OKLAHOMA CENTRAL CANCER REGISTRY

CANCER DATA REPORTING MANUAL

Updated for 2025

November 13, 2025

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- Standards for Oncology Registry Entry (STORE) 2025
- International Classification of Diseases for Oncology Third Edition (ICD-O-3)
- NAACCR Data Standards and Data Dictionary, Volume II – Version 25
- SEER Program Coding and Staging Manual 2025
- SEER Solid Tumor Rules, 2025 Update
- SEER Hematopoietic and Lymphoid Neoplasm Database and Coding Manual
- Grade Coding Instructions and Tables v3.2, published September 2024
- SSDI Manual v3.2, published October 2024

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SECTION 1

INTRODUCTION TO CANCER REPORTING

A BRIEF HISTORY OF THE OKLAHOMA CENTRAL CANCER REGISTRY (OCCR)

1991

The Oklahoma legislature recognized the need for defining the cancer burden in Oklahoma. Oklahoma Statute Title 63 Public Health and Safety, Title 310, Chapter 567 [Appendix A] established the existence of the Oklahoma Central Cancer Registry (OCCR) under the control of the Oklahoma State Department of Health. The inclusion of data necessary for epidemiologic surveys and scientific research along with other data necessary to further the recognition, prevention, control, treatment and cure of cancer, precancerous and tumorous disease was mandated. Unfortunately, no funding was provided.

1992

The National Program of Cancer Registries (NPCR) is established by US Public Law 102-515, [Appendix A] administered by US Centers for Disease Control and Prevention (CDC). The law authorizes the CDC to provide funds and technical assistance to states and territories to improve existing cancer registries and implement registries where none existed.

1994

NPCR began providing financial support and technical assistance to state health departments for statewide, population-based cancer registries. This funding, along with an emergency amendment by the Oklahoma State Legislature to fund a state cancer registry led to the official establishment of the OCCR in 1995, with a reference date of data submission of January 1, 1997. Cancer cases occurring prior to the reference date are not required to be reported.

Cancer registries are data systems for collecting, storing, and managing information about people with cancer. Registries are essential for cancer surveillance, research, and development of effective cancer treatment. For cancer data to be useful, it must be accurate, timely and complete. This manual was developed to assist in generating reliable cancer data.

The importance of quality cancer data reporting and the role of cancer registries can be summed up by the following:

> Measures of cancer survival at the population level rely on our extensive surveillance infrastructure, particularly a national network of high-quality cancer registries. These cancer survival measures offer new insights into the need to address inequities in cancer diagnosis, treatment, and survivorship. Together with data regarding cancer incidence and death rates, cancer survival measures provide a comprehensive picture of the burden of cancer in a population and support public health efforts to prevent new cancers, extend survival and quality of life after a cancer diagnosis, and reduce cancer health disparities.[1]

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5846186/

The Oklahoma Central Cancer Registry (OCCR) is able to provide outstanding data to the North American Association of Central Cancer Registries (NAACCR) and the National Program of Cancer Registries (NPCR) due to the collective efforts of all Oklahoma cancer reporters, including the highest certification from NAACCR, **Gold Standard for Quality, Completeness and Timeliness** for the past 8 years.

ACRONYMS

ACoS–American College of Surgeons

ACS–American Cancer Society

AJCC–American Joint Committee on Cancer

CDC–Centers for Disease Control and Prevention

CoC–Commission on Cancer (of the American College of Surgeons)

CCR–Central Cancer Registry

CTR–Certified Tumor Registrar

DOH–Department of Health

DVR–Division of Vital Records

EDITS–Exchangeable-edits, Data–dictionary, and Information Translation Standard

EOD–Extent of Disease

FIPS–Federal Information Processing System

HIPAA–Health Insurance Probability and Accountability Act

ICD-O-3–International Classification of Diseases for Oncology, Third Edition, 2000

JC–Joint Commission (previously JCAHO Joint Commission on Accreditation of Healthcare Organizations)

NAACCR–North American Association of Central Cancer Registries

NCDB–National Cancer Data Base

NCI–National Cancer Institute

NCRA–National Cancer Registrars Association

NIH–National Institutes of Health

NPCR–National Program of Cancer Registries, CDC

OCCR–Oklahoma Central Cancer Registry

SEER–Surveillance, Epidemiology, and End Results a Program of NCI

SS – Summary Stage

STORE – Standards for Oncology Registry Entry

TNM–Tumor, Nodes, Metastasis (staging system of AJCC and UICC)

WHO – World Health Organization

TERMS COMMON TO CANCER DATA REPORTING

Abstract – A review of detailed medical records, summarized in an organized reportable form for each incident of malignancy.

Cancer/Cancerous – A collection of diseases in which body cells multiply without stopping. Most cancer can form masses called tumors and spread into surrounding tissues. The cells can also travel throughout the body via blood vessels and the lymphatic system where additional tumors can develop. Leukemias, cancers of the bone marrow and blood, generally do not form tumors. Another term for cancer is malignancy.

Clinic – Any licensed medical facility serving persons on an outpatient basis, which provides a diagnosis and/or treatment of cancerous and precancerous conditions.

Cytology – The study of cells under microscope to aid in diagnosing diseases and conditions.

Diagnostic Services – Any service that identifies the nature of an illness including cancerous diseases or precancerous diseases by examination including, but not limited to, imaging, laboratory testing.

Facility – A general term used for any licensed or certified medical establishment that provides patient care on an inpatient or outpatient basis including diagnostic services and/or treatment of cancerous and precancerous conditions.

Hematopoiesis & Hematopoietic System – Relating to the production of blood (blood cells, plasma etc.) and the organs and tissues, primarily the bone marrow, spleen, tonsils, and lymph nodes involved in the production of blood.

Histology – The microscopic study of biologic tissue. Histology in cancer reporting includes, but is not limited to, morphology, grade, and behavior.

Hospital – A licensed healthcare institution equipped and staffed for the purpose of diagnosing and treating patients with cancer, including medical and surgical care on an inpatient or outpatient basis.

Hospital Identifier – A unique code assigned by the OCCR to each reporting facility in Oklahoma for identification of cancer cases reported from each facility.

In Situ – A group of abnormal cells that remain where they first formed within the body. These abnormal cells may become invasive and spread into nearby tissue.

Laboratory – A facility providing a wide range of procedures that aids physicians in carrying out the diagnosis, treatment, and management of cancer. This includes, but is not limited to, histopathology (examination of tissue), cytopathology (examination of fluids), and hematology (examination and characterization of blood) related to both cancerous and precancerous conditions.

Lymphoid – Relating to the lymphatic system including lymph, lymph nodes, bone marrow, and other lymphatic tissue that produces lymphocytes (a type of white blood cells).

Pathologist – A physician certified by the American Board of Pathology and licensed by the state to carry out pathologic examination of bodily tissues. This includes the diagnosis of cancerous and precancerous conditions.

Physician – Any person who has completed a course of medical training resulting in a medical degree and licensed by the Oklahoma Board of Medical Licensure and Supervision or the Oklahoma Osteopathic Board of Examiners to practice medicine.

Precancerous Condition – A disease process exhibiting abnormal cells with an increased risk of developing into cancer.

Registry – A computerized system for collecting and compiling cancer data in a standard format, with the functional ability to merge data from various sources and perform correlations among a variety of data elements. Summary reports and statistical analysis reports can be generated from registry data.

Solid Tumor – A tumor that develops in body tissue other than lymphoid tissue, bone marrow or blood. Examples include bone, skin, and organs.

Stage of Disease – Stage defines the extent of a patient's malignancy and can change throughout the disease process. This includes disease limited to localized tissue, invasion from the original tumor into surrounding tissue, invasion of regional lymph nodes (usually lymph nodes in the typical draining pathway of the primary site of disease) and distant spread (distant metastasis) including distant tissue and distant lymph nodes.

TNM – The three components of tumor staging: T – tumor, N – nodes (regional lymph nodes), and M – metastasis.

Treatment Services – The delivery of therapeutic services for cancerous disease or precancerous conditions, performed in a medical facility, clinic or physician's office.

Tumor/Tumorous – A circumscribed, non–inflammatory growth arising from existing tissue but growing independently of the normal rate or structural development of such tissue and serving no physiological function. Tumors may or may not be malignant.

Additional cancer related definitions can be found on the NCI website and the SEER Glossary for Registrars.
https://www.cancer.gov/publications/dictionaries/cancer-terms/
https://seer.cancer.gov/seertools/glossary/

CODING PRIMARY SITE AND HISTOLOGY

Primary site and histology are the backbones of accurate cancer abstracting. Along with date of diagnosis, data items are generated based on combinations of primary site and histology; therefore, coding these two items correctly is crucial. The standard setters for coding primary site and histology for cancer reporting in the United States are SEER and the CoC.

PRIMARY SITE

According to the SEER Program Coding and Staging Manual 2025, the principal resource for coding primary site (topography) is the International Classification of Disease for Oncology, Third Edition (ICD-O-3). The Solid Tumor Rules manual is used in conjunction with the ICD-O-3 for additional primary site coding guidance for cancers with site specific modules, including Head and Neck, Breast, Lung, and others. The full list can be found in Section 8, Solid Tumor Rules.

Exception – Since 2010 primary site for hematopoietic and lymphoid neoplasms is coded according to the SEER Hematopoietic and Lymphoid Neoplasm Database and Coding Manual.

Note – although the ICD-O-3 had updates for coding morphology/histology for 2023, no topography codes were changed.

HISTOLOGY

Beginning January 1, 2001, ICD-O-3 was the primary resource for coding the correct histology/morphology for all cancer cases. As of January 1, 2018, the Solid Tumor Rules are the primary source for coding histology for the all sites:

- Breast
- Colon (includes rectosigmoid and sigmoid colon)
- Cutaneous Melanoma (beginning 1/1/2021)
- Head & Neck
- Kidney
- Lung
- Malignant CNS and Peripheral Nerves
- Non-malignant CNS
- Urinary Sites (includes bladder, renal pelvis, ureter, etc.)
- Other Sites (beginning 01/01/2023)

The Solid Tumor Rules will continue to be the first manual to consult when coding histology for the all sites for diagnosis year 2025, followed by these resources listed in priority order:

1. ICD-O 3.2: https://www.naaccr.org/icdo3/
2. SEER Inquiry System: https://seer.cancer.gov/seerinquiry/index.php
3. Ask a SEER Registrar: https://seer.cancer.gov/registrars/contact.html

Exception – as with coding primary site, hematopoietic malignancies (leukemia, lymphoma, etc.) have their own set of rules for coding histology/morphology. Please refer to the SEER Hematopoietic and Lymphoid Neoplasm Database and Coding Manual.

CANCER REGISTRY RESOURSES FOR CASES DIAGNOSED BEGINNING 2018

1. **International Classification of Diseases for Oncology (ICD-O) Manuals**

Use: To determine applicable codes for primary site (topography) and histology (morphology) of solid tumors.

ICD-O-3.1 is currently available only in PDF form. The PDF or printed of ICD-O-3, 1st revision ("purple" book) versions are still valid for coding primary site. The book has three main sections: topography, morphology, and the alphabetic index. The grade information is **obsolete.** Use only for coding primary site in conjunction with the Solid Tumor Rules manual. ICD-O-3.1 and 3.2 should only be used as the second resource for assigning histology as previously instructed. ICD-O-3 has been obsolete for hematopoietic and lymphoid neoplasms since 2010. The source for coding primary site for these conditions is the SEER hematopoietic and lymphoid neoplasm database and coding manual.

Use for **General Instructions** and **primary site codes only**. Do not use this manual for histology codes since it is out-of-date.
https://apps.who.int/iris/handle/10665/96612

ICD-O-3.2 are secondary resources for coding histology. ICD-O-3.1 is applicable from diagnosis year 2018 through 2020. ICD-O-3.2 is applicable for diagnosis year 2021 and forward for solid tumors. It is important to use the correct manual for the diagnosis year being abstracted as major changes were implemented in both versions. The North American coding guidelines and supplemental tables are available on the NAACCR website. Currently there is no PDF or printed book available for version 3.2, only the spreadsheet available at the link below.

ICD-O-3.2 2024 revisions:
https://www.naaccr.org/icdo3/
See previous guidelines, at the link above, for historical revisions.

2. American Joint Committee on Cancer (AJCC) Cancer Staging
(Effective for cases diagnosed January 1, 2018, and after)

Note: OCCR does not require AJCC TNM staging. This information is included for informational purposes and for facilities who wish to assign AJCC staging or who are required to assign it for other standard setters.

Use: To determine TNM Stage and Stage Grouping

TNM staging is a process for determining the severity of cancer. Each letter stands for a different part of the staging formula. T defines the tumor's size and extension into nearby tissue; N defines spread into regional lymph nodes and M defines metastasis (spread of cancer to other parts of the body).

TNM staging classification is categorized by clinical (cTNM), pathological (pTNM), post therapy or post neoadjuvant therapy (ycTNM and ypTNM), Recurrence or Retreatment (rTNM) and Autopsy (aTNM). For the purposes of cancer registry, we will only discuss clinical, pathological and posttherapy. Clinical classification determines how much cancer there is based on physical examination, imaging tests, endoscopies, and biopsies of affected areas prior to any cancer treatment. Pathologic classification can only be determined for patients who have had surgery to remove a tumor or explore the extent of disease. Pathologic staging combines the results of both clinical staging with surgical results such as operative findings from the surgeon and pathology reports from the resected specimen. Posttherapy stage is determined after treatment for patients receiving systemic and/or radiation therapy alone as a component of their initial treatment, or as neoadjuvant therapy before planned surgery.

Each primary site has a chapter within the TNM Manual; however, there are guidelines in **chapter one** that must be read before moving on to site specific chapters.

The 8th Edition and Version 9 AJCC Cancer Staging Manuals are available by purchase only. The 1st edition through 7th edition AJCC manuals are available for free as scanned PDFs here: https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

Free training webinars are available from AJCC on how to use the manual: https://www.facs.org/quality-programs/cancer/ajcc/staging-education/registrar

Beginning in 2021, as each chapter is revised, it will be released in **Kindle format and available by subscription**. AJCC is transitioning from "editions" to "versions". There are no plans currently to release a Version 9 printed book containing all chapters. Version 9 protocols continue to be released and/or updated annually. They should be used in conjunction with the 8th edition, 3rd printing of the cancer staging manual until version 9 protocols for all sites have been released. FAQ for Version 9 Cancer Staging System

3. **Standards for Oncology Registry Entry (STORE) Manual**
   https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-data-submission/
   The current STORE manual is for cases diagnosed beginning 1/1/2025. Previous editions are also available at the above website and should be used for the applicable diagnosis year.

   Use: Utilized by the OCCR for coding instructions.

   This manual provides instructions and standards for coding and should be the first manual referenced to determine applicable codes, unless indicated otherwise.

4. **SEER Program Coding & Staging Manual diagnosis year 2025**
   https://seer.cancer.gov/tools/codingmanuals/index.html

   Previous editions are available here:
   https://seer.cancer.gov/tools/codingmanuals/historical.html

   Use: Utilized by the OCCR for coding instructions.

   This manual provides instructions and standards for coding and should be the second manual referenced to determine applicable codes, unless indicated otherwise.

5. **CTR Guide to Coding Radiation Therapy Treatment version 6.0 January 2024**
   Appendix R of the 2025 Store manual linked above.

   Use: Coding radiation data items for 01/01/2018 and forward

   The method of collecting radiation data items changed significantly in 2018. This manual provides extensive instructions on how to code the data and provides comprehensive case studies with the intent to provide coding examples for 95% of the most common scenarios cancer registrars will encounter.

6. **NAACCR v25B Edit Detail Report**
   https://www.naaccr.org/wp-content/uploads/2025/05/Edits-Detail-Report-V25B.pdf

   Use: Understand and resolve edits.

   The NAACCR v24B Edit Detail Report is a document describing each edit in the metafile, which edit sets include the edit, which data items are included in each edit and the edit logic. If an error occurs when running edits on an abstract, this document can be helpful in understanding why it occurred and how to resolve it.

Note: Ensure you are using the edit detail report that corresponds to the version of the edit metafile in your software. Edit metafile versions are indicated by a number followed by a letter if the version has been revised. As of the writing of this manual, v25B is the most current version available. If you are unsure what version your software is using, please contact the software vendor.

7. **SEER Summary Stage 2018, v3.2 (published November 2024)**
(Effective for cases diagnosed January 1, 2018, and forward)
https://seer.cancer.gov/tools/ssm/

Note: SEER Summary Stage is the staging system used by the Oklahoma Central Cancer Registry and is a required data item.
Use: To determine SEER Summary Stage.

Summary stage is the most basic way of categorizing how far a cancer has spread from its point of origin. The 2018 Summary Staging Manual includes all anatomical sites including lymphoma and leukemia. All information in the medical record is used to establish stage and does not limit staging based on whether or not the patient has had primary site surgery. The manual includes a general instructions chapter along with modules for each specific site. As with all cancer coding manuals, the **general instructions** must be reviewed **first** to avoid coding errors**.**

Note: SEER Summary Stage is also included in SEER*RSA. However, general instructions are only available in the summary stage manual.

8. **NAACCR Site Specific Data Items (SSDI) v3.2**
(Effective for cases diagnosed January 1, 2018, for software converted to NAACCR v25)
https://apps.naaccr.org/ssdi/list/

Use: Provides instructions for coding Site-Specific Data Items

The SSDI Manual is the primary resource for documentation and coding instructions for site-specific data items introduced in 2018. There are two versions available at the above web address. Version 3.0 for use with NAACCR v23 layout, diagnosis years 2018 forward and version 3.1 for use with NAACCR v24 layout, diagnosis years 2018 forward. The individual version selections are above and to the right of the blue “Resources” box on the web page. Within the blue area there are links for the SSDI manual, appendices, grade manual and a change log. Review the opening chapters of the manual before moving on to individual schemas (primary site groupings) to learn about timing for collecting SSDIs and general rules for entering lab values and other measurements. The individual schemas are also listed in the manual. Once you have become familiar with SSDIs, you may wish to reference the interactive cancer schema list on the SSDI webpage.

Note: Schema instructions take priority over the general instructions when they differ from the general instructions. SSDI individual schema information is also included in SEER*RSA. However, general instructions are only available in the SSDI manual.

9. **2018 Grade Coding Instructions and Tables (Grade Manual) v3.2**
   (Effective for cases diagnosed January 1, 2018, for software converted to NAACCR v25)
   https://apps.naaccr.org/ssdi/list/

   Use: Coding instructions for Grade data items.

   The Grade Coding Instructions and Tables (Grade Manual) is the primary resource for documentation and coding instructions for Grade. Before using the Grade Manual as a coding reference, it is important to **review the introductory materials and general instructions of the manual** carefully. These reflect several important changes in the collection of Grade data items, including use of AJCC–recommended grade tables where applicable, and the introduction of Clinical, Pathological and Post–Therapy Grade data items.

   Note: Grade data items are also included in SEER*RSA. However, general instructions are only available in the Grade manual.

10. **SEER Solid Tumor Rules 2025 Update**
    https://seer.cancer.gov/tools/solidtumor/

    Use: To determine the appropriate histology code and whether a tumor is considered one or multiple primaries based on its site, histology, and in some cases, date of diagnosis.

    The 2018 Solid Tumor coding rules (STR) replace the 2007 Multiple Primary and Histology (MP/H) rules for sites. Unlike the previous MPH rules, The Solid Tumor Rules are only available in text format. Within the solid tumor rules, the multiple primary rules are used to determine the number of primaries. The histology coding rules are used to determine histology. The rules are hierarchical and must be followed in order. Use the first rule that applies and then **stop**, do not go any further. Please refer to the STR General Rules, How to Use the Solid Tumor Rules section on page 7 of the manual to determine which site specific rules to use based on diagnosis date and site.

    Note: The rules do not apply to hematopoietic primaries (lymphoma and leukemia) of any site. Use the Hematopoietic and Lymphoid Neoplasm Coding Manual for determining multiple primaries and histology.

11. **SEER Hematopoietic and Lymphoid Neoplasm Database and Coding Manual**
    https://seer.cancer.gov/tools/heme/

Use: To determine primary site, histology, reportability, and multiplicity of hematopoietic and lymphoid neoplasms.

The Database contains abstracting and coding information for all hematopoietic and lymphoid neoplasms (9590/3–9993/3). The Coding Manual provides reportability instructions and rules for determining the number of primaries, the primary site and histology, and the cell lineage or phenotype.

12. **SEER Rx–Interactive Antineoplastic Drugs Database**
https://seer.cancer.gov/seertools/seerrx/

Use: To research drugs or regimens used in treating cancer.

Utilize the search field to look for the drug or regimen in question. Select the name for more information about the drugs' category, type of cancer the drug is usually used for and if it is to be reported as cancer-directed treatment.

13. **NAACCR Data Dictionary Version 25**
https://apps.naaccr.org/data-dictionary/data-dictionary/version=25/chapter-view/

Use: To provide a rationale for collecting a data item and for using the codes listed.

The NAACCR Data Dictionary Version 25provides a description of each data item, along with the specific codes and definitions for data collection for 2025. Other versions are available for NAACCR record layout 23 and 24. Earlier versions are available by request to NAACCR.

The NAACCR Data Standards and Data Dictionary web page underwent a major update in 2023. A demo can be viewed on how to navigate and use the new website on the data dictionary homepage.

SECTION 2

STANDARDS FOR CONFIDENTALITY, DISCLOSURE OF DATA AND DATA QUALITY

HIPAA

The Federal government addressed disclosure of confidential data within the Health Insurance Portability and Accountability Act of 1996 (HIPAA) enacted by Federal Public Law 104–191 and implemented beginning April 24, 2003. It provides access to protected health information without individual authorization for Health Care Operations that involve quality assessment and improvement activities. It also authorizes the release of data sets for the purpose of research and public health. The complete law can be found here: https://www.hhs.gov/hipaa/index.html

CONFIDENTIALITY POLICIES

Confidentiality

The OCCR program director has ultimate responsibility for maintaining confidentiality and compliance with Oklahoma state law and federal HIPAA guidelines. OCCR is bound by the rules of confidentiality as set forth by state laws, administrative rules, and this manual. Each staff member must sign a confidentiality agreement. Other departments, sections, or programs within the Oklahoma state department of health that are outside the OCCR and have a need for registry data, must also sign confidentiality agreements. The agreement describes their obligation regarding confidential data, documents that they have read this section of our confidential policy and acknowledges that the penalty for not complying constitutes commission of a class a misdemeanor with discipline in accordance with state policies. A copy of the confidentiality agreement is available upon request.

INFORMATION REQUESTS

Oklahoma Reporting Facilities

Requests from Oklahoma reporting facilities for data from the facility registry may be made by phone or in writing. Confidential information may be released to health care providers and institutions directly involved in the care of the patient.

The State Registry may release confidential data to treating hospitals for the purpose of patient follow-up. All requests for follow-up must follow 63 O.S., 1–551.1 and 1–552. Confidential data is information that can be used to identify a specific patient.

Research Activities

Research activities are monitored by the Program Director who ensures that only relevant activities are undertaken. Data from the State Registry may be used in research projects upon approval. Such uses include survival statistics, epidemiological studies, planning of services, controlling the disease, and assessing the effects of intervention. Because any information that specifically identifies a healthcare professional is confidential, researchers must sign a confidentiality statement. This statement confirms their agreement to maintain patient confidentiality, cite the source of the data in any presentation or

publication, and provide the OCCR with copies of any publication or presentation prior to release. Violation of any part of the agreement shall prevent further access to the data and result in a letter of reprimand to the chief executive officer of the researcher's institution and other researchers at the institution may be denied access to data for an indeterminate time.

Article 5 of the Public Health Code under Oklahoma Statue Title 63 protects the identity of patients and physicians reported to the Oklahoma Central Cancer Registry through data submission. Written consent is required for the release of confidential information. The Commissioner of Health may authorize release of information for research activity in the interest of public health and welfare. Researchers must protect the confidentiality of patients. Only by obtaining the physician's signature, and a "release of confidential medical information" form from the patient, can a researcher request additional information or patient participation in a research project.

Research data will be provided only upon written request that **must** include:

- The exact purpose for the data requested.
- Agreement that the data will not be used for purposes other than agreed upon at the time of release.
- Data will not be released to unauthorized individuals or parties.
- Data that is no longer needed for the designated purpose will be returned or destroyed.

Confidential cancer registry data will **neve**r be made available to any institution for the purpose of recruiting new clients.

Cancer Patients
If an individual were to call and ask if there is data in the state cancer registry about them, they would not be given any information. They will be referred to their treating physician for this information.

Data on deceased persons held in the cancer registry are subject to the same data release restrictions as those for the living.

DISCLOSURE OF DATA

State law stipulates that patient data may be shared with other registries, private or governmental, within or outside of the state, provided that a reciprocal data sharing agreement, approved by the Commissioner of Health, is implemented with that registry.

OCCR COMPUTER SECURITY

The Program Director is responsible for ensuring the overall security of the computer system. This includes verifying that only authorized individuals have access. Employees are strictly forbidden from releasing any information regarding codes, numbers, or names used to access the computer except to authorized individuals. **Failure to comply with the provision is grounds for immediate dismissal.**

Gaining access to confidential patient information is a four-tier security process. The first tier of protection is badge-only access to the OCCR's work environment. Visitors to the area are registered at the Oklahoma Commons reception desk and must be escorted by authorized OCCR employees. The second tier is the user login name and password for accessing OCCR computers. The password must be changed on a regular basis and must meet specific security measures to be valid. The third level of protection is provided by limited access to the network server where the OCCR database resides. Access is granted only to staff with authorized clearance. Finally, tier four is password access to the Rocky Mountain Cancer Data Systems (RMCDS) software. Only those individuals for whom access to the database is essential will be assigned usernames and passwords.

Read only access to **non-confidential** portions of RMCDS data can be granted to non-essential department users for research purposes.

PAPER RECORDS

The need for paper records in today's environment is very limited. However, computer printouts of data with protected health information (PHI) are treated as medical records and all confidentiality procedures and rules apply. All personnel with a potential need for confidential paper records have locking file cabinets at their disposal as well as locked offices.

The Oklahoma State Department of Health (OSDH) server on which RMCDS is installed is backed up on a regular basis by the Office of Management and Enterprise Services.

Handling of Data in the Field

Staff working in the field are discouraged from transporting any confidential information such as abstract forms or data disks. If confidential information must be transported in printed format, precautions are taken to protect the information. It will be carried in a locked briefcase, which will never be left unattended unless it is within a secure locked enclosure.

When a site visit is made, the abstract forms being discussed will be shown or discussed only with the individual responsible for initially submitting the abstract form or their supervisor and our OCCR staff member.

HARD COPIES OF MEDICAL RECORDS

Medical records should **always** be submitted electronically. If absolutely necessary, documents containing confidential patient information may be sent by mail or courier service following these guidelines:

- Notify the recipient at OCCR prior to mailing them a package so they will be on alert.

- Securely enclose the records in tear resistant, tamper-proof packaging. **Do not** use thin pasteboard envelopes regardless of the carrier or class of mail. OCCR is not responsible for torn or lost packaging containing patient information.
- Always use tracking codes to determine if the package has reached its destination.
- Keep a copy of the records, or, at the very least, a listing of patient names and/or medical record numbers included in the mailing in the event there is a problem with package delivery.
- Address the package **exactly** as indicated below to ensure delivery to the proper person.

  Center for Health Statistics
  Oklahoma Central Cancer Registry
  Name of cancer registry staff person receiving mail
  Oklahoma State Department of Health
  123 Robert S Kerr Ave STE 1702
  Oklahoma City, OK 73102-6406

QUALITY ASSURANCE

OCCR follows quality assurance procedures established by SEER, the CDC NPCR, and NAACCR and other national standard setters. This includes both internal and external processes to ensure the reliability, completeness, consistency, and comparability of Oklahoma reported cancer data.

Submission Review

The OCCR uses the CDC's Registry Plus™ Web Plus online software for facilities to upload their abstracted cancer cases. Prior to submission, abstracts must be run through current NAACCR edits to check for errors. All errors must be corrected prior to upload. Submitted data is processed through a set of edits at the central registry to ensure that it meets accuracy standards. The OCCR rejects uploaded case files if they do not clear 100% of the edits. Edits must be corrected before the case files can be resubmitted and accepted by the central cancer registry.

Facility Training

OCCR staff provides training and education for Oklahoma cancer reporters via online training, Microsoft TEAMS video conference and telephone. Training encompasses the following topics:

- Use of RMCDS and Web Plus
- Casefinding and reportability
- Abstracting process and required data items
- Technical assistance
- Other specific topics, as identified

Casefinding Audit

Each year, OCCR staff conducts casefinding audits to assess a facility's adherence to completeness requirements. Facilities will be selected randomly or specifically due to a significant reduction in reported cases. The auditor(s) will systematically review a facility's disease index and/or hospital discharge data, compare it with submitted cases from the facility in the OCCR database and determine if the audited facility has submitted all reportable cancers. A second method of auditing could involve an on-site visit to a facility to review the medical record for reportable cases. The purpose of an audit is threefold: to identify problem areas affecting a facility's casefinding process, provide advice on improving the process, and to aid in assessing the completeness of OCCR data.

Reabstraction Data Quality Audits

The OCCR staff or designated third party performs annual reabstraction audits. A reabstraction audit is a method for assessing the quality of a facility's abstracted data and text documentation. Facilities can be selected randomly, chosen when new abstractors are hired, chosen if text is consistently inadequate, or if patterns of inaccurate coding have been identified. Randomized cases from the selected facility's uploaded data will be reabstracted. If the intent of the audit is to evaluate text documentation, the chosen cases will be reabstracted based solely on the text provided by the audited facility. Cases that cannot be completely abstracted with text-only documentation will be reviewed with the facility abstractor and coaching on improvement will be provided. If the intent of an audit is to evaluate accuracy of coding, the audited facility will be notified of the selected cases and will be instructed on how to provide the necessary records to the auditor. Currently, medical records will need to be submitted to the OCCR or designated third party. A second method of auditing could involve an on-site audit.

Death Clearance

Death clearance is conducted annually to improve data completion and accuracy. The OCCR matches yearly incidence of cancer documented in the database against cancer deaths reported to the Oklahoma Division of Vital Records. If a match is found, the date of death and underlying cause of death are updated in the registry database. Any person with a documented, reportable cancer as a cause of death, and not listed in the OCCR database, must be investigated to identify potentially missed incidence of cancer. When a facility is listed on the death certificate as place of death, the OCCR uses this information for follow-back to the listed facility. Hospital discharge data is also used to identify possible follow-back sources.

Facilities are required to review all death clearance follow-back cases to determine if they have missed a reportable malignancy. In Oklahoma, a patient who dies with active cancer at a reporting facility must be reported to OCCR as a class of case 32 unless previously reported. The information required on a class of case 32 death includes demographics, date of diagnosis (or best estimate), type of cancer (primary site/histology) and any other readily available information about the cancer. If a case is determined to be non-reportable, facilities will be required to provide information from their medical record to assist

the OCCR with reconciling the case. This includes an estimated date of diagnosis, as well as any information regarding another facility or a physician that may have treated the patient.

SECTION 3

REPORTABLE DISEASES AND CASEFINDING

Oklahoma requires that all hospitals, clinics, laboratories, pathologists, physicians, dentists, or facilities providing diagnostic or treatment services in relation to cancer or precancerous conditions, submit an abstract for each reportable diagnosis and/or treatment of cancer to the OCCR within 180 days of date of first contact. This includes but is not limited to hospitals, ambulatory surgery centers, free standing clinics, oncology clinics, and radiation oncology clinics. The data required includes patient demographics, diagnostic information, disease characteristics, first course of treatment, and vital status. The basis for these requirements is found in Oklahoma Administrative Code at https://rules.ok.gov/code?q (enter "Cancer Registry" in the search box).

REPORTABILITY

Cases reportable to the OCCR include patients newly diagnosed with cancer, clinically or pathologically; patients receiving first course cancer treatment; patients that present from an outside facility with a clinical diagnosis and are seeking tissue confirmation by biopsy; patients that have cancer previously diagnosed and treated elsewhere and present for diagnosis and/or treatment of recurrent or persistent disease; or patients who expire with active cancer at the reporting facility. Class of Case defines the facility's role in the patient's cancer diagnosis and treatment.
For a complete explanation, see Class of Case in Section 5.

Class of Case	Description
00	Newly diagnose a patient with a reportable disease
10-14	Diagnose and treat reportable diseases
20-22	Treatment only for a newly diagnosed reportable disease
30	Clinical diagnosis (imaging or physician statement) elsewhere and the patient presents to the reporting facility for a confirmatory biopsy (histologic confirmation). **DO NOT** report cases presenting for other types of diagnostic workup, including consult only, treatment plan only, and additional imaging.
32	Diagnose and/or treat recurrence or persistence of a reportable disease previously diagnosed and treated elsewhere. *Class of case 32 also includes patients who expire at a facility with active cancer.*
34, 36	Not required by the CoC but reportable to OCCR.

REPORTABLE DISEASES

Diseases reportable to the OCCR include:

1. Malignancies with an ICD-O-3 (ICD-O-3.2 beginning with diagnosis year 2021) behavior code of 2 (in situ) or 3 (invasive) are reportable for all sites (for exceptions see Non-Reportable Diseases below).
2. Vulvar intraepithelial neoplasia (VIN III) C51._, vaginal intraepithelial neoplasia (VAIN III) C52.9, anal intraepithelial neoplasia (AIN III) C21._ are reportable to the OCCR by all facilities as required by the NPCR. The class of case is either 34 or 36 depending on the facility's role in caring for the patient.

3. Non-malignant primary intracranial and central nervous system tumors, diagnosed on or after 1/1/2004 with an ICD-O-3 behavior code of 0 or 1 are reportable for the following sites:
    - Meninges (C70.0, C70.1, C70.9)
    - Brain (C71.0- C71.9)
    - Spinal cord (C72.0)
    - Cauda equina (C72.1)
    - Olfactory nerve (72.2)
    - Optic nerve (C72.3)
    - Acoustic nerve (C72.4)
    - Cranial nerve NOS (C72.5)
    - Overlapping lesion of brain and CNS (C72.8)
    - Nervous system NOS (C72.9)
    - Pituitary gland (C75.1)
    - Craniopharyngeal duct (C75.2)
    - Pineal gland (C75.3)
4. As of diagnosis year 2021, GIST is reportable by default with behavior code /3 ***unless stated to be benign***. If stated to be benign, the behavior code is /0 and not reportable. Prior to 2021 Gastrointestinal Stromal Tumor (GIST) (8936) was reportable if noted to have multiple foci, metastasis, positive lymph nodes, or stated to be malignant. Assign behavior code /3.
5. As of diagnosis year 2021, nearly all thymomas are reportable with behavior code /3 ***unless stated to be benign***. Exceptions are microscopic thymoma or thymoma benign (8580/0), micronodular thymoma with lymphoid stroma (8580/1), and ectopic hamartomatous thymoma (8587/0) which remain non-reportable. Prior to 2021, thymomas are reportable if noted to have multiple foci, metastasis, positive lymph nodes, or stated by a physician to be malignant.
6. Beginning 1/1/2023, all cases diagnosed with pilocytic astrocytoma/juvenile pilocytic astrocytoma and related terminology are to be reported with behavior /1. They will no longer be collected with malignant behavior (/3). ICD-O code 9421/3 will be valid for the diagnosis of high-grade astrocytoma with piloid features or HGAP only. Coding instructions are included in the remarks section for 9421/1 and 9421/3 in the 2023 ICD-O Update Tables 1 and 2.
    - From 1976 to 2000, WHO assigned code 9421/3 to pilocytic astrocytoma of the brain. Beginning with the release of ICD-O-3 in 2001, WHO changed the behavior for this neoplasm from /3 to /1 making it non-reportable. 9421/3 was removed from ICD-O-3, however, the standard setting organizations in North America opted to continue collecting these tumors as 9421/3 in CNS sites. The practice did not change once benign/borderline CNS tumors became reportable in 2004. The exception being pilocytic astrocytoma/optic glioma of the optic nerve which are coded 9421/1 effective 2018 and forward.

