WHAT'S NEW:

The following Newsletters and Reports are currently available from the FCDS website:

- FCDS REGISTER VOL. 24
- FCDS MAY 2004 MONTHLY MEMO
- 6/24/2004: FCDS CHANGES FOR HOSPITALS SUBMITTING FULL CANCER ABSTRACTS FOR NAACCR V10.1 *(Does not pertain to Pathology Data or Radiation Therapy ID Data)*
- 6/9/2004: NEW INFORMATION ABOUT JULY 1, 2004 DEADLINE (This memo applies only to those submitting full cancer abstracts - not Path or Radiation Therapy data.)

On the Web:

FLORIDA DEPARTMENT OF HEALTH
http://www.doh.state.fl.us/

CDC'S DIVISION OF CANCER PREVENTION AND CONTROL'S (DCPC)
http://www.cdc.gov/cancer/

PDQ - PHYSICIANS DATA QUERY
http://www.cancer.gov/cancertopics/pdq/cancerdatabase

INTERNATIONAL AGENCY FOR RESEARCH ON CANCER
http://www.iarc.fr/

FLORIDA CANCER DATA SYSTEM

JUNE 2004 MONTHLY MEMO

CODING PRIMARY SITE & TUMOR MORPHOLOGY

Seer Training Website: http://training.seer.cancer.gov/module_coding_primary/coding_primary_home.html

CODING PRIMARY SITE & TUMOR MORPHOLOGY

HISTORICAL BACKGROUND

Since 1893 there has been an international classification for coding mortality. When the World Health Organization (WHO) was established after the Second World War, it took charge of publishing these classifications. The Sixth Revision of the International Statistical Classification of Diseases, Injuries, and Causes of Death (ICD) (9) was published in 1948 and soon afterwards it began to to code and tabulate mortality and morbidity data.

In the early years of nomenclature and coding of neoplasms (1950s and 1960s), the principal system for classifying diseases was the ICD series published by WHO. Eventually ICD was used to code and tabulate the diagnoses on medical records for the purpose of storage and retrieval, and Chapter II of ICD was always assigned to neoplasms.

In the Sixth Revision of ICD in 1948, the classification of neoplasms has been based primarily on topographic site and behavior (that is, whether the neoplasm was malignant, benign, or not specified). Except for lymphatic and hematopoietic neoplasms, choriocarcinoma, melanoma, and certain benign neoplasms, there had been no codes assigned for other histologic types.

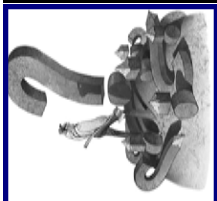
The first code manual for the morphology of neoplasms was published by the American Cancer Society (ACS) in 1951 as the Manual of Tumor Nomenclature and Coding (MOTNAC) (10). Tumor codes consisted of a two-digit code for morphology with a third digit denoting the behavior of the neoplasm. This code was the basis of a statistical code proposed by WHO in 1956 for tumor morphology.

In the 1960s, with the aid of the ACS, the College of American Pathologists (CAP) published the Systematized Nomenclature of Pathology (SNOP) (11). SNOP provided a morphology code including two sections, 8 and 9 on neoplasms and a completely new, highly detailed topography code to cover the whole body. An agreement stipulated that ACS could use the SNOP neoplasm morphology sections 8 and 9 and publish these with their own topography codes. Since cancer registries had always used the malignant neoplasm section of ICD for topography, ACS based its topography on the malignant neoplasm section of ICD-8. A new edition of MOTNAC appeared in 1968, and was used extensively by cancer registrars.

In 1968, the International Agency for Research on Cancer (IARC) was asked by WHO to make recommendations about the content and structure of the neoplasm chapter for ICD-9 in consultation with the cancer and ICD units of WHO and various national bodies. Physicians expressed a desire for a cancer supplement that would also include morphology. Many consultants worldwide made suggestions for the neoplasm section of ICD-9 and emphasized the need for the coding of morphology or histology of tumors. The consultants suggested using the 1968 edition of MOTNAC as a basis for the morphology (histology) section: the morphology section of MOTNAC had been based on the neoplasm section of SNOP published by CAP. MOTNAC was widely accepted and translated into a number of languages.

Working parties for ICD-9 also recommended a requirement that the morphology of a tumor be recorded and coded. For many years, on-

(Continued on page 3)



FCDS Q & A

SEER INQUIRY SYSTEM

http://seer.cancer.gov/seerinquiry/

References

CS Manual, Part II ;pg 603 (Vers 1.0, Jan. 1, 2004)

Question

CS Extension/CS Tumor Size--Brain and CNS: How should Collaborative Stage Extension and Tumor Size be coded for BENIGN CNS tumors?

Answer

Code CS Extension as 05 [Benign or borderline brain tumors]. Code the size of the tumor if specified, otherwise code CS Tumor Size as 999 for benign CNS tumors.

References

CS Manual, Part I ;pg 53 (Vers 1.0, Jan. 1, 2004)

Question

CS Site Specific Factor--Prostate: If Site Specific Factor PAP is not mentioned in the chart are we to code 999 unknown or assume not done/not ordered and code 000?

Answer

Assign code 999 [Unknown or no information; Not documented in patient record].

If there is no report of a lab test in the health record, code as 999. Assign code 000 [Test not done] when there is a statement in the record that a test was not performed.

References

CS Manual, Part I ;pg 26 (Vers 1.0, Jan. 1, 2004)

Question

CS Tumor Size/Ovary: We do not record the size of a cyst, but do we use the size of a cystic mass? Please see discussion below.

Answer

If the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

Please note: Ovarian cancer stage is not based on tumor size.

(Continued from page 1)

cologists had realized that knowledge solely of the site or topography of a tumor was not sufficient for planning treatment or conducting research. For example, incidence and survival rates differ according to the histologic type of the tumor.

The working parties further recommended that a special adaptation of ICD, designated the International Classification of Diseases for Oncology (1), be created as the successor to MOTNAC for use by specialists in oncology who require greater detail of histologic classification. The recommendation was endorsed by a Study Group on the Classification of Diseases convened by WHO in 1971.

In 1976, WHO published the first edition of the International Classification of Diseases for Oncology, which had a topography section based on the malignant neoplasm rubrics of ICD-9 and a morphology section that expended the MOTNAC morphology code by one digit. CAP adopted the morphology of ICD-O for its revised edition of SNOP called the Systematized Nomenclature of Medicine (SNOMED) (2). The topography in SNOMED was again entirely different from that of ICD-O. Some of the SNOMED morphology terms for non-neoplastic tumor-like lesions and premalignant conditions are listed in ICD-O to help users differentiate these terms from those of true neoplasms. The SNOMED codes are no longer given because of continual changes to the codes, now principally published on the Internet. An ICD-O user simply needs to recognize that a term referenced in ICD-O-3 to SNOMED is not a neoplasm.

