRILA	MENDRE	MERIZALDE	MICHACA

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

MICHELENA	MIRAGORRI	MIRAVALL	MOLEDO	MONCLOVA
MICHELTORENA	MINAMIDE	MIRAYYA	MOLENA	MONDACA
MIEDES	MINATRE	MIRAZ	MOLENDEZ	MONDEJAR
MIELES	MINAYA	MIRAZO	MOLERA	MONDELO
MIELGO	MINCHACA	MIRDITA	MOLERES	MONDONA
MIERA	MINDIETA	MIRELES	MOLERIO	MONDOZA
MIERES	MINDIOLA	MIRELEZ	MOLGADO	MONDRAGON
MIEREZ	MINERA	MIRET	MOLINA	MONEDA
MIESES	MINERO	MIRILES	MOLINAR	MONEDERO
MIGNARDOJ	MINGUELA	MIRO	MOLINARES	MONEGRO
MIGOYA	MINGURA	MIROLLA	MOLINARY	MONEO
MIGUEL	MINIAREZ	MISAS	MOLINAS	MONGE
MIGUELES	MINICA	MISLA	MOLINER	MONGES
MIGUELEZ	MINITREZ	MISQUEZ	MOLINEROS	MONGUIA
MIGUELIZ	MINJARES	MITYAR	MOLINET	MONITA
MIGURA	MINJAREZ	MITYARES	MOLLEDA	MONJARAS
MIJANGOS	MINOBE	MOCEGA	MOLLES	MONJARAZ
MIJARES	MINONDO	MOCETE	MOLLINDO	MONJARDIN
MIJAREZ	MINOSO	MOCHO	MOLLINEDO	MONJE
MIJENES	MINSAL	MOCTEZUMA	MONAGAS	MONJES
MILA	MIQUEO	MODERO	MONARCO	MONLEON
MILANES	MIR	MODIA	MONARES	MONLLOR
MILANES	MIRABAL	MODRONO	MONARQUE	MONNAR
MILARA	MIRABEL	MOGAS	MONARRES	MONNOZ
MILERA	MIRABENT	MOGOLLON	MONARRES	MONRAZ
MILIAN	MIRADA	MOGRO	MONARREZ	MONREAL
MILINA	MIRAFLORES	MOGUEL	MONCADA	MONREAL
MILLAN	MIRALES	MOHEDANO	MONCADO	MONROIG
MILLAND	MIRALLA	MOIZA	MONCAYO	MONROY
MILLANES	MIRALLES	MOJADO	MONCEVAIS	MONRREAL
MILLANEZ	MIRAMON	MOJARRO	MONCEVAIZ	MONRRIAL
MILLANPONCE	MIRAMONTES	MOJEDA	MONCEVIAS	MONSALVE
MILLARES	MIRAMONTEZ	MOJENA	MONCIBAIS	MONSALVO
MILLAYES	MIRANA	MOJICA	MONCIBAIZ	MONSEBAIS
MIMIAGA	MIRANDA	MOLANO	MONCIVAIZ	MONSEGUR
MINABE	MIRANO	MOLDES	MONCIVAIZ	MONSERRAT
MINAGA	MIRASOL	MOLDONADO	MONCIVALLEZ	MONSERRATE

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

MONSEVAIS	MONTEON	MORADO	MORENO	MORRAZ
MONSEVALLES	MONTERA	MORAGA	MORENTIN	MORRERO
MONSIBAIS	MONTERDE	MORAGO	MORERA	MORRINA
MONSIBAIZ	MONTEREY	MORAGUEZ	MORERO	MORTEO
MONSISVAIS	MONTERO	MORAJDA	MORETA	MORTERA
MONSIVAIS	MONTEROLA	MORAILA	MOREYRA	MORUA
MONSIVAIZ	MONTEROS	MORAL	MORFA	MORVA
MONTAIVO	MONTERREY	MORALE	MORFFI	MOSCOSO
MONTALBAN	MONTERROSA	MORALEJO	MORFI	MOSINO
MONTALBO	MONTERROSO	MORALES	MORFIN	MOSQUEA
MONTALUO	MONTERROZA	MORALES	MORGA	MOSQUEDA
MONTALVAN	MONTERROZA	MORALES	MORGA	MOSQUEDO
MONTALVO	MONTERRUBIO	MORALES	MORGALO	MOSQUERA
MONTAN	MONTES	MORALES	MORGAS	MOTA
MONTANE	MONTESDEOCA	MORALES	MORHAR	MOTAL
MONTANER	MONTESINO	MORALES	MORIEL	MOTAL
MONTANES	MONTESINOS	MORALESTORRES	MORILLA	MOTILLA
MONTANEZ	MONTEVERDE	MORALEZ	MORILLAS	MOURE
MONTANIO	MONTEZ	MORANDA	MORILLO	MOUREN
MONTANO	MONTEZUMA	MORANTES	MORILLO	MOURINO
MONTANES	MONTIEL	MORATA	MORILLON	MOURIZ
MONTAYA	MONTIJO	MORATALLA	MORILLOS	MOYA
MONTAZ	MONTIJA	MORATAYA	MORIONES	MOYADO
MONTAGUDO	MONTION	MORATO	MORIYON	MOYANO
MONTALEGRE	MONTMAYOR	MORAZA	MORLA	MOYEDA
MONTAVARO	MONTOLLA	MORCATE	MORLES	MOYENO
MONTECELO	MONTONO	MORCIEGO	MORLET	MOYET
MONTECINO	MONTOTO	MORCIGLIO	MORLOTE	MOYRON
MONTEDEOCA	MONTOVA	MORCOS	MOROCHO	MOZAS
MONTEFALCON	MONTOY	MOREDA	MORODO	MOZQUEDA
MONTEJANO	MONTOYA	MOREDO	MOROLEZ	MUCALA
MONTEJO	MONTOYO	MOREIDA	MOROLEZ	MUCINO
MONTELLANO	MONTUFAR	MOREIRAS	MORON	MUDAFORT
MONTELONGO	MONTUYA	MOREJON	MORONES	MUELA
MONTEMAJOR	MONZON	MORELES	MORONEZ	MUELAS
MONTEMAYOR	MOQUETE	MORELION	MOROYQUI	MUENTES
MONTENEGRO	MOQUINO	MORELLO	MORQUECHO	MUGA
	MORA	MORELO	MORQUEZ	MUGARTEGUI
		MORELOS	MORRAS	

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

MUGERZA	MUNOZ	MUSQUIZ	NAREZO	NAVEIRAS
MUGICA	MUNOZCANO	MUSTELIER	NARINO	NAVEIA
MUGUERCIA	MUNQUIA	MUTTO	NARIO	NAVEJAR
MUGUERZA	MUNTANER	MUXART	NARONJO	NAVELAS
MUGUIRO	MURADAS	MUXO	NARRANJO	NAVERAN
MUIL	MURADAZ	MUZAURIETA	NARRO	NAVIA
MUNA	MURADO	MUZQUIZ	NARVAES	NAVIDAD
MUNAS	MURAIMA	NABA	NARVAEZ	NAVO
MUNO	MURAIRA	NABARRETTE	NARVAIS	NAVODA
MUNOS	MURALLEZ	NABARRETTE	NARVAIZ	NAYA
MURRAGUI	MURANE	NABAYAN	NARVAREZ	NAYARES
MUIS	MURATALLA	NABETA	NARVARTE	NAZABAL
MUJICA	MURAVEZ	NACER	NATAL	NAZARIO
MULERO	MURCIA	NACHON	NATERA	NAZCO
MULET	MURCIANO	NACIANGENO	NATERAS	NAZUR
MULGADO	MURCIO	NADAL	NATIVIDAD	NEBLINA
MUNA	MURGA	NAFARRATE	NAVA	NEBRIDA
MUNANA	MURGADO	NAFARRATE	NAVAIIRA	NECOCHEA
MUNARRIZ	MURGUIA	NAFARRETE	NAVAMAR	NECOCHEA
MUNDO	MURIAS	NAGORE	NAVAL	NECUZE
MUNECAS	MURIEDAS	NAJAR	NAVALES	NEGRE
MUNERA	MURIEL	NAJARA	NAVALLO	NEGRE
MUNERO	MURIENTE	NAJARES	NAVANJO	NEGREIRA
MUNET	MURIETTA	NAJARRO	NAVAR	NEGREIRA
MUNETON	MURILLO	NAJERA	NAVARETE	NEGRET
MUNEZ	MURILLO	NALDA	NAVARETE	NEGRETE
MUNGARAY	MURO	NANDIN	NAVARETTE	NEGRETTE
MUNGARRO	MURROLAS	NANDINO	NAVAREZ	NEGRIN
MUNGIA	MUROS	NANEZ	NAVARRIA	NEGRIN
MUNGUIA	MUROYA	NAPOLIS	NAVARRIJO	NEGRON
MUNILLA	MURRIETA	NARANIO	NAVARR	NEGRONCOLON
MUNIVE	MURRIETTA	NARAVIO	NAVARRERTE	NEGRONI
MUNIVEZ	MURRILLO	NARAVEZ	NAVARRERTE	NEGUERUELA
MUNIZ	MURSULI	NARBAIZ	NAVARRRO	NEIRA
MUNNE	MURUA	NARCIA	NAVAS	NETTO
MUNOA	MURUAGA	NAREDO	NAVEDA	NEIVES
MUNOS	MURUATO	NARES	NAVEDO	NEJAR
	MUSQUEZ	NAREZ	NAVEIRA	NERADA

APPENDIX E
CENSUS LIST OF SPANISH SURNAMAMES

NEREY	NISTAL	NORAT	NUNO	OCHINERO
NERIA	NIVAL	NORDA	NUNTEZ	OCHIPA
NERIO	NIVAR	NORDELLA	OAXACA	OCHOA
NERIOS	NIVES	NORDELO	OBALLE	OCHOS
NERIS	NIZ	NOREIGA	OBALLES	OCHOTERENA
NERVAIS	NOA	NORENA	OBANDO	OCHOTORENA
NEVARES	NOBARA	NORERO	OBARRIO	OCON
NEVAREZ	NOBIDA	NORIA	OBAS	ODAMA
NEVARREZ	NOBOA	NORIEGA	OBAYA	ODIO
NEYRA	NOBREGAS	NORIEGO	OBERA	ODRIOZOLA
NIALS	NOCAS	NORIZ	OBESO	OFARRILL
NIAVE	NOCEDA	NORMANDIA	OBESO	OFERRAL
NIAVES	NOCEDAL	NORONA	OBEDO	OGALDEZ
NAVEZ	NOCHE	NORTE	OBIEDO	OGANDO
NICACIO	NOCHERA	NORZAGARAY	OBLEA	OGARRIO
NICASIO	NODAL	NOVALES	OBLEDO	OGARRO
NICOT	NODAR	NOVAS	OBLIGACION	OGAS
NIDEZ	NODARSE	NOVELA	OBRAADOR	OGAZ
NIDO	NOGALES	NOVELO	OBREGON	OGUENDO
NIEBLA	NOGARE	NOVEMBRE	OCA	OGUETE
NIEBLAS	NOGUE	NOVIAN	OCACIO	OHIGGINS
NIEGO	NOGUEDA	NOVILLO	OCADIZ	OJEDA
NIELES	NOGUEIRAS	NOVO	OCAMPO	OJINAGA
NIETO	NOGUELLES	NOVOA	OCAMPOS	OJITO
NIEVA	NOGUER	NOYA	OCANA	OLABARRIA
NIEVE	NOGUERA	NOYAS	OCANAS	OLABARRIETA
NIEVES	NOGUERAS	NOYOLA	OCANO	OLACHEA
NIEVEZ	NOGUES	NUANES	OCANTO	OLAECHEA
NIEZ	NOGUEZ	NUANEZ	OCARANZA	OLAETA
NIGAGLIONI	NOLASCO	NUCHE	OCARIZ	OLAEZ
NIGOS	NOLINE	NUEVO	OCARIZA	OLAGE
NILA	NOLLA	NUEZ	OCASIO	OLAGUE
NIN	NOMBRANA	NUIN	OCEGUEDA	OLAGUES
NINA	NOMBRANO	NUMEZ	OCEGUERA	OLAGUEZ
NINO	NOPERI	NUNCIO	OCEJO	OLAGUIBEL
NIRA	NORALES	NUNEZ	OCEQUEDA	OLAIS
NISPEROS	NORALEZ	NUNGARAY	OCHEA	OLAIZ

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

OLALDE	OLIVAROS	OLVEDO	ORATE	ORIGEL
OLALLA	OLIVARRI	OLVEIRA	ORBAY	ORIGINALES
OLAQUE	OLIVARRIA	OLVERA	ORBEA	ORIHUELA
OLAQUEZ	OLIVAS	OLVEZ	ORBEGOZO	ORJUEL
OLARTE	OLIVENCIA	OMAECHEVARRIA	ORCA	ORIQUE
OLASCOAGA	OLIVERA	OMANA	ORCASITAS	ORISIO
OLASCUAGA	OLIVERAS	OMS	ORDAZ	ORTIZ
OLAVARRI	OLIVERAZ	ONATE	ORDENANA	ORTIZ
OLAVARRIA	OLIVERES	ONDARO	ORDENANA	ORIVE
OLAVARRIETA	OLIVEREZ	ONDARZA	ORDENER	ORIZAGA
OLAVE	OLIVERO	ONDOY	ORDENES	ORJALES
OLAYA	OLIVEROS	ONDREAS	ORDENEZ	ORJUELA
OLAYO	OLIVES	ONDRIAS	ORDIALES	ORJUELA
OLAZABA	OLIVIAS	ONGANIA	ORDINARIO	ORNELAS
OLAZABAL	OLIVIS	ONGAY	ORDONES	ORNELAZ
OLAZAGASTI	OLIVO	ONOFRE	ORDONEZ	ORNELES
OLAZARAN	OLIVOS	ONOFRE	ORDONO	OROBIO
OLBA	OLLACA	ONOFRE	ORDONO	OROL
OLBERA	OLLERBIDEZ	ONSUREZ	ORDOQUI	ORONA
OLBES	OLLERVIDES	ONTANEDA	ORDORICA	ORONA
OLDRATE	OLLERVIDES	ONTIBEROZ	ORDOVER	ORONAZ
OLEA	OLLIVAREZ	ONTIVERAS	ORDUNA	ORONAZ
OLEAS	OLLIVARES	ONTIVERAS	ORDUNEZ	OROPESA
OLETA	OLLOQUE	ONTIVERO	ORDUNO	OROSPEZA
OLETA	OLLOQUI	ONTIVEROS	ORDUNO	OROSA
OLGIN	OLME	ONTIVEROZ	OREGEL	OROSCO
OLGUIN	OLMEDA	OPIO	OREJEL	OROZ
OLIBARES	OLMEDA	OPORTO	ORELLANA	OROZCO
OLIBAREZ	OLMEDO	OQUENDO	ORELLANO	OROZCO
OLIBARRIA	OLMO	OQUITA	ORENDAIN	ORPILLA
OLIDE	OLMOZ	ORABUENA	ORENGO	ORPINEL
OLIU	OLMOZ	ORACION	ORENSE	ORQUIZ
OLIVA	OLONA	ORAMA	ORETEGA	ORRACA
OLIVAN	OLONIA	ORAMAS	ORETGA	ORRADRE
OLIVAR	OLONO	ORANA	ORFLA	ORRANTE
OLIVAR	OLORTEGUI	ORANDAY	ORGANISTA	ORRANTIA
OLIVARE	OLQUIN	ORANTE	ORGE	ORREGO
OLIVARES	OLTIVERO	ORANTES	ORIA	ORRIOLA
OLIVAREZ	OLVEDA	ORANTEZ	ORIBA	ORRIOLS
			ORIBE	ORSABA

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

ORSUA	OSVALLE	PACHECO	PAGUAGA
ORTA	OVALLES	PACHELO	PAGUIO
ORTAL	OVALLEZ	PACHEO	PAHISSA
ORTAS	OVANDO	PACHERO	PAIACIOS
ORTEG	OVARES	PACHICANO	PAIRADA
ORTEGA	OVIEDA	PACHO	PAIRIS
ORTEGAS	OVIEDO	PACHON	PAIZ
ORTEGON	OXIOS	PACHUCA	PAJARITO
ORTES	OYACA	PACIAS	PAJARO
ORTEZ	OYAGUE	PACIFICAR	PAJUELO
ORTIGAS	OYANGUREN	PACILLAS	PALACIES
ORTIGOSA	OYARBIDE	PACIN	PALACIO
ORTIGOZA	OYARZABAL	PACINA	PALACIOS
ORTIVEZ	OYARZUN	PACO	PALADINES
ORTIVIZ	OYAS	PADDILLA	PALAFOS
ORTIZ	OYERBIDES	PADER	PALAFOS
ORTIZYPINO	OYERVIDES	PADIA	PALAFOS
ORTOLAZA	OYERVIDEZ	PADIAL	PALAGANAS
ORTUNIO	OYOLA	PADIAS	PALAMO
ORTUNO	OYOQUE	PADIERNA	PALASOTA
ORTUZAR	OYUELA	PADILL	PALATO
ORUE	OZAETA	PADILLA	PALAU
ORUNA	OZETA	PADILLIA	PALAZON
ORVANANOS	OZORES	PADILLO	PALAZUELOS
ORZA	OZORIA	PADIN	PALENCIA
ORZABAL	OZORNIA	PADOR	PALENZUELA
ORZO	OZUNA	PADRES	PALEO
OSA	OZUNIGA	PADRINO	PALGON
OSANO	PABEY	PADRO	PALICIO
OSCOS	PABLICO	PADRON	PALITOS
OSCOY	PABLO	PADUA	PALIZO
OSEDA	PABLOS	PAEZ	PALLAIS
OSEGUEDA	PABON	PAGAN	PALLAN
OSEGUERA	PABROS	PAGANRIVERA	PALLANES
OSEJO	PACHARZINA	PAGES	PALLANEZ
OSELIO	PACHEC	PAGOLA	PALLARES
OSEQUERA	PACHECANO	PAGON	PALLAREZ
			PALLEJA

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

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PALLENS	PANCORBO	PARAYNO	PARTIDA	PAYERO
PALLOT	PANDAL	PARAYUELOS	PARTIDO	PAZ
PALMARES	PANDAS	PARAZO	PASADA	PAZMINO
PALMAREZ	PANDES	PARCES	PASAMONTE	PAZOS
PALMARIN	PANDO	PARDAVE	PASANTES	PECARO
PALMAS	PANDURO	PARDILLO	PASARELL	PECELUNAS
PALMEIRO	PANELO	PARDINAS	PASARET	PECERO
PALMERIN	PANENO	PARDO	PASARIN	PECHERO
PALMEROS	PANEQUE	PARDOS	PASCARIN	PECINA
PALOMA	PANERO	PARDUCHO	PASCACIO	PECOS
PALOMAR	PANETO	PARDEDES	PASCUAL	PEDEVILLA
PALOMARES	PANIAGUA	PARDEDEZ	PASCUALI	PEDRAJA
PALOMAREZ	PANIAQUA	PAREIRA	PASENA	PEDRAJAS
PALOMEQUE	PANIZ	PAREJA	PASILLAS	PEDRAYES
PALOMERA	PANOPIO	PARELLADA	PASOS	PEDRAZ
PALOMIN	PANTA	PARERA	PASSAPERA	PEDRAZA
PALOMINO	PANTAJA	PARERA	PASTORA	PEDRE
PALOMINOS	PANTALEON	PARETS	PASTORIZA	PEDREGAL
PALOMO	PANTIGA	PAREYA	PASTRAN	PEDREGO
PALOP	PANTIN	PARIZ	PASTRANA	PEDREGON
PALOS	PANTLEO	PARGA	PASTRANO	PEDREGUERA
PALOU	PANTOJA	PARGAS	PATINA	PEDRERA
PAMANES	PANTOJAS	PARIZ	PATINO	PEDREIRO
PAMARAN	PANTOYA	PAROCUA	PATLAN	PEDRERA
PAMBLANCO	PANTUSA	PARQUE	PATRANELLA	PEDRERO
PAMIAS	PANUCO	PARRA	PATRON	PEDRIANES
PAMINTUAN	PANZARDI	PARRADO	PAUDA	PEDRINO
PAMPIN	PANZIERA	PARRAGA	PAULA	PEDROCHE
PAMPLONA	PARACHE	PARRAL	PAULLADA	PEDROGO
PANALES	PARADEDA	PARRALES	PAVEDES	PEDROLA
PANALEDZ	PARADEDA	PARRAS	PAVILA	PEDROSA
PANAMA	PARADELA	PARRAZ	PAVON	PEDROSO
PANAMENO	PARADELO	PARRENO	PAYAN	PEDROZA
PANARISO	PARADES	PARRIERA	PAYANO	PEGO
PANCEGRAN	PARADEZ	PARRILLA	PAYARES	PEGODA
PANCHANA	PARAMO	PARRONDO	PAYAS	PEGUERO
PANCHO	PARAPAR	PARTAGAS	PAYEN	PEGUEROS

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

PEINADO	PENON	PEREYRA	PESCADO	PIMIENTA
PEIRO	PENSADO	PEREZ	PESCADOR	PIMIENTO
PELACHE	PENUELA	PEREZA	PESINA	PIMINTEL
PELAEZ	PENUELAS	PEREZCANO	PESQUEDA	PINA
PELAIZ	PENUELAZ	PEREZCHICA	PESQUEIRA	PINADEARCOS
PELALLO	PENUNURI	PEREZCOLON	PESQUERA	PINAL
PELATA	PEON	PEREZDEALEJO	PESQUIERA	PINALES
PELAYO	PEPERAS	PEREZDELRIO	PEYDRO	PINALEZ
PELEGRINA	PEPITO	PEREZDIAZ	PEYNADO	PINARES
PELECEER	PEQUENO	PEREZGONZALEZ	PEYRO	PINCAY
PELLERANO	PEQUERO	PEREZJIMENEZ	PEZA	PINEDA
PELLICIER	PERAL	PEREZLOPEZ	PEZEZ	PINEDO
PELLOT	PERALES	PEREZMENDEZ	PEZINA	PINEIRA
PELUFFO	PERALEZ	PEREZMONTES	PIARD	PINEIRO
PENA	PERALTA	PEREZRAMOS	PICALLO	PINELA
PENABAD	PERALTO	PERFECTO	PICAR	PINELO
PENADO	PERATIS	PERFINO	PICART	PINERA
PENAFIEL	PERAZA	PERICAS	PICASCIA	PINERO
PENAFLOR	PERCHES	PERLAS	PICASO	PINEROS
PENAFLORIDA	PERCHEZ	PERMUY	PICAZO	PINEY
PENAGARZA	PERDICES	PERNAS	PICENO	PINEYRO
PENAHERRERA	PERDIDO	PEROLDO	PICHARDO	PINGARRON
PENALBA	PERDIGON	PEROZO	PICO	PINIELLA
PENALES	PERDOMO	PERRES	PICON	PINILLA
PENALO	PEREA	PERRIRAZ	PICOS	PINILLO
PENALOSA	PEREDA	PERTIERRA	PIEDAD	PINILLOS
PENALOZA	PEREDIA	PERU	PIEDRA	PINO
PENALVER	PEREDO	PERUMEAN	PIEDRAHITA	PINOL
PENALVERT	PEREGRINA	PERUSINA	PIEDRAS	PINON
PENANO	PEREGRINO	PERUSQUIA	PIELAGO	PINONES
PENARANDA	PEREIDA	PERUYERA	PIERAS	PINTADO
PENATE	PEREIRO	PERUYERO	PIJUAN	PINTOR
PENDAS	PERELES	PERVEZ	PILA	PINTOS
PENEZ	PERERA	PERYATEL	PILAR	PINUELA
PENICHE	PERES	PESANTE	PILARTE	PINUELAS
PENICHET	PEREYDA	PESANTES	PILLADO	PINZON
PENILLA	PEREYO	PESANTEZ	PILOTO	PIOQUINTO

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

PIQUERO	PLASCENCIA	POMELEO	PORTUGAL	PRESAS
PIREZ	PLASENCIA	POMPA	PORTUGUES	PRESIADO
PIRINEA	PLASENCIO	PONCABARE	PORTUGUEZ	PRENSO
PIRIS	PLATA	PONCE	PORTUONDO	PRESTAMO
PIRIZ	PLATAMONE	PONCEDELEON	POSADA	PREZAS
PIS	PLATAS	PONCHO	POSADAS	PRIDA
PISANA	PLATERO	PONCIANO	POSAS	PRIEDE
PISENO	PLAZA	PONCIO	POSO	PRIEGO
PISONERO	PLAZAS	PONSDOMENECH	POSOS	PRIEGUEZ
PITA	PLAZOLA	PONZOA	POSTIGO	PRIETO
PITALUGA	PLIEGO	PORATA	POSTIL	PRIMELLES
PITARCH	PLUMA	PORCAYO	POTESTAD	PRIMERA
PITONES	PLUMAS	PORCHAS	POUGES	PRIMERO
PITRONES	PLUMEDA	PORCHO	POUSA	PRIO
PIZANA	PLUMEX	PORDIA	POVEDA	PROA
PIZANO	POBAR	PORFIL	POVENTUD	PROANO
PIZARO	POBLANO	PORLAS	POVIONES	PROCEL
PIZARRA	POBLETE	PORRAS	POYORENA	PROCELA
PIZARRO	POBRE	PORRATA	POZA	PROCSAL
PIZULA	PODILLA	PORRAZ	POZAS	PROENZA
PLA	POEY	PORRERO	POZARO	PROHIAS
PLACENCIA	POGAN	PORRES	POZO	PROO
PLACENCIO	POLA	PORROS	POZOS	PROVENCIO
PLACENSIA	POLACO	POTAL	POZUELOS	PROVEYER
PLACENTIA	POLANCO	POTALATIN	PRADAS	PRUDENCIO
PLACERES	POLENDO	PORTALES	PRADERE	PRUNA
PLAJA	POLIDURA	PORTALEZ	PRADIA	PRUNEDA
PLANA	POLINA	PORTELA	PRADO	PRUNES
PLANAS	POLITRON	PORTELLES	PRAT	PUBILL
PLANCARTE	POLLERANA	PORTES	PRATS	PUBILLONES
PLANCENCIA	POLLORENO	PORTIELES	PRATTS	PUCHADES
PLANELL	POLVADO	PORTILLA	PRECIADO	PUEBLA
PLANELLAS	POMALE	PORTILLO	PRELLEZO	PUELLA
PLANES	POMALES	PORTILLOS	PRENDES	PUELLO
PLANOS	POMARES	PORTOCARRERO	PRENDEZ	PUENTE
PLANTILLAS	POMAREZ	PORTOLAN	PRENDIZ	PUENTES
PLANTO	POMBROL	PORTORREAL	PRESA	PUENTEZ

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CENSUS LIST OF SPANISH SURNAMAMES

PUERTA	QUASADA	QUIMIRO	QUIRENO	RAFAEL
PUERTAS	QUECLAS	QUINAL	QUIRINDONGO	RAFALIN
PUERTO	QUEIPO	QUINCOCES	QUIRINO	RAFULS
PUERTOS	QUEIRO	QUINDE	QUIRO	RAICES
PUEYO	QUEIRUGA	QUINDNEZ	QUIROA	RAIGOSA
PUGA	QUELLAR	QUINENES	QUIROBA	RAIGOZA
PUGEDA	QUEMADA	QUINES	QUIROGA	RAIMUNDEZ
PUIG	QUERALT	QUINI	QUIROL	RAIMUNDI
PUJADAS	QUERDO	QUINIONES	QUIROLA	RAISOLA
PUJAL	QUERIDO	QUINOA	QUIROS	RAJOY
PUJALS	QUERO	QUINONE	QUIROZ	RALDIRIS
PUJOL	QUERT	QUINONES	QUITA	RAMALLO
PUJOLS	QUESADA	QUINONEZ	QUITANIA	RAMARIZ
PULGAR	QUESADO	QUINONOS	QUITOS	RAMAS
PULGARIN	QUETEL	QUINORES	QUITUGUA	RAMBES
PULIDA	QUETGLAS	QUINTAMA	QUIZ	RAMBLAS
PULIDO	QUEVEDO	QUINTANA	RABADE	RAMBONGA
PULOMENA	QUEZADA	QUINTANAL	RABAGO	RAMENTOL
PUMAR	QUIALA	QUINTANAR	RABAJA	RAMEREZ
PUMARADA	QUIAN	QUINTANILLA	RABANO	RAMERIZ
PUMAREJO	QUIBUYEN	QUINTANS	RABASA	RAMERO
PUMARES	QUICENO	QUINTARO	RABASSA	RAMERY
PUMARIEGA	QUICHOCHO	QUINTAS	RABAZA	RAMIEREZ
PUMAROL	QUIDERA	QUINTEIRO	RABEIRO	RAMIERZ
PUNALES	QUIHUIS	QUINTELA	RABELL	RAMIEZ
PUNNARA	QUIHUIZ	QUINTENILLA	RABELO	RAMIL
PUNO	QUIJADA	QUINTERA	RABIA	RAMINEZ
PUNTA	QUIJALVO	QUINTERO	RABIELA	RAMIR
PUNTIEL	QUIJANO	QUINTEROS	RABINA	RAMIRE
PUPO	QUIJAS	QUINTINO	RABINO	RAMIRES
PURA	QUILALA	QUINTONA	RABOS	RAMIREZ
PURCELLA	QUILANTAN	QUINTONES	RADAVERO	RAMIRIZ
PURISIMA	QUILENDERINO	QUINTONEZ	RADILLA	RAMIRO
PUYADA	QUILES	QUINTOS	RADILLO	RAMIS
PUYOL	QUILEZ	QUIONES	RADRIGUEZ	RAMON
QUADRENY	QUILIMACO	QUIRARTE	RAEL	RAMONEDA
QUALIA	QUIMBAR	QUIRCH	RAEZ	RAMONES

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

RAMOS	RAYMUNDO	RECINOS	REINOSO	RESCHMAN
RAMOSGONZALEZ	RAYNA	RECIO	REINUS	RESENDEZ
RAMOSMEDINA	RAYONEZ	RECLUSADO	REIAS	RESENDIS
RAMOSRIVERA	RAYOR	RECOVO	REJINO	RESENDIZ
RAMOSRODRIGUEZ	RAYOS	RECUSSET	REJO	RESERYA
RAMOZ	RAZATOS	REDE	REJON	RESINA
RAMUDO	RAZO	REDERO	REL	RESMA
RAMUZ	REALES	REDONA	RELLES	RESON
RANCANO	REALIVASQUEZ	REDONDO	RELLEZ	RESPEYO
RANDEZ	REALME	REDRUELLO	RELUCIO	RESSY
RANERO	REALYVASQUEZ	REFUERZO	REMACHE	RESTO
RANESES	REANO	REGALADO	REMEDIOS	RESTOY
RANGEL	REATEGUI	REGALDO	REMIGIO	RESTREDO
RANGELL	REAZA	REGALES	REMILIO	RESTREPO
RANGELLOPEZ	REAZOLA	REGALO	REMOS	RESTUREZ
RANIEL	REBELES	REGALOS	RENDEROS	RETA
RANSOLA	REBELEZ	REGATO	RENDON	RETAMAL
RAQUENIO	REBELLON	REGINO	RENEDO	RETAMALES
RAQUEPO	REBETERANO	REGOJO	RENGE	RETAMAR
RASALES	REBOLLAR	REGOS	RENOBATO	RETAMOSA
RASCOM	REBOLLEDO	REGUTTO	RENOVA	RETAMOZA
RASCON	REBOLLO	REGUA	RENOVALES	RETANA
RASPALDO	REBOLLOSO	REGUEIRA	RENOVATO	RETANO
RASURA	REBOREDO	REGUEIRO	RENTA	RETES
RATON	REBOSO	REGUERA	RENTAS	RETEZ
RAUDA	REBOYRAS	REGUERO	RENTERIA	RETIZ
RAVAGO	REBOZO	REGULES	RENTERIAS	RETTA
RAVARD	REBUSTILLO	REGUSA	REORDA	RETURETA
RAVELO	RECALDE	REICEN	REOYO	REVADA
RAVENTOS	RECARREY	REICES	REPOLLET	REVADO
RAXACH	RECARTE	REIGOSA	REPREZA	REVELES
RAYA	RECENDES	REINA	REQUEJO	REVELLEZ
RAYAS	RECENDEZ	REINAGA	REQUEENA	REVELLES
RAYGOSA	RECHANI	REINALDO	REQUENES	REVERON
RAYGOZA	RECHANY	REINAT	REQUENEZ	REVILLA
RAYMOS	RECHY	REINERO	REQUENO	REVILLAS
	RECILLAS	REINOSA	REQUIRO	REVOLLAR

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REVOLLEDO	RIBAS	RINAURO	RIVADULLA	ROBELDO
REVOREDO	RIBERA	RINCHE	RIVALE	ROBELO
REVUELTA	RIBERAL	RINCON	RIVALI	ROBLAS
REVUELTAS	RIBERAS	RINCONENO	RIVARES	ROBLEDA
REXACH	RIBOT	RINCONES	RIVAROLA	ROBLEDO
REY	RIBOTA	RINGLERO	RIVAS	ROBLEJO
REYEROS	RICABAL	RIOBO	RIVAZ	ROBLERO
REYERS	RICALDE	RIOCABO	RIVEIRA	ROBLES
REYES	RICANO	RIOFRIO	RIVEIRO	ROBLETO
REYESPEREZ	RICARDEZ	RIOJA	RIVERA	ROBLEZ
REYESRODRIGUEZ	RICARDO	RIOJAS	RIVERACOLON	ROBREDO
REYEZ	RICART	RIOJAZ	RIVERACRUZ	ROCA
REYGADAS	RICARTE	RIOJOS	RIVERADIAZ	ROCAFORT
REYNA	RICHARTE	RIOLLANO	RIVERALUGO	ROCAFUERTE
REYNADO	RICHIEZ	RIONDA	RIVERAPEREZ	ROCAMONTES
REYNAGA	RICHINA	RIOPEDRE	RIVERARIVERA	ROCAMONTEZ
REYNALDO	RICO	RIOS	RIVERAS	ROCERO
REYNALDOS	RICONDO	RIOSECO	RIVERIA	ROCES
REYNERO	RIDRIGUEZ	RIOSEPINOZA	RIVERO	ROCHA
REYNEROS	RIEDO	RIOSFLORES	RIVEROL	ROCHAS
REYNOS	RIEGA	RIOSMARTINEZ	RIVEROLL	ROCHES
REYNOSA	RIEGO	RIOSPEREZ	RIVERON	ROCHIN
REYNOSO	RIEGOS	RIOZ	RIVEROS	ROCHOA
REYNOZA	RIERA	RIPALDA	RIVERRA	ROCIO
REYNOZO	RIERAS	RIPEZ	RIVIERO	RODADO
REYO	RIESCO	RIPOL	RIZO	RODALLEGAS
REYOS	RIESGO	RIPOLL	ROA	RODARTE
REZA	RIESTRA	RIPOLLES	ROACHO	RODAS
REZENDEZ	RIGAL	RIQUELME	ROANO	RODEA
RIALI	RIGALES	RIQUERO	ROBALINA	RODELA
RIANCHO	RIGAU	RISQUET	ROBALI	RODELAS
RIANDA	RIGUAL	RISUENO	ROBALIN	RODELO
RIAVE	RIGUERA	RIUS	ROBALINO	RODENA
RIAZA	RIGUERO	RIUSECH	ROBAU	RODENAS
RIBADENEIRA	RIJO	RIVADA	ROBAYNA	RODERO
RIBAL	RIJOS	RIVADENEIRA	ROBAYO	RODEZ
RIBALTA	RIMBLAS	RIVADENEYRA	ROBEDA	RODRIGUEZ

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

RODICIO	ROGANS	ROMIRO	ROSENEY	RUBALACA
RODIGUEZ	ROGERIO	ROMO	ROSERO	RUBALCABA
RODIL	ROGES	ROMOS	ROSES	RUBALCADA
RODILES	ROGRIGUEZ	ROMPAL	ROSETE	RUBALCADO
RODIQUEZ	ROGUE	RON	ROSLES	RUBALCAVA
RODIRGUEZ	ROHENA	RONCES	ROSLEZ	RUBALCAVA
RODREGUEZ	ROIBAL	RONDA	ROSILLO	RUBERO
RODRGUEZ	ROIIDE	RONDAN	ROSITAS	RUBERTE
RODRIG	ROIIG	RONDERO	ROSQUETE	RUBI
RODRIGEUX	ROIS	RONDEZ	ROSTRO	RUBIA
RODRIGEZ	ROIZ	RONDON	ROTEA	RUBIALES
RODRIGIEZ	ROJA	RONGAVILLA	ROTELA	RUBIANES
RODRIGNEZ	ROJANO	RONJE	ROTGER	RUBIANO
RODRIGOEZ	ROJAS	RONQUILLO	ROUCO	RUBIDO
RODRIGS	ROJEL	ROQUE	ROURA	RUBIELLA
RODRIGU	ROJERO	ROQUENI	ROURE	RUBIERA
RODRIGUEA	ROJES	ROQUERO	ROVAYO	RUBILDO
RODRIGUERA	ROJO	ROQUETA	ROVERA	RUBINOS
RODRIGUEZ	ROJOS	ROS	ROVIRA	RUBIO
RODRIGUEZMARTIN	ROLDAN	ROSA	ROVIROSA	RUBIOLA
EZ	ROLDON	ROSABAL	ROXAS	RUCIO
RODRIGUEZS	ROLDOS	ROSADA	ROYBAL	RUCOBO
RODRIGUEZ	ROLON	ROSADO	ROYBALL	RUEDA
RODRIGUIZ	ROMAGOSA	ROSAL	ROYBOL	RUEDAFLORES
RODRIGUZ	ROMAGUERA	ROSAL	ROYERO	RUEDAS
RODRIQUEZ	ROMANDIA	ROSALES	ROYO	RUELAS
RODRIQUEZ	ROMANES	ROSALEDELRIO	ROYOS	RUELAZ
RODRITUEZ	ROMANEZ	ROSALEZ	ROYVAL	RUELOS
RODRITUGEZ	ROMANILLOS	ROSALY	ROYVAL	RUEMPEL
RODRITUGUEZ	ROMANILLOS	ROSARIA	ROZADA	RUENES
RODRITUGUEZ	ROMAY	ROSARIO	ROZALEZ	RUESGA
RODRITUGUEZ	ROMAYOR	ROSARIODIAZ	ROZO	RUEZGA
RODRITUGUEZ	ROMERA	ROSARO	RUACHO	RUFAT
RODRITUGUEZ	ROMERO	ROSAS	RUACHO	RUFFENO
RODRITUGUEZ	ROMEROS	ROSELI	RUALO	RUFIN
RODUIGUEZ	ROMEU	ROSELLO	RUANO	RUGAMA
RODULFO	ROMEZ	ROSELLON	RUANO	RUGARCIA
ROEL	ROMIREZ	ROSENDO	RUAS	

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RUGERIO	SABATES	SAGARNAGA	SALAVARRIETA	SALINAZ
RUIBAL	SABEDRA	SAGARO	SALAVERRIA	SALINOS
RUIDAS	SABI	SAGARRA	SALAYA	SALIVA
RUIDIAZ	SABICER	SAGAS	SALAYANDIA	SALIVAS
RUILOBA	SABIDO	SAGASTA	SALAZ	SALIZ
RUISANCHEZ	SABINES	SAGASTEGUI	SALAZA	SALIZAR
RUISECO	SABLATURA	SAGASTUME	SALAZAN	SALLES
RUIZ	SABOGAL	SAGRADO	SALAZAR	SALMERON
RUIZCALDERON	SABORI	SAGREDO	SALBATO	SALMINA
RUIZCASTANEDA	SABORIDO	SAGRERO	SALCEDA	SALMONES
RUIZDEESPARZA	SABORIO	SAGUN	SALCEDO	SALORT
RUIZDELVIZO	SABORIT	SAHAGUN	SALCIDA	SALOS
RUIZE	SABOYA	SAIJO	SALCIDO	SALSA
RUIZESPARZA	SABRES	SAILAS	SALCINES	SALSAMEDA
RUIZZ	SABROSO	SAINA	SALDAMA	SALSEDO
RUL	SABUGO	SAINEZ	SALDAMANDO	SALSIDO
RULLAN	SACA	SAINZ	SALDANA	SALTARES
RUMAYOR	SACARELLO	SAIS	SALDANO	SALTERO
RUMBAUT	SACASAS	SAIZ	SALDARRIAGA	SALTOS
RUTIAGA	SACERIO	SAIZA	SALDATE	SALUDES
RUTIZ	SACOS	SALABARRIA	SALDEZ	SALUMBIDES
RUVALCABA	SACRISTAN	SALABERRIOS	SALDIERNA	SALVACION
RUVALCAVA	SADA	SALACAN	SALDIVAR	SALVARIA
RUVIRA	SADES	SALADO	SALDONA	SALVARREY
RUYBAL	SADULE	SALAEYS	SALDUA	SALVAT
RUYBALID	SAEDA	SALAIRES	SALEGUI	SALVATIERRA
RUYBOL	SAENS	SALAIS	SALGADO	SALVIDE
RUZ	SAENZ	SALAISES	SALGADOLUNA	SAMADA
SAA	SAETA	SALAIZ	SALGUEIRO	SAMALA
SAABEDRA	SAEZ	SALAMANCA	SALGUERO	SAMALOT
SAAUEDRA	SAFADY	SALANAS	SALGUERO	SAMANEGO
SAAVEDRA	SAFILLE	SALANO	SALHUANA	SAMANIEGO
SABALA	SAFONT	SALARS	SALIAS	SAMANO
SABALLOS	SAGARA	SALAS	SALIDO	SAMARIO
SABALZA	SAGARDIA	SALASAR	SALINAS	SAMARIPIA
SABANDO	SAGARDOY	SALAVARIA	SALINASGARCIA	SAMARO
SABATER	SAGARIBAY	SALAVARRIA	SALINASRAMIREZ	SAMARRIPA

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

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SAMARRIPAS	SANCHIDRIAN	SANTOSE	SANTELLANA	SAPEDA
SAMARRON	SANCHIZ	SANTUAN	SANTELLANES	SAPENA
SAMAYOA	SANCHO	SANTURJO	SANTELLANO	SAPIEN
SAMBADO	SANCHOYERTO	SANLUCAS	SANTESTEBAN	SAPIENS
SAMBOLIN	SANCHZ	SANMARTIN	SANTEYAN	SAPINOSO
SAMBRANO	SANCIPRIAN	SANMIGUEL	SANTIAG	SARABIA
SAMBUESO	SANDATE	SANMILLAN	SANTIAGO	SARACHAGA
SAMBULA	SANDAVAL	SANNICOLAS	SANTIANA	SARACHO
SAMILPA	SANDAVOL	SANOQUET	SANTIBANES	SARAGOSA
SAMONIEGO	SANDEZ	SANORA	SANTIBANEZ	SARAGOZA
SAMORA	SANDIA	SANPEDRO	SANTIESTEBAN	SARAGUETA
SAMORANO	SANDIEGO	SANQUICHE	SANTIESTEYAN	SARALEGUI
SAMOT	SANDIGO	SANROMAN	SANTILLAN	SARANTE
SAMPAYAN	SANDOBAL	SANSERINO	SANTILLANA	SARATE
SAMPAYO	SANDOMINGO	SANSORES	SANTILLANES	SARAVIA
SAMPEDEO	SANDOUAL	SANTAANA	SANTILLANEZ	SARCEDA
SAMPERA	SANDOVA	SANTAANNA	SANTILLANO	SARDANETA
SAMPERIO	SANDOVAL	SANTACOLOMA	SANTILLIAN	SARDINAS
SAMTOS	SANDOZ	SANTACRUZ	SANTISTEBAN	SARDUY
SAMUDIA	SANEMETERIO	SANTAELLA	SANTISTEVAN	SARELLANO
SAMUDIO	SANETO	SANTAGO	SANTISTEVEN	SARENANA
SANABIA	SANEZ	SANTALIZ	SANTIVANEZ	SARIA
SANABRIA	SANFELIPE	SANTALLA	SANTIZO	SARIEGO
SANAGUSTIN	SANFELIX	SANTALO	SANTODOMINGO	SARINA
SANAME	SANFELIZ	SANTAMARINA	SANTORINIOS	SARINANA
SANANDRES	SANFIEL	SANTAMATO	SANTOS	SARINAS
SANBARTOLOME	SANFIORENZO	SANTANA	SANTOSCOY	SARIOL
SANBRANO	SANGABRIEL	SANTANDER	SANTOVENA	SARMENTERO
SANCEDO	SANGRE	SANTANDREU	SANTOVENIA	SARMIENTA
SANCEN	SANGUESA	SANTANO	SANTOX	SARMIENTO
SANCHA	SANGUILY	SANTAPAU	SANTOYA	SARMIENTOFLORES
SANCHE	SANGUINO	SANTAROSA	SANTOYO	SARMIENTOS
SANCHEN	SANIN	SANTARRIAGA	SANTURIO	SAROZA
SANCHES	SANINOCENCIO	SANTEIRO	SANUDO	SARQUIS
SANCHEZ	SANJENS	SANTELICES	SANVICENTE	SARQUIZ
SANCHEZDETAGLE	SANJORGE	SANTELISES	SANZ	SARRACINO
SANCHEZPEREZ	SANJORJO	SANTELLAN	SAPATA	SARRAGA

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

SARRARAZ	SAYAVEDRA	SEISDEDOS	SEOANE	SERRANO
SARRATEA	SAYGIDIA	SEJA	SEOANES	SERRANTES
SARREAL	SEANEZ	SEJAS	SEPEDA	SERRAT
SARRIA	SEARA	SELAYA	SEPIAN	SERRATA
SARRIERA	SEAVELLO	SELAYANDIA	SEPTIEN	SERRATE
SARTUCHE	SEBALLOS	SELEM	SEPULBEDA	SERRATO
SARZO	SEBEO	SELESTINO	SEPULUEDA	SERRATOS
SARZOZA	SECA	SELGADO	SEPULVEDA	SERRAVILLO
SASPE	SECADA	SELGAS	SEPULVEDO	SERRAVO
SASTRE	SECADES	SELLES	SEPULVIDA	SERRET
SASTURAIN	SECATERO	SELVERA	SEQUEIDA	SERRITOS
SATARAIN	SECO	SEMAYA	SEQUEIRO	SERRONO
SATARAY	SEDA	SEMBERA	SEQUERA	SERROS
SATURNINO	SEDANO	SEMBRANO	SEQUERRA	SERTUCHE
SAUCEDA	SEDENO	SEMEXANT	SEQURA	SERVANTES
SAUCEDO	SEDILLA	SEMEY	SERABALLS	SERVANTEZ
SAUCIDO	SEDILLIO	SEMIDAY	SERABIA	SERVERA
SAUCILLO	SEDILLO	SEMIDEI	SERALENA	SERVILLA
SAUDIA	SEDILLOS	SEMIDEY	SERANTES	SERVILLO
SAUEDRA	SEGANA	SEMINARIO	SERASIO	SERVIN
SAULEDA	SEGARRA	SEMPERTEGUI	SERAYDAR	SESANTO
SAUMA	SEGOBIA	SEMPRE	SERBANTES	SESATE
SAUMELL	SEGONIA	SENA	SERBANTEZ	SESE
SAURA	SEGORIA	SENCION	SERDA	SESMA
SAUREZ	SEGOVIA	SENDEJAR	SERDAS	SESMAS
SAURI	SEGOVIANO	SENDEJAS	SERENIL	SESTEAGA
SAUSAMEDA	SEGRERA	SENDEJO	SERMENO	SESTIAGA
SAUSEDA	SEGUERA	SENDIS	SERMINO	SEVA
SAUSEDO	SEGUI	SENDON	SERNA	SEVALLOS
SAUZA	SEGUNDO	SENDRAL	SERNAS	SEVILLA
SAVALA	SEGURA	SENERIZ	SERRACINO	SEVILLANO
SAVALZA	SEGURE	SENJUDO	SERRADELL	SEVILLO
SAVEDRA	SEGUROLA	SENOSIAIN	SERRADO	SEXTO
SAVELLANO	SEGUY	SENQUIZ	SERRALLES	SEZATE
SAVINON	SEIJAS	SENTENA	SERRALTA	SEZUMAGA
SAVORILLO	SEIJO	SENTENO	SERRAND	SIACA
SAYAGO	SEIN	SENTMANAT	SERRANIA	SIADOR

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

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SIANEZ	SILLER	SIVERIO	SOLENO	SORBA
SIAZ	SILLERO	SIXTO	SOLER	SORDIA
SIBAJA	SILLOS	SIXTOS	SOLERA	SORDO
SIBERIO	SILLOT	SOBA	SOLERO	SORIA
SIBERON	SILQUERO	SOBALVARRO	SOLIS	SORIANO
SIBRIAN	SILVARREY	SOBERAL	SOLISGARZA	SORIENO
SICAIROS	SILVAS	SOBERANES	SOLIVA	SORIO
SICARDO	SILVERIO	SOBERANEZ	SOLIVAN	SORNOSO
SICRE	SILVESTRE	SOBERANIS	SOLIZ	SOROA
SIDA	SILVESTRY	SOBERON	SOLONO	SOROLA
SIEDO	SILVEYRA	SOBRADO	SOLORIO	SORONDO
SIERRA	SIMENTAL	SOBREMONTE	SOLORSANO	SORRANO
SIERRAS	SIMENTEL	SOBRERO	SOLORZA	SORROCHE
SIERRO	SIMIANO	SOBREVILLA	SOLORZANO	SORTILLON
SIERZE	SINTAS	SOBRIN	SOLOZABAL	SORZANO
SIFONTE	SIORDIA	SOBRINO	SOLSONA	SOSA
SIFONTES	SIPRIAN	SOCA	SOLTERO	SOSAPAYON
SIFERE	SIPULA	SOCARRAS	SOMANO	SOSAYA
SIFUENTES	SIQUEIDO	SOCAS	SOMARRIBA	SOSIAS
SIFUENTEZ	SIQUEIRO	SOCIAS	SOMAVIA	SOSTRE
SIFVENTES	SIQUEIROS	SOCORRO	SOMBRA	SOTA
SIGALA	SIQUEROS	SODOY	SOMOANO	SOVELLO
SIGALES	SIQUEROS	SOEGAARD	SOMODEVILLA	SOVELO
SIGARAN	SIQUEROS	SOJO	SOMOHANO	SOTERAS
SIGARROA	SIRA	SIRET	SOMONTE	SOTERO
SIGUA	SIRIAS	SOL	SOMOZA	SOTILLO
SIGUEIROS	SIRIO	SOLACHE	SONABRIA	SOTO
SIGUENZA	SIROS	SOLANILLA	SONCHAR	SOTOLONGO
SILBAS	SISNERO	SOLANO	SONCHEZ	SOTOMAYOR
SILGERO	SISNEROS	SOLARES	SONERA	SOTOMAYOR
SILGUERO	SISNEROZ	SOLAREZ	SONICO	SOTORRIO
SILIEZAR	SISNEGAS	SOLARIO	SONOQUI	SOTRO
SILLANO	SISTOS	SOLARZANO	SONORA	SOTTO
SILLART	SITAL	SOLAUN	SOPENA	SOTOSANTO
SILLAS	SITJAR	SOLDEVILA	SOPENA	SOTURA
SILLEN	SIURANO	SOLDEVILLA	SOQUI	SOTUYO
	SIVA	SOLEAD	SOR	SOUCHET
		SOLEIDAD	SORATOS	

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

SOUFFRONT	TABERAS	TALAMENTEZ	TAPORCO
SOURINA	TABERNERO	TALANA	TARABINO
SOVERANEZ	TABIO	TALANCON	TARACENA
SOZA	TABIZON	TALAVERA	TARAFÁ
SPINDOLA	TABLADA	TALLABAS	TARAGON
SUARE	TABLADO	TALLAVAS	TARAILO
SUARES	TABOADA	TALLEDA	TARAJANO
SUAREZ	TABOAS	TALLEDO	TARAMASCO
SUASTE	TABORA	TALLERINO	TARANCO
SUASTEGUI	TABORDA	TAMAME	TARANGO
SUAVEZ	TABRAUE	TAMARES	TARAZON
SUAZO	TABUENA	TAMAREZ	TARAZONA
SUBEALDEA	TABUENCA	TAMARGO	TARBES
SUBEDAR	TABULLO	TAMARIT	TARGA
SUBEGA	TACHIAS	TAMARIZ	TARIN
SUBELDIA	TACHIQUIN	TAMAYA	TARNAVA
SUBES	TACORDA	TAMAYO	TARRAGO
SUBIA	TACORONTE	TAMBARA	TARRANGO
SUBIAS	TADEO	TAMBUNGA	TARRATS
SUBIDO	TAFFOLLA	TAMERON	TARRAU
SUBIRANA	TAFOLA	TAMEZ	TARRAZA
SUBIRIAS	TAFOLLA	TAMGUMA	TARRIDE
SUCO	TAFORO	TANCHEZ	TARULA
SUDARIA	TAFOYA	TANCO	TASABIA
SUEIRAS	TAGABAN	TANDA	TATIS
SUEIRO	TAGANAS	TANFORAN	TAVALES
SUELA	TAGLE	TANGUMA	TAVAR
SUELTO	TAGUDAR	TANON	TAVAREZ
SUENGAS	TAJES	TANORI	TAVERA
SUERA	TALABERA	TANTAO	TAVERAS
SUEREZ	TALACHE	TANUZ	TAVIRA
SUERO	TALAMANTE	TAPANES	TAVISON
SUESCUN	TALAMANTES	TAPETILLO	TAVITAS
SUEYRAS	TALAMANTEZ	TAPIA	TAVIZON
SUGRANES	TALAMAS	TAPIAS	TAVORA
SUINA	TALAMENTE	TAPICERIA	TAYABAS
SULAICA	TALAMENTES	TAPIZ	TEBA

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

TEBAQUI	TEMPRANA	TERUSA	TIXIER	TORANZO
TEBAR	TENA	TERVINO	TIZNADO	TORDESILLAS
TEHAS	TENARIO	TERZADO	TIZOL	TORENO
TEJEIRO	TENAS	TESILLO	TOBAL	TORIBIO
TEJIZ	TENERIAS	TEVERE	TOBAR	TORICES
TEJIO	TENERIO	TEXCAHUA	TOBARES	TORLIANO
TEISSONNIERE	TENES	TEXIDOR	TOBAS	TORRIZ
TEIXIDOR	TENEYUCA	TEYECHEA	TOBILLA	TORMES
TEJADA	TENEYUQUE	TEZCUCANO	TOBON	TORMOS
TEJAS	TENIENTE	TEZINO	TOCA	TORNEL
TEJEDA	TENORIA	THILLET	TOFOYA	TORNERO
TEJEDAS	TENORIO	TIA	TOGAR	TORO
TEJEDO	TEPERA	TIBALDEO	TOGORES	TORQUEMADA
TEJEDOR	TEPEZANO	TIBLIAS	TOIMIL	TORRADO
TEJEIRO	TEPOSTE	TIBON	TOJEIRA	TORRALBA
TEJERA	TEQUIDA	TIBURCIO	TOJEIRO	TORRALBAS
TEJERAS	TERAN	TICO	TOLANO	TORRALES
TEJERINA	TERCERO	TIENDA	TOLEDANO	TORRALVA
TEJERO	TERCEROS	TIJERINA	TOLEDO	TORRANO
TEJIDOR	TERCILLA	TIJERINO	TOLENTINO	TORREBLANCA
TEJO	TERMINEL	TIJERO	TOLLARDO	TORRECH
TELAS	TERON	TINAJERO	TOLOSA	TORRECILLA
TELAVERA	TERRADO	TINAZA	TOLOZA	TORRECILLAS
TELLADO	TERRASA	TINEO	TOLSA	TORREGROSA
TELLAECHE	TERRASAS	TINERELLA	TOMADA	TORRELLAS
TELLECHEA	TERRASAZ	TINOCO	TOMAYO	TORRENTERA
TELLERIA	TERRAZA	TIO	TOMELLOSO	TORRES
TELLES	TERRAZAS	TIRADO	TOMEU	TORRESCANO
TELLEZ	TERRERO	TIRADOR	TOMINES	TORRES DIAZ
TELLO	TERREROS	TIRAN	TOPETE	TORRESMARTINEZ
TELLOS	TERRIGUEZ	TIRRE	TOPIA	TORRESOLA
TELON	TERRIQUEZ	TIRRES	TOQUERO	TORRESRODRIGUEZ
TEMBLADOR	TERRROBA	TIRREZ	TORAL	TORRESS
TEMBRAS	TERRON	TIRSE	TORALBA	TORREZ
TEMER	TERRONES	TISCARENO	TORALES	TORRICELLA
TEMORES	TERSERO	TISINO	TORANO	TORRIENTE
TEMPO	TERUEL	TISNADO	TORANS	TORRILIOS

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

TORRIO	TRASOBARES	TRILLAS	TUASON	UBIAS
TORROELLA	TRASPENA	TRILLAYES	TUAZON	UBIDES
TORRON	TRASVINA	TRILLES	TUBENS	UBIERA
TORROS	TRAVAL	TRILLO	TUBON	UBIETA
TORRUELLA	TRAVASO	TRILLOS	TUDELA	UBILES
TORRUELLAS	TRAVERZO	TRIMINO	TUDON	UBILLA
TORTALITA	TRAVIESO	TRINCADO	TUEME	UBINA
TORTES	TREBIZO	TRINCHET	TUERO	UBINAS
TORTILLA	TREFILIO	TRINIDAD	TUFARES	UCEDA
TORUGA	TREGARO	TRIPIS	TULIER	UCETA
TORUNO	TREJO	TRISTAN	TUNCHES	UCHA
TOSA	TREJOS	TRISTE	TUNCHES	UCHITA
TOSADO	TRELLES	TRIUNFO	TUNCHEZ	UCHIZONO
TOSAR	TREMILLO	TRIVISO	TUNDIDOR	UDABE
TOSSAS	TRENZADO	TRIVIZO	TUNON	UDAETA
TOSTA	TRES	TRIVIZO	TUR	UDAVE
TOSTADO	TRESPALACIOS	TROCHE	TURBAY	UDERO
TOVA	TRETO	TROCHEZ	TURBE	UFRACIO
TOVALIN	TREVILLA	TROJILLO	TURCIOS	UFRET
TOVANCHE	TREVINA	TRONCOSA	TURCIOS	UGALDE
TOVAR	TREVINIO	TRONCOSA	TURCIOS	UGARRIZA
TOVARES	TREVINO	TRONCOSO	TURCIOS	UGARTE
TOVAREZ	TREVISO	TRONCOZA	TURCIOS	UGARTECHEA
TOVIAS	TREVIZO	TRONCOZO	TURRIETA	UGUES
TOYA	TREVIZU	TROYA	TURRIETTA	UJUETA
TOYENS	TRIANA	TROZERA	TURRUBIARTES	ULACIA
TOYMIL	TRIAS	TRUCIOS	TURRUBIATE	ULATE
TOYOS	TRIAS	TRUEBA	TURRUBIATES	ULIBARI
TRABA	TRIAZ	TRUIJILLO	TURULL	ULIBARRI
TRABAL	TRICOCHE	TRUIJILLO	TUYA	ULIBARRI
TRABANCO	TRIGO	TRUJANO	UBALDE	ULLIVARRI
TRABAZO	TRIGOS	TRUJEQUE	UBALLE	ULLIVARRI
TRACONIS	TRIGOURA	TRUJILLA	UBALLEZ	ULLOA
TRANCOSA	TRIGUERO	TRUJILLO	UBALS	ULTRERAS
TRANQUADA	TRIGUEROS	TRUJILLO	UBANDO	UMANA
TRAPAGA	TRIJILLO	TRUYOL	UBARRI	UMANZOR
TRASLAVINA	TRILLA	TUALLA	UBAY	UMARAN
	TRILLANES	TUANDO	UBEDA	UMPIERRE

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

UNALE	URGELLES	URQUIZU	UTRIA	VALDENEGRO
UNAMUNO	URGILES	URRA	UTRILLA	VALDEPENIA
UNANUE	URGUIDI	URRABAS	UTSET	VALDERAMA
UNATE	URIA	URRABAZ	UVALLE	VALDERAS
UNEDA	URIARTE	URRABAZO	UVALLLES	VALDERAZ
UNGO	URIAS	URRACA	UVIEDO	VALDEREZ
UNZALU	URIAZ	URREA	UZETA	VALDERRAIN
UNZUETA	URIBARRI	URRECHAGA	UZUETA	VALDERRAMA
URAGA	URIBE	URREGO	VACA	VALDES
URAINA	URIBES	URRETA	VACIO	VALDESPINO
URANDAY	URIBURU	URRIETA	VADELL	VALDESSRODRIGUEZ
URANGA	URIEGA	URRIZA	VADI	VALDESUSO
URANGO	URIEGAS	URROZ	VADIA	VALDEZ
URBAEZ	URIEL	URRUCHUA	VADILLO	VALDEZATE
URBALEJO	URRIETA	URRUTIA	VADIZ	VALDILLES
URBAY	URIOLA	URSUA	VAELL	VALDILLEZ
URBIETA	URIONAGUENA	URSULO	VAELLO	VALDIVA
URBINA	URIOSTE	URTADO	VAEZ	VALDIVIA
URBINO	URIOSTEGUI	URTASUN	VAEZA	VALDIVIESO
URBISTONDO	URISTA	URTEAGA	VAI0	VALDIVIEZ
URBIZU	URITA	URTEZ	VAISA	VALDIVIEZO
URCADEZ	URIVE	URTIAGA	VAIZ	VALDO
URCELAY	URIZ	URTUSUASTEGUI	VAIZA	VALDONADO
URCIEL	URIZA	URTUZUASTEGUI	VAL	VALDOVIN
URDANETA	URIZAR	URUBURU	VALADEZ	VALDOVINO
URDANIVIA	UROZA	URUCHURTU	VALADON	VALDOVINOS
URDAZ	URQUIA	RUENA	VALAGUE	VALDRIZ
URDIALES	URQUIAGA	RUETA	VALARDE	VALEA
URDIALEZ	URQUIDES	URVANELJO	VALAREZO	VALEDON
URENA	URQUIDEZ	URVINA	VALASQUEZ	VALENCIA
URENDA	URQUIDI	URZO	VALAZQUEZ	VALENCIANA
URENIA	URQUIETA	URZUA	VALBUENA	VALENCIANO
URENO	URQUJO	USALLAN	VALCARCE	VALENEUELA
URESTE	URQUILLA	USATORRES	VALCARCEL	VALENQUELA
URESTI	URQUIOLA	USCANGA	VALCAZAR	VALENSUELA
URETA	URQUIZA	USEDA	VALDASO	VALENTIN
URGELL	URQUIZO	USON	VALDEMAR	VALENZUELA