    - The 5th Ed Central Nervous System Tumors reinstated code 9421/3 for a newly identified neoplasm: High-grade astrocytoma with piloid features (HGAP).

- Mature teratoma of the testis in adults is malignant (assign 9080/3) but continues to be non-reportable in prepubescent children (9080/0). Report only if pubescence is explicitly stated in the medical record. Do not report if there is no mention of pubescence in the medical record.

7. Cystic pancreatic endocrine neoplasm (CPEN), 8150/3.
8. Beginning 2021, solid pseudopapillary neoplasm of pancreas, 8452/3 (synonymous with solid pseudopapillary carcinoma, C25._).
9. Beginning 2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable.
10. Beginning 2022, low-grade appendiceal mucinous neoplasm (LAMN) is reportable. LAMN now has a behavior of /2 and /3 making it reportable. LAMNs are slow-growing neoplasms that have the potential for peritoneal spread and can result in patient death. LAMNs demonstrate an interesting biology in that they do not have hematogenous dissemination risk, but risk for appendiceal perforation, which can result in peritoneal dissemination, repeated recurrences after surgery and even death.

    8480/2 Low-grade appendiceal mucinous neoplasm
    8480/2 High-grade appendiceal mucinous neoplasm
    8480/3 Appendiceal mucinous neoplasm with extra-appendiceal spread
11. Beginning 01/01/2023
    - Lymphangioleiomyomatosis behavior has changed from /1 to /3 and is reportable.
    - Mesothelioma In situ (C38.4) is reportable.
    - Diffuse leptomeningeal glioneuronal tumor (9509/3)
12. Beginning 01/01/2016
    - Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast C500-C509 is reportable.
    - Pancreatic intraepithelial neoplasia (PanIN III) is reportable.
13. Penile intraepithelial neoplasia III (PeIN III) is reportable. Assign class of case 34 or 36 as appropriate to the facility's role in the patient's care.
14. Beginning 01/01/2025 Post Transplant Lymphoproliferative Disorder (PTLD) 9971/1 is reportable as 9971/3 .
15. Beginning 01/01/2018 Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high-grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high-grade dysplasia *replaces the term mucinous cystadenocarcinoma, non-invasive*. MCN with low or intermediate grade dysplasia or no dysplasia is NOT reportable.

NON-REPORTABLE DISEASES

Malignancies **not** reportable to OCCR include:

1. Malignant primary skin cancers (C44._) with histology codes 8000-8005, 8010-8046, 8050-8084, 8090-8110.
   Example: squamous cell carcinoma (8070/3) and basal cell carcinoma (8090/3) of skin are not reportable.
   - **Note:** malignant primary skin cancers that do not fall within the above-specified histology codes **are reportable**. Such diagnoses may include but are not limited to melanoma, Merkel cell carcinoma, primary cutaneous lymphomas among others.
2. Carcinoma in situ of the cervix (CIS), cervical intraepithelial neoplasia grade III (CIN III), and squamous intraepithelial neoplasia (SIN III) of cervix and skin.
   There are two histology codes for HPV-related adenocarcinoma in situ of the cervix. These are not reportable.
   8483/2 Adenocarcinoma in situ, HPV-associated (C530-C531, C538-C539)
   8484/2 Adenocarcinoma in situ, HPV-independent, NOS (C530-C531, C538-C539)
3. Prostatic intraepithelial neoplasia (PIN III) after 01/01/2001.
4. Serous borderline tumor micropapillary variant (C56.9) histology code 8460/2 beginning with diagnosis year 2018. Histology code 8460/2 is still reportable for non-invasive low grade serous carcinoma (C56.9).
5. Benign/borderline central nervous system tumors diagnosed prior to 2004.
6. Malignant tumors diagnosed prior to 1997 (OCCR reference date) and class of case 00-22.
7. In situ (behavior code /2) lymphomas are not reportable.
8. Non-invasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP), for primary site thyroid, code 8343/2. Reportable 2017-2020 only.
9. High grade dysplasia of the colon is not reportable even though it has been designated in situ (/2) in the WHO classification.

DIAGNOSIS – PATHOLOGICAL VS CLINICAL

A pathological diagnosis is made by examining body tissues (histology) or fluids (cytology) under a microscope to identify the presence of malignant cells. A clinical diagnosis is made by a physician after a physical exam, reviewing signs and symptoms, lab reports and/or imaging tests. Most of the time a clinical diagnosis will be followed by a pathological diagnosis. Both methods of diagnosis are reportable with one exception. If a clinical diagnosis is made and is then proven to be benign by pathology, it becomes non-reportable.

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

AMBIGUOUS TERMINOLOGY FOR DETERMINING REPORTABILITY

There are times when a definitive statement of malignancy cannot be found. A thorough review of a patient's medical record may result in the finding of ambiguous terms. The ambiguous terms listed below are considered reportable when they are used in conjunction with the words malignant, cancer, carcinoma, sarcoma, etc.

Ambiguous Terms that Constitute a Reportable Diagnosis	
Apparent(ly)	Most likely (must have both words)
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect(ed)
Consistent with	Suspicious (for)
Favors	Typical of
Malignant appearing	
Additional Terms that Constitute a Reportable Diagnosis for **Nonmalignant Primary Intracranial and Central Nervous System Tumors Only***	
Neoplasm	Tumor
*Beginning with diagnosis year 2004 and only for C70.0-C72.9 and C75.1-C75.3	

Note 1: Do not substitute synonyms such as 'supposed' for 'presumed,' or 'equal' for 'comparable.' Do not substitute 'likely' for 'most likely.' Use only the exact words on the list or their conjugate forms, for example, "favored" is allowed as a substitute for 'favor.'

Note 2: If a **cytology report** uses only an ambiguous term for the diagnosis, do not interpret it as a diagnosis of cancer. Do not report ambiguous cytology *unless* a physician makes a statement of malignancy, the patient receives cancer-directed therapy or tissue diagnosis confirms ambiguous cytology. Under these circumstances, cytology may be used as the date of diagnosis.

Note 3: For hematopoietic and lymphoid neoplasms, the ambiguous terms list is applicable to **reportability only**. The use of ambiguous terms for assigning and reporting histology for hematopoietic and lymphoid neoplasms is covered in the Hematopoietic and Lymphoid Neoplasms Coding Manual.

https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

Note 4: The RADS system should not be used when reviewing ambiguous terminology to determine reportability. This includes BI-RADS (breast), Bone-RADS (musculoskeletal), C-RADS (CT colonography), LI-RADS (liver), Lung-RADS (lung cancer screening CT), NI-RADS (head & neck), O-RADS (ovarian/adnexal), PI-RADS (prostate) and TI-RADS (thyroid).

Ambiguous Terms that **DO NOT** Constitute a Reportable Diagnosis	
Cannot be ruled out	Questionable
Equivocal	Rule out
Possible	Suggests
Potentially malignant	Worrisome

EXAMPLES USING AMBIGUOUS TERMS

Do report – Mammogram report states breast mass is **suspicious** for malignancy. Suspicious for malignancy is reportable ambiguous terminology. Please note, BI-RADS terms are not considered diagnostic on their own. For example, BI-RADS 5, highly suggestive of malignancy, does not constitute a diagnosis.

Do report – Discharge summary final diagnosis states **probable** primary lung malignancy. Probable primary lung malignancy is reportable ambiguous terminology.

Do not report – An outpatient CT scan of the chest documents a right lower lobe lung nodule, **possible** malignancy. The patient has no other encounters with your facility. Possible is not a reportable ambiguous term.

Do not report – **Cytology** from bronchial washings, final diagnosis: **Suspicious** for malignancy. Suspicious is an ambiguous reportable term, but cytology is the exception (see Note 2).

DIFFERENTIAL DIAGNOSIS

A **differential** diagnosis is made when a physician does not have enough information to assign a **definitive** diagnosis. Only report cases with a differential diagnosis if all possible disease processes mentioned are reportable.

Do report – CT exam of the chest shows a nodule in the left lower lung. The radiologist report has a differential diagnosis of **suspicious** for lung cancer vs **metastatic** lung lesion. Both are reportable terms.

Do report – Pathology report of brain tissue states **CNS lymphoma** vs **CNS metastasis** from unknown primary. Both are reportable conditions.

Do not report – MRI of the left thigh says deep tissue mass consistent with **atypical lipoma** or **liposarcoma**. The patient does not return to your facility. Atypical lipoma is not a reportable condition.

Do not report – Bone survey states patient has a solitary lesion in the right humerus compatible with a **bone island** or **solitary plasmacytoma**. “Compatible” is a reportable ambiguous term, but a bone island is not a reportable condition.

CASEFINDING

Casefinding is a system for identifying every patient (inpatient or outpatient) who is diagnosed and/or treated with a reportable condition. The reporter for each facility is responsible for identifying all

reportable conditions. Methods of casefinding include review of disease index, pathology reports, radiology reports and treatment records (surgery, chemotherapy, radiation, etc.).

Medical Record Disease Index

The disease index is a comprehensive listing of all patients—inpatient or outpatient, who are discharged with an ICD-10-CM cancer diagnosis code. The disease index should be obtained after medical records are completed and coded and must be based on year of admission. The report should include the following information: patient's first and last names, medical record number, date of birth, social security number, discharge date, all primary and secondary ICD-10-CM codes, and the type of encounter. Since many cancer patients have multiple encounters at a facility, the report should be sorted by medical record number. This will ensure all visits for each patient are grouped together. The facility reporter is responsible for reviewing each patient on the disease index to identify reportable cases.

The following list is to be used by appropriate staff to create the disease index. It includes the required reportable neoplasms and ICD-10-CM codes. An Excel spreadsheet and a PDF file with the current codes can be downloaded at: https://seer.cancer.gov/tools/casefinding/. If IT staff is available at your facility, enlist their help in creating the disease index report.

How to use the Case Finding Code List for Reportable Tumors

In the first column, first row "C00.- - C43.-" means all codes that begin at C00.- and end at C43.- are included as reportable. For example, C00.9 is not specifically stated but it falls in that range as does C43.9. On the second row we find "C44.0, C44.9." There are no dashes, therefore these are the only two codes that apply. They are not ranges.

COMPREHENSIVE ICD-10-CM Casefinding Code List for Reportable Tumors (EFFECTIVE DATES: 10/1/2024-9/30/2025) Please refer to your standard setter(s) for specific reporting requirements before using the Casefinding List	
ICD-10-CM Code	**Explanation of Code**
C00.- C43., C4A.-, C45-C96	Malignant neoplasms (excluding category C44), stated or presumed to be primary (of specified site) and certain specified histologies
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.10_, C44.19_	Unspecified/other malignant neoplasm of skin of eyelid
C44.13-	Sebaceous cell carcinoma of skin of eyelid, including canthus
C44.20-, C44.29-	Unspecified/other malignant neoplasm skin of ear and external auricular canal
C44.30-, C44.39-	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.40, C44.49	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50-, C44.59-	Unspecified/other malignant neoplasm of skin of trunk
C44.60-, C44.69-	Unspecified/other malignant neoplasm of skin of upper limb, incl. shoulder
C44.70-, C44.79-	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin
C49.A-	Gastrointestinal Stromal Tumors

	Note: All GIST tumors are now reportable starting in 2021 (per ICD-O-3.2), including GIST, NOS
D00.- - D05.-, D07.--D09	In-situ neoplasms *Note 1: Excludes carcinoma in situ of the cervix (D06._)* *Note 2: Excludes prostatic intraepithelial neoplasia (PIN III-8148/2) of the prostate. Other prostate in situ histologies are reportable.* *Note 3: For D04 (carcinoma in situ of the skin), excludes basal and squamous cell in situ lesions.*
D18.02	Hemangioma of intracranial structures and any site
D32.-	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.-	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3) ICD-10-CM Coding instruction note: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)
D46.-	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992, 9993)
D47.02	Systemic mastocytosis
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3) ICD-10-CM Coding instruction note: Excludes the following: Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_) Chronic myeloid leukemia BCR/ABL-positive (C92.1_) Myelofibrosis & Secondary myelofibrosis (D75.81) Myelophthisic anemia & Myelophthisis (D61.82)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia
D47.4	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis Myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D47.Z-	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3) **Note**: Effective 1/1/2021, PTLD (9971/3) is no longer reportable (9971/1)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
D72.11-	Hypereosonophilic syndrome [HES] (9964/3)
K31.A22	Gastric intestinal metaplasia with high grade dysplasia
N85.02	Endometrial intraepithelial neoplasia [EIN]
R85.614	Cytologic evidence of malignancy on smear of anus
R87.613	High grade squamous intraepithelial lesion on cytologic smear of anus (HGSIL)
R87.614	Cytologic evidence of malignancy on smear of anus

R87.614	Cytologic evidence of malignancy on smear of cervix
R87.623	High grade squamous intraepithelial lesion on cytologic smear of vagina (HGSIL)
R87.624	Cytologic evidence of malignancy on smear of vagina
R90.0	Intracranial space-occupying lesion found on diagnostic imaging of central nervous system

Pathology Reports
All pathology reports, both positive and negative, must be reviewed by the facility reporter to ensure that all reportable cases are identified. Included in the pathology review are histology reports, cytology reports, bone marrow reports, hematology reports and autopsy reports.

Treatment Logs
Either electronic or physical logs of patients receiving treatment (radiation therapy, systemic therapy, surgery, interventional radiology, and interventional gastroenterology) should be reviewed to ensure that all reportable cases are identified. Reviewing treatment logs is required for free standing treatment facilities and ambulatory surgery centers.

Imaging Reports
Imaging reports should be reviewed for either definitive terminology or ambiguous terminology that constitutes a diagnosis of cancer. This is especially important for imaging centers (with or without the ability to perform biopsies, etc.)

RADS System
The RADS system ***should not*** be used to determine reportability. This includes BI-RADS (breast), Bone-RADS (musculoskeletal), C-RADS (CT colonography), LI-RADS (liver), Lung-RADS (lung cancer screening CT), NI-RADS (head & neck), O-RADS (ovarian/adnexal), PI-RADS (prostate) and TI-RADS (thyroid).

MULTIPLE PRIMARIES AND HISTOLOGIES

Rules have been devised to aid cancer reporters in identifying whether a recurrence of a previously reported cancer is considered a new primary and must be reported as such, or whether a newly diagnosed cancer is in fact, multiple primaries based on location and histology, with the need to report more than one primary. The current guidelines for this process are the Solid Tumor Rules.

SOLID TUMOR RULES (All histologies EXCEPT *9590/3 – 9993/3)*
The SEER Solid Tumor Rules were initially released in 2018 and are similar to the 2007 Multiple Primary and Histology Coding Rules. Follow the guidelines as described in the General Instructions and in the Site–Specific Modules of the Solid Tumor Rules when determining multiple primaries for the listed sites.

Site-specific modules include:

- Head & Neck
- Colon (includes colon, rectosigmoid, and rectum)

- Lung
- Cutaneous Melanoma (beginning 2021)
- Breast
- Kidney
- Urinary Sites (includes bladder, renal pelvis, ureter, etc.)
- Malignant CNS and Peripheral Nerves
- Non-Malignant CNS Tumors
- Other Sites

Access the current Solid Tumor Rules at the SEER website also linked in section 1 of this manual.

HEMATOPOIETIC AND LYMPHOID NEOPLASMS (*9590/3 – 9993/3)*

Follow the guidelines as described in the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database when determining multiple primaries and histology. Also found in section 1 of this manual.

TRANSPLANTS

Transplanted organs or tissue may originate from

1. Organs or tissues from the patient's own body (autograft) or
2. Another human donor (homograft or allograft)

Accession a new primary in the transplanted organ as you would any new primary, applying the current Solid Tumor Rules. Code the primary site to the location of the primary tumor.

Example: Diagnosis of malignancy in transplanted section of colon serving as esophagus. Code the primary site as esophagus.

Example: Diagnosis of metastatic colon cancer in transplanted liver. Code the primary site as colon.

OCCR CODING AND STAGING REQUIREMENTS BY MANUAL & DIAGNOSIS YEAR

STAGING		
Manual	**Effective Years**	**Use for OCCR diagnosis years**
Summary Staging Guide	1977-2000	1997-2000
SEER Summary Stage 2000	2001-2003, 2016-2017	2001-2003, 2016-2017
SEER Summary Stage 2018	2018-	2018-
AJCC Cancer Staging Manual 7th Ed.	2010-2017	2016-2017
Collaborative Stage Data Collection System	2004-2017	2004-2017
DATA COLLECTION		
Registry Operations and Data Standards (ROADS)	1996-2002	1997-2002
Facility Oncology Registry Data Standards (FORDS)	2003-2017	2003-2017
Standards for Oncology Registry Entry (STORE)	2018-	2018-
SEER Program Code Manual	1988-2004	1997-2004
Historical SEER Program Coding and Staging Manuals	2004-2023	2004-2023
SEER Program Coding and Staging Manual	2024 & 2025	2024 & 2025
GRADE		
Grade Coding Instructions 2014	2014-2017	2014-2017
Grade Coding instructions and Tables	2018-	2018-
PRIMARY SITE AND HISTOLOGY		
International Classification of Diseases for Oncology (ICD-O)	1976-2000	1997-2000
ICD-O Third Edition, First revision	2001-2017 2018+ (primary site only)	2001-2017 2018+ (primary site only)
ICD O 3 Coding Updates Histology Only	(3.1) 2018-2020 (3.2) 2021-	(3.1) 2018-2020 (3.2) 2021-
ICD-O-3 Hematopoietic Primaries Table	2001-2009	2001-2009
MPH Coding Rules – Hematopoietic & Lymphoid Neoplasms (online database and manual)	2010-	2010
Multiple Primaries and Histology Coding Rules (MPH)	2007-2017	2007-2017
Solid Tumor Rules	2018-	2018-
TREATMENT		
SEER Self Instructional Manuals for Cancer Registrars, Book 8: Antineoplastic Agents, third edition	1993-2004	1997-2004
SEER*RX Interactive Antineoplastic Database	2005-	2005-
CTR Guide to Coding Radiation Therapy Treatment in the STORE	2019-	2019-
MISCELLANEOUS		
PSA Lab Value (Prostate CS SSF 1) Coding Guidelines	2004-2017	2004-2017

SECTION 4

REPORTING REQUIREMENTS

TIMELINESS

All hospitals, clinics, laboratories, pathologists, physicians or dentists, or all facilities providing diagnostic or treatment services in relation to cancer diseases or precancerous conditions, shall report all cancer within 180 days of initial diagnosis, or admission for treatment, or admission for disease recurrence/persistence.

Although treatment is generally started within the first four months after diagnosis, the initial course of treatment can cover a long period of time (i.e., prostate patient treated with hormone therapy before brachytherapy or surgery). That is why the planned first course of treatment can be used to complete treatment information. Do not exclude cases from submission due to incomplete treatment. Document the incomplete treatment with treatment plan information.

SUBMISSION SCHEDULE

Patients Admitted for Diagnosis, Treatment or Recurrence/Persistence:	Should be Submitted in the Following Month:
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

SUBMITTING CASE CORRECTIONS

The OCCR does not accept modified case submissions generally known as M records. If a case has been submitted and later found that critical pertinent information was left out at the time of abstraction or needs to be corrected, please contact the OCCR data manager by phone or encrypted email with patient information and the updates/corrections that are needed. ***Do not reabstract or resubmit the case.*** *Pertinent Information includes* diagnosis date, date of birth, missing diagnosis and/or treatment at your facility.

SECTION 5

PATIENT INFORMATION

Reporting Facility Number

NAACCR Item #	*Length*	*Source of Standard*
540	10	CoC

Description

Number that identifies the facility reporting the case.

Justification

Used for monitoring data submissions and accuracy of the data.

Coding Instructions

The Oklahoma Central Cancer Registry assigns a unique 3-digit number to every cancer reporter in the State of Oklahoma. This is entered as a 10-digit code with leading zeros. The reporting facility number is either automatically entered by the cancer registry software or it is assigned when files are uploaded to the central registry.

Type of Reporting Source

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
500	1	SEER	SEER Program Coding and Staging Manual

Description

Identifies the source documents used to abstract the majority of information in the tumor being reported. This may not be the source document that identified the case but rather the source document(s) that provided the most complete information.

Justification

This data item records the source of the documents used to abstract the case.

Coding Instructions

Enter the code for the source of the facility and/or documents used to abstract the case.

CODE	LABEL	SOURCE DOCUMENTS	PRIORITY
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records	Hospital inpatient offices/facilities with a comprehensive, unified record • HMO physician office or group • HMO–affiliated freestanding laboratory, surgery, radiation or oncology clinic Includes outpatient services of HMOs and large multispecialty physician group practices with unified records	1
2	Radiation Treatment Centers or Medical Oncology Centers (hospital affiliated or independent)	Facilities with a stand–alone medical 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 a stand–alone medical record There were no source documents from codes 1, 2, 8, or 4.	5
4	Physician's Office/Private Medical Practitioner (LMD)	Physician's office that is NOT an HMO or large multispecialty 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	The cancer was first diagnosed on autopsy. There were no source documents from codes 1, 2, 8, 4, 3, or 5.	7
7	Death Certificate Only	Death certificate 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, 5, or 6.	8
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 were no source documents from codes 1 or 2.	3

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

Definitions

Comprehensive, unified medical record: A hospital or managed health care system that maintains a single record for each patient. That record includes all encounters in affiliated locations.
Stand–alone medical record: An independent facility; a facility that is not a part of a hospital or managed care system. An independent medical record containing only information from encounters with that specific facility.
Managed health plan: Any facility where all of the diagnostic and treatment information is maintained in one-unit record (all records for the patient from all departments, clinics, offices, etc. in a single file with the same medical record number). The abstractor is able to use the unit record when abstracting the case.
Examples: HMOs or other health plan such as Kaiser, Veterans Administration, or military facilities.
Physician office: A physician's office performs examinations and tests. Physician offices may perform limited surgical procedures.
Note: The category "physician's office" also includes facilities that are called surgery centers when surgical procedures under general anesthesia cannot be performed in these facilities.
Surgery center: Surgery centers are equipped and staffed to perform surgical procedures under general

Anesthesia. The patient usually does not stay overnight.
Note: If the facility cannot perform surgical procedures under general anesthesia, code as physician's office.

Priority Order for Assigning Type of Reporting Source
Code the source that provided the best information used to abstract the case.

Example A: A patient is admitted to your hospital and subsequently diagnosed with breast cancer. Code the reporting source to 1 (Facility Inpatient/Outpatient or Clinic). All documents in the medical record are used to abstract case.
Example B: A patient is admitted to your facility and expires. It is unknown at the time of death if the patient has cancer. An autopsy is performed at your facility and kidney cancer is found. Code the reporting source to 6 (autopsy only). The autopsy report is the only document used for cancer information.
Example C: The patient had a biopsy in a physician's office. The only patient record available is the pathology report from a freestanding laboratory. Code the reporting source to 3 [Laboratory Only (hospital–affiliated or independent)]. Reporting source should reflect the lab where this case was identified. The MD office added nothing to the case, not even a confirmation of malignancy.

Date of First Contact

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
580	8	CoC	Standards for Oncology Registry Entry (STORE)

Description
The date of the facility's first contact with the patient (inpatient or outpatient) for diagnosis or treatment of cancer. If the patient admits for reasons other than cancer, the date of first contact is the date that cancer was first suspected during the admission. If the patient has been diagnosed and/or treated for cancer elsewhere and has active cancer, the date of first contact is the date of admission to your facility with active cancer. **Note:** Date of First Contact cannot be a date prior to the date of initial diagnosis

Justification
Used to determine compliance with reporting cases to the Oklahoma Central Cancer Registry within the required 180 days from the date of first contact. It can also be used to determine the time from first contact to date abstracted or date of treatment.

Coding Instructions
- Date format is YYYYMMDD however, most cancer registry software allows the registrar to input the date as MMDDYYYY and will automatically convert the date into the correct format when sent to the state central registry.
    - A date must be entered in this field.
- Autopsy only cases, use the date of death.

Example A: On March 28, 2019, a patient is admitted to the hospital with complaints of abdominal pain and 20-pound weight loss over the last month. A CT of the abdomen and pelvis is performed on March 29, 2019, showing a mass in the colon and a liver lesion that is suspicious for metastatic malignancy. Enter the date of first contact as 03/29/2019.

Example B: A patient presents to your facility on January 13, 2018, for radiation oncology consultation after being diagnosed with cancer elsewhere three weeks prior. Staging scans are ordered and are performed on January 17, 2018. Simulation takes place on January 23, 2018. Radiation therapy begins on January 29, 2018. Enter the date of first contact as 01/29/2018.

Accession Number

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
550	9	CoC	Standards for Oncology Registry Entry (STORE)

Description

A unique number assigned by the reporting facility. It consists of the year in which the patient was first seen at the reporting facility and the sequential order in which the patient was abstracted.

Justification

Protects the patient's identity and allows cases to be identified on a local, state, and national level. The central registry refers to this number when following back to reporting facilities.

Coding Instructions

1. The first four digits consist of the year the patient was first seen at the facility for diagnosis or treatment of cancer reportable to the central cancer registry. The following five digits are assigned in consecutive order in which the case is entered into the registry. Each year accession numbers start over at 00001.
2. **Do not** assign a new accession number for patients who are already in the registry and have been reported to OCCR. Sequence numbers are used to differentiate between multiple primaries for the same patient. All primaries for the same patient in the reporting facility's registry must have the same accession number.

   Example**:** A patient is diagnosed at your facility in 2014 with colon cancer. The accession number was assigned as 201400249. The patient has a second reportable cancer diagnosed in 2018, Lung primary. The accession number is assigned as 201400249. The sequence number is used to differentiate between the two primary cancers.

Note: Some registry software automates entry of the accession number. It is important to note that Web Plus abstraction does not automate this entry and you must maintain a separate list that is easily searchable to avoid assigning the same patient multiple accession numbers. A spreadsheet is recommended. You may create your own or contact OCCR for a template.

Medical Record Number

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2300	11	CoC	NAACCR Data Dictionary

Description

Number used to identify the patient in the reporting facility's medical record system. This should be the number assigned by the hospital's HIM department only and not department-specific numbers.

Justification

Patients are identified within a reporting facility using the medical record number. The central registry refers to this number when following back to reporting facilities.

Coding Instructions

Enter the eleven-digit number used to identify the patient within the medical record on the first admission with a reportable cancer. Medical record number containing less than 11 digits are acceptable.

Class of Case

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
610	2	CoC	Standards for Oncology Registry Entry (STORE)

Description

Class of case reflects the facility's relationship to the patient and its role in the diagnosis and/or treatment of the cancer.

Justification

Separates the reporting facility's cancer cases into analytic and nonanalytic categories. OCCR requires facilities to report both analytic and some nonanalytic cases regardless of accreditation status with the ACoS Commission on Cancer. Class of Case codes required to be reported are 00, 10, 11, 12, 13, 14, 20, 21, 22, 32, and 38. Class of Case 34 and 36 are also required for specific histologies. See Class of Table below for additional guidance.

1. **Analytic cases** (codes 00–22) Cancer diagnosed at the reporting facility or in a staff physician's office and/or received any of the first course treatment at the reporting facility.
   Note: A facility network clinic or outpatient center belonging to the facility is part of the facility.
2. **Non–analytic cases** (codes 30–49 and 99) Cancer diagnosed and received all of the first course of treatment at another facility, or cases which were diagnosed and/or received all or part of the first course of treatment at the reporting facility prior to the registry's reference date (reference date applies to ACoS CoC accredited facilities, facilities striving for ACoS certification, or facilities that follow ACoS standards and do not seek certification).

   Note: Class of case 40 – 49 and 99 are for cases where the patient does not physically present themselves to your facility; these cases are not reportable to OCCR.

Coding Instructions

1. Code the Class of Case that most accurately describes the patient's relationship to the facility.

2. Code 00 applies only when it is known that the patient went elsewhere for treatment. If that information is not available, code Class of Case 10.
3. 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.
4. If the hospital purchases 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 activity) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved have routine admitting privileges or not, as with any other physician.

Class of Case

Analytic Cases		R=Required N=Not Required
Initial diagnosis at the reporting facility or in a staff physician's office		**R**
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere. *Note: 00 only applies when it is known that the patient went elsewhere for treatment. If you do not know this information, you should code Class of Case 10.*	**R**
10	Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS.	**R**
11	Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility.	**R**
12	Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility.	**R**
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.	**R**
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility.	**R**
Initial diagnosis elsewhere		**R**
20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS.	**R**
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.	**R**
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility.	**R**
Non–analytic Cases		
Patient appears in person at reporting facility		
30*	Initial diagnosis and all first course treatment elsewhere AND reporting facility performed a **confirmation biopsy** after being diagnosed on imaging elsewhere. ***Note**: only reportable for confirmation biopsy of initial diagnosis. You must know the patient was clinically diagnosed elsewhere on imaging or physician statement and document such in text. ***DO NOT** report consult only, treatment plan only, staging workup only after initial diagnosis elsewhere.*	**R**

31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement).	**N**
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility for diagnosis or treatment of disease recurrence or persistence (active disease). ***Note**: 32 includes patients that expire at the reporting facility with a reportable active disease that does not meet the criteria for an analytic Class of Case.*	**R**
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active).	**N**
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. ***Reportable only for the following histology and primary sites: squamous intraepithelial neoplasia, grade III (8077/2) to include AIN III (C21.1), VIN III (C51.*) VAIN III (C52.*). LN III/LIN III (C500-C509), PanIN III, PeIN III 2016+. LCIS for CoC accredited hospitals only.***	**R***
35	Case diagnosed before facility's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility.	**N**
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. ***Reportable only for the following histology and primary sites: squamous intraepithelial neoplasia, grade III (8077/2) to include AIN III (C21.1), VIN III (C51.*) VAIN III (C52.*). LN III/LIN III (C500-C509), PanIN III, PeIN III 2016+. LCIS for CoC accredited hospitals only.***	**R***
37	Case diagnosed before facility's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility	**N**
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death. ***Note: 38 should only be used if the reporting facility performs autopsies***	**R**
Patient does not appear in person at reporting facility		
40	Diagnosis AND all first course treatment given at the same staff physician's office.	**N**
41	Diagnosis and all first course treatment given in two or more different offices of physicians with admitting privileges.	**N**
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).	**N**
43	Pathology or other lab specimens only.	**N**
49	Death certificate only (central registry only)	**N**
99	Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).	**N**

Last Name

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
2230	40	SEER	SEER Program Coding & Staging Manual

Description

Identifies the last name of the patient.

Justification

Used by the central registry and reporting facility as a patient identifier.

Coding Instructions

1. Enter the last name in UPPER CASE letters.
2. Blank spaces, hyphens and apostrophes are allowed. Other punctuations are **not** allowed.
3. Truncate the name if longer than 40 characters.
4. If the last name is unknown, do **not** leave the field blank. Enter the last name as UNKNOWN. Every effort should be made to locate a last name in the medical record. UNKNOWN should only be used as a last resort. *Note: document in Text Remarks that last name is unknown.*
5. This field may be updated if the last name changes.

First Name

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
2240	40	SEER	SEER Program Coding & Staging Manual

Description

Identifies the first name of the patient.

Justification

Used by the central registry and reporting facility as a patient identifier.

Coding Instructions

1. Enter the last name in UPPER CASE letters.
2. Blank spaces, hyphens and apostrophes are allowed. Other punctuation is **not** allowed.
3. Truncate the name if longer than 40 characters.
4. If the first name is unknown, do **not** leave the field blank. Enter the first name as UNKNOWN. Every effort should be made to locate a first name in the medical record. UNKNOWN should only be used as a last resort. *Note: document in Test Remarks that first name is unknown.*
5. This field may be updated if the last name changes.

Middle Name

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
2250	40	SEER	SEER Program Coding & Staging Manual

Description

Identifies the middle name or middle initial of the patient.

Justification

Used by the central registry and reporting facility to differentiate between patients with the same first and last names.

Coding Instructions

1. Enter the full middle name. Enter the middle initial if the full middle name is not available.
2. Blank spaces, hyphens and apostrophes are allowed. Other punctuation is **not** allowed.
3. Truncate the name if longer than 40 characters.
4. If the middle name is unknown, or the patient has no middle name, **leave the field blank.** Do **not** enter UNK for unknown, NA for not applicable or NMN for no middle name.

Name-Birth Surname

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
2232	40	NAACCR	SEER Program Coding & Staging Manual

Description

Last name (surname) of patient at birth, regardless of gender or marital status.

Justification

Used by the central registry and reporting facility to link a single patient's cancers when a name change has occurred. It is also useful in identifying Spanish/Hispanic origin.

Coding Instructions

1. Enter the maiden name of female patients who are or have been married if the information is available. Do **not** enter both first name and maiden name.
2. Blank spaces, hyphens, apostrophes, and other punctuation is allowed.
3. If the maiden name is unknown or the patient has no maiden name, **leave the field blank.**

Alias Name

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2280	40	NAACCR	NAACCR Data Dictionary

Description

Records an alternate name or "AKA" (also known as) used by the patient, if known. Note that maiden name is entered in Name--Maiden [2390].

Justification

A patient may use different names or nicknames. These names are used for matching multiple records for the same patient.

Coding Instructions

1. If the patient has no alias name, **leave the field blank.**
2. Enter only the part of the patient's name that is used as an alias: First, Last or Last First.
3. If the patient uses an alias for both first and last names, enter alias last name followed by a space, then the alias first name.
4. Blank spaces, hyphens, apostrophes, and other punctuation is allowed.
5. No other special characters are allowed.

Example

1. Robert Smith uses the name Bob Smith. Enter Bob in NAME--ALIAS.
2. Francis Brown uses the name Francis Smith. Enter Smith in NAME--ALIAS.
3. Stanley Lieber uses the name Stan Lee. Enter Lee Stan in NAME--ALIAS.

Street Address at Diagnosis

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
2330	60	SEER	SEER Program Coding & Staging Manual

Description

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

Justification

Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes. A patient's physical address takes precedence over a post office box. If a patient has multiple primary tumors the address may be different if diagnosed at different times. Do not update this field if the patient moves after diagnosis.

Coding Instructions

1. Record the number and street address, or the rural mailing address of the patient's usual residence, when the cancer was diagnosed. If the address contains more than 60 characters, omit the least important element, such as the apartment number or space number.
2. Record the physical number and street address of the patient at diagnosis. If the patient also has a Post Office (PO) Box address, record the PO Box address in Address at Diagnosis--*Supplemental*.
3. Do not omit elements needed to locate the address in a census tract, such as house number, street, direction or quadrant and street type (street, drive, lane, road, etc.).
4. Periods, slashes, hyphens, and pound signs may be used in this field.
5. Only use the post office box or the rural mailing address when the physical address is not available. Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Every effort should be made to obtain complete valid address information.
6. Only use standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory,* published by the U.S. Postal Service (USPS). A complete list of abbreviations can be found in Appendix C of USPS Pub 28.