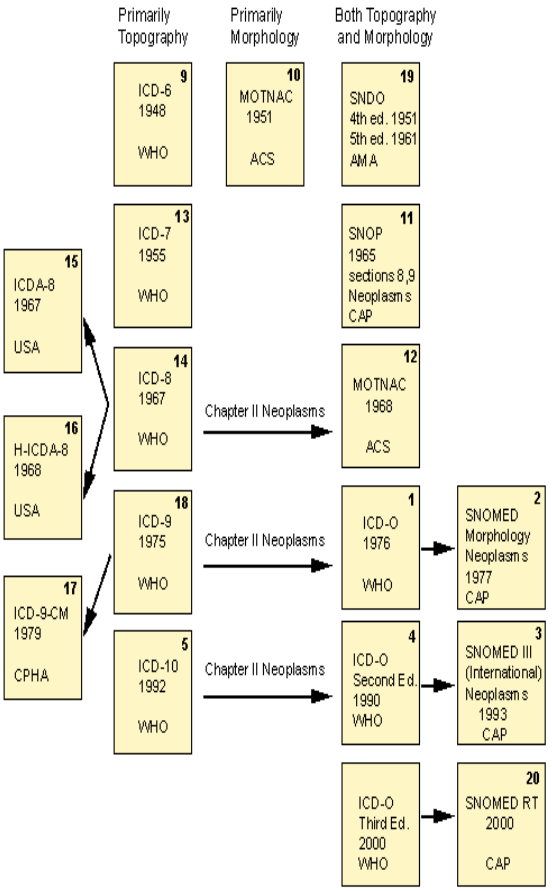
The Second Edition of ICD-O (4) was developed by a WHO/IARC working party and edited by Constance Percy, Valerie Van Holten, and Calum Muir. It was published by WHO in 1990 for use in cancer registries and by departments specializing in cancer begining with cancers diagnosed on January 1, 1992 through cases diagnosed on December 31, 2000. The Second Edition of the International Classification of Disease for Oncology is a dual classification and coding system for both topography and morphology. The topography code uses the same three- and four-character categories as ICD-10 for malignant neoplasms (C00-C80), allowing greater specificity for the site of nonmalignant neoplasms than is possible in ICD-10. The Second Edition of ICD-O has been used extensively throughout the world and has been translated into many languages, including Chinese, Czech, French, German, Greek, Italian, Japanese, Portuguese, Russian, Slovak, and Spanish.

The Third Edition of ICD-O (ICD-O-3) has also been developed by a working party convened by WHO/IARC. The morphology codes for neoplasms have been revised, especially for lymphomas and leukemias. The codes incorporate the WHO classification (21, 22), which superseded the REAL (Revised European-American Lymphoma) classification for lymphomas (6) and the FAB (Frech-American-British) classification for leukemias (7). The Third Edition also recognizes the WHO classification of myeloid leukemias, including distinct combinations of morphology and cytogenetic abnormalities. An example is M-9863/3, chronic myelogenous leukemia, Philadelphia chromosome (Phl) positive, which is also referred to as chronic myelogenous leukemia, t(9;22)(q34;q11) or chronic myelogenous leukemia, BCR/ABL. ICD-O-3 was intended to be used in cancer registries throughout the world beginning with cancers diagnosed on January 1, 2001 and forward. However, there are a few countries that have decided to delay implementation of ICD-O-3 until 2003 and 2004 due to

(Continued on page 4)

Figure 1

Table 1. Coding of Neoplasms 1946-2000: Historical Lineage of ICD-O



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the many changes incorporated in ICD-O-3. You may visit the Seer Training website to view the ICD-O-3 training module.

Conversions

Conversion algorithms (comparability codes) from ICD-O, Third Edition, to other coding systems are available. There is no change in topography between the Second and Third Editions of ICD-O, and the major changes in the morphology section are in the lymphomas and leukemias. *To view a diagram of historical lineage of ICD-O, see Figure 1, page 3.*

DIFFERENCES BETWEEN ICD-O & ICD-10

Basic Differences

There are basic differences between the structure of ICD-O and that of ICD. In Chapter II (Neoplasm) of ICD, the topography code describes the behavior of the neoplasm (malignant, benign, in situ, or uncertain whether malignant or benign) by assigning it to a specific range of codes identifying each of these types of behavior. As a result, in ICD-10, five different categories of four characters each are needed to describe all lung neoplasms (see Table 2). Very few histological types are identified in ICD. For example, there is no way in ICD to distinguish between an adenocarcinoma of the lung and a squamous cell carcinoma of the lung: both would be coded to C34.9.

The ICD-10 alphabetic index (Vol.3) contains, under the term "neoplasm," a table of five columns with the following headings: Malignant, Secondary or Metastatic, In situ, Benign, Uncertain and Unknown Behavior. Appropriate ICD-10 categories for each site of the body are then listed in alphabetic order. Table 2 shows the entry for lung neoplasms.

Table 2. ICD-10 Alphabetic Index Entry for Lung Neoplasms

	Malignant	Secondary or Metastatic	In situ	Benign	Uncertain and Unknown
Lung	C34.9	C78.0	D02.2	D14.3	D38.1

In contrast, ICD-O uses only one set of four characters for topography (based on the malignant neoplasm section of ICD-10); the topography code (C34.9, lung) remains the same for all neoplasms of that site. The behavior code, incorporated as the fifth digit in the morphology field, identifies whether the neoplasm is malignant, benign, and so forth. ICD-O also describes the type or morphology of the neoplasm, as shown in Table 3; an adenocarcinoma of the lung would thus be coded C34.9, M-8140/3, and a squamous cell carcinoma of the lung C34.9, M8070/3.

Table 3. ICD-O Coding of Lung Neoplasms

Malignant neoplasm of the lung (such as carcinoma)	C34.9	M-8010/3
Metastatic neoplasm of the lung (such as metastatic seminoma from the testis)	C34.9	M-9061/6
In situ neoplasm of the lung (such as squamous carcinoma in situ)	C34.9	M-8070/2
Benign neoplasm of lung (such as adenoma)	C34.9	M-8140/0
Uncertain behavior of neoplasm of lung (such as carcinoid of uncertain behavior)		

* Note: Cancer registries throughout the world do not use the /6 behavior code (metastatic). Registries report the behavior of the primary tumor, not the metastic tumor. The /6 is used infrequently by pathologists in very few places in the world

Table 4 shows the correspondence between the behavior code of ICD-O and the different sections of Chapter II of ICD-10.

Table 4. ICD-O Behavior Code and Corresponding Section of Chapter II, ICD-10

Behavior Code	Category	Term
/0	D10-D36	Benign neoplasms
/1	D37-D48	Neoplasms of uncertain and unknown behavior
/2	D00-D09	In situ neoplasms
/3	C00-C76, C80-C97	Malignant neoplasms stated or presumed to be primary
/6	C77-C79	Malignant neoplasms, stated or presumed to be secondary

ICD-10 Categories Not Used in ICD-O-3

As noted previously, the ICD-10 categories C00-C97 include a few categories that are either based on morphology or denote metastatic or secondary neoplasms which are described by the behavior code in ICD-O. Table 5 shows the ICD-10 categories omitted from the topography section of ICD-O.

The C81-C96 section of ICD-10 is used for malignant neoplasms of lymphoid, hematopoietic and related tissues. In ICD-O, Third Edition, these are assigned specific morphology codes and the behavior code /3. The morphology code, combined with the appropriate topography code in the range C00-C80, expresses the complete diagnosis. For example, in ICD-10,

(Continued on page 5)

(Continued from page 4)

Table 5. ICD-10 Alphabetic Index Entry for Lung Neoplasms

ICD-10 Code	Equivalent ICD-O, Third Edition,			
Category	Term	Site	Histology	Behavior
C43	Melanoma of skin	C44._	M-872—M-879	/3
C45	Mesothelioma	C__._	M-905	/3
C46	Kaposi's sarcoma	C__._	M-9140	/3
C81-C96	Malignant neoplasms of lymphoid, hematopoietic and related tissue	C00-C80	M-959-M-998	/3
C78	Secondary malignant neoplasms of respiratory and digestive systems	C15-C39	M-_____	/6
C79	Secondary malignant neoplasms of other specified sites	C00-C14, C40-C80	M-_____	/6
D00-D09	In situ neoplasms	C00-C80	M-_____	/2
D10-D36	Benign neoplasms	C00-C80	M-_____	/0
D37-D48	Neoplasms of uncertain and unknown behavior	C00-C80	M-_____	/1
C97	Malignant neoplasms of independent (primary) multiple sites	*code each one*		/3

lymphocytic lymphoma of the stomach is coded C83.0. In ICD-O, small cell (diffuse) non-Hodgkin lymphoma would be coded to stomach C16.9 and the morphology to M-9670/3 (diffuse small cell lymphoma).

