SECTION II: GENERAL ABSTRACTING INSTRUCTIONS

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It is the responsibility of every abstractor to know the content of the *FCDS Data Acquisition Manual (FCDS DAM)* and to update it upon receipt of any change from FCDS. Should you need training in cancer registry data collection, please visit the FLccSC 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 sex and family history of malignancy. Data items MUST be well documented in text field(s); specifically, Place of Diagnosis, Physical Exam, Patient Sex, 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 AJCC Cancer Stage data items including both core items and site specific data items. Treatment information MUST also be documented in the text fields, particularly if the treatment is non-standard or the case is non-analytic or historical. Dates should be included within text in each section to provide a chronology of events, imaging, lab tests, surgeries, and other treatments.

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

Basic Rules For Date Fields:

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

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

   Example: Patient was diagnosed April 2000; use 2000/04/15 as the Date of Diagnosis.

REGISTRY INFORMATION

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

Data Items Included In This Section

NAACCR Item Number	Item Name
540	Reporting Facility
550	Accession Number- Hosp
560	Sequence Number – Hospital
580	Date of First Contact
581	Date of First Contact Flag
2300	Medical Record Number
2090	Date Case Completed/Date Abstracted
570	Abstracted By (FCDS Abstractor Code)
2152	CoC Accredited Flag
500	Type of Reporting Source

REPORTING FACILITY NAACCR ITEM #540

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

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

Coding Instructions

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

ACCESSION NUMBER- HOSP NAACCR ITEM #550

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

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

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

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

Each patient receives only one accession number from your facility for a lifetime, regardless of the facility "reference date," number of primary cancers reported, or alternate numbering assignment.

Accession numbers are never reassigned, even if a patient is removed from your facility registry.

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

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

SEQUENCE NUMBER-HOSPITAL NAACCR ITEM #560

Enter the two-digit sequence number that corresponds to this primary tumor. This data item records the chronological appearance of each reportable primary malignant and non-malignant neoplasm over the entire lifetime of the person, regardless of where they were diagnosed or treated.

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

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

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

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

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

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

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

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

If two or more non-malignant neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis.

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

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

DATE OF FIRST CONTACT NAACCR ITEM #580

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

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

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

DATE OF FIRST CONTACT FLAG NAACCR ITEM #581

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

Coding Instructions

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

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

MEDICAL RECORD NUMBER NAACCR ITEM #2300

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

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

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 RQRS CASES TO FCDS. Please wait until ALL first course therapy has been completed or provide FCDS with treatment recommended codes for treatment pending. FCDS continues to monitor patient/cancer to ensure first course therapy is consistent with stage of disease and specific biomolecular and genetic tumor markers for targeted therapies.

ABSTRACTED BY (FCDS ABSTRACTOR CODE) 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.

COC ACCREDITED FLAG NAACCR ITEM #2152

CoC Accredited Flag is assigned at the point and time of data abstraction to label an abstract being prepared for an analytic cancer case at a facility accredited by the Commission on Cancer (CoC). The flag may be assigned manually or can be defaulted by the registry's software.

CoC-accredited facilities are required to collect certain data items including TNM staging. It is burdensome for central registries to maintain a list of accredited facilities, and the list changes frequently. The flag is a means of incorporating the accredited status into abstracts at the time of abstraction by someone who has knowledge of the status. The flag thus simplifies validating that required items have been abstracted by CoC-accredited facilities. NPCR will use this flag to for validating and consolidating TNM.

Codes

0	Abstract prepared at a facility WITHOUT CoC accreditation of its cancer program
1	ANALYTIC abstract prepared at facility WITH CoC accreditation of its cancer program (Includes Class of Case codes 10-22)
2	NON-ANALYTIC abstract prepared at facility WITH CoC accreditation of its cancer program (Includes Class of Case codes 30-43 and 99, plus code 00 which CoC considers analytic but does not require to be staged)
Blank	Not applicable; DCO

TYPE OF REPORTING SOURCE NAACCR ITEM #500

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

Code	Description
1	Hospital Inpatient; managed health plans with comprehensive, unified medical records
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
3	Laboratory only (hospital-affiliated or independent)

4	Physician's Office/Private Medical Practitioner (LMD)
5	Nursing/Convalescent Home/Hospice
6	Autopsy Only
7	Death Certificate Only (DCO) - FCDS Use Only
8	Other hospital outpatient units/surgery centers

Definitions

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

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

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

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

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

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

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

PATIENT DEMOGRAPHICS

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

Data Items Included in this section:

NAACCR Item Number	Item Name
2230	Name – Last
2240	Name – First
2250	Name – Middle
2280	Name – Alias
2390	Name - Maiden
2320	Social Security Number
240	Date of Birth
241	Date of Birth Flag
252	Birthplace State
254	Birthplace Country
220	Sex
160	Race 1
161	Race 2
162	Race 3
163	Race 4
164	Race 5
190	Spanish/Hispanic Origin
150	Marital Status
9960	Height at Diagnosis (inches)
9961	Weight at Diagnosis (lbs.)
9965	Tobacco Use – Cigarette
9966	Tobacco Use – OthSmoke
9967	Tobacco Use - NOS
9968	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 NAME OR 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.

The NEW Medicare Beneficiary ID (MBI) is not yet in use, nationally. So, it is not yet required.