Street Address Abbreviations

Abbreviation	Description	Abbreviation	Description	Abbreviation	Description
APT	Apartment	FL	Floor	S	South
AVE	Avenue	B	North	SE	Southeast
BLDG	Building	NE	Northeast	SQ	Square
BLVD	Boulevard	NW	Northwest	ST	Street
CIR	Circle	PLZ	Plaza	STE	Suite
CT	Court	PK	Park	SW	Southwest
DEPT	Department	PKWY	Parkway	UNIT	Unit
DR	Drive	RD	Road	W	West
E	East	RM	Room		

7. If the patient's address is not available in the medical record, enter **NO ADDRESS** or **UNKNOWN**. Do not leave blank. *Every effort should be made to obtain a valid address.* Record city as **Unknown**, states as **ZZ**, zip code as **99999** and county (FIPS) code as **999**.
8. Address at diagnosis should **never** be changed.

Please refer to the SEER Program Coding & Staging Manual pg. 46 for instructions on:

- Changing the **current** address
- Legal status and citizenship
- Ambiguous residences: more than one residence (summer and winter homes), no usual residence (transients, homeless), persons away at school, persons in institutions, persons in the Armed Forces and on Maritime Ships
- Coding Country and State

Address at Diagnosis – Supplemental

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
2335	60	SEER	SEER Program Coding & Staging Manual

Description

Provides the ability to store additional address information such as the name of a place or facility (for example a nursing home, apartment complex, jail, or PO Box residential or other mailing address at the time of diagnosis.

Justification

A registry may receive the name of a facility instead of a proper street address containing the street number, name, direction, and other elements necessary to locate an address on a street file for the purpose of geocoding.

Coding Instructions

1. Record the place or facility (for example, a nursing home or name of an apartment complex) of the patient's usual residence when the tumor was diagnosed.
2. Do not use this data item to record the number and street address of the patient.

City at Diagnosis

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
70	50	CoC	SEER Program Coding & Staging Manual

Description

Identifies the name of the city or town in which the patient resides at the time of diagnosis.

Justification

Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes.

Coding Instructions

1. Record the patient's city or town at diagnosis.

2. If the city or town is unknown, record **UNKNOWN**, do not leave blank.
3. Do not use punctuation, special characters, or numbers.

State at Diagnosis

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
80	2	CoC	Standards for Oncology Registry Entry (STORE)

Description

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

Justification

It allows for analysis of geographic and environmental studies and inclusion in state and national cancer publications/studies.

Coding Instructions

1. Record the patient's state at diagnosis using the appropriate two-letter abbreviation. Refer to the code table in the STORE Manual pages 46-47 or the SEER Program Coding and Staging Manual Appendix B: Country and State Codes https://seer.cancer.gov/tools/codingmanuals/index.html
2. If the state is unknown, record **ZZ** for **UNKNOWN**, do not leave blank.
3. Do not use punctuation, special characters, or numbers.

Postal Code at Diagnosis

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
100	9	CoC	Standards for Oncology Registry Entry (STORE)

Description

Identifies the postal code of the patient address at the time of diagnosis.

Justification

Allows for the analysis of cancer clusters, environmental studies, or health services research.

Coding Instructions

1. Enter the 5–digit zip code at time of diagnosis. Enter the 4–digit extended zip code if known. **Do not enter a hyphen** between the first five digits and the last four digits if entering a 9–digit zip code. Blanks are allowed for the extended 4–digits if it is unknown.
2. Unknown zip codes may be queried using the USPS Look Up a Zip Code™ or https://www.getzips.com/zip.htm

County at Diagnosis

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
90	3	CoC	Standards for Oncology Registry Entry (STORE)

Description

Identifies the county of residence at the time of diagnosis.

Justification
It allows for the analysis of cancer clusters, geographic or environmental studies and health services research.

Coding Instructions
1. Record the appropriate 3–digit code for county of residence.
2. Use codes issued by the Federal Information Processing Standards (FIPS) publication, Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas. More information can be found in the NAACCR Data Standards and Data Dictionary under FIPS Codes for Counties and Equivalent Entities.
3. Use code 998 if the patient is or was a resident of a state other than Oklahoma at time of their initial diagnosis.

Country at Diagnosis

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
102	3	CoC	Standards for Oncology Registry Entry (STORE)

Description
Identifies the country of residence at the time of diagnosis.

Justification
May be used for epidemiological purposes.

Coding Instructions
1. Record the appropriate 3–digit code for country of residence.
2. Refer to the SEER Program and Coding Manual: Appendix B https://seer.cancer.gov/tools/codingmanuals/index.html

Social Security Number

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
2320	9	CoC	SEER Program Coding & Staging Manual

Description
Identifies the patient by social security number

Justification
The OCCR uses this data item for internal processes such as linking for resolution of duplicate persons and consolidation.

Coding Instructions
1. Record the social security if known. ***Please double check for accuracy.***
2. If the social security number is unknown, record all **9's –999999999.**
3. **Non-CoC accredited facilities only:** If only the last four digits are known, record the first five digits as **8's– 888881234** if the facility is state report only. *CoC accredited facilities should continue to use all 9's and document the last four digits in Text-Remarks.*

4. Every effort should be made to locate a social security number in the medical record.
5. The Medicare Beneficiary Identifier is not the patient's social security number.
6. No hyphens or slashes are allowed.

Invalid SSN

Numbers with the criteria below are invalid and are not assigned by the social security administration. If the medical record has a number matching this criterion, please enter the number as unknown.

- First three digits = 000
- First three digits = 666
- Fourth and fifth digits = 00
- Last four digits = 0000
- First digit = 9 (except when first digit of 999999999)

Date of Birth

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
240	8	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

Identifies the date of birth of the patient.

Justification

The OCCR uses this data item for matching records and is also used to calculate the age at diagnosis. It is useful when analyzing tumors according to age cohort.

Coding Instructions

1. Age at diagnosis must be entered.
2. The NAACCR format for this data item is YYYYMMDD, however some registry software allow you to code MMDDYYYY and will automatically convert the format for you when the abstract is selected for data submission.
3. If only the patient's age is known, calculate the year of birth from the age and year of diagnosis. Record as YYYY, leaving the MM and DD blank.
4. Every effort should be made to locate a date of birth in the medical record.

Birthplace – State

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
252	2	NAACCR	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

USPS abbreviation for the state, commonwealth, U.S. possession; or Canada Post abbreviation for the Canadian province/territory in which the patient was born.

Justification
Birthplace is used to ascertain ethnicity, identify special populations at risk for certain types of cancers, and for epidemiological analyses.

Coding Instructions
1. When available, record the patient's state of birth. Record unknown as ZZ.
2. Do NOT assume current state of residence is the state of birthplace. Place of birth must be specifically stated in the medical record to be coded.
3. A complete list of country and state codes can be found in the SEER Program Coding and Staging Manual Appendix B.

Birthplace – Country

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
254	3	NAACCR	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description
Code for the country in which the patient was born.

Justification
Place of Birth is helpful for patient matching and can be used when reviewing race and ethnicity. It is important for algorithms for inputting race and ethnicity. It allows for more specific definition of the population being reported. Birthplace has been associated with variation in genetic, socioeconomic, cultural, and nutritional characteristics that affect patterns of disease.

Coding Instructions
1. When available, record the patient's country of birth. Record unknown as ZZU.
2. Do NOT assume current residence is the country of birth. Place of birth must be specifically stated in the medical record to be coded.
3. A complete list of country and state codes can be found in the SEER Program Coding and Staging Manual Appendix B.

Race 1–5

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
160 - 164	2	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description
Identifies the primary race of the person.

Justification
Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison. The five race fields allow for coding of multiple races consistent with the Census 2000.

Coding Instructions

1. Code all 5 race data items.
2. Race is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. If the patient has multiple tumors, all records must have the same race code.
3. Use the following priority order for coding race:
    a. The patient's self–declared identification
    b. Documentation in the medical record
    c. Death certificate
4. If the patient is White or Caucasian with no other documented race, code Race 1 as white and race 2–5 as 88, regardless of the place of birth.
5. If there is a statement that the patient is Hispanic or Latino(a) and no further information is available, code Race 1 as white and race 2–5 as 88, regardless of the place of birth.
   ***Note**:* Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually White. Do NOT code a patient stated to be Hispanic or Latino as 98 (Other Race) in Race 1 and 88 in Race 2 – Race 5.
6. If the patient is multiracial, code all races using Race 2–5 and remaining race items as 88.
7. If the patient is multiracial and one race is white, code the other race(s) first with white in the net race data item.
8. If the person is multiracial and one of the races is Hawaiian, code Hawaiian as Race 1, followed by the other race(s).
9. A known race code must not be duplicated.
10. If Race 1 is 99, then Race 2–5 must be 99.
11. Code **07** takes priority over all other codes.
12. Codes **02–32, 96–98** take priority over code **01.**
13. Code only the specific race when both a specific race code and a non–specific race code apply.
    a. Codes 04–17 take priority over code 96
    b. Codes 16–17 take priority over code 15
    c. Codes 20–32 take priority over code 97
    d. Codes 02–32 and 96–97 take priority over code 98
    e. Code 98 takes priority over code 99
14. Assign code **02** (Black) when the stated race is African American, Black, or Negro.
15. Assign code **03** for any person stated to be:
    a. Native American (Western Hemisphere) OR
    b. Indian, whether from North, Central, South, or Latin America
16. Assign a specific code when a specific Asian race is stated. Do not use code 96 when a specific race is known.
17. Code the race based on birthplace information when the race is recorded as Oriental, Mongolian, or Asian and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation.
    Example 1: Race is recorded as Asian, and the place of birth is recorded as Japan. Code race as 05 (Japanese) because it is more specific than 96.
    Example 2: The person describes himself as an Asian–American born in Laos. Code race as 11 (Laotian) because it is more specific than 96.

18. Do not use codes 96, 97 or 98 for "multi–racial".

- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose-Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- If Race Coding System–Current [170] is less than six (6) for cases diagnosed prior to January 1, 2000, then Race 2 through Race 5 must be blank.
- If a patient diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then Race Coding System–Current must be seven (7), and data items Race 2 through Race 5 that do not have specific race recorded must be coded 88.

Refer to Appendix D in SEER Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics when race is unknown or not stated in the medical record and birthplace is recorded. In some cases, race may be inferred from nationality. Use Appendix D to identify nationalities from which race codes may be inferred. https://seer.cancer.gov/tools/codingmanuals/

Spanish/Hispanic Origin

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
190	1	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

This data item is used to identify patients with Spanish/Hispanic surname or of Spanish origin.

Justification

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

Coding Instructions

1. Coding Spanish Surname or Origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.
2. Use all information to determine the Spanish/Hispanic Origin including:
    a. The ethnicity stated in the medical record
        i. Self–reported information takes priority over other sources of information
    b. Hispanic origin stated on the death certificate
    c. Birthplace
    d. Information about life history and/or language spoken found in the abstracting process
    e. A last name or maiden name found on a list of Hispanic/Spanish names

3. Assign code 6 when there is more than one ethnicity/origin (multiple codes), such as Mexican (code 1) and Dominican Republic (code 8). There is no hierarchy among the codes 1–5 or 8.
4. Assign code 7 when the only evidence of the patient's Hispanic origin is a surname or maiden name and there is no evidence that the patient is not Hispanic. Code 7 is ordinarily for central registry use only.
5. Portuguese, Brazilians, and Filipinos are not presumed to be Spanish or non–Spanish. Assign code 7 when the patient is Portuguese, Brazilian, or Filipino and their name appears on a Hispanic surname list. Assign code 0 when the patient is Portuguese, Brazilian, or Filipino and their name does NOT appear on a Hispanic surname list.
6. Assign code 9 for death certificate only (DCO) cases when Spanish/Hispanic origin is unknown.

Sex

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
220	1	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

Code for the sex of the patient.

Definitions

- **Intersex**: A person born with ambiguous reproductive or sexual anatomy: chromosomal genotype and sexual phenotype other than XY–male and XX–female. An example is 45,X/46,XY mosaicism, also known as X0/XY mosaicism.
- **Transsexual**: A person who was assigned one gender at birth based on physical characteristics but who self-identifies psychologically and emotionally as the other gender.

Coding Instructions

1. Assign code 3 for:
    a. Intersexed (persons with sex chromosome abnormalities)
    b. Hermaphrodite Note: Hermaphrodite is an outdated term.
2. Codes 5 and 6 may be used for cases diagnosed prior to 2015.
3. Codes 5 and 6 have priority over codes 1 and 2.
4. Assign code 5 for transsexuals who are natally male or transsexuals with primary site of C600–C639.
5. Assign code 6 for transsexuals who are natally female or transsexuals with primary site of C510–C589.
6. Assign code 4 for transsexuals with unknown natal sex and primary site is not C510–C589 or C600–C639.
7. When gender is not known:
    a. Assign code 1 when the primary site is C600–C639.
    b. Assign code 2 when the primary site is C510–C589.
    c. Assign code 9 for primary sites not included above.

Text Usual Occupation

NAACCR Item #	*Length*	*Source of Standard*	*National Program of Cancer Registries*
310	100	NPCR	https://www.cdc.gov/niosh/docs/2011-173/pdfs/2011-173.pdf

Description

Text area for information about the patient's usual occupation, also known as usual type of job or work.

Justification

Used to identify new work–related health hazards; serves as an additional measure of socioeconomic status; identifies occupational groups in which cancer screening or prevention activities may be beneficial.

Coding Instructions

1. Record as available in the medical record. Be descriptive, specific, and complete.
2. Record the patient's usual occupation (i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor).
3. Do not record "retired." If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation. If no occupation is documented in the medical record or there is no indication of the occupation, record as **UNKNOWN.** ***Do not*** record NA, N/A, or Unavailable or leave this field blank.
4. This data item may be updated if information providing a more accurate industry becomes available at a later date.
5. Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.

Please refer to *A Registrar's Guide to Coding Industry and Occupation*
https://www.cdc.gov/niosh/docs/2011-173/pdfs/2011-173.pdf

Examples

Inadequate	**Adequate**
Teacher	High School Teacher
Laborer	Residential bricklayer
Worked in a warehouse	Worked in a shipping department
Self–employed	Self–employed landscaper

Text Usual Industry

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
320	100	NPCR	https://www.cdc.gov/niosh/docs/2011-173/pdfs/2011-173.pdf

Description

Text area for information about the patient's usual industry, also known as usual kind of business/industry.

Justification

Used to identify new work–related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or worksite–related groups in which cancer screening or prevention activities may be beneficial.

Coding Instructions

1. Record as available in the medical record. Be descriptive, specific, and complete.
2. Record the primary type of activity carried on by the business/industry at the location where the patient was **employed for the greatest number of years** *(longest held)* before diagnosis of the cancer. Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that performs more than one of these components.
3. If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient for facility registrars to record the name of the company (with city or town) in which the patient performed his/her usual industry. In these situations, if resources permit, a central or regional registry may be able to use the employer's name and city/town to determine the type of activity conducted at that location.
4. This data item may be updated if information providing a more accurate industry becomes available at a later date.
5. If no information is available regarding the industry in which the reported occupation was carried out, record as **UNKNOWN**. ***Do not*** record NA, N/A, Unavailable or Retired.
6. If the patient was not a student or homemaker and had never worked, record "never worked" as the usual industry.
7. Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.

Examples

Inadequate	**Adequate**
Automobile industry	Automobile manufacturing
Manufacturing	Automobile manufacturing
ABC, Inc	ABC, Inc., Los Angeles, CA

Please refer to *A Registrar's Guide to Coding Industry and Occupation*
https://www.cdc.gov/niosh/docs/2011-173/pdfs/2011-173.pdf

Tobacco Use Smoking Status

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
344	1000	NPCR	SEER Program Coding & Staging Manual

Description

Record the patient's past or current use of tobacco (cigarette, cigar and/or pipe). Tobacco smoking history can be obtained 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.

Justification

Cigarette smoking is the leading preventable cause of death in the US and a major risk factor for cancer. In addition to describing tobacco use patterns and trends in patients diagnosed with cancer, the collection of cigarette smoking history can enable researchers to better understand the association of cigarette smoking to cancer outcomes. Cigarette use data at diagnosis may help health professionals better understand how tobacco use impacts cancer prognosis, including how smoking is related to effectiveness of treatment and survival. In addition, this information is important to target and assess tobacco control efforts to cancer survivors and their families.

Coding Instructions

1. Record the past or current use of tobacco.
    a. Tobacco use includes cigarette, cigar, and/or pipe.
2. Do not record the patient's past or current use of e-cigarette vaping devices.
3. Assign code 2 when the medical record indicates patient has smoked tobacco in the past but does not smoke now
    a. If there is evidence in the medical record that the patient quit recently (within 30 days prior to diagnosis), assign code 1: current smoker. The 30 days prior information, if available, is intended to differentiate patients who may have quit recently due to symptoms that lead to a cancer diagnosis.
4. Assign **code 9** when the medical record only indicates **"No"**

Code	Description
0	Never smoker
1	Current smoker
2	Former smoker
3	Smoker, current status unknown
9	Unknown if ever smoked

Text–Remarks

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
260	1000	NPCR	http://datadictionary.naaccr.org/default.aspx?c=10&Version=22

Description

Text area for information that is given only in coded form elsewhere or for which the abstract provides no other place. Overflow data can also be placed here. Problematic coding issues can also be discussed in this section. ***Note: when using solid tumor rules to determine the number of primaries and/or histology, you MUST document the module and rule that was used.***

Justification

- Information that may be texted here (if not texted elsewhere) includes patient's social history (smoking, alcohol use, etc.), Native American tribal affiliation (if known), details related to patient death such as place of death, date of death and where that information was found or obtained. Known history of cancer(s) for the patient, if not documented in physical exam text, should include date of diagnosis, primary site, type of cancer and where the patient was diagnosed to the greatest extent possible; if details are unknown or estimated, state information is unknown or estimated
- NAAACR approved abbreviations should be used (see the NAACCR Data Dictionary Abbreviations and Acronyms and Context Sensitive Abbreviations)
- Do not repeat information from other text fields.
- For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- Do not include irrelevant information.
- Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.

Sequence Number

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
560	2	CoC	Standards for Oncology Registry Entry (STORE)

Description

Used to indicate the order in which multiple reportable neoplasms (malignant and non-malignant) for a single person over their lifetime without regard to when or where the cancer was diagnosed. Sequence Number 00 indicates that the person has only one malignant neoplasm in his lifetime. Sequence Number 01 indicates the first of two or more malignant neoplasms, while 02 indicates the second of two or more malignant neoplasms, and so on. Because the time period of Sequence Number is a person's lifetime, reportable neoplasms not included in the hospital registry are also allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the hospital registry's reference date. Similarly, Sequence Number 60 indicates the patient has only one non-malignant neoplasm, and Sequence Number 61 represents the first of multiple non-malignant neoplasms.

Justification

Used to distinguish among cases with the same accession number and to select patients for certain studies according to single or multiple tumors.

Coding Instructions

1. Codes 00-59 and 99 indicate neoplasms of malignant (in situ or invasive) behavior (Behavior equals 2 or 3). Codes 60-88 indicate neoplasms of non–malignant behavior (Behavior equals 0 or 1).
2. Code 00 if the patient has a single reportable primary. If the patient develops a subsequent invasive or in situ reportable tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially.
3. Code 60 only if the patient has a single non–malignant reportable primary. If the patient develops a subsequent non–malignant reportable primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent non–malignant reportable primaries sequentially.
4. Any tumor in the patient's past which is reportable or reportable–by–agreement at the time the current tumor is diagnosed must be taken into account when sequencing subsequently accessioned tumors. However, do not reassign sequence numbers if one of those tumors becomes non–reportable later.
5. Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence

Timing Rule

If two or more invasive or in situ reportable primaries are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.

Primary Payer at Diagnosis

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
630	2	CoC	Standards for Oncology Registry Entry (STORE)

Description

Primary payer/insurance carrier at the time of initial diagnosis and/or treatment at the reporting facility.

Justification

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

Coding Instructions

1. Record the type of insurance documented on the patient admission page.
2. When multiple insurances are listed for the admission, code the first insurance.
3. Code the insurance listed on the admission page that is closest to the date of diagnosis. Do not update the insurance if it changes.
4. Codes 21 and 65–68 should be used for patients diagnosed on or after January 1, 2006.

Medicare Beneficiary Identifier

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
2315	11	NAACCR	NAACCR Data Dictionary

Description

Congress passed the Medicare Access and CHIP Reauthorization ACT to remove Social Security Number (SSN) from Medicare ID card and replace the existing Medicare Health Insurance Claim Numbers with a Medicare Beneficiary Identifier (MBI). The MBI will be a randomly generated identifier that will not include a SSN or any personal identifiable information.

Justification

The MBI is a step to minimize the risk of identity theft for Medicare beneficiaries and reduce opportunities for fraud. In early 2018, CMB plans to issue new Medicare cards with an MBI. A Health Insurance Claim Number will still be assigned to each Medicare beneficiary and will still be used for internal data exchanges between CMS and the states, but the new MBI must be used in all interactions with the beneficiary, the provider community and all external partners. The collection of the MBI should not change how registries currently collect SSN.

Coding Instructions

Note: The Medicare Beneficiary Identifier (MBI) is randomly generated and has 11 characters, consisting of numbers and letters, entered without dashes. The MBI format: https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI-with-Format.pdf

SECTION 6

CANCER INFORMATION

Prior to beginning the abstract

It is helpful to read the general instructions at the beginning of each of the following references:

NAACCR Data Standards and Data Dictionary
STORE Manual
ICD-O Manual
Site Specific Data Items Manual
Grade Manual
Solid Tumor Rules

This will help you understand what needs to be considered before you start the first abstract and to refresh the information in question later in abstracting.
Many of these sources provide a means for submitting inquiries to help clarify the requirements. STORE and SEER offer collections of previously addressed questions and answers that can be useful for clarification. These resources are the CAnswer forum and SEER Inquiry (SINQ). You must have an account to view and post questions on the CAnswer forum. Registration is free. Helpful websites are listed in Section 1.

Date of Initial Diagnosis

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
390	8	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

Date of initial diagnosis of the reportable tumor by a recognized medical practitioner, whether clinically or microscopically confirmed. Initial diagnosis may take place at the reporting facility or elsewhere.

Justification

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

Coding Instructions

1. Date format:

YYYYMMDD	complete date is known
YYYYMM	Year and month are known/estimated day is unknown
YYYY	Year is known/estimated; month and day cannot be estimated or are unknown
Blank	Year, month and day cannot be estimated or are unknown

2. Cases with an unknown year of diagnosis cannot be transmitted to NPCR and NAACCR by the central registry. It is very important to do everything possible to determine the year of diagnosis.
3. The initial diagnosis can be from a clinical diagnosis using ambiguous reportable terminology. Use this date as the initial date of diagnosis. If later confirmed by a pathology specimen, do not update the initial date of diagnosis. The date remains the date reportable diagnostic terms were used. Refer to the list of ambiguous terms under Reportable Diseases and Casefinding.

4. Date of diagnosis based on pathology report is the date the specimen was taken and not the date the pathology report was read, created, or finalized.
5. If in retrospect, a recognized medial practitioner states the patient had cancer at an earlier date, record the date of diagnosis as the earlier date. If documentation later shows an earlier date of diagnosis, record the date from the documentation. *It is important that the text documentation supports the date of initial diagnosis that is recorded in the abstract.*
6. For autopsy and death certificate only cases, the date of initial diagnosis will be the date of death.
7. If the patient receives treatment prior to a definitive diagnosis, use the date that treatment was started as the date of initial diagnosis.
8. Positive **tumor markers** alone are **not** diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.
9. Use the date of suspicious cytology when the diagnosis is proven by subsequent biopsy, excision, or other means.
   Example: Cytology suspicious for malignancy 01/12/2022. Diagnosis of carcinoma per biopsy on 02/06/2022. Record 01/12/2022 as the date of diagnosis.

   Note 1: "Ambiguous" cytology means that the diagnosis is preceded by an ambiguous term such as apparently, appears, compatible with, etc.
   Note 2: Do not use ambiguous cytology **alone** for case ascertainment.

Estimating Dates

If an exact date is not available, use all the information available to calculate the month and year of diagnosis. After applying these rules, you should rarely have a blank date. *Blank dates are strongly discouraged as these cases are not counted in Oklahoma's annual cancer incidence.*

Documentation	Date code/description
Spring	April (04)
Summer or Middle of the Year	July (07)
Fall or Autumn	October (10)
Winter	Determine if this means the beginning or end of the year. Use December (12) or January (01) as determined.
Early in the Year	January (01)
Late in the Year	December (12)
Recently	Use the year and month of admission and leave the day blank. If the patient was admitted during the first week of a month, use the previous month.
Several Months Ago	If the patient was not previously treated or if first course treatment started elsewhere and was continued at the reporting facility, assume the case was first diagnosed three months before admission with day unknown (blank).
A Couple of Years	Code two years earlier
A Few Years	Code three years earlier

Example: A patient was admitted to your facility on June 15, 2018. The History and Physical states the patient has lung carcinoma diagnosed about two months ago. Record the date of diagnosis as 04/ /2018.
Example: A patient was admitted to your facility on October 30, 2019. History and Physical states the patient has bone metastasis from prostate cancer diagnosed in the spring. Record the date of diagnosis as 04/ /2019.
Example: On February 05, 2018, a mammogram reveals a mass in the lower inner quadrant of the patient's left breast. The radiologist's impression states compatible with carcinoma. On February 15, 2018, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma. Record the date of diagnosis as 02/05/2018.

Morphology ICD-O-3: Type and Behavior

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
522, 523	4, 1	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description
Histologic Type ICD–O–3 describes the microscopic composition of cells and/or tissue for a specific primary. Behavior Code describes the malignant potential of the tumor, ranging from /0 benign to /3 malignant (invasive).

Justification
Histology is a basis for staging and the determination of treatment options. It also affects the prognosis and course of the disease. It assists in identifying multiple primaries.

Standard References for Histology Codes in Priority Order
Solid Tumor Rules
https://seer.cancer.gov/tools/solidtumor/
ICD-O-3.2
https://www.naaccr.org/icdo3/
Hematopoietic and Lymphoid Neoplasm Coding Manual
https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf
Hematopoietic and Lymphoid Neoplasm Database
https://seer.cancer.gov/seertools/hemelymph/

Note: A definitive solid tumor histology can be coded only after the determination of single vs. multiple primaries has been made. Refer to Solid Tumor Rules to determine the number of primaries for solid tumors, as well as coding solid tumor histology. Refer to the Hematopoietic and Lymphoid Neoplasm Manual and Database to determine the number of hematopoietic primaries, as well as histology.

Coding Instructions

Solid Tumor Manual

Use the Solid Tumor Manual to determine the number of primaries first, then the definitive histology https://seer.cancer.gov/tools/solidtumor/

1. Apply the general instructions for coding histologic type in the Solid Tumor Rules
2. Apply the site-specific histology coding rules in the Solid Tumor Rules

Primary site groupings currently available for 2018 STR: Colon, Head and Neck, Kidney, Lung, Malignant CNS and Peripheral Nerves, Non-Malignant CNS, Urinary Sites and Cutaneous Melanoma

> ***Note:*** Do not use these rules to determine case reportability, tumor grade or behavior.

ICD-O-3 Changes Effective January 1, 2024

https://www.naaccr.org/icdo3/

There are no ICD-O-3 changes for 2025. You will continue to use the 2024 coding guidelines and tables for diagnosis year 2025 cases.

The 2024 ICD-O-3.2 Update Guidelines includes comprehensive tables listing changes to ICD-O-3.2 including new ICD-O codes, terminology and reportability changes effective for cases diagnosed 1/1/2024 forward. The 2023 update represents changes identified in recently published 5th Ed WHO Classification of Tumors books. Included in these guidelines are instructions for using the tables together with ICD-O-3.2.

Note: Do not use the printed or PDF version of the ICD-O manual to determine histology for cases diagnosed 01/01/2018 and forward. If the Solid Tumor Rules instruct you to use the ICD-O-3.2, use the Excel spreadsheet and coding tables.

Use the Coding Instructions for Hematopoietic and Lymphoid Neoplasms (9530/3-9993/3):

1. Search the database to determine reportability https://seer.cancer.gov/seertools/hemelymph/
2. Use the database to code primary site, histology, grade
3. Use the *Hematopoietic and Lymphoid Neoplasms* coding manual and not the online database to determine the number of primaries. Only use the Multiple Primaries Calculator in the online database when the manual instructs you to use it. https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

Behavior Coding Instructions

Code	Description
0	Benign (for use with intracranial and CNS site only beginning with 2004)
1	Uncertain whether benign or malignant, borderline malignancy, low malignant potential, and uncertain malignant potential
2	Carcinoma in situ; intraepithelial; noninfiltrating; noninvasive
3	Malignant, primary and/or metastatic site; Invasive

Primary Site

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
400	4	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

Identifies the primary site of the cancer. This is the site in which the cancer originated or began. A *metastatic* site indicates that the primary (originating) cancer has spread from the original site to other areas in the body.

Justification

Identifies the primary site of the cancer

Coding Instructions

Resources for Coding Primary Site for Solid Tumors, in priority order

1. ICD-O
2. SEER Program Manual
    a. Including Coding Guidelines in Appendix C
3. Solid Tumor Rules

Physician Priority Order for Coding Primary Site for Solid Tumors

As a general rule, the surgeon is usually in a better position to determine the site of origin compared to the pathologist. The surgeon sees the tumor in its anatomic location, while the pathologist is often using information given to him/her by the surgeon and looking at a specimen removed from the anatomic landmarks. However, when a pathologist is looking at an entire organ, such as the pancreas, he/she may be able to pinpoint the site of origin within that organ.

> *Example*: The surgeon states during a pancreatectomy that the primary site is body of pancreas while the pathologist states in their CAP Synoptic Reports that the primary site is neck of pancreas. In the case of pancreas body vs. neck, the neck is a thin section of the pancreas located between the head and the body. It may be a matter of opinion whether a tumor is located in the "body" vs. the "neck." In this example, we would give preference to the surgeon and assign the code for body of pancreas, C251.

Record the ICD-O-3 topography code for the site of origin. The current Solid Tumor Rules contain additional coding instructions for some primary sites, including Head and Neck, Lung and Urinary.

Coding Instructions for Solid Tumors

See the Coding Guidelines for Topography and Morphology in the introduction of the ICD-O-3 for additional details. Refer also to the current Solid Tumor Rules for selected primary site coding instructions.

1. Use all available information in the medical record to code the site (including subsite)
2. Code the site in which the primary tumor **originated**, even if it extends onto/into an adjacent subsite
   a. Primary site should always be coded to reflect the site of origin according to the medical opinion on the case. Look for information about where the neoplasm originated. Always code the primary site based on where the tumor arose / site of origin.
   b. Site of origin may be indicated by terms such as "tumor arose from…," "tumor originated in…," "tumor emanated from…" or similar statements
   c. Site of origin is **not** necessarily the site of a biopsy
   d. Tumors may involve one or more sites. The primary site should reflect the site where the tumor arose rather than all sites of involvement (sites of involvement is collected in staging)

      Example 1: Final diagnosis is adenocarcinoma of the upper lobe of the right lung. Code the topography to lung, upper lobe (C341).

      Example 2: The patient has a 4 cm tumor in the right breast. The tumor originated in the upper inner quadrant and extends into the lower inner quadrant. Code the primary site to upper inner quadrant of breast (C502).

      Example 3: Patient has a right branchial cleft cyst; the pathology report identifies an adenocarcinoma arising in an ectopic focus of thyroid tissue within the branchial cleft cyst. Thyroidectomy pathology is negative. Code the primary site to branchial cleft (C104).

      Example 4: The patient had a total hysterectomy with a bilateral salpingo-oophorectomy ten years ago for non-cancer reasons. She now has widespread cystadenocarcinoma in the peritoneum. Code the primary site to peritoneum, NOS (C482). (The chart may or may not state that the patient has extra-ovarian carcinoma.)

      Example 5: Pathology report shows adenocarcinoma arising in a patch of endometriosis on the sigmoid colon. Code the primary site to sigmoid colon (C187), the site in which the cancer originated.

      Example 6: The patient has a left lower lip wedge excision showing invasive squamous cell carcinoma at the mucocutaneous junction. There is no further information in operative report or pathology report regarding the location of this tumor that would indicate this is a skin primary. Assign C001, external lower lip. C001 includes vermilion border of lower lip. Vermilion border is synonymous with mucocutaneous junction.
3. Do not adjust the primary site code to fit staging or any other data items
4. Code the last digit of the primary site code to '8' when a single tumor overlaps an adjacent subsite(s) of an organ, and the point of origin cannot be determined.

   Example: The patient has a primary tumor of the cervicothoracic esophagus, and the point of origin is unknown. Code the primary site to C158.

Note: Skin cancers overlapping sites in the head and neck ONLY.

a. Assign the primary site code for the site where the bulk of the tumor is or where the epicenter is; do **not** use code C448.
b. Single tumor overlapping a reportable site and a non-reportable site: Determine the site of origin or the site with the greatest involvement
    i. If the site of origin/site with greatest involvement is the reportable site, report the case and assign the appropriate topography code
    ii. If the site of origin/site with greatest involvement is the non-reportable site, do not report the case If the site of origin/site with greatest involvement cannot be determined, do not report the case because you cannot confirm reportability

    Example: Squamous cell carcinoma overlapping skin and vermillion of upper lip. If the site of origin is the vermillion, report the case. If the site of origin cannot be determined and more than 50% of the lesion is on the vermillion, report the case. If less than 50% of the lesion is on the vermillion, do not report the case. If the site with the greatest involvement cannot be determined, do not report the case.

5. Code the site of the invasive tumor when there is an invasive tumor and in situ tumor in different subsites of the same anatomic site
   Example 1: Patient has an invasive breast tumor in the upper-outer quadrant of the left breast and in situ tumor in multiple quadrants of the left breast. Code the primary site to C504 (upper outer quadrant of breast).
   Example 2: Patient has in situ Paget disease of the right nipple and invasive duct carcinoma of the lower inner quadrant of the right breast. Code the primary site to C503 (lower inner quadrant).
6. Code the last digit of the primary site code to '9' for single primaries, when multiple tumors arise in different subsites of the same anatomic site and the point of origin cannot be determined
   Example 1: During a transurethral resection of the bladder (TURB), the physician describes multiple papillary tumors in the bladder neck (C675) and the lateral wall of the bladder (C672). Code the primary site as bladder, NOS (C679).
   Example 2: Patient has an infiltrating duct tumor in the upper outer quadrant (C504) of the right breast and another infiltrating duct carcinoma in the lower inner (C503) quadrant of the right breast. Code the primary site as breast, NOS (C509).
7. Some histology/behavior terms in ICD-O-3.2 have a related site code in parentheses; for example, hepatoma (C220)
    a. Code the site as documented in the medical record and ignore the suggested ICD-O-3.2 code when a primary site is specified in the medical record

    Example: The path report says "infiltrating duct carcinoma of the head of pancreas." The listing in ICD-O-3.2 is infiltrating duct carcinoma 8500/3 (C50_). Code the primary site to head of pancreas (C250), NOT to breast (C50_) as suggested by the ICD-O-3.2.

    b. Use the site code suggested by ICD-O-3.2 when the primary site is the same as the site code suggested or the primary site is unknown

    Example 1: The biopsy is positive for hepatoma, and no information is available about the primary site. Code the primary site to liver (C220) as suggested by ICD-O-3.2.

Example 2: Excision of the right axillary nodes reveals metastatic infiltrating duct carcinoma. The right breast is negative. ICD-O-3.2 shows infiltrating duct carcinoma (8500) with a suggested site of breast (C50_). Code the primary site as breast, NOS (C509).

c. Use the site code suggested by ICD-O-3.2 when there is no information available indicating a different primary site

Example: Biopsy of lymph node diagnosed as metastatic non-small cell carcinoma. Patient expired and there is no information available about the primary site. Assign C349 based on the site code suggested in ICD-O-3.2.