The C97 category in ICD-10 is not included in ICD-O as each primary site is usually coded separately. Guidelines for determining what constitutes multiple primaries vary among countries. (See *Multiple Primary Neoplasms* on page 17)

Other Differences

Special Codes in ICD-O for Topography of Lymph Nodes (C77) and Hematopoietic and Reticuloendothelial Systems (C42)

In ICD-10, the category C77 is used for secondary and unspecified malignant neoplasms of lymph nodes. In ICD-O, C77 is used as the topography code for lymph nodes. As a result, most of the malignant lymphomas (C81-C85) in ICD-10 are coded to the topography code C77 in ICD-O.

C42 is a vacant category in ICD-10 but is used in ICD-O to designate several topographic sites within the hematopoietic and reticuloendothelial systems. This category serves principally as the topography site for most of the leukemias and related conditions classified to C90-C95 in ICD-10. Table 6 lists the subcategories for C42 in ICD-O.

Table 6. ICD-O Topography Codes Not in ICD-10

C42	Hematopoietic and Reticuloendothelial System
C42.0	Blood
C42.1	Bone Marrow
C42.2	Spleen
C42.3	Reticuloendothelial system, NOS
C42.4	Hematopoietic system, NOS

(Continued on page 8)

EDUCATION AND TRAINING

FLORIDA CANCER DATA SYSTEM 2004 ANNUAL MEETING

July 27-28, 2004

Embassy Suites Hotel,
Tampa, Florida

For further information visit the FCDS website at
http://fcds.med.miami.edu and click What's New tab.

FLORIDA CANCER REGISTRARS ASSOCIATION 2004 ANNUAL MEETING

"PROMOTING CANCER CARE AND RESEARCH"

July 28 –30, 2004

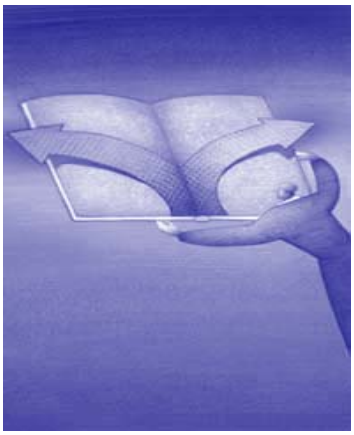
Embassy Suites Hotel
Tampa, Florida

CME credits are pending approval

FOR ADDITIONAL INFORMATION CONTACT:

2004 FCRA Chair: Barbara Dearmon, CTR
Voice: (813) 632-1479
Fax: (813) 632-1435
Email: dearmobj@moffitt.usf.edu

Or visit the FCRA website at http://fcra.org/conference_overview.shtml



PRINCIPLES OF ONCOLOGY FOR CANCER REGISTRY PROFESSIONALS

July 26-30, 2004
December 6-10, 2004

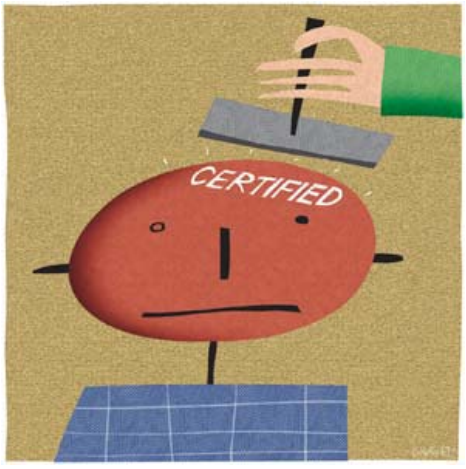
Bolger Center for Leadership Development
Potomac, Maryland
Registration fee: $695.00 *

Principles of Oncology is an intensive five-day training program in cancer registry operations and procedures emphasizing accurate data collection. The training program includes extensive site-specific, hands-on case abstracting and coding sessions using both full medical records and abstracts that are representative of the many situations registrars may face. This program is endorsed by the National Cancer Registrars Association (NCRA) and the North American Association of Central Cancer Registries (NAACCR). NAACCR also serves as the fiscal agent for this program.

*The registration fee is reduced for participants who stay at the conference center.

For further information visit the SEER website at http://seer.cancer.gov/training/oncology/

CERTIFIED TUMOR REGISTRAR EXAMINATION



Certified Tumor Registrar Examination

Application Deadline: July 31, 2004
Testing Begins: September 11, 2004
Testing Ends: September 25, 2004

The Certification will be administered during two week periods on a daily basis, Monday through Saturday, excluding holidays, at Laser Grade Computer Testing Inc.'s computer-based testing facilities managed by Professional Testing Corporation.

For more information on the CTR Exam , go to *www.ctrexam.org*.

(Continued from page 5)

For example chronic lymphocytic lymphoma is coded C91.1 in ICD-10. In ICD-O, it is coded C42.1 (the topography code for bone marrow), M-9823/3 (the morphology code for chronic lymphocytic leukemia).

The ICD-10 category for malignant neoplasm of the spleen (C26.1) does not appear under digestive organs in ICD-O, Third Edition. Following the practice of ICD-O, First Edition, the spleen is assigned code C42.2, under the hematopoietic and reticuloendothelial systems.

Hydatidiform Mole and Neurofibromatosis (Von Recklinghausen disease except bone)

The final differences between ICD-O and Chapter II of ICD-10 are that hydatidiform mole, NOS (C58.9 M-9100/0 in ICD-O) is classified not in Chapter II (Neoplasms) of ICD-10 but in Chapter XV "Pregnancy, Childbirth and the Puerperium" (Category O01.9, Hydatidiform mole), and neurofibromatosis including Von Recklinghausen disease except bone (M-9540/1 in ICD-O) appears in Chapter XVII "Congenital Malformations, Deformations and Chromosomal Abnormalities" as Category Q85.0.

HIV Disease and AIDS

There has been great interest in malignant neoplasms associated with human immunodeficiency virus (HIV) disease. These neoplasms should be coded following the rules in the ICD-O-3 manual. The associated condition, acquired immunodeficiency syndrome (AIDS), could be coded in a separate field of the cancer registry data file.

Functions of Neoplasms

ICD-O does not generally provide code numbers for the function of neoplasms, for example catecholamine production by a malignant pheochromocytoma (C74.1, M-8700/3). Separate codes, such as those in Chapter IV "Endocrine, Nutritional and Metabolic Diseases" of ICD-10, can be used to record some of the functions of neoplasm. Catecholamine production in the example above would be coded to E27.5.

Structure & Format of ICD-O, Third Edition

ICD-O is a dual classification with coding systems for both topography and morphology of tumors. The topography code describes the site of origin of the neoplasms and uses the same 3-character and 4-character categories as ICD-10 for malignant neoplasms (C00-C80); this allows greater specificity for coding sites of nonmalignant neoplasms than is possible in ICD-10. The morphology code describes the cell type of the tumor and its biologic activity, in other words, the characteristics of the tumor itself.

Main Sections of ICD-O, the Third Edition

ICD-O consists of five main sections:

1. Instructions for Use
2. Topography-Numerical List
3. Morphology-Numerical List
4. Alphabetic Index
5. Differences in Morphology Codes between Second and Third Editions

Abbreviations Used in ICD-O

The following abbreviations are used throughout ICD-O, the Third Edition:

- M - Morphology
- NOS - Not Otherwise Specified
- ICD-O - International Classification of Diseases for Oncology

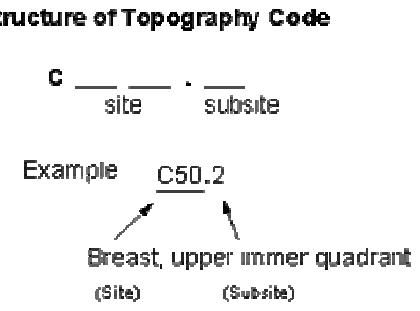
American and British Spelling

In order to avoid repetitions caused by differences in spelling, the American spelling of words has been used, for example "leukemia" and "tumor" rather than "leukaemia" and "tumour." These examples do not present a serious problem in alphabetization. However, when the differences in spelling, such as "esophagus" and "oesophagus," result in an appreciable separation of the two forms in the alphabetic index, the reader seeking the British spelling under the letter "O" is referred to the American spelling by the entry, "Oesophagus (see Esophagus)."