APPENDIX E
CENSUS LIST OF SPANISH SURNAMMES

VALENZULA	VASCONES	VEJARA	VELOS
VALENZVELA	VASCONEZ	VEJARANO	VELOSO
VALERA	VASCOS	VEJIL	VELOZ
VALERIOS	VASGUEZ	VEJO	VELOZQUEZ
VALERO	VASQUE	VELA	VELUNZA
VALESQUEZ	VASQUES	VELAARCE	VELUZ
VALEZ	VASQUEZ	VELACUELLAR	VENCES
VALGAS	VASSQUEZ	VELADO	VENDRELL
VALHUERDI	VASTI	VELADOR	VENECIA
VALIDO	VAZGUEZ	VELAQUEZ	VENEGAS
VALIENTE	VAZQUE	VELAR	VENERACION
VALIGURA	VAZQUEL	VELARDE	VENEREO
VALINA	VAZQUES	VELARDES	VENEZUELA
VALINAS	VAZQUETELLES	VELARDEZ	VENSOR
VALINO	VAZQUEZ	VELASCO	VENTA
VALLADARES	VAZQUEZRIVERA	VELASGUEZ	VENTOSO
VALLADAREZ	VEALSQUEZ	VELASQUES	VENZAL
VALLADO	VEAS	VELASQUEZ	VENZOR
VALLADOLID	VECIN	VELASTEGUI	VENZUELA
VALLARTA	VECINO	VELAZCO	VERA
VALLDEPERAS	VEDARTE	VELAZGUEZ	VERACRUZ
VALLE	VEDIA	VELAZQUES	VERAMENDI
VALLECILLA	VEGA	VELAZQUEZ	VERANDAS
VALLECILLO	VEGARA	VELDERRAIN	VERAS
VALLECILLOS	VEGATORRES	VELENZUELA	VERASTEGUI
VALLEDOR	VEGAZO	VELES	VERASTEQUI
VALLEGOS	VEGERANO	VELESQUEZ	VERASTIGUI
VALLEJA	VEGES	VELEZ	VERASTIQUE
VALLEJO	VEGO	VELEZPEREZ	VERASTIQUI
VALLEJOS	VEGOS	VELEZROMAN	VERAY
VALLELLANES	VEGUE	VELILLA	VERAZ
VALLENS	VEGUEZ	VELIS	VERAZA
VALLERINO	VEGUILLA	VELIZ	VERBERA
VALLES	VEIGUELA	VELLAS	VERCELES
VALLEZ	VEINTIDOS	VELLIDO	VERDAGUER
VALLIN	VEITIA	VELLON	VERDECANNA
VALLS	VEJAR	VELO	VERDECIA

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

VERDEGUEZ	VIADERO	VIDAURRE	VIJIL	VILLAFLORES
VERDEJA	VIADES	VIDAURRETA	VILA	VILLAFRANCA
VERDEJO	VIADO	VIDAURRI	VILABOY	VILLAFRANCO
VERDERA	VIAGRAN	VIDAURRY	VILADROSA	VILLAFUERTE
VERDESCA	VIALES	VIDENA	VILANO	VILLAGAS
VERDESE	VIALIZ	VIDES	VILANOVA	VILLAGOMES
VERDESOTO	VIALPANDO	VIDOT	VILAR	VILLAGOMEZ
VERDIA	VIAMONTE	VIDRIALES	VILARCHAO	VILLAGRAMA
VERDOZA	VIANA	VIDRIO	VILARDELL	VILLAGRAN
VERDUGA	VIANES	VIDRIOS	VILARINO	VILLAGRANA
VERDUGO	VIAPANDO	VIDUYA	VILARO	VILLAHERMOSA
VERDUSCO	VIAREAL	VIEGO	VILLAS	VILLALABOS
VERDUZCO	VIARRIAL	VIENTES	VILLASQUEZ	VILLALABA
VERDUZEO	VIAYRA	VIEJO	VILATO	VILLALBAZO
VEREA	VICARIA	VIELMA	VILAUBI	VILLALBAZO
VERELA	VICEDO	VIELMAN	VILCHES	VILLALBOS
VEREZ	VICENCIO	VIELMAS	VILCHEZ	VILLALOBOS
VERGARA	VICENS	VIENTOS	VILCHIS	VILLALOBO
VERGARO	VICENT	VIERA	VILDOSOLA	VILLALOBOZ
VERGEL	VICENTE	VIERAS	VILLA	VILLALOHOS
VERGUZAS	VICENTY	VIESCA	VILLABLANCA	VILLALOHOS
VERINO	VICHOT	VIESCAS	VILLACAMPA	VILLALON
VERJIL	VICEDO	VIESCA	VILLACANA	VILLALONIA
VERNENGO	VICINAIZ	VIEETA	VILLACANA	VILLALONGA
VERONIN	VICIOSO	VIEETTY	VILLACARLOS	VILLALONGIN
VERQUER	VICTORERO	VIEYRA	VILLACORTA	VILLALONGO
VERTIZ	VICTORES	VIEZCAS	VILLACORTE	VILLALOVAS
VERVER	VICUNA	VIGIL	VILLACORTE	VILLALOVAS
VETA	VIDACA	VIGLIA	VILLACRES	VILLALOYOZ
VEVE	VIDAL	VIGNAU	VILLACRESES	VILLALPANDO
VEYNA	VIDALES	VIGO	VILLADA	VILLALTA
VEYTIA	VIDALEZ	VIGOA	VILLADO	VILLALTA
VIACAVA	VIDANA	VIGON	VILLADONIGA	VILLALUNA
VIACOBO	VIDANO	VIGUERA	VILLABERREAL	VILLALUNA
VIADA	VIDAURE	VIGUERAS	VILLAESCUA	VILLALUZ
VIADAS	VIDAURI	VIGUERIA	VILLAFAN	VILLALVA
VIADE	VIDAURRAZAGA	VIGUES	VILLAFANA	VILLALVASO
		VIJARRO	VILLAFANE	VILLALVAZO
				VILLAMAN

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

VILLAMAR	VILLARROEL	VILLELA	VINFRIDO	VISSEPO
VILLAMARIN	VILLARONGA	VILLENA	VINGOCHEA	VISTRO
VILLAMAYOR	VILLAROS	VILLERREAL	VINIEGRA	VITAL
VILLAMIA	VILLARRE	VILLERREAL	VINUELA	VITAR
VILLAMIL	VILLARREAL	VILLESCA	VINUELAS	VITELA
VILLAMOR	VILLARRIAL	VILLESICAS	VINZON	VITIER
VILLAN	VILLARROEL	VILLESCAZ	VIOLETA	VIVANCO
VILLANEDA	VILLARRUBIA	VILLETE	VIORATO	VIVANCOS
VILLANES	VILLARRUEL	VILLEZCAS	VIOTA	VIVAR
VILLANEUVA	VILLARRUZ	VILLICANA	VIQUEZ	VIVAS
VILLANEVA	VILLARTA	VILLICANO	VIRADIA	VIVERO
VILLANEZ	VILLARUBIA	VILLIEGAS	VIRAMONTE	VIVEROS
VILLANNEVA	VILLARUZ	VILLIS	VIRAMONTES	VIVES
VILLANUEBA	VILLAS	VILLOCH	VIRAMONTEZ	VIVO
VILLANUERA	VILLASAIZ	VILLODAS	VIRATA	VIZCAINO
VILLANUEVA	VILLASANA	VILLOLDO	VIRAY	VIZCARRA
VILLANUEVO	VILLASANO	VILLORIA	VIRCHIS	VIZCARRO
VILLANVEVA	VILLASANTE	VILLORIN	VIRELLA	VIZCARRONDO
VILLAO	VILLASECA	VILLORO	VIRGEN	VIZCAYA
VILLAPADIERNA	VILLASENOR	VILLOT	VIRJAN	VIZCON
VILLAPANDO	VILLASIS	VILLOTA	VIROLA	VIZOSO
VILLAPLANA	VILLASTRIGO	VILORIO	VIRREY	VIZUET
VILLAPOL	VILLASUSO	VILTRE	VIRRUETA	VIZUETA
VILLAPONDO	VILLATE	VINA	VIRUEGAS	VOLBEDA
VILLAPUDUA	VILLATORO	VINAGERAS	VIRUET	VOSQUEZ
VILLAQUIRAN	VILLAVA	VINAIXA	VIRUETE	VOZQUEZ
VILLAR	VILLAVERDE	VINAJA	VIRUETO	VUELTA
VILLARAN	VILLAVICENCIO	VINAJERAS	VISARRAGA	XIMENES
VILLARAOS	VILLAVISENCIO	VINALES	VISARRIAGAS	XIMENEZ
VILLARAUS	VILLAZANA	VINALS	VISCAINA	XIMINEZ
VILLAREAL	VILLAZON	VINAS	VISCAINO	XIQUES
VILLAREJO	VILLEDA	VINAT	VISCARRA	XOCHICALE
VILLARES	VILLEGA	VINCENTY	VISCASILLAS	XUAREZ
VILLARICO	VILLEGAS	VINCIONI	VISCAYA	YABUT
VILLARINO	VILLEGES	VINDIOLA	VISERTO	YANAS
VILLARINY	VILLEGOS	VINEGRA	VISOSO	YANES
VILLARIZA	VILLEJO	VINENT	VISPERAS	YANEZ

**APPENDIX E
CENSUS LIST OF SPANISH SURNAMES**

YANEZA	YESTE	YRIARTE	YUDICE	ZALVIDEA
YANIZ	YEVERINO	YRIBARREN	YUDICO	ZAMACONA
YANOSO	YGLECIAS	YRIBE	YULAN	ZAMAGO
YAQUES	YGLESIAS	YRIGOLLA	YULFO	ZAMANIEGO
YARA	YGNACIO	YRIGOLLEN	YURIAR	ZAMANILLO
YARRITO	YGUADO	YRIGOYEN	YUSTE	ZAMANO
YARRITU	YGUERABIDE	YRINEO	YVANEZ	ZAMAR
YARTE	YLARREGUI	YRIQUE	YVARRA	ZAMARIPA
YBABEN	YLIZALTURRI	YRIQUI	YZABAL	ZAMARIPPA
YBANEZ	YLLA	YRISARRI	YZAGUIRRE	ZAMARO
YBARA	YLLADA	YRIZARRY	YZNAGA	ZAMARRI
YBARBO	YLLANES	YROZ	YZQUIERDO	ZAMARRIPA
YBARRA	YLLESCAS	YRUEGAS	ZABAL	ZAMARRIPAS
YBARROLA	YNCERA	YRUNGARAY	ZABALA	ZAMARRON
YBARRONDO	YNCLAN	YRURETAGOYENA	ZABALETA	ZAMAYOA
YBERA	YNDA	YSAGUIRRE	ZABALLA	ZAMAZAL
YBERRA	YNEGAS	YSAIS	ZABALO	ZAMBADA
YCAZA	YNEGES	YSAQUIRRE	ZABALZA	ZAMBRANA
YCEDO	YNEFANTE	YSASAGA	ZACARIAS	ZAMBRANO
YCIANO	YNINGO	YSASI	ZACUTO	ZAMILPA
YDROGO	YNIQUEZ	YSASSI	ZADRIAMA	ZAMORA
YEBARA	YNIQUEZ	YSER	ZAERA	ZAMORANO
YEBRA	YNOA	YSERN	ZAFEREO	ZAMORES
YEDO	YNOCENCIO	YSET	ZAFRA	ZAMOREZ
YEDOR	YNOSENCIO	YSLA	ZAGALA	ZAMOT
YEDRA	YNOSTROSA	YSLAS	ZAGALES	ZAMUDIO
YEPA	YNOSTROZA	YSLAVA	ZAGONA	ZANABRIA
YEPES	YNZUNZA	YSQUIERDO	ZALACAIN	ZANDATE
YEPEZ	YOGUEZ	YTUARTE	ZALACE	ZANDONA
YEPIS	YORBA	YTURBE	ZALAMEA	ZANGRONIZ
YERA	YORDAN	YTURRALDE	ZALAPA	ZANUDO
YERAS	YPARRAGUIRRE	YTURRI	ZALAZAR	ZAPARA
YERENA	YPARREA	YTURRIA	ZALDANA	ZAPATA
YERO	YPINA	YTURRIAGA	ZALDIVAR	ZAPATER
YESCAS	YRACEBURU	YUBETA	ZALDUA	ZAPATERO
YESETA	YRACHETA	YUCUPICIO	ZALDUMBIDE	ZAPEDA
	YRASTORZA	YUDESIS	ZALDUONDO	ZAPIAIN

APPENDIX E
CENSUS LIST OF SPANISH SURNAMMES

ZAPIEN	ZAVALZA	ZOLETA
ZARABOZO	ZAVAT	ZOMORA
ZARAGOSA	ZAYAS	ZOROLA
ZARAGOZ	ZAYASBAZAN	ZORRILLA
ZARAGOZA	ZAYAZ	ZOZAYA
ZARAGOZI	ZAZUETA	ZUAZNABAR
ZARATE	ZAZUETTA	ZUAZO
ZARAZUA	ZEAS	ZUAZUA
ZARCO	ZEBALLOS	ZUBELDIA
ZARCOS	ZEDENO	ZUBIA
ZARDENETA	ZEDILLO	ZUBIATE
ZARDENETTA	ZEGARRA	ZUBIETA
ZARDO	ZELADA	ZUBILLAGA
ZARDON	ZELAYA	ZUBIRAN
ZARDOYA	ZELEDON	ZUBIRI
ZAROGOZA	ZEMEN	ZUBIRIA
ZARRAGA	ZENDEJAS	ZUBIZARRETA
ZARRAGOITIA	ZENGOTITIA	ZUGASTI
ZARRAGOZA	ZENIZO	ZULAICA
ZARRIA	ZENOZ	ZULETA
ZARUBICA	ZENTELLA	ZULOAGA
ZARZANA	ZENTENO	ZULUAGA
ZARZOSA	ZEPADA	ZULUETA
ZARZOZA	ZEPEDA	ZUMARRAGA
ZARZUELA	ZEQUEIRA	ZUMAYA
ZASUETA	ZERDA	ZUNIGA
ZATARAIN	ZERIN	ZUNIZA
ZATARAY	ZERMENO	ZUNO
ZATARIAN	ZERPA	ZUNZUNEGUI
ZATOREN	ZERQUERA	ZURBANO
ZAUALA	ZERTUCHE	ZURBARAN
ZAUL	ZERVIGON	ZURITA
ZAUZA	ZETINA	ZURRICA
ZAVALA	ZETINO	ZUVIA
ZVALETA	ZEVALLLOS	ZUVIETA
ZVALETTA	ZILBAR	ZUZUARREGUI
ZAVALLA	ZILLAS	

Appendix F

Site Specific Surgery Codes

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

ORAL CAVITY

**Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9,
 Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9,
 Other Parts of Mouth C06.0-C06.9**

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

00 None; **no surgery** of primary site; **autopsy ONLY**

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

No specimen sent to pathology from surgical events 10-14.

20 **Local tumor excision**, NOS

26 Polypectomy

27 Excisional biopsy

Any **combination** of 20 or 26-27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

[**NOTE:** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation]

25 Laser excision

Specimen sent to pathology from surgical events 20-27.

30 Wide excision, NOS

Code 30 includes:

Hemiglossectomy

Partial glossectomy

40 **Radical excision** of tumor, NOS

41 Radical excision of tumor **ONLY**

42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)

43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

[**NOTE:** In continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

Codes 40-43 include:

Total glossectomy

Radical glossectomy

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

Specimen sent to pathology from surgical events 20-43.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

PAROTID AND OTHER UNSPECIFIED GLANDS
Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

- 00 None; **no surgery** of primary site; **autopsy ONLY**
- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from surgical events 10-14.

- 20 **Local tumor excision**, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy
 Any **combination** of **20** or **26-27** WITH
 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation

[**NOTE:** Codes 21 to 24 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation]

- 25 Laser excision

Specimen sent to pathology from surgical events 20-27.

[**NOTE:** Codes 30-80 include major salivary gland, NOS]

- 30 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS

[**NOTE:** Includes less than total removal of other major salivary gland when the operative report specifies nerve monitoring it means that a nerve sparing surgery is being done]

 - 31 Facial nerve spared
 - 32 Facial nerve sacrificed
- 33 Superficial lobe **ONLY**
 - 34 Facial nerve spared
 - 35 Facial nerve sacrificed
- 36 Deep lobe (Total)
 - 37 Facial nerve spared
 - 38 Facial nerve sacrificed

[**NOTE:** With or without superficial lobe]

[**NOTE:** Codes 40-80 include submandibulectomy; submaxillectomy]

- 40 Total parotidectomy, NOS; total removal of major salivary gland, NOS
 - 41 Facial nerve spared
 - 42 Facial nerve sacrificed

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

- 50 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
 - 51 WITHOUT removal of temporal bone
 - 52 WITH removal of temporal bone
 - 53 WITH removal of overlying skin (requires graft or flap coverage)

80 Parotidectomy, NOS

Specimen sent to pathology from surgical events 20–80.

- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

PHARYNX

Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9

Pyriiform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

00 **None**; no surgery of primary site; **autopsy ONLY**

10 **Local tumor destruction, NOS**

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

15 Stripping

No specimen sent to pathology from surgical events 10-15.

20 **Local tumor excision, NOS**

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26.27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

[**NOTE:** Codes 21 to 24 and 28 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

25 Laser excision

28 Stripping

Specimen sent to pathology from surgical events 20-28.

30 Pharyngectomy, NOS

31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy

32 Total pharyngectomy

40 **Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS** (does NOT include total mandibular resection)

[**NOTE:** Code 40 includes mandibulectomy (marginal, segmental, hemi-, and/or laryngectomy) NOS Contiguous bone tissue refers to the mandible]

41 WITH Laryngectomy (laryngopharyngectomy)

42 WITH bone [mandibulectomy]

43 WITH both 41 and 42

[**NOTE:** Use code 40 when the patient had a pharyngectomy and maybe some sort of mandibulectomy and/or maybe a laryngectomy, but the exact procedures are not clear

Use code 41 when the patient had pharyngectomy and laryngectomy but no mandibulectomy

Use code 42 when the patient had pharyngectomy and mandibulectomy but no laryngectomy

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

Use code 43 when it is certain that the patient had both a mandibulectomy and laryngectomy in addition to the pharyngectomy]

- 50 Radical pharyngectomy (includes **total mandibular** resection), NOS
- 51 WITHOUT laryngectomy
- 52 WITH laryngectomy

Specimen sent to pathology from surgical events 20–52.

- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

F - 7

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

ESOPHAGUS
C15.0-15.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

00 **None**; no surgery of primary site; **autopsy ONLY**

10 **Local tumor destruction, NOS**

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

No specimen sent to pathology from surgical events 10-14.

20 **Local tumor excision, NOS**

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26.27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

[**NOTE:** Codes 21 to 24 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation]

25 Laser excision

Specimen sent to pathology from surgical events 20-27.

30 Partial esophagectomy

40 Total esophagectomy, NOS

50 **Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS**

[**NOTE:** Esophagectomy WITH other procedures may be partial, total, or NOS]

51 WITH laryngectomy

52 WITH gastrectomy, NOS

53 Partial gastrectomy

54 Total gastrectomy

55 Combination of 51 WITH any of 52-54

80 Esophagectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate **ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

STOMACH
C16.0-C16.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

- 00 None; **no surgery** of primary site; **autopsy ONLY**
- 10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

- 20 **Local tumor excision, NOS**
- 26 Polypectomy
- 27 Excisional biopsy
- Any combination of 20 or 26-27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- [**NOTE:** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation]
- 25 Laser excision

Specimen sent to pathology from surgical events 20-27.

- 30 **Gastrectomy, NOS (partial, subtotal, hemi-)**
- 31 Antrectomy, lower (distal-less than 40% of stomach) ***
- 32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
- 33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:

Partial gastrectomy, including a sleeve resection of the stomach
 Billroth I: anastomosis to duodenum (duodenostomy)
 Billroth II: anastomosis to jejunum (jejunostomy)

- 40 Near-total or total gastrectomy, NOS
- 41 Near-total gastrectomy
- 42 Total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach.

- 50 **Gastrectomy, NOS WITH removal of a portion of esophagus**
- 51 Partial or subtotal gastrectomy
- 52 Near total or total gastrectomy

Codes 50-52 are used for gastrectomy resection when only portions of esophagus are included in procedure.

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

STOMACH
C16.0-C16.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

- 60 **Gastrectomy** with a resection in continuity with the resection of **other organs**, NOS***
- 61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***
- 62 Near total or total gastrectomy, in continuity with the resection of other organs***
- 63 Radical gastrectomy, in continuity with the resection of other organs***

Codes 60-63 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection.

[**NOTE:** A portion of the duodenum may be removed during this procedure; assign codes 60-63 unless the entire duodenum was removed and a gastrojejunostomy was performed. Codes 60-63 may include omentectomy among the organs/tissues removed. In continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

- 80 Gastrectomy, NOS

Specimen sent to pathology from surgical events 20–80.

- 90 Surgery, NOS
- 99 **Unknown** if surgery performed; **death certificate ONLY**

*** Incidental splenectomy NOT included

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

COLON
C18.0-C18.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

SURGERY OF PRIMARY SITE

Codes

00 None; **no surgery** of primary site; **autopsy ONLY**

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

No specimen sent to pathology from surgical events 10-14.

20 **Local tumor excision**, NOS

27 Excisional biopsy

26 Polypectomy, NOS

28 Polypectomy-endoscopic

29 Polypectomy-surgical excision

Any **combination** of **20** or **26-29** WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

[**NOTE:** Codes 21 to 25 above combine 20 Local tumor excision, 27 Excisional biopsy, 26 Polypectomy, NOS, 28 Polypectomy-endoscopic or 29 Polypectomy-surgical excision WITH 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation]

25 Laser excision

Specimen sent to pathology from surgical events 20-25.

30 Partial colectomy, segmental resection

32 Plus resection of contiguous organ; example: small bowel, bladder

[**NOTE:** Codes 30 and 32 include but are not limited to: Appendectomy (for an appendix primary only), enterocolectomy, ileocolectomy, partial colectomy, NOS, partial resection of transverse colon and flexures, and segmental resection, such as cecectomy or sigmoidectomy. Removal of a short portion of the distal ileum is not coded as removal of a contiguous organ.]

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)

41 Plus resection of contiguous organ; example: small bowel, bladder

[**NOTE:** Code 40 includes extended (but less than total) right or left colectomy

Removal of a short portion of the distal ileum is not coded as removal of a contiguous organ]

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

- 50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)
 51 Plus resection of contiguous organ; example: small bowel, bladder
 [NOTE: Removal of a short portion of the distal ileum is not coded as removal of a contiguous organ]
- 60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
 [NOTE: Commonly used for familial polyposis or polyposis coli]
 61 Plus resection of contiguous organ; example: small bowel, bladder
 [NOTE: Removal of a short portion of the distal ileum is not coded as removal of a contiguous organ]
- 70 Colectomy or coloproctectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)
Code 70 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.
 [NOTE: In continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]
- 80 Colectomy, NOS

Specimen sent to pathology from surgical events 20–80.

- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

F - 12

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

RECTOSIGMOID
C19.9

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site (NAACCR Item #1294)*.

SURGERY OF PRIMARY SITE

Codes

- 00 None; **no surgery** of primary site; **autopsy ONLY**
- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser ablation

No specimen sent to pathology from surgical events 10-14.

- 20 **Local tumor excision**, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy

Combination of 20 or 26-27 WITH

 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation - 25 Laser excision
- [**NOTE:** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to pathology from surgical events 20-27.

- 30 Wedge or segmental resection; partial proctosigmoidectomy, NOS
 - 31 Plus resection of contiguous organs; example: small bowel, bladder

Procedures coded 30 include, but are not limited to:

- Anterior resection
- Hartmann operation
- Low anterior resection (LAR)
- Partial colectomy, NOS
- Rectosigmoidectomy, NOS
- Sigmoidectomy

- 40 Pull through WITH sphincter preservation (colo-anal anastomosis)
[**NOTE:** Procedures coded 40 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbull's operation]
- 50 Total proctectomy
[**NOTE:** Procedures coded 50 include but are not limited to: Abdominoperineal resection (A & P resection), anterior/posterior resection (A/P resection)/Miles' operation, Rankin's operation]
- 51 Total colectomy
[**NOTE:** Removal of the colon from cecum to rectosigmoid or portion of rectum]

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

- 55 Total colectomy WITH ileostomy, NOS
 56 Ileorectal reconstruction
 57 Total colectomy WITH other pouch; example: Koch pouch
- 60 Total proctocolectomy, NOS
 65 Total proctocolectomy WITH ileostomy, NOS
 66 Total proctocolectomy WITH ileostomy and pouch
Removal of the colon from cecum to the rectosigmoid or a portion of the rectum
 [NOTE: Removal of the colon from cecum to the rectosigmoid junction including the entire rectum.]
- 70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration
 [NOTE: Procedures that may be part of an en bloc resection include, but are not limited to: an oophorectomy and a rectal mucosectomy. Code 70 includes any colectomy (partial, hemicolectomy or total) with an en bloc resection of any other organs. There may be partial or total removal of other organs in continuity with the primary. In continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]
- 80 Colectomy, NOS; Proctectomy, NOS
- Specimen sent to pathology from surgical events 20–80.**
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

F - 14

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

RECTUM
C20.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294)

SURGERY OF PRIMARY SITE

Codes

00 None; **no surgery** of primary site; **autopsy ONLY**

10 **Local tumor destruction, NOS**

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

No specimen sent to pathology from surgical events 10-14.

20 **Local tumor excision, NOS**

27 Excisional biopsy

26 Polypectomy

Any combination of 20 or 26-27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

[**NOTE:** Codes 21 to 25 and 28 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation]

25 Laser excision

28 Curette and fulguration

Specimen sent to pathology from surgical events 20-28.

30 Wedge or segmental resection; partial proctectomy, NOS

Procedures coded 30 include, but are not limited to:

Anterior resection

Hartmann's operation

Low anterior resection (LAR)

Transsacral rectosigmoidectomy

Total mesorectal excision (TME)

40 Pull through WITH sphincter preservation (coloanal anastomosis)

[**NOTE:** Procedures coded 40 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbull's operation]

50 Total proctectomy

Procedure coded 50 includes, but is not limited to:

[**NOTE:** Also called Abdominoperineal resection A & P resection, anterior/posterior (A/P) resection/Miles' operation, Rankin's operation]

60 Total proctocolectomy, NOS

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

RECTUM

C20.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site Site* (NAACCR Item #1294)

SURGERY OF PRIMARY SITE

Codes

- 70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration
- 80 Proctectomy, NOS

Specimen sent to pathology from surgical events 20–80.

- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

ANUS
C21.0-C21.8

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

- 00 None; **no surgery** of primary site; **autopsy ONLY**
- 10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal Ablation

No specimen sent to pathology from surgical events 10-15

- 20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy
- Any combination of 20 or 26-27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- [**NOTE:** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation]
- 25 Laser excision

[**NOTE:** Margins of resection may have microscopic involvement]

Specimen sent to pathology from surgical events 20-27

- 60 Abdominal perineal resection, NOS (APR; Miles procedure)
- 61 APR and sentinel node excision
- 62 APR and unilateral inguinal lymph node dissection
- 63 APR and bilateral inguinal lymph node dissection

The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery (NAACCR Item #1292) or Scope of Regional Lymph Node Surgery at This Facility (NAACCR Item #672).

Specimen sent to pathology from surgical events 20–63.

- 90 Surgery, NOS
- 99 **Unknown** if surgery performed; **death certificate ONLY**

F - 17

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

LIVER AND INTRAHEPATIC BILE DUCTS
C22.0-C22.1

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

00 None; **no surgery** of primary site; **autopsy ONLY**

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Alcohol (Percutaneous Ethanol Injection-PEI)
[**NOTE:** Code 15 Alcohol (Percutaneous Ethanol Injection-PEI) can also be described as an “intratumoral injection of alcohol” or “alcohol ablation”]
- 16 Heat-Radio-frequency ablation (RFA)
- 17 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events 10-17

20 Wedge or segmental resection, NOS

- 21 Wedge resection
- 22 Segmental resection, NOS
 - 23 One
 - 24 Two
 - 25 Three
 - 26 Segmental resection AND local tumor destruction

30 Lobectomy, NOS

- 36 Right lobectomy
- 37 Left lobectomy
- 38 Lobectomy AND local tumor destruction

[**NOTE:** Code 30 also referred to as simple lobectomy]

50 **Extended lobectomy**, NOS (extended: resection of a single lobe plus a segment of another lobe)

- 51 Right lobectomy
- 52 Left lobectomy
- 59 Extended lobectomy AND local tumor destruction

60 Hepatectomy, NOS

- 61 Total hepatectomy and **transplant**

65 **Excision of a bile duct** (for an intra-hepatic bile duct primary only)

- 66 Excision of a bile duct PLUS partial hepatectomy

75 Bile duct and hepatectomy WITH transplant

Specimen sent to pathology from surgical events 20–75.

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

PANCREAS
C25.0-C25.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

- 00 None; **no surgery** of primary site; **autopsy ONLY**
- 25 **Local excision** of tumor, NOS
- 30 **Partial pancreatectomy**, NOS; example: distal
- 35 Local or partial pancreatectomy and duodenectomy
 - 36 WITHOUT distal/partial gastrectomy
 - 37 WITH partial gastrectomy (Whipple)
- 40 Total pancreatectomy
- 60 Total pancreatectomy and subtotal gastrectomy or duodenectomy
- 70 Extended pancreatoduodenectomy
- 80 Pancreatectomy, NOS
- 90 Surgery, NOS
- 99 **Unknown** if surgery performed; **death certificate ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

LARYNX
C32.0-C32.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

- 00 None; **no surgery** of primary site; **autopsy ONLY**
- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Stripping

No specimen sent to pathology from surgical events 10-15

- 20 **Local tumor excision**, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy
 Any combination of 20 or 26-27 WITH
 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
 [**NOTE:** Codes 21 to 25 and 28 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation]
 - 25 Laser excision
 - 28 Stripping

Specimen sent to pathology from surgical events 20-28

- 30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy NOS
 - 31 Vertical laryngectomy
 - 32 Anterior commissure laryngectomy
 - 33 Supraglottic laryngectomy
 [**NOTE: Vertical laryngectomy:** Removal of involved true vocal cord, ipsilateral false vocal cord, intervening ventricle, ipsilateral thyroid and may include removal of the arytenoids.
Supraglottic laryngectomy: Conservative surgery intended to preserve the laryngeal function. Standard procedure involves removal of epiglottis, false vocal cords, aryepiglottic folds, arytenoid cartilages, ventricle, upper one third of thyroid cartilage, thyroid membrane. The true vocal cords and arytenoids remain in place to allow vocalization and deglutition.]
- 40 Total or radical laryngectomy, NOS
 - 41 Total laryngectomy ONLY
 - 42 Radical laryngectomy ONLY
 [**NOTE:** Radical laryngectomy: Includes removal of adjacent sites. Do not code the removal of adjacent sites in Surgical Procedure of Other Site.]
- 50 Pharyngolaryngectomy
- 80 Laryngectomy, NOS

Specimen sent to pathology from surgical events 20–80.

- 90 Surgery, NOS
- 99 **Unknown** if surgery performed; **death certificate ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

LUNG
C34.0-C34.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

- 00 None; **no surgery** of primary site; **autopsy ONLY**
- 19 **Local tumor destruction** or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19
- 15 Local tumor destruction, NOS
 12 Laser ablation or cryosurgery
 13 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
No specimen sent to pathology from surgical events 12-13 and 15
- 20 Excision or resection of less than one lobe, NOS
 23 Excision, NOS
 24 Laser excision
 25 Bronchial sleeve resection ONLY
 21 Wedge resection
 22 Segmental resection, including lingulectomy
- 30 **Resection** of [at least one] **lobe** or **bilobectomy**, but less than the whole lung (partial pneumonectomy, NOS)
The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery
 33 Lobectomy WITH mediastinal lymph node dissection
The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery (NAACCR Item #1292) or Scope of Regional Lymph Node Surgery at This Facility (NAACCR Item #672).
- 45 Lobe or bilobectomy extended, NOS
 46 WITH chest wall
 47 WITH pericardium
 48 WITH diaphragm
- 55 Pneumonectomy, NOS
 [NOTE: Code 55 includes complete pneumonectomy, Sleeve pneumonectomy, Standard pneumonectomy, Total pneumonectomy, Resection of whole lung]
 56 WITH mediastinal lymph node dissection (radical pneumonectomy)
The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery (NAACCR Item # 1292) or Scope of Regional Lymph Node Surgery at This Facility (NAACCR Item #672).
- 65 Extended pneumonectomy
 66 Extended pneumonectomy plus pleura or diaphragm
- 70 Extended radical pneumonectomy
The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery (NAACCR Item # 1292) or Scope of Regional Lymph Node Surgery at This Facility (NAACCR Item #672).
 [NOTE: An extended radical pneumonectomy is a radical pneumonectomy (including removal of mediastinal nodes) and the removal of other tissues or nodes]

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

LUNG
C34.0-C34.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

80 Resection of lung, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

**HEMATOPOIETIC/RETICULOENDOTHELIAL/
IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE**
C42.0, C42.1, C42.3, C42.4 (with any histology)

or

M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992 (with any site)

SURGERY OF PRIMARY SITE

Code

98 **All** hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease **sites** and/or **histologies**, WITH or WITHOUT surgical treatment.

Surgical procedures for hematopoietic/ reticuloendothelial/ immunoproliferative/ myeloproliferative primaries are to be recorded using the data item Surgical Procedure/Other Site (NAACCR Item #1294) or Surgical Procedure/Other Site at This Facility (NAACCR Item #674).

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

BONES, JOINTS, AND ARTICULAR CARTILAGE C40.0-C41.9
PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C47.0-C47.9
CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES C49.0-C49.9
 (Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

00 None; **no surgery** of primary site; **autopsy ONLY**

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19

15 Local tumor destruction

No specimen sent to pathology from surgical event 15

25 Local excision

26 Partial resection

30 **Radical excision** or **resection** of lesion WITH limb salvage

40 Amputation of limb

41 Partial amputation of limb

42 Total amputation of limb

50 Major amputation, NOS

51 Forequarter, including scapula

52 Hindquarter, including ilium/hip bone

53 Hemipelvectomy, NOS

54 Internal hemipelvectomy

Specimen sent to pathology from surgical events 25–54.

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

SPLEEN
Spleen C42.2

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19

21 Partial splenectomy

22 Total splenectomy

80 Splenectomy, NOS

Specimen sent to pathology for surgical events 21-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

SKIN
C44.0-C44.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

- 00 None; **no surgery** of primary site; **autopsy ONLY**
- 10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

No specimen sent to pathology from surgical events 10-14

- 20 **Local tumor excision**, NOS
- 26 Polypectomy
- 27 Excisional biopsy
- Any **combination** of **20** or **26-27** WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- [**NOTE:** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation]
- 25 Laser excision

Specimen sent to pathology from surgical events 20-27.

[**NOTE:** Code UVB phototherapy for mycosis fungoides primaries under Surgery of Primary Site for skin.]

- 30 **Biopsy** of primary tumor **followed by a gross excision** of the lesion (does not have to be done under the same anesthesia)
- 31 Shave biopsy followed by a gross excision of the lesion
- 32 Punch biopsy followed by a gross excision of the lesion
- 33 Incisional biopsy followed by a gross excision of the lesion
- 34 Mohs surgery, NOS
- 35 Mohs with 1-cm margin or less
- 36 Mohs with more than 1-cm margin
- [**NOTE:** Codes 30 to 33 include less than a wide excision, less than 1 cm margin or margins are unknown. If it is stated to be a **wide excision** or **reexcision**, but the **margins are unknown**, code to 30. Code 45 represents a wide excision in which it is known that the margins of excision are greater than 1 cm.]
- 45 **Wide excision** or **re-excision** of lesion or **minor** (local) **amputation** with margins more than 1 cm, NOS
 Margins **MUST** be microscopically negative.
- 46 WITH margins more than 1 cm and less than 2 cm
- 47 WITH margins greater than 2 cm
- If the excision does not have microscopically negative margins greater than 1cm, use the appropriate code, 20-36.**

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

SKIN
C44.0-C44.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

60 Major amputation

Specimen sent to pathology from surgical events 20–60.

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate ONLY**

F - 27

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

BREAST
C50.0-C50.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

00 None; **no surgery** of primary site; **autopsy ONLY**

19 Local tumor destruction, NOS

No specimen was sent to pathology for surgical events coded 19

20 Partial mastectomy, NOS; less than total mastectomy, NOS

21 Partial mastectomy **WITH** nipple resection

22 Lumpectomy or excisional biopsy

23 Reexcision of the biopsy site for gross or microscopic residual disease

24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded 20-24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

30 Subcutaneous mastectomy

A subcutaneous mastectomy is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.

40 **Total** (simple) **mastectomy**, NOS

41 **WITHOUT** removal of uninvolved contralateral breast

43 Reconstruction NOS

44 Tissue

45 Implant

46 Combined (Tissue and Implant)

42 **WITH** removal of uninvolved contralateral breast

47 Reconstruction NOS

48 Tissue

49 Implant

75 Combined (Tissue and Implant)

[NOTE: If axillary lymph nodes are present in the specimen, code the Surgery of Primary Site field to 51. If there are no axillary lymph nodes present in the specimen, code the Surgery of Primary Site field to 41. Placement of a tissue expander at the time of original surgery means that reconstruction is planned as part of the first course of treatment.]

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item # 1294).

If contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

Reconstruction that is planned as part of first course treatment is coded 43-49 or 75, whether it is done at the time of mastectomy or later.

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

BREAST
C50.0-C50.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

- 50 Modified radical mastectomy
- 51 WITHOUT removal of uninvolved contralateral breast
- 53 Reconstruction, NOS
- 54 Tissue
- 55 Implant
- 56 Combined (Tissue and Implant)
- 52 WITH removal of uninvolved contralateral breast
- 57 Reconstruction, NOS
- 58 Tissue
- 59 Implant
- 63 Combined (Tissue and Implant)

Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle.

If contralateral breast reveals a second primary, it is abstracted separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site (NAACCR Item #1294)* or *Surgical Procedure/Other Site at This Facility (NAACCR Item #674)*.

[**NOTE:** In continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen. “Tissue” for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants). Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment. Assign code 51 or 52 if a patient has an excisional biopsy and axillary dissection followed by a simple mastectomy during the first course of therapy.]

- 60 Radical mastectomy, NOS
- 61 WITHOUT removal of uninvolved contralateral breast
- 64 Reconstruction, NOS
- 65 Tissue
- 66 Implant
- 67 Combined (Tissue and Implant)
- 62 WITH removal of uninvolved contralateral breast
- 68 Reconstruction, NOS
- 69 Tissue
- 73 Implant
- 74 Combined (Tissue and Implant)

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

BREAST
C50.0-C50.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

[**NOTE:** Removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, pectoralis major. Includes en bloc axillary dissection. Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment.]

Codes

- 70 Extended radical mastectomy
 71 WITHOUT removal of uninvolved contralateral breast
 72 WITH removal of uninvolved contralateral breast
 [**NOTE:** Removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, pectoralis major. Includes removal of internal mammary nodes and en bloc axillary dissection.]
- 76 **Bilateral mastectomy for a single tumor involving both breasts(bilateral inflammatory carcinoma).**
- 80 Mastectomy, NOS

Specimen sent to pathology for surgical events coded 20-80.

- 90 Surgery, NOS
- 99 **Unknown** if surgery performed; **death certificate ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

CERVIX UTERI
C53.0-C53.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

[NOTE: For invasive cancers, dilation and curettage (D&C) is not to be coded as surgery of primary site. D&C for invasive cancers is “biopsy-only” to confirm disease and is not “surgical treatment” of the cancer.]

Codes

- 00 None; **no surgery** of primary site; **autopsy ONLY**
- 10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Laser ablation
- 17 Thermal ablation

No specimen sent to pathology from surgical events 10-17

- 20 **Local tumor excision**, NOS
- 26 Excisional biopsy, NOS
- 27 Cone biopsy
- 24 Cone biopsy **WITH** gross excision of lesion
- 29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27 or 29 WITH

- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

[NOTE: Codes 21 to 23 above combine 20 Local tumor excision, 24 Cone biopsy **WITH** gross excision of lesion, 26 Excisional biopsy, NOS, 27 Cone biopsy or 29 Trachelectomy, removal of cervical stump; cervicectomy with 21 Electrocautery, 22 Cryosurgery, 23 Laser ablation or excision]

- 25 Dilatation and curettage; endocervical curettage (for in situ only)
- 28 Loop electrocautery excision procedure (LEEP)

[NOTE: Margins of resection may have microscopic involvement.

Procedures in code 20 include but are not limited to: cryosurgery, electrocautery, excisional biopsy, laser ablation, thermal ablation.]

Specimen sent to pathology from surgical events 20-29

- 30 Total hysterectomy (simple, pan-) **WITHOUT** removal of tubes and ovaries
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.
- 40 Total hysterectomy (simple, pan-) **WITH** removal of tubes and/or ovary
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

- 50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 51 Modified radical hysterectomy
- 52 Extended hysterectomy
- 53 Radical hysterectomy; Wertheim procedure
- 54 Extended radical hysterectomy
- 60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
- 61 WITHOUT removal of tubes and ovaries
- 62 WITH removal of tubes and ovaries
- 70 Pelvic exenteration
- 71 Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.
- 72 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.
- 73 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.
- 74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.
- Specimen sent to pathology from surgical events 20–74.**
- 90 Surgery, NOS
- 99 **Unknown** if surgery performed; **death certificate ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

CORPUS UTERI

C54.0-C55.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

[NOTE: For invasive cancers, dilation and curettage (D&C) is not to be coded as surgery of primary site. D&C for invasive cancers is “biopsy-only” to confirm disease and is not “surgical treatment” of the cancer.]

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

15 Loop Electocautery Excision Procedure (LEEP)

16 Thermal ablation

No specimen sent to pathology from surgical events 10-16

20 Local tumor excision, NOS; simple excision, NOS

24 Excisional biopsy

25 Polypectomy

26 Myomectomy

Any combination of 20 or 24.26 WITH

21 Electrocautery

22 Cryosurgery

23 Laser ablation or excision

[NOTE: Codes 21 to 23 above combine 20 Local tumor excision, 24 Excisional biopsy, 25 Polypectomy, or 26 Myomectomy with 21 Electrocautery, 22 Cryosurgery or 23 Laser ablation or excision]

Specimen sent to pathology from surgical events 20-26

30 **Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary (ies).**

31 WITHOUT tube(s) and ovary (ies)

32 WITH tube(s) and ovary (ies)

[NOTE: For these procedures, the cervix is left in place]

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary (ies)

Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary (ies)

Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

60 **Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy**

61 Modified radical hysterectomy

62 Extended hysterectomy

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

CORPUS UTERI

C54.0-C55.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

- 63 Radical hysterectomy; Wertheim procedure
 [**NOTE:** Use code 63 for “Type III” hysterectomy]
- 64 Extended radical hysterectomy

- 65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary (ies)
- 66 WITHOUT removal of tube(s) and ovary (ies)
- 67 WITH removal of tube(s) and ovary (ies)

- 75 Pelvic exenteration
- 76 Anterior exenteration
 Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

- 77 Posterior exenteration
 Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

- 78 Total exenteration
 Includes removal of all pelvic contents and pelvic lymph nodes.

- 79 Extended exenteration
 Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20–79.

- 90 Surgery, NOS
- 99 **Unknown** if surgery performed; **death certificate ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

OVARY
C56.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

00 None; **no surgery** of primary site; **autopsy ONLY**

17 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 17.

25 **Total removal** of tumor or (single) **ovary**, NOS

26 Resection of ovary (wedge, subtotal, or partial) **ONLY**, NOS; unknown if hysterectomy done

27 **WITHOUT** hysterectomy

28 **WITH** hysterectomy

Specimen sent to pathology from surgical events 25.28.

35 Unilateral (salpingo-) oophorectomy; unknown if hysterectomy done

36 **WITHOUT** hysterectomy

37 **WITH** hysterectomy

[**NOTE:** Use code 37 for current unilateral (salpingo-) oophorectomy with previous history of hysterectomy]

50 Bilateral (salpingo-) oophorectomy; unknown if hysterectomy done

51 **WITHOUT** hysterectomy

52 **WITH** hysterectomy

[**NOTE:** Use code 52 for current bilateral (salpingo-) oophorectomy with previous history of hysterectomy]

55 Unilateral or bilateral (salpingo-) **oophorectomy WITH OMENTECTOMY**, NOS; partial or total; **unknown if hysterectomy** done

56 **WITHOUT** hysterectomy

57 **WITH** hysterectomy

60 Debulking; cytoreductive surgery, NOS

61 **WITH** colon (including appendix) and/or small intestine resection (not incidental)

62 **WITH** partial resection of urinary tract (not incidental)

63 Combination of 61 and 62

Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.

[**NOTE:** Debulking or cytoreductive surgery is implied by the following phrases (This is not intended to be a complete list. Other phrases may also imply debulking).

Adjuvant treatment pending surgical reduction of tumor

Ovaries, tubes buried in tumor

Tumor burden

Tumor cakes

Very large tumor mass

Do not code multiple biopsies alone as debulking or cytoreductive surgery. Do not code debulking or cytoreductive surgery based only on the mention of “multiple tissue fragments” or “removal of multiple implants.” Multiple biopsies and multiple specimens confirm the presence or absence of metastasis].

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

OVARY
C56.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

- 70 Pelvic exenteration, NOS
 71 Anterior
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.
- 72 Posterior
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.
- 73 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.
- 74 Extended
Includes pelvic blood vessels or bony pelvis.
- 80 (Salpingo-) oophorectomy, NOS

Specimen sent to pathology from surgical events 25–80.

- 90 Surgery, NOS
- 99 **Unknown** if surgery performed; **death certificate ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

PROSTATE

C61.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item *Hematologic Transplant and Endocrine Procedures* (NAACCR Item #3250).

SURGERY OF PRIMARY SITE

Codes

00 None; **no surgery** of primary site; **autopsy ONLY**

18 Local tumor destruction or excision, NOS

19 Transurethral resection (TURP), NOS

Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19

10 **Local tumor destruction, NOS**

14 Cryoprostatectomy (**Cryoablation**)

15 Laser ablation

16 Hyperthermia

17 Other method of local tumor destruction

No specimen sent to pathology from surgical events 10-17

[**NOTE:** Code Transurethral Microwave Thermotherapy (TUMT) as 16
 Code High Intensity Focused Ultrasonography (HIFU) as 17
 Code Transurethral Needle Ablation (TUNA) as 17]

20 **Local tumor excision, NOS**

21 Transurethral resection (**TURP**), NOS

22 TURP.cancer is incidental finding during surgery for benign disease

23 TURP.patient has suspected/known cancer

Any combination of 20-23 WITH

24 Cryosurgery

25 Laser

26 Hyperthermia

[**NOTE:** Codes 24 to 26 above combine 20 Local tumor excision, NOS, 21 TURP, NOS, 22 TURP incidental or 23 TURP suspected/known cancer with 24 Cryosurgery, 25 Laser or 26 Hyperthermia]

Specimen sent to pathology from surgical events 20-26

30 **Subtotal, segmental, or simple prostatectomy**, which may leave all or part of the capsule intact

50 **Radical prostatectomy, NOS; total prostatectomy, NOS**

Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

70 **Prostatectomy WITH resection in continuity with other organs; pelvic exenteration**
Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs.
The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.

[**NOTE:** In continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen] *Da Vinci* prostatectomy would be coded as any other prostatectomy depending on the extent of the procedure codes 50 -80 per FORDS.

80 Prostatectomy, NOS

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

Specimen sent to pathology from surgical events 20–80.

- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

TESTIS
C62.0.C62.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

00 None; **no surgery** of primary site; **autopsy ONLY**

12 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 12

20 **Local** or **partial** excision of **testicle**
Specimen sent to pathology from surgical event 20

30 Excision of testicle **WITHOUT** cord
 [**NOTE:** Orchiectomy not including spermatic cord]

40 Excision of testicle **WITH** cord/or cord not mentioned (radical orchiectomy)
 [**NOTE:** Orchiectomy with or without spermatic cord]

80 **Orchiectomy, NOS** (unspecified whether partial or total testicle removed)

Specimen sent to pathology from surgical events 20–80

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

KIDNEY, RENAL PELVIS, AND URETER
Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

00 None; **no surgery** of primary site; **autopsy ONLY**

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

15 Thermal ablation

No specimen sent to pathology from this surgical event 10-15

20 **Local tumor excision**, NOS

26 Polypectomy

27 Excisional biopsy

Any **combination** of **20** or **26-27** WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

[**NOTE:** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation]

25 Laser excision

Specimen sent to pathology from surgical events 20-27

30 **Partial** or **subtotal nephrectomy** (kidney or renal pelvis) or **partial ureterectomy** (ureter)

Procedures coded 30 include, but are not limited to:

Segmental resection

Wedge resection

40 Complete/total/simple nephrectomy.for kidney parenchyma

Nephroureterectomy

Includes bladder cuff for renal pelvis or ureter.

50 Radical nephrectomy

May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter.

70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with the resection of other organ(s) (colon, bladder)

The other organs, such as colon or bladder, may be partially or totally removed.

[**NOTE:** In continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Nephrectomy, NOS

Ureterectomy, NOS**Specimen sent to pathology from surgical events 20–80.**

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

BLADDER
C67.0–C67.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

- 00 None; **no surgery** of primary site; **autopsy ONLY**
- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Intravesical therapy
 - 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy
 [NOTE: Code BCG as both surgery and immunotherapy]

Also code the introduction of immunotherapy in the immunotherapy items. If immunotherapy is followed by surgery of the type coded 20-80 code that surgery instead and code the immunotherapy only as immunotherapy items.

No specimen sent to pathology from surgical events 10–16

- 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy
 [NOTE: Code TURB as 27]
- Combination of 20 or 26–27 WITH
 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
 [NOTE: Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation]
 - 25 Laser excision

Specimen sent to pathology from surgical events 20–27.

- 30 Partial cystectomy
- 50 Simple/total/complete cystectomy
- 60 Radical cystectomy (**male only**)
 [NOTE: This code is used only for men. It involves removal of bladder and prostate, with or without urethrectomy. The procedure is also called cystoprostatectomy. If a radical cystectomy is the procedure for a woman, use code 71.]
 - 61 Radical cystectomy PLUS ileal conduit
 - 62 Radical cystectomy PLUS continent reservoir or pouch, NOS
 - 63 Radical cystectomy PLUS abdominal pouch (cutaneous)

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

F - 41

BLADDER
C67.0–C67.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

- 64 Radical cystectomy PLUS in situ pouch (orthotopic)
- 70 Pelvic exenteration, NOS
- 71 Radical cystectomy (**female** only); anterior exenteration
A radical cystectomy in a female includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra. For males, includes removal of the prostate. When a procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64).
- 72 Posterior exenteration
For females, also includes removal of vagina, rectum and anus. For males, also includes prostate, rectum and anus.
- 73 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.
- 74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.
- 80 Cystectomy, NOS
Specimen sent to pathology from surgical events 20–80.
- 90 Surgery, NOS
- 99 **Unknown** if surgery performed; **death certificate ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

BRAIN

Meninges C70.0–C70.9, Brain C71.0–C71.9,
Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C72.0–C72.9
 (Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code laminectomy for spinal cord primaries.

SURGERY OF PRIMARY SITE

Codes

00 None; **no surgery** of primary site; **autopsy ONLY**

10 Tumor **destruction**, NOS
 [Note: Local tumor destruction, NOS]

No specimen sent to pathology from surgical event 10.

Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as surgical tumor destruction. Modalities are recorded in radiation treatment fields.

20 Local excision of tumor, lesion, or mass; excisional biopsy
USE THESE CODES TO DESCRIBE LOCAL EXCISION (excisional biopsy) OF THE BRAIN.

21 Subtotal resection of tumor, lesion or mass in brain

22 Resection of tumor of **spinal cord** or **spinal nerve**, **applicable only for spinal cord or spinal nerve primary sites**

30 Radical, total, gross resection of tumor, lesion or mass in brain

40 Partial resection of lobe of brain, when the surgery cannot be coded as 20-30
USE THIS CODE TO DESCRIBE PARTIAL RESECTION OF A LOBE OF THE BRAIN.

55 Gross total resection of lobe of brain (**Lobectomy**)
USE THIS CODE TO DESCRIBE GROSS TOTAL RESECTION OF A LOBE (LOBECTOMY).
THIS IS A LESS COMMON FORM OF SURGICAL TREATMENT.

Codes 30 - 55 are not applicable for spinal cord or spinal nerve primary sites.

Specimen sent to pathology from surgical events 20–55.

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate ONLY**

NOTE: CoC added new brain surgery codes for cases diagnosed in 2010

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

THYROID GLAND

C73.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

00 None; **no surgery** of primary site; **autopsy ONLY**

13 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 13.

25 Removal of **less than a lobe**, NOS

26 Local surgical excision

27 Removal of a partial lobe **ONLY**

20 Lobectomy and/or isthmectomy

21 Lobectomy **ONLY**

22 Isthmectomy **ONLY**

23 Lobectomy **WITH** isthmus

Specimen sent to pathology from surgical events 20–27.

30 Removal of a **lobe** and **partial** removal of the **contralateral lobe**

40 **Subtotal** or **near total** thyroidectomy

50 Total thyroidectomy

80 Thyroidectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

LYMPH NODES

C77.0.C77.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

[**NOTE:** Lymph node chains are subsites of lymph node regions. Use information pertaining to lymph node **chains** to code lymph node surgery; use lymph node **region** information to code stage.]

Codes

00 None; **no surgery** of primary site; **autopsy ONLY**

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded to 19

15 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 15.

25 Local tumor excision, NOS

Less than a full chain includes an excisional biopsy of a single lymph node.

30 Lymph node dissection, NOS

Less than a full chain includes an excisional biopsy of a single lymph node.

31 One chain

32 Two or more chains

40 Lymph node dissection, NOS PLUS splenectomy

41 One chain

42 Two or more chains

50 Lymph node dissection, NOS and partial/total removal of **adjacent organ(s)**

51 One chain

52 Two or more chains

60 Lymph node dissection, NOS and partial/total removal of **adjacent organ(s)** PLUS **splenectomy**
 (Includes staging laparotomy for lymphoma.)

61 One chain

62 Two or more chains

Specimen sent to pathology for surgical events 25-62.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate **ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
 FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

ALL OTHER SITES

C14.2-C14.8, C17.0-C17.9, C23.9, C24.0-C24.9, C26.0-C26.9, C30.0-C30.1, C31.0-C31.9, C33.9, C37.9,
 C38.0-C38.8, C39.0-C39.9, C48.0-C48.8, C51.0-C51.9, C52.9, C57.0-C57.9, C58.9,
 C60.0-C60.9, C63.0-C63.9, C68.0-C68.9, C69.0-C69.9, C74.0-C74.9, C75.0-C75.9
 (Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

- 00 None; **no surgery** of primary site; **autopsy ONLY**
- 10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10.14

- 20 **Local tumor excision**, NOS
- 26 Polypectomy
- 27 Excisional biopsy
- Any **combination** of **20** or **26-27** WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

Specimen sent to pathology from surgical events 20–27.

- 30 Simple/partial surgical removal of primary site
- 40 **Total surgical removal** of primary site; enucleation
- 41 Total enucleation (for eye surgery only)
- 50 Surgery stated to be. “**debulking**”
- 60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.

[**NOTE:** In continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

APPENDIX F

SITE SPECIFIC SURGERY CODES

FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

Specimen sent to pathology from surgical events 20–60.

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate ONLY**

APPENDIX F
SITE SPECIFIC SURGERY CODES
FORDS APPENDIX B: Site-Specific Surgery Code (01/01/2013)

UNKNOWN AND ILL-DEFINED PRIMARY SITES
C76.0.C76.8, C80.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Code

- 98 **All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.**
Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item
Surgical Procedure/Other Site (NAACCR Item #1294).