DATE OF BIRTH NAACCR ITEM #240

Identifies the date of birth of the patient. **Coding Instructions**

1. Record the patient's date of birth as indicated in the patient record. For single-digit day or month, record with a lead 0 (for example, September is 09). Use the full four-digit year for year.
2. For *in utero* diagnosis and treatment, record the actual date of birth.
3. If only the patient age is available, calculate the year of birth from age and the year of diagnosis and
4. leave day and month of birth unknown (for example, a 60 year old patient diagnosed in 2010 is calculated to have been born in 1950).
5. If month is unknown, the day is coded unknown. If the year cannot be determined, the day and month are both coded unknown.
6. If the date of birth cannot be determined at all, record the reason in *Date of Birth Flag* (NAACCR Item #241)

DATE OF BIRTH FLAG NAACCR ITEM #241

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

Coding Instructions

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

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

BIRTHPLACE STATE NAACCR ITEM #252

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

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

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

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

BIRTHPLACE COUNTRY — NAACCR ITEM #254

Enter the three-character International Organization for Standardization (ISO) Country Code abbreviation (Appendix B) for the country in which the patient was born.

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

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

Please refer to Appendix B for specific 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 #9960

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

See Appendix J for converting feet to inches.

Coding Instructions

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

Code "98" for 98 inches or greater.

Code "99" for unknown height.

Code "99" for historical cases.

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

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

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

WEIGHT AT DIAGNOSIS NAACCR ITEM #9961

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 #9965, 9966, 9967, 9968

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. Please be sure to document type ot tobacco consumption in text, especially when using Tobacco Use NOS for e-cigarette/vaporizor.

FCDS has received numerous inquiries regarding the use of other smoke-able products such as marijuana. Currently, the tobacco use fields are only set up for tobacco use. There is no data item to code consumption of other products via smoking or vaping. These items are strictly for tobacco use.

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:

- **Item 9965 - TobaccoUseCigarette** -Cigarette smoking
- **Item 9966 - TobaccoUseOtherSmoke** - Smoking tobacco products other than cigarettes (e.g., pipes, cigars, kreteks)
- **Item 9967 - TobaccoUseSmokeless** - Smokeless tobacco products (e.g, chewing tobacco, snuff, etc.)
- **Item 9968 - TobaccoUseNOS** - Tobacco, NOS – **includes use of e-cigarettes and vaporizers**

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 888888888.

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

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

COUNTY – CURRENT NAACCR ITEM #1840

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

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

Codes (in addition to FIPS)

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

999 COUNTY UNKNOWN

Use code 998 for Canadian residents.

FCDS Address field requirements:

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

TELEPHONE CURRENT NAACCR ITEM #2360

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

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

PRIMARY PAYER at DX NAACCR ITEM #630

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

Code	Label	Description
01	Not Insured	Patient has no insurance and is declared a charity write-off
02	Not Insured, self-pay	Patient has no insurance and is declared responsible for charges.
10	Insurance, NOS	Type of insurance unknown or other than the type listed in codes **20, 21, 31, 35, 60-68.**
20	Private Insurance: Managed care, HMO, PPO	Patient has insurance with a managed care provider health maintenance organization [HMO] preferred provider organization [PPO]
21	Private Insurance:	An insurance plan that does not have negotiated fee

Code	Label	Description
	Fee-for-Service	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 Health Service or the Public Health Service.
99	Insurance status unknown	It is unknown from the patient's medical record whether or not the patient is insured.

PHYSICIAN – MANAGING NAACCR ITEM #2460

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

NPI – MANAGING PHYSICIAN NAACCR ITEM #2465

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

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

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

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

NPI – FOLLOWING PHYSICIAN NAACCR ITEM #2475

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

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

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

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

NPI – PRIMARY SURGEON NAACCR ITEM #2485

Identifies the physician who performed the most definitive surgical procedure.

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

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

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

NPI – PHYSICIAN #3 – (RADIATION ONCOLOGIST) NAACCR ITEM #2495

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

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

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

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

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

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

Coding Instructions

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

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

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

TEXT – USUAL OCCUPATION NAACCR ITEM #310

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

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

Do enter "Unknown" when no information is available.

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

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

If the patient was a housewife/househusband and did NOT work outside of the home for most of his/her adult life, record "housewife" or househusband."

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

TEXT – USUAL INDUSTRY NAACCR ITEM #320

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

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

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

TUMOR INFORMATION

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

Data Items Included in This Chapter

NAACCR Item Number	Item Name
390	Date of Diagnosis
391	Date of Diagnosis Flag
2690	Text – Place of Diagnosis
610	Class of Case
490	Diagnostic Confirmation
400	Primary Site
2580	Text- Primary Site Title
410	Laterality
522	Histologic Type ICD-O-3
2590	Text- Histology Title
523	Behavior ICD-O-3
3843	Grade Clinical
3844	Grade Pathological
3845	Grade Post Therapy
756	Tumor Size Summary
820	Regional Lymph Nodes Positive
830	Regional Lymph Nodes Examined
1182	Lymph-Vascular Invasion

Reference: 2018 SEER Coding and Staging Manual – Appendix C: Site SpecificCoding Modules
https://seer.cancer.gov/manuals/2018/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 of 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. **BIRADS category 4 and category 5 mammograms are the exception to Instruction 2 and are never to be used to code the date of diagnosis regardless as to whether the patient subsequently has a malignancy confirmed. Do not use the BIRADS date as the date of diagnosis.**

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

5. 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.

6. 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.
7. 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.
8. 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.
9. 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.
10. 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.

11. 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.
12. 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.
13. **If the year of diagnosis cannot be identified, the date of diagnosis must be approximated based on information from the H&P. Only the month and day of diagnosis are coded "unknown".**
14. Use the actual date of diagnosis for an in utero diagnosis (For cases diagnosed before January 1, 2009, assign the date of birth).