Topography — Numerical List

The topography section has been adapted from the malignant neoplasm section of Chapter II of ICD-10. These topography terms have four-character codes that run from C00.0 to C80.9. A decimal point (.) separates subdivisions of the three-character categories. The structure of the topography code is shown in Table 7.

Table 7. Structure of a Topography Code



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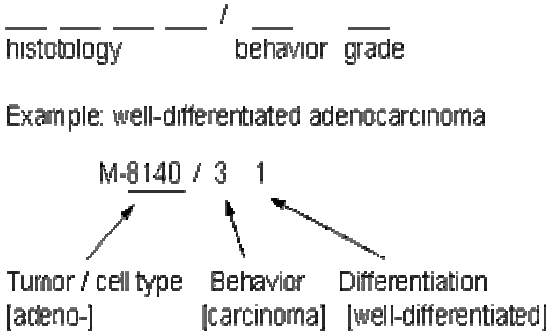
Morphology — Numerical List

The morphology section of ICD-O, First and Second Editions, has been revised in ICD-O-3. New terms have been added and the non-Hodgkin lymphoma and leukemia sections have been revised on the basis of the WHO Classification of Hematopoietic and Lymphoid Diseases (21, 22). The numerical list displays the structure of the coded morphology nomenclature and constitutes the primary point of reference for retrieval or decoding.

In revising the morphology section, every effort has been made to include new terms that have appeared in the recent literature. In several instances the terms for neoplasms from more than one classification scheme have been included, for example malignant lymphomas (M-959 through M-971). It should be stressed that ICD-O is a coded nomenclature and not a classification scheme for neoplasms; the listing of terms from different classifications does not represent endorsement of any particular one.

Morphology terms have five-digit codes ranging from M-8000/0 to M-9989/3. The first four digits indicate the specific histologic term (Table 8). The fifth digit, after the slash or solidus (/), is a behavior code, which indicates whether a tumor is malignant, benign, in situ, or uncertain whether malignant or benign.

Table 8. Structure of a Morphology Code



A separate one-digit code for histologic grading or differentiation is provided. For a lymphoma or leukemia, this element of the code is used to identify T-, B-, Null-, and NK-cell origin.

A complete ICD-O code thus requires 10 digits or characters to identify the topographic site (4 characters), morphologic type (4 digits), behavior (1 digit), and grade or differentiation of a neoplasm or its equivalent in leukemias and lymphomas (1 digit). Table 10 provides an example of the structure of a complete code.

Table 9. Structure of a Complete Code

Diagnostic term:
Poorly differentiated squamous cell carcinoma, upper lobe of lung

C34.1 M-8070/33

Format of ICD-O Terms in Numerical List

Each topographic and morphologic term appears only once in the numerical list, as the examples in Table 10 demonstrate. The first listed term, printed in bold type under a particular code, is the preferred term.

In this example, "parotid gland" would describe all cases coded to C07.9. The bold type indicates that this is the preferred (first) term. The synonym, "parotid, NOS," is indented under "Parotid gland." The non-indented terms, "Stensen duct" and "parotid gland duct," are called equivalent terms. They are not synonyms of the preferred term (parotid gland) but are listed under the same code number because they are topographic subdivisions of the term listed first and are not sufficiently different to have their own codes. In the alphabetic index all these terms are given the code C07.9. Similarly, for morphology, "oxyphilic adenocarcinoma" would describe all morphologies coded to M-8290/3. "Oncocytic carcinoma" and "oncocytic adenocarcinoma" are other names (synonyms) for "oxyphilic adenocarcinoma," but "Hurthle cell carcinoma," "Hurthle cell adenocarcinoma," and "follicular carcinoma, oxyphilic cell" (equivalent terms) are other types of carcinomas involving the oxyphilic cell.

Table 10. Examples of Numerical List Format

C07.9	Parotid gland
	Parotid, NOS
	Stensen duct
	Parotid gland duct
M-8290/3	Oxyphilic adenocarcinoma
	Oncocytic carcinoma
	Oncocytic adnocarninoma
	Hurthle cell carcinoma (C73.9)
	Hurthle cell adenocarcinoma (C73.9)
	Follicular carcinoma, oxyphilic cell (C73.9)

(Continued on page 10)

(Continued from page 9)

Alphabetic Index

The alphabetic index is used to code topography (anatomical sites) and morphology (histological terms). The index also includes selected tumor-like lesions and conditions. Topography codes are identified by the letter C, the first character of codes in Chapter II ICD-10. The prefix M is used to identify morphology codes. The terms are listed under both the noun and the adjective. For example, basophil adeno-carcinoma is listed under B for "basophil" and under A for "adenocarcinoma, basophil."

Format and Use of Alphabetic Index

Table 11 shows the first column of terms in the alphabetic index. Any word that appears as part of three or more terms is in bold type (such as "Abdomen," "Abdominal," and "Abdominal wall"), and the terms that include this word are indented under it. Topographic (C) and Morphologic terms (M) are not mixed under a single heading; there is always a vertical space before and after each group.

The first lead term is "Abdomen." Since there are more than three modifying terms, Abdomen is in bold type. The "NOS" term is always listed first under a heading in the index (rather than in alphabetic order under N).

A vertical space separates the "Abdomen" group and the next two terms containing the word "abdominal." Since there are only two morphologic terms beginning with "abdominal," they do not need a heading; however the following four topography terms do have a bold heading "Abdominal."

In the alphabetic index, a vertical space means:

1. a change from topographic to morphologic term(s) or vice versa

2. the end of a group

Tumor-like lesions and conditions

At the bottom of the column in Table 11 , the alphabetic index also includes certain tumor-like lesions and conditions in their appropriate alphabetic order. These could be confused with neoplasms: for example, they end in "oma" or are premalignant conditions. No ICD-O morphology code is given after the M-, only seven dashes (M-------), because these conditions are not considered to be neoplasms. Instead, there is a note in parentheses (see SNOMED) to refer the reader to the Systematized Nomenclature of Medicine (2,3).

(Continued on page 11)

Table 11. First Column of Alphabetic Index

- A -

	Abdomen
C76.2	NOS
C47.4	autonomic nervous system
C49.4	connective tissue
C49.4	muscle
C47.4	peripheral nerve
C44.5	skin
C49.4	subcutaneous tissue
M-8822/1	Abdominal desmoid
M-8822/1	Abdominal fibromatosis
	Abdominal
C49.4	aorta
C15.2	esophagus
C77.2	lymph node
C49.4	vena cava
	Abdominal wall
C76.2	NOS
C44.5	NOS (carcinoma, melanoma, nevus)
C49.4	NOS (sarcoma, lipoma)
C49.4	adipose tissue
C47.4	autonomic nervous system
C49.4	connective tissue
C49.4	fatty tissue
C49.4	fibrous tissue
C49.4	muscle
C47.4	peripheral nerve
C49.4	skeletal muscle
C44.5	skin
C49.4	soft tissue
C49.4	subcutaneous tissue
C72.5	Abducens nerve
M-9871/3	Abnormal marrow eosinophils, acute myeloid leukemia with (includes all variants)
M-9871/3	Abnormal marrow eosinophils, acute myelomonocytic leukemia with (includes all variants)
M-8075/3	Acantholytic squamous cell carcinoma
M-------	Acanthoma, clear cell (see SNOMED)
M-------	Acanthosis nigricans (see SNOMED)

(Continued from page 10)

In ICD-O-1 and ICD-O-2, a SNOMED code was provided. However, because at least two editions of SNOMED are in current use and the codes differ slightly for these non-neoplastic lesions and conditions, specific SNOMED codes were omitted from ICD-O, Third Edition.