If any Surgical procedure for unknown and ill-defined primaries are done then use the data item
Surgical Procedure/Other Site = 1

Appendix G

2016 FCDS Record Layout Version 16

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
Record ID Section		10	Record Type	1	1	1		
		20	Patient ID Number	42	49	8		
		21	Patient System ID-Hosp	50	57	8		
		30	Registry Type	2	2	1		
		35	FIN Coding System	3	3	1		
		37	Reserved 00	4	16	13		
		40	Registry ID	30	39	10		
		45	NPI--Registry ID	20	29	10		
		50	NAACCR Record Version	17	19	3		
		60	Tumor Record Number	40	41	2		
Demographic Section	C	70	Addr at DX--City	95	144	50		2001
	C	80	Addr at DX--State	145	146	2		2010
	C	90	County at DX	156	158	3		2010
	C	100	Addr at DX--Postal Code	147	155	9		2001
	C	102	Addr at DX – Country	436	438	3		2013
		110	Census Tract 1970/80/90	159	164	6		
		120	Census Cod Sys 1970/80/90	166	166	1		
		130	Census Tract 2000	168	173	6		
		140	Census Tract Cod Sys--Alt					
	C	150	Marital Status at DX	176	176	1		1981
	C	160	Race 1	177	178	2		1981
	C	161	Race 2	179	180	2		2001
	C	162	Race 3	181	182	2		2001
	C	163	Race 4	183	184	2		2001
	C	164	Race 5	185	186	2		2001
		170	Race Coding Sys--Current	187	187	1		
		180	Race Coding Sys--Original	188	188	1		
	C	190	Spanish/Hispanic Origin	189	189	1		1981
		191	NHIA Derived Hisp Origin	418	418	1		
		192	IHS Link	421	421	1		
		193	Race--NAPIIA (derived API)	419	420	2		
		200	Computed Ethnicity	190	190	1		
		210	Computed Ethnicity Source	191	191	1		
	C	220	Sex	192	192	1		1981
		230	Age at Diagnosis	193	195	3		1981
C	240	Date of Birth	196	203	8		1981	
C	241	Date of Birth Flag	204	205	2		2010	
	250	Birthplace	206	208	3		1981-2012	
C	252	Birthplace State	442	443	2		2013	
C	254	Birthplace Country	444	446	3		2013	

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
		260	Religion					
		270	Census Occ Code 1970-2000	209	211	3		
		280	Census Ind Code 1970-2000	212	214	3		
		290	Occupation Source	215	215	1		
		300	Industry Source	216	216	1		
	C	310	Text--Usual Occupation	217	316	100		1995
	C	320	Text--Usual Industry	317	416	100		2001
		330	Census Occ/Ind Sys 70-00	417	417	1		
		340	Tobacco History					
		350	Alcohol History					
		360	Family History of Cancer					
		362	Census Block Group 2000	174	174	1		
		364	Census Tr Cert 1970/80/90	167	167	1		
		365	Census Tr Certainty 2000	175	175	1		
		366	GIS Coordinate Quality	422	423	2		
		368	Census Block Grp 1970-90	165	165	1		
		370	Reserved 01	58	94	37		
Cancer Identification		380	Sequence Number--Central	528	529	2		
	C	390	Date of Diagnosis	530	537	8		1981
	C	391	Date of Diagnosis Flag	538	539	2		2010
	C	400	Primary Site	540	543	4		1981
	C	410	Laterality	544	544	1		1995
		419	Morph--Type&Behav ICD-O-2	545	549	5		
		420	Histology (92-00) ICD-O-2 (all cases must be coded in ICD-O-3; see item 522)	545	548	4		1981-2009
		430	Behavior (92-00) ICD-O-2 (all cases must be coded in ICD-O-3; see item 523)	549	549	1		1981-2009
		439	Date of Mult Tumors Flag	587	588	2		
	C	440	Grade	555	555	1		1981
		441	Grade Path Value	556	556	1		
		442	Ambiguous Terminology DX	566	566	1		
		443	Date Conclusive DX	567	574	8		
		444	Mult Tum Rpt as One Prim	577	578	2		
		445	Date of Mult Tumors	579	586	8		
		446	Multiplicity Counter	589	590	2		
		447	Number of Tumors/Hist					
		448	Date Conclusive DX Flag	575	576	2		
		449	Grade Path System	557	557	1		
		450	Site Coding Sys--Current	558	558	1		
	460	Site Coding Sys--Original	559	559	1			

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
		470	Morph Coding Sys--Current	560	560	1		
		480	Morph Coding Sys--Originl	561	561	1		
	C	490	Diagnostic Confirmation	562	562	1		1981
	C	500	Type of Reporting Source	563	563	1		1995
		501	Casefinding Source	564	565	2		
		510	Screening Date					
		520	Screening Result					
		521	Morph--Type&Behav ICD-O-3	550	554	5		
	C	522	Histologic Type ICD-O-3	550	553	4		2001
	C	523	Behavior Code ICD-O-3	554	554	1		2001
		530	Reserved 02	428	527	100		
		535	Reserved 25					
Hospital-Specific Section		538	Reporting Hospital FAN					
	C	540	Reporting Facility	701	710	10		2010
		545	NPI--Reporting Facility	691	700	10		
	C	550	Accession Number--Hosp	731	739	9		2010
	C	560	Sequence Number--Hospital	740	741	2		1981
	C	570	Abstracted By	742	744	3		1981
	C	580	Date of 1st Contact	745	752	8		1981
	C	581	Date of 1st Contact Flag	753	754	2		2010
		590	Date of Inpt Adm	755	762	8		
		591	Date of Inpt Adm Flag	763	764	2		
		600	Date of Inpt Disch	765	772	8		
		601	Date of Inpt Disch Flag	773	774	2		
		605	Inpatient Status	775	775	1		
	C	610	Class of Case	776	777	2		1995
		615	Reserved 26					
		620	Year First Seen This CA					
	C	630	Primary Payer at DX	778	779	2		2003
		635	Reserved 27					
		640	Inpatient/Outpt Status					
		650	Presentation at CA Conf					
		660	Date of CA Conference					
		665	RX Hosp--ASA Class	780	780	1		
		668	RX Hosp--Surg App 2010	781	781	1		
		670	RX Hosp--Surg Prim Site	782	783	2		
	672	RX Hosp--Scope Reg LN Sur	784	784	1			
	674	RX Hosp--Surg Oth Reg/Dis	785	785	1			
	676	RX Hosp--Reg LN Removed	786	787	2			
	678	RX Hosp--Surg Timing	788	788	1			

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
		680	Reserved 03	591	690	100		
		690	RX Hosp--Radiation	789	789	1		
		700	RX Hosp--Chemo	790	791	2		
		710	RX Hosp--Hormone	792	793	2		
		720	RX Hosp--BRM	794	795	2		
		730	RX Hosp--Other	796	796	1		
		740	RX Hosp--DX/Stg Proc	797	798	2		
		741	Reserved 28					
		742	RX Hosp--Screen/BX Proc1					
		743	RX Hosp--Screen/BX Proc2					
		744	RX Hosp--Screen/BX Proc3					
		745	RX Hosp--Screen/BX Proc4					
		746	RX Hosp--Surg Site 98-02	800	801	2		
		747	RX Hosp--Scope Reg 98-02	802	802	1		
		748	RX Hosp--Surg Oth 98-02	803	803	1		
		750	Reserved 04	804	903	100		
Stage/Prognostic Factors	C	759	SEER Summary Stage 2000	904	904	1		2001-2003 2015
		760	SEER Summary Stage 1977	905	905	1		1995-2003
		765	Reserved 29					
		770	Loc/Reg/Distant Stage					
		779	Extent of Disease 10-Dig	906	917	12		
		780	EOD--Tumor Size (FCDS will derive from CS, see item 2800)	906	908	3		1995-2003
		790	EOD--Extension	909	910	2		
		800	EOD--Extension Prost Path	911	912	2		
		810	EOD--Lymph Node Involv	913	913	1		
	C	820	Regional Nodes Positive	914	915	2		1995
	C	830	Regional Nodes Examined	916	917	2		1995
		840	EOD--Old 13 Digit	918	930	13		
		850	EOD--Old 2 Digit	931	932	2		
		860	EOD--Old 4 Digit	933	936	4		
		870	Coding System for EOD	937	937	1		
	C	880	TNM Path T	940	943	4		2016+ Dx
	C	890	TNM Path N	944	947	4		2016+ Dx
	C	900	TNM Path M	948	951	4		2016+ Dx
	C	910	TNM Path Stage Group	952	955	4		2016+ Dx
	C	920	TNM Path Descriptor	956	956	1		2016+ Dx
C	930	TNM Path Staged By	834	835	2		2016+ Dx	
C	940	TNM Clin T	958	961	4		2011 CER Only	

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
								2016+ Dx
	C	950	TNM Clin N	962	965	4		2011 CER Only 2016+ Dx
	C	960	TNM Clin M	966	969	4		2011 CER Only 2016+ Dx
	C	970	TNM Clin Stage Group	970	973	4		2011 CER Only 2016+ Dx
	C	980	TNM Clin Descriptor	974	974	1		2011 CER Only 2016+ Dx
	C	990	TNM Clin Staged By	836	837	2		2011 CER Only 2016+ Dx
		995	Reserved 30					
		1000	TNM Other T					
		1010	TNM Other N					
		1020	TNM Other M					
		1030	TNM Other Stage Group					
		1040	TNM Other Staged By					
		1050	TNM Other Descriptor					
	C	1060	TNM Edition Number	938	939	2		2011 CER Only 2016
		1065	Reserved 31					
		1070	Other Staging System					
		1080	Date of 1st Positive BX					
		1090	Site of Distant Met 1					
		1100	Site of Distant Met 2					
		1110	Site of Distant Met 3					
		1120	Pediatric Stage	976	977	2		
		1130	Pediatric Staging System	978	979	2		
		1140	Pediatric Staged By	980	980	1		
		1150	Tumor Marker 1	981	981	1		
		1160	Tumor Marker 2	982	982	1		
		1170	Tumor Marker 3	983	983	1		
		1180	Reserved 05	1236	1435	200		
	C	1182	Lymph-vascular Invasion	984	984	1		2010
		1190	Reserved 06	1624	1723	100		
Treatment - 1rst Course	C	1200	RX Date Surgery	1456	1463	8		1995
	C	1201	RX Date Surgery Flag	1464	1465	2		2010
	C	1210	RX Date Radiation	1486	1493	8		1995
	C	1211	RX Date Radiation Flag	1494	1495	2		2010
	C	1220	RX Date Chemo	1516	1523	8		1995
	C	1221	RX Date Chemo Flag	1524	1525	2		2010
	C	1230	RX Date Hormone	1526	1533	8		1995
	C	1231	RX Date Hormone Flag	1534	1535	2		2010

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
	C	1240	RX Date BRM	1536	1543	8		1995
	C	1241	RX Date BRM Flag	1544	1545	2		2010
	C	1250	RX Date Other	1546	1553	8		1995
	C	1251	RX Date Other Flag	1554	1555	2		2010
		1260	Date Initial RX SEER	1436	1443	8		
		1261	Date Initial RX SEER Flag	1444	1445	2		
		1270	Date 1st Crs RX COC	1446	1453	8		
		1271	Date 1st Crs RX COC Flag	1454	1455	2		
		1280	RX Date DX/Stg Proc	1556	1563	8		
		1281	RX Date DX/Stg Proc Flag	1564	1565	2		
	C	1285	RX Summ--Treatment Status	1566	1566	1		2010
	C	1290	RX Summ--Surg Prim Site	1567	1568	2		1981
	C	1292	RX Summ--Scope Reg LN Sur	1569	1569	1		2001
	C	1294	RX Summ--Surg Oth Reg/Dis	1570	1570	1		2001
		1296	RX Summ--Reg LN Examined	1571	1572	2		2001-2003
	C	1300	Height	1315	1316	2		2011
	C	1300	Weight	1317	1319	3		2011
	C	1300	Tobacco Use - Cigarette	1320	1320	1		2011
	C	1300	Tobacco Use - OthSmoke	1321	1321	1		2011
	C	1300	Tobacco Use - Smokeless Tob	1322	1322	1		2011
	C	1300	Tobacco Use - NOS	1323	1323	1		2011
		1310	RX Summ--Surgical Approach	1573	1573	1		
		1320	RX Summ--Surgical Margins	1574	1574	1		
		1330	RX Summ--Reconstruct 1st	1575	1575	1		
	C	1340	Reason for No Surgery	1576	1576	1		2001
		1350	RX Summ--DX/Stg Proc	1577	1578	2		
		1355	Reserved 22					
	C	1360	RX Summ--Radiation	1580	1580	1		1981
		1370	RX Summ--Rad to CNS	1581	1581	1		
	C	1380	RX Summ--Surg/Rad Seq	1582	1582	1		2006
	C	1390	RX Summ--Chemo	1585	1586	2		1981
	C	1400	RX Summ--Hormone	1587	1588	2		1981
	C	1410	RX Summ--BRM	1589	1590	2		1981
	C	1420	RX Summ--Other	1591	1591	1		1981
	C	1430	Reason for No Radiation	1592	1592	1		2011
		1435	Reserved 32					
		1440	Reason for No Chemo					
		1450	Reason for No Hormone					
		1460	RX Coding System--Current	1593	1594	2		
		1465	Reserved 33					

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
		1470	Protocol Eligibility Stat					
		1480	Protocol Participation					
		1490	Referral to Support Serv					
		1500	First Course Calc Method	1595	1595	1		
		1510	Rad--Regional Dose: cGy	1596	1600	5		
		1520	Rad--No of Treatment Vol	1601	1603	3		
		1530	Rad--Elapsed RX Days					
		1535	Reserved 34					
		1540	Rad--Treatment Volume	1604	1605	2		
		1550	Rad--Location of RX	1606	1606	1		
		1555	Reserved 35					
		1560	Rad--Intent of Treatment					
C		1570	Rad--Regional RX Modality	1607	1608	2		2006
		1580	Rad--RX Completion Status					
		1590	Rad--Local Control Status					
		1600	Chemotherapy Field 1					
		1610	Chemotherapy Field 2					
		1620	Chemotherapy Field 3					
		1630	Chemotherapy Field 4					
		1635	Reserved 23					
C		1639	RX Summ--Systemic/Sur Seq	1616	1616	1		2006
		1640	RX Summ--Surgery Type	1617	1618	2		
		1641	Reserved 36					
		1642	RX Summ--Screen/BX Proc1					
		1643	RX Summ--Screen/BX Proc2					
		1644	RX Summ--Screen/BX Proc3					
		1645	RX Summ--Screen/BX Proc4					
		1646	RX Summ--Surg Site 98-02	1620	1621	2		2003-2003
		1647	RX Summ--Scope Reg 98-02	1622	1622	1		2003-2003
		1648	RX Summ--Surg Oth 98-02	1623	1623	1		2003-2003
		1650	Reserved 08	2016	2115	100		
Treatment - Subsq & Other		1660	Subsq RX 2nd Course Date	1724	1731	8		
		1661	Subsq RX 2ndCrS Date Flag	1732	1733	2		
		1670	Subsq RX 2nd Course Codes	1734	1744	11		
		1671	Subsq RX 2nd Course Surg	1734	1735	2		
		1672	Subsq RX 2nd Course Rad	1740	1740	1		
		1673	Subsq RX 2nd Course Chemo	1741	1741	1		
		1674	Subsq RX 2nd Course Horm	1742	1742	1		
		1675	Subsq RX 2nd Course BRM	1743	1743	1		
		1676	Subsq RX 2nd Course Oth	1744	1744	1		

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
		1677	Subsq RX 2nd--Scope LN SU	1736	1736	1		
		1678	Subsq RX 2nd--Surg Oth	1737	1737	1		
		1679	Subsq RX 2nd--Reg LN Rem	1738	1739	2		
		1680	Subsq RX 3rd Course Date	1745	1752	8		
		1681	Subsq RX 3rdCrs Date Flag	1753	1754	2		
		1690	Subsq RX 3rd Course Codes	1755	1765	11		
		1691	Subsq RX 3rd Course Surg	1755	1756	2		
		1692	Subsq RX 3rd Course Rad	1761	1761	1		
		1693	Subsq RX 3rd Course Chemo	1762	1762	1		
		1694	Subsq RX 3rd Course Horm	1763	1763	1		
		1695	Subsq RX 3rd Course BRM	1764	1764	1		
		1696	Subsq RX 3rd Course Oth	1765	1765	1		
		1697	Subsq RX 3rd--Scope LN Su	1757	1757	1		
		1698	Subsq RX 3rd--Surg Oth	1758	1758	1		
		1699	Subsq RX 3rd--Reg LN Rem	1759	1760	2		
		1700	Subsq RX 4th Course Date	1766	1773	8		
		1701	Subsq RX 4thCrs Date Flag	1774	1775	2		
		1710	Subsq RX 4th Course Codes	1776	1786	11		
		1711	Subsq RX 4th Course Surg	1776	1777	2		
		1712	Subsq RX 4th Course Rad	1782	1782	1		
		1713	Subsq RX 4th Course Chemo	1783	1783	1		
		1714	Subsq RX 4th Course Horm	1784	1784	1		
		1715	Subsq RX 4th Course BRM	1785	1785	1		
		1716	Subsq RX 4th Course Oth	1786	1786	1		
		1717	Subsq RX 4th--Scope LN Su	1778	1778	1		
		1718	Subsq RX 4th--Surg Oth	1779	1779	1		
		1719	Subsq RX 4th--Reg LN Rem	1780	1781	2		
		1720	Subsq RX 5th Course Date					
		1725	Reserved 37					
		1726	Reserved 38					
		1730	Subsq RX 5th Course Codes					
		1731	Subsq RX 5th Course Surg					
		1732	Subsq RX 5th Course Rad					
		1733	Subsq RX 5th Course Chemo					
		1734	Subsq RX 5th Course Horm					
		1735	Subsq RX 5th Course BRM					
		1736	Subsq RX 5th Course Oth					
		1737	Subsq RX 5th--Scope LN Su					
		1738	Subsq RX 5th--Surg Oth					
		1739	Subsq RX 5th--Reg LN Rem					

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
		1740	Reserved 09	2290	2339	50		
		1741	Subsq RX--Reconstruct Del	1787	1787	1		
F-Up/Recurrence/Death	C	1750	Date of Last Contact	2116	2123	8		1981
	C	1751	Date of Last Contact Flag	2124	2125	2		2010
		1755	Date of Death--Canada	2280	2287	8		
		1756	Date of Death--CanadaFlag	2288	2289	2		
	C	1760	Vital Status	2126	2126	1		1995
	C	1770	Cancer Status	2127	2127	1		1995
		1780	Quality of Survival	2128	2128	1		
		1790	Follow-Up Source	2129	2129	1		
		1791	Follow-up Source Central	2278	2279	2		
		1800	Next Follow-Up Source	2130	2130	1		
	C	1810	Addr Current--City	2131	2180	50		1981
	C	1820	Addr Current--State	2181	2182	2		2010
	C	1830	Addr Current--Postal Code	2183	2191	9		1981
	C	1832	Addr Current – Country	439	441	3		2013
		1835	Reserved 10	4085	4284	200		
	C	1840	County--Current	2192	2194	3		2010
		1842	Follow-Up Contact--City	2208	2257	50		
		1844	Follow-Up Contact--State	2258	2259	2		
		1846	Follow-Up Contact--Postal	2260	2268	9		
		1850	Unusual Follow-Up Method	2195	2195	1		
		1860	Recurrence Date--1st	2196	2203	8		
		1861	Recurrence Date--1st Flag	2204	2205	2		
		1870	Recurrence Distant Sites					
		1871	Recurrence Distant Site 1					
		1872	Recurrence Distant Site 2					
		1873	Recurrence Distant Site 3					
		1880	Recurrence Type--1st	2206	2207	2		
		1890	Recurrence Type--1st--Oth					
		1895	Reserved 39					
		1900	Reserved 11	4345	4394	50		
		1910	Cause of Death	2269	2272	4		
	1920	ICD Revision Number	2273	2273	1			
	1930	Autopsy	2274	2274	1			
	1940	Place of Death	2275	2277	3		1981-2012	
	1942	Place of Death – State	450	451	2		2013	
	1944	Place of Death – Country	452	454	3		2013	
	1950	Reserved 12						

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
Over-rides/Conversion/System Admin.		1960	Site (73-91) ICD-O-1	1909	1912	4		
		1970	Morph (73-91) ICD-O-1	1913	1918	6		
		1971	Histology (73-91) ICD-O-1	1913	1916	4		
		1972	Behavior (73-91) ICD-O-1	1917	1917	1		
		1973	Grade (73-91) ICD-O-1	1918	1918	1		
		1980	ICD-O-2 Conversion Flag	1919	1919	1		
		1981	Over-ride SS/NodesPos	1888	1888	1		
		1982	Over-ride SS/TNM-N	1889	1889	1		
		1983	Over-ride SS/TNM-M	1890	1890	1		
		1984	Over-ride SS/DisMet1					
		1985	Over-ride Acsn/Class/Seq	1891	1891	1		
		1986	Over-ride HospSeq/DxConf	1892	1892	1		
		1987	Over-ride COC-Site/Type	1893	1893	1		
		1988	Over-ride HospSeq/Site	1894	1894	1		
		1989	Over-ride Site/TNM-StgGrp	1895	1895	1		
		1990	Over-ride Age/Site/Morph	1896	1896	1		
		2000	Over-ride SeqNo/DxConf	1897	1897	1		
		2010	Over-ride Site/Lat/SeqNo	1898	1898	1		
		2020	Over-ride Surg/DxConf	1899	1899	1		
		2030	Over-ride Site/Type	1900	1900	1		
		2040	Over-ride Histology	1901	1901	1		
		2050	Over-ride Report Source	1902	1902	1		
		2060	Over-ride Ill-define Site	1903	1903	1		
		2070	Over-ride Leuk, Lymphoma	1904	1904	1		
		2071	Over-ride Site/Behavior	1905	1905	1		
		2072	Over-ride Site/EOD/DX Dt	1906	1906	1		
		2073	Over-ride Site/Lat/EOD	1907	1907	1		
		2074	Over-ride Site/Lat/Morph	1908	1908	1		
		2080	Reserved 13 (Retired item)	5065	5564	500		
		2081	CRC CHECKSUM	1920	1929	10		
	2082	Reserved 24						
	2085	Date Case Initiated	1951	1958	8			
	C	2090	Date Case Completed	1959	1966	8		1981
		2092	Date Case Completed--CoC	1967	1974	8		
		2100	Date Case Last Changed	1975	1982	8		
		2110	Date Case Report Exported	1983	1990	8		
		2111	Date Case Report Received	1991	1998	8		
		2112	Date Case Report Loaded	1999	2006	8		
		2113	Date Tumor Record Available	2007	2014	8		
		2114	Future Use Timeliness 1					

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End	
		2115	Future Use Timeliness 2						
		2116	ICD-O-3 Conversion Flag	2015	2015	1			
		2120	SEER Coding Sys--Current	1930	1930	1			
		2130	SEER Coding Sys--Original	1931	1931	1			
		2140	COC Coding Sys--Current	1932	1933	2			
		2150	COC Coding Sys--Original	1934	1935	2			
		2160	Subsq Report for Primary						
		2161	Reserved for Expansion						
C		2170	Vendor Name	1936	1945	10		2001	
		2180	SEER Type of Follow-Up	1946	1946	1			
		2190	SEER Record Number	1947	1948	2			
		2200	Diagnostic Proc 73-87	1949	1950	2			
		2210	Reserved 14	20825	22824	2000			
Special Use		2220.001	FCDS Addr Current - County (data will be derived from new location starting July 1, 2010; see item 1840)	2340	2341	2		1981-2009	
		2220.002	FCDS Addr Current - State (data will be derived from new location starting July 1, 2010; see item 1820)	2342	2344	3		1981-2009	
		2220.003	FCDS County of Dx (facility) (data will be derived from facility # at new location starting July 1, 2010; see item 540)	2345	2346	2		1981-2009	
		2220.004	FCDS Stage @ 1st Contact 1977-2000	2347	2347	1		1981-2003	
		2220.005	FCDS Tobacco Use (retired July 1, 2010)	2348	2348	1		1981-2009	
		2220.006	FCDS Facility Number (data will be derived from new location starting July 1, 2010; see item 540)	2349	2352	4		1981-2009	
		2220.007	FCDS Primary Payor - Current (see item 630)	2353	2354	2		1995-2002	
		2220.008	FCDS Accession # (data will be derived from new location starting July 1, 2010; see item 550)	2355	2363	9		1981-2009	
		2220.090	FCDS Stage @ 1st Contact 2000	2364	2364	1		2001-2003	
		2220.010	Addr at DX - State (data will be derived from new location starting July 1, 2010; see item 80)	2365	2367	3		2001-2009	
		2220.011	Addr at DX - County (data will be derived from new location starting July 1, 2010; see item 90)	2368	2369	2		2001-2009	
		2220.012	RX Summ Date --Transplnt/Endocr (retired July 1, 2010)	2370	2377	8		2003-2009	
	C		2220.013	Historical #1: Sequence Number	2378	2379	2		2007
	C		2220.014	Historical #1: DX Date	2380	2387	8		2007
	C		2220.015	Historical #1: Primary Site	2388	2391	4		2007
	C		2220.016	Historical #1: Morphology	2392	2395	4		2007
	C		2220.017	Historical #1: Behavior	2396	2396	1		2007
	C		2220.018	Historical #1: Laterality	2397	2397	1		2007

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
	C	2220.019	Historical #1: Dx State <i>Abbreviation</i>	2398	2399	2		2007
	C	2220.020	Historical #1: Dx County <i>FIPS</i>	2400	2402	3		2007
	C	2220.021	Historical #1: CS SSF25 Discriminator	2403	2405	3		2010
	C	2220.022	Historical #2: Sequence Number	2406	2407	2		2007
	C	2220.023	Historical #2: DX Date	2408	2415	8		2007
	C	2220.024	Historical #2: Primary Site	2416	2419	4		2007
	C	2220.025	Historical #2: Morphology	2420	2423	4		2007
	C	2220.026	Historical #2: Behavior	2424	2424	1		2007
	C	2220.027	Historical #2: Laterality	2425	2425	1		2007
	C	2220.028	Historical #2: Dx State <i>Abbreviation</i>	2426	2427	2		2007
	C	2220.029	Historical #2: Dx County <i>FIPS</i>	2428	2430	3		2007
	C	2220.030	Historical #2: CS SSF25 Discriminator	2431	2433	3		2010
	C	2220.031	Historical #3: Sequence Number	2434	2435	2		2007
	C	2220.032	Historical #3: DX Date	2436	2443	8		2007
	C	2220.033	Historical #3: Primary Site	2444	2447	4		2007
	C	2220.034	Historical #3: Morphology	2448	2451	4		2007
	C	2220.035	Historical #3: Behavior	2452	2452	1		2007
	C	2220.036	Historical #3: Laterality	2453	2453	1		2007
	C	2220.037	Historical #3: Dx State <i>Abbreviation</i>	2454	2455	2		2007
	C	2220.038	Historical #3: Dx County <i>FIPS</i>	2456	2458	3		2007
	C	2220.039	Historical #3: CS SSF25 Discriminator	2459	2461	3		2010
	C	2220.040	Historical #4: Sequence Number	2462	2463	2		2007
	C	2220.041	Historical #4: DX Date	2464	2471	8		2007
	C	2220.042	Historical #4: Primary Site	2472	2475	4		2007
	C	2220.043	Historical #4: Morphology	2476	2479	4		2007
	C	2220.044	Historical #4: Behavior	2480	2480	1		2007
	C	2220.045	Historical #4: Laterality	2481	2481	1		2007
	C	2220.046	Historical #4: Dx State <i>Abbreviation</i>	2482	2483	2		2007
	C	2220.047	Historical #4: Dx County <i>FIPS</i>	2484	2486	3		2007
	C	2220.048	Historical #4: CS SSF25 Discriminator	2487	2489	3		2010
	C	2220.049	Historical #5: Sequence Number	2490	2491	2		2007
	C	2220.050	Historical #5: DX Date	2492	2499	8		2007
	C	2220.051	Historical #5: Primary Site	2500	2503	4		2007
	C	2220.052	Historical #5: Morphology	2504	2507	4		2007
	C	2220.053	Historical #5: Behavior	2508	2508	1		2007
	C	2220.054	Historical #5: Laterality	2509	2509	1		2007
	C	2220.055	Historical #5: Dx State <i>Abbreviation</i>	2510	2511	2		2007
	C	2220.056	Historical #5: Dx County <i>FIPS</i>	2512	2514	3		2007
	C	2220.057	Historical #5: CS SSF25 Discriminator	2515	2517	3		2010

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
		2220.058	RX Date--Transplnt/Endocr Flag (retired starting July 1, 2010 but never collected by FCDS)	2518	2519	2		
		2200.059	Height	2520	2521	2		Moved to 1300
		2200.060	Weight	2522	2524	3		Moved to 1300
		2200.061	Tobacco Use - Cigarette	2525	2525	1		Moved to 1300
		2200.062	Tobacco Use - OthSmoke	2526	2526	1		Moved to 1300
		2200.063	Tobacco Use - Smokeless Tob	2527	2527	1		Moved to 1300
		2200.064	Tobacco Use - NOS	2528	2528	1		Moved to 1300
		2220	Reserved for State Items	2529	3339	811		
Patient - Confidential	C	2230	Name--Last	3340	3379	40		1981
	C	2240	Name--First	3380	3419	40		1981
	C	2250	Name--Middle	3420	3459	40		1981
		2260	Name--Prefix	3460	3462	3		
		2270	Name--Suffix	3463	3465	3		
	C	2280	Name--Alias	3466	3505	40		2006
		2290	Name--Spouse/Parent	3546	3605	60		
	C	2300	Medical Record Number	3606	3616	11		1981
		2310	Military Record No Suffix	3617	3618	2		
	C	2320	Social Security Number	3619	3627	9		1981
	C	2330	Addr at DX--No & Street	3628	3687	60		2001
	C	2335	Addr at DX--Supplementl	3688	3747	60		2006
	C	2350	Addr Current--No & Street	3748	3807	60		1981
		2352	Latitude	4064	4073	10		
		2354	Longitude	4074	4084	11		
		2355	Addr Current--Supplementl	3808	3867	60		
	C	2360	Telephone	3868	3877	10		2003
		2370	DC State					
		2371	Reserved for Expansion (Retired item)					
		2380	DC State File Number	3878	3883	6		
	C	2390	Name--Maiden	3506	3545	40		1995
		2392	Follow-Up Contact--No&St	3944	4003	60		
		2393	Follow-Up Contact--Suppl	4004	4063	60		
	2394	Follow-Up Contact--Name	3884	3943	60			
	2400	Reserved for Expansion (Retired item)						
Hospital - Confidential		2410	Institution Referred From	4315	4324	10		
		2415	NPI--Inst Referred From	4305	4314	10		
		2420	Institution Referred To	4335	4344	10		

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
		2425	NPI--Inst Referred To	4325	4334	10		
		2430	Last Follow-Up Hospital					
		2435	Reserved 40					
		2440	Following Registry	4295	4304	10		
		2445	NPI--Following Registry	4285	4294	10		
		2450	Reserved for Expansion (Retired item)					
Other - Confidential	C	2460	Physician--Managing	4405	4412	8		1981
	C	2465	NPI--Physician--Managing	4395	4404	10		2011
		2470	Physician--Follow-Up	4423	4430	8		
	C	2475	NPI--Physician--Follow-Up	4413	4422	10		2011
		2480	Physician--Primary Surg	4441	4448	8		
	C	2485	NPI--Physician--Primary Surg	4431	4440	10		2011
		2490	Physician 3	4459	4466	8		
	C	2495	NPI--Physician 3	4449	4458	10		2011
		2500	Physician 4	4477	4484	8		
	C	2505	NPI--Physician 4	4467	4476	10		2011
		2510	Reserved 12	4485	4534	50		
Text - Diagnosis	C	2520	Text--DX Proc--PE	5565	6564	1000		2001
	C	2530	Text--DX Proc--X-ray/scan	6565	7564	1000		1997
	C	2540	Text--DX Proc--Scopes	7565	8564	1000		2001
	C	2550	Text--DX Proc--Lab Tests	8565	9564	1000		1997
	C	2560	Text--DX Proc--Op	9565	10564	1000		1997
	C	2570	Text--DX Proc--Path	10565	11564	1000		1997
	C	2580	Text--Primary Site Title	11565	11664	100		2006
	C	2590	Text--Histology Title	11665	11764	100		2006
	C	2600	Text--Staging	11765	12764	1000		1997
Text - Treatment	C	2610	RX Text--Surgery	12765	13764	1000		2001
	C	2620	RX Text--Radiation (Beam)	13765	14764	1000		2006
	C	2630	RX Text--Radiation Other	14765	15764	1000		2006
	C	2640	RX Text--Chemo	15765	16764	1000		2006
	C	2650	RX Text--Hormone	16765	17764	1000		2006
	C	2660	RX Text--BRM	17765	18764	1000		2006
	C	2670	RX Text--Other	18765	19764	1000		2006
			2680	Text--Remarks	19765	20764	1000	
Text - Misc.	C	2690	Text--Place of Diagnosis	20765	20824	60		2001
		2700	Reserved 19					
		2730	CS PreRx Tumor Size	1078	1080	3		
		2735	CS PreRx Extension	1081	1083	3		
		2740	CS PreRx Tum Sz/Ext Eval	1084	1084	1		
		2750	CS PreRx Lymph Nodes	1085	1087	3		

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
		2755	CS PreRx Reg Nodes Eval	1088	1088	1		
		2760	CS PreRx Mets at DX	1089	1090	2		
		2765	CS PreRx Mets Eval	1091	1091	1		
		2770	CS PostRx Tumor Size	1092	1094	3		
		2775	CS PostRx Extension	1095	1097	3		
		2780	CS PostRx Lymph Nodes	1098	1100	3		
		2785	CS PostRx Mets at DX	1101	1102	2		
	C*	2800	CS Tumor Size	985	987	3		*2004-2015 Dx
	C*	2810	CS Extension	988	990	3		*2004-2015 Dx
	C*	2820	CS Tumor Size/Ext Eval	991	991	1		*2004-2015 Dx
	C*	2830	CS Lymph Nodes	992	994	3		*2004-2015 Dx
	C*	2840	CS Lymph Nodes Eval	995	995	1		*2004-2015 Dx
	C*	2850	CS Mets at DX	996	997	2		*2004-2015 Dx
		2851	CS Mets at Dx-Bone	999	999	1		
		2852	CS Mets at Dx-Brain	1000	1000	1		
		2853	CS Mets at Dx-Liver	1001	1001	1		
		2854	CS Mets at Dx-Lung	1002	1002	1		
	C*	2860	CS Mets Eval	998	998	1		*2004-2015 Dx
	C	2861	CS Site-Specific Factor 7	1021	1023	3		2010
	C	2862	CS Site-Specific Factor 8	1024	1026	3		2010
	C	2863	CS Site-Specific Factor 9	1027	1029	3		2010
	C	2864	CS Site-Specific Factor10	1030	1032	3		2010
	C	2865	CS Site-Specific Factor11	1033	1035	3		2010
	C	2866	CS Site-Specific Factor12	1036	1038	3		2010
	C	2867	CS Site-Specific Factor13	1039	1041	3		2010
	C	2868	CS Site-Specific Factor14	1042	1044	3		2010
	C	2869	CS Site-Specific Factor15	1045	1047	3		2010
	C	2870	CS Site-Specific Factor16	1048	1050	3		2010
	C	2871	CS Site-Specific Factor17	1051	1053	3		2010
	C	2872	CS Site-Specific Factor18	1054	1056	3		2010
	C	2873	CS Site-Specific Factor19	1057	1059	3		2010
	C	2874	CS Site-Specific Factor20	1060	1062	3		2010
	C	2875	CS Site-Specific Factor21	1063	1065	3		2010
	C	2876	CS Site-Specific Factor22	1066	1068	3		2010
	C	2877	CS Site-Specific Factor23	1069	1071	3		2010
	C	2878	CS Site-Specific Factor24	1072	1074	3		2010
	C	2879	CS Site-Specific Factor25	1075	1077	3		2010
	C	2880	CS Site-Specific Factor 1	1003	1005	3		2004
	C	2890	CS Site-Specific Factor 2	1006	1008	3		2004
	C	2900	CS Site-Specific Factor 3	1009	1011	3		2004

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
	C	2910	CS Site-Specific Factor 4	1012	1014	3		2004
	C	2920	CS Site-Specific Factor 5	1015	1017	3		2004
	C	2930	CS Site-Specific Factor 6	1018	1020	3		2004
		2935	CS Version Input Original	1167	1172	6		
		2936	CS Version Derived	1173	1178	6		
		2937	CS Version Input Current	1161	1166	6		
		2940	Derived AJCC-6 T	1103	1104	2		
		2950	Derived AJCC-6 T Descript	1105	1105	1		
		2960	Derived AJCC-6 N	1106	1107	2		
		2970	Derived AJCC-6 N Descript	1108	1108	1		
		2980	Derived AJCC-6 M	1109	1110	2		
		2990	Derived AJCC-6 M Descript	1111	1111	1		
		3000	Derived AJCC-6 Stage Grp	1112	1113	2		
		3010	Derived SS1977	1155	1155	1		
		3020	Derived SS2000	1156	1156	1		
		3030	Derived AJCC--Flag	1158	1158	1		
		3040	Derived SS1977--Flag	1159	1159	1		
		3050	Derived SS2000--Flag	1160	1160	1		
		3100	Archive FIN	721	730	10		
		3105	NPI--Archive FIN	711	720	10		
		3110	Comorbid/Complication 1	1186	1190	5		
		3120	Comorbid/Complication 2	1191	1195	5		
		3130	Comorbid/Complication 3	1196	1200	5		
		3140	Comorbid/Complication 4	1201	1205	5		
		3150	Comorbid/Complication 5	1206	1210	5		
		3160	Comorbid/Complication 6	1211	1215	5		
		3161	Comorbid/Complication 7	1216	1220	5		
		3162	Comorbid/Complication 8	1221	1225	5		
		3163	Comorbid/Complication 9	1226	1230	5		
		3164	Comorbid/Complication 10	1231	1235	5		
		3165	ICD Revision Comorbid	1185	1185	1		
	C	3170	RX Date Mst Defn Srg	1466	1473	8		2015
	C	3171	RX Date Mst Defn Srg Flag	1474	1475	2		2015
		3180	RX Date Surg Disch	1476	1483	8		
		3181	RX Date Surg Disch Flag	1484	1485	2		
		3190	Readm Same Hosp 30 Days	1619	1619	1		
		3200	Rad--Boost RX Modality	1609	1610	2		
		3210	Rad--Boost Dose cGy	1611	1615	5		
		3220	RX Date Rad Ended	1496	1503	8		
		3221	RX Date Rad Ended Flag	1504	1505	2		

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
		3230	RX Date Systemic	1506	1513	8		
		3231	RX Date Systemic Flag	1514	1515	2		
	C	3250	RX Summ--Transplnt/Endocr	1583	1584	2		2003
		3270	RX Summ--Palliative Proc	1579	1579	1		
		3280	RX Hosp--Palliative Proc	799	799	1		
		3300	RuralUrban Continuum 1993	424	425	2		
		3310	RuralUrban Continuum 2003	426	427	2		
Derived/SEER/Path		3400	Derived AJCC-7 T	1114	1116	3		
		3402	Derived AJCC-7 T Descript	1117	1117	1		
		3410	Derived AJCC-7 N	1118	1120	3		
		3412	Derived AJCC-7 N Descript	1121	1121	1		
		3420	Derived AJCC-7 M	1122	1124	3		
		3422	Derived AJCC-7 M Descript	1125	1125	1		
		3430	Derived AJCC-7 Stage Grp	1126	1128	3		
		3440	Derived PreRx-7 T	1129	1131	3		
		3442	Derived PreRx-7 T Descrip	1132	1132	1		
		3450	Derived PreRx-7 N	1133	1135	3		
		3452	Derived PreRx-7 N Descrip	1136	1136	1		
		3460	Derived PreRx-7 M	1137	1139	3		
		3462	Derived PreRx-7 M Descrip	1140	1140	1		
		3470	Derived PreRx-7 Stage Grp	1141	1143	3		
		3480	Derived PostRx-7 T	1144	1146	3		
		3482	Derived PostRx-7 N	1147	1149	3		
		3490	Derived PostRx-7 M	1150	1151	2		
		3492	Derived PostRx-7 Stge Grp	1152	1154	3		
		3600	Derived Neoadjuv Rx Flag	1157	1157	1		
		3700	SEER Site-Specific Fact 1	1179	1179	1		
		3702	SEER Site-Specific Fact 2	1180	1180	1		
		3704	SEER Site-Specific Fact 3	1181	1181	1		
		3706	SEER Site-Specific Fact 4	1182	1182	1		
		3708	SEER Site-Specific Fact 5	1183	1183	1		
		3710	SEER Site-Specific Fact 6	1184	1184	1		
		7010	Path Reporting Fac ID 1	4535	4559	25		
		7011	Path Reporting Fac ID 2	4641	4665	25		
		7012	Path Reporting Fac ID 3	4747	4771	25		
		7013	Path Reporting Fac ID 4	4853	4877	25		
		7014	Path Reporting Fac ID 5	4959	4983	25		
	7090	Path Report Number 1	4560	4579	20			
	7091	Path Report Number 2	4666	4685	20			
	7092	Path Report Number 3	4772	4791	20			
	7093	Path Report Number 4	4878	4897	20			

FCDSv16 Record Layout

Section	Data Opt.	Item #	FCDSv14 / NAACCRv14 Item Name	Start	End	Length	Year	Start-End
		7094	Path Report Number 5	4984	5003	20		
		7100	Path Order Phys Lic No 1	4621	4640	20		
		7101	Path Order Phys Lic No 2	4727	4746	20		
		7102	Path Order Phys Lic No 3	4833	4852	20		
		7103	Path Order Phys Lic No 4	4939	4958	20		
		7104	Path Order Phys Lic No 5	5045	5064	20		
		7190	Path Ordering Fac No 1	4596	4620	25		
		7191	Path Ordering Fac No 2	4702	4726	25		
		7192	Path Ordering Fac No 3	4808	4832	25		
		7193	Path Ordering Fac No 4	4914	4938	25		
		7194	Path Ordering Fac No 5	5020	5044	25		
		7320	Path Date Spec Collect 1	4580	4593	14		
		7321	Path Date Spec Collect 2	4686	4699	14		
		7322	Path Date Spec Collect 3	4792	4805	14		
		7323	Path Date Spec Collect 4	4898	4911	14		
		7324	Path Date Spec Collect 5	5004	5017	14		
		7480	Path Report Type 1	4594	4595	2		
		7481	Path Report Type 2	4700	4701	2		
		7482	Path Report Type 3	4806	4807	2		
		7483	Path Report Type 4	4912	4913	2		
		7484	Path Report Type 5	5018	5019	2		

Appendix H

2015 FCDS Required CSv02.05 Site Specific Factors (SSFs)

Appendix H - 2016 FCDS Required CSv02.05 Site Specific Factors (SSFs)

Schema Number	Schema Name	TNM/SS Required	2013 FCDS Required	Additional CoC Required
116	AdnexaUterineOther	None	None	None
147	AdrenalGland	None	None	None
66	AmpullaVater	None	None	None
59	Anus	None	None	None
50	Appendix	2,11	2,11	1,3
65	BileDuctsDistal	25	25	None
61	BileDuctsIntraHepat	10	10	1,2,11
63	BileDuctsPerihilar	25	25	11
68	BiliaryOther	None	None	None
128	Bladder	2	2	1,3
95	Bone	None	None	3
143	Brain	None	1	4,5,6
106	Breast	3,4,5	1,2,3,4,5,8,9,11,13,14,15,16	6,7,10,12,21,22,23
25	BuccalMucosa	1	1	3,4,5,6,9,11
51	CarcinoidAppendix	2	2	None
110	Cervix	None	None	1
144	CNSOther	None	1	4,5,6
53	Colon	2	2	1,3,4,6,8,9
131	Conjunctiva	1	1	None
112	CorpusAdenosarcoma	2	2	1,3,4,5,6
111	CorpusCarcinoma	2	2	1,3,4,5,6
113	CorpusSarcoma	2	2	1,3,4,5,6
64	CysticDuct	25	25	None
72	DigestiveOther	None	None	None
148	EndocrineOther	None	None	None
32	EpiglottisAnterior	1	1	3,4,5,6,9
41	Esophagus	1	1	None
43	EsophagusGEJunction	1,25	1,25	None
133	EyeOther	None	None	None
115	FallopianTube	None	None	1,4,5,6,7
17	FloorMouth	1	1	3,4,5,6,9,11
62	Gallbladder	None	None	None
117	GenitalFemaleOther	None	None	None
123	GenitalMaleOther	None	None	None
52	GISTAppendix	11	11	12
54	GISTColon	11	11	12
42	GISTEsophagus	6	6	7
104	GISTPeritoneum	5,10	5,10	6
57	GISTRectum	11	11	12
48	GISTSmallIntestine	6	6	7
45	GISTStomach	6	6	7
13	GumLower	1	1	3,4,5,6,9,11
15	GumOther	1	1	3,4,5,6,9,11

Appendix H - 2016 FCDS Required CSv02.05 Site Specific Factors (SSFs)

Schema Number	Schema Name	TNM/SS Required	2013 FCDS Required	Additional CoC Required
11	GumUpper	1	1	3,4,5,6,9,11
92	HeartMediastinum	1	1	3
151	HemeRetic	None	1	1
37	Hypopharynx	1	1	3,4,5,6,9,10
153	IllDefinedOther	None	None	None
145	IntracranialGland	None	1	None
149	KaposiSarcoma	None	None	1
126	KidneyParenchyma	None	None	1,2,3,4,6,8
127	KidneyRenalPelvis	None	None	1,2
138	LacrimaGland	25	25	4,6,8
139	LacrimaSac	25	25	None
82	LarynxGlottic	1	1	3,4,5,6,9
88	LarynxOther	1	1	3,4,5,6,9
86	LarynxSubglottic	1	1	3,4,5,6,9
84	LarynxSupraglottic	1	1	3,4,5,6,9
3	LipLower	1	1	3,4,5,6,9,11
5	LipOther	1	1	3,4,5,6,9,11
1	LipUpper	1	1	3,4,5,6,9,11
60	Liver	None	None	1,2,3,4,5,6,7,8
91	Lung	1	1	2
150	Lymphoma	2	2	1,3
142	LymphomaOcularAdnexa	2	2	1,3,6
26	MelanomaBuccalMucosa	None	None	1,3,4,5,6,9,11
136	MelanomaChoroid	2,3,4	2,3,4	5,6,7,9,10,11,12,13
135	MelanomaCiliaryBody	2,3,4,25	2,3,4,25	5,6,7,9,10,11,12,13
132	MelanomaConjunctiva	1,2	1,2	None
33	MelanomaEpiglottisAnterior	None	None	1,3,4,5,6,9,11
137	MelanomaEyeOther	None	None	None
18	MelanomaFloorMouth	None	None	1,3,4,5,6,9,11
14	MelanomaGumLower	None	None	1,3,4,5,6,9,11
16	MelanomaGumOther	None	None	1,3,4,5,6,9,11
12	MelanomaGumUpper	None	None	1,3,4,5,6,9,11
38	MelanomaHypopharynx	None	None	1,3,4,5,6,9,11
134	MelanomaIris	4,25	4,25	3,5,6,7,9,10,11,12,13
83	MelanomaLarynxGlottic	None	None	1,3,4,5,6,9,11
89	MelanomaLarynxOther	None	None	1,3,4,5,6,9,11
87	MelanomaLarynxSubglottic	None	None	1,3,4,5,6,9,11
85	MelanomaLarynxSupraglottic	None	None	1,3,4,5,6,9,11
4	MelanomaLipLower	None	None	1,3,4,5,6,9,11
6	MelanomaLipOther	None	None	1,3,4,5,6,9,11
2	MelanomaLipUpper	None	None	1,3,4,5,6,9,11
24	MelanomaMouthOther	None	None	1,3,4,5,6,9,11
74	MelanomaNasalCavity	None	None	1,3,4,5,6,9,11

Appendix H - 2016 FCDS Required CSv02.05 Site Specific Factors (SSFs)

Schema Number	Schema Name	TNM/SS Required	2013 FCDS Required	Additional CoC Required
35	MelanomaNasopharynx	None	None	1,3,4,5,6,9,11
31	MelanomaOropharynx	None	None	1,3,4,5,6,9,11
20	MelanomaPalateHard	None	None	1,3,4,5,6,9,11
22	MelanomaPalateSoft	None	None	1,3,4,5,6,9,11
40	MelanomaPharynxOther	None	None	1,3,4,5,6,9,11
79	MelanomaSinusEthmoid	None	None	1,3,4,5,6,9,11
77	MelanomaSinusMaxillary	None	None	1,3,4,5,6,9,11
81	MelanomaSinusOther	None	None	1,3,4,5,6,9,11
99	MelanomaSkin	1,2,3,4,7	1,2,3,4,7	5,6
10	MelanomaTongueAnterior	None	None	1,3,4,5,6,9,11
8	MelanomaTongueBase	None	None	1,3,4,5,6,9,11
120	MerkelCellPenis	3	3	1,16,17,18,22
125	MerkelCellScrotum	3	3	1,16,17,18,22
98	MerkelCellSkin	3	3	1,16,17,18,22
108	MerkelCellVulva	3,11	3,11	1,16,17,18,22
75	MiddleEar	None	None	1,3,4,5,6,9
23	MouthOther	1	1	3,4,5,6,9,11
100	MycosisFungoides	1	1	None
152	MyelomaPlasmaCellDisorder	None	None	2,3
73	NasalCavity	1	1	3,4,5,6,9,11
34	Nasopharynx	1,25	1,25	3,4,5,6,9,10
67	NETAmpulla	None	None	5,6
55	NETColon	2	2	16,17
58	NETRectum	2	2	16,17
49	NETSmallIntestine	None	None	11,12
46	NETStomach	1	1	11,12
140	Orbit	None	None	None
30	Oropharynx	1	1	3,4,5,6,9,10
114	Ovary	None	None	1,2,3
19	PalateHard	1	1	3,4,5,6,9,11
21	PalateSoft	1	1	3,4,5,6,9,10
70	PancreasBodyTail	None	None	None
69	PancreasHead	None	None	None
71	PancreasOther	None	None	None
27	ParotidGland	1	1	3,4,5,6,9
119	Penis	17	17	10
102	Peritoneum	1,25	1,25	None
105	PeritoneumFemaleGen	25	25	1,2,3
36	PharyngealTonsil	1,25	1,25	3,4,5,6,9,10
39	PharynxOther	None	None	3,4,5,6,9,10
118	Placenta	1	1	2
93	Pleura	1	1	2
121	Prostate	1,3,8,10	1,3,8,10	2,7,9,11,12,13

Appendix H - 2016 FCDS Required CSv02.05 Site Specific Factors (SSFs)

Schema Number	Schema Name	TNM/SS Required	2013 FCDS Required	Additional CoC Required
56	Rectum	2	2	1,3,4,6,8,9
94	RespiratoryOther	None	None	None
141	Retinoblastoma	1	1	None
103	Retroperitoneum	1	1	None
29	SalivaryGlandOther	1	1	3,4,5,6,9
124	Scrotum	12,16	12,16	1
78	SinusEthmoid	1	1	3,4,5,6,9,11
76	SinusMaxillary	1	1	3,4,5,6,9,11
80	SinusOther	None	None	3,4,5,6,9,11
96	Skin	12,16	12,16	1,11
97	SkinEyelid	6	6	3,8,10
47	SmallIntestine	2	2	1,3
101	SoftTissue	1	1	3
44	Stomach	1,25	1,25	None
28	SubmandibularGland	1	1	3,4,5,6,9
122	Testis	4,5,13,15,16	4,5,13,15,16	6,7,8,9,10
146	Thyroid	None	None	1
9	TongueAnterior	1	1	3,4,5,6,9,11
7	TongueBase	1	1	3,4,5,6,9,10
90	Trachea	None	None	None
129	Urethra	None	None	1
130	UrinaryOther	None	None	None
109	Vagina	None	None	1,2,3,4,5,6,7
107	Vulva	11	11	10

Appendix I

Free-Standing Radiation Therapy Centers Cancer Case Identification Program

Tab separated file layout for uploads via FCDS IDEA

Field #	Item Name	Maximum Field Length
1.	FCDS Facility Number	4
2.	Patient ID / Medical Record	12
3.	Facility Name	4
4.	Patient Last Name	25
5.	Patient First Name	14
6.	Patient Social Security Number	9
7.	Patient Date of Birth (YYYYMMDD)	8
8.	Patient Sex	1
9.	Patient Race	2
10.	Patient State	2
11.	Patient Zip Code	5
12.	Patient Encounter Date (YYYYMMDD)	8
13.	ICD-9-CM or ICD-10-CM Diagnosis Code	7

File structure notes:

- Files must be in ASCII, with one CR/LF sequence at end of each record.
- Fields are separated by 1 tab character, beginning after field 1 and no tab after field 12. Since there are 12 fields, each record must have exactly 11 separating tabs. Files with extra/missing tabs - in any record - will be rejected.
- No embedded CR/LF, TABS other than as field separators, or other control characters in text fields.
- No quotes "" around fields, just data.
- Dates are in YYYYMMDD format – do not add “/” or “-“. Dates will be validated (don’t submit 99999999 or 20030229).
- No "Header" records with variable names, just data.
- All fields are required. Do not use blanks for missing information. Required fields that are missing/unknown, such as Sex, have codes for missing.
- Field lengths are the maximum allowed length for that field. Don’t add extra trailing spaces to field.
- Files may be compressed before upload using the DOS/Windows ZIP compression standard. PKZIP or WINZIP are examples of programs that produce the correct compressed format.

DATA ITEM DESCRIPTIONS

Field#	Item Name	Maximum Field Length
1	FCDS Facility Number	4

This is a required data item containing the FCDS Facility number for your Radiation Center. Appendix A has a list of FCDS Facility numbers. Contact FCDS if your facility is not on this list.

Field#	Item Name	Maximum Field Length
2	Patient ID or Medical Record Number	12

This is a required data item containing your facility's patient ID number or medical record number that will uniquely identify a patient in your records. If no medical record number or patient ID is available use 999999999.

Field#	Item Name	Maximum Field Length
3	Facility Name	4

This is a required data field that uniquely identifies each facility by name.

Field#	Item Name	Maximum Field Length
4	Patient Last Name	25

This is a required data item containing the patient's last name.

Field#	Item Name	Maximum Field Length
5	Patient First Name	14

This is a required data item containing the patient's first name.

Field#	Item Name	Maximum Field Length
6	Patient Social Security Number	9

This is a required data item containing the patient's Social Security Number. Enter 9s in this field if the SSN is unknown or missing.

Field#	Item Name	Maximum Field Length
7	Patient Date of Birth	8

This is a required data item containing the patient's date of birth in (YYYYMMDD) format. The date will be validated so 9s or other invalid dates will cause the file upload to be rejected.

Field#	Item Name	Maximum Field Length
8	Patient Sex	1

This is a required data item containing the patient's sex. Use the following codes:
1=Male, 2=Female, 3=Hermaphrodite, 4=Transsexual, 9=Unknown/not stated

Field#	Item Name	Maximum Field Length
9	Patient Race	2

This is a required data item containing the patient's race. Use the following codes:
1=White, 2=Black, 3=American Indian, 98=Other, 99=Unknown

Field#	Item Name	Maximum Field Length
10	Patient State	2

This is a required data item containing the USPS 2 character Postal abbreviation for the patient's address state. Appendix B has a list of valid state abbreviations.

Field#	Item Name	Maximum Field Length
11	Patient Zip code	5

This is a required data item containing the USPS 5 digit Postal code for the patient's address.

Field#	Item Name	Maximum Field Length
12	Date of Encounter	8

This is a required data item containing the date of encounter at your facility in (YYYYMMDD) format. The date will be validated so 9s or other invalid dates will cause the file upload to be rejected.

Field#	Item Name	Maximum Field Length
13	ICD-9-CM or ICD-10-CM Diagnosis Code	7

This is a required data item containing the ICD-9-CM or ICD-10-CM Diagnosis Code associated with the patient encounter at your facility. The field will support either an ICD-9-CM Diagnosis Code (used through 9/30/2015 patient encounters) or an ICD-10-CM Diagnosis Code (used starting with 10/1/2015 patient encounters).

ICD-9-CM CASEFINDING LIST FOR REPORTABLE TUMORS – Jan-Sept 2015

ICD-9-CM	Description
140.00-209.36	Malignant neoplasms (excluding skin 173.0-173.9)
209.70-209.79	Secondary neuroendocrine tumors
225.0-225.9	Benign neoplasm of brain and spinal cord neoplasm
227.3-227.4	Benign neoplasm of pituitary gland, pineal body, and intracranial endocrine-related structures
228.02	Hemangioma; of intracranial structures
228.1	Lymphangioma, any site brain, other parts of CNS
230.0-234.9	Carcinoma in situ (exclude: skin, cervix and prostate– 232.0-232.9, 233.1, 233.4)
237.0-237.1, 237.5, 237.6, 237.9	Neoplasm of uncertain behavior (borderline) of intracranial endocrine glands, brain and CNS
238.4	Polycythemia vera (9950/3)
239.6-239.7	Neoplasms of unspecified nature Brain and CNS
273.3	Waldenstrom macroglobulinemia (9761/3)
511.81	Malignant pleural effusion (code first malignant neoplasm if known)
789.51	Malignant ascites (code the first malignant neoplasm if known)
V58.0	Encounter for radiotherapy
V58.1	Encounter for chemotherapy and immunotherapy
V58.11	Antineoplastic Chemotherapy
V58.12	Antineoplastic Immunotherapy

ICD-10-CM CASEFINDING LIST FOR REPORTABLE TUMORS – Oct 1, 2015 and later encounters

ICD-10-CM	Description
C00._ - C43._	Malignant neoplasms
C4A._	Merkel Cell Carcinoma
C45._ - C96._	Malignant neoplasms
D00._ - D09._	Carcinoma in situ (exclude: skin, cervix and prostate– D04._, D06._ and D07.5)
D18.02	Hemangioma; of intracranial structures
D18.1	Lymphangioma, any site brain, other parts of CNS
D32._	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33._	Benign neoplasm of brain and other parts of central nervous system
D35.2, D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42._, D43._	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3-D44.5	Neoplasm of uncertain behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3)
D46._	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D47.1	Chronic myeloproliferative disease (9960, 9963)
D47.3	Essential (hemorrhagic) thrombocythemia (9962)
D47.4	Osteomyelofibrosis (9961)
D47.Z_	Other specified neoplasm of uncertain/unknown behavior of lymphoid, hematopoietic (9965, 9966, 9967, 9971, 9975, 9987)
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960, 9970, 9931)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
J91.0	Malignant Pleural Effusion
R18.0	Malignant ascites
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.11	Encounter for antineoplastic chemotherapy
Z51.12	Encounter for antineoplastic immunotherapy

DETAILED ICD-10-CM CODE LIST FOR CASEFINDING REPORTABLE TUMORS – Oct 1, 2015 and later encounters

The following Detailed ICD-10-CM code list is to be used to identify potentially reportable tumors. Some ICD-10-CM codes contain conditions that are not reportable. These records should be reviewed and assessed individually to verify whether or not they are reportable to FCDS. ICD-10-CM nationwide implementation on October 1, 2015.