DATE OF DIAGNOSIS FLAG NAACCR ITEM# 391

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

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

TEXT – PLACE OF DIAGNOSIS NAACCR ITEM #2690

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

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

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

CLASS OF CASE NAACCR ITEM #610

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

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

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

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

physicians involved are staff physicians or not, as with any other physician.

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

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

Non-Analytic Classes of Case	
Patient appears in person at reporting facility	
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only) NOTE: The 2010 FORDS Manual changed the definition Class of Case = 30 the CoC added a new component to what previously had been "consult only." The addition is for cases where the facility is part of the "staging workup after initial diagnosis elsewhere." These cases are "analytic" to FCDS and in Florida a "consult only" case only refers to a case where the facility provides a second opinion without additional testing.
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (**active disease**)
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (**disease not active**)
34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility
35	Case diagnosed before program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility
36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37	Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death
Patient does not appear in person at reporting facility	
40	Diagnosis AND all first course treatment given at the same staff physician's office
41	Diagnosis and all first course treatment given in two or more different staff physician offices
Patient appears in person at reporting facility	
42	Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43	Pathology or other lab specimens only
49	Death certificate only
99	Non-analytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).

DIAGNOSTIC CONFIRMATION NAACCR ITEM #490

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

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

1. The codes are in **priority order**; code 1 has the highest priority. Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods. This data item must be changed to the lower (higher priority) code if a more definitive method confirms the diagnosis *at any time during* the course of the disease.

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

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

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

Code	Description	Definition
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only, other than 5, 6 or 7	The malignancy was reported by the physician in the medical record.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).

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

1. There is no priority hierarchy for coding *Diagnostic Confirmation* for hematopoietic and lymphoid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing See the *Hematopoietic Database (DB)* for information on the definitive diagnostic confirmation for specific types of tumors.

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

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

4. Code 2 when the microscopic diagnosis is based on cytologic examination of *cells* (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.

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

6. Code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer, but no positive histologic confirmation.

7. Code 6 when the diagnosis is based only on the surgeon's report from a surgical exploration or endoscopy or from gross autopsy findings without tissue or cytological findings.

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

9. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.

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

Code	Description	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined).

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

PRIMARY SITE NAACCR ITEM#400

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

Coding Instructions

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

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

3. **DO NOT USE ANY TOPOGRAPHY CODES IN THE C76.* SERIES of ICD-O-3 CODES.**

   EXCEPTION: You MUST use C76.0 for Unknown Primary of Head & Neck. Note: There are specific requirements for this exception. The cancer must be found in cervical nodes, only and the tumor must be EBV and HPV negative. Do NOT Use C80.9, C14.8, C02.8 or C08.8 for H&N Unk.

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

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

6. 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.

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

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

Specific Tissues with Ill-Defined Sites

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

2. **DO NOT USE ANY TOPOGRAPHY CODES IN THE C76.* SERIES of ICD-O-3 CODES.**

   EXCEPTION: You MUST use C76.0 for Unknown Primary of Head & Neck. Note: There are specific requirements for this exception. The cancer must be found in cervical nodes, only and the tumor must be EBV and HPV negative. Do NOT Use C80.9, C14.8, C02.8 or C08.8 for H&N Unk.

   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.)

3. 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

4. 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. There are new rules for how to handle determination of primary site and number of head and neck primary cancers per the 2018 MPH Rules for Solid Tumors and the AJCC Cancer Staging Manual, 8th ed. Please refer to both references when abstracting head and neck cancers.

IMPOSSIBLE PRIMARY SITE/HISTOLOGY COMBINATIONS

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

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

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

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

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

4. Peripheral Nerves/Connective Tissue and Carcinomas or Melanomas: If a carcinoma or melanoma is

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

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

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

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

IMPOSSIBLE PRIMARY SITE/HISTOLOGY COMBINATIONS

SITE	HISTOLOGY
C480-C488 Retroperitoneum and peritoneum	8720-8790 Melanomas
C300 Nasal Cavity C301 Middle ear C310-C319 Accessory sinuses	9250-9342 Osteosarcoma (Giant cell Ewing's odontogenic)
C381-C388 Pleura and mediastinum	8010-8245 8247-8671 8940-8941 8720-8790 Melanomas
C470-C479 Peripheral nerves C490-C499 Connective tissue	8010-8671 Carcinomas 8940-8941 8720-8790 Melanomas
C700-C709 Meninges C710-C719 Brain C720-C729 Other central nervous system	8010-8671 Carcinomas 8940-8941
C400-C419 Bone	8010-8060 Carcinoma (except squamous cell) 8075-8671 8940-8941 8720-8790 Melanomas
C760-C768 Ill-defined Sites	8720-8790 Melanoma 8800-8811 Sarcoma except myeloid sarcoma

SITE	HISTOLOGY
	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
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 automatic nervous system of upper limb shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous and other soft tissues of lower limb and hip
C50.0 – C 50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube

ICD-O-3	SITES
C62.0 – C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0 – C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges, NOS (excluding diagnoses prior to 2004)
C71.0	Cerebrum (excluding diagnoses prior to 2004)
C71.1	Frontal lobe (excluding diagnoses prior to 2004)
C71.2	Temporal lobe (excluding diagnoses prior to 2004)
C71.3	Parietal lobe (excluding diagnoses prior to 2004)
C71.4	Occipital lobe (excluding diagnoses prior to 2004)
C72.2	Olfactory nerve (excluding diagnoses prior to 2004)
C72.3	Optic nerve (excluding diagnoses prior to 2004)
C72.4	Acoustic nerve (excluding diagnoses prior to 2004)
C72.5	Cranial nerve, NOS (excluding diagnoses prior to 2004)
C74.0 – C74.9	Adrenal gland
C75.4	Carotid body

HISTOLOGIC TYPE ICD-O-3 NAACCR ITEM #522

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

2018 UPDATE TO ICD-O-3: Between 2011 and 2017 the World Health Organization published multiple 4th edition WHO Classification of Neoplasms "Blue Books". These updates to the ICD-O-3 included new and updated histology codes, new and updated behavior codes, and much more. North America has been managing these updates in a step-wise roll-out taking place in 2011 and 2018. New 4th edition WHO Classsfication of Neoplasms books as well as updates to previously released 4th edition WHO Classification of Neoplasms have been incorporated into the 2018 Updates to ICD-O-3 by the U.S.