Meaning of "NOS" & How It Is Used

"NOS" is printed after topographic and morphologic terms that appear elsewhere in ICD-O with an additional modifying word or phrase. In the alphabetic index, "NOS" is listed, followed by the alphabetic listing of modifying words. Use the code for a term followed by "NOS" when:

1. a topographic or morphologic term is not modified
2. a topographic or morphologic term has an adjective that does not appear elsewhere
3. a term is used in a general sense

For example, Table 12 shows that in the alphabetic index "adenocarcinoma, NOS" is followed by a long list of adjectival descriptors, each with its specific code. If the diagnosis is adenocarcinoma, the correct code is M-8140/3 "adenocarcinoma, NOS."

Table 12. Examples of NOS Code Placement

	Adenocarcinoma (See also Carcinoma)
M-8140/3	NOS
M-8140/6	NOS, metastatic
M-8280/3	acidophil
M-8550/3	acinar
M-8550/3	acinic cell
M-8370/3	adrenal cortical
M-8251/3	alveolar
M-8244/3	and carcinoid, combined
M-8560/3	and epidermoid carcinoma, mixed
M-8560/3	and squamous cell carcinoma, mixed
M-8402/3	apocrine
M-8147/3	basal cell
M-8300/3	basophil
M-8160/3	bile duct
M-8250/3	bronchilolar
M-8250/3	bronchiolo-alveolar
M-8420/3	ceruminous
M-8270/3	chromophobe and so forth

If a diagnostic phrase such as "atypical adenocarcinoma" is used, the code is also M-8140/3 because the adjective (atypical) does not appear in the list of terms modifying "adenocarcinoma." Thus, "NOS" is printed in both the numerical lists and the alphabetic index to indicate to the coder and to the decoder that other modifiers of the term are listed elsewhere.

In a few instances, "NOS" is also used to indicate that a particular term is used in a general sense. For example, "NOS" is printed after "endocrine gland" in "C75.9 endocrine gland, NOS" to indicate that other specific endocrine glands such as "pineal gland" and "pituitary gland" are also listed with their specific codes.

(Continued on page 12)

(Continued from page 11)

Hematologic Malignancies

Classifications for all neoplasms have been reviewed and updated in ICD-O-3, but the most extensive revision concerned hematologic malignancies.

Over the past 50 years, many classifications of leukemia and lymphoma have been proposed. Some of these had a major impact on clinical practice while others are now largely forgotten. For most of this period, however, the distinction between lymphoma and leukemia has been regarded as fundamental importance and classifications have tended to evolve separately.

Most lymphoma classifications can be grouped into two major categories. Tumors may be subdivided according to purely morphologic characteristics such as cell size and shape and the pattern of tumor growth within the lymph node or other tissue. In contrast, the Kiel classification and the Lukes and Collins classification were based on the ideas that the cells in a malignant lymphoma have undergone maturational arrest and that tumors could be classified by comparison with the normal stages of lymphocyte differentiation. In the USA, the National Cancer Institute's Working Formulation was an attempt to provide a tool for converting diagnostic data into a common format for comparative purposes. In practice, the Working Formulation became a primary classification based, like the Rappaport classification, mainly on morphologic characteristics.

A grading system was used in most lymphoma classifications to simplify the numerous tumor types into a few categories, primarily for clinical use. It is important to recognize, however, that grades were not strictly comparable between different systems of classification. In the Kiel classification, high and low grade referred to the size of cells in a tumor. Grades used in the Working Formulation were derived from prognostic data collected in the course of the original study that gave rise to the classification; in clinical terms, high grade came to mean an aggressive tumor potentially curable by chemotherapy, while low-grade lymphomas were more indolent but often incurable.

The French-American-British (FAB)(7) system provided a parallel, but distinct, system for the classification of lymphoid and myeloid leukemias and myelodysplasia based on traditionally stained specimens.

In the early 1990s, it was becoming apparent that there were many problems with the existing classification systems for leukemia and lymphoma. The introduction of immunophenotypic and molecular biological techniques had shown that individual categories were, in fact, heterogeneous. It was evident that the use of lymphoma grades as the basis for clinical trials or epidemiological studies was potentially highly misleading. As definitions became clearer, it was increasingly obvious that the distinction between lymphoid leukemias and lymphomas was largely artificial; it reflected patterns of spread in the individual patient rather than basic cellular or clinical differences. The distinction between Hodgkin disease and non-Hodgkin lymphoma was a cornerstone of lymphoma classification. However, various investigations showed that the tumor cells in Hodgkin disease were derived from germinal center B-cells and that Hodgkin disease should therefore be regarded as a distinctive form of B-cell lymphoma rather than as a completely separate group of disorders. Cytogenetic studies revealed the importance of chromosomal translocations with dysregulation of individual genes in the pathogenesis and clinical behavior of several types of leukemia and lymphoma, although achieving a complete understanding of tumor pathogenesis is clearly going to be a lengthy process.

These developments were the basis of the Revised European-American Lymphoma (REAL) classification published in 1994 (6). Although many of the terms used are similar to those used in the Kiel classification, the underlying concepts are different. In the REAL classification definitions of clinico-pathological entities are based on a combination of morphology, immunophenotype, genetic abnormalities, and clinical features. Despite the vast number of possible combinations of these variables, there are in fact relatively few disease entities, and more than 90% of lymphoid malignancies can be classified using this approach. The WHO classification of hematologic malignancies (21,22) is based on the same approach and the section on lymphoproliferative disorders is broadly similar. The approach to subclassification of acute myeloid leukemia (AML) recognizes the central importance of cytogenetic abnormalities and the distinction between "de novo" and myelodysplasia-associated AML.

The WHO classification cannot be regarded as definitive, but it provides a sound basis for future developments. Many of the major categories, such as diffuse large B-cell lymphoma, are clearly heterogeneous in terms of clinical features and response to treatment. In the future these will be further subdivided according to cellular and molecular criteria, but at present there is no consensus as to how this should be done. It is likely that the differences in the hematologic malignancy section of the next edition of ICD-O will be every bit as great as the differences between the Second and Third Editions.

Please view Table 13 on pages 13,14, and 15,_ showing the WHO classification of Hematopoietic and Lymphoid Neoplasms with ICD-O codes.

Using the Lymphoma and Leukemia Sections

The Use of Synonyms

In the Second Edition of ICD-O, cases could be coded using terms from any of the current classifications, as well as a number of archaic terms. This made comparison of datasets very difficult, especially where terms from multiple classifications where used in the same dataset. ICD-O-3 incorporates terms from the WHO systems as preferred terms for hematological malignancies, but terms from older systems are retained to permit universal coding and analysis of historical data. In some cases a synonym may not be an exact equivalent of the preferred (WHO) term, but in the judgment of experts in this field the majority of cases would lie within the category concerned.