ICD-10-CM	Code Description
C00	Malignant neoplasm of lip
C00.0	Malignant neoplasm of external upper lip
C00.1	Malignant neoplasm of external lower lip
C00.2	Malignant neoplasm of external lip, unspecified
C00.3	Malignant neoplasm of upper lip, inner aspect
C00.4	Malignant neoplasm of lower lip, inner aspect
C00.5	Malignant neoplasm of lip, unspecified, inner aspect
C00.6	Malignant neoplasm of commissure of lip, unspecified
C00.8	Malignant neoplasm of overlapping sites of lip
C00.9	Malignant neoplasm of lip, unspecified
C01	Malignant neoplasm of base of tongue
C02	Malignant neoplasm of other and unspecified parts of tongue
C02.0	Malignant neoplasm of dorsal surface of tongue
C02.1	Malignant neoplasm of border of tongue
C02.2	Malignant neoplasm of ventral surface of tongue
C02.3	Malignant neoplasm of anterior two-thirds of tongue, part unspecified
C02.4	Malignant neoplasm of lingual tonsil
C02.8	Malignant neoplasm of overlapping sites of tongue
C02.9	Malignant neoplasm of tongue, unspecified
C03	Malignant neoplasm of gum
C03.0	Malignant neoplasm of upper gum
C03.1	Malignant neoplasm of lower gum
C03.9	Malignant neoplasm of gum, unspecified
C04	Malignant neoplasm of floor of mouth
C04.0	Malignant neoplasm of anterior floor of mouth
C04.1	Malignant neoplasm of lateral floor of mouth
C04.8	Malignant neoplasm of overlapping sites of floor of mouth
C04.9	Malignant neoplasm of floor of mouth, unspecified
C05	Malignant neoplasm of palate
C05.0	Malignant neoplasm of hard palate
C05.1	Malignant neoplasm of soft palate
C05.2	Malignant neoplasm of uvula
C05.8	Malignant neoplasm of overlapping sites of palate
C05.9	Malignant neoplasm of palate, unspecified
C06	Malignant neoplasm of other and unspecified parts of mouth
C06.0	Malignant neoplasm of cheek mucosa
C06.1	Malignant neoplasm of vestibule of mouth
C06.2	Malignant neoplasm of retromolar area
C06.8	Malignant neoplasm of overlapping sites of other and unspecified parts of mouth
C06.80	Malignant neoplasm of overlapping sites of unspecified parts of mouth

ICD-10-CM	Code Description
C06.89	Malignant neoplasm of overlapping sites of other parts of mouth
C06.9	Malignant neoplasm of mouth, unspecified
C07	Malignant neoplasm of parotid gland
C08	Malignant neoplasm of other and unspecified major salivary glands
C08.0	Malignant neoplasm of submandibular gland
C08.1	Malignant neoplasm of sublingual gland
C08.9	Malignant neoplasm of major salivary gland, unspecified
C09	Malignant neoplasm of tonsil
C09.0	Malignant neoplasm of tonsillar fossa
C09.1	Malignant neoplasm of tonsillar pillar (anterior) (posterior)
C09.8	Malignant neoplasm of overlapping sites of tonsil
C09.9	Malignant neoplasm of tonsil, unspecified
C10	Malignant neoplasm of oropharynx
C10.0	Malignant neoplasm of vallecula
C10.1	Malignant neoplasm of anterior surface of epiglottis
C10.2	Malignant neoplasm of lateral wall of oropharynx
C10.3	Malignant neoplasm of posterior wall of oropharynx
C10.4	Malignant neoplasm of branchial cleft
C10.8	Malignant neoplasm of overlapping sites of oropharynx
C10.9	Malignant neoplasm of oropharynx, unspecified
C11	Malignant neoplasm of nasopharynx
C11.0	Malignant neoplasm of superior wall of nasopharynx
C11.1	Malignant neoplasm of posterior wall of nasopharynx
C11.2	Malignant neoplasm of lateral wall of nasopharynx
C11.3	Malignant neoplasm of anterior wall of nasopharynx
C11.8	Malignant neoplasm of overlapping sites of nasopharynx
C11.9	Malignant neoplasm of nasopharynx, unspecified
C12	Malignant neoplasm of pyriform sinus
C13	Malignant neoplasm of hypopharynx
C13.0	Malignant neoplasm of postcricoid region
C13.1	Malignant neoplasm of aryepiglottic fold, hypopharyngeal aspect
C13.2	Malignant neoplasm of posterior wall of hypopharynx
C13.8	Malignant neoplasm of overlapping sites of hypopharynx
C13.9	Malignant neoplasm of hypopharynx, unspecified
C14	Malignant neoplasm of other and ill-defined sites in the lip, oral cavity and pharynx
C14.0	Malignant neoplasm of pharynx, unspecified
C14.2	Malignant neoplasm of Waldeyers ring
C14.8	Malignant neoplasm of overlapping sites of lip, oral cavity and pharynx
C15	Malignant neoplasm of esophagus
C15.3	Malignant neoplasm of upper third of esophagus
C15.4	Malignant neoplasm of middle third of esophagus
C15.5	Malignant neoplasm of lower third of esophagus
C15.8	Malignant neoplasm of overlapping sites of esophagus
C15.9	Malignant neoplasm of esophagus, unspecified

ICD-10-CM	Code Description
C16	Malignant neoplasm of stomach
C16.0	Malignant neoplasm of cardia
C16.1	Malignant neoplasm of fundus of stomach
C16.2	Malignant neoplasm of body of stomach
C16.3	Malignant neoplasm of pyloric antrum
C16.4	Malignant neoplasm of pylorus
C16.5	Malignant neoplasm of lesser curvature of stomach, unspecified
C16.6	Malignant neoplasm of greater curvature of stomach, unspecified
C16.8	Malignant neoplasm of overlapping sites of stomach
C16.9	Malignant neoplasm of stomach, unspecified
C17	Malignant neoplasm of small intestine
C17.0	Malignant neoplasm of duodenum
C17.1	Malignant neoplasm of jejunum
C17.2	Malignant neoplasm of ileum
C17.3	Meckels diverticulum, malignant
C17.8	Malignant neoplasm of overlapping sites of small intestine
C17.9	Malignant neoplasm of small intestine, unspecified
C18	Malignant neoplasm of colon
C18.0	Malignant neoplasm of cecum
C18.1	Malignant neoplasm of appendix
C18.2	Malignant neoplasm of ascending colon
C18.3	Malignant neoplasm of hepatic flexure
C18.4	Malignant neoplasm of transverse colon
C18.5	Malignant neoplasm of splenic flexure
C18.6	Malignant neoplasm of descending colon
C18.7	Malignant neoplasm of sigmoid colon
C18.8	Malignant neoplasm of overlapping sites of colon
C18.9	Malignant neoplasm of colon, unspecified
C19	Malignant neoplasm of rectosigmoid junction
C20	Malignant neoplasm of rectum
C21	Malignant neoplasm of anus and anal canal
C21.0	Malignant neoplasm of anus, unspecified
C21.1	Malignant neoplasm of anal canal
C21.2	Malignant neoplasm of cloacogenic zone
C21.8	Malignant neoplasm of overlapping sites of rectum, anus and anal canal
C22	Malignant neoplasm of liver and intrahepatic bile ducts
C22.0	Liver cell carcinoma
C22.1	Intrahepatic bile duct carcinoma
C22.2	Hepatoblastoma
C22.3	Angiosarcoma of liver
C22.4	Other sarcomas of liver
C22.7	Other specified carcinomas of liver
C22.8	Malignant neoplasm of liver, primary, unspecified as to type
C22.9	Malignant neoplasm of liver, not specified as primary or secondary

ICD-10-CM	Code Description
C23	Malignant neoplasm of gallbladder
C24	Malignant neoplasm of other and unspecified parts of biliary tract
C24.0	Malignant neoplasm of extrahepatic bile duct
C24.1	Malignant neoplasm of ampulla of Vater
C24.8	Malignant neoplasm of overlapping sites of biliary tract
C24.9	Malignant neoplasm of biliary tract, unspecified
C25	Malignant neoplasm of pancreas
C25.0	Malignant neoplasm of head of pancreas
C25.1	Malignant neoplasm of body of pancreas
C25.2	Malignant neoplasm of tail of pancreas
C25.3	Malignant neoplasm of pancreatic duct
C25.4	Malignant neoplasm of endocrine pancreas
C25.7	Malignant neoplasm of other parts of pancreas
C25.8	Malignant neoplasm of overlapping sites of pancreas
C25.9	Malignant neoplasm of pancreas, unspecified
C26	Malignant neoplasm of other and ill-defined digestive organs
C26.0	Malignant neoplasm of intestinal tract, part unspecified
C26.1	Malignant neoplasm of spleen
C26.9	Malignant neoplasm of ill-defined sites within the digestive system
C30	Malignant neoplasm of nasal cavity and middle ear
C30.0	Malignant neoplasm of nasal cavity
C30.1	Malignant neoplasm of middle ear
C31	Malignant neoplasm of accessory sinuses
C31.0	Malignant neoplasm of maxillary sinus
C31.1	Malignant neoplasm of ethmoidal sinus
C31.2	Malignant neoplasm of frontal sinus
C31.3	Malignant neoplasm of sphenoid sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
C31.9	Malignant neoplasm of accessory sinus, unspecified
C32	Malignant neoplasm of larynx
C32.0	Malignant neoplasm of glottis
C32.1	Malignant neoplasm of supraglottis
C32.2	Malignant neoplasm of subglottis
C32.3	Malignant neoplasm of laryngeal cartilage
C32.8	Malignant neoplasm of overlapping sites of larynx
C32.9	Malignant neoplasm of larynx, unspecified
C33	Malignant neoplasm of trachea
C34	Malignant neoplasm of bronchus and lung
C34.0	Malignant neoplasm of main bronchus
C34.00	Malignant neoplasm of unspecified main bronchus
C34.01	Malignant neoplasm of right main bronchus
C34.02	Malignant neoplasm of left main bronchus
C34.1	Malignant neoplasm of upper lobe, bronchus or lung
C34.10	Malignant neoplasm of upper lobe, unspecified bronchus or lung

ICD-10-CM	Code Description
C34.11	Malignant neoplasm of upper lobe, right bronchus or lung
C34.12	Malignant neoplasm of upper lobe, left bronchus or lung
C34.2	Malignant neoplasm of middle lobe, bronchus or lung
C34.3	Malignant neoplasm of lower lobe, bronchus or lung
C34.30	Malignant neoplasm of lower lobe, unspecified bronchus or lung
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung
C34.32	Malignant neoplasm of lower lobe, left bronchus or lung
C34.8	Malignant neoplasm of overlapping sites of bronchus and lung
C34.80	Malignant neoplasm of overlapping sites of unspecified bronchus and lung
C34.81	Malignant neoplasm of overlapping sites of right bronchus and lung
C34.82	Malignant neoplasm of overlapping sites of left bronchus and lung
C34.9	Malignant neoplasm of unspecified part of bronchus or lung
C34.90	Malignant neoplasm of unspecified part of unspecified bronchus or lung
C34.91	Malignant neoplasm of unspecified part of right bronchus or lung
C34.92	Malignant neoplasm of unspecified part of left bronchus or lung
C37	Malignant neoplasm of thymus
C38	Malignant neoplasm of heart, mediastinum and pleura
C38.0	Malignant neoplasm of heart
C38.1	Malignant neoplasm of anterior mediastinum
C38.2	Malignant neoplasm of posterior mediastinum
C38.3	Malignant neoplasm of mediastinum, part unspecified
C38.4	Malignant neoplasm of pleura
C38.8	Malignant neoplasm of overlapping sites of heart, mediastinum and pleura
C39	Malignant neoplasm of other and ill-defined sites in the respiratory system and intrathoracic organs
C39.0	Malignant neoplasm of upper respiratory tract, part unspecified
C39.9	Malignant neoplasm of lower respiratory tract, part unspecified
C40	Malignant neoplasm of bone and articular cartilage of limbs
C40.0	Malignant neoplasm of scapula and long bones of upper limb
C40.00	Malignant neoplasm of scapula and long bones of unspecified upper limb
C40.01	Malignant neoplasm of scapula and long bones of right upper limb
C40.02	Malignant neoplasm of scapula and long bones of left upper limb
C40.1	Malignant neoplasm of short bones of upper limb
C40.10	Malignant neoplasm of short bones of unspecified upper limb
C40.11	Malignant neoplasm of short bones of right upper limb
C40.12	Malignant neoplasm of short bones of left upper limb
C40.2	Malignant neoplasm of long bones of lower limb
C40.20	Malignant neoplasm of long bones of unspecified lower limb
C40.21	Malignant neoplasm of long bones of right lower limb
C40.22	Malignant neoplasm of long bones of left lower limb
C40.3	Malignant neoplasm of short bones of lower limb
C40.30	Malignant neoplasm of short bones of unspecified lower limb
C40.31	Malignant neoplasm of short bones of right lower limb
C40.32	Malignant neoplasm of short bones of left lower limb
C40.8	Malignant neoplasm of overlapping sites of bone and articular cartilage of limb

ICD-10-CM	Code Description
C40.80	Malignant neoplasm of overlapping sites of bone and articular cartilage of unspecified limb
C40.81	Malignant neoplasm of overlapping sites of bone and articular cartilage of right limb
C40.82	Malignant neoplasm of overlapping sites of bone and articular cartilage of left limb
C40.9	Malignant neoplasm of unspecified bones and articular cartilage of limb
C40.90	Malignant neoplasm of unspecified bones and articular cartilage of unspecified limb
C40.91	Malignant neoplasm of unspecified bones and articular cartilage of right limb
C40.92	Malignant neoplasm of unspecified bones and articular cartilage of left limb
C41	Malignant neoplasm of bone and articular cartilage of other and unspecified sites
C41.0	Malignant neoplasm of bones of skull and face
C41.1	Malignant neoplasm of mandible
C41.2	Malignant neoplasm of vertebral column
C41.3	Malignant neoplasm of ribs, sternum and clavicle
C41.4	Malignant neoplasm of pelvic bones, sacrum and coccyx
C41.9	Malignant neoplasm of bone and articular cartilage, unspecified
C43	Malignant melanoma of skin
C43.0	Malignant melanoma of lip
C43.1	Malignant melanoma of eyelid, including canthus
C43.10	Malignant melanoma of unspecified eyelid, including canthus
C43.11	Malignant melanoma of right eyelid, including canthus
C43.12	Malignant melanoma of left eyelid, including canthus
C43.2	Malignant melanoma of ear and external auricular canal
C43.20	Malignant melanoma of unspecified ear and external auricular canal
C43.21	Malignant melanoma of right ear and external auricular canal
C43.22	Malignant melanoma of left ear and external auricular canal
C43.3	Malignant melanoma of other and unspecified parts of face
C43.30	Malignant melanoma of unspecified part of face
C43.31	Malignant melanoma of nose
C43.39	Malignant melanoma of other parts of face
C43.4	Malignant melanoma of scalp and neck
C43.5	Malignant melanoma of trunk
C43.51	Malignant melanoma of anal skin
C43.52	Malignant melanoma of skin of breast
C43.59	Malignant melanoma of other part of trunk
C43.6	Malignant melanoma of upper limb, including shoulder
C43.60	Malignant melanoma of unspecified upper limb, including shoulder
C43.61	Malignant melanoma of right upper limb, including shoulder
C43.62	Malignant melanoma of left upper limb, including shoulder
C43.7	Malignant melanoma of lower limb, including hip
C43.70	Malignant melanoma of unspecified lower limb, including hip
C43.71	Malignant melanoma of right lower limb, including hip
C43.72	Malignant melanoma of left lower limb, including hip
C43.8	Malignant melanoma of overlapping sites of skin
C43.9	Malignant melanoma of skin, unspecified
C45	Mesothelioma

ICD-10-CM	Code Description
C45.0	Mesothelioma of pleura
C45.1	Mesothelioma of peritoneum
C45.2	Mesothelioma of pericardium
C45.7	Mesothelioma of other sites
C45.9	Mesothelioma, unspecified
C46	Kaposi sarcoma
C46.0	Kaposi sarcoma of skin
C46.1	Kaposi sarcoma of soft tissue
C46.2	Kaposi sarcoma of palate
C46.3	Kaposi sarcoma of lymph nodes
C46.4	Kaposi sarcoma of gastrointestinal sites
C46.5	Kaposi sarcoma of lung
C46.50	Kaposi sarcoma of unspecified lung
C46.51	Kaposi sarcoma of right lung
C46.52	Kaposi sarcoma of left lung
C46.7	Kaposi sarcoma of other sites
C46.9	Kaposi sarcoma, unspecified
C47	Malignant neoplasm of peripheral nerves and autonomic nervous system
C47.0	Malignant neoplasm of peripheral nerves of head, face and neck
C47.1	Malignant neoplasm of peripheral nerves of upper limb, including shoulder
C47.10	Malignant neoplasm of peripheral nerves of unspecified upper limb, including shoulder
C47.11	Malignant neoplasm of peripheral nerves of right upper limb, including shoulder
C47.12	Malignant neoplasm of peripheral nerves of left upper limb, including shoulder
C47.2	Malignant neoplasm of peripheral nerves of lower limb, including hip
C47.20	Malignant neoplasm of peripheral nerves of unspecified lower limb, including hip
C47.21	Malignant neoplasm of peripheral nerves of right lower limb, including hip
C47.22	Malignant neoplasm of peripheral nerves of left lower limb, including hip
C47.3	Malignant neoplasm of peripheral nerves of thorax
C47.4	Malignant neoplasm of peripheral nerves of abdomen
C47.5	Malignant neoplasm of peripheral nerves of pelvis
C47.6	Malignant neoplasm of peripheral nerves of trunk, unspecified
C47.8	Malignant neoplasm of overlapping sites of peripheral nerves and autonomic nervous system
C47.9	Malignant neoplasm of peripheral nerves and autonomic nervous system, unspecified
C48	Malignant neoplasm of retroperitoneum and peritoneum
C48.0	Malignant neoplasm of retroperitoneum
C48.1	Malignant neoplasm of specified parts of peritoneum
C48.2	Malignant neoplasm of peritoneum, unspecified
C48.8	Malignant neoplasm of overlapping sites of retroperitoneum and peritoneum
C49	Malignant neoplasm of other connective and soft tissue
C49.0	Malignant neoplasm of connective and soft tissue of head, face and neck
C49.1	Malignant neoplasm of connective and soft tissue of upper limb, including shoulder
C49.10	Malignant neoplasm of connective and soft tissue of unspecified upper limb, including shoulder
C49.11	Malignant neoplasm of connective and soft tissue of right upper limb, including shoulder
C49.12	Malignant neoplasm of connective and soft tissue of left upper limb, including shoulder

ICD-10-CM	Code Description
C49.2	Malignant neoplasm of connective and soft tissue of lower limb, including hip
C49.20	Malignant neoplasm of connective and soft tissue of unspecified lower limb, including hip
C49.21	Malignant neoplasm of connective and soft tissue of right lower limb, including hip
C49.22	Malignant neoplasm of connective and soft tissue of left lower limb, including hip
C49.3	Malignant neoplasm of connective and soft tissue of thorax
C49.4	Malignant neoplasm of connective and soft tissue of abdomen
C49.5	Malignant neoplasm of connective and soft tissue of pelvis
C49.6	Malignant neoplasm of connective and soft tissue of trunk, unspecified
C49.8	Malignant neoplasm of overlapping sites of connective and soft tissue
C49.9	Malignant neoplasm of connective and soft tissue, unspecified
C4A	Merkel cell carcinoma
C4A.0	Merkel cell carcinoma of lip
C4A.1	Merkel cell carcinoma of eyelid, including canthus
C4A.10	Merkel cell carcinoma of unspecified eyelid, including canthus
C4A.11	Merkel cell carcinoma of right eyelid, including canthus
C4A.12	Merkel cell carcinoma of left eyelid, including canthus
C4A.2	Merkel cell carcinoma of ear and external auricular canal
C4A.20	Merkel cell carcinoma of unspecified ear and external auricular canal
C4A.21	Merkel cell carcinoma of right ear and external auricular canal
C4A.22	Merkel cell carcinoma of left ear and external auricular canal
C4A.3	Merkel cell carcinoma of other and unspecified parts of face
C4A.30	Merkel cell carcinoma of unspecified part of face
C4A.31	Merkel cell carcinoma of nose
C4A.39	Merkel cell carcinoma of other parts of face
C4A.4	Merkel cell carcinoma of scalp and neck
C4A.5	Merkel cell carcinoma of trunk
C4A.51	Merkel cell carcinoma of anal skin
C4A.52	Merkel cell carcinoma of skin of breast
C4A.59	Merkel cell carcinoma of other part of trunk
C4A.6	Merkel cell carcinoma of upper limb, including shoulder
C4A.60	Merkel cell carcinoma of unspecified upper limb, including shoulder
C4A.61	Merkel cell carcinoma of right upper limb, including shoulder
C4A.62	Merkel cell carcinoma of left upper limb, including shoulder
C4A.7	Merkel cell carcinoma of lower limb, including hip
C4A.70	Merkel cell carcinoma of unspecified lower limb, including hip
C4A.71	Merkel cell carcinoma of right lower limb, including hip
C4A.72	Merkel cell carcinoma of left lower limb, including hip
C4A.8	Merkel cell carcinoma of overlapping sites
C4A.9	Merkel cell carcinoma, unspecified
C50	Malignant neoplasm of breast
C50.0	Malignant neoplasm of nipple and areola
C50.01	Malignant neoplasm of nipple and areola, female
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.012	Malignant neoplasm of nipple and areola, left female breast

ICD-10-CM	Code Description
C50.019	Malignant neoplasm of nipple and areola, unspecified female breast
C50.02	Malignant neoplasm of nipple and areola, male
C50.021	Malignant neoplasm of nipple and areola, right male breast
C50.022	Malignant neoplasm of nipple and areola, left male breast
C50.029	Malignant neoplasm of nipple and areola, unspecified male breast
C50.1	Malignant neoplasm of central portion of breast
C50.11	Malignant neoplasm of central portion of breast, female
C50.111	Malignant neoplasm of central portion of right female breast
C50.112	Malignant neoplasm of central portion of left female breast
C50.119	Malignant neoplasm of central portion of unspecified female breast
C50.12	Malignant neoplasm of central portion of breast, male
C50.121	Malignant neoplasm of central portion of right male breast
C50.122	Malignant neoplasm of central portion of left male breast
C50.129	Malignant neoplasm of central portion of unspecified male breast
C50.2	Malignant neoplasm of upper-inner quadrant of breast
C50.21	Malignant neoplasm of upper-inner quadrant of breast, female
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
C50.219	Malignant neoplasm of upper-inner quadrant of unspecified female breast
C50.22	Malignant neoplasm of upper-inner quadrant of breast, male
C50.221	Malignant neoplasm of upper-inner quadrant of right male breast
C50.222	Malignant neoplasm of upper-inner quadrant of left male breast
C50.229	Malignant neoplasm of upper-inner quadrant of unspecified male breast
C50.3	Malignant neoplasm of lower-inner quadrant of breast
C50.31	Malignant neoplasm of lower-inner quadrant of breast, female
C50.311	Malignant neoplasm of lower-inner quadrant of right female breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
C50.319	Malignant neoplasm of lower-inner quadrant of unspecified female breast
C50.32	Malignant neoplasm of lower-inner quadrant of breast, male
C50.321	Malignant neoplasm of lower-inner quadrant of right male breast
C50.322	Malignant neoplasm of lower-inner quadrant of left male breast
C50.329	Malignant neoplasm of lower-inner quadrant of unspecified male breast
C50.4	Malignant neoplasm of upper-outer quadrant of breast
C50.41	Malignant neoplasm of upper-outer quadrant of breast, female
C50.411	Malignant neoplasm of upper-outer quadrant of right female breast
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
C50.419	Malignant neoplasm of upper-outer quadrant of unspecified female breast
C50.42	Malignant neoplasm of upper-outer quadrant of breast, male
C50.421	Malignant neoplasm of upper-outer quadrant of right male breast
C50.422	Malignant neoplasm of upper-outer quadrant of left male breast
C50.429	Malignant neoplasm of upper-outer quadrant of unspecified male breast
C50.5	Malignant neoplasm of lower-outer quadrant of breast
C50.51	Malignant neoplasm of lower-outer quadrant of breast, female
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast

ICD-10-CM	Code Description
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
C50.519	Malignant neoplasm of lower-outer quadrant of unspecified female breast
C50.52	Malignant neoplasm of lower-outer quadrant of breast, male
C50.521	Malignant neoplasm of lower-outer quadrant of right male breast
C50.522	Malignant neoplasm of lower-outer quadrant of left male breast
C50.529	Malignant neoplasm of lower-outer quadrant of unspecified male breast
C50.6	Malignant neoplasm of axillary tail of breast
C50.61	Malignant neoplasm of axillary tail of breast, female
C50.611	Malignant neoplasm of axillary tail of right female breast
C50.612	Malignant neoplasm of axillary tail of left female breast
C50.619	Malignant neoplasm of axillary tail of unspecified female breast
C50.62	Malignant neoplasm of axillary tail of breast, male
C50.621	Malignant neoplasm of axillary tail of right male breast
C50.622	Malignant neoplasm of axillary tail of left male breast
C50.629	Malignant neoplasm of axillary tail of unspecified male breast
C50.8	Malignant neoplasm of overlapping sites of breast
C50.81	Malignant neoplasm of overlapping sites of breast, female
C50.811	Malignant neoplasm of overlapping sites of right female breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
C50.819	Malignant neoplasm of overlapping sites of unspecified female breast
C50.82	Malignant neoplasm of overlapping sites of breast, male
C50.821	Malignant neoplasm of overlapping sites of right male breast
C50.822	Malignant neoplasm of overlapping sites of left male breast
C50.829	Malignant neoplasm of overlapping sites of unspecified male breast
C50.9	Malignant neoplasm of breast of unspecified site
C50.91	Malignant neoplasm of breast of unspecified site, female
C50.911	Malignant neoplasm of unspecified site of right female breast
C50.912	Malignant neoplasm of unspecified site of left female breast
C50.919	Malignant neoplasm of unspecified site of unspecified female breast
C50.92	Malignant neoplasm of breast of unspecified site, male
C50.921	Malignant neoplasm of unspecified site of right male breast
C50.922	Malignant neoplasm of unspecified site of left male breast
C50.929	Malignant neoplasm of unspecified site of unspecified male breast
C51	Malignant neoplasm of vulva
C51.0	Malignant neoplasm of labium majus
C51.1	Malignant neoplasm of labium minus
C51.2	Malignant neoplasm of clitoris
C51.8	Malignant neoplasm of overlapping sites of vulva
C51.9	Malignant neoplasm of vulva, unspecified
C52	Malignant neoplasm of vagina
C53	Malignant neoplasm of cervix uteri
C53.0	Malignant neoplasm of endocervix
C53.1	Malignant neoplasm of exocervix
C53.8	Malignant neoplasm of overlapping sites of cervix uteri

ICD-10-CM	Code Description
C53.9	Malignant neoplasm of cervix uteri, unspecified
C54	Malignant neoplasm of corpus uteri
C54.0	Malignant neoplasm of isthmus uteri
C54.1	Malignant neoplasm of endometrium
C54.2	Malignant neoplasm of myometrium
C54.3	Malignant neoplasm of fundus uteri
C54.8	Malignant neoplasm of overlapping sites of corpus uteri
C54.9	Malignant neoplasm of corpus uteri, unspecified
C55	Malignant neoplasm of uterus, part unspecified
C56	Malignant neoplasm of ovary
C56.1	Malignant neoplasm of right ovary
C56.2	Malignant neoplasm of left ovary
C56.9	Malignant neoplasm of unspecified ovary
C57	Malignant neoplasm of other and unspecified female genital organs
C57.0	Malignant neoplasm of fallopian tube
C57.00	Malignant neoplasm of unspecified fallopian tube
C57.01	Malignant neoplasm of right fallopian tube
C57.02	Malignant neoplasm of left fallopian tube
C57.1	Malignant neoplasm of broad ligament
C57.10	Malignant neoplasm of unspecified broad ligament
C57.11	Malignant neoplasm of right broad ligament
C57.12	Malignant neoplasm of left broad ligament
C57.2	Malignant neoplasm of round ligament
C57.20	Malignant neoplasm of unspecified round ligament
C57.21	Malignant neoplasm of right round ligament
C57.22	Malignant neoplasm of left round ligament
C57.3	Malignant neoplasm of parametrium
C57.4	Malignant neoplasm of uterine adnexa, unspecified
C57.7	Malignant neoplasm of other specified female genital organs
C57.8	Malignant neoplasm of overlapping sites of female genital organs
C57.9	Malignant neoplasm of female genital organ, unspecified
C58	Malignant neoplasm of placenta
C60	Malignant neoplasm of penis
C60.0	Malignant neoplasm of prepuce
C60.1	Malignant neoplasm of glans penis
C60.2	Malignant neoplasm of body of penis
C60.8	Malignant neoplasm of overlapping sites of penis
C60.9	Malignant neoplasm of penis, unspecified
C61	Malignant neoplasm of prostate
C62	Malignant neoplasm of testis
C62.0	Malignant neoplasm of undescended testis
C62.00	Malignant neoplasm of unspecified undescended testis
C62.01	Malignant neoplasm of undescended right testis
C62.02	Malignant neoplasm of undescended left testis

ICD-10-CM	Code Description
C62.1	Malignant neoplasm of descended testis
C62.10	Malignant neoplasm of unspecified descended testis
C62.11	Malignant neoplasm of descended right testis
C62.12	Malignant neoplasm of descended left testis
C62.9	Malignant neoplasm of testis, unspecified whether descended or undescended
C62.90	Malignant neoplasm of unspecified testis, unspecified whether descended or undescended
C62.91	Malignant neoplasm of right testis, unspecified whether descended or undescended
C62.92	Malignant neoplasm of left testis, unspecified whether descended or undescended
C63	Malignant neoplasm of other and unspecified male genital organs
C63.0	Malignant neoplasm of epididymis
C63.00	Malignant neoplasm of unspecified epididymis
C63.01	Malignant neoplasm of right epididymis
C63.02	Malignant neoplasm of left epididymis
C63.1	Malignant neoplasm of spermatic cord
C63.10	Malignant neoplasm of unspecified spermatic cord
C63.11	Malignant neoplasm of right spermatic cord
C63.12	Malignant neoplasm of left spermatic cord
C63.2	Malignant neoplasm of scrotum
C63.7	Malignant neoplasm of other specified male genital organs
C63.8	Malignant neoplasm of overlapping sites of male genital organs
C63.9	Malignant neoplasm of male genital organ, unspecified
C64	Malignant neoplasm of kidney, except renal pelvis
C64.1	Malignant neoplasm of right kidney, except renal pelvis
C64.2	Malignant neoplasm of left kidney, except renal pelvis
C64.9	Malignant neoplasm of unspecified kidney, except renal pelvis
C65	Malignant neoplasm of renal pelvis
C65.1	Malignant neoplasm of right renal pelvis
C65.2	Malignant neoplasm of left renal pelvis
C65.9	Malignant neoplasm of unspecified renal pelvis
C66	Malignant neoplasm of ureter
C66.1	Malignant neoplasm of right ureter
C66.2	Malignant neoplasm of left ureter
C66.9	Malignant neoplasm of unspecified ureter
C67	Malignant neoplasm of bladder
C67.0	Malignant neoplasm of trigone of bladder
C67.1	Malignant neoplasm of dome of bladder
C67.2	Malignant neoplasm of lateral wall of bladder
C67.3	Malignant neoplasm of anterior wall of bladder
C67.4	Malignant neoplasm of posterior wall of bladder
C67.5	Malignant neoplasm of bladder neck
C67.6	Malignant neoplasm of ureteric orifice
C67.7	Malignant neoplasm of urachus
C67.8	Malignant neoplasm of overlapping sites of bladder
C67.9	Malignant neoplasm of bladder, unspecified

ICD-10-CM	Code Description
C68	Malignant neoplasm of other and unspecified urinary organs
C68.0	Malignant neoplasm of urethra
C68.1	Malignant neoplasm of paraurethral glands
C68.8	Malignant neoplasm of overlapping sites of urinary organs
C68.9	Malignant neoplasm of urinary organ, unspecified
C69	Malignant neoplasm of eye and adnexa
C69.0	Malignant neoplasm of conjunctiva
C69.00	Malignant neoplasm of unspecified conjunctiva
C69.01	Malignant neoplasm of right conjunctiva
C69.02	Malignant neoplasm of left conjunctiva
C69.1	Malignant neoplasm of cornea
C69.10	Malignant neoplasm of unspecified cornea
C69.11	Malignant neoplasm of right cornea
C69.12	Malignant neoplasm of left cornea
C69.2	Malignant neoplasm of retina
C69.20	Malignant neoplasm of unspecified retina
C69.21	Malignant neoplasm of right retina
C69.22	Malignant neoplasm of left retina
C69.3	Malignant neoplasm of choroid
C69.30	Malignant neoplasm of unspecified choroid
C69.31	Malignant neoplasm of right choroid
C69.32	Malignant neoplasm of left choroid
C69.4	Malignant neoplasm of ciliary body
C69.40	Malignant neoplasm of unspecified ciliary body
C69.41	Malignant neoplasm of right ciliary body
C69.42	Malignant neoplasm of left ciliary body
C69.5	Malignant neoplasm of lacrimal gland and duct
C69.50	Malignant neoplasm of unspecified lacrimal gland and duct
C69.51	Malignant neoplasm of right lacrimal gland and duct
C69.52	Malignant neoplasm of left lacrimal gland and duct
C69.6	Malignant neoplasm of orbit
C69.60	Malignant neoplasm of unspecified orbit
C69.61	Malignant neoplasm of right orbit
C69.62	Malignant neoplasm of left orbit
C69.8	Malignant neoplasm of overlapping sites of eye and adnexa
C69.80	Malignant neoplasm of overlapping sites of unspecified eye and adnexa
C69.81	Malignant neoplasm of overlapping sites of right eye and adnexa
C69.82	Malignant neoplasm of overlapping sites of left eye and adnexa
C69.9	Malignant neoplasm of unspecified site of eye
C69.90	Malignant neoplasm of unspecified site of unspecified eye
C69.91	Malignant neoplasm of unspecified site of right eye
C69.92	Malignant neoplasm of unspecified site of left eye
C70	Malignant neoplasm of meninges
C70.0	Malignant neoplasm of cerebral meninges

ICD-10-CM	Code Description
C70.1	Malignant neoplasm of spinal meninges
C70.9	Malignant neoplasm of meninges, unspecified
C71	Malignant neoplasm of brain
C71.0	Malignant neoplasm of cerebrum, except lobes and ventricles
C71.1	Malignant neoplasm of frontal lobe
C71.2	Malignant neoplasm of temporal lobe
C71.3	Malignant neoplasm of parietal lobe
C71.4	Malignant neoplasm of occipital lobe
C71.5	Malignant neoplasm of cerebral ventricle
C71.6	Malignant neoplasm of cerebellum
C71.7	Malignant neoplasm of brain stem
C71.8	Malignant neoplasm of overlapping sites of brain
C71.9	Malignant neoplasm of brain, unspecified
C72	Malignant neoplasm of spinal cord, cranial nerves and other parts of central nervous system
C72.0	Malignant neoplasm of spinal cord
C72.1	Malignant neoplasm of cauda equina
C72.2	Malignant neoplasm of olfactory nerve
C72.20	Malignant neoplasm of unspecified olfactory nerve
C72.21	Malignant neoplasm of right olfactory nerve
C72.22	Malignant neoplasm of left olfactory nerve
C72.3	Malignant neoplasm of optic nerve
C72.30	Malignant neoplasm of unspecified optic nerve
C72.31	Malignant neoplasm of right optic nerve
C72.32	Malignant neoplasm of left optic nerve
C72.4	Malignant neoplasm of acoustic nerve
C72.40	Malignant neoplasm of unspecified acoustic nerve
C72.41	Malignant neoplasm of right acoustic nerve
C72.42	Malignant neoplasm of left acoustic nerve
C72.5	Malignant neoplasm of other and unspecified cranial nerves
C72.50	Malignant neoplasm of unspecified cranial nerve
C72.59	Malignant neoplasm of other cranial nerves
C72.9	Malignant neoplasm of central nervous system, unspecified
C73	Malignant neoplasm of thyroid gland
C74	Malignant neoplasm of adrenal gland
C74.0	Malignant neoplasm of cortex of adrenal gland
C74.00	Malignant neoplasm of cortex of unspecified adrenal gland
C74.01	Malignant neoplasm of cortex of right adrenal gland
C74.02	Malignant neoplasm of cortex of left adrenal gland
C74.1	Malignant neoplasm of medulla of adrenal gland
C74.10	Malignant neoplasm of medulla of unspecified adrenal gland
C74.11	Malignant neoplasm of medulla of right adrenal gland
C74.12	Malignant neoplasm of medulla of left adrenal gland
C74.9	Malignant neoplasm of unspecified part of adrenal gland
C74.90	Malignant neoplasm of unspecified part of unspecified adrenal gland

ICD-10-CM	Code Description
C74.91	Malignant neoplasm of unspecified part of right adrenal gland
C74.92	Malignant neoplasm of unspecified part of left adrenal gland
C75	Malignant neoplasm of other endocrine glands and related structures
C75.0	Malignant neoplasm of parathyroid gland
C75.1	Malignant neoplasm of pituitary gland
C75.2	Malignant neoplasm of craniopharyngeal duct
C75.3	Malignant neoplasm of pineal gland
C75.4	Malignant neoplasm of carotid body
C75.5	Malignant neoplasm of aortic body and other paraganglia
C75.8	Malignant neoplasm with pluriglandular involvement, unspecified
C75.9	Malignant neoplasm of endocrine gland, unspecified
C76	Malignant neoplasm of other and ill-defined sites
C76.0	Malignant neoplasm of head, face and neck
C76.1	Malignant neoplasm of thorax
C76.2	Malignant neoplasm of abdomen
C76.3	Malignant neoplasm of pelvis
C76.4	Malignant neoplasm of upper limb
C76.40	Malignant neoplasm of unspecified upper limb
C76.41	Malignant neoplasm of right upper limb
C76.42	Malignant neoplasm of left upper limb
C76.5	Malignant neoplasm of lower limb
C76.50	Malignant neoplasm of unspecified lower limb
C76.51	Malignant neoplasm of right lower limb
C76.52	Malignant neoplasm of left lower limb
C76.8	Malignant neoplasm of other specified ill-defined sites
C77	SECONDARY AND UNSPECIFIED MALIGNANT NEOPLASM OF LYMPH NODES
C77.0	Secondary and unspecified malignant neoplasm of lymph nodes of head, face and neck
C77.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
C77.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
C77.3	Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes
C77.4	Secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes
C77.5	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
C77.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple regions
C77.9	Secondary and unspecified malignant neoplasm of lymph node, unspecified
C78	SECONDARY MALIGNANT NEOPLASM OF RESPIRATORY AND DIGESTIVE ORGANS
C78.0	Secondary malignant neoplasm of lung
C78.00	Secondary malignant neoplasm of unspecified lung
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left lung
C78.1	Secondary malignant neoplasm of mediastinum
C78.2	Secondary malignant neoplasm of pleura
C78.3	Secondary malignant neoplasm of other and unspecified respiratory organs
C78.30	Secondary malignant neoplasm of unspecified respiratory organ
C78.39	Secondary malignant neoplasm of other respiratory organs

ICD-10-CM	Code Description
C78.4	Secondary malignant neoplasm of small intestine
C78.5	Secondary malignant neoplasm of large intestine and rectum
C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C78.8	Secondary malignant neoplasm of other and unspecified digestive organs
C78.80	Secondary malignant neoplasm of unspecified digestive organ
C78.89	Secondary malignant neoplasm of other digestive organs
C79	SECONDARY MALIGNANT NEOPLASM OF OTHER AND UNSPECIFIED SITES
C79.0	Secondary malignant neoplasm of kidney and renal pelvis
C79.00	Secondary malignant neoplasm of unspecified kidney and renal pelvis
C79.01	Secondary malignant neoplasm of right kidney and renal pelvis
C79.02	Secondary malignant neoplasm of left kidney and renal pelvis
C79.1	Secondary malignant neoplasm of bladder and other urinary organs
C79.10	Secondary malignant neoplasm of unspecified urinary organs
C79.11	Secondary malignant neoplasm of bladder
C79.19	Secondary malignant neoplasm of other urinary organs
C79.2	Secondary malignant neoplasm of skin
C79.3	Secondary malignant neoplasm of brain cerebral meninges
C79.31	Secondary malignant neoplasm of brain
C79.32	Secondary malignant neoplasm of cerebral meninges
C79.4	Secondary malignant neoplasm of other and unspecified digestive organs
C79.40	Secondary malignant neoplasm of unspecified part of nervous system
C79.49	Secondary malignant neoplasm of other parts of nervous system
C79.5	Secondary malignant neoplasm of bone and bone marrow
C79.51	Secondary malignant neoplasm of bone
C79.52	Secondary malignant neoplasm of bone marrow
C79.6	Secondary malignant neoplasm of ovary
C79.60	Secondary malignant neoplasm of unspecified ovary
C79.61	Secondary malignant neoplasm of right ovary
C79.62	Secondary malignant neoplasm of left ovary
C79.7	Secondary malignant neoplasm of adrenal gland
C79.70	Secondary malignant neoplasm of unspecified adrenal gland
C79.71	Secondary malignant neoplasm of right adrenal gland
C79.72	Secondary malignant neoplasm of left adrenal gland
C79.8	Secondary malignant neoplasm of other specified sites
C79.81	Secondary malignant neoplasm of breast
C79.82	Secondary malignant neoplasm of genital organs
C79.89	Secondary malignant neoplasm of other specified sites
C79.9	Secondary malignant neoplasm of unspecified site
C7A	Malignant neuroendocrine tumors
C7A.0	Malignant carcinoid tumors
C7A.00	Malignant carcinoid tumor of unspecified site
C7A.01	Malignant carcinoid tumors of the small intestine
C7A.010	Malignant carcinoid tumor of the duodenum

ICD-10-CM	Code Description
C7A.011	Malignant carcinoid tumor of the jejunum
C7A.012	Malignant carcinoid tumor of the ileum
C7A.019	Malignant carcinoid tumor of the small intestine, unspecified portion
C7A.02	Malignant carcinoid tumors of the appendix, large intestine, and rectum
C7A.020	Malignant carcinoid tumor of the appendix
C7A.021	Malignant carcinoid tumor of the cecum
C7A.022	Malignant carcinoid tumor of the ascending colon
C7A.023	Malignant carcinoid tumor of the transverse colon
C7A.024	Malignant carcinoid tumor of the descending colon
C7A.025	Malignant carcinoid tumor of the sigmoid colon
C7A.026	Malignant carcinoid tumor of the rectum
C7A.029	Malignant carcinoid tumor of the large intestine, unspecified portion
C7A.09	Malignant carcinoid tumors of other sites
C7A.090	Malignant carcinoid tumor of the bronchus and lung
C7A.091	Malignant carcinoid tumor of the thymus
C7A.092	Malignant carcinoid tumor of the stomach
C7A.093	Malignant carcinoid tumor of the kidney
C7A.094	Malignant carcinoid tumor of the foregut NOS
C7A.095	Malignant carcinoid tumor of the midgut NOS
C7A.096	Malignant carcinoid tumor of the hindgut NOS
C7A.098	Malignant carcinoid tumors of other sites
C7A.1	Malignant poorly differentiated neuroendocrine tumors
C7A.8	Other malignant neuroendocrine tumors
C7B	SECONDARY NEUROENDOCRINE TUMORS
C7B.0	Secondary carcinoid tumors
C7B.00	Secondary carcinoid tumors, unspecified site
C7B.01	Secondary carcinoid tumors of distant lymph nodes
C7B.02	Secondary carcinoid tumors of liver
C7B.03	Secondary carcinoid tumors of bone
C7B.04	Secondary carcinoid tumors of peritoneum
C7B.09	Secondary carcinoid tumors of other sites
C7B.1	Secondary merkel cell carcinoma
C7B.8	Other secondary neuroendocrine tumors
C80	Malignant neoplasm without specification of site
C80.0	Disseminated malignant neoplasm, unspecified
C80.1	Malignant (primary) neoplasm, unspecified
C80.2	Malignant neoplasm associated with transplanted organ
C81	Hodgkin lymphoma
C81.0	Nodular lymphocyte predominant Hodgkin lymphoma
C81.00	Nodular lymphocyte predominant Hodgkin lymphoma, unspecified site
C81.01	Nodular lymphocyte predominant Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.02	Nodular lymphocyte predominant Hodgkin lymphoma, intrathoracic lymph nodes
C81.03	Nodular lymphocyte predominant Hodgkin lymphoma, intra-abdominal lymph nodes
C81.04	Nodular lymphocyte predominant Hodgkin lymphoma, lymph nodes of axilla and upper limb

ICD-10-CM	Code Description
C81.05	Nodular lymphocyte predominant Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.06	Nodular lymphocyte predominant Hodgkin lymphoma, intrapelvic lymph nodes
C81.07	Nodular lymphocyte predominant Hodgkin lymphoma, spleen
C81.08	Nodular lymphocyte predominant Hodgkin lymphoma, lymph nodes of multiple sites
C81.09	Nodular lymphocyte predominant Hodgkin lymphoma, extranodal and solid organ sites
C81.1	Nodular sclerosis classical Hodgkin lymphoma
C81.10	Nodular sclerosis classical Hodgkin lymphoma, unspecified site
C81.11	Nodular sclerosis classical Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.12	Nodular sclerosis classical Hodgkin lymphoma, intrathoracic lymph nodes
C81.13	Nodular sclerosis classical Hodgkin lymphoma, intra-abdominal lymph nodes
C81.14	Nodular sclerosis classical Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.15	Nodular sclerosis classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.16	Nodular sclerosis classical Hodgkin lymphoma, intrapelvic lymph nodes
C81.17	Nodular sclerosis classical Hodgkin lymphoma, spleen
C81.18	Nodular sclerosis classical Hodgkin lymphoma, lymph nodes of multiple sites
C81.19	Nodular sclerosis classical Hodgkin lymphoma, extranodal and solid organ sites
C81.2	Mixed cellularity classical Hodgkin lymphoma
C81.20	Mixed cellularity classical Hodgkin lymphoma, unspecified site
C81.21	Mixed cellularity classical Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.22	Mixed cellularity classical Hodgkin lymphoma, intrathoracic lymph nodes
C81.23	Mixed cellularity classical Hodgkin lymphoma, intra-abdominal lymph nodes
C81.24	Mixed cellularity classical Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.25	Mixed cellularity classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.26	Mixed cellularity classical Hodgkin lymphoma, intrapelvic lymph nodes
C81.27	Mixed cellularity classical Hodgkin lymphoma, spleen
C81.28	Mixed cellularity classical Hodgkin lymphoma, lymph nodes of multiple sites
C81.29	Mixed cellularity classical Hodgkin lymphoma, extranodal and solid organ sites
C81.3	Lymphocyte depleted classical Hodgkin lymphoma
C81.30	Lymphocyte depleted classical Hodgkin lymphoma, unspecified site
C81.31	Lymphocyte depleted classical Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.32	Lymphocyte depleted classical Hodgkin lymphoma, intrathoracic lymph nodes
C81.33	Lymphocyte depleted classical Hodgkin lymphoma, intra-abdominal lymph nodes
C81.34	Lymphocyte depleted classical Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.35	Lymphocyte depleted classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.36	Lymphocyte depleted classical Hodgkin lymphoma, intrapelvic lymph nodes
C81.37	Lymphocyte depleted classical Hodgkin lymphoma, spleen
C81.38	Lymphocyte depleted classical Hodgkin lymphoma, lymph nodes of multiple sites
C81.39	Lymphocyte depleted classical Hodgkin lymphoma, extranodal and solid organ sites
C81.4	Lymphocyte-rich classical Hodgkin lymphoma
C81.40	Lymphocyte-rich classical Hodgkin lymphoma, unspecified site
C81.41	Lymphocyte-rich classical Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.42	Lymphocyte-rich classical Hodgkin lymphoma, intrathoracic lymph nodes
C81.43	Lymphocyte-rich classical Hodgkin lymphoma, intra-abdominal lymph nodes
C81.44	Lymphocyte-rich classical Hodgkin lymphoma, lymph nodes of axilla and upper limb

ICD-10-CM	Code Description
C81.45	Lymphocyte-rich classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.46	Lymphocyte-rich classical Hodgkin lymphoma, intrapelvic lymph nodes
C81.47	Lymphocyte-rich classical Hodgkin lymphoma, spleen
C81.48	Lymphocyte-rich classical Hodgkin lymphoma, lymph nodes of multiple sites
C81.49	Lymphocyte-rich classical Hodgkin lymphoma, extranodal and solid organ sites
C81.7	Other classical Hodgkin lymphoma
C81.70	Other classical Hodgkin lymphoma, unspecified site
C81.71	Other classical Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.72	Other classical Hodgkin lymphoma, intrathoracic lymph nodes
C81.73	Other classical Hodgkin lymphoma, intra-abdominal lymph nodes
C81.74	Other classical Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.75	Other classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.76	Other classical Hodgkin lymphoma, intrapelvic lymph nodes
C81.77	Other classical Hodgkin lymphoma, spleen
C81.78	Other classical Hodgkin lymphoma, lymph nodes of multiple sites
C81.79	Other classical Hodgkin lymphoma, extranodal and solid organ sites
C81.9	Hodgkin lymphoma, unspecified
C81.90	Hodgkin lymphoma, unspecified, unspecified site
C81.91	Hodgkin lymphoma, unspecified, lymph nodes of head, face, and neck
C81.92	Hodgkin lymphoma, unspecified, intrathoracic lymph nodes
C81.93	Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes
C81.94	Hodgkin lymphoma, unspecified, lymph nodes of axilla and upper limb
C81.95	Hodgkin lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C81.96	Hodgkin lymphoma, unspecified, intrapelvic lymph nodes
C81.97	Hodgkin lymphoma, unspecified, spleen
C81.98	Hodgkin lymphoma, unspecified, lymph nodes of multiple sites
C81.99	Hodgkin lymphoma, unspecified, extranodal and solid organ sites
C82	Follicular lymphoma
C82.0	Follicular lymphoma grade I
C82.00	Follicular lymphoma grade I, unspecified site
C82.01	Follicular lymphoma grade I, lymph nodes of head, face, and neck
C82.02	Follicular lymphoma grade I, intrathoracic lymph nodes
C82.03	Follicular lymphoma grade I, intra-abdominal lymph nodes
C82.04	Follicular lymphoma grade I, lymph nodes of axilla and upper limb
C82.05	Follicular lymphoma grade I, lymph nodes of inguinal region and lower limb
C82.06	Follicular lymphoma grade I, intrapelvic lymph nodes
C82.07	Follicular lymphoma grade I, spleen
C82.08	Follicular lymphoma grade I, lymph nodes of multiple sites
C82.09	Follicular lymphoma grade I, extranodal and solid organ sites
C82.1	Follicular lymphoma grade II
C82.10	Follicular lymphoma grade II, unspecified site
C82.11	Follicular lymphoma grade II, lymph nodes of head, face, and neck
C82.12	Follicular lymphoma grade II, intrathoracic lymph nodes
C82.13	Follicular lymphoma grade II, intra-abdominal lymph nodes

ICD-10-CM	Code Description
C82.14	Follicular lymphoma grade II, lymph nodes of axilla and upper limb
C82.15	Follicular lymphoma grade II, lymph nodes of inguinal region and lower limb
C82.16	Follicular lymphoma grade II, intrapelvic lymph nodes
C82.17	Follicular lymphoma grade II, spleen
C82.18	Follicular lymphoma grade II, lymph nodes of multiple sites
C82.19	Follicular lymphoma grade II, extranodal and solid organ sites
C82.2	Follicular lymphoma grade III, unspecified
C82.20	Follicular lymphoma grade III, unspecified, unspecified site
C82.21	Follicular lymphoma grade III, unspecified, lymph nodes of head, face, and neck
C82.22	Follicular lymphoma grade III, unspecified, intrathoracic lymph nodes
C82.23	Follicular lymphoma grade III, unspecified, intra-abdominal lymph nodes
C82.24	Follicular lymphoma grade III, unspecified, lymph nodes of axilla and upper limb
C82.25	Follicular lymphoma grade III, unspecified, lymph nodes of inguinal region and lower limb
C82.26	Follicular lymphoma grade III, unspecified, intrapelvic lymph nodes
C82.27	Follicular lymphoma grade III, unspecified, spleen
C82.28	Follicular lymphoma grade III, unspecified, lymph nodes of multiple sites
C82.29	Follicular lymphoma grade III, unspecified, extranodal and solid organ sites
C82.3	Follicular lymphoma grade IIIa
C82.30	Follicular lymphoma grade IIIa, unspecified site
C82.31	Follicular lymphoma grade IIIa, lymph nodes of head, face, and neck
C82.32	Follicular lymphoma grade IIIa, intrathoracic lymph nodes
C82.33	Follicular lymphoma grade IIIa, intra-abdominal lymph nodes
C82.34	Follicular lymphoma grade IIIa, lymph nodes of axilla and upper limb
C82.35	Follicular lymphoma grade IIIa, lymph nodes of inguinal region and lower limb
C82.36	Follicular lymphoma grade IIIa, intrapelvic lymph nodes
C82.37	Follicular lymphoma grade IIIa, spleen
C82.38	Follicular lymphoma grade IIIa, lymph nodes of multiple sites
C82.39	Follicular lymphoma grade IIIa, extranodal and solid organ sites
C82.4	Follicular lymphoma grade IIIb
C82.40	Follicular lymphoma grade IIIb, unspecified site
C82.41	Follicular lymphoma grade IIIb, lymph nodes of head, face, and neck
C82.42	Follicular lymphoma grade IIIb, intrathoracic lymph nodes
C82.43	Follicular lymphoma grade IIIb, intra-abdominal lymph nodes
C82.44	Follicular lymphoma grade IIIb, lymph nodes of axilla and upper limb
C82.45	Follicular lymphoma grade IIIb, lymph nodes of inguinal region and lower limb
C82.46	Follicular lymphoma grade IIIb, intrapelvic lymph nodes
C82.47	Follicular lymphoma grade IIIb, spleen
C82.48	Follicular lymphoma grade IIIb, lymph nodes of multiple sites
C82.49	Follicular lymphoma grade IIIb, extranodal and solid organ sites
C82.5	Diffuse follicle center lymphoma
C82.50	Diffuse follicle center lymphoma, unspecified site
C82.51	Diffuse follicle center lymphoma, lymph nodes of head, face, and neck
C82.52	Diffuse follicle center lymphoma, intrathoracic lymph nodes
C82.53	Diffuse follicle center lymphoma, intra-abdominal lymph nodes

ICD-10-CM	Code Description
C82.54	Diffuse follicle center lymphoma, lymph nodes of axilla and upper limb
C82.55	Diffuse follicle center lymphoma, lymph nodes of inguinal region and lower limb
C82.56	Diffuse follicle center lymphoma, intrapelvic lymph nodes
C82.57	Diffuse follicle center lymphoma, spleen
C82.58	Diffuse follicle center lymphoma, lymph nodes of multiple sites
C82.59	Diffuse follicle center lymphoma, extranodal and solid organ sites
C82.6	Cutaneous follicle center lymphoma
C82.60	Cutaneous follicle center lymphoma, unspecified site
C82.61	Cutaneous follicle center lymphoma, lymph nodes of head, face, and neck
C82.62	Cutaneous follicle center lymphoma, intrathoracic lymph nodes
C82.63	Cutaneous follicle center lymphoma, intra-abdominal lymph nodes
C82.64	Cutaneous follicle center lymphoma, lymph nodes of axilla and upper limb
C82.65	Cutaneous follicle center lymphoma, lymph nodes of inguinal region and lower limb
C82.66	Cutaneous follicle center lymphoma, intrapelvic lymph nodes
C82.67	Cutaneous follicle center lymphoma, spleen
C82.68	Cutaneous follicle center lymphoma, lymph nodes of multiple sites
C82.69	Cutaneous follicle center lymphoma, extranodal and solid organ sites
C82.8	Other types of follicular lymphoma
C82.80	Other types of follicular lymphoma, unspecified site
C82.81	Other types of follicular lymphoma, lymph nodes of head, face, and neck
C82.82	Other types of follicular lymphoma, intrathoracic lymph nodes
C82.83	Other types of follicular lymphoma, intra-abdominal lymph nodes
C82.84	Other types of follicular lymphoma, lymph nodes of axilla and upper limb
C82.85	Other types of follicular lymphoma, lymph nodes of inguinal region and lower limb
C82.86	Other types of follicular lymphoma, intrapelvic lymph nodes
C82.87	Other types of follicular lymphoma, spleen
C82.88	Other types of follicular lymphoma, lymph nodes of multiple sites
C82.89	Other types of follicular lymphoma, extranodal and solid organ sites
C82.9	Follicular lymphoma, unspecified
C82.90	Follicular lymphoma, unspecified, unspecified site
C82.91	Follicular lymphoma, unspecified, lymph nodes of head, face, and neck
C82.92	Follicular lymphoma, unspecified, intrathoracic lymph nodes
C82.93	Follicular lymphoma, unspecified, intra-abdominal lymph nodes
C82.94	Follicular lymphoma, unspecified, lymph nodes of axilla and upper limb
C82.95	Follicular lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C82.96	Follicular lymphoma, unspecified, intrapelvic lymph nodes
C82.97	Follicular lymphoma, unspecified, spleen
C82.98	Follicular lymphoma, unspecified, lymph nodes of multiple sites
C82.99	Follicular lymphoma, unspecified, extranodal and solid organ sites
C83	Non-follicular lymphoma
C83.0	Small cell B-cell lymphoma
C83.00	Small cell B-cell lymphoma, unspecified site
C83.01	Small cell B-cell lymphoma, lymph nodes of head, face, and neck
C83.02	Small cell B-cell lymphoma, intrathoracic lymph nodes

ICD-10-CM	Code Description
C83.03	Small cell B-cell lymphoma, intra-abdominal lymph nodes
C83.04	Small cell B-cell lymphoma, lymph nodes of axilla and upper limb
C83.05	Small cell B-cell lymphoma, lymph nodes of inguinal region and lower limb
C83.06	Small cell B-cell lymphoma, intrapelvic lymph nodes
C83.07	Small cell B-cell lymphoma, spleen
C83.08	Small cell B-cell lymphoma, lymph nodes of multiple sites
C83.09	Small cell B-cell lymphoma, extranodal and solid organ sites
C83.1	Mantle cell lymphoma
C83.10	Mantle cell lymphoma, unspecified site
C83.11	Mantle cell lymphoma, lymph nodes of head, face, and neck
C83.12	Mantle cell lymphoma, intrathoracic lymph nodes
C83.13	Mantle cell lymphoma, intra-abdominal lymph nodes
C83.14	Mantle cell lymphoma, lymph nodes of axilla and upper limb
C83.15	Mantle cell lymphoma, lymph nodes of inguinal region and lower limb
C83.16	Mantle cell lymphoma, intrapelvic lymph nodes
C83.17	Mantle cell lymphoma, spleen
C83.18	Mantle cell lymphoma, lymph nodes of multiple sites
C83.19	Mantle cell lymphoma, extranodal and solid organ sites
C83.3	Diffuse large B-cell lymphoma
C83.30	Diffuse large B-cell lymphoma, unspecified site
C83.31	Diffuse large B-cell lymphoma, lymph nodes of head, face, and neck
C83.32	Diffuse large B-cell lymphoma, intrathoracic lymph nodes
C83.33	Diffuse large B-cell lymphoma, intra-abdominal lymph nodes
C83.34	Diffuse large B-cell lymphoma, lymph nodes of axilla and upper limb
C83.35	Diffuse large B-cell lymphoma, lymph nodes of inguinal region and lower limb
C83.36	Diffuse large B-cell lymphoma, intrapelvic lymph nodes
C83.37	Diffuse large B-cell lymphoma, spleen
C83.38	Diffuse large B-cell lymphoma, lymph nodes of multiple sites
C83.39	Diffuse large B-cell lymphoma, extranodal and solid organ sites
C83.5	Lymphoblastic (diffuse) lymphoma
C83.50	Lymphoblastic (diffuse) lymphoma, unspecified site
C83.51	Lymphoblastic (diffuse) lymphoma, lymph nodes of head, face, and neck
C83.52	Lymphoblastic (diffuse) lymphoma, intrathoracic lymph nodes
C83.53	Lymphoblastic (diffuse) lymphoma, intra-abdominal lymph nodes
C83.54	Lymphoblastic (diffuse) lymphoma, lymph nodes of axilla and upper limb
C83.55	Lymphoblastic (diffuse) lymphoma, lymph nodes of inguinal region and lower limb
C83.56	Lymphoblastic (diffuse) lymphoma, intrapelvic lymph nodes
C83.57	Lymphoblastic (diffuse) lymphoma, spleen
C83.58	Lymphoblastic (diffuse) lymphoma, lymph nodes of multiple sites
C83.59	Lymphoblastic (diffuse) lymphoma, extranodal and solid organ sites
C83.7	Burkitt lymphoma
C83.70	Burkitt lymphoma, unspecified site
C83.71	Burkitt lymphoma, lymph nodes of head, face, and neck
C83.72	Burkitt lymphoma, intrathoracic lymph nodes

ICD-10-CM	Code Description
C83.73	Burkitt lymphoma, intra-abdominal lymph nodes
C83.74	Burkitt lymphoma, lymph nodes of axilla and upper limb
C83.75	Burkitt lymphoma, lymph nodes of inguinal region and lower limb
C83.76	Burkitt lymphoma, intrapelvic lymph nodes
C83.77	Burkitt lymphoma, spleen
C83.78	Burkitt lymphoma, lymph nodes of multiple sites
C83.79	Burkitt lymphoma, extranodal and solid organ sites
C83.8	Other non-follicular lymphoma
C83.80	Other non-follicular lymphoma, unspecified site
C83.81	Other non-follicular lymphoma, lymph nodes of head, face, and neck
C83.82	Other non-follicular lymphoma, intrathoracic lymph nodes
C83.83	Other non-follicular lymphoma, intra-abdominal lymph nodes
C83.84	Other non-follicular lymphoma, lymph nodes of axilla and upper limb
C83.85	Other non-follicular lymphoma, lymph nodes of inguinal region and lower limb
C83.86	Other non-follicular lymphoma, intrapelvic lymph nodes
C83.87	Other non-follicular lymphoma, spleen
C83.88	Other non-follicular lymphoma, lymph nodes of multiple sites
C83.89	Other non-follicular lymphoma, extranodal and solid organ sites
C83.9	Non-follicular (diffuse) lymphoma, unspecified
C83.90	Non-follicular (diffuse) lymphoma, unspecified, unspecified site
C83.91	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of head, face, and neck
C83.92	Non-follicular (diffuse) lymphoma, unspecified, intrathoracic lymph nodes
C83.93	Non-follicular (diffuse) lymphoma, unspecified, intra-abdominal lymph nodes
C83.94	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of axilla and upper limb
C83.95	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C83.96	Non-follicular (diffuse) lymphoma, unspecified, intrapelvic lymph nodes
C83.97	Non-follicular (diffuse) lymphoma, unspecified, spleen
C83.98	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of multiple sites
C83.99	Non-follicular (diffuse) lymphoma, unspecified, extranodal and solid organ sites
C84	Mature T/NK-cell lymphomas
C84.0	Mycosis fungoides
C84.00	Mycosis fungoides, unspecified site
C84.01	Mycosis fungoides, lymph nodes of head, face, and neck
C84.02	Mycosis fungoides, intrathoracic lymph nodes
C84.03	Mycosis fungoides, intra-abdominal lymph nodes
C84.04	Mycosis fungoides, lymph nodes of axilla and upper limb
C84.05	Mycosis fungoides, lymph nodes of inguinal region and lower limb
C84.06	Mycosis fungoides, intrapelvic lymph nodes
C84.07	Mycosis fungoides, spleen
C84.08	Mycosis fungoides, lymph nodes of multiple sites
C84.09	Mycosis fungoides, extranodal and solid organ sites
C84.1	Sezary disease
C84.10	Sezary disease, unspecified site
C84.11	Sezary disease, lymph nodes of head, face, and neck

ICD-10-CM	Code Description
C84.12	Sezary disease, intrathoracic lymph nodes
C84.13	Sezary disease, intra-abdominal lymph nodes
C84.14	Sezary disease, lymph nodes of axilla and upper limb
C84.15	Sezary disease, lymph nodes of inguinal region and lower limb
C84.16	Sezary disease, intrapelvic lymph nodes
C84.17	Sezary disease, spleen
C84.18	Sezary disease, lymph nodes of multiple sites
C84.19	Sezary disease, extranodal and solid organ sites
C84.4	Peripheral T-cell lymphoma, not classified
C84.40	Peripheral T-cell lymphoma, not classified, unspecified site
C84.41	Peripheral T-cell lymphoma, not classified, lymph nodes of head, face, and neck
C84.42	Peripheral T-cell lymphoma, not classified, intrathoracic lymph nodes
C84.43	Peripheral T-cell lymphoma, not classified, intra-abdominal lymph nodes
C84.44	Peripheral T-cell lymphoma, not classified, lymph nodes of axilla and upper limb
C84.45	Peripheral T-cell lymphoma, not classified, lymph nodes of inguinal region and lower limb
C84.46	Peripheral T-cell lymphoma, not classified, intrapelvic lymph nodes
C84.47	Peripheral T-cell lymphoma, not classified, spleen
C84.48	Peripheral T-cell lymphoma, not classified, lymph nodes of multiple sites
C84.49	Peripheral T-cell lymphoma, not classified, extranodal and solid organ sites
C84.6	Anaplastic large cell lymphoma, ALK-positive
C84.60	Anaplastic large cell lymphoma, ALK-positive, unspecified site
C84.61	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of head, face, and neck
C84.62	Anaplastic large cell lymphoma, ALK-positive, intrathoracic lymph nodes
C84.63	Anaplastic large cell lymphoma, ALK-positive, intra-abdominal lymph nodes
C84.64	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of axilla and upper limb
C84.65	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of inguinal region and lower limb
C84.66	Anaplastic large cell lymphoma, ALK-positive, intrapelvic lymph nodes
C84.67	Anaplastic large cell lymphoma, ALK-positive, spleen
C84.68	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of multiple sites
C84.69	Anaplastic large cell lymphoma, ALK-positive, extranodal and solid organ sites
C84.7	Anaplastic large cell lymphoma, ALK-negative
C84.70	Anaplastic large cell lymphoma, ALK-negative, unspecified site
C84.71	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of head, face, and neck
C84.72	Anaplastic large cell lymphoma, ALK-negative, intrathoracic lymph nodes
C84.73	Anaplastic large cell lymphoma, ALK-negative, intra-abdominal lymph nodes
C84.74	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of axilla and upper limb
C84.75	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of inguinal region and lower limb
C84.76	Anaplastic large cell lymphoma, ALK-negative, intrapelvic lymph nodes
C84.77	Anaplastic large cell lymphoma, ALK-negative, spleen
C84.78	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of multiple sites
C84.79	Anaplastic large cell lymphoma, ALK-negative, extranodal and solid organ sites
C84.9	Mature T/NK-cell lymphomas, unspecified
C84.90	Mature T/NK-cell lymphomas, unspecified, unspecified site
C84.91	Mature T/NK-cell lymphomas, unspecified, lymph nodes of head, face, and neck