The result of the 2010 and 2018 ICD-O-3 Updates to the ICD-O-3 and the introduction of the Multiple Primary and Histology Coding Rules for Solid Tumors and for Hematopoeitic and Lymphoid Neoplasms without publication of a new ICD-O-4 have complicated ICD-O-3 Histology Coding. You now need to use several references to ensure the correct ICD-O-3 Histology Code for 2018 and forward – until an ICD-O-4 is published by the World Health Organization. Please do not rely solely on software vendor drop down selection menus for choosing the best histology without applying the coding rules/updates.

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

The WHO 2018 ICD-O-3 Updates are covered in **Appendix R** and should be followed carefully.

2018 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 (C22.0). This indicates that this particular histology is usually associated with the primary site C22.0 (liver). The intent and guidelines for use of some site-associated codes has been modified for 2018. Some of the new for 2018 histology codes and some of the existing ICD-O-3 histology codes now are provided for very specific use for very specific anatomic site(s) and/or conditions. Please adhere closely to the annotation.

- Use specific histology codes associated with specific primary site topography codes as annotated and now required for the 2018 ICD-O-3 Updates as indicated in the ICD-O-3 Update Materials.
- 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 siotet is unknown but the histology is known.
- Code the site documented in the 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.

2018 Solid Tumors Histology: The standard references for histology coding for solid tumors is the Solid Tumors Multiple Primary and Histology Coding Rules, the current Solid Tumors Database and the International Classification of Diseases for Oncology, Third Edition (ICD-O-3) including any published errata that have been implemented as of 1/1/2018. The 2018 Solid Tumors Database and accompanying MPH Rules can be found at https://seer.cancer.gov/seertools/mphrules/.

2018 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 1/1/2018. The 2018 Heme/Lymph Database and accompanying MPH Rules can be found at: https://seer.cancer.gov/seertools/hemelymph/

TEXT – HISTOLOGY TITLE NAACCR ITEM #2590

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

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.

Please note that a number of 2018 ICD-O-3 Histology Codes have NEW Behavior Codes.

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.

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.

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	AIN III (C211) Behavior code '2' Bowen disease (not reportable for C440-C449) Clark level I for melanoma (limited to epithelium) Confined to epithelium Hutchinson melanotic freckle, NOS (C44_) Intracystic, non-infiltrating Intraductal Intraepidermal, NOS Intraepithelial, NOS Involvement up to, but not including the basement membrane Lentigo maligna (C44_) Lobular, noninfiltrating (C50_) Noninfiltrating Noninvasive No stromal invasion/involvement Papillary, noninfiltrating or intraductal Precancerous melanosis (C44_) Queyrat erythroplasia (C60_) Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria) VAIN III (C529) VIN III (C51_)
3	Invasive	Malignant, primary site (invasive) or Microinvasive

INTRODUCTION TO CODING GRADE – 2018

Solid tumors diagnosed 2018 and forward, grade will be collected in three NEW data items, Grade Clinical, Grade Pathological, and Grade Post-Therapy. The codes and coding instructions will depend on the type of cancer. The revised grade codes are based on the recommended grading systems specified in the relevant chapters of the AJCC Cancer Staging Manual, 8th edition and/or the CAP cancer protocols.

The recommended AJCC grading system for a particular chapter are also used for histologic types of tumors occurring in the relevant organs but not eligible for staging in AJCC 8th edition.

Please download and reference the 2018 Grade Coding Instructions and Tables on the NAACCR SSDI and Grade Coding Site at https://apps.naaccr.org/ssdi/list/

The tables for coding grade have been re-structured for 2018. There may be a combination of numeric and alphabetic codes within the same table, according to the template below.

Template for a Cancer-Specific Grade Table

Code	Grade Description
1	Site-specific grade system category
2	Site-specific grade system category
3	Site-specific grade system category
4	Site-specific grade system category
5	Site-specific grade system category
L	Low grade
H	High grade
M	Site-specific grade system category
S	Site-specific grade system category
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated and anaplastic
8	Not applicable (Hematopoietic neoplasms only)
9	Grade cannot be assessed; Unknown
Blank	(Post-therapy only)

Codes 1-5, L, H, M, S, and 9 all represent AJCC recommended grading systems.

Codes 1-5 are applicable for the AJCC-recommended grading systems. Not all grade tables will have five codes; most will have three or four. GX is coded to 9.

Categories L and H are applicable for the AJCC recommended grading systems of "low grade" and "high grade" for those cancers for which these are used (e.g. urinary cancers with urothelial histologies). It also includes M for intermediate grade to be used with L and H for breast in situ cancers. S is utilized for sarcomatous overgrowth in corpus uteri adenosarcoma, an AJCC registry data collection variable.

Codes A-D are the generic grade categories (definitions) that have been used by the cancer surveillance community for many years. Codes A-D are not available for all cancers since although many AJCC chapters continue to use the traditional grade terms, many of the chapters now use a three-grade system, instead of the four-grade system.