(Continued on page 15)

Table 13. WHO Classification of Hematopoietic & Lymphoid Neoplasmas with ICD-O Codes
NOTE: Only major disease categories are listed.
{} indicates an alternative description of the neoplasm

MYELOID NEOPLASMS	
ICD-O	WHO TERM
	Myeloproliferative diseases
9875/3	Chronic myelogenous leukemia, Philadelphia chromosome positive
	{t(9;22)(q34;q11)}, {BCR/ABL}
9963/3	Chronic neutrophilic leukemia
9964/3	Chronic eosinophilic leukemia/hypereosinophilic syndrome
9961/3	Chronic idiopathic myelofibrosis
9950/3	Polycythemia vera
9962/3	Essential thrombocythemia
9975/1	Myeloproliferative disease, unclassifiable
	Myelodysplastic/myeloproliferative diseases
9945/3	Chronic myelomonocytic leukemia
9876/3	Atypical chronic myelogenous leukemia
9946/3	Juvenile myelomonocytic leukemia
	Myelodysplastic syndromes
9980/3	Refractory anemia
9982/3	With ringed sideroblasts
9980/3	Without ringed sideroblasts
9985/3	Refractory cytopenia (myelodysplastic syndrome) with multilineaage dysplasia
9983/3	Refractory anemia (myelodysplastic syndrome) with excess blasts
9986/3	5q- (5q deletion) syndrome
9989/3	Myelodysplastic syndrome, unclassifiable
	Acute myeloid leukemias (AMLs)
	AMLs with recurrent cytogenetic translacations
9896/3	AML with {t(8;21)(q22;q22)}, {AML1(CBF-alpha)/ETO}
9866/3	Acute promyelocytic leukemia {AML with with t(15;17)(q22;q11-12} and variants, {PML/RAR-alpha}
9871/3	AML with abnormal bone marrow eosinophils {inv(16)(p13q22)} or {t(16;16)(p13;q11)}, {CBFb/MYH11}
9897/3	AML with 11q23 abnormalities {MLL}
9895/3	AML with multilineage dysplasia
9895/3	With prior myelodysplasic syndrome
9895/3	Without prior myelodysplastic syndrome
9920/3	AML and myelodysplastic syndromes, therapy-related
9920/3	Alkylating agent-related
9920/3	Epipodophyllotoxin-related (some may be lymphoid)
9920/3	Other types
9861/3	AML not otherwise categoriezed
9872/3	AML minimally differentiated
9873/3	AML without maturation
9874/3	AML with maturation
9867/3	Acute myelomonocytic leukemia
9891/3	Acute monocytic leukemia
9840/3	Acute erythroid leukemia
9910/3	Acute megakaryocytic leukemia
9870/3	Acute basophilic leukemia
9931/3	Acute panmyelosis with myelofibrosis
9805/3	Acute biphenotypic leukemias

Table 13 continued.
LYMPHOID NEOPLASMS

ICD-O	WHO TERM
	B-CELL NEOPLASMS
	Precursor B-cell neoplasm
9728/3	Precursor B-lymphoblastic leukemia/lymphoma
9836/3	Precursor B-cell acute lymphoblastic leukemia
	Mature (peripheral) B-cell neoplasms
9823/3, 9670/3	B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma
9833/3	B-cell prolymphocytic leukemia
9671/3	Lymphoplasmacytic lymphoma
9689/3	Splenic marginal zone B-cell lymphoma (with/without villous lymphocytes)
9940/3	Hairy cell leukemia
9732/3 9731/3	Plasma cell myeloma/plasmacytoma
9699/3	Extranodal marginal zone B-cell lymphoma of MAL type
9699/3	Nodal marginal zone B-cell lymphoma (with/without monocytoid Bcells)
9690/3 9691/3 9695/3 9698/3	Follicular lymphoma
9673/3	Mantle-cell lymphoma
9680/3	Diffuse large B-cell lymphoma
9679/3	Mediastinal large B-cell lymphoma
9678/3	Primary effusion lymphoma
9687/3 9826/3	Burkitt lymphoma/Burkitt cell leukemia
	T-CELL AND NK-CELL NEOPLASMS
	Precursor T-cell neoplasm
9729/3	Precursor T-lymphoblastic lymphoma/leukemia
9837/3	Precursor T-cell acute lymphoblastic leukemia
	Mature (peripheral) T-cell neoplasms
9834/3	T-cell prolymphocytic leukemia
9831/3	T-cell granular lymphocytic leukemia
9948/3	Aggressive NK-cell leukemia
9827/3	Adult T-cell lymphoma/leukemia (HTLV-1 positive)
9719/3	Extranodal NK/T-cell lymphoma, nasal type
9717/3	Enteropathy-type T-cell lymphoma
9716/3	Hepatosplenic gamma-delta T-cell lymphoma
9708/3	Subcutaneous panniculities-like T-cell lymphoma
9700/3, 9701/3	Mycosis fungoides/Sezarysyndrome
9714/3	Anaplastic large-cell lymphoma, T/null cell, primary cutaneous type
9702/3	Peripheral T-cell lymphoma, not otherwise characterized
9705/3	Angioimmunoblastic T-cell lymphoma
9714/3	Anaplastic large-cell lymphoma, T/null cell, primary systemic type

Table 13 continued.
HODGKIN LYMPHOMA (HODGKIN DISEASE)

9659/3	Nodular lymphocyte-predominant Hodgkin lymphoma
9650/3	Classical Hodgkin lymphoma
9665/3, 9667/3	Nodular sclerosis Hodgkin lymphoma (grades 1 and 2)
9651/3	Lymphocyte-rich classical Hodgkin lymphoma
9652/3	Mixed cellularity Hodgkin lymphoma
9653/3	Lymphocyte depletion Hodgkin lymphoma

MAST CELL DISEASES

ICD-O	WHO TERM
9741/3	Cutaneous mastocytosis
9741/3	Systemic mast cell disease
9742/3, 9740/3	Mast cell lekemia/sarcoma

HISTIOCYTIC AND DENDRITIC CELL NEOPLASMS

Macrophage/histiocytic sarcoma

9755/3	Histiocytic sarcoma

Dendritic cell neoplasms

9751/1	Langerhans cell histiocytosis
9756/3	Langerhans cell sarcoma
9758/3	Follicular dendritic cell sarcoma/tumor
9757/3	Dendritic cell sarcoma, not otherwise specified

(Continued from page 12)

Compatibility with ICD-10

In order to ensure compatibility with ICD-10, there are a number of ways in which the Third Edition of ICD-O difers from the structure of the WHO classification of hematological malignancies. Separate codes have been allocated to B-cell chronic lymphocytic leukemia and B-cell small lymphocytic lymphoma. These are now recognized to be exactly the same entity, and for presentation of data these categories may therefore be combined. The same argument applies to lymphoblastic lymphoma and acute lymphoblastic leukemia, which are now regarded as the same disease but for which separate codes are provided.

Immunophenotypic Data

The use of cell marker studies has transformed hematopathology and is a major element in achieving a high standard of diagnostic accuracy. In the WHO classification, the lineage of the tumor is almost always implicit in the diagnostic term used. For example, a follicular lymphoma is by definition a B-cell malignancy. The only instance where this does not apply is lymphoblastic leukemia and lymphoblastic lymphoma, for which the lineage (T-cell or B-cell) must be specified. This was not the case in the Second Edition of ICD-O, where many of the terms were ambiguous with respect to cell lineage. In the Third Edition, the cell lineage is implicit in the four-digit morphology code, and an additional (6th) digit is not required. However, registries may wish to retain the additional digit to identify cases in which the diagnosis is supported by immunophenotypic data.

Cytogenetic Data

Cytogenetics and molecular biological data are now of key - and increasing - importance in the diagnosis of many types of hematologic malignancies. In ICD-O-3, an important change has been the introduction of subcategories of acute myeloid leukemia described according to cytogenetic abnormalities. Where these abnormalities are included in a laboratory report, they take precedence in classification over other data such as the FAB morphology type.

Coding Rules for Topography & Morphology

Summary of Principal Rules for Using ICD-O, Third Edition

(See page 16 for Table 14 for corresponding numbers in ICD-O, Second Edition)

Rule A. ***Topographic regions and ill-defined sites:*** **If the diagnosis does not specify the tissue of origin, code the appropriate tissues suggested in the alphabetic index for each ill-defined site in preference to the "NOS" category.** Ill-defined sites, such as "arm," have several component tissues. For example, "squamous cell carcinoma of the arm" should be coded to C44.6 (skin of arm) rather than to C76.4 (arm, NOS). There are a few exceptions to this, such as chin and forehead, because these regions are predominantly composed of skin, and the NOS category was therefore assigned to skin.