8. Code the primary site, not the metastatic site. If a tumor is metastatic and the primary site is unknown, code the primary site as unknown (C809).
    a. Code primary site using results of the molecular test CancerTYPE ID **only when** there is no other information about the primary site. Document in the text that the site is solely based on results from CancerTYPE ID molecular testing.

    Note: CancerTYPE ID tests are a standardized molecular method of determining primary site in tumors initially identified in a metastatic site. The use of CancerTYPE ID to determine primary site is not yet a standard practice and has not received FDA clearance.
9. See the site-specific coding guidelines in Appendix C for primary site coding guidelines for the following sites: Anus Kidney Bladder Lung Brain/CNS, Benign and Borderline Lymphoma Brain/CNS, Malignant Melanoma Breast Pancreas Colon Esophagus Rectosigmoid Junction Renal Pelvis and Ureter Intracranial Glands Tongue Kaposi Sarcoma of All Sites Urethra
10. See section below for primary site coding guidelines for sarcoma
11. Angiosarcoma
    a. Code C422 (spleen) as the primary site for angiosarcoma of spleen
    b. Code C50_ (breast) for angiosarcoma of breast. Although angiosarcoma actually originates in the lining of the blood vessels, an angiosarcoma originating in the breast has a poorer prognosis than many other breast tumors.
12. Gastrointestinal Stromal Tumors (GIST): Code the primary site to the location where the GIST originated
13. Transplants
    a. Code the primary site to the location of the transplanted organ when a malignancy arises in a transplanted organ, i.e., code the primary site to where the malignancy resides or lies
    Example: There is a diagnosis of malignancy in transplanted section of colon serving as esophagus. Code the primary site as esophagus. Document the situation in a text field.
    b. For information about organ or tissue transplants, see the section Determining Multiple Primaries.
    c. For additional information about hematopoietic-related transplants, refer to the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database
14. Assign primary site code C449, skin NOS, for a Merkel cell carcinoma presenting in a nodal or distant metastatic site and site of origin is unknown
15. When the choice is between ovary, fallopian tube, or primary peritoneal without designation of the site of origin, any indication of fallopian tube involvement indicates the primary tumor is a tubal primary. Fallopian tube primary carcinomas can be confirmed by reviewing the fallopian tube sections as described on the pathology report to document the presence of either serous

tubal intraepithelial carcinoma (STIC) and/or tubal mucosal invasive serous carcinoma. In the absence of fallopian tube involvement, refer to the histology and look at the treatment plans for the patient. If all else fails, assign C579 as a last resort. For additional information, see the CAP GYN protocol, Table 1: Criteria for assignment of primary site in tubo-ovarian serous carcinomas.

17. When the medical record does not contain enough information to assign a primary
    a. Consult a physician advisor to assign the site code
    b. Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site
    c. Occult Tumors of the Head and Neck
        i. Assign primary site C119 (nasopharynx) for occult head and neck tumors with cervical lymph node metastasis in Levels I-VII, and other group lymph nodes positive for Epstein–Barr virus (EBV+) (regardless of p16 status) encoded small RNAs (EBER) identified by in situ hybridization
        ii. Assign primary site C109 (oropharynx) for occult head and neck tumors with cervical lymph node metastasis in Levels I-VII, and other group lymph nodes, p16 positive with histology consistent with HPV-mediated oropharyngeal carcinoma (OPC)
        iii. Assign C760 for Occult Head and Neck primaries with positive cervical lymph nodes. Schema Discriminator 1: Occult Head and Neck Lymph Nodes is used to discriminate between these cases and other uses of C760 For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
    d. Assign the NOS code for the body system when there are two or more possible primary sites documented and all are within the same system Example: Two possible sites are documented in the GI system such as colon and small intestine; code to the GI tract, NOS (C269). Document the possible primary sites in a text field.
    e. Code unknown primary site when there is a physician statement of unknown primary site ONLY when none of the above instructions can be applied
    f. Code unknown primary site (C809) if there is not enough information to assign an NOS or Ill-Defined Site category

Sarcoma

The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system, which includes the fat, muscles, blood vessels, deep skin tissues, nerves, bones, and cartilage. The default code for sarcomas of unknown primary site is C499 rather than C809.

Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. **Code the primary site to the organ of origin.**

Example 1: The pathology identifies a carcinosarcoma of the uterine corpus. Code the primary site to corpus uteri (C549).

Example 2: Rhabdomyosarcoma of ethmoid sinus. Code primary site to C311.

Code the organ of origin as the primary site when leiomyosarcoma arises in an organ. Do not code soft tissue as the primary site in this situation.

Example 1: Leiomyosarcoma arises in kidney. Code the primary site to kidney (C649).

Example 2: Leiomyosarcoma arises in prostate. Code primary site to prostate (C619).

Coding Instructions for Hematopoietic and Lymphoid Neoplasms (9590/3-9993/3)

See the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database for instructions on coding the primary site for hematopoietic and lymphoid neoplasms.

Grade Clinical

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
3843	1	NAACCR	Grade Manual https://apps.naaccr.org/ssdi/list/ Standards for Oncology Registry Entry (STORE)

Description

Grade Clinical is new beginning 2018. This data item records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant). For cases diagnosed 2018 and later, this data -- item along with Grade Pathological and Grade Post Therapy -- replaces the data item Grade [NAACCR Item #440] as well as site specific factors for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Justification

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the AJCC clinical stage group.

Coding Instructions

1. Refer to the most recent version of the Grade manual for general and specific primary site grouping instructions. https://apps.naaccr.org/ssdi/list/
   The Grade Manual should always be the primary resource for grade coding instructions. The OCCR Manual provides only general guidelines and is not intended to replace the Grade Manual.
2. For those cases that are eligible for AJCC staging, the recommended grading system is specified in the AJCC Chapter.
   Note: the OCCR only requires AJCC staging for cases diagnosed in 2016 or 2017.
3. Code grade from the primary tumor only; do not include grade from surgical resections in this field.
   a. Do NOT code grade based on metastatic tumor or recurrence. In the instance that primary tumor tissue extends directly (contiguously) to an adjacent site and tissue from the primary tumor site is not available, code grade from the contiguous site.
   b. If primary site is unknown, or was not biopsied, code grade to 9.
4. The AJCC Chapter-specific grading systems (codes 1-5) take priority over the generic grade definitions (codes A-E, L, H, 9).
5. For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.
   Code grade for hematopoietic and lymphoid neoplasms using the current hematopoietic and lymphoid neoplasm manual.

6. If there is more than one grade available for an individual grade data item (i.e., within the same time frame):
    a. Priority goes to the recommended AJCC grade listed in the applicable AJCC system.
    b. If none of the specified grades are from the recommended AJCC grade system, **or** there is no recommended AJCC grade for a particular site, code the highest grade per the applicable grade categories for that site.
    c. For those cases that are eligible for AJCC staging, the recommended grading system is specified in the AJCC Chapter.

    Note: *the OCCR only requires AJCC staging for cases diagnosed in 2016 or 2017; AJCC staging is not required for cases diagnosed in 2018 or later.*
7. In situ and/or combined in situ/invasive components:
    a. If a grade is given for an in situ tumor, code it. Do **NOT** code grade for dysplasia such as high-grade dysplasia.
    b. If there are both in situ and invasive components, code the grade for the invasive portion even if its grade is unknown.
8. Priority for grade:
    a. Synoptic pathology report (including CAP protocol)
    b. Pathology report: Final diagnosis
    c. Physician statement
9. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code clinical grade based on information **prior** to neoadjuvant therapy even if grade is unknown during the clinical timeframe. Grade is now be collected in grade post therapy clinical (yc) when grade is available after neoadjuvant therapy and prior to surgical resection and grade post therapy pathological (yp) cases when grade is available from post neoadjuvant surgery.
10. If a case is sent out for consultation and the grade results are different than the original case, record the results from the consultation.
    a. Example 1: Patient had biopsy done at a facility which showed a moderately differentiated tumor. Slides were sent out for consultation and their review showed a well differentiated tumor.3
        i. Record the well differentiated grade based on the consult

Grade Pathological

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
3844	1	NAACCR	Grade Manual https://apps.naaccr.org/ssdi/list/ Standards for Oncology Registry Entry (STORE)

Description

Grade Pathological is new beginning in 2018. This data item records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered.

Justification

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the clinical stage group.

Coding Instructions

1. Refer to the most recent version of the SSDI-Grade manual for general and specific primary site grouping instructions. https://apps.naaccr.org/ssdi/list/
2. Record the highest grade documented from any microscopic specimen of the primary site whether from the clinical workup or the surgical resection.
3. Unless the grade instruction manual states to code as 8, this data item should be coded to 9 when the patient receives neoadjuvant treatment followed by resection of the primary site.
4. For those cases that are eligible AJCC staging, the recommended grading system is specified in the AJCC Chapter.
5. The AJCC Chapter-specific grading systems (codes 1-5) take priority over the generic grade definitions (codes A-E, L, H, 9).
6. For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.
7. Code grade for hematopoietic and lymphoid neoplasms using the current hematopoietic and lymphoid neoplasm manual.
8. **NAACCR data item #440 Grade is no longer applicable for cases diagnosed 2018 and forward.** Grade is still required for cases diagnosed prior to 2018.

Grade Post Therapy Clin (yc)

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1068	1	NAACCR	Grade Manual https://apps.naaccr.org/ssdi/list/ Standards for Oncology Registry Entry (STORE)

Description

Grade Post Therapy Clin (yc) is new for 2021. This data item records the grade of a solid primary tumor that has been biopsied following neoadjuvant therapy.

Justification

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the clinical stage group.

Coding Instructions

1. This item should be left blank unless the patient received neoadjuvant treatment followed by tissue biopsy of the primary site.
2. When the patient has received neoadjuvant treatment followed by tissue biopsy of the primary site, Grade Clinical, Grade Pathological and Grade Post Therapy Clin (yc) will all be recorded.

Grade Post Therapy Path (yp)

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
3845	1	NAACCR	Grade Manual https://apps.naaccr.org/ssdi/list/ Standards for Oncology Registry Entry (STORE)

Description

Grade Post Therapy Path (yp) is revised for 2021. This data item records the grade of a solid primary tumor that has been resected following neoadjuvant therapy.

Justification

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the clinical stage group.

Coding Instructions

1. This item should be left blank unless the patient received neoadjuvant treatment followed by resection of the primary site.
2. When the patient has received neoadjuvant treatment followed by resection of the primary site, Grade Clinical, Grade Pathological and Grade Post Therapy Path (yp) will all be recorded.

Laterality

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
410	1	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

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

Justification

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

Coding Instructions

1. Assign code 0 when
    a. The primary site is not a paired site (see Paired Organs List, below)
    b. The primary site is unknown (C809) or ill-defined (C760-768)
2. Code laterality using codes 1-9 for all sites listed in the Paired Organs List (below)
3. Code the side where the primary tumor **originated**
    a. Assign code 3 if the primary tumor is confined to a single side of the paired organ, but it is not known which side the tumor originated
4. Code 4 is seldom used EXCEPT for the following:
    a. Both ovaries involved simultaneously with a **single** histology and is considered a single primary according to the Solid Tumor Rules.
    b. Diffuse bilateral lung tumors (abstracted as a single primary according to the Solid Tumor Rules)

c. Bilateral retinoblastomas
d. Bilateral Wilms tumors
e. Both breasts when inflammatory carcinoma is bilateral at diagnosis
f. Bilateral involvement at time of diagnosis and lateral origin unknown for a site listed in the Paired Organs List, below
    i. Example: Both arms are involved with Kaposi Sarcoma and no other sites are involved. It is not known on which arm the Kaposi sarcoma originated. Assign Laterality code 4. Skin of upper limb and should is listed as a paired organ in the Paired Organs List below.

5. Assign code 5 **only** when the tumor originates in the midline of the following sites:
    a. C700, C710 – C714, C722 – C725
    b. C443, C444, C445
        i. Do **not** assign code 5 to any site not listed above in 5.a or 5.b
6. Assign code 9 when the primary tumor originated in a paired site, the laterality is unknown AND there is no statement that only side of the paired organ is involved
7. Document laterality in Text-Primary Site; documentation should substantiate the laterality code selected.

Paired Organs List

ICD-0-3 CODES	PRIMARY SITE
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 code)
C30.1	Middle ear (tympanic cavity)
C31.0	Maxillary sinus (antrum)
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 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")
C44.4	Skin of Scalp and Neck
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and 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-C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0-C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges, NOS (excluding diagnoses prior to 2004)
C71.0	Cerebrum (excluding diagnoses prior to 2004)
C71.1	Frontal lobe (excluding diagnoses prior to 2004)
C71.2	Temporal lobe (excluding diagnoses prior to 2004)
C71.3	Parietal lobe (excluding diagnoses prior to 2004)
C71.4	Occipital lobe (excluding diagnoses prior to 2004)
C72.2	Olfactory nerve (excluding diagnoses prior to 2004)
C72.3	Optic nerve (excluding diagnoses prior to 2004)
C72.4	Acoustic nerve (excluding diagnoses prior to 2004)
C72.5	Cranial nerve, NOS (excluding diagnoses prior to 2004)
C74.0-C74.9	Adrenal gland (cortex, medulla)
C75.4	Carotid body

Lymphovascular Invasion

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1182	1	AJCC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

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.

Justification

Lymphovascular invasion is an indicator of prognosis.

Coding Instructions

- Codes have been updated to align with the current AJCC Cancer Staging System for appropriate disease sites. Additional clarifications implemented for thyroid and adrenal per suggestions from CAP.
- Revised CAP Protocols and AJCC Cancer Staging System chapters will indicate which chapters will use the new codes (2, 3, and 4) and which will only use the existing codes(0, 1, 8, 9), as there are some disease sites where distinguishing between L and V is not medically appropriate.
- Code 8, Not Applicable for benign/borderline brain and CNS tumors and Gastrointestinal Stromal Tumors (GIST).
- For cases diagnosed January 1, 2018, and later, new codes indicating lymphatic, small vessel, and/or large vessel invasion were added.

1. **Code from the pathology report(s).** If not available, code the absence or presence of lymphovascular invasion as described in the medical record.
    a. The primary sources of information about lymphovascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from other sections of the pathology report or a physician's statement, in that order.
    b. Do not code perineural invasion in this field.
    c. Information to code this field can be taken from any specimen from the primary tumor (biopsy or resection).
    d. If lymphovascular invasion is identified in any primary tumor specimen, code as present/identified.
    e. For cases with benign or borderline behavior, code the lymphovascular invasion documented (negative or positive) and, if not documented, code unknown.
    f. For cases treated with neoadjuvant therapy, refer to table below in order to code this field. However, if documentation in the medical record indicates information that conflicts with this table, code lymphovascular invasion with the documentation in the medical record.
    g. If LVI was present prior to neoadjuvant therapy (codes 1-4) but LVI was not present after neoadjuvant therapy (codes 0 or 9), code the LVI to present (codes 1-4). Benign/borderline brain and/or CNS and GIST use code 8 (not applicable).
    h. If the LVI was not present prior to neoadjuvant therapy (codes 0 or 9), but LVI was present after neoadjuvant therapy (codes 1-4), code LVI to present (codes 1-4).

LVI on pathology report PRIOR to neoadjuvant therapy	LVI on pathology report AFTER neoadjuvant therapy	*Code LVI to:*
0 – Not present/Not identified	0 – Not present/Not identified	*0 – Not present/Not identified*
0 – Not present/Not identified	1 – Present/Identified	*1 – Present/Identified*
0 – Not present/Not identified	9 – Unknown/Indeterminate	*9 – Unknown/Indeterminate*
1 – Present/Identified	0 – Not present/Not identified	*1 – Present/Identified*
1 – Present/Identified	1 – Present/Identified	*1 – Present/Identified*
1 – Present/Identified	9 – Unknown/Indeterminate	*1 – Present/Identified*
9 – Unknown/Indeterminate	0 – Not present/Not identified	*9 – Unknown/Indeterminate*
9 – Unknown/Indeterminate	1 – Present/Identified	*1 – Present/Identified*
9 – Unknown/Indeterminate	9 – Unknown/Indeterminate	*9 – Unknown/Indeterminate*

2. Use of Codes
    a. Use **code 0** when the pathology report indicates there is no lymphovascular invasion. This includes cases of purely in situ carcinoma which biologically have no access to lymphatic or vascular channels below the basement membrane.
    b. Use code 1 when the pathology report or a physician's statement that lymphovascular invasion (or one of its synonyms) is present in the specimen. *(Synonyms include: LVI, angiolymphatic invasion, blood vessel invasion, lymphvascular emboli, lymphatic invasion, lymphvascular invasion and vascular invasion.)*
3. Use **code 1** when the pathology report or a physician's statement indicates that lymphovascular invasion (or one of its synonyms) is present in the specimen**.**
   Synonyms for lymphovascular invasion: Angiolymphatic invasion, Blood vessel invasion, Lymph Vascular emboli, Lymphatic invasion, Lymph-vascular invasion, and Vascular invasion.
4. Use **code 8** for Lymphoma and Hematopoietic diseases.
5. Use **code 9** where there is no microscopic examination of primary tissue specimen, primary specimen is cytology only or fine needle aspiration, the biopsy is a very small tissue sample, it is not possible to determine whether lymphovascular invasion is present, the pathologist indicates the specimen is insufficient to determine lymphovascular invasion.
6. Revised CAP Protocols and AJCC Staging System chapters will indicate which chapters will use the new codes (2, 3, and 4) and which will only use the existing codes (0, 1, 8, 9), as there are some disease sites where distinguishing between L and V is not medically appropriate.

NOTE: Refer to the STORE manual for the complete list of detailed instructions, table, and lists.

Diagnostic Confirmation

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
490	1	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

This data item records the best method used to confirm the presence of the cancer being reported. The best method could occur at any time throughout the entire course of the disease. It is not limited to the confirmation at the time of initial diagnosis.

Justification

This item is an indicator of the precision of diagnosis. The percentage of solid tumors that are clinically diagnosed only is an indication of whether casefinding includes sources beyond pathology reports. Complete casefinding must include both clinically and pathologically confirmed cases.

Coding Instructions

Solid Tumors (All histologies except 9590/3 – 9993/3)

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.

2. Change to a lower code (higher priority), if a more definitive method confirms the diagnosis at **any time** during the course of the disease.
3. Assign **code 1** when the microscopic diagnosis is based on:
    a. **Tissue** specimens from fine needle aspirate, biopsy, frozen section, surgery, autopsy, D&C, **OR**
    b. Bone marrow specimens (aspirate and biopsy).
4. Assign **code 2** when the microscopic diagnosis is based on:
    a. Examination of cells from **cytology** (rather than tissue) including but not limited to: sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears, or vaginal smears.
    b. Paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid
5. Assign **code 4** when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown
6. Assign **code 5** when the diagnosis of cancer is based on laboratory tests or tumor marker studies that are clinically diagnostic for that specific cancer
   Note: For tests and tumor markers that may be used to help diagnose cancer, see:
   http://www.cancer.gov/cancertopics/factsheet/detection
   http://www.cancer.gov/cancertopics/factsheet/detection/tumor-markers
7. Assign **code 6** when the diagnosis is based only on:
    a. The surgeon's operative report from a surgical exploration or endoscopy such as colonoscopy, mediastinoscopy, or peritoneoscopy and no tissue was examined
    b. Gross autopsy findings (no tissue or cytologic confirmation)
8. Assign code 7 when the only confirmation of malignancy was diagnostic imaging such as computerized axial tomography (CT scans), magnetic resonance imaging (MRI scans), or ultrasounds/sonography
9. Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes. The diagnostic confirmation is coded 8 when the only confirmation of disease is a physician's clinical diagnosis.
10. Assign **code 9** when it is unknown if the diagnosis was confirmed microscopically or for death certificate only case

Hematopoietic and Lymphoid Neoplasms (9590/3 – 9993/3):
See the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database for coding instructions.

Text General Rules

- **Text is required and MUST BE PROVIDED BY ALL REPORTING FACILITIES.**
- **Refer to the Texting Tables and Case Examples in Appendix G for full details on required text**
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G of the NAACCR Data Dictionary).
- Do not repeat information from other text fields.

- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Operative Report Text

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2560	4000	NPCR	NAACCR Data Dictionary

Description

Text area for manual documentation of all surgical procedures that provide information for staging. Biopsy procedures are documented here.

Refer to the Texting Tables and Case Examples in Appendix G for full details on required text

Justification

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Suggestions for text: Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived, Number of lymph nodes removed, Size of tumor removed, Documentation of residual tumor, Evidence of invasion of surrounding areas, Reason primary site surgery could not be completed,
- Data Item(s) to be verified/validated using the text entered in this field. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes.

Surgery Text

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2610	4000	NPCR	NAACCR Data Dictionary

Description

Text area for information describing all surgical procedures performed as part of treatment.
Refer to the Texting Tables and Case Examples in Appendix G for full details on required text

Justification

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Suggestions for text: Date of each procedure, Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites, Lymph nodes removed, Regional tissues removed, Metastatic sites, Facility where each procedure was performed, Record positive and negative findings, Record positive findings first, Other treatment information, e.g., planned procedure aborted; unknown if surgery performed.
- Data Item(s) to be verified/validated using the text entered in this field. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes.
- **Chronologically** (using date of surgical ablation or resection) enter all relevant **surgical ablations or resections** done to provide cancer-directed treatment, including:
  - **Date** of surgical ablation or resection
  - **Location/place** where surgical ablation or resection was performed
  - **Name or description** of surgical ablation or resection performed
  - **Tissues removed**, including **lymph nodes, regional or adjacent tissues and metastatic sites** (as applicable)
  - **Note:** The preferred text placement of observations by the surgeon(s) during the procedure is Text-DX Proc-OP
    Documentation of **patient refusal or reason why surgical ablation or resection was not performed**

Radiation (Beam) Text

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2620	4000	NPCR	NAACCR Data Dictionary

Description

Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation.

Refer to the Texting Tables and Case Examples in Appendix G for full details on required text

Justification

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Suggestions for text: Date radiation treatment began, Where treatment was given, e.g., at this facility, at another facility, Type(s) of beam radiation, e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities, Other treatment information, e.g., patient discontinued after 5 treatments; unknown if radiation was given
- Data Item(s) to be verified/validated using the text entered in this field. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes.
- **Chronologically** (using radiation start date) enter all relevant **beam radiation treatments** administered as cancer-directed treatment including:
  - **Date** beam radiation started for Phase 1 Radiation
  - **Place** where beam radiation was administered for Phase 1 Radiation
  - **Treatment details** for Phase 1 Radiation such as:
    - **Treatment modality (type of beam radiation** such as photon, proton, electron, HDR brachytherapy, LDR brachytherapy, radioisotope, etc.)
- Documentation of **patient refusal or reason why** beam radiation was not administered

Radiation (Other) Text

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2630	4000	NPCR	NAACCR Data Dictionary

Description

Text area for manual documentation of information regarding treatment of the tumor being reported with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy. **Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.**

Justification

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Suggestions for text: Date treatment was started, Where treatment was given, e.g., at this facility, at another facility, Type(s) of nonbeam radiation, e.g., High Dose rate brachytherapy, seed implant, Radioisotopes (I-131), Other treatment information, e.g., unknown if radiation was given
- Data Item(s) to be verified/validated using the text entered in this field. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes.
- **Chronologically** (using radiation start date) enter all relevant **beam radiation treatments** administered as cancer-directed treatment including:
  - **Date** beam radiation started for Phase 1 Radiation
  - **Place** where beam radiation was administered for Phase 1 Radiation
  - **Treatment details** for Phase 1 Radiation such as:
    - **Treatment modality (type of beam radiation** such as photon, proton, electron, HDR brachytherapy, LDR brachytherapy, radioisotope, etc.)
- Documentation of **patient refusal or reason why** beam radiation was not administered

Chemo Text

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2640	4000	NPCR	NAACCR Data Dictionary

Description

Text area for manual documentation of information regarding chemotherapy treatment of the reported tumor.

Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.

Justification

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Suggestions for text: Date 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
- Data Item(s) to be verified/validated using the text entered in this field. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes.
- **Chronologically** (using chemotherapy start date) enter all relevant chemotherapy treatment details administered as cancer-directed treatment such as:
  - **Date(s)** chemotherapy agents were administered
  - **Place(s)** where chemotherapy was administered
  - **Treatment details** including names of all chemotherapy agents administered, documentation of **patient refusal or reason why** chemotherapy was not administered

Hormone Text

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2650	4000	NPCR	NAACCR Data Dictionary

Description

Text area for information about hormonal treatment.

Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.

Justification

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Suggestions 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
- Data Item(s) to be verified/validated using the text entered in this field. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes.
- **Chronologically** (using hormone therapy start date) enter all relevant hormone therapy treatment details administered as cancer-directed treatment such as:
  - **Date(s)** hormone therapy agents were administered
  - **Place(s)** where hormone therapy was administered
  - **Treatment details** including names of all hormone therapy agents administered
  - Documentation of **patient refusal or reason why** hormone therapy was not administered

Biologic Response Modifier (BRM) Text

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2660	4000	NPCR	NAACCR Data Dictionary

Description

Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.

Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.

Justification

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Suggestions for text: Date treatment began, Where 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
- Data Item(s) to be verified/validated using the text entered in this field. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes.
- **Chronologically** (using immunotherapy start date) enter all relevant immunotherapy treatment details administered as cancer-directed treatment such as:
  - **Date(s)** immunotherapy agents were administered
  - **Place(s)** where immunotherapy was administered
  - **Treatment details** including names of all immunotherapy agents administered
  - Documentation of **patient refusal or reason why** immunotherapy was not administered
- **Hematologic Transplants and Endocrine Procedures** documentation:
- Hematopoietic transplants should include the source (bone marrow, peripheral blood, cord, etc.)

OTHER TEXT

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2660	4000	NPCR	NAACCR Data Dictionary

Description

Text area for manual documentation of information 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.

Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.

Justification

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded

values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Suggestions 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.
- Data Item(s) to be verified/validated using the text entered in this field. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes.
- **Chronologically** (using other therapy start date) enter all relevant other therapy treatment details administered as cancer-directed treatment, including experimental treatments and blinded clinical trials such as:
    - **Date(s)** other therapy agents were administered
    - **Place(s)** where other therapy was administered
    - **Treatment details** including names of all other therapy agents administered or clinical trial information
    - Documentation of **patient refusal or reason why** other therapy was not administered

Primary Site Title Text

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2580	100	NPCR	NAACCR Data Dictionary

Description

This narrative text section is used to document the primary site and laterality of the tumor being reported.

Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.

Justification

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.

- Suggestions for text: State the specific location of the primary site, including subsite, Include available information on tumor laterality
- Data Item(s) to be verified/validated using the text entered in this field. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes.

Histology Title Text

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2590	100	NPCR	NAACCR Data Dictionary

Description

This narrative text section is used to document information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.

Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.

Justification

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Suggestions for text: Information on histologic type and behavior, Information on differentiation from scoring systems such as Gleason's Score, Bloom-Richardson Grade (both clinical grade and pathologic grade), etc.
- Data Item(s) to be verified/validated using the text entered in this field. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes.

Pathology Text

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2570	4000	NPCR	NAACCR Data Dictionary

Description

This narrative text section is used to provide information from pathology and cytology reports that are pertinent to the diagnosis and extent of disease. Use this field to substantiate the histology, behavior, grade, lymph node(s), tumor size, surgical margin status, extent of disease (e.g., direct extension and/or metastatic disease) as well as the date, place, pathology accession number and specimen examined.

Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.

Justification

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Data Item(s) to be verified/validated using the text entered in this field. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes.
- No codes are to be entered into this field. This field is for narrative text only.
- Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.
- Record all pathology (tissue, cytology, etc.) reports that pertain to the diagnosis, staging and treatment of the tumor.
- Tumor size is to be recorded in this field; if multiple tumor dimension are provided on the pathology report, record all dimensions (if appropriate).
- In the order listed, record all of the following details as stated in each pathology report:

Priority Order	Details to be recorded
1	Date(s) of procedure.
2	Place where tissue specimen was obtained.
3	Pathology report number.
4	Origin and description of the specimen being examined (e.g., biopsy, surgical specimen, etc.)
5	Final histologic diagnosis (include microscopic information if a more specific histology and/or grade is described, following the guidelines in the histology/behavior/grade section of this manual.
6	Lymph node status.
7	Description of tumor size; include all tumor dimensions when given.
8	Surgical (residual) margin status as it relates to the residual tumor status.
9	Description of tumor invasion from final diagnosis (e.g., through the basement membrane; invasion of the wall without extension through the wall; invasion into adjacent structures/tissues/organs); include information from the gross or microscopic section of the pathology report when information from these sections are more complete or not found in the Final Diagnosis. Record both positive and negative findings.
10	Record additional comments from the pathologist, including differential diagnoses considered and ruled out or favored.

Physical Exam Text

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2520	4000	NPCR	NAACCR Data Dictionary

Description

Text area for manual documentation from the history and physical examination about the history of the current tumor and the clinical description of the tumor. It should also contain the patient's age, race and reason for presenting to the facility. Past medical history, social history (smoking alcohol, marital status, occupation/industry) and family history can be documented here or in remarks text.

Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.

Justification

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Suggestions for text: Date of physical exam, Age, sex, race/ethnicity, History that relates to cancer diagnosis, Palpable lymph nodes, Record positive and negative clinical findings. Record positive results first.
- Data Item(s) to be verified/validated using the text entered in this field. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes.
- Record the date of first contact with your facility, dates of inpatient admit/discharge, place of visit/provider's name, type of visit, signs or symptoms leading to the initial diagnosis, , provider's final diagnosis/impression, treatment plan and physical exam findings
    a. For lymphomas, any mention of lymph nodes, such as "enlarged", "visible swelling", or "palpable" is considered involvement and should be recorded.
- For prostate cancers, record the results of the digital rectal exam. Any mention of "induration" or "palpable nodule" should be reported.

X-ray/Scan Text

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2530	4000	NPCR	NAACCR Data Dictionary

Description

This data item is used to describe in narrative format date, type of procedure, and all positive and negative findings that substantiate the staging that is recorded. These reports may describe findings

related to malignant involvement. Procedures such as bowel studies (GI series, barium enema), bladder and kidney studies (IVP), or radioisotope scan (brain, bone, liver scans) should be recorded if they provide additional information about the extent of disease, positive or negative.
Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.

Justification
Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions
- Prioritize entered information in the order of the fields listed below.
- Suggestions for text: Date(s) and type(s) of X-ray/Scan(s), Primary site, Histology (if given), Tumor location, Tumor size, Lymph nodes, Record positive and negative clinical findings. Record positive results first, Distant disease or metastasis.
- Data Item(s) to be verified/validated using the text entered in this field. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes.
- Record ALL X-rays, scans, and/or other imaging reports that pertain to the diagnosis and extent of disease of the tumor; this may include imaging leading to the patient's diagnosis
- In the order listed, record the date, place, type of imaging technique and findings:

Priority Order	Details to be recorded
1	Date(s), type(s) of X-ray/scan(s), and imaging area.
2	Place where imaging was performed, imaging modality & body part being imaged.
3	Final diagnosis
4	**Description** of tumor, tumor invasion, lymph node status, tumor size (if mentioned) and presence or absence of metastatic disease. Record both positive and negative findings, with positive findings first.
5	**Results, findings and/or conclusions** from appropriate report(s) including differential diagnoses considered/ruled out/favored

Lab Tests Text

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2550	4000	NPCR	NAACCR Data Dictionary

Description

This data item is used to describe in narrative format date, type and value of a lab test that specifically applies to the type of cancer or primary site being abstracted and it is a part of a definitive clinical picture for the disease. Indicate whether positive, negative, elevated, normal, etc. Below are some examples:

Breast	Estrogen/progesterone receptor assay; HER2 studies
Colorectal	Carcinoembryonic Antigen (CEA)
Prostate	Prostatic specific antigen (PSA)
Multiple myeloma	Monoclonal immunoglobulin in urine or serum protein electrophoresis
Testis	Human chorionic gonadotrophin (HcG)
Liver	Alphafetoprotein (AFP)
Thyroid (Medullary carcinoma)	Elevated calcitonin

Justification

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

1. Text documentation is **REQUIRED AND MUST BE PROVIDED BY ALL REPORTING FACILITIES**.
2. Record the date, type of lab test, and findings. Narrative documentation to support the required lab site specific data items must be provided. If a registrar elects to code other optional lab values, please provide narrative documentation in this free text field.
3. See additional clarifications in the OCCR Texting Table in Appendix G.
4. In the order listed, record the date, place, type of lab tests and findings:

1	Date(s), type(s) of lab test/tissue specimen(s).
2	Place where lab test/tissue specimen(s) was performed.
3	Final diagnosis
4	Information can include tumor markers, serum and urine electrophoresis, special studies, etc. Record both positive and negative findings.

SECTION 7

STAGING

SEER Summary Stage 2018

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
764	1	SEER	SS2018 Manual or SEER*RSA + SS2018 Gen Instructions

Description

This item stores the directly assigned Summary Stage 2018. Effective for cases diagnosed 1/1/2018 and forward.

Justification

The SEER program has collected staging information on cases since its inception in 1973. Summary Stage groups cases into broad categories of in situ, local, regional, and distant. Summary Stage can be used to evaluate disease spread at diagnosis, treatment patterns and outcomes over time.

Coding Instructions

The coding instructions below are **NOT** all-inclusive. For the complete set of coding instructions, please refer to most recent Summary Stage 2018 (SS2018) manual linked in section 1 . In particular, there are Guidelines by Stage, General Instructions for Using the Summary Stage 2018 Manual, Guidelines for Summary Stage and How to Assign Summary Stage.

- Summary Stage chapters apply to ALL primary sites and histologies. Most chapters are based on primary site, while some are based on histology alone, or both primary site and histology.
- Although SEER Summary Stage 2018 and AJCC Cancer Staging System are similar, there are many differences between them. For example, something that is regional in AJCC (recorded in T or N) may be distant in Summary Stage.
- **ALWAYS** check site-specific SS2018 chapters for exceptions and/or additional information. Chapter-specific guidelines take precedence over general guidelines. Always read the information pertaining to a specific primary site or histology chapter.
- Any information found that is clinical or pathological can be used in staging the cancer if it is within **four months of diagnosis** in the absence of disease progression or upon completion **of surgery(ies)** in first course of treatment, whichever is longer.
- Disease progression, including metastatic involvement, known to have developed after the initial stage workup, should be excluded when assigning Summary Stage.
- For ALL primary sites and histologies, Summary Stage is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are particularly important when all malignant tissue cannot be, or was not, removed.
- When there is doubt about assigning the appropriate stage, assign the lesser stage. Do not over stage.
- When multiple tumors are reported as a single primary, assign the greatest Summary Stage from any tumor.
- Information for Summary Stage from a surgical resection **after neoadjuvant treatment may be used,** but ONLY if the extent of disease is greater than the pre-treatment clinical findings.
- Autopsy reports are used just as are pathology reports, applying the same rules for inclusion and exclusion.
- TNM information may be used to assign Summary Stage if it is the only information available.

- Document the assessment of the Summary Stage as well as the choice of the Summary Stage assignment in the Stage text field on the abstract.
- Text for PE, X-ray/Scan text, Scopes, Lab Test, Operative and Path should contain the pertinent information which led to the assigned Summary Stage.