Your software will include mapping to the correct grade coding system based on your selection of primary site (topography) and histology/behavior and on occasion other factor(s). However, it is important to understand the concepts used to develop the 30+ Grade Coding Tables used in software.

GRADE CLINICAL NAACCR ITEM 3843

Record the grade of a solid primary tumor before any treatment. Treatment may include surgical resection, systemic therapy, radiation therapy, or neoadjuvant therapy. All surgical procedures are not treatment, e.g. TURB and endoscopic biopsies.

For cases diagnosed January 1, 2018 and later, this data item, along with Grade Pathological and Grade Post-Neoadjuvant, replaces NAACCR Data Item Grade (#440) as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Please download and reference the 2018 Grade Coding Instructions and Tables on the NAACCR SSDI and Grade Coding Site at https://apps.naaccr.org/ssdi/list/

GRADE PATHOLOGICAL NAACCR ITEM 3844

Record the grade of a solid primary tumor that has been surgically resected and for which no neoadjuvant therapy was administered. If AJCC pathological staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup, as all information from diagnosis (clinical staging) through the surgical resection is used for pathological staging.

For cases diagnosed January 1, 2018 and later, this data item, along with Grade Clinical and Grade Post-Neoadjuvant, replaces NAACCR Data Item Grade (#440) as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Please download and reference the 2018 Grade Coding Instructions and Tables on the NAACCR SSDI and Grade Coding Site at https://apps.naaccr.org/ssdi/list/

GRADE POST THERAPY NAACCR ITEM 3845

Record the grade of a solid primary tumor that has been resected following neoadjuvant therapy. If AJCC post-therapy staging is being assigned, the tumor must have met the surgical resection requirements for yp in the AJCC manual. Neoadjuvant therapy must meet guidelines or standards, and not be that given for variable or unconventional reasons as noted in the AJCC manual.

For cases diagnosed January 1, 2018 and later, this data item, along with Grade Clinical and Grade Pathological, replaces NAACCR Data Item Grade (#440) as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

This data item corresponds to the yp staging period only.

Please download and reference the 2018 Grade Coding Instructions and Tables on the NAACCR SSDI and Grade Coding Site at https://apps.naaccr.org/ssdi/list/

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. Tumor Size Summary 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	SITE-SPECIFIC CODES 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) **If no size is documented:** Circumferential: Esophagus (C15.0 C15.5, C15.8 C15.9) Diffuse; widespread: 3/4s or more; linitis plastica: Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9) Diffuse, entire lung or NOS: Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9) Diffuse: Breast (C50.0 C50.6, C50.8 C50.9)
999	Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed; Not applicable

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 (LVI) indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist. LVI includes lymphatic invasion, vascular invasion, and lymphovascular invasion.

Presence or absence of cancer cells in the lymphatic ducts or blood vessels is useful for prognosis. CAP Protocols for some disease sites will be expanded to distinguish between lymphatic and small vessel invasion only, venous (large vessel) invasion only, and BOTH lymphatic and small vessel AND venous (large vessel) invasion.

Codes

0 Lymph-vascular Invasion stated as Not Present
1 Lymph-vascular Invasion Present/Identified
2 Lymphatic and small vessel invasion only (L)
3 Venous (large vessel) invasion only (V)
4 BOTH lymphatic and small vessel AND venous (large vessel) invasion
8 Not Applicable
9 Unknown/Indeterminate/not mentioned in path report

CANCER STAGING INFORMATION AND REQUIREMENTS BY DATE OF DIAGNOSIS

FCDS Cancer Staging Requirements follow the NPCR Stage Requirements by Year

State and National cancer staging requirements have changed over time. The focus of State and National cancer programs is monitoring cancer incidence over time. In order to support standardization and consistency in reporting stage of cancer at time of diagnosis, state and national cancer surveillance programs have often utilized a "summary staging" approach with stable anatomic staging criteria that includes both clinical data from imaging reports and medical procedures combined with pathological data gleaned from surgical resection of the primary tumor and regional lymph nodes. This is known as SEER Summary Stage. SEER Summary Stage has only gone through 2 revisions since it was instituted back in the mid 1970s. The latest edition is Summary Stage 2018 or SS2018. Summary Stage is required for all cases since 1981.

Facilities accredited by the Commission on Cancer tend to support changing clinical requirements for cancer staging – requiring frequent updates to the criteria used to determine cancer stage applying the AJCC Cancer Staging System which utilizes more detail in cancer staging data than does the state of Florida or the National Program of Cancer Registries. FCDS only requires AJCC Cancer Staging for 2016-2017 DX.

Continuity of staging requirements is essential for longitudinal cancer studies – but, our programs recognize that changes in anatomic staging criteria have and continue to be modified over time. Furthermore, biomolecular and genetic tests to help qualify stage subgroups are being used more frequently with tests offering greater details for staging than ever before. In order to begin capturing these new tumor markers and other cancer-specific testing or prognostic-related laboratory tests, the United States created the Collaborative Stage Data Collection System including Site-Specific Factors to house these cancer-specific tests results and other clinical care and research oriented data items to expand 'staging'.

The Collaborative Stage Data Collection System was implemented for cases diagnosed 1/1/2004-12/31/2015 and provided algorithmic solutions to deriving standardized stage groupings based in multiple cancer staging systems including SS1977, SS2000, AJCC TNM 6th ed and AJCC TNM 7th ed.

The combined system of staging parameters was decommissioned and replaced by the originating staging systems being directly coded for SS2000 and AJCC TNM 7th ed. in 2016 and again updated in 2018 to provide updated anatomic and prognostic staging data items to meet current and future research needs.