ICD-10-CM	Code Description
C84.92	Mature T/NK-cell lymphomas, unspecified, intrathoracic lymph nodes
C84.93	Mature T/NK-cell lymphomas, unspecified, intra-abdominal lymph nodes
C84.94	Mature T/NK-cell lymphomas, unspecified, lymph nodes of axilla and upper limb
C84.95	Mature T/NK-cell lymphomas, unspecified, lymph nodes of inguinal region and lower limb
C84.96	Mature T/NK-cell lymphomas, unspecified, intrapelvic lymph nodes
C84.97	Mature T/NK-cell lymphomas, unspecified, spleen
C84.98	Mature T/NK-cell lymphomas, unspecified, lymph nodes of multiple sites
C84.99	Mature T/NK-cell lymphomas, unspecified, extranodal and solid organ sites
C84.A	Cutaneous T-cell lymphoma, unspecified
C84.A0	Cutaneous T-cell lymphoma, unspecified, unspecified site
C84.A1	Cutaneous T-cell lymphoma, unspecified lymph nodes of head, face, and neck
C84.A2	Cutaneous T-cell lymphoma, unspecified, intrathoracic lymph nodes
C84.A3	Cutaneous T-cell lymphoma, unspecified, intra-abdominal lymph nodes
C84.A4	Cutaneous T-cell lymphoma, unspecified, lymph nodes of axilla and upper limb
C84.A5	Cutaneous T-cell lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C84.A6	Cutaneous T-cell lymphoma, unspecified, intrapelvic lymph nodes
C84.A7	Cutaneous T-cell lymphoma, unspecified, spleen
C84.A8	Cutaneous T-cell lymphoma, unspecified, lymph nodes of multiple sites
C84.A9	Cutaneous T-cell lymphoma, unspecified, extranodal and solid organ sites
C84.Z	Other mature T/NK-cell lymphomas
C84.Z0	Other mature T/NK-cell lymphomas, unspecified site
C84.Z1	Other mature T/NK-cell lymphomas, lymph nodes of head, face, and neck
C84.Z2	Other mature T/NK-cell lymphomas, intrathoracic lymph nodes
C84.Z3	Other mature T/NK-cell lymphomas, intra-abdominal lymph nodes
C84.Z4	Other mature T/NK-cell lymphomas, lymph nodes of axilla and upper limb
C84.Z5	Other mature T/NK-cell lymphomas, lymph nodes of inguinal region and lower limb
C84.Z6	Other mature T/NK-cell lymphomas, intrapelvic lymph nodes
C84.Z7	Other mature T/NK-cell lymphomas, spleen
C84.Z8	Other mature T/NK-cell lymphomas, lymph nodes of multiple sites
C84.Z9	Other mature T/NK-cell lymphomas, extranodal and solid organ sites
C85	Other specified and unspecified types of non-Hodgkin lymphoma
C85.1	Unspecified B-cell lymphoma
C85.10	Unspecified B-cell lymphoma, unspecified site
C85.11	Unspecified B-cell lymphoma, lymph nodes of head, face, and neck
C85.12	Unspecified B-cell lymphoma, intrathoracic lymph nodes
C85.13	Unspecified B-cell lymphoma, intra-abdominal lymph nodes
C85.14	Unspecified B-cell lymphoma, lymph nodes of axilla and upper limb
C85.15	Unspecified B-cell lymphoma, lymph nodes of inguinal region and lower limb
C85.16	Unspecified B-cell lymphoma, intrapelvic lymph nodes
C85.17	Unspecified B-cell lymphoma, spleen
C85.18	Unspecified B-cell lymphoma, lymph nodes of multiple sites
C85.19	Unspecified B-cell lymphoma, extranodal and solid organ sites
C85.2	Mediastinal (thymic) large B-cell lymphoma
C85.20	Mediastinal (thymic) large B-cell lymphoma, unspecified site

ICD-10-CM	Code Description
C85.21	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of head, face, and neck
C85.22	Mediastinal (thymic) large B-cell lymphoma, intrathoracic lymph nodes
C85.23	Mediastinal (thymic) large B-cell lymphoma, intra-abdominal lymph nodes
C85.24	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of axilla and upper limb
C85.25	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of inguinal region and lower limb
C85.26	Mediastinal (thymic) large B-cell lymphoma, intrapelvic lymph nodes
C85.27	Mediastinal (thymic) large B-cell lymphoma, spleen
C85.28	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of multiple sites
C85.29	Mediastinal (thymic) large B-cell lymphoma, extranodal and solid organ sites
C85.8	Other specified types of non-Hodgkin lymphoma
C85.80	Other specified types of non-Hodgkin lymphoma, unspecified site
C85.81	Other specified types of non-Hodgkin lymphoma, lymph nodes of head, face, and neck
C85.82	Other specified types of non-Hodgkin lymphoma, intrathoracic lymph nodes
C85.83	Other specified types of non-Hodgkin lymphoma, intra-abdominal lymph nodes
C85.84	Other specified types of non-Hodgkin lymphoma, lymph nodes of axilla and upper limb
C85.85	Other specified types of non-Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C85.86	Other specified types of non-Hodgkin lymphoma, intrapelvic lymph nodes
C85.87	Other specified types of non-Hodgkin lymphoma, spleen
C85.88	Other specified types of non-Hodgkin lymphoma, lymph nodes of multiple sites
C85.89	Other specified types of non-Hodgkin lymphoma, extranodal and solid organ sites
C85.9	Non-Hodgkin lymphoma, unspecified
C85.90	Non-Hodgkin lymphoma, unspecified, unspecified site
C85.91	Non-Hodgkin lymphoma, unspecified, lymph nodes of head, face, and neck
C85.92	Non-Hodgkin lymphoma, unspecified, intrathoracic lymph nodes
C85.93	Non-Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes
C85.94	Non-Hodgkin lymphoma, unspecified, lymph nodes of axilla and upper limb
C85.95	Non-Hodgkin lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C85.96	Non-Hodgkin lymphoma, unspecified, intrapelvic lymph nodes
C85.97	Non-Hodgkin lymphoma, unspecified, spleen
C85.98	Non-Hodgkin lymphoma, unspecified, lymph nodes of multiple sites
C85.99	Non-Hodgkin lymphoma, unspecified, extranodal and solid organ sites
C86	Other specified types of T/NK-cell lymphoma
C86.0	Extranodal NK/T-cell lymphoma, nasal type
C86.1	Hepatosplenic T-cell lymphoma
C86.2	Enteropathy-type (intestinal) T-cell lymphoma
C86.3	Subcutaneous panniculitis-like T-cell lymphoma
C86.4	Blastic NK-cell lymphoma
C86.5	Angioimmunoblastic T-cell lymphoma
C86.6	Primary cutaneous CD30-positive T-cell proliferations
C88	Malignant immunoproliferative diseases and certain other B-cell lymphomas
C88.0	Waldenstrom macroglobulinemia
C88.2	Heavy chain disease
C88.3	Immunoproliferative small intestinal disease
C88.4	Extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue [MALT-lymphoma]

ICD-10-CM	Code Description
C88.8	Other malignant immunoproliferative diseases
C88.9	Malignant immunoproliferative disease, unspecified
C90	Multiple myeloma and malignant plasma cell neoplasms
C90.0	Multiple myeloma
C90.00	Multiple myeloma not having achieved remission
C90.02	Multiple myeloma in relapse
C90.1	Plasma cell leukemia
C90.10	Plasma cell leukemia not having achieved remission
C90.12	Plasma cell leukemia in relapse
C90.2	Extramedullary plasmacytoma
C90.20	Extramedullary plasmacytoma not having achieved remission
C90.22	Extramedullary plasmacytoma in relapse
C90.3	Solitary plasmacytoma
C90.30	Solitary plasmacytoma not having achieved remission
C90.32	Solitary plasmacytoma in relapse
C91	Lymphoid leukemia
C91.0	Acute lymphoblastic leukemia [ALL]
C91.00	Acute lymphoblastic leukemia not having achieved remission
C91.02	Acute lymphoblastic leukemia, in relapse
C91.1	Chronic lymphocytic leukemia of B-cell type
C91.10	Chronic lymphocytic leukemia of B-cell type not having achieved remission
C91.12	Chronic lymphocytic leukemia of B-cell type in relapse
C91.3	Prolymphocytic leukemia of B-cell type
C91.30	Prolymphocytic leukemia of B-cell type not having achieved remission
C91.32	Prolymphocytic leukemia of B-cell type, in relapse
C91.4	Hairy cell leukemia
C91.40	Hairy cell leukemia not having achieved remission
C91.42	Hairy cell leukemia, in relapse
C91.5	Adult T-cell lymphoma/leukemia (HTLV-1-associated)
C91.50	Adult T-cell lymphoma/leukemia (HTLV-1-associated) not having achieved remission
C91.52	Adult T-cell lymphoma/leukemia (HTLV-1-associated), in relapse
C91.6	Prolymphocytic leukemia of T-cell type
C91.60	Prolymphocytic leukemia of T-cell type not having achieved remission
C91.62	Prolymphocytic leukemia of T-cell type, in relapse
C91.9	Lymphoid leukemia, unspecified
C91.90	Lymphoid leukemia, unspecified not having achieved remission
C91.92	Lymphoid leukemia, unspecified, in relapse
C91.A	Mature B-cell leukemia Burkitt-type
C91.A0	Mature B-cell leukemia Burkitt-type not having achieved remission
C91.A2	Mature B-cell leukemia Burkitt-type, in relapse
C91.Z	Other lymphoid leukemia
C91.Z0	Other lymphoid leukemia not having achieved remission
C91.Z2	Other lymphoid leukemia, in relapse
C92	Myeloid leukemia

ICD-10-CM	Code Description
C92.0	Acute myeloblastic leukemia
C92.00	Acute myeloblastic leukemia, not having achieved remission
C92.02	Acute myeloblastic leukemia, in relapse
C92.1	Chronic myeloid leukemia, BCR/ABL-positive
C92.10	Chronic myeloid leukemia, BCR/ABL-positive, not having achieved remission
C92.12	Chronic myeloid leukemia, BCR/ABL-positive, in relapse
C92.2	Atypical chronic myeloid leukemia, BCR/ABL-negative
C92.20	Atypical chronic myeloid leukemia, BCR/ABL-negative, not having achieved remission
C92.22	Atypical chronic myeloid leukemia, BCR/ABL-negative, in relapse
C92.3	Myeloid sarcoma
C92.30	Myeloid sarcoma, not having achieved remission
C92.32	Myeloid sarcoma, in relapse
C92.4	Acute promyelocytic leukemia
C92.40	Acute promyelocytic leukemia, not having achieved remission
C92.42	Acute promyelocytic leukemia, in relapse
C92.5	Acute myelomonocytic leukemia
C92.50	Acute myelomonocytic leukemia, not having achieved remission
C92.52	Acute myelomonocytic leukemia, in relapse
C92.6	Acute myeloid leukemia with 11q23-abnormality
C92.60	Acute myeloid leukemia with 11q23-abnormality not having achieved remission
C92.62	Acute myeloid leukemia with 11q23-abnormality in relapse
C92.9	Myeloid leukemia, unspecified
C92.90	Myeloid leukemia, unspecified, not having achieved remission
C92.92	Myeloid leukemia, unspecified in relapse
C92.A	Acute myeloid leukemia with multilineage dysplasia
C92.A0	Acute myeloid leukemia with multilineage dysplasia, not having achieved remission
C92.A2	Acute myeloid leukemia with multilineage dysplasia, in relapse
C92.Z	Other myeloid leukemia
C92.Z0	Other myeloid leukemia not having achieved remission
C92.Z2	Other myeloid leukemia, in relapse
C93	Monocytic leukemia
C93.0	Acute monoblastic/monocytic leukemia
C93.00	Acute monoblastic/monocytic leukemia, not having achieved remission
C93.02	Acute monoblastic/monocytic leukemia, in relapse
C93.1	Chronic myelomonocytic leukemia
C93.10	Chronic myelomonocytic leukemia not having achieved remission
C93.12	Chronic myelomonocytic leukemia, in relapse
C93.3	Juvenile myelomonocytic leukemia
C93.30	Juvenile myelomonocytic leukemia, not having achieved remission
C93.32	Juvenile myelomonocytic leukemia, in relapse
C93.9	Monocytic leukemia, unspecified
C93.90	Monocytic leukemia, unspecified, not having achieved remission
C93.92	Monocytic leukemia, unspecified in relapse
C93.Z	Other monocytic leukemia

ICD-10-CM	Code Description
C93.Z0	Other monocytic leukemia, not having achieved remission
C93.Z2	Other monocytic leukemia, in relapse
C94	Other leukemias of specified cell type
C94.0	Acute erythroid leukemia
C94.00	Acute erythroid leukemia, not having achieved remission
C94.02	Acute erythroid leukemia, in relapse
C94.2	Acute megakaryoblastic leukemia
C94.20	Acute megakaryoblastic leukemia not having achieved remission
C94.22	Acute megakaryoblastic leukemia, in relapse
C94.3	Mast cell leukemia
C94.30	Mast cell leukemia not having achieved remission
C94.32	Mast cell leukemia, in relapse
C94.4	Acute panmyelosis with myelofibrosis
C94.40	Acute panmyelosis with myelofibrosis not having achieved remission
C94.42	Acute panmyelosis with myelofibrosis, in relapse
C94.6	Myelodysplastic disease, not classified
C94.8	Other specified leukemias
C94.80	Other specified leukemias not having achieved remission
C94.82	Other specified leukemias, in relapse
C95	Leukemia of unspecified cell type
C95.0	Acute leukemia of unspecified cell type
C95.00	Acute leukemia of unspecified cell type not having achieved remission
C95.02	Acute leukemia of unspecified cell type, in relapse
C95.1	Chronic leukemia of unspecified cell type
C95.10	Chronic leukemia of unspecified cell type not having achieved remission
C95.12	Chronic leukemia of unspecified cell type, in relapse
C95.9	Leukemia, unspecified
C95.90	Leukemia, unspecified not having achieved remission
C95.92	Leukemia, unspecified, in relapse
C96	Other and unspecified malignant neoplasms of lymphoid, hematopoietic and related tissue
C96.0	Multifocal and multisystemic (disseminated) Langerhans-cell histiocytosis
C96.2	Malignant mast cell tumor
C96.4	Sarcoma of dendritic cells (accessory cells)
C96.5	Multifocal and unisystemic Langerhans-cell histiocytosis
C96.6	Unifocal Langerhans-cell histiocytosis
C96.9	Malignant neoplasm of lymphoid, hematopoietic and related tissue, unspecified
C96.A	Histiocytic sarcoma
C96.Z	Other specified malignant neoplasms of lymphoid, hematopoietic and related tissue
D00	Carcinoma in situ of oral cavity, esophagus and stomach
D00.0	Carcinoma in situ of lip, oral cavity and pharynx
D00.00	Carcinoma in situ of oral cavity, unspecified site
D00.01	Carcinoma in situ of labial mucosa and vermilion border
D00.02	Carcinoma in situ of buccal mucosa
D00.03	Carcinoma in situ of gingiva and edentulous alveolar ridge

ICD-10-CM	Code Description
D00.04	Carcinoma in situ of soft palate
D00.05	Carcinoma in situ of hard palate
D00.06	Carcinoma in situ of floor of mouth
D00.07	Carcinoma in situ of tongue
D00.08	Carcinoma in situ of pharynx
D00.1	Carcinoma in situ of esophagus
D00.2	Carcinoma in situ of stomach
D01	Carcinoma in situ of other and unspecified digestive organs
D01.0	Carcinoma in situ of colon
D01.1	Carcinoma in situ of rectosigmoid junction
D01.2	Carcinoma in situ of rectum
D01.3	Carcinoma in situ of anus and anal canal
D01.4	Carcinoma in situ of other and unspecified parts of intestine
D01.40	Carcinoma in situ of unspecified part of intestine
D01.49	Carcinoma in situ of other parts of intestine
D01.5	Carcinoma in situ of liver, gallbladder and bile ducts
D01.7	Carcinoma in situ of other specified digestive organs
D01.9	Carcinoma in situ of digestive organ, unspecified
D02	Carcinoma in situ of middle ear and respiratory system
D02.0	Carcinoma in situ of larynx
D02.1	Carcinoma in situ of trachea
D02.2	Carcinoma in situ of bronchus and lung
D02.20	Carcinoma in situ of unspecified bronchus and lung
D02.21	Carcinoma in situ of right bronchus and lung
D02.22	Carcinoma in situ of left bronchus and lung
D02.3	Carcinoma in situ of other parts of respiratory system
D02.4	Carcinoma in situ of respiratory system, unspecified
D03	Melanoma in situ
D03.0	Melanoma in situ of lip
D03.1	Melanoma in situ of eyelid, including canthus
D03.10	Melanoma in situ of unspecified eyelid, including canthus
D03.11	Melanoma in situ of right eyelid, including canthus
D03.12	Melanoma in situ of left eyelid, including canthus
D03.2	Melanoma in situ of ear and external auricular canal
D03.20	Melanoma in situ of unspecified ear and external auricular canal
D03.21	Melanoma in situ of right ear and external auricular canal
D03.22	Melanoma in situ of left ear and external auricular canal
D03.3	Melanoma in situ of other and unspecified parts of face
D03.30	Melanoma in situ of unspecified part of face
D03.39	Melanoma in situ of other parts of face
D03.4	Melanoma in situ of scalp and neck
D03.5	Melanoma in situ of trunk
D03.51	Melanoma in situ of anal skin
D03.52	Melanoma in situ of breast (skin) (soft tissue)

ICD-10-CM	Code Description
D03.59	Melanoma in situ of other part of trunk
D03.6	Melanoma in situ of upper limb, including shoulder
D03.60	Melanoma in situ of unspecified upper limb, including shoulder
D03.61	Melanoma in situ of right upper limb, including shoulder
D03.62	Melanoma in situ of left upper limb, including shoulder
D03.7	Melanoma in situ of lower limb, including hip
D03.70	Melanoma in situ of unspecified lower limb, including hip
D03.71	Melanoma in situ of right lower limb, including hip
D03.72	Melanoma in situ of left lower limb, including hip
D03.8	Melanoma in situ of other sites
D03.9	Melanoma in situ, unspecified
D05	Carcinoma in situ of breast
D05.0	Lobular carcinoma in situ of breast
D05.00	Lobular carcinoma in situ of unspecified breast
D05.01	Lobular carcinoma in situ of right breast
D05.02	Lobular carcinoma in situ of left breast
D05.1	Intraductal carcinoma in situ of breast
D05.10	Intraductal carcinoma in situ of unspecified breast
D05.11	Intraductal carcinoma in situ of right breast
D05.12	Intraductal carcinoma in situ of left breast
D05.8	Other specified type of carcinoma in situ of breast
D05.80	Other specified type of carcinoma in situ of unspecified breast
D05.81	Other specified type of carcinoma in situ of right breast
D05.82	Other specified type of carcinoma in situ of left breast
D05.9	Unspecified type of carcinoma in situ of breast
D05.90	Unspecified type of carcinoma in situ of unspecified breast
D05.91	Unspecified type of carcinoma in situ of right breast
D05.92	Unspecified type of carcinoma in situ of left breast
D07	Carcinoma in situ of other and unspecified genital organs
D07.0	Carcinoma in situ of endometrium
D07.1	Carcinoma in situ of vulva
D07.2	Carcinoma in situ of vagina
D07.3	Carcinoma in situ of other and unspecified female genital organs
D07.30	Carcinoma in situ of unspecified female genital organs
D07.39	Carcinoma in situ of other female genital organs
D07.4	Carcinoma in situ of penis
D07.6	Carcinoma in situ of other and unspecified male genital organs
D07.60	Carcinoma in situ of unspecified male genital organs
D07.61	Carcinoma in situ of scrotum
D07.69	Carcinoma in situ of other male genital organs
D09	Carcinoma in situ of other and unspecified sites
D09.0	Carcinoma in situ of bladder
D09.1	Carcinoma in situ of other and unspecified urinary organs
D09.10	Carcinoma in situ of unspecified urinary organ

ICD-10-CM	Code Description
D09.19	Carcinoma in situ of other urinary organs
D09.2	Carcinoma in situ of eye
D09.20	Carcinoma in situ of unspecified eye
D09.21	Carcinoma in situ of right eye
D09.22	Carcinoma in situ of left eye
D09.3	Carcinoma in situ of thyroid and other endocrine glands
D09.8	Carcinoma in situ of other specified sites
D09.9	Carcinoma in situ, unspecified
D32	Benign neoplasm of meninges
D32.0	Benign neoplasm of cerebral meninges
D32.1	Benign neoplasm of spinal meninges
D32.9	Benign neoplasm of meninges, unspecified
D33	Benign neoplasm of brain and other parts of central nervous system
D33.0	Benign neoplasm of brain, supratentorial
D33.1	Benign neoplasm of brain, infratentorial
D33.2	Benign neoplasm of brain, unspecified
D33.3	Benign neoplasm of cranial nerves
D33.4	Benign neoplasm of spinal cord
D33.7	Benign neoplasm of other specified parts of central nervous system
D33.9	Benign neoplasm of central nervous system, unspecified
D35.2	Benign neoplasm of pituitary gland
D35.3	Benign neoplasm of craniopharyngeal duct
D35.4	Benign neoplasm of pineal gland
D42	Neoplasm of uncertain behavior of meninges
D42.0	Neoplasm of uncertain behavior of cerebral meninges
D42.1	Neoplasm of uncertain behavior of spinal meninges
D42.9	Neoplasm of uncertain behavior of meninges, unspecified
D43	Neoplasm of uncertain behavior of brain and central nervous system
D43.0	Neoplasm of uncertain behavior of brain, supratentorial
D43.1	Neoplasm of uncertain behavior of brain, infratentorial
D43.2	Neoplasm of uncertain behavior of brain, unspecified
D43.3	Neoplasm of uncertain behavior of cranial nerves
D43.4	Neoplasm of uncertain behavior of spinal cord
D43.8	Neoplasm of uncertain behavior of other specified parts of central nervous system
D43.9	Neoplasm of uncertain behavior of central nervous system, unspecified
D44.3	Neoplasm of uncertain behavior of pituitary gland
D44.4	Neoplasm of uncertain behavior of craniopharyngeal duct
D44.5	Neoplasm of uncertain behavior of pineal gland
D45	Polycythemia vera
D46	Myelodysplastic syndromes
D46.0	Refractory anemia without ring sideroblasts, so stated
D46.1	Refractory anemia with ring sideroblasts
D46.2	Refractory anemia with excess of blasts
D46.20	Refractory anemia with excess of blasts, unspecified

ICD-10-CM	Code Description
D46.21	Refractory anemia with excess of blasts 1
D46.22	Refractory anemia with excess of blasts 2
D46.4	Refractory anemia, unspecified
D46.9	Myelodysplastic syndrome, unspecified
D46.A	Refractory cytopenia with multilineage dysplasia
D46.B	Refractory cytopenia with multilineage dysplasia and ring sideroblasts
D46.C	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality
D46.Z	Other myelodysplastic syndromes
D47.1	Chronic myeloproliferative disease
D47.3	Essential (hemorrhagic) thrombocythemia
D47.4	Osteomyelofibrosis
D49.6	Neoplasm of unspecified behavior of brain
D49.7	Neoplasm of unspecified behavior of endocrine glands and other parts of nervous system
J91.0	Malignant pleural effusion
R18.0	Malignant ascites
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.11	Encounter for antineoplastic chemotherapy
Z51.12	Encounter for antineoplastic immunotherapy

Appendix J

Height Conversion Table Feet (ft), Inches (in) / Centimeters (cm)

Appendix J
Height Conversion Table
Feet (ft), Inches (in) / Centimeters (cm)

Feet/Inches	Total Inches	Centimeters
1' 6"	18"	46
1' 7"	19"	48
1' 8"	20"	51
1' 9"	21"	53
1' 10"	22"	56
1' 11"	23"	58
2'	24"	61
2' 1"	25"	64
2' 2"	26"	66
2' 3"	27"	69
2' 4"	28"	71
2' 5"	29"	74
2' 6"	30"	76
2' 7"	31"	79
2' 8"	32"	81
2' 9"	33"	84
2' 10"	34"	86
2' 11"	35"	89
3'	36"	91
3' 1"	37"	94
3' 2"	38"	97

Feet/Inches	Total Inches	Centimeters
3' 3"	39"	99
3' 4"	40"	102
3' 5"	41"	104
3' 6"	42"	107
3' 7"	43"	109
3' 8"	44"	112
3' 9"	45"	114
3' 10"	46"	117
3' 11"	47"	119
4'	48"	122
4' 1"	49"	124
4' 2"	50"	127
4' 3"	51"	130
4' 4"	52"	132
4' 5"	53"	135
4' 6"	54"	137
4' 7"	55"	140
4' 8"	56"	142
4' 9"	57"	145
4' 10"	58"	147
4' 11"	59"	150

Feet/Inches	Total Inches	Centimeters
5'	60"	152
5' 1"	61"	155
5' 2"	62"	157
5' 3"	63"	160
5' 4"	64"	163
5' 5"	65"	165
5' 6"	66"	168
5' 7"	67"	170
5' 8"	68"	173
5' 9"	69"	175
5' 10"	70"	178
5' 11"	71"	180
6'	72"	183
6' 1"	73"	185
6' 2"	74"	188
6' 3"	75"	191
6' 4"	76"	193
6' 5"	77"	195
6' 6"	78"	198
6' 7"	79"	201
6' 8"	80"	203

Appendix K

Weight Conversion Table Pounds (lb) / Kilograms (kg)

Appendix K

Weight Conversion Table = Pounds (lb) / Kilograms (kg)

Pounds	Kilograms
2	1
4	2
7	3
9	4
11	5
13	6
15	7
18	8
20	9
22	10
24	11
26	12
29	13
31	14
33	15
35	16
37	17
40	18
42	19
44	20
46	21
49	22
51	23
53	24
55	25
57	26
60	27
62	28
64	29
66	30
68	31
71	32
73	33
75	34
77	35
79	36
82	37
84	38
86	39
88	40
90	41
93	42

Pounds	Kilograms
95	43
97	44
99	45
101	46
104	47
106	48
108	49
110	50
112	51
115	52
117	53
119	54
121	55
123	56
126	57
128	58
130	59
132	60
134	61
137	62
139	63
141	64
143	65
146	66
148	67
150	68
152	69
154	70
157	71
159	72
161	73
163	74
165	75
168	76
170	77
172	78
174	79
176	80
179	81
181	82
183	83
185	84

Pounds	Kilograms
187	85
190	86
192	87
194	88
196	89
198	90
201	91
203	92
205	93
207	94
209	95
212	96
214	97
216	98
218	99
220	100
223	101
225	102
227	103
229	104
231	105
234	106
236	107
238	108
240	109
243	110
245	111
247	112
249	113
251	114
254	115
256	116
258	117
260	118
262	119
265	120
267	121
269	122
271	123
273	124
276	125
278	126

Pounds	Kilograms
280	127
282	128
284	129
287	130
289	131
291	132
293	133
295	134
298	135
300	136
302	137
304	138
306	139
309	140
311	141
313	142
315	143
317	144
320	145
322	146
324	147
326	148
328	149
331	150
333	151
335	152
337	153
340	154
342	155
344	156
346	157
348	158
351	159
353	160
355	161
357	162
359	163
362	164
364	165
366	166
368	167
370	168

Appendix L

FCDS Text Documentation Requirements

**NCRA has published a series of Informational Abstracts
FREE FOR DOWNLOAD
Providing cancer-site specific guidelines for text to be included in Abstracts**

**Please refer to the NCRA Informational Abstracts for More Information
<http://www.cancerregistryeducation.org/rr>**

**Bladder
Breast
Cervix
Colon
Endometrium
Lung
Melanoma
Ovary
Prostate**

APPENDIX L FCDS TEXT DOCUMENTATION REQUIREMENTS

Text documentation is an essential component of a complete electronic abstract and is heavily utilized in quality control, to validate data at time of FCDS and NPCR Audits, and for special studies. Text **documentation is required to justify coded values** and to supplement information not transmitted with coded values. **FCDS recommends that abstractors print and post this document for easy reference.** Adequate text is a data quality indicator and will be major part of QC.

Below is a list of FCDS Required Data Items that carry an additional requirement of complete and accurate text documentation. See Table on Following Page for Specific Examples for each Text Area.

DATA ITEMS REQUIRING COMPLETE TEXT DOCUMENTATION	
Date of DX	RX Summ – Surg Prim Site
Seq No	RX Summ – Scope Reg LN Surgery
Sex	RX Summ – Surg Oth Reg/Distant
Primary Site	RX Date – Surgery
Subsite	RX Summ – Radiation
Laterality	Rad Rx Modality
Histologic Type	RX Date – Radiation
Behavior Code	RX Summ – Chemo
Grade	RX Date – Chemo
	RX Summ – Hormone
CS Tumor Size	RX Date – Hormone
CS Ext	RX Summ – BRM/Immunotherapy
CS Tumor Ext/Eval	RX Date – BRM/Immunotherapy
Regional Nodes Positive	RX Summ – Transplant/Endocrine
Regional Nodes Examined	RX Date – Transplant/Endocrine
CS LN	RX Summ – Other
CS LN Eval	RX Date - Other
CS Mets	
CS Mets Eval	Any Unusual Case Characteristics
All FCDS Req'd SSFs	Any Pertinent Patient/Family History

Text documentation should always include the following components:

- Date(s) – include date(s) references – this allows the reviewer to determine event chronology
- Date(s) – note when date(s) are estimated [i.e. Date of DX 3/15/2014 (est.)]
- Location – include facility/physician/other location where the event occurred (test/study/treatment/other)
- Description – include description of the event (test/study/treatment/other) – include positive/negative results
- Details – include as much detail as possible – document treatment plan even if treatment is initiated as planned
- Include “relevant-to-this-person/cancer” information only – edit your text documentation
- DO NOT REPEAT INFORMATION from section to section
- DO USE Standard Abbreviations (Appendix C)
- DO NOT USE non-standard or stylistic shorthand
- Enter “N/A” or “not available” when no information is available related to any specific text area.

APPENDIX L FCDS TEXT DOCUMENTATION REQUIREMENTS

Text Data Item Name	Text Documentation Source and Item Description
NAACCR Item # Field Length	<i>FCDS Required Text Documentation</i> Example:
Text - Physical Exam H&P NAACCR Item #2520 Field Length = 1000	Enter text information from history and physical exams. <i>History and physical examination findings that relate to family history or personal history of cancer diagnosis, physical findings on examination, type and duration of symptoms, reason for admission.</i> Example: Hx RCC Rt Kidney – Dx 9/2011 in Georgia. Adm c/o fever and night sweats. Adm for w/u and found to have enlarged axillary nodes which on biopsy revealed diffuse B-cell lymphoma.
Text - X-rays/Scans NAACCR Item #2530 Field Length = 1000	Enter text information from diagnostic imaging reports, including x-rays, CT, MRI, and PET scans, ultrasound and other imaging studies. <i>Date, facility where procedure was performed, type of procedure, detailed findings (primary site, size of tumor, location of tumor, nodes, metastatic sites), clinical assessment, positive/negative results</i> Example: 4/12/14 (Breast Center xyz) Mammo - Rt Breast w/1.5cm mass at 12:00 o'clock
Text - Scopes NAACCR Item #2540 Field Length = 1000	Enter text information from diagnostic endoscopic examinations. <i>Date of Procedure, facility where procedure was performed, type of procedure, detailed findings (primary site, extent of tumor spread, satellite lesions), clinical assessment, positive/ negative results</i> Example: 4/12/13 (Endoscopy Ctr xyz) EGD: gastric mucosa w/ evidence of large tumor occupying half of the stomach. Numerous satellite tumors seen on opposite wall of the stomach
Text - Lab Tests NAACCR Item #2550 Field Length = 1000	Enter text information from diagnostic/prognostic laboratory tests (not cytology or histopathology). Text for Collaborative Stage Site Specific Factor or SSF documentation. <i>Date(s) of Test(s), facility where test was performed, type of test(s), test results (value and assessment)</i> Example: 4/12/14 (Hosp xyz) ER +, PR -, HER2 neg by IHC method, PSA 5.3 (elevated)
Text - Operative Report NAACCR Item #2560 Field Length = 1000	Enter text information from surgical operative reports (not diagnostic needle, incisional biopsy). Include observations at surgery, tumor size, and extent of involvement of primary or metastatic sites. <i>Date of procedure, facility where procedure was performed, type of surgical procedure, detailed surgical findings, documentation of residual tumor, evidence of invasion of surrounding areas</i> Example: 4/12/14 (Hosp xyz) right colon resection - Pt was found to have extensive disease in the pelvis (carcinomatosis) and resection was aborted, no biopsies were taken, no specimen obtained.
DX Text - Pathology NAACCR Item #2570 Field Length = 1000	Enter text information from cytology and histopathology reports. <i>Date of specimen/resection, facility where specimen examined, pathology accession #, type of specimen, final diagnosis, comments, addenda, supplemental information, histology, behavior, size of tumor, tumor extension, lymph nodes (removed/biopsied), margins, some special histo studies</i> Example: 2/5/14 (Hosp xyz) – Path Acc # - Rectum: Final Dx: adenoca, 2.5cm, ext. to pericolic fat. 1/22 lymph nodes +, margins neg, S100 stain is positive (melanoma, sarcoma), pT3N1Mx
DX Text - Staging NAACCR Item #2600 Field Length = 1000	Enter Details of Collaborative Stage and other stage information not already entered in other text areas. Include specific information on Tumor Size, Extension of Primary Tumor, Metastatic Sites, etc. <i>Organs involved by direct extension, size of tumor, status of margins, sites of distant metastasis, special consideration for staging, overall stage, etc. Text for SSF documentation if not under Labs.</i> Example: 2/15/14 - T2aN1a per path, distant mets in lungs, ER/PR neg, HER2 neg by IHC method

APPENDIX L FCDS TEXT DOCUMENTATION REQUIREMENTS

Text Data Item Name	Text Documentation Source and Item Description
NAACCR Item # Field Length	<i>FCDS Required Text Documentation</i> Example:
RX Text - Surgery NAACCR Item #2610 Field Length = 1000	Enter text describing the surgical procedure(s) performed as part of 1 st course treatment. <i>Treatment plan, date surgery performed, type of procedure, facility where surgery was performed</i> Example: 2/15/14 (Hosp xyz) - rt breast mrm w/ax ln dissection
RX Text Radiation (Beam) NAACCR Item #2620 Field Length = 1000	Enter information regarding the treatment of the tumor being reported with radiation. <i>Treatment Plan (if no treatment given), date treatment initiated/completed, facility where treatment administered, type of radiation, dose (if known)</i> Example: 2/15/14-3/15/14 (Hosp xyz) – 45 Gy orthovoltage with 20 Gy boost to tumor bed
RX Text Radiation (Other) NAACCR Item #2630 Field Length = 1000	Enter information regarding the treatment of the tumor being reported with radiation. <i>Treatment Plan (if no treatment given), date treatment initiated/completed, facility where treatment was administered, type of radiation, dose (if known),</i> Example: 2/15/14 (Hosp xyz) - radioactive seed implant, radioisotopes (I-131)
RX Text - Chemo NAACCR Item #2640 Field Length = 1000	Enter information regarding the treatment of the tumor being reported with chemotherapy. <i>Date treatment initiated, facility/physician office where administered/prescribed, name of agent(s)/protocol, dose/cycle (if known), treatment plan(if known)</i> Example: 2/15/14 (Dr Smith) – Start 6 cycles R-CHOP14 – standard dose at 2-week intervals
RX Text - Hormone NAACCR Item #2650 Field Length = 1000	Enter information regarding the treatment of the tumor being reported with hormone. <i>date treatment initiated, facility/physician office where administered/prescribed, name of hormone/anti-hormone agent or procedure, dose (if known), Treatment Plan</i> Example: 2/15/14 (Dr Jones) - tamoxifen (dose/duration not stated) or bilateral orchiectomy
RX Text - BRM NAACCR Item #2660 Field Length = 1000	Enter information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy. <i>date treatment initiated, facility/physician office where administered/prescribed, name of BRM or immunotherapy agent or procedure, dose (if known), Treatment Plan,</i> Example: 2/15/14 (Hosp xyz) - interferon or BCG (dose/duration not stated)
RX Text - Other NAACCR Item #2670 Field Length = 1000	Enter information regarding treatment that cannot be defined as surgery, radiation, or systemic therapy. <i>Date treatment planned/initiated, name of other therapy, agent or procedure, dose (if known), facility where performed</i> Example: 2/15/14 (Hosp xyz) - blinded clinical trial or hyperthermia (may include study number)
Text - Remarks NAACCR Item #2680 Field Length = 1000	Document information not provided in any other text field or overflow from text fields. Document personal history of carcinogenic exposure (arsenic, drinking water, uranium, asbestos), other Example: 40 year h/o of working in ship building and construction w/ lots of asbestos exposure

Appendix M

Hematopoietic and Lymphoid Neoplasm Master Code Lists (alpha/numeric)

2010 Hematopoietic and Lymphoid ICD-O Codes - Alphabetical List
THIS TABLE REPLACES ALL ICD-O-3 Codes 9590-9989

Preferred Histologic Term - updated for 2012 Heme/Lymph		Histology
Acute basophilic leukemia		9870/3
Acute biphenotypic leukemia [OBS] See 9809/3	NOTE: DO NOT USE [OBS] Codes Beginning 1/1/2010 - [OBS] Codes are OBSOLETE	9805/2
Acute erythroid leukemia		9840/3
Acute megakaryoblastic leukemia		9910/3
Acute monoblastic and monocytic leukemia		9891/3
Acute myeloid leukemia (megakaryoblastic) with t(1;22)(p13;q13);RBM15-MKL1		9911/3
Acute myeloid leukemia with inv(16)(p13.1q22) or t(16;16)(p13.1;q22), CBFβ/MYH11		9871/3
Acute myeloid leukemia with inv(3)(q21;q26.2) or t(3;3)(q21;q26.2); RPN1-EV11		9869/3
Acute myeloid leukemia with maturation		9874/3
Acute myeloid leukemia with minimal differentiation		9872/3
Acute myeloid leukemia with myelodysplasia-related changes		9895/3
Acute myeloid leukemia with t(6;9)(p23;q34); DEK-NUP214		9865/3
Acute myeloid leukemia with t(8;21)(q22;q22); RUNX1-RUNX1T1		9896/3
Acute myeloid leukemia with t(9;11)(p22;q23); MLLT3-MLL		9897/3
Acute myeloid leukemia without maturation		9873/3
Acute myeloid leukemia, NOS		9861/3
Acute myelomonocytic leukemia		9867/3
Acute panmyelosis with myelofibrosis		9931/3
Acute promyelocytic leukemia (AML with t(15;17)(q22;q12), PML/RARA		9866/3
Acute undifferentiated leukemia		9801/3
Adult T-cell leukemia/lymphoma		9837/3
Adult T-cell leukemia/lymphoma (HTLV-1 positive)		9827/3
Aggressive NK-cell leukemia		9948/3
ALK positive large B-cell lymphoma		9737/3
Anaplastic large cell lymphoma, ALK positive		9714/3
Angioimmunoblastic T-cell lymphoma		9705/3
Atypical chronic myeloid leukemia, BCR-ABL1 negative		9876/3
B lymphoblastic leukemia/lymphoma with hyperdiploidy		9815/3
B lymphoblastic leukemia/lymphoma with hypodiploidy (hypodiploid ALL)		9816/3
B lymphoblastic leukemia/lymphoma with t(1;19)(q23;p13.3);E2A-PBX1 (TCF3-PBX1)		9818/3
B lymphoblastic leukemia/lymphoma with t(12;21)(p13;q22);TEL-AML1 (ETV6-RUNX1)		9814/3
B lymphoblastic leukemia/lymphoma with t(5;14)(q31;q32);IL3-IGH		9817/3

2010 Hematopoietic and Lymphoid ICD-O Codes - Alphabetical List
THIS TABLE REPLACES ALL ICD-O-3 Codes 9590-9989

Preferred Histologic Term - updated for 2012 Heme/Lymph		Histology
	NOTE: DO NOT USE [OBS] Codes Beginning 1/1/2010 - [OBS] Codes are OBSOLETE	
B lymphoblastic leukemia/lymphoma with t(9;22)(q34;q11.2);BCR-ABL1		9812/3
B lymphoblastic leukemia/lymphoma with t(v;11q23);MLL rearranged		9813/3
B lymphoblastic leukemia/lymphoma, NOS		9811/3
B-cell lymphoma, unclassifiable, with features intermediate between diffuse large B-cell lymphoma and classical Hodgkin lymphoma		9596/3
B-cell prolymphocytic leukemia		9833/3
Blastic plasmacytoid dendritic cell neoplasm		9727/3
Burkitt cell leukemia		9826/3
Burkitt lymphoma		9687/3
Chronic eosinophilic leukemia, NOS		9964/3
Chronic lymphocytic leukemia/small lymphocytic lymphoma		9823/3
Chronic myelogenous leukemia, BCR-ABL1 positive		9875/3
Chronic myeloid leukemia, NOS		9863/3
Chronic myelomonocytic leukemia		9945/3
Chronic myeloproliferative disease, NOS [OBS] See 9975/3		9960/3-
Chronic neutrophilic leukemia		9963/3
Classical Hodgkin lymphoma		9650/3
Diffuse large B-cell lymphoma (DLBCL)		9680/3
Enteropathy-associated T-cell lymphoma		9717/3
Essential thrombocythemia		9962/3
Extranodal marginal zone lymphoma of mucosa-associated lymphoid tissue (MALT lymphoma)		9699/3
Extranodal NK/T cell lymphoma, nasal type		9719/3
Extrasseous plasmacytoma		9734/3
Fibroblastic reticular cell tumor		9759/3
Follicular dendritic cell sarcoma		9758/3
Follicular lymphoma		9690/3
Follicular lymphoma, grade 1		9695/3
Follicular lymphoma, grade 2		9691/3
Follicular lymphoma, grade 3		9698/3
Hairy cell leukemia		9940/3
Heavy chain disease		9762/3
Hepatosplenic T-cell lymphoma		9716/3
Histiocytic sarcoma		9755/3

2010 Hematopoietic and Lymphoid ICD-O Codes - Alphabetical List
THIS TABLE REPLACES ALL ICD-O-3 Codes 9590-9989

Preferred Histologic Term - updated for 2012 Heme/Lymph		Histology
	NOTE: DO NOT USE [OBS] Codes Beginning 1/1/2010 - [OBS] Codes are OBSOLETE	
Hodgkin disease, lymphocytic predominance, diffuse [OBS]	See 9651/3	9658/3
Hodgkin disease, lymphocytic predominance, NOS [OBS]	See 9651/3	9657/3
Hodgkin granuloma [OBS]	See 9650/3	9661/3
Hodgkin lymphoma, lymphocyte depletion, diffuse fibrosis [OBS]	See 9650/3	9654/3
Hodgkin lymphoma, lymphocyte depletion, reticular		9655/3
Hodgkin lymphoma, nodular sclerosis, cellular phase [OBS]	See 9663/3	9664/3
Hodgkin lymphoma, nodular sclerosis, grade 1 [OBS]	See 9663/3	9665/3
Hodgkin lymphoma, nodular sclerosis, grade 2 [OBS]	See 9663/3	9667/3
Hodgkin sarcoma [OBS]	See 9650/3	9662/3
Hydroa vacciniforme-like lymphoma		9725/3
Immunoproliferative disease, NOS [OBS]	See 9762/3	9760/3
Immunoproliferative small intestinal disease [OBS]	See 9762/3	9764/3
Interdigitating dendritic cell sarcoma		9757/3
Intravascular large B-cell lymphoma		9712/3
Juvenile myelomonocytic leukemia		9946/3
Langerhans cell histiocytosis		9751/3
Langerhans cell histiocytosis, disseminated [OBS]	See 9751/3	9754/3
Langerhans cell histiocytosis, multifocal [OBS]	See 9751/3	9753/3
Langerhans cell histiocytosis, unifocal [OBS]	See 9751/3	9752/3
Langerhans cell sarcoma		9756/3
Large B-cell lymphoma arising in HHV8-associated multicentric Castlemans disease		9738/3
Leukemia, NOS		9800/3
Lymphocyte-depleted classical Hodgkin lymphoma		9653/3
Lymphocyte-rich classical Hodgkin lymphoma		9651/3
Lymphoid leukemia, NOS		9820/3
Lymphoplasmacytic lymphoma		9671/3
Lymphoproliferative disorder, NOS		9970/1
Malignant histiocytosis [OBS]	See 9751/3	9750/3
Malignant lymphoma, large B-cell, diffuse, immunoblastic, NOS [OBS]	See 9680/3	9684/3
Malignant lymphoma, mixed small and large cell, diffuse [OBS]	See 9690/3	9675/3
Malignant lymphoma, NOS		9590/3
Malignant lymphoma, small B-lymphocytic, NOS [OBS]	See 9823/3	9670/3

2010 Hematopoietic and Lymphoid ICD-O Codes - Alphabetical List
THIS TABLE REPLACES ALL ICD-O-3 Codes 9590-9989

Preferred Histologic Term - updated for 2012 Heme/Lymph		Histology
	NOTE: DO NOT USE [OBS] Codes Beginning 1/1/2010 - [OBS] Codes are OBSOLETE	
Mantle cell lymphoma		9673/3
Mast cell leukemia		9742/3
Mast cell sarcoma		9740/3
Mixed cellularity classical Hodgkin lymphoma		9652/3
Mixed phenotype acute leukemia with t(9;22)(q34;q11.2);BCR-ABL1		9806/3
Mixed phenotype acute leukemia with t(v;11q23);MLL, rearranged		9807/3
Mixed phenotype acute leukemia, B/myeloid, NOS		9808/3
Mixed phenotype acute leukemia, T/myeloid, NOS		9809/3
Monoclonal gammopathy, unknown significance (MGUS)		9765/1
Mycosis fungoides		9700/3
Myelodysplastic syndrome associated with isolated del(5q)		9986/3
Myelodysplastic syndrome, unclassifiable		9989/3
Myelodysplastic/myeloproliferative neoplasm, unclassifiable		9975/3
Myeloid and lymphoid neoplasm with FGFR1 abnormalities		9967/3
Myeloid and lymphoid neoplasm with PDGFRA rearrangement		9965/3
Myeloid leukemia associated with Down syndrome		9898/3
Myeloid leukemia, NOS		9860/3
Myeloid neoplasm with PDGFRB arrangement		9966/3
Myeloid sarcoma		9930/3
Nodular lymphocyte predominant Hodgkin lymphoma		9659/3
Nodular sclerosis classical Hodgkin lymphoma		9663/3
Non-Hodgkin lymphoma, NOS		9591/3
Peripheral T-cell lymphoma, NOS		9702/3
Plasma-cell-leukemia [OBS] See 9732/3		9733/3-
Plasma cell myeloma		9732/3
Plasmablastic lymphoma		9735/3
Polycythemia vera		9950/3
Post Transplant Lymphoproliferative Disorder (PTLD)		9971/3
Precursor B-cell lymphoblastic-leukemia [OBS] See 9811/3		9836/3-
Precursor B-cell lymphoblastic-lymphoma [OBS] See 9811/3		9728/3-
Precursor cell-lymphoblastic-leukemia, NOS [OBS] See 9811/3		9835/3-
Precursor T-cell lymphoblastic-lymphoma [OBS] See 9837/3		9729/3-

2010 Hematopoietic and Lymphoid ICD-O Codes - Alphabetical List
THIS TABLE REPLACES ALL ICD-O-3 Codes 9590-9989

Preferred Histologic Term - updated for 2012 Heme/Lymph		Histology
	NOTE: DO NOT USE [OBS] Codes Beginning 1/1/2010 - [OBS] Codes are OBSOLETE	
Primary cutaneous CD30-positive T-cell lymphoproliferative disorders		9718/3
Primary cutaneous follicle centre lymphoma		9597/3
Primary cutaneous gamma-delta T-cell lymphoma		9726/3
Primary cutaneous T-cell lymphoma		9709/3
Primary effusion lymphoma		9678/3
Primary mediastinal (thymic) large B-cell lymphoma		9679/3
Primary myelofibrosis		9961/3
Prolymphocytic leukemia, NOS		9832/3
Refractory anemia		9980/3
Refractory anemia with excess blasts		9983/3
Refractory anemia with excess blasts in transformation [OBS] See 9983/3		9984/3-
Refractory anemia with ring sideroblasts		9982/3
Refractory cytopenia with multilineage dysplasia		9985/3
Refractory neutropenia		9991/3
Refractory thrombocytopenia		9992/3
Sezary syndrome		9701/3
Solitary plasmacytoma of bone		9731/3
Splenic marginal zone lymphoma		9689/3
Subcutaneous panniculitis-like T-cell lymphoma		9708/3
Systemic EBV positive T-cell lymphoproliferative disease of childhood		9724/3
Systemic mastocytosis		9741/3
T-cell large granular lymphocytic leukemia		9831/3
T-cell prolymphocytic leukemia		9834/3
T-cell/histiocyte rich large B-cell lymphoma		9688/3
Therapy-related myelodysplastic syndrome, NOS [OBS] See 9920/3		9987/3-
Therapy-related myeloid neoplasm		9920/3
Waldenstrom macroglobulinemia		9761/3

2010 Hematopoietic and Lymphoid ICD-O Codes - Numerical List
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Preferred Histologic Term - updated for 2012 Heme/Lymph		Histology
	NOTE: DO NOT USE [OBS] Codes Beginning 1/1/2010 - [OBS] Codes are OBSOLETE	
Malignant lymphoma, NOS		9590/3
Non-Hodgkin lymphoma, NOS		9591/3
B-cell lymphoma, unclassifiable, with features intermediate between diffuse large B-cell lymphoma and classical Hodgkin lymphoma		9596/3
Primary cutaneous follicle centre lymphoma		9597/3
Classical Hodgkin lymphoma		9650/3
Lymphocyte-rich classical Hodgkin lymphoma		9651/3
Mixed cellularity classical Hodgkin lymphoma		9652/3
Lymphocyte-depleted classical Hodgkin lymphoma		9653/3
Hodgkin lymphoma, lymphocyte depletion, diffuse fibrosis [OBS] See 9653/3		9654/3-
Hodgkin lymphoma, lymphocyte depletion, reticular		9655/3
Hodgkin disease, lymphocyte predominance, NOS [OBS] See 9651/3		9657/3
Hodgkin disease, lymphocyte predominance, diffuse [OBS] See 9651/3		9658/3
Nodular lymphocyte predominant Hodgkin lymphoma		9659/3
Hodgkin granuloma [OBS] See 9650/3		9661/3-
Hodgkin sarcoma [OBS] See 9650/3		9662/3-
Nodular sclerosis classical Hodgkin lymphoma		9663/3
Hodgkin lymphoma, nodular sclerosis, cellular phase [OBS] See 9663/3		9664/3-
Hodgkin lymphoma, nodular sclerosis, grade 1 [OBS] See 9663/3		9665/3-
Hodgkin lymphoma, nodular sclerosis, grade 2 [OBS] See 9663/3		9667/3-
Malignant lymphoma, small B-lymphocytic, NOS [OBS] See 9823/3		9670/3-
Lymphoplasmacytic lymphoma		9671/3
Mantle cell lymphoma		9673/3
Malignant lymphoma, mixed small and large cell, diffuse [OBS] See 9690/3		9675/3-
Primary effusion lymphoma		9678/3
Primary mediastinal (thymic) large B-cell lymphoma		9679/3
Diffuse large B-cell lymphoma (DLBCL)		9680/3
Malignant lymphoma, large B-cell, diffuse, immunoblastic, NOS [OBS] See 9680/3		9684/3-
Burkitt lymphoma		9687/3
T-cell/histiocyte rich large B-cell lymphoma		9688/3
Splenic marginal zone lymphoma		9689/3
Follicular lymphoma		9690/3
Follicular lymphoma, grade 2		9691/3

2010 Hematopoietic and Lymphoid ICD-O Codes - Numerical List
THIS TABLE REPLACES ALL ICD-O-3 Codes 9590-9989

	Preferred Histologic Term - updated for 2012 Heme/Lymph	Histology
	NOTE: DO NOT USE [OBS] Codes Beginning 1/1/2010 - [OBS] Codes are OBSOLETE	
Follicular lymphoma, grade 1		9695/3
Follicular lymphoma, grade 3		9698/3
Extranodal marginal zone lymphoma of mucosa-associated lymphoid tissue (MALT lymphoma)		9699/3
Mycosis fungoides		9700/3
Sezary syndrome		9701/3
Peripheral T-cell lymphoma, NOS		9702/3
Angioimmunoblastic T-cell lymphoma		9705/3
Subcutaneous panniculitis-like T-cell lymphoma		9708/3
Primary cutaneous T-cell lymphoma		9709/3
Intravascular large B-cell lymphoma		9712/3
Anaplastic large cell lymphoma, ALK positive		9714/3
Hepatosplenic T-cell lymphoma		9716/3
Enteropathy-associated T-cell lymphoma		9717/3
Primary cutaneous CD30-positive T-cell lymphoproliferative disorders		9718/3
Extranodal NK/T cell lymphoma, nasal type		9719/3
Systemic EBV positive T-cell lymphoproliferative disease of childhood		9724/3
Hydroa vacciniforme-like lymphoma		9725/3
Primary cutaneous gamma-delta T-cell lymphoma		9726/3
Blastic plasmacytoid dendritic cell neoplasm		9727/3
Preursor B-cell lymphoblastic lymphoma [OBS] See 9811/3		9728/3-
Preursor T-cell lymphoblastic lymphoma [OBS] See 9837/3		9729/2-
Solitary plasmacytoma of bone		9731/3
Plasma cell myeloma		9732/3
Plasma-cell-leukemia [OBS] See 9732/3		9733/3-
Extraosseous plasmacytoma		9734/3
Plasmablastic lymphoma		9735/3
ALK positive large B-cell lymphoma		9737/3
Large B-cell lymphoma arising in HHV8-associated multicentric Castlemann disease		9738/3
Mast cell sarcoma		9740/3
Systemic mastocytosis		9741/3
Mast cell leukemia		9742/3
Malignant histiocytosis [OBS] See 9751/3		9750/3-

2010 Hematopoietic and Lymphoid ICD-O Codes - Numerical List
THIS TABLE REPLACES ALL ICD-O-3 Codes 9590-9989

Preferred Histologic Term - updated for 2012 Heme/Lymph		Histology
	NOTE: DO NOT USE [OBS] Codes Beginning 1/1/2010 - [OBS] Codes are OBSOLETE	
Langerhans cell histiocytes		9751/3
Langerhans-cell-histiocytosis, unifocal	[OBS] See 9751/3	9752/3
Langerhans-cell-histiocytosis, multifocal	[OBS] See 9751/3	9753/3
Langerhans-cell-histiocytosis, disseminated	[OBS] See 9751/3	9754/3
Histiocytic sarcoma		9755/3
Langerhans cell sarcoma		9756/3
Interdigitating dendritic cell sarcoma		9757/3
Follicular dendritic cell sarcoma		9758/3
Fibroblastic reticular cell tumor		9759/3
Immunoproliferative disease, NOS	[OBS] See 9762/3	9760/3-
Waldenstrom macroglobulinemia		9761/3
Heavy chain disease		9762/3
Immunoproliferative small intestinal disease	[OBS] See 9762/3	9764/3-
Monoclonal gammopathy, unknown significance (MGUS)		9765/1
Leukemia, NOS		9800/3
Acute undifferentiated leukemia		9801/3
Acute-biphenotypic-leukemia	[OBS] See 9809/3	9805/3-
Mixed phenotype acute leukemia with t(9;22)(q34;q11.2);BCR-ABL1		9806/3
Mixed phenotype acute leukemia with t(v;11q23);MLL, rearranged		9807/3
Mixed phenotype acute leukemia, B/myeloid, NOS		9808/3
Mixed phenotype acute leukemia, T/myeloid, NOS		9809/3
B lymphoblastic leukemia/lymphoma, NOS		9811/3
B lymphoblastic leukemia/lymphoma with t(9;22)(q34;q11.2);BCR-ABL1		9812/3
B lymphoblastic leukemia/lymphoma with t(v;11q23);MLL rearranged		9813/3
B lymphoblastic leukemia/lymphoma with t(12;21)(p13;q22);TEL-AML1 (ETV6-RUNX1)		9814/3
B lymphoblastic leukemia/lymphoma with hyperdiploidy		9815/3
B lymphoblastic leukemia/lymphoma with hypodiploidy (hypodiploid ALL)		9816/3
B lymphoblastic leukemia/lymphoma with t(5;14)(q31;q32);IL3-IGH		9817/3
B lymphoblastic leukemia/lymphoma with t(1;19)(q23;p13.3);E2A-PBX1 (TCF3-PBX1)		9818/3
Lymphoid leukemia, NOS		9820/3
Chronic lymphocytic leukemia/small lymphocytic lymphoma		9823/3
Burkitt cell leukemia		9826/3

2010 Hematopoietic and Lymphoid ICD-O Codes - Numerical List
THIS TABLE REPLACES ALL ICD-O-3 Codes 9590-9989

Preferred Histologic Term - updated for 2012 Heme/Lymph		Histology
NOTE: DO NOT USE [OBS] Codes Beginning 1/1/2010 - [OBS] Codes are OBSOLETE		
Adult T-cell leukemia/lymphoma (HTLV-1 positive)		9827/3
T-cell large granular lymphocytic leukemia		9831/3
Prolymphocytic leukemia, NOS		9832/3
B-cell prolymphocytic leukemia		9833/3
T-cell prolymphocytic leukemia		9834/3
Preursor-cell-lymphoblastic-leukemia-, NOS [OBS] See 9811/3		9835/3-
Preursor-B-cell-lymphoblastic-leukemia [OBS] See 9811/3		9836/3-
Adult T-cell leukemia/lymphoma		9837/3
Acute erythroid leukemia		9840/3
Myeloid leukemia, NOS		9860/3
Acute myeloid leukemia, NOS		9861/3
Chronic myeloid leukemia, NOS		9863/3
Acute myeloid leukemia with t(6;9)(p23;q34); DEK-NUP214		9865/3
Acute promyelocytic leukemia (AML with t(15;17)(q22;q12), PML/RARA		9866/3
Acute myelomonocytic leukemia		9867/3
Acute myeloid leukemia with inv(3)(q21;q26;2) or t(3;3)(q21;q26;2); RPN1-EV1		9869/3
Acute basophilic leukemia		9870/3
Acute myeloid leukemia with inv(16)(p13.1q22) or t(16;16)(p13.1;q22), CBFβ/MYH11		9871/3
Acute myeloid leukemia with minimal differentiation		9872/3
Acute myeloid leukemia without maturation		9873/3
Acute myeloid leukemia with maturation		9874/3
Chronic myelogenous leukemia, BCR-ABL1 positive		9875/3
Atypical chronic myeloid leukemia, BCR-ABL1 negative		9876/3
Acute monoblastic and monocytic leukemia		9891/3
Acute myeloid leukemia with myelodysplasia-related changes		9895/3
Acute myeloid leukemia with t(8;21)(q22;q22); RUNX1-RUNX1T1		9896/3
Acute myeloid leukemia with t(9;11)(p22;q23); MLLT3-MLL		9897/3
Myeloid leukemia associated with Down syndrome		9898/3
Acute megakaryoblastic leukemia		9910/3
Acute myeloid leukemia (megakaryoblastic) with t(1;22)(p13;q13); RBM15-MKL1		9911/3
Therapy-related myeloid neoplasm		9920/3
Myeloid sarcoma		9930/3

2010 Hematopoietic and Lymphoid ICD-O Codes - Numerical List
THIS TABLE REPLACES ALL ICD-O-3 Codes 9590-9989

Preferred Histologic Term - updated for 2012 Heme/Lymph		Histology
	NOTE: DO NOT USE [OBS] Codes Beginning 1/1/2010 - [OBS] Codes are OBSOLETE	
Acute panmyelosis with myelofibrosis		9931/3
Hairy cell leukemia		9940/3
Chronic myelomonocytic leukemia		9945/3
Juvenile myelomonocytic leukemia		9946/3
Aggressive NK-cell leukemia		9948/3
Polycythemia vera		9950/3
Chronic myeloproliferative disease, NOS [OBS] See 9975/3		9960/3-
Primary myelofibrosis		9961/3
Essential thrombocythemia		9962/3
Chronic neutrophilic leukemia		9963/3
Chronic eosinophilic leukemia, NOS		9964/3
Myeloid and lymphoid neoplasm with PDGFRA rearrangement		9965/3
Myeloid neoplasm with PDGFRB arrangement		9966/3
Myeloid and lymphoid neoplasm with FGFR1 abnormalities		9967/3
Lymphoproliferative disorder, NOS		9970/1
Post Transplant Lymphoproliferative Disorder (PTLD)		9971/3
Myelodysplastic/myeloproliferative neoplasm, unclassifiable		9975/3
Refractory anemia		9980/3
Refractory anemia with ring sideroblasts		9982/3
Refractory anemia with excess blasts		9983/3
Refractory anemia with excess blasts in transformation [OBS] See 9983/3		9984/3-
Refractory cytopenia with multilineage dysplasia		9985/3
Myelodysplastic syndrome associated with isolated del(5q)		9986/3
Therapy related myelodysplastic syndrome, NOS [OBS] See 9920/3		9987/3-
Myelodysplastic syndrome, unclassifiable		9989/3
Refractory neutropenia		9991/3
Refractory thrombocytopenia		9992/3

Appendix N

Consensus Technical Working Group

Release Memo for 2014+ Grade Coding Instructions

and

Instructions for Coding Grade for 2014+

To: The Cancer Registry Community

From: CoC-SEER-NPCR Technical Working Group

Date: 21 November 2013

Subject: Grade coding instructions to be implemented for cases diagnosed 1 January 2014+

The coding of grade (**GRADE, DIFFERENTIATION OR CELL INDICATOR [NAACCR Item #: 440]**) has become complicated over time by the introduction of specialized site-specific grading systems. In addition, the coding instructions listed in CoC's FORDS Manual and SEER's Coding Manual differed. Therefore, a small group has been meeting to see if a consensus on grade could be reached among CoC, SEER, and NPCR. The consensus decision was to draft a set of instructions that were simpler, the same among all 3 groups, and in the end, were different from CoC's or SEER's previous instructions. Separate documentation will be produced later to outline these differences.