Ambiguous Terminology for Summary Stage 2018

Use the following lists to interpret the intent of the clinician ONLY when further documentation is not available and/or there is no specific statement of involvement in the medical record. The physician's definitions/descriptions and choice of therapy have priority over these lists because individual clinicians may use these terms differently. Refer to the Summary Stage 2018 manual General Coding Instructions https://seer.cancer.gov/tools/ssm/. Do **NOT** use these lists to determine reportability; see Ambiguous Terminology for Determining Reportability instead.

Use the following lists as a guide ***when no other information is available.***

Involved

Adherent	Incipient invasion
Apparent(ly)	Induration
Appears to	Infringe/infringing
Comparable with	Into*
Compatible with	Intrude
Contiguous/continuous with	Most likely
Encroaching upon*	Onto*
Extension to, into, onto, out onto	Overstep
Features of	Presumed
Fixation to another structure other than primary**	Probable
Fixed to another structure**	Protruding into (unless encapsulated)
Impending perforation of	Suspected
Impinging upon	Suspicious
Impose/imposing on	To*
	Up to

Not Involved

Abuts	Extension to without invasion/involvement of
Approaching	Kiss/kissing
Approximates	Matted (except for lymph nodes)
Attached	Possible
Cannot be excluded/ruled out	Questionable
Efface/effacing/effacement	Reaching
Encased/encasing	Rule out
Encompass(ed)	Suggests
Entrapped	Very close to
Equivocal	Worrisome

* interpret as involvement whether the description is clinical or operative/pathological

** interpret as involvement of other organ or tissue

Code	Description
0	In situ
1	Localized Only
2	Regional by Direct Extension Only
3	Regional to Lymph Nodes Only
4	Regional by BOTH direct extension AND regional lymph nodes
7	Distant site(s)/nodes involved or systemic for some hematopoietic cancers
8	Benign, borderline *
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death certificate only case

*Applicable for the following Summary Stage 2018 Chapters: Brain, CNS Other, Intracranial Gland

Note: *Code 5 Regional, NOS can no longer be coded beginning with SS2018. It is still applicable for SS2000.*

Staging Text

NAACCR Item #	*Length*	*Source of Standard*	*NAACCR Data Dictionary*
2600	4000	NPCR	NAACCR Data Dictionary

Description

This data item is used to provide narrative text to substantiate codes assigned for the stage of disease at diagnosis. This field may also be used for additional text for staging information not entered in the DX Procedures Text data item.

Refer to the Texting Tables and Case Examples in Appendix G for full details on required text.

Justification

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

No codes are to be written in this field. This field is for narrative documentation only. Write a brief description of the extent of disease that substantiates the assigned SEER Summary Stage 2018. Describe the organs, tissues, and lymph nodes involved with cancer. If the tumor is localized, a statement such as “cancer confined to prostate capsule” or “confined to prostate, nodal and metastatic workup is negative” is sufficient. A regional cancer might be described as “hepatocellular carcinoma of the liver

with extension to the gallbladder". A distant cancer might be described as "left breast cancer with metastasis to the lung, bone and mediastinal lymph nodes."

Documentation should include:

- **A synoptic narrative** of rationale to support **SEER Summary Stage** coded in the abstract.
- A brief description is acceptable (e.g., "cancer confined to prostate")
- Facilities may use this area to also document AJCC TNM stage; however, AJCC TNM is **not** an acceptable substitute for justifying the assigned SEER Summary Stage.
- Suggestions for text: Date(s) of procedure(s), including clinical procedures, that provided information for assigning stage, Organs involved by direct extension, Size of tumor, Status of margins, Number and sites of positive lymph nodes, Site(s) of distant metastasis, Physician's specialty and comments.
- After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes

See Appendix D for acceptable abbreviations.

Site-Specific Data Items (SSDI)

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
See table below		NAACCR	https://apps.naaccr.org/ssdi/list/

Description

Site specific data items apply to specific primary sites, histologies and years of diagnosis. In some cases, a Schema discriminator is required to be coded to further describe the site and /or histology. A list of schema discriminators 1 and 2 can be found in the SSDI manual.

Coding Instructions

You will need to use the SSDI manual or SEER*RSA for the general rules and specific coding instructions for each primary site grouping.

**NOTE: SEER*RSA does not provide general instructions. It is important that you review and are familiar with the general instructions. Site-specific instructions take priority over the general instructions.*

OCCR Required SSDIs

	NAACCR Item #	Item Name	Primary Site(s)	Histologies
Brain (2018-2022)	3816	Brain Molecular Markers	C700, C710-C719	8000-8700, 8720-8790, 8802, 8810, 8815, 8850, 8890, 8900, 9064, 9070-9071, 9080, 9084-9085, 9100-9105, 9120, 9133, 9140, 9180, 9220, 9362, 9364, 9380-9540, 9680, 9699, 9702-

				9715, 9751-9759; *Behavior 3*
			C700, C710-C719	8000-9993 *Behavior 0,1*
Melanoma Skin (2018+)	3817	Breslow Tumor Thickness	C000-C002, C006, C440-C449, C500, C510-C512, C518-C519, C600-C602, C608-C609, C632	8720-8790
	3932	LDH Lab Value		
Breast (2018+)	3827	Estrogen Receptor Summary	C500-C506, C508-C509	8000-8700, 8982-8983
			C501-C506, C508-C509	8720-8790
	3915	Progesterone Receptor Summary	C500-C506, C508-C509	8000-8700, 8982-8983
			C501-C506, C508-C509	8720-8790
	3855	HER2 Overall Summary	C500-C506, C508-C509	8000-8700, 8982-8983
			C501-C506, C508-C509	8720-8790
Liver (2018+)	3835	Fibrosis Score	C220	8000-8700, 8720-8790
Bile Ducts Intrahepatic (2018+)			C221	8000-8700, 8720-8790, 8980
Prostate (2018+)	3838	Gleason Patterns Clinical	C619	8000-8700, 8720-8790
	3840	Gleason Score Clinical		
	3839	Gleason Patterns Pathological		
	3841	Gleason Score Pathological		
	3842	Gleason Tertiary Pattern		
	3920	PSA Lab Value		
Colon & Rectum (2018+)	3890	Microsatellite Instability (MSI)	C180, C182-C189, C199, C209	8000-8149, 8154, 8160-8231, 8243-8248, 8250-8682, 8690-8700, 8720-8790
Cervix (2021+)	3956	p16	C530-C531, C538-C539	8000-8700, 8720-8790, 8980, 9110 Year of Diagnosis: 2021-9998, 9999
Anus (2023+)			C210-C212, C218	8000-8700, 8720-8790

Vulva (2024+)			C510-C512, C518-C519	8000-8040, 8042-8180, 8191-8246, 8248-8700, 9020, 9071
Esophagus & EG J (Squamous) (2018+)	3829	Esophagus and EGJ Tumor Epicenter	C150-C155, C158-159 C160	8050-8054, 8020, 8070, 8074, 8077, 8083, 8560
Appendix (2023+)	3960	Histologic Subtype	C181	8480
Lymphoma (excluding CLL/SLL) (2018+)	1172	PTLD	See SSDI Appendix A Schema 00790	
Lymphoma-CLL/SLL (2018+)			See SSDI Appendix A Schema 00795	
Primary Cutaneous Lymphomas (excluding Mycosis Fungoides) (2018+)			See SSDI Appendix A Schema 00812	
Plasma Cell Myeloma (2018+)			See SSDI Appendix A Schema 00821	
Plasma Cell Disorders (2018+)			See SSDI Appendix A Schema 00822	
Lung (2025+)	1174	PD-L1	C340-C343, C348-C349	8000-8700, 8720-8790, 8972, 8980, 8982

STAGE PROGNOSTIC FACTORS

Tumor Size Summary

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
756	3	NPCR/CoC	Standards for Oncology Registry Entry (STORE)

Description

Records the most accurate measurement of a solid primary tumor.

Justification

The size of the tumor is one indication of the extent of disease. It is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Coding Instructions

All measurements should be in millimeters (mm).

Record the size in the specified order:

1. Size measured on the surgical resection specimen, when surgery is administered as the first definitive treatment, i.e., no pre-surgical (neoadjuvant) treatment administered.
    a. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (also known as CAP protocol or pathology report checklist).
    b. If only a text report is available, use: final diagnosis, microscopic, or gross examination, in that order.

Example: Chest x-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. Record tumor size as 028 (28 mm).

Example: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. Record tumor size as 032 (32 mm).

2. If neoadjuvant therapy is followed by surgery, do not record the size of the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size 999.

   Example: Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size after total resection is 2.8 cm. Record tumor size as 022 (22mm).

3. If no surgical resection, then record the largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures prior to any other form of treatment (See Coding Rules below).

4. If 1, 2, and 3 do not apply, the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

Coding Rules

1. Tumor size is the **diameter** of the tumor, **not the depth or thickness** of the tumor.
2. Recording less than/greater than Tumor Size:
   a. If tumor size is reported as less than x mm, or less than x cm, the reported tumor size should be 1 mm less; for example, if size is < 1 cm code as 009, < 2 cm is coded as 019, < 3 cm is coded as 029, < 4 cm is coded as 039, < 5 cm is coded as 049. If stated as less than 1 mm, use code 001.
   b. If tumor size is reported as more than x mm or more than x cm, code size as 1 mm more; for example, if size is >10 mm, size should be coded as 011. Often these are given in cm such as > 1 cm, which is coded as 011, > 2 cm is coded as 021, > 3 cm is coded as 031, > 4 cm is coded as 041, > 5 cm is coded as 051. If described as anything greater than 989 mm (98.9 cm) code as 989.
   c. If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two: i.e., add the two sizes together and then divide by two (“between 2 and 3 cm” is coded as 025).
3. **Rounding:** Round the tumor size only if it is described in fractions of millimeters. If the largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm), record size as 001 (do not round down to 000). If tumor size is greater than 1-millimeter, round tenths of millimeters in the 1-4 range down to the nearest whole millimeter, and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. Do not round tumor size expressed in centimeters to the nearest whole centimeter (rather, move the decimal point one space to the right, converting the measurement to millimeters). For breast cancer, please follow the AJCC 8th Edition, Breast Chapter.

Examples:

Breast cancer described as 6.5 millimeters in size*. Round up Tumor Size as 007.*

Cancer in polyp described as 2.3 millimeters in size. *Round down Tumor Size as 002.*

Focus of cancer described as 1.4 mm in size. *Round down as 001.*

5.2 mm breast cancer. *Round down to 5 mm and code as 005.*

4. **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.
5. **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.
6. **Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis.** However, if the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.
7. Record the size of the invasive component, if given.
    a. If both an in situ and an invasive component are present and the invasive component is measured, record the size of the invasive component even if it is smaller.

        Example: Tumor is mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive. Record tumor size as 014 (14 mm).

    b. If the size of the invasive component is not given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

        Example: A breast tumor with infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023 (23 mm).

        Example: Duct carcinoma in situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (19 mm).

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. Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).
9. Record the size as stated for purely in situ lesions.
10. **Disregard microscopic residual or positive surgical margins when coding tumor size.** Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data item.
11. **Do not add the size of pieces or chips together to create a whole**; they may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size. If the only measurement describes pieces or chips, record tumor size as 999.

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. **Tumor size code 999 is used when size is unknown or not applicable.** Sites/morphologies where tumor size is not applicable are listed here.

    Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms: histology codes 9590-9993
    - *Excludes* cases collected in the following schemas: Lymphoma Ocular Adnexa, Primary Cutaneous Lymphomas, Mycosis Fungoides and lymphomas that are collected in the Brain, CNS Other and Intracranial Gland schemas.

    Kaposi Sarcoma
    Melanoma Choroid
    Melanoma Ciliary Body
    Melanoma Iris

14. Tumor size code 000 is used for the following schema:
    i. Schema is Cervical Lymph Nodes and Unknown Primary 00060
    ii. Occult Cervical Lymph Node (See STORE, Overview of Coding Principles, page 44).
15. ***Document the information to support coded tumor size in the appropriate text data item of the abstract.***
16. Tumor size is also important for staging for certain sites/schemas and schema IDs; refer to STORE 2025 for the complete list of schemas.

Code	Label
000	No Mass/Tumor Found
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2 mm to 988 mm)
989	989 millimeters or larger
990	Microscopic focus or foci **and** no size of focus is given
998	SITE-SPECIFIC CODES Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: - Rectosigmoid and rectum (C19.9, C20.9) - Colon (C18.0, C18.2-C18.9) 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

SECTION 8

SOLID TUMOR RULES

Preface

The Solid Tumor Rules (along with its predecessor, the 2007 Multiple Primary and Histology Rules) were developed to promote consistent and standardized coding by cancer registrars. The primary reference for both the 2007 MPH rules and Solid Tumor Rules are the WHO Classification of Tumors books (blue books). Since 2007, WHO has continued publishing updates to the WHO Classification of Tumors series. As part of each new edition, subject matter experts review current literature and make recommendations regarding current practices in histology terminology and diagnosis. The Solid Tumors Rules are continually revised to reflect current CAP and WHO practices. Beginning 2024, the Solid Tumor Editorial Board replaces the Solid Tumor Work Group and is comprised of the Solid Tumor editors, expert Oncology Data Specialists, and expert pathologists, oncologists, surgeons, and clinicians. As part of ongoing revisions to the rules, the editors and Solid Tumor Editorial Board review issues and questions NCI SEER received from the registrar community. These questions provided valuable information as to what clarifications were needed in the form of additional rules, tables, examples, and notes. Physician guidance by specialty pathologists and clinicians is integral to the review and revision process. Regular consultation with the editors of the WHO Classification of Tumors series and AJCC physicians ensures that the rules accurately reflect the editors' intent and purpose

Solid Tumor Rules Notes:

The purpose of the Solid Tumor Rules is to determine the number of primaries to abstract and the histology to code. (This helps to prevent over-reporting tumors.) **The most recent Solid Tumor Rules update should be used as soon as it is released** and can be applied to 2018+ cases (see General Instructions for start years for each Site Group). If a specific code or instruction has an effective date later than 2018, it will be noted in the text. ***Previous versions are archived and should not be used.***

The Solid Tumor Rules are revised annually to reflect new terminology, ICD-O codes, and other changes to keep in step with current clinical practice. It is important to review the current change log as it will provide helpful information on changes made to the annual update. Beginning with the 2025 Solid Tumor Update, the rules will be available in a combined file only. Individual site-specific sections will no longer be provided. **ALWAYS** open the Solid Tumor Rules from the SEER website (https://seer.cancer.gov/tools/solidtumor/). This ensures that you are using the most recent Solid Tumor Rules update.

If there are any questions regarding the primary site and/or histology to assign, submit your question to OCCR at OCCR@Health.OK.gov. Always include the primary site and diagnosis year, as well as any known prior cancers; this assists us in answering any questions. If necessary, OCCR will submit the question to Ask a SEER Registrar on behalf of the reporter or registrar.

Using the Solid Tumor Rules

It is **vital** that the following sections of the Solid Tumor Rules be read before any site-specific instructions are applied:

1. General Equivalent or Equal Terms

2. How to Navigate the Solid Tumor Rules
3. How to Use the Solid Tumor Rules
4. How to Use the Equivalent Terms and Definitions
5. Multiple Primary Rules Do NOT Apply to Tumors Described as Metastases
6. How to Use the Multiple Primary Rules
7. Timing Rules
8. Histologic Type ICD-O-3
9. Important Information for Coding Histologic Type for Cases Diagnosed 1/1/2018 Forward
10. How to Use the Histology Rules
11. Priority Order for Using Documentation to Code Histology
    a. **Note:** Ambiguous terminology from the SEER Manual and/or CoC Manual is used to determine reportability, not to determine histology.
12. Definitions

SECTION 9

ABSTRACTING TREATMENT DATA

Text Requirements

Text documentation to support cancer diagnosis, stage and treatment codes **must be provided by all facilities**. ***The main purpose of text fields in the abstract is to justify coded values and to document supplemental information not transmitted within coded values.***

Text documentation is an essential component of an abstract and is heavily utilized in quality control, to validate data at time of NPCR audits and special studies. It is also used to ensure that the data meets the standards of ACoS, NAACCR, NCDB, SEER and NPCR. Adequate text is a data quality indicator and a major part of Quality and Completeness studies.

The OCCR relies solely on the text documentation provided from reporting facilities to ensure coding in the abstract is correct. High quality text facilitates consolidation of information from multiple reporting sources at the central registry, as well as in reabstraction audits.

See section six for all text data item descriptions. Please see Appendix G for details on text documentation requirements, as well as examples.

First Course of Treatment

Cancer-directed therapy or definitive treatment is treatment that is recommended by the physician that will affect control, change, remove or destroy the cancer-involved tissue of the primary site or of a metastatic site. It is administered before the disease progresses or recurrence occurs. The first course of treatment is any cancer-directed treatment recorded in the treatment plan and administered before disease progression or recurrence. If there is no treatment plan, established protocol or management guidelines (such as NCCN) 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." This includes any first course treatment administered at the reporting facility or elsewhere, all treatment planned or administered by physician(s). Treatment can include multiple types and may last for a year or more. Any treatment meeting this guideline evaluation must be coded in the appropriate treatment data field and documented in the *treatment text* field(s).

> "Active surveillance" is a form of planned treatment for some patients. It is coded in *RX--Summ--Treatment Status* [1285].
>
> "*No therapy*" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given. If the patient refuses all treatment, code "patient refused" (code 7 or 87) for all treatment modalities.
>
> Maintenance treatment given as part of the first course of planned care is first course treatment.

NOTE: Leukemia treatment includes all therapies planned and delivered by the physician(s) during the first diagnosis of leukemia. This includes all treatment that is remission-inducing or remission-maintaining. It may include multiple methods and can last more than a year. After relapse of the first remission, the treatment administered is not considered first course of treatment.

NOTE: If there is a change in systemic therapy because of a failure of the original delivered treatment or a reaction to the treatment by the patient, the new treatment therapy is considered to be first course of treatment if the replacement agents belong to the same group as the original agent, there is no change in the regimen. However, if the replacement agent is of a different group than the original agent, the new regimen represents the start of subsequent therapy. Please refer to SEER*RX https://seer.cancer.gov/tools/seerrx/.

NOTE: Prostate cancer patients are often treated with "watchful waiting." This is considered first course of treatment. If a PSA is done later and additional treatment is started, this is considered subsequent treatment and not part of first course of treatment. Prostate patients are also treated with hormone therapy followed by brachytherapy as part of first course of treatment and may take up to a year to complete the treatment.

Neoadjuvant Treatment

Sometimes radiation therapy or chemotherapy is given before surgery is performed to shrink the size of the tumor or reduce the cancer spread. This neoadjuvant treatment (pre-treatment before surgery) is coded as part of first course of treatment.

Subsequent Treatment

This is for informational purposes only. The OCCR does NOT collect or require subsequent treatment.

Subsequent course of treatment is any and all cancer-directed treatment that is not given in accordance with the definition of first course of treatment, including treatment given for disease recurrence and/or disease progression. It also includes cancer-directed treatment starting *after* a course of active surveillance of watchful waiting.

Example: Patient with prostate cancer is being followed with serial PSA draws. He is noted to have a rise in PSA. His physician recommends active treatment in the form of radiation now be administered. Patient receives radiation therapy as recommended. The first course of treatment is "active surveillance" with serial PSA draws. Radiation therapy is a subsequent course of treatment.

Example: Patient diagnosed with chronic lymphocytic leukemia (CLL) and is being followed by their oncologist (i.e., "watchful waiting"). A few months later, patient notes swelling in their axillary and inguinal lymph node regions. Upon further workup, the oncologist notes that the patient has experienced disease progression and starts the patient on a chemotherapy regimen. The first course of treatment is "watchful waiting" and the subsequent course of treatment is the chemotherapy regimen.

Diagnostic Procedure

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1350	2	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

Identifies the positive surgical procedure(s) performed to diagnose and/or stage disease.

Justification

This data item is used to track the use of surgical procedure resources that are not considered treatment.

Coding Instructions

Codes	Description
00	No surgical diagnostic or staging procedure was performed.
01	A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.
03	A surgical exploration only. The patient was not biopsied or treated.
04	A surgical procedure with a bypass was performed, but no biopsy was done.
05	An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06	A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07	A procedure was done, but the type of procedure is unknown.
09	No information of whether a diagnostic or staging procedure was performed.

1. Record the type of procedure performed as part of the initial diagnosis and workup, whether this is done at your institution or another facility.
2. Only record positive procedures. For benign and borderline reportable tumors, report the biopsies positive for those conditions. For malignant tumors, report procedures if they were positive for malignancy.
3. If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (incisional biopsy of primary site).
4. If a lymph node is biopsied or removed to diagnose or stage lymphoma, and that node is NOT the only node involved with lymphoma, use code 02. If there is a single lymph node involve with lymphoma, use the data item *RX – Surg 2023* [1291] to code these procedures.
5. Do not code surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease in this data item. Use the data item Scope of Regional Lymph Node Surgery [1292] to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item Date of Surgical Diagnostic and Staging Procedure [1280]. See instructions for Scope of Regional Lymph Node Surgery [1292].

6. Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item Diagnostic Confirmation [490]. These are not considered surgical procedures and should not be coded in this item.
7. Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *RX Summ – Surg 2023* [1291] to code these procedures.
8. If a needle biopsy precedes an excisional biopsy or more extensive surgery, and upon the excisional biopsy or more extensive surgery the surgical margins are clear (i.e., no tumor remains), DO NOT consider the needle biopsy to be an excisional biopsy. The needle biopsy should be recorded as such in the Surgical Diagnostic and Staging Procedure [1350] data item and the excisional biopsy or more extensive surgery in the *RX Summ – Surg 2023* [1291].
9. Do not code palliative surgical procedures in this data item. Use the data item Palliative Procedure [3270] to code these procedures.

Date of Diagnostic Procedure

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1280	8	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

Records the date on which the surgical diagnostic and/or staging procedure was performed.

Justification

This data item is used to track the use of surgical procedure resources that are not considered treatment.

Coding Instructions

1. Record the date on which surgical diagnostic and/or staging procedure described in Surgical Diagnostic and Staging Procedure [1350] was performed at this or any facility.
2. Blank is allowed.
3. Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this modification does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for Date of Surgical Diagnostic and Staging Procedure is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of Date of Surgical Diagnostic and Staging Procedure transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable.

Date 1st Course RX CoC

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1270	8	CoC	Standards for Oncology Registry Entry (STORE)

Description

Date on which treatment (surgery, radiation, systemic, other therapy, active surveillance, or decision for no treatment) began at any hospital or non-hospital setting to include treatment centers, physician offices, ambulatory surgery centers, etc. The date of first treatment includes the date a decision was made not to treat the patient. See STORE for details.

Justification

Used to measure the delay between diagnosis and the onset of treatment. A secondary use for this date is as a starting point for survival statistics (rather than using the diagnosis date). This date cannot be calculated from the respective first course treatment modality dates if no treatment was given. Therefore, providing the date on which active surveillance is chosen, a physician decides not to treat a patient, or a patient's family or guardian declines treatment is important.

Coding Instructions

1. Record the earliest of the following dates:
    - Date of First Surgical Procedure [1200]
    - Date Radiation started [1210]
    - Date Systemic therapy started [3230]
        - RX Date Chemotherapy [1220]
        - RX Date-Hormone Therapy [1230]
        - RX Date Immunotherapy [1240]
    - Date Other Treatment started [1250]
    - RX Summary—Scope of Reg Ln Surgery [1292]
        - **EXCEPT** for code 1
2. If active surveillance or watchful waiting is selected as the first course of treatment (*RX Summ--Treatment Status* [1285] = 2), record the date this decision was made.
3. In cases of non-treatment (*RX Summ–Treatment Status* [1285] = 0), in which a physician decides not to treat a patient, a patient's family, or guardian declines all treatment, or patient receives palliative care for pain management only, the date of first course of treatment is the date this decision was made.
4. Leave data item blank if the cancer was diagnosed at autopsy and not suspected prior to that.
5. Date Format:
    - MMDDYYYY when the complete date is known.
    - MMYYYY when the year and month are known but the day is unknown.
    - YYYY when the year is known but the month and day are unknown.
    - Treatment dates for a fetus prior to birth are to be assigned the actual date of the event.
6. Unproven Therapy: code date initiated as date therapy initiated.
7. Unknown Date: code the date of admission to the hospital for inpatient or outpatient. treatment when the exact date of the first treatment is unknown.

8. Leave Blank:
    - Death Certificate only cases when the date is unknown and cannot be estimated.
    - Autopsy only cases.

See Section 6: Cancer Information, Estimating Dates for instruction on estimating dates.

Examples

Code	Reason
20240214*	Patient had a core biopsy on February 12, 2024, and subsequently undergoes an excisional biopsy on February 14, 2024.
20240421*	A patient started preoperative (neoadjuvant) radiation therapy elsewhere on April 21, 2024, followed by surgical resection at your facility on June 12, 2025.
20240617*	Patient diagnosed with prostate cancer by prostate biopsy on May 6, 2024. On June 17, 2024, he met with his urologist and opted for active surveillance as his first course of treatment.

*Registrars will enter dates as MMDDYYCC. Registry software automatically transmits dates in the required NAACCR record layout format CCYYMMDD.

RX Summary – Scope of Reg LN Surgery

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1292	2	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

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 at all facilities.

Justification

Can be used to compare and evaluate the extent of surgical treatment.

Coding Instructions

1. The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.
2. Record all surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item. Record the date of this surgical procedure in data item Date of First Course of Treatment [1270] and/or Date of First Surgical Procedure [1200] if applicable (excluding code 1).
    a. The regional lymph node surgical procedure(s) may be done to **diagnose** cancer, **stage** the disease, or as a part of the initial **treatment**.
    Example: Patient has a sentinel node biopsy of a single lymph node. Assign code 2 (Sentinel lymph node biopsy [only]).
3. Record the date of this procedure in Date of Sentinel Lymph Node Biopsy [832] and/or Date Regional Lymph Node Dissection [682], if applicable.
4. Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
5. If two or more surgical procedures of regional lymph nodes are performed, the codes entered in the registry for each subsequent procedure must include the cumulative effect of all preceding procedures. For example, a sentinel lymph node biopsy followed by a regional lymph node

dissection at a later time is coded 7. **Do not rely on registry software** to determine the cumulative code.

6. Do not code distant lymph nodes remove during surgery to the primary site for this data item. Distant nodes are coded in the data field Surgical Procedure/Other Site [1294].
7. Refer to the current *AJCC Cancer Staging System* and/or *Extent of Disease (EOD) 2018* manual for site-specific identification of regional lymph nodes.
8. If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item Palliative Care [3270].
9. Use the **entire operative report** as the primary source document to determine whether the operative procedure was sentinel lymph node biopsy (SLNBx), a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The body of 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 two 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.
10. Add the number of all lymph nodes removed during each surgical procedure performed as part of the first course of treatment. The Scope of Regional Lymph Nodes field is **cumulative**.
    a. Lymph node needle biopsies or aspirations
        i. Do **not** add regional nodes that were biopsied or aspirated, and that node is in the resection field. Do not add the aspirated node to the total number.
        ii. Count as an additional node when a regional node is biopsied or aspirated and it is NOT in the resection field, count as an additional node and add it to the total number.
        iii. Assume the lymph node that is aspirated is part of the lymph node chain surgically removed and do **not** include it in the count when its location is **not known**
11. Code the removal of regional nodes for both primaries when the patient has two primaries with common regional lymph nodes
    a. 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.
12. Assign the appropriate code for occult head and neck primaries with positive cervical lymph nodes (schema 00060). Do not default to code 9 for this schema.
13. Assign code 0 when
    a. Regional lymph node removal procedure was not performed (**Note:** Excludes all sites and histologies that would be coded 9. (See Coding Instruction #13 below.) OR
    b. First course of treatment was active surveillance/watchful waiting OR
    c. The operative report lists a lymph node dissection, but no nodes were found by the pathologist

14. Assign code 1 when a regional lymph node is biopsied or aspirated and no further lymph node procedures were performed.
15. Assign code 2 when
    a. The operative report states that a **SLNBx was performed, OR**
    b. 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.
    c. **NOTE:** 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 (harvested) as part of the SLNBx procedure by the surgeon. Code this as SLNBx (code **2**). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as **6**.
16. Codes **3, 4 and 5:** The operative report states that a regional lymph node dissection was performed (a SLNBx was **not** done during a prior procedure or during this procedure)
    a. Code **3**: : 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)
    b. Code **4** should be used infrequently. Review the operative report to ensure the procedure was **not** SLNBx only.
    c. Code **5**: If a relatively small number of nodes was examined pathologically, review the operative report to confirm 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 same, or separate, procedure (code 6 or 7)
17. Code **6**: SLNBx and regional lymph dissection (code 3, 4 or 5) during the same surgical event or timing not known.
18. Code **7**: SLNBx and regional lymph node dissection (code 3, 4 or t) in separate surgical events.
19. Code **9**: The status of regional lymph node evaluation should be known for surgically treated cases. Review surgically treated cases coded as 9 to confirm the code.
    a. Assign code **9** for any Schema ID with primary site: C420, C421, C423, C424, C589, C700-C709, C710-C729, C751- C753, C761-C768, C770-C779, C809

Code	Description	Definition	General Instructions
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.	
1	Biopsy or aspiration of regional lymph nodes, NOS	Biopsy or aspiration of regional lymph nodes(s) regardless of the extent of involvement.	Review the operative report to confirm the type of biopsy performed (excisional or aspiration). It should not include dye or tracer for SLNBx (code 2)
2	Sentinel lymph node biopsy only	Biopsy of the first few lymph node(s) into which a tumor drains.	The operative report states that a SLNBx was performed or describes using dye, tracer, or combination to identify a lymph node(s) for removal. *Note:* When a SLNBx is performed, additional non-SLNs can be taken during the same operative procedure. Code this

			SLNBx (code **2**). If the operative report confirms that a regional lymph node dissection followed the SLNBx, code these as **6**.
3	Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS	Sampling or dissection of regional lymph node(s) and the number removed is not stated or is unknown. The operative report should not identify this as SLNBx.	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)
4	1 to 3 regional lymph nodes removed	Sampling or dissection of lymph node(s) with between one and three lymph nodes in the specimen and is not a SLNBx.	Code **4** should be used infrequently. Review the operative report to ensure the procedure was not SLNBx only.
5	4 or more regional lymph nodes removed	Sampling or dissection of lymph node(s) with four or more lymph nodes in the specimen and is not a SLNBx.	Code **5**: If a relatively small number of nodes was examined pathologically, review the operative report to confirm the procedure was not 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 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). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. Code these cases as 2 if no further dissection of regional lymph nodes was undertaken, or 6 when regional lymph nodes were dissected during the same operative event.
6	Sentinel node biopsy and code 3, 4, or 5 at same time or timing not noted	SLNBx performed in the same surgical procedure with either code 3, 4 or 5 or timing is not known.	Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only. Infrequently, a 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). 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	SLNBx performed followed by Code 3, 4 or 5 performed at different times.	Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery was performed Death Certificate Only Lymphomas with a lymph node primary Unknown or Ill-defined primary Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.	The status of regional lymph node surgery should be known for surgically treated cases (i.e., cases coded 19-90 in the data item Surgery of Primary Site [NAACCR Item #1290]). Review surgically treated cases coded as 9 in Scope of Regional Lymph Node Surgery to confirm the code. See additional instructions below.

Regional Nodes Positive

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
820	2	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

Records the exact number of regional nodes examined by the pathologist and found to contain metastases. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system (CS). In 2016, use of CS was discontinued, however this data item continues to be required.

Justification

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.

Coding Instructions

Codes	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

1. **Regional lymph nodes only.** Record information about only regional lymph nodes in this field. Distant lymph node information should not be coded in this field.
    a. Include lymph nodes that are regional in the current AJCC Staging System or *EOD Regional Nodes*.
2. This field is based on **pathologic information only**. Record regardless of whether the patient received neoadjuvant (preoperative) treatment.
3. **Nodes positive is cumulative**. Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.
    a. The number of regional nodes positive is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.
    b. Do **not** count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection. In other words, if there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also Use of Code 95 below.
    c. Include the node in the count of Regional Nodes Positive when the positive aspiration or core biopsy is from a node in a different node region.
    d. If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Positive.
    e. **Priority of lymph node counts**. Use information in the following priority when there is a discrepancy regarding the number of positive lymph nodes use the information in the following priority order: final diagnosis, synoptic report (also known as the CAP protocol or pathology report checklist), microscopic, gross.
4. **Positive nodes in multiple primaries in same organ:**
    a. If there are multiple primary cancers with different histologic types in the same organ and the pathology report just states the number of nodes positive, the registrar should first try to determine the histology of the metastases in the node(s) and code the node(s) as positive for the primary with that histology. If no further information is available, code the node(s) as positive for all primaries.
5. **Isolated Tumor Cells (ITCs)** in lymph nodes:
   All primary sites **except** cutaneous melanoma and Merkel cell carcinoma of skin
    a. Count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size). Do not include in the count of lymph nodes positive any nodes that are identified as containing ITCs.
    b. Assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive when the path report indicates that nodes are positive, but the size of metastasis is not stated.
6. **For Cutaneous melanoma and Merkel cell carcinoma**: count nodes with ITCs as positive lymph nodes.
7. **Use of Code 95:** Use **code 95** when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue). There are no surgically resected lymph nodes or surgically resected lymph nodes are negative. Use code 95 when a positive lymph node is core

biopsied or aspirated and there are no surgically resection lymph nodes. Use code 95 when a positive lymph node is aspirated and surgically resected lymph nodes are negative.

8. **Definition of Code 97:** Use **code 97** for any combination of positive aspirated, biopsied, sampled, or dissected lymph nodes when the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology. Note: If the core biopsied or aspirated node is the one that is microscopically positive, use code 95.
9. **Use of Code 98.** Code 98 may be used in several situations:
    a. When the assessment of lymph nodes is clinical only,
    b. When no lymph nodes are removed and examined, a
    c. When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
    d. When Regional Nodes Positive is coded 98, Regional Nodes Examined is usually coded 00.
10. **Use of Code 99.** Use **code 99** when it is unknown whether regional lymph nodes are positive or for:
    a. Any case coded to primary site: C420, C421, C423, C424, C589, C700-C709, C710-C729,
    b. C751-C753, C761-C768, C770-C779, or C809
    c. b. Lymphoma 00790
    d. c. Lymphoma-CLL/SLL 00795
    e. d. Plasma Cell Disorders (excluding 9734/3) 00822
    f. e. HemeRetic 00830 (excluding primary sites C420, C421, C423, C424)
    g. f. Ill-Defined/Other 99999
    h. Cases with no information about positive regional lymph nodes

Regional Nodes Examined

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
830	2	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system (CS). In 2016, use of CS was discontinued, however this data item continues to be required.

Justification

This data item serves as a quality measure of the pathologic and surgical evaluation and treatment of the patient.

Codes	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 stated in patient record

Coding Instructions

1. Code only **regional lymph nodes in this data item**. Include lymph nodes that are regional in the current AJCC staging manual. Do not code distant lymph node information in this data item.
    a. Include lymph nodes that are regional in the current AJCC Staging System or *EOD Regional Nodes*.
2. This field is based on **pathologic information only**. Record regardless of whether the patient received neoadjuvant (preoperative) treatment.
3. **Use of Code 00: Code 00** may be used in several situations.
    a. When the assessment of lymph nodes is clinical.
    b. When no lymph nodes are removed or examined.
    c. When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
    d. When Regional Nodes Examined is coded 00, Regional Nodes Positive is coded 98.
4. **Cumulative nodes removed and examined**. Record the total number of regional lymph nodes removed and examined by the pathologist.
    a. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment with the exception of aspiration or core biopsies coded to 95.
    b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Examined.
    c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Examined.
    d. If the location of the lymph node that is aspirated or core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Examined.
    e. When neither the type of lymph node removal procedure nor the number of lymph nodes examined is known, use code 98.
5. **Priority of lymph node counts.** If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.
6. **Use of code 95:** Use **code 95** when the **only** procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).
7. **Lymph node biopsy**. If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, use code 96.