REQUIRED for ALL CASES - SUMMARY STAGE 2018 (SS2018): Direct-Assignment of SEER Summlary Stage using the SEER Summary Stage 2018 Manual is required for all cases diagnosed and reported to FCDS 1/1/2018 forward.

NOT REQUIRED - AJCC TNM CANCER STAGING, 8TH EDITION; AJCC Cancer Staging using the 8th edition AJCC Cancer Staging Manual is NOT REQUIRED for ANY CASES reported to FCDS.

NOT REQUIRED - 2018 SEER Extent of Disease (SEER EOD): SEER EOD using the 2018 SEER EOD Criteria is NOT REQUIRED for ANY CASES reported to FCDS . FCDS has never required SEER EOD coding for any cases. We do not check for correctness of coding EOD or even for valid codes. FCDS erases any EOD data received. If you decide to code these data, they are not verified, QC'd or used in any way. And, please note - before the 2018 SEER EOD was released; none of the previous versions of SEER EOD were supported, updated, or reflect anatomical staging of cancer for any of the years 2004-2016.

2018 Site-Specific Data Items (SSDI): An "SSDI'" is a site-specific data item. "Site" in this instance is based on the primary site, the histologic type or histology of the tumor, the AJCC Chapter, Summary Stage Chapter and the EOD Schema. SSDIs were preceded by Collaborative Stage Data Collection System Site-Specific Factors or SSFs, which were first introduced in 2004 with CSv1, and went through major revisions in 2010 with Collaborative Stage v2 (CSv2). The CS SSFs were discontinued as of 12/31/2017.

SSDIs have their own data item name and number and can be collected for as many sites/chapters/schemas as needed. Each Site-Specific Data Item (SSDI) applies only to selected schemas. SSDI fields should be blank for schemas where they do not apply. Please refer to the SSDI Manual for SSDI definitions, rationale, and coding instructions. Comparison of SSDI to SSF is not advised due to differences in coding over time.

The SSDI and Grade Coding Manuals and Tools are available at https://apps.naaccr.org/ssdi/list/

FCDS requires only 15 of the 136 new SSDIs documented in the SSDI Manual. FCDS requires all SSDIs that are 'required for staging' or 'prognostically significant' according to AJCC, NPCR, and SEER reviews. Appendix H includes a complete listing of all FCDS-Required SSDIs. These are also listed in the FCDS Record Layout in Appendix G. Commission on Cancer accredited cancer programs require ALL SSDIs.

HISTORICAL STAGING SYSTEMS REFERENCE BY DIAGNOSIS YEAR

SEER SUMMARY STAGE 1977: Direct-Assignment of SEER Summary Stage using the SEER Summary Stage 1977 Manual was required for all cases abstracted and reported to FCDS before 1/1/2000.

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 before 1/1/2018

AJCC TNM CANCER STAGING, 7TH EDITION: Direct-Assignment of clinical, pathological, and post-treatment AJCC TNM Cancer Staging using the AJCC Cancer Staging Manual, 7th edition is required for all cases diagnosed and reported to FCDS 1/1/2016 - 12/31/2017.

Required AJCC TNM 7th ed. Cancer Staging Items (Cancers diagnosed 1/1/2016 -12/21/2017)
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 was required for all cases diagnosed 1/1/2004 and 12/31/2015 and seen at the 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. Some cases may still require the abstractor to use Collaborative Stage – please use the on-screen help to assign.

NOTE: Minimal Historical Cases (historical cancers with no evidence of the historical cancer – but having a new primary cancer diagnosis or undergiong 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 1/1/20014 thru 12/31/2015)

- *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 were required for all cancers with an exception made for Minimal Historical Cases.

SEER EXTENT OF DISEASE: FCDS has never required SEER EOD coding for any cases. Not in any version for any year of abstracting. We do not check for correctness or even valid codes. FCDS erases any EOD data received. If you decide to code these data, they are not verified, QC'd or used in any way. Please note - before the 2018 SEER EOD was released; none of the previous versions of SEER EOD were supported, updated, or reflect anatomical staging of cancer for any of the years 2004-2016.

SEER SUMMARY STAGE 2018 General Coding Instructions – Required for ALL Cancers

You MUST refer to the *SEER Summary Summary Stage 2018 General Coding Instructions* for site-specific coding instructions. This information can be found online at https://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 2018 is based on all information available through completion of surgery(ies) 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 2018 at the time of initial Diagnosis or treatment of the reportable tumor using the *SEER Summary Staging Manual 2018*.

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

CODES	DEFINITIONS
0	*in situ*
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**.

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.

Reference: 2018 SEER Coding and Staging Manual – Appendix C: Site SpecificCoding Modules
https://seer.cancer.gov/manuals/2018/appendixc.html

Data Items Included In This Section:

NAACCR Item Number	Item Name
1290	Rx Summ – Surg Prim Site
1201	Rx Date—Surgery Flag
1292	Rx Summ – Scope Regional Lymph Node Surgery
1294	Rx Summ – Surgery of Oth Reg/Dis
1200	Date of First Surgical Procedure
3170	Rx Date – Date of Most Definitive Surgical Procedure
3171	Rx Date – Date Most Definitive Surgery Flag
1340	Reason for No Surgery
1380	Rx Summ – Surg/Rad Seq
1506	Phase I Radiation Treatment 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 "patienht 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 receiveing 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 us 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 chemotheraputic drugs directly to the tumor. Code as chemotherapy when the embolizing agent(s) is a chemotheraputic drug(s). Use SEER*RX to determine whether the drugs used are classified as chemotheraputic 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 Ytrium 90. Do not code as radioisotope, code as brachytherapy. Embolization is coded as Other Therapy (code 1) if the embolizing agent is alcohol, or if the embolized site is other than the liver and the only information in the record is that the patient was given "embolization" with no reference to the agent.