Rule B. ***Prefixes:*** **If a topographic site is modified by a prefix such as peri-, para-, or the like, and is not specifically listed in ICD-O-3, code to the appropriate ill-defined subcategory C76 (ill-defined site), unless the type of tumor indicates origin from a particular tissue.** This general rule also applies to imprecise phrases such as "area of" or "region of."

Rule C. ***Tumors involving more than one topographic category or subcategory:*** **Use subcategory ".8" when a single tumor overlaps the boundaries of two or more categories or subcategories and its point of origin cannot be determined.** Because

(Continued on page 16)

Table 14. ICD-O, Third Edition, Rules and thier Corresponding Numbers in ICD-O, Second Edition

Subject	ICD-O Third Edition	ICD-O Second Edition*
Topographic regions and ill-defined sites	A	2
Prefixes	B	3
More than one topographic category or subcategory	C	4
Topography codes for lymphomas	D	12
Topography code for leukemias	E	13
Behavior code	F	5
Grading or differentiation	G	6
Site-associated morphology	H	8,9
Compound morphology diagnoses	J	10
Coding multiple morphology terms	K	11

*Notes: Second Edition rule 1 described the structure of the 10-digit code.

Second Edition rule 7 described the differences between the terms "cancer" and "carcinoma."

Second Edition rule 14 described the issues in coding multiple neoplasms.

There is no Rule I in the Third Edition to avoid possible confusion with a Rule 1.

(Continued from page 15)

more categories have been allotted to neoplasms in ICD-10 than in ICD-9, some previous three-digit categories have been replaced by two three-character categories.

Rule D. *Topography codes for lymphomas:* If the site of origin of the lymphoma is in the lymph nodes, code to C77._. If a lymphoma involves multiple lymph node regions, code to C77.8 (lymph nodes of multiple regions). Code extranodal lymphomas to the site of origin, which may not be the site of the biopsy. If no site is indicated for a lymphoma and it is suspected to be extranodal, code to C80.9 (unknown primary site). Lymphomas occur in specific sites, for example stomach, as well as in one or more lymph nodes and therefore are not assigned a site-specific topography code. Lymphomas occurring in specific sites are called extranodal.

Rule E. *Topography code for leukemia:* Code all leukemias except myeloid sarcoma (M-9930/3) to C42.1 (bone marrow).

Rule F. *Behavior code in morphology:* Use the appropriate 5th digit behavior code even if the exact term is not listed in ICD-O. Use of the 5th digit behavior code number that fits the diagnosis, even though the exact term is not listed in ICD-O. For example, "benign chordoma" as a diagnosis should be coded M-9370/0. If the pathologist states that the behavior differs from the usual behavior as given in ICD-O, code as the pathologist indicates.

Rule G. *Grading or differentiation code:* Assign the highest grade or differentiation code described in the diagnostic statement. If a diagnosis indicates two different degrees of grade or differentiation (such as "well and poorly differentiated" or grades II-III"), code to the higher grade.
The 6th digit may also be used for identifying cell origin for lymphomas and leukemias. In these lymphatic and hematopoietic diseases, T-cell (code 5), B-cell (code 6), Null cell(code 7), and NK cell (code 8) take priority over grade codes 1-4.

Rule H. *Site-associated morphology terms:* Use the topography code provided when a topographic site is not stated in the diagnosis. This topography code should be disregarded if the tumor is known to arise at another site. The appropriate site-specific codes are listed in parentheses after morphology terms for neoplasms that usually occur in the same site or tissue, for example "retinoblastoma" (C69.2). If no site is indicated in the diagnosis, the site-specific code should be used (in this case, the site should be coded to retina C69.2).

If a site is given that is different from the site indicated by the suggested code, use the site code appropriate to the diagnosis. This should be done only after thoroughly reviewing the case to ascertain that the neoplasm at the site mentioned is not a metastasis.

Only three-character codes are given for some sites, for example C44._ (skin), because the appropriate fourth-digit cannot be assigned in advance. Use the detail provided in the actual diagnosis to assign the subsite.

Certain neoplasms have names that could be interpreted as implying a topographic location (pseudotopographic morphology terms), but these entities should not necessarily be coded to that site. For example, bile duct carcinoma is a tumor frequently arising in intrahepatic bile ducts of liver (C22.1).

Rule I. Intentionally, there is no Rule I in ICD-O-3. There is a Rule 1 in ICD-O-1 and ICD-O-2, and to keep "Rule 1" separate from "Rule I," the editors of ICD-O-3 elected to intentionally not include a Rule I

Rule J. *Compound morphology diagnoses:* Change the order of word roots in a compound term if the term is not listed in ICD-O. Not all forms of compound words are listed in ICD-O-3. For example, "myxofibrosarcoma" is not in ICD-O-3 but "fibromyxosarcoma"

(Continued on page 17)

(Continued from page 16)
is. The coder must check various permutations of the prefixes if the first one is not found.

Rule K. *Coding multiple morphology terms:* When no single code includes all diagnostic terms, use the numerically higher code number if the diagnosis of a single tumor includes two modifying adjectives with different code numbers. If a term has two or more modifying adjectives which have different code numbers, code to the one with the highest code number, as it is usually more specific.

For further information about coding complex morphologic diagnoses visit the SEER Web site at http://training.seer.cancer.gov/

MULTIPLE PRIMARY NEOPLASMS

Multiple neoplasms present many coding difficulties. These may arise in the form of:

1. two or more separate neoplasms in different topographic sites
2. certain conditions that are characterized by multiple tumors
3. lymphomas, which often involve multiple lymph nodes or organs at diagnosis
4. two or more neoplasms of different morphology arising in the same site
5. a single neoplasm involving multiple sites whose precise origin cannot be determined

Multiple tumors are defined differently by various registries, and specific solutions to all problems cannot be given here.

A working party of IARC recommended definitions of multiple neoplasms for the purpose of incidence reporting for international comparison. Their recommendations are:

1. Recognition of the existence of two or more primary cancers does not depend on time.
2. A primary cancer is one that originates in a primary site or tissue and is not an extension, a recurrence, or metastasis.
3. Only one tumor shall be recognized as arising in an organ or pair of organs or a tissue. For tumors where site is coded by the First Edition of ICD-O (or by ICD-9), an organ or tissue is defined by the three-character category of the topography code.

ICD-10 and the Second and Third Editions of ICD-O have a more detailed set of topography codes. The site covered by some groups of codes are considered to be a single organ for the purposes of defining multiple tumors. These topography code groups are shown in Table 24, on page 18.

Multifocal tumors -- that is, discrete masses apparently not in continuity with other primary cancers originating in the same primary site or tissue, for example bladder -- are counted as a single cancer.

Skin cancer presents a special problem as the same individual may have many such neoplasms over a lifetime. The IARC/IACR rules imply that only the first tumor of a defined histological type, anywhere on the skin, is counted as an incident cancer unless, for example, one primary was a malignant melanoma and the other a basal cell carcinoma.

1. Rule 3 does not apply in two circumstances:

- For systemic or multicentric cancers potentially involving many discrete organs, four histological groups -- lymphomas, leukemias, Kaposi sarcoma, and mesothelioma (groups 7, 8, 9, and 10 in Table 25) -- are included. They are counted only once in any individual.
- Other specific histologies -- groups 1, 2, 3, 4, 6, and 11 in Table 25, pg. 19 -- are considered to be different for the purpose of defining multiple tumors. Thus, a tumor in the same organ with a "different" histology is counted as a new tumor. Groups 5 and 12 include tumors that have not been satisfactorily typed histologically and cannot therefore be distinguished from the other groups.