8. **Code 96 Definition of "sampling."** A lymph node "sampling" is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.
9. **Code 97 Definition of "dissection."** A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed, and the number is unknown.
10. **Multiple lymph node procedures**. If both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown, use code 97.
11. **Use of Code 99.** If it is unknown whether nodes were removed or examined, code as 99.
12. Use code **99** for
    a. Any case coded to primary site: C420, C421, C423, C424, C589, C700-C709, C710-C729, C751-C753, C761-C768, C770-C779, or C809
    b. Lymphoma 00790
    c. Lymphoma-CLL/SLL 00795
    d. Plasma Cell Disorders (excluding 9734/3) 00822
    e. HemeRetic 00830 (excluding primary sites C420, C421, C423, C424)
    f. Ill-Defined/Other 99999
    g. Cases with information about positive regional lymph nodes.

RX Summ--Surg Prim Site 03-2022

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1290	2	SEER/CoC	SEER Program Coding & Staging Manual Standards for Oncology Registry Entry (STORE)

Description

Describes a surgical procedure that removes and/or destroys tissue of the primary site and is performed as part of the initial diagnostic and staging work-up or first course of therapy. The most definitive surgical procedure performed at any facility should be coded in this data item. Applicable for cases diagnosed 2003-2022.

Justification

Identifies the specific cancer-directed surgery of the primary site.

Coding Instructions

Code	Label	Definition
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10-19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced.
20-80	Site-specific codes; resection	Surgery codes can be found in the STORE manual Appendix A or the SEER Coding Manual Appendix C
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

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.

Surgery codes can be found in the STORE manual Appendix A or the SEER Coding Manual Appendix C

- If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site.
- If registry software allows multiple procedures to be recorded, this item refers to the most invasive surgical procedure of the primary site.
- For codes 00 through 79, the codes are hierarchical. Codes listed last take precedence over preceding codes. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is not available.
- Excisional biopsies that remove the entire tumor and/or leave only microscopic margins are coded in this data item.
- If a needle biopsy is performed prior to an excisional biopsy or more extensive surgery, and the excisional biopsy or more extensive surgery reveals no residual cancer, the needle biopsy is NOT considered an excisional biopsy and should be coded in the data item *Surgical Diagnostic and Staging Procedure*.
- If regional tissue or organs are removed, only code in this data item if they are removed in continuity with the primary site, except where noted in STORE appendix B.
- If a portion of the primary site is surgically resected followed by an additional surgical resection to remove the remainder of the primary site, code the total final results. Do not rely on registry software to perform this task for you.
- If the procedure coded in this data item is also palliative (provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable) then **also** record this surgery in the *Palliative Care* data item.

RX Summ--Surg Prim Site 2023

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1291	4	SEER/CoC	Standards for Oncology Registry Entry (STORE) SEER Program Coding & Staging Manual

Description

Records the Surgery of Primary Site describes a surgical procedure that removes and/or destroys tissue of the primary site that is performed as part of the initial diagnostic and staging work-up or first course of therapy. Applicable for cases diagnosed 2023 and forward.

Justification

This data item can be used to compare the efficacy of treatment options.

Coding Instructions

1. Replaces Surgical Procedure of Primary Site [1290] for cases diagnosed 01/01/2023 and forward.
2. For diagnosis years 2003 – 2022, leave this data item blank and complete data item Surgical Procedure of Primary Site [NAACCR data item #1290]
3. See the 2023 STORE manual site-specific codes found in Appendix A.
4. For diagnosis year 2023 and forward, this data item must be completed.
5. If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site.
6. If registry software allows multiple procedures to be recorded, this item refers to the most invasive surgical procedure of the primary site.
7. Codes A000-A790 or B000-B790 are hierarchical. Use codes A800 (B800) and A900 (B900) only if more precise information about the surgery is not available.
8. Use code A000 or B000, as applicable, when cancer-directed surgery of the primary site is not performed.
9. Code A980 for any case coded to primary site C420, C421, C423, C424, C760-C768,C809

Note: All 2023 site specific surgery codes begin with a letter A except for skin which start with a letter B to indicate a significate change in coding.

For melanoma skin surgical codes ONLY:

- The priority order for sources used to assign surgery codes:
    - Operative report, statement from a physician, description of the surgical procedure on a pathology report, results of the pathology report. Code based on the description of the procedure.
    - Do not code based on margin status documented in the pathology report.

Rx Date - Most Definitive Surgical Resection of The Primary Site

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
3170	8	CoC	Standards for Oncology Registry Entry (STORE)

Description

Records the date of the most invasive, extensive or definitive surgical procedure of the primary site performed as part of the first course of treatment.

Justification

This item is used to measure the lag time between diagnosis and the most definitive surgery of the primary site. This may or may not be the date of **RX Date - Surgery.** The most definitive surgery is the most extensive resection of the primary site done during the first course of treatment.

Coding Instructions

Date of most definitive surgery should be entered even when no residual cancer is found in the most invasive, extensive definitive surgical specimen.

1. **Manually** record the date of the most invasive, extensive, or definitive surgery when Surgery of Primary Site 2023 was recorded as part of the first course of therapy.
    a. This is the date of the procedure coded in Surgery of Primary Site 2023
2. Transmit date data items in the year, month, day format (YYYYMMDD)
3. Leave date blank when Surgery of Primary Site 2023 is coded A000 or B000 (no surgery of primary site performed

Reason for No Surgery of Primary Site

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1340	2	SEER/CoC	SEER Program Coding & Staging Manual Standards for Oncology Registry Entry (STORE)

Description

Records the reason that no surgery was performed on the primary site.

Justification

This data item provides information related to the quality of care and describes why primary site surgery was not performed.

Coding Instructions

Code	Label
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. Diagnosed at autopsy.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned surgery 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. Death certificate only.

- Assign **Code 0** when surgery of the primary site performed. Surgery codes A100 – A900 or B100 – B900 (surgery of the primary site was performed).
- Assign **code 1-8** when surgery of the primary site is coded A980 (not applicable).
    - Assign **code 1** when:
        - When surgery of the primary site is coded A980 (not applicable).
        - Surgery is not planned as first course treatment which is documented in a treatment plan in the medical record or a physician statement that it was not recommended.
        - There is no information in the medical record about surgery and:
            - either 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 the primary site, e.g., the patient has advanced stage cancer.
        - The treatment plan offered multiple treatment options including surgery and the patient selected treatment other than surgery of the primary site.
        - Surgery was part of the planned first course of treatment but was cancelled due to complete response to radiation and/or systemic therapy.
        - The patient chose not to have any treatment. This includes refusal **before** any treatment recommendations are made.
        - Watchful waiting or active surveillance is recommended by the physician.
    - Assign **code** 2 when surgery of the primary site is contraindicated due to factors including, but not limited to, comorbid conditions, advanced age, or progression of disease prior to planned surgery.
    - Assign **code 6** when it is *known* that surgery was recommended, *and* it is *known* that surgery was not performed *and* there is **no documentation** to explain why no surgery was performed.
    - Assign **code 7** when the patient chooses not to have any treatment. This includes refusal **after** treatment recommendations are made and surgery is included in the recommended treatment.

        Note: A discussion with a physician that surgery *may* be an option is not a recommendation for surgery.

        A referral to a surgeon is *not* considered a recommendation for surgery.
    - Assign **code 8** when surgery is known to be recommended but it is unknown if the patient had surgery.
- Assign code 9 when there is no documentation that surgery was recommended or performed. For death certificate only and autopsy only cases.

RX Summ--Surg Other Regional/Distant

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1294	2	SEER/CoC	SEER Program Coding & Staging Manual Standards for Oncology Registry Entry (STORE)

Description

Records the surgical removal of distant lymph nodes or other tissue(s) or organ(s) removed beyond the primary site performed at any facility as part of first course treatment.

Justification

Documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Coding Instructions

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

- Assign the highest numbered code that describes the surgical resection of distant lymph nodes or other tissue or organs beyond the primary site surgical code and received as first course treatment at any facility.
- If other tissue or organs are removed to evaluate for possible malignant involvement during primary site surgery that are not specifically defined by the site-specific Rx Hosp – Surg 2023 [1291] or Rx Summ-Surg 2023 [671] code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code. Assign the highest numbered code that describes the surgical resection of *distant lymph node(s).* Incidental removal of tissue or organs that are not involved with cancer is not coded in this data item.
- Surgical Procedure/Other Site is collected for each surgical event even if surgery of the primary site was not performed.
- If multiple first course surgical procedures coded in this item are performed for a single primary, the code should represent the cumulative effect of those surgeries. Do not rely on registry software to perform this task for you. Assign Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0– 76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and

9975-9993). When the involved contralateral breast is removed for a single primary breast cancer.
- If the procedure coded in this item was palliative (provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable) then also record this surgery in the item Palliative Care.

Date Radiation Started

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1210	8	CoC	Standards for Oncology Registry Entry (STORE)

Description

Date on which first course radiation therapy for the diagnosis was started at any facility.

Justification

Identifies the Initial start date of first course radiation therapy.

Coding Instructions

1. Enter the date radiation therapy began.
2. Date format is DDMMYYYY when the full date is known, MMYYYY when only the month and year are known and YYYY when only the year is known.
3. If radiation therapy was performed but the date is not known, enter the year of diagnosis as the start date and leave the month and day blank. *Do not leave the date blank*.
4. If no radiation therapy was given or it is unknown if radiation therapy was given, leave the date blank.

Radiation Treatment Modality Phase I

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1506	2	CoC	Standards for Oncology Registry Entry (STORE)

Description

Identifies the radiation modality administered during the first phase of radiation treatment delivered during the first course of treatment.

Justification

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.

Coding Instructions

1. Radiation treatment modality will typically be found in the radiation oncologist's summary letter for first course of treatment. The OCCR only requires Radiation Treatment Modality Phase I. We do not require phase II and phase III to be reported.
2. For purposes of this data item, photons, x-rays, and gamma-rays are equivalent.

3. Use code 13 - Radioisotopes, NOS for radioembolization procedures, e.g., intravascular Yttrium-90.
    a. Do not confuse a radioiodine scan with treatment. Only treatment is recorded in this item.
4. This data item intentionally does not include reference to various MV energies because this is not a clinically important aspect of technique. A change in MV energy (e.g., 6MV to 12MV) is not clinically relevant and does not represent a change in treatment technique. It is rare for change in MV energy to occur during any phase of radiation therapy.
5. Code 98 was added to the data item Phase I Radiation Treatment Modality for cases where it is known radiation was given, but modality is unknown.
6. • Code 99 is only used when it is unknown if radiation was given or if diagnosis was by death certificate only.
7. This data item replaces RX--Regional RX Modality.

Code	Description
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-223
15	Radioisotopes, strontium-89
16	Radioisotopes, strontium-90
98	Radiation therapy administered but treatment modality is not specified or unknown
99	Unknown if radiation treatment administered

RX Summary - Surgery/Radiation Sequence

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1380	1	SEER/CoC	SEER Program Coding & Staging Manual Standards for Oncology Registry Entry (STORE)

Description

Records the order in which radiation and surgical procedures were given as part of first course treatment.

Justification

The sequence of radiation and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Coding Instructions

1. Surgery includes surgery of the primary site, scope of regional lymph node surgery or surgical procedure of other site.
2. Assign **code 0** when:
    - Either surgery or radiation was not performed
    - Surgery was performed but not radiation
    - Radiation was performed but not surgery
    - It is unknown if the patient has surgery and/or radiation
        - Death certificate only cases
3. Assign codes 2-9 when first course of therapy includes both cancer-directed surgery and radiation therapy.
4. If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

Code	Label	Definition
0	No radiation therapy and/or surgical procedures	No radiation therapy given or unknown if 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 it is unknown whether any surgery given.
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	At least two courses of radiation therapy are given before and at least two more after surgery to the 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 radiation	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.

Reason for No Radiation

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1430	1	CoC	Standards for Oncology Registry Entry (STORE)

Description

Records the reason that no regional radiation therapy was administered to the patient.

Justification

When evaluating the quality of care, it is useful to know the reason that various methods of therapy were not used, and whether the failure to provide a given type of therapy was due to the physician's failure to recommend that treatment, or due to the refusal of the patient, a family member, or the patient's guardian.

Coding Instructions

1. If Regional Treatment Modality Phase I is coded 00, then use the documentation in the record to code the reason radiation was not administered.
2. Assign **code 1** if the treatment plan offered multiple alternative treatment options and the patient chose treatment that did not include radiation therapy.
3. Assign **code 7** if radiation therapy was recommended and the patient refused the treatment specifically, or refused all recommended treatment, or refused all treatment before any was recommended.
4. Assign **code 8** if it is known that a physician recommended radiation therapy but there is no further documentation to confirm that it was administered.
5. Assign **code 9** if multiple treatment options were included in the treatment plan and it is unknown which treatment, if any, was administered.

Code	Label
0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first course treatment. Diagnosed at autopsy.
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 cases only.

Date Chemotherapy Started

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1220	8	CoC	Standards for Oncology Registry Entry (STORE)

Description

Date of initiation of chemotherapy that is part of the first course of treatment.

Justification

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

1. Record the first or earliest date on which chemotherapy was administered at any facility. This date corresponds to the administration of the agents coded in *Chemotherapy*.
    a. This is not the date that a port was placed.
2. This data item is required by OCCR for all reporting years.
3. Date format is DDMMYYYY when the full date is known, MMYYYY when only the month and year are known and YYYY when only the year is known.
4. Date Chemotherapy Started should be the same as Date Therapy Initiated when chemotherapy is the only treatment administered

RX Summ--Chemo

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1390	2	SEER/CoC	SEER Program Coding & Staging Manual Standards for Oncology Registry Entry (STORE)

Description

Documents the type of chemotherapy of the first course of treatment at any facility. If chemotherapy is not administered, then this item records the reason it was not administered.

Justification

Allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy. When evaluating the quality of care, it is useful to know the reason chemotherapy was not administered.

Coding Instructions

NOTE: The following drugs changed categories effective with cases diagnosed 01/01/2013 and forward.

Drug Name/Brand Name	Pre-2013 Category	New Category effective 01/01/2013
Alemtuzumab/Campath	Chemotherapy	BRM/Immunotherapy
Bevacizumab/Avastin	Chemotherapy	BRM/Immunotherapy
Rituximab/Rituxin	Chemotherapy	BRM/Immunotherapy
Trastuzumab/Herceptin	Chemotherapy	BRM/Immunotherapy
Pertuzumab/Perjeta	Chemotherapy	BRM/Immunotherapy
Cetuximab/Erbitux	Chemotherapy	BRM/Immunotherapy

*SEER*RX should be used for assistance in coding systemic therapy correctly.*

- Assign code 00 when:
  - Chemotherapy was not administered, not recommended, or not indicated for the type of cancer.
  - If there is no information in the medical record regarding chemotherapy and it is typically not administered for this type of cancer or stage.
  - If the treatment offered multiple alternative treatment options and the patient chose treatment that did not include chemotherapy, or the treatment plan was no treatment.
  - Diagnosis is at autopsy.
- Assign codes 82, 85, 86 or 87 when it is known that chemotherapy is usually administered for the type of cancer but was not administered to the patient.
  - Assign code 87 when the patient refuses recommended chemotherapy or refused all treatment before or after treatment recommendations were made.
- Code 88 if it is known that a physician recommended the patient receive chemotherapy, but no further documentation is available yet to confirm its administration
- Code 88 to indicate referral was made to a medical oncologist and the registry must follow to determine whether it was given. If follow-up with the specialist or facility indicates the patient was never there, code 00.
- Assign code 99 when it is unknown if chemotherapy is typically administered for the type and stage of cancer and there is no mention in the medical record if it was recommended or administered. Death certificate only case.
- *Chemoembolization* should be coded to 01, 02 or 03 depending on the number of chemotherapeutic agents involved.
- *Change in chemotherapeutic agent(s)*: 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.* Refer to SEER*RX for assistance.
- Beginning with cases diagnosed 01/01/2025 or after, radiosensitizing chemotherapy should be recorded as chemotherapy.
- Refer to the SEER*Rx Interactive Drug Database (*https://seer.cancer.gov/tools/seerrx/*) for immunotherapeutic agents.
- *Palliative Care:* If chemotherapy was administered as palliative (provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable) then also record in the item Palliative Care.

Code	Label
00	None, chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as first course therapy.

03	Multiagent chemotherapy administered as first course therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age progression of tumor prior to administration, 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 the first course of therapy. No reason was stated in patient record.
87	Chemotherapy 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 patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Date Hormone Therapy Started

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1230	8	CoC	Standards for Oncology Registry Entry (STORE)

Description

Date of initiation for hormone therapy that is part of the first course of treatment.

Justification

The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

Coding Instructions

1. Record the first or earliest date on which hormone therapy was administered at any facility. This date corresponds to the administration of the agents coded in *Hormone Therapy*.
2. This data item is required by OCCR for all reporting years.
3. Date format is DDMMYYYY when the full date is known, MMYYYY when only the month and year are known and YYYY when only the year is known.

RX Summ – Hormone Therapy

NAACCR Item #	*Length*	*Source of Standard*	
1400	2	NAACCR	SEER Program Coding & Staging Manual Standards for Oncology Registry Entry (STORE)

Description

Records whether systemic hormonal agents were administered as first course treatment at any facility, or the reason they were not given. 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.

Justification

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy.

Coding Instructions

Code	Label
00	None, hormone therapy was not part of the planned first course of therapy.
01	Hormone therapy administered as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
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 first course 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, the 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.
89	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in the patient record. Death certificate-only cases.

- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone), COPP (cyclophosphamide, vincristine, procarbazine, prednisone), CHOP or R-CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone).
- Always check SEER*Rx Interactive Antineoplastic Drugs Database (https://seer.cancer.gov/tools/seerrx/) to determine if a hormone agent is part of a combination chemotherapy regimen
- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy. (**Exception:** See note below regarding hormone thyroid replacement therapy.) Assign code 00 when:
    - Hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
    - Diagnosed at autopsy.
    - The treatment plan offered multiple treatment options and the patient selected treatment that did not include hormone therapy or if the option of “no treatment” was accepted by the patient.
- Assign code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
- Assign code 82, 85, 86 or 87 to record the reason why no hormone therapy was administered when it is known that hormone therapy is usually administered for this type and stage of cancer but was not administered to the patient.
    - Assign code 87 when the patient refuses recommended hormone or refused all treatment before or after treatment recommendations were made.
- Assign code 88 if hormone therapy was recommended but it is unknown if it was administered.

- Assign code 99 when it is unknown if hormone therapy is typically administered for the type and stage of cancer and there is no mention in the medical record if it was recommended or administered. Death certificate only case. Refer to the SEER*Rx Interactive Drug Database (https://seer.cancer.gov/seertools/seerrx/) for hormonal therapy agents.
- *Palliative Care:* If hormone therapy was administered as palliative (provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable) then also record in the item Palliative Care.

Date BRM (Immunotherapy) Started

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1240	8	CoC	Standards for Oncology Registry Entry (STORE)

Description

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

Justification

The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first course therapy and to reconstruct the sequence of first course treatment modes.

Coding Instructions

1. Record the first or earliest date on which immunotherapy or a biologic response modifier was administered by any facility. This date corresponds to the administration of the agents coded in Immunotherapy.
2. This data item is required by OCCR for all reporting years.
3. Date format is DDMMYYYY when the full date is known, MMYYYY when only the month and year are known and YYYY when only the year is known.

RX Summ – BRM (Immunotherapy)

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1410	2	SEER/CoC	SEER Program Coding & Staging Manual Standards for Oncology Registry Entry (STORE)

Description

Records immunotherapeutic (biological therapy, biotherapy, or biological response modifier) agents administered as first course of therapy. Immunotherapy uses the body's immune system, either directly or indirectly, to fight cancer or to reduce the side effects that may be caused by some cancer treatments. Record only those treatments that are administered to affect the cancer cells.

Justification

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of immunotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if immunotherapy was not administered.

Coding Instructions

NOTE: The following drugs changed categories effective with cases diagnosed 01/01/2013 and forward.

Drug Name/Brand Name	Pre-2013 Category	New Category effective 01/01/2013
Alemtuzumab/Campath	Chemotherapy	BRM/Immunotherapy
Bevacizumab/Avastin	Chemotherapy	BRM/Immunotherapy
Rituximab/Rituxin	Chemotherapy	BRM/Immunotherapy
Trastuzumab/Herceptin	Chemotherapy	BRM/Immunotherapy
Pertuzumab/Perjeta	Chemotherapy	BRM/Immunotherapy
Cetuximab/Erbitux	Chemotherapy	BRM/Immunotherapy

*SEER*RX should be used for assistance in coding systemic therapy correctly.*

- Assign code 00 when:
  - Immunotherapy was not administered, not recommended, or not indicated for the type of cancer.
  - If there is no information in the medical record regarding immunotherapy and it is typically not administered for this type of cancer or stage.
  - If the treatment offered multiple alternative treatment options and the patient chose treatment that did not include immunotherapy, or the treatment plan was no treatment.
  - Diagnosis is at autopsy.
- Assign codes 82, 85, 86 or 87 when it is known that immunotherapy is usually administered for the type of cancer but was not administered to the patient.
  - Assign code 87 when the patient refuses recommended immunotherapy or refused all treatment before or after treatment recommendations were made.
- Assign code 88 if immunotherapy was recommended but it is unknown if it was administered.
- Assign code 88 when the only information available is that the patient was referred to an oncologist
- Assign code 99 when it is unknown if immunotherapy is typically administered for the type and stage of cancer and there is no mention in the medical record if it was recommended or administered. Death certificate only case. Refer to the SEER*Rx Interactive Drug Database (https://seer.cancer.gov/tools/seerrx/) for immunotherapeutic agents.
- *Palliative Care:* If immunotherapy was administered as palliative (provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable) then also record in the item Palliative Care.

RX Summ – Hematologic Transplant/Endocrine Procedure

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
3250	2	CoC	Standards for Oncology Registry Entry (STORE)

Description

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.

Justification

Allows the evaluation of patterns of treatment, which involve the alteration of the immune system or change the patient's response to tumor cells, but do not involve the administration of antineoplastic agents. In addition, when evaluating the quality of care, it is useful to know the reason if these procedures were not performed.

Coding Instructions

Code	Label
00	No transplant procedure or endocrine therapy was administered as part of first course therapy. Diagnosed at autopsy.
10	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 and infusion. Umbilical cord stem cell transplant, with blood from one or multiple umbilical cords.
30	Endocrine surgery and/or endocrine radiation therapy.
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, progression of disease prior to administration, etc.).
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 the first course of therapy. No reason was stated in 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, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record. Death certificate only.

- *Bone Marrow Transplants:* Code as either autologous (bone marrow originally taken from the patient) or allogenic (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.
- *Stem Cell Harvest:* involves the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.
- *Stem Cell Transplant: Procedure to replenish supply of healthy blood-forming cells. Also known as bone marrow transplant, PBSCT, or umbilical cord blood transplant, depending on the source of the stem cells. When stem cells are collected from bone marrow and transplanted into a patient, the procedure is known as a bone marrow transplant. If the transplanted stem cells came from the bloodstream, the procedure is called a peripheral blood stem cell transplant, sometimes shortened to stem cell transplant.*

- *Umbilical cord stem cell transplant: Treatment with stem cells harvested from umbilical cord blood.*
- *Endocrine irradiation and/or endocrine surgery:* 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.
- Assign code 00 when:
    - A transplant or endocrine procedure was not administered, not recommended, or not indicated for the type of cancer.
    - If there is no information in the medical record regarding a transplant or endocrine procedure and it is typically not administered for this type of cancer or stage.
    - If the treatment offered multiple alternative treatment options and the patient chose treatment that did not include a transplant or endocrine procedure, or the treatment plan was no treatment.
    - Diagnosis is at autopsy.
- Assign code 10 if the patient has a bone marrow transplant and it is unknown if autologous or allogeneic (BMT, NOS) or "mixed chimera transplant (mini-transplant or non- myeloablative transplant). These transplants are a mixture of the patient's cells and donor cells.
- Codes 11 (Bone marrow transplant autologous) and 12 (Bone marrow transplant allogeneic) have priority over code 10 (BMT, NOS)
- Assign code 12 (allogeneic) for a syngeneic bone marrow transplant (from an identical twin) or for a transplant from any person other than the patient
- Assign code 20 for
    - Allogeneic stem cell transplant
    - Peripheral blood stem cell transplant
    - Umbilical cord stem cell transplant (single or double)
- Assign code 30 for endocrine radiation and/or surgery. Endocrine organs are testes and ovaries. Endocrine radiation and/or surgical procedures must be bilateral or must remove the remaining paired organ for hormonal effect.
    - Note: Bilateral oophorectomy is coded 30 when it is performed for hormonal effect for breast, endometrial, vaginal, and other primary cancers
- Assign codes 82, 85, 86 or 87 when it is known that a transplant or endocrine procedure is usually administered for the type of cancer but was not administered to the patient.
    - Assign code 87 when the patient refuses recommended transplant or endocrine procedure or refused all treatment before or after treatment recommendations were made.
- Assign code 88 if a transplant or endocrine procedure was recommended but it is unknown if it was administered.
- Assign code 99 when it is unknown if a transplant or endocrine procedure is typically administered for the type and stage of cancer and there is no mention in the medical record if it was recommended or administered. Death certificate only case.

- *Palliative Care:* If a transplant or endocrine procedure was administered as palliative (provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable) then also record in the item Palliative Care.

RX Summary Systemic/Surgery Sequence

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1639	1	CoC	Standards for Oncology Registry Entry (STORE)

Description

Records the order in which systemic therapy and surgical procedures were given as part of first course treatment.

Justification

The sequence of systemic therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Coding Instructions

1. For the purpose of coding the data item Systemic Sequence with Surgery, 'Surgery' is defined as a Surgical Procedure of Primary Site (codes 10-90) or Scope of Regional Lymph Node Surgery (codes 2-7) or Surgical Procedure of Other Site (codes 1-5). Systemic therapy encompasses the treatment modalities captured by chemotherapy, hormone therapy, immunotherapy and Hematologic Transplants and Endocrine Procedures.
2. Assign **code 0** when:
    - Neither surgery nor systemic therapy was performed.
    - Surgery was performed but not systemic therapy.
    - Systemic therapy was performed but not surgery.
    - It is unknown if the patient has surgery and/or systemic therapy.
        - Death certificate only cases
    - Both systemic therapy and surgery were performed, use codes 2-9
3. If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

Code	Label	Definition
0	No systemic therapy and/or surgical procedures	No systemic therapy given or unknown if systemic 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 it is unknown whether any surgery given.
2	Systemic therapy before surgery	Systemic 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	Systemic therapy after surgery	Systemic 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	Systemic therapy both before and after surgery	At least two courses of systemic therapy are given before and at least two more after surgery to the primary site; scope of regional lymph

		node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed. This includes cancer treated with neoadjuvant systemic therapy (not bridge therapy) followed by surgery followed by hormone therapy.
5	Intraoperative systemic 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 systemic therapy with other therapy administered before or after surgery	Intraoperative systemic 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 systemic 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 systemic therapy	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 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.

Date Other Treatment Started

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1250	8	CoC	Standards for Oncology Registry Entry (STORE)

Description

Records the date of initiation of other treatment that is part of the first course of treatment at any facility. Other treatment is defined in the data item, “Other Treatment” [1240], below.

Justification

The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first course therapy and to reconstruct the sequence of first course treatment modes.

Coding Instructions

1. Record the first or earliest date on which other treatment was administered by any facility.
2. This data item is required by OCCR for all reporting years.
3. Date format is DDMMYYYY when the full date is known, MMYYYY when only the month and year are known and YYYY when only the year is known.

Other Treatment

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1420	1	SEER/CoC	SEER Program Coding & Staging Manual Standards for Oncology Registry Entry (STORE)

Description

Other treatment is cancer-directed therapy that cannot be defined as surgery, radiation or systemic therapy according to the defined data items in this manual. This item is also used for supportive care

treatment for reportable hematopoietic diseases that do not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." 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. OCCR Note: This data item is also used to code the participation in a double-blind clinical trial.

Justification

Information on other therapy is used to describe and evaluate the quality-of-care and treatment practices.

Coding Instructions

- Primary treatment for certain reportable hematopoietic diseases could be supportive care that does not meet the usual definition of treatment that modifies, controls, removes, or destroys proliferating cancer tissue.
- Supportive care may include phlebotomy, transfusion, or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the Commission on Cancer have agreed to record treatments such as phlebotomy, transfusion, or aspirin as "Other Treatment" (Code 1) for certain hematopoietic diseases ONLY. 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.

Code	Label	Definition
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.
1	Other	Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy).
2	Other-Experimental	This code is not defined. It may be used to record participation in institution-based clinical trials.
3	Other-Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven	Cancer treatments administered by nonmedical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.

- Assign code 1 for:
    - Embolization using alcohol as an embolizing agent.

  - Embolization to a site other than the liver where the embolizing agent is unknown
  - PUVA (psoralen and long-wave ultraviolet radiation).
- Assign code 2 for any experimental or newly developed treatment, such as a clinical trial, that differs greatly from proven types of cancer therapy.
- 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 appropriately.
- Assign code 6 for cancer treatment administered by nonmedical personnel or for unconventional methods whether they are the only therapy or are given in combination with conventional therapy.
- Do not code embolization given prior to surgery to shrink the tumor.
- *Palliative Care:* If other treatment was administered as palliative (provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable) then also record in the item Palliative Care.
- Assign code 8 if it is known that a physician recommended *Other Treatment* but is unknown if it was administered.
- Assign code 0 when diagnosed at autopsy.
- Code 9 for Death Certificate Only cases.

RX Summ – Treatment Status

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1285	1	SEER/CoC	SEER Program Coding & Staging Manual Standards for Oncology Registry Entry (STORE)

Description

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

Justification

This item documents active surveillance (watchful waiting) and eliminates searching each treatment modality to determine whether treatment was given.

Coding Instructions

- 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 is not coded in this item.
- Use code 0 when treatment is refused, or the physician decides not to treat for any reason, such as the presence of comorbidities.
- Assign code 0 when the patient does not receive any treatment.
- Scope of Regional Lymph Node Surgery may be coded 0, 1-7, or 9.
- Assign code 1 when the patient receives treatment collected in any of the following data items.
  a. Surgery of Primary Site
  b. Surgical Procedure of Other Site
  c. Radiation Treatment Modality, Phase I, II, III
  d. Chemotherapy
  e. Hormone Therapy

f. Immunotherapy
g. Hematologic Transplant and Endocrine Procedures
h. Other Therapy

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

Date Case Completed

NAACCR Item #	*Length*		*Source of Standard*	*Manual*
2090	8		NAACCR	NAACCR Data Dictionary Version 23

Description
The date that: (1) the abstractor decided that the tumor report was complete, and (2) the case passed all edits that were applied.

Abstracted By

NAACCR Item #	*Length*	*Source of Standard*	Manual
570	3	CoC	Standards for Oncology Registry Entry (STORE)

Description
Records the initials of the individual abstracting the case.
Justification
This item can be used for quality control and management in multi-staffed registries.

Coding Instructions
Code all three initials of the abstractor.

SECTION 10

ABSTRACTING FOLLOW–UP DATA

Date of Last Contact or Date of Death

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1750	8	SEER/CoC	SEER Program Coding & Staging Manual Standards for Oncology Registry Entry (STORE)

Description

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

Justification

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

Coding Instructions

Record the last date on which the patient was known to be alive or the date of death.

- This can include the day the patient was last seen at your facility, date of last contact, or date of death.
- Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
- If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the **Remarks** text area, document that the patient is deceased, and the date of death is unavailable.
- If the patient has more than one primary tumor, code each primary with the last date of contact or the date of death of the patient.

Vital Status

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1760	8	SEER/CoC	SEER Program Coding & Staging Manual Standards for Oncology Registry Entry (STORE)

Description

This data element records whether the patient is still living or has expired.

Justification

This information is related to the *Date of Last Contact or of Death* and will not pass edits without being completed. It is used to evaluate the registry follow-up index and outcome statistics.

Coding Instructions

- Code the patient's vital status as of the date recorded in the *Date of Last Contact or Death* field. Use the most current and accurate information available.
- If the patient has multiple primaries **simultaneously**, all records should have the same vital status.

Code	Label
0	Dead
1	Alive

Place of Death – State

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1942	2	NAACCR	NAACCR Data Dictionary Version

Description

State or Province where the patient died and where certificate of death is filed.

Justification

This field helps carry out death clearance. When a reporting facility reports a place of death, the information can help in death certificate matching.

Coding Instructions

- Leave blank if the patient is alive.
- See the SEER Program and Coding Manual Appendix B for proper Country and State Codes.

Code	Label
Blank	Patient is alive
ZZ	Unknown state
State Codes	https://seer.cancer.gov/tools/codingmanuals/index.html Appendix B

Place of Death – Country

NAACCR Item #	*Length*	*Source of Standard*	*Manual*
1944	3	NAACCR	NAACCR Data Dictionary

Description

Country in which the patient died and where certificate of death is filed.

Justification

This field also helps carry out death clearance. When a reporting facility reports a place of death, the information can help in death certificate matching.

Coding Instructions

- Leave blank if the patient is alive.
- See the SEER Program and Coding Manual Appendix B for proper Country and State Codes.

Code	Label
Blank	Patient is alive
ZZU	Unknown state
State Codes	https://seer.cancer.gov/tools/codingmanuals/index.html Appendix B

Follow–Up Source

NAACCR Item #	*Length*	*Source of Standard*	Manual
1790	3	CoC	Standards for Oncology Registry Entry (STORE)

Description

Records the source from which the latest follow-up/vital status information was obtained.

Justification

This data item is used by registries to identify the most recent follow-up source.

Coding Instructions

Code	Label	Definition
0	Reported Hospitalization	Hospitalization at another institution/hospital or first admission to the reporting facility.
1	Readmission	Hospitalization or outpatient visit at the reporting facility.
2	Physician	Information from a physician.
3	Patient	Direct contact with the patient.
4	Department of Motor Vehicles	The Department of Motor Vehicles confirmed the patient has a current license.
5	Medicare/Medicaid file	The Medicare or Medicaid office confirmed the patient is alive.
7	Death Certificate	Information from the death certificate only.
8	Other	Friends, relatives, employers, other registries, or any sources not covered by other codes.
9	Unknown; not stated in patient record	The follow-up source is unknown or not stated in patient record.

SECTION 11

DATA REVIEW GUIDELINES

Data Review Guidelines

These simple reviews will help to eliminate common reporting errors:

- Is the **primary site** clearly supported in the text and is it consistent with the code used for primary site?
- Is the **histology code, behavior code and grade codes** correct according to the description in the pathology report?
- If this is a **paired organ**, is the laterality code supported in the text?
- Is **summary stage** clearly documented in stage text in the abstract (tumor size, extension, lymph nodes, distant metastasis)?
- Are all **treatment dates, agents and/or procedure codes** supported by text?
- Do dates make sense when compared to the **date of first contact** and **date of diagnosis?**

BOTTOM LINE: does the abstract data make sense and **does the text documentation support the coding and dates in the abstract**?