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

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. Palliataive 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 descdribe 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 preceed 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 ore 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 periotoneal 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, plateletphoresis, fresh frozen plasma (FFP), plasmaphoresis, and cryoprecipitate. **DO NOT CODE transfusion as "other treatment" for any site.**

GENERAL CODING INSTRUCTIONS SITE-SPECIFIC SURGERY

1. Refer to **Appendix F** for site-specific surgery codes.
2. Once it is determined that cancer-directed surgery was performed, use the best information in the operative/pathology reports to determine the operative procedure. Do not depend on the name of the procedure since it may be incomplete.
3. If the operative report is unclear regarding what was excised or if there is a discrepancy between the operative and pathology reports, use the pathology report, unless there is a reason to doubt its accuracy.
4. If a surgical procedure removes the remaining portion of an organ, which had been partially resected previously for any condition, code as total removal of the organ.
5. A date field is also included to document the first date of any surgery performed.

6. If there is no indication anywhere in the patient's medical record that surgery was either planned or performed enter Surgery Rx Summary as 00 – No Surgical Procedure.
7. There is no need to code any non-cancer-directed surgery performed (i.e., the patient had only a biopsy, exploratory or bypass surgery without resection of the primary or metastatic tumor).
8. If multiple primaries are excised at the same time, code the appropriate surgery for each site.

For example:

1. If a total abdominal hysterectomy was done for a patient with two primaries, one of the cervix and one of the endometrium, code each as having had a total abdominal hysterectomy.
2. If a total colectomy was done for a patient with multiple primaries in several segments of the colon, code total colectomy for each of the primary segments. Ignore the surgical approach when coding procedures. Ignore the surgical margins when coding procedures. Ignore the use of laser if used only for the initial incision.
3. Surgical procedures performed solely for the purpose of establishing a diagnosis/stage or for the relief of symptoms, and procedures such as brushings, washings, and aspiration of cells as well as hematologic findings (peripheral blood smears) are not considered cancer therapy.
4. Surgery for extranodal lymphomas should be coded using the schema for the extranodal site.

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

RX SUMM – SURG PRIM SITE NAACCR ITEM #1290

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

Code the most invasive surgical procedure for the primary site.

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

Coding Instructions

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

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

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

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

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

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

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

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

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

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

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

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

a. 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.

RX SUMM – SCOPE REG LN SUR NAACCR ITEM #1292

This field describes the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event. Regional lymph node(s) are defined in numerous manuals. Please do not code distant lymph nodes removed in this data item. Also, please do not double-code lymph node surgery in both this field and the field Surgery Other Regional Distant Sites.

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

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

			nodes examined and positive in the data items *Regional Lymph Nodes Examined* (NAACCR Item #830) and *Regional Lymph Nodes Positive* (NAACCR Item #820).
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	• The operative report states that a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure). • Code 3 (Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS). Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7). • Code 4 (1-3 regional lymph nodes removed) should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only. • Code 5 (4 or more regional lymph nodes removed). If a relatively small number of nodes was examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes was examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7). • Infrequently, a SNLBx is attempted and the patient	Generally, ALND removes at least 7~9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same procedure (code 6 or 7).
4	1-3 regional lymph nodes removed		
5	4 or more regional lymph nodes removed		
6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated	• SNLBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known • Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether	• Generally, SLNBx followed by ALND will yield a minimum of7-9 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.

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

General Instructions

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

Coding Instructions

1. Do not double-code surgical procedures in more than one surgery field. This field is for regional lymph node procedures, only. Do not code surgical procedures on distant lymph nodes in this field.

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

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

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

5. 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]).

6. 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).

7. 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)

8. 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.

Do not double-code surgical procedures in more than one surgery field. This field is for other than regional lymph node procedures.

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

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

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

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

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

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

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

RX DATE 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 DATEOF 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 RX *Date--Surgery of First Surgical Procedure* (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 *Date of Most Definitive Surgical Resction of Primary Site* (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

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

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

3. Assign **code 1**

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

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

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

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

    e. 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

PHASE I RADIATION TREATMENT MODALITY NAACCR ITEM #1506

Identifies the radiation modality administered during the first phase of radiation treatment delivered during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities. This data item should be used to indicate the radiation modality administered during the first phase of radiation.

Historically, the previously-named Regional Treatment Modality data item [1570] utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of radiation modality and radiation treatment planning techniques is to clarify this information and implement mutually exclusive categories. A separate data item for delivery technique has not been implemented because this information is not consistently reported in end treatment summaries.

Codes

00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-232
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Treatment radiation modality unknown; Unknown if radiation treatment administered

RX DATE RADIATION NAACCR ITEM #1210

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

Coding Instructions

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

RX DATE—RADIATION FLAG NAACCR ITEM #1211

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

Coding Instructions

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

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

REASON FOR NO RADIATION NAACCR ITEM #1430

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

Coding Instructions

• If *Regional Treatment Modality* (NAACCR Item #1570) is coded 00, then record the reason based on documentation in patient record.
• Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include radiation therapy.
• Code 7 if the patient refused recommended radiation therapy, made a blanket refusal of all recommended
treatment, or refused all treatment before any was recommended.
• Code 8 if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.
• Code 8 to indicate referral to a radiation oncologist was made and the registry should follow to determine

whether radiation was administered. If follow-up to the specialist or facility determines the patient was never there and no other documentation can be found, code 1.
• Cases coded 8 should be followed and updated to a more definitive code as appropriate.
• Code 9 if the treatment plan offered multiple options, but it is unknown which treatment, if any, was provided.