Registries may follow different rules; in the United States of America, for example, most registries follow the rules of the Surveillance, Epidemiology, and End Results (SEER) Program. The detailed instructions are outlined in the SEER Program Code Manual (25). The specific SEER rules for multiple primary determination are complex and historic-based. SEER rules differ from the IARC/IACR rules, and from the Canadian rules. SEER takes timing of the diagnoses into consideration, and counts as an individual site each segment of the colon, whereas IARC would consider the colon as one site. For histology, SEER counts each three-digit morphologic type mentioned as occurring in a site as one cancer, whereas the IARC guidelines use the broad groups outlined in Table 24, pg. 18 to define "different" histology. The SEER Program Code Manual contains many pages of discussion and instructions for determining and coding multiple combinations of lymphomas and leukemias.

Each registry must decide what rules to use and follow for handling multiple tumors and the conventions followed should be outlined when presenting data.

Table 24. Groups of Topography Codes from the Second and Third Editions of ICD-O Considered a Single Site in the Definition of Multiple Cancers

Second/Third Editions	
C01	Base of tongue
C02	Other and unspecified parts of tongue
C05	Palate
C06	Other and unspecified parts of mouth
C07	Parotid gland
C08	Other and unspecified major salivary glands
C09	Tonsil
C10	Oropharynx
C12	Pyriform sinus
C13	Hypopharynx
C23	Gallbladder
C24	Other and unspecified parts of biliary tract
C30	Nasal cavity and middle ear
C31	Accessory sinuses
C33	Trachea
C34	Bronchus and lung
C37	Thymus
C38.0	Heart
C38.1-3	Mediastinum
C38.8	Overlapping lesion of heart, mediastinum and pleura
C38.4	Pleura (visceral, parietal, NOS)
C51	Vulva
C52	Vagina
C57.7	Other specified female genital
C56	Ovary
C57.0	Fallopian tube
C57.1	Broad ligament
C57.2	Round ligament
C57.3	Parametrium
C57.4	Uterine adnexa
C60	Penis
C63	Other and unspecified male genital organs
C64	Kidney
C65	Renal pelvis
C66	Ureter
C68	Other and unspecified urinary organs
C74	Adrenal gland
C75	Other endocrine glands and related structure

DEADLINES AND REMINDERS

FCDS CONVERSION TO NAACCR V10.1

The following time frame lists the upcoming changes for the FCDS conversion to NAACCR V10.1. Due to the 2003 abstracting extension authorized by COC, FCDS will maintain two complete and separate abstracting and uploading modules (one for V10 and one for V10.1). For the period July 1, 2004 through September 30, 2004, facilities may continue to submit 2003 data to FCDS in the V10 record layout. Any facility that is ready to submit their 2004 cases to FCDS may do so in a V10.1 format. The V10.1 module will be available for both single entry and batch upload submissions. V10.1 data submissions must include collaborative stage items and FORDS treatment (items 1290, 1292, 1294) for each record.

After September 30th all cases, regardless of their admission or diagnosis date, must be submitted in the V10.1 format (with all collaborative stage fields completed). This includes 'historical' cases. After September 30th FCDS will no longer accept Summary Stage 1977 or Summary Stage 2000 on any cases regardless of the date of admission or diagnosis. FCDS will no longer collect Roads fields (items 1296, 1646, 1647, 1648).

Please contact FCDS with any additional questions (305) 243-4600.

POLICIES AND PROCEDURES

FCDS is revising certain sections of the FCDS Data Acquisition Manual (DAM) to include the NAACCR V10.1 revisions. This is expected to be completed in July. The revisions will include updating some fields and deleting a few fields. A draft of the new manual will be available on the FCDS website in July.

If you have any suggestions on the content, format, etc. for the DAM. Please contact Mayra Alvarez, at 305-243-4603 or mayra_alvarez@miami.edu with details.

RADIATION THERAPY CENTERS CANCER CASE IDENTIFICATION PROGRAM

Beginning with the 2003 patient encounters, Radiation Therapy Centers are responsible for identifying and reporting all of their cancer cases to the Florida Cancer Data System using the FCDS-IDEA Single Entry or the File Upload modules. The submission of cases were due on **June 30, 2004**. Please log on to the FCDS website fcds.med.miami.edu or call Betty Hallo at (305) 243-2627 for additional information.

PATH LAB REPORTING

Every anatomic pathology laboratory that reads biopsy and surgical resection specimens collected from Florida patient encounters within the state of Florida MUST electronically submit the specified data for every malignant cancer case. **Specimens read between July 1, 2003 and December 31, 2003 were due on June 30, 2004. All 2003 data were due on June 30, 2004.**

(July 1, 2004 through December 31, 2004 data are due June 30, 2005.)

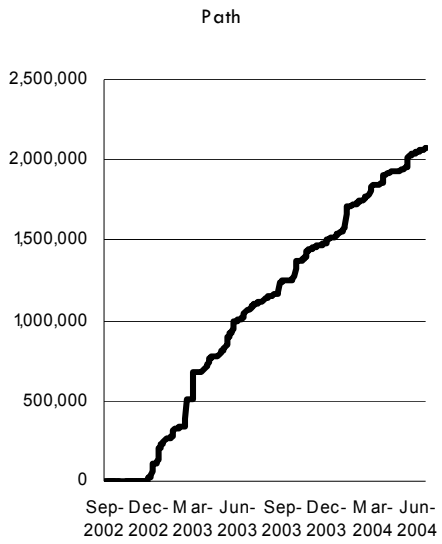
Table 25. Groups of Malignant Neoplasms Considered to Be Histologically "Different" for the Purpose of Defining Multiple Tumors (adapted from Berg, 1994) (24)

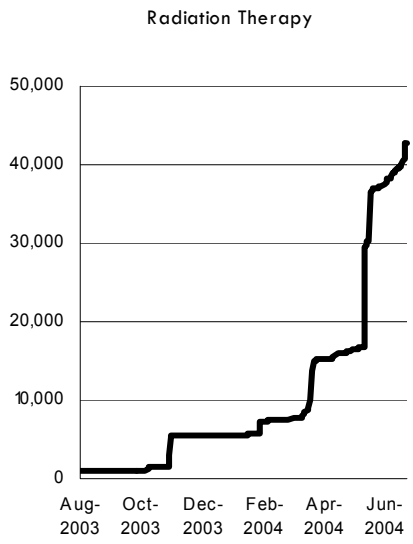
Carcinomas	
1. Squamous carcinomas	M-805—M-808, M-812, M-813
2. Basal cell carcinomas	M-809—M-811
3. Adenocarcinomas	M-814, M-816, M-819—M-822, M-826—M-833 M-835—M-855, M-857, M-894
4. Other specific carcinomas	M-803, M-804, M-815, M-817, M-818 M-823—M-825, M-834, M-856, M-858—M-867
5. Unspecified carcinomas NOS)	M-801, M-802
6. Sarcomas and soft tissue tumors	M-868—M-871, M-880—M-892, M-899, M-904 M-912, M-913, M-915—M-925, M-937, M-954—M-958
7. Lymphomas	M-959—M-972
8. Leukemia	M-980—M-994, M-995, M-996, M-998
9. Kaposi sarcoma	M-914
10. Mesothelioma	M-905
11. Other specified types of cancer	M-872—M-879, M-893, M-895—M-898, M-900—M-903, M-906—M-911, M-926—M-936, M-938—M-953, M-973—M-975, M-976
12. Unspecified types of cancer	M-800, M-997

FLORIDA CANCER DATA SYSTEM

Path Reporting and Radiation Therapy Reporting

Cumulative Data Received





Florida Cancer Data System
A Joint Project of the Sylvester Comprehensive Cancer Center and the Florida Department of Health

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