APPENDIX A – Reporting Laws and HIPAA

FEDERAL LEGISLATION

106 STAT. 3373 Public Law 102-515 - 102d Congress October 24, 1992
https://www.congress.gov/bill/102nd-congress/senate-bill/3312/text/cps

OKLAHOMA LEGISLATION

Oklahoma Statute (OS) Title 63. Public Health and Safety Public Health Code 551.1
§63-1-551.1. Establishment and Maintenance of Tumor Registry.
https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=98115

Oklahoma Statute (OS) Title 63. Public Health and Safety Public Health Code 1701.1A and 1701.2
§63–1–1701.1A Violation of rules, regulations, or standards - Orders - Penalties.
§63–1–1701.2 Administrative Warrants.
https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=98535
https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=98537

Oklahoma Administrative Code
Title 310, Ch 567 State Central Cancer Registry
https://rules.ok.gov/code?q=

HEALTH INSURANCE PORTABILITY AND ACCOUNTABIITY ACT (HIPAA)

https://www.hhs.gov/hipaa/index.html

HIPAA resources for Cancer Registrars
https://www.naaccr.org/hippa/

FAQs about HIPAA and Reporting for Hospital Based Cancer Registry

FAQs about HIPAA and Cancer Registry Revised (revised 05/19)

APPENDIX B – Instructions for Lymphatic & Hematopoietic Diseases

APPENDIX B – Instructions for Lymphatic & Hematopoietic Diseases

Coding leukemia, lymphoma and myeloid malignancies is a complex process. This appendix provides data collection resources for coding these primaries. There are two tools for use with these rules:

1. Hematopoietic & Lymphoid Neoplasm Database (Heme DB)
    a. A tool to assist in screening for reportable cases and determining reportability requirements.
    b. The database contains abstracting and coding information for all hematopoietic and lymphoid neoplasm (9590/3-9993/3).
2. Hematopoietic & Lymphoid Neoplasm Coding Manual (PDF, 1.0 MB)
    a. Reportability instructions and rules for determining the number of primaries, the primary site and histology, and the cell lineage or phenotype.
    b. The introduction to the manual has an updated Steps in Priority Order for using the Hematopoietic and Lymphoid Neoplasm Coding Manual & Database.

General Instructions

The Heme DB and Manual enable registrars to identify and understand hematopoietic and lymphoid neoplasms as well as to correctly and consistently abstract and code cases. Briefly, the steps for using these resources are as follows:

1. Identify the working (preliminary) histology code(s).

2. Use the Multiple Primary Rules to determine the number of primaries using the working histology code(s).

3. Verify or revise the working histology code(s) using the Primary Site and Histology (PH) Rules.

4. Determine primary site using the Primary Site and Histology Rules in this manual (see Note on next page).

There are many sub-topics that need to be reviewed for the above steps. Abstractors **must** review the coding rules, guidelines, and instructions in the opening chapters of the Hematopoietic & Lymphoid Neoplasm Coding Manual prior to abstracting these disease processes.

Education

SEER*Educate provides training on how to use the Heme Manual and DB. Step-by-step instructions are provided for each case scenario to learn how to use the application and manual to arrive at the answer provided.

Citation

Ruhl J, Adamo M, Dickie L., Negoita, S. (September 2020). *Hematopoietic and Lymphoid Neoplasm Coding Manual.* National Cancer Institute, Bethesda, MD, 2020.

The rules, guidelines, and the Hematopoietic Database follow the *World Health Organization (WHO) Classification of Tumours of Haematopoietic and Lymphoid Tissues.* Revised 4th ed. Swerdlow SH, Campo E, Harris NL, Jaffe ES, Pileri SA, Stein H, Thiele J, Vardiman JW, eds. WHO Classification of Tumours, Volume 2. IARC Press; 2016.

APPENDIX C – SEER Country and State Codes

SEER Country and State Codes

For Coding Place of Birth and Place of Death

https://seer.cancer.gov/tools/codingmanuals/index.html Appendix B

ALPHABETICAL LISTING

Name of Country/State	ISO Country Code	USPS State Code
Afghanistan	AFG	XX
Africa, NOS1	ZZF	YY
Alabama	USA	AL
Aland Islands	ALA	XX
Alaska	USA	AK
Albania	ALB	XX
Alberta	CAN	AB
Algeria	DZA	XX
American Samoa	ASM	AS
Andorra	AND	XX
Angola	AGO	XX
Anguilla	AIA	XX
Antarctica	ATA	XX
Antigua and Barbuda	ATG	XX
Argentina	ARG	XX
Arizona	USA	AZ
Arkansas	USA	AR
Armed Forces Americas (except Canada)	USA	AA
Armed Forces Europe, the Middle East, and Canada	USA	AE
Armed Forces Pacific	USA	AP
Armenia	ARM	XX
Aruba	ABW	XX
Asia, NOS[1]	ZZA	YY
Australia	AUS	XX
Austria	AUT	XX
Azerbaijan	AZE	XX
Bahamas (the)	BHS	XX
Bahrain	BHR	XX
Bangladesh	BGD	XX
Barbados	BRB	XX
Belarus	BLR	XX
Belgium	BEL	XX
Belize	BLZ	XX

Name of Country/State	ISO Country Code	USPS State Code
Benin	BEN	XX
Bermuda	BMU	XX
Bhutan	BTN	XX
Bolivia (Plurinational State of)	BOL	XX
Bonaire, Saint Eustatius and Saba	BES	XX
Bosnia and Herzegovina	BIH	XX
Botswana	BWA	XX
Bouvet Island	BVT	XX
Brazil	BRA	XX
British Columbia	CAN	BC
British India	IOT	XX
Brunei Darussalam	BRN	XX
Bulgaria	BGR	XX
Burkina Faso	BFA	XX
Burundi	BDI	XX
California	USA	CA
Cabo Verde (formerly Cape Verde)	CPV	XX
Cambodia	KHM	XX
Cameroon	CMR	XX
Canada	CAN	CD
Cayman Islands (the)	CYM	XX
Central African Republic (the)	CAF	XX
Central America, NOS[1]	ZZC	YY
Chad	TCD	XX
Chile	CHL	XX
China	CHN	XX
Christmas Island	CXR	XX
Cocos (Keeling) Islands (the)	CCK	XX
Colombia	COL	XX
Colorado	USA	CO
Comoros (the)	COM	XX
Congo (the)	COG	XX
Congo (the Democratic Republic of)	COD	XX
Connecticut	USA	CT
Cook Islands (the)	COK	XX
Costa Rica	CRI	XX
Cote d'Ivoire (formerly Ivory Coast)	CIV	XX
Croatia	HRV	XX

Name of Country/State	ISO Country Code	USPS State Code
Cuba	CUB	XX
Curacao	CUW	XX
Cyprus	CYP	XX
Czechia (formerly Czech Republic)	CZE	XX
Czechoslovakia1	CSK	YY
Delaware	USA	DE
Denmark	DNK	XX
District of Columbia	USA	DC
Djibouti	DJI	XX
Dominica	DMA	XX
Dominican Republic (the)	DOM	XX
Ecuador	ECU	XX
Egypt	EGY	XX
El Salvador	SLV	XX
England	ENG	XX
Equatorial Guinea	GNQ	XX
Eritrea	ERI	XX
Estonia	EST	XX
Eswatini (formerly Swaziland)	SWZ	XX
Ethiopia	ETH	XX
Europe, NOS[1]	ZZE	YY
Falkland Islands (the)	FLK	XX
Faroe Islands (the)	FRO	XX
Fiji	FJI	XX
Finland	FIN	XX
Florida	USA	FL
France	FRA	XX
French Guiana	GUF	XX
French Polynesia	PYF	XX
French Southern Territories (the)		
Gabon	GAB	XX
Gambia (the)	GMB	XX
Georgia	USA	GA
Georgia	GEO	XX
Germany	DEU	XX
Ghana	GHA	XX
Gibraltar	GIB	XX
Greece	GRC	XX

Name of Country/State	ISO Country Code	USPS State Code
Greenland	GRL	XX
Grenada	GRD	XX
Guadeloupe	GLP	XX
Guam	GUM	GU
Guatemala	GTM	XX
Guernsey	GGY	XX
Guinea	GIN	XX
Guinea-Bissau	GNB	XX
Guyana	GUY	XX
Haiti	HTI	XX
Hawaii	USA	HI
Heard Island and McDonald Islands		
Holy See (the)		
Honduras	HND	XX
Hong Kong	HKG	XX
Hungary	HUN	XX
Iceland	ISL	XX
Idaho	USA	ID
Illinois	USA	IL
India	IND	XX
Indiana	USA	IN
Indonesia	IDN	XX
Iowa	USA	IA
Iran (Islamic Republic of)		
Iraq	IRQ	XX
Ireland	IRL	XX
Isle of Man	IMN	XX
Israel	ISR	XX
Italy	ITA	XX
Jamaica	JAM	XX
Japan	JPN	XX
Jersey	JEY	XX
Jordan	JOR	XX
Kansas	USA	KS
Kazakhstan	KAZ	XX
Kentucky	USA	KY
Kenya	KEN	XX
Kiribati	KIR	XX

Name of Country/State	ISO Country Code	USPS State Code
Korea (the Democratic People's Republic of) (used for North Korea)		
Korea (the Republic of) (used for South Korea)		
Kuwait	KWT	XX
Kyrgyzstan	KGZ	XX
Lao People's Democratic Republic (the)		
Latvia	LVA	XX
Lebanon	LBN	XX
Lesotho	LSO	XX
Liberia	LBR	XX
Libya	LBY	XX
Liechtenstein	LIE	XX
Lithuania	LTU	XX
Louisiana	USA	LA
Luxembourg	LUX	XX
Macao	MAC	XX
Madagascar	MDG	XX
Maine	USA	ME
Malawi	MWI	XX
Malaysia	MYS	XX
Maldives	MDV	XX
Mali	MLI	XX
Malta	MLT	XX
Manitoba	CAN	MB
Marshall Islands (the)	MHL	MH
Martinique	MTQ	XX
Maryland	USA	MD
Massachusetts	USA	MA
Mauritania	MRT	XX
Mauritius	MUS	XX
Mayotte	MYT	XX
Mexico	MEX	XX
Michigan	USA	MI
Micronesia (Federal States of)		
Minnesota	USA	MN
Mississippi	USA	MS
Missouri	USA	MO
Moldova (the Republic of)		
Monaco	MCO	XX

Name of Country/State	ISO Country Code	USPS State Code
Mongolia	MNG	XX
Montana	USA	MT
Montenegro	MNE	XX
Montserrat	MSR	XX
Morocco	MAR	XX
Mozambique	MOZ	XX
Myanmar (formerly Burma)	MMR	XX
Namibia	NAM	XX
Nauru	NRU	XX
Nebraska	USA	NE
Nepal	NPL	XX
Netherlands (the)	NLD	XX
Nevada	USA	NV
New Brunswick	CAN	NB
New Caledonia	NCL	XX
New Hampshire	USA	NH
New Jersey	USA	NJ
New Mexico	USA	NM
New York	USA	NY
New Zealand	NZL	XX
Newfoundland and Labrador	CAN	NL
Nicaragua	NIC	XX
Niger (the)	NER	XX
Nigeria	NGA	XX
Niue	NIU	XX
Non-US/Canada NOS[1]	ZZX	YY
Norfolk Island	NFK	XX
North America, NOS[1]	ZZN	YY
North Carolina	USA	NC
North Dakota	USA	ND
North Korea	PRK	XX
North Macedonia	MKD	XX
Northern Ireland	NIR	XX
Northern Mariana	MNP	MP
Northwest Territories	CAN	NT
Norway	NOR	XX
Nova Scotia	CAN	NS
Nunavut	CAN	NU

Name of Country/State	ISO Country Code	USPS State Code
Ohio	USA	OH
Oklahoma	USA	OK
Oman	OMN	XX
Ontario	CAN	ON
Oregon	USA	OR
Pacific, NOS[1]	ZZP	YY
Pakistan	PAK	XX
Palau	PLW	PW
Palestine (State of)	PSE	XX
Panama	PAN	XX
Papua New Guinea	PNG	XX
Paraguay	PRY	XX
Pennsylvania	USA	PA
Peru	PER	XX
Philippines (the)	PHL	XX
Pitcairn	PCN	XX
Poland	POL	XX
Portugal	PRT	XX
Prince Edward Island	CAN	PE
Puerto Rico	PRI	PR
Qatar	QAT	XX
Quebec	CAN	QC
Réunion	REU	XX
Rhode Island	USA	RI
Romania	ROU	XX
Russian Federation (the)	RUS	XX
Rwanda	RWA	XX
Saint Barthelemy	BLM	XX
Saint Helena, Ascension and Tristanda Cunha		
Saint Kitts and Nevis	KNA	XX
Saint Lucia	LCA	X
Saint Martin (French part)	MAF	XX
Saint Pierre and Miquelon	SPM	XX
Saint Vincent the Grenadines	VCT	XX
Samoa	WSM	XX
San Marino	SMR	XX
Sao Tome	STP	XX
Saskatchewan	CAN	SK

Name of Country/State	ISO Country Code	USPS State Code
Saudi Arabia	SAU	XX
Scotland	SCT	XX
Senegal	SEN	XX
Serbia	SRB	XX
Seychelles	SYC	XX
Sierra Leone	SLE	XX
Singapore	SGP	XX
Sint-Maarten (Dutch part)	SXM	XX
Slovakia	SVK	XX
Slovenia	SVN	XX
Solomon Islands	SLB	XX
Somalia	SOM	XX
South Africa	ZAF	XX
South America, NOS[1]	ZZS	YY
South Carolina	USA	SC
South Dakota	USA	SD
South Georgia and the South Sandwich Islands	SGS	XX
South Korea (see Korea (the Republic of))	KOR	XX
South Sudan	SSD	XX
Spain	ESP	XX
Sri Lanka	LKA	XX
Sudan (the)	SDN	XX
Suriname	SUR	XX
Svalbard and Jan Mayen	SJM	XX
Sweden	SWE	XX
Switzerland	CHE	XX
Syrian Arab Republic (the)	SYR	XX
Taiwan (Province of China)	TWN	XX
Tajikistan	TJK	XX
Tanzania, the United Republic of	TZA	XX
Tennessee	USA	TN
Texas	USA	TX
Thailand	THA	XX
Timor-Leste	TLS	XX
Togo	TGO	XX
Tokelau	TKL	XX
Tonga	TON	XX
Trinidad, and Tobago	TTO	XX

Name of Country/State	ISO Country Code	USPS State Code
Tunisia	TUN	XX
Turkey	TUR	XX
Turkmenistan	TKM	XX
Turks and Caicos Islands (the)	TCA	XX
Tuvalu	TUV	XX
Uganda	UGA	XX
Ukraine	UKR	XX
United Arab Emirates (the)	ARE	XX
United Kingdom of Great Britain and Northern Ireland (the)	GBR	XX
United States Minor Outlying Islands (the)	UMI	XX
United States of America (the)	USA	US
Unknown1	ZZU	ZZ
Uruguay	URY	XX
Utah	USA	UT
Uzbekistan	UZB	XX
Vanuatu	VUT	XX
Venezuela (Bolivarian Republic of)	VEN	XX
Vermont	USA	VT
Viet Nam	VNM	XX
Virgin Islands (British)	VGB	XX
Virgin Islands (U.S.)	VIR	VI
Virginia	USA	VA
Wales	WLS	XX
Wallis and Futuna	WLF	XX
Washington	USA	WA
West Virginia	USA	WV
Western Sahara	ESH	XX
Wisconsin	USA	WI
Wyoming	USA	WY
Yemen	YEM	XX
Yugoslavia1	YUG	YY
Yukon Territory	CAN	YT
Zambia	ZMB	XX
Zimbabwe	ZWE	XX

APPENDIX D – Common Abbreviations

NAACCR Abbreviations and Acronyms

Abbreviation/Symbol	Word/Term(S)
^	Above or elevated
&	And
≈	Approximately
@	At
=	Equals
>	Greater than, more, or more than
<	Less or less than
-	Negative or minus
#	Number or pound(s)
+	Plus or positive
X	Times
A	
A FIB	Atrial fibrillation
A/P	Abdomen/Pelvis
AA	African American
ABD	Abdomen (abdominal)
ABG	Arterial blood gases
ABN	Abnormal
ABNL	Abnormal
ABS	Absent/Absence
ABST	Abstract/Abstracted
ABX	Antibiotics
ACH	Adrenal cortical hormone
ACID PHOS	Acid phosphatase
A-COLON	Ascending Colon
ACTH	Adrenocorticotrophic hormone
ADENOCA	Adenocarcinoma

Abbreviation/Symbol	Word/Term(S)
ADENOP	Adenopathy
ADH	Antidiuretic hormone
ADJ	Adjacent
ADL	Activities of daily living
ADM	Admission/Admit
ADR	Adverse drug reaction
AFP	Alpha-fetoprotein
AG	Antigen
AGL	Acute granulocytic leukemia
AI	Aromatase inhibitor
AIDS	Acquired Immune Deficiency Syndrome
AIHA	Autoimmune hemolytic anemia
AIN III or AIN 3	Anal intraepithelial neoplasia, grade III
AK(A)	Above knee (amputation)
AKA	Also known as
ALB	Albumin
ALK PHOS	Alkaline phosphatase
ALL	Acute lymphocytic leukemia
ALND	Axillary Lymph node dissection
AM	Before noon
AMA	Against medical advice
AMB	Ambulatory
AMI	Acute myocardial infarction
AML	Acute myelogenous leukemia
AMP	Amputation
AMT	Amount
ANAP	Anaplastic
ANGIO	Angiography/Angiogram

Abbreviation/Symbol	Word/Term(S)
ANS	Autonomic nervous system
ANT	Anterior
AP	Abdominal perineal
A-P	Anteroposterior
APP	Appendix
APPL'Y	Apparently
ARDS	Acute Respiratory Distress (Disease) Syndrome
ARF	Acute renal failure
ART	Artery (ial)
ASA	Aspirin, Acetylsalicylic acid
ASAP	As soon as possible
ASP	Aspiration
ASSOC	Associated
ATP	Adenosine triphosphate
AUT	Autopsy
AVG	Average
AVM	Arteriovenous malformation
AX	Axilla(ry)
AXLND	Axillary Lymph node dissection
B	
B/F	Black female
B/L	Bilateral
B/M	Black male
BCC	Basal cell carcinoma
BCG	Bacillus Calmette-Guerin
BD	Bile duct
BF	Black female
BID	Twice a day (daily)

Abbreviation/Symbol	Word/Term(S)
BIL	Bilateral
BK(A)	Below knee (amputation)
B/L	Bilateral
BM	Black Male
BM	Bone marrow
BM	Bowel movement
BMBX	Bone marrow biopsy
BMI	Body mass index
BMT	Bone marrow transplant
BOT	Base of tongue
BP	Blood pressure
BPH	Benign prostatic hypertrophy/hyperplasia
BR	Bloom-Richardson
BRACHY	Brachytherapy
BRBPR	Bright red blood per rectum
BRCA 1 and BRCA 2	Breast cancer susceptibility gene
BRM	Biological response modifier
BRO	Brother
BSA	Body surface area
BSC	Bone scan
BSO	Bilateral salpingo-oophorectomy
BT	Bladder tumor or Brain tumor
BUN	Blood urea nitrogen
BX	Biopsy
C	
C/A/P	Chest, abdomen, pelvis
C/O	Complaint (-ning) of
C/W	Consistent with

Abbreviation/Symbol	Word/Term(S)
C1-C7	Cervical vertebrae
CA	Carcinoma
CA 125	Cancer antigen 125
CA 19-9	Carbohydrate antigen 19-9
CABG	Coronary artery bypass graft
CAD	Coronary artery disease
CALC(S)	Calcification(s)
CBC	Complete blood count
CC	Chief complaint or Cubic centimeter
CCU	Coronary care unit
CEA	Carcinoembryonic antigen
CF	Cystic fibrosis
CFN	Centimeters from nipple
CGA	Serum chromogranin A
CGL	Chronic granulocytic leukemia
CGY	Centigray
CHD	Congenital heart disease
CHEMO	Chemotherapy
CHF	Congestive heart failure
CHG	Change
CHR	Chronic
CIG	Cigarettes
CIN	Cervical intraepithelial neoplasia
CIN III or CIN 3	Cervical intraepithelial neoplasia, grade III
CIS	Carcinoma *in situ*
CISH	Chromogenic in situ hybridization
CLL	Chronic lymphocytic leukemia
CLR	Clear

Abbreviation/Symbol	Word/Term(S)
CM	Centimeter
CML	Chronic myeloid (myelocytic) leukemia
CNS	Central nervous system
CO60	Cobalt 60
COLD	Chronic obstructive lung disease
CONT	Continue/continuous
CONTRA	Contralateral
COPD	Chronic obstructive pulmonary disease
CRF	Chronic renal failure
CRM	Circumferential resection margin
CS	Collaborative stage
CSF	Cerebrospinal fluid
C-SPINE	Cervical spine
CT	CAT/CT scan/Computerized axial tomography
CTC	Circulating tumor cells
CUC	Chronic ulcerative colitis
CVA	Cerebrovascular accident
CVD	Cardiovascular disease
CXR	Chest X-ray
CYSTO	Cystoscopy
CYTO	Cytology
D	
D&C	Dilatation and curettage
D/C	Discharge
D/T	Due to
DC	Discontinue(d)
DCIS	Ductal carcinoma in situ
D-COLON	Descending colon

Abbreviation/Symbol	Word/Term(S)
DDX	Differential diagnosis
DECR	Decrease(d)
DERM	Dermatology
DIAM	Diameter
DIFF	Differentiated/differential
DISCH	Discharge
DJD	Degenerative joint disease
DK	Don't/Doesn't know
DM	Diabetes mellitus
DNA	Deoxyribonucleic acid
DOA	Dead on arrival
DOB	Date of birth
DOD	Date of death
DOE	Dyspnea on exertion
DRE	Digital rectal examination
DTC	Disseminated tumor cells
DVT	Deep vein thrombosis
DX	Diagnosis
DZ	Disease
E	
E.G.	For example
E/O	Evidence of
EBRT	External beam radiotherapy
ECG/EKG	Electrocardiogram
ED	Emergency department
EEG	Electroencephalogram
EENT	Eye, ear, nose, throat
EGD	Esophagogastroduodenoscopy

Abbreviation/Symbol	Word/Term(S)
EGFR	Epidermal growth factor receptor
ELEV	Elevated
EMG	Electromyogram
ENL	Enlarged
ENLGD	Enlarged
ENT	Ears, nose, and throat
ER	Emergency room
ER(A)	Estrogen receptor (assay)
ERCP	Endoscopic retrograde cholangiopancreatography
ESRD	End stage renal disease
ETOH	Alcohol
EUA	Exam under anesthesia
EV	Electron volt
EVAL	Evaluation
EXAM	Examination
EXC(D)	Excision/excised
EXP	Expired
EXP LAP	Exploratory laparotomy
EXPL	Exploratory
EXPL LAP	Exploratory laparotomy
EXT	Extend/extension
F	
FAP	Familial adenomatous polyposis
FCOT	First course of treatment
FHX	Family History
FISH	Fluorescence in situ hybridization
FL	Fluid
FLIPI	Follicular lymphoma international prognostic index

Abbreviation/Symbol	Word/Term(S)
FLOW CYTO	Flow cytometry
FLURO	Fluoroscopy
FNA	Fine needle aspiration
FNAB	Fine needle aspiration biopsy
FOM	Floor of mouth
FREQ	Frequent/Frequency
FS	Frozen section
FTSG	Full thickness skin graft
FU	Follow-up
FUO	Fever of unknown origin
FX	Fracture
FX(S)	Fractions(s)
G	
GB	Gallbladder
GE	Gastroesophageal
GEN	General/Generalized
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GIST	Gastrointestinal stromal tumors
GR	Grade
GU	Genitourinary
GY	Gray
GYN	Gynecology
H	
H&E	Hematoxylin and Eosin
H&P	History and physical
H/H	Hemoglobin and hematocrit
H/O	History of

Abbreviation/Symbol	Word/Term(S)
HAV	Hepatitis A (virus)
HBV	Hepatitis B (virus)
HCG	Human chorionic gonadotropin
HCT	Hematocrit
HCV	Hepatitis C (virus)
HDR	High dose rate
HDV	Hepatitis D (virus)
HEM/ONC	Hematology/Oncology (ist)
HEP A	Hepatitis A (virus)
HEP B	Hepatitis B (virus)
HEP C	Hepatitis C (virus)
HEP D	Hepatitis D (virus)
HER2	Human epidermal growth factor receptor 2
HF	Hispanic female
HGB	Hemoglobin
HGSIL	High grade squamous intraepithelial lesion
HIV	Human Immunodeficiency Virus
HM	Hispanic male
HORM	Hormone
HOSP	Hospital
HPI	History of present illness
HPV	Human Papilloma Virus
HR(S)	Hour/Hours
HRT	Hormone replacement therapy
HSM	Hepatosplenomegaly
HTLV	Human T-Lymphotropic Virus, (Type III)
HTN	Hypertension
HX	History

Abbreviation/Symbol	Word/Term(S)
HYST	Hysterectomy
I	
I&D	Incision & drainage
I-131	Iodine 131
IBD	Inflammatory bowel disease
ICB	Intracavitary brachytherapy
ICM	Intercostal margin
ICS	Intercostal space
ICU	Intensive care unit
IDC	Infiltrating/invasive ductal carcinoma
IDDM	Insulin-dependent diabetes mellitus
IG	Immunoglobulin
IHC	Immunohistochemical
ILD	Interstitial lung disease
IM	Intramuscular
IMP	Impression
IMRT	Intensity modulated radiation therapy
INCL	Includes/Including
INCR	Increase(d)
INF	Inferior
INFIL	Infiltrating
INFILT	Infiltrating
INPT	Inpatient
INT	Internal
INV	Invade(s)/invading/invasion
INVL	Involve(s)/involvement/involving
IP	Inpatient
IPI	International prognostic index (for lymphoma)

Abbreviation/Symbol	Word/Term(S)
IPS	International prognostic score
IPSI	Ipsilateral
IRREG	Irregular
IT	Intrathecal
ITC	Isolated tumor cells
ITP	Idiopathic thrombocytopenia
IV	Intravenous
IVC	Inferior vena cava
IVCA	Intravenous cholangiogram
IVP	Intravenous pyelogram
J	
JAK2	Janus kinase 2
JRA	Juvenile rheumatic arthritis
JVD	Jugular venous distention
K	
KG	Kilogram
KS	Kaposi sarcoma
KUB	Kidneys, ureters, bladder
KV	Kilovolt
L	
L1-L5	Lumbar vertebra
LAB	Laboratory
LAD	Lymphadenopathy
LAN	Lymphadenopathy
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-associated virus
LB(S)	Pound(s)

Abbreviation/Symbol	Word/Term(S)
LCIS	Lobular carcinoma in situ
LCM	Left costal margin
LDH	Lactic dehydrogenase
LDR	Low dose rate
LE	Lower extremity
LFT	Liver function test
LIN	Laryngeal intraepithelial neoplasia
LINAC	Linear accelerator
LIQ	Lower inner quadrant
LLE	Left lower extremity
LLL	Left lower lobe
LLQ	Left lower quadrant
LMP	Last menstrual period
LN(S)	Lymph node(s)
LND	Lymph node dissection
LOQ	Lower outer quadrant
LRG	Large
LS	Lumbosacral
LSO	Left salpingo-oophorectomy
L-SPINE	Lumbar spine
LS SCAN	Liver/spleen scan
LT	Left
LUE	Left upper extremity
LUL	Left upper lobe
LUOQ	Left upper outer quadrant
LUQ	Left upper quadrant
LVI	Lymph/vascular invasion / Lymphovascular invasion
M	

Abbreviation/Symbol	Word/Term(S)
M/DIFF	Moderately differentiated
MAL	Malignant
MALIG	Malignant
MAMMO	Mammogram
MAND	Mandible/mandibular
MAX	Maximum
MC	Medical center
MC(H)	Millicurie (hours)
MCG	Microgram
MCN	Mucinous cystic neoplasm
MCTD	Mixed connective tissue disease
MD	Moderately differentiated
MDS	Myelodysplastic syndrome
MED	Medication
MED ONC	Medical oncology (ist)
METS	Metastatic/Metastasis
MEV	Million electron volts
MG	Myasthenia gravis
MG(H)	Milligram (hours)
MGF	Maternal grandfather
MGM	Maternal grandmother
MGUS	Monoclonal gammopathy of uncertain significance
MI	Myocardial infarction
MIBB	Minimally invasive breast biopsy
MICRO	Microscopic
MIN	Minimum
MIN	Minute
MIS	Melanoma in situ

Abbreviation/Symbol	Word/Term(S)
ML	Middle lobe
ML	Milliliter
MM	Millimeter
MMG	Mammogram
MO(S)	Months
MOD	Moderate(ly)
MOD DIFF	Moderately differentiated
MRCP	Magnetic resonance cholangiopancreatography
MRI	Magnetic resonance imaging
MRM	Modified radical mastectomy
MRSA	Methicillin Resistant Staphylococcus Aureus
MS	Multiple sclerosis
MSB	Main stem bronchus
MSI	Microsatellite instability
MULT	Multiple
MV	Megavolt
N	
N&V	Nausea and vomiting
N/A	Not applicable
N/V	Nausea and vomiting
NA	Not applicable
NE	No evidence
NEC	Not elsewhere classified
NED	No evidence of disease
NEG	Negative
NEOPL	Neoplasm
NET	Neuroendocrine tumor
NEURO	Neurology

Abbreviation/Symbol	Word/Term(S)
NH	Nursing home
NHL	Non-Hodgkin lymphoma
NIDDM	Non-insulin dependent diabetes mellitus
NML	Normal
NORM	Normal
NOS	Not otherwise specified
NR	Not recorded
NR	Not reportable
NSCCA	Non-small cell carcinoma
NSCLC	Non-small cell lung carcinoma
NSF	No significant findings
O	
OB	Obstetrics
OBS	Organic brain syndrome
OBST	Obstructed (-ing, -ion)
ONC	Oncology (ist)
OP	Outpatient
OP RPT	Operative report
OR	Operating room
ORTHO	Orthopedics
OTO	Otology
OUTPT	Outpatient
OZ	Ounce
P	
P/DIFF	Poorly differentiated
P32	Phosphorus 32
PAC	Premature atrial contraction
PALP	Palpated (-able)

Abbreviation/Symbol	Word/Term(S)
PAP	Papanicolaou smear
PAP	Papillary
PATH	Pathology
PBSCT	Peripheral blood stem cell transplant
PCP	Primary care physician
PCV	Polycythemia vera
PD	Poorly differentiated
PE	Physical examination
PEDS	Pediatrics
PERC	Percutaneous
PET	Positron emission tomography
PGF	Paternal grandfather
PGM	Paternal grandmother
PIN III or PIN 3	Prostatic intraepithelial neoplasia, grade III
PLT	Platelets
PMH	Past/personal (medical) history
PMP	Primary medical physician
PNS	Peripheral nervous system
POOR DIFF	Poorly differentiated
POS	Positive
POSS	Possible
POST	Posterior
POST OP	Postoperative(-ly)
PPD	Packs per day
PR	Per rectum
PR(A)	Progesterone receptor (assay)
PRE-OP	Preoperative(-ly)
PREV	Previous

Abbreviation/Symbol	Word/Term(S)
PROB	Probable (-ly)
PROCTO	Proctoscopy
PS	Performance status
PSA	Prostatic specific antigen
PT	Patient
PT	Physiotherapy/Physical therapy
PTA	Prior to admission
PTC	Percutaneous transhepatic cholecystogram
PTCC	Papillary transitional cell carcinoma
PUD	Peptic ulcer disease
PULM	Pulmonary
PVD	Peripheral vascular disease
P VERA	Polycythemia vera
PY	Pack years
Q	
Q	Every
QD	Every day
QUAD	Quadrant
R	
R/O	Rule out
RA	Rheumatoid arthritis
RAD	Radiation absorbed dose
RAD ONC	Radiation Oncology
RAEB	Refractory anemia with excess blasts
RAI	Radioactive iodine
RAIU	Radioactive iodine uptake
RAL	Robotic assisted laparoscopy
RARP	Robotic assisted radical prostatectomy

Abbreviation/Symbol	Word/Term(S)
RBBB	Right bundle branch block
RBC	Red blood cells (count)
RCC	Renal cell carcinoma
RCM	Right costal margin
RCS	Reticulum cell sarcoma
RE	Regarding
REC	Recommend
REC'D	Received
REFRACT ANEM	Refractory anemia
REG	Regional
REG	Regular
RESEC	Resection (ed)
RIA	Radioimmunoassay
RIQ	Right inner quadrant
RLE	Right lower extremity
RLL	Right lower lobe
RLQ	Right lower quadrant
RMC	Regional medical center
RML	Right middle lobe
ROF	Review of outside films
RONC	Radiation Oncology
ROQ	Right outer quadrant
ROS	Review of outside slides
RRP	Radical retropubic prostatectomy
RSO	Right salpingo-oophorectomy
RT	Radiation therapy
RT	Right
RUE	Right upper extremity

Abbreviation/Symbol	Word/Term(S)
RUL	Right upper lobe
RUQ	Right upper quadrant
RX	Prescription
RXT	Radiation therapy
S	
S/P	Status post
S1-S5	Sacral vertebra
SATIS	Satisfactory
SB	Small bowel
SCC	Squamous cell carcinoma
SCF	Supraclavicular fossa
SCID	Severe combined immunodeficiency syndrome
S-COLON	Sigmoid colon
SCT	Stem cell transplant
SCV	Supraclavicular
SGOT	Serum glutamic oxaloacetic transaminase
SGPT	Serum glutamic pyruvic transaminase
SH	Social history
SHX	Social history
SIG COLON	Sigmoid colon
SIN III or SIN 3	Squamous intraepithelial neoplasia
SLE	Systemic lupus erythematosus
SLL	Small lymphocytic lymphoma
SLN	Sentinel lymph node
SLNBX	Sentinel lymph node biopsy
SM	Small
SmCC	Small cell carcinoma
SO	Salpingo-oophorectomy

Abbreviation/Symbol	Word/Term(S)
SOB	Short(ness) of breath
SPEC	Specimen
SPEP	Serum protein electrophoresis
SQ	Squamous
SS	Summary stage
S-SPINE	Sacral spine
SSS	Sick sinus syndrome
STSG	Split thickness skin graft
SQCC	Squamous cell carcinoma
SUBCU	Subcutaneous
SUBQ	Subcutaneous
SUGG	Suggestive
SURG	Surgery/Surgical
SUSP	Suspicious/suspected
SVC	Superior vena cava
SX	Symptoms
T	
T1-T12	Thoracic vertebra
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy- bilateral salpingo-oophorectomy
TB	Tuberculosis
TB	Tumor board
TCC	Transitional cell carcinoma
T-COLON	Transverse colon
TIA	Transient ischemic attack
TNM	Tumor, node, metastasis
TOB	Tobacco
TRANS-COLON	Transverse colon

Abbreviation/Symbol	Word/Term(S)
TRUS	Transrectal ultrasound
TS	Tumor size
T-SPINE	Thoracic spine
TTP	Thrombotic thrombocytopenia purpura
TUR	Transurethral resection
TURB	Transurethral resection bladder
TURP	Transurethral resection prostate
TVC	True vocal cord
TVH	Total vaginal hysterectomy
TX	Treatment
U	
UE	Upper extremity
UGI	Upper gastrointestinal (series)
UIQ	Upper inner quadrant
UNDIFF	Undifferentiated
UNK	Unknown
UOQ	Upper outer quadrant
URI	Upper respiratory infection
US	Ultrasound
UTI	Urinary tract infection
V	
VAG	Vagina/Vaginal
VAG HYST	Vaginal hysterectomy
VAIN III or VAIN 3	Vaginal intraepithelial neoplasia (grade III)
VIN III or VIN 3	Vulvar intraepithelial neoplasia (grade III)
VGP	Vertical growth phase
VGR	Vertical growth rate
VS	Vital signs

Abbreviation/Symbol	Word/Term(S)
W	
W/	With
W/DIFF	Well differentiated
W/F	White female
W/M	White male
W/O	Without
W/U	Work-up
WBC	White blood cells (count)
WD	Well differentiated
WELL DIFF	Well differentiated
WF	White female
WK(S)	Week(s)
WL	Weight loss
WM	White male
WNL	Within normal limits
WPW	Wolff-Parkinson-White syndrome
WT	Weight
X	
XR	X-ray
XRT	External radiation therapy
Y	
Y/O	Year old
YO	Year old
YR(S)	Year(s)
Y-90	Ytrium-90

APPENDIX E – 2025 Changes and Updates

2025 New Data Items and Changes
Oklahoma Central Cancer Registry

Applicable for cases diagnosed January 1, 2025 and forward, NAACCR version 25

New Data Items

Site Specific Data Items

NAACCR Item #	SSDI Name	Schema
1172	**PTLD**	**Lymphoma (00790)** **Lymphoma-CLL/SLL (00795)** **Plasma Cell Disorders (00822)** **Plasma Cell Myeloma (00821)** **Primary Cutaneous Lymphoma (00812)**
This SSDI is effective for diagnosis years 2025+ PTLD [1172] or Post Transplant Lymphoproliferative Disorder, when identified in conjunction with the schemas below, is added as an SSDI. The presence of PTLD, either polymorphic or monomorphic, has clinical significance and prognostic value, especially in the Pediatric and Adolescent and Young Adult (AYA) populations. **Note:** PTLD identified not in conjunction with these schemas would be abstracted as a separate primary, refer to Hematopoietic Manual for additional information.		
1174	**PD-L1**	**Lung V9* (09360)**
This SSDI is effective for diagnosis years 2025+ PD-L1 [1174] is added as an SSDI to Lung V9 (09360) as it is recommended by treatment guidelines for lung cancer to determine if the patient may benefit from checkpoint inhibitor drugs (immunotherapy).		