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

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

RX-SUMM-CHEMO NAACCR ITEM #1390

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

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

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

Coding Instructions

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

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

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

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

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

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

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

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

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

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

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

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

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

RX DATE – CHEMO NAACCR ITEM #1220

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

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

RX DATE—CHEMO FLAG NAACCR ITEM #1221

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

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

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

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

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

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

RX DATE – HORMONE NAACCR ITEM #1230

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

Coding Instructions

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

RX DATE—HORMONE FLAG NAACCR ITEM #1231

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

Coding Instructions

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

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

RX 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 SUMM – BRM/IMMUNOTHERAPY NAACCR ITEM #1410

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

Types of immunotherapy

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

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

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

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

Coding Instructions

1. Assign code 00
    a. When there is no information in the patient's medical record that immunotherapy was either planned or administered
    b. There is no reason to suspect that the patient would have had immunotherapy.
    c. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include immunotherapy.
    d. Patient elects to pursue no treatment following the discussion of immunotherapy. Discussion does not equal a recommendation.
    e. Only information available is that the patient was referred to an oncologist. Referral does not equal a recommendation.
    f. Watchful waiting (prostate)
    g. Patient diagnosed at autopsy
2. Assign code 87
    a. If the patient refused recommended immunotherapy.
    b. If the patient made a blanket refusal of all recommended treatment.
3. Assign code 99 if the patient refused all treatment before any was recommended.
    a. Death certificate only.

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

Code	Description
00	None, Immunotherapy was not part of the first course of therapy; not customary therapy for this cancer
01	Immunotherapy

82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered; it was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was noted in the patient record.
87	Immunotherapy was not administered; the patient's physician recommended it, but the patient, the patient's family member, or the patient's guardian refused this treatment. The refusal was noted in the patient's records
88	Immunotherapy was recommended, but it is unknown if it was administered
99	It is unknown if Immunotherapy was recommended or administered because it is not stated in patient record; death certificate-only cases.

RX DATE – BRM/IMMUNOTHERAPY NAACCR ITEM #1240

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

Coding Instructions

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

RX DATE- BRM FLAG NAACCR ITEM #1241

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

Coding Instructions

1. Leave this item blank if *RX Date BRM/Immunotherapy* (NAACCR Item #1240) has a full or partial date recorded.
2. Code 12 if the *RX Date BRM/Immunotherapy* cannot be determined, but the patient did receive first course immunotherapy or a biologic response modifier.
3. Code 10 if it is unknown whether any immunotherapy or a biologic response modifier was given.
4. Code 11 if no immunotherapy or biologic response modifier is planned or given.
5. Code 15 if immunotherapy or a biologic response modifier is planned, but not yet started.

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

RX 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

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

RX SUMM – TRANSPLNT/ENDOCR NAACCR ITEM #3250

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

Definitions:

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

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

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

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

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

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

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

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

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

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

Coding Instructions

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

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

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

RX SUMM – OTHER NAACCR ITEM #1420

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

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

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

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

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

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

Coding Instructions

1. Assign **Code 0** when
    a. There is no indication anywhere in the patient's medical record that other therapy was either planned or administered.
    b. 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	ALTERNATIVE SYSTEMS
Carnivora	Acupuncture
Glyoxylide	Ayurveda
Iscador	Environmental Medicine
Koch Synthetic Antitoxins	Homeopathic Medicine
Krebiozen	Natural Products
Laetrile	Native American, Latin American, Or
Malonide	Traditional Oriental Medicine
Parabenzoquinone	Bioelectromagnetic Applications
	Blue Light Treatment
ALTERNATIVE AND COMPLEMENTARY THERAPIES	Electroacupuncture
MANUAL HEALING	Magnetoresonance Spectroscopy
Acupressure	Diet, Nutrition, Lifestyle
Biofield Therapeutics	Changes In Lifestyle
Massage Therapy	Diet
Reflexology	Gerson Therapy
Zone Therapy	Macrobiotics
MIND/BODY CONTROL	Megavitimins
Biofeedback	Nutritional Supplements
Humor Therapy	Herbal Medicine
Meditation	Ginger
Relaxation Techniques	Ginkgo Biloba Extract
Yoga	Ginseng Root
PHARMACOLOGICAL AND BIOLOGICAL TREATMENTS	
Anti-Oxidizing Agents	
Cell Treatment	

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

RX DATE – OTHER NAACCR ITEM #1250

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

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

RX DATE – OTHER FLAG NAACCR ITEM #1251

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

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

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

RX SUMM – TREATMENT STATUS NAACCR ITEM #1285

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

Instructions for Coding

- This item may be left blank for cases diagnosed prior to 2010.
- Treatment given after a period of active surveillance is considered subsequent treatment and it not coded in this item.
- Use code 0 (No Treatment) 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 – this does not include the decision not to treat the patient
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

Reference: 2018 SEER Coding and Staging Manual – Appendix C: Site SpecificCoding Modules
https://seer.cancer.gov/manuals/2018/appendixc.html

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

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

DATE OF LAST CONTACT NAACCR ITEM #1750

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

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

DATE OF LAST CONTACT FLAG NAACCR ITEM #1751

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

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

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

VITAL STATUS NAACCR ITEM # 1760

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

Code	Description
0	Dead
1	Alive

CANCER STATUS NAACCR ITEM #1770

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

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