The 'Instructions for Coding Grade' can be found at <http://seer.cancer.gov/tools/grade/> and are to be implemented for cases diagnosed 1 January 2014 and forward for CoC, SEER, and NPCR. CoC and SEER will incorporate these instructions into their respective coding manuals for 2014. CoC, SEER, and NPCR will notify their respective constituents of their general coding instructions for 2014 including grade.

No codes have been added or deleted. Vendors will not be required to make any changes to software. However, vendors may be able to implement some of the grading instructions electronically to aid cancer registrars in coding the grade field.

Educational materials/presentations will be developed. Short articles/announcements are being developed to highlight some of the changes.

The impact of these new instructions on the analyses of grade trends over time may be substantial for some sites especially prostate. It was difficult to balance changing rules with a desire to keep grade trends intact. For prostate, however, earlier changes based on 'current at the time' AJCC/UICC rules had already wreaked havoc on trying to analyze prostate grade trends.

Many thanks to those who reviewed the instructions. Your comments and questions were very helpful.

The members of the CoC-SEER-NPCR Technical Working Group who drafted this document were Margaret Adamo (NCI-SEER), Mary Lewis (CDC-NPCR), Jerri Linn Phillips (CoC), Joan Phillips (CDC-NPCR), Lynn Ries (NCI contractor), Jennifer Ruhl (NCI-SEER), and Shannon Vann (NAACCR).

Instructions for Coding Grade for 2014+

GRADE, DIFFERENTIATION OR CELL INDICATOR

Item Length: 1

NAACCR Item #: 440

NAACCR Name: Grade

Grade, Differentiation for solid tumors (Codes 1, 2, 3, 4, 9) and Cell Indicator for Lymphoid Neoplasms (Codes 5, 6, 7, 8, 9)

Note: These instructions pertain to the data item Grade, Differentiation or Cell Indicator.

These are coding instructions for **cases diagnosed 1/1/2014** and forward.

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.

Coding Grade for Hematopoietic and Lymphoid Neoplasms

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

Grade codes for hematopoietic and lymphoid neoplasms

Terminology	Grade Code
T-cell; T-precursor	5
B-Cell; Pre-B; B-precursor	6
Null cell; Non T-non B	7
NK cell (natural killer cell)	8
Grade unknown, not stated, or not applicable	9

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 nucleolar) features, or a combination of these elements, depending upon the grading system that is used. Some grading systems use only pattern, for example Gleason grading in prostate. Others use only a nuclear grade (usually size, amount of chromatin, degree of irregularity, and mitotic activity). Fuhrman's grade for kidney is based only on nuclear features. Most systems use a combination of pattern and cytologic and nuclear features; for example Nottingham's for breast combines numbers for pattern, nuclear size and shape, and mitotic activity. The information from this data item is useful for determining prognosis and treatment.

Pathologists describe the tumor grade using three systems or formats:

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

Breast and prostate grades may convert differently than other sites. These exceptions are noted in "Coding for Solid Tumors", #7-8 below.

Coding for Solid Tumors

1. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code grade based on information prior to neoadjuvant therapy even if grade is unknown.
2. Code the grade from the primary tumor only.
 - a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site.
 - b. If primary site is unknown, code grade to 9.
3. Code the grade shown below (6th digit) for specific histologic terms that imply a grade.
 - Carcinoma, undifferentiated (8020/34)
 - Carcinoma, anaplastic (8021/34)
 - Follicular adenocarcinoma, well differentiated (8331/31)
 - Thymic carcinoma, well differentiated (8585/31)
 - Sertoli-Leydig cell tumor, poorly differentiated (8631/33)
 - Sertoli-Leydig cell tumor, poorly differentiated with heterologous elements (8634/33)
 - Undifferentiated sarcoma (8805/34)

Liposarcoma, well differentiated (8851/31)
 Seminoma, anaplastic (9062/34)
 Malignant teratoma, undifferentiated (9082/34)
 Malignant teratoma, intermediate type (9083/32)
 Intraosseous osteosarcoma, well differentiated (9187/31)
 Astrocytoma, anaplastic (9401/34)
 Oligodendroglioma, anaplastic (9451/34)
 Retinoblastoma, differentiated (9511/31)
 Retinoblastoma, undifferentiated (9512/34)

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

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

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

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.

CS Schema	Special grade system
Breast	Nottingham or Bloom-Richardson (BR) Score/Grade (SSF7)
Prostate	Gleason's Score on Needle Core Biopsy/Transurethral Resection of Prostate (TURP) (SSF 8)
Prostate	Gleason's Score on Prostatectomy/Autopsy (SSF 10)
Heart, Mediastinum	Grade for Sarcomas (SSF 1)
Peritoneum	Grade for Sarcomas (SSF 1)
Retroperitoneum	Grade for Sarcomas (SSF 1)
Soft Tissue	Grade for Sarcomas (SSF 1)
Kidney Parenchyma	Fuhrman Nuclear Grade (SSF 6)

Do not use these tables to code grade for any other groups including WHO (CNS tumors), WHO/ISUP (bladder, renal pelvis), or FIGO (female gynecologic sites) grades.

7. Use the Two-, Three- or Four-grade system information

a. Two-grade system

Term	Description	Grade Code	Exception for Breast and Prostate Grade Code
1/2, I/II	Low grade	2	1
2/2, II/II	High grade	4	3

In transitional cell carcinoma for bladder, the terminology high grade TCC and low grade TCC are coded in the two-grade system.

b. Three-grade system

Term	Description	Grade Code	Exception for Breast and Prostate Grade Code
1/3	Low grade	2	1
2/3	Intermediate grade	3	2
3/3	High grade	4	3

c. Four-grade system: Any four-grade system including Edmondson and Steiner grade for liver.

Term	Description	Grade Code
1/4	Grade I; Well differentiated	1
2/4	Grade II; Moderately differentiated	2
3/4	Grade III; Poorly differentiated	3
4/4	Grade IV; Undifferentiated	4

8. Terminology: use the 'Description' column or the 'Grade' column to code grade. Breast & Prostate use the same grade code with a few noted exceptions.

Description	Grade	Assign Grade Code	Exception for Breast and Prostate Grade Code
Differentiated, NOS	I	1	
Well differentiated	I	1	
Only stated as 'Grade I'	I	1	
Fairly well differentiated	II	2	
Intermediate differentiation	II	2	
Low grade	I-II	2	1
Mid differentiated	II	2	
Moderately differentiated	II	2	
Moderately well differentiated	II	2	
Partially differentiated	II	2	
Partially well differentiated	I-II	2	1
Relatively or generally well differentiated	II	2	
Only stated as 'Grade II'	II	2	

Description	Grade	Assign Grade Code	Exception for Breast and Prostate Grade Code
Medium grade, intermediate grade	II-III	3	2
Moderately poorly differentiated	III	3	
Moderately undifferentiated	III	3	
Poorly differentiated	III	3	
Relatively poorly differentiated	III	3	
Relatively undifferentiated	III	3	
Slightly differentiated	III	3	
Dedifferentiated	III	3	
Only stated as 'Grade III'	III	3	
High grade	III-IV	4	3
Undifferentiated, anaplastic, not differentiated	IV	4	
Only stated as 'Grade IV'	IV	4	
Non-high grade		9	

9. If no description fits or grade is unknown prior to neoadjuvant therapy, code as a 9 (unknown).

SPECIAL GRADE SYSTEMS RULES

Breast (site: breast excluding lymphomas; CS schema: breast)

Use Bloom Richardson (BR) or Nottingham score/grade to code grade based on CSv2 site-specific factor 7 (SSF) as stated below. If your registry does not collect this SSF, use the description in the table below to determine grade. If you collect this SSF, codes 030-130 could be automatically converted into the grade field.

BR could also be referred to as: Bloom-Richardson, modified Bloom-Richardson, BR, BR grading, Scarff-Bloom-Richardson, SBR grading, Elston-Ellis modification of Bloom-Richardson score, Nottingham modification of Bloom-Richardson score, Nottingham modification of Scarff-Bloom-Richardson, Nottingham-Tenovus grade, or Nottingham grade.

Code the tumor grade using the following priority order

- a. BR scores 3-9
- b. BR grade (low, intermediate, high)

BR score may be expressed as a range, 3-9. The score is based on three morphologic features: degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism/nuclear grade of tumor cells. If a report uses words such as low, intermediate, or high rather than numbers, use the table below to code grade.

If only a grade of 1 through 4 is given with no information on the score and it is unclear if it is a Nottingham or BR Grade, do not use the table below. Continue with the next priority according to “Coding for Solid Tumors” #7 above.

Code the highest score if multiple scores are reported (exclude scores from tests after neoadjuvant therapy began). Examples: different scores may be reported on multiple pathology reports for the same primary cancer; different scores may be reported for multiple tumors assigned to the same primary cancer.

**CS Site-Specific Factor 7
Nottingham or Bloom-Richardson (BR) Score/Grade**

Description	CS Code	Grade Code
Score of 3	030	1
Score of 4	040	1
Score of 5	050	1
Score of 6	060	2
Score of 7	070	2
Score of 8	080	3
Score of 9	090	3
Low Grade, Bloom-Richardson (BR) grade 1, score not given	110	1
Medium (Intermediate) Grade, BR grade 2, score not given	120	2
High Grade, BR grade 3, score not given	130	3

**Kidney Parenchyma (Site: kidney parenchyma excluding lymphomas; CS schema: KidneyParenchyma):
Fuhrman Nuclear Grade**

The Fuhrman Nuclear Grade should be used to code grade for kidney parenchyma only based on CSv2 SSF 6 as stated below. Do not use for kidney renal pelvis. If your registry does not collect this SSF, use the description in the table to determine grade. If you collect this SSF, the information could be automatically converted into the grade field if it is coded 010-040. Fuhrman nuclear grade is a four-grade system based on nuclear diameter and shape, the prominence of nucleoli, and the presence of chromatin clumping in the highest grade.

Description	CS Code	Grade Code
Grade 1	010	1
Grade 2	020	2
Grade 3	030	3
Grade 4	040	4

SoftTissue (sites excluding lymphomas: soft tissue, heart, mediastinum, peritoneum, and retroperitoneum; for CS users: SoftTissue, HeartMediastinum, Peritoneum, Retroperitoneum schemas): Grade for Sarcomas

The Grade for Sarcomas should be used to code grade based on CSv2 SSF 1 as stated below. If your registry does not collect this SSF, use the description in the table to determine grade. If you collect this SSF, the information could be automatically converted into the grade field if it is coded 010-200. The grading system of the French Federation of Cancer Centers Sarcoma Group (FNCLCC) is the preferred system.

Record the grade from any three-grade sarcoma grading system the pathologist uses. For terms such as "well differentiated" or "poorly differentiated," go to Coding for Solid Tumors #8.

In some cases, especially for needle biopsies, grade may be specified only as "low grade" or "high grade." The numeric grade takes precedence over "low grade" or "high grade."

Description	CS Code	Grade Code
Specified as Grade 1 [of 3]	010	2
Specified as Grade 2 [of 3]	020	3
Specified as Grade 3 [of 3]	030	4
Grade stated as low grade, NOS	100	2
Grade stated as high grade, NOS	200	4

Prostate (site: prostate excluding lymphomas; CS schema: prostate)

Use the highest Gleason score from the biopsy/TURP or prostatectomy/autopsy. Use a known value over an unknown value. Exclude results from tests performed after neoadjuvant therapy began. This information is collected in CSv2 SSF 8 (Gleason score from biopsy/TURP) and SSF 10 (Gleason score from prostatectomy/autopsy) as stated below. Use the table below to determine grade even if your registry does not collect these SSFs. If you collect these SSFs, the information could be converted into the grade field automatically.

Usually prostate cancers are graded using Gleason score or pattern. Gleason grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason grade, and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10. If there are two numbers, assume that they refer to two patterns (the first number being the primary pattern and the second number the secondary pattern), and sum them to obtain the score. If only one number is given on a particular test and it is less than or equal to 5 and not specified as a score, do not use the information because it could refer to either a score or a grade. If only one number is given and it is greater than 5, assume that it is a score and use it. If the pathology report specifies a specific number out of a total of 10, the first number given is the score. Example: The pathology report says Gleason 3/10. The Gleason score would be 3.

Historic Perspective

Gleason score	Description					
	CS Code	Grade Code	AJCC 7th	SEER 2003-2013	AJCC 6th	SEER prior 2003
2	002	1	G1	G1	G1	G1
3	003	1	G1	G1	G1	G1
4	004	1	G1	G1	G1	G1
5	005	1	G1	G2	G2	G2
6	006	1	G1	G2	G2	G2
7	007	2	G2	G3	G3	G2
8	008	3	G3	G3	G3	G3
9	009	3	G3	G3	G3	G3
10	010	3	G3	G3	G3	G3

Historical perspective on long term trends in prostate grade: The relationship of Gleason score to grade changed for 1/1/2014+ diagnoses in order to have the grade field in sync with AJCC 7th ed. Analysis of prostate grade before 2014 based solely on the grade field is not recommended. In Collaborative Stage (CS), Gleason score was originally coded in CSv1 in one field (SSF 6) and then it was split into two fields in CSv2 based on the tissue used for the test: needle biopsy/TURP (SSF 8) and prostatectomy/autopsy (SSF 10). For trends using data back to 2004, if one collected the various CS Gleason scores, one could design a recode to have the same criteria as the data collected 2014+. The original grade field would NOT be changed, but for analyses this recode could be based on the CS SSFs and the original grade code.

Computer algorithm to derive grade for prostate based on SSF 8 and SSF 10: if SSF 8 or SSF 10 has known values for Gleason's, the information could be used to automatically derive the grade field.

SSF 8 Code	SSF 10 Grade Code											
	002	003	004	005	006	007	008	009	010	988	998	999
002	1	1	1	1	1	2	3	3	3	*	1	1
003	1	1	1	1	1	2	3	3	3	*	1	1
004	1	1	1	1	1	2	3	3	3	*	1	1
005	1	1	1	1	1	2	3	3	3	*	1	1
006	1	1	1	1	1	2	3	3	3	*	1	1
007	2	2	2	2	2	2	3	3	3	*	2	2
008	3	3	3	3	3	3	3	3	3	*	3	3
009	3	3	3	3	3	3	3	3	3	*	3	3
010	3	3	3	3	3	3	3	3	3	*	3	3
988	*	*	*	*	*	*	*	*	*	*	*	*
998	1	1	1	1	1	2	3	3	3	*	*	*
999	1	1	1	1	1	2	3	3	3	*	*	*

* Grade can't be automatically calculated based on SSF 8 and SSF 10; Go to Step 7

Appendix O

2015 FCDS Casefinding List of Reportable Tumors

ICD-9-CM Code List

ICD-10-CM Code List

Guidelines for ICD-O-3 Update Implementation

Updates to the International Classification of Diseases for Oncology, third edition (ICDO-3)

ICD-9-CM CASEFINDING LIST FOR REPORTABLE TUMORS – Jan-Sept 2015

The following ICD-9-CM list is to be used to identify potentially reportable tumors. Some ICD-9-CM codes contain conditions that are not reportable. These records should be reviewed and assessed individually to verify whether or not they are reportable to FCDS.

ICD-9-CM	Description
140.00-209.36	Malignant neoplasms (excluding skin 173.0-173.9)
209.70-209.79	Secondary neuroendocrine tumors
225.0-225.9	Benign neoplasm of brain and spinal cord neoplasm
227.3-227.4	Benign neoplasm of pituitary gland, pineal body, and intracranial endocrine-related structures
228.02	Hemangioma; of intracranial structures
228.1	Lymphangioma, any site brain, other parts of CNS
230.0-234.9	Carcinoma in situ (exclude: skin, cervix and prostate– 232.0-232.9, 233.1, 233.4)
237.0-237.1, 237.5, 237.6, 237.9	Neoplasm of uncertain behavior (borderline) of intracranial endocrine glands, brain and CNS
238.4	Polycythemia vera (9950/3)
239.6-239.7	Neoplasms of unspecified nature Brain and CNS
273.3	Waldenstrom macroglobulinemia (9761/3)
511.81	Malignant pleural effusion (code first malignant neoplasm if known)
789.51	Malignant ascites (code the first malignant neoplasm if known)
V58.0	Encounter for radiotherapy
V58.1	Encounter for chemotherapy and immunotherapy
V58.11	Antineoplastic Chemotherapy
V58.12	Antineoplastic Immunotherapy

Note: Pilocytic/juvenile astrocytoma (M-9421) is reported with the behavior coded /3 (9421/3 not 9421/1).

ICD-10-CM CASEFINDING LIST FOR REPORTABLE TUMORS – Oct 1, 2015 and later encounters

The following ICD-10-CM list is to be used to identify potentially reportable tumors. Some ICD-10-CM codes contain conditions that are not reportable. These records should be reviewed and assessed individually to verify whether or not they are reportable to FCDS. ICD-10-CM implementation is expected nationwide October 1, 2015 for all hospitals.

ICD-10-CM	Description
C00._ - C43._	Malignant neoplasms
C4A._	Merkel cell carcinoma
C45._ - C96._	Malignant neoplasms
D00._ - D09._	Carcinoma in situ (exclude: skin, cervix and prostate– D04._, D06._ and D07.5)
D18.02	Hemangioma; of intracranial structures
D18.1	Lymphangioma, any site brain, other parts of CNS
D32._	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33._	Benign neoplasm of brain and other parts of central nervous system
D35.2, D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42._, D43._	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3-D44.5	Neoplasm of uncertain behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3)
D46._	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D47.1	Chronic myeloproliferative disease (9960, 9963)
D47.3	Essential (hemorrhagic) thrombocythemia (9962)
D47.4	Osteomyelofibrosis (9961)
D47.7	Other specified neoplasm of uncertain/unknown behavior of lymphoid, hematopoietic (9965, 9966, 9967, 9971, 9975, 9987)
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960, 9970, 9931)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
J91.0	Malignant Pleural Effusion
R18.0	Malignant ascites
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.11	Encounter for antineoplastic chemotherapy
Z51.12	Encounter for antineoplastic immunotherapy

Note: Pilocytic/juvenile astrocytoma (M-9421) is reported with the behavior coded /3 (9421/3 not 9421/1).

DETAILED ICD-10-CM CODE LIST FOR CASEFINDING REPORTABLE TUMORS – Oct 1, 2015 and later encounters

The following Detailed ICD-10-CM code list is to be used to identify potentially reportable tumors. Some ICD-10-CM codes contain conditions that are not reportable. These records should be reviewed and assessed individually to verify whether or not they are reportable to FCDS. ICD-10-CM implementation is expected nationwide October 1, 2015 for all hospitals.

ICD-10-CM	Code Description
C00	Malignant neoplasm of lip
C00.0	Malignant neoplasm of external upper lip
C00.1	Malignant neoplasm of external lower lip
C00.2	Malignant neoplasm of external lip, unspecified
C00.3	Malignant neoplasm of upper lip, inner aspect
C00.4	Malignant neoplasm of lower lip, inner aspect
C00.5	Malignant neoplasm of lip, unspecified, inner aspect
C00.6	Malignant neoplasm of commissure of lip, unspecified
C00.8	Malignant neoplasm of overlapping sites of lip
C00.9	Malignant neoplasm of lip, unspecified
C01	Malignant neoplasm of base of tongue
C02	Malignant neoplasm of other and unspecified parts of tongue
C02.0	Malignant neoplasm of dorsal surface of tongue
C02.1	Malignant neoplasm of border of tongue
C02.2	Malignant neoplasm of ventral surface of tongue
C02.3	Malignant neoplasm of anterior two-thirds of tongue, part unspecified
C02.4	Malignant neoplasm of lingual tonsil
C02.8	Malignant neoplasm of overlapping sites of tongue
C02.9	Malignant neoplasm of tongue, unspecified
C03	Malignant neoplasm of gum
C03.0	Malignant neoplasm of upper gum
C03.1	Malignant neoplasm of lower gum
C03.9	Malignant neoplasm of gum, unspecified
C04	Malignant neoplasm of floor of mouth
C04.0	Malignant neoplasm of anterior floor of mouth
C04.1	Malignant neoplasm of lateral floor of mouth
C04.8	Malignant neoplasm of overlapping sites of floor of mouth
C04.9	Malignant neoplasm of floor of mouth, unspecified
C05	Malignant neoplasm of palate
C05.0	Malignant neoplasm of hard palate
C05.1	Malignant neoplasm of soft palate
C05.2	Malignant neoplasm of uvula
C05.8	Malignant neoplasm of overlapping sites of palate
C05.9	Malignant neoplasm of palate, unspecified
C06	Malignant neoplasm of other and unspecified parts of mouth
C06.0	Malignant neoplasm of cheek mucosa
C06.1	Malignant neoplasm of vestibule of mouth
C06.2	Malignant neoplasm of retromolar area
C06.8	Malignant neoplasm of overlapping sites of other and unspecified parts of mouth
C06.80	Malignant neoplasm of overlapping sites of unspecified parts of mouth

ICD-10-CM	Code Description
C06.89	Malignant neoplasm of overlapping sites of other parts of mouth
C06.9	Malignant neoplasm of mouth, unspecified
C07	Malignant neoplasm of parotid gland
C08	Malignant neoplasm of other and unspecified major salivary glands
C08.0	Malignant neoplasm of submandibular gland
C08.1	Malignant neoplasm of sublingual gland
C08.9	Malignant neoplasm of major salivary gland, unspecified
C09	Malignant neoplasm of tonsil
C09.0	Malignant neoplasm of tonsillar fossa
C09.1	Malignant neoplasm of tonsillar pillar (anterior) (posterior)
C09.8	Malignant neoplasm of overlapping sites of tonsil
C09.9	Malignant neoplasm of tonsil, unspecified
C10	Malignant neoplasm of oropharynx
C10.0	Malignant neoplasm of vallecula
C10.1	Malignant neoplasm of anterior surface of epiglottis
C10.2	Malignant neoplasm of lateral wall of oropharynx
C10.3	Malignant neoplasm of posterior wall of oropharynx
C10.4	Malignant neoplasm of branchial cleft
C10.8	Malignant neoplasm of overlapping sites of oropharynx
C10.9	Malignant neoplasm of oropharynx, unspecified
C11	Malignant neoplasm of nasopharynx
C11.0	Malignant neoplasm of superior wall of nasopharynx
C11.1	Malignant neoplasm of posterior wall of nasopharynx
C11.2	Malignant neoplasm of lateral wall of nasopharynx
C11.3	Malignant neoplasm of anterior wall of nasopharynx
C11.8	Malignant neoplasm of overlapping sites of nasopharynx
C11.9	Malignant neoplasm of nasopharynx, unspecified
C12	Malignant neoplasm of pyriform sinus
C13	Malignant neoplasm of hypopharynx
C13.0	Malignant neoplasm of postcricoid region
C13.1	Malignant neoplasm of aryepiglottic fold, hypopharyngeal aspect
C13.2	Malignant neoplasm of posterior wall of hypopharynx
C13.8	Malignant neoplasm of overlapping sites of hypopharynx
C13.9	Malignant neoplasm of hypopharynx, unspecified
C14	Malignant neoplasm of other and ill-defined sites in the lip, oral cavity and pharynx
C14.0	Malignant neoplasm of pharynx, unspecified
C14.2	Malignant neoplasm of Waldeyers ring
C14.8	Malignant neoplasm of overlapping sites of lip, oral cavity and pharynx
C15	Malignant neoplasm of esophagus
C15.3	Malignant neoplasm of upper third of esophagus
C15.4	Malignant neoplasm of middle third of esophagus
C15.5	Malignant neoplasm of lower third of esophagus
C15.8	Malignant neoplasm of overlapping sites of esophagus
C15.9	Malignant neoplasm of esophagus, unspecified
C16	Malignant neoplasm of stomach

ICD-10-CM	Code Description
C16.0	Malignant neoplasm of cardia
C16.1	Malignant neoplasm of fundus of stomach
C16.2	Malignant neoplasm of body of stomach
C16.3	Malignant neoplasm of pyloric antrum
C16.4	Malignant neoplasm of pylorus
C16.5	Malignant neoplasm of lesser curvature of stomach, unspecified
C16.6	Malignant neoplasm of greater curvature of stomach, unspecified
C16.8	Malignant neoplasm of overlapping sites of stomach
C16.9	Malignant neoplasm of stomach, unspecified
C17	Malignant neoplasm of small intestine
C17.0	Malignant neoplasm of duodenum
C17.1	Malignant neoplasm of jejunum
C17.2	Malignant neoplasm of ileum
C17.3	Meckels diverticulum, malignant
C17.8	Malignant neoplasm of overlapping sites of small intestine
C17.9	Malignant neoplasm of small intestine, unspecified
C18	Malignant neoplasm of colon
C18.0	Malignant neoplasm of cecum
C18.1	Malignant neoplasm of appendix
C18.2	Malignant neoplasm of ascending colon
C18.3	Malignant neoplasm of hepatic flexure
C18.4	Malignant neoplasm of transverse colon
C18.5	Malignant neoplasm of splenic flexure
C18.6	Malignant neoplasm of descending colon
C18.7	Malignant neoplasm of sigmoid colon
C18.8	Malignant neoplasm of overlapping sites of colon
C18.9	Malignant neoplasm of colon, unspecified
C19	Malignant neoplasm of rectosigmoid junction
C20	Malignant neoplasm of rectum
C21	Malignant neoplasm of anus and anal canal
C21.0	Malignant neoplasm of anus, unspecified
C21.1	Malignant neoplasm of anal canal
C21.2	Malignant neoplasm of cloacogenic zone
C21.8	Malignant neoplasm of overlapping sites of rectum, anus and anal canal
C22	Malignant neoplasm of liver and intrahepatic bile ducts
C22.0	Liver cell carcinoma
C22.1	Intrahepatic bile duct carcinoma
C22.2	Hepatoblastoma
C22.3	Angiosarcoma of liver
C22.4	Other sarcomas of liver
C22.7	Other specified carcinomas of liver
C22.8	Malignant neoplasm of liver, primary, unspecified as to type
C22.9	Malignant neoplasm of liver, not specified as primary or secondary
C23	Malignant neoplasm of gallbladder
C24	Malignant neoplasm of other and unspecified parts of biliary tract

ICD-10-CM	Code Description
C24.0	Malignant neoplasm of extrahepatic bile duct
C24.1	Malignant neoplasm of ampulla of Vater
C24.8	Malignant neoplasm of overlapping sites of biliary tract
C24.9	Malignant neoplasm of biliary tract, unspecified
C25	Malignant neoplasm of pancreas
C25.0	Malignant neoplasm of head of pancreas
C25.1	Malignant neoplasm of body of pancreas
C25.2	Malignant neoplasm of tail of pancreas
C25.3	Malignant neoplasm of pancreatic duct
C25.4	Malignant neoplasm of endocrine pancreas
C25.7	Malignant neoplasm of other parts of pancreas
C25.8	Malignant neoplasm of overlapping sites of pancreas
C25.9	Malignant neoplasm of pancreas, unspecified
C26	Malignant neoplasm of other and ill-defined digestive organs
C26.0	Malignant neoplasm of intestinal tract, part unspecified
C26.1	Malignant neoplasm of spleen
C26.9	Malignant neoplasm of ill-defined sites within the digestive system
C30	Malignant neoplasm of nasal cavity and middle ear
C30.0	Malignant neoplasm of nasal cavity
C30.1	Malignant neoplasm of middle ear
C31	Malignant neoplasm of accessory sinuses
C31.0	Malignant neoplasm of maxillary sinus
C31.1	Malignant neoplasm of ethmoidal sinus
C31.2	Malignant neoplasm of frontal sinus
C31.3	Malignant neoplasm of sphenoid sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
C31.9	Malignant neoplasm of accessory sinus, unspecified
C32	Malignant neoplasm of larynx
C32.0	Malignant neoplasm of glottis
C32.1	Malignant neoplasm of supraglottis
C32.2	Malignant neoplasm of subglottis
C32.3	Malignant neoplasm of laryngeal cartilage
C32.8	Malignant neoplasm of overlapping sites of larynx
C32.9	Malignant neoplasm of larynx, unspecified
C33	Malignant neoplasm of trachea
C34	Malignant neoplasm of bronchus and lung
C34.0	Malignant neoplasm of main bronchus
C34.00	Malignant neoplasm of unspecified main bronchus
C34.01	Malignant neoplasm of right main bronchus
C34.02	Malignant neoplasm of left main bronchus
C34.1	Malignant neoplasm of upper lobe, bronchus or lung
C34.10	Malignant neoplasm of upper lobe, unspecified bronchus or lung
C34.11	Malignant neoplasm of upper lobe, right bronchus or lung
C34.12	Malignant neoplasm of upper lobe, left bronchus or lung
C34.2	Malignant neoplasm of middle lobe, bronchus or lung

ICD-10-CM	Code Description
C34.3	Malignant neoplasm of lower lobe, bronchus or lung
C34.30	Malignant neoplasm of lower lobe, unspecified bronchus or lung
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung
C34.32	Malignant neoplasm of lower lobe, left bronchus or lung
C34.8	Malignant neoplasm of overlapping sites of bronchus and lung
C34.80	Malignant neoplasm of overlapping sites of unspecified bronchus and lung
C34.81	Malignant neoplasm of overlapping sites of right bronchus and lung
C34.82	Malignant neoplasm of overlapping sites of left bronchus and lung
C34.9	Malignant neoplasm of unspecified part of bronchus or lung
C34.90	Malignant neoplasm of unspecified part of unspecified bronchus or lung
C34.91	Malignant neoplasm of unspecified part of right bronchus or lung
C34.92	Malignant neoplasm of unspecified part of left bronchus or lung
C37	Malignant neoplasm of thymus
C38	Malignant neoplasm of heart, mediastinum and pleura
C38.0	Malignant neoplasm of heart
C38.1	Malignant neoplasm of anterior mediastinum
C38.2	Malignant neoplasm of posterior mediastinum
C38.3	Malignant neoplasm of mediastinum, part unspecified
C38.4	Malignant neoplasm of pleura
C38.8	Malignant neoplasm of overlapping sites of heart, mediastinum and pleura
C39	Malignant neoplasm of other and ill-defined sites in the respiratory system and intrathoracic organs
C39.0	Malignant neoplasm of upper respiratory tract, part unspecified
C39.9	Malignant neoplasm of lower respiratory tract, part unspecified
C40	Malignant neoplasm of bone and articular cartilage of limbs
C40.0	Malignant neoplasm of scapula and long bones of upper limb
C40.00	Malignant neoplasm of scapula and long bones of unspecified upper limb
C40.01	Malignant neoplasm of scapula and long bones of right upper limb
C40.02	Malignant neoplasm of scapula and long bones of left upper limb
C40.1	Malignant neoplasm of short bones of upper limb
C40.10	Malignant neoplasm of short bones of unspecified upper limb
C40.11	Malignant neoplasm of short bones of right upper limb
C40.12	Malignant neoplasm of short bones of left upper limb
C40.2	Malignant neoplasm of long bones of lower limb
C40.20	Malignant neoplasm of long bones of unspecified lower limb
C40.21	Malignant neoplasm of long bones of right lower limb
C40.22	Malignant neoplasm of long bones of left lower limb
C40.3	Malignant neoplasm of short bones of lower limb
C40.30	Malignant neoplasm of short bones of unspecified lower limb
C40.31	Malignant neoplasm of short bones of right lower limb
C40.32	Malignant neoplasm of short bones of left lower limb
C40.8	Malignant neoplasm of overlapping sites of bone and articular cartilage of limb
C40.80	Malignant neoplasm of overlapping sites of bone and articular cartilage of unspecified limb
C40.81	Malignant neoplasm of overlapping sites of bone and articular cartilage of right limb
C40.82	Malignant neoplasm of overlapping sites of bone and articular cartilage of left limb
C40.9	Malignant neoplasm of unspecified bones and articular cartilage of limb

ICD-10-CM	Code Description
C40.90	Malignant neoplasm of unspecified bones and articular cartilage of unspecified limb
C40.91	Malignant neoplasm of unspecified bones and articular cartilage of right limb
C40.92	Malignant neoplasm of unspecified bones and articular cartilage of left limb
C41	Malignant neoplasm of bone and articular cartilage of other and unspecified sites
C41.0	Malignant neoplasm of bones of skull and face
C41.1	Malignant neoplasm of mandible
C41.2	Malignant neoplasm of vertebral column
C41.3	Malignant neoplasm of ribs, sternum and clavicle
C41.4	Malignant neoplasm of pelvic bones, sacrum and coccyx
C41.9	Malignant neoplasm of bone and articular cartilage, unspecified
C43	Malignant melanoma of skin
C43.0	Malignant melanoma of lip
C43.1	Malignant melanoma of eyelid, including canthus
C43.10	Malignant melanoma of unspecified eyelid, including canthus
C43.11	Malignant melanoma of right eyelid, including canthus
C43.12	Malignant melanoma of left eyelid, including canthus
C43.2	Malignant melanoma of ear and external auricular canal
C43.20	Malignant melanoma of unspecified ear and external auricular canal
C43.21	Malignant melanoma of right ear and external auricular canal
C43.22	Malignant melanoma of left ear and external auricular canal
C43.3	Malignant melanoma of other and unspecified parts of face
C43.30	Malignant melanoma of unspecified part of face
C43.31	Malignant melanoma of nose
C43.39	Malignant melanoma of other parts of face
C43.4	Malignant melanoma of scalp and neck
C43.5	Malignant melanoma of trunk
C43.51	Malignant melanoma of anal skin
C43.52	Malignant melanoma of skin of breast
C43.59	Malignant melanoma of other part of trunk
C43.6	Malignant melanoma of upper limb, including shoulder
C43.60	Malignant melanoma of unspecified upper limb, including shoulder
C43.61	Malignant melanoma of right upper limb, including shoulder
C43.62	Malignant melanoma of left upper limb, including shoulder
C43.7	Malignant melanoma of lower limb, including hip
C43.70	Malignant melanoma of unspecified lower limb, including hip
C43.71	Malignant melanoma of right lower limb, including hip
C43.72	Malignant melanoma of left lower limb, including hip
C43.8	Malignant melanoma of overlapping sites of skin
C43.9	Malignant melanoma of skin, unspecified
C45	Mesothelioma
C45.0	Mesothelioma of pleura
C45.1	Mesothelioma of peritoneum
C45.2	Mesothelioma of pericardium
C45.7	Mesothelioma of other sites
C45.9	Mesothelioma, unspecified

ICD-10-CM	Code Description
C46	Kaposi sarcoma
C46.0	Kaposi sarcoma of skin
C46.1	Kaposi sarcoma of soft tissue
C46.2	Kaposi sarcoma of palate
C46.3	Kaposi sarcoma of lymph nodes
C46.4	Kaposi sarcoma of gastrointestinal sites
C46.5	Kaposi sarcoma of lung
C46.50	Kaposi sarcoma of unspecified lung
C46.51	Kaposi sarcoma of right lung
C46.52	Kaposi sarcoma of left lung
C46.7	Kaposi sarcoma of other sites
C46.9	Kaposi sarcoma, unspecified
C47	Malignant neoplasm of peripheral nerves and autonomic nervous system
C47.0	Malignant neoplasm of peripheral nerves of head, face and neck
C47.1	Malignant neoplasm of peripheral nerves of upper limb, including shoulder
C47.10	Malignant neoplasm of peripheral nerves of unspecified upper limb, including shoulder
C47.11	Malignant neoplasm of peripheral nerves of right upper limb, including shoulder
C47.12	Malignant neoplasm of peripheral nerves of left upper limb, including shoulder
C47.2	Malignant neoplasm of peripheral nerves of lower limb, including hip
C47.20	Malignant neoplasm of peripheral nerves of unspecified lower limb, including hip
C47.21	Malignant neoplasm of peripheral nerves of right lower limb, including hip
C47.22	Malignant neoplasm of peripheral nerves of left lower limb, including hip
C47.3	Malignant neoplasm of peripheral nerves of thorax
C47.4	Malignant neoplasm of peripheral nerves of abdomen
C47.5	Malignant neoplasm of peripheral nerves of pelvis
C47.6	Malignant neoplasm of peripheral nerves of trunk, unspecified
C47.8	Malignant neoplasm of overlapping sites of peripheral nerves and autonomic nervous system
C47.9	Malignant neoplasm of peripheral nerves and autonomic nervous system, unspecified
C48	Malignant neoplasm of retroperitoneum and peritoneum
C48.0	Malignant neoplasm of retroperitoneum
C48.1	Malignant neoplasm of specified parts of peritoneum
C48.2	Malignant neoplasm of peritoneum, unspecified
C48.8	Malignant neoplasm of overlapping sites of retroperitoneum and peritoneum
C49	Malignant neoplasm of other connective and soft tissue
C49.0	Malignant neoplasm of connective and soft tissue of head, face and neck
C49.1	Malignant neoplasm of connective and soft tissue of upper limb, including shoulder
C49.10	Malignant neoplasm of connective and soft tissue of unspecified upper limb, including shoulder
C49.11	Malignant neoplasm of connective and soft tissue of right upper limb, including shoulder
C49.12	Malignant neoplasm of connective and soft tissue of left upper limb, including shoulder
C49.2	Malignant neoplasm of connective and soft tissue of lower limb, including hip
C49.20	Malignant neoplasm of connective and soft tissue of unspecified lower limb, including hip
C49.21	Malignant neoplasm of connective and soft tissue of right lower limb, including hip
C49.22	Malignant neoplasm of connective and soft tissue of left lower limb, including hip
C49.3	Malignant neoplasm of connective and soft tissue of thorax
C49.4	Malignant neoplasm of connective and soft tissue of abdomen

ICD-10-CM	Code Description
C49.5	Malignant neoplasm of connective and soft tissue of pelvis
C49.6	Malignant neoplasm of connective and soft tissue of trunk, unspecified
C49.8	Malignant neoplasm of overlapping sites of connective and soft tissue
C49.9	Malignant neoplasm of connective and soft tissue, unspecified
C4A	Merkel cell carcinoma
C4A.0	Merkel cell carcinoma of lip
C4A.1	Merkel cell carcinoma of eyelid, including canthus
C4A.10	Merkel cell carcinoma of unspecified eyelid, including canthus
C4A.11	Merkel cell carcinoma of right eyelid, including canthus
C4A.12	Merkel cell carcinoma of left eyelid, including canthus
C4A.2	Merkel cell carcinoma of ear and external auricular canal
C4A.20	Merkel cell carcinoma of unspecified ear and external auricular canal
C4A.21	Merkel cell carcinoma of right ear and external auricular canal
C4A.22	Merkel cell carcinoma of left ear and external auricular canal
C4A.3	Merkel cell carcinoma of other and unspecified parts of face
C4A.30	Merkel cell carcinoma of unspecified part of face
C4A.31	Merkel cell carcinoma of nose
C4A.39	Merkel cell carcinoma of other parts of face
C4A.4	Merkel cell carcinoma of scalp and neck
C4A.5	Merkel cell carcinoma of trunk
C4A.51	Merkel cell carcinoma of anal skin
C4A.52	Merkel cell carcinoma of skin of breast
C4A.59	Merkel cell carcinoma of other part of trunk
C4A.6	Merkel cell carcinoma of upper limb, including shoulder
C4A.60	Merkel cell carcinoma of unspecified upper limb, including shoulder
C4A.61	Merkel cell carcinoma of right upper limb, including shoulder
C4A.62	Merkel cell carcinoma of left upper limb, including shoulder
C4A.7	Merkel cell carcinoma of lower limb, including hip
C4A.70	Merkel cell carcinoma of unspecified lower limb, including hip
C4A.71	Merkel cell carcinoma of right lower limb, including hip
C4A.72	Merkel cell carcinoma of left lower limb, including hip
C4A.8	Merkel cell carcinoma of overlapping sites
C4A.9	Merkel cell carcinoma, unspecified
C50	Malignant neoplasm of breast
C50.0	Malignant neoplasm of nipple and areola
C50.01	Malignant neoplasm of nipple and areola, female
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.012	Malignant neoplasm of nipple and areola, left female breast
C50.019	Malignant neoplasm of nipple and areola, unspecified female breast
C50.02	Malignant neoplasm of nipple and areola, male
C50.021	Malignant neoplasm of nipple and areola, right male breast
C50.022	Malignant neoplasm of nipple and areola, left male breast
C50.029	Malignant neoplasm of nipple and areola, unspecified male breast
C50.1	Malignant neoplasm of central portion of breast
C50.11	Malignant neoplasm of central portion of breast, female

ICD-10-CM	Code Description
C50.111	Malignant neoplasm of central portion of right female breast
C50.112	Malignant neoplasm of central portion of left female breast
C50.119	Malignant neoplasm of central portion of unspecified female breast
C50.12	Malignant neoplasm of central portion of breast, male
C50.121	Malignant neoplasm of central portion of right male breast
C50.122	Malignant neoplasm of central portion of left male breast
C50.129	Malignant neoplasm of central portion of unspecified male breast
C50.2	Malignant neoplasm of upper-inner quadrant of breast
C50.21	Malignant neoplasm of upper-inner quadrant of breast, female
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
C50.219	Malignant neoplasm of upper-inner quadrant of unspecified female breast
C50.22	Malignant neoplasm of upper-inner quadrant of breast, male
C50.221	Malignant neoplasm of upper-inner quadrant of right male breast
C50.222	Malignant neoplasm of upper-inner quadrant of left male breast
C50.229	Malignant neoplasm of upper-inner quadrant of unspecified male breast
C50.3	Malignant neoplasm of lower-inner quadrant of breast
C50.31	Malignant neoplasm of lower-inner quadrant of breast, female
C50.311	Malignant neoplasm of lower-inner quadrant of right female breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
C50.319	Malignant neoplasm of lower-inner quadrant of unspecified female breast
C50.32	Malignant neoplasm of lower-inner quadrant of breast, male
C50.321	Malignant neoplasm of lower-inner quadrant of right male breast
C50.322	Malignant neoplasm of lower-inner quadrant of left male breast
C50.329	Malignant neoplasm of lower-inner quadrant of unspecified male breast
C50.4	Malignant neoplasm of upper-outer quadrant of breast
C50.41	Malignant neoplasm of upper-outer quadrant of breast, female
C50.411	Malignant neoplasm of upper-outer quadrant of right female breast
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
C50.419	Malignant neoplasm of upper-outer quadrant of unspecified female breast
C50.42	Malignant neoplasm of upper-outer quadrant of breast, male
C50.421	Malignant neoplasm of upper-outer quadrant of right male breast
C50.422	Malignant neoplasm of upper-outer quadrant of left male breast
C50.429	Malignant neoplasm of upper-outer quadrant of unspecified male breast
C50.5	Malignant neoplasm of lower-outer quadrant of breast
C50.51	Malignant neoplasm of lower-outer quadrant of breast, female
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
C50.519	Malignant neoplasm of lower-outer quadrant of unspecified female breast
C50.52	Malignant neoplasm of lower-outer quadrant of breast, male
C50.521	Malignant neoplasm of lower-outer quadrant of right male breast
C50.522	Malignant neoplasm of lower-outer quadrant of left male breast
C50.529	Malignant neoplasm of lower-outer quadrant of unspecified male breast
C50.6	Malignant neoplasm of axillary tail of breast
C50.61	Malignant neoplasm of axillary tail of breast, female

ICD-10-CM	Code Description
C50.611	Malignant neoplasm of axillary tail of right female breast
C50.612	Malignant neoplasm of axillary tail of left female breast
C50.619	Malignant neoplasm of axillary tail of unspecified female breast
C50.62	Malignant neoplasm of axillary tail of breast, male
C50.621	Malignant neoplasm of axillary tail of right male breast
C50.622	Malignant neoplasm of axillary tail of left male breast
C50.629	Malignant neoplasm of axillary tail of unspecified male breast
C50.8	Malignant neoplasm of overlapping sites of breast
C50.81	Malignant neoplasm of overlapping sites of breast, female
C50.811	Malignant neoplasm of overlapping sites of right female breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
C50.819	Malignant neoplasm of overlapping sites of unspecified female breast
C50.82	Malignant neoplasm of overlapping sites of breast, male
C50.821	Malignant neoplasm of overlapping sites of right male breast
C50.822	Malignant neoplasm of overlapping sites of left male breast
C50.829	Malignant neoplasm of overlapping sites of unspecified male breast
C50.9	Malignant neoplasm of breast of unspecified site
C50.91	Malignant neoplasm of breast of unspecified site, female
C50.911	Malignant neoplasm of unspecified site of right female breast
C50.912	Malignant neoplasm of unspecified site of left female breast
C50.919	Malignant neoplasm of unspecified site of unspecified female breast
C50.92	Malignant neoplasm of breast of unspecified site, male
C50.921	Malignant neoplasm of unspecified site of right male breast
C50.922	Malignant neoplasm of unspecified site of left male breast
C50.929	Malignant neoplasm of unspecified site of unspecified male breast
C51	Malignant neoplasm of vulva
C51.0	Malignant neoplasm of labium majus
C51.1	Malignant neoplasm of labium minus
C51.2	Malignant neoplasm of clitoris
C51.8	Malignant neoplasm of overlapping sites of vulva
C51.9	Malignant neoplasm of vulva, unspecified
C52	Malignant neoplasm of vagina
C53	Malignant neoplasm of cervix uteri
C53.0	Malignant neoplasm of endocervix
C53.1	Malignant neoplasm of exocervix
C53.8	Malignant neoplasm of overlapping sites of cervix uteri
C53.9	Malignant neoplasm of cervix uteri, unspecified
C54	Malignant neoplasm of corpus uteri
C54.0	Malignant neoplasm of isthmus uteri
C54.1	Malignant neoplasm of endometrium
C54.2	Malignant neoplasm of myometrium
C54.3	Malignant neoplasm of fundus uteri
C54.8	Malignant neoplasm of overlapping sites of corpus uteri
C54.9	Malignant neoplasm of corpus uteri, unspecified
C55	Malignant neoplasm of uterus, part unspecified

ICD-10-CM	Code Description
C56	Malignant neoplasm of ovary
C56.1	Malignant neoplasm of right ovary
C56.2	Malignant neoplasm of left ovary
C56.9	Malignant neoplasm of unspecified ovary
C57	Malignant neoplasm of other and unspecified female genital organs
C57.0	Malignant neoplasm of fallopian tube
C57.00	Malignant neoplasm of unspecified fallopian tube
C57.01	Malignant neoplasm of right fallopian tube
C57.02	Malignant neoplasm of left fallopian tube
C57.1	Malignant neoplasm of broad ligament
C57.10	Malignant neoplasm of unspecified broad ligament
C57.11	Malignant neoplasm of right broad ligament
C57.12	Malignant neoplasm of left broad ligament
C57.2	Malignant neoplasm of round ligament
C57.20	Malignant neoplasm of unspecified round ligament
C57.21	Malignant neoplasm of right round ligament
C57.22	Malignant neoplasm of left round ligament
C57.3	Malignant neoplasm of parametrium
C57.4	Malignant neoplasm of uterine adnexa, unspecified
C57.7	Malignant neoplasm of other specified female genital organs
C57.8	Malignant neoplasm of overlapping sites of female genital organs
C57.9	Malignant neoplasm of female genital organ, unspecified
C58	Malignant neoplasm of placenta
C60	Malignant neoplasm of penis
C60.0	Malignant neoplasm of prepuce
C60.1	Malignant neoplasm of glans penis
C60.2	Malignant neoplasm of body of penis
C60.8	Malignant neoplasm of overlapping sites of penis
C60.9	Malignant neoplasm of penis, unspecified
C61	Malignant neoplasm of prostate
C62	Malignant neoplasm of testis
C62.0	Malignant neoplasm of undescended testis
C62.00	Malignant neoplasm of unspecified undescended testis
C62.01	Malignant neoplasm of undescended right testis
C62.02	Malignant neoplasm of undescended left testis
C62.1	Malignant neoplasm of descended testis
C62.10	Malignant neoplasm of unspecified descended testis
C62.11	Malignant neoplasm of descended right testis
C62.12	Malignant neoplasm of descended left testis
C62.9	Malignant neoplasm of testis, unspecified whether descended or undescended
C62.90	Malignant neoplasm of unspecified testis, unspecified whether descended or undescended
C62.91	Malignant neoplasm of right testis, unspecified whether descended or undescended
C62.92	Malignant neoplasm of left testis, unspecified whether descended or undescended
C63	Malignant neoplasm of other and unspecified male genital organs
C63.0	Malignant neoplasm of epididymis

ICD-10-CM	Code Description
C63.00	Malignant neoplasm of unspecified epididymis
C63.01	Malignant neoplasm of right epididymis
C63.02	Malignant neoplasm of left epididymis
C63.1	Malignant neoplasm of spermatic cord
C63.10	Malignant neoplasm of unspecified spermatic cord
C63.11	Malignant neoplasm of right spermatic cord
C63.12	Malignant neoplasm of left spermatic cord
C63.2	Malignant neoplasm of scrotum
C63.7	Malignant neoplasm of other specified male genital organs
C63.8	Malignant neoplasm of overlapping sites of male genital organs
C63.9	Malignant neoplasm of male genital organ, unspecified
C64	Malignant neoplasm of kidney, except renal pelvis
C64.1	Malignant neoplasm of right kidney, except renal pelvis
C64.2	Malignant neoplasm of left kidney, except renal pelvis
C64.9	Malignant neoplasm of unspecified kidney, except renal pelvis
C65	Malignant neoplasm of renal pelvis
C65.1	Malignant neoplasm of right renal pelvis
C65.2	Malignant neoplasm of left renal pelvis
C65.9	Malignant neoplasm of unspecified renal pelvis
C66	Malignant neoplasm of ureter
C66.1	Malignant neoplasm of right ureter
C66.2	Malignant neoplasm of left ureter
C66.9	Malignant neoplasm of unspecified ureter
C67	Malignant neoplasm of bladder
C67.0	Malignant neoplasm of trigone of bladder
C67.1	Malignant neoplasm of dome of bladder
C67.2	Malignant neoplasm of lateral wall of bladder
C67.3	Malignant neoplasm of anterior wall of bladder
C67.4	Malignant neoplasm of posterior wall of bladder
C67.5	Malignant neoplasm of bladder neck
C67.6	Malignant neoplasm of ureteric orifice
C67.7	Malignant neoplasm of urachus
C67.8	Malignant neoplasm of overlapping sites of bladder
C67.9	Malignant neoplasm of bladder, unspecified
C68	Malignant neoplasm of other and unspecified urinary organs
C68.0	Malignant neoplasm of urethra
C68.1	Malignant neoplasm of paraurethral glands
C68.8	Malignant neoplasm of overlapping sites of urinary organs
C68.9	Malignant neoplasm of urinary organ, unspecified
C69	Malignant neoplasm of eye and adnexa
C69.0	Malignant neoplasm of conjunctiva
C69.00	Malignant neoplasm of unspecified conjunctiva
C69.01	Malignant neoplasm of right conjunctiva
C69.02	Malignant neoplasm of left conjunctiva
C69.1	Malignant neoplasm of cornea

ICD-10-CM	Code Description
C69.10	Malignant neoplasm of unspecified cornea
C69.11	Malignant neoplasm of right cornea
C69.12	Malignant neoplasm of left cornea
C69.2	Malignant neoplasm of retina
C69.20	Malignant neoplasm of unspecified retina
C69.21	Malignant neoplasm of right retina
C69.22	Malignant neoplasm of left retina
C69.3	Malignant neoplasm of choroid
C69.30	Malignant neoplasm of unspecified choroid
C69.31	Malignant neoplasm of right choroid
C69.32	Malignant neoplasm of left choroid
C69.4	Malignant neoplasm of ciliary body
C69.40	Malignant neoplasm of unspecified ciliary body
C69.41	Malignant neoplasm of right ciliary body
C69.42	Malignant neoplasm of left ciliary body
C69.5	Malignant neoplasm of lacrimal gland and duct
C69.50	Malignant neoplasm of unspecified lacrimal gland and duct
C69.51	Malignant neoplasm of right lacrimal gland and duct
C69.52	Malignant neoplasm of left lacrimal gland and duct
C69.6	Malignant neoplasm of orbit
C69.60	Malignant neoplasm of unspecified orbit
C69.61	Malignant neoplasm of right orbit
C69.62	Malignant neoplasm of left orbit
C69.8	Malignant neoplasm of overlapping sites of eye and adnexa
C69.80	Malignant neoplasm of overlapping sites of unspecified eye and adnexa
C69.81	Malignant neoplasm of overlapping sites of right eye and adnexa
C69.82	Malignant neoplasm of overlapping sites of left eye and adnexa
C69.9	Malignant neoplasm of unspecified site of eye
C69.90	Malignant neoplasm of unspecified site of unspecified eye
C69.91	Malignant neoplasm of unspecified site of right eye
C69.92	Malignant neoplasm of unspecified site of left eye
C70	Malignant neoplasm of meninges
C70.0	Malignant neoplasm of cerebral meninges
C70.1	Malignant neoplasm of spinal meninges
C70.9	Malignant neoplasm of meninges, unspecified
C71	Malignant neoplasm of brain
C71.0	Malignant neoplasm of cerebrum, except lobes and ventricles
C71.1	Malignant neoplasm of frontal lobe
C71.2	Malignant neoplasm of temporal lobe
C71.3	Malignant neoplasm of parietal lobe
C71.4	Malignant neoplasm of occipital lobe
C71.5	Malignant neoplasm of cerebral ventricle
C71.6	Malignant neoplasm of cerebellum
C71.7	Malignant neoplasm of brain stem
C71.8	Malignant neoplasm of overlapping sites of brain

ICD-10-CM	Code Description
C71.9	Malignant neoplasm of brain, unspecified
C72	Malignant neoplasm of spinal cord, cranial nerves and other parts of central nervous system
C72.0	Malignant neoplasm of spinal cord
C72.1	Malignant neoplasm of cauda equina
C72.2	Malignant neoplasm of olfactory nerve
C72.20	Malignant neoplasm of unspecified olfactory nerve
C72.21	Malignant neoplasm of right olfactory nerve
C72.22	Malignant neoplasm of left olfactory nerve
C72.3	Malignant neoplasm of optic nerve
C72.30	Malignant neoplasm of unspecified optic nerve
C72.31	Malignant neoplasm of right optic nerve
C72.32	Malignant neoplasm of left optic nerve
C72.4	Malignant neoplasm of acoustic nerve
C72.40	Malignant neoplasm of unspecified acoustic nerve
C72.41	Malignant neoplasm of right acoustic nerve
C72.42	Malignant neoplasm of left acoustic nerve
C72.5	Malignant neoplasm of other and unspecified cranial nerves
C72.50	Malignant neoplasm of unspecified cranial nerve
C72.59	Malignant neoplasm of other cranial nerves
C72.9	Malignant neoplasm of central nervous system, unspecified
C73	Malignant neoplasm of thyroid gland
C74	Malignant neoplasm of adrenal gland
C74.0	Malignant neoplasm of cortex of adrenal gland
C74.00	Malignant neoplasm of cortex of unspecified adrenal gland
C74.01	Malignant neoplasm of cortex of right adrenal gland
C74.02	Malignant neoplasm of cortex of left adrenal gland
C74.1	Malignant neoplasm of medulla of adrenal gland
C74.10	Malignant neoplasm of medulla of unspecified adrenal gland
C74.11	Malignant neoplasm of medulla of right adrenal gland
C74.12	Malignant neoplasm of medulla of left adrenal gland
C74.9	Malignant neoplasm of unspecified part of adrenal gland
C74.90	Malignant neoplasm of unspecified part of unspecified adrenal gland
C74.91	Malignant neoplasm of unspecified part of right adrenal gland
C74.92	Malignant neoplasm of unspecified part of left adrenal gland
C75	Malignant neoplasm of other endocrine glands and related structures
C75.0	Malignant neoplasm of parathyroid gland
C75.1	Malignant neoplasm of pituitary gland
C75.2	Malignant neoplasm of craniopharyngeal duct
C75.3	Malignant neoplasm of pineal gland
C75.4	Malignant neoplasm of carotid body
C75.5	Malignant neoplasm of aortic body and other paraganglia
C75.8	Malignant neoplasm with pluriglandular involvement, unspecified
C75.9	Malignant neoplasm of endocrine gland, unspecified
C76	Malignant neoplasm of other and ill-defined sites
C76.0	Malignant neoplasm of head, face and neck

ICD-10-CM	Code Description
C76.1	Malignant neoplasm of thorax
C76.2	Malignant neoplasm of abdomen
C76.3	Malignant neoplasm of pelvis
C76.4	Malignant neoplasm of upper limb
C76.40	Malignant neoplasm of unspecified upper limb
C76.41	Malignant neoplasm of right upper limb
C76.42	Malignant neoplasm of left upper limb
C76.5	Malignant neoplasm of lower limb
C76.50	Malignant neoplasm of unspecified lower limb
C76.51	Malignant neoplasm of right lower limb
C76.52	Malignant neoplasm of left lower limb
C76.8	Malignant neoplasm of other specified ill-defined sites
C77	SECONDARY AND UNSPECIFIED MALIGNANT NEOPLASM OF LYMPH NODES
C77.0	Secondary and unspecified malignant neoplasm of lymph nodes of head, face and neck
C77.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
C77.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
C77.3	Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes
C77.4	Secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes
C77.5	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
C77.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple regions
C77.9	Secondary and unspecified malignant neoplasm of lymph node, unspecified
C78	SECONDARY MALIGNANT NEOPLASM OF RESPIRATORY AND DIGESTIVE ORGANS
C78.0	Secondary malignant neoplasm of lung
C78.00	Secondary malignant neoplasm of unspecified lung
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left lung
C78.1	Secondary malignant neoplasm of mediastinum
C78.2	Secondary malignant neoplasm of pleura
C78.3	Secondary malignant neoplasm of other and unspecified respiratory organs
C78.30	Secondary malignant neoplasm of unspecified respiratory organ
C78.39	Secondary malignant neoplasm of other respiratory organs
C78.4	Secondary malignant neoplasm of small intestine
C78.5	Secondary malignant neoplasm of large intestine and rectum
C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C78.8	Secondary malignant neoplasm of other and unspecified digestive organs
C78.80	Secondary malignant neoplasm of unspecified digestive organ
C78.89	Secondary malignant neoplasm of other digestive organs
C79	SECONDARY MALIGNANT NEOPLASM OF OTHER AND UNSPECIFIED SITES
C79.0	Secondary malignant neoplasm of kidney and renal pelvis
C79.00	Secondary malignant neoplasm of unspecified kidney and renal pelvis
C79.01	Secondary malignant neoplasm of right kidney and renal pelvis
C79.02	Secondary malignant neoplasm of left kidney and renal pelvis
C79.1	Secondary malignant neoplasm of bladder and other urinary organs
C79.10	Secondary malignant neoplasm of unspecified urinary organs

ICD-10-CM	Code Description
C79.11	Secondary malignant neoplasm of bladder
C79.19	Secondary malignant neoplasm of other urinary organs
C79.2	Secondary malignant neoplasm of skin
C79.3	Secondary malignant neoplasm of brain cerebral meninges
C79.31	Secondary malignant neoplasm of brain
C79.32	Secondary malignant neoplasm of cerebral meninges
C79.4	Secondary malignant neoplasm of other and unspecified digestive organs
C79.40	Secondary malignant neoplasm of unspecified part of nervous system
C79.49	Secondary malignant neoplasm of other parts of nervous system
C79.5	Secondary malignant neoplasm of bone and bone marrow
C79.51	Secondary malignant neoplasm of bone
C79.52	Secondary malignant neoplasm of bone marrow
C79.6	Secondary malignant neoplasm of ovary
C79.60	Secondary malignant neoplasm of unspecified ovary
C79.61	Secondary malignant neoplasm of right ovary
C79.62	Secondary malignant neoplasm of left ovary
C79.7	Secondary malignant neoplasm of adrenal gland
C79.70	Secondary malignant neoplasm of unspecified adrenal gland
C79.71	Secondary malignant neoplasm of right adrenal gland
C79.72	Secondary malignant neoplasm of left adrenal gland
C79.8	Secondary malignant neoplasm of other specified sites
C79.81	Secondary malignant neoplasm of breast
C79.82	Secondary malignant neoplasm of genital organs
C79.89	Secondary malignant neoplasm of other specified sites
C79.9	Secondary malignant neoplasm of unspecified site
C7A	Malignant neuroendocrine tumors
C7A.0	Malignant carcinoid tumors
C7A.00	Malignant carcinoid tumor of unspecified site
C7A.01	Malignant carcinoid tumors of the small intestine
C7A.010	Malignant carcinoid tumor of the duodenum
C7A.011	Malignant carcinoid tumor of the jejunum
C7A.012	Malignant carcinoid tumor of the ileum
C7A.019	Malignant carcinoid tumor of the small intestine, unspecified portion
C7A.02	Malignant carcinoid tumors of the appendix, large intestine, and rectum
C7A.020	Malignant carcinoid tumor of the appendix
C7A.021	Malignant carcinoid tumor of the cecum
C7A.022	Malignant carcinoid tumor of the ascending colon
C7A.023	Malignant carcinoid tumor of the transverse colon
C7A.024	Malignant carcinoid tumor of the descending colon
C7A.025	Malignant carcinoid tumor of the sigmoid colon
C7A.026	Malignant carcinoid tumor of the rectum
C7A.029	Malignant carcinoid tumor of the large intestine, unspecified portion
C7A.09	Malignant carcinoid tumors of other sites
C7A.090	Malignant carcinoid tumor of the bronchus and lung
C7A.091	Malignant carcinoid tumor of the thymus