NPCR Data Items

NAACCR Item #	Item Name
No new NPCR required data items for 2024 not already identified in Site Specific Data Items above.	

Revised Data Items

Site Specific Data Items

NAACCR Item #	SSDI Name	Schema
3940	**BRAF Mutational Analysis**	**Colon and Rectum**
For BRAF Mutational Analysis [3940] within the Colon and Rectum schema, code 3 was added to capture abnormal (mutated)/detected, *KIAA1549: BRAF* gene fusion.		

Retired Data Items

NAACCR Item #	Item Name	Source of Standard
605	Inpatient Status	NAACCR
1510	Rad--Regional Dose: cGy	CoC
1520	Rad--No of Treatment Vol	CoC
1540	Rad--Treatment Volume	CoC
1741	Subsq RX--Reconstruct Del	CoC
1780	Quality of Survival	CoC
2155	RQRS NCDB Submission Flag	CoC
2310	Military Record No Suffix	CoC
3200	Rad--Boost RX Modality	CoC
3210	Rad--Boost Dose cGy	CoC

ICD-O-3

Beginning with cases diagnosed January 1, 2021, ICD-O-3.2 is the preferred morphology coding reference manual. This manual should be used jointly with the 2024 ICD-O Histology and Behavior Code Update tables, Hematopoietic and Lymphoid Neoplasm Database, and Solid Tumor Rules. Edits will enforce the new codes/behaviors.

There are no ICD-O-3 changes for 2025
You will continue to use the 2024 ICD-O Histology and Behavior Code Update tables for 2025 cases.

The IARC/WHO ICD-O Committee has indicated they will not be developing or publishing a print or downloadable .pdf version of ICD-O-3.2. Please use the coding table, linked below, available on the NAACCR website.
https://www.naaccr.org/wp-content/uploads/2020/10/Copy-of-ICD-O-3.2_MFin_17042019_web.xls

Coding Guidelines, tables 1-2 and the annotated list are located here https://www.naaccr.org/icdo3/
Note: Use of these guidelines is required for determining reportability and accurate coding.
Table 1: lists all changes for 2024 including five new ICD-O codes and terms, one code with changes to behavior, and new preferred or related terms, in numerical order by ICD-O number.
Table 2: lists all changes for 2024 including five new ICD-O codes and terms, one code with changes to behavior, and new preferred or related terms, in alpha order by histology term.

For 2024, no major changes have been identified during review of the 5th Editions WHO Urinary and Male Genital Tumors. Majority of changes for 2024 are new related terms for existing codes, five new ICD-O codes, four reportable and one non-reportable, and one histology that has changed behaviors and is now reportable.

IMPORTANT REMINDERS

Please check the 2024 ICD-O-3 Update Table 1 or 2 to determine if the histology is listed. If the histology is not included in the update, then review ICD-O-3.2 and/or Hematopoietic and Lymphoid Database and/or Solid Tumor Rules (MP/H).

ICD-O-3.2 included changes from all 4th Ed WHO Classification of Tumors books. New editions released following the publication of 4th editions are not included in 3.2. A new ICD-O version will be released once all 5th Ed Blue Books are published.

Site/Histology Validation List

The SEER Site/Histology Validation List was updated through 2023 and is used to check validity of site and morphology code combinations for cases diagnosed 2023 and earlier. See Cancer PathCHART for 2024+.

For cases diagnosed in 2024, this list was replaced by the 2024 Cancer PathCHART ICD-O-3 Site Morphology Validation List (2024 CPC SMVL). For cases diagnosed 2025 and forward, the applicable 2025 standards are in the 2025 CPC SMVL.

Both the 2024 and 2025 CPC SMVL files can be found at Cancer PathCHART ICD-O-3 Site Morphology Validation List.

Solid Tumor Rules

The content of the Solid Tumor Rules will be made consistent with the Cancer PathCHART tumor site and morphology standards annually.

General

The addition of new terminology, clarifications to equal/equivalent terms, and clarifications to terms that are not equal/equivalent comprise most of the changes for 2025.

New site-specific modules are not planned for 2025 at this time, pending the publication of the remaining *5th Edition WHO Classification of Tumours* books.

Reportability

Reportability for cases diagnosed in 2025 is based on the ICD-O Third Edition, Second Revision Morphology (ICD-O-3.2) plus the ICD-O-3.2 updates posted on the NAACCR website.

As of January 1, 2025, Post Transplant Lymphoproliferative Disorder (PTLD) 9971/1 is reportable as 9971/3. Refer to the Hematopoietic Manual for additional information.

Summary Stage 2018

OCCR continues to require directly assigned Summary Stage 2018 (most current version) for cases diagnosed on or after January 1, 2018. https://seer.cancer.gov/tools/ssm/
Older cases still require Summary Stage 1977, Summary Stage 2000 or CS Derived Summary Stage 2000 depending on the diagnosis year.

The notes for Summary Stage 2018 [764] were restructured to add titles. This modification should improve readability and help end users find relevant notes more quickly.

Some Summary Stage 2018 [764] notes were updated to improve clarity or address questions raised in various forums. Registrars are not required to update previously coded information.

Pediatric Data System

The OCCR will not require the Pediatric Data System.

Hematopoietic and Lymphoid Neoplasm Manual and Database

The Hematopoietic and Lymphoid Neoplasms Manual and Database (Heme manual) is effective for cases diagnosed 2010+.

Post Transplant Lymphoproliferative Disorder (PTLD) was previously reportable as 9971/3 for 2010-2020 when it was the only diagnosis. In 2021, based on the 4th edition of WHO Hematopoietic Blue Book, PTLD became 9971/1, where it was only reportable if it occurred in the brain. Starting in 2025, PTLD as the only diagnosis will become a /3 (malignant) again and will be reportable for all cases.

In addition, a new SSDI has been added to several schemas (Lymphoma, Lymphoma-CLL/SLL, Primary Cutaneous Lymphoma (excluding MF/SS), Plasma Cell Disorders, Plasma Cell Myeloma) for when a PTLD is diagnosed WITH a lymphoma, plasmacytoma, or multiple myeloma. (See the Hematopoietic Manual, Rules M14, PH1).

Cancer PathCHART

The Cancer Pathology Coding Histology and Registration Terminology (Cancer PathCHART) initiative is a ground-breaking collaboration of North American and global registrar, registry, pathology, and clinical organizations, including tumor and histology cancer data standard setters.

Cancer PathCHART aims to improve cancer surveillance data quality by updating standards for tumor site, histology, and behavior code combinations and associated terminology.

Updated standards will be implemented as follows:

- For cases diagnosed in 2023 and earlier, The 2023 ICD-O-3 SEER Site/Histology Validation List (the basis for the Primary Site, Morphology-Type, Beh ICDO3 (SEER IF38) (edit tag: N0446) edit) will be used to check site and morphology code combinations.
- For cases diagnosed in 2024, and later:
    - The CPC SMVLs will serve as the basis for the Primary Site, Morphology-Type, Beh ICDO3 2024 (N7040) edit, which checks for valid, unlikely, and impossible site, histology, and behavior code combinations based on diagnosis year
    - For any sites/organ systems yet to be reviewed by CPC, the 2023 standards will continue to be applied.
    -

For more information about Cancer PathCHART see the NAACCR 2025 Implementation Guidelines or the NCI SEER Cancer PathCHART webpage.

V25 Edits Meatfile

Changes to edits for cases diagnosed 2018 through 2024 address fixes to edit logic as well as updates to accommodate changes to existing data items for 2025. You may view changes in the NAACCR v25 Change Spreadsheet

Not sure how to correct an edit error? Use the Edit Detail Report to locate the edit error and its details.

The OCCR uses the standard NAAACR edit metafile released for each NAACCR version update. Within this edit metafile, the OCCR requires use of the Central: VsYY State Example – Incoming Abstracts edit set. All commercial

cancer registry software vendors will be provided with this information, as required, by October prior to the implementation date 01/01/YYYY.
2025 NAACCR Implementation
Webinar The NAACCR webinar "V25 Updates: Solid Tumor Rules, SSDIs and More!" can be viewed here https://education.naaccr.org/updates-implementation **Summary for Hospital Registrars and Reporting Facilities** https://www.naaccr.org/implementation-guidelines/ 2025, Section 13, page 31

*V9 refers to AJCC Version 9 Protocols

Information listed in this document pertains exclusively to the OCCR reporting requirements as mandated by the CDC NPCR. ACoS CoC accredited hospitals have additional updates and changes beyond the scope of this document. Please refer to the NAACCR implementation guidelines for updates and changes from all standard setters or contact the ACoS for CoC accredited hospital questions.

APPENDIX F – Required Data Items

NPCR Required Data Items, current and historical per the NAACCR Data Dictionary v24 Required Status Table

OCCR Reference year: 1997
Diagnosis years required to be reported to the OCCR: 1997-2024

Codes for Requirements	
R	Required
R#	Required; central registries may code available data using either SEER or CoC data items and associated rules
R*	Required, when available
R^	Required, these text requirements may be met with one or several text block fields
RH	Historically collected and currently transmitted
RH*	Historically collected and currently transmitted when available
RS*	Required, site specific; when available

NAACCR Data Item Number	Data Item Name	Section Name	NPCR Collect
70	Addr at DX--City	Demographic	R
80	Addr at DX--State	Demographic	R
90	County at DX Reported	Demographic	R
100	Addr at DX--Postal Code	Demographic	R
160	Race 1	Demographic	R
161	Race 2	Demographic	R
162	Race 3	Demographic	R
163	Race 4	Demographic	R
164	Race 5	Demographic	R
190	Spanish/Hispanic Origin	Demographic	R
220	Sex	Demographic	R
230	Age at Diagnosis	Demographic	R
240	Date of Birth	Demographic	R
252	Birthplace--State	Demographic	R*
254	Birthplace--Country	Demographic	R*
272	Census Ind Code 2010 CDC	Demographic	R*
282	Census Occ Code 2010 CDC	Demographic	R*
310	Text--Usual Occupation	Demographic	R*
320	Text--Usual Industry	Demographic	R*
344	Tobacco Use Smoking Status	Demographic	R*
390	Date of Diagnosis	Cancer Identification	R
400	Primary Site	Cancer Identification	R
410	Laterality	Cancer Identification	R
501	Casefinding Source	Cancer Identification	R*

NAACCR Data Item Number	Data Item Name	Section Name	NPCR Collect
522	Histologic Type ICD-O-3	Cancer Identification	R
523	Behavior Code ICD-O-3	Cancer Identification	R
540	Reporting Facility	Hospital-Specific	R
545	NPI--Reporting Facility	Hospital-Specific	R*
580	Date of 1st Contact	Hospital-Specific	R*
610	Class of Case	Hospital-Specific	R
630	Primary Payer at DX	Hospital-Specific	R*
756	Tumor Size Summary	Stage/Prognostic Factors	R
764	Summary Stage 2018	Stage/Prognostic Factors	R
820	Regional Nodes Positive	Stage/Prognostic Factors	R
830	Regional Nodes Examined	Stage/Prognostic Factors	R
1068	Grade Post Therapy Clin (yc)	Stage/Prognostic Factors	R*
1172	PTLD	Stage/Prognostic Factors	RS*
1174	PD-L1	Stage/Prognostic Factors	RS*
1182	Lymphovascular Invasion	Stage/Prognostic Factors	R*
1200	RX Date Surgery	Treatment-1st Course	R*
1210	RX Date Radiation	Treatment-1st Course	R*
1220	RX Date Chemo	Treatment-1st Course	R*
1230	RX Date Hormone	Treatment-1st Course	R*
1240	RX Date BRM	Treatment-1st Course	R*
1250	RX Date Other	Treatment-1st Course	R*
1270	Date 1st Crs RX CoC	Treatment-1st Course	R#*
1285	RX Summ--Treatment Status	Treatment-1st Course	R#
1291	RX Summ--Surg Prim Site 2023	Treatment-1st Course	R
1292	RX Summ--Scope Reg LN Sur	Treatment-1st Course	R
1294	RX Summ--Surg Oth Reg/Dis	Treatment-1st Course	R
1340	Reason for No Surgery	Treatment-1st Course	R
1380	RX Summ--Surg/Rad Seq	Treatment-1st Course	R
1390	RX Summ--Chemo	Treatment-1st Course	R
1400	RX Summ--Hormone	Treatment-1st Course	R
1410	RX Summ--BRM	Treatment-1st Course	R
1420	RX Summ--Other	Treatment-1st Course	R
1430	Reason for No Radiation	Treatment-1st Course	R
1506	Phase I Radiation Treatment Modality	Treatment-1st Course	R
1639	RX Summ--Systemic/Sur Seq	Treatment-1st Course	R
1750	Date of Last Contact	Follow-up/Recurrence/ Death	R
1760	Vital Status	Follow-up/Recurrence/ Death	R

NAACCR Data Item Number	Data Item Name	Section Name	NPCR Collect
1910	Cause of Death	Follow-up/Recurrence/Death	R
1920	ICD Revision Number	Follow-up/Recurrence/Death	R
1942	Place of Death--State	Demographic	R
1944	Place of Death--Country	Demographic	R*
1990	Over-ride Age/Site/Morph	Edit Overrides/Conversion History/System Admin	R
2000	Over-ride SeqNo/DxConf	Edit Overrides/Conversion History/System Admin	R
2010	Over-ride Site/Lat/SeqNo	Edit Overrides/Conversion History/System Admin	R
2020	Over-ride Surg/DxConf	Edit Overrides/Conversion History/System Admin	R
2030	Over-ride Site/Type	Edit Overrides/Conversion History/System Admin	R
2040	Over-ride Histology	Edit Overrides/Conversion History/System Admin	R
2050	Over-ride Report Source	Edit Overrides/Conversion History/System Admin	R
2060	Over-ride Ill-define Site	Edit Overrides/Conversion History/System Admin	R
2070	Over-ride Leuk, Lymphoma	Edit Overrides/Conversion History/System Admin	R
2071	Over-ride Site/Behavior	Edit Overrides/Conversion History/System Admin	R
2074	Over-ride Site/Lat/Morph	Edit Overrides/Conversion History/System Admin	R
2078	Over-ride Name/Sex	Edit Overrides/Conversion History/System Admin	R
2152	CoC Accredited Flag	Edit Overrides/Conversion History/System Admin	R
2230	Name--Last	Patient-Confidential	R
2232	Name--Birth Surname	Patient-Confidential	R
2240	Name--First	Patient-Confidential	R
2250	Name--Middle	Patient-Confidential	R
2280	Name--Alias	Patient-Confidential	R
2300	Medical Record Number	Patient-Confidential	R
2315	Medicare Beneficiary Identifier	Patient-Confidential	R*
2320	Social Security Number	Patient-Confidential	R
2330	Addr at DX--No & Street	Patient-Confidential	R
2335	Addr at DX--Supplementl	Patient-Confidential	R
2520	Text--DX Proc--PE	Text-Diagnosis	R^
2530	Text--DX Proc--X-ray/Scan	Text-Diagnosis	R^
2540	Text--DX Proc--Scopes	Text-Diagnosis	R^
2550	Text--DX Proc--Lab Tests	Text-Diagnosis	R^
2560	Text--DX Proc--Op	Text-Diagnosis	R^
2570	Text--DX Proc--Path	Text-Diagnosis	R^
2580	Text--Primary Site Title	Text-Diagnosis	R^
2590	Text--Histology Title	Text-Diagnosis	R^
2600	Text--Staging	Text-Diagnosis	R^
2610	RX Text--Surgery	Text-Treatment	R^

NAACCR Data Item Number	Data Item Name	Section Name	NPCR Collect
2620	RX Text--Radiation (Beam)	Text-Treatment	R^
2630	RX Text--Radiation Other	Text-Treatment	R^
2640	RX Text--Chemo	Text-Treatment	R^
2650	RX Text--Hormone	Text-Treatment	R^
2660	RX Text--BRM	Text-Treatment	R^
2670	RX Text--Other	Text-Treatment	R^
3170	RX Date Mst Defn Srg	Treatment-1st Course	R*
3250	RX Summ--Transplnt/Endocr	Treatment-1st Course	R
3816	Brain Molecular Markers	Stage/Prognostic Factors	RS
3817	Breslow Tumor Thickness	Stage/Prognostic Factors	RS
3827	Estrogen Receptor Summary	Stage/Prognostic Factors	RS
3829	Esophagus and EGJ Tumor Epicenter	Stage/Prognostic Factors	RS
3835	Fibrosis Score	Stage/Prognostic Factors	RS
3838	Gleason Patterns Clinical	Stage/Prognostic Factors	RS
3839	Gleason Patterns Pathological	Stage/Prognostic Factors	RS
3840	Gleason Score Clinical	Stage/Prognostic Factors	RS
3841	Gleason Score Pathological	Stage/Prognostic Factors	RS
3842	Gleason Tertiary Pattern	Stage/Prognostic Factors	RS*
3843	Grade Clinical	Stage/Prognostic Factors	R
3844	Grade Pathological	Stage/Prognostic Factors	R
3845	Grade Post Therapy Path (yp)	Stage/Prognostic Factors	R*
3855	HER2 Overall Summary	Stage/Prognostic Factors	RS
3890	Microsatellite Instability (MSI)	Stage/Prognostic Factors	RS*
3915	Progesterone Receptor Summary	Stage/Prognostic Factors	RS
3920	PSA (Prostatic Specific Antigen) Lab Value	Stage/Prognostic Factors	RS
3926	Schema Discriminator 1	Stage/Prognostic Factors	RS
3927	Schema Discriminator 2	Stage/Prognostic Factors	RS
3932	LDH Lab Value	Stage/Prognostic Factors	RS
3956	p16	Stage/Prognostic Factors	RS
3960	Histologic Subtype	Stage/Prognostic Factors	RS*
3964	Brain Primary Tumor Location	Stage/Prognostic Factors	RS

APPENDIX G – Texting Table

NAACCR Item #	Field Name, (NAACCR Field Name) and Field Length	OCCR Required Text Specifies the text that must be included in any abstract submitted to the Oklahoma Central Cancer Registry (OCCR).
		Text Diagnosis
2520	**Physical Exam Text** **(Text-DX Proc-PE)** **Length: 4000**	**Synoptic narrative** of any pertinent findings from the patient's inpatient and outpatient visits, including: • **Date of visit**. Must substantiate the date of first contact and the date of diagnosis (if not substantiated elsewhere in the abstract) • **Place of Visit/Provider's Name, Impression and Treatment Plan.** • **Symptoms at Diagnosis**. If asymptomatic or incidentally diagnosed, state reason for presenting to medical care. • **Pertinent Personal Medical History** related to the current cancer diagnosis, including prior history of cancer(s) if any. • **Physical exam findings at initial diagnosis**, including date of exam, where exam was performed, age, sex and race of patient and pertinent findings. ○ **All prostate primaries** must include results of DRE prior to any needle biopsies of the prostate. **All lymphoma primaries** must include PE evaluation of lymph nodes & presence or absence of 'B symptoms.
2530	**X-ray/Scan Text** **(Text-DX Proc-X-rays/Scans)** **Length: 4000**	**Chronologically** (using date of imaging) enter all relevant **film/imaging report results** done to diagnose and/or detail the extent of tumor involvement: • **Date** films taken • **Place** where films were taken • **Imaging modality & body part** being imaged (CT C, MRI Abd, TBBS, etc.) • **Description** of tumor, tumor invasion, lymph node status, tumor size (if mentioned) and presence or absence of metastatic disease. Record both positive and negative findings, with positive findings first. • **Results, findings and/or conclusions** from appropriate report(s) including differential diagnoses considered/ruled out/favored

2540	**Scopes Text**
	(Text-DX Proc-Scopes)
	Length: 4000
		Chronologically (using date of exam) enter all **endoscopic examinations** relevant to the initial diagnosis, staging and/or treatment of this primary:
		• **Date and place** of endoscopic exam
		• **Type or name** of endoscopic exam performed (including site scoped)
		• **Results, findings and/or conclusions** from endoscopic exam including:
		  ○ Primary site and histology (if given)
		  ○ Tumor size
		  ○ Lymph node evaluation
		• Tumor location (e.g., esophageal tumor extends from 32 cm to 40 cm from the incisors

2550	**Lab Tests Text** **(Text-DX Proc-Lab Tests)** **Length: 4000**	**Chronologically** (using date specimen obtained) enter all relevant **lab tests or tumor markers:** • **Date and place** lab tests or tumor markers taken • **Pathology or cytology report number** (if obtained from a histologic or cytologic pathology specimen) • **Type/Name** of lab test performed ○ Narrative documentation to support values coded in SSDIs, unless documented in another field **Test Results**, including normal test reference range or value, and/or physician interpretation

2560	**DX Procedures Text** **(Text-DX Proc-OP)** **Length: 4000**	**Chronologically** (using date of procedure) enter the observations of the surgeon or other appropriate physician from all diagnostic and surgical procedures, including: • **Date and place** of all diagnostic and surgical procedure(s) • **Name or type** of diagnostic and surgical procedure(s) • **Description** of tumor, tumor invasion, lymph node status and tumor size (if mentioned). Record both positive and negative findings. **Note:** Do not enter information from the pathology report here; information from pathology reports is entered in Text-DX Proc-Path.
2570	**Pathology Text** **(Text-DX Proc-Path)** **Length: 4000**	**Chronologically** (using date the specimen was obtained) record all relevant pathology and/or cytology results from all **diagnostic and surgical procedures**, including: • **Date** specimen(s) **Obtained (Date of Procedure)** • **Location/Place** where specimen was obtained. • **Pathology and/or Cytology Report Number(s)** • **Origin and Description** of specimens or tissue examined (e.g., biopsy, smear, surgical specimen, FNA, etc.) • **Final Histologic Diagnosis and Additional Details** including (but not limited to): o Morphology (cell type), behavior & grade of tumor o Primary tumor size, all dimensions when given o Description of tumor invasion from gross, microscopic and/or final diagnosis o Lymph node information o Surgical margins • **Additional Impressions from the Pathologist** (Including addendums, differential diagnoses considered/ruled out/favored, and consults that confirm or change the diagnosis) **Include information from the synoptic report, when available**
2580	**Primary Site** **Text (Text Primary Site)** **Length: 100**	**Synoptic narrative of:** • **Primary site,** and **Laterality** (for all paired sites)
2590	**Histology Text** **(Text-Histology Title)** **Length: 100**	**Synoptic narrative of:** • **Histologic (cell) type** and **behavior,** and Grade (both Clinical Grade and Pathologic Grade)
2600	**Text Staging** **(Text-Staging)** **Length: 4000**	**Synoptic narrative** of rationale to support **SEER Summary Stage** • Codes **must** include a narrative documentation of extent of disease • A brief description is acceptable (e.g., “cancer confined to prostate” or “SS2018 7/Distant mets to liver”) Facilities may use this area to also document AJCC TNM stage
Text-Treatment		
2610	**Text Surgery** **(RX Text-Surgery)** **Length: 4000**	**Chronologically** (using date of surgical ablation or resection) enter all relevant **surgical ablations or resections** done to provide cancer-directed treatment, including: • **Date** of surgical ablation or resection • **Location/place** where surgical ablation or resection was performed • **Name or description** of surgical ablation or resection performed • **Tissues removed**, including **lymph nodes, regional or adjacent tissues and metastatic sites** (as applicable) **Note:** The preferred text placement of observations by the surgeon(s) during the procedure is Text-DX Proc-OP
2620	**Text Radiation Beam** **(RX Text-Radiation Beam)** **Length: 4000**	**Chronologically** (using radiation start date) enter all relevant **beam radiation treatments** administered as cancer-directed treatment including: • **Date** beam radiation started for Phase 1 Radiation • **Place** where beam radiation was administered for Phase 1 Radiation

		• **Treatment details** for Phase 1 Radiation such as: ○ **Treatment modality (type of beam radiation** such as photon, proton, electron, etc.) Documentation of **patient refusal or reason why** beam radiation was not administered
2630	**Text Radiation Other** **(RX Text-Radiation Other)** **Length: 4000**	**Chronologically** (using radiation start date) enter all relevant **brachytherapy, systemic or other radiation treatments** administered as cancer-directed treatment including: • **Date brachytherapy, systemic or other radiation treatment** was administered for Phase 1 radiation • **Place** where brachytherapy, systemic or other radiation treatment was administered for Phase 1 Radiation • **Treatment details** for Phase 1 Radiation such as: ○ **Type of radiation** (including **modality** such as brachytherapy, etc.) Documentation of **patient refusal or reason why** beam radiation was not administered
2640	**Text Chemotherapy** **(RX Text-Chemotherapy)** **Length: 4000**	**Chronologically** (using chemotherapy start date) enter all relevant chemotherapy treatment details administered as cancer-directed treatment such as: • **Date(s)** chemotherapy agents were administered • **Place(s)** where chemotherapy was administered • **Treatment details** including names of all chemotherapy agents administered • Documentation of **patient refusal or reason why** chemotherapy was not administered
2650	**Text Hormone** **(RX Text-Hormone Therapy)** **Length: 4000**	**Chronologically** (using hormone therapy start date) enter all relevant hormone therapy treatment details administered as cancer-directed treatment such as: • **Date(s)** hormone therapy agents were administered • **Place(s)** where hormone therapy was administered • **Treatment details** including names of all hormone therapy agents administered Documentation of **patient refusal or reason why** hormone therapy was not administered
2660	**Text BRM** **(RX Text-BRM)** **Length: 4000**	**Chronologically** (using immunotherapy start date) enter all relevant immunotherapy treatment details administered as cancer-directed treatment such as: • **Date(s)** immunotherapy agents were administered • **Place(s)** where immunotherapy was administered • **Treatment details** including names of all immunotherapy agents administered • Documentation of **patient refusal or reason why** immunotherapy was not administered **Hematologic Transplants and Endocrine Procedures** documentation: • RX Text-BRM is also used to document hematologic transplants and endocrine procedures Hematopoietic transplants should include the source (bone marrow, peripheral blood, cord, etc.)
2670	**Text Other Treatment** **(RX Text-Other)** **Length: 4000**	**Chronologically** (using other therapy start date) enter all relevant other therapy treatment details administered as cancer-directed treatment, including experimental treatments and blinded clinical trials such as: • **Date(s)** other therapy agents were administered • **Place(s)** where other therapy was administered • **Treatment details** including names of all other therapy agents administered

		• Documentation of **patient refusal or reason why** other therapy was not administered
Text-Miscellaneous		
2680	**Text Remarks** **(Text Remarks)** **Length: 4000**	**Record all other known primary tumors**, including: • Sequence number of additional primaries (e.g., seq. 01) • **Primary site and laterality** • **Histology and behavior** • **Date of diagnosis** • **Location of diagnosis** (if known) **Additional information** could include: • Solid Tumor Rules used to determine number of primaries, recurrent disease, primary site and/or histology codes • Native American tribal affiliation (if known) • Place of death, date of death and where information was obtained • Pertinent family medical history Social history (smoking, alcohol use, etc.) if not documented in Text, PE
Demographic		
310	**Text-Usual Occupation** **Length: 100**	**Synoptic narrative** of the patient's usual occupation (usual type of job or work) • Record the patient's usual occupation (e.g., the kind of work performed during most of the patient's working life before diagnosis of this tumor). Do not record "retired" or NA (N/A or not available). If the usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation. If no occupational history is known or available, record "unknown".
320	**Text-Usual Industry** **Length: 100**	**Synoptic narrative** of the patient's usual occupation (usual type of business/industry) Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the greatest number of years prior to diagnosis of this tumor. The information for industry should be based on information listed in the "Occupation" field.

Texting Notes
NAACCR approved abbreviations should be used (see the NAACCR Data Dictionary Appendix G).
Do not repeat information from other fields.
Do not include irrelevant information; also, do not include information that the registry is not permitted to collect.
With the increase in field length, there should not be overflow text; however, in the rare instance this should occur, overflow text from other fields can be placed in Text-Remarks. For text documentation that is continued from one field to another, use asterisks or other symbols to indicate the connection with preceding text.
Text pertinent positive and negative findings. Text pertinent positive findings first followed by a simply stated summary of negative findings.
Text must substantiate all codes for that treatment type.
If a specific treatment or treatment modality has been recommended as part of a treatment plan or is typically administered as standard of care for the type and stage of disease but was not administered, document reason why it was not given (i.e., patient refused, etc.)
Information should be entered manually from the medical record and should not be generated automatically from coded values.

TEXT EXAMPLES

Case #1 (Skin primary)	
Field Name	**Text Example**
Pathology Text	11/1/2023 Downtown Derm Shave bx skin of Lt foot ABC23-123456: Invasive melanoma, acral type, Breslow's thickness 3.3 mm; 5 mitoses per mm2; LVI pos; PNI neg. Margins pos. pT3a 11/17/2023 ABC Hosp Wide excision skin of L foot w/SLN ABD23-234567: Malignant melanoma, acral type. Residual tumor thickness 2.2 mm. Margins neg. BRAF neg. 2/3 sentinel inguinal LNs w/mets melanoma, 0.3 mm. pT3a pN2a
Physical Exam Text	11/1/2023 Downtown Derm 54 y/o WF c/o skin lesion between her toes on Lt foot, present approx. 6 years, recently began increasing in size and bleeding. PE: Extensively sun damaged skin. An approx. 0.75 mm dark brown ulcerated lesion on webspace between the first and second toes on Lt. Recommended shave biopsy, performed. Remainder of exam WNL. 11/17/2023 ABC Hosp H&P: Pt presents for wide excision of previously diagnosed melanoma between her toes on Lt. She is also to have a sentinel lymph node biopsy.
X-ray/Scan Text	None
Lab Texts Text	11/5/2023 Downtown Derm LDH: 293 U/L (normal)
Scopes Text	None
DX Procedures Text	11/17/2023 ABC Hosp Wide excision skin of Lt foot w/SLN: NSF; greater than 1 cm margins were obtained.
Text Staging	SS2018: 3/LN Mets to 2 of 3 sentinel (Lt inguinal) lymph nodes
Primary Site Text	Skin of Lt foot
Histology Text	Melanoma, acral type
Text Surgery	11/1/2023 Downtown Derm Shave biopsy of Lt foot 11/17/2023 ABC Hosp Wide excision skin of Lt foot w/SLN
Text Radiation (Beam)	None
Text Radiation Other	None
Text Chemotherapy	None
Text Hormone	None
Text BRM (Immunotherapy)	12/29/2023 ABC Oncology Nivolumab
Text Other Treatment	None
Text, Remarks	
Text Usual Occupation	Unknown
Text Usual Industry	Unknown

Case #2 (Lung primary)	
Field Name	**Text Example**
Pathology Text	4/2/2023 ABC Med Ctr RUL bx w/FNA of stations 4R & 7 LNs ABC23-1234: Pulmonary adenocarcinoma w/solid predominant growth pattern. No evidence of mets in sampled LNs. 5/14/2023 ABC Med Ctr RUL Lobectomy w/MLND ABC23-3456 Synoptic report: Unifocal 5.7x3.5x2.1 cm solid adenocarcinoma poorly diff invading visceral pleura w/LVI. Peribronchial margin positive; bronchial & vascular margins neg. STAS not id'd. 1/3 10R LNs, 1/2 peribronchial LNs & 0/1 interlobar LN w/mets. pT4 pN1
Physical Exam Text	1/31/2023 ABC Med Ctr 67 y/o Hispanic male presents for evaluation of Rt shoulder pain and abnormal x-ray. Admits to mild SOB/DOE. No other significant PMH. Current smoker. PE: Decreased range of motion in Rt shoulder. Remainder of PE: NSF. Will order CT scan.
X-ray/Scan Text	2/5/2023 ABC Med Ctr CT C/A/P: 6.4 cm spiculated mass RUL abuts mediastinum, obstructs RUL airway w/suspected post obstructive pneumonia. Add'l nodule measures up to 1.5 cm. Findings almost certainly represent malignancy. Soft tissue fullness extends to Rt hilum. Mediastinal LNs are seen but not enlarged by size criteria. Remainder neg for mets. 3/8/2023 ABC Med Ctr PET: RUL malignancy measures 5.6 cm. No other malig uptake.
Lab Texts Text	ALK & EGFR not performed.
Scopes Text	4/2/2023 ABC Med Ctr Bronchoscopy w/bx, lavage & EBUS LN sampling: Complete occlusion of RUL apical segment. Station 4R & station 7 enlarged LNs, sampled.
DX Procedures Text	5/14/2023 ABC Med Ctr Robotic assisted converted to open RUL lobectomy w/MLND: NSF.
Text Staging	SS2018: 4/DE&RLN Direct extension to visceral pleura w/mets to hilar & peribronchial LNs
Primary Site Text	RUL Lung
Histology Text	Solid adenocarcinoma
Text Surgery	5/14/2023 ABC Med Ctr Robotic assisted converted to open RUL lobectomy w/MLND
Text Radiation (Beam)	5/28/2023 ABC Rad: Recommended combined chemoradiation but pt decided they did not want to proceed.
Text Radiation Other	None.
Text Chemotherapy	5/28/2023 ABC Onc: Recommended combined chemoradiation w/Cisplatin & Alimta x4 cycles but pt decided they did not want to proceed.
Text Hormone	Not recommended.

Text BRM (Immunotherapy)	Not recommended.
Field Name	**Text Example**
Text Other Treatment	Not recommended.
Text, Remarks	
Text Usual Occupation	Truck driver
Text Usual Industry	Transportation