ICD-10-CM	Code Description
C7A.092	Malignant carcinoid tumor of the stomach
C7A.093	Malignant carcinoid tumor of the kidney
C7A.094	Malignant carcinoid tumor of the foregut NOS
C7A.095	Malignant carcinoid tumor of the midgut NOS
C7A.096	Malignant carcinoid tumor of the hindgut NOS
C7A.098	Malignant carcinoid tumors of other sites
C7A.1	Malignant poorly differentiated neuroendocrine tumors
C7A.8	Other malignant neuroendocrine tumors
C7B	SECONDARY NEUROENDOCRINE TUMORS
C7B.0	Secondary carcinoid tumors
C7B.00	Secondary carcinoid tumors, unspecified site
C7B.01	Secondary carcinoid tumors of distant lymph nodes
C7B.02	Secondary carcinoid tumors of liver
C7B.03	Secondary carcinoid tumors of bone
C7B.04	Secondary carcinoid tumors of peritoneum
C7B.09	Secondary carcinoid tumors of other sites
C7B.1	Secondary merkel cell carcinoma
C7B.8	Other secondary neuroendocrine tumors
C80	Malignant neoplasm without specification of site
C80.0	Disseminated malignant neoplasm, unspecified
C80.1	Malignant (primary) neoplasm, unspecified
C80.2	Malignant neoplasm associated with transplanted organ
C81	Hodgkin lymphoma
C81.0	Nodular lymphocyte predominant Hodgkin lymphoma
C81.00	Nodular lymphocyte predominant Hodgkin lymphoma, unspecified site
C81.01	Nodular lymphocyte predominant Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.02	Nodular lymphocyte predominant Hodgkin lymphoma, intrathoracic lymph nodes
C81.03	Nodular lymphocyte predominant Hodgkin lymphoma, intra-abdominal lymph nodes
C81.04	Nodular lymphocyte predominant Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.05	Nodular lymphocyte predominant Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.06	Nodular lymphocyte predominant Hodgkin lymphoma, intrapelvic lymph nodes
C81.07	Nodular lymphocyte predominant Hodgkin lymphoma, spleen
C81.08	Nodular lymphocyte predominant Hodgkin lymphoma, lymph nodes of multiple sites
C81.09	Nodular lymphocyte predominant Hodgkin lymphoma, extranodal and solid organ sites
C81.1	Nodular sclerosis classical Hodgkin lymphoma
C81.10	Nodular sclerosis classical Hodgkin lymphoma, unspecified site
C81.11	Nodular sclerosis classical Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.12	Nodular sclerosis classical Hodgkin lymphoma, intrathoracic lymph nodes
C81.13	Nodular sclerosis classical Hodgkin lymphoma, intra-abdominal lymph nodes
C81.14	Nodular sclerosis classical Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.15	Nodular sclerosis classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.16	Nodular sclerosis classical Hodgkin lymphoma, intrapelvic lymph nodes
C81.17	Nodular sclerosis classical Hodgkin lymphoma, spleen
C81.18	Nodular sclerosis classical Hodgkin lymphoma, lymph nodes of multiple sites
C81.19	Nodular sclerosis classical Hodgkin lymphoma, extranodal and solid organ sites

ICD-10-CM	Code Description
C81.2	Mixed cellularity classical Hodgkin lymphoma
C81.20	Mixed cellularity classical Hodgkin lymphoma, unspecified site
C81.21	Mixed cellularity classical Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.22	Mixed cellularity classical Hodgkin lymphoma, intrathoracic lymph nodes
C81.23	Mixed cellularity classical Hodgkin lymphoma, intra-abdominal lymph nodes
C81.24	Mixed cellularity classical Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.25	Mixed cellularity classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.26	Mixed cellularity classical Hodgkin lymphoma, intrapelvic lymph nodes
C81.27	Mixed cellularity classical Hodgkin lymphoma, spleen
C81.28	Mixed cellularity classical Hodgkin lymphoma, lymph nodes of multiple sites
C81.29	Mixed cellularity classical Hodgkin lymphoma, extranodal and solid organ sites
C81.3	Lymphocyte depleted classical Hodgkin lymphoma
C81.30	Lymphocyte depleted classical Hodgkin lymphoma, unspecified site
C81.31	Lymphocyte depleted classical Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.32	Lymphocyte depleted classical Hodgkin lymphoma, intrathoracic lymph nodes
C81.33	Lymphocyte depleted classical Hodgkin lymphoma, intra-abdominal lymph nodes
C81.34	Lymphocyte depleted classical Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.35	Lymphocyte depleted classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.36	Lymphocyte depleted classical Hodgkin lymphoma, intrapelvic lymph nodes
C81.37	Lymphocyte depleted classical Hodgkin lymphoma, spleen
C81.38	Lymphocyte depleted classical Hodgkin lymphoma, lymph nodes of multiple sites
C81.39	Lymphocyte depleted classical Hodgkin lymphoma, extranodal and solid organ sites
C81.4	Lymphocyte-rich classical Hodgkin lymphoma
C81.40	Lymphocyte-rich classical Hodgkin lymphoma, unspecified site
C81.41	Lymphocyte-rich classical Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.42	Lymphocyte-rich classical Hodgkin lymphoma, intrathoracic lymph nodes
C81.43	Lymphocyte-rich classical Hodgkin lymphoma, intra-abdominal lymph nodes
C81.44	Lymphocyte-rich classical Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.45	Lymphocyte-rich classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.46	Lymphocyte-rich classical Hodgkin lymphoma, intrapelvic lymph nodes
C81.47	Lymphocyte-rich classical Hodgkin lymphoma, spleen
C81.48	Lymphocyte-rich classical Hodgkin lymphoma, lymph nodes of multiple sites
C81.49	Lymphocyte-rich classical Hodgkin lymphoma, extranodal and solid organ sites
C81.7	Other classical Hodgkin lymphoma
C81.70	Other classical Hodgkin lymphoma, unspecified site
C81.71	Other classical Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.72	Other classical Hodgkin lymphoma, intrathoracic lymph nodes
C81.73	Other classical Hodgkin lymphoma, intra-abdominal lymph nodes
C81.74	Other classical Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.75	Other classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.76	Other classical Hodgkin lymphoma, intrapelvic lymph nodes
C81.77	Other classical Hodgkin lymphoma, spleen
C81.78	Other classical Hodgkin lymphoma, lymph nodes of multiple sites
C81.79	Other classical Hodgkin lymphoma, extranodal and solid organ sites
C81.9	Hodgkin lymphoma, unspecified

ICD-10-CM	Code Description
C81.90	Hodgkin lymphoma, unspecified, unspecified site
C81.91	Hodgkin lymphoma, unspecified, lymph nodes of head, face, and neck
C81.92	Hodgkin lymphoma, unspecified, intrathoracic lymph nodes
C81.93	Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes
C81.94	Hodgkin lymphoma, unspecified, lymph nodes of axilla and upper limb
C81.95	Hodgkin lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C81.96	Hodgkin lymphoma, unspecified, intrapelvic lymph nodes
C81.97	Hodgkin lymphoma, unspecified, spleen
C81.98	Hodgkin lymphoma, unspecified, lymph nodes of multiple sites
C81.99	Hodgkin lymphoma, unspecified, extranodal and solid organ sites
C82	Follicular lymphoma
C82.0	Follicular lymphoma grade I
C82.00	Follicular lymphoma grade I, unspecified site
C82.01	Follicular lymphoma grade I, lymph nodes of head, face, and neck
C82.02	Follicular lymphoma grade I, intrathoracic lymph nodes
C82.03	Follicular lymphoma grade I, intra-abdominal lymph nodes
C82.04	Follicular lymphoma grade I, lymph nodes of axilla and upper limb
C82.05	Follicular lymphoma grade I, lymph nodes of inguinal region and lower limb
C82.06	Follicular lymphoma grade I, intrapelvic lymph nodes
C82.07	Follicular lymphoma grade I, spleen
C82.08	Follicular lymphoma grade I, lymph nodes of multiple sites
C82.09	Follicular lymphoma grade I, extranodal and solid organ sites
C82.1	Follicular lymphoma grade II
C82.10	Follicular lymphoma grade II, unspecified site
C82.11	Follicular lymphoma grade II, lymph nodes of head, face, and neck
C82.12	Follicular lymphoma grade II, intrathoracic lymph nodes
C82.13	Follicular lymphoma grade II, intra-abdominal lymph nodes
C82.14	Follicular lymphoma grade II, lymph nodes of axilla and upper limb
C82.15	Follicular lymphoma grade II, lymph nodes of inguinal region and lower limb
C82.16	Follicular lymphoma grade II, intrapelvic lymph nodes
C82.17	Follicular lymphoma grade II, spleen
C82.18	Follicular lymphoma grade II, lymph nodes of multiple sites
C82.19	Follicular lymphoma grade II, extranodal and solid organ sites
C82.2	Follicular lymphoma grade III, unspecified
C82.20	Follicular lymphoma grade III, unspecified, unspecified site
C82.21	Follicular lymphoma grade III, unspecified, lymph nodes of head, face, and neck
C82.22	Follicular lymphoma grade III, unspecified, intrathoracic lymph nodes
C82.23	Follicular lymphoma grade III, unspecified, intra-abdominal lymph nodes
C82.24	Follicular lymphoma grade III, unspecified, lymph nodes of axilla and upper limb
C82.25	Follicular lymphoma grade III, unspecified, lymph nodes of inguinal region and lower limb
C82.26	Follicular lymphoma grade III, unspecified, intrapelvic lymph nodes
C82.27	Follicular lymphoma grade III, unspecified, spleen
C82.28	Follicular lymphoma grade III, unspecified, lymph nodes of multiple sites
C82.29	Follicular lymphoma grade III, unspecified, extranodal and solid organ sites
C82.3	Follicular lymphoma grade IIIa

ICD-10-CM	Code Description
C82.30	Follicular lymphoma grade IIIa, unspecified site
C82.31	Follicular lymphoma grade IIIa, lymph nodes of head, face, and neck
C82.32	Follicular lymphoma grade IIIa, intrathoracic lymph nodes
C82.33	Follicular lymphoma grade IIIa, intra-abdominal lymph nodes
C82.34	Follicular lymphoma grade IIIa, lymph nodes of axilla and upper limb
C82.35	Follicular lymphoma grade IIIa, lymph nodes of inguinal region and lower limb
C82.36	Follicular lymphoma grade IIIa, intrapelvic lymph nodes
C82.37	Follicular lymphoma grade IIIa, spleen
C82.38	Follicular lymphoma grade IIIa, lymph nodes of multiple sites
C82.39	Follicular lymphoma grade IIIa, extranodal and solid organ sites
C82.4	Follicular lymphoma grade IIIb
C82.40	Follicular lymphoma grade IIIb, unspecified site
C82.41	Follicular lymphoma grade IIIb, lymph nodes of head, face, and neck
C82.42	Follicular lymphoma grade IIIb, intrathoracic lymph nodes
C82.43	Follicular lymphoma grade IIIb, intra-abdominal lymph nodes
C82.44	Follicular lymphoma grade IIIb, lymph nodes of axilla and upper limb
C82.45	Follicular lymphoma grade IIIb, lymph nodes of inguinal region and lower limb
C82.46	Follicular lymphoma grade IIIb, intrapelvic lymph nodes
C82.47	Follicular lymphoma grade IIIb, spleen
C82.48	Follicular lymphoma grade IIIb, lymph nodes of multiple sites
C82.49	Follicular lymphoma grade IIIb, extranodal and solid organ sites
C82.5	Diffuse follicle center lymphoma
C82.50	Diffuse follicle center lymphoma, unspecified site
C82.51	Diffuse follicle center lymphoma, lymph nodes of head, face, and neck
C82.52	Diffuse follicle center lymphoma, intrathoracic lymph nodes
C82.53	Diffuse follicle center lymphoma, intra-abdominal lymph nodes
C82.54	Diffuse follicle center lymphoma, lymph nodes of axilla and upper limb
C82.55	Diffuse follicle center lymphoma, lymph nodes of inguinal region and lower limb
C82.56	Diffuse follicle center lymphoma, intrapelvic lymph nodes
C82.57	Diffuse follicle center lymphoma, spleen
C82.58	Diffuse follicle center lymphoma, lymph nodes of multiple sites
C82.59	Diffuse follicle center lymphoma, extranodal and solid organ sites
C82.6	Cutaneous follicle center lymphoma
C82.60	Cutaneous follicle center lymphoma, unspecified site
C82.61	Cutaneous follicle center lymphoma, lymph nodes of head, face, and neck
C82.62	Cutaneous follicle center lymphoma, intrathoracic lymph nodes
C82.63	Cutaneous follicle center lymphoma, intra-abdominal lymph nodes
C82.64	Cutaneous follicle center lymphoma, lymph nodes of axilla and upper limb
C82.65	Cutaneous follicle center lymphoma, lymph nodes of inguinal region and lower limb
C82.66	Cutaneous follicle center lymphoma, intrapelvic lymph nodes
C82.67	Cutaneous follicle center lymphoma, spleen
C82.68	Cutaneous follicle center lymphoma, lymph nodes of multiple sites
C82.69	Cutaneous follicle center lymphoma, extranodal and solid organ sites
C82.8	Other types of follicular lymphoma
C82.80	Other types of follicular lymphoma, unspecified site

ICD-10-CM	Code Description
C82.81	Other types of follicular lymphoma, lymph nodes of head, face, and neck
C82.82	Other types of follicular lymphoma, intrathoracic lymph nodes
C82.83	Other types of follicular lymphoma, intra-abdominal lymph nodes
C82.84	Other types of follicular lymphoma, lymph nodes of axilla and upper limb
C82.85	Other types of follicular lymphoma, lymph nodes of inguinal region and lower limb
C82.86	Other types of follicular lymphoma, intrapelvic lymph nodes
C82.87	Other types of follicular lymphoma, spleen
C82.88	Other types of follicular lymphoma, lymph nodes of multiple sites
C82.89	Other types of follicular lymphoma, extranodal and solid organ sites
C82.9	Follicular lymphoma, unspecified
C82.90	Follicular lymphoma, unspecified, unspecified site
C82.91	Follicular lymphoma, unspecified, lymph nodes of head, face, and neck
C82.92	Follicular lymphoma, unspecified, intrathoracic lymph nodes
C82.93	Follicular lymphoma, unspecified, intra-abdominal lymph nodes
C82.94	Follicular lymphoma, unspecified, lymph nodes of axilla and upper limb
C82.95	Follicular lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C82.96	Follicular lymphoma, unspecified, intrapelvic lymph nodes
C82.97	Follicular lymphoma, unspecified, spleen
C82.98	Follicular lymphoma, unspecified, lymph nodes of multiple sites
C82.99	Follicular lymphoma, unspecified, extranodal and solid organ sites
C83	Non-follicular lymphoma
C83.0	Small cell B-cell lymphoma
C83.00	Small cell B-cell lymphoma, unspecified site
C83.01	Small cell B-cell lymphoma, lymph nodes of head, face, and neck
C83.02	Small cell B-cell lymphoma, intrathoracic lymph nodes
C83.03	Small cell B-cell lymphoma, intra-abdominal lymph nodes
C83.04	Small cell B-cell lymphoma, lymph nodes of axilla and upper limb
C83.05	Small cell B-cell lymphoma, lymph nodes of inguinal region and lower limb
C83.06	Small cell B-cell lymphoma, intrapelvic lymph nodes
C83.07	Small cell B-cell lymphoma, spleen
C83.08	Small cell B-cell lymphoma, lymph nodes of multiple sites
C83.09	Small cell B-cell lymphoma, extranodal and solid organ sites
C83.1	Mantle cell lymphoma
C83.10	Mantle cell lymphoma, unspecified site
C83.11	Mantle cell lymphoma, lymph nodes of head, face, and neck
C83.12	Mantle cell lymphoma, intrathoracic lymph nodes
C83.13	Mantle cell lymphoma, intra-abdominal lymph nodes
C83.14	Mantle cell lymphoma, lymph nodes of axilla and upper limb
C83.15	Mantle cell lymphoma, lymph nodes of inguinal region and lower limb
C83.16	Mantle cell lymphoma, intrapelvic lymph nodes
C83.17	Mantle cell lymphoma, spleen
C83.18	Mantle cell lymphoma, lymph nodes of multiple sites
C83.19	Mantle cell lymphoma, extranodal and solid organ sites
C83.3	Diffuse large B-cell lymphoma
C83.30	Diffuse large B-cell lymphoma, unspecified site

ICD-10-CM	Code Description
C83.31	Diffuse large B-cell lymphoma, lymph nodes of head, face, and neck
C83.32	Diffuse large B-cell lymphoma, intrathoracic lymph nodes
C83.33	Diffuse large B-cell lymphoma, intra-abdominal lymph nodes
C83.34	Diffuse large B-cell lymphoma, lymph nodes of axilla and upper limb
C83.35	Diffuse large B-cell lymphoma, lymph nodes of inguinal region and lower limb
C83.36	Diffuse large B-cell lymphoma, intrapelvic lymph nodes
C83.37	Diffuse large B-cell lymphoma, spleen
C83.38	Diffuse large B-cell lymphoma, lymph nodes of multiple sites
C83.39	Diffuse large B-cell lymphoma, extranodal and solid organ sites
C83.5	Lymphoblastic (diffuse) lymphoma
C83.50	Lymphoblastic (diffuse) lymphoma, unspecified site
C83.51	Lymphoblastic (diffuse) lymphoma, lymph nodes of head, face, and neck
C83.52	Lymphoblastic (diffuse) lymphoma, intrathoracic lymph nodes
C83.53	Lymphoblastic (diffuse) lymphoma, intra-abdominal lymph nodes
C83.54	Lymphoblastic (diffuse) lymphoma, lymph nodes of axilla and upper limb
C83.55	Lymphoblastic (diffuse) lymphoma, lymph nodes of inguinal region and lower limb
C83.56	Lymphoblastic (diffuse) lymphoma, intrapelvic lymph nodes
C83.57	Lymphoblastic (diffuse) lymphoma, spleen
C83.58	Lymphoblastic (diffuse) lymphoma, lymph nodes of multiple sites
C83.59	Lymphoblastic (diffuse) lymphoma, extranodal and solid organ sites
C83.7	Burkitt lymphoma
C83.70	Burkitt lymphoma, unspecified site
C83.71	Burkitt lymphoma, lymph nodes of head, face, and neck
C83.72	Burkitt lymphoma, intrathoracic lymph nodes
C83.73	Burkitt lymphoma, intra-abdominal lymph nodes
C83.74	Burkitt lymphoma, lymph nodes of axilla and upper limb
C83.75	Burkitt lymphoma, lymph nodes of inguinal region and lower limb
C83.76	Burkitt lymphoma, intrapelvic lymph nodes
C83.77	Burkitt lymphoma, spleen
C83.78	Burkitt lymphoma, lymph nodes of multiple sites
C83.79	Burkitt lymphoma, extranodal and solid organ sites
C83.8	Other non-follicular lymphoma
C83.80	Other non-follicular lymphoma, unspecified site
C83.81	Other non-follicular lymphoma, lymph nodes of head, face, and neck
C83.82	Other non-follicular lymphoma, intrathoracic lymph nodes
C83.83	Other non-follicular lymphoma, intra-abdominal lymph nodes
C83.84	Other non-follicular lymphoma, lymph nodes of axilla and upper limb
C83.85	Other non-follicular lymphoma, lymph nodes of inguinal region and lower limb
C83.86	Other non-follicular lymphoma, intrapelvic lymph nodes
C83.87	Other non-follicular lymphoma, spleen
C83.88	Other non-follicular lymphoma, lymph nodes of multiple sites
C83.89	Other non-follicular lymphoma, extranodal and solid organ sites
C83.9	Non-follicular (diffuse) lymphoma, unspecified
C83.90	Non-follicular (diffuse) lymphoma, unspecified, unspecified site
C83.91	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of head, face, and neck

ICD-10-CM	Code Description
C83.92	Non-follicular (diffuse) lymphoma, unspecified, intrathoracic lymph nodes
C83.93	Non-follicular (diffuse) lymphoma, unspecified, intra-abdominal lymph nodes
C83.94	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of axilla and upper limb
C83.95	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C83.96	Non-follicular (diffuse) lymphoma, unspecified, intrapelvic lymph nodes
C83.97	Non-follicular (diffuse) lymphoma, unspecified, spleen
C83.98	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of multiple sites
C83.99	Non-follicular (diffuse) lymphoma, unspecified, extranodal and solid organ sites
C84	Mature T/NK-cell lymphomas
C84.0	Mycosis fungoides
C84.00	Mycosis fungoides, unspecified site
C84.01	Mycosis fungoides, lymph nodes of head, face, and neck
C84.02	Mycosis fungoides, intrathoracic lymph nodes
C84.03	Mycosis fungoides, intra-abdominal lymph nodes
C84.04	Mycosis fungoides, lymph nodes of axilla and upper limb
C84.05	Mycosis fungoides, lymph nodes of inguinal region and lower limb
C84.06	Mycosis fungoides, intrapelvic lymph nodes
C84.07	Mycosis fungoides, spleen
C84.08	Mycosis fungoides, lymph nodes of multiple sites
C84.09	Mycosis fungoides, extranodal and solid organ sites
C84.1	Sezary disease
C84.10	Sezary disease, unspecified site
C84.11	Sezary disease, lymph nodes of head, face, and neck
C84.12	Sezary disease, intrathoracic lymph nodes
C84.13	Sezary disease, intra-abdominal lymph nodes
C84.14	Sezary disease, lymph nodes of axilla and upper limb
C84.15	Sezary disease, lymph nodes of inguinal region and lower limb
C84.16	Sezary disease, intrapelvic lymph nodes
C84.17	Sezary disease, spleen
C84.18	Sezary disease, lymph nodes of multiple sites
C84.19	Sezary disease, extranodal and solid organ sites
C84.4	Peripheral T-cell lymphoma, not classified
C84.40	Peripheral T-cell lymphoma, not classified, unspecified site
C84.41	Peripheral T-cell lymphoma, not classified, lymph nodes of head, face, and neck
C84.42	Peripheral T-cell lymphoma, not classified, intrathoracic lymph nodes
C84.43	Peripheral T-cell lymphoma, not classified, intra-abdominal lymph nodes
C84.44	Peripheral T-cell lymphoma, not classified, lymph nodes of axilla and upper limb
C84.45	Peripheral T-cell lymphoma, not classified, lymph nodes of inguinal region and lower limb
C84.46	Peripheral T-cell lymphoma, not classified, intrapelvic lymph nodes
C84.47	Peripheral T-cell lymphoma, not classified, spleen
C84.48	Peripheral T-cell lymphoma, not classified, lymph nodes of multiple sites
C84.49	Peripheral T-cell lymphoma, not classified, extranodal and solid organ sites
C84.6	Anaplastic large cell lymphoma, ALK-positive
C84.60	Anaplastic large cell lymphoma, ALK-positive, unspecified site
C84.61	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of head, face, and neck

ICD-10-CM	Code Description
C84.62	Anaplastic large cell lymphoma, ALK-positive, intrathoracic lymph nodes
C84.63	Anaplastic large cell lymphoma, ALK-positive, intra-abdominal lymph nodes
C84.64	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of axilla and upper limb
C84.65	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of inguinal region and lower limb
C84.66	Anaplastic large cell lymphoma, ALK-positive, intrapelvic lymph nodes
C84.67	Anaplastic large cell lymphoma, ALK-positive, spleen
C84.68	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of multiple sites
C84.69	Anaplastic large cell lymphoma, ALK-positive, extranodal and solid organ sites
C84.7	Anaplastic large cell lymphoma, ALK-negative
C84.70	Anaplastic large cell lymphoma, ALK-negative, unspecified site
C84.71	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of head, face, and neck
C84.72	Anaplastic large cell lymphoma, ALK-negative, intrathoracic lymph nodes
C84.73	Anaplastic large cell lymphoma, ALK-negative, intra-abdominal lymph nodes
C84.74	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of axilla and upper limb
C84.75	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of inguinal region and lower limb
C84.76	Anaplastic large cell lymphoma, ALK-negative, intrapelvic lymph nodes
C84.77	Anaplastic large cell lymphoma, ALK-negative, spleen
C84.78	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of multiple sites
C84.79	Anaplastic large cell lymphoma, ALK-negative, extranodal and solid organ sites
C84.9	Mature T/NK-cell lymphomas, unspecified
C84.90	Mature T/NK-cell lymphomas, unspecified, unspecified site
C84.91	Mature T/NK-cell lymphomas, unspecified, lymph nodes of head, face, and neck
C84.92	Mature T/NK-cell lymphomas, unspecified, intrathoracic lymph nodes
C84.93	Mature T/NK-cell lymphomas, unspecified, intra-abdominal lymph nodes
C84.94	Mature T/NK-cell lymphomas, unspecified, lymph nodes of axilla and upper limb
C84.95	Mature T/NK-cell lymphomas, unspecified, lymph nodes of inguinal region and lower limb
C84.96	Mature T/NK-cell lymphomas, unspecified, intrapelvic lymph nodes
C84.97	Mature T/NK-cell lymphomas, unspecified, spleen
C84.98	Mature T/NK-cell lymphomas, unspecified, lymph nodes of multiple sites
C84.99	Mature T/NK-cell lymphomas, unspecified, extranodal and solid organ sites
C84.A	Cutaneous T-cell lymphoma, unspecified
C84.A0	Cutaneous T-cell lymphoma, unspecified, unspecified site
C84.A1	Cutaneous T-cell lymphoma, unspecified lymph nodes of head, face, and neck
C84.A2	Cutaneous T-cell lymphoma, unspecified, intrathoracic lymph nodes
C84.A3	Cutaneous T-cell lymphoma, unspecified, intra-abdominal lymph nodes
C84.A4	Cutaneous T-cell lymphoma, unspecified, lymph nodes of axilla and upper limb
C84.A5	Cutaneous T-cell lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C84.A6	Cutaneous T-cell lymphoma, unspecified, intrapelvic lymph nodes
C84.A7	Cutaneous T-cell lymphoma, unspecified, spleen
C84.A8	Cutaneous T-cell lymphoma, unspecified, lymph nodes of multiple sites
C84.A9	Cutaneous T-cell lymphoma, unspecified, extranodal and solid organ sites
C84.Z	Other mature T/NK-cell lymphomas
C84.Z0	Other mature T/NK-cell lymphomas, unspecified site
C84.Z1	Other mature T/NK-cell lymphomas, lymph nodes of head, face, and neck
C84.Z2	Other mature T/NK-cell lymphomas, intrathoracic lymph nodes

ICD-10-CM	Code Description
C84.Z3	Other mature T/NK-cell lymphomas, intra-abdominal lymph nodes
C84.Z4	Other mature T/NK-cell lymphomas, lymph nodes of axilla and upper limb
C84.Z5	Other mature T/NK-cell lymphomas, lymph nodes of inguinal region and lower limb
C84.Z6	Other mature T/NK-cell lymphomas, intrapelvic lymph nodes
C84.Z7	Other mature T/NK-cell lymphomas, spleen
C84.Z8	Other mature T/NK-cell lymphomas, lymph nodes of multiple sites
C84.Z9	Other mature T/NK-cell lymphomas, extranodal and solid organ sites
C85	Other specified and unspecified types of non-Hodgkin lymphoma
C85.1	Unspecified B-cell lymphoma
C85.10	Unspecified B-cell lymphoma, unspecified site
C85.11	Unspecified B-cell lymphoma, lymph nodes of head, face, and neck
C85.12	Unspecified B-cell lymphoma, intrathoracic lymph nodes
C85.13	Unspecified B-cell lymphoma, intra-abdominal lymph nodes
C85.14	Unspecified B-cell lymphoma, lymph nodes of axilla and upper limb
C85.15	Unspecified B-cell lymphoma, lymph nodes of inguinal region and lower limb
C85.16	Unspecified B-cell lymphoma, intrapelvic lymph nodes
C85.17	Unspecified B-cell lymphoma, spleen
C85.18	Unspecified B-cell lymphoma, lymph nodes of multiple sites
C85.19	Unspecified B-cell lymphoma, extranodal and solid organ sites
C85.2	Mediastinal (thymic) large B-cell lymphoma
C85.20	Mediastinal (thymic) large B-cell lymphoma, unspecified site
C85.21	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of head, face, and neck
C85.22	Mediastinal (thymic) large B-cell lymphoma, intrathoracic lymph nodes
C85.23	Mediastinal (thymic) large B-cell lymphoma, intra-abdominal lymph nodes
C85.24	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of axilla and upper limb
C85.25	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of inguinal region and lower limb
C85.26	Mediastinal (thymic) large B-cell lymphoma, intrapelvic lymph nodes
C85.27	Mediastinal (thymic) large B-cell lymphoma, spleen
C85.28	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of multiple sites
C85.29	Mediastinal (thymic) large B-cell lymphoma, extranodal and solid organ sites
C85.8	Other specified types of non-Hodgkin lymphoma
C85.80	Other specified types of non-Hodgkin lymphoma, unspecified site
C85.81	Other specified types of non-Hodgkin lymphoma, lymph nodes of head, face, and neck
C85.82	Other specified types of non-Hodgkin lymphoma, intrathoracic lymph nodes
C85.83	Other specified types of non-Hodgkin lymphoma, intra-abdominal lymph nodes
C85.84	Other specified types of non-Hodgkin lymphoma, lymph nodes of axilla and upper limb
C85.85	Other specified types of non-Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C85.86	Other specified types of non-Hodgkin lymphoma, intrapelvic lymph nodes
C85.87	Other specified types of non-Hodgkin lymphoma, spleen
C85.88	Other specified types of non-Hodgkin lymphoma, lymph nodes of multiple sites
C85.89	Other specified types of non-Hodgkin lymphoma, extranodal and solid organ sites
C85.9	Non-Hodgkin lymphoma, unspecified
C85.90	Non-Hodgkin lymphoma, unspecified, unspecified site
C85.91	Non-Hodgkin lymphoma, unspecified, lymph nodes of head, face, and neck
C85.92	Non-Hodgkin lymphoma, unspecified, intrathoracic lymph nodes

ICD-10-CM	Code Description
C85.93	Non-Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes
C85.94	Non-Hodgkin lymphoma, unspecified, lymph nodes of axilla and upper limb
C85.95	Non-Hodgkin lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C85.96	Non-Hodgkin lymphoma, unspecified, intrapelvic lymph nodes
C85.97	Non-Hodgkin lymphoma, unspecified, spleen
C85.98	Non-Hodgkin lymphoma, unspecified, lymph nodes of multiple sites
C85.99	Non-Hodgkin lymphoma, unspecified, extranodal and solid organ sites
C86	Other specified types of T/NK-cell lymphoma
C86.0	Extranodal NK/T-cell lymphoma, nasal type
C86.1	Hepatosplenic T-cell lymphoma
C86.2	Enteropathy-type (intestinal) T-cell lymphoma
C86.3	Subcutaneous panniculitis-like T-cell lymphoma
C86.4	Blastic NK-cell lymphoma
C86.5	Angioimmunoblastic T-cell lymphoma
C86.6	Primary cutaneous CD30-positive T-cell proliferations
C88	Malignant immunoproliferative diseases and certain other B-cell lymphomas
C88.0	Waldenstrom macroglobulinemia
C88.2	Heavy chain disease
C88.3	Immunoproliferative small intestinal disease
C88.4	Extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue [MALT-lymphoma]
C88.8	Other malignant immunoproliferative diseases
C88.9	Malignant immunoproliferative disease, unspecified
C90	Multiple myeloma and malignant plasma cell neoplasms
C90.0	Multiple myeloma
C90.00	Multiple myeloma not having achieved remission
C90.02	Multiple myeloma in relapse
C90.1	Plasma cell leukemia
C90.10	Plasma cell leukemia not having achieved remission
C90.12	Plasma cell leukemia in relapse
C90.2	Extramedullary plasmacytoma
C90.20	Extramedullary plasmacytoma not having achieved remission
C90.22	Extramedullary plasmacytoma in relapse
C90.3	Solitary plasmacytoma
C90.30	Solitary plasmacytoma not having achieved remission
C90.32	Solitary plasmacytoma in relapse
C91	Lymphoid leukemia
C91.0	Acute lymphoblastic leukemia [ALL]
C91.00	Acute lymphoblastic leukemia not having achieved remission
C91.02	Acute lymphoblastic leukemia, in relapse
C91.1	Chronic lymphocytic leukemia of B-cell type
C91.10	Chronic lymphocytic leukemia of B-cell type not having achieved remission
C91.12	Chronic lymphocytic leukemia of B-cell type in relapse
C91.3	Prolymphocytic leukemia of B-cell type
C91.30	Prolymphocytic leukemia of B-cell type not having achieved remission
C91.32	Prolymphocytic leukemia of B-cell type, in relapse

ICD-10-CM	Code Description
C91.4	Hairy cell leukemia
C91.40	Hairy cell leukemia not having achieved remission
C91.42	Hairy cell leukemia, in relapse
C91.5	Adult T-cell lymphoma/leukemia (HTLV-1-associated)
C91.50	Adult T-cell lymphoma/leukemia (HTLV-1-associated) not having achieved remission
C91.52	Adult T-cell lymphoma/leukemia (HTLV-1-associated), in relapse
C91.6	Prolymphocytic leukemia of T-cell type
C91.60	Prolymphocytic leukemia of T-cell type not having achieved remission
C91.62	Prolymphocytic leukemia of T-cell type, in relapse
C91.9	Lymphoid leukemia, unspecified
C91.90	Lymphoid leukemia, unspecified not having achieved remission
C91.92	Lymphoid leukemia, unspecified, in relapse
C91.A	Mature B-cell leukemia Burkitt-type
C91.A0	Mature B-cell leukemia Burkitt-type not having achieved remission
C91.A2	Mature B-cell leukemia Burkitt-type, in relapse
C91.Z	Other lymphoid leukemia
C91.Z0	Other lymphoid leukemia not having achieved remission
C91.Z2	Other lymphoid leukemia, in relapse
C92	Myeloid leukemia
C92.0	Acute myeloblastic leukemia
C92.00	Acute myeloblastic leukemia, not having achieved remission
C92.02	Acute myeloblastic leukemia, in relapse
C92.1	Chronic myeloid leukemia, BCR/ABL-positive
C92.10	Chronic myeloid leukemia, BCR/ABL-positive, not having achieved remission
C92.12	Chronic myeloid leukemia, BCR/ABL-positive, in relapse
C92.2	Atypical chronic myeloid leukemia, BCR/ABL-negative
C92.20	Atypical chronic myeloid leukemia, BCR/ABL-negative, not having achieved remission
C92.22	Atypical chronic myeloid leukemia, BCR/ABL-negative, in relapse
C92.3	Myeloid sarcoma
C92.30	Myeloid sarcoma, not having achieved remission
C92.32	Myeloid sarcoma, in relapse
C92.4	Acute promyelocytic leukemia
C92.40	Acute promyelocytic leukemia, not having achieved remission
C92.42	Acute promyelocytic leukemia, in relapse
C92.5	Acute myelomonocytic leukemia
C92.50	Acute myelomonocytic leukemia, not having achieved remission
C92.52	Acute myelomonocytic leukemia, in relapse
C92.6	Acute myeloid leukemia with 11q23-abnormality
C92.60	Acute myeloid leukemia with 11q23-abnormality not having achieved remission
C92.62	Acute myeloid leukemia with 11q23-abnormality in relapse
C92.9	Myeloid leukemia, unspecified
C92.90	Myeloid leukemia, unspecified, not having achieved remission
C92.92	Myeloid leukemia, unspecified in relapse
C92.A	Acute myeloid leukemia with multilineage dysplasia
C92.A0	Acute myeloid leukemia with multilineage dysplasia, not having achieved remission

ICD-10-CM	Code Description
C92.A2	Acute myeloid leukemia with multilineage dysplasia, in relapse
C92.Z	Other myeloid leukemia
C92.Z0	Other myeloid leukemia not having achieved remission
C92.Z2	Other myeloid leukemia, in relapse
C93	Monocytic leukemia
C93.0	Acute monoblastic/monocytic leukemia
C93.00	Acute monoblastic/monocytic leukemia, not having achieved remission
C93.02	Acute monoblastic/monocytic leukemia, in relapse
C93.1	Chronic myelomonocytic leukemia
C93.10	Chronic myelomonocytic leukemia not having achieved remission
C93.12	Chronic myelomonocytic leukemia, in relapse
C93.3	Juvenile myelomonocytic leukemia
C93.30	Juvenile myelomonocytic leukemia, not having achieved remission
C93.32	Juvenile myelomonocytic leukemia, in relapse
C93.9	Monocytic leukemia, unspecified
C93.90	Monocytic leukemia, unspecified, not having achieved remission
C93.92	Monocytic leukemia, unspecified in relapse
C93.Z	Other monocytic leukemia
C93.Z0	Other monocytic leukemia, not having achieved remission
C93.Z2	Other monocytic leukemia, in relapse
C94	Other leukemias of specified cell type
C94.0	Acute erythroid leukemia
C94.00	Acute erythroid leukemia, not having achieved remission
C94.02	Acute erythroid leukemia, in relapse
C94.2	Acute megakaryoblastic leukemia
C94.20	Acute megakaryoblastic leukemia not having achieved remission
C94.22	Acute megakaryoblastic leukemia, in relapse
C94.3	Mast cell leukemia
C94.30	Mast cell leukemia not having achieved remission
C94.32	Mast cell leukemia, in relapse
C94.4	Acute panmyelosis with myelofibrosis
C94.40	Acute panmyelosis with myelofibrosis not having achieved remission
C94.42	Acute panmyelosis with myelofibrosis, in relapse
C94.6	Myelodysplastic disease, not classified
C94.8	Other specified leukemias
C94.80	Other specified leukemias not having achieved remission
C94.82	Other specified leukemias, in relapse
C95	Leukemia of unspecified cell type
C95.0	Acute leukemia of unspecified cell type
C95.00	Acute leukemia of unspecified cell type not having achieved remission
C95.02	Acute leukemia of unspecified cell type, in relapse
C95.1	Chronic leukemia of unspecified cell type
C95.10	Chronic leukemia of unspecified cell type not having achieved remission
C95.12	Chronic leukemia of unspecified cell type, in relapse
C95.9	Leukemia, unspecified

ICD-10-CM	Code Description
C95.90	Leukemia, unspecified not having achieved remission
C95.92	Leukemia, unspecified, in relapse
C96	Other and unspecified malignant neoplasms of lymphoid, hematopoietic and related tissue
C96.0	Multifocal and multisystemic (disseminated) Langerhans-cell histiocytosis
C96.2	Malignant mast cell tumor
C96.4	Sarcoma of dendritic cells (accessory cells)
C96.5	Multifocal and unisystemic Langerhans-cell histiocytosis
C96.6	Unifocal Langerhans-cell histiocytosis
C96.9	Malignant neoplasm of lymphoid, hematopoietic and related tissue, unspecified
C96.A	Histiocytic sarcoma
C96.Z	Other specified malignant neoplasms of lymphoid, hematopoietic and related tissue
D00	Carcinoma in situ of oral cavity, esophagus and stomach
D00.0	Carcinoma in situ of lip, oral cavity and pharynx
D00.00	Carcinoma in situ of oral cavity, unspecified site
D00.01	Carcinoma in situ of labial mucosa and vermilion border
D00.02	Carcinoma in situ of buccal mucosa
D00.03	Carcinoma in situ of gingiva and edentulous alveolar ridge
D00.04	Carcinoma in situ of soft palate
D00.05	Carcinoma in situ of hard palate
D00.06	Carcinoma in situ of floor of mouth
D00.07	Carcinoma in situ of tongue
D00.08	Carcinoma in situ of pharynx
D00.1	Carcinoma in situ of esophagus
D00.2	Carcinoma in situ of stomach
D01	Carcinoma in situ of other and unspecified digestive organs
D01.0	Carcinoma in situ of colon
D01.1	Carcinoma in situ of rectosigmoid junction
D01.2	Carcinoma in situ of rectum
D01.3	Carcinoma in situ of anus and anal canal
D01.4	Carcinoma in situ of other and unspecified parts of intestine
D01.40	Carcinoma in situ of unspecified part of intestine
D01.49	Carcinoma in situ of other parts of intestine
D01.5	Carcinoma in situ of liver, gallbladder and bile ducts
D01.7	Carcinoma in situ of other specified digestive organs
D01.9	Carcinoma in situ of digestive organ, unspecified
D02	Carcinoma in situ of middle ear and respiratory system
D02.0	Carcinoma in situ of larynx
D02.1	Carcinoma in situ of trachea
D02.2	Carcinoma in situ of bronchus and lung
D02.20	Carcinoma in situ of unspecified bronchus and lung
D02.21	Carcinoma in situ of right bronchus and lung
D02.22	Carcinoma in situ of left bronchus and lung
D02.3	Carcinoma in situ of other parts of respiratory system
D02.4	Carcinoma in situ of respiratory system, unspecified
D03	Melanoma in situ

ICD-10-CM	Code Description
D03.0	Melanoma in situ of lip
D03.1	Melanoma in situ of eyelid, including canthus
D03.10	Melanoma in situ of unspecified eyelid, including canthus
D03.11	Melanoma in situ of right eyelid, including canthus
D03.12	Melanoma in situ of left eyelid, including canthus
D03.2	Melanoma in situ of ear and external auricular canal
D03.20	Melanoma in situ of unspecified ear and external auricular canal
D03.21	Melanoma in situ of right ear and external auricular canal
D03.22	Melanoma in situ of left ear and external auricular canal
D03.3	Melanoma in situ of other and unspecified parts of face
D03.30	Melanoma in situ of unspecified part of face
D03.39	Melanoma in situ of other parts of face
D03.4	Melanoma in situ of scalp and neck
D03.5	Melanoma in situ of trunk
D03.51	Melanoma in situ of anal skin
D03.52	Melanoma in situ of breast (skin) (soft tissue)
D03.59	Melanoma in situ of other part of trunk
D03.6	Melanoma in situ of upper limb, including shoulder
D03.60	Melanoma in situ of unspecified upper limb, including shoulder
D03.61	Melanoma in situ of right upper limb, including shoulder
D03.62	Melanoma in situ of left upper limb, including shoulder
D03.7	Melanoma in situ of lower limb, including hip
D03.70	Melanoma in situ of unspecified lower limb, including hip
D03.71	Melanoma in situ of right lower limb, including hip
D03.72	Melanoma in situ of left lower limb, including hip
D03.8	Melanoma in situ of other sites
D03.9	Melanoma in situ, unspecified
D05	Carcinoma in situ of breast
D05.0	Lobular carcinoma in situ of breast
D05.00	Lobular carcinoma in situ of unspecified breast
D05.01	Lobular carcinoma in situ of right breast
D05.02	Lobular carcinoma in situ of left breast
D05.1	Intraductal carcinoma in situ of breast
D05.10	Intraductal carcinoma in situ of unspecified breast
D05.11	Intraductal carcinoma in situ of right breast
D05.12	Intraductal carcinoma in situ of left breast
D05.8	Other specified type of carcinoma in situ of breast
D05.80	Other specified type of carcinoma in situ of unspecified breast
D05.81	Other specified type of carcinoma in situ of right breast
D05.82	Other specified type of carcinoma in situ of left breast
D05.9	Unspecified type of carcinoma in situ of breast
D05.90	Unspecified type of carcinoma in situ of unspecified breast
D05.91	Unspecified type of carcinoma in situ of right breast
D05.92	Unspecified type of carcinoma in situ of left breast
D07	Carcinoma in situ of other and unspecified genital organs

ICD-10-CM	Code Description
D07.0	Carcinoma in situ of endometrium
D07.1	Carcinoma in situ of vulva
D07.2	Carcinoma in situ of vagina
D07.3	Carcinoma in situ of other and unspecified female genital organs
D07.30	Carcinoma in situ of unspecified female genital organs
D07.39	Carcinoma in situ of other female genital organs
D07.4	Carcinoma in situ of penis
D07.6	Carcinoma in situ of other and unspecified male genital organs
D07.60	Carcinoma in situ of unspecified male genital organs
D07.61	Carcinoma in situ of scrotum
D07.69	Carcinoma in situ of other male genital organs
D09	Carcinoma in situ of other and unspecified sites
D09.0	Carcinoma in situ of bladder
D09.1	Carcinoma in situ of other and unspecified urinary organs
D09.10	Carcinoma in situ of unspecified urinary organ
D09.19	Carcinoma in situ of other urinary organs
D09.2	Carcinoma in situ of eye
D09.20	Carcinoma in situ of unspecified eye
D09.21	Carcinoma in situ of right eye
D09.22	Carcinoma in situ of left eye
D09.3	Carcinoma in situ of thyroid and other endocrine glands
D09.8	Carcinoma in situ of other specified sites
D09.9	Carcinoma in situ, unspecified
D32	Benign neoplasm of meninges
D32.0	Benign neoplasm of cerebral meninges
D32.1	Benign neoplasm of spinal meninges
D32.9	Benign neoplasm of meninges, unspecified
D33	Benign neoplasm of brain and other parts of central nervous system
D33.0	Benign neoplasm of brain, supratentorial
D33.1	Benign neoplasm of brain, infratentorial
D33.2	Benign neoplasm of brain, unspecified
D33.3	Benign neoplasm of cranial nerves
D33.4	Benign neoplasm of spinal cord
D33.7	Benign neoplasm of other specified parts of central nervous system
D33.9	Benign neoplasm of central nervous system, unspecified
D35.2	Benign neoplasm of pituitary gland
D35.3	Benign neoplasm of craniopharyngeal duct
D35.4	Benign neoplasm of pineal gland
D42	Neoplasm of uncertain behavior of meninges
D42.0	Neoplasm of uncertain behavior of cerebral meninges
D42.1	Neoplasm of uncertain behavior of spinal meninges
D42.9	Neoplasm of uncertain behavior of meninges, unspecified
D43	Neoplasm of uncertain behavior of brain and central nervous system
D43.0	Neoplasm of uncertain behavior of brain, supratentorial
D43.1	Neoplasm of uncertain behavior of brain, infratentorial

ICD-10-CM	Code Description
D43.2	Neoplasm of uncertain behavior of brain, unspecified
D43.3	Neoplasm of uncertain behavior of cranial nerves
D43.4	Neoplasm of uncertain behavior of spinal cord
D43.8	Neoplasm of uncertain behavior of other specified parts of central nervous system
D43.9	Neoplasm of uncertain behavior of central nervous system, unspecified
D44.3	Neoplasm of uncertain behavior of pituitary gland
D44.4	Neoplasm of uncertain behavior of craniopharyngeal duct
D44.5	Neoplasm of uncertain behavior of pineal gland
D45	Polycythemia vera
D46	Myelodysplastic syndromes
D46.0	Refractory anemia without ring sideroblasts, so stated
D46.1	Refractory anemia with ring sideroblasts
D46.2	Refractory anemia with excess of blasts
D46.20	Refractory anemia with excess of blasts, unspecified
D46.21	Refractory anemia with excess of blasts 1
D46.22	Refractory anemia with excess of blasts 2
D46.4	Refractory anemia, unspecified
D46.9	Myelodysplastic syndrome, unspecified
D46.A	Refractory cytopenia with multilineage dysplasia
D46.B	Refractory cytopenia with multilineage dysplasia and ring sideroblasts
D46.C	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality
D46.Z	Other myelodysplastic syndromes
D47.1	Chronic myeloproliferative disease
D47.3	Essential (hemorrhagic) thrombocythemia
D47.4	Osteomyelofibrosis
D49.6	Neoplasm of unspecified behavior of brain
D49.7	Neoplasm of unspecified behavior of endocrine glands and other parts of nervous system
J91.0	Malignant pleural effusion
R18.0	Malignant ascites
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.11	Encounter for antineoplastic chemotherapy
Z51.12	Encounter for antineoplastic immunotherapy

Appendix P

2015 Resources for Registrars

APPENDIX P – REFERENCES AND RESOURCES FOR REGISTRARS – updated March 2016

2016 References and Resources for Cancer Registrars		
2016 REQUIRED References	Web Address For Source	Notes
2016 FCDS Data Acquisition Manual (DAM)	http://www.fcds.med.miami.edu/inc/DAM.shtml	Details cancer data reporting guidelines and casefinding mechanisms for identifying reportable cancers.
2007 MPH Rules - Solid Tumors, rev Aug 24, 2012	http://www.seer.cancer.gov/tools/mphrules/index.html	On the home page click on "Information for Cancer Registrars", MPH Rules
2015 MPH Rules - Heme/Lymph Neoplasm MPH Rules and Interactive Heme/Lymph Database for Coding	http://seer.cancer.gov/seertools/hemelymph/	On the home page click on "Information for Cancer Registrars", Hematopoietic & Lymphoid Neoplasm Project
ICD-O-3 Coding Materials Also See FCDS DAM for WHO 2011 ICD-O-3 Updates	http://www.seer.cancer.gov/icd-o-3/index.html	On the home page click "Data Collection Tools", Errata and Clarifications".
2014 Grade Coding Instructions	http://seer.cancer.gov/tools/grade/	SEE FCDS DAM Appendix N for complete set of Instructions for Coding Grade for 2014+ or Download from SEER website
AJCC Cancer Staging Manual 7 th Edition (plus errata) Required for ALL 2016> Cases	http://www.springer.com/medicine	Springer (publisher) ISBN: 978-0-387-88440-0
AJCC TNM Staging Curriculum for Cancer Registrars Self-Instruction Modules for Self-Guided Education	http://cancerstaging.org/CSE/Registrar	<p>AJCC TNM Staging Self-Instruction Modules</p> <ul style="list-style-type: none"> ✓ Module 1 – Introduction ✓ Module 2 – Beginning ✓ Module 3 – Intermediate ✓ Module 4 – Advanced <p>Additional Presentations:</p> <ul style="list-style-type: none"> ✓ Registrars Guide to Chapter 1, AJCC Seventh Edition ✓ Explaining Blanks and X, Ambiguous Terminology ✓ AJCC T, N, and M Category Options for 2016
SEER Summary Staging Manual 2000 w/ all errata Required for ALL 2015> Cases	http://seer.cancer.gov/tools/ssm/	Electronic version plus 1 update and 2 errata
SEER *Rx – Interactive Drug Database	http://seer.cancer.gov/seertools/seerrx/	A one-step lookup for coding oncology drug and regimen treatment categories in cancer registries
Collaborative Stage Data Collection System – v02.05 Part I Reference for Site-Specific Factor Coding ONLY. Brain & CNS Tumor Reporting	http://www.cancerstaging.org/cstage http://www.cdc.gov/cancer/nper/training	Collaborative Stage Data Collection System is no longer supported or in use in the United States beginning 1/1/2016. Brain Tumor Registry Reporting Materials
TEXT DOCUMENTATION	http://www.cancerregistryeducation.org/tr	Free Download – NCRA Informational Abstracts – Guidelines for Text Documentation by Cancer Site (bladder, breast, cervix, colon, endometrium, lung, melanoma, ovary, prostate)
Online Help For Abstracting Questions		
Ask a SEER Registrar/SEER Inquiry System	http://www.seer.cancer.gov/registrars/contact.html	Type in a topic, search, and it will show you similar questions that other registrars have submitted along with the answers.
Canswer Forum (Interactive Q&A Bulletin Board)	http://cancerbulletin.facs.org/forums/	Type in a topic, search, and it will show you similar questions that other registrars have submitted along with the answers.

APPENDIX P – REFERENCES AND RESOURCES FOR REGISTRARS – updated March 2016

Newsletters	Web Address	Notes
FCDS Memo	http://www.fcds.med.miami.edu/inc/publications.shtml	Florida Cancer Data System Memo written for registrars
FCRA Sun Times Newsletter	http://www.fcra.org/	Florida Cancer Registrars Association quarterly newsletter
COC Source	https://www.facs.org/publications/newsletters/coc-source	Commission on Cancer's newsletter.
The CoC Brief	http://www.multibriefs.com/briefs/acsof/	Multi-Briefs for American College of Surgeons/CoC
The NAACCR Narrative	http://www.naacr.org/AboutNAACCR/Newsletter.aspx	Newsletter for Central Cancer Registries in North America
NCRA News	http://www.ncra-usa.org	NCRA Newsletter and Peer-Review Journal
NCRA Connection		
The Journal of Registry Management		

2016 References and Resources for Cancer Registrars

Education and Training Resources

FCDS Abstracting Basics Training Course	20 Modules of Self Instruction with 1000 slides = 60 hrs	http://fcdsmoodle.med.miami.edu/
FCDS Continuing Education Webcast Series, NAACCR Series, and FCDS Annual Conference	Recorded Webcasts, Webinars and Conference Materials	http://fcds.med.miami.edu/inc/educationtraining.shtml
SEER Self-Instruction Training Website	SEER's Training Website	http://training.seer.cancer.gov/
SEER*Educat	Online Training Platform for Cancer Registrars	https://educate.fhcr.org/LandingPage.aspx
SEER Self-Instructional Training Resources	MPH Rules Training – Solid Tumors Glossary for Registrars – New for 2016 Hematopoietic and Lymphoid Neoplasms Training SEER Self-Instructional Manuals for Tumor Registrars SEER Advanced Topics for Registry Professionals	http://seer.cancer.gov/training/
NCRA Education and Training	Multiple Resources, Annual Conference, Continuing Ed NCRA Center for Cancer Registry Education	http://www.ncra-usa.org http://www.cancerregistryeducation.org
CTR Examination Requirements and Resources	NCRA Council on Certification	http://www.ctrexam.org and http://www.ctrexam.org/resources/
AJCC TNM Education and Training	Self-Instruction Modules for AJCC TNM Training Recorded Resources for AJCC TNM Training	https://cancerstaging.org/cstage/education/Pages/Education https://cancerstaging.org/CSE/general/Pages/articles.aspx
NAACCR Education and Training	NAACCR Webinar Series, Continuing Education and Training and NAACCR Annual Conference	http://www.naacr.org
CDC NPCR NETS Modules	NPCR Education and Training Series – 11 modules	http://www.cdc.gov/cancer/npcr/training/nets/
American Cancer Society	Learn About Cancer and Various Cancer Topics	http://www.cancer.org/cancer/index
National Cancer Institute	Understanding Cancer Series (also in Spanish)	http://www.cancer.gov/ http://www.cancer.gov/about-cancer/what-is-cancer http://www.cancer.gov/espanol/cancer/que-es
National Comprehensive Cancer Network (NCCN)	Treatment Guidelines by Cancer Site	http://www.nccn.org/

APPENDIX P – REFERENCES AND RESOURCES FOR REGISTRARS – updated March 2016

2016 References and Resources for Cancer Registrars	
2016 Casefinding/Reportable List	<ul style="list-style-type: none"> ➤ 2016 FCDS Data Acquisition Manual (FCDS DAM) is the Primary Reference for Florida Requirements ▪ SEER Website – Resources for Registrars – Casefinding
2016 Coding Manual and Instructions	<ul style="list-style-type: none"> ➤ 2016 FCDS Data Acquisition Manual (FCDS DAM) is the Primary Reference for Florida Requirements ▪ 2016 CoC Facility Oncology Data Standards (CoC FORDS) - https://www.facs.org/quality-programs/cancer/nccn/registriymannuals/cocmanuals ▪ 2016 SEER Coding and Staging Manual - http://seer.cancer.gov/tools/codingmanuals/
2007 MPH Rules - Solid Tumors	<ul style="list-style-type: none"> ➤ MPH Rules – Solid Tumors http://www.seer.cancer.gov/tools/mphrules/index.html
2015 MPH Rules - Heme/Lymph Neoplasms	<ul style="list-style-type: none"> ➤ MPH Rules and Database – Heme/Lymph Neoplasms http://seer.cancer.gov/seertools/hemelymph/
ICD-O-3 Primary Site/Histology Codes	<ul style="list-style-type: none"> ➤ ICD-O-3 (except for Heme/Lymph Neoplasms – codes 9590-9989) ➤ ICD-O-3 Updates (2011 WHO) and NAACCR Implementation Guide for 2011 ICD-O-3 Updates ➤ MPH Rules - Heme/Lymph Neoplasms for all codes 9590-9992
2014 Grade Coding Instructions	<ul style="list-style-type: none"> ➤ SEE FCDS DAM Appendix N for complete set of Instructions for Coding Grade for 2014+ Or go to http://seer.cancer.gov/tools/grade/
AJCC Cancer Staging Manual 7 th Edition	<ul style="list-style-type: none"> ➤ ISBN: 978-0-387-88440-0 (order your copy at http://www.springer.com/medicine)
SEER *Rx – Interactive Drug Database	<ul style="list-style-type: none"> ➤ http://seer.cancer.gov/seertools/seerx/
Collaborative Stage Data Collection System, v2	<ul style="list-style-type: none"> ▪ Part I – Section 2 – Lab Tests, Tumor Markers, and SSF Notes ▪ http://fcds.med.miami.edu/inc/whatsnew_shtml ▪ http://www.facs.org/cancer ▪ http://www.cancerstaging.org/ ▪ http://seer.cancer.gov/tools/mphrules ▪ http://seer.cancer.gov/tools/seerx ▪ http://seer.cancer.gov/tools/heme ▪ http://www.ncra-usa.org ▪ http://www.naaccr.org ▪ http://who.int/classifications/icd/adaptations/oncology/en
TEXTBOOK: Cancer Registry Management – Principles and Practice for Hospitals and Central Registries, 3 rd edition	<ul style="list-style-type: none"> ➤ ISBN 978-0-7575-6900-5 (order your copy at http://ncra-usa.org/ or http://www.kendallhunt.com)
National Cancer Institute	<ul style="list-style-type: none"> ➤ http://www.cancer.gov
Centers for Disease Control and Prevention	<ul style="list-style-type: none"> ➤ http://www.cdc.gov/cancer
American Cancer Society	<ul style="list-style-type: none"> ➤ http://www.cancer.org
Cancer Staging	<ul style="list-style-type: none"> ➤ http://www.cancerstaging.org
NCCN	<ul style="list-style-type: none"> ➤ http://nccn.org/
ASCO	<ul style="list-style-type: none"> ➤ http://asco.org/

Appendix Q

NEW - - Florida DOH Letter Outlining Florida SSN Data Collection Requirement - - NEW

FCDS Frequently Asked Questions

FCDS IDEA User Accounts

Facility Access Administrator (FAA) and FAA Responsibilities

FCDS Abstractor Code

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

Vision: To be the Healthiest State in the Nation

To: Florida Reporting Facilities and Abstractors**RE: Patient Social Security Number – A Florida Mandated Data Item**

The Florida Department of Health would like to remind all reporting entities that a complete and accurately transcribed Social Security Number (SSN) is a required data item that **MUST** be reported to the state cancer registry, the Florida Cancer Data System (FCDS). Per Rule 64D-3, *Florida Administrative Code (F.A.C.)*, diseases or conditions of public health significance identified by the Florida Department of Health must be reported by the practitioner, hospital, laboratory, or other entity or individual, and this report must include at a minimum the patient's first and last name, including middle initial; address, including city, state, and zip code; telephone number, including area code; date of birth; sex; race; ethnicity; **social security number**; diagnosis; type of diagnostic tests; and treatment given. Cancer is a reportable disease in the state of Florida and all reportable cancers submitted to the FCDS must have a social security number (SSN).

Within the reporting entity, the appropriate assigned staff (e.g. registrar and abstractor) **MUST** have access to a complete and valid SSN for every case reported to the FCDS, regardless of cancer program affiliation, health care network policy, corporate policy or local institutional policy restricting access to these data. Reportable cancers **MUST** be submitted to the FCDS with full SSN. There are no exceptions to this reporting rule.

The number of unknown SSNs submitted to the FCDS must be kept to an absolute minimum. Partial SSN (last 4-digits or last 6-digits) and IT or billing system generated proxy SSN are not acceptable and will be rejected if uploaded to the FCDS. Operationally, the FCDS is required to match and consolidate cancer cases to accurately determine the cancer burden in the state. Cancer burden statistics disseminated from the FCDS are integral to local, state, and national cancer prevention and intervention plans.

For more information on current reporting requirements to the FCDS and specific coding instructions, please reference the Florida Cancer Data System Data Acquisition Manual (FCDS DAM). Specifically, within the 2014 FCDS DAM, Section II pages 69-70, the collection and coding of Social Security Number (SSN) is outlined.

Thank you for your continued support of Florida's statewide cancer surveillance and registry. If you should have any further questions please contact Steve Peace at 305-243-4601 or speace@med.miami.edu.

Sincerely,

A handwritten signature in black ink, appearing to read "Dongming Cui".

Dongming Cui, MD, DrPH
Cancer Registry Project Director
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health

Florida Department of Health

Division of Disease Control & Health Protection • Bureau of Epidemiology
4052 Bald Cypress Way, Bin A-12 • Tallahassee, FL 32399-1720
PHONE: 850/245-4401 • FAX 850/922-9299

www.FloridaHealth.gov

TWITTER: HealthyFLA
FACEBOOK: FLDepartmentofHealth
YOUTUBE: fldoh

FCDS IDEA Frequently Asked Questions (FAQs)

FCDS IDEA USER ACCOUNT

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- p. 2 Password Reset
- User ID Retrieval
- User Account Renewal

FACILITY ACCESS ADMINISTRATOR (FAA)

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- p. 3 FCDS Requirements
- Establishing the FAA
- p. 4 Management of FAA User Role Assignments

FCDS ABTRACTOR CODE

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- p. 6 FCDS Abstractor Code Requirements
- p. 7 Obtaining FCDS Abstractor Code
- p. 8 FCDS Learning Management System
- Registration and course enrollment process

FCDS IDEA User Accounts

1.) Do I need an FCDS IDEA User Account?

Yes, anyone accessing IDEA will need an FCDS IDEA User Account.

2.) How do I create an FCDS IDEA user account?

Please follow the instructions as listed below:

- a. Access the FCDS IDEA Requirements page at <http://fcds.med.miami.edu/inc/idea.shtml#>
- b. Click 'Create new FCDS IDEA account'
- c. The 'User Type Identification Screen' appears
- d. Select user role appropriate for your user account
- e. Click Continue
- f. The 'Create FCDS User Account' screen appears - **(all fields with an * are required)**
 - a. Create a password (select ? criteria)
 - b. Re-enter the password to verify
 - c. Enter your email address
 - i. **Email address cannot be used with any other IDEA User Account**
 - ii. **Email address is required to receive your user information**
 - d. Re-enter your email address to verify
 - e. Select security question and answer
 - f. Complete demographic information
 - i. Name
 - ii. Complete mailing address
 - iii. Phone number/ Fax/ Alternate number
 - g. Verify your entries before clicking submit.
 - i. Once you click **Submit** an e-mail is generated and sent to your e-mail address.
 - ii. This email includes your assigned **User ID** and activation information.
 - iii. **You MUST respond to activate the user account.**
- g. Click on the link within the email to activate your account
- h. The IDEA log-in screen will appear
 - a. Input the username provided in email
 - b. Input the password you created during your account setup
- i. The 'Abstractor Attestation Details' dialog box appears if you chose 'Abstractor' as your role.
 - a. **Read the Abstractor Attestation dialog box carefully before checking the I Certify box.**
 - b. Click **Save** to complete attestation.
- j. An "abstractor" will have limited access until an FAA assigns them to a facility.

FCDS IDEA Frequently Asked Questions (FAQs)

3.) What is the procedure for lost or forgotten User ID and/or Password?

Access the FCDS IDEA website at <http://fcds.med.miami.edu>

Select the FCDS IDEA icon (located to the right of the page)

The FCDS IDEA log-in screen will appear

Click on the **User/Password Reset** button located bottom center of the login window.

The Forgot My Password dialog window will appear

Select correct button

The system will request specific information

Once the correct information is provided an email will be sent for reset.

4.) Are multiple user accounts required for each facility that I am employed with?

No, a user may work for multiple facilities from one user account, by supplying specific information to the facility's Facility Access Administrator (FAA).

5.) How do I renew or update information in my FCDS User Account?

1. Log into **FCDS IDEA**
2. Go to the '**IDEA User**' menu
3. Select **Account Manager**
4. You can update information as needed (*exception: User Type*)
5. Double click in the box titled '**PASSWORD**' hit backspace and change password.
 - Select the **(?)** icon for the password requirements
 - The password must be changed to renew the user account.
 - Cannot reuse a previous password
 - The Renewal is valid for one year from the password change date.
6. Retype the password in the box titled '**VERIFY PASSWORD**'
7. Click on the '**SUBMIT**' button.
8. The system will give message of successful update to user account.

Note: System prompts for renewal on log-in beginning 30 days prior to expiration.

Facility Access Administrator

1. Which facilities are required to establish a Facility Access Administrator (FAA)?

Every Hospital, Ambulatory Care, and Radiation Therapy facility must have an FAA.
Physicians' Offices and Pathology Labs **DO NOT** require an FAA.

2. Who can be a Facility Access Administrator (FAA)?

The FAA must be an employee of the facility. *Facility personnel such as the Director of Medical Records, Quality Assurance, Office Manager, etc ., can be designated as the FAA.*

A CONTRACTOR CANNOT BE THE FAA.

3. How do I apply for the FAA role?

Before registering as a FAA, an FCDS IDEA user account must be established.

Log into **IDEA** as usual

Go to the '**IDEA User**' menu

Select '**Add Additional Role**'

Select '**Facility Access Administrator**'

Click '**add role**'

Confirm request

Select the '**File**' menu

Click '**Close All**'

The Facility Administrator Application will appear

Double click on greyed out **Facility** within the Facility table

Enter the 4-digit FCDS Facility Number

Select the TAB key (the table will populate with facility's information)

You will do this for each facility (if they share the same administration)

Provide the Authorizing Medical Facility Individual Information

This information is the person who is approving your designation as the facility's FAA.

Your information cannot substitute for the authorizing individual credentials.

Click the process button

A PDF copy of the Facility Access Administration letter is generated.

FCDS IDEA Frequently Asked Questions (FAQs)

Print letter

Close only the window containing the letter.

Verify all documentation has printed

Click **OK**

A notification message will display.

Copy letter onto facility letterhead

Sign and date where indicated (your name will appear beneath the signature line)

Provide letter to the authorizing personnel to sign and date where indicated.

Fax the letter to FCDS at 305-243-4871.

*When the user adds the FAA role, the “**FAA User Role Assignments**” menu appears under the **IDEA User Menu**; however, it will not be active for use until the user’s FAA request has been approved.

4. How do I manage the user role assignments:

Management of User Role Assignments - (Initial Set-up)

Go to the **IDEA User** menu

Select **FAA User Role Assignments** menu.

Select the **Renew/Revoke Facility** Tab

Select facility you are adding the personnel by clicking on the down arrow

You will see all names for abstractors who currently have access to your facility including yourself.

You will select **renew** for your current users.

Revoke for those no longer with your facility.

Click on **Update** and you are done.

To Assign NEW User

Select the **Assign New User** Tab

Provide the following in the indicated fields:

- User ID
- Email Address
- Select the facility you are adding the personnel

Select the **Assign** button for the role you would like to assign the user.

FCDS IDEA Frequently Asked Questions (FAQs)

Renewal of User Role Assignments:

- If the abstractor is currently associated with the facility, the FAA will only need to renew their access using the 'Revoke/Renew' tab.
- To assign a user access requires the individuals' user-id and the email address associated with their user account.
- Select the desired role for user within your facility.
- The user's role is now reset for 6 months from date of renewal.

FCDS Abstractor Code

1.) What is an FCDS Abstractor Code?

The FCDS Abstractor Code is an alpha/numeric code (**2A3**) which certifies the abstractor is an approved State of Florida Abstractor.

Every registrar/abstractor planning to work in the State of Florida is required to obtain an Individual FCDS Abstractor Code.

2.) Do I need an FCDS Abstractor Code?

The FCDS Abstractor Code Requirement has been FCDS Policy for many years and applies to every cancer registrar working in the state of Florida (CTR or non-CTR, Florida resident or out-of-state contractor, regardless of years as an abstractor).

Physician Office personnel are **not required** to have an abstractor code.

Individuals hoping to acquire a NEW FCDS Abstractor Code will need to take the New FCDS Abstractor Code Exam.

Individuals with an ACTIVE (not yet expired) FCDS Abstractor Code will be required to take and pass the FCDS Abstractor Code Renewal Exam once their code has expired.

Individuals with an EXPIRED FCDS Abstractor Code will be required to take the FCDS Abstractor Code Renewal Exam each year in order to keep their FCDS Abstractor Code current and to renew their individual FCDS Abstractor Code, annually. If an individual's FCDS Abstractor Code has been expired for greater than 365 days, the individual must re-take and pass, the New FCDS Abstractor Code Exam.

FCDS IDEA Frequently Asked Questions (FAQs)

3.) How do I obtain an FCDS Abstractor Code?

As of January 8th 2013, any individual planning to acquire a **New** FCDS Abstractor Code must take the **FCDS Abstractor Code Exam** and pass with a minimum of (80%).

Abstractors with an **existing** FCDS Abstractor Code must take the FCDS Abstractor Code Renewal Exam and pass with a minimum of (80%). All FCDS Abstractor Codes require annual renewal.

If unsuccessful you can retake the exam 30 minutes after the first attempt.

If unsuccessful on the 2nd attempt the system puts into effect a 7 day wait period thereafter.

Registration on the FCDS Learning Management System (LMS) is required to take exams.

See Question 5, page 8 - 10 for LMS registration instructions.

FCDS Abstractor Codes are processed one business day after successful completion of an exam.

4.) What is the content within the FCDS Abstractor Code Exams?

The content of The FCDS Abstractor Code Exam and The FCDS Abstractor Code Renewal Exam are:

- General Abstracting Knowledge
- General Abstracting Rules and Florida-Specific Rules
- Primary Site/Histology/Grade
- Stage at Diagnosis (Collaborative Stage Data Collection System and Site Specific Factors)
- Latest Rule Changes
- Treatment and Survival

NEW FCDS Abstractor Code:

[COURSE 2 - FCDS Abstractor Code Exam](#)

(20 Multiple Choice and True/False questions)

RENEWAL of an existing Abstractor Code:

[COURSE 3 - FCDS Abstractor Code Annual Renewal Exam](#)

(15 Multiple Choice and True/False questions)

FCDS IDEA Frequently Asked Questions (FAQs)

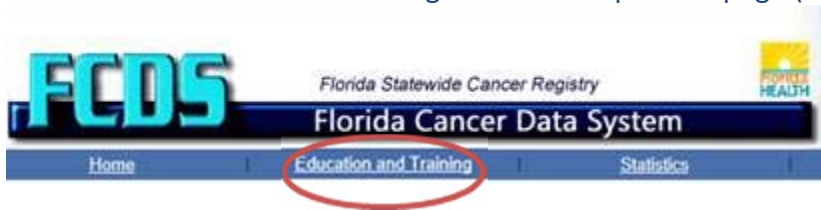
5. How do I register on the FCDS Learning Management System (LMS):

- *Registration on the FCDS Learning Management System (LMS) is required to take exams.*
- *When creating your account for the LMS please use the same email address associated with your FCDS IDEA user account.*

To access the FCDS Learning Management System (LMS):

Visit the FCDS Website at <http://fcds.med.miami.edu>

Select the Education and Training Tab at the top of the page (second tab).



The Education and Training page will appear.

Select Web Training tab



Select the Learning Management Icon.

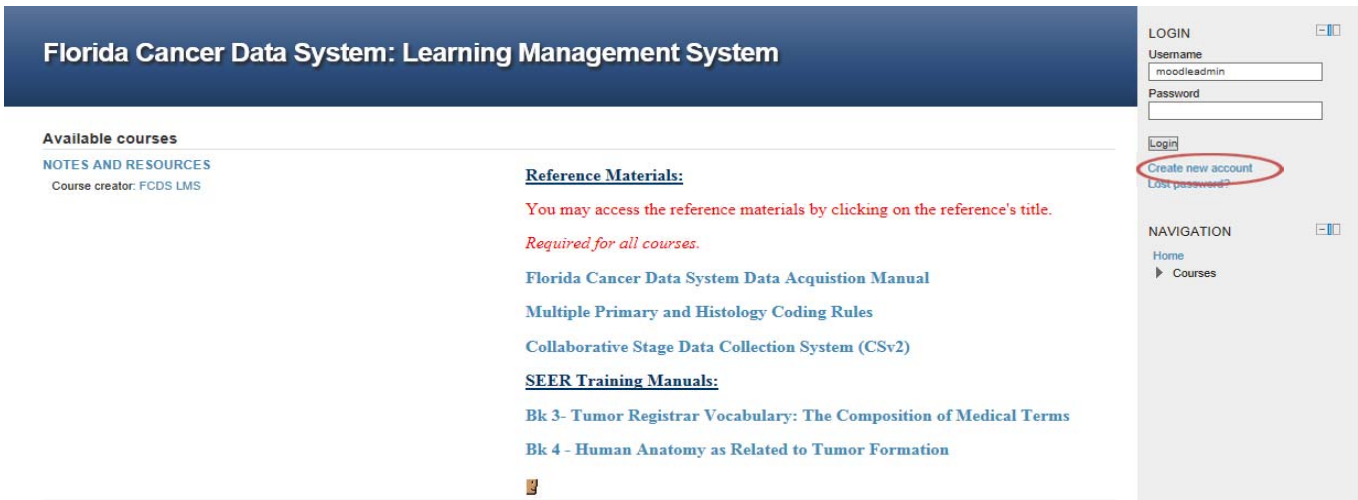
Learning Management System



A New Learning Management System for FCDS

FCDS IDEA Frequently Asked Questions (FAQs)

The FCDS LMS site will appear:



Florida Cancer Data System: Learning Management System

Available courses

NOTES AND RESOURCES
Course creator: FCDS LMS

Reference Materials:
You may access the reference materials by clicking on the reference's title.
Required for all courses.

Florida Cancer Data System Data Acquisition Manual
Multiple Primary and Histology Coding Rules
Collaborative Stage Data Collection System (CSv2)

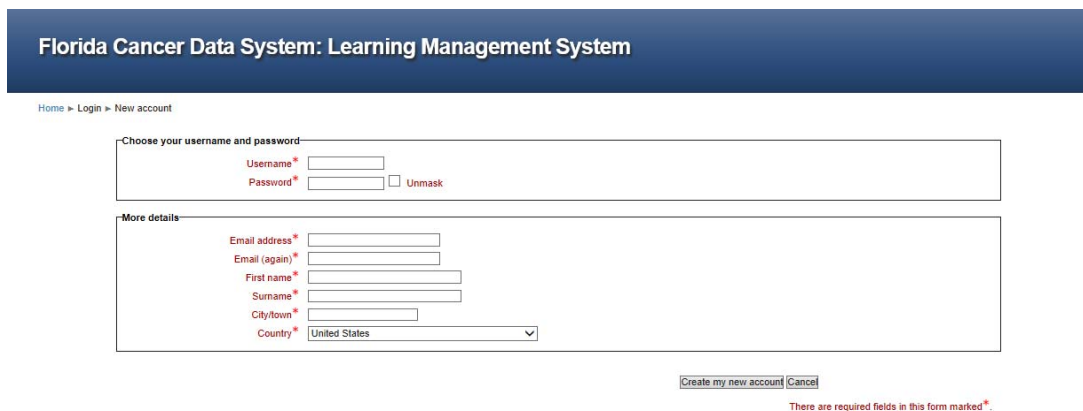
SEER Training Manuals:
Blk 3- Tumor Registrar Vocabulary: The Composition of Medical Terms
Blk 4 - Human Anatomy as Related to Tumor Formation

LOGIN
Username
moodleadmin
Password
Login
Create new account
Lost password?

NAVIGATION
Home
Courses

Select the 'Create New Account' link located directly under the login button

The (Login) New Account page will appear:



Florida Cancer Data System: Learning Management System

Home > Login > New account

Choose your username and password

Username*
Password* Unmask

More details

Email address*
Email (again)*
First name*
Surname*
City/town*
Country* United States

Create my new account Cancel

There are required fields in this form marked*

*****Use your FCDS IDEA login information to create your LMS new account*****
If you do not have an FCDS IDEA User Account, please create an FCDS IDEA account.

Once you have created and confirmed your LMS account; log into the LMS.

Select the desired course by clicking on the course title and then the 'enrol' button.

You will receive a course registration notification email.

The FCDS Learning Management System (LMS) can also be accessed via FCDS IDEA

- Once you are logged in select the Education/FCDS Tools menu
- Then select Learning Management System

Appendix R

NAACCR Guidelines for ICD-O-3 Update Implementation, January 1, 2014

2011 Updates to the International Classification of Diseases for Oncology, 3rd ed. (ICD-O-3)

2015 FCDS Data Acquisition Manual (FCDS DAM) Summary of Changes

North American Association of Central Cancer Registries, Inc.

**GUIDELINES FOR
ICD-O-3 UPDATE
IMPLEMENTATION
Effective January 1, 2014**

Prepared by the

**NAACCR ICD-O-3 Update
Implementation Work Group**

December 1, 2013

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5 REMAINING ISSUES9

ICD-O-3 WORK GROUP MEMBERS

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1 INTRODUCTION

These implementation guidelines, developed by the North American Association of Central Cancer Registries, Inc. (NAACCR) ICD-O-3 Implementation Work Group and approved by the Cancer Registration Steering Committee (CRSC) Change Management Board (CMB), address implementation of ICD-O-3 Update terms and codes for cases diagnosed on or after January 1, 2014. Members of the work group represent standard setting organizations, central registries, and cancer registry software vendors.

On an international level, the need was recognized in 2010 for updating the morphology section to accurately code contemporary diagnoses described in the terms of the fourth editions of the World Health Organization's Classifications of Hematopoietic and Lymphoid Neoplasms, Tumors of the Central Nervous System, and Tumors of the Digestive System. In September 2011, the International Agency for Research on Cancer (IARC) and the World Health Organization (WHO) released the document *Updates to the International Classification of Diseases for Oncology, third edition (ICDO-3)* (<http://www.who.int/classifications/icd/updates/ICDO3Updates2011.pdf>). According to that document, the changes were valid for implementation with cases diagnosed January 1, 2012, and later. Many countries adopted the new terms and codes immediately; others, along with the United States, have taken a more stepwise approach to implementation.

The CRSC in North America recommended that NAACCR member registries not incorporate the updates until the impact of these changes could be evaluated. CRSC requested that NAACCR create a work group to determine how and when NAACCR member registries should implement the ICD-O-3 changes. The ICD-O-3 Update Implementation Work Group, with April Fritz as chair, began meeting in July 2012. The Work Group forwarded their implementation recommendations to the CMB in June 2013. The CMB reviewed the recommendations and accepted them with implementation dates as shown below. The CMB instructed the ICD-O-3 Update Implementation Work Group to prepare a communication plan to disseminate the information to NAACCR members. This implementation document is one step in disseminating the information. The changes and effective dates follow.

The ICD-O-3 Implementation Work Group was charged with developing the implementation document and they will also act as the clearinghouse for review and resolution of ICD-O-3 implementation questions. If there are any questions, email them to April Fritz (april@afritz.org) as chair of this Work Group. Updates will be posted on NAACCR's web site (www.naacr.org). The Work Group will also be communicating updates via email using the NAACCR listserv and mailing lists of all organizations involved.

2 BACKGROUND AND IMPLEMENTATION ISSUES

Implementation of new standards is never 100 percent problem-free. In anticipation of questions that may arise in this update, the Work Group has developed the following explanations.

2.1 Why is there an update to ICD-O-3 at this time?

WHO has been publishing updates to the WHO Classification of Tumors (Blue Book) series for several years. As part of each new edition, subject matter experts review current literature pertaining to the organ or body system covered in the WHO Classification and make recommendations regarding revised histologic terminology. These revisions are reviewed pre-publication by the WHO/IARC Committee on ICD-O-3 to make sure that recommended code changes and additions are appropriate. When each new Blue Book edition is published, the terminology and codes are introduced into contemporary pathology terminology to be used in pathology reports. Malignant diagnoses from these books that find their way into cancer registries may not be listed in ICD-O-3, the standard reference for reportable conditions. This becomes an issue if there is no histology code available to register a case.

The IARC and WHO responded to this by creating a list of terms and codes that were added or modified in the new edition of the Blue Books in print as of 2010. In September 2011, WHO published the first update to the ICD-O-3 since its publication in 2000. The 2011 Update list incorporated terms from the Blue Books published at the time:

WHO Classification of Tumors of the Central Nervous System (2007)

WHO Classification of Tumors of the Hematopoietic and Lymphoid Tissues (2008)

WHO Classification of Tumors of the Digestive System (2010)

It should be noted that the terms and codes pertaining to the *WHO Classification of Tumors of the Hematopoietic and Lymphoid Tissues* (fourth edition, 2008) had already been reviewed and accepted by NAACCR and were implemented for use in North America effective with cases diagnosed on or after January 1, 2010. These hematopoietic and lymphoid terms comprised almost half of the terms on the 2011 WHO ICD-O-3 Update List.

2.2 How sweeping are the changes?

The CMB has approved 36 new terms to be added to existing codes in ICD-O-3 for use in the United States and Canada beginning with cases diagnosed on or after January 1, 2014. Of these terms, 21 are malignant (/3) terms, and one is a new borderline (/1) tumor of the central nervous system. All of these are reportable. The remaining 14 are benign (/0) or uncertain malignancy (/1) and are not reportable conditions. Table 1 displays the terms approved for use with 2014 diagnoses and forward.

It is important to understand that cancer registry reportability rules based on behavior code still apply. With the exception of primary intracranial and central nervous system benign and borderline tumors, the addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable.

For 2015, 16 new codes and terms were proposed for addition to ICD-O-3. Of these, 7 are reportable malignant (/3) tumors and 4 are reportable borderline (/1) tumors of the central nervous system (see Table 2). The implementation of these updates was postponed until 2015 because these are new codes, and the terms cannot be used until the codes have been added to registry manuals, software, edits, and documentation. Most of these new codes and terms are rare or very site-specific. The newly reportable malignant codes were not incorporated into CS version 02.05 and thus cannot be used at this time because no CS Stage Group will be derived. Until the new codes can be used, the Work Group has prepared a coding guideline (Table 2) for the terms with new codes on the WHO Update List, (which may appear in pathology reports) showing which existing codes to use.

Also proposed for 2015 is a behavior and reportability change for carcinoid of the appendix (See section 4). This change was made in the *WHO Classification of Digestive System Tumors* published in 2010. The Work Group supports this reportability change, since current terminology for “carcinoid” – well-differentiated neuroendocrine tumor – is coded to 8240/3 and most ‘former’ carcinoids of the appendix are already being accessioned under the new terminology. Based on an analysis of data from a large university hospital pathology department and cancer registry, the Work Group believes there will be only a minimal effect on casefinding and abstracting if all carcinoids of the appendix are made reportable. Canada adopted this behavior and reportability change for carcinoid of the appendix as of 2012 diagnoses.

2.3 Why is the 2014 list of approved terms so limited compared to the WHO ICD-O-3 Update List?

As mentioned above, the CRSC wanted to proceed deliberately and study the implications of adding new codes and terms. The first terms approved by the CMB (for 2014) are additions (synonymous terms) to existing codes so there should be no problems with invalid codes or edit conflicts. The next set of terms to be implemented in 2015 includes new codes and terms. The delay in implementing terms with new codes is to allow software vendors and others who work with ICD-O-3 codes in their databases to have more time to add new codes, check code ranges and test any software revisions. The discontinuation of Collaborative Staging has further delayed the use of the new malignant codes until 2016. The remaining terms may or may not be implemented for cancer registries in the United States because of the terminology used and potential reportability issues. Please refer to the remaining ICD-O-3 issues in section 5 of this guide.

2.4 What about training for data collectors?

Short articles/announcements have been issued in blast emails from standard setting organizations and in the *Journal of Registry Management* to highlight some of the changes, and more are planned. Educational materials/presentations are also planned.

2.5 What are the conversion issues?

To the Work Group’s knowledge, there are no conversion issues with the list of terms in Table 1, as they are terminology additions to existing codes. There is one recode required in 2015, which will have minimal impact on cancer registries and could be done manually (see section 4).

2.6 Will a new version of the ICD-O-3 manual be available?

WHO has announced a “first revision” of ICD-O-3. It is important to note that this new printing includes all of the terms added to ICD-O-3 in the 2011 WHO Update. Consequently, purchasers of the “ICD-O-3 First Revision” may be confused by terms added internationally but not yet implemented in the United States and/or Canada. At this time, the Work Group recommends using the original publication of the ICD-O-3 book (Copyright 2000) since only the terms in Table 1 have been approved in the United States and Canada for 2014 and forward.

Until all update terms are approved for use in the United States and Canada, print Tables 1 and 2 and include those terms in the original ICD-O-3 book.

3 TABLE 1. ICD-O-3 CHANGES EFFECTIVE JANUARY 1, 2014

Use the following new terms, synonyms, and related terms for existing ICD-O-3 codes.

Bold indicates a preferred term. Sans-serif font indicates a new reportable term.

New preferred term	8150/0 Pancreatic endocrine tumor, benign (C25._)
Move former preferred term to synonym	8150/0 Islet cell adenoma (C25._)
New related term	8150/0 Pancreatic microadenoma (C25._)
New preferred term	8150/1 Pancreatic endocrine tumor, NOS (C25._)
Move former preferred term to synonym	8150/1 Islet cell tumor, NOS (C25._)
New preferred term	8150/3 Pancreatic endocrine tumor, malignant (C25._)
Move former preferred term to synonym	8150/3 Islet cell carcinoma (C25._)
New related term	8150/3 Pancreatic endocrine tumor, nonfunctioning (C25._)
New related term	8152/1 L-cell tumor
New related term	8152/1 Glucagon-like peptide-producing tumor (C25._)
New related term	8152/1 Pancreatic peptide and pancreatic peptide-like peptide within terminal tyrosine amide producing tumor
New synonym for related term	8152/1 PP/PYY producing tumor
New preferred term	8154/3 Mixed pancreatic endocrine and exocrine tumor, malignant (C25._)
New related term	8154/3 Mixed endocrine and exocrine adenocarcinoma (C25._)
New synonym for related term	8154/3 Mixed islet cell and exocrine adenocarcinoma (C25._)
New related term	8154/3 Mixed acinar-endocrine-ductal carcinoma
New related term	8201/3 Cribriform comedo-type carcinoma (C18._, C19.9, C20.9)
New synonym	8201/3 Adenocarcinoma, cribriform comedo-type (C18._, C19.9, C20.9)
New synonym to primary term	8213/0 Traditional serrated adenoma
New related term	8213/0 Sessile serrated adenoma
New related term	8213/0 Sessile serrated polyp
New related term	8213/0 Traditional sessile serrated adenoma
New related term	8240/3 Neuroendocrine tumor, grade 1
New related term	8240/3 Neuroendocrine carcinoma, low grade
New related term	8240/3 Neuroendocrine carcinoma, well-differentiated
New preferred term	8244/3 Mixed adenoneuroendocrine carcinoma
Move former preferred term to synonym	8244/3 Composite carcinoid
New synonym	8244/3 Combined/mixed carcinoid and adenocarcinoma
New synonym	8244/3 MANEC

New synonym	8249/3	Neuroendocrine tumor, grade 2
New related term	8249/3	Neuroendocrine carcinoma, moderately differentiated
New synonym	8263/0	Tubulo-papillary adenoma
New related term	8290/0	Spindle cell oncocytoma (C75.1)
New related term	8490/3	Poorly cohesive carcinoma
New related term	8811/0	Plexiform fibromyxoma
New related term	8970/3	Hepatoblastoma, epithelioid (C22.0)
New related term	8970/3	Hepatoblastoma, mixed epithelial-mesenchymal (C22.0)
New related term	9471/3	Medulloblastoma with extensive nodularity
New related term	9474/3	Anaplastic medulloblastoma
New related term	9506/1	Extraventricular neurocytoma

NOTE: It is important to understand that cancer registry reportability rules based on behavior code still apply. With the exception of primary intracranial and central nervous system benign and borderline tumors, the addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable.

TABLE 2. ICD-O-3 CHANGES EFFECTIVE FOR JANUARY 1, 2015

ICD-O-3 change	New code in ICD-O-3	Description	Comment	Use this code in 2015
New term and code	8158/1	Endocrine tumor, functioning, NOS	Not reportable	
New related term	8158/1	ACTH-producing tumor	Not reportable	
New term and code	8163/3	Pancreatobiliary-type carcinoma (C24.1)	DO NOT use new code	8255/3
New synonym	8163/3	Adenocarcinoma, pancreatobiliary-type (C24.1)	DO NOT use new code	8255/3
New term	8213/3	Serrated adenocarcinoma		8213/3*
New code and term	8265/3	Micropapillary carcinoma, NOS (C18._, C19.9, C20.9)	DO NOT use new code	8507/3*
New code and term	8480/1	Low grade appendiceal mucinous neoplasm (C18.1)	Not reportable	
New term and code	8552/3	Mixed acinar ductal carcinoma	DO NOT use new code	8523/3
New term and code	8975/1	Calcifying nested epithelial stromal tumor (C22.0)	Not reportable	
New term and code	9395/3	Papillary tumor of the pineal region	DO NOT use new code	9361/3*
New term and code	9425/3	Pilomyxoid astrocytoma	DO NOT use new code	9421/3
New term and code	9431/1	Angiocentric glioma	DO NOT use new code	9380/1*
New term and code	9432/1	Pituicytoma	DO NOT use new code	9380/1*
New term and code	9509/1	Papillary glioneuronal tumor	DO NOT use new code	9505/1
New related term	9509/1	Rosette-forming glioneuronal tumor	DO NOT use new code	9505/1
New term and code	9741/1	Indolent systemic mastocytosis	Not reportable	

* ICD-O-3 rule F applies (code the behavior stated by the pathologist). If necessary, over-ride any advisory messages.

4 REPORTABILITY AND RECODE CHANGES EFFECTIVE IN 2015

Make the following reportability change.

Behavior code change

- Delete code and term, 8240/1, Carcinoid tumor, NOS, of appendix (C18.1).
- Code carcinoid tumor, NOS, of appendix to 8240/3. (Change made in Canada in 2012).

Recode the following conditions as shown.

- Recode all cases of enteroglucagonoma, NOS, as 8152/1. *Enteroglucagonoma is now a related term for glucagonoma.*
- Then delete code 8157/1 Enteroglucagonoma, NOS.
- Recode all cases of enteroglucagonoma, malignant as 8152/3. *Enteroglucagonoma, malignant is now a related term for glucagonoma, malignant.*
- Then delete code 8157/3 Enteroglucagonoma, malignant.

NOTE: It is important to understand that cancer registry reportability rules based on behavior code still apply. With the exception of primary intracranial and central nervous system benign and borderline tumors, the addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable.

5 REMAINING ISSUES

The publication of this implementation guideline document containing the list of approved new terms and its dissemination through the United States standards setters does not mean that the job of the ICD-O-3 Update Implementation Work Group is complete. A number of other issues remain.

The review of other terms that were included in the WHO Updates List has not been completed. While the WHO “Blue Books” reflect current thinking and current terminology among pathologists and specialists, reportability to population-based cancer registries is not clear in many instances. NAACCR is taking a close look at some of the terms and the potential challenges in implementing them as reportable neoplasms in the United States. Most of the problematic terms include the words “high grade neoplasia” or “high grade dysplasia” or “severe dysplasia” in digestive system sites and breast. These dysplasia terms are not included in most states’ reporting legislation. The implications of accepting these terms as reportable are being carefully studied as they may affect not only reporting legislation, but also workload in case ascertainment (casefinding), abstracting, follow-up (as applicable) and incidence reporting. The ICD-O-3 Work Group is cooperating with CRSC and the College of American Pathologists (CAP) (among others) to make recommendations on the adoption of various dysplasia terminologies for future inclusion in cancer registries. (Note: Canada has recommended the adoption and collection of all reportable high grade dysplasia tumors in the digestive system beginning with cases diagnosed on or after January 1, 2012).

In addition, other issues regarding morphology coding have been identified. These are not within the original scope of the Work Group but should be addressed soon.

- The *WHO Classifications of Soft Tissue and Bone, Breast, and Female Genital Organs* have been published since 2011. These pathology references include more new terms and codes but they have not been organized into updated lists for future adoption. More updated volumes of WHO Classification are planned, and WHO is planning further update lists as new editions of the classifications are published.
Suggested Next steps: North American standard setting organizations provide guidance on how to handle new codes, obsolete codes, other changes, and timing of implementation. In conjunction with the assessments of the impact of additions and changes on incidence, there should be assessments of the impact on the Multiple Primary and Histology coding rules.
- Although the new edition of the Lung WHO Classification is not expected until 2015, updated terms for bronchioloalveolar carcinoma – including changes in behavior codes – are already in use by pathologists around the United States and Canada.
Suggested Next steps: Review new terminology and provide recommendations for interim codes to disseminate for consistent use in registries long before the WHO Lung Classification is published.
- Reportability guidelines for GIST tumors has been partially addressed in a sentence added to *FORDS 2013* and the *SEER 2013 Coding Manual*, which indicate that GIST tumors and thymomas are reportable when there is evidence of multiple foci, lymph node involvement, or metastasis.
Suggested Next steps: North American standard setters provide additional guidance for GIST tumors, such as formal interpretation of the “risk assessment” categories as benign, borderline, or malignant.

Updates to the International Classification of Diseases for Oncology, third edition (ICDO-3)

This document provides a listing of all official additions, changes, and revisions to the International Classification of Diseases for Oncology, third edition (ICD-O-3) as at Sep 01 2011 and has been approved by the IARC/WHO Committee for ICD-O-3. Any comments should be sent to ICDO3@iarc.fr, or at whofic@who.int . The changes become valid from 1 January 2012.

In 2010, the WHO/IARC ICD-O Update Committee was established. Modifications to the classification are recommended to the committee by the international boards that review the WHO Classification of Tumors Blue Book series.

Relevant changes in other language versions of ICD-O and in related tools will also have to be made and disseminated by the appropriate authority.

(Note: Every effort has been made in the following pages to reproduce the updates to the ICD-O in an understandable format. Page references have not been used in all instances since these do not apply to electronic and other language versions of the Classification.)

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Status	ICD-O-3	Term	Indent 1	Comment
Bold indicates change from what is printed in ICD-O-3	Bold code/behavior combination	Bold indicates preferred term		
Related term=not indented				
Synonym = indented				
New code and term	8077/0	Squamous intraepithelial neoplasia, low grade		
New synonym	8077/0	Squamous intraepithelial neoplasia, grade I		
New synonym	8077/0	Squamous intraepithelial neoplasia, grade II		
New related term	8077/0	Anal intraepithelial neoplasia, low grade (C21.1)		
New related term	8077/0	Cervical intraepithelial neoplasia, low grade (C53._)		
New related term	8077/0	Esophageal squamous intraepithelial neoplasia (dysplasia), low grade (C15._)		
New preferred term	8077/2	Squamous intraepithelial neoplasia, high grade		
Move former preferred term to synonym	8077/2	Squamous intraepithelial neoplasia, grade III		<i>Unbold and indent former preferred term</i>
New related term	8077/2	Esophageal squamous intraepithelial neoplasia (dysplasia), high grade (C15._)		
New code and term	8148/0	Glandular intraepithelial neoplasia, low grade		
New synonym	8148/0	Glandular intraepithelial neoplasia, grade I		
New synonym	8148/0	Glandular intraepithelial neoplasia, grade II		
New related term	8148/0	Biliary intraepithelial neoplasia, low grade		

Bold indicates change from what is printed in ICD-O-3	Bold	indicates a new code/behavior combination	Bold indicates preferred term					
Related term=not indented								
Synonym = indented								
New code and term	8077/0	Squamous intraepithelial neoplasia, low grade						
New related term	8148/0	Esophageal glandular dysplasia (intraepithelial neoplasia), low grade (C16._)						
New preferred term	8148/2	Glandular intraepithelial neoplasia, high grade						
term to synonym	8148/2	Glandular intraepithelial neoplasia, grade III					<i>preferred term</i>	
New synonym	8148/2	Flat intraepithelial neoplasia, high grade						
New related term	8148/2	Flat intraepithelial glandular neoplasia, high grade (C24.1)						
New synonym	8148/2	Flat intraepithelial neoplasia (dysplasia), high grade (C24.1)						
New related term	8148/2	Biliary intraepithelial neoplasia, high grade						
New synonym	8148/2	Biliary intraepithelial neoplasia, grade 3 (BillIN-3)						
New related term	8148/2	Esophageal glandular dysplasia (intraepithelial neoplasia), high grade (C16._)						
New synonym	8148/2	Esophageal intraepithelial neoplasia, high grade (C16._)						
New preferred term	8150/0	Pancreatic endocrine tumor, benign (C25._)						
Move former preferred term to synonym	8150/0	Islet cell adenoma (C25._)					<i>Unbold and indent former preferred term</i>	
New related term	8150/0	Pancreatic microadenoma (C25._)						
New preferred term	8150/1	Pancreatic endocrine tumor, NOS (C25._)						
Move former preferred term to synonym	8150/1	Islet cell tumor, NOS (C25._)					<i>Unbold and indent former preferred term</i>	
New preferred term	8150/3	Pancreatic endocrine tumor, malignant						
Move former preferred term to synonym	8150/3	Islet cell carcinoma (C25._)					<i>Unbold and indent former preferred term</i>	
New related term	8150/3	Pancreatic endocrine tumor, nonfunctioning						
related term	8152/1	Enteroglucagonoma, NOS					<i>term for glucagonoma</i>	
New related term	8152/1	L-cell tumor						
New related term	8152/1	Glucagon-like peptide-producing tumor						
New related term	8152/1	Pancreatic peptide and pancreatic peptide-like peptide within terminal tyrosine amide producing tumor						
term	8152/1	PP/PYY producing tumor						

Bold indicates change from what is printed in ICD-O-3 Related term=not indented Synonym = indented	Bold indicates a new code/ behavior combination	Bold indicates preferred term								
New code and term	8077/0	Squamous intraepithelial neoplasia, low grade								
related term	8152/3	Enteroglucagonoma, malignant							<i>term for glucagonoma,</i>	
New preferred term	8154/3	Mixed pancreatic endocrine and exocrine tumor, malignant (C25...)								
New related term	8154/3	Mixed endocrine and exocrine adenocarcinoma (C25...)								
term	8154/3	Mixed islet cell and exocrine adenocarcinoma (C25...)							<i>term</i>	
New related term	8154/3	Mixed acinar-endocrine-ductal carcinoma								
Delete code and term	8157/1	Enteroglucagonoma, NOS							<i>Term recorded as 8152/1</i>	
Delete code and term	8157/3	Enteroglucagonoma, malignant							<i>Term recorded as 8152/3</i>	
New term and code	8158/1	Endocrine tumor, functioning, NOS								
New related term	8158/1	ACTH-producing tumor								
New term and code	8163/0	Pancreatobiliary neoplasm, non-invasive								
New synonym	8163/0	Noninvasive pancreatobiliary papillary neoplasm with low grade dysplasia								
New synonym	8163/0	Noninvasive pancreatobiliary papillary neoplasm with low grade intraepithelial neoplasia								
New term and code	8163/2	Papillary neoplasm, pancreatobiliary-type, with high grade intraepithelial neoplasia (C24.1)								
New synonym	8163/2	Noninvasive pancreatobiliary papillary neoplasm with high grade dysplasia (C24.1)								
New synonym	8163/2	Noninvasive pancreatobiliary papillary neoplasm with high grade intraepithelial neoplasia (C24.1)								
New term and code	8163/3	Pancreatobiliary-type carcinoma (C24.1)								
New synonym	8163/3	Adenocarcinoma, pancreatobiliary type (C24.1)								
New related term	8201/3	Cribiform comedo-type carcinoma (C18..., C19.9, C20.9)								
New synonym	8201/3	Adenocarcinoma, cribriform comedo-type (C18..., C19.9, C20.9)								
New synonym to primary term	8213/0	Traditional serrated adenoma								
New related term	8213/0	Sessile serrated adenoma								

Bold indicates change from what is printed in ICD-O-3	Bold indicates a new code/behavior combination	Bold indicates preferred term					
Related term=not indented	behavior combination	indicates preferred term					
Synonym = indented	tion	term					
New code and term	8077/0	Squamous intraepithelial neoplasia, low grade					
New related term	8213/0	Sessile serrated polyp					
New related term	8213/0	Traditional sessile serrated adenoma					
New term	8213/3	Serrated adenocarcinoma					
Behavior code change:							
delete code and term	8240/1	Carcinoid tumor, NOS, of appendix (C18.1)				Code changed to 8240/3	
Behavior code change:							
delete code and term	8240/1	Carcinoid, NOS, of appendix (C18.1)				Code changed to 8240/3	
Wording change	8240/3	Carcinoid tumor, NOS				Delete "(except of appendix M-8240/1)"	
		Carcinoid, NOS				Delete "(except of appendix M-8240/1)"	
Wording change	8240/3	Neuroendocrine tumor, grade 1					
New related term	8240/3	Neuroendocrine carcinoma, low grade					
New related term	8240/3	Neuroendocrine carcinoma, well-differentiated					
New preferred term	8244/3	Mixed adenoneuroendocrine carcinoma					
Move former preferred term to synonym	8244/3	Composite carcinoid				<i>Unbold and indent former preferred term</i>	
New synonym	8244/3	Combined/mixed carcinoid and adenocarcinoma					
New synonym	8244/3	MANEC					
New synonym	8249/3	Neuroendocrine tumor, grade 2					
New related term	8249/3	Neuroendocrine carcinoma, moderately differentiated					
New synonym	8263/0	Tubulo-papillary adenoma					
New code and term	8265/3	Micropapillary carcinoma, NOS (C18.1, C19.9, C20.9)					
New related term	8290/0	Spindle cell oncocytoma (C75.1)					
New related term	8453/0	Intraductal papillary-mucinous tumor with low grade dysplasia (C25.1)					
New synonym	8453/0	Intraductal papillary-mucinous neoplasm with low grade dysplasia (C25.1)					

Bold indicates change from what is printed in ICD-O-3	Bold indicates a new code/behavior combination	Bold indicates preferred term							
Related term=not indented									
Synonym = indented									
New code and term	8077/0	Squamous intraepithelial neoplasia, low grade							
related term	8453/0	Intraductal papillary-mucinous tumor with moderate dysplasia (C25._)						Was 8453/1	
New synonym	8453/0	Intraductal papillary-mucinous neoplasm with moderate dysplasia (C25._)							
New related term	8453/0	Intraductal papillary-mucinous tumor with intermediate dysplasia (C25._)							
Delete code and term	8453/1	Intraductal papillary-mucinous tumor with moderate dysplasia (C25.1)							Code changed to 8453/0
New related term	8453/2	Intraductal papillary mucinous neoplasm with high grade dysplasia							
New related term	8453/3	Intraductal papillary mucinous neoplasm with an associated invasive carcinoma							
New related term	8470/0	Mucinous cystic tumor with low grade dysplasia (C25._)							
New related term	8470/0	Mucinous cystic neoplasm with low-grade intraepithelial neoplasia (C22._)							
New related term	8470/0	Mucinous cystic neoplasm with intermediate-grade intraepithelial neoplasia (C22._)							
New related term	8470/0	Mucinous cystic neoplasm with low-grade dysplasia (C25._)							
New related term	8470/0	Mucinous cystic neoplasm with intermediate-grade dysplasia (C25._)							
related term	8470/0	Mucinous cystic tumor with moderate dysplasia (C25._)							Was 8470/1
New related term	8470/0	Mucinous cystic tumor with intermediate dysplasia (C25._)							
Delete code and term	8470/1	Mucinous cystic tumor with moderate dysplasia (C25._)							Code changed to 8470/0
New related term	8470/2	Mucinous cystic tumor with high-grade dysplasia (C25._)							
New synonym	8470/2	Mucinous cystic neoplasm with high-grade intraepithelial neoplasia (C22._)							
New synonym	8470/2	Mucinous cystic neoplasm with high-grade dysplasia (C25._)							
New related term	8470/3	Mucinous cystic tumor with an associated invasive carcinoma (C25._)							
New synonym	8470/3	Mucinous cystic neoplasm with an associated invasive carcinoma (C25._)							
New code and term	8480/1	Low grade appendiceal mucinous neoplasm (C18.1)							
New related term	8490/3	Poorly cohesive carcinoma							
New related term	8503/0	Intraductal papillary neoplasm, NOS							
New related term	8503/0	Intraductal papillary neoplasm with low grade intraepithelial neoplasia (C22._, C24.0)							
New synonym	8503/0	Intraductal papillary neoplasm with intermediate grade neoplasia (C22._, C24.0)							

Bold indicates change from what is printed in ICD-O-3 Related term=not indented Synonym = indented	Bold indicates a new code/ behavior combination	Bold indicates preferred term						
New code and term	8077/0	Squamous intraepithelial neoplasia, low grade						
New related term	8503/0	Intracystic papillary neoplasm with low grade intraepithelial neoplasia (C23.9)						
New synonym	8503/0	Intracystic papillary neoplasm with intermediate grade intraepithelial neoplasia (C23.9)						
New synonym	8503/0	Intraglandular papillary neoplasm with low grade intraepithelial neoplasia (C22.1, C24.0)						
New related term	8503/0	Intraductal tubular-papillary neoplasm, low grade						
New related term	8503/2	Intraductal papillary neoplasm with high grade intraepithelial neoplasia						
New synonym	8503/2	Intraductal papillary neoplasm with high grade dysplasia						
New synonym	8503/2	Intraductal papillary tumor with high grade intraepithelial neoplasia						
New synonym	8503/2	Intraductal papillary tumor with high grade dysplasia						
New synonym	8503/2	Intracystic papillary neoplasm with high grade intraepithelial neoplasia (C23.9)						
New synonym	8503/2	Intracystic papillary tumor with high grade intraepithelial neoplasia (C23.9)						
New synonym	8503/2	Intracystic papillary tumor with high grade dysplasia (C23.9)						
New synonym	8503/2	Intracystic papillary tumor with high grade intraepithelial neoplasia (C23.9)						
New related term	8503/2	Intraductal tubular-papillary neoplasm, high grade						
New related term	8503/3	Intraductal papillary neoplasm with associated invasive carcinoma						
New related term	8503/3	Intracystic papillary neoplasm with associated invasive carcinoma (C23.9)						
New term and code	8552/3	Mixed acinar-ductal carcinoma						
New related term	8811/0	Plexiform fibromyxoma						
New related term	8970/3	Hepatoblastoma, epithelioid (C22.0)						
New related term	8970/3	Hepatoblastoma, mixed epithelial-mesenchymal (C22.0)						
New term and code	8975/1	Calcifying nested epithelial stromal tumor (C22.0)						
New term and code	9395/3	Papillary tumor of the pineal region						
New term and code	9425/3	Piloxyoid astrocytoma						
New term and code	9431/1	Angiocentric glioma						
New term and code	9432/1	Pituitoma						
New related term	9471/3	Medulloblastoma with extensive nodularity						

Bold indicates change from what is printed in ICD-O-3	Bold indicates a new code/behavior combination	Bold indicates preferred term							
Related term=not indented									
Synonym = indented									
New code and term	8077/0	Squamous intraepithelial neoplasia, low grade							
New related term	9474/3	Anaplastic medulloblastoma							
New related term	9506/1	Extraventricular neurocytoma							
New term and code	9509/1	Papillary glioneuronal tumor							
New related term	9509/1	Rosette-forming glioneuronal tumor							
New related term	9591/3	Splenic B-cell lymphoma/leukemia, unclassifiable							
New related term	9591/3	Splenic diffuse red pulp small B-cell lymphoma							
New related term	9591/3	Hairy cell leukemia variant							
New related term	9596/3	B-cell lymphoma, unclassifiable, with features intermediate between diffuse large B-cell lymphoma and classical Hodgkin lymphoma							
New term and code	9597/3	Primary cutaneous follicle centre lymphoma							
New related term	9680/3	Diffuse large B-cell lymphoma associated with chronic inflammation							<i>Formerly pyothorax-associated lymphoma</i>
New related term	9680/3	B-cell lymphoma, unclassifiable, with features intermediate between diffuse large B-cell lymphoma and Burkitt lymphoma							
New related term	9680/3	EBV positive diffuse large B-cell lymphoma of the elderly							
New related term	9680/3	Primary diffuse large B-cell lymphoma of the CNS (C70.0, C71.0, C72.0)							
New related term	9680/3	Primary cutaneous DLBCL, leg type (C44.7)							
Delete code and term	9680/3	T-cell/histiocyte rich large B-cell lymphoma							<i>Code changed to 9688/3</i>
code and term	9684/3	Plasmablastic lymphoma							<i>Code changed to 9735/3</i>
Code restored	9688/3	T-cell/histiocyte rich large B-cell lymphoma							<i>Was 9688/3 in ICD-O-2</i>
New synonym	9698/3	Follicular lymphoma, grade 3A							
New synonym	9698/3	Follicular lymphoma, grade 3B							
New synonym of Mucosal associated lymphoid tissue lymphoma	9699/3	Extranodal marginal zone lymphoma of mucosa-associated lymphoid tissue							

Bold indicates change from what is printed in ICD-O-3	Bold indicates a new code/behavior combination	Bold indicates preferred term							
Related term=not indented	behavior combination	indicates preferred term							
Synonym = indented	tion								
New code and term	8077/0	Squamous intraepithelial neoplasia, low grade							
New related term	9702/3	Anaplastic large cell lymphoma, ALK negative							
New related term	9709/3	Primary cutaneous CD8-positive aggressive epidermotropic cytotoxic T-cell lymphoma							
New related term	9709/3	Primary cutaneous CD4-positive small/medium T-cell lymphoma							
Code restored	9712/3	Intravascular large B-cell lymphoma (C49.9)						<i>Was 9712/3 in ICD-O-2</i>	
New related term	9714/3	Anaplastic large cell lymphoma, ALK positive							
New preferred term	9716/3	Hepatosplenic T-cell lymphoma							
term to synonym	9716/3	Hepatosplenic $\gamma\delta$ (gamma-delta) cell lymphoma						<i>preferred term</i>	
New synonym	9719/3	Extranodal NK/T-cell lymphoma, nasal type							
New term and code	9724/3	Systemic EBV positive T-cell lymphoproliferative disease of childhood							
New term and code	9725/3	Hydroa vacciniforme-like lymphoma							
New term and code	9726/3	Primary cutaneous gamma-delta T-cell lymphoma							
New related term	9727/3	Blastic plasmacytoid dendritic cell neoplasm							
New related term	9727/3	Blastic NK cell lymphoma [obs]							
New synonym	9734/3	Extraosseous plasmacytoma							
New term and code	9735/3	Plasmablastic lymphoma							
New term and code	9737/3	ALK positive large B-cell lymphoma							
New term and code	9738/3	Large B-cell lymphoma arising in HHV8-associated multicentric Castlemans disease							
New related term	9740/1	Cutaneous mastocytosis							
New related term	9740/1	Urticaria pigmentosa							

Bold indicates change from what is printed in ICD-O-3	Bold indicates a new code/behavior combination	Bold indicates preferred term							
New code and term	8077/0	Squamous intraepithelial neoplasia, low grade							
New related term	9740/1	Diffuse cutaneous mastocytosis							
New synonym	9740/1	Solitary mastocytoma of skin							
New synonym	9740/1	Extracutaneous mastocytoma							
New term and code	9741/1	Indolent systemic mastocytosis							
New related term	9741/3	Systemic mastocytosis with associated hematological clonal non-mast cell disorder							
New related term	9741/3	Systemic mastocytosis with AHNMD							
New related term	9741/3	Aggressive systemic mastocytosis							
Notes added	9751/1	Langerhans cell histiocytosis, NOS [obs] (use 9751/3)							
Notes added	9751/1	Langerhans cell granulomatosis [obs] (use 9751/3)							
Note added	9751/1	Histiocytosis X, NOS [obs] (use 9751/3)							
Behavior code change	9751/3	Langerhans cell histiocytosis, NOS							<i>of Langerhans cell</i>
Notes added	9752/1	Langerhans cell histiocytosis, unifocal [obs] (use 9751/3)							
Notes added	9752/1	Langerhans cell granulomatosis, unifocal [obs] (use 9751/3)							
Notes added	9752/1	Langerhans cell histiocytosis, mono-ostotic [obs] (use 9751/3)							
Notes added	9753/1	Langerhans cell histiocytosis, multifocal [obs] (use 9751/3)							
Notes added	9753/1	Langerhans cell histiocytosis, poly-ostotic [obs] (use 9751/3)							
Note added	9753/1	Hand-Schuller-Christian disease [obs] (use 9751/3)							
Notes added	9754/3	Langerhans cell histiocytosis, disseminated [obs] (use 9751/3)							
Notes added	9754/3	Langerhans cell histiocytosis, generalized [obs] (use 9751/3)							
Notes added	9754/3	Letterer-Siwe disease [obs] (use 9751/3)							
Notes added	9754/3	Acute progressive histiocytosis X [obs] (use 9751/3)							
Note added	9754/3	Nonlipid reticuloendotheliosis [obs] (use 9751/3)							
New related term	9757/3	Indeterminate dendritic cell tumor							
New term and code	9759/3	Fibroblastic reticular cell tumor							

Bold indicates change from what is printed in ICD-O-3	Bold indicates a new code/behavior combination	Bold indicates preferred term						
Related term=not indented	behavior combination	indicates preferred term						
Synonym = indented	tion							
New code and term	8077/0	Squamous intraepithelial neoplasia, low grade						
Wording correction	9766/1	Lymphomatoid granulomatosis					<i>Formerly lymphoid granulomatosis</i>	
New term and code	9806/3	Mixed phenotype acute leukemia with t(9;22)(q34;q11.2); BCR-ABL1						
New term and code	9807/3	Mixed phenotype acute leukemia with t(v;11q23); MLL rearranged						
New term and code	9808/3	Mixed phenotype acute leukemia, B/myeloid, NOS						
New term and code	9809/3	Mixed phenotype acute leukemia, T/myeloid, NOS						
ICD-O Header revision	981-983	L YMPHOID LEUKEMIAS (C42.1)						
New term and code	9811/3	B lymphoblastic leukemia/lymphoma, NOS						
New term and code	9812/3	B lymphoblastic leukemia/lymphoma with t(9;22)(q34;q11.2); BCR-ABL1						
New term and code	9813/3	B lymphoblastic leukemia/lymphoma with t(v;11q23); MLL rearranged						
New term and code	9814/3	B lymphoblastic leukemia/lymphoma with t(12;21)(p13;q22); TEL-AML1 (ETV6-RUNX1)						
New term and code	9815/3	B lymphoblastic leukemia/lymphoma with hyperdiploidy						
New term and code	9816/3	B lymphoblastic leukemia/lymphoma with hypodiploidy (Hypodiploid ALL)						
New term and code	9817/3	B lymphoblastic leukemia/lymphoma with t(5;14)(q31;q32); IL3-IGH						
New term and code	9818/3	B lymphoblastic leukemia/lymphoma with t(1;19)(q23;p13.3); E2A-PBX1 (TCF3-PBX1)						
Behavior code change	9831/3	T-cell large granular lymphocytic leukemia						
New related term	9831/3	Chronic lymphoproliferative disorder of NK cells					<i>Was 9831/1</i>	
New related term	9837/3	T lymphoblastic leukemia/lymphoma						
New related term	9861/3	Acute myeloid leukemia with mutated NPM1						
New related term	9861/3	Acute myeloid leukemia with mutated CEBPA						
New term and code	9865/3	Acute myeloid leukemia with t(6;9)(p23;q34); DEK-NUP214						

Bold indicates change from what is printed in ICD-O-3	Bold indicates a new code/behavior combination	Bold indicates preferred term							
Related term=not indented									
Synonym = indented									
New code and term	8077/0	Squamous intraepithelial neoplasia, low grade							
New term and code	9869/3	Acute myeloid leukemia with inv(3)(q21q26.2) or t(3;3)(q21;q26.2); RPN1-EV1							
New related term	9891/3	Acute monoblastic and monocytic leukemia							
New preferred term	9895/3	Acute myeloid leukemia with myelodysplasia-related changes							
Move former preferred term to synonym	9895/3	Acute myeloid leukemia with multilineage dysplasia						<i>Unbold and indent former preferred term</i>	
New synonym	9896/3	Acute myeloid leukemia with t(8;21)(q22;q22); RUNX1-RUNX1T1							
New synonym	9897/3	Acute myeloid leukemia with t(9;1)(p22;q23); MLLT3-MLL							
New term and code	9898/1	Transient abnormal myelopoiesis							
New term and code	9898/3	Myeloid leukemia associated with Down Syndrome							
New term and code	9911/3	Acute myeloid leukemia (megakaryoblastic) with t(1;22)(p13;q13); RBM15-MKL1							
New preferred term	9920/3	Therapy related myeloid neoplasm							
Move former preferred term to synonym	9920/3	Therapy-related acute myeloid leukemia, NOS						<i>Unbold and indent former preferred term</i>	
New preferred term	9960/3	Myeloproliferative neoplasm, NOS							
Move former preferred term to synonym	9960/3	Chronic myeloproliferative disease, NOS						<i>Unbold and indent former preferred term</i>	
Code change; new synonym	9960/3	Myeloproliferative disease, NOS						<i>Was 9975/1</i>	
New preferred term	9961/3	Primary myelofibrosis							
Move former preferred term to synonym	9961/3	Myelofibrosis with myeloid metaplasia						<i>Unbold and indent former preferred term</i>	
New preferred term	9964/3	Chronic eosinophilic leukemia, NOS							
Move former preferred term to synonym	9964/3	Hypereosinophilic syndrome						<i>Unbold and indent former preferred term</i>	
New term and code	9965/3	Myeloid and lymphoid neoplasms with PDGFRA rearrangement							

Bold indicates change from what is printed in ICD-O-3 Related term=not indented Synonym = indented	Bold indicates a new code/behavior combination	Bold indicates preferred term						
New code and term	8077/0	Squamous intraepithelial neoplasia, low grade						
New term and code	9966/3	Myeloid neoplasms with PDGFRB rearrangement						
New term and code	9967/3	Myeloid and lymphoid neoplasms with FGFR1 abnormalities						
New term and code	9971/1	Post transplant lymphoproliferative disorder, NOS						
New synonym	9971/1	PTLD, NOS						
New term and code	9971/3	Polymorphic post transplant lymphoproliferative disorder						
Delete code and term	9975/1	Myeloproliferative disease, NOS [obs]					<i>Code changed to 9960/3</i>	
New code and term	9975/3	Myeloproliferative neoplasm, unclassifiable						
New synonym	9975/3	Myelodysplastic/myeloproliferative neoplasm, unclassifiable						
New synonym	9982/3	Refractory anemia with ring sideroblasts associated with marked thrombocytosis						
New synonym	9985/3	Refractory cytopenia of childhood						
New synonym	9986/3	Myelodysplastic syndrome with isolated del (5q)						
New synonym	9989/3	Myelodysplastic syndrome, unclassifiable						
New term and code	9991/3	Refractory neutropenia						
New term and code	9992/3	Refractory thrombocytopenia						

2016 FCDS Data Acquisition Manual (FCDS DAM) Summary of Changes

Section I – MAJOR CLARIFICATION – NEOPLASMS TO BE REPORTED TO FCDS

- Section I – Carcinoid Tumor of Appendix with a Diagnosis Date 1/1/2015 and Forward – Reportable
- Section I – Pancreatic Neoplasms – Table Inserted to Clarify Reportability, Histology Code, Behavior

Section I – MINOR CLARIFICATION – Comparison of Reportable Cancers: FCDS, CoC, and NPCR

- Table A: NAACCR Layout Version 16: Comparison of Reportable Cancers: FCDS, CoC, and NPCR
- ICD-9-CM Casefinding List (short) – Coding Reference for Annual AHCA Casefinding and Follow-Back Audit
- ICD-10-CM Casefinding List (short) – See Appendix O for a Detailed Code List [ICD-10-CM Casefinding (long)]
- REMINDER: 100% Pathology Casefinding is an ANNUAL REQUIREMENT for every facility reporting to FCDS
- Case Abstracting Requirements – Timeliness – expanded and clarified
- Annual Reporting Deadline – expanded and clarified
- Case Abstracting Requirements – Historical Cases Optional Minimal Data Set – expanded and clarified
- Data Transmission – Quarterly Reporting – expanded and clarified

Section II – NEW and CHANGED DATA ITEM(s)

- NEW Data Item– Tumor Size Summary (NAACCR Item #756) – Required for ALL Cases Diagnosed 1/1/2016>
- CHANGE Data Item – Clinical TNM Staged By & Pathologic TNM Staged By – 2-character Field & New Codes
- CHANGE Code Description for Existing Data Item – Sex (NAACCR Item #220) – Code 3 Description Updated
- TUMOR INFORMATION Section – SEER Site-Specific Coding Modules – Link to SEER Appendix C Updated
- CANCER STAGING INFORMATION AND REQUIREMENTS – Major Section Update
 - SEER Summary Stage 2000 (directly-coded) – Required for ALL Cases Diagnosed 1/1/2015 forward
 - AJCC TNM Cancer Staging – Required for All Cases Diagnosed 1/1/2016 forward
 - NEW AJCC T, N, M Category Codes for 2016 – Description, Basic Instructions, Link to Curriculum
 - NEW AJCC T, N, M Category Codes for 2016 – NEW Allowable Codes and Code Descriptions
 - Collaborative Stage Site-Specific Factors – Required for ALL Cases/All Years
 - Exception: Minimal Historical Cases entered in the Historical Case Grid – NED with New Cancer
 - Collaborative Stage Data Collection – Required for ALL Cases Diagnosed before 1/1/2016
 - Exception: Minimal Historical Cases entered in the Historical Case Grid – NED with New Cancer
- TREATMENT INFORMATION Section – SEER Site-Specific Coding Modules – Link to SEER Appendix C Updated
- TEXT REQUIRED Section – Clarifications on Text Required for Non-Analytic Cases with Evidence of Cancer
- TEXT REQUIRED Section – Reference to the New 2016 NAACCR Standard Abbreviations List (Appendix C)
- TEXT REQUIRED Section – Use of Non-Standard Abbreviations
 - Non-Standard Abbreviations may have multiple interpretations and should not be used.
 - Do not customize abbreviations or overuse abbreviations to the point where the information has no meaning or context.

APPENDICES

- Appendix A – Updated Facility Listings
- Appendix B – Updated ISO Country Codes (Tables Available in Code Order and Country Order)
- Appendix C – ER/PR/HER2 – Updated Section with 2014 ASCO and CAP Guidelines
- Appendix C – SEER Site Specific Coding Modules – Updated Reference and Links to SEER Appendix C
- Appendix C – NEW 2016 NAACCR Recommended Standard Abbreviations List(s)
- Appendix G – FCDSv16 Record Layout (Core Required Data Items)
- Appendix O – DETAILED ICD-10-CM CODE LIST FOR CASEFINDING REPORTABLE TUMORS
- Appendix P – 2016 Resources for Registrars – Updated for 2016 Resources
- Appendix Q – Florida Department of Health Letter Regarding Social Security Number (SSN) Requirement